# 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 THURSDAY 29TH MARCH 2018**

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

**A G E N D A – PART 1**

| Ref. | Item | Lead presenter | Attachment |
|---|---|---|---|
| 3-1 | To receive apologies for absence | Chair of the Trust Board | Verbal |
| 3-2 | To declare interests relevant to agenda items | Chair of the Trust Board | Verbal |
| 3-3 | Minutes of the Part 1 meeting of 1st March 2018 | Chair of the Trust Board | 1 |
| 3-4 | To note progress with previous actions | Chair of the Trust Board | 2 |
| 3-5 | Safety moment | Chief Nurse | Verbal |
| 3-6 | Report from the Chair of the Trust Board | Chair of the Trust Board | Verbal |
| 3-7 | Report from the Chief Executive | Chief Executive | 3 |
| 3-8 | A patient's experiences of the Trust's services | Chief Nurse[1] | Verbal |
| 3-9 | Integrated Performance Report for February 2018<br>▪ Effectiveness / Responsiveness<br>▪ Safe / Effectiveness / Caring<br>▪ Safe / Effectiveness (incl. mortality)<br>▪ Safe (infection control)<br>▪ Well-Led (finance)<br>▪ Well-Led (workforce) | Chief Executive<br>Chief Operating Officer<br>Chief Nurse<br>Medical Director<br>Dir. of Infect. Prev. & Control<br>Director of Finance<br>Director of Workforce | 4 |
| 3-10 | Update on Emergency Care Improvement Programme visit to the Maidstone & Tunbridge Wells hospitals, Jan. 2018 | Chief Operating Officer | 5 (to follow) |
| | **Quality items** | | |
| 3-11 | Approval of Trust response to the Kent and Medway Stroke review consultation | Medical Director | 6 (to follow) |
| 3-12 | Care Quality Commission inspection – report and response | Chief Nurse | 7 |
| 3-13 | Planned and actual ward staffing for February 2018 | Chief Nurse | 8 |
| 3-14 | Approval of updated declaration of compliance with eliminating Mixed Sex Accommodation | Chief Nurse | 9 |
| 3-15 | Quarterly mortality data | Medical Director | 10 |
| 3-16 | Proposals re Board members' Quality Walkarounds | Chief Nurse / Trust Sec. | 11 (to follow) |
| 3-17 | Proposals re the future of 'patient and staff experience' items at the Trust Board | Chief Nurse / Director of Workforce | Presentation |
| | **Planning and strategy** | | |
| 3-18 | Update on the Trust's 2018/19 planning | Director of Finance | Verbal |
| 3-19 | Update on the working capital loan | Director of Finance | 12 (N.B. The full document has been issued as a supplement to the main reports) |
| | **Assurance and policy** | | |
| 3-20 | Update from the SIRO (incl. approval of the IG Toolkit submission for 2017/18 & Board annual refresher training on Information Governance) | Chief Nurse | 13 |
| | **Reports from Trust Board sub-committees (and the Trust Management Executive)** | | |
| 3-21 | Audit and Governance Committee, 26/02/18 (incl. ratification of amendments to the Scheme of Delegation) | Committee Chair | 14 |
| 3-22 | Charitable Funds Committee, 27/02/18 | Committee Chair | 15 |
| 3-23 | Patient Experience C'ttee, 07/03/18 (incl. revised Terms of Ref.) | Committee Chair | 16 |
| 3-24 | Quality Committee, 14/03/18 | Committee Chair | 17 |
| 3-25 | Trust Management Executive (TME), 21/03/18 | Committee Chair | 18 (to follow) |
| 3-26 | Finance and Performance Committee, 27/03/18 | Committee Chair | Verbal |
| | **Other matters** | | |
| 3-27 | Review of Trust Board Terms of Reference | Chair of the Trust Board | 19 |
| 3-28 | **To consider any other business** | | |
| 3-29 | **To receive any questions from members of the public** | | |
| 3-30 | 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:** 26th April 2018, 10am, Academic Centre, Maidstone Hospital | | |

**David Highton,**
**Chair of the Trust Board**

[1] A patient will also be in attendance for this item

# MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 1ST MARCH 2018, 10A.M, AT MAIDSTONE HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

**FOR APPROVAL**

| | | | |
|---|---|---|---|
| Present: | David Highton | Chair of the Trust Board | (DH) |
| | Maureen Choong | Non-Executive Director | (MC) |
| | Sarah Dunnett | Non-Executive Director | (SDu) |
| | Angela Gallagher | Chief Operating Officer | (AG) |
| | Tim Livett | Non-Executive Director | (TL) |
| | Peter Maskell | Medical Director | (PM) |
| | Claire O'Brien | Interim Chief Nurse | (COB) |
| | Steve Orpin | Director of Finance | (SO) |
| | Steve Phoenix | Non-Executive Director | (SP) |
| | Miles Scott | Chief Executive | (MS) |
| In attendance: | Simon Hart | Director of Workforce | (SH) |
| | Mark Holland | General Manager (for item 2-8) | (MHo) |
| | Mildred Johnson | Chief Pharmacist (for items 2-6 to 2-8) | (MJ) |
| | Jim Lusby | Deputy Chief Executive | (JL) |
| | Sara Mumford | Director of Infection Prevention and Control | (SM) |
| | Kevin Rowan | Trust Secretary | (KR) |
| Observing: | Annemieke Koper | Staff Side representative (from item 2-5) | (AKo) |
| | Darren Yates | Head of Communications | (DY) |

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

## 2-1 To receive apologies for absence

Apologies were received from Alex King (AK), Non-Executive Director. It was also noted that Nazeya Hussain (NH), Associate Non-Executive Director, would not be in attendance.

## 2-2 To declare interests relevant to agenda items

No interests were declared.

## 2-3 Minutes of the 'Part 1' meeting of 25th January 2018

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

## 2-4 To note progress with previous actions

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

- **12-8 ("Submit, to the Trust Board, the recovery plan arising from the impending review of the approach to managing patients experiencing a long waiting time")**. The proposal that a more detailed report be submitted to the 'main' Quality Committee in March 2018 & that the findings also be considered at that Committee (i.e. instead of the Trust Board) was agreed.
- **1-8 ("Circulate, to Trust Board Members, a report responding to the specific points and general themes arising from the "A patient's experiences of the Trust's services" item at the Trust Board meeting on 25/01/18").** It was confirmed that the report should just be circulated to Trust Board Members, and not formally submitted to a Trust Board meeting.
- **1-12 ("Liaise to clarify the arrangements for the scheduling of Board members' Quality Walkarounds").** It was confirmed that a report would be submitted to the next Trust Board meeting.

## 2-5 Safety moment

COB reported that the theme for February was Venous Thromboembolism (VTE) and highlighted the following points:

- VTE had been selected as the theme because of the number of VTEs that had occurred (10)
- The month would focus on use of thromboprophylaxis, anti-embolic stockings, patient mobility, and patient's fluid balance. The mnemonic CHAMP, which stood for Compression, Hydration, Anticoagulation, Mobility and Patient Information, would also be promoted
- The number of VTE cases was not measured against Occupied Bed Days, so it was not yet known how the Trust's figures compared to other Trusts
- It was however recognised that further work was required on Medicines, in relation to prescriptions and administration

DH asked how many of the 10 VTE cases were post-operative. COB replied that she was not certain, but did not expect many of the 10 to be related to this.

## 2-6 Report from the Chair of the Trust Board

DH reported the following points:
- On behalf of the Trust Board, he wished to thank all staff for their continued hard work, particularly during the last week (which had been adversely affected by snow)
- Jeremy Hunt, The Secretary of State for Health and Social Care, had visited Tunbridge Wells Hospital (TWH) (although staff from Maidstone Hospital (MH) also attended). Mr Hunt articulated his concerns regarding patient safety very well and gave a heartfelt talk to which staff responded with some good questions. Greg Clark MP was also in attendance, so MS and DH took the opportunity to have a brief meeting with both
- There had been no Advisory Appointments Committees (AACs) since the last Board meeting

## 2-7 Report from the Chief Executive

MS referred to the circulated report and highlighted the following points:
- The Best Care programme would be covered in the Trust Board Seminar to be held later that day, but the programme was absolutely critical to the Trust
- The development of Strategic Clinical Service plans, which included work on Stroke, would be covered by JL under item 2-16
- The work on the engagement strategy would be covered by JL and SH under item 2-13
- The final report of the Care Quality Commission (CQC) inspection was expected to be received w/c 05/03/18

## Presentation from a Clinical Directorate

## 2-8 Diagnostics & Pharmacy

DH welcomed MHo and MJ to the meeting. SM then introduced a presentation which highlighted the following points:
- The presentation would not cover Infection Control although this was included within the Directorate, as this was reported at the Trust Board via other items
- The Directorate management team comprised SM, MHo, MJ, and Lesley Smith (Nurse Consultant, Infection Prevention and Control)
- Pathology included Blood Sciences (Haematology, Chemistry and Transfusion); Microbiology; and Cellular Pathology (Histology, Cytology, Molecular and the Mortuary). The total workforce for these services was 297.3 Whole Time Equivalent (WTE)
- Pharmacy included clinical, dispensary and oncology service (including aseptics), and the workforce was 126.4 WTE
- Infection Prevention and Control involved a workforce of 6.3 WTE
- The 2017/18 budget allocation was £11.3m, with a forecast year-end deficit of £1.5m. Income was £15.9m. The issues affecting the variance included income underperformance (of £222k); Histopathology activity reduction compared to 2016/17 (of £140k), a private patient income reduction (of £100k), a pay underspend (of £35k) for Pharmacy (due to a high vacancy level and difficulty sourcing locum cover in the summer months) and a non-pay overspend of £1m

MHo then then continued, and highlighted the following points:
- Performance on Key Performance Indicators (KPIs) showed that there had been an improvement in Histology response times

- Cellular Pathology and Microbiology had been recommended for UKAS accreditation (the Blood Sciences inspection had been in February and would take place again in April 2018)
- There was reduced Agency staff in Blood Sciences from 10 WTE in February 2017 to 4.3 WTE in February 2018, following the successful application of a Recruitment & Retention premium and a training plan
- Voice recognition software (Dragon) had been implemented (which had led to a reduction in 2 Band 4 WTE)
- The immunology contract with East Kent Hospitals University NHS Foundation Trust (EKHUFT) had been renewed, saving £66k p.a.
- The Aligned Incentives Contract (AIC) had led to the development of protocols, minimum retest intervals, and education meetings with Clinical Commissioning Group (CCG) clusters which had resulted in a reduction of Vitamin D (with a potential £5.5k saving)
- A Kent Pathology Group had been established under the Sustainability and Transformation Partnership (STP) and this met regularly
- Tutela (temperature monitoring) had been installed in the MH mortuary, as had been required by the CQC
- An equipment re-fresh was underway as part of the Managed Laboratory Service (MLS)

DH asked for further details of the progress with Pathology consolidation across the STP. MHo replied that progress had been made. DH noted that external parties would continue to expect progress. SM acknowledged this, and stated that she expected swift progress during the spring.

MHo then continued, and highlighted the following future planned improvements:
- Matrix-assisted laser desorption/ionisation (MALDI) had been installed on 12/03/18, enabling rapid identification of bacteria
- The partial conversion of Liquid Based Cytology (LBC) to primary Human Papilloma Virus (HPV) cervical screening had been agreed in principle by the commissioner
- PDL-1 and ALK testing would be undertaken in-house (leading to savings and improved turnaround times)
- Blood360, the next phase of the Bloodhound IT system, would be implemented
- Productivity would be improved by reducing unwanted variation, in accordance with the Lord Carter efficiency review

MHo then explained the Trust's relative position in terms of the Lord Carter work in terms of cost per test metrics. MS asked MHo to elaborate on the opportunities available for the Trust within the Pathology network. MHo stated that the Trust was in a strong position given its UKAS accredited laboratories, but MHo was uncertain whether the single centralised approach recommended by NHS Improvement (NHSI) was appropriate, as technology appeared to moving in the other direction. MHo added that the need for a single networked IT system was an important factor in centralisation, including at GP practices, whilst the ability to transport samples effectively was paramount.

DH asked whether there was good liaison between providers in the STP network. MHo replied that there was mixed liaison, and although EKHUFT felt they had 'won the game' because of NHSI's recommendation, the situation was not as straightforward.

SP remarked that he might have expected more progress to have been made, given the Pathology networking that had taken place in Kent and Medway over the last 15 years, and suggested that the focus had perhaps been on the transaction rather than on transformation. SM replied that although the timescale referred to by SP was correct, the lack of major progress was related to the fact that technology (which required capital expenditure) needed to be introduced in the first instance, and this had not been forthcoming. SP acknowledged the point, but opined that it was within providers' collective power to address this, if the will existed. MHo highlighted that the current liaison felt different, and more open, than previous networking efforts.

DH asked whether the lack of an Electronic Patient Record (EPR) had influenced the delays, SM replied that she did not believe this was the case.

SP reiterated the need to be bold. MHo acknowledged this and noted that liaison was starting to take place with Directors of IT.

MS then stated that the longer term (i.e. 20 year) situation needed to be taken into account, and he did not have a sense of what the Trust should do regarding this, particularly given the significant changes that had taken place over the past 10 years. MHo acknowledged the point, but noted that it was very difficult to predict the future, as for example, 10 years ago it had been felt that molecular testing would be widespread by now, and this was not the case.

MJ then reported that improvements in Pharmacy included the following:
- The development of a Pharmacy Strategy, which included the centralisation of aseptic services
- Addressing the issues caused by staff leaving
- The creation of crucial senior posts
- The implementation of a cost-effective dispensing service (pharmacy outpatient outsourcing)
- The Drugs and Therapeutics and Medicines Management Committees had merged

DH pointed out that he understood the centralisation of aseptic services was included in the STP work. MJ confirmed this was the case, but stated that she expected national developments to overtake STP developments in relation to aseptic services.

MJ then continued, and highlighted the following points:
- The Pharmacy Strategy also included the Medicine Optimisation Over Night (MOON) initiative
- Three options regarding the outsourcing of outpatient pharmacy were being considered, including establishing a subsidiary company or consorting with a third party in a Joint Venture

DH referred to the latter point, and stated that he presumed third party capital funding would be available via the Joint Venture option. MJ agreed this was possible, but noted that this was not without cost.

SM then continued, and highlighted that the Directorate's risks and challenges included the following issues:
- Difficulty in maintaining a Quality Monitoring System (QMS), which posed a risk for maintaining ISO accreditation
- Difficulty in maintaining turnaround times for Cytology screening
- Delay in implementing the Pharmacy Strategy (e.g. in reinstating the TWH aseptic service)
- Delay in achieving full compliance with the Hackett report ("Towards a Vision for the Future") and full utilisation of the Homecare service due to the lack of a lead Pharmacist for these areas
- Mortuary capacity. A Business Case had been produced for additional fridges at TWH and MH, but this remained a challenge
- The implementation of Order Comms (Allscripts), as the uptake was lower than anticipated. Downtime forms continued to be used and it may be necessary to consider removing these
- The indexation increase in Pharmacy consumable costs for 2018/19 between 3% and 6%
- The capital requirement to implement the aforementioned outsourced Pharmacy
- Legal challenges elsewhere in UK regarding Avastin may restrict the opportunities to use biosimilar medicines

DH remarked that removing downtime forms would be a major issue, and asked PM to comment. PM stated that he was content for these to be removed provided a supply was available in Pathology when required. AG confirmed that a supply of such forms would always be available.

SO then highlighted and commended the success that MJ had had in the use of biosimilar medicines, noting the financial target that had been set had been achieved. SO then asked MJ to describe the differences between the guidance issued by the National Institute for Health and Clinical Care Excellence (NICE) and the General Medical Council (GMC) with regards to Avastin. MJ explained that NICE had recommended that the least expensive available Anti-VEG treatment should be used for wet age-related macular degeneration (AMD), but did not cite Avastin in the 2 options it had put forward. MJ continued that the GMC had confirmed that doctors would not have fitness to practice proceedings taken against them if they used the unlicensed medication, but the Medicines Act, which covered all professions (i.e. not just doctors), stated that Medicines could not be used in an unlicensed way if a licensed alternative medication was available. MJ continued that

12 CCGs in the North of England had written a policy regarding this and were in the process of implementing it, but Novartis, the manufacturers of Avastin, had challenged the policy via a Judicial Review, as they believed it conflicted with the Medicines Act. MJ noted that the Trust's Drugs, Therapeutics and Medicines Management Committee had discussed the situation and agreed that the Trust should await the outcome of the Judicial Review. MJ added that she was aware other Trusts had adopted the same approach. MS asked when the Judicial Review would be concluded. MJ confirmed she did not know. PM asked whether there was risk to other biosimilar medicines, MJ confirmed this was not the case, as Avastin was not technically a biosimilar.

DH thanked MHo, MJ and SM for their presentation.

## 2-9 Review of the Board Assurance Framework 2017/18

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

- This was the fourth time the Board Assurance Framework (BAF) had been submitted to the Trust Board in 2017/18, and the last time it would be submitted before the year-end review of objectives, which was scheduled to be considered by the Board in April 2018
- The February 2018 ratings of "How confident is the Responsible Director that the objective will be achieved by the end of 2017/18?" should hopefully not be a surprise
- A summary of the status of the Risk Register was enclosed in Appendix 1
- The full report had been discussed at the Audit and Governance Committee on 26/02/18 and the relevant aspects of the BAF had been reviewed at the Finance and Performance Committee on 27/02/18

DH noted that the objectives regarding finance, Cancer and Referral to Treatment (RTT) would be covered during item 2-10, & suggested that these be discussed under that item, unless any Trust Board Member wished to challenge the ratings within Attachment 4. No such challenge was made.

## 2-10 Integrated Performance Report for January 2018

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

- The key issue to note was that the A&E 4-hour waiting time target had been delivered in January, and the increased trajectory was believed to have been achieved in February. The delivery of the target involved considerable effort, and this should be commended
- It was important to make the link between RTT performance and quality of care, and this would be covered further during item 2-12

### Effectiveness / Responsiveness (incl. DTOCs)

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

- There were 3 priority areas for operational performance, one of which was the A&E 4-hour waiting time target, which was achieved in January and was likely to have been achieved in February. Performance in January had also markedly improved compared to January 2017
- The focus was on maintaining safe patient flow, and the key driver was to reduce length of stay. This was being achieved, as there had been a 0.3 day reduction since January 2017
- Delayed Transfer of Care (DTOC) data was included in the report, and showed a continued improvement through the year
- The 62-day Cancer waiting time target was also an area of focus, as it was underperforming, but the performance for 'MTW only' patients was above 85% in December 2017. The Trust had recently had a 'critical friend' review from the Cancer improvement team within NHSI, to consider how, and where, improvements could be made. The report of the visit had been received by AG and she would share this in due course
- For RTT/18 week target performance, there had been a small reduction in the waiting list backlog, although some of the data had been skewed by the erroneous creation of duplicate pathways within the PAS. Although an expert team was addressing this, there would be an impact on waiting lists, and the Trust would therefore underperform on its trajectory
- The review of patients experiencing a long waiting time, which would be discussed under item 2-12, was progressing well

DH asked about the utilisation of Home First Pathway 3 beds. AG replied that there had been significant increased demand, and a number of patients were currently awaiting such beds, as all current capacity had been used. AG added that a review of the beds needed for 2018/19 was required, as the previous assessment of a need for 30 beds did not appear to take into account the increased number of beds required for the winter period.

SDu asked what messages were being issued to GP referrers in relation to the waiting list backlog. AG replied that no specific messages had been given, but commissioners understood that more activity needed to be commissioned to address the backlog. AG added that the majority of the backlog was in Orthopaedics, but no specific messages were planned to be issued. SDu queried whether the Trust's reliance on West Kent CCG's communication with GPs was appropriate. SO concurred, noting that he understood that Independent Sector providers engaged considerably with GP referrers to explain the latest situation. SDu therefore queried whether more proactive messages should be issued. MC agreed, noting that the Trust's continued reporting of treatment delays would be the message received by the public, and it would therefore be pertinent to also communicate the steps the Trust was taking to ensure services remained safe. DH noted there was support for the suggestion. KR noted that MC's comments appeared to propose a different action to that proposed by SDu. SP agreed that the 2 issues were different. It was therefore agreed to firstly consider providing information to GPs about the Trust's elective services, to assist them in their referral decisions.

**Action: Consider providing information to GPs about the Trust's elective services, to assist them in their referral decisions (Deputy Chief Executive, March 2018 onwards)**

It was also agreed to publicise the steps the Trust was taking to ensure the safety of its services, in the context of the recent media coverage regarding increased demand and treatment delays across the NHS.

**Action: Publicise the steps the Trust was taking to ensure the safety of its services, in the context of the recent media coverage regarding increased demand and treatment delays across the NHS (Deputy Chief Executive, March 2018 onwards)**

**Safe / Effectiveness / Caring**

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

- The number of falls-related Serious Incidents (SIs) had increased, and a revised falls action plan would be reviewed at the next Trust Management Executive (TME) meeting. A range of actions were being taken and/or considered
- The pressure ulcer rate was static, but there would be no complacency
- Friends and Family Test (FFT) performance was also static, although there had been a small decline. The Trust now had a new contract manager with iwantgreatcare, which provided an opportunity to consider a fresh approach to the issue. COB would also meet with PM to consider how iwantgreatcare could be used for clinical engagement
- Complaints had increased, and the key themes and trends were included in Attachment 5, which included reporting on the month about which the concerns had been raised (which was usually not the same month the complaint was received). Staff attitude had not been identified as an issue as much as in previous months, but some of the themes reflected the issues raised under the 'patient story' item at the Trust Board meeting held on 25/01/18. A report would be circulated to Trust Board Members in March with a response to the issues raised in that item

**Safe / Effectiveness (incl. Mortality)**

PM the reported the following points:

- The Hospital Standardised Mortality Ratio (HSMR) had improved from 106.9 to 106
- The Summary Hospital-level Mortality Indicator (SHMI) was the same as last month, as this would not be updated until May 2018
- A quarterly mortality report would be submitted to the next Trust Board meeting
- Mortality would also be discussed during the Trust Board Seminar later that afternoon, as it was included within the Best Care programme

- The percentage of Mortality Reviews being undertaken had declined significantly over the winter period, but action was being taken, so PM would be able to discuss this more at the next Trust Board meeting
- The Clinical Coding of comorbidities seemed to have improved slightly
- The point had been reached where the Trust could regard itself as having a new baseline mortality rate, but it was acknowledged that more could be done to learn lessons and reduce mortality further

**Safe (infection control)**

SM referred to the circulated information and reported the following points:
- The 1 case of MRSA bacteraemia reported previously had now been formally removed from the performance dashboard (as this had been attributed to a third party)
- There had been 2 cases of Clostridium difficile in January, but none in February, so the Trust would be 2 cases below its trajectory at the end of the latter month
- A total of 40 inpatients had been diagnosed with influenza, 8 of which required admission to the ICU. There were however currently 11 patients in the Trust with an influenza diagnosis

DH asked how many of the 40 cases had received the influenza vaccine. SM confirmed that this was not known as this was very difficult to establish, despite efforts to do so.

**Well-Led (finance)**

SO then highlighted the following points:
- The deficit (including Sustainability and Transformation Fund (STF) monies) in January was £1.6m, which was £2.9m adverse to plan. The key drivers were non-receipt of the STF and slippage on the Cost Improvement Programme (CIP). However, the Trust remained on course to deliver the revised forecast, of a pre-STF deficit of £17.9m & a post-STF deficit of £13.99m
- The Trust provided laundry services to Dartford and Gravesham NHS Trust (DGT) via Carillion PLC. The Trust was owed £300k of debt regarding this, and this had been registered as a bad debt. The Trust had registered itself as a debtor of Carillon, but the offers being made to creditors were very meagre. An appeal had also been made to NHSI

DH referred to the latter point, and emphasised that ordinarily, a bad debt would result in the service being withheld, but this had not been the case with the Trust, given the collegiate relationship it wished to maintain with DGT. DH suggested that this point be drawn to NHSI's attention. SO acknowledged the suggestion.

SO then continued, and highlighted there had been an increase in staffing expenditure, for temporary staffing in particular. DH remarked that increased pay costs could have been expected, given the recent activity. DH also commended the fact that the Trust was on course to achieve the revised year-end forecast.

**Well-led (workforce)**

SH then reported the following points:
- Sickness absence had contributed to the aforementioned increased temporary staffing expenditure. It was acknowledged that further work was required from the Occupational Health department, particularly in supporting staff with mental health issues
- Staff turnover had improved slightly, which reflected the positive work undertaken in Pharmacy and Maternity. However, there remained some problem areas

DH then commented that staffing in March was traditionally difficult to manage, as staff took their Annual Leave (A/L) entitlement before the year-end, and asked for a comment. AG confirmed that March was expected to be difficult, but COB noted that a firm approach was however required with Matrons, to ensure that they allowed their staff to take their A/L but also ensure their Wards were being staffed safely. COB stated that the eRostering system would therefore need to be closely monitored. DH acknowledged the point, but asked whether the Trust could benchmark its approach, to consider whether an alternative approach, such as having the A/L year based on a

calendar, rather than financial, year, could be adopted. It was agreed that SH would review the Trust's current policy, taking other NHS provider organisations' policies into account.

**Action: Review the Trust's current policy regarding the start and end dates of the staff Annual Leave year, taking into account other NHS provider organisations' policies (Director of Workforce, March 2018 onwards)**

**2-11 Emergency Care Improvement Programme (ECIP): report of acute site visit to Maid. & Tun. Wells hospitals, Jan '18**

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

- ECIP had provided an 'end to end' review of the urgent care pathway
- Some very positive comments had been made in relation to the Trust's good practice, and ECIP had stated its intention to promote some of this among other Trusts
- ECIP had remarked on the different culture and approach in place at MH and TWH. The Trust was already aware of this, but it had been very palpable to ECIP
- A particular recommendation had been made regarding the Clinical Decisions Unit (CDU) at MH, as ECIP felt that it was not fit for the purpose for which it was being used i.e. an inpatient unit. This required immediate action, which had been taken. The Unit was due to reopen by the end of w/c 05/03/18
- The report was well written and the Trust had no real issues with anything recommended
- The recommendations would be monitored via the Best Patient Flow programme

DH remarked that it was always beneficial to have an external view, adding that he thought the report was very balanced. DH also noted that the differences between TWH and MH were likely to involve 'softer' actions to address, and this may therefore be worthy of a report to the Board. MS instead stated that he expected this to be covered via the Best Patient Flow programme, so if this was not evident, Trust Board Members should challenge this. DH accepted the proposal.

**2-12 The approach to managing patients experiencing a long waiting time: interim report on recovery plan**

AG referred to the circulated report and noted that although the clinical operational teams were undertaking the work, PM was the Executive Lead. PM then referred to the circulated report and highlighted that over 1000 patients had been identified for review, and clinicians had been asked to review any potential harm using a proforma. DH asked whether the work would act as a waiting list validation process. AG agreed that the audit served more than one purpose.

**Quality Items**

**2-13 Update on engagement plan**

JL reported the following points:

- This item was a precursor to a more substantial item at a future Board meeting, either in March, or more likely, April 2018
- Listening into Action (LiA) was approaching a key milestone as the 12-month contract with Optimise Ltd expired soon, and JL's strong recommendation to the Board was that LiA should continue, as not doing so would send a strong adverse message to staff. This was separate to the question as to whether the contract with Optimise Ltd should be renewed
- SH had worked on an internal engagement plan and this would be submitted for review at the Trust Board along with the work JL was undertaking
- External liaison and engagement also needed to be addressed, including working with primary care and how the Trust positioned itself within the West Kent community, given its role as the most substantial employer, and the existence of its 2 major hospitals
- A report would be submitted for review at the TME before being submitted to the Board, and the timing of the latter would be dictated by the discussion at TME

DH stated that he believed the Trust should support the LiA process, regardless of whether the contract with Optimise Ltd was renewed, noting that JL's recommendation regarding that renewal

was awaited. SH agreed, adding that the 2017 NHS Staff Survey findings did not show a significant shift from the 6 months of LiA that had been in place before the survey.

**2-14 Staffing (planned and actual ward staffing for January 2018; and 6-monthly review of Ward and non-Ward areas)**

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

- The first part of the report was the usual planned and actual Ward staffing for January 2018, and the Wards worthy of note were listed on page 1
- The Quality, Effectiveness & Safety Trigger Tool (QuESTT) was still being reviewed to consider whether this could be used for future reports, and it was hoped to obtain the first tranche of QuESTT data by the end of March 2018

DH asked for a comment on the potential for Nursing staff to work between hospitals at late notice. AG confirmed that this happened often, every day, and Matrons risk assessed for every shift. AG added that temporary staff were however less keen to operate in this way, as they had accepted the offer to work a shift under specific expectations and would sometimes rather forfeit that shift than work under alternative conditions and/or locations. COB agreed that temporary staff often needed some cajoling. DH stated that staff should be commended for their flexibility, and then asked whether there was a connection between staff turnover rates and the frequency with which staff had to work across hospital sites. SH replied that there were a number of issues involved in staff turnover, including the quality of management. AG added that the intention was to ensure that each Ward had a strong substantive base workforce to mitigate such circumstances. DH acknowledged the points, but asked COB to request that Matrons relayed the Board's gratitude to the relevant Nursing staff.

**Action: Request that Matrons relay the Trust Board's gratitude to the Nursing staff who responded to requests (often at short notice) to work at the Trust's other acute hospital site (Chief Nurse, March 2018 onwards)**

MC then queried whether it was possible to include something within the Trust's Workforce Strategy to recognise the separation between the administrative/improvement/data analysis duties and the clinical leadership duties of clinical staff. COB acknowledged the point and noted that there was a need to consider how systems worked together, to avoid asking staff to undertake repetition as a result of the differences between such systems, such as that between the Clinical Utilisation Review (CUR) and eRostering systems. COB added that Ward Managers' supernumerary time, of 4 days per week, had been absent during the recent past, and it was important to ensure this was reintroduced. COB also noted that new jobs, and new roles, were developing, and some posts had been created to release Ward Managers from carrying out certain duties.

COB then referred to the second part of the report (the 6-monthly review) and highlighted the following points:

- The guidance from the National Quality Board (NQB) now stated that the previous 6-monthly staffing review was only required annually. However, COB had decided to continue with the 6-monthly review that had been scheduled
- Appendix B showed a breakdown of gaps in the workforce and the Registered Nurse:Clinical Support Worker ratio. The recommended ratio had only not been met on 1 Ward (Mercer)
- The review did not suggest changes beyond those already identified by the Divisions as part of their 2018/19 planning
- The document described the 'next steps' that were planned, which included the development of new roles and the use of the Occupational English Test (OET), which had a higher success rate than the International English Language Testing System (IELTS), despite being more expensive
- Plans were in place to commission Nurse Associate training via the Apprenticeship Levy. Liaison had taken place with Health Education Kent, Surrey and Sussex (HEKSS), and the process was approaching the stage of procuring a training provider

DH referred to the latter point, and asked whether the Trust had to tender the end-point assessment with the training provider, as he understood an independent end point assessment was required under all Apprenticeship Levy schemes. SH stated that he believed this was included

within the service being procured, but COB agreed to clarify the arrangements that had been made.

**Action: Clarify the arrangements the Trust had made regarding the end-point assessments for the Nurse Associate training being procured via the Apprenticeship Levy (Chief Nurse / Director of Workforce, March 2018 onwards)**

KR then referred to the NQB guidance, and asked COB whether she intended to just submit an annual staffing review in future (i.e. rather than the 6-monthly reviews that had been submitted in the past). COB replied that she needed to reflect on this.

**Planning and strategy**

**2-15 Update on the Trust's 2018/19 planning**

SO referred to the report that had been circulated and highlighted that:

- The national planning guidance had been issued since the last Trust Board meeting, and the key points were included in the report
- A Commissioner Sustainability Fund (CSF) had been created. The STF would also now become the Provider Sustainability Fund (PSF) i.e. the transformation aspect had been dropped. Receipt of the PSF was likely to depend again on the delivery of the A&E 4-hour waiting time target and financial plan
- The potential bonus associated with the PSF was now circa £15m, not the initial £11m that had been indicated. This could not be spent in-year but could be used for capital expenditure
- The Trust's control total for 2018/19 had been expected to be a break-even underlying financial position, but that had assumed a continued increase in the Trust's Clinical Negligence Scheme for Trusts (CNST) subscriptions, which had not occurred, as the CNST subscription had reduced by £600k, so it was therefore considered that the Trust had received a windfall. In the Trust's original plans, the reduced CNST subscription had been assumed to be a benefit, but it had now been confirmed the Trust needed to generate a further £2m as part of its control total

SO elaborated on the latter point, stating that although he understood the rationale, he did not believe that rationale was clear enough, at a macro level, to warrant the approach being applied. DH remarked that he did not see evidence of the same approach being applied to the other factors influencing the control total. SDu pointed out that the reduced CNST subscription could, theoretically, have reflected investment the Trust had made to prevent litigation, and she had made the point at the Finance and Performance Committee meeting on 27/02/18 that she believed the approach was unduly penal. SO noted that formal representation had not been made to NHSI regarding the issue. DH asked MS whether a formal approach was recommended. MS replied that he instead advised lobbying through bodies such as the Healthcare Financial Management Association, who had a greater chance of changing policy than lone Trusts, but also suggested liaising with NHSI in relation to the Trust's exit from Financial Special Measures, given the change in planning assumptions. DH confirmed that the Trust Board supported lobbying via the appropriate bodies.

**Action: Lobby the appropriate national bodies (including the Healthcare Financial Management Association) to make representation to NHS Improvement to change their policy of increasing the 2018/19 control totals of Trusts with reduced CNST subscriptions (Chief Executive / Director of Finance, March 2018)**

**2-16 The development of Strategic Clinical Service Plans**

JL reported the following points:

- The item was a precursor to a more detailed future discussion, either at a formal Trust Board meeting, or perhaps a future Trust Board Seminar
- The work undertaken to date on strategy had been good, and this was expected to be recognised by the CQC in the forthcoming inspection report, but the next phase of work was focused on considering what the Trust's strategy meant for individual clinical services
- In the first instance, the work was focusing on the services that were fundamental to the future of the Trust, as 'anchor points' to strategic thinking

- A discussion regarding this had commenced at the TME meeting on 21/02/18, and comments had been raised as to whether or not a fast pace should be set

DH remarked on the importance of external factors affecting the Trust's strategy, noting that although the STP had this far been focused on services in East Kent and on Stroke services, further services in West Kent would be considered in due course. JL acknowledged the point.

**2-17 Final Agreement for working capital support**

SO referred to the circulated report and highlighted that an application had also been made for March, which had been approved by NHSI and was awaiting formal approval by the Department of Health and Social Care. SO added that mitigations were however in place to manage the cash position should the March application not be approved.

DH then drew attention to the supplement that had been circulated (Attachment 10a) which contained the final Agreement for the working capital support.

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

**2-18 Workforce Committee, 25/01/18 (incl. approval of revised Terms of Reference and quarterly report from the Guardian of Safe Working Hours)**

SP referenced the report that had been circulated and drew attention to the following points:

- The meeting had been his and SH's first Workforce Committee meeting
- Thanks should be given to AK for his time as the previous Chair of the Committee
- The functioning of previous Workforce Committee meetings had largely been adopted, but in future, the focus would be on the Best Workforce programme, with the intention being to review more strategic, and less operational, issues
- The proposed amendments to the Terms of Reference were to enact initial changes regarding membership and frequency, but further changes were likely to be submitted later in the year, including the Committee's relationship with Staff Side

DH asked whether the Committee intended to differentiate its work with that of the Best Workforce programme. SP replied that the intention was that the Workforce Committee be the first line of scrutiny, not the last line of management.

The report from the Guardian for Safe Working Hours was noted.

The revised Terms of Reference were approved as circulated.

**2-19 Quality Committee, 06/02/18**

SDu referred to the circulated report and highlighted that the Quality Impact Assessment (QIA) process was good and working increasingly well. SDu also added that Medical engagement had been reviewed and acknowledged as a potential catalyst for a range of workforce improvements.

**2-20 Trust Management Executive (TME), 21/02/18**

MS referred to the circulated report and highlighted that all of the major items discussed had been covered elsewhere during the Trust Board meeting, whilst the Kent and Medway Stroke review would be discussed during the Trust Board Seminar later that afternoon. MS did however note that the Director of Medical Education (DME) was now a member of TME.

**2-21 Audit and Governance Committee, 26/02/18**

KR noted that a written report would be submitted to the next Trust Board meeting. SP confirmed that no issues were required to be reported to the Board at the meeting.

**2-22 Finance and Performance Committee, 27/02/18 (incl. quarterly progress update on Procurement Transformation Plan)**

SDu referred to Attachment 15 and highlighted that the AIC had been discussed in detail. SDu continued that the slippage on delivery of the CIP delivery slippage had also been noted, whilst the planning for 2018/19 had also been discussed. SDu then referred to Attachment 14 and noted that good progress had been made on implementing the Procurement Transformation Plan. MS highlighted the importance of the STP work on procurement, adding that MS had noted, during a recent walkaround, that the Trust's Associate Director of Procurement appeared to engage very well with clinical staff.

**2-23 Charitable Funds Committee, 27/02/18**

SDu reported the following points:

- Expenditure was higher than the previous year
- The need to appoint a Fundraising Manager had been agreed previously, and a candidate had been appointed to the post but then withdrew. This had emphasised the need to consider the strategic fundraising priorities that should be pursued, as well as the Agenda for Change (AfC) banding of the post. The Committee supported the band being increased to attract suitable candidates
- The Associate Director for Cancer and Clinical Support Services attended to report on the proposed fundraising for a Macmillan Health and Well-being centre at MH

**2-24 To approve revised Terms of Reference for the Remuneration & Appointments Committee**

The revised Terms of Reference were approved as circulated.

**2-25 To consider any other business**

KR asked that the Trust Board delegate the authority to the 'Part 2' meeting being held later that day to approve the approach regarding the Trust's residential accommodation in Maidstone. The requested authority was duly delegated.

**2-26 To receive any questions from members of the public**

AKo referred to one of the points raised under item 2-23, and pointed out that any change in AfC banding required an amended Job Description. SDu replied that due process would be followed. SO added that the Job Description created for the post had been based on a post with a higher banding at another Trust, but the post was allocated a lower band. JL commented that the issue related to the level of ambition. The point was acknowledged.

**2-27 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**

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

**Trust Board Meeting – March 2018**

NHS Maidstone and Tunbridge Wells NHS Trust

## 3-4 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] |
|---|---|---|---|---|
| 12-5 (Dec 17) | Arrange for the development of an appropriate Key Performance Indicator for Acute Kidney Injury, for inclusion in the monthly "Trust Performance Dashboard" | Medical Director (N.B. this was originally allocated to the Chief Nurse, but transferred to the Medical Director by mutual consent) | December 2017 onwards | The matter has not yet been able to be considered by the AKI Task and Finish group |
| 1-8 (Jan 18) | Circulate, to Trust Board Members, a report responding to the specific points and general themes arising from the "A patient's experiences of the Trust's services" item at the Trust Board meeting on 25/01/18 | Chief Nurse | January 2018 onwards | The report is being finalised, and will be circulated to Trust Board Members in due course (its development having been informed by the discussion held under the "Proposals re the future of 'patient and staff experience' items at the Trust Board" item at the Trust Board meeting on 29/03/18) |
| 2-10a (Feb 18) | Consider providing information to GPs about the Trust's elective services, to assist them in their referral decisions | Deputy Chief Executive | March 2018 onwards | A verbal update will be given at the Trust Board meeting on 29/03/18 |
| 2-10b (Feb 18) | Publicise the steps the Trust was taking to ensure the safety of its services, in the context of the recent media coverage regarding increased demand and treatment delays across the NHS | Deputy Chief Executive | March 2018 onwards | A verbal update will be given at the Trust Board meeting on 29/03/18 |
| 2-10c (Feb 18) | Review the Trust's current policy regarding the start and end dates of the staff Annual Leave year, taking into account other NHS provider organisations' policies | Director of Workforce | March 2018 onwards | The review is ongoing but the standards Annual Leave year is from April to March. Options will be discussed regarding the feasibility of a future approach |
| 2-15 (Feb 18) | Lobby the appropriate national bodies (including the Healthcare Financial Management Association) to make representation to NHS Improvement to | Chief Executive / Director of Finance | March 2018 | A letter to the Healthcare Financial Management Association and NHS Providers is being drafted to highlight the issue. The |

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

| Ref. | Action | Person responsible | Original timescale | Progress [1] |
|---|---|---|---|---|
| | change their policy of increasing the 2018/19 control totals of Trusts with reduced CNST subscriptions | | | Director of Finance will also soon meet with the regional Chief Financial Officer of NHS Improvement and intends to discuss the issue at that meeting |

**Actions due and 'closed'**

| Ref. | Action | Person responsible | Date completed | Action taken to 'close' |
|---|---|---|---|---|
| 1-12 (Jan 18) | Liaise to clarify the arrangements for the scheduling of Board members' Quality Walkarounds | Trust Secretary / Chair of the Trust Board | March 2018 | Liaison occurred, and following discussion with the Chief Nurse, a report regarding the Trust's approach to Quality Walkarounds was discussed at the Executive Team Meeting on 13/02/18. Following this, Non-Executive Directors were then asked to comment. The report arising from the consultations has been submitted for consideration to the Trust Board on 29/03/18 |
| 2-14a (Feb 18) | Request that Matrons relay the Trust Board's gratitude to the Nursing staff who responded to requests (often at short notice) to work at the Trust's other acute hospital site | Chief Nurse | March 2018 | The request was made |
| 2-14b (Feb 18) | Clarify the arrangements the Trust had made regarding the end-point assessments for the Nurse Associate training being procured via the Apprenticeship Levy | Chief Nurse / Director of Workforce | March 2018 | It was clarified that the Trust has taken the lead for chairing the joint procurement initiative for Nurse associate training provision as part of the West Kent Collaboration group. At the next meeting (29/03/18) the tender specification will be approved and then a Memorandum of Understanding signed off as it is a collaborative approach. The Trust should then be able to issue a tender and is aiming for a late spring/early summer start date. As part of the tender documents for Nursing associate role, training providers have to list their price for training and the end point assessment. The apprentice will be offered one re-sit as part of this contract and then the Trust would need to pay for any further re-sits, support will be put in place to make sure apprentices are ready |

**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 |

**Trust Board meeting – March 2018**

NHS
Maidstone and Tunbridge Wells NHS Trust

## 3-7 Report from the Chief Executive — Chief Executive

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

- The Care Quality Commission (CQC) has found a considerable improvement in patient experience at Maidstone and Tunbridge Wells NHS Trust (MTW), with over two-thirds of quality measures in key areas of patient care now rated as `good'.
- The CQC's latest report on MTW, which was published earlier this month, follows a series of inspections at Maidstone and Tunbridge Wells Hospitals that found `significant and sustained improvement throughout the Trust'. This includes a dramatic improvement in the well-led domain, resulting in a `good' rating for leadership (compared to a rating of `inadequate' three years ago).
- Each one of five inspected services at our Trust is now rated `good' for caring. The CQC inspection team recognised that the Trust puts quality at the heart of everything it does, and that it has improved numerous areas of patient care at a time of unprecedented operational and financial pressure across the NHS as a whole.
- The CQC identified 17 should-do actions (compared to 52 three years ago) and these are being actively addressed. While the Trust is closing in on an overall `good' rating, it stays as `requires improvement' for the time being. The report shows very positive progress for MTW and I have congratulated our workforce for their clear and ongoing commitment to providing the highest possible standards of care for our patients.
- I would like to congratulate Claire O'Brien on her appointment as our new substantive Chief Nurse. Claire took up the role of acting Chief Nurse at MTW early last year when her predecessor started a secondment in London. Claire's leadership and oversight of our annual review by the CQC was exceptional. We can now look forward to working collectively with our Chief Nurse on the ongoing improvements in patient and staff experience that will make MTW an outstanding provider of care.
- It is important for MTW to transition from the CQC inspection process to a continued commitment to quality improvements that are part of everyday business for our staff. We are making that transition in a carefully coordinated way to further improve our patient and staff experience.
- The Trust is in the final stages of developing a new Quality Strategy and quality priorities. These are integrated with our Best Care programme and other service developments to make MTW even more of a caring, sustainable and improvement driven organisation during 2018/19 and beyond.
- A series of closely linked, clinically-led work streams have been set up to provide MTW with a cohesive focus on quality improvements. The Trust's directorate clinical leads presented their quality improvement plans for 2018-19 to the Trust Management Executive on March 21st as part of our oversight and inclusivity process for achieving clinically-led patient-focused improvements.
- One of our corporate priorities is to create a supportive environment at MTW that encourages more of our staff to report incidents, learn lessons from their practice and reduce avoidable harms to our patients within a no blame culture. This month's CQC report recognises that just as importantly and perhaps more so than anything else, at MTW we have an open and transparent culture that allows quality improvements to happen.
- Other areas of our quality improvements are collectively focused on ensuring our patients receive the right care, in the right place, at the right time, reducing unnecessary patient admissions and improving flow through our hospitals.

- It is important that we have a strong clinical strategy and clinical services plan in place to meet the changing care needs of our ageing population. We are progressing this work and undertaking further service improvements to meet our changing patient needs. As an example of our intent, building work commenced on the 19th March on Ward 2 at Tunbridge Wells Hospital to create a Frailty Unit. This will be ready in June to support emergency patients from A&E. These patients will be reviewed by a multi-disciplinary team including the support of senior geriatrician, nursing, therapy, pharmacy and IDT members, to offer rapid intervention and safe and timely discharge. A similar service is benefiting patients at Maidstone Hospital as part of our quality improvements.
- We are also working with our partners to bring about sustainable change throughout Kent and Medway that enables the NHS to work at its best for its patients and staff. With this in mind, I was delighted to learn that the NHS is to open a brand new medical school in the county, as part of national plans to expand the NHS medical workforce. This is a major fillip for the NHS in Kent and Medway and I look forward to MTW playing a key role in this exciting much needed development.
- I have continued to spend valuable time with our staff individually and collectively. It is my ongoing aim to meet as many of our clinical and non-clinical staff and volunteers wherever MTW runs services. I am always struck by the welcoming and helpful nature of our staff and their professionalism, unwavering commitment and loyalty to our patients.
- It should come as no surprise to learn of the out and out efforts our staff made to keep patients safe and well during the recent snow storms. I have heard many remarkable stories of the lengths individuals have gone to in order to assist their colleagues and care for patients. I have thanked our staff both collectively and individually, and on a general note, am now supporting several nominations for national awards as a consequence of their many achievements during 2017/18.
- The latest awards and national recognition to be received by our staff include:
    - Midwives Susan Powley and Angie Clarke reaching the final of the national Royal College of Midwives awards, for Excellence in Maternity Care.
    - Ward Manager Nyadzai Ruzayi invited to Buckingham Palace to celebrate NHS staff as part of the NHS70 celebrations.
    - Alison Cannell, reception and radiotherapy administrator in the Therapeutic Radiotherapy Team at Canterbury, and Ruth Perry, ward co-ordinator for the Maidstone Short Stay Surgery Unit, nominated for NHS Unsung Hero Awards
- I would also like to publicly recognise the collective contribution of staff at MTW which enabled thousands of patients to be seen in our emergency departments within the national four hour standard in February. MTW saw 90% of ED attendances within four hours last month, exceeding the 85% national average. This was also a five percentage improvement on the Trust's performance for February 2017. MTW's achievement came as the NHS saw a five percent increase in ED attendances nationally. We saw 1,000 more unplanned ED attendances and 400 more emergency admissions at MTW in February this year compared to last, which is the equivalent of two and a half days additional work.
- We are continuing to work hard to address the impact surges in emergency demand are having locally and nationally on planned care.

**Which Committees have reviewed the information prior to Board submission?**

- N/A

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

Information and assurance

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

**Trust Board meeting – March 2018**

NHS
Maidstone and Tunbridge Wells NHS Trust

| **3-9** | **Integrated Performance Report, February 2018** | **Chief Executive / Members of the Executive Team** |
|---|---|---|

The enclosed report includes:

- The 'story of the month' for February 2018 (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
- An Infection Prevention and Control 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

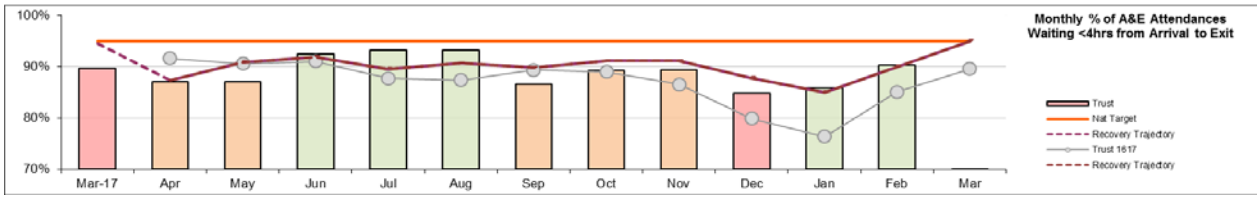
**The 'story of the month' for February 2018**

**OPERATIONAL PERFORMANCE REPORT FOR FEBRUARY-18**

## 1. 4 hour emergency standard

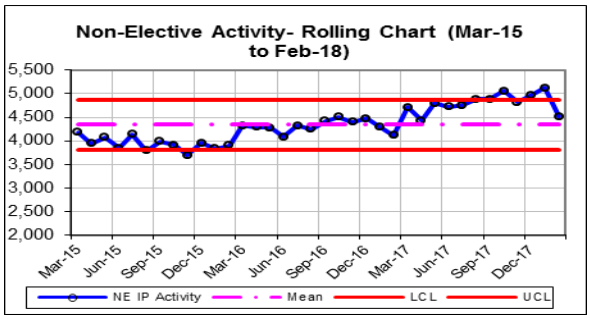
Performance for the Trust achieved the expected trajectory in February, scoring 90.32% against a target of 90%. Jan-18's score is 5.2 percentage points better than Feb-17. The Trust is aiming to achieve 90% or more for A&E every month, although it is not mathematically possible for us to achieve 90% for quarter 4.

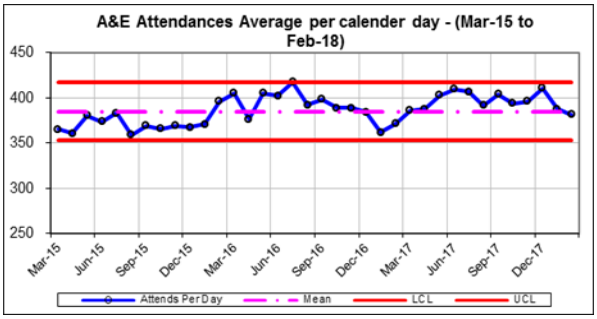
February 2018 was the worst month on record for the English NHS, with a type 1 score of 76.9% and a total score of 85.0%. MTWs type 1 score was 88.1%, which was 11.2 percentage points higher than national, and placing us within the top 20% of performing trusts.



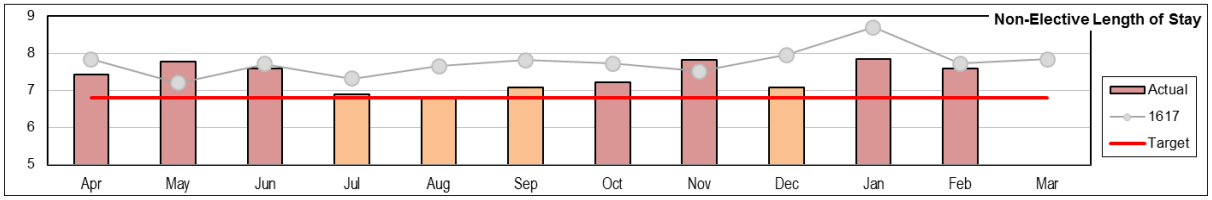

- A&E Attendances continue to increase. The sudden rapid growth seen in late 2015 and early 2016 has eased off, but 1718 YTD attendance is still 2.9% up on last year, and there was a significant increase in attendances between mid-November and early January that has no clear reason.

- Non-Elective Activity (excluding Maternity) remains considerably above plan 21% higher than plan for Feb at 3,897 discharges, and 8.6% higher than Feb last year. A proportion of this is driven by increased use of ambulatory / assessment wards, and increased capacity in CDU.




- Non-elective LoS was 7.59 days for February discharges. YTD, average non-zero NE LoS is 7.37 days, 0.26 days less than 1617.




- The average occupied bed days rose to a record 847 average through January

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.
- Twice daily board rounds on AMUs
- Frail Elderly Unit at Maidstone
- Focus on SAFER to achieve an improved length of stay.

- Weekly review of the KPI dashboard to monitor improvements
- Daily breach analysis & RCA reviews as appropriate
- Winter "Capacity Huddle"s commenced chaired by the COO
- Implementation of Live Data dashboards to give an understanding of the current position
- Continuing to work on the areas of improvement identified by 2020 Productivity – AEC, GP Streaming, Frailty and LOS.

## 2. Delayed Transfers of Care

The percentage occupied bed-days due to DTOC improved further from 4.27% in Jan to 3.98% in February. February 2018 is the fourth consecutive month that the DTOC percentage has been below 5% and is also the second lowest monthly percentage in the last 2 years. The number of bed days lost decreased from 1,023 in Jan to 833 in Feb. We have experienced a greater focus from external partners on the exit routes from the hospital and have now rolled out Pathway 1, 2 & 3 of the Home First initiative in full. The Frail Elderly unit at Maidstone is operating effectively with plans for the TWH Frailty Unit in advanced development but with limiting factors of staffing and capacity being a key risk.

| | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A : Awaiting Assessment | 32 | 14 | 14 | 13 | 11 | 7 | 2 | 2 | 7 | 6 | 2 | 5 | 2 |
| B : Awaiting Public Funding | 4 | 3 | 1 | 3 | 3 | 3 | 2 | | 2 | 1 | | 1 | 5 |
| C : Awaiting Further Non-Acute NHS Care | 13 | 16 | 17 | 21 | 27 | 11 | 8 | 21 | 15 | 10 | 18 | 21 | 9 |
| Di : Awaiting Residential Home | 24 | 35 | 21 | 8 | 16 | 16 | 23 | 32 | 21 | 19 | 18 | 24 | 18 |
| Dii : Awaiting Nursing Home | 77 | 76 | 57 | 70 | 94 | 53 | 63 | 42 | 46 | 54 | 38 | 37 | 47 |
| E : Awaiting Care Package | 30 | 38 | 35 | 39 | 43 | 27 | 27 | 32 | 24 | 36 | 14 | 18 | 20 |
| F : Awaiting Community Adaptations | 10 | 13 | 6 | 8 | 7 | 15 | 8 | 5 | 10 | 12 | 4 | 12 | 10 |
| G : Patient or Family Choice | 19 | 28 | 6 | 10 | 8 | 10 | 13 | 14 | 28 | 38 | 13 | 11 | 5 |
| H : Disputes | 1 | 1 | 1 | 1 | 2 | | 1 | | | 1 | | | |
| I : Housing | 5 | 4 | 3 | 3 | 5 | 6 | 8 | 2 | 2 | 1 | 2 | 3 | 3 |
| Total | 215 | 228 | 161 | 176 | 216 | 148 | 155 | 150 | 155 | 178 | 109 | 132 | 119 |
| Trust Rate of Delayed Transfers of Care | 7.1% | 6.2% | 5.6% | 6.0% | 6.1% | 5.4% | 4.5% | 5.3% | 5.4% | 4.8% | 3.7% | 4.3% | 3.9% |

## 3. Cancer 62 Day First Definitive Treatment

62 day performance has decreased in January to 67.6%. There were 35.5 breaches in January of which 25 were MTW only patients: 15 patients from other Trusts to MTW and 6 patients from MTW to elsewhere (1 patient = 0.5 breach). MTW received breaches: 4 patients from Medway, 1 patients from Darent Valley, 1 patient from East Sussex and 9 patients from East Kent (Patients shared across Trusts = 0.5 of a breach).

- The size of the backlog at the end of January was 53 patients (patients waiting over 62 days for treatment with a diagnosis of cancer). For the MTW only patients the backlog was 28. This is a 1 patient increase compared to December for all patients and no change for MTW only.
- 28.2% of patients were dated for a C2WW appointment by day 10 (a 3.1% increase compared to December).
- Urology contributed the largest number of breaches in December (9.0 breaches overall and 6 MTW only patients). The total number of breaches was significantly higher than in December (35.5 up from 22).
- Lung contributed the next largest number of breaches at 6.5 overall and 4 patients/breaches for MTW only.

