

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

10am – c.12.30pm THURSDAY 28TH JUNE 2018

LECTURE ROOMS 1 & 2, THE EDUCATION CENTRE, TUN. WELLS HOSPITAL

A G E N D A – P A R T 1

Ref.	Item	Lead presenter	Attachment
6-1	To receive apologies for absence	Chair of the Trust Board	Verbal
6-2	To declare interests relevant to agenda items	Chair of the Trust Board	Verbal
6-3	Minutes of the Part 1 meeting of 24 th May 2018	Chair of the Trust Board	1
6-4	To note progress with previous actions	Chair of the Trust Board	2
6-5	Safety moment	Chief Nurse	Verbal
6-6	Report from the Chair of the Trust Board	Chair of the Trust Board	Verbal
6-7	Report from the Chief Executive	Chief Executive	3
Staff experience			
6-8	The Trust's Staff Network Chairs	Head of Staff Engagement and Equality and Chairs of the Cultural Diversity, LGBT+ and Workability Staff Networks	Presentation
6-9	Integrated Performance Report for May 2018 <ul style="list-style-type: none"> ▪ Effectiveness / Responsiveness ▪ Safe / Effectiveness / Caring (incl. complaints response times recovery plan; and planned and actual ward staffing for June 2018) ▪ Safe / Effectiveness (incl. mortality) ▪ Safe (infection control) ▪ Well-Led (finance) ▪ Well-Led (workforce) 	Chief Executive Chief Operating Officer Chief Nurse	4
6-10	The recovery plans for the 62-day Cancer waiting time target	Medical Director Chief Nurse Director of Finance Director of Workforce	5
6-11	Update from the Best Care Programme Board	Chief Op. Officer / Trust Lead Cancer Clinician / Assoc. Dir. of Op's, Cancer & Clin. Supp't Chief Executive	6 (to follow)
Quality items			
6-12	Update on the compliance status of the 10 maternity safety actions in the CNST incentive scheme	Chief Nurse	7
6-13	Quarterly mortality data	Medical Director	8
6-14	Findings of the national inpatient survey 2017	Chief Nurse	9
6-15	Approval of Quality Accounts, 2017/18	Chief Nurse	10 (to follow)
Planning and strategy			
6-16	Approval of revised Quality Strategy	Chief Nurse	11
6-17	Electronic Patient Record - Review of changes between the Outline Business Case & Full Business Case (FBC)	Chief Op. Officer / Interim Dir. of Health Informatics / Chief Clinical Information Officer	12 (N.B. The FBC has been issued as a supplement to the main reports)
6-18	Winter planning and Operational Resilience 2018/19	Chief Operating Officer	13
6-19	Principles for Pathology reconfiguration in Kent	Chief Executive	14 (N.B. A supplement has also been issued)
Assurance and policy			
6-20	Cyber security threat – assurance report	Chief Nurse	15
6-21	Outcome of review the Trust's current policy regarding the start and end dates of the staff Annual Leave year	Director of Workforce	16
6-22	Review of the formal hosting arrangements for the Kent & Medway Sustainability and Transformation Partnership (and approval of the Trust's STP contribution)	Director of Finance	17 (to follow)
Reports from Trust Board sub-committees (and the Trust Management Executive)			
6-23	Audit and Governance Committee, 24/05/18	Committee Chair	18
6-24	Workforce Committee, 24/05/18	Committee Chair	19
6-25	Quality Committee, 19/06/18	Committee Chair	20
6-26	Trust Management Executive (TME), 20/06/18	Committee Chair	21
6-27	Finance and Performance Committee, 26/06/18	Committee Chair	22 (to follow)
6-28	To consider any other business		
6-29	To receive any questions from members of the public		
6-30	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 July 2018, 10am, Lecture Rooms 1 & 2, The Education Centre, Tunbridge Wells Hospital

David Highton, Chair of the Trust Board

**MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY
24TH MAY 2018, 10A.M, AT MAIDSTONE HOSPITAL**



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)
	Nazeya Hussain	Non-Executive Director	(NH)
	Tim Livett	Non-Executive Director	(TL)
	Peter Maskell	Medical Director	(PM)
	Claire O'Brien	Chief Nurse	(COB)
	Steve Orpin	Director of Finance	(SO)
	Steve Phoenix	Non-Executive Director	(SP)
	Miles Scott	Chief Executive	(MS)
In attendance:	Michael Beckett	Interim Director of Health Informatics (for items 5-10 & 5-15)	(MB)
	Tina Cooper	Practice Development Nurse for Specialist Medicine (for item 5-8)	(TC)
	Selina Gerard-Sharp	NExT Director	(SGS)
	Simon Hart	Director of Workforce	(SH)
	Madeline Jarvis	Clinical team lead, Orthopaedic-medical rehabilitation physiotherapy (for item 5-8)	(MJ)
	Nicola Lewis	Practice Development Nurse for Specialist Medicine (for item 5-8)	(NL)
	James Macdonald	Chief Clinical Information Officer (for items 5-10 & 5-15)	(JM)
	Claire Morris	In-patient Physiotherapy Clinical Manager (for item 5-8)	(CM)
	Kevin Rowan	Trust Secretary	(KR)
	Observing:	Pam Croucher	Healthwatch Kent (from item 5-8)
Darren Yates		Head of Communications	(DY)
Richard Hallett		Friends of Crowborough Hospital / Maternity Voices Partnership	(RH)
Evonne Harding		Member of the public	(EH)

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

5-1 To receive apologies for absence

There were no apologies, but it was noted that Sara Mumford (SM), Director of Infection Prevention and Control, would not be in attendance.

DH then welcomed SGS to her first Trust Board meeting.

5-2 To declare interests relevant to agenda items

No interests were declared.

5-3 Minutes of the 'Part 1' meeting of 26th April 2018

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

5-4 To note progress with previous actions

The circulated report (Attachment 2) was noted. The following actions were discussed in detail:

- **2-10c ("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").** DH

noted that the issue was intended to be discussed at Workforce Committee and then be considered by the Trust Board in June

- **4-16 (“Clarify whether the Trust was able to ask NHS Digital to undertake an on-site cyber and data security assessment (and if so, to request that such an assessment be undertaken”).** It was noted that confirmation was still awaited.

MC then referred to the problems with cancellations in outpatients that had been discussed at the last Board meeting (item 4-10, page 4 of 9), and asked for an update. AG reported that the challenges remained and a Task and Finish group had been established. AG added that Ophthalmology had the highest volume of cancelled activity and therefore the highest volume of calls received from patients, but gave assurance that the Trust continued to focus on the issue, and support the staff involved.

5-5 Safety moment

COB reported that the focus for May was on dementia and highlighted the following points:

- The “This is Me” booklet was being promoted, to help staff understand the often bewildering environment that Wards posed for patients with dementia
- A company called “Time to Dementia” had been engaged by the Trust, and all pre-registration Nurses would be allocated a buddy, to aid the understanding of staff
- That week was ‘Dementia Action Week’, and the event had been used to prompt staff to undertake actions such as completing their mandatory dementia training and ensuring that patients’ dementia risk assessments were completed

NH commended the training, and noted that some other Trusts had dementia champions on each Ward. COB confirmed that some champions for dementia were already in place, but agreed that there was no time for complacency and the Best Care workstream would pursue further improvements.

5-6 Report from the Chair of the Trust Board

DH reported that recruitment was underway to appoint 2 Associate Non-Executive Directors and interviews were scheduled for 25/05/18. DH also noted that there had been 1 Advisory Appointments Committee since the last Trust Board meeting, and a Consultant Haematologist had been appointed (although their start date had not yet been finalised).

5-7 Report from the Chief Executive

MS referred to Attachment 3 and drew attention to the following points:

- The theme of the report was ensuring the Trust’s potential was fully realised, and in this context, the recent trip to Northumbria Healthcare NHS Foundation Trust was relevant. Three things arose from the trip: firstly a recognition that many of the things in place in Northumbria were in place at the Trust, which led MS to feel that the success seen at Northumbria was within the Trust’s grasp. Secondly, given the importance of patient demand and Length of Stay (LOS), a number of steps could be applied at the Trust, including having a separate emergency hospital (the emergency hospital at Northumbria had an average LOS of 2 days). Thirdly, the ‘buzz’ on the return train journey was palpable, and a number of ideas were being formulated. A formal debrief of the visit was being scheduled, to consider the lessons learned
- The Trust had been modest in relation to putting itself forward for awards, but Trust staff deserved more accolades, and the Best Care programme would enable more award nominations to be made

Staff experience

5-8 The “End PJ Paralysis” campaign

DH welcomed TC, MJ, NL and CM to the meeting. MJ then delivered a presentation which highlighted the following points:

- The #EndPJparalysis campaign had started with a tweet by Professor Brian Dolan, Ann-Marie Riley, Pete Gordon and Tim Gillat.

- The campaign focused on time as a major currency in healthcare
- Staying in bed caused deconditioning which was a major determinant of falls and functional decline. Deconditioning could create a range of adverse effects, including contributing to 47% of an older persons' delayed discharge. However, the campaign was intended to achieve cultural changes, rather than focusing on statistics/indicators

TC then continued, and highlighted the following points:

- The campaign was trialled on Ward 20 and Edith Cavell Ward
- Launch week involved staff wearing their pyjamas, and a tree was erected where staff could post their pledges
- The campaign had been very successful in changing the atmosphere, and there was a marked change in attitudes. It felt like staff had been given permission to do the things they already wanted to do

NL then continued, and highlighted the following points:

- Edith Cavell Ward had engaged with the campaign very well
- Patients were not forced to wear pyjamas, and some had chosen to continue to don their nightwear, but the point was that patients now had the choice whether or not to do this
- The campaign had led to a number of achievements, including a significant increase in the average number of patients who were dressed (15, compared to the 1 to 2 patients before the trial). There has also been a number of inspirational stories

CM then continued, and highlighted the following points:

- In terms of planning ahead, the campaign was being extended across the Trust, 1 to 2 Wards at a time. Champions were also being recruited in each Ward
- Data was also being collected, to monitor the progress and impact of the campaign, whilst further volunteers were being recruited to assist
- The suggestions and ideas from the Trust Board were also very welcome
- Challenges included the need to maintain momentum, and thoughts were being given regarding merchandising, such as mouse mats etc., linking with the monthly focus areas, and working with staff in the Emergency Department (ED) and Acute Medical Unit (AMU)
- A number of other suggestions were being considered, including a media campaign and the appointment of an End PJ Paralysis lead
- Continued promotion, including via the Chief Executive's weekly update, would be very welcome. Continuing the campaign would enable patients to "down the gown forever"

The presentation concluded by showing a video, "Your Last 1000 Days".

DH remarked that he was very pleased the Trust had joined the movement, as he had known Brian Dolan for a long time and had been following the national campaign.

MC noted that there had been some coverage of the campaign on South East TV news, but the video shown for the item had been made in Cumbria, so suggested it would be beneficial if DY worked with the team to promote the campaign among the local media. The suggestion was acknowledged.

SP commented that the presentation emphasised how quickly things become the norm, and illustrated his point with an example of when he had been an inpatient and been encouraged to stay in bed, but his desire to mobilise had caused some consternation among staff.

PM commended the presentation, noting that all of the ideas he would have proposed had already been incorporated into the team's plans.

NH stated that the presentation was one of the most inspirational stories she had heard from Trust staff, and demonstrated what could be achieved without much resource.

MS stated that the campaign had captured the imagination of the staff, but asked what had been learned from the Edith Cavell trial. TC replied that Brian Dolan had made the point that the campaign was not about Key Performance Indicators (KPIs), but notwithstanding that, there was some evidence of improvement. NL then emphasised the importance of continuing the

conversation. TC added that it was crucial that Board Rounds emphasised the point that patients needed permission to mobilise. TC added that the challenge was to balance the needs of the team's routine duties against the need to maintain momentum with the campaign. MS noted that he had some ideas regarding this and stated that these would be discussed further outside of the meeting.

DH thanked the team for attending.

5-9 Board Assurance Framework (BAF): Agreement of key objectives for 2018/19

KR referred to Attachment 4 and the information therein and highlighted that:

- The Trust Board was asked to consider the approach it wished to take for the BAF and key objectives for 2018/19. For the former, it was proposed that the approach used in 2017/18 be taken, in terms of the layout and questions asked etc., although the format would be revised slightly to reflect the 2 amendments requested by the Audit and Governance and Finance and Performance Committees. The format was illustrated in Appendix 1
- Ten key objectives for 2018/19 were proposed. This was an increase from the 6 in 2017/18, but still retained the principle that the key objectives were a 'litmus test'/proxy for wider performance, rather than reflecting the full range of objectives the Trust had. The Trust had previously had a more comprehensive set of BAF objectives, but had deliberately chosen to adopt the current approach
- The proposed objectives had been discussed with individual Members of the Executive Team and with MS, and were now submitted for approval. Any approval given at the meeting was however not fixed, as changes could be made throughout the year, as the Board desired

MS referred to the discussion at the last Trust Board meeting regarding setting achievable objectives, and stated that he wanted assurance that the 2 workforce-related objectives were the product of a plan, and did not just reflect an aspiration. MS elaborated that the 8.5% vacancy rate in particular appeared aspirational. SH remarked that the turnover rate proposed reflected the Trust's participation in the NHS Improvement (NHSI) retention programme; and whilst the vacancy rate proposed was more challenging, a plan was in place (although a number of variables affected performance). MS proposed that those 2 objectives be approved in principle, but that the final details be confirmed at the June 2018 Trust Board meeting. This was agreed.

Action: Arrange for the details of the workforce-related key objectives for 2018/19 to be confirmed at the June 2018 Trust Board meeting (Trust Secretary, June 2018)

SDu remarked that the proposed objectives were a mixture of very specific objectives and broader themes i.e. the achievement of the financial plan. KR explained the approach, noted that the financial objective related to the delivery of the control total, which was the outcome that SO in particular would be held to account over, but there was no equivalent larger, SMART, objectives that could be applied to other Members of the Executive Team. SDu noted that there were no strategic objectives that reflected what the Board was ultimately trying to achieve. KR highlighted that there were no SMART strategic objectives within the Trust's current Strategy, and strategic objectives were also not linked to the annual framework in which the BAF operated, as they usually had a longer timescale. SDu noted that MS had made reference in his report to a desire to achieve an "outstanding" rating. MS acknowledged the point, but stated that it may be better to start with the objectives proposed, and consider whether SDu's comments could be addressed at a later point. DH also acknowledged SDu's point, but concurred with MS and proposed that the objectives be approved as circulated, but that a review then be undertaken after the first quarter of the year, at which point the inclusion of more strategic objectives could be considered. This was agreed.

Action: Arrange for a review of the key objectives for 2018/19 to be undertaken after the first quarter of the year (Trust Secretary, May 2018 onwards)

5-10 Integrated Performance Report for April 2018

MS referred to Attachment 5 and highlighted that the key issue was the performance on the Cancer standards, adding that as the Cancer Centre, the Trust must lead the way in this area, and the Trust Board should be cognisant of this.

Effectiveness / Responsiveness (incl. DTOCs)

AG then highlighted the following points:

- The Trust was in the top 20% of Trusts for A&E 4-hour waiting time target performance in April
- There had been a stabilisation of LOS, but a downward trend was required
- The Trust was emerging from winter, so although the volume of activity was still high, there had been a change in patient acuity
- This was the time of the year that new initiatives were tested, and winter planning for 2018/19 had started
- Delayed Transfers of Care (DTOCs) continued to be above the Care Quality Commission (CQC) standard of 3.5% but the rate had been stable at circa 5%
- There was unacceptable underperformance against the 62-day Cancer waiting time target, but this was a key area of focus. The 85% national target had not been achieved for over 4 years and a deep dive review had been held to try and understand the reasons for this. The outcome of the review would be submitted to the Finance and Performance Committee in June 2018
- The Trust did not currently triage/allocate a status on the Cancer referrals it received, but it was now felt that triage should occur.
- The suspicion threshold for GPs to refer cancer cases had also been reduced
- The 62-day Cancer waiting time target was a very high priority, and was now regarded more highly than the A&E 4-hour waiting time target
- For the 18-week Referral to Treatment target, there was still an issue with the level of backlog and overall waiting list. Some data quality issues were also still being seen which had falsely inflated the numbers involved, so work was taking place with all teams to improve their processing of the new Patient Administration System (PAS). Additional support had also been provided

DH welcomed the increased focus on the 62-day Cancer waiting time target, noting this would be discussed further in June SP also welcomed receiving further details, but noted that the work carried out in relation to the A&E 4-hour waiting time target showed what could be achieved.

MC asked about the Haematology pathway. AG explained the current status.

MC asked whether the report to be considered in June would address patients who had waited a long time. AG explained that harm reviews were carried out as patients were processed, and the majority of patients who were subject to a 104-day wait experienced this because of the complexity of their pathways. MC noted the importance of patient perception regarding delays. The point was acknowledged.

KR then pointed out that the report being prepared for June was currently only scheduled to be considered at the Finance and Performance Committee, not the Trust Board. DH stated that he sensed the Trust Board wished to consider the report. SP concurred, but that this should be in addition to, not instead of, the Finance and Performance Committee's review. This was agreed.