Current forecast 62 day position for February = 67.7% (which is undergoing validation) [72.9% MTW only].

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 backlog at the end of January was 53, a 1 patient increase over the month. 28 of these were MTW patients - this number had been steadily reducing, but December was up 3, no change in January.

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.

The Oncology PTL is taking place weekly to replicate the main PTL meeting in order to progress radiotherapy and chemotherapy treatments and oncology are calling in to the daily huddle as well

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.

The process and approach used by MTW to track, monitor and manage patients who have been referred with a possible cancer diagnosis was reviewed in February by NHSI, using a critical friend approach. We have received positive feedback overall and we have agreed to work with them to further improve our approach to demand and capacity and specifically the urology pathway.

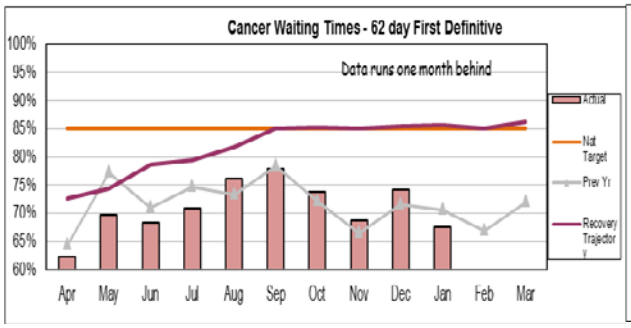
**Cancer 2 week waits**

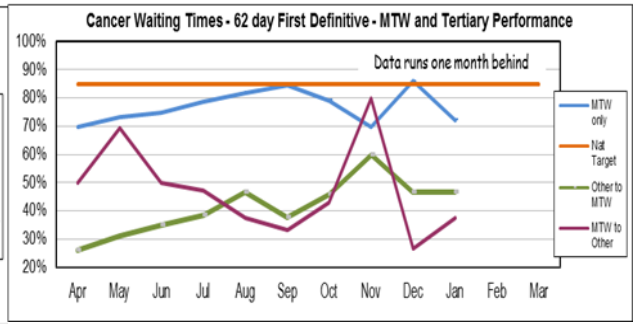
The introduction of e-referrals has resulted in a backlog for 2 week-wait breast referrals, from late February. This was because the breast appointments were made directly-bookable at go live but there were a number of referrals that had been received from the previous week that the 2ww Office still needed to book. This meant that the 2ww office was competing with GPs/patients to book in to the same slots and a number of patients subsequently had to be booked to later appointments.

This was manageable and would have been resolved with only a couple of extra clinics. However, there were two clinics cancelled due to the snow and a further 30 patients were then added to that backlog. There is now an over 70's awareness campaign being run and so the referral rate is expected to be higher.

Additional clinics have now been arranged and an additional 90 patients are expected to be seen this week. This will resolve the backlog issue but will result in a significant increase in the number of 2ww breaches in March.

The surgical team are reviewing how to increase their capacity longer term as it is known that demand is in excess of capacity. The implementation of a new model of sending letters to patients on annual follow up rather than bringing them back to clinic will release around 3,000 appointments per year and so this can be reused for new patients. The new process is expected to go live for patients from May.



| 62 Day Performance - All | | | |
|---|---|---|---|
| Tumour | Total | Brch | % |
| Breast | 14.0 | 2.0 | 85.7 |
| Lung | 13.5 | 6.0 | 55.6 |
| Haemat. | 8.5 | 3.0 | 64.7 |
| Upper GI | 5.5 | 3.5 | 36.4 |
| Lower GI | 21.5 | 7.5 | 65.1 |
| Skin | 1.0 | 1.0 | 0.0 |
| Gynae | 13.5 | 2.5 | 81.5 |
| Urology | 27.0 | 9.0 | 66.7 |
| Head & Nk | 2.5 | 0.0 | 100.0 |
| Sarcoma | 0.5 | 0.0 | 100.0 |
| Other | 2.0 | 1.5 | 25.0 |
| **Total** | **109.5** | **36.0** | **67.1** |

| 62 Day Performance - MTW | | | |
|---|---|---|---|
| Tumour | Total | Brch | % |
| Breast | 14 | 2 | 85.7 |
| Lung | 10 | 4 | 60.0 |
| Haemat. | 8 | 3 | 62.5 |
| Upper GI | 3 | 2 | 33.3 |
| Lower GI | 19 | 5 | 73.7 |
| Skin | 1 | 0 | 100.0 |
| Gynae | 11 | 2 | 81.8 |
| Urology | 23 | 6 | 73.9 |
| Head & Nk | 1 | 0 | 100.0 |
| Sarcoma | 0 | 0 | ##### |
| Other | 1 | 1 | 0.0 |
| **Total** | **91** | **25** | **72.5** |

In January, Lower GI, Urology and Lung have contributed the largest number of breaches overall.

MTW only patient performance for January is 72.2%.

## 4. Referral To Treatment – 18 weeks

February performance shows the Trust continues to forecast non-compliance with the Incomplete RTT standards at an aggregate level – 82.3% which is a slight decrease since last month. Our trajectory required us to achieve 91.7% by the end of Feb 18.

The Trust is investigating some 52wk breaches which have been highlighted but these have not been concluded currently. The key issues contributing to the low performance and increased backlog remain:

- The inability to do a sufficient level of elective work caused by the increased non-elective activity
- Cessation of outsourcing to IS providers
- Planned reduction of activity during PAS implementation, prolonged by on-going data and admin issues post go-live.
- Key vacancies in consultant and trainee posts in a variety of specialties (GS, Urology, Neurology & Endocrinology)
- Reduced activity in January to support NEL flow and further reduction in February due to snow.

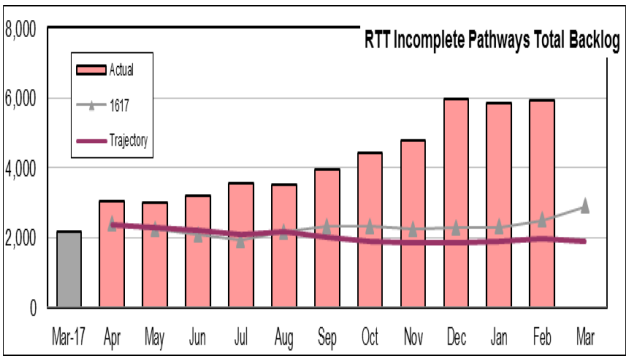
The majority of the backlog is concentrated in T&O, Gynae, ENT, General Surgery, Ophthalmology and Neurology-all of which are being carefully monitored against trajectories and action plans on a weekly basis.

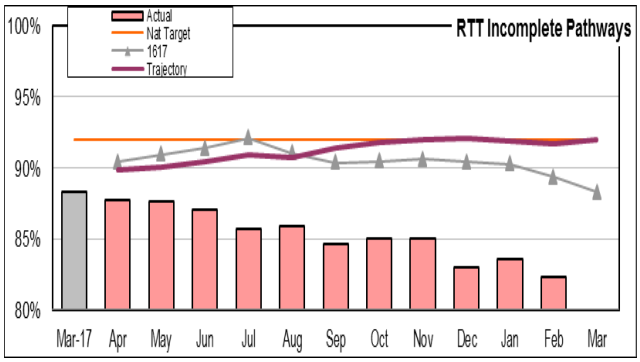
| | Feb-18 | Revised Feb-18 Trajectory | Variance from trajectory |
|---|---|---|---|
| RTT Backlog Incomplete | 5,929 | 5,782 | 147 |
| RTT Waiting List | 33,462 | 33,886 | -424 |
| RTT Incomplete performance % | 82.3% | 82.9% | -0.6% |

Operational teams have focused their recovery plans to increase elective activity and arrange extra clinics to ensure backlog does not grow further. The key actions are:

- Continue to ensure achievement of Incomplete targets month on month at an aggregate level by reducing RTT backlog for Incompletes through implementation of speciality plans
- Monitor weekly all Non-Admitted patients at 11wks or over without an OPA and all Admitted patients at 18wks or over without a TCI
- Ensure backlog patients are booked chronologically to avoid long waits/52 wk breaches
- Outsourcing to continue for Neurology in order to maintain the minimum activity level and prevent further increase in the backlog.
- External validation team employed for 8 weeks to remove duplicate pathways that have been created post go live of Allscripts PAS
- Intense training on PTL management has been instigated and rolled out to each CAU which should be completed by end of March

- Increase clinic/theatre capacity/activity on weekends to increase activity levels and reduce the number of long waiters.
- Continue weekly PTL/RTT performance monitoring to maintain overall performance
- Ensure robust management of Diagnostic waiting lists to ensure problems identified early to allow for solutions to be identified in a timely manner.



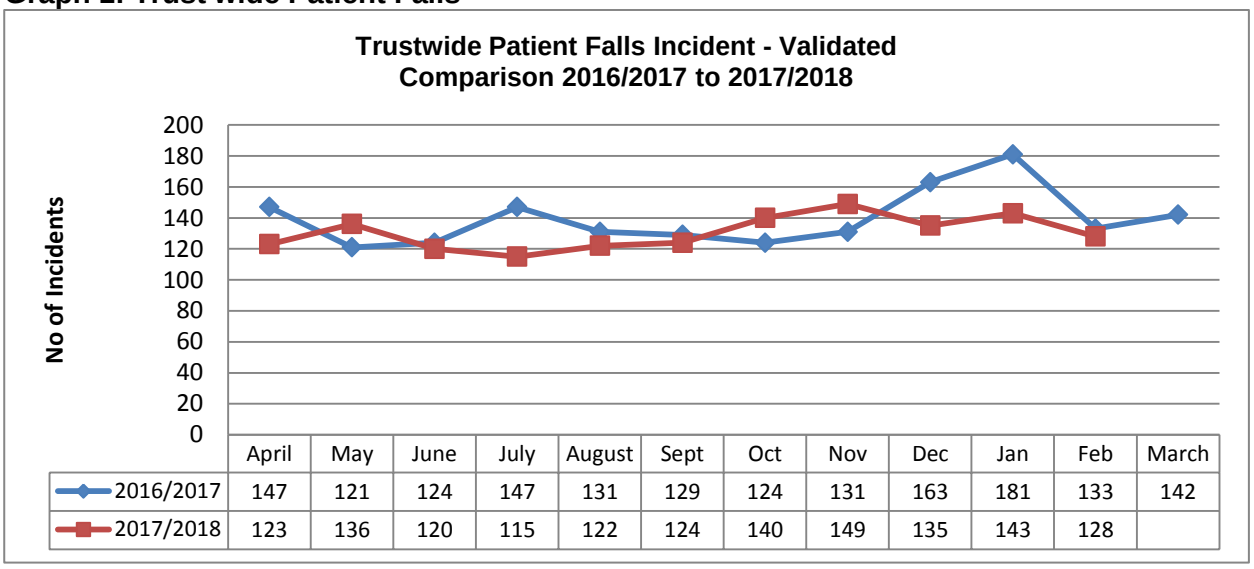

## Quality and Safety March Trust Board (February data)

### Patient Falls incidents

There were 128 falls reported for the month of February, this is a small decrease compared to 143 in January. This can be seen in graph 1, which provides a comparison year to date and to last year. The rate per 1000 occupied bed days is currently 5.92 which is below our internal limit of 6.0. (rate for same period in 2016/17 was 6.05 per 1000 OBD).
The breakdown of incidents by site is shown in graph 2, indicating a higher rate at Tunbridge Wells compared to Maidstone.

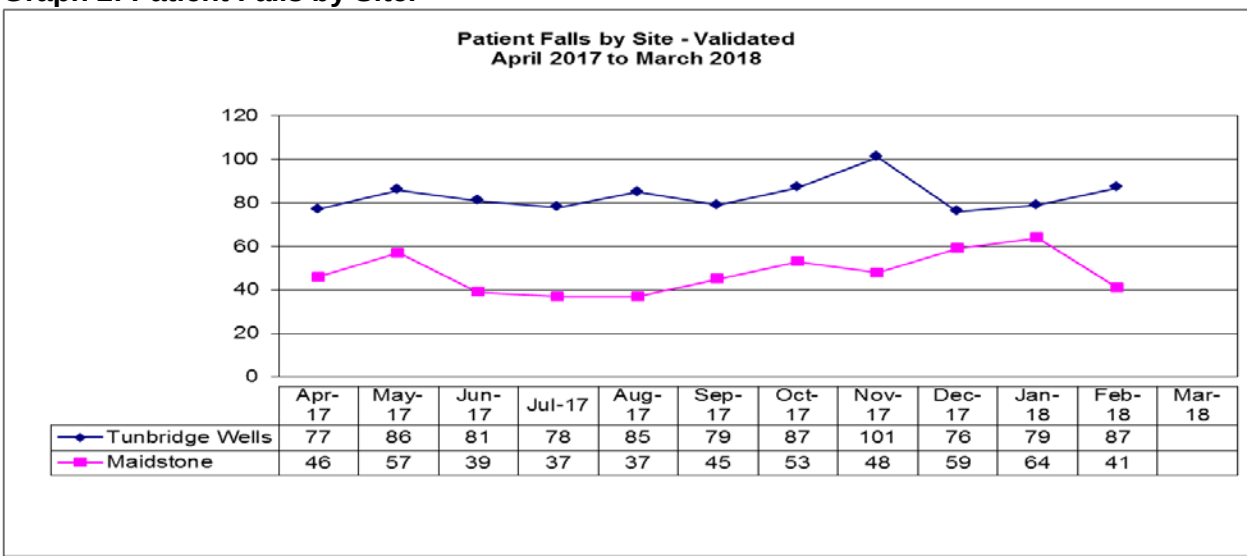
There were no falls related Serious incidents declared for February (but there were 2 falls that resulted in injury at the end of February that had been declared as Serious Incidents (SI) in March) compared to 5 declared in January. The total number of falls SIs year to date is 31 (excluding 2 SI downgraded by CCG) compared to 30 this time last year.

**Graph 1: Trust wide Patient Falls**




| | 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 | 140 | 149 | 135 | 143 | 128 | |

**Graph 2: Patient Falls by Site.**




| | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Tunbridge Wells | 77 | 86 | 81 | 78 | 85 | 79 | 87 | 101 | 76 | 79 | 87 | |
| Maidstone | 46 | 57 | 39 | 37 | 37 | 45 | 53 | 48 | 59 | 64 | 41 | |

The national falls audit has been completed, and an action plan developed which is overseen by the Slips, Trips and Falls Group (chaired by Associate Director of Nursing Planned Care). Actions currently being implemented include:

- Implementation of assessment form within the Emergency Department for patients with dementia and/or delirium.
- Ensuring lying and standing blood pressure is recorded and that this becomes embedded in practice. The Falls Prevention Practitioner is working with the Professional Standards team to have this element incorporated into the existing falls prevention assessment.
- Visit has been undertaken to a neighbouring trust (SASH) that has seen sustained improvements in falls prevention to share ideas and processes.
- A conversation with the NHSI National lead on falls to benchmark our work around falls prevention.
- Plans being developed to refine and implement the Safety Huddle with an initial trail on two wards (one on each site) to ensure the frame work of the huddle is correct before wider implementation.

These actions are on track for implementation and completion by the end of April.

**Pressure Ulcers:**

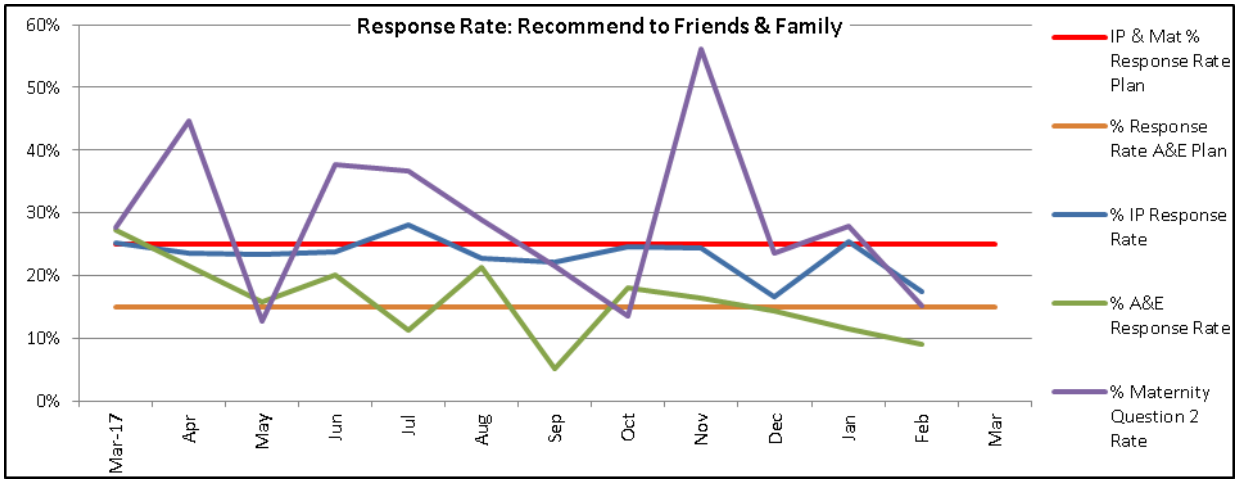
The incidence of pressure injury has seen a slight increase this month, however remains well below the limit of concern. The rate (per 1000 admissions) for February is 2.64 compared to 2.40 for the same month last year. The incidence rate for the year to date is 2.23 compared to 2.75 last year. This is against an improvement threshold of 3.0.

**Friends and Family test**

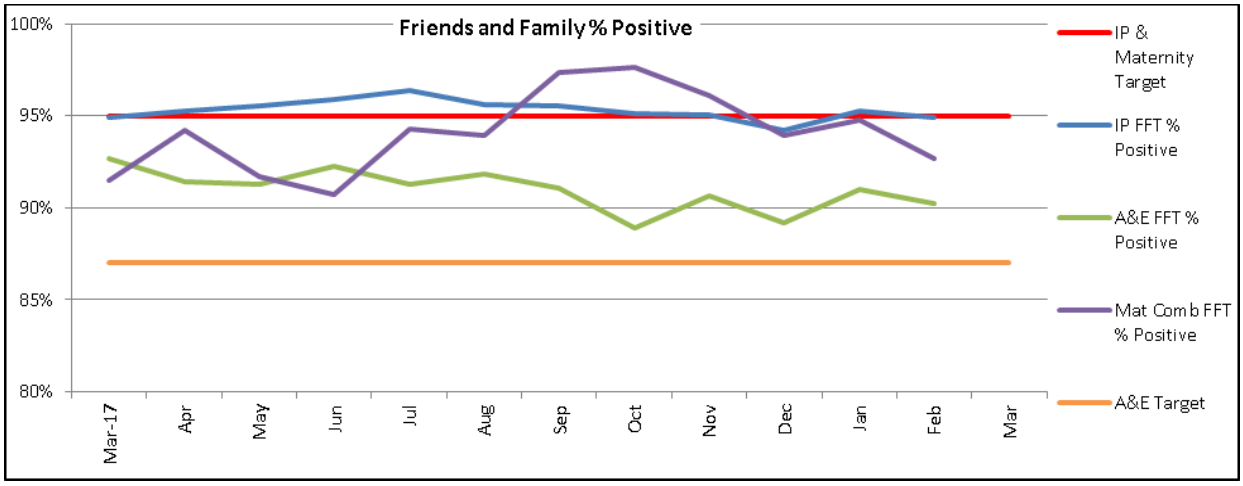
The response rates for February can be seen in graph 3, and demonstrate a significant decrease compared to January. Initial investigation into this suggests it was due to a local collection issue which is being resolved.

Positive response rates have also dropped, with inpatients at target level and maternity below target. Accident & Emergency have also decreased, however they remain above the national level.

**Graph 3 FFT Response Rates**




**Graph 4: FFT Positive Responses**




**Single Sex Compliance:**

There were a total of 21 mixed sex breaches in the month of February. These were made up of 5 incidences at Tunbridge Wells Hospital.

1 incident of 5 patients affected in Recovery 1, whilst the area was being used as an escalation ward. The remaining 4 incidences occurred in the Acute Medical Unit at Tunbridge Wells Hospital, where a bay was mixed overnight due to capacity issues on the site.

The Trust contributed to an audit of mixed sex compliance and reporting at the end of 2017, for the South East region, led by NHS England. This audit was triggered by the variation in the sector with many trusts either reporting significantly high numbers or zero. The feedback from the local area team is that Maidstone and Tunbridge Wells NHS Trust is not giving cause for concern in the way that we report and that our processes are in line with the guidance on mixed sex compliance.

The Trust is required to publish an annual declaration of compliance with single sex accommodation. This compliance statement will be presented to the Trust Board for approval in March and will be published on the Trust's website in April.

**Complaints**

There were 51 new complaints reported for February which equates to a rate of 2.38 new complaints per 1,000 occupied bed days. This is an increase compared to 2.00 for January. There were 157 open complaints at the end of February compared to 140 in January. 59.5% were responded to within deadline compared to a target of 75%.

A summary of the overall key themes and trends from complaints received on a monthly basis provided below.

The available data has been analysed by the date of the event being complained about, rather than when the complaint itself was received. It is hoped that this will give a truer picture of the current issues affecting our patients and service users. However, it should be noted that although the majority of complaints are raised within a month or two of the event occurring, there will be a degree of time delay. As a result, there will be less data available for the current and preceding month, than there will be for earlier months. The charts/graphs below will therefore be updated each month and may show variations (if compared retrospectively) for this reason.

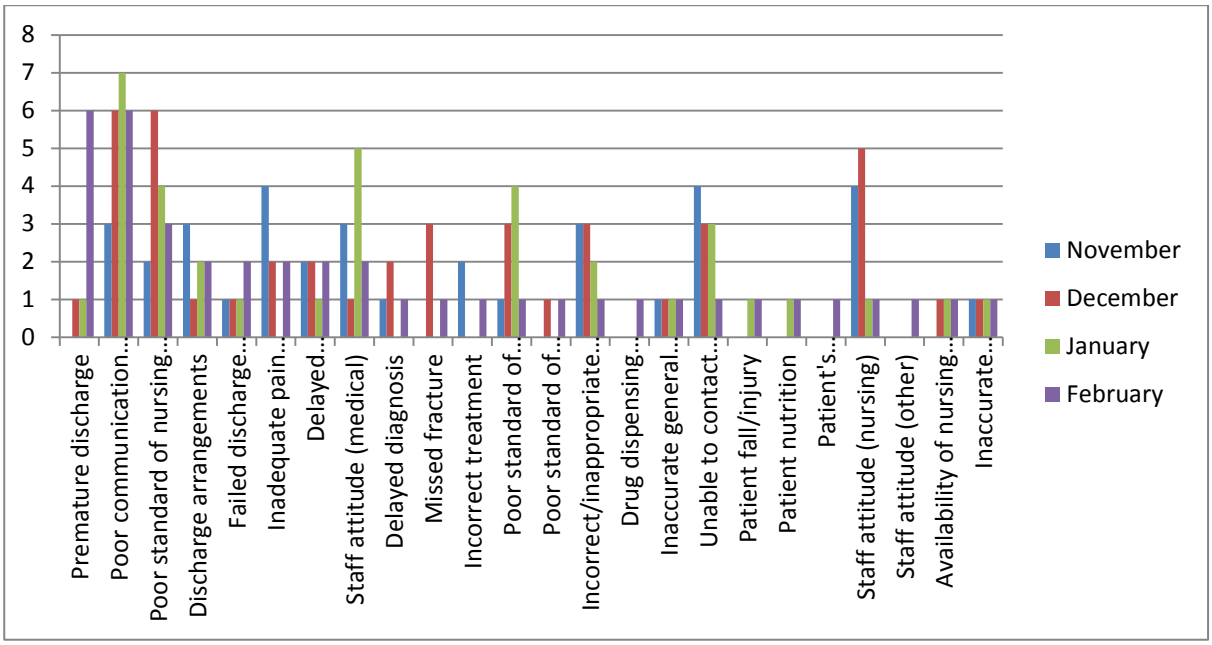
**Table 1: Complaints by Sub-subject – most frequently raised in February 2018**

| | Nov 17* | Dec 17* | Jan 18* | Feb 18* |
|---|---|---|---|---|
| **Premature discharge** | 0 | 1 | 1 | 6 |
| **Poor communication with patient/relative** | 3 | 6 | 7 | 6 |
| **Poor standard of nursing care** | 2 | 6 | 4 | 3 |
| **Discharge arrangements** | 3 | 1 | 2 | 2 |
| **Failed discharge (readmission within 48 hours)** | 1 | 1 | 1 | 2 |
| **Inadequate pain management** | 4 | 2 | 0 | 2 |
| **Delayed investigations/tests** | 2 | 2 | 1 | 2 |
| **Staff attitude (medical)** | 3 | 1 | 5 | 2 |

*reflects the date of the event being complained about

The following graph (Graph 5) shows an expanded view of the themes of complaints about events that occurred in February 2018.

**Graph 5: All themes/subjects raised in complaints made about events occurring February 2018.**




It is clear that consistently, communication with patients/relatives remains the key theme within complaints. Between October and January, this has remained one of the top 2 most frequently raised subjects in new complaints.

Looking at emerging issues, there has been a rising trend of complaints about:

- Discharges
- Poor standard of nursing care
- Inadequate pain management

All other areas show stable or slightly reducing trends, with no single area showing a significant reducing trend.

Complaint case studies are published in the Governance Gazette to highlight key themes and trends seen coming through complaints and the learning taken from complaint investigations.

**Quality up- date on Maternity**

Over the past two years there has been a programme of work namely the National Maternity Transformation work which has focussed on personalised choice, safety and quality for women.

This programme is now moving into the 3rd year when the work supported by the Early Adopter and Choice Pioneer is spreading to all maternity units and Local Maternity systems (LMS) across the country. MTW is one of the national Choice Pioneer sites, working closely with East Sussex & West Kent CCG to ensure women understand the choices they have in regards to various parts of the maternity pathway.

This focus is set out in the document 'Better Births' (2015) which sets out the Five Year Forward View for NHS Maternity Services in England and working towards the Secretary of States ambition of reducing the number of maternal deaths and the number of neonatal deaths and injuries by 20 % by 2020 and 50% by 2025.

The Kent & Medway LMS are working on plans for maternity services setting out the vision of building strong partnerships with the many agencies involved in maternity care in Kent & Medway, in order to deliver long term improvements for women, babies and their families and help reduce county wide variations in the service and outcomes

There are a number of work streams involved in this work as listed below; MTW staff will be members of all the work streams:

- Choice & Personalisation
- Perinatal Mental Health
- Maternity Voices Partnership ( new MSLC)
- Continuity of Care – by 2019 20% of women need to be on a pathway where they know the midwife caring for them in labour
- Safety & Quality
- Health Prevention
- Education & Training
- Data, IT and Finance
- Workforce Planning

**Infection Prevention and Control**

**MRSA –** The MRSA screening programme is integral to preventing MRSA bacteraemia. The screening rate for January was 98% for elective screening. Due to data issues following the Allscripts implementation the data are still not sufficiently robust to report non-elective screening.

**C. difficile** - There were no cases of post-72 hour C. difficile infection in February against a monthly limit of two cases. The current rate of C. difficile infection is 9.6 per 100 000 obd for the year to date. The trust is currently below trajectory for the year with 23 cases seen.

**Methicillin sensitive *Staphylococcus aureus* bacteraemia** – 24 cases of hospital attributable MSSA bacteraemia have been seen year to date, 4 cases below the same period last year. More intensive monitoring of these bacteraemias is currently undertaken following increases in numbers in previous years, with all cases reviewed at the *C. difficile* panel and learning shared at clinical governance meetings.

**Gram negative bacteraemia -** Following the Secretary of State's announcement of a 50% reduction target in avoidable gram negative blood stream infection by 2020/21, data collection has been commenced to establish the baseline. Community acquired blood stream infections continue to rise steeply, placing a significant burden on the acute services as the majority of these patients require admission

From the beginning of April epidemiological data has been collected on all cases of *Pseudomonas sp* and *Klebsiella sp* blood stream infection, in addition to the E. coli data collected for some years, and submitted to the national Data Collection System.

**Influenza**
During February 2018 the Trust diagnosed 57 cases of Influenza (28 Flu B and 28 Flu A and one patient who had infections with both viruses). Five of these patients required ITU admission.

**Financial commentary**

- The Trusts deficit including STF was £2.2m in February which was £3.1m adverse to plan, due to, £1.3m STF underperformance in month due to non-delivery of the financial control target and A&E trajectory, £0.8m slippage against the original plan CIP phasing and £1m adverse variances against budget the majority due to private patient income underperformance (£0.4m) and continued escalation.
- The Trust's YTD deficit excluding STF is £17.1m which is £11.2m adverse to the plan.
- In February the Trust operated with an EBITDA surplus of £0.2m which is consistent with January but £3.3m adverse to plan.
- The Trusts deficit in February was in line with the forecast submitted to NHSI in January, Income over performance of £2m offset by overspends within non pay (£2m), mainly due to pass through STP and PAS All Scripts costs.
- The Trust's normalised pre STF run rate in February was a deficit of £2.8m which was £0.5m higher than the YTD average. The main normalised adjustments in February related to: Nurse Agency Accrual adjustment (£0.3m), Release of Medical Banding arrears of pay provision (£0.25m), Biosimilar Income (£0.1m), Reduction in Outsourcing costs (£0.1m), various accrual adjustments (£0.1m) and increase in Winter Funding for GP service in A&E (£0.1m), these adjustments were above the month 9 forecast.
- The key variances in the month are as follows:
  - Total income was £0.5m favourable in the month; Clinical Income excluding HCDs was £0.5m adverse in February. The key adverse variances in February were Elective & Day Cases (£1.3m), and outpatients (£0.6m) offset by favourable variances within non elective (£0.6m) , inclusion of £0.5m Winter funding, £0.2m neo natal pricing adjustment and A&E (£0.2m). The position included a favourable adjustment of £1.1m relating to the aligned incentive contract (£2.5m) positive YTD. STF was £1.3m adverse in February due to non-delivery of the financial target, Other Operating Income £2.1m favourable in the month, £2.6m relating to pass through costs associated with STP (£0.7m) and PAS AllScripts (£1.9m) partly offset by underperformance in the month within Private Patient income (£0.4m).
  - Pay was £0.8m adverse in the month, the normalised pay spend (excluding reserves) in February was the second highest this financial year. Medical Staffing costs reduced by £0.4m between months which is mainly due to £0.25m release of banding provision accrual. The normalised February costs were £0.2m higher than the month 9 forecast which is due to higher than forecasted vacancies within Surgery and Ophthalmology, and the continuation of additional Medical tier to support escalation. Nursing costs were £20k adverse to the month 9 forecast however a one off accrual adjustment of £0.3m was released in February therefore the normalised position was £0.3m adverse to the month 9 forecast. This is mainly due to the continued escalation of Cornwallis ward (previously forecasted to be closed by 1st February) generating a pressure of c£0.2m against the forecast. The level of bank hours increased from c43,000 hours to c48,000 hours in January which impacted adversely in February due to the level of accrual for January being at the lower usage level.
  - Non Pay was overspent by £3m in February, this was mainly due to Pass through costs (£2.2m) relating to STP, PAS Allscripts and high cost drugs offset by additional income, and Clinical Supplies £0.6m adverse (mainly due to unidentified CIP)
- The CIP performance in February delivered efficiencies of £2.2m which was £0.8m adverse to the phasing of the original plan, £8.7m 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 £22.4m, £9.4m adverse to plan.

- The Trust held £8.6m of cash at the end of February which is lower than the plan of £14.8m. In March the Trust is receiving £3.99m in working capital loans, which added to the previous values received in 2017/18 totals £13.99m. The Trust continues to proactively engage with NHS organisations trying to collect all agreed values and organising "like for like" arrangements to reduce both debtor and creditor balances. It has also been agreed to switch to invoicing the STP budget in advance, rather than retrospectively
- The Trust has received approval of all the phases for its Salix loan application of £744k for 2017/18 to support its energy infrastructure renewal and received £629k to date with the remaining balance expected before the end of March. The Trust has also received to date £645k of capital financing for its GP A&E Streaming works. The Springs property sale completed on 22nd January with sale proceeds of £800k. In March the Trust has received the £1.7m PDC funding for the replacement linear accelerator. The Trust is planning an underspend in depreciation to support the Income & Expenditure position and this has been matched by a corresponding reduction in the planned capital spend. The current FOT is £11.64m (before donations and asset sales).
- Risks to the financial position have been discussed in detail at the Finance and Performance Meeting.
- The Trust is forecasting a Year End deficit including STF of £14m, £7.3m adverse to plan. The Trusts forecast excluding STF is a deficit of £17.9m which is £13.4m adverse to plan.

**Workforce Commentary**

March 2018 Board (February Dashboard)

As at the end of February 2018, the Trust employed 5033.3 whole time equivalent substantive staff, a 1.7 WTE decrease from the previous month. Bank and agency use is higher than planned, in line with the higher than anticipated vacancy levels.

Sickness absence in the month (January) decreased by 0.29% to 4.71%, 1.4% over target and higher than the same period last year. Directorates demonstrating the highest sickness rates include Clinical Governance (8.71%), Facilities (7.60%) and Children's Services (7.19%) but with rates having decreased in two of the three areas since last month. At a divisional level, Planned Care has a lower combined sickness absence rate (3.89%) than Urgent Care (4.65%) or Women, Children and Sexual Health (6.36%). In contrast with the others, Women, Children and Sexual Health has demonstrated a small increase in sickness levels from last month. At a trust level, the breakdown in December is 54.30% short-term, 45.70% long term. It is evident that while the increase in seasonal cold and influenza contributes to the overall rate rise, long-term absence is still having a significant impact. Effective sickness absence management remains a key area of focus for the HR and operational management teams, particularly targeting long term sickness in outlying areas.

Statutory and mandatory training compliance has decreased marginally by 0.52% to 87.44%, but remains above the target percentage. In general, corporate areas demonstrate a higher level of training compliance, in line with the more limited range of training needs that are required. Directorates with lower overall compliance include Trauma and Orthopaedic (82.10%) and General Surgery (81.98%) with the latter having decreased slightly from the previous month.
Turnover has decreased slightly since last month to 11.54%, higher than target with outliers in Estates (23.84%) and ICT (22.18%) (although both have reduced from last month). It should be noted that due to the 12 month rolling calculation, turnover figures typically move more slowly and incorporate historic data as well as the most recent month. 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 February, following the end of the Trust's designated appraisal window in June, stands at 89.37%, an increase of 0.15% from the previous month, but still slightly below the Trust target.

# Trust Performance Dashboard

**Position as at: 28 February 2018**

| | |
|---|---|
| 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) | 0.00 | 0.0 | 10.3 | 9.6 | -0.7 | - 0.8 | 11.5 | 9.5 | |
| '1-02 | Number of cases C.Difficile (Hospital) | 0 | 0 | 25 | 23 | -2 | - 2 | 27 | 25 | |
| '1-03 | Number of cases MRSA (Hospital) | 0 | 0 | 1 | 0 | -1 | 0 | 0 | 0 | |
| '1-04 | Elective MRSA Screening | 99.0% | 98.0% | 99.0% | 98.0% | -1.0% | 0.0% | 98.0% | 98.0% | |
| '1-05 | % Non-Elective MRSA Screening | 96.0% | No data | 96.0% | No data | -96.0% | -95.0% | 95.0% | No data | |
| '1-06 | **Rate of Hospital Pressure Ulcers | 2.40 | 2.64 | 2.75 | 2.23 | - 0.52 | - 0.78 | *3.01* | 2.39 | 3.00 |
| '1-07 | ***Rate of Total Patient Falls | 6.06 | 5.98 | 6.05 | 5.92 | - 0.13 | - 0.08 | *6.00* | 5.90 | |
| '1-08 | ***Rate of Total Patient Falls Maidstone | 6.05 | 4.95 | 5.35 | 5.58 | 0.23 | | | 5.52 | |
| '1-09 | ***Rate of Total Patient Falls TWells | 7.20 | 6.63 | 6.58 | 6.14 | - 0.44 | | | 6.15 | |
| '1-10 | Falls - SIs in month | 4 | 0 | 34 | 31 | - 3 | | | | |
| '1-11 | Number of Never Events | 1 | 0 | 3 | 3 | 0 | 3 | *0* | 3 | |
| '1-12 | Total No of SIs Open with MTW | 35 | 50 | | | 15 | | | | |
| '1-13 | Number of New SIs in month | 13 | 5 | 104 | 155 | 51 | 45 | | | |
| '1-14 | ***Serious Incidents rate | 0.62 | 0.23 | 0.43 | 0.64 | 0.22 | 0.59 | *0.0584 - 0.6978* | 0.64 | *0.0584 - 0.6978* |
| '1-15 | Rate of Patient Safety Incidents - harmful | 1.12 | 1.08 | 0.76 | 1.17 | 0.41 | - 0.06 | *0 - 1.23* | 1.17 | *0 - 1.23* |
| '1-16 | Number of CAS Alerts Overdue | 0 | 0 | | | 0 | 0 | *0* | | |
| '1-17 | VTE Risk Assessment - month behind | 95.9% | 95.1% | 95.4% | 95.3% | 0.0% | 0.3% | 95.0% | 95.3% | 95.0% |
| '1-18 | Safety Thermometer % of Harm Free Care | 97.5% | 97.5% | 96.6% | 97.3% | 0.7% | 2.3% | 95.0% | | 93.4% |
| '1-19 | Safety Thermometer % of New Harms | 2.39% | 2.40% | 3.16% | 2.54% | -0.62% | -0.5% | *3.00%* | 2.54% | |
| '1-20 | C-Section Rate (non-elective) | 12.9% | 14.4% | 12.8% | 13.7% | 0.86% | -1.3% | *15.0%* | 13.7% | |

| | 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 | 1.0492 | 0.0 | 0.0 | Band 2 | Band 2 | 1.0 |
| 2-02 | Standardised Mortality HSMR | Prev Yr: Apr 15 to Mar 16 | | 108.0 | 104.1 | - 3.9 | 4.1 | Lower confidence limit to be <100 | | 100.0 |
| 2-03 | Crude Mortality | 1.4% | 1.4% | 1.3% | 1.2% | -0.1% | | | | |
| 2-04 | ****Readmissions <30 days: Emergency | 10.9% | 13.7% | 11.7% | 12.7% | 1.1% | -0.9% | *13.6%* | 12.7% | 14.1% |
| 2-05 | ****Readmissions <30 days: All | 0.0% | 13.2% | 8.8% | 12.1% | 3.4% | -2.5% | *14.7%* | 12.1% | 14.7% |
| 2-06 | Average LOS Elective | 3.13 | 3.12 | 3.28 | 3.24 | - 0.04 | 0.04 | *3.20* | 3.20 | |
| 2-07 | Average LOS Non-Elective | 7.72 | 7.59 | 7.63 | 7.37 | - 0.26 | 0.57 | *6.80* | 7.37 | |
| 2-22 | NE Discharges - Percent zero LoS | 30.4% | 38.2% | 30.8% | 36.7% | 5.9% | | | 36.7% | |
| 2-08 | ******FollowUp : New Ratio | 1.82 | 1.57 | 1.80 | 1.70 | - 0.10 | 0.18 | *1.52* | 1.70 | |
| 2-09 | Day Case Rates | 87.6% | 87.4% | 85.7% | 86.4% | 0.7% | 6.4% | 80.0% | 86.4% | 82.2% |
| 2-10 | Primary Referrals | 9,016 | 9,101 | 106,409 | 107,294 | 0.8% | -1.9% | 119,266 | 117,176 | |
| 2-11 | Cons to Cons Referrals | 4,884 | 3,494 | 56,241 | 48,035 | -14.6% | -10.1% | 58,644 | 52,459 | |
| 2-12 | First OP Activity (adjusted for uncashed) | 15,383 | 15,438 | 181,498 | 176,195 | -2.9% | -4.6% | 201,705 | 210,926 | |
| 2-13 | Subsequent OP Activity (adjusted for uncashed ) | 29,121 | 22,546 | 339,273 | 299,624 | -11.7% | -14.7% | 383,906 | 358,684 | |
| 2-14 | Elective IP Activity | 473 | 415 | 6,952 | 6,018 | -13.4% | -21.3% | 8,303 | 6,018 | |
| 2-15 | Elective DC Activity | 3,312 | 2,840 | 40,806 | 37,809 | -7.3% | -5.9% | 43,602 | 41,291 | |
| 2-16 | **Non-Elective Activity | 4,113 | 4,515 | 47,437 | 52,854 | 11.4% | 24.8% | 46,435 | 57,760 | |
| 2-17 | A&E Attendances (Inc Clinics. Calendar Mth) | 12,005 | 13,082 | 150,975 | 156,524 | 3.7% | 2.1% | 168,161 | 171,991 | |
| 2-18 | Oncology Fractions | 5,315 | 4,378 | 65,322 | 59,896 | -8.3% | -13.2% | 75,273 | 65,341 | |
| 2-19 | No of Births (Mothers Delivered) | 453 | 478 | 5,482 | 5,513 | 0.6% | 0.6% | 5,977 | 6,014 | |
| 2-20 | % Mothers initiating breastfeeding | 80.8% | 80.5% | 77.8% | 81.4% | 3.6% | 3.4% | 78.0% | 81.4% | |
| 2-21 | % Stillbirths Rate | 0.4% | 0.41% | 0.22% | 0.32% | *0.1%* | *-0.1%* | *0.47%* | 0.32% | 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 | 21 | 12 | 42 | 30 | 42 | 0 | 42 | |
| 3-02 | *****Rate of New Complaints | 1.37 | 2.38 | 1.69 | 1.89 | 0.2 | 0.57 | *1.318-3.92* | 1.88 | |
| 3-03 | % complaints responded to within target | 76.7% | 59.5% | 74.3% | 61.1% | -13.2% | -13.9% | 75.0% | 61.1% | |
| 3-04 | ****Staff Friends & Family (FFT) % rec care | 76.6% | 66.7% | 76.6% | 66.7% | -9.9% | -12.3% | 79.0% | 66.7% | |
| 3-05 | *****IP Friends & Family (FFT) % Positive | 95.8% | 94.9% | 95.5% | 95.4% | -0.1% | 0.4% | 95.0% | 95.4% | 95.8% |
| 3-06 | A&E Friends & Family (FFT) % Positive | 92.6% | 90.3% | 90.4% | 90.9% | 0.5% | 3.9% | 87.0% | 90.9% | 85.5% |
| 3-07 | Maternity Combined FFT % Positive | 93.4% | 92.7% | 93.8% | 94.3% | 0.5% | -0.7% | 95.0% | 94.3% | 95.6% |
| 3-08 | OP Friends & Family (FFT) % Positive | 83.9% | No data | 82.9% | 84.4% | 1.5% | | | 84.4% | |

* 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 now both consultant and non-consultant led for all specialties -plan still being agreed so currently last year plan

| | Responsiveness | Latest Month Prev Yr | Latest Month Curr Yr | Year/Qtr to Date Prev Yr | Year/Qtr 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 | 85.1% | 90.33% | 86.9% | 89.0% | 2.1% | -0.6% | 90.1% | 88.9% | 83.0% |
| 4-02 | Emergency A&E >12hr to Admission | 0 | 0 | 0 | 6 | 6 | 6 | *0* | 6 | |
| 4-03 | Ambulance Handover Delays >30mins | New | 476 | New | 4,295 | | | | | |
| 4-04 | Ambulance Handover Delays >60mins | New | 87 | New | 596 | | | | | |
| 4-05 | RTT Incomplete Admitted Backlog | 916 | 2,574 | 916 | 2,574 | 1,658 | 1,275 | 1,259 | 2,765 | |
| 4-06 | RTT Incomplete Non-Admitted Backlog | 459 | 3,325 | 459 | 3,325 | 2,866 | 2,674 | 631 | 2,989 | |
| 4-07 | RTT Incomplete Pathway | 89.3% | 82.3% | 89.3% | 82.3% | -7.1% | -8.9% | 92% | 83.3% | |
| 4-08 | RTT 52 Week Waiters | - | 9 | - | 36 | 36 | 36 | - | 27 | |
| 4-09 | RTT Incomplete Total Backlog | 2,493 | 5,899 | 2,493 | 5,899 | 3,406 | 3,949 | 1,890 | 5,754 | |
| 4-10 | % Diagnostics Tests WTimes <6wks | 99.63% | 99.3% | 99.7% | 99.3% | -0.4% | 0.3% | 99.0% | 99.3% | |
| 4-11 | *Cancer WTimes - Indicators achieved | 3 | 1 | 3 | 5 | 2 | - 4 | 9 | 6 | |
| 4-12 | *Cancer two week wait | 95.3% | 85.7% | 93.0% | 87.1% | -5.9% | -5.9% | 93.0% | 86.9% | |
| 4-13 | *Cancer two week wait-Breast Symptoms | 84.3% | 83.9% | 88.7% | 81.8% | -6.9% | -11.2% | 93.0% | 81.7% | |
| 4-14 | *Cancer 31 day wait - First Treatment | 92.7% | 95.0% | 96.3% | 97.4% | 1.2% | 1.4% | 96.0% | 96.4% | |
| 4-15 | *Cancer 62 day wait - First Definitive | 70.6% | 67.6% | 71.9% | 72.2% | 0.3% | -9.2% | 85.0% | 70.2% | |
| 4-16 | *Cancer 62 day wait - First Definitive - MTW | 75.9% | 72.2% | 75.9% | 77.6% | 1.7% | | 85.0% | | |
| 4-17 | *Cancer 104 Day wait Accountable | 10.5 | 7.5 | 90.0 | 65.5 | -24.5 | 65.5 | *0* | 65.5 | |
| 4-18 | *Cancer 62 Day Backlog with Diagnosis | 78 | 99 | 78 | 99 | 21 | | | | |
| 4-19 | *Cancer 62 Day Backlog with Diagnosis - MTW | 63 | 90 | 63 | 90 | 27 | | | | |
| 4-20 | Delayed Transfers of Care | 7.1% | 3.9% | 6.7% | 5.0% | -1.7% | 1.5% | 3.5% | 5.0% | |
| 4-21 | % TIA with high risk treated <24hrs | 84.2% | 83.9% | 82.7% | 72.7% | -9.9% | 12.7% | 60% | 72.7% | |
| 4-22 | *******% spending 90% time on Stroke Ward | 86.3% | 91.8% | 87.6% | 90.9% | 3.4% | 10.9% | 80% | 90.9% | |
| 4-23 | *******Stroke:% to Stroke Unit <4hrs | 63.2% | 45.1% | 52.6% | 57.9% | 5.3% | -2.1% | 60.0% | 57.9% | |
| 4-24 | *******Stroke: % scanned <1hr of arrival | 55.9% | 69.5% | 56.8% | 65.6% | 8.8% | 17.6% | 48.0% | 65.6% | |
| 4-25 | *******Stroke:% assessed by Cons <24hrs | 71.2% | 80.3% | 66.6% | 80.5% | 13.8% | 0.5% | 80.0% | 80.5% | |
| 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 | 26 | 20 | 26 | *0* | 26 | |

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

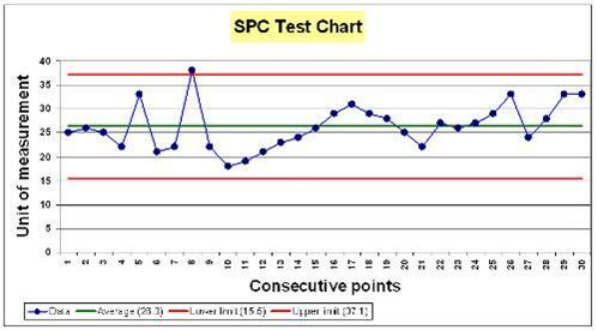
**CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory*

**** 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 | 33,504 | 36,920 | 389,041 | 399,543 | 2.7% | 0.3% | 436,716 | 433,933 | |
| 5-02 | EBITDA | 341 | 211 | 11,172 | 13,245 | 18.6% | -59.5% | 38,055 | 15,300 | |
| 5-03 | Surplus (Deficit) against B/E Duty | (2,045) | (2,216) | (16,170) | (13,229) | | | 6,673 | (13,989) | |
| 5-04 | CIP Savings | 2,659 | 2,169 | 20,706 | 20,051 | -3.2% | -30.3% | 31,721 | 22,404 | |
| 5-05 | Cash Balance | 13,632 | 8,558 | 13,632 | 8,558 | | | 1,000 | 1,000 | |
| 5-06 | Capital Expenditure | 681 | 1,059 | 4,022 | 5,217 | | | *16,948* | 11,471 | |
| 5-07 | Establishment WTE | 5,605.4 | 5,608.4 | 5,605.4 | 5,608.4 | 0.1% | 0.0% | 5,608.4 | 5,608.4 | |
| 5-08 | Contracted WTE | 5,165.0 | 5,033.3 | 5,165.0 | 5,033.3 | -2.5% | -1.5% | 5,109.5 | 5,109.5 | |
| 5-09 | Vacancies WTE | 440.4 | 575.2 | 440.4 | 575.2 | 30.6% | 15.3% | 498.9 | 498.9 | |
| 5-11 | Vacancy Rate (%) | 7.9% | 10.3% | 7.9% | 10.3% | 2.4% | 1.4% | 8.9% | 8.9% | |
| 5-12 | Substantive Staff Used | 4,991.5 | 4,897.6 | 4,991.5 | 4,897.6 | -1.9% | -4.1% | 5,109.5 | 5,109.5 | |
| 5-13 | Bank Staff Used | 321.5 | 514.3 | 321.5 | 514.3 | 60.0% | 53.5% | 335 | 335.0 | |
| 5-14 | Agency Staff Used | 201.7 | 122.6 | 201.7 | 122.6 | -39.2% | -25.2% | 164.0 | 164.0 | |
| 5-15 | Overtime Used | 35.5 | 47.3 | 35.5 | 47.3 | 33.2% | | | | |
| 5-16 | Worked WTE | 5,550.2 | 5,581.8 | 5,550.2 | 5,581.8 | | -0.5% | 5,608.4 | 5,608.4 | |
| 5-17 | Nurse Agency Spend | (638) | (626) | (7,634) | (7,124) | -6.7% | | | | |
| 5-18 | Medical Locum & Agency Spend | (942) | (1,472) | (13,374) | (14,264) | 6.7% | | | | |
| 5-19 | Temp costs & overtime as % of total pay bill | 13.4% | 17.2% | 15.4% | 16.0% | 0.6% | | | | |
| 5-20 | Staff Turnover Rate | 10.7% | 11.5% | | 11.8% | 0.8% | 1.3% | *10.5%* | 11.8% | 11.05% |
| 5-21 | Sickness Absence | 4.6% | 4.7% | | 3.8% | 0.1% | 0.5% | *3.3%* | 3.8% | 4.3% |
| 5-22 | Statutory and Mandatory Training | 90.2% | 87.4% | | 88.0% | -2.7% | 3.0% | 85.0% | 88.0% | |
| 5-23 | Appraisal Completeness | 87.7% | 91.0% | | 91.0% | 3.3% | 1.0% | 90.0% | 91.0% | |
| 5-24 | Overall Safe staffing fill rate | 97.9% | 97.0% | 98.8% | 98.1% | -0.7% | | 93.5% | 98.1% | |
| 5-25 | ****Staff FFT % recommended work | 52.5% | 61% | 52.5% | 61% | 8.1% | -1.4% | 62.0% | 61% | |
| 5-26 | ***Staff Friends & Family -Number Responses | 619 | 33 | 619 | 33 | -586 | | | | |
| 5-27 | *****IP Resp Rate Recmd to Friends & Family | 25.6% | 17.4% | 23.1% | 23.0% | 0.0% | -2.0% | 25.0% | 25.0% | 25.7% |
| 5-28 | A&E Resp Rate Recmd to Friends & Family | 15.6% | 9.1% | 14.4% | 15.0% | 0.6% | 0.0% | 15.0% | 15.0% | 12.7% |
| 5-29 | Mat Resp Rate Recmd to Friends & Family | 35.9% | 15.2% | 26.5% | 28.7% | 2.2% | 3.7% | 25.0% | 28.7% | 24.0% |

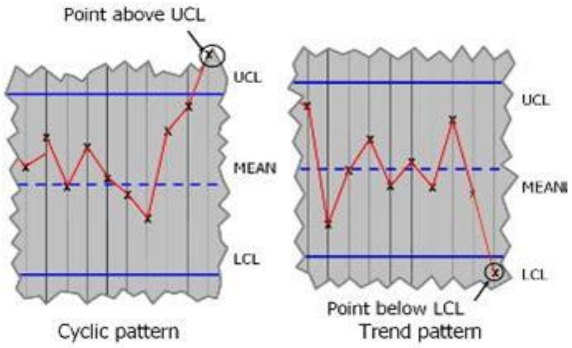
# Explanation of Statistical Process Control (SPC) Charts

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

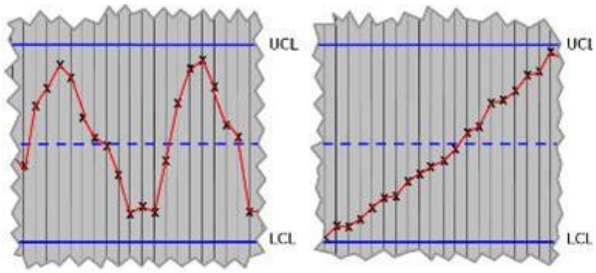



SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system.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

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

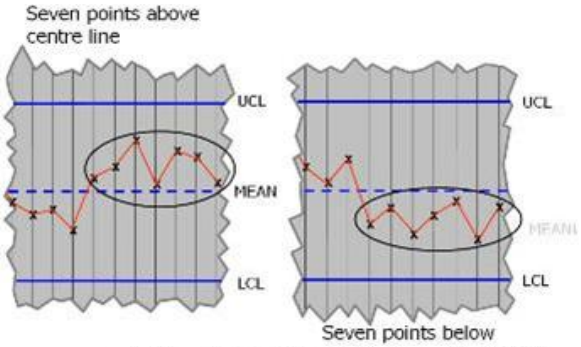



**Rule 2:** Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the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

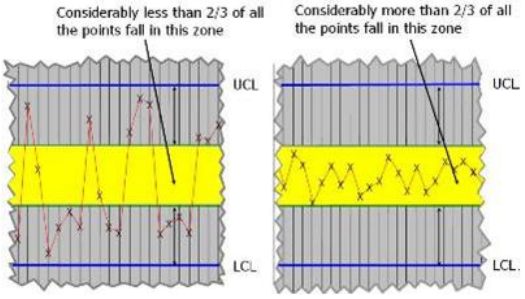



Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

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

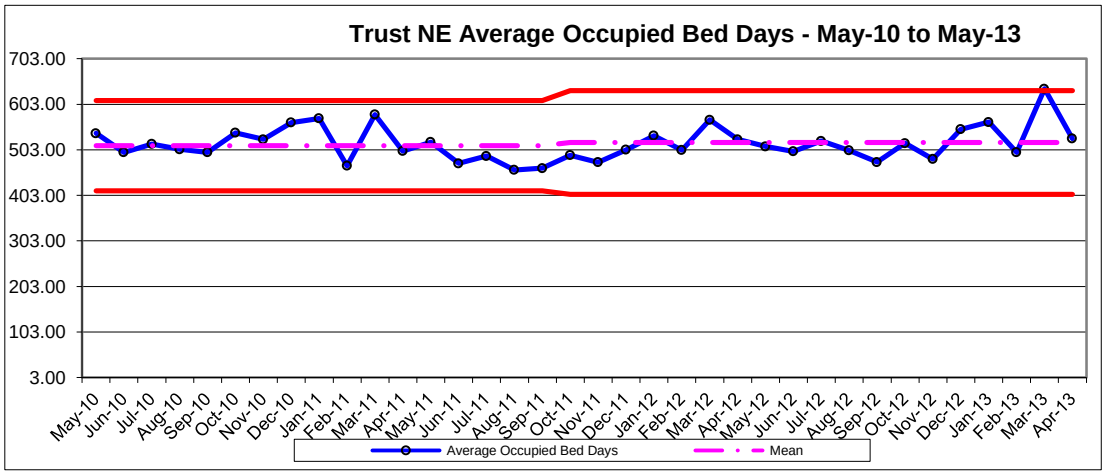



**Rule 4:** The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is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

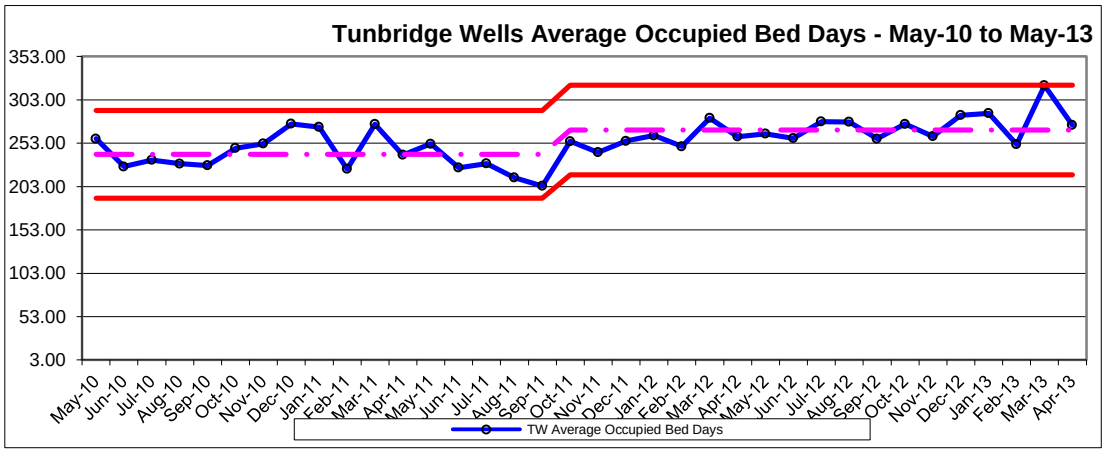


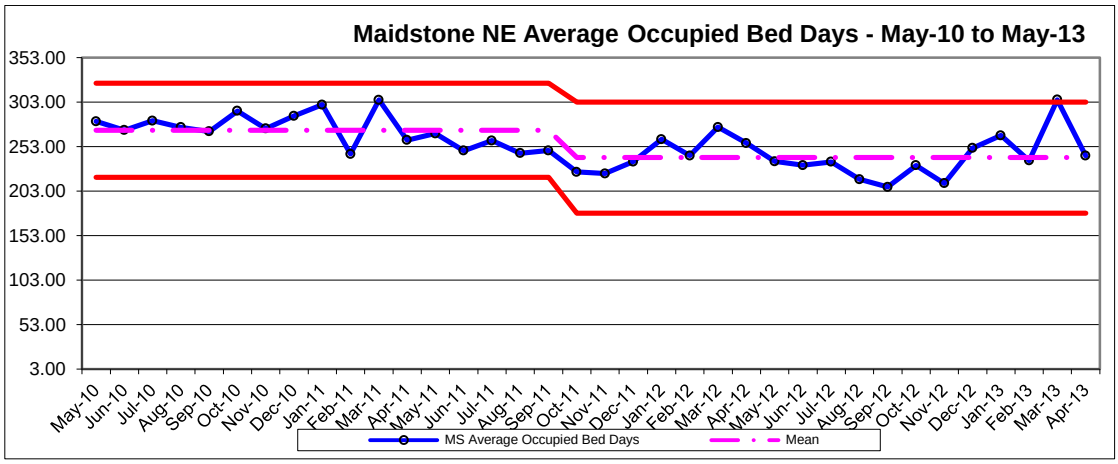
**Changes to Control Lines**

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




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

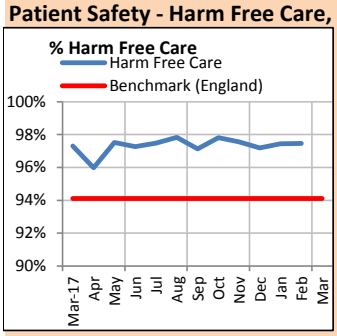


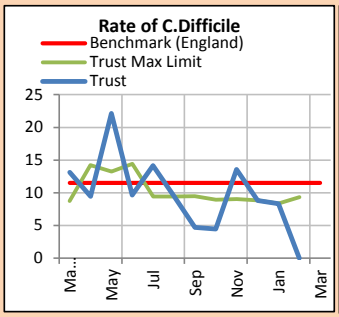



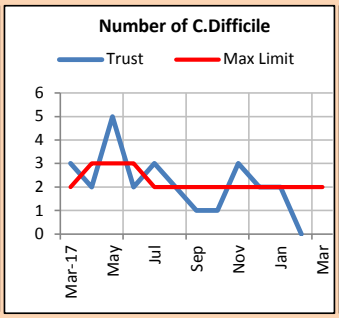

So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

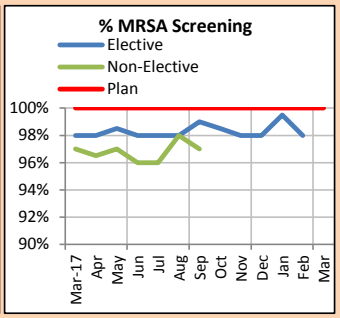
# INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

## Patient Safety - Harm Free Care, Infection Control

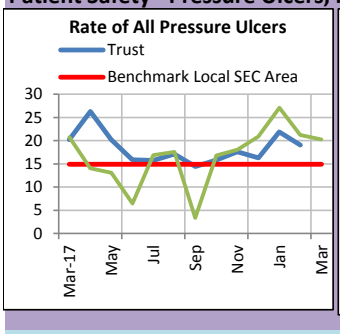


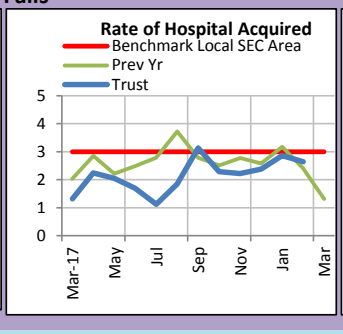



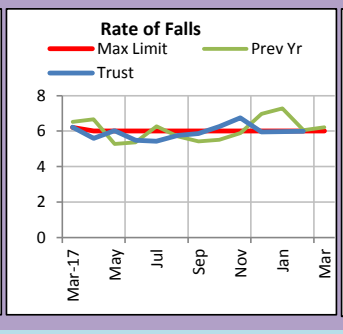



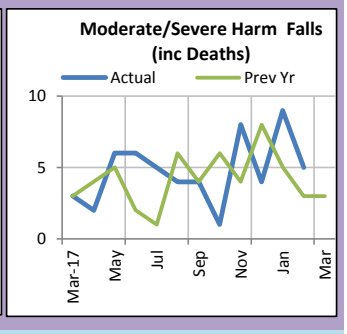




## Patient Safety - Pressure Ulcers, Falls

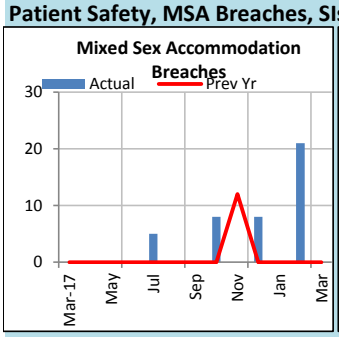


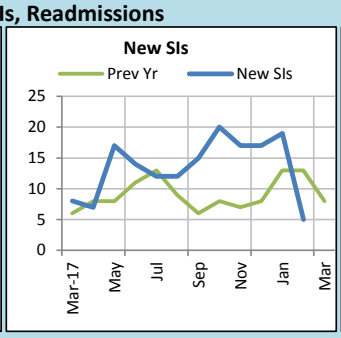



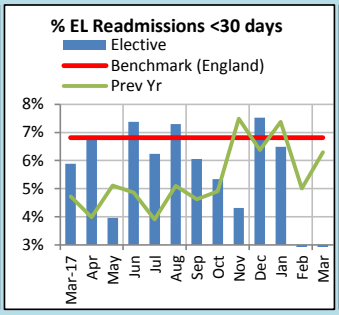



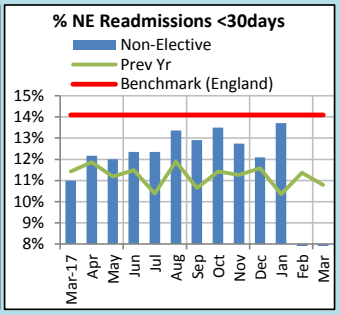




## Patient Safety, MSA Breaches, SIs, Readmissions

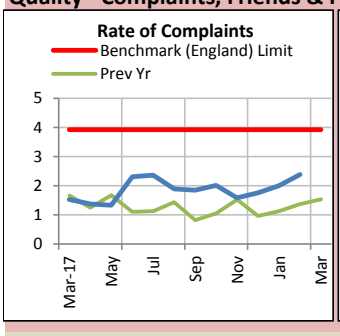


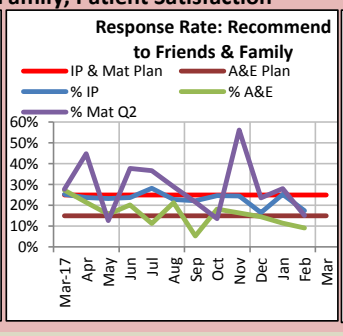



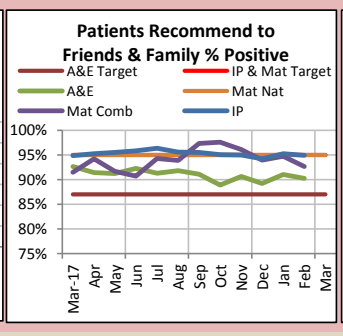



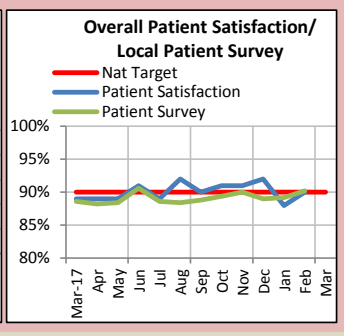




## Quality - Complaints, Friends & Family, Patient Satisfaction

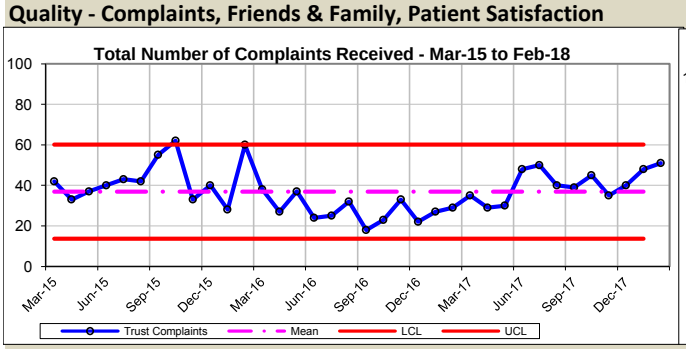


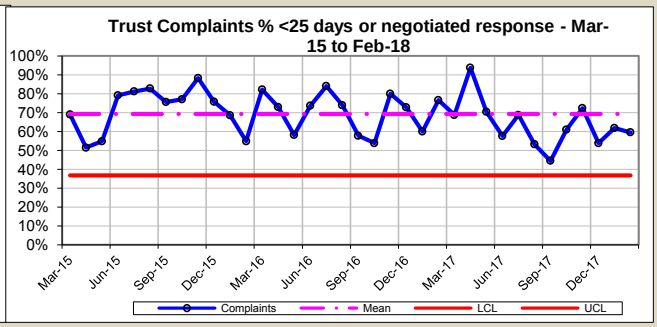



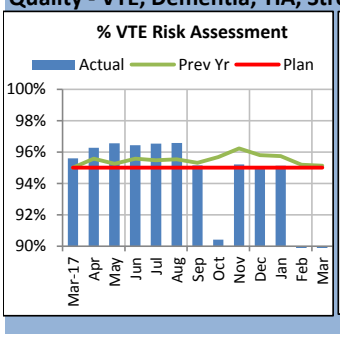



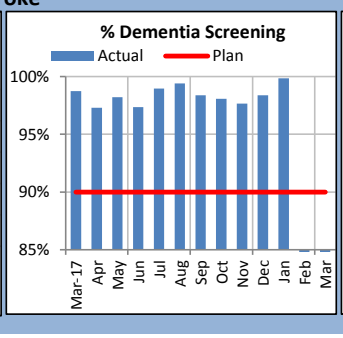

## Quality - Complaints, Friends & Family, Patient Satisfaction

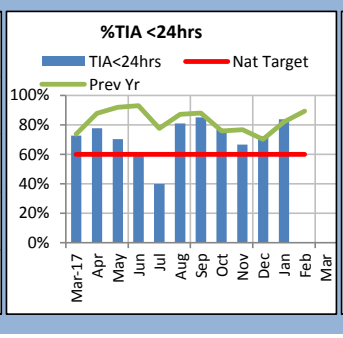


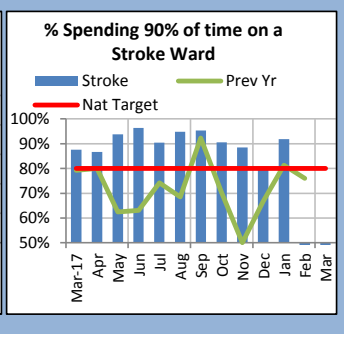




## Quality - VTE, Dementia, TIA, Stroke



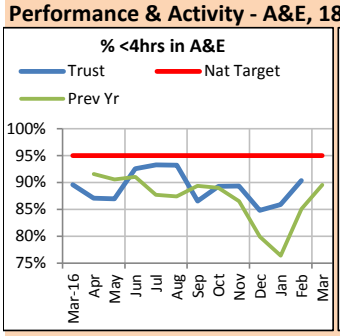



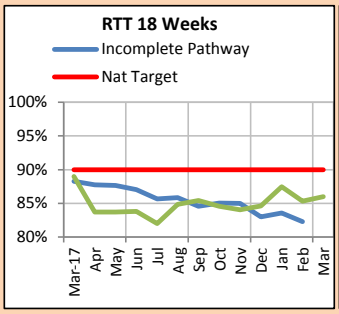



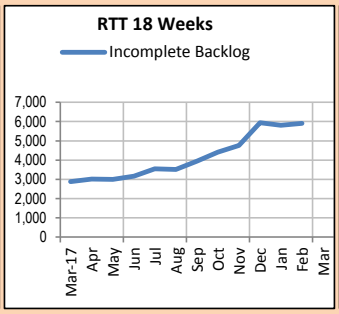



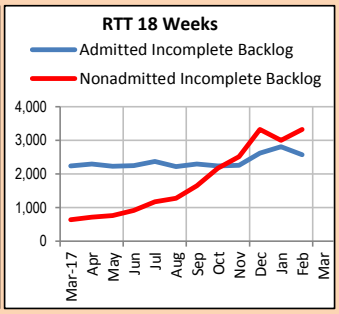
# INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

## Performance & Activity - A&E, 18 Weeks

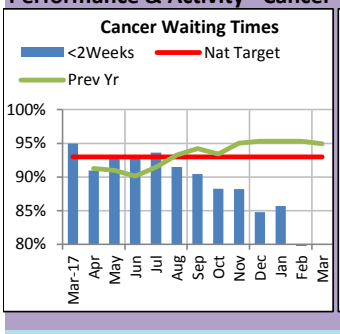


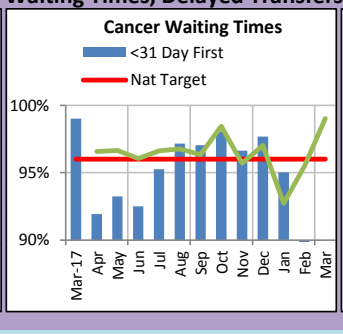



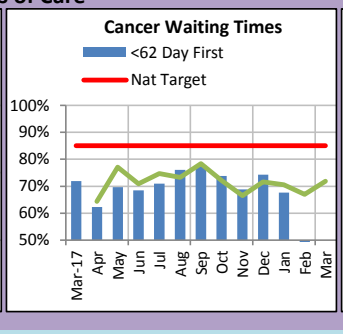



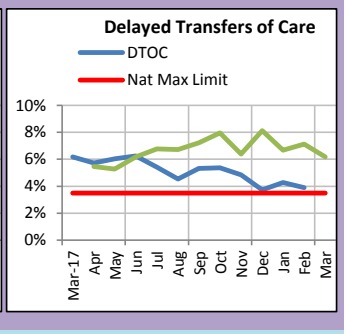




## Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

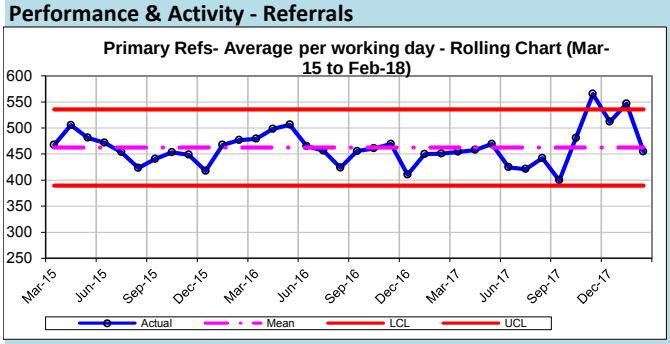


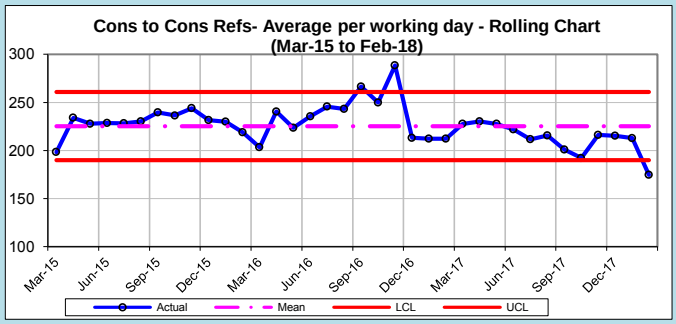



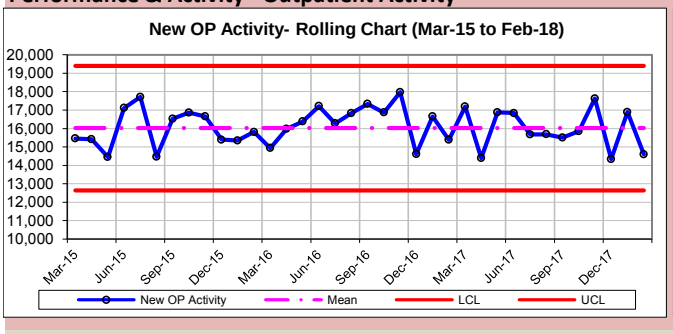



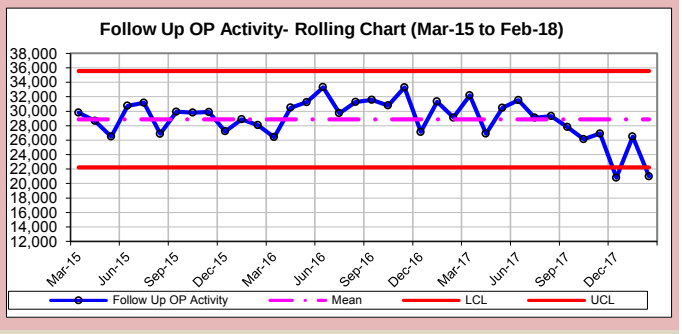

## Performance & Activity - Referrals



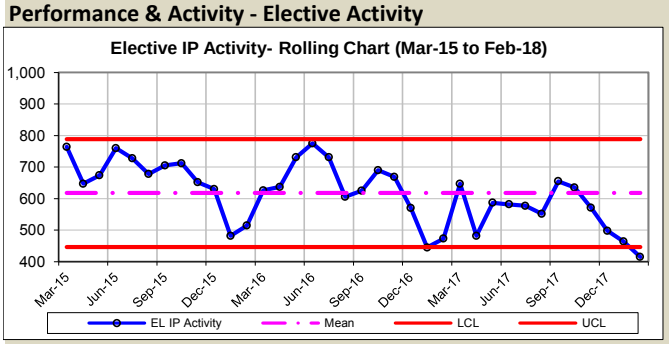



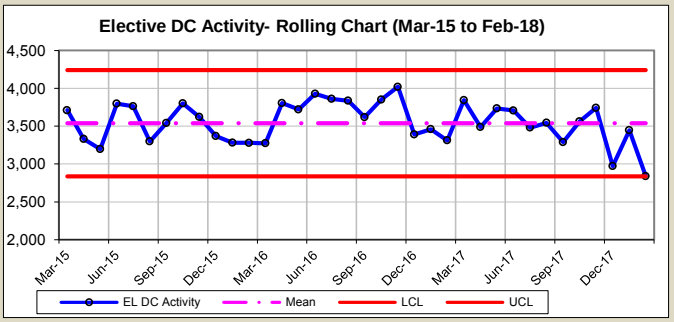

## Performance & Activity - Outpatient Activity



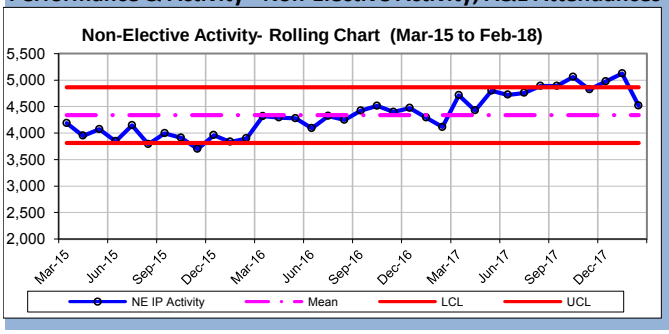



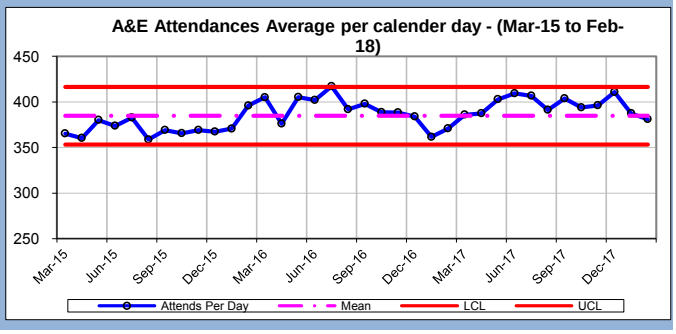

## Performance & Activity - Elective Activity



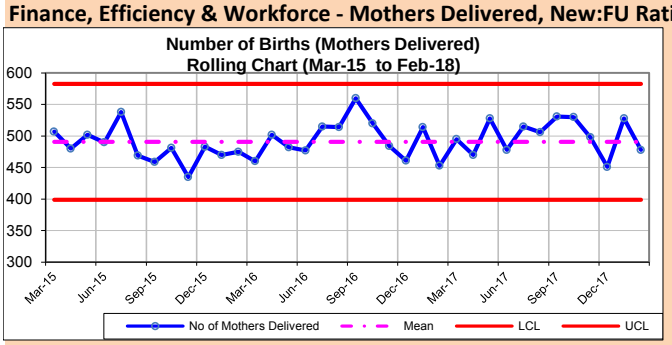

## Performance & Activity - Non-Elective Activity, A&E Attendances

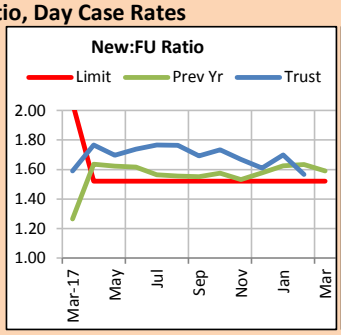


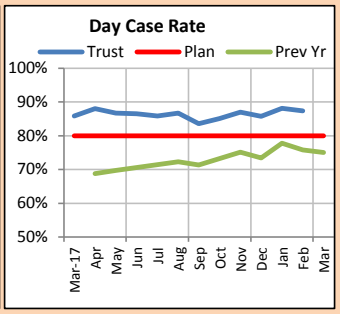



# INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

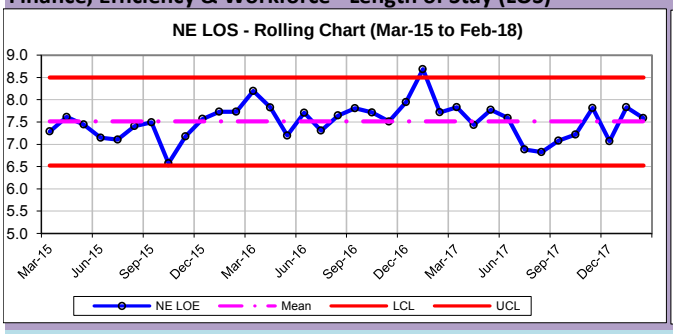
## Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

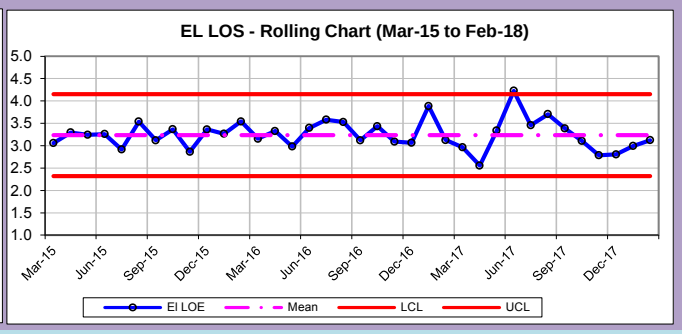


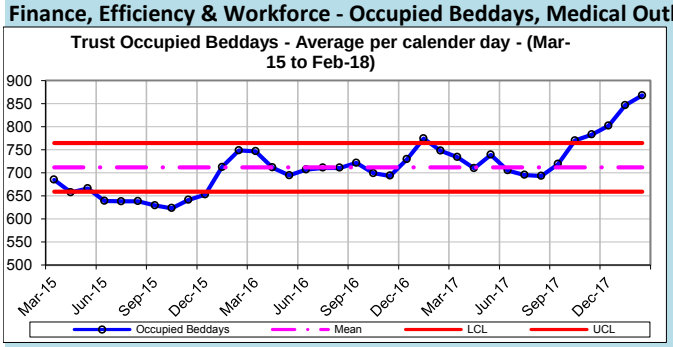



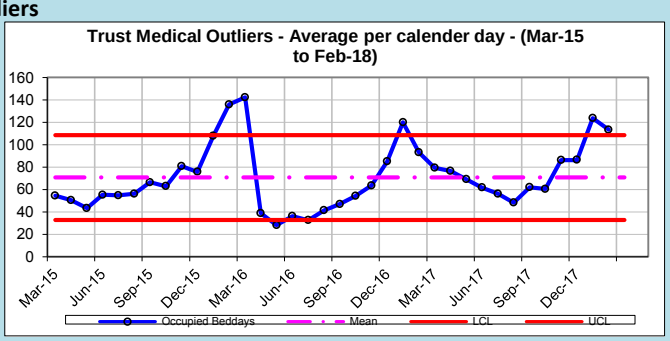

## Finance, Efficiency & Workforce - Length of Stay (LOS)



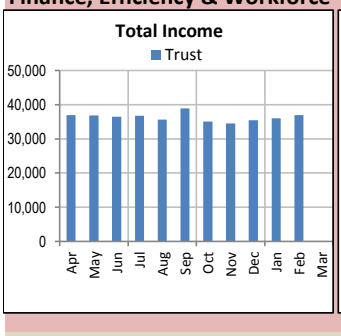



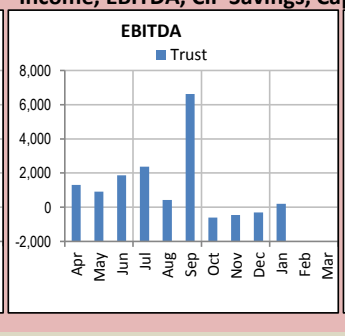

## Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

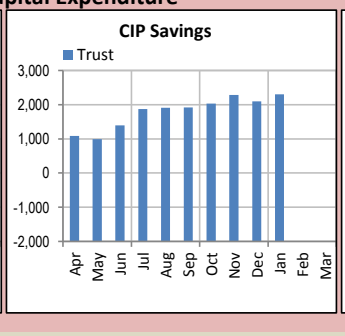


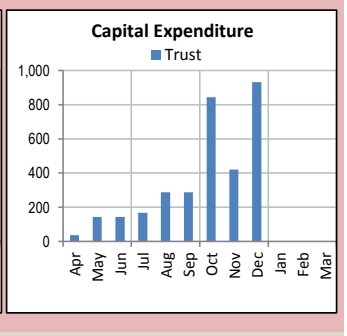




## Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

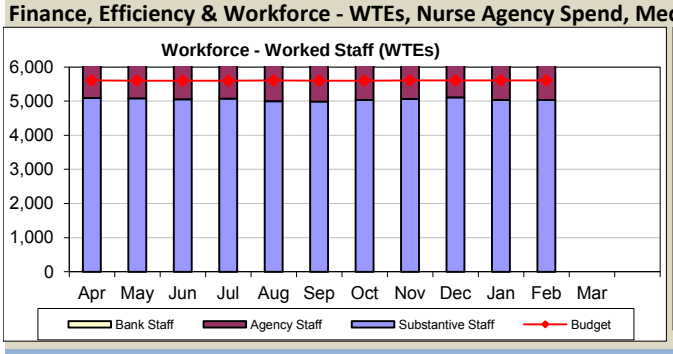


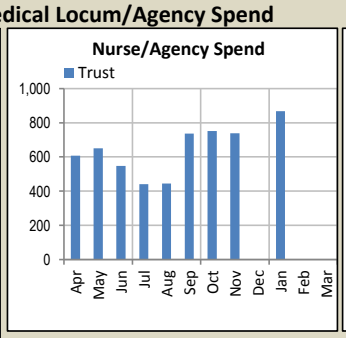



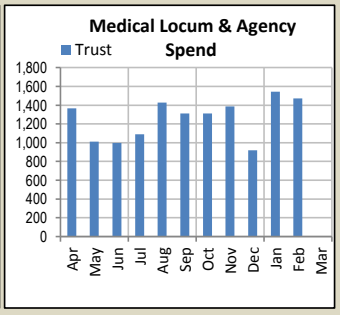



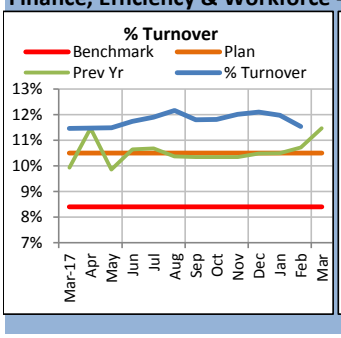

## Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

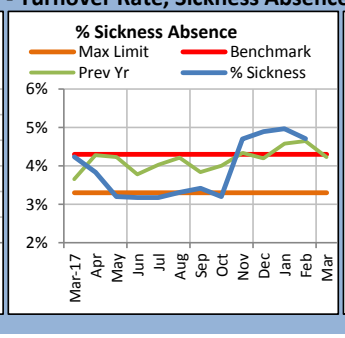


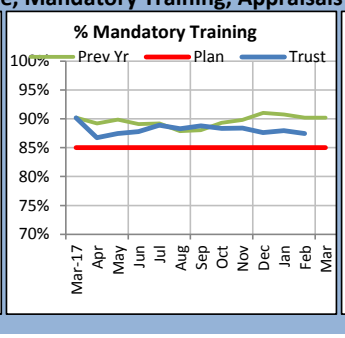



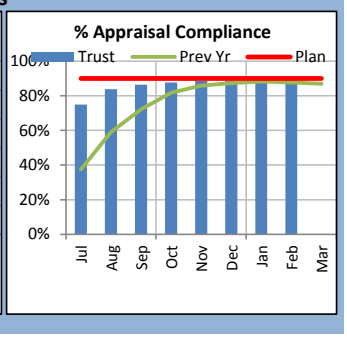




## Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals



Maidstone and Tunbridge Wells NHS Trust

# Trust Board Finance Pack

## Month 11
## 2017/18

# Content

Maidstone and Tunbridge Wells NHS Trust

## Trust Board Finance Pack for February 2017



mtw

# 1.Executive Summary

Maidstone and Tunbridge Wells NHS

## 1a. Executive Summary February 2017

### Key Variances £m

| | February | YTD | | Headlines |
|---|---|---|---|---|
| **Total Surplus (+) / Deficit (-)** | (3.1) | (17.2) | Adverse | The Trusts deficit including STF was £2.2m in February which was £3.1m adverse to plan, £1.3m STF slippage relating to non delivery of financial performance for February, £0.8m slippage against CIP and £1m overspent against budget. |
| **Clinical Income** | (0.5) | (0.4) | Adverse | Clinical Income excluding HCDs was £0.5m adverse in February. The key adverse variances in February were Elective & Day Cases (£1.3m), and outpatients (£0.6m) offset by favourable variances within non elective (£0.6m) , inclusion of £0.5m Winter funding, £0.2m neo natal pricing adjustment and A&E (£0.2m). The position included a favourable adjustment of £1.1m relating to the aligned incentive contract (£2.5m) positive YTD. |
| **Elective IP and DC** | (1.3) | (9.6) | Adverse | Elective and Day Case activity is adverse to plan in month by £1.3m in month and £9.6m year to date. |
| **Sustainability and Transformation Fund** | (1.3) | (6.0) | Adverse | The Trust did not deliver its financial performance and A&E trajectory in February therefore was not eligible for STF income. |
| **Other Operating Income** | 2.1 | 6.4 | Favourable | Other Operating Income £2.1m favourable in the month, £2.6m relating to pass through costs associated with STP (£0.7m) and PAS AllScripts (£1.9m) partly offset by underperformance in the month within Private Patient income (£0.4m). |
| **Pay** | (0.8) | (5.5) | Adverse | Pay was £0.8m adverse in the month, the normalised pay spend (excluding reserves) in February was the second highest this financial year. Medical Staffing costs reduced by £0.4m between months which is mainly due to £0.25m release of banding provision accrual. The normalised February costs were £0.2m higher than the month 9 forecast which is due to higher than forecasted vacancies within Surgery and Ophthalmology, and the continuation of additional Medical tier to support escalation.<br>Nursing costs were £20k adverse to the month 9 forecast however a one off accrual adjustment of £0.3m was released in February therefore the normalised position was £0.3m adverse to the month 9 forecast. This is mainly due to the continued escalation of Cornwallis ward (previously forecasted to be closed by 1st February) generating a pressure of c£0.2m against the forecast. The level of bank hours increased from c43,000 hours to c48,000 hours in January which impacted adversely in February due to the level of accrual for January being at the lower usage level. |
| **Non Pay** | (3.0) | (14.9) | Adverse | Non Pay was overspent by £3m in February, this was mainly due to Pass through costs (£2.2m) relating to STP, PAS Allscripts and high cost drugs offset by additional income, and Clinical Supplies £0.6m adverse (mainly due to unidentified CIP) . |
| **Other Finance Costs** | 0.2 | (1.5) | Adverse | Other Finance Costs £0.2m favourable in February due to underspends within depreciation and PDC which are consistent with the month 9 forecast. |
| **CIP / FRP** | (0.8) | (8.7) | Adverse | The Trust achieved £2.2m savings in February which was £0.1m less than January and this was £0.8m adverse to plan. The Trust has delivered £20.1m savings YTD and is £8.7m adverse to plan. |

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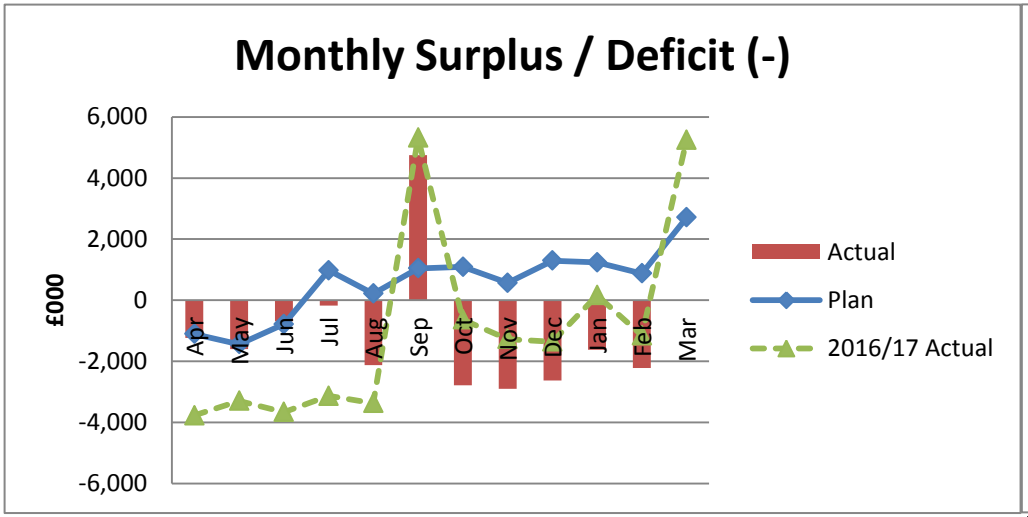
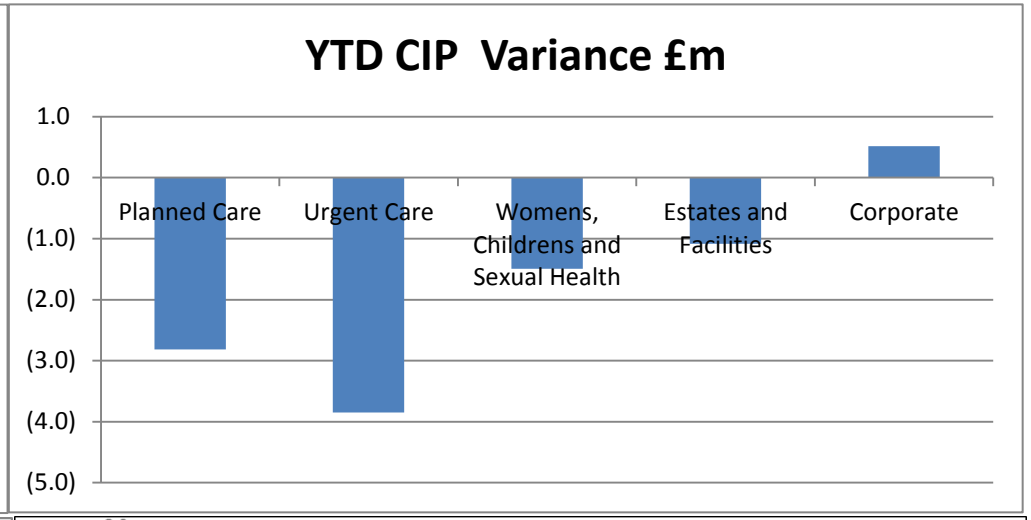
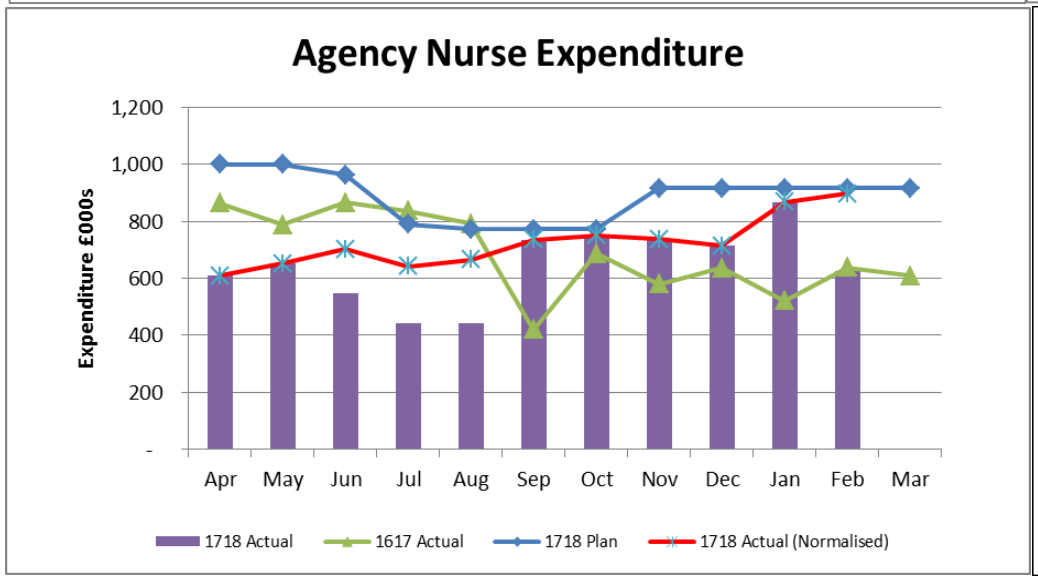
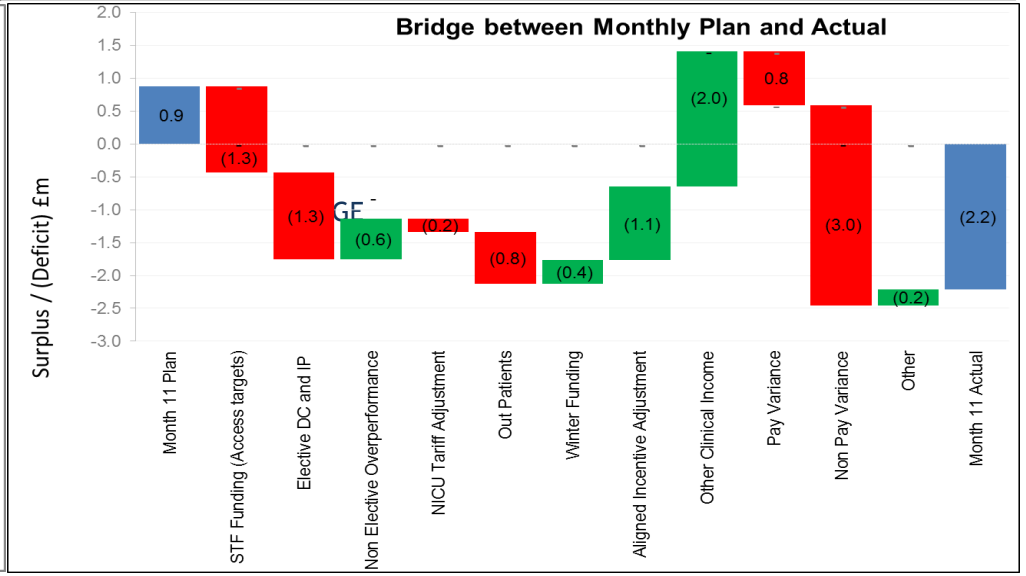
Maidstone and Tunbridge Wells NHS Trust

## 1b. Executive Summary KPI's February 2017



# 2.Income and Expenditure

Maidstone and Tunbridge Wells NHS Trust

## 2a. Income & Expenditure

Income & Expenditure February 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 | 27.6 | 28.0 | (0.5) | 309.9 | 310.3 | (0.4) | 330.1 | 339.7 | (9.6) |
| | High Cost Drugs | 3.6 | 3.4 | 0.2 | 39.4 | 38.3 | 1.1 | 52.5 | 42.2 | 10.4 |
| | **Total Clinical Income** | **31.2** | **31.4** | **(0.2)** | **349.3** | **348.6** | **0.6** | **382.6** | **381.9** | **0.8** |
| | STF | 0.0 | 1.3 | (1.3) | 3.9 | 9.9 | (6.0) | 3.9 | 11.2 | (7.3) |
| | Other Operating Income | 5.7 | 3.6 | 2.1 | 46.4 | 40.0 | 6.4 | 47.4 | 43.7 | 3.7 |
| | **Total Revenue** | 36.9 | 36.4 | 0.5 | 399.5 | 398.5 | 1.0 | 433.9 | 436.7 | (2.8) |
| **Expenditure** | | | | | | | | | | |
| | Substantive | (17.5) | (17.8) | 0.3 | (196.5) | (197.5) | 1.0 | (214.7) | (215.3) | 0.6 |
| | Bank | (1.3) | (0.5) | (0.8) | (12.5) | (5.8) | (6.7) | (13.2) | (6.3) | (6.9) |
| | Locum | (1.5) | (0.8) | (0.6) | (14.3) | (9.4) | (4.9) | (15.2) | (10.2) | (4.9) |
| | Agency | (0.7) | (1.1) | 0.4 | (9.0) | (12.2) | 3.1 | (10.0) | (13.3) | 3.2 |
| | Pay Reserves | (0.3) | (0.2) | (0.0) | (0.8) | (2.6) | 1.9 | (1.0) | (2.9) | 1.9 |
| | **Total Pay** | (21.3) | (20.5) | (0.8) | (233.0) | (227.5) | (5.5) | (254.1) | (248.0) | (6.1) |
| | Drugs & Medical Gases | (4.3) | (4.2) | (0.1) | (48.4) | (46.7) | (1.7) | (52.9) | (50.9) | (2.0) |
| | Blood | (0.1) | (0.2) | 0.1 | (2.1) | (2.3) | 0.1 | (2.4) | (2.5) | 0.0 |
| | Supplies & Services - Clinical | (2.5) | (1.9) | (0.6) | (28.3) | (21.8) | (6.6) | (31.0) | (23.7) | (7.3) |
| | Supplies & Services - General | (0.5) | (0.4) | (0.1) | (5.2) | (4.7) | (0.5) | (5.5) | (5.1) | (0.5) |
| | Services from Other NHS Bodies | (0.7) | (0.6) | (0.1) | (8.3) | (6.9) | (1.4) | (9.1) | (7.6) | (1.5) |
| | Purchase of Healthcare from Non-NHS | (0.2) | (0.6) | 0.4 | (3.8) | (7.4) | 3.6 | (4.4) | (7.9) | 3.6 |
| | Clinical Negligence | (1.7) | (1.7) | (0.0) | (18.9) | (18.9) | (0.0) | (20.6) | (20.6) | (0.0) |
| | Establishment | (0.3) | (0.3) | 0.0 | (3.2) | (3.4) | 0.3 | (3.4) | (3.7) | 0.3 |
| | Premises | (3.8) | (1.8) | (2.0) | (22.3) | (19.8) | (2.6) | (22.4) | (21.5) | (0.9) |
| | Transport | (0.1) | (0.1) | (0.0) | (1.3) | (1.3) | (0.0) | (1.5) | (1.4) | (0.1) |
| | Other Non-Pay Costs | (1.1) | (0.4) | (0.7) | (11.5) | (4.5) | (7.0) | (11.3) | (4.9) | (6.4) |
| | Non-Pay Reserves | (0.0) | (0.1) | 0.0 | 0.0 | (0.8) | 0.9 | (0.0) | (0.9) | 0.9 |
| | **Total Non Pay** | (15.4) | (12.4) | (3.0) | (153.3) | (138.3) | (14.9) | (164.6) | (150.7) | (13.9) |
| | **Total Expenditure** | (36.7) | (32.8) | (3.9) | (386.3) | (365.8) | (20.5) | (418.6) | (398.7) | (20.0) |
| **EBITDA** | **EBITDA** | 0.2 | 3.5 | (3.3) | 13.2 | 32.7 | (19.4) | 15.3 | 38.1 | (22.8) |
| | | *0.0* | *0.0* | *(0.0)* | *3.3%* | *8.2%* | *-1890.9%* | *3.5%* | *8.7%* | *817.4%* |
| **Other Finance Costs** | | | | | | | | | | |
| | Depreciation | (1.1) | (1.3) | 0.1 | (12.5) | (13.5) | 1.0 | (13.8) | (14.8) | 1.0 |
| | Interest | (0.1) | (0.1) | (0.0) | (1.1) | (1.2) | 0.0 | (1.2) | (1.3) | 0.1 |
| | Dividend | (0.1) | (0.1) | 0.1 | (0.6) | (1.3) | 0.7 | (0.7) | (1.5) | 0.8 |
| | PFI and Impairments | (1.2) | (1.2) | (0.0) | (16.6) | (13.3) | (3.3) | (18.3) | (14.9) | (3.5) |
| | **Total Finance Costs** | (2.5) | (2.7) | 0.2 | (30.8) | (29.3) | (1.5) | (34.0) | (32.4) | (1.6) |
| **Net Surplus / Deficit (-)** | **Net Surplus / Deficit (-)** | (2.2) | 0.9 | (3.1) | (17.6) | 3.3 | (20.9) | (18.7) | 5.7 | (24.4) |
| **Technical Adjustments** | **Technical Adjustments** | 0.0 | 0.0 | 0.0 | 4.4 | 0.6 | 3.8 | 4.7 | 1.0 | 3.7 |
| **Surplus/ Deficit (-) to B/E Duty** | **Surplus/ Deficit (-) to B/E Duty Incl STF** | (2.2) | 0.9 | (3.1) | (13.2) | 4.0 | (17.2) | (14.0) | 6.7 | (20.7) |
| | **Surplus/ Deficit (-) to B/E Duty Excl STF** | (2.2) | (0.4) | (1.8) | (17.1) | (5.9) | (11.2) | (17.9) | (4.5) | (13.4) |

**Commentary**

The Trusts deficit including STF was £2.2m in February which was £3.1m adverse to plan, £1.3m STF slippage relating to non delivery of financial performance for February, £0.8m slippage against CIP and £1m overspent against budget.

The Trust's normalised pre STF run rate in February was a deficit of £2.8m which was £0.5m higher than the YTD average. The main normalised adjustments in February related to: Nurse Agency Accrual adjustment (£0.3m), Release of Medical Banding arrears of pay provision (£0.25m), Biosimilar Income (£0.1m), Reduction in Outsourcing costs (£0.1m), various accrual adjustments (£0.1m) and increase in Winter Funding for GP service in A&E (£0.1m), these adjustments were above the month 9 forecast.

The Trusts deficit in February was in line with the forecast submitted to NHSI in January, Income over performance of £2m offset by overspends within non pay (£2m), mainly due to pass through STP and PAS All Scripts costs. A full review is incorporated in slide 3d.

Clinical Income excluding HCDs was £0.5m adverse in February. The key adverse variances in February were Elective & Day Cases (£1.3m), and outpatients (£0.6m) offset by favourable variances within non elective (£0.6m) , inclusion of £0.5m Winter funding, £0.2m neo natal pricing adjustment and A&E (£0.2m). The position included a favourable adjustment of £1.1m relating to the aligned incentive contract (£2.5m) positive YTD.

STF income £1.3m adverse in February, the Trust did not deliver the financial performance or A&E trajectory in February.

Other Operating Income £2.1m favourable in the month, £2.6m relating to pass through costs associated with STP (£0.7m) and PAS AllScripts (£1.9m) partly offset by underperformance in the month within Private Patient income (£0.4m).

Pay was £0.8m adverse in the month, the normalised pay spend (excluding reserves) in February was the second highest this financial year. Medical Staffing costs reduced by £0.4m between months which is mainly due to £0.25m release of banding provision accrual. The normalised February costs were £0.2m higher than the month 9 forecast which is due to higher than forecasted vacancies within Surgery and Ophthalmology, and the continuation of additional Medical tier to support escalation.
Nursing costs were £20k adverse to the month 9 forecast however a one off accrual adjustment of £0.3m was released in February therefore the normalised position was £0.3m adverse to the month 9 forecast. This is mainly due to the continued escalation of Cornwallis ward (previously forecasted to be closed by 1st February) generating a pressure of c£0.2m against the forecast. The level of bank hours increased from c43,000 hours to c48,000 hours in January which impacted adversely in February due to the level of accrual for January being at the lower usage level.

Non Pay was overspent by £3m in February, this was mainly due to Pass through costs (£2.2m) relating to STP, PAS Allscripts and high cost drugs offset by additional income, and Clinical Supplies £0.6m adverse (mainly due to unidentified CIP) .

Other Finance Costs £0.2m favourable in February due to underspends within depreciation and PDC which are consistent with the month 9 forecast.

The Trust is forecasting a Year End deficit including STF of £14m, £20.7m adverse to plan. The Trusts forecast excluding STF is a deficit of £17.9m which is £13.4m adverse to plan.

# 3. Expenditure Analysis

Maidstone and Tunbridge Wells NHS Trust

## 3a. Run Rate Analysis

**Analysis of 13 Monthly Performance (£m's)**

| | | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Change between Months |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Revenue** | Clinical Income | 26.4 | 28.7 | 31.9 | 31.8 | 32.3 | 32.1 | 31.2 | 32.6 | 31.3 | 31.2 | 31.7 | 32.0 | 31.2 | (0.8) |
| | STF | 0.0 | 0.8 | 0.4 | 0.4 | 0.6 | 0.3 | 0.0 | 2.2 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | High Cost Drugs | 3.3 | 3.6 | (0.1) | (0.0) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Other Operating Income | 3.9 | 7.6 | 4.7 | 4.6 | 3.5 | 4.3 | 4.5 | 4.1 | 3.8 | 3.4 | 3.8 | 4.0 | 5.7 | 1.7 |
| | **Total Revenue** | **33.5** | **40.7** | **37.0** | **36.8** | **36.5** | **36.7** | **35.7** | **38.9** | **35.0** | **34.5** | **35.5** | **36.0** | **36.9** | **0.9** |
| **Expenditure** | Substantive | (17.8) | (17.3) | (17.9) | (18.0) | (18.1) | (17.8) | (17.7) | (17.8) | (17.9) | (18.0) | (17.8) | (17.9) | (17.5) | 0.4 |
| | Bank | (0.8) | (1.0) | (0.9) | (0.9) | (0.9) | (1.1) | (0.9) | (1.3) | (1.3) | (1.1) | (1.3) | (1.3) | (1.3) | 0.0 |
| | Locum | (0.9) | (1.6) | (1.4) | (1.0) | (1.0) | (1.1) | (1.4) | (1.3) | (1.3) | (1.4) | (1.3) | (1.5) | (1.5) | 0.1 |
| | Agency | (0.9) | (1.0) | (0.8) | (0.8) | (0.8) | (0.5) | (0.6) | (1.0) | (0.8) | (0.9) | (0.8) | (1.1) | (0.7) | 0.4 |
| | Pay Reserves | 0.0 | 0.0 | (0.2) | (0.2) | (0.2) | (0.2) | (0.1) | 1.5 | (0.2) | (0.2) | (0.2) | (0.2) | (0.3) | (0.0) |
| | Total Pay | (20.5) | (20.8) | (21.3) | (21.0) | (21.1) | (20.8) | (20.8) | (20.0) | (21.6) | (21.6) | (21.6) | (22.2) | (21.3) | 0.9 |
| **Non-Pay** | Drugs & Medical Gases | (4.0) | (5.1) | (4.2) | (4.6) | (4.6) | (4.2) | (4.8) | (4.1) | (4.4) | (4.5) | (4.2) | (4.5) | (4.3) | 0.1 |
| | Blood | (0.2) | (0.2) | (0.2) | (0.2) | (0.2) | (0.2) | (0.2) | (0.2) | (0.2) | (0.2) | (0.2) | (0.2) | (0.1) | 0.0 |
| | Supplies & Services - Clinical | (2.5) | (3.1) | (2.6) | (2.8) | (2.7) | (2.7) | (2.7) | (2.2) | (2.5) | (2.6) | (2.5) | (2.6) | (2.5) | 0.1 |
| | Supplies & Services - General | (0.4) | (0.6) | (0.4) | (0.5) | (0.5) | (0.5) | (0.3) | (0.5) | (0.5) | (0.5) | (0.5) | (0.4) | (0.5) | (0.0) |
| | Services from Other NHS Bodies | (0.7) | (0.5) | (0.8) | (0.7) | (0.6) | (0.7) | (0.7) | (0.7) | (0.6) | (1.3) | (0.9) | (0.7) | (0.7) | 0.0 |
| | Purchase of Healthcare from Non-NHS | (0.5) | (0.5) | (0.5) | (0.5) | (0.2) | (0.3) | (0.3) | (0.3) | (0.4) | (0.4) | (0.4) | (0.2) | (0.2) | 0.1 |
| | Clinical Negligence | (1.5) | (1.5) | (1.7) | (1.7) | (1.7) | (1.7) | (1.7) | (1.7) | (1.7) | (1.7) | (1.7) | (1.7) | (1.7) | (0.0) |
| | Establishment | (0.3) | (0.3) | (0.3) | (0.3) | (0.3) | (0.3) | (0.2) | (0.3) | (0.3) | (0.3) | (0.3) | (0.3) | (0.3) | (0.0) |
| | Premises | (1.7) | (1.7) | (2.0) | (2.3) | (1.6) | (1.7) | (1.9) | (1.5) | (1.8) | (1.8) | (2.2) | (1.8) | (3.8) | (2.0) |
| | Transport | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.2) | (0.1) | (0.1) | (0.2) | (0.1) | 0.0 |
| | Other Non-Pay Costs | (0.7) | (0.5) | (1.5) | (1.1) | (0.7) | (1.4) | (1.6) | (0.5) | (1.5) | (0.0) | (1.0) | (1.1) | (1.1) | (0.0) |
| | Non-Pay Reserves | 0.0 | 1.3 | (0.1) | (0.1) | (0.1) | 0.2 | 0.0 | 0.3 | (0.0) | (0.0) | (0.0) | (0.0) | (0.0) | 0.0 |
| | Total Non Pay | (12.7) | (12.9) | (14.4) | (14.9) | (13.5) | (13.6) | (14.4) | (11.7) | (14.1) | (13.4) | (14.2) | (13.7) | (15.4) | (1.7) |
| | Total Expenditure | (33.2) | (33.7) | (35.7) | (35.9) | (34.6) | (34.3) | (35.2) | (31.6) | (35.7) | (35.0) | (35.8) | (35.8) | (36.7) | (0.9) |
| **EBITDA** | EBITDA | 0.3 | 7.0 | 1.3 | 0.9 | 1.9 | 2.4 | 0.4 | 7.3 | (0.6) | (0.5) | (0.3) | 0.2 | 0.2 | 0.0 |
| | | *1%* | *17%* | *4%* | *2%* | *5%* | *6%* | *1%* | *19%* | *-2%* | *-1%* | *-1%* | *1%* | *1%* | |
| **Other Finance Costs** | Depreciation | (1.0) | (1.2) | (1.2) | (1.2) | (1.2) | (1.2) | (1.2) | (1.2) | (0.8) | (1.1) | (1.0) | (1.2) | (1.1) | 0.0 |
| | Interest | (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 |
| | Dividend | 0.7 | 0.1 | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | (0.1) | 0.5 | (0.1) | (0.6) |
| | PFI and Impairments | (42.3) | (1.2) | (1.2) | (1.2) | (1.2) | (1.2) | (1.1) | (1.1) | (1.1) | (1.2) | (5.2) | (1.1) | (1.2) | (0.0) |
| | **Total Other Finance Costs** | **(42.7)** | **(2.4)** | **(2.6)** | **(2.5)** | **(2.6)** | **(2.6)** | **(2.6)** | **(2.6)** | **(2.2)** | **(2.5)** | **(6.4)** | **(1.9)** | **(2.5)** | **(0.6)** |
| **Net Surplus / Deficit (-)** | Net Surplus / Deficit (-) | (42.4) | 4.6 | (1.3) | (1.6) | (0.7) | (0.2) | (2.2) | 4.7 | (2.8) | (2.9) | (6.7) | (1.7) | (2.2) | (0.6) |
| **Technical Adjustments** | Technical Adjustments | 40.3 | (0.1) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 4.0 | 0.0 | 0.0 | (0.0) |
| **Surplus/ Deficit (-) to B/E Duty Incl STF** | Surplus/ Deficit (-) to B/E Duty | (2.0) | 4.5 | (1.2) | (1.6) | (0.7) | (0.2) | (2.1) | 4.8 | (2.8) | (2.9) | (2.6) | (1.6) | (2.2) | (0.6) |
| **Surplus/ Deficit (-) to B/E Duty Excl STF** | Surplus/ Deficit (-) to B/E Duty | (2.0) | 3.7 | (1.6) | (2.0) | (1.3) | (0.4) | (2.1) | 2.5 | (2.8) | (2.9) | (2.6) | (1.6) | (2.2) | (0.6) |

# 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 | 0.1 | 0.2 | (0.1) |
| Critical Care | 0.2 | 0.2 | (0.0) |
| Diagnostics | 0.2 | 0.2 | 0.0 |
| Head and Neck | 0.1 | 0.1 | (0.0) |
| Surgery | 0.1 | 0.2 | (0.1) |
| T&O | 0.5 | 0.4 | 0.1 |
| Patient Admin | 0.0 | 0.0 | 0.0 |
| Private Patient Unit | 0.0 | 0.0 | (0.0) |
| **Planned Care** | **1.2** | **1.3** | **(0.1)** |
| Urgent Care | **0.6** | **0.8** | **(0.2)** |
| Womens, Childrens and Sexual Health | **0.1** | **0.4** | **(0.3)** |
| Estates and Facilities | **0.1** | **0.3** | **(0.2)** |
| Corporate | **0.2** | **0.2** | **0.0** |
| **Total** | **2.2** | **2.9** | **(0.8)** |

**Comment**

The Trust achieved £2.2m savings in February which was £0.1m less than last month however this was £0.8m adverse to plan. The plan includes £2m unidentified savings phased from July.