Action: Arrange for the June 2018 Trust Board meeting to receive "The recovery plans for the 62-day Cancer waiting time target" report that is scheduled to be reviewed by the Finance and Performance Committee on 26/06/18 (Trust Secretary, May 2018 onwards)

Safe / Effectiveness / Caring

COB highlighted the following points:

- There had been an improved position with falls
- There had been 9 pressure ulcers, including one grade 3, and these had mainly affected the sacrum and heel areas. However, the rate was below the target threshold
- The response rates for the Friends and Family Test (FFT) were subject to peaks and troughs
- There had been fewer complaints for April than for March. The complaints response rate had also improved significantly but was still below the target rate

Safe / Effectiveness (incl. Mortality)

PM the highlighted the following points:

- The Trust's Hospital Standardised Mortality Ratio (HSMR) had reduced from 105 to 103

- The proportion of Mortality Reviews that had been completed had improved, and further improvements were expected
- The rate of deaths with no comorbidities recorded was also expected to improve

Safe (infection control)

In SMs absence, COB highlighted that 1 new case of post 48-hour MRSA bloodstream infection had been seen in April, but the case was still under investigation.

Well-Led (finance)

SO highlighted that the plan had been achieved for month 1, overall, but there were 3 main areas of pressure: there had not been as much elective and day case activity as had been planned (although activity had improved during the month, following de-escalation and improvements in Theatres); the planned reduction in temporary staffing had not occurred; and the Trust had outsourced more activity than had been planned.

Well-led (workforce)

SH then reported the following points:

- There had been continued improvement (albeit much slower), on staff turnover and sickness absence. A series of focus groups had been held with staff regarding retention, and some Listening into Action (LiA) crowdfixing sessions would be scheduled
- The vacancy rate had been very stable, but this belied some significant variations in areas, particularly within Nursing and specialist and general medicine
- A new provider had been identified for the Trust's Learning Management System and this would be implemented over the coming months (which should lead to improvements)

5-11 Planned and actual ward staffing for April 2018

COB referred to Attachment 6 and highlighted that the ratings were better, but this reflected the new process of using the Quality, Effectiveness & Safety Trigger (QuEST) tool. COB added that compliance with the new tool was not at the level required, but she was hopeful that compliance would be closer to 100% by the June 2018 Trust Board meeting.

DH asked how long the QuEST took Wards to complete. COB replied that it took circa 15 minutes.

5-12 Winter review 2017/18 (incl. CQC letter on winter pressures in Emergency Departments)

AG referred to Attachment 7 and highlighted the following key points:

- The planning for the previous winter had not just focused on the usual template provided by NHSI, as a practical approach had been taken, and each Division used information provided by the Trust's Business Intelligence Unit
- A number of 'game changers' had been introduced, which included the Home First Pathway 3, the extension of the Hilton model into East Sussex, and the introduction of the Medical outlier team (to manage medical patients that were not within the medical bed base). Elective capacity was also reduced at Tunbridge Wells Hospital
- All of this worked well, but elective activity had been substantially reduced. The planning for the next winter therefore needed to take this reduction into account, along with the impact of a prolonged winter period on staff (staff had been asked to cancel leave and work longer hours)
- The initiatives for the next winter would be the emergency pathway for surgery (which needed improvement), creating a Virtual Ward, and using digitalisation and real-time data to use information in a smarter way
- The report showed the tactical response from each Directorate
- A winter review meeting was held in March 2018 and the outcome would be reflected in the winter plan
- If no major changes were made for next winter there would again be overcrowding in ED etc.
- The Operational Pressures Escalation Level (OPEL) system rated Trusts, and the Trust entered OPEL 4 on 10 occasions over the winter and stayed at that level for 24 hours each time. Additional resources needed to be deployed during each period

- The Trust's escalation plan stated that non-inpatient areas should be used if required. This was not ideal, but a number of priorities needed to be balanced, especially when OPEL 4 status was reached
- OPEL 3 and 4 meant the Trust was in escalation, and more effort would be made to communicate this to staff over the next year
- The initiative for non-clinical staff to support clinical staff had been successful and would be repeated

DH noted the Trust was heavily reliant on the G4S Patient Transport contract, and asked how actively West Kent Clinical Commissioning Group (CCG) managed that service. AG replied that the service had not been delivered as planned, so the Trust had been required to undertake specific investment in patient transport. AG continued that she now understood that some other local Trusts had however been better served by G4S. SO added that West Kent CCG had recently undertaken a review of the contract, and issued a new specification, which recognised that the previous specification had been unsatisfactory.

NH highlighted the need to focus on workforce issues, particularly in relation to staff flexibility for working across sites. SH confirmed that such flexibility already existed in contracts, but acknowledged that this needed to be communicated better. SH also added that work was taking place with partner organisations to aim to align the rates of pay for Bank staff earlier in the year.

5-13 Update from the Best Care Programme Board

DH noted that the circulation of the report was adversely affected by the fact that the Best Care Programme Board was generally scheduled for the Monday before the Trust Board meeting. MS then referred to Attachment 8 and highlighted the following key points:

- The key focus was on ensuring the projects were rated green and ready to deliver, as well as on ensuring capability and capacity were in place
- The need to improve the use of data had been acknowledged
- There was also a focus on improvement methods, including Quality, Service Improvement and Redesign (QSIR) and LiA
- DY had done much work on communications and engagement, but more was required

Quality items

5-14 Approval of progress report against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

COB referred to Attachment 9 and highlighted the following key points:

- Changes to the Trust's submission were required, as some communication regarding the specific criteria to be applied had been received on the evening of 23/05/18
- The supplementary report (Attachment 9a) contained the detailed evidence. The evidence was not required to be submitted, but COB would review that evidence in detail, for assurance
- For Standard 8 ("Can you evidence that 90% of each maternity unit staff group have attended an 'inhouse' multi-professional maternity emergencies training session within the last training year?"), the Trust had now been informed that it was able to use data for the staff trained in May and June 2018. One Consultant needed to be trained before the submission which meant the Trust would be able to report compliance
- For Standard 10 ("Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?"), compliance had been declared in Attachment 9, but the Trust was in fact not yet compliant. However, full compliance was anticipated by the time of the submission

DH noted that there was one further Trust Board meeting before the submission deadline, so proposed that the submission for Standards 1 to 7 and 9 be approved as circulated, but the status of Standards 8 and 10 be confirmed at the June 2018 Trust Board meeting. This was agreed.

Action: Submit an update to the June 2018 Trust Board meeting on the compliance status of the 10 maternity safety actions in the CNST incentive scheme (Chief Nurse, June 2018)

Planning and strategy

5-15 Approval of the Outline Business Case for an Electronic Patient Record (EPR)

DH welcomed MB and JMc to the meeting. MB then referred to Attachment 10 and highlighted the following points:

- The Outline Business Case (OBC) had been considered and supported, at the Trust Management Executive (TME) in May, and also considered at Finance and Performance Committee on 22/05/18, where it was agreed to recommend the OBC to the Board for approval
- The capital costs required would lead to a cost pressure of £3.78m due to the time lag between implementation and the realisation of the benefits. A review of benefits was being considered, to see if the non-cash releasing benefits could be converted into cash-releasing benefits
- A number of options had been considered, including a 'best of breed' approach, rather than a single EPR solution, but MB had been unable to identify a 'best of breed' implementation that had led to the level of benefits referred to in the OBC
- Options 3 and 4 were very similar, and the differences related to the contracting method
- Option 5 related to a Kent-wide single EPR, and this had been explored, but an agreement had been unable to be reached. This approach would also lead to a longer time to realise the benefits, due to the time required to agree the same approach/policies etc. among Trusts
- The Full Business Case (FBC) was intended to be approved by the end of June 2018
- A 12-month implementation was achievable, based on experience elsewhere, but an 18-month implementation was proposed, based on the Trust's experience of implementing the Allscripts PAS, providing additional resilience for the timescales, and resulting in the go-live occurring after potential winter pressures

NH about the lessons that had been learned from the implementation of the Allscripts PAS, and also asked what engagement had been undertaken, beyond the TME discussion. NH further asked whether MB could give assurance that the preferred system could communicate with other systems. JMc replied that the lessons learned from the PAS implementation was the need to engage more with clinical staff, and the Chief Clinical Information Officer (CCIO) role had been created to try and address this and increase engagement. JMc added that the preferred solution would be a single system, which would address many of the previous integration issues. MB added that the configuration of the PAS had predominantly been done by the supplier, so the implementation of the EPR project would be different, and a group of staff would be trained to understand the configuration, to enable its development to be informed by users. MB continued that the implementation would involve the engagement of configuration and change experts for a longer period than had been the case for the Allscripts PAS project. MB also noted that training needed to be better, and there would be more face-to-face training than e-learning. MB concluded that lessons would also be learned from other Trusts, including East Kent Hospitals University NHS Foundation Trust (EKHUFT), who were circa 6 months ahead in their plans. MB further remarked that although the preferred system did not focus on integration between products, as it provided a single solution, some integration would be required, and discussions had started with external partners on this aspect, including with GP systems.

MS noted that the Finance and Performance Committee had raised a number of issues regarding the Case, and asked if these had been recorded. KR confirmed that he had drafted the minute of the discussion and asked MB and JMc to check for accuracy. MS proposed that the draft minute be circulated to Trust Board Members. This was agreed.

Action: Circulate, to Trust Board Members, the draft minute of the "Review of the Outline Business Case for an Electronic Patient Record" item at the Finance and Performance Committee meeting on 22/05/18 (Trust Secretary, May 2018)

MS then stated that it would be beneficial to have external expert review, to provide assurance that the implementation plans were adequate to control clinical, operational and financial risks, and to secure the full range of benefits identified in the Business Case, and asked MB to consider this. DH stated that the key issues were whether implementation should be scheduled for 12 rather than 18 months, and whether the configuration was correct, so opined that the external review would be best undertaken by those with a clinical background, rather than by individuals with technical expertise. MB agreed that an external review would be beneficial, and noted that it would be

possible to ask someone from a Trust that had implemented an EPR recently to undertake this. MS queried whether undertaking such reviews was part of the role of the Global Digital Exemplars (GDEs). MB acknowledged the suggestion, and agreed arrange for an external review.

Action: Arrange for an external review of the Trust's plans regarding the introduction of an Electronic Patient Record (Chief Operating Officer, May 2018 onwards)

The Trust Board approved the Outline Business Case, subject to the requested external review.

DH then proposed that the June 2018 Trust Board meeting just receive a report describing the differences between the OBC and FBC, rather than the entire FBC. KR agreed, but proposed that the FBC be issued as a supplementary report, using the model that had been applied under item 5-14. This was agreed.

Action: Arrange for the June 2018 Trust Board meeting to receive a report highlighting the changes between the Full Business Case (FBC) and the Outline Business Case for an Electronic Patient Record, and for the FBC to be issued as a supplementary report (Trust Secretary, June 2018)

Assurance and policy

5-16 NHS Provider licence: Self-certification for 2017/18

KR referred to Attachment 11 and highlighted the following points:

- NHS Trusts were required to self-certify against the Licence for providers of NHS services for the first time in May 2017, and at the Trust Board that month, it agreed to adopt the approach whereby the evidence for compliance against the Licence conditions would be included in the Trust's Annual Report, and in particular the Annual Governance Statement, rather than in a separate report to the Board. The same approach had been applied for the 2017/18 self-certification which was now due
- The self-certification did not need to be submitted to NHSI but was required to be posted on the Trust's website. The Trust may then be asked by NHSI to provide details of its self-certification

Questions were invited. None were received. The Trust Board approved the proposed self-certification as circulated, on the proviso that the Trust Board approved the Annual Report under item 5-20.

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

5-17 Audit and Governance Committee, 02/05/18 & 24/05/18 (incl. Audit & Governance Committee Annual Report for 2017/18)

SP referred to Attachment 12 and highlighted that the Audit and Governance Committee meeting held earlier that day had agreed that the Annual Report, Annual Accounts, and Management Representation Letter for 2017/18 should be recommended for approval by the Trust Board (which would be requested under items 5-20, 5-21 and 5-22).

5-18 Trust Management Executive (TME), 16/05/18

AG referred to Attachment 13 and noted that the OBC for an EPR had been reviewed and supported, whilst the Committee had received a presentation on Human Factors.

DH noted that the interim arrangements for the Planned Care management team had been reported, and asked AG to describe the changes taking place. AG explained that the Director of Operations for Planned Care would be taking a 6-month secondment, and as a result a review had been held, and it had been agreed that the Division would be divided into 2 Divisions (Cancer and Clinical Support, and Surgery and Critical Care) for the period of the secondment.

5-19 Finance and Performance Committee, 22/05/18 (incl. quarterly progress update on Procurement Transformation Plan, and approval of proposed amendments to Terms of Reference)

TL referred to Attachments 14, 15 and 16, and highlighted the following points:

- The Procurement Transformation Plan (Attachment 14) had been noted at the meeting
- The Terms of Reference had been amended to reflect the removal of the Deputy Chief Executive from the membership
- The meeting on 22/05/18 had considered the laundry contract with Dartford and Gravesham NHS Trust, temporary staffing costs, the recent Financial Special Measures (FSM) review meetings, outpatient activity, recruitment planning, and the OBC for an EPR

SO added that the Trust would have been in FSM for 2 years in July 2018, and the key exit criteria that NHSI were focusing on was having a sustainable and demonstrable track record of delivery. DH added that the oversight by NHSI needed to be better calibrated with the monthly review cycle, to enable the Executive Team to devote their energy into delivery rather than in preparing for oversight. It was therefore agreed to request that the FSM review meetings with NHSI be scheduled after the Finance and Performance Committee and Trust Board meetings (to enable the information submitted to be used for the FSM meetings).

Action: Request that the Financial Special Measures review meetings with NHS Improvement be scheduled after the Trust's Finance and Performance Committee and Trust Board meetings (to enable the information submitted to be used for the FSM meetings) (Chief Executive, May 2018 onwards)

SDu then referred to the statement in Attachment 16 that "It was also agreed that the Chief Operating Officer should arrange for proactive steps to be taken to encourage Cardiology referrals from local GPs" and clarified that although Cardiology had been suggested, this was only an example, and had not been mandated, as the specialities should be determined by the Executive Team. DH confirmed this was his understanding.

The Trust Board then approved the proposed amendments to the Finance and Performance Committee Terms of Reference as circulated.

Annual Report and Accounts

5-20 Approval of the Annual Report, 2017/18 (incl. Governance Statement)

SP referred to Attachment 17 and highlighted that the Annual Report had been discussed at the Audit and Governance Committee meeting held earlier that day, and it had been agreed to recommend that the Trust Board approve the Report. KR also drew attention to Attachment 17a, which described the amendments that had been made since Attachment 17 had been circulated.

Questions were invited. None were received. The Trust Board approved the Annual Report for 2017/18 as circulated (noting the amendments described in Attachment 17a).

5-21 Approval of the Annual Accounts, 2017/18

SP referred to Attachment 18 and highlighted that the Annual Accounts had been discussed at the Audit and Governance Committee meeting held earlier that day, and it had been agreed to recommend that the Trust Board approve the Accounts. KR also drew attention to Attachment 17a, which described the amendments that had been made since Attachment 18 had been circulated.

Questions were invited. None were received. The Trust Board approved the Annual Accounts for 2017/18 as circulated (noting the amendments described in Attachment 17a).

5-22 Approval of the Management Representation Letter, 2017/18

SP referred to the Attachment 19, which had been issued on 23/05/18, and highlighted that the Letter had been reviewed at the Audit and Governance Committee meeting held earlier that day, and it had been agreed to recommend that the Trust Board approve the Letter.

Questions were invited. None were received. The Trust Board approved the Management Representation Letter for 2017/18 as circulated.

5-23 To consider any other business

SDu reported that she had been invited to attend Trauma simulation training, and stated that this had been very good, but there had been an absence of leadership demonstrated, in that, for example, the individuals who comprised the on-call team of the day for specialties servicing the ED for trauma cases did not know each other. SDu continued that if such individuals were mandated to meet for a brief introduction each day then handovers etc. would be much faster in the ED. PM agreed to liaise with the Clinical Director for Critical Care to investigate the issues raised.

Action: Investigate the issues raised by the Chair of the Quality Committee following her attendance at the Emergency Department/Trauma simulation training (Medical Director, May 2018 onwards)

5-24 To receive any questions from members of the public

PC referred to the End PJ Paralysis" campaign and asked about the arrangements for patients who did not have family and/or friends to take their home clothes away to wash. COB acknowledged the importance of the issue, and conceded that a solution had been explored, but had not yet been identified.