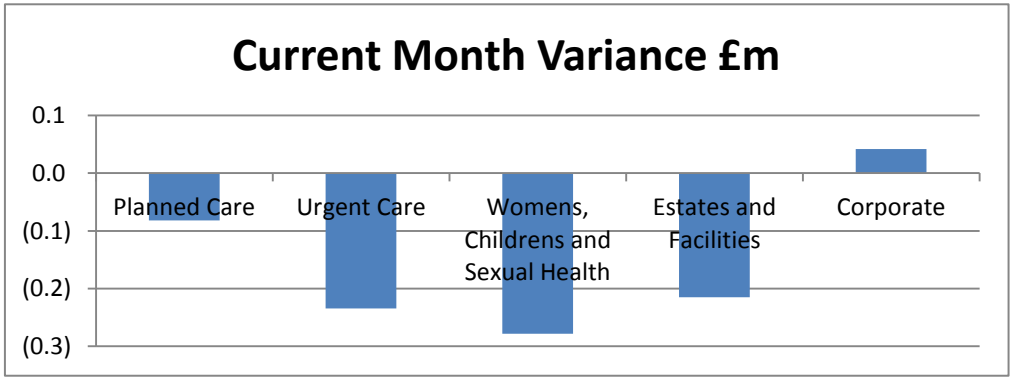
The plan value is based upon the Trusts submitted plan to NHSI in December 16 and March 17. The Trust has a 'live' plan for monitoring the actuals and phasing of the CIP programme. Based upon the 'live plan the savings achieved in February were £2.8m below plan.

**Planned Care:** £0.1m adverse compared to original CIP plan and £0.5m adverse to the 'live' plan. The main directorates adverse to plan (Live) are Critical Care Directorate were £101k adverse in February, £65k due to unidentified CIP, £20k adverse due to unidentified Procurement savings and £20k adverse relating to Endoscopy Bowel screening sessions. Diagnostics are £111k adverse in February, £83k due to unidentified CIP, £40k due to unidentified procurement savings and £10k due to slippage associated with reduction in outsourcing costs.

**Urgent Care:** £0.2m adverse compared to the original plan, when compared to the 'live' plan the directorate are £0.8m adverse in the month which is mainly due to £0.45m unidentified savings , slippage in closing 1ward (£0.1m), slippage in deep dive savings plan (£0.15m) and slippage in identifying procurement savings (£0.1m).

**Womens, Childrens and Sexual Health:** £0.3m adverse compared to the original plan and £0.2m adverse to the 'live' plan, the slippage relates to unidentified savings.

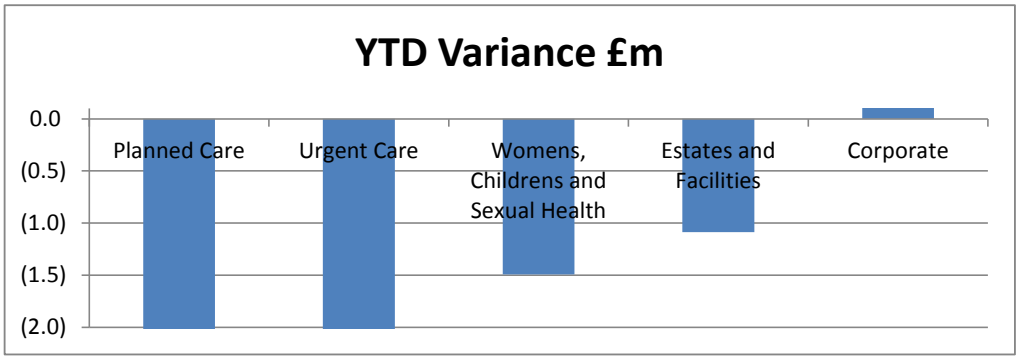
**Estates and Facilities:** £0.2m adverse to the original and £1.3m adverse to 'live' plan. The main slippage relates to Asset Sale (£1.1m) EPC energy business case (£70k per month) , Laundry contract (£30k) and bus service contract review (£20k).



Maidstone and Tunbridge Wells NHS Trust

## 4b. Year to Date savings by Directorate

| | YTD | | |
|---|---|---|---|
| | *Actual* | *Original Plan* | *Variance* |
| | £m | £m | £m |
| Cancer | 1.4 | 1.8 | (0.4) |
| Critical Care | 1.3 | 2.0 | (0.6) |
| Diagnostics | 1.0 | 2.0 | (1.0) |
| Head and Neck | 0.8 | 0.9 | (0.1) |
| Surgery | 0.9 | 1.6 | (0.7) |
| T&O | 4.7 | 4.7 | (0.0) |
| Patient Admin | 0.1 | 0.1 | 0.0 |
| Private Patient Unit | 0.1 | 0.1 | (0.0) |
| **Planned Care** | **10.4** | **13.2** | **(2.8)** |
| **Urgent Care** | **4.2** | **8.1** | **(3.8)** |
| **Womens, Childrens and Sexual Health** | **1.8** | **3.3** | **(1.5)** |
| **Estates and Facilities** | **1.5** | **2.5** | **(1.1)** |
| **Corporate** | **2.2** | **1.7** | **0.5** |
| **Total** | **20.1** | **28.8** | **(8.7)** |




**Comment**

The Trust has achieved £20.1m savings YTD which is £8.7m 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 £16.1m below plan.

**Planned Care:** £2.8m adverse compared to original CIP planned phasing, £5m slippage YTD when compared to the 'live' plan. The main directorate adverse to plan is Diagnostics (£1.2m adverse) which is due to £660k unidentified, procurement 10% savings target (£470k) and £20k slippage relating to outsourcing reduction. Surgery Directorate (£1m) adverse which is due to unidentified savings (£0.7m), deep dive review (£130k) and medical pay savings (£95k) relating to job planning and WLI savings.

**Urgent Care:** £3.8m adverse compared to the original plan, when compared to the 'live' plan the directorate are £6.6m adverse YTD. This is due to £3.6m unidentified savings, delay in closing wards (£1.5m), slippage in procurement savings (£0.6m) and slippage in deep dive savings target (£0.6m).

**Womens, Childrens and Sexual Health:** £1.5m adverse compared to the original plan, when compared to the 'live' plan the directorate are £1.6m adverse YTD. The YTD adverse variance (£1.5m) is due to unidentified savings.

**Estates and Facilities:** £1.1m adverse compared to the original plan, when compared to the 'live' plan the directorate are £2.2m adverse YTD. This is due to £1.3m Asset Sale, £0.43m Energy Savings, £0.2m Bus Service contract, £0.17m Laundry contract savings and £0.12m Rental income from East Kent.

**Corporate:** Corporate directorates are £0.5m favourable to the original plan and are £0.4m favourable to the 'live' plan. The main slippage relating to the live plan relates to HR (£50k) due to the savings plans associated with restricting advertising (£50k) no longer being explored.

mtw

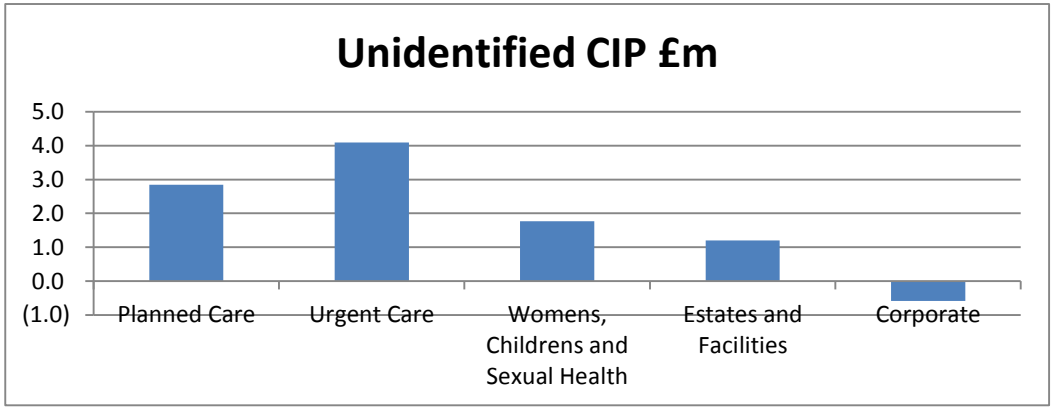
Maidstone and Tunbridge Wells NHS Trust

# 4c. Forecast savings by Directorate

## Directorate Performance

| | Forecast Savings | | | |
|---|---|---|---|---|
| | *Risk Adjusted Forecast* | *Unidentified (Risk Adjusted)* | *Plan* | *% Unidentified* |
| | £m | £m | £m | |
| Cancer | 1.8 | 0.6 | 2.4 | 24% |
| Critical Care | 1.5 | 0.7 | 2.2 | 31% |
| Diagnostics | 1.1 | 0.7 | 1.8 | 40% |
| Head and Neck | 0.9 | 0.1 | 1.0 | 12% |
| Surgery | 1.0 | 0.8 | 1.8 | 44% |
| T&O | 5.2 | (0.1) | 5.1 | -2% |
| Patient Admin | 0.1 | (0.0) | 0.1 | -6% |
| Private Patient Unit | 0.1 | 0.0 | 0.2 | 22% |
| **Planned Care** | **11.7** | **2.8** | **14.6** | **20%** |
| **Urgent Care** | **4.8** | **4.1** | **8.9** | **46%** |
| **Womens, Childrens and Sexual Health** | **1.9** | **1.8** | **3.7** | **48%** |
| **Estates and Facilities** | **1.6** | **1.2** | **2.8** | **44%** |
| **Corporate** | **2.5** | **(0.6)** | **1.9** | **-31%** |
| **Total** | **22.4** | **9.3** | **31.7** | **29%** |

*Savings as per 8th December*




The Trust has a £31.7m CIP plan for 2017/18 and has identified £22.6m (non risk adjusted) , £9.1m unidentified. The current forecasted risk adjusted identified savings is £22.4m, a shortfall of £9.3m.

**Planned Care Division** have identified £11.9m savings which is risk adjusted to deliver £11.7m. The division has £2.8m risk adjusted shortfall (20%).

**Urgent Care Division** have identified £4.8m savings which is risk adjusted to deliver £4.8m. The division has £4.1m risk adjusted shortfall (46%).

**W&CH Division** have identified £1.9m savings which is risk adjusted to deliver £1.9m. The division has £1.8m risk adjusted shortfall (48%).

**Estates and Facilities Division** have identified £1.6m savings which forecasted to fully deliver. The division has a risk adjusted shortfall of £1.2m (43%).

mtw

# 5. Balance Sheet and Liquidity

Maidstone and Tunbridge Wells NHS Trust

## 5a. Balance Sheet

**February 2017**

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

| | February | | | January | Full year | |
|---|---|---|---|---|---|---|
| **£m's** | **Reported** | **Plan** | **Variance** | **Reported** | **Plan** | **Forecast** |
| Property, Plant and Equipment (Fixed Assets) | 269.8 | 274.8 | (5.0) | 269.8 | 282.1 | 297.7 |
| Intangibles | 2.3 | 2.8 | (0.4) | 2.4 | 2.1 | 2.5 |
| PFI Lifecycle | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Debtors Long Term | 1.1 | 1.2 | (0.1) | 1.2 | 1.2 | 1.5 |
| **Total Non-Current Assets** | **273.3** | **278.8** | **(5.5)** | **273.4** | **285.4** | **301.7** |
| **Current Assets** | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Inventory (Stock) | 7.4 | 8.3 | (0.9) | 7.7 | 8.3 | 7.9 |
| Receivables (Debtors) - NHS | 22.6 | 50.6 | (28.0) | 24.5 | 21.0 | 29.8 |
| Receivables (Debtors) - Non-NHS | 13.7 | 9.5 | 4.3 | 15.3 | 9.5 | 11.2 |
| Cash | 8.6 | 14.8 | (6.3) | 8.3 | 1.0 | 1.0 |
| Assets Held For Sale | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Total Current Assets** | **52.3** | **83.2** | **(30.9)** | **55.8** | **39.7** | **49.9** |
| **Current Liabilities** | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Payables (Creditors) - NHS | (8.3) | (6.8) | (1.5) | (8.2) | 0.0 | (4.5) |
| Payables (Creditors) - Non-NHS | (38.7) | (38.1) | (0.5) | (36.1) | (14.5) | (40.7) |
| Deferred Income | (7.3) | (18.1) | 10.8 | (14.1) | (3.5) | (7.1) |
| Capital & Working Capital Loan | (19.2) | (2.2) | (17.0) | (2.3) | (19.1) | (18.7) |
| Temporary Borrowing | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Borrowings - PFI | (5.0) | (5.0) | (0.0) | (5.0) | (5.5) | (5.5) |
| Provisions for Liabilities and Charges | (1.9) | (1.3) | (0.6) | (1.8) | (1.3) | (2.0) |
| **Total Current Liabilities** | **(80.4)** | **(71.5)** | **(8.9)** | **(67.5)** | **(43.9)** | **(78.6)** |
| Net Current Assets | (28.2) | 11.6 | (39.8) | (11.7) | (4.2) | (28.7) |
| Finance Lease - Non- Current | (193.2) | (193.8) | 0.7 | (193.6) | (192.7) | (193.2) |
| Capital Loan - (interest Bearing Borrowings) | (11.8) | (15.2) | 3.5 | (11.7) | (26.3) | (10.8) |
| Working Capital Facility | (22.1) | (29.0) | 6.9 | (36.3) | 0.0 | (26.0) |
| Provisions for Liabilities and Charges- Long term | (1.1) | (0.5) | (0.6) | (1.1) | (0.4) | (0.9) |
| **Total Assets Employed** | **17.0** | **51.9** | **(34.9)** | **19.0** | **61.8** | **42.1** |
| **Financed By:** | | | | | | |
| **Capital & Reserves** | | | | | | |
| Public dividend capital | 205.5 | 206.8 | (1.3) | 205.3 | 208.6 | 207.3 |
| Revaluation reserve | 30.3 | 30.3 | (0.0) | 30.3 | 36.2 | 54.5 |
| Retained Earnings Reserve | (218.8) | (185.2) | (33.6) | (216.6) | (182.9) | (219.7) |
| **Total Capital & Reserves** | **17.0** | **51.9** | **(34.9)** | **19.0** | **61.8** | **42.1** |

**Commentary:**

**Commentary:**

The balance sheet is £34.9m less than plan. This is due to a combination of the 2016/17 impairment of fixed assets being larger than originally planned following the report from the valuer and the reported YTD deficit as opposed to the planned surplus.

**Non-Current Assets** -

The total additional purchases of assets have been offset by the depreciation charge for the period.

**Current Assets** -

Inventory is relatively similar to the January reported position.

NHS Receivables have reduced by £1.9m compared to the January reported position. £1.5m of the March SLA payment has been received in advance. It is also below the plan value by £28m.

Of the £22.6m reported balance, £9m relates to invoiced debt of which £2.4m is aged debt over 90 days. Invoiced debt over 90 days has decreased by £1.6m compared with the January reported position. The remaining £13.6m relates to uninvoiced accrued income comprising partially completed spells. Due to the financial situation of many neighbouring NHS bodies regular communication is continuing and arrangements are being put in place to help reduce the level of debts.

Non NHS Receivables have decreased by £1.6m compared with the January reported position, but is above plan by £4.2m. Included within this balance is trade invoiced debt of £3.4m and private patient invoiced debt of £0.7m and Prepayments and accrued income totalling £6.9m. Prepayments primarily relate to rates & annual service maintenance contracts, which will reduce throughout the year as they are expensed.

**Current Liabilities** -

NHS payables have increased from the January reported position by £0.1m. Non-NHS trade payables have increased since January by £2.6m.

Of the £47m combined payables balances, £24.1m relates to actual invoices, £22.9m relates to uninvoiced accruals. The accruals include expected values for tax , NI, Superannuation and PDC payments.

Deferred income of £7.3m primarily relates to SLA income received in advance from West Kent CCG, High Weald CCG and Medway CCG, along with and other funding for PAS AllScript and LDA.

£16.9m of the existing loans is repayable in February 2019 and has been disclosed as a short term creditor. Hence the movement in capital and working capital loans is a reclassification of the Trust's debt.

**Long term Liabilities-**

The PFI liability reduces each month as the Unitary Charge includes financing repayments.

The Trust successfully applied for £0.7m in Salix loans in 2017/18 relating to improving the energy efficiency of the Trust. It has received £0.6m as at February 2018. The loan is repayable over 5 years, interest free and appears on the capital loans line.

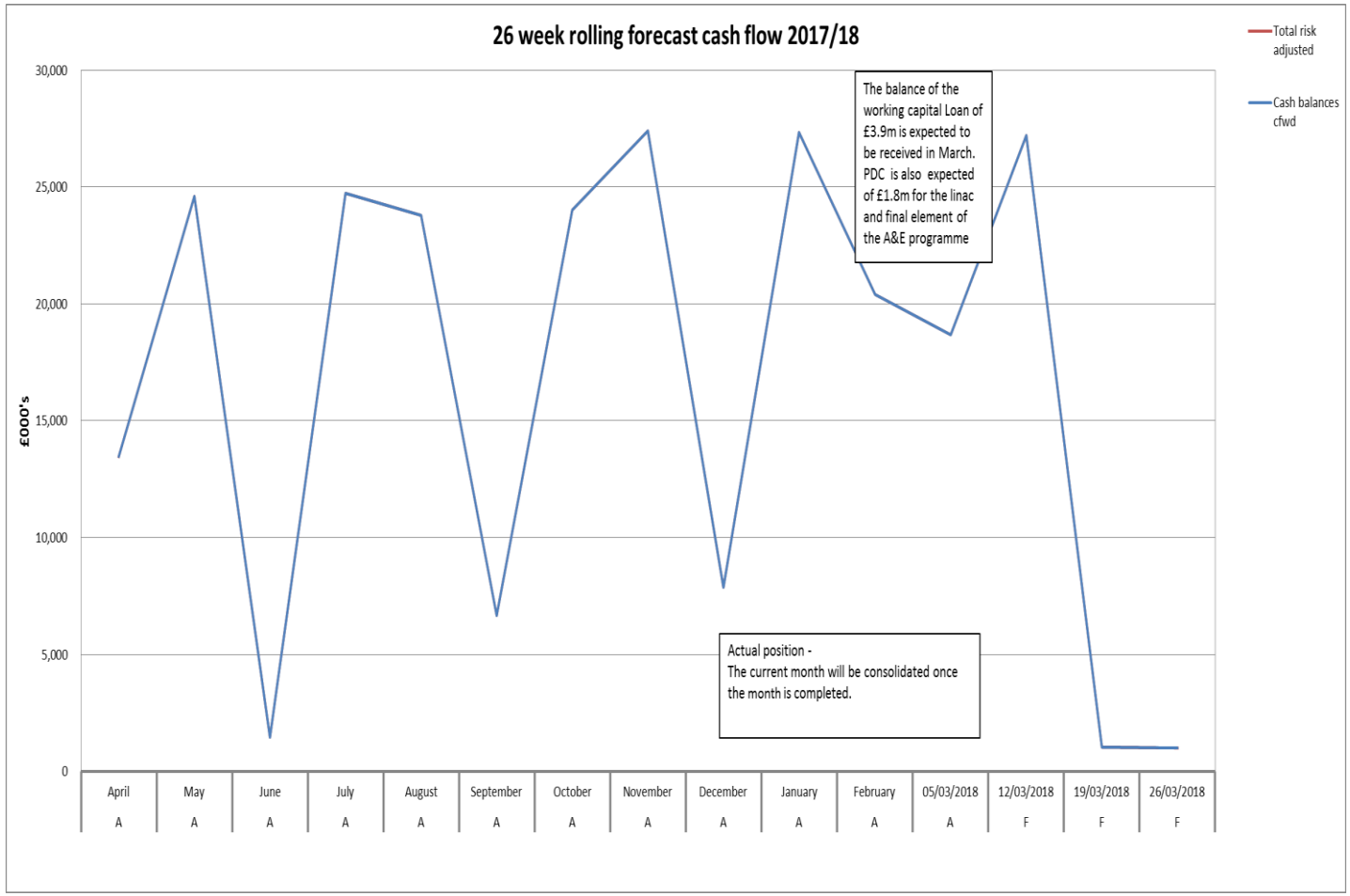
£22.1m working capital facility line represents 2 loans, £12.1m repayable in October 2020 and the new loan received in 2017/18 of £10m repayable 2020/21. The Trust has got approval from NHSI and DH on the remaining £3.9m borrowings, which the Trust will receive in March, this brings the total value of working capital loan received in 2017/18 to £13.99m.

**Capital and Reserves**-

The increase in Public Dividend Capital reflects the additional £0.2m received from DH to support the funding of the A&E GP streaming project. Total received to date is £0.5m with an additional £0.1m expected in March 2018. This will be reported next month.

Maidstone and Tunbridge Wells NHS Trust

## 5b. | Cash Flow




**Commentary**

The blue line shows the Trust's cash position from the start of April until March 2018.

Additional working capital of £4m has been approved by DH and NHSI to help fund the forecast deficit in March 2018. For 2017/18 the Trust in total has received £13.99m working capital loans . The Trust anticipates receipt of double block in April 2018 from West Kent CCG and High Weald CCG. This addresses the liquidity risk in the short term from April 2018 onwards.
Up to December , the Trust managed its liquidity even though the actual position has been a I&E deficit through a combination of:

-Sustained pressure on partner CCG and local Trusts to reduce the burden of intra-NHS debt. The Trust tends to be a net provider of services to other local Trusts and is therefore exposed to their cash pressures as trade creditors tend to be preferred in payment. This has been to some extent accentuated by the informal hosting of the STP, though this situation is improving for 2017/18.

-Effectively "borrowing" temporarily in the early part of the year from capital resource as the Trust's programme is back-ended in timing, and has been reduced.

# 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 | 3,082 | 8,723 | 5,641 | 8,873 | 5,034 | 3,839 |
| ICT | 1,140 | 1,590 | 450 | 1,664 | 2,107 | -443 |
| Equipment | 995 | 4,010 | 3,015 | 5,909 | 3,828 | 2,081 |
| PFI Lifecycle (IFRIC 12) | 268 | 268 | 0 | 502 | 502 | 0 |
| Donated Assets | 0 | 350 | 350 | 450 | 167 | 283 |
| **Total** | **5,485** | **14,941** | **9,456** | **17,398** | **11,638** | **5,761** |
| Less donated assets | 0 | -350 | -350 | -450 | -167 | -283 |
| Asset Sales (net book value) | -1,741 | 0 | 1,741 | -1,727 | -1,740 | 13 |
| Contingency Against Non-Disposal | 0 | 0 | 0 | 0 | 0 | 0 |
| **Adjusted Total** | **3,744** | **14,591** | **10,847** | **15,221** | **9,731** | **5,491** |

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. Linac 1 at Maidstone has been installed and is now in clinical use.

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 May 2018. The Trust has been awarded £645k for GP A&E Streaming works, as additional PDC, which has now been received. The Trust disposed of the Hillcroft property for £1.04m gross receipts generating a small profit on sale of c.£20k. The Springs property sale was completed on 22nd January with sale proceeds of £800k. The originally planned Salix loan of £4m has been reduced to £744k as plans for CHP plant would no longer meet the Salix metrics. All three phases have now been approved by Salix and NHSI are agreeing CRL cover with the DH and the Trust has received £629k to date with the remaining balance expected before the end of March. The Trust has received £1.7m PDC funding in March for the replacement linear accelerator.

The Trust is already planning an underspend in depreciation to support the Income & Expenditure position and this has been matched by a corresponding reduction in the planned capital spend. Some major schemes (e.g. Energy infrastructure) have taken longer to initiate than planned which will reduce the in year depreciation. The current FOT shown below of £11.64m (before donations and asset sales) reflecting the forecast underspend in depreciation of up to £1.2m.

mtw

**Trust Board meeting – March 2018**

Maidstone and Tunbridge Wells NHS Trust

## 3-10 Update on ECIP visit — Chief Operating Office

The enclosed report provides information on:

- ECIP visit in January 2018
- Recommendations following ECIP visit
- Action plan from Urgent Care Division following review of recommendations

The Emergency Care Improvement Programme (ECIP) is a clinically led programme that offers intensive practical help and support to over 40 urgent and emergency care systems across England leading to safer, faster and better care for patients. A team of 10 specialists, led by Professor Matthew Cooke, ECIP regional clinical director (London region), visited the Trust in January 2018 and met with 25 key stakeholders in the emergency care pathway. This included Executive Team members, discharge team, ward managers, general managers, clinicians and AHPs. A report was written containing a number of recommendations, following a gap analysis against the publication "Good practice guide: Focus on improving patient flow (July 2017)", a copy of which is available here.

The team from ECIP recognised that MTW had already undertaken significant changes, most recently with the support of the consultancy company 2020 & encouraged that the new recommendations are incorporated into existing action plans & streams of work in order to sustain improvement. However the ECIP team assessed that the trust knows what it needs to do & there is good organisational self-awareness, at all levels, of where the challenges are. "There are many areas of good practice in place, particularly on the Maidstone site, but there is a lack of consistency across the trust. The trust needs to focus its resources on addressing these issues & empowering teams locally to create & deliver solutions to these problems. To support this, the trust will need to develop its internal reporting mechanisms & metrics so that variation is easily identifiable."

The recommendations have been reviewed with appropriate actions. The action plan is attached below.

Key areas to note are as follows:

- The Patient Flow workstream has 4 defined projects which will address a number of the recommendations outlined by ECIP. These projects are:
  - Improved LOS
  - Out of Hospital Capacity
  - Frailty
  - AEC/ AMU
- There is a recommendation from ECIP to improve documentation from emergency door to discharge. This crosses over a number of workstreams (namely Best Quality and Best Patient Flow) and will require a number of stakeholders to achieve
- There are recommendations to improve patient flow and consider all pathways from ED through to AEC/ AMU/ SAU which is part of business as usual and will also be addressed within the AMU/ AEC project group.
- Building work on the CDU units started within 3 weeks of the ECIP visit to achieve the recommendations
- The Frailty Unit at TW opened on 21st March to provide frailty pathways
- The CUR (Clinical Utilisation Review) system is already in place within the Trust and provides an electronic way to capture patient delays on a daily basis. This is being developed to facilitate the roll out of R2G and to monitor SAFER.

**Which Committees have reviewed the information prior to Board submission?**

- The action plan has been developed within the Patient Flow structure.

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

For 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

| Area | Recommendation | Action | Owner | Compliance |
|---|---|---|---|---|
| **Admission, Discharge, Transfer** | Assessment of Home First Service | Being undertaken | AG | |
| | 2.) Recommend that a MADE event is undertaken at TW. | Discussed with ECIP - not required at this stage | LG | |
| | 3.) Recommend testing front loaded therapy and community assessments | HIT team in place with trusted assesor format, Urgent Care therapy team in place, further work being undertaken. | AA/ DH | |
| | 4.) Recommend testing more simple therapy and discharge paperwork | 4.) A review of the therapy documentation used in front of house, on the wards and in the community is planned from April 2018 to ensure documentation supports best practice recommendations and effective patient flow. | AA | |
| **Ambulance Handovers** | 1.) Recommendation that the Trust and SECAmb test processes to convey patients directly to other areas in the ED (e.g. minors, GP assessment) to reduce avoidance pressure on the RAP service. | | NS/GV | |
| | 2.) Recommendation that an emergency conveyance audit is undertaken based on 6As methodology at the Tunbridge Wells site to assess the potential for non-conveyance or alternative conveyance routes. | Operationally it has been agreed with the CCG that the data does not correctly represent the performance status | NS/GV | |
| **Ambulatory** | 1.) Recommend that the Ambulatory care service and AMU at TWs test different approaches to ensure all clinically stable GP referred patients are able to be accepted directly in to the medical area not via the ED. | This will fit into the AEC/ ED project group under the Best Patient Flow workstream. | NS/GV | |

| Area | Recommendation | Action | Owner | Compliance |
|---|---|---|---|---|
| | 2.) Recommend that the Trust undertakes AEC opportunity case note audit at the TWs site. | This will fit into the AEC/ ED project group under the Best Patient Flow workstream. | NS/GV | |
| | 3.) Recommendation that the TW AEC team continue to run rapid cycle PDSA tests | This will fit into the AEC/ ED project group under the Best Patient Flow workstream. | NS/GV | |
| **AMU and other assessment services** | 1.) Recommend that high volume surgical specialties to be accepted directly into the SAU and not via ED | This will fit into the AEC/ AMU project group under the Best Patient Flow workstream which will have Surgical representation. | ST | |
| | 2.) Recommend that the Trust with clinical support of ECIP review the medical model and flow throughout AMU at Tunbridge Wells. An objective should be to deliver 7 day consultant input | This will fit into the AEC/ AMU project group under the Best Patient Flow workstream and is part of Business as Usual | LG/ LM | |
| | 3.) Recommend that AMU at Tunbridge Wells tests an early morning board round with MDT huddles around midday and mid afternoon to drive actions and flow through unit which flows with the patient during their journey through hospital. | Currently use midday huddle in AEC. Future developments will fit inot the AEC/ AMU project group. | NS/GV | |
| **CDU** | 1.) The clinical decision units: actions taken to ensure that they meet the criteria for an inpatient ward | Building work underway to achieve this | NS/GV | |

| Area | Recommendation | Action | Owner | Compliance |
|---|---|---|---|---|
| | 2.) Recommend reviewing the medical oversight of the CDUs to ensure that patients are admitted to the unit with appropriate plans and results are acted on as soon as available. Supervised and led by a named Consultant. | NICK/ GEMMA | NS/GV | |
| **ED** | 1.) Recommend TW site tests different models to increase the availability of 'red chairs' | This is already implemented and reviewed on Symphony | NS/GV | |
| | 2.) Recommendation that an emergency admission (6As) audit undertaken at the Tunbridge Wells site to understand scope for alternative pathways to admission | This will form part of the AEC/ AMU project group under the Best Patient Flow workstream | NS/GV | |
| **Frailty** | 1.) Recommendation that an Acute Frailty unit is established at Tunbridge Wells site . | 1.) Frailty unit at Tunbridge Wells has opened on a small scale 21/03/18 within ward 2 at TWH. Building work has commenced 19/03/18 to create a permanent unit. | DP/ SP | |
| | 2.) Recommendation that an emergency admission audit (6As) of older patients is undertaken to understand the current gaps in service | This will form part of the Frailty project group under the Best Patient Flow workstream | DP/ SP | |
| | 3.) Recommend the use of the Rockwood clinical frailty scale is standardised across the sites as per national guidance. | 3.) Rockwood frailty scale to be implemented on new Tunbridge Wells Frailty unit and teaching planned for staff. This will serve as a pilot and the lessons learned to be reflected back to Maidstone Frailty Unit who currently use an expanded Bournemouth criteria. | CHT/ KD | |

| Area | Recommendation | Action | Owner | Compliance |
|---|---|---|---|---|
| | 4.) Recommendation that the frailty team at Maidstone run some small PDSA tests of holding a direct access phone for community health professionals (e.g. GPs ambulance service) to avoid ED attendances. | This will form part of the Frailty project group under the Best Patient Flow workstream | DP/ SP | |
| | 5.) Given the consultant vacancies, we recommend that the non-inpatient workload (i.e. clinics) at the Tunbridge Wells site reviewed to assess if there is any scope to convert outpatient work to inpatient acute frailty care. | This is ongoing as part of the Deep Dive programme, where each specialty is reviewed individually by clinicians and managers following review of benchmarking data | DP/SP | |
| **Mental Health** | 1.) Recommendation that ECIP support the system to undertake a system assessment against good practice in the management of mental health patients. If required, ECIP can then facilitate the ECIP mental health team to undertake a deep dive review of the system | The Trust will work with the Mental Health team to achieve this goal. | NS/GV | |
| **Primary Care streaming** | 1.)Recommendation that the service streams patient through to the OOH, protocol based approach to increase numbers and reduced wasted effort. No restriction on volume | This work is ongoing | NS/GV | |

| Area | Recommendation | Action | Owner | Compliance |
|---|---|---|---|---|
| **Specialities** | 1.) Recommendation that the trust rolls out a process to identify constraints to patient flow. | This will be part of the Patient Flow Workstream.<br><br>Sprint week focus on stranded and super stranded patients with the associate director of operations, ADNS Urgent care, Matrons and ward sisters to resolve barriers to patient flow, problem solve and escalate issues. Ultimate aim to reduce LOS whilst ensuring robust and safe patient discharge. | DP/ SP | |
| | 2.) Recommend that this is the use of Red2Green days, however, with the trust already using a CUR system it may be more appropriate to focus on maximising this process first. | Plan in place for 1x Band 7 CUR Implementation manager to manage and embed CUR as an effective trust wide tool to improve patient flow. | DP/ SP | |
| | 3.) Recommendation that the TRUST implements the SAFER patient flow bundle | This will be facilitiated by CUR (see above) | DP/ SP | |
| | 4.) Recommend that the trust tests on the Tunbridge Wells site, admitting patients to wards whilst the room cleaning process is happening to improve flow | This will form part of the Reducing LOS project. | DP/SP | |

**Trust Board meeting – March 2018**

NHS Maidstone and Tunbridge Wells NHS Trust

**3-12 Care Quality Commission inspection – Report and response Chief Nurse**

The purpose of this report is to provide the Trust Board with an update on the CQC Inspection report, the immediate response to the report and the plan for securing ongoing quality improvements across the Trust.

The series of unplanned and planned CQC inspections between October 2017 and December 2017 consisted of 12 separate visits, carried out collectively by 81 inspectors. Five core services at our hospitals were inspected. Following the inspections the Central project team have continued the actions to the mapped key objectives and activities within the 6 Phase model of delivery specifically transitioning in to PHASE 5 - Post Inspection and PHASE 6 - Wrap up/Handover/BAU. Since Completed actions include;

- Lessons learnt log
- Transition of project group formatted into proposed Quality improvement committee.
- CQC "How to guide" completed
- CQC pack developed – to be shared at site control office's
- Completion of 2015 – 2017 Action log and tracker and transition to draft 2018 tracker and action log.

On completion of the inspections the CQC published its Final Inspection Report for MTW on 9 March (enclosed as Appendix 1). The Trust had previously received a draft copy of the report on 9 February 2018 and provided comments about factual accuracy and completeness on 23 February 2018.

**CQC Inspection Report**

While the CQC Report leaves the Trust's overall position unchanged as 'Requires Improvement'**,** the report identifies 'significant and sustained improvement throughout the Trust' since the last inspection report in 2015.

Key highlights:

- Rated 'Good' in over two thirds of the CQC standards across the five core services that were inspected – a significant increase from less than a third in 2015.
- All inspected services rated 'Good' in the caring domain
- No individual standards rated 'Inadequate', compared to six in 2015.
- Examples of outstanding practice noted in urgent and emergency care, surgery, critical care services and services for children and young people.
- The Trust's Well Led rating significantly improves from `inadequate' to `good'
- 17 recommendations were made by the CQC compared with 52 'should do's' and 18 'must do's' in 2015 – a substantial difference
- No 'must do's' identified


Significant improvement compared with 2015 as demonstrated below**:**

**Response to the Inspection Report**

Following receipt of the published report, the Trust initiated its action plan for continuation of Phase 5 – Post Publication.

On 9 March 2018, communications to all staff shared the key findings from the report and provided links to the full report. The CEO bulletin to all staff on the same day provided further detail and commentary about the findings; the scale of improvements achieved and recognised the contribution of all staff to that achievement. The report has been placed on the Trust's website and planned external communications to key partners and audiences have been actioned.

Open sessions for staff to discuss and reflect on the CQC report with Executives and CQC Project Team Leads have been arranged for 23 March 2018. Informal weekly CQC / Quality drop in sessions have been re –established during March and April 2018 on both sites providing opportunity for all staff to discuss any concerns or share experiences.

Reflecting the change in CQC inspection and methodology whereby providers may expect an annual cycle of inspection and ongoing quarterly contact and monitoring, preparations have been made to support the Trust in assimilating CQC inspection within a BAU model. Drawing on experience from the 2018 CQC Inspection cycle, a draft *How to Guide* has been produced setting out how the Trust prepares, manages and engages throughout the annual CQC inspection cycle in BAU mode across the Trust.

The 17 'should do' actions identified in the report have been incorporated into the Trust's CQC Action Plan and Tracker.

| | |
|---|---|
| SD1 | URGENT AND EMERGENCY SERVICES :The service should ensure significant and sustained improvements in the quality of patient records, including in relation to: risk assessments; triage assessments and observations; documentation of patient outcomes at the triage stage; use of the early warning score tools; pain relief; overall compliance with trust standards |
| SD2 | SURGERY: The trust should implement systems to ensure that learning from incidents and complaints is shared and embedded |
| SD3 | SURGERY<br>The trust should embed a system of prioritisation to ensure holes in theatres department walls and doors are addressed in a timely fashion to minimise infection risk. |
| SD4 | SURGERY<br>The trust should embed a system to ensure all staff meet mandatory training targets. |
| SD5 | SURGERY: The trust should take steps to ensure all shifts are staffed in line with staffing requirements. |
| SD6 | SURGERY: The trust should implement a system to respond to patient complaints in compliance with timelines set out in the trust's complaint policy. |
| SD7 | The Tunbridge Wells Hospital at Pembury should put a system and policy in place to ensure only clinically suitable patients are cared for on the escalated short stay surgery unit. |
| SD8 | SURGERY: The Tunbridge Wells Hospital at Pembury should put a system in place to ensure all patients on the short stay surgery unit, including medical patients, have regular access to consultant care and consultants respond to requests for care on that ward. |
| SD9 | SURGERY: The Tunbridge Wells Hospital at Pembury should work to retain and recruit staff members to address the vacancy rate of 26.6%, more than three times the hospital's target. |
| SD10 | SURGERY: The Tunbridge Wells Hospital at Pembury should ensure patient starvation times are not longer than clinically necessary, and actively manage starvation times when there are delays. |

| | |
|---|---|
| SD11 | SURGERY: The Tunbridge Wells Hospital at Pembury should implement systems to ensure patient's pain levels are pro-actively assessed and treated. |
| SD12 | SURGERY: The Tunbridge Wells Hospital at Pembury should put a system in place to address paperwork issues which delay patient discharges. |
| SD13 | CRITICAL CARE: The trust should ensure that there is a standard operating procedure in place for children who may be treated on the unit. |
| SD14 | CRITICAL CARE: The trust should ensure all patient deaths are discussed at morbidity and mortality meetings. |
| SD15 | CRITICAL CARE: The trust should ensure that overnight discharges are reduced. |
| SD16 | CRITICAL CARE: The trust should ensure that all staff receive an appraisal. |
| SD17 | CHILDREN & YOUNG PEOPLE: The trust should ensure children admitted to adult wards are cared for by staff with level 3 safeguarding training. |

Responsibilities for delivering the required improvement and key milestones for actions are outlined in the attached action plan (Appendix 2). This will be monitored by the proposed quality improvement committee, which will be part of the Best Care Programme. To evidence the responsiveness of the Trust to the CQC, stretch targets have been proposed that seek to complete all of the 17 'should do' recommendations within the first quarter of 2018 / 19 financial year. This represents a significant acceleration of response compared to 2015.

**Securing ongoing quality improvement beyond the CQC report**

Coordination and oversight of the Trust's response to the CQC report will be provided by the Quality Improvement Committee. Chaired by the Chief Nurse, this new committee supersedes the CQC Project Team and seeks to more closely align the response to the CQC report with the Trust's wider quality improvement plans and the nurturing of a shift in culture where continuous quality improvement is embedded and staff understand their individual and team responsibilities and contribution to quality improvement.

Delivery of the above is an integral part of the wider Quality Improvement project within the Best Quality Work stream. The Best Quality Work stream Board will have responsibility for oversight and coordination of quality improvement planning and delivery across the Trust and driving the cultural shift around continuous quality improvement.

In this way, the Trust should be well placed to build on momentum to achieve an early CQC 'Good' status and provide stretch and pace in transforming its approach to and delivery of quality improvement across the Trust.

**Which Committees have reviewed the information prior to Board submission?**

- N/A

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

Information

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

# Maidstone and Tunbridge Wells NHS Trust

## Inspection report

Maidstone District General Hospital
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Date of inspection visit: <xx Mon> to <xx Mon> 2017
Date of publication: 09/03/2018

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

| Overall rating for this trust | Requires improvement |
|---|---|
| Are services safe? | **Requires improvement** |
| Are services effective? | **Requires improvement** |
| Are services caring? | **Good** |
| Are services responsive? | **Requires improvement** |
| Are services well-led? | **Good** |

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

# Summary of findings

## Background to the trust

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

The trust has three registered locations:

- Maidstone Hospital
- The Tunbridge Wells Hospital at Pembury
- The Crowborough Birthing Centre

## Overall summary

**Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement**



## What this trust does

Maidstone and Tunbridge Wells NHS Trust's core catchment areas are Maidstone and Tunbridge Wells and their surrounding boroughs, and it operates from two main clinical sites: Maidstone Hospital and Tunbridge Wells Hospital at Pembury. The latter is a private finance initiative hospital and provides single bedded en-suite accommodation for inpatients. It also operates a birthing unit: Crowborough Birthing Centre, which was newly acquired in January 2016 and has other small community and satellite services. The trust has around 912 beds across two sites and employs around 5,000 staff.

In addition, the trust provides specialist cancer services to around 1.8 million people across Kent, Hastings and Rother, via the Kent Oncology Centre, which is sited at Maidstone Hospital and at Kent and Canterbury Hospital in Canterbury. The trust also provides outpatient clinics across a wide range of locations in Kent and East Sussex.

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We carried out two day inspections of five core services at two locations from 18 October 2017 to 1 February 2018. At the last inspection in 2015, one of these core services was rated inadequate and four were rated as requires improvement.

# Summary of findings

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at trust level. Our findings are in the section headed 'Is this organisation well-led?' We inspected the well-led key question on 12 and 13 December 2017.

## What we found

### Overall trust

We found there had been significant and sustained improvement throughout the trust. Overall, the trust rating stayed the same. We rated it as requires improvement because:

- At our last inspection in 2015, we rated safe as requires improvement at Maidstone Hospital and The Tunbridge Wells Hospital at Pembury. At this inspection, the rating stayed the same.
- We rated effective as requires improvement in 2015 at Maidstone Hospital and The Tunbridge Wells Hospital at Pembury. At this inspection, the rating stayed the same.
- The trust was rated as good for caring at both locations and remained unchanged from the last inspection.
- The rating for responsive had stayed the same at requires improvement at both locations.
- There was improvement in the well led domain at one site and overall for the trust. At the last inspection, we rated the trust as inadequate for well led, but it had improved to requires improvement at The Tunbridge Well Hospital at Pembury and improved to good at Maidstone Hospital at this inspection.
- We did not inspect maternity and gynaecology, end of life care or outpatients and diagnostic imaging. We are monitoring the progress of improvements to these services and will re-inspect them as required.

### Are services safe?

Our rating of safe stayed the same. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- Urgent and emergency services and surgery had stayed the same and were rated as requires improvement. Medical care, critical care, services for children and young people had improved from requires improvement and were rated as good.
- We found overall trust services had adequate numbers of staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse, and to provide the right care and treatment. However, not all staff were trained to the appropriate level of safeguarding to look after children if they were on an adult ward.
- Areas we visited were visibly clean; staff demonstrated good infection control practices and procedures. Management of medicines was in line with best practice guidance and legislation.

### Are services effective?

Our rating of effective stayed the same. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- The trust had recruitment policies and procedures together with job descriptions to help ensure staff were experienced, qualified, competent and suitable for their post. All new permanent and temporary employees undertook trust and local induction with additional support and training when required.

# Summary of findings

- The trust provided care and treatment to patients based on national guidance and evidence of its effectiveness, monitored through dashboards and audits.
- Staff from different departments and disciplines worked together as effective multidisciplinary teams for the benefit of patients.

## Are services caring?

Our rating of caring stayed the same. We took into account the current ratings of services not inspected this time. We rated it as good because:

- We saw staff treated patients with compassion, dignity and respect. Staff involved patients and their carers in decisions about their care and treatment. Staff considered all aspects of a patient's wellbeing, including the emotional, psychological and social aspects.
- The response rates to friends and family surveys were generally above the national average. Patients told us the care they received respected their wishes.
- The feedback we received from patients and their loved ones showed they were satisfied with the services provided.

## Are services responsive?

Our rating of responsive stayed the same. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- The trust worked with commissioners and other external bodies to make sure it planned and delivered services according to the needs of local people.
- Access and flow had improved in the emergency department, which improved flow through the hospital.
- Staff throughout the organisation worked to ensure individual needs were met. Patients and carers with additional needs were supported.
- The trust treated concerns and complaints seriously and investigated them. Where there were learned lessons or changed practices as a result, these were shared with all staff.

## Are services well-led?

Our rating of well led improved. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- At Maidstone Hospital well led had improved from inadequate to good and at The Tunbridge Wells Hospital at Pembury, the rating for well led had improved from inadequate to requires improvement.
- The trust had made improvements whilst experiencing significant financial challenge.
- The trust had a clear vision and strategy that all staff understood and they put this into practice by displaying and working in line with the trust's values.
- The trust had arrangements for continually improving the quality of care and promoting high standards. Managers monitored performance and used the results to help improve care. All staff identified risks to good care and the service took action to eliminate or minimise risks.
- The trust involved staff, patients and the public in decisions on how services were run and improved.

**Maidstone Hospital**

# Summary of findings

Our rating of this hospital stayed the same. We took into account the ratings of services not inspected at this time. We rated the hospital as requires improvement because:

- We rated safe, effective and responsive as requires improvement. We rated caring and well led as good.
- Urgent and emergency services and surgery remained the same and were rated as requires improvement.
- Critical care improved and was rated as requires improvement.
- Medical care and children's and young people services improved and were rated as good.

**The Tunbridge Wells Hospital a Pembury**

Our rating of this hospital stayed the same. We took into account the ratings of services not inspected at this time. We rated the hospital as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement and we rated caring as good.
- We rated urgent and emergency services and surgery as requires improvement, which stayed the same since the last inspection. Critical care improved to requires improvement. Services for children and young people improved to good.

## Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Outstanding practice

We found examples of outstanding practice in urgent and emergency care, surgery, critical care services and services for children and young people throughout the trust.

For more information, see the outstanding practice section in this report.

## Areas for improvement

We found 17 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement or to improve a service quality.

For more information, see the areas for improvement section of this report.

## What happens next

We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

## Outstanding practice

**Urgent and emergency services**

- Staff had opportunities for training and development including joining network training days, taking part in simulated exercises and engaging with emergency care nurses in other trusts as part of facilitated multi-professional learning events.

# Summary of findings

**Surgery**

- The trust promoted training, research and innovation which staff took pride in.
- The department had a simulation machine which provided staff the opportunity to practice scenarios in a realistic setting with no risk to patients.

**Critical care**

- The Maidstone Hospital critical care unit had set up a memory keepsake service for relatives of patients who passed away on the unit. Relatives could choose a hand print, a hand cast or a lock of hair; all in presentation keep sake boxes, to take home with them.

**Services for children and young people**

- The service used play specialists through the whole of the child's inpatient journey, from outpatients' right through to theatres applying distraction techniques.
- The matron had initiated and led on bringing together a children services matron's professional group across the region. The group was also used as supervision with peers and benchmarking how services could be improved in all areas.

## Areas for improvement

Action a trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

**Action the trust SHOULD take to improve**

We told the trust it should take action to either comply with a minor breach that did not justify regulatory action, to avoid breaching a legal requirement in future or to improve services. This action related to four core services:

**Urgent and emergency services**

- The service should ensure significant and sustained improvements in the quality of patient records, including in relation to: risk assessments; triage assessments and observations; documentation of patient outcomes at the triage stage; use of the early warning score tools; pain relief; overall compliance with trust standards

**Surgery**

- The trust should implement systems to ensure that learning from incidents and complaints is shared and embedded.
- The trust should embed a system of prioritisation to ensure holes in theatres department walls and doors are addressed in a timely fashion to minimise infection risk.
- The trust should embed a system to ensure all staff meet mandatory training targets.
- The trust should take steps to ensure all shifts are staffed in line with staffing requirements.
- The trust should implement a system to respond to patient complaints in compliance with timelines set out in the trust's complaint policy.
- The Tunbridge Wells Hospital at Pembury should put a system and policy in place to ensure only clinically suitable patients are cared for on the escalated short stay surgery unit.

# Summary of findings

- The Tunbridge Wells Hospital at Pembury should put a system in place to ensure all patients on the short stay surgery unit, including medical patients, have regular access to consultant care and consultants respond to requests for care on that ward.
- The Tunbridge Wells Hospital at Pembury should work to retain and recruit staff members to address the vacancy rate of 26.6%, more than three times the hospital's target.
- The Tunbridge Wells Hospital at Pembury should ensure patient starvation times are not longer than clinically necessary, and actively manage starvation times when there are delays.
- The Tunbridge Wells Hospital at Pembury should implement systems to ensure patient's pain levels are pro-actively assessed and treated.
- The Tunbridge Wells Hospital at Pembury should put a system in place to address paperwork issues which delay patient discharges.

**Critical care**

- The trust should ensure that there is a standard operating procedure in place for children who may be treated on the unit.
- The trust should ensure all patient deaths are discussed at morbidity and mortality meetings.
- The trust should ensure that overnight discharges are reduced.
- The trust should ensure that all staff receive an appraisal.

**Services for children and young people**

- The trust should ensure children admitted to adult wards are cared for by staff with level 3 safeguarding training.

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services; in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

The trust had made significant improvements across the services. Well-led at Maidstone Hospital had improved to good and well-led at the Tunbridge Wells Hospital at Pembury had improved to requires improvement.

We rated well-led overall at the trust as good because:

- The trust had systems in place to share learning from incidents and complaints. However, we had concerns there were no monitory systems to indicate learning had been shared.
- The trust had made improvements in several service areas since the last inspection, despite being put in financial special measures.

# Summary of findings

- The trust board had been through a period of significant change since the last inspection, which had not affected patient care or the delivery of improvement.
- The trust had a leadership team with the skills, abilities, and commitment to provide high-quality services. They recognised the training needs of managers at all levels, including themselves, and worked to provide development opportunities for the future of the organisation.
- The board and senior leadership team had a clear vision and values that were at the heart of all the work within the organisation. They worked hard to make sure staff at all levels understood them in relation to their daily roles.
- The trust's strategy had been developed in line with the National Health Service Five Year Forward View and was aligned to local plans in the wider health and social care economy.
- Senior leaders made sure they visited all parts of the trust and fed back to the board to discuss challenges staff and the services faced.
- We found an open and honest culture throughout the organisation. Staff felt able to raise concerns amongst their peers and with leaders. Leaders and staff understood the importance of staff being able to raise concerns.
- The trust had a clear structure for overseeing performance, quality and risk, with board members represented across the divisions. This gave them greater oversight of issues facing the service and they responded when services needed more support.
- The trust used information from a variety of data sources to gain assurance and measured improvement in the quality of its services. The board reviewed performance reports regularly.
- Processes were in place to ensure the trust included and communicated effectively with patients, staff, the public, local organisations and local health and care services.

# Ratings tables

| Key to tables | | | | | |
|---|---|---|---|---|---|
| Ratings | **Not rated** | **Inadequate** | **Requires improvement** | **Good** | **Outstanding** |
| Rating change since last inspection | Same | Up one rating | Up two ratings | Down one rating | Down two ratings |
| **Symbol *** | →← | ↑ | ↑↑ | ↓ | ↓↓ |
| Month Year = Date last rating published | | | | | |

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

## Ratings for the whole trust

| Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|
| Requires improvement →← Feb 2018 | Requires improvement →← Feb 2018 | Good →← Feb 2018 | Requires improvement →← Feb 2018 | Good ↑ Feb 2018 | Requires improvement →← Feb 2018 |

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

## Rating for acute services/acute trust

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Maidstone Hospital | Requires improvement →← Feb 2018 | Requires improvement →← Feb 2018 | Good →← Feb 2018 | Requires improvement →← Feb 2018 | Good ↑↑ Feb 2018 | Requires improvement →← Feb 2018 |
| The Tunbridge Wells Hospital at Pembury | Requires improvement →← Feb 2018 | Requires improvement →← Feb 2018 | Good →← Feb 2018 | Requires improvement →← Feb 2018 | Requires improvement ↑ Feb 2018 | Requires improvement →← Feb 2018 |
| **Overall trust** | Requires improvement →← Feb 2018 | Requires improvement →← Feb 2018 | Good →← Feb 2018 | Requires improvement →← Feb 2018 | Good ↑ Feb 2018 | Requires improvement →← Feb 2018 |

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for Maidstone Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Requires improvement →← Feb 2018 | Requires improvement →← Feb 2018 | Good →← Feb 2018 | Requires improvement ↓ Feb 2018 | Good ↑↑ Feb 2018 | Requires improvement →← Feb 2018 |
| Medical care (including older people's care) | Good ↑ Feb 2018 | Good ↑ Feb 2018 | Good →← Feb 2018 | Good ↑ Feb 2018 | Good →← Feb 2018 | Good ↑ Feb 2018 |
| Surgery | Requires improvement →← Feb 2018 | Good ↑ Feb 2018 | Good →← Feb 2018 | Requires improvement →← Feb 2018 | Requires improvement →← Feb 2018 | Requires improvement →← Feb 2018 |
| Critical care | Good ↑ Feb 2018 | Good ↑ Feb 2018 | Good →← Feb 2018 | Requires improvement ↑ Feb 2018 | Good ↑↑ Feb 2018 | Good ↑ Feb 2018 |
| Maternity | Good Feb 2015 | Good Feb 2015 | Good Feb 2015 | Good Feb 2015 | Good Feb 2015 | Good Feb 2015 |
| Services for children and young people | Good ↑ Feb 2018 | Good ↑ Feb 2018 | Good →← Feb 2018 | Good ↑ Feb 2018 | Good ↑↑ Feb 2018 | Good ↑ Feb 2018 |
| End of life care | Good Feb 2015 | Requires improvement Feb 2015 | Good Feb 2015 | Requires improvement Feb 2015 | Good Feb 2015 | Requires improvement Feb 2015 |
| Outpatients | Good Feb 2015 | Requires improvement Feb 2015 | Good Feb 2015 | Requires improvement Feb 2015 | Requires improvement Feb 2015 | Requires improvement Feb 2015 |
| **Overall*** | Requires improvement →← Feb 2018 | Requires improvement →← Feb 2018 | Good →← Feb 2018 | Requires improvement ↑ Feb 2018 | Good ↑ Feb 2018 | Requires improvement →← Feb 2018 |

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for The Tunbridge Wells hospital at Pembury

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Requires improvement → ← Feb 2018 | Requires improvement → ← Feb 2018 | Good → ← Feb 2018 | Requires improvement ↑ Feb 2018 | Good ↑↑ Feb 2018 | Requires improvement ↑ Feb 2018 |
| Medical care (including older people's care) | Good ↑ Feb 2018 | Good ↑ Feb 2018 | Good ↑ Feb 2018 | Good ↑ Feb 2018 | Good → ← Feb 2018 | Good ↑ Feb 2018 |
| Surgery | Requires improvement → ← Feb 2018 | Requires improvement → ← Feb 2018 | Good → ← Feb 2018 | Requires improvement → ← Feb 2018 | Requires improvement → ← Feb 2018 | Requires improvement → ← Feb 2018 |
| Critical care | Good ↑ Feb 2018 | Requires improvement → ← Feb 2018 | Good → ← Feb 2018 | Requires improvement ↑ Feb 2018 | Good ↑↑ Feb 2018 | Requires improvement ↑ Feb 2018 |
| Maternity | Requires improvement Feb 2015 | Requires improvement Feb 2015 | Good Feb 2015 | Good Feb 2015 | Requires improvement Feb 2015 | Requires improvement Feb 2015 |
| Services for children and young people | Good ↑ Feb 2018 | Good ↑ Feb 2018 | Good → ← Feb 2018 | Good ↑ Feb 2018 | Good ↑ Feb 2018 | Good ↑ Feb 2018 |
| End of life care | Requires improvement Feb 2015 | Requires improvement Feb 2015 | Good Feb 2015 | Requires improvement Feb 2015 | Good Feb 2015 | Requires improvement Feb 2015 |
| Outpatients | Good Feb 2015 | N/A | Good Feb 2015 | Requires improvement Feb 2015 | Requires improvement Feb 2015 | Requires improvement Feb 2015 |
| **Overall*** | Requires improvement → ← Feb 2018 | Requires improvement → ← Feb 2018 | Good → ← Feb 2018 | Requires improvement → ← Feb 2018 | Requires improvement ↑ Feb 2018 | Requires improvement → ← Feb 2018 |

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

# Maidstone Hospital

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## Key facts and figures

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

The Trust's core catchment areas are Maidstone and Tunbridge Wells and their surrounding boroughs, and it operates from two main clinical sites: Maidstone Hospital and Tunbridge Wells Hospital at Pembury. The latter is a Private Finance Initiative (PFI) hospital and provides wholly single bedded en-suite accommodation for in-patients.

The Trust employs a team of over 5000 full and part-time staff. In addition, the Trust provides specialist cancer services to around 1.8 million people across Kent, Hastings and Rother, via the Kent Oncology Centre, which is sited at Maidstone Hospital, and at Kent and Canterbury Hospital in Canterbury. The Trust also provides outpatient clinics across a wide range of locations in Kent and East Sussex.

## Summary of services at Maidstone Hospital

**Requires improvement** ↑

Our rating of these services stayed the same. We rated them as requires improvement.

A summary of services at this hospital appears in the overall summary above.

# Urgent and emergency services

**Requires improvement** 

## Key facts and figures

The emergency care centre at Maidstone Hospital includes a four-bedded resuscitation unit, a nine-bedded majors unit, a five-bedded minors unit and a rapid assessment point with five bed bays. A seating area is available in the majors unit and provides additional capacity for patients who do not need a trolley to be observed. A clinical decision unit is located in a dedicated room in the minors area with nurse cover and five comfortable chairs. The resuscitation unit has a dedicated paediatric bay. A rapid assessment point with three trolley bays and two chair bays provides additional capacity. A diagnostic radiology unit is available adjacent to the emergency care centre and a plaster room is located in the department.

A paediatric waiting area and two treatment rooms are located in the emergency care centre and staffed by a team of paediatric nurses.

A multidisciplinary team of emergency department doctors, nurses, emergency nurse practitioners, emergency department practitioners and clinical support workers provide care and treatment. The wider multidisciplinary team includes a high impact therapy team, extended scope physiotherapists and psychiatric liaison team.

At our last inspection we told the trust they must:

- Ensure security staff have the knowledge and skills to safely work with vulnerable patients and those with mental health needs

## Summary of this service

Our overall rating of this service stayed the same. We rated it as requires improvement because:

- Between October 2016 and September 2017 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Maidstone Hospital.
- Over the period an average of 42% of ambulance journeys had a turnaround time over 30 minutes.
- From August 2016 to July 2017 the trust reported 364 “black breaches”, with an upward trend over the period. A black breach occurs when a patient spends more than 60 minutes on an ambulance waiting to be seen in the emergency department.
- A significant backlog of incident investigations and limited evidence of learning from incidents meant we were not assured safety improved as a result.
- Triage processes were inconsistent and did not always keep people safe. In addition the results of triage records indicated a need for improved quality.
- Audits identified a need for improvement in the quality of patient records.
- There was very limited evidence of health promotion work or intervention despite a significant number of patients presenting with alcohol or drug overdoses, or with suicidal intent.

However:

# Urgent and emergency services

- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for all months over the 12 month period between September 2016 and August 2017 although this did not include patients who arrived by ambulance.
- The unit performed consistently well in the national patient-led assessment of the care environment (PLACE) and in weekly environmental audits. In the previous 12 months, the unit performed better than national and trust averages in all categories.
- From September 2016 to August 2017, the trust reported no incidents classified as never events for urgent and emergency care.
- The recruitment of practice development nurses had significantly improved the training and professional development opportunities for staff. This improved tracking and assessment of staff competencies and enabled individuals in different roles to work and develop together.
- There was a demonstrable track record of well-coordinated multidisciplinary working that contributed to patient outcomes.
- From January 2017 the trust showed a general trend of improvement in performance against Department of Health access and flow metrics, including the national standard to be seen, discharged or admitted within four hours.
- There were clear and demonstrable improvements in clinical governance and leadership, and this was reflected in the morale of staff and initiatives to improve performance and risk management.

## Is the service safe?

**Requires improvement** 

Our rating of safe stayed the same. We rated it as requires improvement because:

- There were very high usage rates for bank, agency and locum staff including in the paediatrics team. In addition, although staffing cover per shift, including consultant cover, met Royal College of Emergency Medicine standards, supernumerary staff were often relied on to take patients.
- A backlog of 400 incidents for emergency care had been entered onto the department's risk register with Maidstone Hospital and there was limited evidence staff in the department had capacity to address this. The incidents had not been fully investigated or closed, which meant the senior team had not yet identified learning from them.
- There was very limited evidence of health promotion work or intervention despite a significant number of patients presenting with alcohol or drug overdoses or with suicidal intent.
- Although infection control and environmental standards in the main department were consistently good, there were unresolved risks in the paediatric area. These included damaged flooring, dirty and dusty repairs and damaged fixtures.
- Documented checks on resuscitation equipment were inconsistent and did not always meet trust standards.
- Audits of patient notes indicated areas for improvement. However, records we saw during our inspection were of a high standard.
- There was limited evidence of learning and improvements to practice as a result of incident investigations.

However:

# Urgent and emergency services

- In the patient-led assessment of the care environment, the department scored better than the national average in all five categories.
- Maidstone Hospital had an 87% average mandatory training completion rate, which met the trust target of 85%.
- Where incidents had been investigated and closed, there were demonstrable learning and structured actions plans in place.

## Is the service effective?

**Requires improvement** 

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff did not always document pain scores for each patient and audits demonstrated wide variations in practice.
- The department did not meet any of the Royal College of Emergency Medicine standards for consultant sign-off in the latest audit. In the four audit criteria, the department performed at least 80% worse than the national average.
- Staff did not demonstrate consistent awareness of health promotion opportunities and did not always engage with initiatives launched by colleagues elsewhere in the hospital.

However:

- A practice development nurse had implemented a range of new training and development opportunities for staff. This represented a targeted improvement in increasing clinical competencies in the team.
- There were significant opportunities for staff to work as part of multidisciplinary teams in rotational posts and secondments and this had a demonstrably positive impact of skill mix and morale.
- Multidisciplinary working was embedded in the care and treatment provided. This included from a high impact therapy team and a psychiatric liaison team.
- Although 95% of staff had up to date Mental Capacity Act (2005) training, staff did not consistently complete mental capacity or consent assessments in patient records.

## Is the service caring?

**Good** 

Our rating of caring stayed the same. We rated it as good because:

- The trust performed better than the national average in the NHS Friends and Family Test, including a recommendation rating consistently above 90% between February 2017 and November 2017.
- The parents of children we spoke with said all staff had been kind and they would like to be more involved in understanding emergency care centre processes such as how referrals worked.
- The results of the Care Quality Commission, Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in all 24 questions relevant to caring.
- Staff took the time to involve patients in decisions about their care and worked to find alternatives when requested.

# Urgent and emergency services

## Is the service responsive?

**Requires improvement**  

Our rating of responsive stayed the same. We rated it as requires improvement because:

- From September 2016 to August 2017, the trust's unplanned re-attendance rate to accident and emergency within seven days was generally worse than the national standard of 5% and generally worse than the England average.
- From October 2016 to September 2017 the trust's monthly median total time in accident and emergency for all patients was consistently higher the England average.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in accident and emergency. Between October 2016 and September 2017 did not meet this target in any month. In this period results varied from 76% to 92%.
- Between October 2016 to September 2017 Maidstone and Tunbridge Wells NHS Trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average. However there was a trend of improvement during this period.

However:

- Systems had been implemented to improve access and flow such as a dedicated flow coordinator and discharge coordinator per shift. This contributed to a general improvement against Department of Health targets since January 2017.
- A new head of security had introduced behaviour contracts for patients who behaved violently towards staff.
- The emergency care centre team worked closely with community organisations to speed up discharges into rehabilitation and community beds.
- Staff aimed to meet individual needs during comfort rounds such as making sure a call bell was within reach and the patient had water. This meant staff met patient's holistic needs when they spent extended periods in the department.
- Tools and resources were available for patients with needs relating to dementia and learning disabilities.

## Is the service well-led?

**Good**  

Our rating of well-led improved. We rated it as good because:

- We saw evidence of embedded improvements in leadership.
- All of the staff we spoke with said the working culture was positive and enabled them to be confident in providing feedback and engaging with colleagues.
- Clinical governance systems had improved since our last inspection and we saw evidence meetings were held regularly with a wide range of staff.
- Although the use of the risk register was variable there was evidence in several areas that progress had been made to reduce risks.

# Urgent and emergency services

- There were significant improvements in the training and knowledge of the security team, who demonstrated how they reduced risks to patients who presented with aggression or escalating behaviour.
- Staff had contributed to the development of a vision and strategy for the department. This was clearly embedded in the work of the teams we spoke with and observed.

However:

- There was variable evidence the risk register was used effectively to mitigate all risks.

## Outstanding practice

- Opportunities for training and development including joining network training days, taking part in simulated exercises and engaging with emergency care nurses in other trusts as part of facilitated multidisciplinary learning events.

## Areas for improvement

- The service should ensure significant and sustained improvements in the quality of patient records, including in relation to: risk assessments; triage assessments and observations; documentation of patient outcomes at the triage stage; use of the early warning score tools; pain relief; overall compliance with trust standards

# Medical care (including older people's care)

## Key facts and figures

The medical care service at the trust provides care and treatment for Gastroenterology, Respiratory, Cardiology, Care of the Elderly (including stroke and transient ischaemic attack) and Diabetes & Endocrinology, as well as offering some services within the community. There is a Cardiac Catheter Laboratory focused on Electrophysiology studies, ablation and devices. There is a full cardio respiratory and respiratory physiology support service on both sites offering diagnostic procedures. Across both sites, there are 236 medical inpatient beds located within 13 wards.

## Summary of this service

Our overall rating of this service improved. We rated it as good because:

- Since our last inspection in 2015, we saw a number of changes.
- There was an improved culture of incident reporting. Incidents were recorded on electronic systems that incorporated fail-safes about aspects such as duty of candour.
- Patients and relatives we spoke with gave positive feedback about the care they received on the unit.
- Staff showed compassion when dealing with patients and protected their privacy and dignity.

However:

- Although medicines were better managed and more available, some aspects of medicines management still needed improvement.

## Is the service safe?

**Good** ↑

Our rating of safe improved since our last inspection. We rated it as good because:

- We found that concerns identified at the previous inspection about managing patients colonised with meticillin-resistant staphylococcus aureus medicine storage, competency checks for agency nurses, confidential medical records storage and handovers between doctors had been addressed.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it. The overall training completion rate exceeded the trust target and the service effectively used the newly upgraded electronic learning management system to enhance support to managers and staff.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The trust had systems and processes in place to help staff identify and report concerns to protect their patients. Training completion rates for Maidstone were better than trust targets.
- All of the areas we inspected were visibly clean, tidy and free from clutter. The service controlled infection risks well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service maintained suitable premises and sufficient equipment to support safe care and treatment.

# Medical care (including older people's care)

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. We noted high rates of bank and agency staff usage, but the trust had sufficient controls in pace to manage risk.
- There was an improved culture of incident reporting. Incidents were recorded on electronic systems that incorporated fail-safes about aspects such as duty of candour.
- We found a positive focus on safety and the service was transparent about the levels of harm-free care achieved, with the prevalence rate of indicators such as pressure ulcers and catheter acquired urinary tract infections declining over the last year.

However:

- While aspects of medicines management had improved since our last inspection, we still observed instances where pharmacy stock was out of date or not stored in accordance within specified temperature ranges. Opening dates were not always on liquid medicines to ensure they were used within specified expiry dates.
- We acknowledge that the trust reacted immediately and effectively to rectify an issue we identified with tamper-evident security on resuscitation trolleys.

## Is the service effective?

**Good** ↑

Our rating of effective improved. We rated it as good because:

- We found a service that provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. New and updated guidance was evaluated and shared with staff.
- Patients at Maidstone Hospital had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- Other outcome measures were in line with national averages. The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the Maidstone Hospital achieved grade A in latest audit.
- The trust had recruitment policies and procedures together with job descriptions to help ensure staff were experienced, qualified, competent and suitable for their post. All new permanent and temporary employees undertook trust and local induction with additional support and training when required.
- Medical services at Maidstone achieved 94% appraisal rates, which were higher than other parts of the hospital and better than trust targets.
- At meetings, we observed positive and proactive engagement between all members of the multidisciplinary team.
- Since our last visit, the trust had introduced and successfully implemented a number of new electronic systems that improved effectiveness.

However,

- Deprivation of liberty training rates has not been provided by the trust. We acknowledge that the service achieved 98% for Mental Capacity Act training within Medicine.

# Medical care (including older people's care)

## Is the service caring?

**Good** ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness and we saw that patient privacy and dignity was maintained at all times.
- The Friends and Family Test response rate for Medicine was better than the England average and recommendations for wards in the service ranged from 80-100%
- The service provided emotional support to patients, information about support groups, and supported spiritual needs through a multi faith chaplaincy.

## Is the service responsive?

**Good** ➔

Our rating of responsive improved. We rated it as good because:

- The service took account of patients' individual needs and referral to treatment times had improved since our last visit. The trust employed specialist nurses to support the ward staff and wards had 'champions' who acted as additional resources to promote best practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- The last patient-led assessment of the care environment survey showed the trust scored 92.79% for dementia care, which was significantly better than the England average of 76% and 94.53% for care of people with disabilities against an average of 82%.

However:

- Average length of stay for medical elective patients at Maidstone was 5.2 days, which is worse than England average of 4.2 days.
- For medical non-elective patients, the average length of stay was 8.6 days, which was worse than the England average of 6.6 days and referral to treatment time for admitted pathways for Medicine has been consistently worse than the England average.

## Is the service well-led?

**Good** ➔➔

Our rating of well-led stayed the same. We rated it as good because:

- We saw examples of strong ward and department leadership. The trust had managers with the right skills and abilities to run a service providing high-quality sustainable care.
- We found that risk management and governance processes were embedded into the service.

# Medical care (including older people's care)

- Staff told us they felt well supported, valued and that that their opinions counted. At a local level, we saw that nurses in charge were clearly identified by the use of armbands, which helped ensure local leaders were visible to staff and visitors.
- There was a clear statement of vision and staff showed they understood this and how it translated to their work.
- There was a trust wide risk register for the directorate which encompassed risks, as well as a local level risk hazard log to document site level risks.

# Surgery

**Requires improvement** 

## Key facts and figures

Maidstone Hospital offers general and specialist surgical services including breast, limited gynaecological, oncology, ophthalmology, urology, gastro-intestinal, orthopaedics, pain management, vascular and ear, nose and throat surgery.

Maidstone Hospital provides pre-planned inpatient complex surgery and has a centre for specialist cancer services. The hospital has an Orthopaedic unit which contains a dedicated theatre and 12 beds for elective Orthopaedic activity. It also provides services to treat patients with urological emergencies.

The trust also provides cancer services at the Kent Oncology Centre, which has a base in Maidstone Hospital.

The hospital had a dedicated day surgery unit.

The hospital had three dedicated surgery recovery wards: one for men, one for women and one short stay surgical unit.

## Summary of this service

Our overall rating of this service stayed the same. We rated it as requires improvement because:

- The hospital improved in safety, effectiveness and leadership.
- Safeguarding training levels for nursing staff met or exceeded targets and staff demonstrated good knowledge of safeguarding principles.
- Records keeping systems had improved. Records we reviewed in the hospital were complete legible and organised.
- Patient pain levels were closely monitored, staff were proactive about pain management and patients reported good pain management.
- The trust exceeded its target for Mental Capacity Act (MCA) mandatory training, staff demonstrated a thorough understanding of the MCA and records reflected that capacity was being assessed in line with guidance and consent was gained prior to care being provided.
- Patients told us they felt they were treated with dignity and respect. They noted that staff were caring, genuine, friendly and kind.

## Is the service safe?

**Requires improvement** 

Our rating of safe stayed the same. We rated it as requires improvement because:

- Learning from incidents continued to be limited. Staff reported there had been improvement in the incident reporting culture and learning. We saw some learning from incidents was shared and there had been improvement in this area. However there was no unified method to ensure all relevant learning was shared with all staff. Staff did not know when incident reviews were competed and we saw little evidence of embedding learning from incidents. Staff and management could not be assured staff members had received learning or knew when there was new information.

# Surgery

- We saw holes in the theatres department hall walls and anaesthetic room doors which created an infection control risk.
- The theatre department had insufficient space to store equipment and supplies. Supplies were stored on shelves in the theatres hallway which limited the amount of stock which could be kept in the department.
- The department nursing staff did not meet its training target for five mandatory training modules including; basic life support, conflict resolution, information governance, moving and handling, medicine management and dementia awareness (the hospital was implementing new dementia training at the time of inspection).
- The department medical staff did not meet its training target for four mandatory training modules including; mental capacity act, safeguarding level 3 (one of three required staff had not completed the training), medicine management and dementia awareness (as above the hospital was implementing new dementia training at the time of inspection).
- Between July 2016 and June 2017, the hospital reported a vacancy rate of 11.6% in surgical care which was above their 8.5% target.
- A total of 1,919 shifts were covered by agency or bank staff; 77% covered by bank staff and 19% covered by agency. A total of 107 shifts were not covered between July 2016 and June 2017.
- Resuscitation trolleys in the department were not tamper evident which meant items could be taken from the trolley or tampered with without staff knowledge. We raised this issue with the trust. The trust reported that it reacted throughout the trust immediately and effectively to rectify the issue by putting tamper-evident security on resuscitation trolleys.

However:

- Safeguarding training levels for nursing staff met or exceeded targets and nursing staff demonstrated good knowledge of safeguarding principles.
- The hospital appeared clean and departments had met all cleaning audits except one, which was resolved the following month.
- We saw no holes in theatres walls and staff reported any damage to walls and doors in theatres was repaired as a matter of urgency.
- Hand hygiene audits results met targets. This showed improvement compared to the previous inspection.
- The service had improved their Legionella testing to ensure water at the hospital was free of the bacteria. This showed improvement compared to a previous inspection.
- The hospital had improved their use of the World Health Organisation Safer Surgery Checklist. We observed good practice during inspection and audits reflected improvement in the application of the checklist. This showed improvement compared to the previous inspection.
- Records we reviewed in the hospital were complete legible and organised. This showed improvement compared to the previous inspection.
- We saw throughout the wards and theatres medicines were stored securely and kept within their expiry dates.
- We saw patient risk assessments had improved; they were performed in accordance with policies and processes and used to manage patient care.
- The service was using the Patient At Risk Score System to evaluate and respond to patient deterioration.

# Surgery

## Is the service effective?

**Good** ↑

Our rating of effective improved. We rated it as good because:

- Staff provided food and drink to meet patient needs and improve their health. They used special feeding and hydration techniques as necessary and made adjustments for patient's religious cultural and other preferences.
- We saw patient pain levels were closely monitored, staff were proactive about pain management and patients reported that they had no pain or their pain was well controlled.
- Patient outcomes for national audits reflected the hospital generally performed within expected ranges.
- Most surgical patients had positive outcomes and experiences. Elective and non-elective surgical patients had a similar or lower risk or readmission than other patients when compared to the England average. The 2016 Hip Fracture Audit and 2015 Bowel Cancer audit reflected mortality rates (at 30 and 90 days respectively) in expected range. The 2015 Bowel Cancer audit reflected the hospital had a higher than expected two year post-operative mortality rate. Patient Reported Outcome Measures (PROMS) were better than the England average for hip replacements and average for knee replacements. The hospital received a green rating for all measures in the 2016 National Emergency Laparotomy Audit (the audit was based on one case).
- We saw evidence based care reflected in policies and guidelines. Staff were able to discuss the evidence base of care and we saw signs and posters in the pre assessment department and theatres break rooms reflecting the evidential basis for pre-assessment processes and care.
- Staff continued to report good support for learning and development in the preoperative department, theatre and wards.
- Staff and patients reported cohesive multidisciplinary care.
- The trust exceeded its target for Mental Capacity Act mandatory training, staff demonstrated a thorough understanding of the Mental Capacity Act and records reflected that capacity was being assessed and consent was gained prior to care being provided.

However:

- The appraisal completion rate of 81% was below the trust target of 90% and the trust average.
- National audits reflected some negative patient outcomes. The 2015 Hip Fracture Audit showed the proportion of patients having surgery on the day of or day after admission was worse than the national standard and the perioperative medical assessment rate of 98% was below the national standard of 100% (although it had improved from 94.6% the previous year). Patient Reported Outcome Measures (PROMS) for groin hernias were worse than the England average.

## Is the service caring?

**Good** →←

Our rating of caring stayed the same. We rated it as good because:

# Surgery

- Patients told us they felt they were treated with dignity and respect. They noted that staff were caring, genuine, friendly and kind. Patients also told us that staff made them feel 'safe' and well looked after. This was in line with earlier inspections.
- Patients generally stated that they received good communications about care which empowered them to make their own decisions. This was in line with earlier inspections.
- Staff understood the importance of patients' maintaining contact with their family and friends and enabled this.
- The Friends and Family Test response rates were higher than the England average.

## Is the service responsive?

**Requires improvement** 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The average length of stay for General Surgery medical elective and non-elective patients at the trust was higher than the England average.
- Cancelled operations as a percentage of elective admissions were higher (worse) than the England average and the percentage of patients not treated within 28 days was worse than average.
- The trust's referral to treatment time for admitted pathways for surgery was higher than the England average, although it fell in the last two reporting months.
- Pre-operative appointments were sometimes delayed or scheduled too close to the surgery date, which did not allow enough time to perform tests or treatments identified at the pre-operative appointment. This caused surgeries to be cancelled or delayed in some cases.
- Staff were not able to provide written information in other languages.
- There were long delays in responding to patient complaints. The target time for completing non-complex complaints was 25 days. No complaint file we reviewed met this target. We reviewed five non-complex complaint files; the response times for these matters were 55 to 183 days.

However:

- Patients and staff provided evidence that staff responded to the individual needs of patients living with dementia. This was not noted in previous inspections.
- Staff reported using translators for patients who needed translation service rather than relying on friends or family members. They were able to demonstrate how they could contact translators. This was better than when we previously inspected the hospital.
- The substance of responses to patient complaints had improved and those we reviewed addressed the underlying complaint in most instances.
- Responses to patient complaints reviewed addressed the underlying complaint in most instances. This was better than during previous inspections.

# Surgery

## Is the service well-led?

**Requires improvement** 

Our rating of well-led stayed the same. We rated it as requires improvement because:

- While the service showed improvement in its leadership since the last inspection, there was not consistent learning from complaints and incidents, there were no assurances around incident reporting, not all staff were able to identify risks or locate risk registers and staff reported a mixed culture and moral.
- Some non-management staff told us they did not feel executive team were visible, accessible or supportive.
- Some staff members were not able to identify the risks that affected their departments and did not know where to find their departmental or directorate risk registers.
- Staff we spoke to had mixed reviews of the culture and moral at the trust, some felt valued and supported, while some did not.

However:

- The trust had a vision for what it wanted to achieve and workable plans to turn it into action. This information was available to staff on their intranet. Staff had an understanding that a primary focus of the long term strategy was building to improve theatres capacity and the shorter term 2016-17 focus in theatres was staffing.
- There were clinical governance meeting at trust and directorate level. Staff members had an understanding of clinical governance issues and felt involved in clinical governance.
- The serious incident policy was comprehensive and provided detailed information. Senior departmental and trust wide staff worked together to manage risks at twice daily meetings and provide support within the hospital and to the Tunbridge Wells Hospital at Pembury.
- There were directorate and department risk registers where risks were held and managed.
- All staff we asked told us they felt their immediate supervisors were visible, accessible and supportive.

# Outstanding practice

- The trust promoted training, research and innovation which the staff took pride in.

# Areas for improvement

- The trust should implement systems to ensure that learning from incidents and complaints is shared and embedded.
- The trust should embed a system of prioritisation to ensure holes in theatres department walls and doors are addressed in a timely fashion to minimise infection risk.
- The trust should embed a system to ensure all staff in the departments meet mandatory training targets.
- The trust should take steps to ensure all shifts are staffed in line with staffing requirements.
- The trust should implement a system to respond to patient complaints in compliance with timelines set out in the trusts complaint policy.

# Critical care

Good ➔➔

## Key facts and figures

The intensive care unit intensive care unit at Maidstone Hospital provides care for the local population 24 hours a day, seven days a week.

Between 1 September 2016 and 20 September 2017, 538 patients were admitted to the unit.

There were nine beds spread over two wings, each with a bay and two side rooms.

## Summary of this service

Our overall rating of this service improved. We rated it as requires improvement because:

Since our last inspection in 2015, we saw a vast number of improvements in critical care.

- There was a good culture of incident reporting and learning, and all incidents were recorded on the trust wide electronic reporting system.
- Medicines were well managed.
- Patient outcomes were mostly in line with or better than other similar critical care units.
- Compliance with national guidelines had improved.
- Patients and relatives we spoke to gave positive feedback about the care they received on the unit.
- Staff showed compassion when dealing with patients.

However:

- The environment did not promote privacy and dignity for patients.
- It was not clear of all intensive care unit deaths were discussed at the morbidity and mortality meetings.
- Delayed discharges from the unit stayed an issue.

## Is the service safe?

Good ➔

Our rating of safe improved. We rated it as good because:

- There was a good incident reporting culture on the unit and all incidents were now recorded on the trust wide system. This was an improvement from the last inspection where some intensive care unit incidents were recorded on a separate system that was not part of the hospital.
- The service had systems that managed prescribing, administering, recording and storage of medicines well.
- Safeguarding training rates were better than the trust target amongst the nursing staff on the unit.

# Critical care

- Most staff had completed mandatory training. Out of 19 mandatory training modules, only three modules had a completion rate worse than the trust target which were conflict resolution, dementia awareness and safeguarding children level three.
- The unit followed the nursing staffing standards from the core standards of the Intensive Care Society and the British Association of Critical Care Nurses guidance for the staffing of critical care units.
- An outreach team was available 24 hours a day, seven days a week. This ensured that patients who were discharged from the unit had support on neighbouring wards.

However:

- Resuscitation trolleys on the unit were not tamper evident. Although some contained medicines in sealed boxes, these trolleys still contained IV fluids and infusions which were not tamper evident. However following the inspection, we saw that this had been rectified.
- From the minutes we reviewed, we did not see evidence that all deaths in the intensive care unit were discussed at the morbidity and mortality meetings.

## Is the service effective?

**Good** ↑

Our rating of effective improved. We rated it as good because:

- Risk adjusted hospital mortality rates for all patients (including low risk patients) was better than the national average.
- Patient outcomes were generally good, although the rates of readmission within 48 hours was worse than other similar units.
- Staff on the unit followed National Institute for Health and Care Excellence guidelines to ensure that best practice was followed for their patients.
- Staff had the right skills to fulfil their job role; 60% of nursing staff at the Maidstone Hospital had a post registration certificate in critical care, which was better than the Intensive Care Society standard.
- New members of staff had an induction when they arrived at the unit and were given a supernumerary period.

However:

Only 78% of staff had received an appraisal. This was worse than the trust target of 90%. Following the inspection, the trust told us that the trust appraisal cycle runs from April each year. This meant that at the time of the data submission, the trust would have only been half way through their appraisal cycle.

## Is the service caring?

**Good** →←

Our rating of caring stayed the same. We rated it as good because:

- The service provided emotional support to patients, information about support groups, and supported spiritual needs through a multi faith chaplaincy.

# Critical care

- Dedicated members of staff ran follow up clinics for patients discharged from the service. As part of this, they completed psychological assessments.
- We observed that staff cared for patients with care and compassion and relatives we spoke with told us that staff were kind and thoughtful.
- Staff in the unit had set up a memory keepsake service for relatives of patients who passed away on the unit. Relatives could choose a hand print, a hand cast or a lock of hair; all in presentation keep sake boxes, to take home with them.

However:

- The set up and environment of the unit made privacy and dignity for patients challenging.

## Is the service responsive?

**Requires improvement** 

Our rating of responsive improved. We rated it as requires improvement because:

- The number of patients with a delayed discharge of more than eight hours was worse than the national average.
- The number of patients with a delayed discharge of up to four hours ranged between 48% and 85%. This meant the majority of patients fit for discharge were kept waiting. However, the mean averages of these amounted to 60% of patients waiting to be discharged, which was an improvement from the previous inspection where 82% of patients were waiting.
- Bed occupancy rates trust-wide were worse than the England average.

However:

- Since our previous inspection, translation services were in use across the trust and staff were able to meet patients individual needs, such as having twiddle muffs available for patients with dementia
- There were no patients transferred from the intensive care unit for non-clinical reasons, which had improved from the previous inspection.
- There was support and information available for patients and relatives including detailed information on the website such as 'Intensive Care – A guide for patients and relatives'
- There were no complaints received by the unit throughout the inspection reporting period which had improved since the previous inspection.

## Is the service well-led?

**Good** 

Our rating of well-led improved. We rated it as good because:

- There was a statement of vision, both for the critical care directorate and the intensive care unit. This had improved from our last inspection where there was no vision in place.

# Critical care

- There was a trust wide risk register for the critical care directorate which encompassed intensive care unit risks, as well as a local level risk hazard log to document site level risks. The matron was aware of the risks to the service. This had improved from the last inspection where intensive care unit risks were not logged.
- At our previous inspection the outreach team worked seven days a week, with plans to increase this to 24 hours on hold due to budgetary constraints. At this inspection we saw that the outreach team was now available 24/7.
- The intensive care unit team was well motivated, enthusiastic and supported at a local leadership level.
- Previously one matron covered both intensive care units with a large remit; at this inspection we saw that there was one matron per site.

However:

- The strategy did not reference any plans for refurbishment or regeneration of the Maidstone intensive care unit site whose environment was not ideal.

## Outstanding practice

The Maidstone unit had set up a memory keepsake service for relatives of patients who passed away on the unit. Relatives could choose a hand print, a hand cast or a lock of hair, all in presentation keep sake boxes.

## Areas for improvement

- The trust should ensure that there is a standard operating procedure is put in place for children who may be treated on the unit.
- The trust should assess whether nursing staff require a higher level of safeguarding children training.
- The trust should ensure all patient deaths are discussed at morbidity and mortality meetings.
- The trust should ensure that overnight discharges are reduced.
- The trust should ensure that all staff have received an appraisal

# Services for children and young people

**Good** ↑

## Key facts and figures

The trust has 46 paediatric beds across two sites – Maidstone Hospital and Tunbridge Wells Hospital. In addition to the across two sites, the trust also provides paediatric outpatient services at both sites.

Maidstone and Tunbridge Wells NHS Trust also offers tertiary service paediatric orthopaedic and gastroenterology surgery for the whole of Kent and parts of Sussex.

The paediatric service at Maidstone hospital consists of Riverbank which has seven ambulatory care beds and six day case surgery beds. There are no overnight beds. There was an outpatient department within the unit and was for children only.

The trust had 4,222 spells between July 2016 and June 2017.

Emergency spells accounted for 77% (3,240 spells), 12% (510 spells) were day case spells, and

the remaining 11% (472 spells) were elective.

## Summary of this service

Our overall rating of this service improved. We rated it as good because:

- Staff recognised incidents and reported them. Managers investigated incidents and shared lessons learn with the paediatric directorate.
- There was comprehensive assessment of children, including a history of any past or current mental health problems alongside the assessment of their physical health needs. This included age-related pain assessments and children's pain levels were regularly assessed and acted upon.
- Children had individualised care pathways for their care and risk assessments were completed for all patients including National Paediatric Early Warning Scores in order to rapidly detect any child whose health was of deteriorating.
- Staff had training in the assessment and management of sepsis antibiotics were given in line with guidance. Reports on antimicrobial prescribing and sepsis management were escalated to the board through the trusts governance framework.
- Staff demonstrated an understanding of the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005, with regard to children over 16 years and the Children Acts 1989 and 2004.
- There was evidence of good multidisciplinary working both within the trust and with external stakeholders.
- The service was responsive to children, young people and their family's needs. They delivered personalised care and took into account needs and choices of different people.
- There was a children's strategy in place that staff we spoke to knew about and were committed to improving child health experiences and outcomes. There was a clear governance framework in place that was led by the chief nurse.
- Staff told us they were supported and felt valued; they thought highly of the matron who they said was very visible supportive and kept them well informed.

# Services for children and young people

However:

- Although it was evident that lessons learned in the children's services was shared within the directorate and practice changed as a result, it was less clear how learning was systematically identified, disseminated or audited across the trust.
- There were no safeguarding level 3 trained staff on adult wards where 16-18 year old patients were cared for.

## Is the service safe?

**Good** ↑

Our rating of safe improved. We rated it as good because:

- The trust had systems and processes in place to keep children safe and safeguarded from abuse and neglect.
- Staff recognised incidents and reported them. Managers investigated incidents and shared lessons learn with the whole team and wider service.
- Risk assessments were completed for all patients and they used the National Paediatric Early Warning Scores for all patients in order to rapidly detect any child whose health was of deteriorating.
- Staff followed and completed the paediatric World Health Organisation surgical safety checklist and five steps to safer surgery.
- The environment was visibly clean and staff adhered to the trust's infection control policies and processes. The theatre recovery area had dedicated paediatric bays that were screened off from adult's recovery.
- Medicines were prescribed, stored and administered to children in line with the relevant legislation and current national guidance.
- Medical records were multidisciplinary, complete by everyone associated with their care and kept securely.

However:

- Although it was evident that lessons learned in the children's services was shared within the directorate and practice changed as a result, it was less clear how learning was systematically identified, disseminated or audited across the trust.

## Is the service effective?

**Good** ↑

Our rating of effective improved. We rated it as good because:

- There was comprehensive assessment of children, including a history of any past or current mental health problems alongside the assessment of their physical health needs. The play therapists ran sessions with children with phobias that were affecting their life and or hospital experience.
- Children had age-related pain assessments and staff routinely assessed children's pain levels. Pain management was evidence-based and provided guidance on managing varying levels of pain including the use of sucrose, paracetamol and opiates.

# Services for children and young people

- Pre-operative starve times follow the two, four, six hour guidelines depending on the procedure and in accordance with national guidelines. Where children were delayed in going to theatre their hydration was addressed. Nutrition was also considered and sucrose was sometimes given to ensure sugar levels were maintained in preoperative patients to enable recovery.
- Quality and dignity audits were carried out six times a year. Essence of care audits, hand washing audits, and patient satisfaction audits were carried out. The service submitted data to a variety of national audits and developed action plans in response to results.
- Registered paediatric nurses cared for children. There were also 11 specialist nurses for specific conditions.
- All surgical patients admitted under a specialist surgeon were also seen by a paediatrician consultant.
- There was evidence of good multidisciplinary working both within the trust and with external stakeholders.

## Is the service caring?

**Good** ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated children and their carers with compassion, dignity and respect. Staff involved children and those close to them in their care. Children, young people and their families were given emotional support when needed.
- Staff gave us examples of going coming up with ideas to assist children who were nervous about procedures or coming in to hospital. They took into consideration children's favourite things and were innovative about making children feel safe.
- Children and their carers were very positive when they discussed the care they received. Staff sought feedback from children, young people and their families and made changes as a result of feedback.
- Staff involved parents in their children's care and parents told us they always felt involved.

## Is the service responsive?

**Good** ➔

Our rating of responsive improved. We rated it as good because:

- Riverbank ward had paediatric specific feedback forms for parents to complete or alternatively they could rate and review their child's care on line along with two types of forms for children to complete. All had a section where parents and children could comment on what was good and what could be done better. These were used to review services and make improvements
- The children's outpatient area had a dedicated waiting area, consulting and treatment rooms.
- Parents were able to visit at any time on the paediatric wards and translation services were available for patients and parents who did not speak English as their first language should this be required.
- A play therapist worked with children and ran sessions for children experiencing emotional difficulties.

# Services for children and young people

- Children were admitted for theatre in the morning for the morning list and at midday for the afternoon list. There were dedicated children's theatre lists but where children were scheduled on a mixed list they were prioritized to be first on the list.
- Children admitted to the unit with an acute medical problem were seen by a middle grade paediatrician within four hours of admission.
- General practitioners assessing or treating children with unscheduled care needs had access to immediate telephone advice from a consultant paediatrician. The service provided a consultant paediatrician-led rapid access service so that any child referred for this service could be seen within 24 hours of the referral being made.
- There was seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography, magnetic resonance imaging (MRI), echocardiography, endoscopy and pathology.

## Is the service well-led?

**Good** ↑↑

Our rating of well-led improved. We rated it as good because:

- There has been significant improvement in the children and young person's core service since the last inspection.
- The leadership team were strong, dynamic and encouraged staff development, innovation and managed change well.
- Leadership at local level was good. The leadership team were aware of the challenges children and young people services. There appeared an open and honest culture with staff prepared to say when things went wrong and what needed improving.
- There was a children's strategy in place and staff we spoke to new about and were committed to improving child health experiences and outcomes.
- Staff we spoke with told us they were supported and felt valued. They thought highly of the matron who they said was very visible supportive and kept them well informed. Staff we spoke to both on inspection and in focus groups were proud of the trust and how it had risen to the challenges they faced.
- Winter management plans included children and young people services with escalation policies and processes to provide more beds and staff as required.

# Outstanding practice

- The service used play specialists through the whole of the child's inpatient journey, from outpatient's right through to theatres applying distraction techniques.
- The matron had initiated and led on bringing together a children services matron's professional group across the region. The group was also used as supervision with peers and benchmarking how services could be improved in all areas.

# Areas for improvement

- The trust should ensure children admitted to adult wards are cared for by staff with level 3 safeguarding training.

# The Tunbridge Wells Hospital at Pembury

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Kent
TN2 4QJ
Tel: 08451551000

www.mtw.nhs.uk

## Key facts and figures

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

The Trust's core catchment areas are Maidstone and Tunbridge Wells and their surrounding boroughs, and it operates from two main clinical sites: Maidstone Hospital and Tunbridge Wells Hospital at Pembury. The latter is a Private Finance Initiative (PFI) hospital and provides wholly single bedded en-suite accommodation for in-patients.

The Trust employs a team of over 5000 full and part-time staff. In addition, the Trust provides specialist cancer services to around 1.8 million people across Kent, Hastings and Rother, via the Kent Oncology Centre, which is sited at Maidstone Hospital, and at Kent and Canterbury Hospital in Canterbury. The Trust also provides outpatient clinics across a wide range of locations in Kent and East Sussex.

## Summary of services at The Tunbridge Wells Hospital at Pembury

Our rating of these services stayed the same. We rated them as requires improvement.

A summary of services at this hospital appears in the overall summary above.

# Urgent and emergency services

**Requires improvement** 

## Key facts and figures

The emergency care centre at Maidstone Hospital includes a four-bedded resuscitation unit, a nine-bedded majors unit, a five-bedded minors unit and a rapid assessment point with five bed bays. A seating area is available in the majors unit and provides additional capacity for patients who do not need a trolley to be observed. A clinical decision unit is located in a dedicated room in the minors area with nurse cover and five comfortable chairs. The resuscitation unit has a dedicated paediatric bay. A rapid assessment point with three trolley bays and two chair bays provides additional capacity. A diagnostic radiology unit is available adjacent to the emergency care centre and a plaster room is located in the department.

A paediatric waiting area and two treatment rooms are located in the emergency care centre and staffed by a team of paediatric nurses.

A multidisciplinary team of emergency department doctors, nurses, emergency nurse practitioners, emergency department practitioners and clinical support workers provide care and treatment. The wider multidisciplinary team includes a high impact therapy team, extended scope physiotherapists and psychiatric liaison team.

At our last inspection we told the trust they must:

- Ensure security staff have the knowledge and skills to safely work with vulnerable patients and those with mental health needs

## Summary of this service

Our overall rating of this service stayed the same. We rated it as requires improvement because:

- Between October 2016 and September 2017 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Maidstone Hospital.
- Over the period an average of 42% of ambulance journeys had a turnaround time over 30 minutes.
- From August 2016 to July 2017 the trust reported 364 “black breaches”, with an upward trend over the period. A black breach occurs when a patient spends more than 60 minutes on an ambulance waiting to be seen in the emergency department.
- A significant backlog of incident investigations and limited evidence of learning from incidents meant we were not assured safety improved as a result.
- Triage processes were inconsistent and did not always keep people safe. In addition the results of triage records indicated a need for improved quality.
- Audits identified a need for improvement in the quality of patient records.
- There was very limited evidence of health promotion work or intervention despite a significant number of patients presenting with alcohol or drug overdoses, or with suicidal intent.

However:

# Urgent and emergency services

- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for all months over the 12 month period between September 2016 and August 2017 although this did not include patients who arrived by ambulance.
- The unit performed consistently well in the national patient-led assessment of the care environment (PLACE) and in weekly environmental audits. In the previous 12 months, the unit performed better than national and trust averages in all categories.
- From September 2016 to August 2017, the trust reported no incidents classified as never events for urgent and emergency care.
- The recruitment of practice development nurses had significantly improved the training and professional development opportunities for staff. This improved tracking and assessment of staff competencies and enabled individuals in different roles to work and develop together.
- There was a demonstrable track record of well-coordinated multidisciplinary working that contributed to patient outcomes.
- From January 2017 the trust showed a general trend of improvement in performance against Department of Health access and flow metrics, including the national standard to be seen, discharged or admitted within four hours.
- There were clear and demonstrable improvements in clinical governance and leadership, and this was reflected in the morale of staff and initiatives to improve performance and risk management.

## Is the service safe?

**Requires improvement** 

Our rating of safe stayed the same. We rated it as requires improvement because:

- There were very high usage rates for bank, agency and locum staff including in the paediatrics team. In addition, although staffing cover per shift, including consultant cover, met Royal College of Emergency Medicine standards, supernumerary staff were often relied on to take patients.
- A backlog of 400 incidents for emergency care had been entered onto the department's risk register with Maidstone Hospital and there was limited evidence staff in the department had capacity to address this. The incidents had not been fully investigated or closed, which meant the senior team had not yet identified learning from them.
- There was very limited evidence of health promotion work or intervention despite a significant number of patients presenting with alcohol or drug overdoses or with suicidal intent.
- Although infection control and environmental standards in the main department were consistently good, there were unresolved risks in the paediatric area. These included damaged flooring, dirty and dusty repairs and damaged fixtures.
- Documented checks on resuscitation equipment were inconsistent and did not always meet trust standards.
- Audits of patient notes indicated areas for improvement. However, records we saw during our inspection were of a high standard.
- There was limited evidence of learning and improvements to practice as a result of incident investigations.

However:

# Urgent and emergency services

- In the patient-led assessment of the care environment, the department scored better than the national average in all five categories.
- Maidstone Hospital had an 87% average mandatory training completion rate, which met the trust target of 85%.
- Where incidents had been investigated and closed, there were demonstrable learning and structured actions plans in place.

## Is the service effective?

**Requires improvement** 

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff did not always document pain scores for each patient and audits demonstrated wide variations in practice.
- The department did not meet any of the Royal College of Emergency Medicine standards for consultant sign-off in the latest audit. In the four audit criteria, the department performed at least 80% worse than the national average.
- Staff did not demonstrate consistent awareness of health promotion opportunities and did not always engage with initiatives launched by colleagues elsewhere in the hospital.

However:

- A practice development nurse had implemented a range of new training and development opportunities for staff. This represented a targeted improvement in increasing clinical competencies in the team.
- There were significant opportunities for staff to work as part of multidisciplinary teams in rotational posts and secondments and this had a demonstrably positive impact of skill mix and morale.
- Multidisciplinary working was embedded in the care and treatment provided. This included from a high impact therapy team and a psychiatric liaison team.
- Although 95% of staff had up to date Mental Capacity Act (2005) training, staff did not consistently complete mental capacity or consent assessments in patient records.

## Is the service caring?

**Good** 

Our rating of caring stayed the same. We rated it as good because:

- The trust performed better than the national average in the NHS Friends and Family Test, including a recommendation rating consistently above 90% between February 2017 and November 2017.
- The parents of children we spoke with said all staff had been kind and they would like to be more involved in understanding emergency care centre processes such as how referrals worked.
- The results of the Care Quality Commission, Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in all 24 questions relevant to caring.
- Staff took the time to involve patients in decisions about their care and worked to find alternatives when requested.

# Urgent and emergency services

## Is the service responsive?

**Requires improvement** ↑

Our rating of responsive stayed the same. We rated it as requires improvement because:

- From September 2016 to August 2017, the trust's unplanned re-attendance rate to accident and emergency within seven days was generally worse than the national standard of 5% and generally worse than the England average.
- From October 2016 to September 2017 the trust's monthly median total time in accident and emergency for all patients was consistently higher the England average.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in accident and emergency. Between October 2016 and September 2017 did not meet this target in any month. In this period results varied from 76% to 92%.
- Between October 2016 to September 2017 Maidstone and Tunbridge Wells NHS Trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average. However there was a trend of improvement during this period.

However:

- Systems had been implemented to improve access and flow such as a dedicated flow coordinator and discharge coordinator per shift. This contributed to a general improvement against Department of Health targets since January 2017.
- A new head of security had introduced behaviour contracts for patients who behaved violently towards staff.
- The emergency care centre team worked closely with community organisations to speed up discharges into rehabilitation and community beds.
- Staff aimed to meet individual needs during comfort rounds such as making sure a call bell was within reach and the patient had water. This meant staff met patient's holistic needs when they spent extended periods in the department.
- Tools and resources were available for patients with needs relating to dementia and learning disabilities.

## Is the service well-led?

**Good** ↑↑

Our rating of well-led improved. We rated it as good because:

- We saw evidence of embedded improvements in leadership.
- All of the staff we spoke with said the working culture was positive and enabled them to be confident in providing feedback and engaging with colleagues.
- Clinical governance systems had improved since our last inspection and we saw evidence meetings were held regularly with a wide range of staff.
- Although the use of the risk register was variable there was evidence in several areas that progress had been made to reduce risks.

# Urgent and emergency services

- There were significant improvements in the training and knowledge of the security team, who demonstrated how they reduced risks to patients who presented with aggression or escalating behaviour.
- Staff had contributed to the development of a vision and strategy for the department. This was clearly embedded in the work of the teams we spoke with and observed.

However:

- There was variable evidence the risk register was used effectively to mitigate all risks.

## Outstanding practice

- Opportunities for training and development including joining network training days, taking part in simulated exercises and engaging with emergency care nurses in other trusts as part of facilitated multidisciplinary learning events.

## Areas for improvement

- The service should ensure significant and sustained improvements in the quality of patient records, including in relation to: risk assessments; triage assessments and observations; documentation of patient outcomes at the triage stage; use of the early warning score tools; pain relief; overall compliance with trust standards

# Medical care (including older people's care)

**Good** ↑

## Key facts and figures

The medical care service at the trust provides care and treatment for Gastroenterology, Respiratory, Cardiology, Care of the Elderly (including stroke and transient ischaemic attack) and Diabetes & Endocrinology, as well as offering some services within the community. There is a Cardiac Catheter Laboratory focused on Electrophysiology studies, ablation and devices. There is a full cardio respiratory and respiratory physiology support service on both sites offering diagnostic procedures. Across both sites, there are 236 medical inpatient beds located within 13 wards.

## Summary of this service

Our overall rating of this service improved. We rated it as good because:

- Since our last inspection in 2015, we saw a number of changes.
- There was an improved culture of incident reporting. Incidents were recorded on electronic systems that incorporated fail-safes about aspects such as duty of candour.
- Patients and relatives we spoke with gave positive feedback about the care they received on the unit.
- Staff showed compassion when dealing with patients and protected their privacy and dignity.

However:

- Although medicines were better managed and more available, some aspects of medicines management still needed improvement.

## Is the service safe?

**Good** ↑

Our rating of safe improved since our last inspection. We rated it as good because:

- We found that concerns identified at the previous inspection about managing patients colonised with meticillin-resistant staphylococcus aureus medicine storage, competency checks for agency nurses, confidential medical records storage and handovers between doctors had been addressed.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it. The overall training completion rate exceeded the trust target and the service effectively used the newly upgraded electronic learning management system to enhance support to managers and staff.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The trust had systems and processes in place to help staff identify and report concerns to protect their patients. Training completion rates for Maidstone were better than trust targets.
- All of the areas we inspected were visibly clean, tidy and free from clutter. The service controlled infection risks well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service maintained suitable premises and sufficient equipment to support safe care and treatment.

# Medical care (including older people's care)

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. We noted high rates of bank and agency staff usage, but the trust had sufficient controls in pace to manage risk.
- There was an improved culture of incident reporting. Incidents were recorded on electronic systems that incorporated fail-safes about aspects such as duty of candour.
- We found a positive focus on safety and the service was transparent about the levels of harm-free care achieved, with the prevalence rate of indicators such as pressure ulcers and catheter acquired urinary tract infections declining over the last year.

However:

- While aspects of medicines management had improved since our last inspection, we still observed instances where pharmacy stock was out of date or not stored in accordance within specified temperature ranges. Opening dates were not always on liquid medicines to ensure they were used within specified expiry dates.
- We acknowledge that the trust reacted immediately and effectively to rectify an issue we identified with tamper-evident security on resuscitation trolley.

## Is the service effective?

**Good** ↑

Our rating of effective improved. We rated it as good because:

- We found a service that provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. New and updated guidance was evaluated and shared with staff.
- Patients at Maidstone Hospital had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- Other outcome measures were in line with national averages. The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the Maidstone Hospital achieved grade A in latest audit.
- The trust had recruitment policies and procedures together with job descriptions to help ensure staff were experienced, qualified, competent and suitable for their post. All new permanent and temporary employees undertook trust and local induction with additional support and training when required.
- Medical services at Maidstone achieved 94% appraisal rates, which were higher than other parts of the hospital and better than trust targets.
- At meetings, we observed positive and proactive engagement between all members of the multidisciplinary team.
- Since our last visit, the trust had introduced and successfully implemented a number of new electronic systems that improved effectiveness.

However,

- Deprivation of liberty training rates has not been provided by the trust. We acknowledge that the service achieved 98% for Mental Capacity Act training within Medicine.

# Medical care (including older people's care)

## Is the service caring?

**Good** ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness and we saw that patient privacy and dignity was maintained at all times.
- The Friends and Family Test response rate for Medicine was better than the England average and recommendations for wards in the service ranged from 80-100%
- The service provided emotional support to patients, information about support groups, and supported spiritual needs through a multi faith chaplaincy.

## Is the service responsive?

**Good** ↑

Our rating of responsive improved. We rated it as good because:

- The service took account of patients' individual needs and referral to treatment times had improved since our last visit. The trust employed specialist nurses to support the ward staff and wards had 'champions' who acted as additional resources to promote best practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- The last patient-led assessment of the care environment survey showed the trust scored 92.79% for dementia care, which was significantly better than the England average of 76% and 94.53% for care of people with disabilities against an average of 82%.

However:

- Average length of stay for medical elective patients at Maidstone was 5.2 days, which is worse than England average of 4.2 days.
- For medical non-elective patients, the average length of stay was 8.6 days, which was worse than the England average of 6.6 days and referral to treatment time for admitted pathways for Medicine has been consistently worse than the England average.

## Is the service well-led?

**Good** ➔➔

Our rating of well-led stayed the same. We rated it as good because:

- We saw examples of strong ward and department leadership. The trust had managers with the right skills and abilities to run a service providing high-quality sustainable care.
- We found that risk management and governance processes were embedded into the service.

# Medical care (including older people's care)

- Staff told us they felt well supported, valued and that that their opinions counted. At a local level, we saw that nurses in charge were clearly identified by the use of armbands, which helped ensure local leaders were visible to staff and visitors.
- There was a clear statement of vision and staff showed they understood this and how it translated to their work.
- There was a trust wide risk register for the directorate which encompassed risks, as well as a local level risk hazard log to document site level risks.

# Surgery

**Requires improvement** 

## Key facts and figures

Tunbridge Wells NHS Hospital offers general and specialist surgical services breast, gynaecological, oncology, ophthalmology, urology, gastro-intestinal, orthopaedics, pain management, vascular and ear, nose and throat surgery

Tunbridge Wells Hospital has a dedicated trauma unit for emergency surgery, including emergency theatres, CT and X-ray machines, and en-suite patient rooms. The unit has with strong links to a local regional trauma centre.

The hospital also an Orthopaedic Unit to provide 11 dedicated elective beds for more complicated cases.

The hospital has a dedicated day surgery unit.

The hospital had three dedicated surgery recovery wards including the Short Stay Surgery Unit which was escalated to care for longer term patients at the time of inspection.