5-25 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 – June 2018

6-4 Log of outstanding actions from previous meetings

Chair of the Trust Board

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress ¹
5-9a (May 18)	Arrange for the details of the workforce-related key objectives for 2018/19 to be confirmed at the June 2018 Trust Board meeting	Trust Secretary	May 2018 onwards	<p>It is proposed that the 2 objectives be as follows:</p> <p>9. "To deliver a vacancy rate of no more than 9%". This has been increased from the 8.5% rate proposed in May 2018, and reflects the fact that the rate is currently 10% (and that a reduction to 9% is achievable); and</p> <p>10. "To deliver a staff turnover rate of less than 10%". This is unchanged from the rate proposed in May 2018, and reflects the fact that the rate is currently 10.7% (and that a reduction to 10% is achievable)</p>
5-9b (May 18)	Arrange for a review of the key objectives for 2018/19 to be undertaken after the first quarter of the year	Trust Secretary	May 2018 onwards	The requested review has been scheduled to be undertaken at the July 2018 Trust Board meeting, as part of the "Review of the Board Assurance Framework 2018/19" item that was already scheduled
5-23 (May 18)	Investigate the issues raised by the Chair of the Quality Committee following her attendance at the Emergency Department / Trauma simulation training	Medical Director	May 2018 onwards	A verbal update will be given at the meeting

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
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	June 2018	A report has been submitted to the June 2018 Trust Board
4-16 (April 18)	Clarify whether the Trust was able to ask NHS Digital to undertake an on-site cyber	Chief Nurse (as Senior Information	June 2018	At the recent STP Digital workstream, NHS Digital were asked if they could provide this

1

Not started

On track

Issue / delay

Decision required

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	and data security assessment (and if so, to request that such an assessment be undertaken)	Risk Owner)		assessment for a number of Trusts in Kent (including the Trust). The NHS Digital representative explained that the cyber team were still in the process of structuring themselves correctly to deal with this demand. The digital group discussed with NHS Digital if a combined Kent and Medway assessment/exercise could be completed due to the integration of our networks. NHS Digital agreed to investigate if this was possible and speed up the potential assessment. Alongside this the Trust appointed a specialist cyber security supplier to conduct a full audit of the Trusts IT solutions. The audit was completed in June 2018 and the full report is expected in July.
5-10 (May 18)	Arrange for the June 2018 Trust Board meeting to receive "The recovery plans for the 62-day Cancer waiting time target" report that is scheduled to be reviewed by the Finance and Performance Committee on 26/06/18	Trust Secretary	May 2018	The item is on the agenda for the June 2018 Trust Board meeting (and a report has been submitted)
5-14 (May 18)	Submit an update to the June 2018 Trust Board meeting on the compliance status of the 10 maternity safety actions in the CNST incentive scheme	Chief Nurse	June 2018	The item is on the agenda for the June 2018 Trust Board meeting (and a report has been submitted)
5-15a (May 18)	Circulate, to Trust Board Members, the draft minute of the "Review of the Outline Business Case for an Electronic Patient Record" item at the Finance and Performance Committee meeting on 22/05/18	Trust Secretary	May 2018	The draft minute was circulated by email on 31/05/18
5-15b (May 18)	Arrange for an external review of the Trust's plans regarding the introduction of an Electronic Patient Record	Chief Operating Officer	June 2018	The Business Case has been reviewed by Stephen Dobson, Chief Digital Officer, Greater Manchester Health and Social Care Partnership (formally CIO at Wrightington, Wigan & Leigh NHS Foundation Trust, where the Allscripts Sunrise EPR was

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
				implemented in 2016) in order to provide assurance to the Trust Board of the validity of case with a focus on Resourcing, Options Appraisal and Benefits Realisation. Mr Dobson had a week to review the case before a conference call on 18/06/18 with the Interim Director of Health Informatics to discuss, clarify and feedback. The call has been recorded. Mr Dobson is due to provide a formal response on 22/06/18, but confirmed on the call that he had no concerns with the Case and felt it cover all required areas
5-15c (May 18)	Arrange for the June 2018 Trust Board meeting to receive a report highlighting the changes between the Full Business Case (FBC) and the Outline Business Case for an Electronic Patient Record, and for the FBC to be issued as a supplementary report	Trust Secretary	June 2018	The item is on the agenda for the June 2018 Trust Board meeting (and the report and supplementary report have been submitted as requested)
5-19 (May 18)	Request that the Financial Special Measures (FSM) review meetings with NHS Improvement be scheduled after the Trust's Finance and Performance Committee and Trust Board meetings (to enable the information submitted to be used for the FSM meetings)	Chief Executive	May 2018	The request was made, and the scheduling of the FSM review meetings has been adjusted

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	<div style="background-color: #008000; height: 15px; width: 100%;"></div> <p>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</p>

Trust Board meeting – June 2018

6-7 Report from the Chief Executive

Chief Executive

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

1. Maidstone and Tunbridge Wells NHS Trust continues to develop strong partnerships locally, nationally and internationally in our pursuit of excellence.

Our partnership working stretches throughout the NHS and beyond to involve our many stakeholders in the co-design of improvements to the quality and safety of our services and patient and staff experience. Since our last Board meeting we have worked at many levels to both share best practice and collectively develop new ways of working.

2. We have welcomed Professor Tim Briggs, National Director of Quality and Efficiency at the Department of Health, to our Trust. Professor Briggs met with clinicians and discussed MTW's winter elective orthopaedic care plan which he wants to promote more widely.
3. Our clinical colleagues have also shared their best practice internationally. A delegation of around 15 maternity experts from Italy and Slovenia, including midwives and obstetricians, visited MTW's maternity services as part of a fact finding mission to look at best practice to develop their maternity services within their respective countries. The group visited the maternity department at Tunbridge Wells Hospital and then spent time at Maidstone Birth Centre. They were particularly keen to find out how MTW has helped promote normal birth, midwifery-led care and the use of birth centres in low risk pregnancies.
4. While there is much that we can share with and learn from others, MTW can take a great deal of personal inspiration and pride from within.

Christine Richards, Head of Radiotherapy Services, has been named in the Queen's birthday honours 2018. Christine, who has worked for the Trust for 28 years and as a radiographer for 46 years, has been honoured with an MBE for her services to cancer patients.

As we approach the NHS's 70th birthday, there is no more fitting recipient of an award than Christine. She exemplifies the very best of the NHS. Her nomination read: "*Christine exemplifies the highest professional standards and her selfless commitment to her patients, her colleagues and to radiography are deserving of national recognition and honour.*"

This is a wonderful example of the leadership behaviours we want to develop at MTW and are currently in the process of identifying to make part of our everyday lives.

5. We have also continued to learn from one another through our Listening into Action (LiA) staff crowdfixing events. Our latest engagement events focused on opportunities to improve areas of Allscripts, staff recruitment and retention. Hybrid mail, finding and saving letters and telephone bookings are examples of areas where our staff are keen to see improvement within Allscripts. Our discussions about recruitment and retention have identified the importance of listening to and valuing our staff, empowering staff-led change, flexible working and convenience – themes that all feature in our Best Care quality improvement actions.

On a personal level, I have continued to meet with our clinical and non-clinical teams to support improvements in an environment that encourages and enables staff-led change.

My visits in recent weeks have emphasised the incredible improvements that can be secured when staff are engaged with and lead improvements, (irrespective of whether these are part of LiA, Best Care or 'business as usual'). Striking examples include:

- End PJ Paralysis has captured the imagination of ward staff in promoting active recovery and rehabilitation
- Air handling and electrical infrastructure improvements at Maidstone Hospital led by the engineers themselves improving service at reduced cost
- Great learning from the simulation team in MTWme reaching out into clinical areas and adding new human factors sessions
- Engagement between procurement and clinical teams in ED and theatres
- Enthusiasm of staff across EDs, AMUs and frailty units to take on board new approaches in partnership with the national Emergency Care Intensive Support Team (ECIST)

I would like to congratulate all staff involved in the successful opening of our new Frailty Unit at Tunbridge Wells Hospital. This is part of our commitment to providing high standards of care for older patients and follows the successful implementation of a Frailty Unit at Maidstone Hospital last year. The new unit brings together experts from a range of clinical teams to offer patient-centred care and rapid intervention from the point of arrival in the Emergency Department, in a specially designed environment.

6. I met with many external partners personally this month, building on MTW's important dual roles as West Kent's biggest provider of acute NHS care and key local employer.

The Chief Executives of Maidstone and Tunbridge Wells Borough Councils are keen to explore opportunities to work together on projects that benefit our local communities and this includes key worker accommodation. I look forward to meeting our other councils in the near future.

I have also taken the opportunity to meet with members of Kent County Council's Health Overview and Scrutiny Committee, sharing detailed information about our performance and key objectives.

7. NHS and social care colleagues throughout Kent and Medway continue to work collaboratively on the Sustainability and Transformation Plan.
- STP programme board is working up proposals for major capital expenditure across the county. Notwithstanding the PM's announcement of funding increases this week, availability of major capital will be very tight; stroke alone could consume what Kent might expect to receive from the next national capital round. There is a requirement for significant asset disposals across the county to fund major capital expenditure.
 - Provider trusts have agreed to come together to support the two universities in developing Kent and Medway Medical School (KMMS). MTW can play a significant role in this development which will offer an important source of new doctors for the future (see below).
 - The STP clinical services strategy will pursue a Kent-wide approach to stroke, vascular, trauma and cancer services, with other clinical plans developed at a local level. Across Medway and North West Kent this means identifying significant quality and/or sustainability issues in key services within individual trusts and CCGs. Where these cannot be resolved in each patch, (e.g. West Kent or Medway), then will we look at how joint working across a wider geography, (Medway and North West Kent), can identify other solutions.
8. MTW continues to work collaboratively with its acute and community care providers on issues of significant shared importance. An example of this is our joint interest in the development of the new KMMS.

We share the same vision of seeing Kent and Medway's new medical school become a beacon for first-class medical education and research. The new academic unit, which opens in September 2020, will attract the most talented aspiring doctors from within the local community and beyond, offering training and development opportunities that will help to keep that talent in Kent and Medway.

It will be the first choice for medical students aiming to work within collaborative multi-professional teams to achieve excellence in person-centred medical care.

I am keen to ensure that MTW plays a key role in this first-class development by maximising the opportunities that exist within our Trust to support medical training and recruitment.

Undergraduate medical courses span five years of full-time study. Students spend their first two years in Canterbury, largely university based with one day a week in primary care. They will then join 'firms' in different parts of the county where they will access a full range of clinical specialties across primary, secondary and mental health 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 – June 2018

6-9 Integrated Performance Report, May 2018**Chief Executive /
Members of the Executive Team**

The enclosed report includes:

- The 'story of the month' for May 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 (including complaints response times recovery plan)
- Planned and actual ward staffing for June 2018
- 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

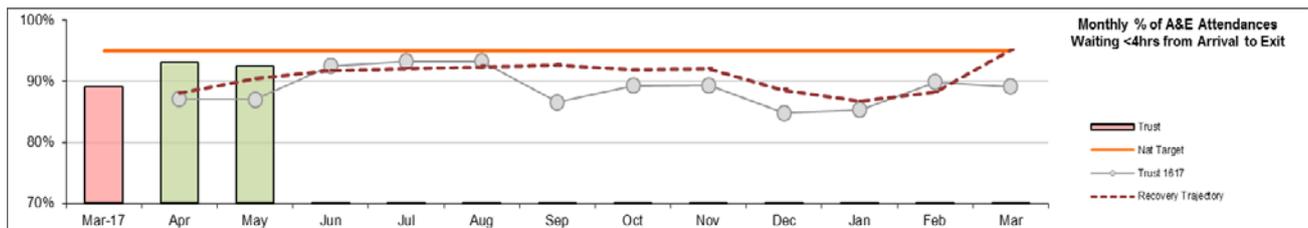
The 'story of the month' for May 2018

OPERATIONAL PERFORMANCE REPORT FOR APRIL -18

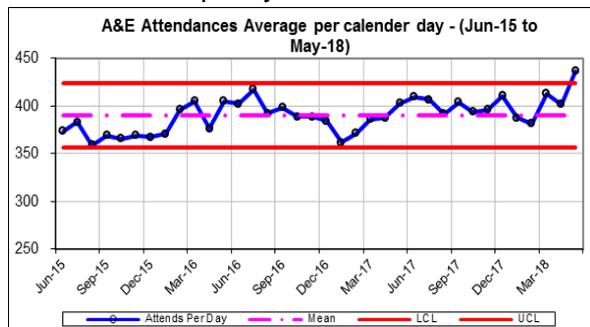
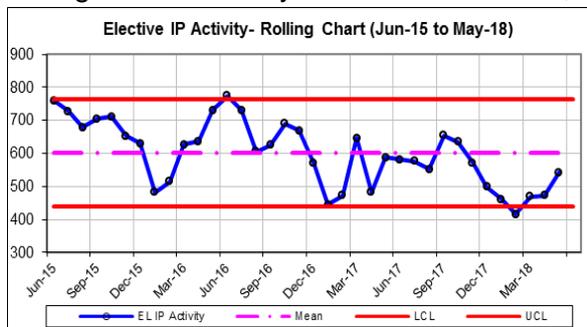
1. 4 Hour Emergency Target

The Trust delivered significantly above the expected trajectory again in May, scoring 92.5% against a target of 90.4%. For the year 1718 we scored 89.1%, compared to 87.12% in 1617.

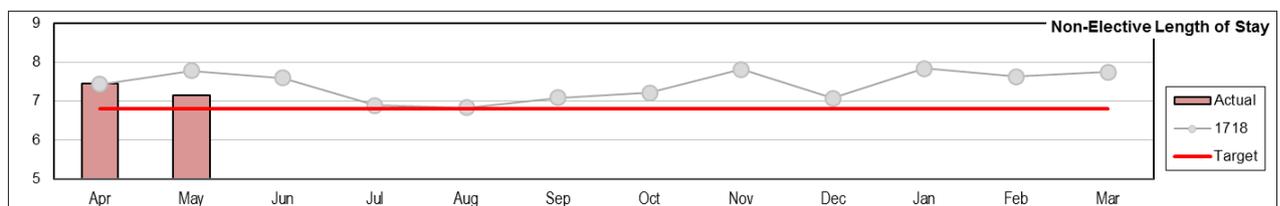
We continue to perform significantly better than the national average on the 4 hour standard. In Feb-Apr, we scored at least 9 percentage points higher than the national average, and were placed in the top 20% of performing trusts. For May we were 5.6% above average



- A&E Attendances continue to increase. The attendance for 1718 (excluding Crowborough MIU) remains 3.2% up on the previous year, and there was a significant increase in attendances between mid-November and early January which had no clear reason. May's attendances were 4.5% more than modelled and 4.4% up on the TDA trajectory, also 7.7% higher than May-17 (excluding Crowborough MIU)
- Non-Elective Activity (excluding Maternity) was 10.7% above plan & 15.1% higher than last May at 4,797 discharges. NE activity has been steadily increasing since early 2016, increasing by 25-30% since then. Much of this is driven by increased ED demand and our improved flow-through of ambulatory / assessment wards, and increased capacity in CDU.



Non-Elective LOS was 7.14 days in May, vs 7.41 in 1718, which is a continuous and steady reduction and improvement, helping to improve the overall patient flow.



- The average occupied bed days increased marginally to 733 per day, down from its record 868 in Feb. For the whole of 1718 it was 764.

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:

- Continue to work collaboratively with ECIP particularly in relation to short stay (ambulatory and acute assessment pathways).

- Frail Elderly Unit at Maidstone, with a frailty manager in place from 14-May
- Tunbridge Wells Acute Frailty Unit opened ahead of schedule (4.6.18) to provide up to 16 spaces per day
- Super stranded patient project continuing to deliver improvements against the set trajectory.
- Community hospital pathways and home treatment service processes projects commenced end of May to yield data end of June
- 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 Huddles" still in place.
- 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 from 4.58% in Apr to 4.34% in May. We ended 1718 on 4.95%, and have now been under 5.0% for 7 consecutive months. On average, 29.8 beds per day were lost to these patients. 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 and the TWH Frailty Unit opened on 4th June 2018.

Category	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 19	Rolling 12 Month
A : Awaiting Assessment	11	7	2	2	7	6	2	5	2	1	2	5	60
B : Awaiting Public Funding	3	3	2	0	2	1	0	1	5	1	2	4	23
C : Awaiting Further Non-Acute NHS Care	27	11	8	21	15	10	18	21	9	21	12	20	194
Di : Awaiting Residential Home	16	16	23	32	21	19	18	24	18	40	15	23	250
Dii : Awaiting Nursing Home	94	53	63	42	46	54	38	37	47	54	53	43	651
E : Awaiting Care Package	43	27	27	32	24	36	14	18	20	28	20	31	328
F : Awaiting Community Adaptations	7	15	8	5	10	12	4	12	10	7	15	7	113
G : Patient or Family Choice	8	10	13	14	28	38	13	11	5	10	3	14	163
H : Disputes	2	0	1	0	0	1	0	0	0	0	1	0	6
I : Housing	5	6	8	2	2	1	2	3	3	2	6	2	43
Grand Total	216	148	155	150	155	178	109	132	119	164	129	149	1,804
Rate	6.24%	5.41%	4.54%	5.32%	5.36%	4.84%	3.73%	4.27%	3.89%	4.26%	4.56%	4.34%	4.73%

3. Length of Stay

- Non-Elective LOS was 7.14 days in May, vs 7.41 in 1718. It tends to go up by half a day or so in winter.
- Including Zero LoS, the average LoS was 4.0 days in May, compared to 5.2 last May and 4.6 for the whole of last year.
- The percentage zero LoS was 43.4% for Non Elective in May, compared to 33.3% last May and 37.2% for the whole of 1718. Zero LoS admissions have been increasing consistently for about 2 years now, reflecting the increased use of Ambulatory & Frailty Pathways, and increased capacity in CDU. Increasing the volume of zero LoS will force the average LoS down, but may apply upward pressure to the non-zero indicator if it is moving patients from short stay group into the zero stay.

4. Cancer 62 Day First Definitive Treatment

62 day performance for Apr was 61.6%. The performance for the year 1718 was 70.4% against the standard of 85%. The main contributory factor to the continuing underperformance is the increase in referrals across the high-volume sites which have a major impact on outpatient and diagnostic capacity in particular.

Although the delivery plan remains focused both on patients in the 40 -62 day category, there is now a concentrated focus on the beginning of the pathway and the appropriate streaming of patients through the diagnostic phase. The backlog (patients with a cancer diagnosis waiting over

62 days) at the end of April was 75, a small reduction from the previous month and 42 of these were MTW patients

The daily huddle continues 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.

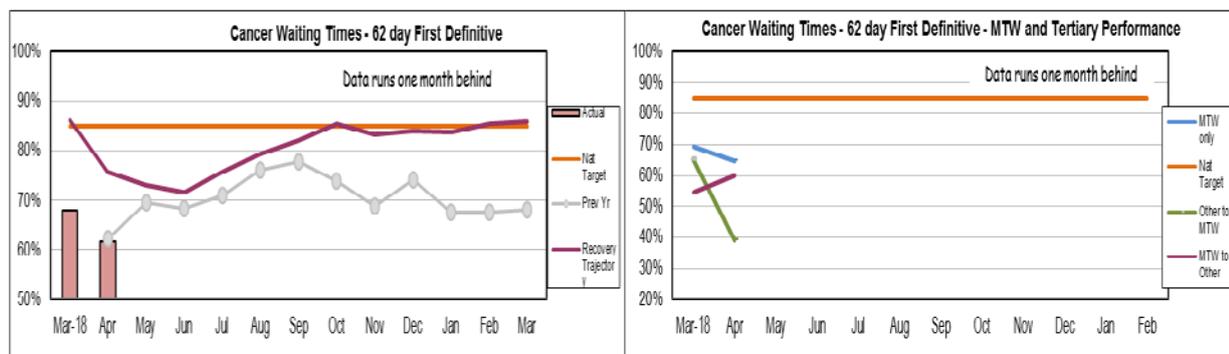
Tumour site action plans are being collated in conjunction with the clinical teams and a recovery plan will be presented to TME and Finance and Performance Committee in June.

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 had a very positive impact on the lower GI pathway.

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

Each of the specialties has been tasked to increase capacity to 85% of the maximum referral rate in order to ensure that capacity meets demand. The Intensive Support Team has provided modelling to identify the capacity needed and the Trust has engaged with FourEyes Insight Ltd to support our plans to improve productivity and utilisation in outpatients to facilitate releasing more capacity for this. Additional breast clinics have already been created, templates have been changed in Urology, and straight to test telephone clinics for upper GI are planned to start before the end of June 2018.



Apr 2018

62 Day Performance : All				62 Day Performance : MTW Only			
Tumour	Tot	Brch	Score	Tumour	Tot	Brch	Score
Brain / CNS	1.0	1.0	0.0%	Brain / CNS	1.0	1.0	0.0%
Breast	22.0	4.0	81.8%	Breast	22.0	4.0	81.8%
Gynae	9.5	1.5	84.2%	Gynae	8.0	1.0	87.5%
Haematology	4.5	2.0	55.6%	Haematology	4.0	2.0	50.0%
Head & neck	7.5	5.0	33.3%	Head & neck	5.0	3.0	40.0%
Lower GI	14.0	9.0	35.7%	Lower GI	12.0	7.0	41.7%
Lung	14.0	7.0	50.0%	Lung	11.0	6.0	45.5%
Other	1.0	0.5	50.0%	Other	-	-	#DIV/0!
Sarcoma	-	-	#DIV/0!	Sarcoma	-	-	#DIV/0!
Skin	1.0	0.5	50.0%	Skin	-	-	#DIV/0!
Upper GI	12.5	6.0	52.0%	Upper GI	9.0	4.0	55.6%
Urology	34.0	10.0	70.6%	Urology	30.0	8.0	73.3%
TOTAL	121.0	46.5	61.6%	TOTAL	102.0	36.0	64.7%

5. Referral To Treatment – 18 weeks

Performance: May performance shows the Trust is non-compliant with the Incomplete RTT standards at an aggregate level – 80.0%. Trust is now non-compliant almost with all specialities with the exception of General Medicine, Thoracic Medicine, Geriatric Medicine and Cardiology. A key risk

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:

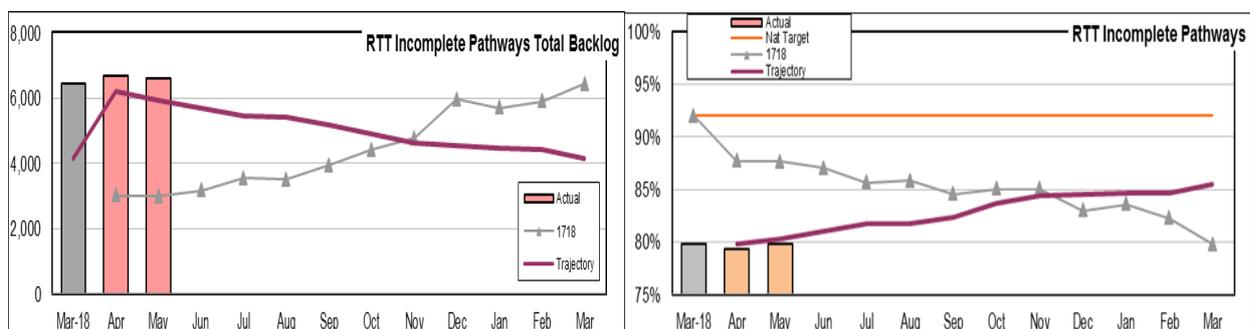
- The inability to do a sufficient level of elective work caused by the increased non-elective activity
- Cessation of outsourcing to IS providers
- Planned reduction of activity during PAS implementation, prolonged by on-going data and admin issues post go-live.
- Key vacancies in consultant and trainee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

The majority of the backlog continues to be 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.

Duplicate pathways are still an issue particularly in Ophthalmology and General Surgery which has caused the waiting list size to grow again. Further training is being given in these areas and internal teams are focusing on these as well. Operational teams are continuing their plans to increase elective activity and arrange extra clinics to ensure backlog does not grow further.

	May-18	May -18 Trajectory	Variance from trajectory
RTT Backlog Incomplete	6,530	5,936	594
RTT Waiting List	32,702	30,211	2,491
RTT Incomplete performance %	80.0%	80.4%	-0.4%

- Continue to monitor each specialty's activity plan to ensure that the agreed level is delivered each month.
- Use the weekly PTL meeting to manage all patients who have reached 44 weeks (with or without a TCI)
- 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
- Recruitment in progress for dedicated CAU Transformation Manager who will assist in supporting training for 18 weeks and Allscripts.
- PTL management training has been reviewed and continues to be rolled out to all the CAU's with completion in July.
- Increase clinic/theatre capacity/activity on weekends to improve income, activity and incomplete performance
- 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 (May data)

Patient Falls incidents

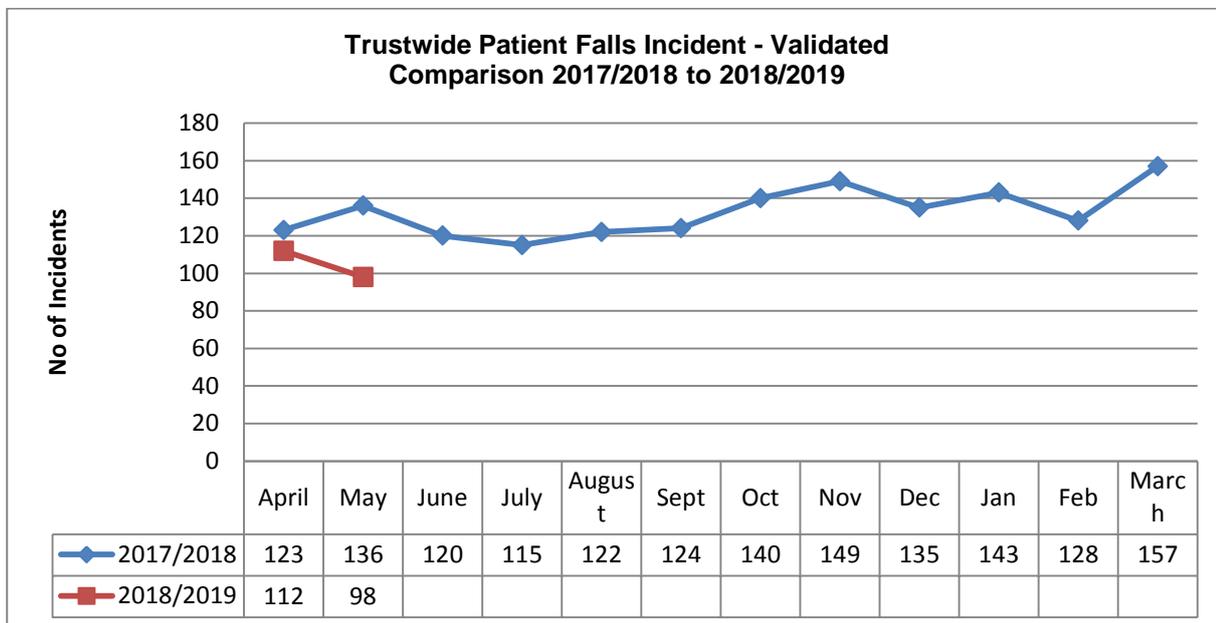
There were 98 falls reported for the month of May, compared to 112 for April 2018. The comparison against May 2017 at 136 can be seen in Graph 1 which provides a comparison for the same period on the previous year. The breakdown of incidents by site equates to 45 falls at Maidstone and 72 at Tunbridge Wells.

The rate per 1000 occupied bed days is for the month of May. (Rate for 2017/18 was 5.98 per 1000 occupied bed days). Comparison of year end falls rate per 1000 occupied bed days for previous years is shown in graph 2.

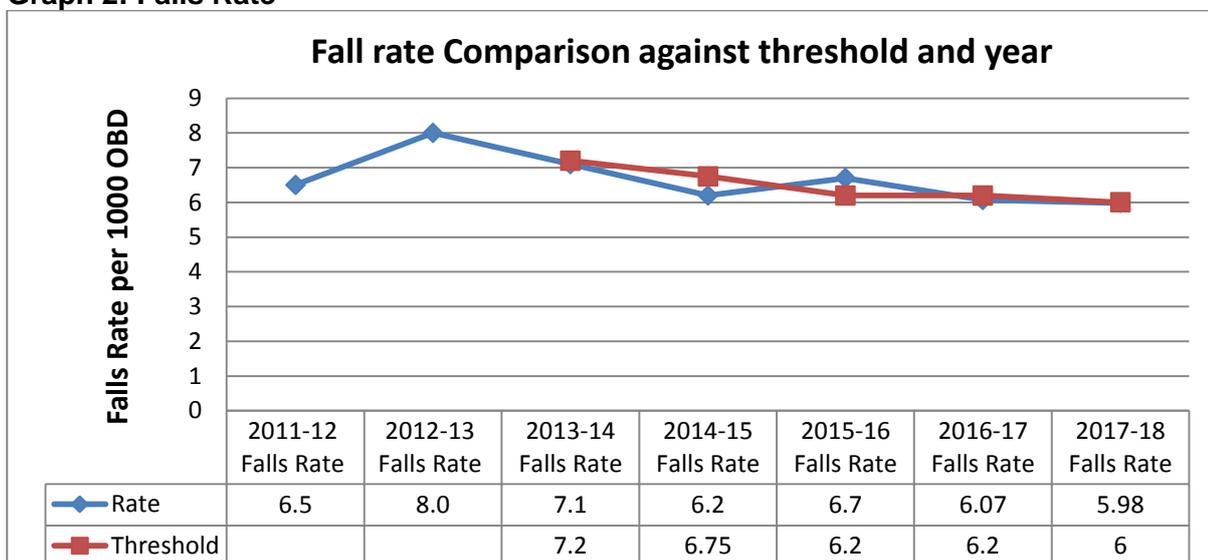
There were 3 Serious Incidents declared in May 2018.

The Trust has signed up to participate in the NHSI falls collaborative which we hope will provide some further opportunities for us to review practice and support a reduction in the level of serious incidents relating to falls incidents.

Graph 1: Trust wide Patient Falls



Graph 2: Falls Rate



Pressure Ulcers:

The incidence of confirmed Hospital acquired Pressure Ulcers for May 2018 is 13. The rate (per 1000 admissions) for May is 2.18 compared to 2.04 for the same month last year. The incidence rate for the year is 1.93 against a threshold of 3.0.

The recruitment of a 2nd TVN is ongoing, support is being provided from the Professional Standards Team with a suitably qualified RN providing 0.8 WTE cover to the service.

We have reported one grade 3 pressure ulcer in May which is being investigated as a serious incident.

Friends and Family test:

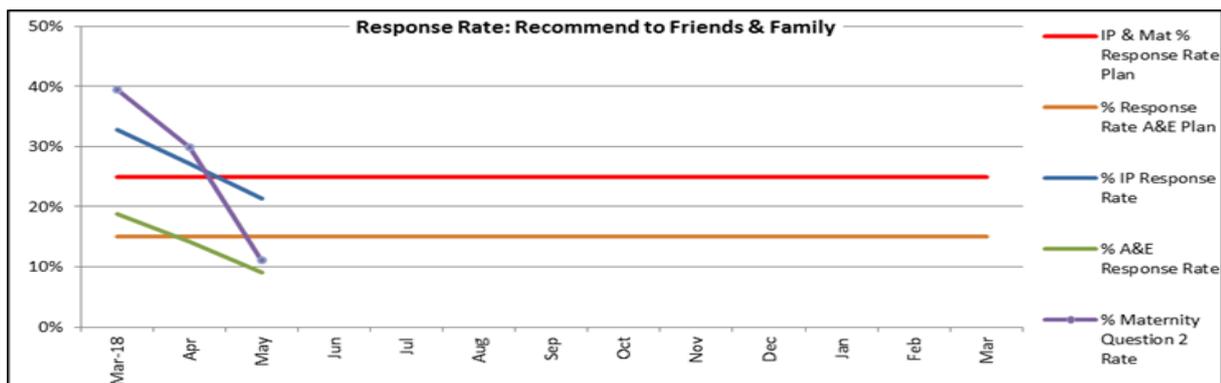
Overall response rates for May have seen a further decrease compared to April. There continues to be ongoing operational challenges including; ward moves for deep cleans, refurbishments and restructuring of a large division. This may have subsequently impacted on the consistency in the level of response. The move to a weekly collection system will provide an earlier opportunity to analyse the data and monitor response rate. A+E hold 300 cards on the unit from May but these will be reflected in June's data

For the monthly performance; Inpatients (now including day case and children) the response rate decreased from 27.2% in April to 21.4% in May. For A&E (including children) it decreased from 14.2% in April to 8.99% in May. For Maternity it decreased from 29.8% in April to 10.98% in May.

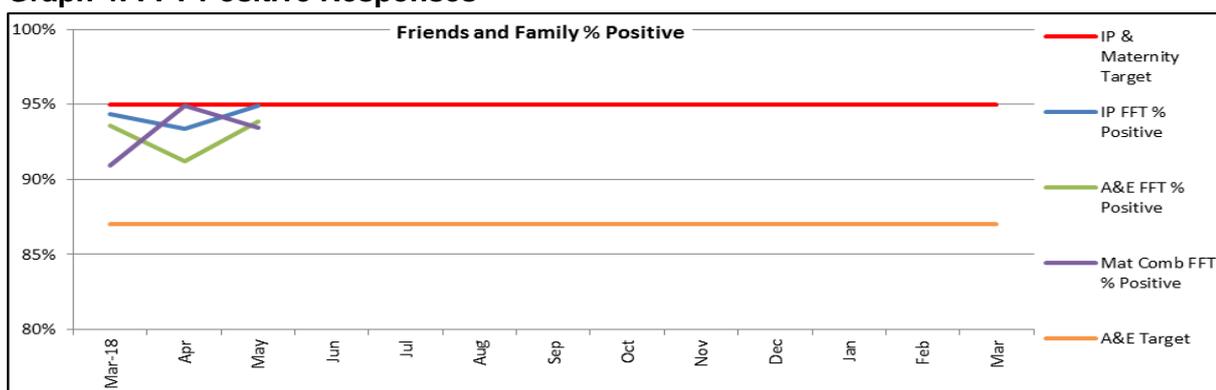
In terms of number of respondents from OP, April was 5684 which has decreased to 5229 in May.

For the % Positive throughout May, inpatients has increased slightly from 93.3% in April to 94.9% in May, A&E increased from 91.2% in April to 93.8% in May and Maternity (all 4 combined) decreased from 94.9% in April to 93.4% in May.

Graph 3 FFT Response Rates:



Graph 4: FFT Positive Responses



Single Sex Compliance:

There were 5 incidences of mixed sex accommodation reported during the month of May. These occurred on the AMU at TWH where care is provided in 4 bedded bays. This was due to high operational demands.

Complaints:

There were 43 new complaints reported for May which equates to a rate of 2.02 new complaints per 1,000 occupied bed days. This is a decrease compared to 2.21 for April. There were 163 open complaints at the end of May compared to 148 in April.

55.6% of complaints were responded to within deadline compared to a target of 75%.

In recognition of the fact that this target has been missed for a sustained period of time, a series of challenge sessions were held with key directorate staff on 31 May 2018, led by the Chief Nurse and supported by the Associate Director of Quality Governance and the Complaints & PALS Manager. It was encouraging to see the engagement in the complaints agenda shown by the staff who attended these sessions.

At each session, the level of complaints activity and performance for 2017-18 were reviewed. Discussion identified a number of issues including;

- inaccurate information being entered on Allscripts,
- problems with the availability of notes,
- lack of handover of complaints within directorates during periods of staff leave/absence,
- delays in directorate approval processes,
- delays in drafting, delays in directorates providing the complaints team with further comments once an initial draft has been prepared,
- And delays with the executive signing process.

During these sessions, an improvement trajectory was set with the individual directorates, taking into account their levels of complaints activity, and some actions were identified to help support the achievement of these targets. These include providing guidance on the roles and responsibilities of key staff in the process, changes to the process for requesting notes, and ensuring that the Executive are aware of the breach date for each complaint response they are sent. The Chief Nurse will continue to monitor compliance with the improvement trajectories closely and plans to recall the directorates in three months' time for a review of their progress in addition to ongoing scrutiny of complaints response rates at each of the divisional performance review meetings.