## Summary of this service

Our overall rating of this service stayed the same. We rated it as requires improvement because:

- While the service improved in some areas, it stayed the same or became worse in others.
- The escalated short stay surgery unit created risks to patient safety and dignity.
- The hospital had had two never events during the reporting period and one additional never event in the week before this inspection.
- Learning from incidents had not significantly improved since the prior inspection. Information about learning was not always complete and there was not a system to ensure learning was shared with staff.
- Capacity to manage the number of patients being admitted led to significant shortfalls in the responsiveness of the service. This issue was identified at the previous inspection and continued to require improvement.
- Some senior staff did not reflect an understanding of the risks in their departments.
- Significant challenges to recruiting caused gaps in rota coverage and high reliance on bank and agency staff. This issue was identified at the previous inspection and continued to require improvement.
- Resuscitation trolleys in the department were not tamper evident which meant items could be taken from the trolley or tampered with without staff knowledge. We raised this issue with the trust. The trust reported that it reacted throughout the trust immediately and effectively to rectify the issue by putting tamper-evident security on resuscitation trolleys.

However:

- The hospital had improved its supplication of World Health Organisation Safer Surgery Checklists. This was an improvement since our last inspection.
- The department had improved staff retention.

# Surgery

## Is the service safe?

**Requires improvement** 

Our rating of safe stayed the same. We rated it as requires improvement because:

- The Surgical Short Stay Unit had been escalated to provide capacity for overnight care to surgical, medical and orthopaedic patients on one unit. The ward was not designed for patients to stay more than 23 hours, but patients were staying on the ward for several days at a time.
- Staff were not able to identify one admission policy for patients on the escalated surgical short stay unit. The trust's Escalation of Bay/ Recovery Guidelines stated, 'infectious patients, patients with dementia and patients requiring a hoist or PAR scoring 4' should not be allocated to this area. Staff told us in some cases they had to 'push back' to keep these patients off the ward.
- The open ward where patients were separated by paper curtains that were often open, did not protect patients from the spread of infectious diseases.
- As the day surgery ward had been escalated, the department no longer had a fixed recovery ward for day patients. Staff 'borrowed' space from other departments.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance. The hospital had had two never events early in the reporting period and one additional never event in the week before this inspection.
- Between July 2016 and June 2017, the hospital reported a vacancy rate of 26.6% in surgical care which was significantly above the 8.5% target.
- A total of 10,360 shifts were covered by bank or agency staff; 68% covered by bank staff and 26% covered by agency. A total of 941 shifts (9%) were not covered.
- The location did not achieve its mandatory training target for five mandatory training modules.

However:

- We observed staff preforming the World Health Organisation Checklist in theatres during our inspection. We saw they applied the checklist correctly. Audits across all theatres, excluding endoscopy, at both sites from April through October 2017 showed staff complied with the World Health Organisation Safer Surgery Checklist in 98% to 100% of audits. This showed theatre staff were completing the World Health Organisation Safer Surgery Checklist and the trust exceeded its target of 90% compliance. This was an improvement since our last inspection.
- Tunbridge Wells Hospital had an 85.8% mandatory training completion rate, thus it met its overall target, although the target was not met for all individual training modules. This showed improvement compared to the previous inspection.
- Hand hygiene audits across the theatre departments and wards showed good hand hygiene. This showed improvement compared to the previous inspection.
- Cleaning audit results reflected all surgical departments and wards met the trust target of 90% or higher for the six months prior to inspection and surgical theatres and wards we observed appeared clean. This showed improvement compared to the previous inspection.
- There was a system for managing the threat of Legionella, a waterborne bacteria. This was an improvement on a previous inspection.

# Surgery

- The hospital turnover rate was 1%, this was much better than the trust target of 10.5%.
- We saw throughout the wards and theatres medicines were stored securely and kept within their expiry dates.

## Is the service effective?

**Requires improvement** 

Our rating of effective stayed the same. We rated it as requires improvement because:

- We saw patients were often starved for longer periods than clinically necessary due to delays and communication failures this was reflected in incident reports and discussions with staff and patients. This issue was identified at the previous inspection and continued to require improvement.
- On the surgical short stay unit, we saw that patients' pain was regularly not managed quickly and proactively. Some patients we spoke to told us their pain was managed well and some told us their pain was not managed well. We saw pain observations were not always taken or recorded by staff. There were delays in administering pain medicines and escalating pain concerns to anaesthetists or consultants. We saw one example where a patient rated their pain eight to ten form more than 48 hours before the issue was escalated for review. This was worse than during our previous inspection.
- National audits reflected some negative patient outcomes. The 2015 Hip Fracture Audit showed the proportion of patients having surgery on the day of or day after admission was worse than the national standard and the perioperative medical assessment rate of 98% was below the national standard of 100% (although it had improved from 94.6% the previous year). Patient Reported Outcome Measures (PROMS) for groin hernias were worse than the England average. The hospital received an amber rating for some measures in the 2016 National Emergency Laparotomy Audit.
- The appraisal completion rate was 76% this was below the trust target of 90% and the trust average.
- Staff on some wards told us they did not have time to attend training.

However:

- Staff provided food and drink to meet patient needs and improve their health. They used special feeding and hydration techniques as necessary and made adjustments for patients with religious, cultural and other preferences.
- Most surgical patients had positive outcomes and experiences. Elective and non-elective surgical patients had a similar or lower risk or readmission than other patients when compared to the England average. The 2016 Hip Fracture Audit and 2015 Bowel Cancer audit reflected mortality rates (at 30 and 90 days respectively) in expected range. The 2015 Bowel Cancer audit reflected the hospital had a higher than expected two year post-operative mortality rate. Patient Reported Outcome Measures (PROMS) were better than the England average for hip replacements and average for knee replacements. The hospital received a green rating for some measures in the 2016 National Emergency Laparotomy Audit.
- We saw that the provider used evidence based guidance to assess and care for patients. For instance, we saw the trust policies were evidence based and cited evidence based guidelines. This was in line with previous inspections.
- Pre-operative department staff demonstrated how they used guidance and internal data to identify risks and areas for improvement. This was in line with previous inspections.
- All patients at The Tunbridge Wells Hospital had a lower expected risk of readmission for elective admissions when compared to the England average. This was better than at the last inspection.

# Surgery

- We saw good multidisciplinary work generally across the hospital. This was in line with previous inspections.
- The trust exceeded its target for Mental Capacity Act mandatory training. Staff demonstrated a thorough understanding of the Mental Capacity Act and records reflected that capacity was assessed and consent was gained prior to care. This was better than at the last inspection.

## Is the service caring?

**Good** ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Patients told us they felt they were treated with dignity and respect. They noted that staff were caring, genuine, friendly and kind. This was in line with earlier inspections.
- Patients generally stated that they received good communications about care which empowered them to make their own decisions. This was in line with earlier inspections.
- Staff understood the importance of patients' maintaining contact with their family and friends we saw this exemplified when they leant out their own phone chargers and facilitated communications with family who could not be at the hospital.

However:

- The Family and Friends Test response rates of 19% fell to below the national average of 29%.
- Privacy and dignity were not respected in the Short Stay Surgical Unit when patients were placed on mixed sex wards and patients could not have private conversations with staff due to the environment. In October 2017, eight mixed sex breaches were reported.

## Is the service responsive?

**Requires improvement** ➔➔

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Capacity to manage the number of patients being admitted led to significant shortfalls in the responsiveness of the service.
- The average length of stay for General Surgery medical elective and non-elective patients at the trust was higher than the England average.
- Cancelled operations as a percentage of elective admissions were higher than the England average.
- The trust's referral to treatment time for admitted pathways for surgery was higher than the England average, although it fell in the last two reporting months.
- Pre-operative appointments were sometimes delayed or scheduled too close to the surgery date, which did not allow enough time to perform tests or treatments identified at the pre-operative appointment. This caused surgeries to be cancelled or delayed in some cases.

# Surgery

- We saw surgeries were often delayed. Patients were not provided any information about the reason for or length of the delay and fasting times were not modified. As a result we saw several instances where patients fasted and were without hydration for much longer than clinically necessary. This was highlighted at the previous inspection but was still an issue.
- Patient discharges were delayed by discharge paperwork delays. As a result, patients remained in beds when it was not clinically necessary.
- Due to the escalation of the surgical short stay unit to a ward, there was no fixed recovery area for day case patients. The lack of space meant that same day surgeries had to be cancelled or put 'on hold' until it was clear whether there would be space for the patients.
- Staff were not able to provide written information in other languages.
- There were long delays in responding to patient complaints. The target time for completing non-complex complaints was 25 days. No complaint file we reviewed met this target. We reviewed five non-complex complaint files and the response times for these matters were 55 to 183 days.

However:

- Patients and staff provided evidence that staff responded to the individual needs of patients living with dementia. This was not noted in previous inspections.
- Staff reported using translators for patients who needed translation service rather than relying on friends or family members. They were able to demonstrate how they could contact translators. This was better than when we previously inspected the hospital.
- The percentage of cancelled operations at the trust has generally been below the England average. This was better than during previous inspections.
- Responses to patient complaints reviewed addressed the underlying complaint in most instances. This was better than during previous inspections.

## Is the service well-led?

**Requires improvement** 

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Staff did not have a clear understanding of a vision or strategy for the department. We had seen the same issue at previous inspections.
- Some non-management staff told us they did not feel senior management were visible, accessible or supportive.
- Some staff members, including at a more senior level, were not able to identify the risks that effected their departments.
- The department had had three never events which reflected a lack of risk management. There was a six day delay in declaring one never event.
- There was a two week delay in declaring one serious incident.
- In two of four root cause analysis we saw the root cause analysis tool was not used in line with best practice. Final reports were not shared with patients or family. This was not in line with the trust policy.

# Surgery

- There were delays to declare incidents and one never event.
- Staff we spoke to had mixed reviews of the culture and morale at the trust. Some staff members told us they felt the morale on the Surgical Short Stay Surgical Unit was poor due to complex demands on staff and continued escalation of the department.

However:

- The trust had a vision for what it wanted to achieve and workable plans to turn it into action. This information was available to staff on their intranet.
- There were clinical governance meeting at trust and department level. Some staff members had an understanding of clinical governance issues and felt involved in clinical governance.
- The Serious Incident Policy was robust and comprehensive.
- Senior departmental and trust wide staff worked together to manage risks at twice daily meetings and provide support within the hospital and to the Tunbridge Wells Hospital at Pembury.
- There were directorate and department risk registers where risks were held and managed.
- All staff we asked told us they felt their immediate supervisors were visible, accessible and supportive.

## Outstanding practice

- The trust promoted training, research and innovation which the staff took pride in.

## Areas for improvement

- The trust should implement systems to ensure that learning from incidents and complaints is shared and imbedded.
- The hospital should put a system and policy in place to ensure only clinically suitable patients were cared for on the escalated short stay surgical unit.
- The hospital should put a system in place to ensure all patients on the short stay surgical unit, including medical patients, have regular access to consultant care and consultants respond to requests for care on that ward.
- The hospital should take steps to ensure all shifts are staffed in line with staffing requirements.
- The hospital should embed a system to ensure the departments meet mandatory training targets.
- The hospital should work to retain and recruit staff members to address the vacancy rate of 26.6%, more than three times the hospital's target.
- The hospital should ensure patient starvation times are not longer than clinically necessary, and actively manage starvation times when there are delays.
- The hospital should implement systems to ensure patient's pain is pro-actively assessed and treated.
- The hospital should put a system in place to address paperwork issues which delay discharge.
- The trust should implement a system to respond to patient complaints in compliance with timelines set out in the trusts complaint policy.

# Critical care

**Requires improvement**  

## Key facts and figures

The intensive care unit at Tunbridge Wells Hospital provides care for the local population 24 hours a day, seven days a week. The unit is purpose built and houses seven intensive care beds in individual rooms.

The unit is staffed to provide level three care for up to seven patients.

Between 1 September 2016 and 30 September 2017, 542 patients were admitted to the intensive care unit.

## Summary of this service

Our overall rating of this service improved. We rated it as requires improvement because:

Since our last inspection in 2015, we saw a vast number of improvements in critical care.

- There was a good culture of incident reporting and learning, and all incidents were recorded on the trust wide electronic reporting system.
- Medicines were well managed.
- Patient outcomes were mostly in line with or better than other similar critical care units.
- Compliance with national guidelines had improved.
- Patients and relatives we spoke to gave positive feedback about the care they received on the unit.
- Staff showed compassion when dealing with patients and protected their privacy and dignity.

However:

- It was not clear if all intensive care unit deaths were discussed at the morbidity and mortality meetings.
- Delayed discharges from the unit remained an issue.

## Is the service safe?

**Good**  

Our rating of safe improved. We rated it as good because:

- There was a good incident reporting culture on the unit and all incidents were now recorded on the trust wide system. This was an improvement from the last inspection where some intensive care unit incidents were recorded on a separate system that was not part of the hospital.
- The service had systems that managed prescribing, administering, recording and storage of medicines well.
- Safeguarding training rates were better than the trust target amongst the nursing staff on the unit.
- Most staff had completed mandatory training. Out of 19 mandatory training modules, only three modules had a completion rate worse than the trust target which were conflict resolution, dementia awareness and safeguarding children level three.

# Critical care

- The unit followed the nursing staffing standards from the core standards of the Intensive Care Society and the British Association of Critical Care Nurses guidance for the staffing of critical care units.
- An outreach team was available 24 hours a day, seven days a week. This ensured that patients who were discharged from the unit had support on neighbouring wards.

However:

- Resuscitation trolleys on the unit were not tamper evident. Although some contained medicines in sealed boxes, these trolleys still contained intravenous fluids and infusions which were not tamper evident. However following our inspection, we saw that this had been rectified.
- From the minutes we reviewed, we did not see evidence that all deaths in the intensive care unit were discussed at the morbidity and mortality meetings.
- Cleaning and equipment checklists were occasionally not documented, although the unit appeared clean.

## Is the service effective?

**Requires improvement** 

Our rating of effective stayed the same. We rated it as requires improvement because:

- Only 28% of staff had received an appraisal. This was much worse than the trust target of 90%.
- Whilst the figures for discharging patients overnight had improved since our last inspection, the rates were still high.

However:

- The hospital monitored the effectiveness of care and treatment through continuous local and national audits.
- Patient outcomes were good. Risk adjusted hospital mortality rates for all patients (including low risk patients) was better than the national average and the rate for patients being readmitted to the intensive care unit within 48 hours was 0%, which was better than other similar units.
- Staff were competent to fulfil their role; 51% of nursing staff at the Tunbridge Wells site had completed a post registration critical care qualification. This was better than the Intensive Care Society Standard of 50%.

## Is the service caring?

**Good** 

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion, and upheld their privacy and dignity at all times.
- The service provided emotional support to patients, information about support groups, and supported spiritual needs through a multi faith chaplaincy.
- Dedicated members of staff ran follow up clinics for patients discharged from the service. As part of this they completed psychological assessments.

# Critical care

## Is the service responsive?

**Requires improvement**  

Our rating of responsive improved. We rated it as requires improvement because:

- Bed occupancy at the trust was worse than the England average.
- The number of patients with a delayed discharge of more than eight hours was worse than the national average.
- The number of patients with a delayed discharge of up to four hours ranged between 48% and 75%, which meant that patients were kept waiting when medically fit for discharge to a medical ward. However, the mean averages of these amounted to 61% of patients waiting to be discharged, which was an improvement from the previous inspection where 82% of patients were waiting.

However:

- Since our previous inspection, translation services were in use across the trust.
- There were no patients transferred from the intensive care unit for non-clinical reasons which had improved since our last inspection. There was support and information available for patients and relatives including detailed information on the website such as 'Intensive Care – A guide for patients and relatives'
- No complaints were received by the unit during the reporting period which had improved since the previous inspection.

## Is the service well-led?

**Good**  

Our rating of well-led improved. We rated it as good because:

- There was a statement of vision, both for the critical care directorate and the intensive care unit. This had improved from our last inspection where there was no vision in place.
- There was a trust wide risk register for the critical care directorate which encompassed intensive care unit risks, as well as a local level risk hazard log to document site level risks. The matron was aware of the risks to the service. This had improved from the last inspection where intensive care unit risks were not logged.
- At our previous inspection the outreach team worked seven days a week, with plans to increase this to 24 hours on hold due to budgetary constraints. At this inspection we saw that the outreach team was now available 24/7.
- The intensive care unit team was well motivated, enthusiastic and supported at a local leadership level.
- Previously one matron covered both intensive care units with a large remit; at this inspection we saw there was one matron per site.

# Areas for improvement

- Provider should ensure all patients are discussed at morbidity and mortality meetings.
- Provider should ensure that overnight discharges are reduced.

# Critical care

- Provider should ensure that all staff have received an appraisal.

# Services for children and young people

**Good** ↑

## Key facts and figures

The trust has 46 paediatric beds across two sites – Maidstone Hospital and Tunbridge Wells Hospital. In addition to the across two sites, the trust also provides paediatric outpatient services at both sites.

Maidstone and Tunbridge Wells NHS Trust also offers tertiary service paediatric orthopaedic surgery for the whole of Kent and parts of Sussex.

The Tunbridge Wells hospital at Pembury has two wards. Hedgehog ward that has 23 inpatient single rooms and Woodland that has an ambulatory care unit and day case beds. There is also a neonatal unit which has 18 beds and provides level 2 unit care.

The trust had 4,222 spells between July 2016 and June 2017.

Emergency spells accounted for 77% (3,240 spells), 12% (510 spells) were day case spells, and the remaining 11% (472 spells) were elective.

## Summary of this service

Our overall rating of this service improved. We rated it as good because:

- Staff recognised incidents and reported them. Managers investigated incidents and shared lessons learn with the paediatric directorate.
- There was comprehensive assessment of children, including a history of any past or current mental health problems alongside the assessment of their physical health needs. This included age-related pain assessments and children's pain levels were regularly assessed and acted upon.
- Children had individualised care pathways for their care and risk assessments were completed for all patients including National Paediatric Early Warning Scores in order to rapidly detect any child whose health was of deteriorating.
- Staff had training in the assessment and management of sepsis antibiotics were given in line with guidance. Reports on antimicrobial prescribing and sepsis management were escalated to the board through the trusts governance framework.
- Staff demonstrated an understanding of the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005, with regard to children over 16 years and the Children Acts 1989 and 2004.
- There was evidence of good multidisciplinary working both within the trust and with external stakeholders.
- The service was responsive to children, young people and their family's needs. They delivered personalised care and took into account needs and choices of different people.
- There was a children's strategy in place that staff we spoke to knew about and were committed to improving child health experiences and outcomes. There was a clear governance framework in place that was led by the chief nurse.
- Staff told us they were supported and felt valued; they thought highly of the matron who they said was very visible supportive and kept them well informed.

# Services for children and young people

However:

- Although it was evident that lessons learned in the children's services was shared within the directorate and practice changed as a result, it was less clear how learning was systematically identified, disseminated or audited across the trust.
- There were no safeguarding level 3 trained staff on adult wards where 16-18 year old patients were cared for.

## Is the service safe?

**Good** ↑

Our rating of safe improved. We rated it as good because:

- The trust had systems and processes in place to keep children safe and safeguarded from abuse and neglect.
- Staff recognised incidents and reported them. Managers investigated incidents and shared lessons learn with the whole team and wider service.
- Risk assessments were completed for all patients and they used the National Paediatric Early Warning Scores for all patients in order to rapidly detect any child whose health was of deteriorating.
- Staff followed and completed the paediatric World Health Organisation surgical safety checklist and five steps to safer surgery.
- The environment was visibly clean and staff adhered to the trust's infection control policies and processes. The theatre recovery area had dedicated paediatric bays that were screened off from adult's recovery.
- Medicines were prescribed, stored and administered to children in line with the relevant legislation and current national guidance.
- Medical records were multidisciplinary, complete by everyone associated with their care and kept securely.

However:

- Although it was evident that lessons learned in the children's services was shared within the directorate and practice changed as a result, it was less clear how learning was systematically identified, disseminated or audited across the trust.

## Is the service effective?

**Good** ↑

Our rating of effective improved. We rated it as good because:

- There was comprehensive assessment of children, including a history of any past or current mental health problems alongside the assessment of their physical health needs. The play therapists ran sessions with children with phobias that were affecting their life and or hospital experience.
- Children had age-related pain assessments and staff routinely assessed children's pain levels. Pain management was evidence-based and provided guidance on managing varying levels of pain including the use of sucrose, paracetamol and opiates.

# Services for children and young people

- Pre-operative starve times followed the two, four and six hour guidelines depending on the procedure and in accordance with national guidelines. Where children were delayed in going to theatre their hydration was addressed. Nutrition was also considered and sucrose was sometimes given to ensure sugar levels were maintained in preoperative patients to enable recovery.
- Quality and dignity audits were carried out six times a year. Essence of care audits, hand washing audits, and patient satisfaction audits were carried out. The service submitted data to a variety of national audits and developed action plans in response to results.
- Registered paediatric nurses cared for children. There were also 11 specialist nurses for specific conditions.
- All surgical patients admitted under a specialist surgeon were also seen by a paediatrician consultant.
- There was evidence of good multidisciplinary working both within the trust and with external stakeholders.
- There had been a large increase of children admitted under the Mental Health Act 1983 at the Hedgehog ward at Pembury Tunbridge Wells as a place of safety for patients sectioned and awaiting tier 4 placements in paediatric mental health units. However, there were no formal section 136 'place of safety' facilities outside the Mental Health section 136 suites and the trust was not commissioned to provide place of safety beds. Registered mental health nurses nursed all children admitted under the Mental Health Act 1983.

## Is the service caring?

**Good** ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated children and their carers with compassion, dignity and respect. Staff involved children and those close to them in their care. Children, young people and their families were given emotional support when needed.
- Children and their carers were very positive when they discussed the care they received. Staff sought feedback from children, young people and their families and made changes as a result of feedback.
- Staff involved parents in their children's care and parents told us they always felt involved.
- Parents and carers were provided with a range of emotional support, when they had experienced the loss of a baby or child. Specialist staff worked with parents and carers during that difficult period and continued to provide support for some time afterward.

## Is the service responsive?

**Good** ➔

Our rating of responsive improved. We rated it as good because:

- Accommodation for children requiring day-case surgery or in patent care was in single rooms with en-suite bathrooms. Hedgehog ward had 23 individual patient rooms, indoor and outdoor play areas were available for children.
- The Woodlands Unit had a five bedded assessment unit and a 10 bed day-case single rooms an there was an escalation policy to convert day case rooms to overnight stay if required.

# Services for children and young people

- There was accommodation available for parents whose babies were admitted to the neonatal unit within the unit enabling mothers to be close by and to assist in the care of their baby.
- The children's outpatient was a dedicated paediatric outpatient department on the same floor as the inpatient ward.
- General practitioners assessing or treating children with unscheduled care needs had access to immediate telephone advice from a consultant paediatrician.
- There was seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography, magnetic resonance imaging, echocardiography, endoscopy and pathology.
- Transition of older children to adult care the service was consistent with the "ready steady go programme".

## Is the service well-led?

**Good** ↑

Our rating of well-led improved. We rated it as good because:

- There has been significant improvement in the children and young person's core service since the last inspection.
- Leadership at local level was good. The leadership team were aware of the challenges children and young people services. There appeared an open and honest culture with staff prepared to say when things went wrong and what needed improving.
- There was a children's strategy in place and staff we spoke with knew about it and were committed to improving child health experiences and outcomes.
- Staff we spoke with told us they were supported and felt valued. They thought highly of the matron who they said was very visible supportive and kept them well informed. Staff we spoke to on inspection and in focus groups were proud of the trust and how it had risen to the challenges they faced.
- Winter management plans included children and young people services with escalation policies and processes to provide more beds and staff as required.

# Outstanding practice

- The service used play specialists through the whole of the child's inpatient journey, from outpatient's right through to theatres applying distraction techniques.
- The matron had initiated and led on bringing together a children services matron's professional group across the region. The group was also used as supervision with peers and benchmarking how services could be improved in all areas.

# Areas for improvement

- Children admitted to adult wards should be cared for by staff with level 3 safeguarding training.

# Our inspection team

Elaine Biddle, CQC inspection manager, led the core service inspections. Louise Thatcher, CQC inspection manager led the well led inspection, which was overseen by Catherine Campbell, Head of Hospital Inspection.

The team included six inspectors and nine specialist advisers.

Specialist advisers are experts in their field who we do not directly employ.

# Appendix 2

MTW 2018 Quality Improvement Tracker

| KLOE Domain | KLOE Ref. | CQC Inspection Cycle | MD/SD/ND Ref. | Site | Description of MD/SD/ND from 2018 CQC Report/ From Trust QIP Action plan | KHLOE Code | KLOE/Prompt | Narrative from CQC | Actions required in for the Trust to evidence compliance | Evidence required prove compliance | Confirmed /Obtained Evidence Summary (including KPIs) | Link to evidence | Owner/ Lead | Action Timeline | BAU Review Date | RAG Rating | RAG Rating Comments | 2018 rating self assessment | Stretch expectations - KLOE Outstanding criteria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Safe 2018 Rating: Requires Improvement** | | | | | | | | | | | | | | | | | | | |
| Safe | S3 | 2017/18 | SD1 | Maidstone and Tunbridge Wells | URGENT AND EMERGENCY SERVICES :The service should ensure significant and sustained improvements in the quality of patient records, including in relation to: risk assessments; triage assessments and observations; documentation of patient outcomes at the triage stage; use of the early warning score tools; pain relief; overall compliance with trust standards | S3.1 | Are people's individual care records, including clinical data, written and managed in a way that keeps people safe? | • Triage processes were inconsistent and did not always keep people safe. In addition the results of triage records indicated a need for improved quality.<br>• Audits identified a need for improvement in the quality of patient records<br>Documented checks on resuscitation equipment were inconsistent and did not always meet trust standards.<br>Staff did not always document pain scores for each patient and audits demonstrated wide variations in practice. | 1. Planned Trust wide documentation audit . Resource to be identified to undertake wide scale audit.<br><br>2. Review of documentation format, staff engagement and awareness, re audit.<br><br>3. Pain referral process in place.<br><br>4. SOP to be devised and implemented to give a guide and remind staff of how to access that service in a timely manner.<br><br>5. Trust wide communication to raise awareness of process / re education | Audit completion, evaluation and implement actions. | | Tracker Evidence\2018\2018 Should Dos | Sally Foy ADNS, Corporate Nursing Team andDanny Lawes & Kevin Fai re: pain assessment actions | May-18 | | Red | | | |
| Safe | S6 | 2017/18 | SD2 | Maidstone and Tunbridge Wells | SURGERY: The trust should implement systems to ensure that learning from incidents and complaints is shared and embedded | S6.4 | How well is the learning from lessons shared to make sure that action is taken to improve safety? Do staff participate in and learn from reviews and investigations by other services and organisations? | • Learning from incidents continued to be limited. Staff reported there had been improvement in the incident reporting culture and learning. We saw some learning from incidents was shared and there had been improvement in this area. However there was no unified method to ensure all relevant learning was shared with all staff. Staff did not know when incident reviews were competed and we saw little evidence of embedding learning from incidents. Staff and management could not be assured staff members had received learning or knew when there was new information.<br><br>• Learning from incidents had not significantly improved since the prior inspection. Information about learning was not always complete and there was not a system to ensure learning was shared with staff. | Planned Care Clinical Governance Adminstrator in post full time. Co-ordinates incident reports and action plans. Produces monthly breakdown of incidents within the division which is sent out to the matrons for dissemination. and discussed at Clinical Governance.A Planned Care complaints leaflet was launched in March 2018 which highlights learning from complaints. Individual feedback via e-mail or 1:1's. Complaints are monitored by Matrons and ADNS for Planned Care.<br><br>Theatres:<br>1. Learning in relation to Complaints, Incidents, SI's, Never Events and LocSIPPS displayed on Safety boards in theatres 2. Minutes from all never events/shared learning displayed in folders widely available for staff in theatre.<br>3. Incidents and complaints is a standing agenda item for Theatres Governance Meetings, Team meetings, and Directorate Board meetings. | Minutes of CG & CG reports . Trustwide CG monthly newsletters. Memos to ward areas. Ward meeting minutes & newsletters. Complaints leaflet and incidents report.<br><br>1. Visual evidence of safety boards insitu 2. Trust Clinical Governance Comittee report. 2. Minutes of meetings, where incidents are discussed. 3. Patient Safety Reports<br><br>Satff feedback<br>Corporate quality Rounds | Complaints Leaflet | | Tracker Evidence\2018\2018 Should Dos | Sarah Turner; ADNS | Complaints leaflet Completed 21st March 2018<br><br>Ongoing and with immediate effect | | Amber | | Requires Improvement | All staff are open and committed to reporting incidents. Good analysis of incident reports and complaints needs to continue and be improved upon. All grades of staff to be encouraged to participate in local, national and international safety programmes. |
| Safe | S1 | 2017/18 | SD3 | Maidstone and Tunbridge Wells | SURGERY<br>The trust should embed a system of prioritisation to enure holes in theatres department walls and doors are addressed in a timely fashion to minimise infection risk. | S1.9 | Do the design, maintenance and use of facilities and premises keep people safe? | • We saw holes in the theatres department hall walls and anaesthetic room doors which created an infection control risk. | 1. develop and implement a staff awareness programme<br>2. Review current processes of cleaning and inspection programmes in place to audit estates and facilities repair work required and ensure timely reporting to estate and facilities to ensure timely response. | Evidence of system in place | recognised system already in place; Faults are reported to the Helpdesk either by Telephone or email as detailed on the intranet.<br><br>Once a fault is reported we will categorise it for repair/rectification etc. There are three priority ratings that we use for reactive works;<br><br>1. Emergency - Health safety or security risk 1 hour<br>2. Urgent - Critical failure affecting the patient service 24 hours<br>3. Routine - Failure not affecting the patient service 14 days | Tracker Evidence\2018\2018 Should Dos | Jo Woodard / DL / Jeanette Batten | Apr-18 | | Amber | | Requires Improvement | |
| Safe | S2 | 2017/18 | SD5 | Maidstone and Tunbridge Wells | SURGERY: The trust should take steps to ensure all shifts are staffed in line with staffing requirements. | S2.1<br><br>S2.2 | How are staffing levels and skill mix planned and reviewed so that people receive safe care and treatment at all times and staff do not work excessive hours?<br><br>How do actual staffing levels and skill mix compare with the planned levels? Is cover provided for staff absence? | MAIDSTSONE : Between July 2016 and June 2017, the hospital reported a vacancy rate of 11.6% in surgical care which was above their 8.5% target.<br>• A total of 1,919 shifts were covered by agency or bank staff; 77% covered by bank staff and 19% covered by agency. A total of 107 shifts were not covered between July 2016 and June 2017.<br><br>TWH: Between July 2016 and June 2017, the hospital reported a vacancy rate of 26.6% in surgical care which was significantly above the 8.5% target.<br>• A total of 10,360 shifts were covered by bank or agency staff; 68% covered by bank staff and 26% covered by agency. A total of 941 shifts (9%) were not covered. | Active recruitment in place. New roles and new ways of working are being introduced e.g. nurse endoscopist, theatre trainee apprentice, doctors assistant, physicians associate. 6 week roster signed off by matrons, daily review by matrons, staffing reported and discussed at the site meetings (3 x day). Lines of temporary staffing approved monthly.<br><br>Staffing establishments reviewed twice yearly and reported to Trust Board<br><br>Workforce is a key component to the Best Care Work stream | Example of rota . Ongoing work with student nurses. Attendance at Open days. Wider Trust work with overseas recruitment. E-mail agreement from CDO to utilise non-framework agency for long term. | | Tracker Evidence\2018\2018 Should Dos | Sarah Turner | Ongoing | | Amber | | Requires Improvement | The individual directorates to take an active approach to anticipate and manage risks within all their areas and not do this in isolation. Anticipating and managing the risk to people who use services is embedded and is recognised as the rsponsibility of all staff. |
| Safe | S2 | 2017/18 | SD9 | Tunbridge Wells Hospital | SURGERY: The Tunbridge Wells Hospital at Pembury should work to retain and recruit staff members to address the vacancy rate of 26.6%, more than three times the hospital's target. | S2.2 | How are staffing levels and skill mix planned and reviewed so that people receive safe care and treatment at all times and staff do not work excessive hours? | TWH: Between July 2016 and June 2017, the hospital reported a vacancy rate of 26.6% in surgical care which was significantly above the 8.5% target.<br>• A total of 10,360 shifts were covered by bank or agency staff; 68% covered by bank staff and 26% covered by agency. A total of 941 shifts (9%) were not covered. | Medical staffing- juniors released from Maidstone Hospital as Resident Medical Officer (RMO) rostered at Maidstone Hospital. Use of long term locums. Re-evaluating job plans to make more attractive. Active recruitment in place. In house course being provided for staff e.g. boot camp<br><br>Active recruitment in place. New roles and new ways of working are being introduced e.g. nurse endoscopist, theatre trainee apprentice, doctors assistant, physicians associate. 6 week roster signed off by matrons, daily review by matrons, staffing reported and discussed at the site meetings (3 x day). Lines of tempoarary staffing approved monthly.<br>Staffing establishments reviewed twice yearly and reported to Trust Board.<br><br>Workforce is a key component to the Best Care Work stream | Medical rota's and job plans. Minutes of Direcotrate meeting where support to juniors discussed.<br><br>Example of rota . Ongoing work with student nurses. Attendance at Open days. Wider Trust work with overseas recruitment. E-mail agreement from CDO to utilise non-framework agency for long term. | | Tracker Evidence\2018\2018 Should Dos | Danny Lawes & Sarah Turner | Ongoing | | Amber | | Requires Improvement | The individual directorates to take an active approach to anticipate and manage risks within all their areas and not do this in isolation. Anticipating and managing the risk to people who use services is embedded and is recognised as the rsponsibility of all staff. |
| Safe | S1 | 2017/18 | SD17 | Maidstone and Tunbridge Wells | CHILDREN & YOUNG PEOPLE: The trust should ensure children admitted to adult wards are cared for by staff with level 3 safeguarding training. | S1.6 | Are there arrangements to safeguard adults and children from abuse and neglect that reflect relevant legislation and local requirements? Do staff understand their responsibilities and adhere to safeguarding policies and procedures, including working in partnership with other agencies? | The trust should assess whether nursing staff require a higher level of safeguarding children training.<br><br>There were no safeguarding level 3 trained staff on adult wards where 16-18 year old patients were cared for | 1. The Trust will need to map out the numbers of staff who need to complete Safeguarding Children training at level 3. 2. The Trust will need to identify the non-Paediatric areas that children are admitted to and the numbers involved (current estimates are that 3 x 16 and 17 year old are admitted daily to non-Paediatric areas).<br>3. The Trust will need to decide whether all ward staff to be trained at Level 3 or whether each area should have 'Safeguarding Children' Champions to provide advice and support to staff as needed (particularly if the Safeguarding Children team not available) - this would be my suggestion.<br>4. The Trust will need to ascertain current compliance (at level 3) in non-Paediatric areas.<br>5. The SGC team to deliver bespoke training to non-Paediatric areas that ensures L3 compliance, and to signpost staff to outside providers of training (e.g., KSCB). | Current compliance versus future compliance (at a date to be decided) | | Tracker Evidence\2018\2018 Should Dos | Alison Jupp Named Nurse Safeguarding Children and Executive Lead for Safeguarding (Chief Nurse) | Training schedule to be agreed by 30.4.18 with all training completed by 31.7.18 | | Red | | | |
| **Effective 2018 Rating: Requires Improvement** | | | | | | | | | | | | | | | | | | | |
| Effective | E3 | 2017/18 | SD4 | Maidstone and Tunbridge Wells | SURGERY<br>The trust should embed a system to ensure all staff meet mandatory training targets. | E3.2 | How are the learning needs of all staff identified? Do staff have appropriate training to meet their learning needs that covers the scope of their work, and is there protected time for this training? | The department nursing staff did not meet its training target for five mandatory training modules including; basic life support, conflict resolution, information governance, moving and handling, medicine management and dementia awareness (the hospital was implementing new dementia training at the time of inspection).<br>• The department medical staff did not meet its training target for four mandatory training modules including; mental capacity act, safeguarding level 3 (one of three required staff had not completed the training), medicine management and dementia awareness (as above the hospital was implementing new dementia training at the time of inspection). | Mandatory training targets monitored and reported monthly at the divisional EPR meetings and Trust Clinical Governance committee. Also monitored monthly by matrons. New HR dashboard. Areas requesting trainers to attend wards and departments in order to target high volumes of staff.<br><br>Staff are required to identify mandatory training requirements as part of the annual appraisal cycle | Training records | | Tracker Evidence\2018\2018 Should Dos | Jeanette Barlow, Head of Learning and Development | Ongoing | | Amber | | Requires Improvement | Following an appraisal all staff members should habve a robust personal development plan. Staff should be encouraged to use innovative practice. |
| Effective | E4 | 2017/18 | SD7 | Tunbridge Wells | The Tunbridge Wells Hospital at Pembury should put a system and policy in place to ensure only clinically suitable patients are cared for on the escalated short stay surgery unit. | E4 | How well do staff, teams and services work together within and across organisations to deliver effective care and treatment? | The Surgical Short Stay Unit had been escalated to provide capacity for overnight care to surgical, medical and orthopaedic patients on one unit. The ward was not designed for patients to stay more than 23 hours, but patients were staying on the ward for several days at a time..<br>• Staff were not able to identify one admission policy for patients on the escalated surgical short stay unit. The trust's Escalation of Bay/ Recovery Guidelines stated, 'infectious patients, patients with dementia and patients requiring a hoist or PAR scoring 4' should not be allocated to this area. Staff told us in some cases they had to 'push back' to keep these patients off the ward.<br>• The open ward where patients were separated by paper curtains that were often open, did not protect patients from the spread of infectious diseases.<br>• As the day surgery ward had been escalated, the department no longer had a fixed recovery ward for day patients. Staff 'borrowed' space from other departments. | Escalation Guidelines for Recovery and Holding Bay implemented.<br><br>Escalation Guideleuines to be reviewed with specific patient criteria to be referenced.<br><br>Work to be trainguilated through the Best Care Programme (Best Flow) | Patient criteria to be added to the guidelines. | | Tracker Evidence\2018\2018 Should Dos | Sarah Turner, ADNS | 30/05/2018 | | Amber | | Requires Improvement | For the AD of the day or the on call manager to take an active approach to anticipate and manage risks within all their areas and not do this in isolation. Anticipating and managing the risk to people who use services is embedded and is recognised as the rsponsibility of all staff. |
| Effective | E4 | 2017/18 | SD8 | Tunbridge Wells Hospital | SURGERY: The Tunbridge Wells Hospital at Pembury should put a system in place to ensure all patients on the short stay surgery unit, including medical patients, have regular access to consultant care and consultants respond to requests for care on that ward. | E4.2 | How is care delivered and reviewed in a coordinated way when different teams, services or organisations are involved? | The Surgical Short Stay Unit had been escalated to provide capacity for overnight care to surgical, medical and orthopaedic patients on one unit. The ward was not designed for patients to stay more than 23 hours, but patients were staying on the ward for several days at a time.<br>• Staff were not able to identify one admission policy for patients on the escalated surgical short stay unit. The trust's Escalation of Bay/ Recovery Guidelines stated, 'infectious patients, patients with dementia and patients requiring a hoist or PAR scoring 4' should not be allocated to this area. Staff told us in some cases they had to 'push back' to keep these patients off the ward.<br><br>Surgical Short Stay Unit staff told us that it was challenging to get doctors from the Medical department (as opposed to surgical or other department) to come to the unit and that patients could wait hours to see a Medical Department doctor. We observed two medical patients' notes in the Surgical Short Stay Unit both verified long patient waits to see medical department doctor, in one case a patient acked 11 hours in another than had acked 13 hours and not yet | 1. Already in place. Nominated medical consultant -daily ward rounds and Registrar based in area. Surgery - daily ward rounds by the "Acute team"<br><br>2. Monitor / evaluate effectiveness of process | Medical rota's and job plans. Minutes of Direcotrate meeting where support to juniors discussed | | Tracker Evidence\2018\2018 Should Dos | Danny Lawes: Consultant | Ongoing | | Amber | | Requires Improvement | Allocated teams for surgical and medical patients to be embedded practice so that information is shared to deliver effective care, treatment and support, which is coordinated to provide real-time information across services, and support integrated care for patients. |
| Effective | E1 | 2017/18 | SD10 | Tunbridge Wells Hospital | SURGERY : • The Tunbridge Wells Hospital at Pembury should ensure patient starvation times are not longer than clinically necessary, and actively manage starvation times when there are delays. | E1.5 | How are people's nutrition and hydration needs (including those related to culture and religion) identified, monitored and met? Where relevant, what access is there to dietary and nutritional specialists to assist in this? | We saw patients were often starved for longer periods than clinically necessary due to delays and communication failures this was reflected in incident reports and discussions with staff and patients. This issue was identified at the previous inspection and continued to require improvement.<br><br>We saw surgeries were often delayed. Patients were not provided any information about the reason for or length of the delay and fasting times were not modified. As a result we saw several instances where patients fasted and were without hydration for much longer than clinically necessary. This was highlighted at the previous inspection but was still an issue. | 1. NBM policy has been reviewed and updated, on 08/12/17. Escalation flow chart to be put in place to support new NBM policy. Ongoing challenge with wider theatre pressures. Staff to escalate when NBM periods extended.<br><br>2. Raise awareness trust wide when Flow Chart produced | New policy. Flow chart- to be produced | | Tracker Evidence\2018\2018 Should Dos | Greg Lawton & Jo Woodard | 30/05/2018 | | Amber | | Requires Improvement | Embed practice so that information is shared to deliver effective care, treatment and support, which is coordinated to provide real-time information across services, and support integrated care for patients. |
| Effective | E1 | 2017/18 | SD11 | Tunbridge Wells Hospital | SURGERY: The Tunbridge Wells Hospital at Pembury should implement systems to ensure patient's pain levels are pro-actively assessed and treated. | E1.6 | How is a person's pain assessed and managed, particularly for people who have difficulty communicating? | On the surgical short stay unit, we saw that patients' pain was regularly not managed quickly and proactively. Some patients we spoke to told us their pain was managed well and some told us their pain was not managed well. We saw pain observations were not always taken or recorded by staff. There were delays in administering pain medicines and escalating pain concerns to anaesthetists or consultants. We saw one example where a patient rated their pain eight to ten form more than 48 hours before the issue was escalated for review. This was worse than during our previous inspection. | 1. Pain referral process in place.<br><br>2. SOP to be devised and implemented to give a guide and remind staff of how to access that service in a timely manner.<br><br>3. Trust wide communication to raise awareness of process / re education | Pain SOP to be devised and implemented<br><br>Audit of outcomes | | Tracker Evidence\2018\2018 Should Dos | Danny Lawes & Kevin Fai | 30/05/2018 | | Amber | | Requires Improvement | Ensure that there is flexibility and informed choice so that so that patients needs and preferences are considered and acted upon. |
| Effective | E4 | 2017/18 | SD13 | Maidstone and Tunbridge Wells | CRITICAL CARE : The trust should ensure that there is a standard operating procedure in place for children who may be treated on the unit. | E4.1 | Are all necessary staff, including those in different teams, services and organisations, involved in assessing, planning and delivering care and treatment? | Most staff had completed mandatory training. Out of 19 mandatory training modules, only three modules had a completion rate worse than the trust target which were conflict resolution, dementia awareness and safeguarding children level three.<br><br>The trust should assess whether nursing staff require a higher level of safeguarding children training. | 1. The Trust will need to map out the numbers of staff who need to complete Safeguarding Children training at level 3. 2. The Trust will need to identify the non-Paediatric areas that children are admitted to and the numbers involved (current estimates are that 3 x 16 and 17 year old are admitted daily to non-Paediatric areas).<br>3. The Trust will need to decide whether all ward staff to be trained at Level 3 or whether each area should have 'Safeguarding Children' Champions to provide advice and support to staff as needed (particularly if the Safeguarding Children team not available) - this would be my suggestion.<br>4. The Trust will need to ascertain current compliance (at level 3) in non-Paediatric areas.<br>5. The SGC team to deliver bespoke training to non-Paediatric areas that ensures L3 compliance, and to signpost staff to outside providers of training (e.g., KSCB). | 1. Current compliance versus future compliance (at a date to be decided)<br><br>2. SOP to be produced following scoping and mapping process | | Tracker Evidence\2018\2018 Should Dos | Jacqui Slingsby, Matron, Critical Care Alsion Jupp Named Nurse Safeguarding Children | Training schedule to be agreed by 30.4.18 with all training completed by 31.7.18 | | Red | | Good | |

| KLOE Domain | KLOE Ref. | CQC Inspection Cycle | MD/SD/ND Ref. | Site | Description of MD/SD/ND from 2018 CQC Report/ From Trust QIP Action plan | KHCUH Code | KLOE/Prompt | Narrative from CQC | Actions required in for the Trust to evidence compliance | Evidence required prove compliance | Confirmed /Obtained Evidence Summary (including KPIs) | Link to evidence | Owner/ Lead | Action Timeline | BAU Review Date | RAG Rating | RAG Rating Comments | 2018 rating self assessment | Stretch expectations - KLOE Outstanding criteria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Effective | E4 | 2017/18 | SD14 | Maidstone and Tunbridge Wells | CRITICAL CARE<br><br>The trust should ensure all patient deaths are discussed at mortbidity and mortality meetings. | E2.1 | Is information about the outcomes of people's care and treatment (both physical and mental where appropriate) routinely collected and monitored? | • From the minutes we reviewed, we did not see evidence that all deaths in the intensive care unit were discussed at the morbidity and mortality meetings. | 1. All Patient Deaths are presented and discussed at Anaesthetics Clinical Governance meetings (Held 10 times per year) and Learning identified<br><br>2. All Deaths requiring a structured judgement review are discussed at the Mortality Surveillance Committee | 1. Minutes and presentations from Clinical Governance Meetings 2. Minutes of Mortality Surveillance Committee | | Tracker Evidence\2018\2018 Should Dos | David Golden | Mar-18 | | Amber | | | |
| Effective | E4 | 2017/18 | SD15 | Maidstone & Tunbridge Wells | CRITICAL CARE : The trust should ensure that overnight discharges are reduced. | E4.4 | Are all relevant teams, services and organisations informed when people are discharged from a service? Where relevant, is discharge undertaken at an appropriate time of day and only done when any necessary ongoing care is in place? | MTW : Delayed discharges from the unit remained an issue.<br><br>MAIDSTONE : The number of patients with a delayed discharge of more than eight hours was worse than the national average.<br>• The number of patients with a delayed discharge of up to four hours ranged between 48% and 85%. This meant the majority of patients fit for discharge were kept waiting. However, the mean averages of these amounted to 60% of patients waiting to be discharged, which was an improvement from the previous inspection where 82% of patients were waiting.<br>• Bed occupancy rates trust-wide were worse than the England average.<br><br>TWH:<br>Whilst the figures for discharging patients overnight had improved since our last inspection, the rates were still high.<br>Bed occupancy at the trust was worse than the England average.<br>• The number of patients with a delayed discharge of more than eight hours was worse than the national average.<br>• The number of patients with a delayed discharge of up to four hours ranged between 48% and 75%, which meant that patients were kept waiting when medically fit for discharge to a medical ward. However, the mean averages of these amounted to 61% of patients waiting to be discharged, which was an improvement from the previous inspection. | 1. All ward fit patients to be identified to the site team at the earliest opportunity but by 1500 at the latest each day.<br>2. Transfer plans to be agreed and completed by 20:00 hrs at the latest. No patients to be routinely transferred from ITU after 22:00. 3. Incident form completed for each patient discharged between the hours of 22:00 and 06:59<br>4. One bed to be allocated to ITU at 9am site meeting to allow for early transfer of patients out to the ward<br>5. Traingulate work with Best Care programme (Best Flow) | 1. Intensive Care National Audit and Research Centre. Case mix programme benchmark data. (Quarterly and Annually) 2. SICCCN Quality Report (Monthly and Quarterly) 3. Directorate Incident report (Monthly) 4. Site Reports (Daily) | | Tracker Evidence\2018\2018 Should Dos | Lindsey Reynolds / Angali Clifton Fearneside | TBC | | Amber | | | |
| Effective | E3 | 2017/18 | SD16 | Maidstone and Tunbridge Wells | CRITICAL CARE<br><br>The trust should ensure that all staff receive an appraisal. | E3.4 | What are the arrangements for supporting and managing staff to deliver effective care and treatment? (This includes one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.) | MAIDSTONE Only 78% of staff had received an appraisal. This was worse than the trust target of 90%. Following the inspection, the trust told us that the trust appraisal cycle runs from April each year. This meant that at the time of the data submission, the trust would have only been half way through their appraisal cycle.<br><br>TWH: Only 28% of staff had received an appraisal. This was much worse than the trust target of 90%. | 1. All non-medical appraisals should be completed between 1 April 2018 and 30 June 2018<br>2. All medical appraisals should be undertaken 1st November 2018 - 31st January 2018.<br>3. Completed appraisals must be scanned to mtw-tr.hr1@nhs.net as individual documents, any appraisals that are not scanned individually will be returned to the department. A received receipt should always be requested.<br>4. 5. Encourage all staff to attend appraisal training sessions for employees and managers. | 1. Directorate Performance report Monthly - Organisational<br>2. Completeness report - Locally (N Drive) 3. Directorate Workforce Report - Monthly | | Tracker Evidence\2018\2018 Should Dos | David Golden / Jacqui Slingsby | Jun-18 | | Amber | | | |
| Caring 2018 rating: Good | | | | | | | | | | | | | | | | | | | |
| Responsive 2018 Rating: Requires Improvement | | | | | | | | | | | | | | | | | | | |
| Responsive | R4 | 2017/18 | SD6 | Maidstone & Tunbridge Wells | SURGERY : • The trust should implement a system to respond to patient complaints in compliance with timelines set out in the trust's complaint policy. | R4.3 | How effectively are complaints handled, including ensuring openness and transparency, confidentiality, regular updates for the complainant, a timely response and explanation of the outcome, and a formal record? | There were long delays in responding to patient complaints. The target time for completing non-complex complaints was 25 days. No complaint file we reviewed met this target. We reviewed five non-complex complaint files; the response times for these matters were 55 to 183 days.<br>Responses to patient complaints reviewed addressed the underlying complaint in most instances. This was better than during previous inspections. | Planned Care Clinical Governance Administrator in post full time. who assists the complaints teamwith co-ordinating the complaints. Complaints are monitored by the Matrons and ADNS for Planned Care. | Complaints results against complaints targets. | | Tracker Evidence\2018\2018 Should Dos | Sarah Turner | Ongoing | | Amber | | Requires Improvement | All staff are committed to responding to complaints in a timely manner. Good analysis of complaints needs to continue and be improved upon. All grades of staff to be encouraged to participate in local, national and international safety programmes. |
| Responsive | R3 | 2017/18 | SD12 | Tunbridge Wells Hospital | SURGERY : The Tunbridge Wells Hospital at Pembury should put a system in place to address paperwork issues which delay patient discharges. | R2.3 | How are people supported during referral, transfer between services and discharge? | Patient discharges were delayed by discharge paperwork delays. As a result, patients remained in beds when it was not clinically necessary. | EDN project undertaken by Sara Mumford- EDN simplified. Trustwide issue regarding junior staff numbers and prioritisation | Junior doctor induction agenda | | Tracker Evidence\2018\2018 Should Dos | Danny Lawes | 30/08/2018 | | Amber | | Requires Improvement | Demonstrated commitment at all levels to sharing data and information proactively to drive and support sytem wide working. |
| Well-Led 2015 Rating: Good | | | | | | | | | | | | | | | | | | | |

RAG Rating: Red (no actions set/no evidence) Amber (actions progressing/evience gathering) Green (actions completed/evidence saved)

Key table:
KLOE = key lines of enquiry
KLOE Domain: S = Safe E = Effective C = Caring R = Responsive WL = Well Led
MD = Must Do SD = Should Do ND = New Do
CA = Compliance Actions EA = Enforcement Actions
KPI = Key Performance Indicators

| | | |
|---|---|---|
| Green MD | | 0 |
| Amber MD | | 0 |
| Red MD | | 0 |
| Green SD | | 0 |
| Amber SD | | 0 |
| Red SD | | 0 |
| Green ND | | 0 |
| Amber ND | | 0 |
| Red ND | | 0 |

**Trust Board Meeting – March 2018**

NHS Maidstone and Tunbridge Wells NHS Trust

**3-13 Staffing (planned and actual ward staffing for February 2018 Chief Nurse**

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for February 2018. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

**Wards of note this month include:**

**Acute Stroke Unit (Maidstone):** Falls rate above agreed threshold by 5 (threshold of 5).

**Cornwallis** (on Foster Clarke)**:** low CSW fill rate. This was due, in part, to an inability to fill from Bank. However support from other wards (either RN or CSW) provided. Falls have decreased this month with 1 compared to 8 last month (threshold of 3).

**CCU (Maidstone):** CSWs x 7 and RN x 1 moved to support other wards. Accepted risk as unit is collocated on Culpepper.

**John Day:** RN: CSW ratio shift. An accepted risk to ensure sufficient staff available to provide fundamental aspects of care. No change in nurse sensitive indicators noted in month.

**Chaucer:** High fill rate due to escalation of frailty assessment unit overnight. Improvements seen in falls with the incidence now at agreed threshold (3 this month compared to 6 last month)

**Edith Cavell:** Increased staffing requirements at night to support 9 patients with DoLS in place.

**Maidstone UMAU:** Escalated overnight,

**Ward 22/ASU:** Low RN fill rate, due to an inability to fill from Bank/Agency.

**CCU (TWH):** RN fill rate reflects 6 RNs transferred to support other wards and 5 shifts unfilled by bank/agency.

**Ward 10:** 20 nights of enhanced care requirements to cover cognitively impaired patients (RMN required on 5 occasions).

**Ward 12:** RN fill rate due to inability of bank or agency to fill requests.

**Ward 20:** RN fill rate due to inability of bank or agency to fill requests. Improvements noted in incidence of falls.

**Ward 2:** overall fill rate low due to inability of bank or agency to fill requests. No improvements noted in falls incidence, 7 above threshold of 7.

**Ward 30:** increase in incidence of falls noted, with 3 above a threshold of 5.

Overall RAG ratings (as detail later in this report) are based on quality indicators (namely incidence of falls and pressure injury in month) and professional judgement. Consideration is being given to refine this approach with a more objective framework. Progress on the reintroduction of the Quality, Effectiveness & Safety Trigger Tool (QuEST), as referred to last month, is on track. The core templates are now available and discussions will be had with the Ward Managers and Matrons over the next couple of weeks, with the intention of having the first round of data by the end of March.

**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 latest update on the NHSI database at November indicated a national average range of 7.5 – 8.5.
The overall CHPPD for Maidstone is 7.3, and for Tunbridge Wells it is 8.0.

**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.

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:**<br>Staffing levels are as expected and the ward is considered to be safely staffed taking into consideration workloads, patient acuity and skill mix.<br><br>RN to patient ratio of 1:7 or better<br>Skill mix within recommended guidance<br>Routine sickness/absence not impacting on safe care delivery<br>Clinical Care given as planned including clinical observations, food and hydration needs met, and drug rounds on time.<br><br>OR<br><br>Staffing numbers not as expected but reasonable given current workload and patient acuity. |

| | |
|---|---|
| | **Moderate Impact:**<br>Staffing levels are not as expected and minor adjustments are made to bring staffing to a reasonable level.<br><br>OR<br>Staffing numbers are as expected, but given workloads, acuity and skill mix additional staff may be required.<br><br>Requires redeployment of staff from other wards<br>RN to Patient ratio >1:8<br>Elements of clinical care not being delivered as planned |
| | **Significant Impact:**<br>Staffing levels are inadequate to manage current demand in terms of workloads, patient acuity and skill mix.<br><br>Key clinical interventions such as intravenous therapy, clinical observations or nutrition and hydration needs not being met.<br><br>Systemic staffing issues impacting on delivery of care.<br>Use of non-ward based nurses to support services<br>RN to Patient ratio >1:9<br><br>Need to instigate Business Continuity |

**Which Committees have reviewed the information prior to Board submission?**
-

**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

| February '18 | | Day | | Night | | | Nurse Sensitive Indicators | | | | | | Financial review | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hospital Site name | Ward name | Average fill rate registered nurses/midwives (%) | Average fill rate care staff (%) | Average fill rate registered nurses/midwives (%) | Average fill rate care staff (%) | Overall Care Hours per pt day | FFT Response Rate | FFT Score % Positive | Falls | PU ward acquired | Overall RAG Status | Comments | Budget £ | Actual £ | Variance £ (overspend) |
| MAIDSTONE | Acute Stroke | 90.7% | 98.2% | 100.0% | 91.1% | 7.0 | 25.6% | 100.0% | 10 | 0 | ⇩ | Falls 5 above threshold | 132,329 | 125,323 | 7,006 |
| MAIDSTONE | Cornwallis (on Foster) | 103.6% | 86.6% | 96.4% | 91.1% | 6.7 | 0.0% | 0.0% | 1 | 0 | ⇧ | CSW fill rate an accepted risk. Support provided from other wards. | 72,057 | 145,535 | (73,478) |
| MAIDSTONE | Coronary Care Unit (CCU) | 94.6% | 64.3% | 98.2% | N/A | 9.2 | 77.8% | 100.0% | 0 | 0 | | CSW fill rate an accepted risk, as staff were moved to other areas (7 CSWs and 1 RN). Risk to CCU mitigated by its colocation on Culpepper. | 106,475 | 97,196 | 9,279 |
| MAIDSTONE | Culpepper | 100.0% | 96.4% | 98.2% | 100.0% | 6.4 | 88.0% | 95.5% | 1 | 0 | | | | | |
| MAIDSTONE | John Day | 82.2% | 111.2% | 107.1% | 103.4% | 6.5 | 40.5% | 100.0% | 6 | 1 | | RN:CSW ratio accepted to support delivery of nursing care. 8 days of unfilled (x1 per day) RN shifts. Priority given to covering nights. | 127,486 | 128,962 | (1,476) |
| MAIDSTONE | Intensive Treatment Unit (ITU) | 100.9% | N/A | 101.8% | N/A | 26.8 | | | 0 | 0 | | | 174,246 | 162,503 | 11,743 |
| MAIDSTONE | Pye Oliver | 96.2% | 88.7% | 100.0% | 95.2% | 5.2 | 68.4% | 88.5% | 6 | 2 | | | 100,557 | 105,942 | (5,385) |
| MAIDSTONE | Chaucer | 89.7% | 111.8% | 141.1% | 92.9% | 7.6 | 24.4% | 94.5% | 3 | 0 | ⇧ | Escalated over night. RN:CSW ratio an accepted risk to ensure RN cover at night. | 112,063 | 108,579 | 3,484 |
| MAIDSTONE | Lord North | 91.4% | 73.2% | 98.8% | 107.1% | 7.1 | 65.4% | 94.1% | 1 | 0 | | CSW fill rate due to combination of sickness, vacancy and inability to fill via Bank. | 101,914 | 99,997 | 1,917 |
| MAIDSTONE | Mercer | 108.0% | 97.3% | 97.6% | 96.4% | 5.9 | 75.0% | 100.0% | 6 | 1 | | | 101,227 | 90,216 | 11,011 |
| MAIDSTONE | Edith Cavell | 99.0% | 109.6% | 97.6% | 153.6% | 6.1 | 64.3% | 77.8% | 0 | 0 | | Increased CSW requirement at night to cover 9 nights of supervision for DoLS | 82,226 | 72,441 | 9,785 |
| MAIDSTONE | Urgent Medical Ambulatory Unit (UMAU) | 90.6% | 90.4% | 128.6% | 200.0% | 9.1 | 14.2% | 94.0% | 1 | 0 | | Escalated over night. | 104,359 | 130,239 | (25,880) |
| TWH | Stroke/W22 | 76.8% | 90.0% | 94.3% | 96.4% | 10.0 | 100.0% | 100.0% | 6 | 0 | | RN fill rate due to inability of bank or agency to fill requests. Priority given to cover at night. Ward supported by specialist nurses and Matron. | 163,074 | 127,416 | 35,658 |
| TWH | Coronary Care Unit (CCU) | 89.1% | 96.4% | 94.0% | N/A | 10.8 | 112.9% | 94.3% | 0 | 0 | | RN fill rate reflects 6 RN transferred to support other wards and 5 unfilled by bank/agency. | 61,501 | 59,535 | 1,966 |
| TWH | Gynaecology/ Ward 33 | 97.9% | 80.4% | 100.0% | 111.9% | 6.6 | 17.4% | 93.8% | 2 | 0 | | Escalated into Post-natal beds x 3. Reduced CSW fill rate accepted during the day to ensure adequate cover at night. | 74,602 | 76,765 | (2,163) |
| TWH | Intensive Treatment Unit (ITU) | 99.6% | 89.3% | 99.6% | 67.9% | 27.1 | 33.3% | 100.0% | 0 | 0 | | CSW accepted risk. | 211,706 | 187,193 | 24,513 |
| TWH | Medical Assessment Unit | 93.3% | 89.3% | 118.6% | 100.0% | 7.5 | 35.2% | 97.1% | 12 | 0 | | Escalated over night. | 162,758 | 191,567 | (28,809) |
| TWH | SAU | 92.9% | 96.4% | 96.4% | 96.4% | 2.8 | | | 1 | 0 | | | 54,120 | 56,860 | (2,740) |
| TWH | Ward 32 | 94.0% | 104.7% | 101.2% | 115.2% | 7.0 | 30.6% | 93.3% | 8 | 2 | | Enhanced care needs over night for falls and wandering risks. | 122,789 | 111,061 | 11,728 |
| TWH | Ward 10 | 85.9% | 97.3% | 78.6% | 164.3% | 8.2 | 3.4% | 100.0% | 4 | 1 | | RN:CSW ratio an considered approach as case mix was high dependency with lower acuity. 20 nights of enhanced care requirements for cognitive impairment. | 112,453 | 109,889 | 2,564 |
| TWH | Ward 11 | 94.9% | 108.3% | 97.3% | 103.6% | 6.9 | 0.0% | 0.0% | 5 | 0 | | | 110,018 | 121,039 | (11,021) |
| TWH | Ward 12 | 76.3% | 97.3% | 94.0% | 95.5% | 0.0 | 10.5% | 87.5% | 8 | 0 | | RN fill rate due to inability of bank or agency to fill requests to cover vacancy. | 122,915 | 109,762 | 13,153 |
| TWH | Ward 20 | 85.7% | 113.4% | 98.8% | 108.9% | 5.8 | 38.5% | 100.0% | 6 | 0 | ⇧ | RN:CSW ratio an accepted risk. Unable to fill shifts via bank/agency. | 106,506 | 113,810 | (7,304) |
| TWH | Ward 21 | 95.8% | 106.0% | 104.3% | 125.0% | 6.6 | 38.2% | 100.0% | 6 | 1 | | Increased CSW requirement at night as a high number (range 4 - 9) of high dependency/acuity patients. | 133,012 | 132,368 | 644 |
| TWH | Ward 2 | 79.5% | 88.6% | 89.3% | 92.9% | 5.6 | 12.1% | 100.0% | 14 | 0 | ⇔ | Unable to fill via bank/agency. Reduced by 1 RN per shift most days in month. | 124,028 | 119,069 | 4,959 |
| TWH | Ward 30 | 92.0% | 97.1% | 100.0% | 90.5% | 6.4 | 19.1% | 88.9% | 8 | 1 | ⇩ | Falls 3 above threshold | 108,041 | 110,612 | (2,571) |
| TWH | Ward 31 | 91.1% | 95.5% | 95.5% | 95.2% | 6.7 | 0.0% | 0.0% | 3 | 2 | | | 129,736 | 118,122 | 11,614 |
| Crowborough | Birth Centre | 89.3% | 57.1% | 100.0% | 89.3% | | | | 0 | 0 | | RM fill rate mitigated by support from community midwives and on-call rota during the day. Priority given to cover nights. | 85,997 | 75,618 | 10,379 |
| TWH | Ante-Natal | 101.8% | 89.3% | 100.0% | 82.1% | 4.8 | 15.2% | 92.7% | 0 | 0 | | MSW fill rate due to vacancy. | | | |
| TWH | Delivery Suite | 98.8% | 87.5% | 92.9% | 80.4% | 10.8 | | | 0 | 0 | | | 615,174 | 643,060 | (27,886) |
| TWH | Post-Natal | 100.0% | 89.3% | 91.1% | 79.8% | 5.8 | | | 1 | 0 | | | | | |
| TWH | Gynae Triage | 98.2% | 96.4% | 100.0% | 100.0% | | | | 0 | 0 | | | 11,974 | 12,127 | (153) |
| TWH | Hedgehog | 99.4% | 42.9% | 92.9% | 135.7% | 8.2 | 24.6% | 97.0% | 0 | 0 | | CSW fill rate priority given to cover nights to support additional capacity. | 215,654 | 190,629 | 25,025 |
| MAIDSTONE | Birth Centre | 96.4% | 96.4% | 98.2% | 92.9% | | | | 0 | 0 | | | 63,527 | 65,389 | (1,862) |
| TWH | Neonatal Unit | 105.9% | 85.7% | 103.6% | 78.6% | 10.5 | | | 0 | 0 | | CSW fill rate accepted risk. | 167,377 | 176,832 | (9,455) |
| MAIDSTONE | MSSU | 105.9% | 65.9% | 60.0% | N/A | | 12.6% | 96.0% | 0 | 0 | | RN fill rate reflects ward being close overnight on 6 occasions. | 40,769 | 46,196 | (5,427) |
| MAIDSTONE | Peale | 104.8% | 86.4% | 100.0% | 100.0% | 7.9 | 0.0% | 0.0% | 2 | 0 | | | 70,239 | 69,619 | 620 |
| TWH | SSSU | 100.0% | 100.0% | 100.0% | 100.0% | | | | 3 | 0 | | | 66,724 | 147,626 | (80,902) |
| MAIDSTONE | Whatman | 98.1% | 93.8% | 102.4% | 125.0% | 5.1 | 93.8% | 93.3% | 3 | 2 | | Enhanced care needs for 11 nights. | 90,069 | 88,198 | 1,871 |
| MAIDSTONE | A&E | 99.1% | 80.4% | 101.0% | 92.9% | | 10.4% | 89.2% | 1 | 0 | | | 205,145 | 170,924 | 34,221 |
| TWH | A&E | 95.8% | 84.5% | 102.4% | 92.9% | | 7.8% | 91.5% | 5 | 0 | | | 311,866 | 353,407 | (41,541) |
| | | | | | | | | | | | | Total Establishment Wards | **4,956,713** | **5,051,626** | **(94,913)** |
| | | | | | | | | | | | | Additional Capacity beds | 39,307 | 31,500 | 7,807 |
| | | | | | | | | | | | | Other associated nursing costs | 2,289,820 | 2,544,276 | -254,456 |
| | | | | | | | | | | | | Total | 7,285,840 | 7,627,403 | (341,563) |

**RAG Key**

Under fill

Over fill

**Trust Board meeting – March 2018**

Maidstone and Tunbridge Wells NHS Trust

| 3-14 | **Approval of updated declaration of compliance with eliminating Mixed Sex Accommodation** | **Chief Nurse** |
|---|---|---|

Since the introduction of the Eliminating Mixed Sex Accommodation declaration exercise in April 2011[1], Trust Boards have been required to make an annual declaration of compliance for delivering single sex accommodation (DSSA), and to publish this on their website.

The Trust Board last approved the DSSA declaration in March 2017, and is therefore asked to approve the statement below:

**Declaration of compliance**

Maidstone and Tunbridge Wells NHS Trust is pleased to confirm that we are compliant with the Government's requirement to eliminate mixed-sex accommodation except when it is in the patient's overall best interest, or reflects their personal choice. We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area.

Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in Intensive Care (ICU), Coronary Care (CCU), or the Acute Stroke Unit, or when patients actively choose to share (for instance Chemotherapy Day Unit).

All in-patient care at Tunbridge Wells Hospital at Pembury is provided in single rooms including Intensive Care, Coronary Care and Acute Stroke. All rooms (except Intensive Care) have en-suite toilet and shower facilities.

Acute Medical Unit (AMU) at Tunbridge Wells Hospital will provide in-patient care in 4 bedded bays. These bays will be single sex, and will have appropriate gender specific toilets and washing facilities adjacent to them.

Patients admitted to the Surgical Assessment Unit (SAU) at Tunbridge Wells Hospital will be cared for in single occupancy cubicles. Provision is made to access appropriate gender specific toilet and washing facilities.

If our care should fall short of the required standard, we will report it to our Quality Committee as a formal sub-committee of the Trust Board. We have also set up an audit mechanism to make sure that we do not misclassify any of our reports.

**Which Committees have reviewed the information prior to Board submission?**

- N/A

**Reason for submission to the Board (decision, discussion, information, assurance etc.)** [2]

Approval

[1] Gateway reference: 15552 (see www.gov.uk/government/uploads/system/uploads/attachment_data/file/215773/dh_124233.pdf)

[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

**Trust Board meeting – March 2018**

NHS Maidstone and Tunbridge Wells NHS Trust

## 3-15 Quarterly mortality data — 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 the 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 a previous 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 December 2016 to November 2017.

**Which Committees have reviewed the information prior to Board submission?**

- N/A

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

Information, assurance and discussion

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

# Mortality Surveillance Group Report

## February 2018

### 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 December 2016 to November 2017 show our HSMR to be 104.1, which is an improvement against last month's position of 106.9.

Figure 1. Rolling 12 Month view

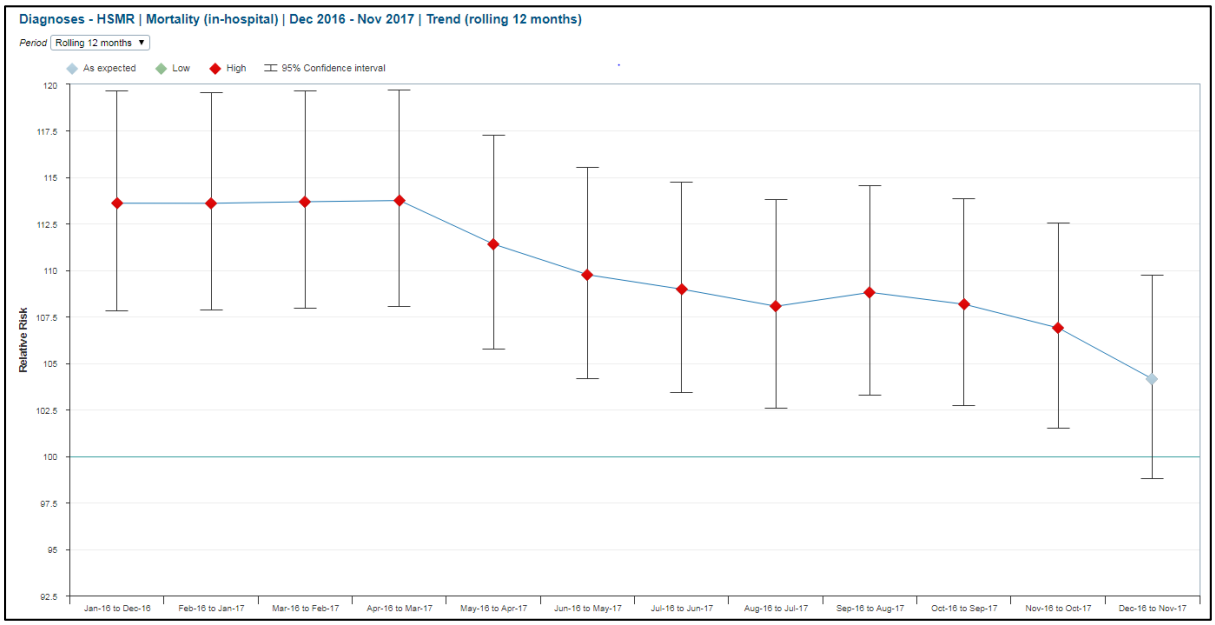
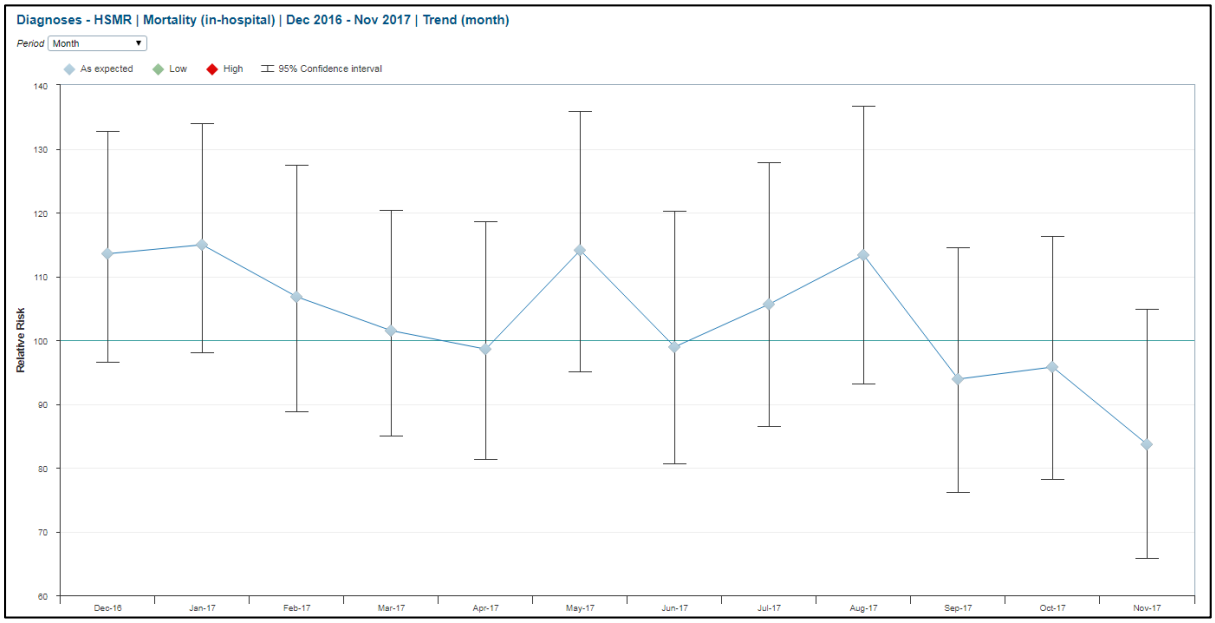



Figure 2. shows a monthly view of our HSMR performance. The latest month should be viewed with caution as this often shows a false position due to the lag in coding activity, however, viewing the previous month, so November 2017 in this case, it shows that the Trust's position improved significantly to 83.7 compared to 95.8 in October 2017.

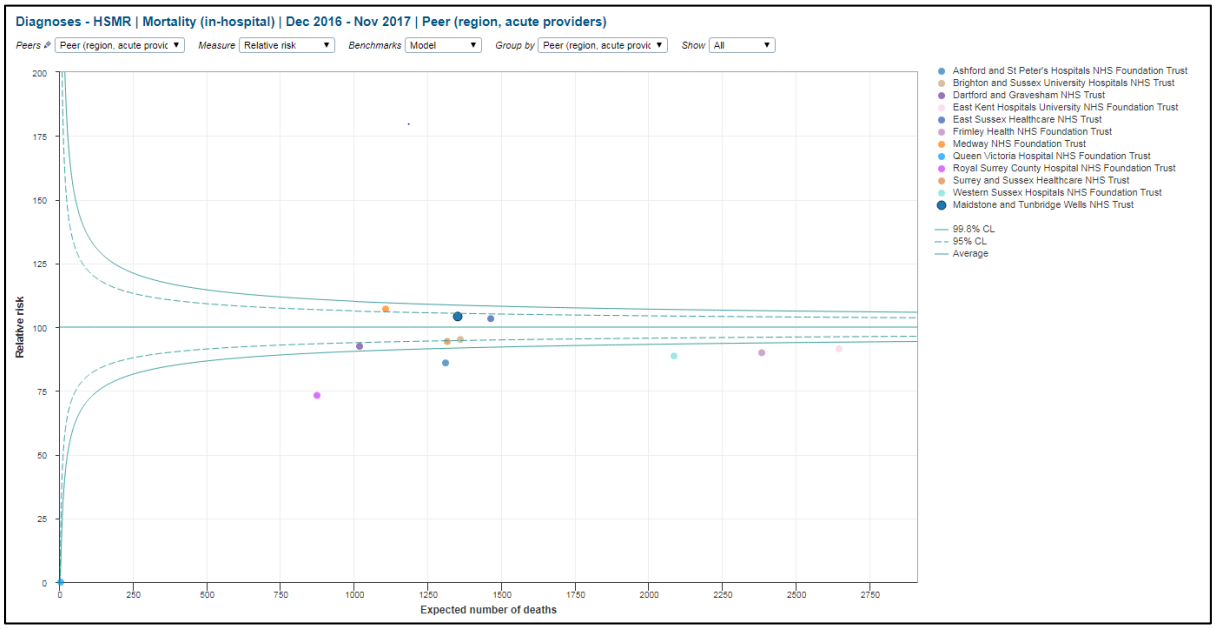
Figure2. Monthly view




### b. Benchmarking

Dr Foster 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 shows the Trust to be an outlier against this group, with Medway & East Sussex being the next outliers for this period.

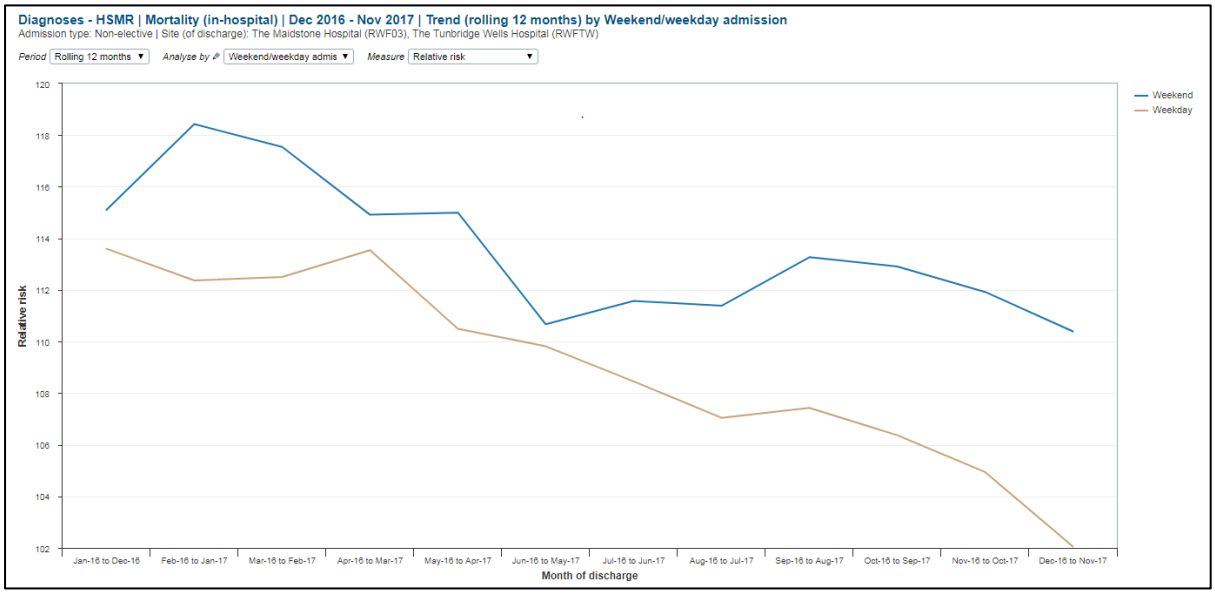
Figure 3. Benchmarking against our regional acute peers




### c. HSMR – Weekend Admissions

The seven day services programme is focused around reducing variation in performance and mortality forms part of the scope of this work. The latest period has a HSMR of 110.4 for weekends and 102.1 for week day admissions, both of these rates are significantly lower than where the Trust was at the beginning of the year.

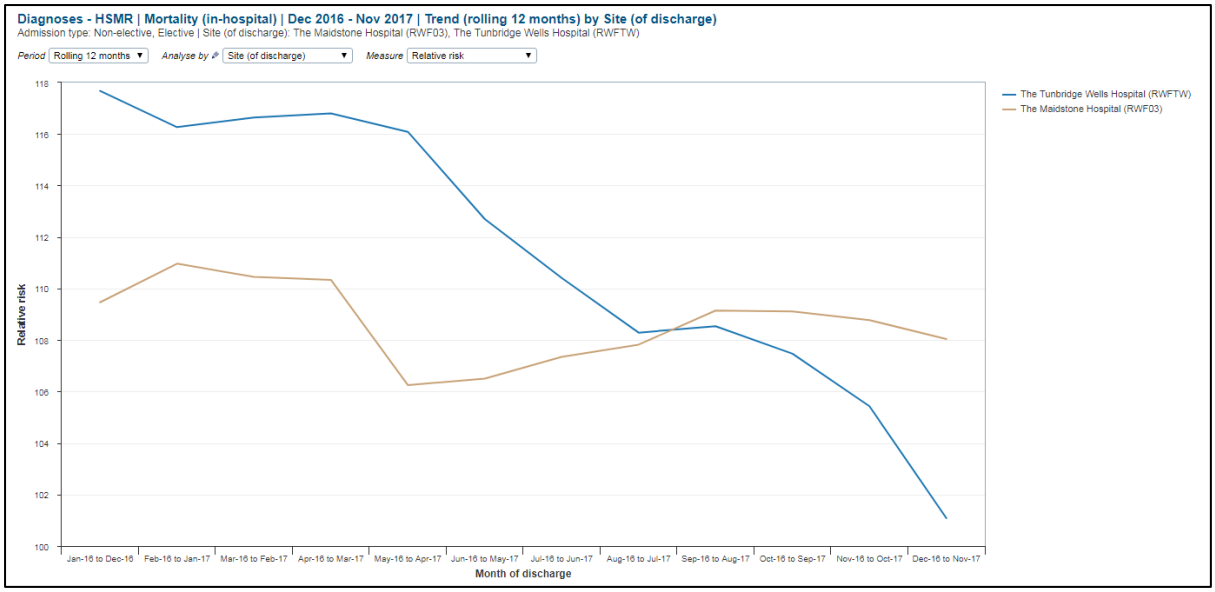
Figure 4. HSMR for Weekend vs. Week Day admissions (Non Elective Admissions)




### d. HSMR – by site

Figure 5 shows the HSMR split by site. The HSMR at the Maidstone site has dropped slightly to 108; the Tunbridge Wells site has continued to improve during the same period from 105.4 down to 101.1.

Figure 5. HSMR by site




**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 1407 deaths recorded in the period December 2016 to November 2017, 278 had no comorbidities recorded (19.8%).

Figure 6. Deaths with a Charlson score of zero recorded by age

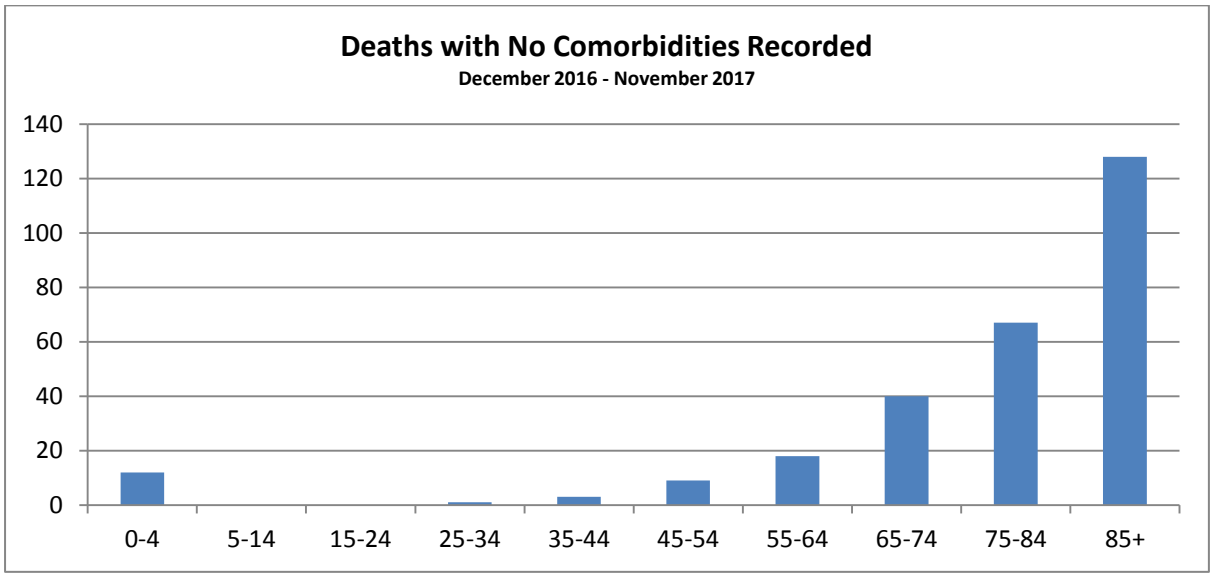
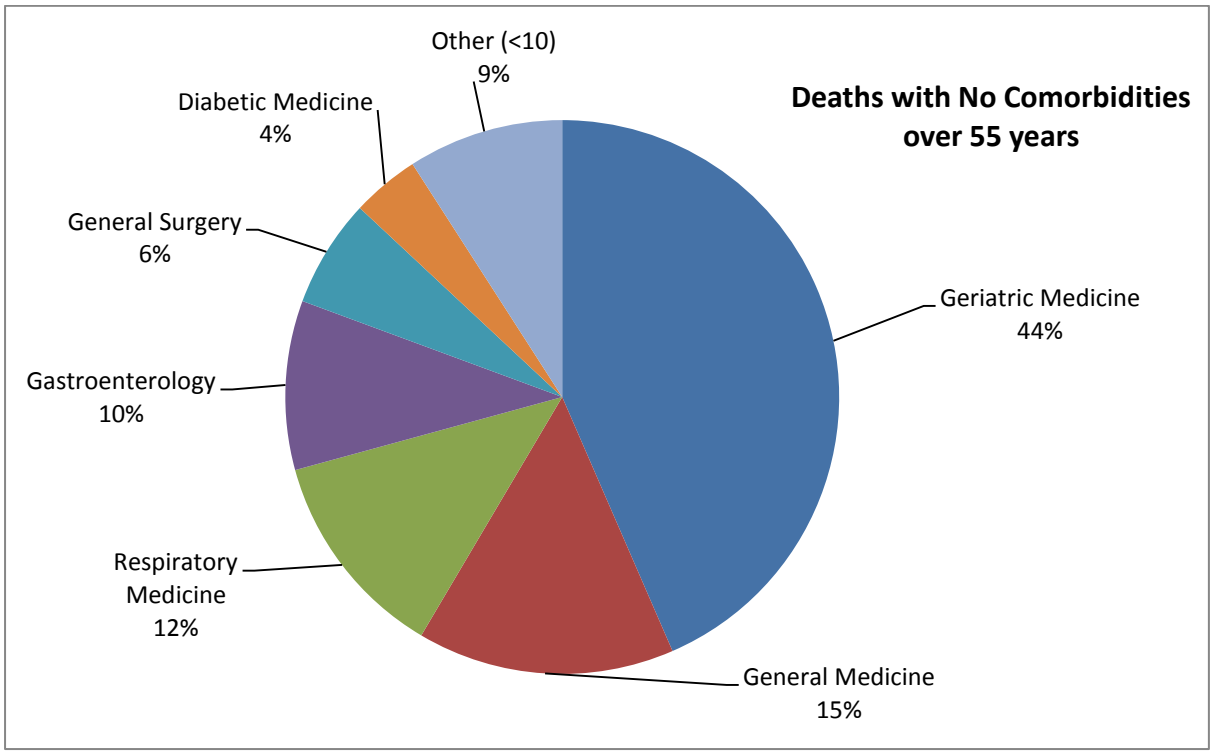



Figure 7. Deaths (>55 years) with a Charlson score of zero recorded by speciality (at diagnosis)




Some targeted work with General Medicine and Geriatric Medicine is required to address this potential underreporting of comorbidities to ensure the 'expected' deaths assigned to the Trust is accurate.

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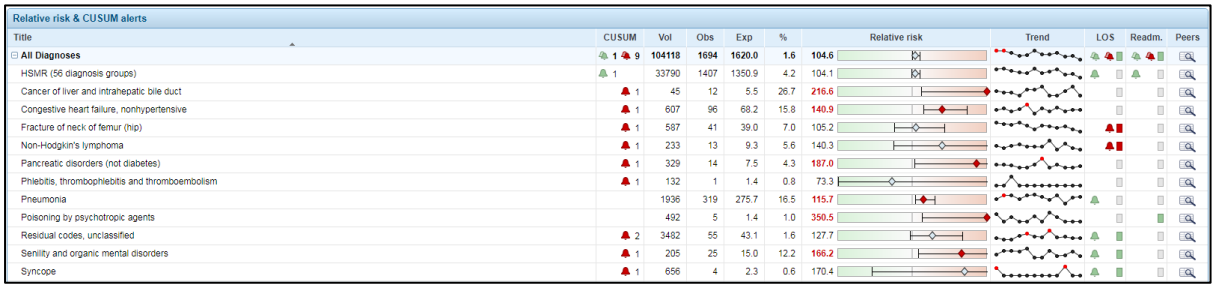
## 2. CUSUM (CUmulative SUM control chart) Alerts

CUSUM is a method of identifying areas where there are an unexpected cumulative number of mortalities which have been following treatment for a specific diagnosis; this can be both due to more and less than expected deaths. The below chart (Fig. 8) demonstrates the diagnosis groups where the Trust has received negative alerts when using A 'high' (99%) detection threshold over the past 12 months.

Figure. 8 Diagnosis with negative CUSUM Alerts



Relative risk & CUSUM alerts

| Title | CUSUM | Vol | Obs | Exp | % | Relative risk | Trend | LOS | Readm. | Peers |
|---|---|---|---|---|---|---|---|---|---|---|
| All Diagnoses | 1 9 | 104118 | 1694 | 1620.0 | 1.6 | 104.6 | | | | |
| HSMR (56 diagnosis groups) | 1 | 33790 | 1407 | 1350.9 | 4.2 | 104.1 | | | | |
| Cancer of liver and intrahepatic bile duct | 1 | 45 | 12 | 5.5 | 26.7 | 216.6 | | | | |
| Congestive heart failure, nonhypertensive | 1 | 607 | 96 | 68.2 | 15.8 | 140.9 | | | | |
| Fracture of neck of femur (hip) | 1 | 587 | 41 | 39.0 | 7.0 | 105.2 | | | | |
| Non-Hodgkin's lymphoma | 1 | 233 | 13 | 9.3 | 5.6 | 140.3 | | | | |
| Pancreatic disorders (not diabetes) | 1 | 329 | 14 | 7.5 | 4.3 | 187.0 | | | | |
| Phlebitis, thrombophlebitis and thromboembolism | 1 | 132 | 1 | 1.4 | 0.8 | 73.3 | | | | |
| Pneumonia | | 1936 | 319 | 275.7 | 16.5 | 115.7 | | | | |
| Poisoning by psychotropic agents | | 492 | 5 | 1.4 | 1.0 | 350.5 | | | | |
| Residual codes, unclassified | 2 | 3482 | 55 | 43.1 | 1.6 | 127.7 | | | | |
| Senility and organic mental disorders | 1 | 205 | 25 | 15.0 | 12.2 | 166.2 | | | | |
| Syncope | 1 | 656 | 4 | 2.3 | 0.6 | 170.4 | | | | |

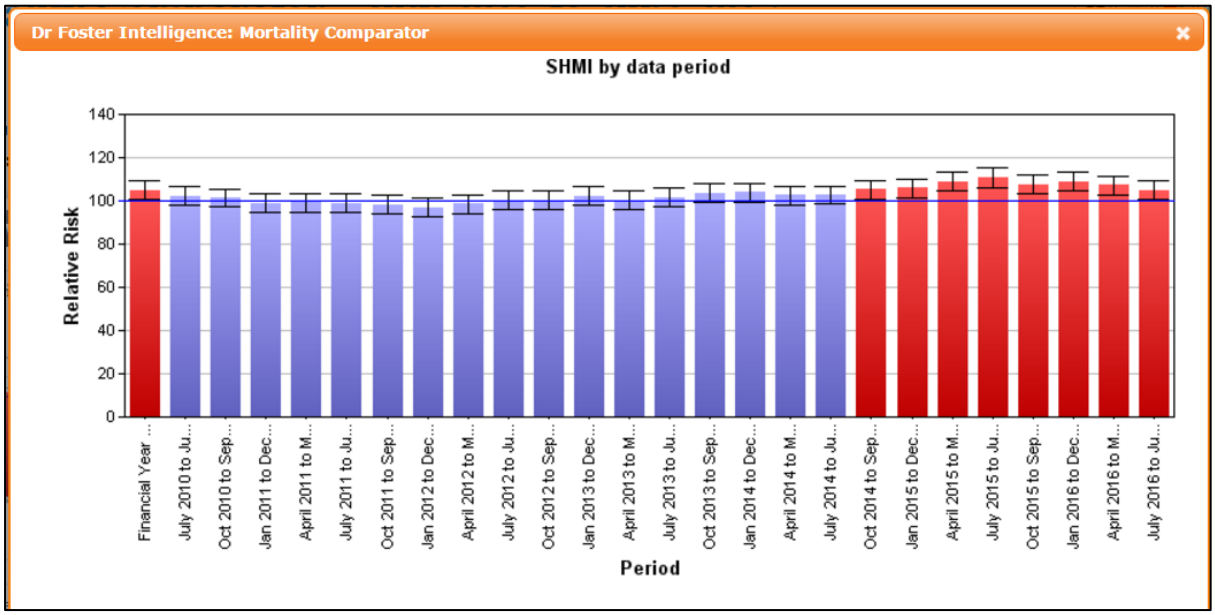
The patient level backing data for these alerts is supplied to the mortality leads to review.

## 3. Summary Hospital-Level Mortality Indicator (SHMI)

SHMI is a measure of mortality and performance which includes all deaths in hospital regardless of diagnosis, in addition to all those individuals who die within 30 days of discharge from hospital.

SHMI published by HSCIC for the period July 2016 – June 2017 shows SHMI as 1.0492 which is banded as level 2 "as expected. Publication of the next data series for the period October 2016 to September 2017 will be published later in April 2018. Figure 9 shows how the SHMI for the Trust has decreased slightly in the latest period of data report.

Figure 9. SHMI by quarter



### a. SHMI - Supplementary information: Depth of Coding

In the pack of information provided as part of the SHMI release each quarter, there is information included about depth of coding. As can be seen from the table below, MTWs mean depth for non-elective admissions is higher than the national average and our local acute peers. This also highlights that our coding of secondary diagnosis is rich as the maximum has been reached.

| Provider name | Mean coding depth for non-elective admissions | Maximum number of secondary diagnosis codes for non-elective admissions |
|---|---|---|
| England | 4.2 | 19 |
| Dartford and Gravesham NHS Trust | 2.9 | 15 |
| East Kent Hospitals University NHS Foundation Trust | 3.4 | 13 |
| Maidstone and Tunbridge Wells NHS Trust | 4.6 | 19 |
| Medway NHS Foundation Trust | 4.4 | 19 |

### b. SHMI - Supplementary information: Palliative Care Coding

Information is also included about our palliative care coding and as can be seen below, the Trust's coding is slightly higher than the England levels. Previously this had been an area where MTW fell below the national average, so this shows an improved position.

| Provider name | Observed deaths | Number of deaths with palliative care diagnosis coding | Number of deaths with either palliative care speciality or diagnosis coding | Percentage of deaths with palliative care diagnosis coding | Percentage of deaths with either palliative care speciality or diagnosis coding |
|---|---|---|---|---|---|
| England | 292,307 | 90,145 | 90,793 | 30.8 | 31.1 |
| Dartford and Gravesham NHS Trust | 1,543 | 729 | 729 | 47.2 | 47.2 |
| East Kent Hospitals University NHS Foundation Trust | 4,214 | 1,074 | 1,074 | 25.5 | 25.5 |
| Maidstone and Tunbridge Wells NHS Trust | 2,402 | 771 | 771 | 32.1 | 32.1 |
| Medway NHS Foundation Trust | 1,901 | 568 | 568 | 29.9 | 29.9 |

### c. SHMI - Supplementary information: Deaths split by deprivation quintile

The pack includes a breakdown of deaths split by deprivation quintile and the following table highlights that proportion deaths at MTW in each. This shows that 2.9% of our deaths fall in quintile 1 'most deprived', whereas 38.1% of our deaths fall into quintile 5 'least deprived'. This profile is significantly different than the national average and our local acute peers.

| Provider name | Percentage of deaths in deprivation quintile 1 (Most) | Percentage of deaths in deprivation quintile 2 | Percentage of deaths in deprivation quintile 3 | Percentage of deaths in deprivation quintile 4 | Percentage of deaths in deprivation quintile 5 (Least) | Percentage of deaths where the deprivation quintile cannot be derived |
|---|---|---|---|---|---|---|
| England | 20.5 | 20.3 | 20.6 | 19.8 | 17.4 | 1.4 |
| Dartford and Gravesham NHS Trust | * | 22.8 | 20.7 | 25.9 | 20.9 | * |
| East Kent Hospitals University NHS Foundation Trust | 16.0 | 22.0 | 25.7 | 28.7 | 7.3 | 0.4 |
| Maidstone and Tunbridge Wells NHS Trust | 2.9 | 6.5 | 20.4 | 31.8 | 38.1 | 0.3 |
| Medway NHS Foundation Trust | 18.5 | 26.9 | 20.4 | 18.8 | * | * |

** indicates value suppressed for the purposes of disclosure control*

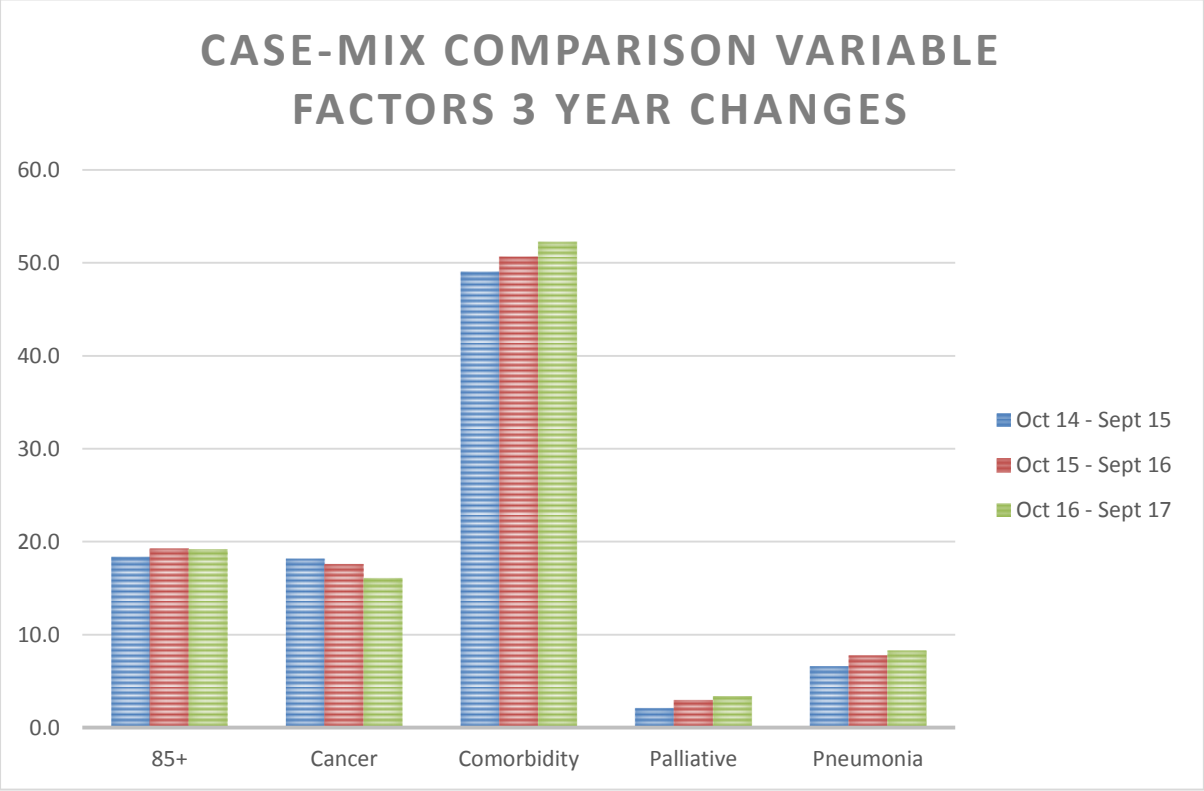
The next steps for us to identify a suitable peer group base on this profile and we will be talking to Dr Foster to identify relevant Trusts to benchmark ourselves against.

## 4. Casemix Comparison (HSMR)

Dr Foster has created the following casemix comparison information, which shows how this has changed over the last three years (October to September), using various criteria. A national benchmark has also been provided for comparison purposes (National – Non Specialist).

| Maidstone and Tunbridge Wells NHS Trust<br>Changes in HSMR Casemix (Ordinary admissions only) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Time Period** | **Oct 14 - Sept 15** | | | **Oct 15 - Sept 16** | | | **Oct 16 - Sept 17** | | |
| | **Trust** | **National (Non Specialist)** | **Variance** | **Trust** | **National (Non Specialist)** | **Variance** | **Trust** | **National (Non Specialist)** | **Variance** |
| Spell volume | 22,562 | 2,932,264 | | 22,063 | 2,978,949 | | 23,464 | 2,993,325 | |
| HSMR | 108.2 | | | 107.7 | | | 106.2 | | |
| | **%** | | | **%** | | | **%** | | |
| 85+ | **18.4** | 16.3 | 2.1 | **19.3** | 16.1 | 3.2 | **19.2** | 16.6 | 2.6 |
| Cancer | **18.2** | 16.2 | 2.0 | **17.6** | 15.7 | 1.9 | **16.1** | 15.6 | 0.5 |
| Comorbidity | **49.0** | 53.3 | -4.3 | **50.7** | 53.8 | -3.1 | **52.2** | 55.1 | -2.9 |
| Palliative | **2.1** | 3.2 | -1.1 | **3.0** | 3.4 | -0.4 | **3.4** | 3.6 | -0.2 |
| Pneumonia | **6.6** | 7.8 | -1.2 | **7.8** | 8.2 | -0.4 | **8.3** | 8.3 | 0.0 |

**Shown graphically**




This confirms that our palliative care coding and the coding of comorbidities have improved across the three periods, but that we are still below the national average for non-specialist hospitals for both.

Interestingly, it shows that our portion if 85 years+ patients is higher than the national average and had grown in 15/16 above the growth seen nationally, but appears to have stabilised in 16/17. Pneumonia in 14/15 was significantly lower than the national average, but has risen to now be in step with the national average for 16/17, whereas Caner shows the reverse trend. In 14/15 our casemix showed higher levels of Cancer than average, but cases have reduced at a fast rate than the national average to be closer to this for 16/17.

## 5. Mortality Reviews

The Trust is required to review all in-hospital deaths following the Mortality Review Process. The results of these reviews are then collated and to reported to ensure that any learning from deaths is identified and shared.

### a. Trust overview – 2017/18

| Trust | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No of Deaths | 151 | 167 | 130 | 132 | 143 | 121 | 139 | 133 | 187 | 202 | 150 | 1655 |
| No of Completed Reviews | 93 | 91 | 71 | 65 | 73 | 55 | 67 | 53 | 59 | 52 | 19 | 698 |
| **%age completed reviews** | **61.6%** | **54.5%** | **54.6%** | **49.2%** | **51.0%** | **45.5%** | **48.2%** | **39.8%** | **31.6%** | **25.7%** | **12.7%** | **42.2%** |
| No of Completed Reviews within agreed timescale | 45 | 39 | 37 | 42 | 37 | 15 | 25 | 12 | 15 | 7 | 1 | 275 |
| **%age completed review within agreed timescale** | **30%** | **23%** | **28%** | **32%** | **26%** | **12%** | **18%** | **9%** | **8%** | **3%** | **1%** | **17%** |
| Unavoidable deaths, No Suboptimal Care | 79 | 77 | 65 | 54 | 57 | 25 | 18 | 5 | 0 | 0 | 0 | 380 |
| Unavoidable Death, Suboptimal care | 12 | 13 | 5 | 6 | 4 | 1 | 0 | 1 | 0 | 0 | 0 | 42 |
| Suboptimal care, possible Serious Incident | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Suboptimal care, a Serious Incident | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Unknown Classification | 1 | 0 | 1 | 2 | 2 | 3 | 1 | 0 | 2 | 7 | 2 | 21 |
| Preliminary Form Completed - SJR Not Requested | 0 | 0 | 0 | 0 | 7 | 16 | 26 | 26 | 29 | 14 | 4 | 122 |
| Preliminary Form Completed - SJR Requested | 0 | 0 | 0 | 2 | 1 | 5 | 7 | 8 | 3 | 8 | 3 | 37 |
| First Stage Review - SJR Not Requested | 0 | 0 | 0 | 0 | 2 | 4 | 11 | 10 | 19 | 18 | 8 | 72 |
| First Stage Review - SJR Requested | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 2 | 5 | 5 | 2 | 18 |
| SJR Completed | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 3 |
| **%age Unavoidable deaths, No Suboptimal Care** | **85%** | **85%** | **92%** | **83%** | **78%** | **45%** | **27%** | **9%** | **0%** | **0%** | **0%** | **54%** |
| **%age Unavoidable Death, Suboptimal care** | **13%** | **14%** | **7%** | **9%** | **5%** | **2%** | **0%** | **2%** | **0%** | **0%** | **0%** | **6%** |
| **%age Suboptimal care, possible Serious Incident** | **1%** | **0%** | **0%** | **2%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| **%age Suboptimal care, a Serious Incident** | **0%** | **1%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| **%age Preliminary Form Completed - SJR Not Requested** | **0%** | **0%** | **0%** | **0%** | **10%** | **29%** | **39%** | **49%** | **49%** | **27%** | **21%** | **17%** |
| **%age Preliminary Form Completed - SJR Requested** | **0%** | **0%** | **0%** | **3%** | **1%** | **9%** | **10%** | **15%** | **5%** | **15%** | | **5%** |
| **%age First Stage Review - SJR Not Requested** | **0%** | **0%** | **0%** | **0%** | **3%** | **7%** | **16%** | **19%** | **32%** | **35%** | **42%** | **10%** |
| **%age First Stage Review - SJR Requested** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **6%** | **4%** | **8%** | **10%** | **11%** | **3%** |
| **%age SJR Completed** | **0%** | **0%** | **0%** | **0%** | **0%** | **2%** | **0%** | **2%** | **2%** | **0%** | **0%** | **0%** |

The table above shows the results for 2017/18 as at 7th March 2018. Reviews are required to be completed within 60 days of the death.

### b. Specialty overview – 2017/18

| %age completed reviews | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Specialist Medicine | 60.2% | 45.7% | 50.5% | 53.8% | 54.2% | 53.2% | 52.4% | 46.2% | 28.1% | 24.6% | 10.5% | 42.5% |
| Acute Medicine | 60.7% | 66.7% | 46.7% | 33.3% | 38.1% | 38.9% | 10.0% | 35.7% | 33.3% | 42.4% | 28.0% | 42.2% |
| Surgery | 100.0% | 85.7% | 100.0% | 87.5% | 75.0% | 10.0% | 11.1% | 0.0% | 11.1% | 5.9% | 5.6% | 42.5% |
| Trauma & Orthopaedics | | 66.7% | 100.0% | 0.0% | 0.0% | 0.0% | 50.0% | 0.0% | 0.0% | 0.0% | | 18.5% |
| A&E | 50.0% | 78.6% | 33.3% | 50.0% | 20.0% | 14.3% | 69.2% | 45.5% | 73.7% | 11.1% | | 47.7% |
| Cancer & Haematology | 0.0% | 0.0% | 0.0% | 0.0% | | 66.7% | 0.0% | | | 50.0% | | 25.0% |
| Children's | | 0.0% | | | 0.0% | | | | | | | 0.0% |
| Head & Neck | | 0.0% | | 0.0% | | | | 0.0% | 50.0% | 0.0% | | 14.3% |
| Trust Total | 61.6% | 54.5% | 54.6% | 49.2% | 51.0% | 45.5% | 48.2% | 39.8% | 31.6% | 25.7% | 12.7% | 42.2% |

The table above shows the completeness of the reviews by specialty for the financial year 2017/18. It should be highlighted that the largest volumes of deaths occur in Specialist and Acute Medicine, which will impact one their ability to process the volume of reviews required.

### a. Trust overview – 2016/17

| 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 | 54 | 48 | 41 | 67 | 88 | 94 | 117 | 137 | 146 | 155 | 134 | 111 | 1192 |
| **%age completed reviews** | **31.8%** | **30.4%** | **30.6%** | **50.8%** | **72.7%** | **77.7%** | **75.5%** | **86.2%** | **71.6%** | **77.1%** | **81.7%** | **67.3%** | **63.3%** |
| No of Completed Reviews within agreed timescale | 18 | 6 | 17 | 17 | 17 | 28 | 48 | 42 | 54 | 74 | 78 | 52 | 451 |
| **%age completed review within agreed timescale** | **11%** | **4%** | **13%** | **13%** | **14%** | **23%** | **31%** | **26%** | **26%** | **37%** | **48%** | **32%** | **24%** |
| Unavoidable deaths, No Suboptimal Care | 46 | 44 | 31 | 59 | 74 | 80 | 99 | 113 | 121 | 133 | 119 | 100 | 1019 |
| Unavoidable Death, Suboptimal care | 5 | 3 | 6 | 5 | 10 | 11 | 12 | 12 | 12 | 16 | 8 | 5 | 105 |
| Suboptimal care, possible Serious Incident | 1 | 1 | 1 | 1 | 2 | 1 | 3 | 2 | 3 | 3 | 2 | 3 | 23 |
| 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 | 3 | 39 |
| **%age Unavoidable deaths, No Suboptimal Care** | **85%** | **92%** | **76%** | **88%** | **84%** | **85%** | **85%** | **82%** | **83%** | **86%** | **89%** | **90%** | **85%** |
| **%age Unavoidable Death, Suboptimal care** | **9%** | **6%** | **15%** | **7%** | **11%** | **12%** | **10%** | **9%** | **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%** |

The table above shows the completeness of the reviews and summarise the results for the financial year 2016/17.

### b. Specialty overview – 2016/17

| %age completed reviews | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Specialist Medicine | 31.1% | 20.5% | 26.1% | 50.0% | 82.5% | 85.5% | 77.4% | 91.6% | 77.8% | 77.5% | 81.7% | 71.9% | 64.4% |
| Acute Medicine | 16.7% | 40.0% | 30.0% | 33.3% | 23.1% | 18.2% | 68.2% | 58.3% | 40.0% | 78.8% | 78.3% | 56.5% | 49.0% |
| Surgery | 85.7% | 88.2% | 60.0% | 85.7% | 90.0% | 83.3% | 82.4% | 109.1% | 90.0% | 100.0% | 100.0% | 81.8% | 86.9% |
| Trauma & Orthopaedics | 75.0% | 40.0% | | 50.0% | 50.0% | 66.7% | 80.0% | 0.0% | 42.9% | 85.7% | 150.0% | 0.0% | 56.6% |
| A&E | 0.0% | 25.0% | 33.3% | 42.9% | 72.7% | 90.9% | 73.3% | 100.0% | 66.7% | 60.0% | 77.3% | 60.0% | 63.8% |
| Cancer & Haematology | 0.0% | | 0.0% | 0.0% | 0.0% | 0.0% | 33.3% | 75.0% | 0.0% | 0.0% | 66.7% | 100.0% | 26.9% |
| Children's | | | | 100.0% | 100.0% | | | 100.0% | 100.0% | | | 0.0% | 80.0% |
| Head & Neck | 0.0% | | | | | | | | | | | | 0.0% |
| Trust Total | 31.8% | 30.4% | 30.6% | 50.8% | 72.7% | 77.7% | 75.5% | 86.2% | 71.6% | 77.1% | 81.7% | 67.3% | 63.3% |

## 6. Summary

The Trust's HSMR is currently 'higher expected'. Best practice in investigating a high HSMR suggests the investigation pathway is followed:

**a. Check coding -** Has the trust submitted incorrect data or applied different data codes to other trusts across the UK? Poor depth of coding can also affect the HSMR, i.e. when there are no or few secondary codes.

**b. Casemix -** Has something extraordinary happened within the time frame i.e. an abnormal run of severely ill patients in a short period of time? Is co-morbidity coding correct? Check the co-morbidity coding to identify the true casemix of the patient. No or poor co-morbidity coding can affect the HSMR.

**c. Structure -** Does the organisation and its surrounding healthcare partners work in a different way to other trusts across the country? Do they have different care pathways i.e. end of life care in the hospital or NHS funded hospices? Other structural differences such as no weekend discharges or nurse-led discharge teams should be considered too.