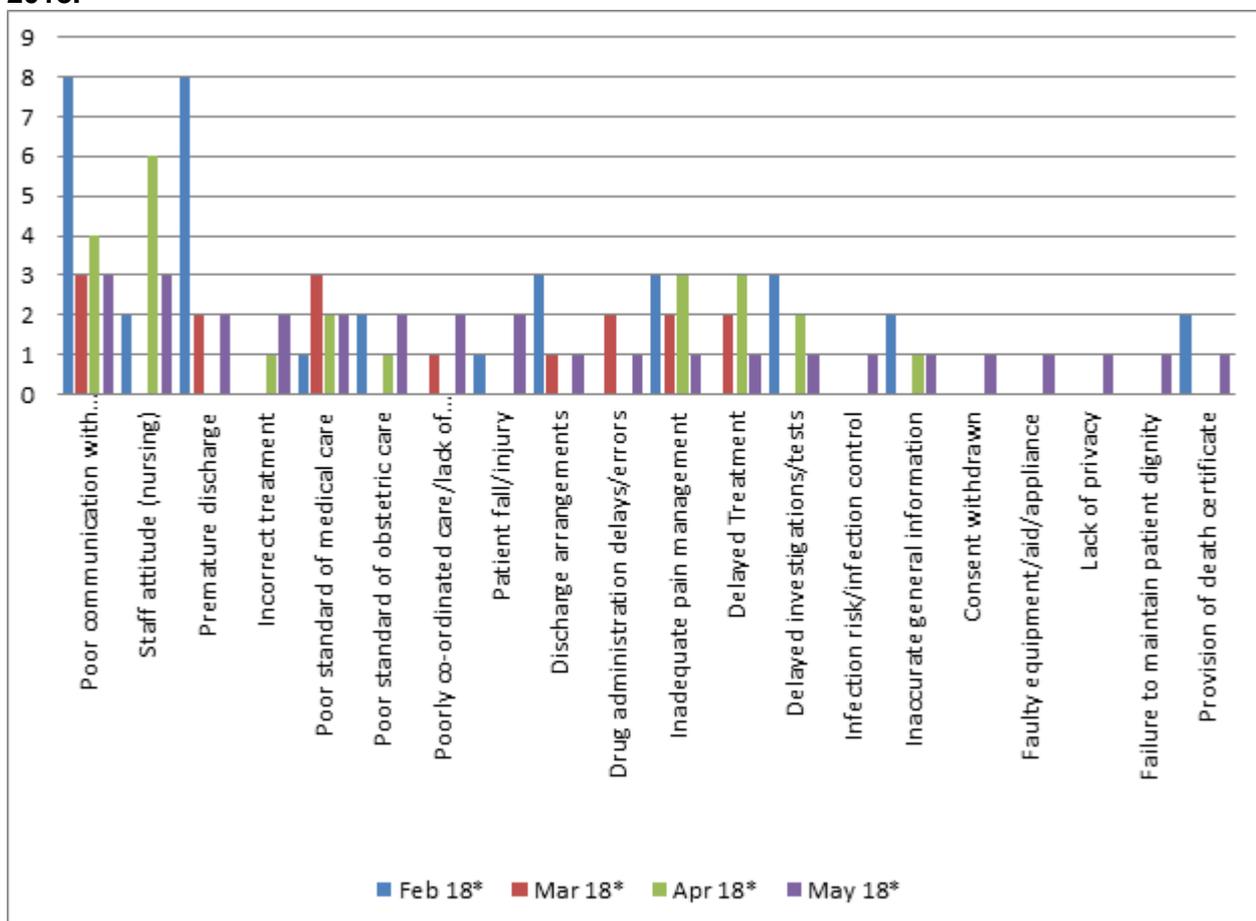
The table below provides the detail of the frequency of each sub subject raised as issues within complaints received in the Trust. The available data has been analysed by the date of the event being complained about, rather than when the complaint itself was received. It is hoped that this will give 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.

Graph 5: Complaints by Sub-subject – most frequently raised in May 2018

	Feb 18*	Mar 18*	Apr 18*	May 18*
Poor communication with patient/relative	8	3	4	3
Staff attitude (nursing)	2	0	6	3
Premature discharge	8	2	0	2
Incorrect treatment	0	0	1	2
Poor standard of medical care	1	3	2	2
Poor standard of obstetric care	2	0	1	2
Poorly co-ordinated care/lack of continuity	0	1	0	2
Patient fall/injury	1	0	0	2

*reflects the date of the event being complained about

The following graph (Graph 6) shows an expanded view of the themes of complaints that occurred in May 2018.

Graph 6: All themes/subjects raised in complaints made about events that occurred in April 2018.

It is clear that consistently, communication with patients/relatives remains a key theme within complaints. Between February and May, this has remained one of the most frequently raised subjects in new complaints and is the single most frequently raised issue over this reporting period (18 incidents in total). This is followed by premature discharges (12) and attitude of nursing staff (11).

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

- Attitude of nursing staff
- Incorrect treatment
- Poorly co-ordinated care/lack of continuity
- Patient fall/injury
- Delayed treatment

Other areas show stable or slightly reducing trends, with the most significant reduction in complaints about poor communication and premature discharges (despite these remaining frequently raised issues).

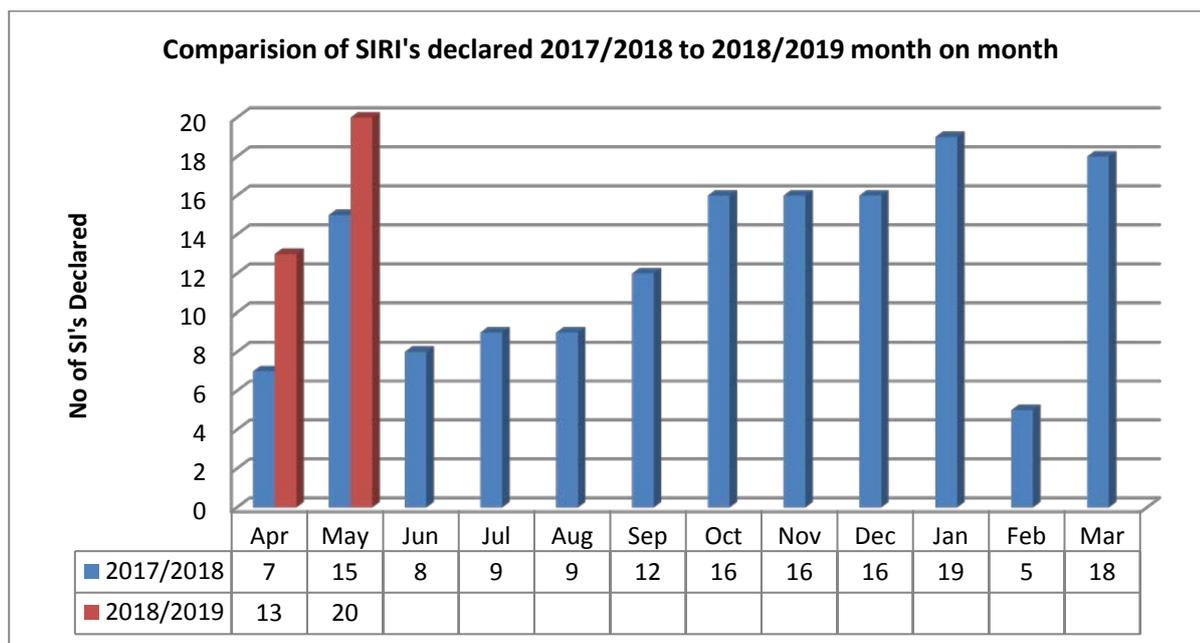
Complaint case studies are published in the Governance Gazette to highlight key themes and trends seen coming through complaints and the learning taken from complaint investigations.

Serious Incidents (SI's)

There were 20 Serious Incidents reported in May 2018 compared to 15 for the same period in 2017:

- 3 falls in Specialist Medicine
 - 2 resulting in fractured hips – patient subsequently died in 1 of these
 - 1 resulting in a fractured humerus
- 1 Pressure damage – category 3 in Specialist Medicine & Therapies
- 3 Safeguarding across 2 divisions
 - 1 allegation of abuse and 1 allegation of assault in Specialist Medicine & Therapies
 - 1 allegation of assault in Acute & Emergency
- 13 Main SI's spanning 8 divisions
 - 3 in Acute & Emergency
 - 2 each in Children's Services and Women's & Sexual Health
 - 1 each in Cancer Haematology & Diagnostics / Corporate / Critical Care / Head & Neck / Specialist Medicine & Therapies / OPD

Graph 8: Total SI's Declared.



During the month of May, we have closed 11 SI's, these included 3 patient falls and 1 hospital acquired VTE.

The learning from the fall's panel identified the importance of ensuring that risk assessments including post fall assessments for injury and post fall medical reviews are fully completed. The importance of assessing the requirement for enhanced care support for patients identified as of being at increased risk of falling is another key element of learning that has come out of the falls serious incident investigations.

Learning from the VTE panel has identified the importance of adherence to ensuring that patients are provided with and supported in wearing prescribed anti-embolism stockings and of the importance of completing a holistic assessment of the patient in relation to their risk of developing VTE.

Learning Disability Week

This week we have been raising awareness of the needs of people with a learning disability when they come into hospital. There have been stands on both sides of the hospital, facilitated by our Learning Disability Nurse. We were delighted to welcome a group of people with learning disabilities to the Maidstone site on Friday, 22nd June, who were able to tour some of our departments.

Trust Board Meeting – June 2018

6-10 Staffing (planned and actual ward staffing for May 2018**Chief Nurse**

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for May 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:

John Day: CSW fill rate reflects need for enhanced care needs on 8 days and nights.

Chaucer: High fill rate due to escalation of frailty assessment unit overnight for 18 nights.

Edith Cavell: Increased staffing requirements at night to support a number of patients under DoLS.

Ward 22/ASU: Low RN fill rate, due to an inability to fill from Bank/Agency. The ward has also scored slightly higher using the new QuESTT tool with a score of 10 which whilst below the threshold of 12 requiring further enquiry we have RAG rated the ward as amber.

Ward 32: CSW increased fill rate reflects need for enhanced care on 8 nights

Ward 10: RN: CSW ratio shift a risk assessed decision to maintain a 'line of sight' level of observation.

Ward 12: Increased fill rate of night CSW to support the provision of care with a high number of tracheostomy patients.

Ward 20: Increased CSW requirement to support cohort care for patients with cognitive impairment and/or risk of falls. One patient requiring constant RMN supervision.

Crowborough Birth Centre: RM fill rate an accepted risk during the day, as community midwives accompany women or can provide support to the unit. This ensures safe staffing levels overnight.

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

QuESTT:

As reported last month, the ‘overall RAG’ ratings are being replaced with a more objective approach to the safety and effectiveness of a ward. The RAG ratings considered only nurse sensitive indicators which did not reflect other aspects of good leadership and multi-professional engagement with care.

The tool has 16 statements that are answered true or false (Table 1). The questions cover a range of domains including leadership, staff support, user feedback and incidence. Each question is weighted with a score between 1 and 3. Any ward or department scoring above 12 would give rise to further enquiry. The aim of the tool is to identify wards that may need additional support or intervention before any adverse impact on the clinical care and outcomes.

The Quality, Effectiveness & Safety Trigger Tool (QuESTT) collection tool is now available to all wards. Completion and review rate is improving with 80% compliance (77% if maternity included).

Table 1

QuESTT: <u>Quality, Effectiveness and Safety Trigger Tool</u>		Score if True		
Name of person completing review:		Date of Review:		
Section One: The content of this completed tool should be used to form the basis of a <i>monthly</i> multi-disciplinary review of the key quality indicators within a clinical area. The assessment should be made by the team leader and then validated by the members of the review group discussing the results. Section One acts as a trigger or early warning tool and must be assessed and completed each month. <i>Instructions: If the statement is true, insert a X in the cell (the score will be calculated automatically). If it is not true, leave blank.</i>				
Indicators	True?	1	2	3
New or no line manager in post (within last 6 months)				
Vacancy rate higher than 3%				
Unfilled shifts is higher than 6%				
Sickness absence rate higher than 3.5%				
No monthly review of key quality indicators by peers, e.g. peer review or governance team meeting				
Planned annual appraisals <u>not</u> performed				
No involvement in Trust-wide multi-disciplinary meetings				
No formal feedback obtained from patients during the month, e.g. questionnaires or surveys				
2 or more formal complaints in a month (Wards) or 3 or more (A&E or OPD) or 1 or more (CCU & IC)				
No evidence of resolution to recurring themes				
Unusual demands on service exceeding capacity to deliver, e.g. national targets, outbreak				
Hand hygiene audits <u>not</u> performed				
Cleanliness audits <u>not</u> performed				
Ward/Department appears untidy				
No evidence of <i>effective</i> multi-disciplinary/multi-professional team working				
Ongoing investigation or disciplinary investigation (including RCA's & infection control RCA's)				
Overall Score:				
Insert comments below (if appropriate):				

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

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

May '18		Day		Night		Overall Care Hours per pt day	Nurse Sensitive Indicators					Financial review		
Hospital Site name	Ward name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)		FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	QESTT Score	Comments	Budget £	Actual £
MAIDSTONE	Acute Stroke	91.5%	99.3%	99.1%	107.6%	7.8	74.2%	91.3%	7	0	N/S	136,633	137,442	(809)
MAIDSTONE	Cornwallis	102.0%	92.6%	100.6%	94.0%	6.4	34.6%	97.2%	0	0	5	89,447	77,187	12,260
MAIDSTONE	Culpepper (Inccu)	98.0%	107.1%	105.6%	122.6%	8.4	110.3%	100.0%	3	0	0	107,155	106,197	958
MAIDSTONE	John Day	104.9%	131.0%	102.0%	129.0%	7.3	56.1%	90.6%	5	1	N/S	126,238	143,939	(17,701)
MAIDSTONE	Intensive Treatment Unit (ITU)	92.6%	89.5%	92.6%	N/A	28.5			0	0	5	155,506	174,023	(18,517)
MAIDSTONE	Pye Oliver	100.9%	87.7%	100.1%	96.9%	5.8	73.3%	90.9%	6	0	8	113,849	112,356	1,493
MAIDSTONE	Chaucer	94.1%	84.0%	146.8%	112.9%	9.1	17.1%	95.7%	6	0	5	115,628	110,536	5,092
MAIDSTONE	Lord North	95.6%	94.5%	100.0%	99.5%	7.1	73.7%	96.4%	1	2	1	100,372	106,185	(5,813)
MAIDSTONE	Mercer	98.9%	96.5%	98.9%	112.0%	6.0	59.5%	81.8%	3	0	5	103,678	115,192	(11,514)
MAIDSTONE	Edith Cavell	94.6%	110.1%	100.1%	143.8%	6.4	129.4%	86.4%	2	0	2	69,757	71,972	(2,215)
MAIDSTONE	Urgent Medical Ambulatory Unit (JMAU)	95.0%	82.6%	101.2%	98.1%	14.1	8.5%	100.0%	0	0	N/S	129,135	132,919	(3,784)
TWH	Stroke/W22	86.7%	90.6%	98.7%	97.8%	9.8	257.1%	94.4%	3	2	10	147,193	156,721	(9,528)
TWH	Coronary Care Unit (CCU)	108.8%	83.2%	99.0%	N/A	11.2	79.3%	100.0%	0	0	5	66,907	78,798	(11,891)
TWH	Gynaecology/ Ward 33	80.7%	92.0%	100.7%	100.0%	7.8	21.2%	93.5%	0	0	5	77,920	72,384	5,536
TWH	Intensive Treatment Unit (ITU)	102.5%	110.1%	101.8%	93.3%	29.2	0.0%	-	0	0	0	184,533	183,235	1,298
TWH	Medical Assessment Unit	95.4%	94.7%	118.5%	189.4%	5.3	28.4%	92.6%	7	0	N/S	186,019	194,076	(8,057)
TWH	SAU	98.4%	93.5%	96.8%	93.5%	4.5			0	0	0	60,652	61,409	(757)
TWH	Ward 32	92.0%	106.2%	100.0%	117.9%	6.7	48.2%	92.6%	3	2	4	136,521	142,648	(6,127)
TWH	Ward 10	101.1%	90.4%	73.4%	179.0%	9.1	15.1%	100.0%	1	0	3	117,435	113,603	3,832
TWH	Ward 11	97.0%	93.8%	95.2%	117.5%	6.2	0.0%	-	2	0	0	123,751	109,376	14,375
TWH	Ward 12	91.6%	111.7%	106.5%	102.4%	6.3	24.6%	100.0%	8	0	6	118,597	128,388	(9,791)
TWH	Ward 20	116.6%	118.2%	117.3%	121.6%	7.1	75.7%	53.6%	10	1	9	115,008	137,479	(22,471)
TWH	Ward 21	99.6%	104.3%	95.5%	124.5%	6.5	39.6%	95.2%	10	2	8	131,980	143,284	(11,304)
TWH	Ward 2	90.7%	85.5%	99.0%	97.5%	7.4	59.6%	87.1%	6	1	3	133,780	129,034	4,746
TWH	Ward 30	89.6%	90.9%	98.9%	94.5%	6.0	0.0%	-	6	0	9	120,058	118,148	1,910
TWH	Ward 31	89.7%	102.5%	100.8%	102.0%	6.8	45.0%	92.6%	1	2	N/S	137,102	126,931	10,171
Crowborough	Birth Centre	70.5%	97.6%	96.4%	96.9%		10.9%	93.4%	0	0	N/S	69,998	75,279	(5,281)
TWH	Maternity Services (incl Ante/Post Natal, Delivery Suite & Triage)	94.3%	82.6%	97.9%	N/A	11.2			1	0	N/S	679,190	681,693	(2,503)
TWH	Hedgehog	95.6%	31.9%	119.1%	100.0%	14.6	24.7%	95.7%	0	0	11	179,806	209,121	(29,315)
MAIDSTONE	Birth Centre	115.0%	96.4%	100.2%	96.2%				0	0	N/S	61,580	64,908	(3,328)
TWH	Neonatal Unit	82.6%	73.0%	87.9%	N/A	12.8			0	0	6	176,176	172,385	3,791
MAIDSTONE	MSSU	97.5%	131.4%	85.6%	N/A		21.7%	97.3%	2	0	1	41,043	40,859	184
MAIDSTONE	Peale	100.9%	83.5%	93.6%	127.0%	9.4	20.0%	100.0%	0	0	5	76,602	83,253	(6,651)
TWH	SSSU	121.2%	124.5%	99.9%	193.4%				2	0	5	118,751	93,665	25,086
MAIDSTONE	Whatman	97.1%	95.7%	98.9%	98.4%	5.5	116.7%	90.5%	2	0	3	97,360	98,142	(782)
MAIDSTONE	A&E	93.3%	82.9%	98.6%	100.0%		4.6%	91.7%	1	0		193,788	216,240	(22,452)
TWH	A&E	103.1%	91.7%	100.7%	92.3%		23.5%	91.1%	4	0		295,467	341,954	(46,487)
Total Establishment Wards												5,094,615	5,260,960	(166,345)
Additional Capacity beds												36,003	36,310	(307)
Other associated nursing costs												2,632,541	2,683,022	-50,481
Total												7,763,159	7,980,292	(217,133)



Infection Prevention and Control

MRSA

There were no cases of hospital attributable MRSA bacteraemia in May

C. difficile - There was one cases of post-72 hour *C. difficile* infection in May against a monthly limit of three cases. We are currently 5 cases below trajectory for the year to date.

The objective for 2018/19 has been set at **26** cases.

Methicillin sensitive *Staphylococcus aureus* bacteraemia

2 cases of hospital attributable MSSA blood stream infection were seen in May. Root cause analysis is being carried out on both cases and they will be reviewed at the *C. difficile* panel

Gram negative bacteraemia

Nine cases of hospital attributable gram negative blood stream infection were seen in May. Six cases due to *E. coli*, two due to *Klebsiella* species and one due to *Pseudomonas* species

We are working with community colleagues to improve continuity of catheter care across health and social care. An updated version of the catheter passport has now been finalised and will be launched over the summer.

IPCC

The IPCC was not due to meet in May. The next meeting is in June.

Financial commentary

- The Trusts deficit including PSF was £0.8m in May which was on plan, the Trust was £0.2m adverse against the CIP plan which was offset by income overperformance.
- In May the Trust operated with an EBITDA surplus of £1.8m which was on plan.
- The Trust's normalised pre PSF run rate in May was a deficit of £2.1m, an improvement of £0.4m compared to last month. The main normalised adjustments in May related to £0.6m prior month income adjustment for cashing up and coding of activity.
- The level of pay expenditure remains the main area of concern, high usage of temporary staffing to cover vacant posts is causing the main overspend (£0.6m) with a further £0.1m adverse due to CIP slippage. The pay pressure in May was offset by clinical income overperformance (£0.6m) which is unlikely to continue at the same level as the majority of the overperformance related to a prior period adjustment to reflect final cashing up and coding.
- The key variances in the month are as follows:
 - Total income was £1.1m favourable in the month; Clinical Income excluding HCDs was £0.6m favourable in May. The key favourable variances in May were Elective & Day Cases (£0.5m), Outpatients (£0.5m) and Non-Electives (£0.7m) offset by an adverse adjustment of £1.6m relating to the aligned incentive contract. PSF income was on plan due to delivery of the financial control target and A&E trajectory in May. Other Operating Income is breakeven to plan although after accounting for pass-through adjustments the revised variance is £0.1m adverse. The main adverse items relate to Private Patient Income (£0.1m) which is adverse to plan in both Cancer and the Private Patient Unit.
 - Pay was £0.7m adverse in the month, £0.1m adverse relating to CIP slippage and £0.6m relating to budget pressures caused by higher than planned temporary staffing costs mainly within Medical (£0.5m) and Nursing (£0.2m). Medical Staffing overspends included Surgery (£167k adverse in May) due to significant number of non-consultant vacancies, Speciality Medicine (£65k adverse) due to large number of consultant vacancies (c12WTE) and Womens and Childrens (£65k) due to vacancies and the requirement for extra Middle grade doctor on the Paediatric rota. Urgent Care Division was £0.2m adverse within Nursing budget, £88k adverse within Emergency and Acute and £80k within Specialist Medicine.
 - Non Pay adjusted for pass through costs was underspent by £0.2m in May this was mainly due to underspends within drugs (£0.3m net of pass through costs). The Trust was adverse to plan within Clinical Supplies by £0.2m due to higher than planned activity levels.
- The Trust achieved £0.8m savings in May which was £0.2m adverse to plan and year to date is £0.4m adverse. This is mainly due to STP Medical rate slippage (£0.2m) and Outsourcing reduction slippage (£0.2m).
- The Trust held £20.2m of cash at the end of May which is higher than the plan of £13.9m. This is primarily due to NHS England paying £7.4m over performance for 17/18. 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
- The Trust has an approved Capital Plan of £14.5m, which is financed by Capital resources of £13.5m depreciation; proposed asset sales of £2.4m (Maidstone Residences); donated assets of £0.7m; national funding for the next replacement Linac of £1.7m (LA5); a proposed Capital Investment Loan for critical imaging equipment of £2.5m; a proposed Salix loan of £1.2m for the additional Energy Infrastructure work; less £7.6m of existing loan repayments. The business case for Estates Backlog Maintenance programme of works has been approved and schemes are underway, with other Estates projects and renewals being prioritised by the Estates Department. A major scheme for the Energy Infrastructure has an approved Salix loan of £0.76m for Phase 4 and agreement from DH to provide the necessary Capital resource cover is being obtained by NHSI. A further loan application will be made at a later stage. The ICT schemes have been prioritised and approved by the ISG in principle but will require IAG Business case sign off. The equipment schemes are being prioritised and the final list will go to TME and Execs for approval subject to individual Business case preparation as required. Linac 4 replacement at Maidstone was delivered in early May and commissioning the equipment will begin and be ready for clinical use by Oct 18. Linac 5 replacement funding has now been agreed in principle with NHSE as additional PDC from the national programme. The donated equipment plan is mainly made up of the remaining Cardiology legacies, and a large donation for Urology/Oncology equipment.

Workforce Commentary

As at the end of May 2018, the Trust employed 5033.8 whole time equivalent substantive staff, an 11.8 WTE increase from the previous month. Agency use is higher than planned, in line with the higher than anticipated vacancy levels.

Sickness absence in the month (April) decreased by 0.34% to 3.39%, 0.09% over target but continuing the downward movement over recent months. Directorates demonstrating the highest sickness rates include Patient Administration (8.02%), Estates (6.33%) and Facilities (5.77%), but with rates having decreased in two of the three areas since last month. At a divisional level, Cancer and Support Services and Women, Children and Sexual Health have higher sickness levels at 2.94% and 5.11% respectively. At a trust level, the breakdown in April is 52.82% short-term, 47.18% long term. 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 increased marginally by 0.66% to 88.54%, and 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 (79.90%), General Surgery (82.44%) and Children's Services (85.14%), but with the latter two having increased from the previous month.

Turnover has decreased since last month to 10.65%, higher than target, with outliers in Clinical Governance (18.95%) and Medical Education (18.79%). 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 is not formally reported during the first three months of the year, while within the appraisal window.

Trust Performance Dashboard

Position as at: **31 May 2018**

	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
	Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/Limit	Forecast	
1-01 *Rate C-Diff (Hospital only)	22.12	4.7	9.2	2.4	-6.8	- 11.8	11.5	8.0	
1-02 Number of cases C.Difficile (Hospital)	2	1	4	1	-3	- 5	26	21	
1-03 Number of cases MRSA (Hospital)	0	0	0	1	1	1	0	1	
1-04 Elective MRSA Screening	98.5%	99.0%	98.5%	99.0%	0.5%	1.0%	98.0%	99.0%	
1-05 % Non-Elective MRSA Screening	Not currently available								
1-06 **Rate of Hospital Pressure Ulcers	2.04	2.18	2.14	1.93	- 0.20	- 1.08	3.01	2.00	3.00
1-07 ***Rate of Total Patient Falls	6.02	4.61	5.81	4.94	- 0.87	- 1.06	6.00	4.79	
1-08 ***Rate of Total Patient Falls Maidstone	4.95	4.62	4.95	4.78	- 0.17			4.26	
1-09 ***Rate of Total Patient Falls TWells	6.04	4.60	6.04	5.04	- 0.99			4.51	
1-10 Falls - SIs in month	5	3	6	4	- 2				
1-11 VTE - SIs in month	1	0	1	0	- 1				
1-11 Number of Never Events	0	0	0	0	0	0	0	0	
1-12 Total No of SIs Open with MTW	35	68				33			
1-13 Number of New SIs in month	17	20	24	33	9	13			
1-14 ***Serious Incidents rate	0.75	0.94	0.55	0.78	0.23	0.72	0.6078	0.58	0.6078
1-15 Rate of Patient Safety Incidents - harmful	1.90	1.22	1.41	1.33	- 0.08	0.10	0 - 1.23	1.23	0 - 1.23
1-16 Number of CAS Alerts Overdue	0	0			0	0	0		
1-17 VTE Risk Assessment - month behind	95.6%	96.8%	95.4%	96.8%	1.4%	1.8%	95.0%	96.8%	95.0%
1-18 Safety Thermometer % of Harm Free Care	97.5%	97.6%	96.6%	97.4%	0.8%	2.4%	95.0%		93.4%
1-19 Safety Thermometer % of New Harms	3.23%	2.24%	3.43%	2.45%	-0.98%	-0.5%	3.00%	2.45%	
1-20 C-Section Rate (non-elective)	15.0%	13.6%	13.7%	13.4%	-0.30%	-1.6%	15.0%	13.4%	

	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
	Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/Limit	Forecast	
2-01 Hospital-level Mortality Indicator (SHMI)*****	Prev Yr: July 14 to June 15		1.0762	1.0440	- 0.0	0.0	Band 2	Band 2	1.0
2-02 Standardised Mortality HSMR	Prev Yr: Apr 15 to Mar 16		108.7	103.7	- 5.0	3.7	Lower confidence limit to be <100		100.0
2-03 Crude Mortality	1.2%	0.8%	1.0%	0.9%	-0.1%				
2-04 ***Readmissions <30 days: Emergency	13.7%	13.7%	11.7%	13.7%	2.0%	0.1%	13.6%	13.6%	14.1%
2-05 ***Readmissions <30 days: All	13.2%	13.2%	11.0%	13.2%	2.3%	-1.5%	14.7%	13.2%	14.7%
2-06 Average LOS Elective	3.34	3.18	2.55	3.05	0.49	- 0.16	3.20	3.05	
2-07 Average LOS Non-Elective	7.77	7.14	7.43	7.29	- 0.15	0.49	6.80	6.80	
2-22 NE Discharges - Percent zero LoS	33.3%	43.4%	33.6%	42.8%	9.2%			42.8%	
2-08 *****FollowUp : New Ratio	1.77	1.59	1.77	1.55	- 0.21	0.04	1.52	1.52	
2-09 Day Case Rates	88.0%	87.0%	88.0%	87.5%	-0.6%	7.5%	80.0%	87.5%	82.2%
2-10 Primary Referrals	9,871	9,566	18,096	19,957	10.3%	6.7%	121,638	123,149	
2-11 Cons to Cons Referrals	5,188	5,609	9,640	11,243	16.6%	22.4%	56,704	69,378	
2-12 First OP Activity (adjusted for uncashed)	16,917	17,807	31,348	35,275	12.5%	6.2%	208,349	446,231	
2-13 Subsequent OP Activity (adjusted for uncashed)	30,510	26,131	57,422	50,478	-12.1%	-17.0%	382,157	638,550	
2-14 Elective IP Activity	587	543	1,069	1,016	-5.0%	-12.0%	7,674	6,269	
2-15 Elective DC Activity	3,734	3,626	7,224	7,087	-1.9%	2.4%	44,403	43,732	
2-16 **Non-Elective Activity	4,798	5,415	9,224	10,367	12.4%	6.5%	58,582	62,032	
2-17 A&E Attendances (Calendar Mth) Excl Crowboro	14,655	15,789	28,207	29,794	5.6%	94.4%	174,428	174,428	
2-18 Oncology Fractions	6,039	5,141	10,897	10,808	-0.8%	-1.8%	67,890	64,848	
2-19 No of Births (Mothers Delivered)	528	544	998	1,001	0.3%	101.0%	5,977	12,012	
2-20 % Mothers initiating breastfeeding	80.0%	83.8%	80.0%	83.2%	3.1%	5.2%	78.0%	83.2%	
2-21 % Stillbirths Rate	0.4%	0.36%	0.37%	0.20%	-0.2%	-0.3%	0.47%	0.20%	0.47%

	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
	Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/Limit	Forecast	
3-01 Single Sex Accommodation Breaches	0	0	0	0	0	0	0	0	
3-02 *****Rate of New Complaints	1.33	2.02	2.59	2.12	-0.5	0.80	1.318-3.92	2.05	
3-03 % complaints responded to within target	70.4%	55.6%	74.3%	60.0%	-14.3%	-15.0%	75.0%	75.0%	
3-04 *****Staff Friends & Family (FFT) % rec care	76.0%	66.7%	76.0%	66.7%	-9.4%	-12.3%	79.0%	79.0%	
3-05 *****IP Friends & Family (FFT) % Positive	95.5%	94.9%	95.3%	94.1%	-1.2%	-0.9%	95.0%	95.0%	95.8%
3-06 A&E Friends & Family (FFT) % Positive	91.2%	93.8%	91.4%	92.3%	0.9%	5.3%	87.0%	92.3%	85.5%
3-07 Maternity Combined FFT % Positive	91.7%	93.4%	93.6%	94.4%	0.9%	-0.6%	95.0%	95.0%	95.6%
3-08 OP Friends & Family (FFT) % Positive	84.2%		83.0%	83.6%	0.6%			83.6%	

* 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

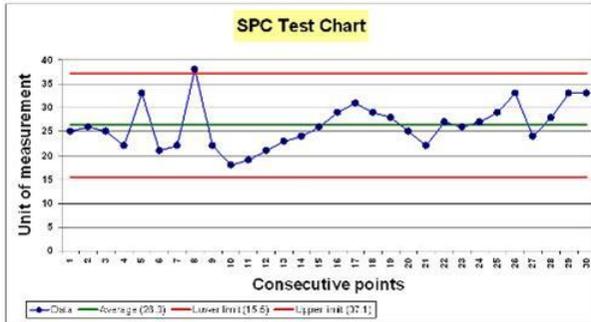
	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
	Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/Limit	Forecast	
4-01 *****Emergency A&E 4hr Wait	87.0%	92.45%	87.0%	92.75%	5.7%	4.0%	90.8%	90.2%	76.4%
4-02 Emergency A&E >12hr to Admission	0	1	0	1	1	1	0	1	
4-03 Ambulance Handover Delays >30mins	248	288	248	578	330			6,936	
4-04 Ambulance Handover Delays >60mins	19	27	19	71	52			852	
4-05 RTT Incomplete Admitted Backlog	2,298	2,559	2,298	2,559	261	- 36	2,151	2,151	
4-06 RTT Incomplete Non-Admitted Backlog	718	3,971	718	3,971	3,253	630	1,995	1,995	
4-07 RTT Incomplete Pathway	87.7%	80.0%	87.7%	80.0%	-7.7%	-0.3%	85.5%	85.5%	
4-08 RTT 52 Week Waiters (new in month)	0	2	0	4	4	4	0	4	
4-09 RTT Incomplete Total Backlog	3,016	6,530	3,016	6,530	3,514	595	4,146	4,146	
4-10 % Diagnostics Tests WTimes <6wks	99.82%	99.4%	99.8%	99.4%	-0.4%	0.4%	99.0%	99.0%	
4-11 *Cancer WTimes - Indicators achieved	3	1	1	1	-	- 8	9	9	
4-12 *Cancer two week wait	83.0%	83.4%	89.1%	83.4%	-5.8%	-9.6%	93.0%	93.0%	
4-13 *Cancer two week wait-Breast Symptoms	69.1%	65.8%	83.9%	65.8%	-18.1%	-27.2%	93.0%	93.0%	
4-14 *Cancer 31 day wait - First Treatment	97.2%	92.1%	95.7%	92.1%	-3.6%	-3.9%	96.0%	96.0%	
4-15 *Cancer 62 day wait - First Definitive	68.0%	61.6%	70.4%	61.6%	-8.8%	-20.6%	85.0%	85.0%	
4-16 *Cancer 62 day wait - First Definitive - MTW	71.7%	69.2%	71.7%	71.3%	-0.5%		85.0%		
4-17 *Cancer 104 Day wait Accountable	15.5	18.0	88.5	18.0	-70.5	18.0	0	18.0	
4-18 *Cancer 62 Day Backlog with Diagnosis	90	83	90	83	-7				
4-19 *Cancer 62 Day Backlog with Diagnosis - MTW	63	58	63	58	-5				
4-20 Delayed Transfers of Care	6.03%	4.34%	5.88%	4.45%	-1.43%	0.95%	3.50%	3.50%	
4-21 % TIA with high risk treated <24hrs	77.8%	90.0%	81.7%	72.5%	-9.2%	12.5%	60%	72.5%	
4-22 ***** spending 90% time on Stroke Ward	86.7%	96.6%	86.7%	92.3%	5.6%	12.3%	80%	92.3%	
4-23 *****Stroke:% to Stroke Unit <4hrs	58.3%	42.9%	52.7%	47.7%	-5.0%	-12.3%	60.0%	60.0%	
4-24 *****Stroke: % scanned <1hr of arrival	62.2%	46.9%	57.5%	54.5%	-2.9%	6.5%	48.0%	54.5%	
4-25 *****Stroke:% assessed by Cons <24hrs	70.3%	83.0%	83.5%	83.5%	0.0%	3.5%	80.0%	83.5%	
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	7	2	7	5	-2	5	0	5	