**d. Process -** At this point start considering that there is a potential issue with quality of care. Where service delivery needs to be reviewed, issues can be identified after monitoring and investigating alerts. Information systems such as Quality Investigator can help with this.

**e. Individual or team -** Very occasionally the investigation will lead you to an individual or team. Where there is a commonality of personnel involved or a particular team, nurse or department, see what extra support they need in order for them to deliver the best possible care.

The Mortality Surveillance Group are overseeing this on behalf of the Trust through the receipt of Mortality reports and the outputs of the Mortality review process.

# Learning from Deaths Dashboard

| | |
|---|---|
| **Organisation** | **Maidstone & Tunbridge Wells NHS Trust** |
| **Financial Year** | **2017-18** |
| **Month** | **February** |

# NHS Learning from Deaths Dashboard

## Purpose of the dashboard

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

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

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

## Guidance on individual fields

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

## How to update the dashboard

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

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

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

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

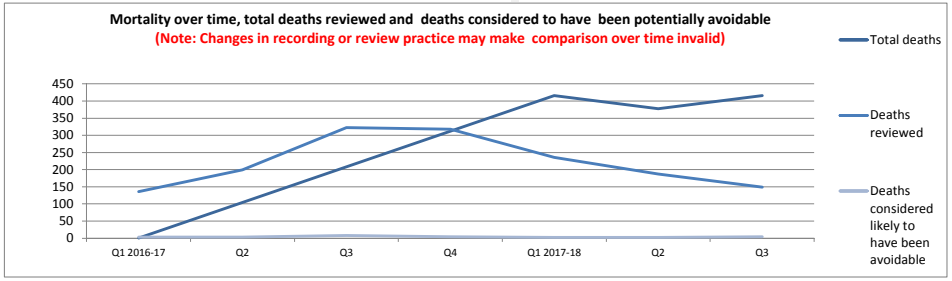
**Description:**
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

## 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 |
| 146 | 193 | 11 | 34 | 2 | 5 |
| This Quarter (QTD) | Last Quarter | This Quarter (QTD) | Last Quarter | This Quarter (QTD) | Last Quarter |
| 339 | 416 | 45 | 149 | 7 | 4 |
| This Year (YTD) | Last Year | This Year (YTD) | Last Year | This Year (YTD) | Last Year |
| 1549 | 1 | 617 | 976 | 15 | 18 |

Time Series: Start date 2016-17 Q1 End date 2017-18 Q3




### Total Deaths Reviewed by RCP Methodology Score

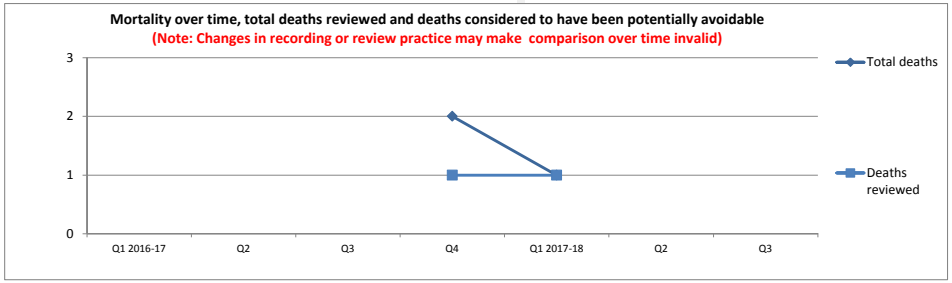
| Score 1 Definitely avoidable | | | Score 2 Strong evidence of avoidability | | | Score 3 Probably avoidable (more than 50:50) | | | Score 4 Probably avoidable but not very likely | | | Score 5 Slight evidence of avoidability | | | Score 6 Definitely not avoidable | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| This Month | 0 | 0.0% | This Month | 2 | 18.2% | This Month | 0 | 0.0% | This Month | 0 | 0.0% | This Month | 0 | 0.0% | This Month | 9 | 81.8% |
| This Quarter (QTD) | 0 | 0.0% | This Quarter (QTD) | 7 | 15.6% | This Quarter (QTD) | 0 | 0.0% | This Quarter (QTD) | 0 | 0.0% | This Quarter (QTD) | 3 | 6.7% | This Quarter (QTD) | 35 | 77.8% |
| This Year (YTD) | 0 | 0.0% | This Year (YTD) | 13 | 2.1% | This Year (YTD) | 2 | 0.3% | This Year (YTD) | 0 | 0.0% | This Year (YTD) | 62 | 10.0% | This Year (YTD) | 540 | 87.5% |

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

Time Series: Start date 2016-17 Q1 End date 2017-18 Q3



**Trust Board meeting – March 2018**

NHS Maidstone and Tunbridge Wells NHS Trust

## 3-19 Update on the working capital loan — Director of Finance

The Trust Board received a report in December 2017 detailing the Trust's position regarding working capital requirements in the light of the continuing pressures on operational finances and the consequential request that the Trust was making to the Department of Health and Social Care for working capital finance, and approved the initial application in January 2018 for £5m of working capital finance. The report set out that the Trust would be likely to require further applications for working capital in February and March to a maximum of £15m.

The Trust's application for £5m in January 2018 was approved by NHS Improvement (NHSI) and the Department of Health and Social Care (DHSC), and was received on the 15th January 2018. The interest rate applied was 3.5%. The full loan document and repayment details were enclosed in this supplement to the formal 'pack' of Board reports in January.

The Trust's second application for £5m in February 2018 was also approved by NHSI and the DHSC. As the Trust was due to repay £2.235m previously advanced against the Sustainability and Transformation Fund quarter two payment, the loan was issued for the net difference of £2.765m, and paid to the Trust on 12 February 2018. The loan principal is repayable in February 2021 and the interest rate applied is also 3.5%. The full loan document was circulated as a supplementary document to the Trust Board paper confirming the loan.

The Trust's third application for £3.99m in March 2018 was also approved by NHSI and the DHSC and paid to the Trust on 12 March 2018, interest rate 3.5% and principal repayable in March 2021. The level of loan was in line with the operational deficit that the Trust has reported in its forecast outturn, and is lower than the original guideline figure of £5m. The loan documentation will be circulated as a supplementary document to this paper.

**Which Committees have reviewed the information prior to Board submission?**

- N/A

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

Information

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

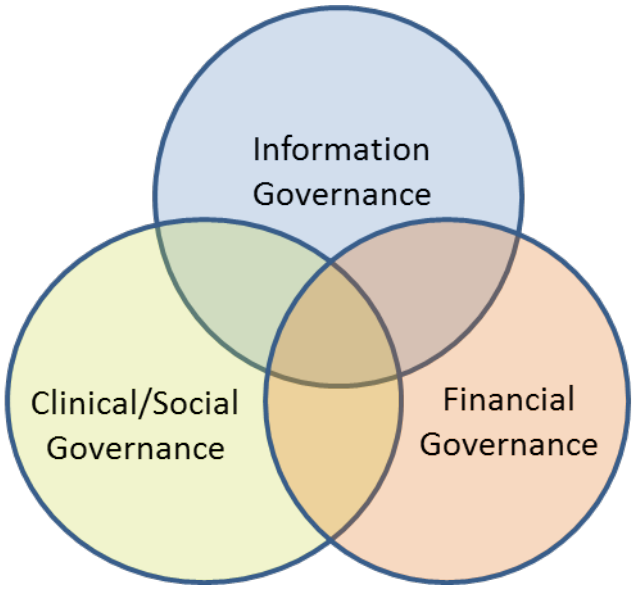
**Trust Board meeting – March 2018**

NHS Maidstone and Tunbridge Wells NHS Trust

| 3-20 | Update from the SIRO (incl. approval of the IG Toolkit submission for 2017/18 & Board annual refresher training on Information Governance) | Chief Nurse |
|---|---|---|

**Summary / Key points**

Information governance is a component of corporate governance.




Poor information governance can lead to never events, missed appointments, increased morbidity, and to many other problems. Appropriate information sharing can prevent serious harm or death, particularly when it concerns vulnerable people. There are many enquiry reports into such deaths and where information has not been shared is cited as a causal factor.

**What does the Trust Board need to know to fulfil its duties?**

In 2015 the Information Governance Alliance published the following:

Information Governance Considerations for NHS Board Members

Information Governance (IG) supports the delivery of high quality care by promoting the effective and appropriate use of information. Whilst an important aspect of IG is the use of information about service users, it also applies to information processing in its broadest sense and underpins both clinical and corporate governance. Whilst every member of staff must follow their organisation's policies and procedures, the ultimate responsibility for IG in the NHS rests with the Board of each organisation.

Key points for NHS Boards to note are that:

- An annual IG performance assessment[1] using the IG Toolkit (IGT) must be published for review by commissioners and care partners, citizens, CQC and the Information Commissioner. Used appropriately the IGT is a proven change management tool that can be used to monitor performance and drive improvements in policy and practice.
- A Senior Information Risk Owner (SIRO) must be appointed to take responsibility for managing the organisation's approach to information risks and to update the Board regularly on information risk issues.
- A Caldicott Guardian, a senior clinician, must be appointed to advise the Board and the organisation on confidentiality and information sharing issues.
- Appropriate annual IG training[2] is mandatory for all staff who have access to personal data with additional training for all those in key roles.

- Details of incidents involving cyber security, loss of personal data or breach of confidentiality must be published in annual reports and reported through the HSCIC Serious Incident Requiring Investigation (SIRI) reporting tool[3]

NHS Board members should seek assurance on the following:
1. Is the duty to share information for care introduced by the Health and Social Care (Safety and Quality) Act 2015 and promoted by the National Data Guardian[4] being effectively addressed? Are arrangements for integrated care working effectively?
2. Is the organisation's IG Toolkit assessment satisfactory? Is it a true reflection of performance? Has it been independently audited? Are there any known weaknesses or auditor recommendations and if so, how are they being addressed? Does the organisation have the capacity and capability to guarantee that plans for improved IG can be implemented?
3. Are the Board satisfied with the indicators of IG performance reported to it, e.g. are key roles filled? Are all staff trained in the basics? Are levels of missing or untraceable case notes acceptable etc?
4. Are IG staff – IG managers, SIRO, Caldicott Guardian - trained appropriately? Are IG staff encouraged to participate in regional Strategic IG Network (SIGN)[5] meetings, contributing to and receiving support from the IGA[6]?
5. Are all significant IG Risks being managed effectively and considered at an appropriate level? Have there been any serious incidents requiring investigation reported? How confident is the organisation that all such incidents are reported? How many cyber-attacks have occurred and were they all successfully prevented?
6. Do the organisation's IG arrangements adequately encompass all teams and work areas, including hosted activity and contracted work that the organisation is legally accountable for?

1 This must be provided via the Information Governance Toolkit (IG Toolkit),
2 This may be provided through the Information Governance Training Tool (IGTT) or equivalent local resource, supplemented where appropriate by additional role specific local training
3 The SIRI reporting tool is accessed from within the IG Toolkit
4 Dame Fiona Caldicott, the National Data Guardian conducted a review of care sector information governance available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf
5 SIGN groups meet regionally with their chairs meeting bi-monthly in a national meeting chaired by the IGA.
6 The Information Governance Alliance (IGA) was established in July 2014 at the request of the National Data Guardian to support the Care Sector with authoritative advice and guidance on information governance issues, more details at IGA@nhs.net

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The enclosed report aims to provide assurance in relation to the six key areas detailed above.

The Board are advised that as SIRO I receive assurance reports in relation to Information Governance from the Information Asset Owners of the Clinical Directorates as well as from the Heads of Corporate functions.

These reports provide assurance against the six areas of Information Governance as outlined in the IG Toolkit:
- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance
- Secondary Use Assurance
- Corporate Information Assurance

**Information Governance Management Framework (IGMF)**

The Information Governance Committee reviewed the IGMF in 2017. The Information Asset Owner Group was established to provide assistance and support to myself as Senior Information Risk Owner in the performance of my duties in relation to information risk management. The Group

reports to the Information Governance Committee. The purpose of this Group is twofold:

1. To provide assurance that:
- Information Assets have been appropriately identified;
- Documentation containing all information necessary to respond to incidents or recover from a disaster affecting the information asset has been completed and tested;
- Business continuity plans have been completed and tested;
- Risk assessments have been completed in relation to individual information assets;
- Risks logs are maintained and risks reported to the Senior Information Risk Owner at least annually.
- Information Asset registers have been completed and reviewed annually;
- Data flow Mapping has been reviewed and risk assessed and that the legal basis for sharing has been clearly identified;
- When necessary Information Sharing Agreements are in established;
- When new systems or processes are to be put in place or substantial changes to existing systems or processes are to be made Information Governance sign off has been received;
- Staff are aware of and comply with IG working practices;
- Mechanisms are in place to identify, report and manage incidents in relation to owned assets;
- System Specific Security Policies are completed and reviewed annually;
- Forensic readiness plans have been completed and reviewed and both internal and external dependencies identified;
- Pertinent Information Standards Notices have been reviewed and actioned.

2. To provide a platform for information risk management training to ensure skills and capabilities are update date and relevant.
The Caldicott Guardian and Data Protection Officer were happy to approve the framework as meeting the needs of the organisation for the year.

**IG Toolkit V14.1**

The Board are advised that the Trust is continuing to work towards achieving the minimum level 2 score against each of the 45 requirement of the Toolkit. A number of the requirements will be met at level 3.

TIAA have undertaken an independent review of evidence pertaining to 10 of the Toolkit requirements. The objective if the audit is to provide assurance on the integrity of the set-assessment against the toolkit criteria, the overall effectiveness of information governance processes within the Trust and wider risk exposures through non-compliance with IG processes. The audit adopted a two stage approach. The draft audit report has just been received and the Trust achieved 'Substantial Assurance'. The key findings of the audit were reported as: There were eight of the 10 IG requirements tested where TIAA agreed with the scores claimed by the Trust with two IG requirements being unsubstantiated. All were assessed at level 2 or above. As a result, the assessment was to give a Substantial audit opinion. The Trust has a suitable IG structure in place with the IGMF and key policies reviewed in this toolkit period. There has been one SIRIs reported to the ICO during 2017-18 which has been closed and no further action.

The year-end submission of not less than 74% (satisfactory) is proposed to be made prior to 31 March 2018.

**New Data Protection Legislation**

The Data Protection Act 1998 (DPA) will be superseded by new legislation on 25 May 2018. The new legislation, currently being enacted by Parliament, will provides UK legislation equivalent to that set out in the General Data Protection Regulation which unifies data protection for all individuals within the 28 member states of the European Union (EU).

Key Changes:
The key changes introduced by the Regulation affecting the Trust include:

1. The definition of personal data is broader – it can now include factors such as genetic,

mental, economic, cultural or society identity. On-line identifiers such as IP addresses can be personal data. Pseudonymised data can be personal data depending on how difficult it is to attribute the data back to a particular individual.

2. Privacy notices – the legislation sets out the information that should be supplied and when individuals should be informed.
3. Children's data – privacy notices must be written in clear, plain language that Children will understand. Consent is required from a parent or guardian if online services are offered to children.
4. Changes to the rules for obtaining valid consent – the Trust will need to review its consent mechanisms to make sure they meet the requirements of the new legislation on being specific, granular, clear, prominent, opt-in, documented and easily withdrawn.
5. Data protection officer (DPO) – should report to the highest level of the Trust i.e., Board level, should operate independently and not be dismissed or penalised for performing their tasks, is adequately resourced to meet their GDPR obligations.
6. The introduction of mandatory privacy risk impact assessments – PIAs must be completed and submitted to the Information Commissioner's Office before processing of data commences (guidance is awaited from the ICO as to how this process will work)
7. New data breach notification requirements – All breaches must be reported within 72 hours
8. Data processor responsibilities – additional obligations are incorporated within the new legislation requiring the Data Controller to ensure that contracts with Data Processors comply with the legislation. New contract clauses have been issued by the Department of Health this week.
9. Data portability – allows individuals to obtain and reuse their personal data for their own purposes across different services – the information must be provided free of charge and within one month.
10. Privacy by design – there is a general obligation to implement technical and organisational measures to show that the organisation has considered and integrated data protection into all processing activities.

**Information Governance Partnership Board (IGPB)**

The Trust has played an active role during the year on the Kent and Medway Information Governance Partnership Board. The board is responsible for maintaining the Kent and Medway Information Sharing Agreement which is currently being refreshed to ensure it meets the requirements of the new Data Protection legislation.

**Information Governance Regulator Activity**

The Trust was required to report one information governance data protection breach incident to the Information Commissioner's Office (ICO) and the Department of Health in the year related to batch printing from the new patient administration system Allscripts. The ICO advised that, after careful consideration, it has been decided that formal enforcement action is not appropriate in respect of this incident for the following reasons:

Our consideration of the case

The seventh data protection principle states that:

"Appropriate technical and organisational measures shall be taken against the unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.

Sensitive personal data was involved so there was potential for this incident to cause distress/detriment but significant detriment seems unlikely.

There is evidence of steps being taken to test the system being used and help prevent such incidents.

It is possible an error occurred with the process that could not have reasonably been foreseen.

Remedial action has been taken to help prevent further incidents of this nature.

The Trust has reported one other data protection incident to the ICO in the last two years but this was of a different nature.

After considering the available information it is our view that this incident does not meet the criteria for formal enforcement action by the ICO.

There have also been a couple of complaints made to the Information Commissioner's Office relating to the Trust's handling of subject access requests. In each case the Information Commissioner has been satisfied with the Trust response and no further action has been taken. Whilst this is the case the Information Commissioner has advised that they will keep the concerns on file as this will help them build up a picture of the Trust's information rights practices.

**Information Risks**

The Board are advised that no new Information Governance risks have been added to the Trust risk register since my last annual report in March 2017.

All Directorates and Departments have been requested to review their Business Continuity Plans to ensure they have been updated to reflect to Trust's ongoing journey to a paper-light environment.

**Which Committees have reviewed the information prior to Board submission?**

- Information Governance Committee
- Trust Management Executive (21/03/18)

**Reason for receipt at the Board (decision, discussion, information, assurance etc.)**

This report is provided to the Board for assurance purposes.

# Version 14.1 (2017-2018) Assessment

## Requirements List

| Req No | Description | Status | Attainment Level |
|---|---|---|---|
| **Information Governance Management** | | | |
| **14.1-101** | There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda | Reviewed And Updated | Level 3 |
| **14.1-105** | There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans | Reviewed And Updated | Level 3 |
| **14.1-110** | Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations | Reviewed And Updated | Level 2 |
| **14.1-111** | Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation | Reviewed And Updated | Level 3 |
| **14.1-112** | Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained | Reviewed And Updated | Level 3 |
| **Confidentiality and Data Protection Assurance** | | | |
| **14.1-200** | The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs | Reviewed And Updated | Level 3 |
| **14.1-201** | The organisation ensures that arrangements are in place to support and promote information sharing for coordinated and integrated care, and staff are provided with clear guidance on sharing information for care in an effective, secure and safe manner | Reviewed And Updated | Level 3 |
| **14.1-202** | Confidential personal information is only shared and used in a lawful manner and objections to the disclosure or use of this information are appropriately respected | Reviewed And Updated | Level 3 |
| **14.1-203** | Patients, service users and the public understand how personal information is used and shared for both direct and non-direct care, and are fully informed of their rights in relation to such use | Reviewed And Updated | Level 3 |
| **14.1-205** | There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data | Reviewed And Updated | Level 2 |
| **14.1-206** | Staff access to confidential personal information is monitored and audited. Where care records are held electronically, audit trail details about access to a record can be made available to the individual concerned on request | Reviewed And Updated | Level 3 |
| **14.1-207** | Where required, protocols governing the routine sharing of personal information have been agreed with other organisations | Reviewed And Updated | Level 2 |
| **14.1-209** | All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines | Reviewed | Level 2 |

| | | | |
|---|---|---|---|
| **14.1-210** | All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements | Reviewed | Level 2 |
| **Information Security Assurance** | | | |
| **14.1-300** | The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs | Reviewed | Level 2 |
| **14.1-301** | A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed | Reviewed | Level 2 |
| **14.1-302** | There are documented information security incident / event reporting and management procedures that are accessible to all staff | Reviewed And Updated | Level 2 |
| **14.1-303** | There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority | Reviewed | Level 2 |
| **14.1-304** | Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use | Reviewed | Level 2 |
| **14.1-305** | Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems | Reviewed | Level 2 |
| **14.1-307** | An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy | Reviewed | Level 2 |
| **14.1-308** | All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers | Reviewed And Updated | Level 2 |
| **14.1-309** | Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place | Reviewed | Level 2 |
| **14.1-310** | Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error | Reviewed And Updated | Level 2 |
| **14.1-311** | Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code | Reviewed And Updated | Level 2 |
| **14.1-313** | Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely | Reviewed And Updated | Level 2 |
| **14.1-314** | Policy and procedures ensure that mobile computing and teleworking are secure | Reviewed | Level 2 |
| **14.1-323** | All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures | Reviewed | Level 2 |
| **14.1-324** | The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate | Reviewed | Level 2 |

| | | | |
|---|---|---|---|
| **Clinical Information Assurance** | | | |
| **14.1-400** | The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience | Reviewed | Level 2 |
| **14.1-401** | There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements | Reviewed | Level 2 |
| **14.1-402** | Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care | Reviewed And Updated | Level 2 |
| **14.1-404** | A multi-professional audit of clinical records across all specialties has been undertaken | Reviewed | Level 2 |
| **14.1-406** | Procedures are in place for monitoring the availability of paper health/care records and tracing missing records | Reviewed | Level 2 |
| **Secondary Use Assurance** | | | |
| **14.1-501** | National data definitions, standards, values and data quality checks are incorporated within key systems and local documentation is updated as standards develop | Reviewed | Level 2 |
| **14.1-502** | External data quality reports are used for monitoring and improving data quality | Reviewed | Level 2 |
| **14.1-504** | Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained | Reviewed | Level 2 |
| **14.1-505** | An audit of clinical coding, based on national standards, has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last 12 months | Reviewed And Updated | Level 3 |
| **14.1-506** | A documented procedure and a regular audit cycle for accuracy checks on service user data is in place | Reviewed | Level 2 |
| **14.1-507** | The secondary uses data quality assurance checks have been completed | Reviewed | Level 2 |
| **14.1-508** | Clinical/care staff are involved in quality checking information derived from the recording of clinical/care activity | Reviewed And Updated | Level 2 |
| **14.1-510** | Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national clinical coding standards | Reviewed And Updated | Level 2 |
| **Corporate Information Assurance** | | | |
| **14.1-601** | Documented and implemented procedures are in place for the effective management of corporate records | Reviewed | Level 2 |
| **14.1-603** | Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000 | Reviewed | Level 2 |
| **14.1-604** | As part of the information lifecycle management strategy, an audit of corporate records has been undertaken | Reviewed | Level 2 |

**Trust Board meeting – March 2018**

NHS Maidstone and Tunbridge Wells NHS Trust

| 3-21 | Summary report from Audit and Governance Committee, 26/02/18 | Committee Chair (Non-Executive Director) |
|---|---|---|

The Audit and Governance Committee met on 26th February 2018.

**1. The key matters considered at the 'main' meeting were as follows:**

- The Committee approved proposed changes to the delegation thresholds for "compensation under legal obligation" within the Scheme of Delegation (as detailed in Appendix 1), and further stipulated that all payments for compensation under legal obligation were to be routinely notified at each of the Committee's meetings
- Under the Safety Moment, the Trust Secretary reported that February's theme was Venous Thromboembolism (VTE) prevention and highlighted the key areas of focus for the month
- There was further discussion of the Trust's policy on acceptance by staff of patient bequests and KR confirmed that the views of each Executive Team member were being sought on this matter
- A review of the Board Assurance Framework (BAF) and Trust Risk Register for 2017/18 was undertaken, and changes in status noted. It was agreed that:
  - Consideration should be given to how the format of the BAF might be modified to incorporate assurances on the data quality of performance information
  - The Trust Secretary should liaise with the Chief Executive to determine a method by which the content of the BAF might be considered by the Executive Team prior to review by the Committee and Trust Board
- It was confirmed that, following a joint tender by MTW, Kent Community Health NHS Foundation Trust and Kent and Medway NHS and Social Care Partnership Trust, TIAA Ltd had been reappointed to provide Internal Audit and Counter Fraud services to the Trust for 3 years
- An update on progress with the Internal Audit plan for 2017/18 (including progress with actions from previous Internal Audit reviews) was reported. The list of recent Internal Audit reviews, all at the draft report stage, is shown below (in section 2). It was noted that there were 4 outstanding ICT audit recommendations
- The Internal Audit Plan for 2018/19 was reviewed. The Committee approved the Plan for Quarter 1 and agreed that the Plan (Quarters 2-4) should be finalised in the light of ongoing work, for approval at the meeting on 02/05/18
- A Counter Fraud update was reviewed, which included: an update on progress against the recommendations from the recent NHS Protect "Focussed Assessment" on 'Prevent and Deter' and 'Hold to Account' activity; the outcome of a Fraud Check on the Trust's payment cards; and a cross-trust review of Single Tender Waivers. The Counter Fraud Workplan for 2018/19 was also reviewed and approved
- A 'Progress and emerging issues' report was received from External Audit. No matters of significance were raised
- The External Audit Plan for 2017/18 was reviewed and approved. The External Audit Lead reported that consideration would be given by Grant Thornton LLP (GT) to whether an 'except for' or an 'adverse' Value for Money qualification was appropriate for the year. GT also reported that the clarity and completeness of the disclosures in the financial statements would be a key focus in respect of the Going Concern conclusion
- The findings from the evaluations of the Internal Audit service and the External Audit Services were reviewed. No issues in need of immediate review were identified and it was agreed that a response to the survey findings should be prepared by TIAA Ltd and GT respectively for consideration by the Committee at its meeting on 02/05/18. It was further agreed that:
  - The responses should include further information on any issues on which Committee members had expressed uncertainty in their answers and
  - The content of future surveys should be amended to reflect the feedback received at the meeting
- The losses & compensations data for the period 01/04/17 – 31/01/18 was reviewed, which showed a reduction in volume and value compared with the previous period
- The latest single tender waivers (STW) data was reviewed, which represented a decrease both in volume and value compared with the previous quarter. The Procurement Team's achievement in exceeding the Carter metric target of 80% for Purchase Order coverage was acknowledged

- A report detailing gifts, hospitality and sponsorship declared in the period 19/09/17 to 26/10/17 was considered. This showed a pro rata decrease in the volume of declarations on the previous reporting period. It was agreed to confirm the values for the four items listed as "not quantified" within the Report on Gifts, Hospitality and Sponsorship for the period 27/10/17 to 22/02/18. The Trust Secretary provided an update on the status of the Trust's new Management of Conflict of Interests Policy and Procedure
- An update was given on the 2017/18 Accounts process and the Director of Finance highlighted the information provided on the Going Concern assumption. The Committee agreed that the rationale for the Trust's adoption of a Going Concern basis should be included in the Committee's verbal report to the Trust Board on 01/03/18. It was also agreed to consider the feasibility of linking comments over the Trust's financial performance and future plans in one of the Notes to the Accounts
- The Director of Finance provided a verbal summary of the latest financial position
- The findings from the Committee's self-assessment / compliance with Terms of Reference exercise were considered and it was agreed that there were sufficient areas of concern for the Trust Secretary to liaise with the Chair of the Trust Board to incorporate a review of the Audit and Governance Committee evaluation findings into a wider review of sub-committee evaluations as part of a Trust Board Seminar (prior to summer 2018). In order to allow for more detailed consideration of specific issues, it was also agreed that a review of the Audit and Governance Committee evaluation findings should be scheduled for the meeting on 08/08/18
- The Committee's forward programme was noted

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

- Critical Financial Assurance – Payroll
- Critical Financial Assurance – Financial Accounting and Non Pay Expenditure
- A&E Data Capture and Recording
- Discharge Processes including Delayed Transfers of Care
- Information Governance Toolkit Part 1
- Cost Improvement Plan

**3. The Committee was also notified of the following "Urgent" priority outstanding actions from Internal Audit reviews:**

- Health Records (1 outstanding action)

**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:**

- The rationale for the Trust's Going Concern assumption was to be drawn to the attention of the Board as part of the Committee Chair's verbal update to the Board on 01/03/18, with particular reference to the audit requirement as set out in the Audit Plan to "obtain sufficient appropriate audit evidence about the appropriateness of management's use of the going concern assumption in the preparation and presentation of the financial statements and to conclude whether there is a material uncertainty about the entity's ability to continue as a going concern" (ISA (UK) 570)… The Trust has a cumulative deficit and also planned for a small deficit in 2017/18. The forecast deficit for the year end is some £10 million more than plan. There are uncertainties about the appropriateness of the going concern assumption for the Trust's financial statements and the clarity and completeness of the disclosures in the financial statements will be key. We will review management's assessment of the going concern assumption and evaluate the disclosures in the financial statements."

**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 ratify the proposed changes to the delegation thresholds for "compensation under legal obligation" within the Scheme of Delegation (Appendix 1)

[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: Review of Reservation of Powers and Scheme of Delegation thresholds for the authorisation of "compensation under legal obligation"**

At the last Audit and Governance Committee meeting, it was agreed that the Trust Secretary should undertake a review of the appropriate delegation thresholds for the authorisation of "compensation under legal obligation" for a) personal injuries and b) medical negligence. The Trust's current thresholds are as follows:

| **Delegated matter** | **Authority delegated to (or noted as being retained by Trust Board)** | **Key reference documents** |
|---|---|---|
| **3.9 Losses, write-offs and compensation** | | SFI section 17 |
| d) Compensation under legal obligation<br>• Up to £10,000 | Director of Finance | |
| • Above £10,000 | Trust Board | |
| Personal Injuries<br>• Up to £10,000 | Director of Finance | |
| • Above £10,000 | Trust Board | |
| Medical Negligence<br>• From £10,000 to £100,000 | Chief Executive | |
| • Above £100,000 | Trust Board | |

A review of other NHS Trust's thresholds was duly undertaken. Many Trusts' Scheme of Delegation makes no specific reference to the issue, but 2 acute NHS Trusts were found to have higher thresholds, as follows:

| **Trust** | **Personal injury** | **Medical negligence** |
|---|---|---|
| East Lancashire Hospitals NHS Trust | Payments for personal injury claims, involving negligence where legal advice obtained and followed up: up to £1m (including claimant legal costs) - Director of Finance or nominated deputy | Payments for clinical negligence (negotiated settlements): up to £1m (including legal costs) - Chief Executive / Deputy Chief Executive / Director of Finance |
| Epsom and St Helier University Hospitals NHS Trust | Payments for personal injury claims, involving negligence where legal advice obtained and relevant advice applied: up to £1m (including claimant legal costs) - Director of Finance and Chief Executive | Payments for clinical negligence (negotiated settlements following legal advice): up to £1m (including legal costs) - Director of Finance and Chief Executive |

In light of this, it is proposed that the Trust's thresholds be simplified and amended, to cease the differentiation between clinical negligence and personal injury, and to delegate the authorisation of payments below £1m to the Director of Finance and Chief Executive, with payments of £1m and above requiring the authorisation of the Trust Board. The proposed arrangements are therefore:

| **Delegated matter** | **Authority delegated to (or noted as being retained by Trust Board)** | **Key reference documents** |
|---|---|---|
| **3.9 Losses, write-offs and compensation** | | SFI section 17 |
| e) Compensation under legal obligation (where legal advice (and that of NHS Resolution) has been obtained and applied)<br>• Up to £1m (including legal costs) | Director of Finance and Chief Executive | |
| • £1m and above (including legal costs) | Trust Board | |

If the Committee approves the change, the Trust Board will be asked to ratify the changes to the Reservation of Powers and Scheme of Delegation.

**Trust Board meeting – March 2018**

NHS
Maidstone and Tunbridge Wells NHS Trust

| **3-22 Charitable Funds Committee, 27/02/18** | **Committee Chair (Non-Executive Director)** |
|---|---|

The Charitable Funds Committee met on 27th February 2018.

**1. The key matters considered at the meeting were as follows:**

- Under the Safety Moment, the Trust Secretary reported that February's theme was Venous Thromboembolism (VTE) prevention and highlighted the key areas of focus for the month
- The Associate Director for Cancer & Clinical Support (ADCCS) provided an update on the status of the campaign to fundraise for a Cancer Health & Wellbeing Centre at Maidstone Hospital. ADCCS outlined a provisional plan to demolish Farm Cottage and reallocate its current offices within a new-build Health & Wellbeing Centre. ADCCS confirmed that fundraising had not yet commenced for this initiative and requested guidance on key governance issues. The committee agreed that this should be progressed through the development of a Business Case for the Centre, to be considered at its meeting in June 2018. It was also provisionally agreed that, should the initiative go ahead, the best approach would be to establish a designated fund within the Trust's existing Charitable Fund (i.e. as opposed to establishing a separate charity).
- It was confirmed that the audit approach for the 2017/18 Charitable Fund accounts would likely be by independent review (rather than an external audit), and it was agreed to amend the forward programme to reflect the reported timetable, i.e. review of the draft accounts in June 2018 and agreement of the audited Charitable Fund Annual Report & Accounts in October 2018
- The financial overview at Month 10 was considered and the following was noted:
  - A decrease in the overall fund balance of approximately £90k since the beginning of the financial year
  - An increase in income by approximately £100k in the same period
  - Overall expenditure of approximately £262k in the year to date, against income of £169k
  - The most significant income in the period related to payments of approximately £40k from Tunbridge Wells Area Diabetes Resources Appeal and a legacy of £42.3k, restricted to the Peggy Wood Breast Care Centre
  - No items of expenditure had been refused during the period
  - There had been no items of revenue expenditure in excess of £150k
  - A management and administration fee of £24.6k had been included

  It was agreed that the terms of the relevant legacy account/s should be checked to ensure that future planned expenditure on cardiology equipment at Tunbridge Wells was consistent with the legacy intentions
- The Head of Communications reported that a high quality candidate had been recruited as a Fundraiser, but had withdrawn for financial/career reasons, prior to commencement in post. The Committee noted the candidate's feedback about the post and the Trust's position in relation to fundraising & supported the Head of Communications' request for reaffirmation of the rationale for the post, as well as an accelerated bid for re-banding of the post to a Band 7
- Recent guidance issued by the Department of Health on NHS Funds held on Trust was considered and it was agreed that a gap analysis should be undertaken against the guidance for consideration at the meeting in June 2018

**2. The Committee agreed that (in addition to any actions noted above):** N/A

**3. The issues that need to be drawn to the attention of the Board are as follows:** N/A

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

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

Information and assurance

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

**Trust Board meeting – March 2018**

NHS Maidstone and Tunbridge Wells NHS Trust

| 3-23 | Summary report from the Patient Experience Committee, 07/03/18 | Committee Chair (Non-Executive Director) |
|---|---|---|

The Patient Experience Committee (PEC) met on 7th March 2018.

**The key matters considered at the meeting were as follows:**

- An update on actions raised at previous meetings was given
- The Terms of Reference (ToRs), were considered as part of their annual review and minor changes agreed. The revised ToRs, as agreed by the PEC, with the proposed changes 'tracked', are enclosed at Appendix 1, for approval
- Confirmation was received that a portable shatterproof mirror was being reviewed by Clinical and Infection Prevention staff for use in patient bathrooms; an update on this and on identification of an appropriate new vanity unit was scheduled for the next meeting
- An update was received on initiatives to ensure the oversight of meal provision for vulnerable patients, and it was agreed for this issue to be incorporated into the PLACE agenda
- The Interim Transformation Outpatient Manager outlined the Outpatients' booking process within the Trust, including details of how the issues presented by implementation of the new Patient Administration System in October 2018 had been resolved, and introduction of the NHS e-Referral Service in February 2018
- An update was given by the Director of Strategy on the latest status of the Stroke Care Review in Kent & Medway, and the contents of the consultation document were highlighted
- An update was given on various Listening into Action initiatives within the Trust.
- The Committee was invited to submit any comments/suggestions on the Stroke Review and LiA initiatives
- The Chief Operating Officer of West Kent Clinical Commissioning Group gave a presentation on "Plans for 2018-20" (the presentation was subsequently circulated to PEC members)
- An update on Complaints & PALS contacts was received for Quarter 3
- A report on Healthwatch Kent's activity was noted, along with reports on feedback from patients in the Discharge Lounge and waiting for transport at TWH, and patient feedback for the period April to September 2017
- The Head of Delivery Development presented the Trust's draft Quality Strategy, 2018-2021 and members were subsequently invited to submit comments and suggestions for consideration
- The Trust's proposed Quality Accounts priorities 2018/19 were noted and members were invited to provide comments and suggestions on these by the end of March 2018
- A report on the PLACE Action Group was considered, which included updates on the previously raised issue of maintenance of hearing loops within the Trust
- Notification of recent/planned service changes was received, including details of weather-related service changes/cancellations due to severe weather at the end of February
- A report on recent Quality Assurance Rounds was given, which highlighted issues related to storage facilities; out of date patient information; Information Governance issues and tamper tags on resuscitation trolleys. The Committee heard that feedback from inspections had been incorporated into the Trust's Care Quality Commission (CQC) Action Plan
- The usual update on communications activity was noted, along with brief details of the Trust's membership composition
- The Head of Staff Engagement and Equality invited contributions from Committee members willing to share personal experiences / material for the Trust's International Nurse Recruitment process
- The Committee heard that the CQC inspection report was due to be published imminently, and that no unanticipated feedback had been received following the inspections in 2017
- The findings from the local patient survey (including the Friends & Family Test) were reported. It was noted that overall patient satisfaction had remained consistent for the year, & that a new survey, with questions aligned to the National Inpatient survey, would be launched in April 2018
- An update was received on the work of the Patient Information and Leaflets Group (PILG). The Committee heard that the current backlog would be addressed by a new PILG lead, due to take up post in May 2018

- A report from the Quality Committee meetings on 18/12/17, 10/01/18 and 06/02/18 was received and a verbal update given on the status of the "Review of Lessons Learnt" findings within the Trust. The refreshed Quality Committee ToRs were noted
- A report from the Patient Representative Working Group was received

**In addition to the actions noted above, the Committee agreed that:**

- The Trust Secretary should confirm the financial penalties that applied to the Trust for breaches of patient access targets
- The whereabouts of the two mobile breast screening units, previously located at the rear of Maidstone Hospital, should be clarified
- Clarification should be sought of any change in policy in the restaurant at Maidstone Hospital in relation to the use of paper plates and plastic cutlery
- The status of the Trust's End of Life Care Policy should be clarified

**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]

1. To approve the revised Terms of Reference for the Patient Experience Committee (Appendix 1)
2. 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

# PATIENT EXPERIENCE COMMITTEE

# TERMS OF REFERENCE

NHS
Maidstone and Tunbridge Wells NHS Trust

## 1. Purpose

The Committee's purpose is to

1. Aim to capture the patient and public perception of the services delivered by Maidstone and Tunbridge Wells NHS Trust, and
2. 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

## 2. Membership

From the Trust:

- Non-Executive Director or Associate Non-Executive Director (Chair)
- Non-Executive Director or Associate Non-Executive Director (Vice Chair)
- Chief Nurse
- Director of Finance
- Deputy Chief Nurse (x 1)
- Associate Director for Quality Governance
- Complaints & PALS Manager
- Trust Secretary

External to the Trust:

- Public representatives from the Trust's catchment area
- Representatives from patient and carer support groups within the Trust's catchment area
- Representative from Healthwatch Kent (1)
- Representative from the local Independent Health Complaints Advocacy service (1)
- Representative from the League of Friends of the Maidstone Hospital (1)
- Representative from the League of Friends of Tunbridge Wells Hospital (1)

## 3. Attendance and quorum

The Committee will be quorate when 4 members from the Trust (including 1 Non-Executive Director or Associate Non-Executive Director) and 4 members external to the Trust are present. Members may request a deputy to attend meetings in their place. Such a deputy will count towards the quorum.

The Associate Director of Nursing (or equivalent) from each Clinical Division will be invited to attend each meeting.

All other Non-Executive Directors (including the Chair~~man~~ of the Trust Board), Associate Non-Executive Directors, and Executive Directors are entitled to attend any meeting of the Committee.

A representative from the 'Doctors in training' (Junior Doctors) and/or junior members of other healthcare professions working at the Trust will be invited to attend each meeting, and provide a report on their reflections of the patient experience-related matters relevant to their role.

A representative from West Kent Clinical Commissioning Group (CCG) will be invited to attend each meeting, and provide a report on relevant matters.

The Chair/s of the Patient Experience Committee's sub-committee will be invited to attend certain meetings, to provide a report on the sub-committee's activity.

The Committee Chair may also invite others to attend, as required, to meet the Committee's duties.

## 4. Frequency of meetings

Meetings will be generally held quarterly.

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

## 5. Duties

- To positively promote the Trust's partnership with its patients and public
- To aim to capture the perspective of patients and the public, and present the patients' and public's perception of the Trust's services
- To oversee the development of patient information within the Trust, via the Patient Information Leaflet Group (PILG)
- To contribute to the development of Trust Policies, procedures, and strategies in so far as they relate to patient experience
- To advise on priorities for patient surveys and on the methods for obtaining local patient feedback
- To act as the primary forum by which the Trust will involve and consult with its patients and public on:
  - The planning of the provision of its services
  - Proposals for changes in the way those services are provided, and
  - Significant decisions that affect the operation of those services
- To monitor (via the receipt of reports) the following subjects:
  - Findings from the national NHS patient surveys (along with a response)
  - Friends and Family Test findings (and response, if required)
  - Findings from local patient surveys
  - Findings from relevant Healthwatch Kent 'Enter & View' visits (with a response, if relevant)
  - Comments from NHS Choices/'My NHS', and Social Media
  - Complaints and PALS contacts information
  - Progress against the "Patient Experience" priorities in the Trust's Quality Accounts
  - Patient experience-related findings from Patient-led Assessments of the Care Environment (PLACE)
  - Patient experience-related findings from the "Patient Representative Working Group", as required
- To review the work being undertaken by Clinical Directorates in relation to patient experience
- To maintain awareness of the developments with the Kent and Medway Sustainability and Transformation P<u>artnership</u>~~lan~~ (STP)

## 6. Parent committees and reporting procedure

The Patient Experience Committee is a sub-committee of the Trust Board. The Committee Chair will report its activities to the next Trust Board meeting following each Patient Experience Committee meeting.

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

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

## 7. Sub-committees and reporting procedure

The following sub-committees will report to the Patient Experience Committee through their respective chairs or representatives following each meeting:

- Patient Information Leaflet Group (PILG)

The frequency of reporting will depend on the frequency of sub-committee meetings.

## 8. Quality Committee

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

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

## 9. Administration

The minutes of the Committee will be formally recorded and presented to the following meeting for agreement and the review of actions

The Trust Secretary will ensure that each committee is given appropriate administrative support and will liaise with the Committee Chair on:

- The Committee's Forward Programme, setting out the dates of key meetings & agenda items
- The meeting agenda, minutes and 'actions log'

## 10. Emergency powers and urgent decisions

The powers and authority of the Patient Experience Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted with either the Chief Nurse or Director of Finance~~at least one Executive Director member~~. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Patient Experience Committee, for formal ratification.

## 11. Review

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

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**History**

- Terms of Reference (amended) agreed by the Patient Experience Committee, 14th October 2009
- Terms of Reference (amended) agreed by the Patient Experience Committee, 4th October 2010
- Terms of Reference (amended) approved by the Patient Experience Committee, 3rd October 2011
- Terms of Reference (amended) agreed by the Patient Experience Committee, 6th February 2012
- Terms of Reference (amended) approved by Patient Experience Committee, 7th March 2013
- Terms of Reference (amended) approved by the Trust Board, 29th April 2015
- Terms of Reference (amended) agreed by the Patient Experience Committee, 7th March 2016
- Terms of Reference (amended) approved by the Trust Board, 23rd March 2016
- Terms of Reference (amended) agreed by the Patient Experience Committee, 8th March 2017
- Terms of Reference (amended) approved by the Trust Board, 29th March 2017
- Terms of Reference approved by Trust Board, 18th October 2017 (to add Associate Non-Executive Directors to the membership)
- Terms of Reference (amended) agreed by the Patient Experience Committee, 7th March 2018

**Trust Board Meeting – March 2018**

NHS Maidstone and Tunbridge Wells NHS Trust

| 3-24 | Summary report from Quality Committee, 14/03/18 | Committee Chair (Non-Executive Director) |
|---|---|---|

The Quality Committee met on 14th March (a 'main' meeting).

1. **The key matters considered were as follows:**
   - The **progress with actions** from previous meetings was noted
   - The Medical Director reported on the **quality matters arising from the plans to exit Financial Special Measures (FSM)**, which included the status of latest Quality Impact Assessments (QIAs). The Committee agreed that based on the level of assurance that had been received regarding the QIA process,, the forward programme of the 'main' Quality Committee should be amended to replace the standing "Quality matters arising from the plans to exit FSM (incl. overview of QIAs)" item/report with an "Annual review of QIAs" covering each future financial year (from May 2019)
   - The latest update on the **work being undertaken to reduce Length of Stay** (LOS) was given, and again, based on the assurance given (and the fact that LOS was being subsumed within the Best Care programme), it was agreed to amend the forward programme of the Committee to remove the item/report from all future meetings
   - The reports from the rolling programme of **Directorate-based clinical outcome reports** were reviewed, for Specialist Medicine and Therapies and Children's Services
   - The report of recent **Trust Clinical Governance Committee** meetings was discussed, and each Directorate then highlighted their key issues
   - The Trust's **proposed response to the current public consultation regarding the locations for Hyper Acute Stroke Unit (and Acute Stroke Unit)** was discussed
   - The Head of Delivery and Development attended to present a **draft updated Quality Strategy**, and it was agreed that they should consider whether the introductory statement included in the Strategy had erroneously omitted the word "at" (i.e. so that the statement should be "To deliver kind, compassionate and sustainable services for our community, through being improvement driven and responsive to the needs of our patients and staff, making MTW a great Trust to visit and work at"). The Associate Director, Quality Governance also submitted the **draft quality priorities for 2018/19, for inclusion in the Quality Accounts 2017/18** for comment
   - The Medical Director gave an **update on the current review of patients experiencing a long waiting time**
   - The **Directorate responses to the 2018 Medical Engagement Scale survey** were reviewed in detail
   - The **CQC's 2017 inspection report** was received, and it was noted that an action plan was being developed in response
   - A **Mortality update** report gave the latest position on Hospital Standardised Mortality Ratio (HSMR) and the Mortality Reviews undertaken by Directorates.
   - The latest **Serious Incidents**, the **recent findings from relevant Internal Audit reviews**, and report of the **Quality Committee 'deep dive' meeting** held on 06/02/18 were noted

2. **In addition to the agreements referred to above, the Committee agreed that:** The Deputy Chief Nurse should clarify the reasons for the recent cancellation/s of face-to-face mandatory training sessions

3. **The issues from the meeting that need to be drawn to the attention of the Board are as follows:** Some concerns were expressed regarding the apparent failure to consult on the recent change to the Trust's Radiology imaging (PACS) viewer

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

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

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

**Trust Board meeting – March 2018**

NHS Maidstone and Tunbridge Wells NHS Trust

## 3-27 Review of the Terms of Reference for the Trust Board — Chair of the Trust Board

The Terms of Reference for the Trust Board are required to be reviewed and approved at least every 12 months. This review and approval last took place in March 2017.

The Terms of Reference have been reviewed, and a number of minor amendments are proposed. These have been 'tracked' in the enclosed. None of the proposed amendments are significant, and can largely be categorised as 'housekeeping', to reflect changes that have already been agreed (as part of the approval of revised Standing Orders), or occur in practice.

**Which Committees have reviewed the information prior to Board submission?**

- N/A

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

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

**Trust Board**

**Terms of Reference**

NHS Maidstone and Tunbridge Wells NHS Trust

## Purpose and duties

1. The Trust exists to 'provide goods and services for any purposes related to the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health'.

2. The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf, but the Trust Board may delegate any of those powers to a committee of Directors or to a Member of ~~n~~the Executive Team~~Director~~. The voting members of the Trust Board comprise ~~consists of~~ a Chair~~man~~ (Non-Executive), five other Non-Executive Directors ~~(voting members)~~, the Chief Executive, and four ~~Executive Directors (~~specified ~~voting~~ M~~m~~embers of the Executive Team). ~~Other Directors (~~Other, non-voting~~)~~ members of the Trust Board ~~also~~ attend ~~the~~ Trust Board meetings, and contribute to its deliberations and decision-making.

3. The Trust Board leads the Trust by undertaking three key roles:
   3.1. Formulating strategy;
   3.2. Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable;
   3.3. Shaping a positive culture for the Trust Board and the organisation.

4. The general duty of the Trust Board and of each ~~Director~~ individual~~ly~~ Trust Board Member, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the patients and communities served and members of the organisation.

5. The practice and procedure of the meetings of the Trust Board – and of its Committees –are described in the Trust's Standing Orders.

### General responsibilities

6. The general responsibilities of the Trust Board are:
   6.1. To work in partnership with all stakeholders and others to provide safe, accessible, effective and well governed services for the Trust's patients;
   6.2. To ensure that the Trust meets its obligations to the population served and its staff in a way that is wholly consistent with public sector values and probity;
   6.3. To exercise collective responsibility for adding value to the Trust by promoting its success through the direction and supervision of its affairs in a cost effective manner.

7. In fulfilling its duties, the Trust Board will work in a way that makes the best use of the skills of all Trust Board Members~~Non-Executive and Executive Directors~~.

### Leadership

8. The Trust Board provides active leadership to the organisation by:
   8.1. Ensuring there is a clear vision and strategy for the Trust that is implemented within a framework of prudent and effective controls which enable risks to be assessed and managed;
   8.2. Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.

### Strategy

9. The Trust Board:
   9.1. Sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
   9.2. Monitors and reviews management performance to ensure the Trust's objectives are met;

9.3. Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
9.4. Develops and maintains an annual plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders;
9.5. Ensure that national policies and strategies are effectively addressed and implemented within the Trust.

Culture

10. The Trust Board is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Trust Board is entirely consistent with those values.

11. A Board Code of Conduct has been developed to guide the operation of the Trust Board and the behaviour of Trust Board Members. This Code is incorporated within the Trust's Gifts, Hospitality, Sponsorship and Interests Policy and Procedure

Governance

12. The Trust Board:
12.1. Ensures that the Trust has comprehensive governance arrangements in place that ensures that resources are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
12.2. Ensures that the Trust complies with its governance and assurance obligations;
12.3. Ensures compliance with the principles of corporate governance and with appropriate codes of conduct, accountability and openness applicable to Trusts;
12.4. Reviews and ratifies Standing Orders, Reservation of Powers and Scheme of Delegation, and Standing Financial Instructions as a means of regulating the conduct and transactions of Trust business;
12.5. Ensures that the statutory duties of the Trust are effectively discharged;
12.6. Acts as the agent of the corporate trustee for the Maidstone and Tunbridge Wells NHS Trust Charitable Fund. This includes approving the Annual Report and Accounts of the Charitable Fund.

Risk Management

13. The Trust Board:
13.1. Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
13.2. Ensures that there are sound processes and mechanisms in place to ensure effective patient and carer involvement with regard to the review of quality of services provided and the development of new services;
13.3. Ensures there are appropriately constituted appointment arrangements for senior positions such as Consultant medical staff and Members of the Executive Team~~Directors~~.

Ethics and integrity

14. The Trust Board:
14.1. Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of Trust business;
14.2. Ensures that Trust Board Members ~~Directors~~ and staff adhere to any codes of conduct adopted or introduced from time to time.

Sub-Committees

15. The Trust Board is responsible for maintaining sub-committees of the Board with delegated powers as prescribed by the Trust's Standing Orders and/or by the Board from time to time

Communication

16. The Trust Board:
    16.1. Ensures an effective communication channel exists between the Trust, staff and the local community;
    16.2. Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
    16.3. Ensures that those Trust Board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website;
    16.4. Approves the Trust's Annual Report and Annual Accounts.

Quality Success and Financial success

17. The Trust Board:
    17.1. Ensures that the Trust operates effectively, efficiently, economically;
    17.2. Ensures the continuing financial viability of the organisation;
    17.3. Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
    17.4. Ensure that the Trust achieves the targets and requirements of stakeholders within the available resources;
    17.5. Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

Role of the Chair~~man~~

18. The Chair~~man~~ of the Trust Board is responsible for leading the Trust Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole;

19. The Chair~~man~~ is responsible for the effective running of the Trust Board and for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives;

20. The Chair~~man~~ is the guardian of the Trust Board's decision-making processes and provides general leadership of the Board.

Role of the Chief Executive

21. The Chief Executive reports to the Chair~~man~~ of the Trust Board and to the Trust Board directly.
22. The Chief Executive is responsible to the Trust Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board;
23. The Chief Executive is responsible for implementing the decisions of the Trust Board and its committees, providing information and support to the Board

**Membership of the Trust Board**

24. The Trust Board will co__mprise the following persons:
    24.1. The Chair of the Trust Board~~A Non-Executive Chairman~~
    24.2. Up to 5 Non-Executive Directors ~~(5)~~. One of these will be designated as Vice-Chair~~man~~
    24.3. The Chief Executive
    24.4. The Director of Finance
    24.5. The Medical Director
    24.6. The Chief Nurse
    24.7. The Chief Operating Officer

Non-voting Trust Board Members will be invited to attend Trust Board meetings at the discretion at the Chair~~man~~.

**Quorum**

25. The Board will be quorate when four Trust Board Members including at least the Chair~~man~~ (or Non-Executive Director nominated to act as Chair~~man~~), one other Non-Executive Director, the

Chief Executive (or Executive Director nominated to act as Chief Executive), and one other Executive Director (member) are present[1].

26. An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum at Trust Board meetings

**Attendance**

27. The Trust Secretary will normally attend each meeting.

28. Other staff members and external experts may be attend Trust Board meetings to contribute to specific agenda items, at the discretion of the Chair~~man~~

**Frequency of meetings**

29. The Board will sit formally at least ten times each calendar year. Other meetings of the Board will be called as the need arises and at the discretion of the Chair~~man~~.

**Board development**

30. The Chair~~man~~, in consultation with the Trust Board will review the composition of the Board to ensure that it remains a "balanced board" where the skills and experience available are appropriate to the challenges and priorities faced;

31. Trust Board Members will participate in Board development activity designed to support shared learning and personal development.

**Sub-committees and reporting procedure**

32. The Trust Board has the following sub-committees
    32.1. The Quality Committee
    32.2. The Patient Experience Committee
    32.3. The Audit and Governance Committee
    32.4. The Finance and Performance Committee
    32.5. The Workforce Committee
    32.6. The Charitable Funds Committee
    32.7. The Remuneration and Appointments Committee

33. For the Quality Committee, Patient Experience Committee, Audit and Governance Committee, Finance and Performance Committee, Charitable Funds Committee, and Workforce Committee, a summary report from each meeting will be provided to the Trust Board (by the Chair of that meeting) in a timely manner

34. The Terms of Reference for each sub-committee will be approved by the Trust Board. The Terms of Reference will be reviewed annually, agreed by each sub-committee, and approved by the Trust Board.

**Emergency powers and urgent decisions**

35. The powers which the Board has reserved to itself within the Standing Orders Set may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair~~man~~ of the Trust Board after having consulted at least two Non-Executive Directors.

36. The exercise of such powers by the Chief Executive and Chair~~man~~ shall be reported to the next formal meeting of the Trust Board in public session ('Part 1') for formal ratification.

[1] This number is set to accord with the relevant section of the Standing Orders, which states that "No business shall be transacted at a Trust Board meeting unless at least one-third of the whole number of the Chairman and members (including at least one Executive Director and one Non-Executive Director) is present"

**Administration**

37. The Trust Board shall be supported administratively by the Trust Secretary whose duties in this respect will include:
    37.1. Agreement of the agenda for Trust Board meetings with the Chair~~man~~ and Chief Executive;
    37.2. Collation of reports for Trust Board meetings;
    37.3. Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward on an action log;
    37.4. Advising the Trust Board on governance matters.

38. A full set of papers comprising the agenda, minutes and associated reports will be sent within the timescale set out in Standing Orders to all Trust Board Members and others as agreed with the Chair~~man~~ and Chief Executive.

**Conflict with Standing Orders Set**

39. In the event of a conflict between these Terms of Reference and the content of the Standing Orders Set, the content of the Standing Orders Set should take precedence.

**Review**

40. These Terms of Reference will be reviewed and approved at least every 12 months.

Approved by the Trust Board, 29th March ~~2017~~2018