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

	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
	Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/Limit	Forecast	
5-01 Income	36,805	38,684	73,773	74,547	1.0%	1.1%	466,464	466,464	
5-02 EBITDA	913	1,755	2,220	2,111	-4.9%	-1.4%	38,910	38,910	
5-03 Surplus (Deficit) against B/E Duty	(1,603)	(759)	(2,832)	(2,920)			11,691	11,691	
5-04 CIP Savings	955	797	1,997	1,618	-19.0%	-19.8%	24,111	24,111	
5-05 Cash Balance	7,825	20,190	7,825	20,190			1,000	1,000	
5-06 Capital Expenditure	143	68	217	282			13,762	13,762	
5-07 Establishment WTE	5,602.4	5,576.0	5,602.4	5,576.0	-0.5%	0.0%	5,576.0	5,576.0	
5-08 Contracted WTE	5,084.1	5,033.8	5,084.1	5,033.8	-1.0%	0.4%	5,014.8	5,014.8	
5-09 Vacancies WTE	518.3	542.3	518.3	542.3	4.6%	-3.4%	561.2	561.2	
5-11 Vacancy Rate (%)	9.3%	9.7%	9.3%	9.7%	0.5%	-0.3%	10.1%	10.1%	
5-12 Substantive Staff Used	4,942.9	4,944.5	4,942.9	4,944.5	0.0%	-0.5%	4,967.7	4,967.7	
5-13 Bank Staff Used	360.1	361.7	360.1	361.7	0.4%	-1.0%	365	365.4	
5-14 Agency Staff Used	170.8	302.0	170.8	302.0	76.8%	24.3%	242.9	242.9	
5-15 Overtime Used	43.8	46.2	43.8	46.2	5.3%				
5-16 Worked WTE	5,517.7	5,654.3	5,517.7	5,654.3		1.4%	5,576.0	5,576.0	
5-17 Nurse Agency Spend	(651)	(839)	(1,259)	(1,668)	32.4%				
5-18 Medical Locum & Agency Spend	(1,013)	(1,623)	(2,378)	(3,042)	28.0%				
5-19 Temp costs & overtime as % of total pay bill	13.7%	17.0%	16.5%	16.9%	0.4%				
5-20 Staff Turnover Rate	11.5%	10.7%		10.7%	-0.8%	0.2%	10.5%	10.5%	11.05%
5-21 Sickness Absence	3.2%	3.4%		3.6%	0.2%	0.3%	3.3%	3.3%	4.3%
5-22 Statutory and Mandatory Training	87.5%	88.5%		88.2%	1.1%	3.2%	85.0%	88.2%	
5-23 Appraisal Completeness	Data not shown for Quarter 1								90.0%
5-24 Overall Safe staffing fill rate	98.9%	98.9%	98.5%	98.5%	0.0%		93.5%	98.5%	
5-25 ****Staff FFT % recommended work	50.9%	61%	50.9%	61%	9.7%	-1.4%	62.0%	62%	
5-26 ***Staff Friends & Family -Number Responses	701	33	701	33	-668				
5-27 *****IP Resp Rate Recmd to Friends & Family	23.3%	21.4%	23.7%	24.2%	0.5%	-0.8%	25.0%	25.0%	25.7%
5-28 A&E Resp Rate Recmd to Friends & Family	15.7%	9.0%	21.4%	11.4%	-10.0%	-3.6%</			

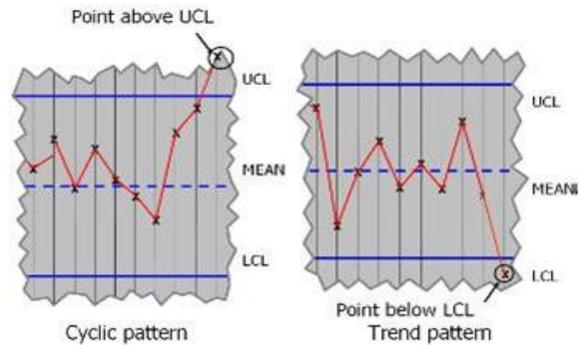
Explanation of Statistical Process Control (SPC) Charts

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

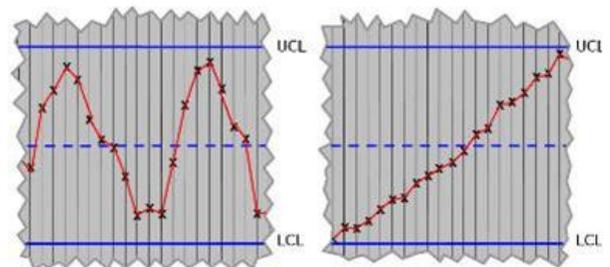


SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause' variation is present in the system.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

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

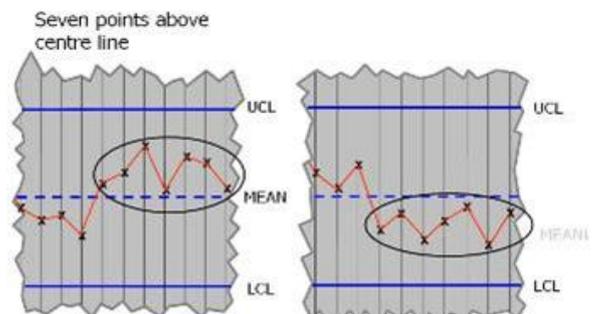


Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key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

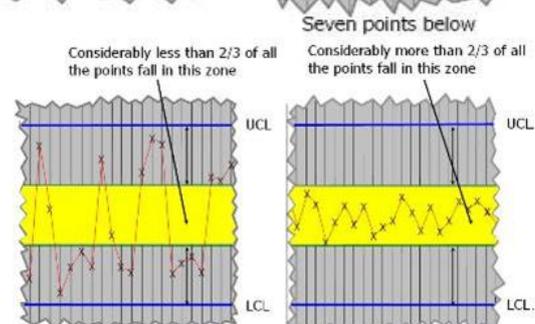


Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

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

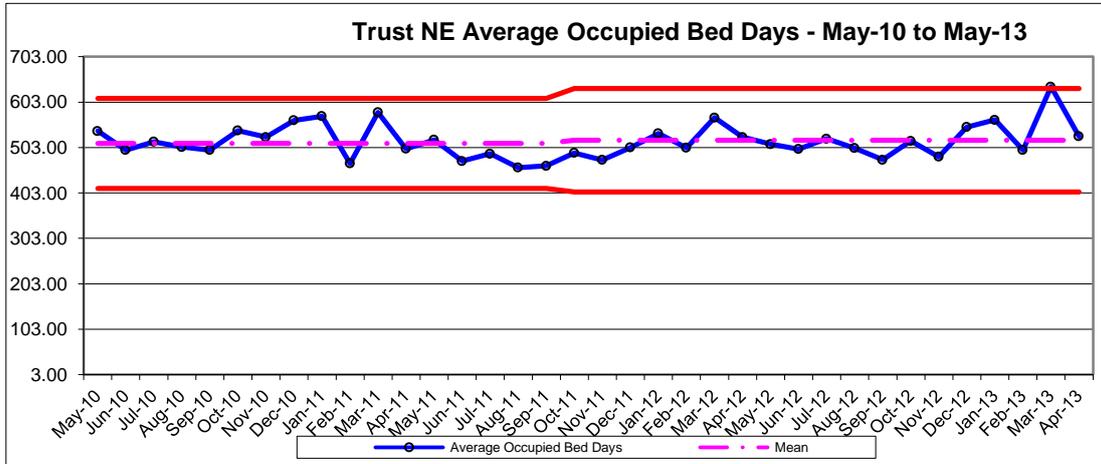


Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two-thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable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

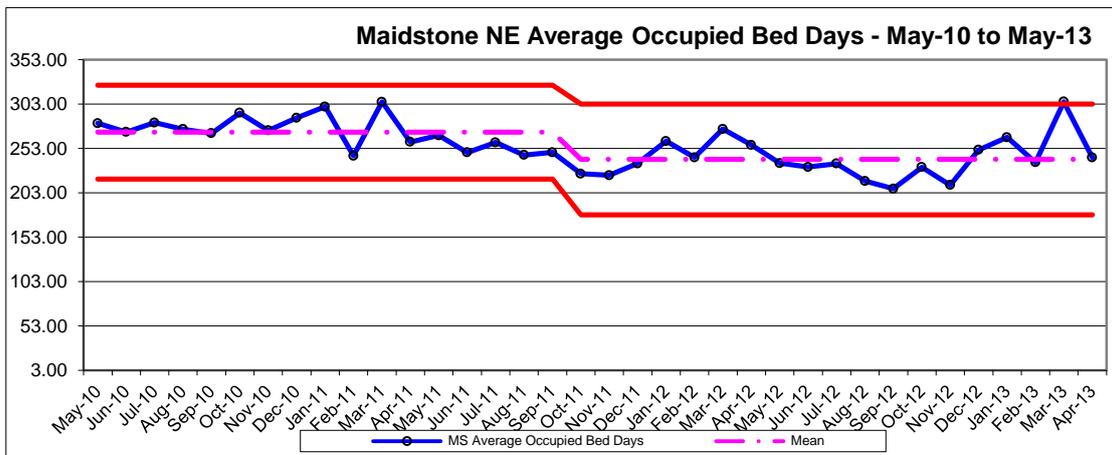
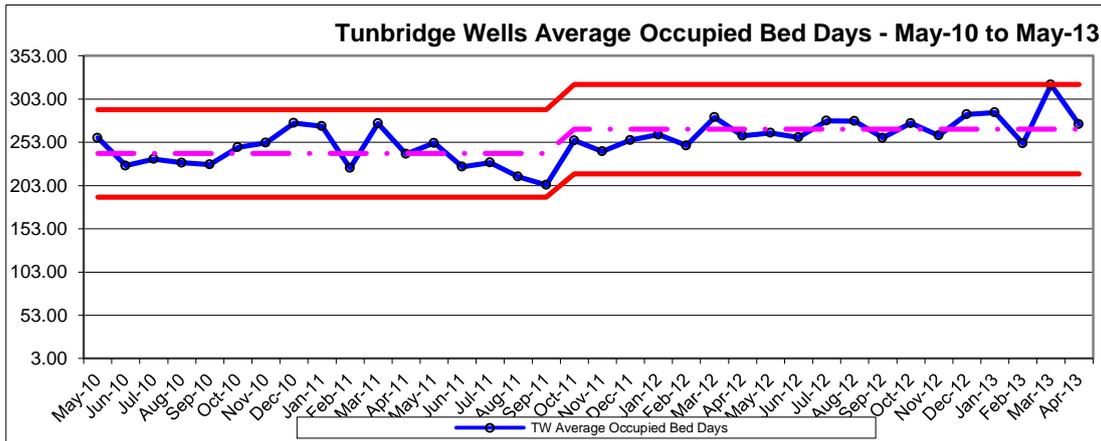


Changes to Control Lines

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



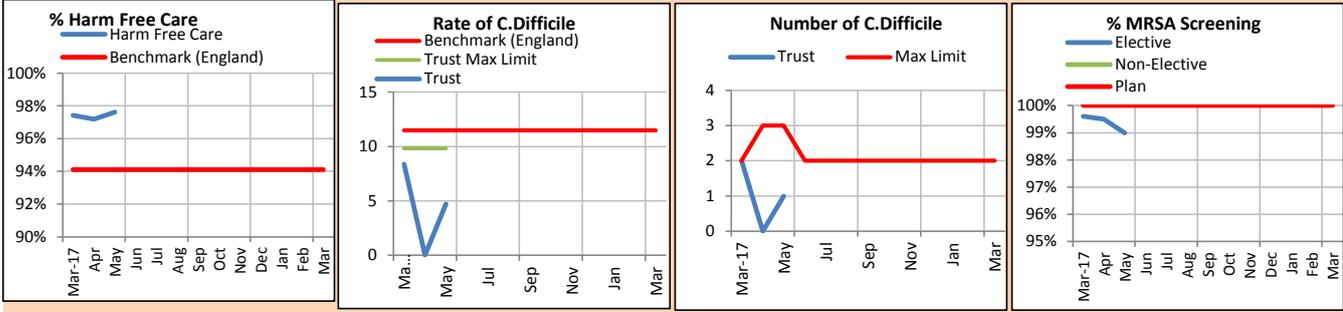
The change is not immediately obvious in the graph above if you look at just the blue line, but we know there were major changes to our inpatient beds. Looking at site level the change is more obvious:



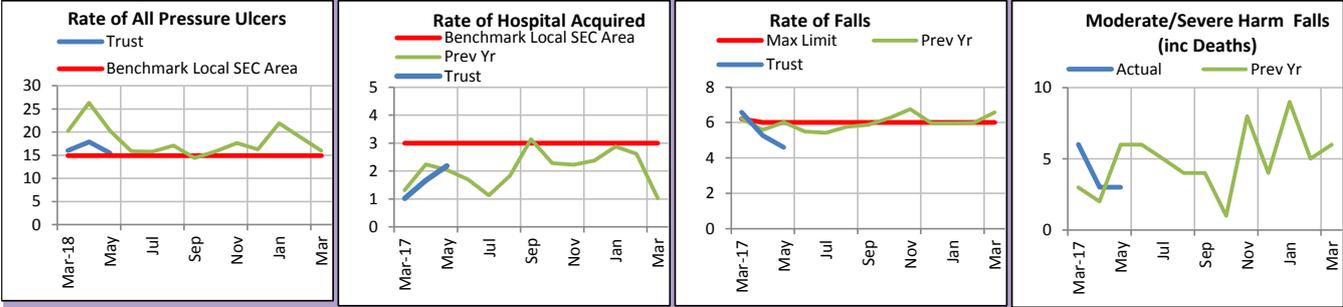
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

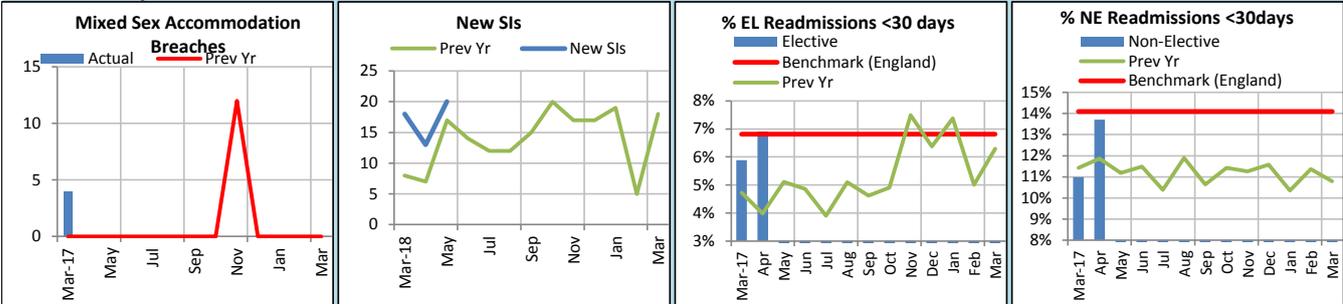
Patient Safety - Harm Free Care, Infection Control



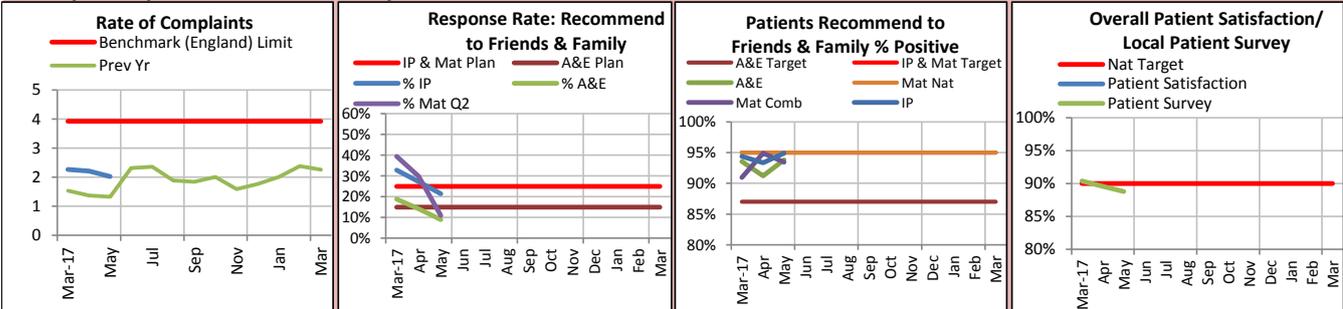
Patient Safety - Pressure Ulcers, Falls



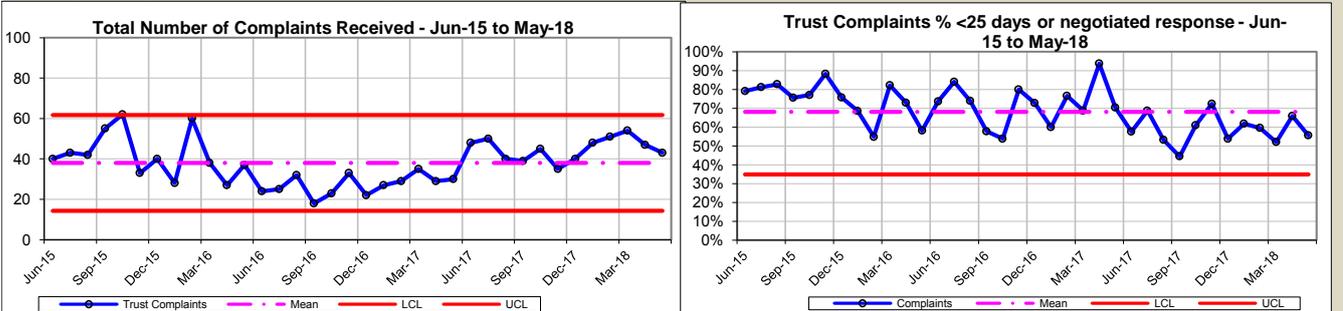
Patient Safety, MSA Breaches, SIs, Readmissions



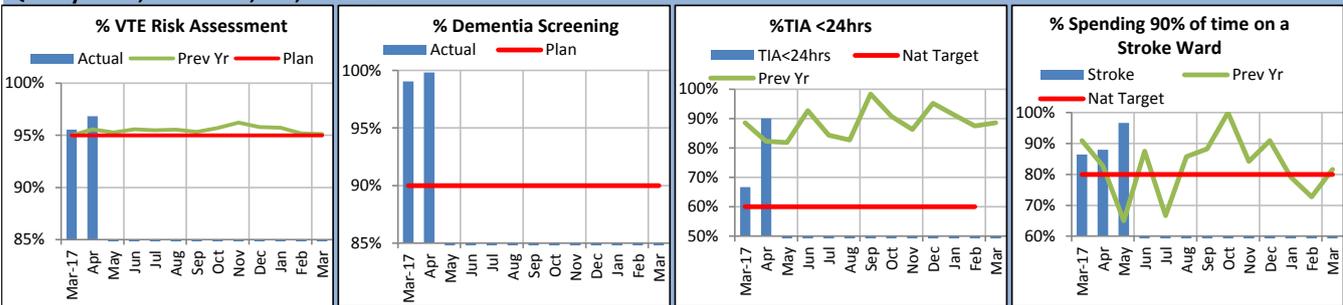
Quality - Complaints, Friends & Family, Patient Satisfaction



Quality - Complaints, Friends & Family, Patient Satisfaction

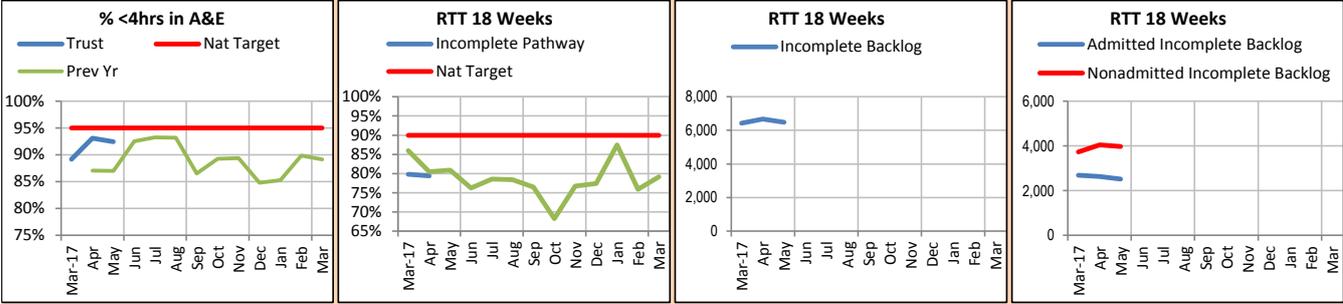


Quality - VTE, Dementia, TIA, Stroke

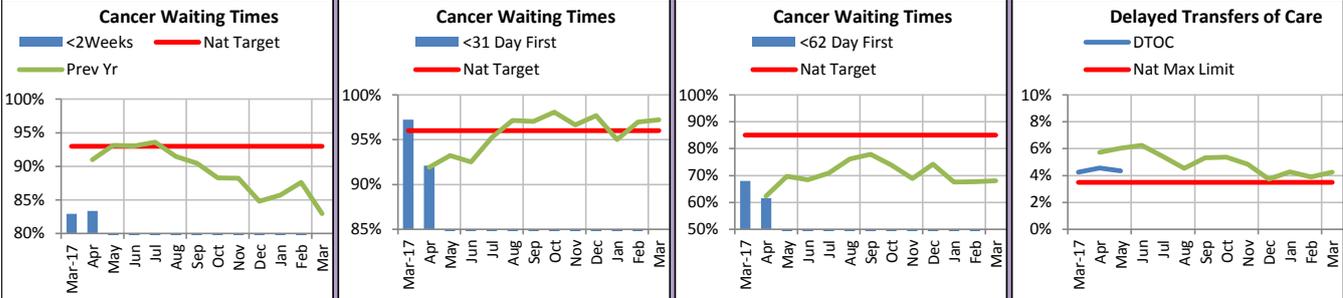


INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

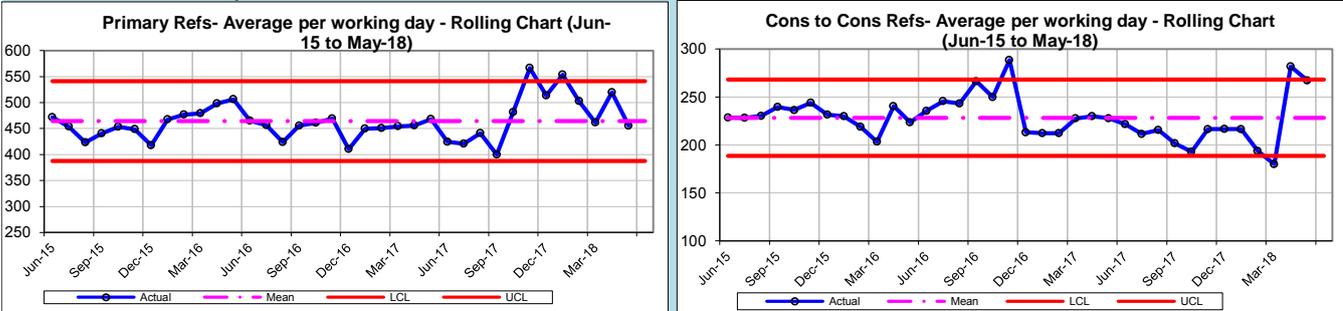
Performance & Activity - A&E, 18 Weeks



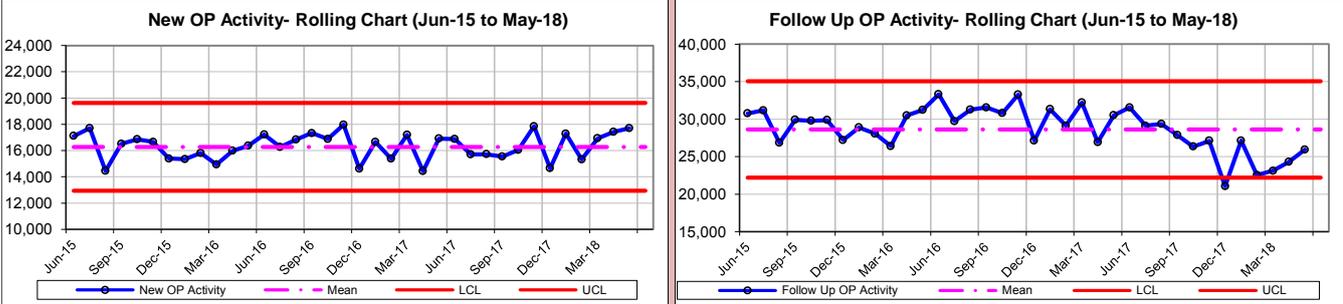
Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care



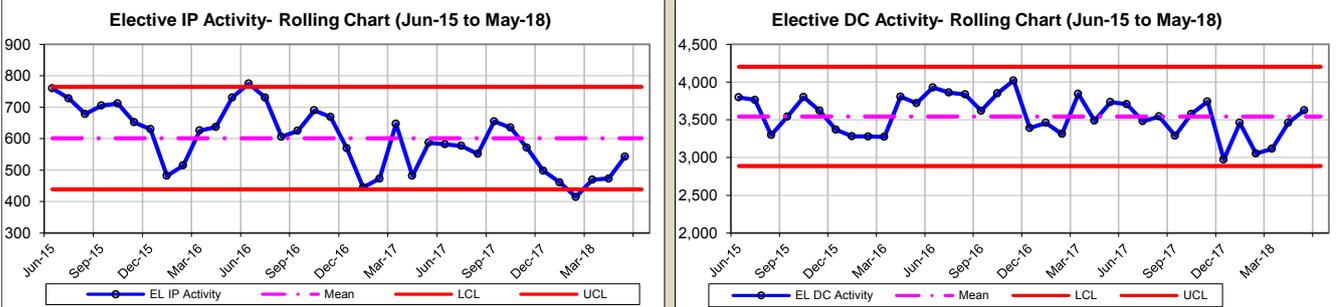
Performance & Activity - Referrals



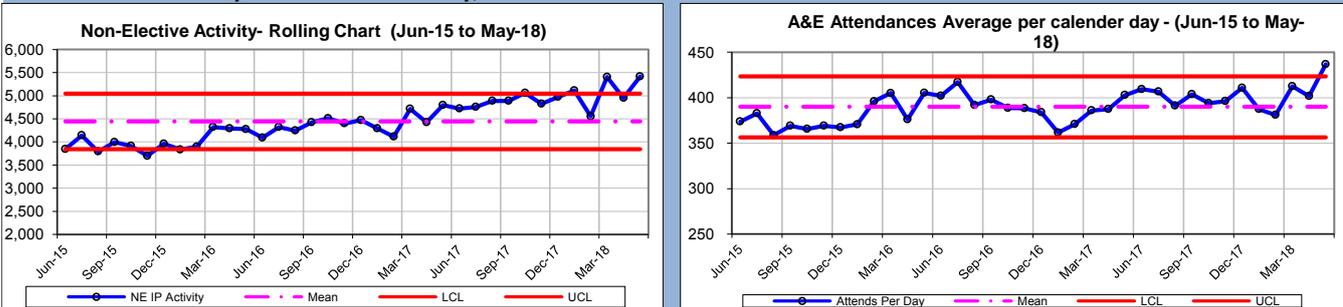
Performance & Activity - Outpatient Activity



Performance & Activity - Elective Activity

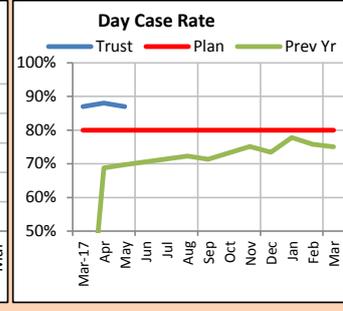
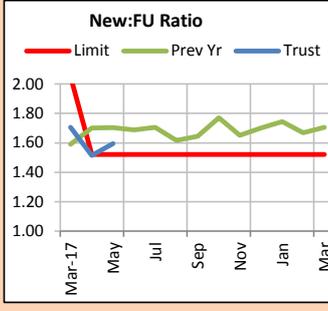
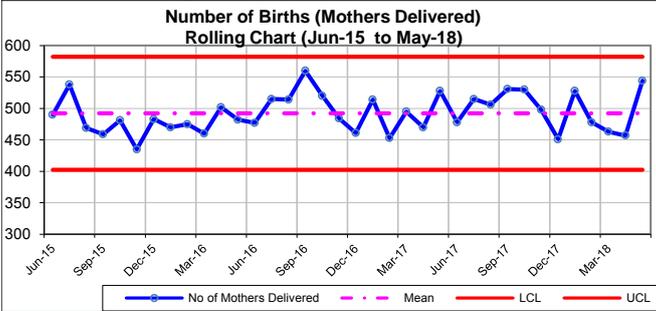


Performance & Activity - Non-Elective Activity, A&E Attendances

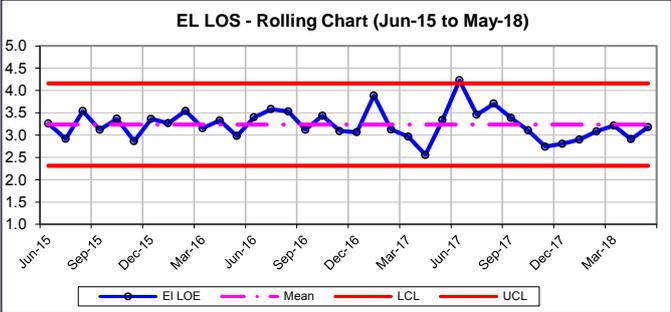
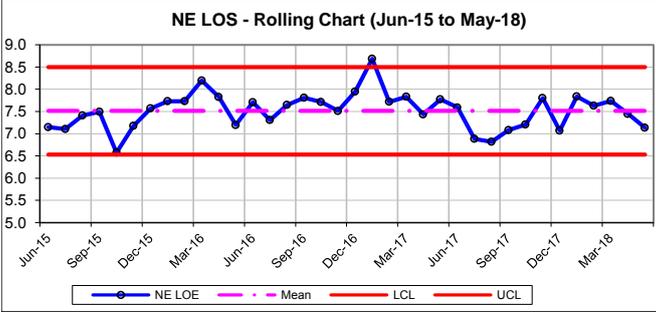


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

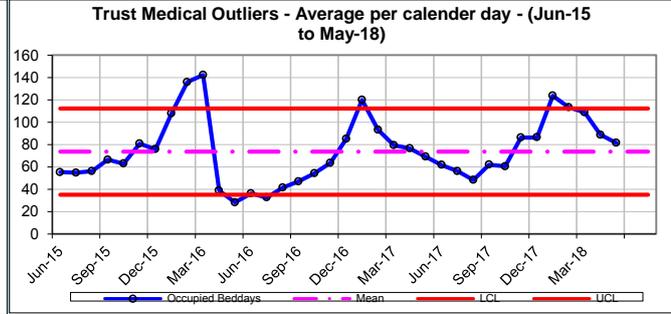
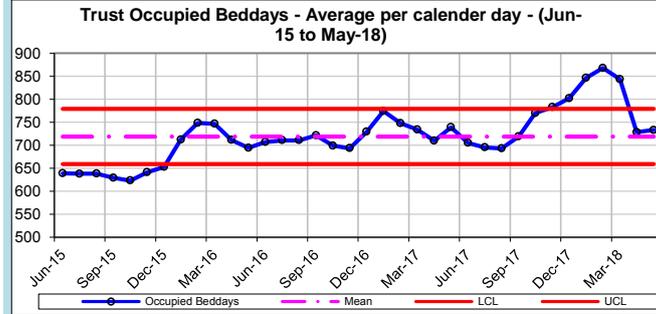
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates



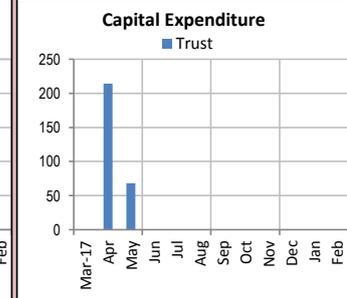
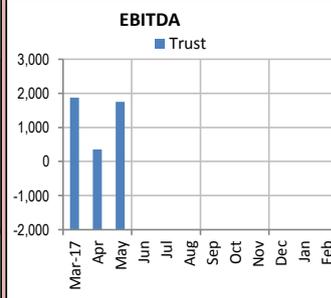
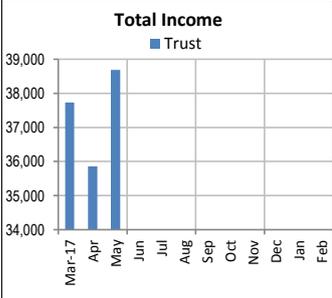
Finance, Efficiency & Workforce - Length of Stay (LOS)



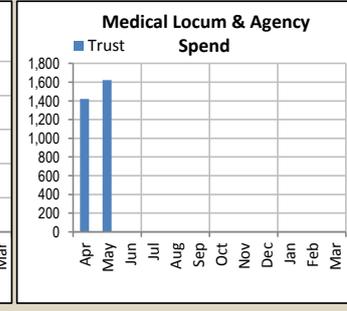
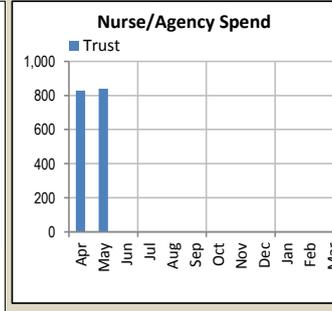
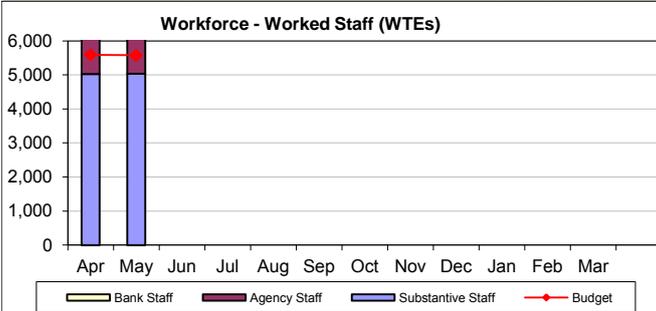
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers



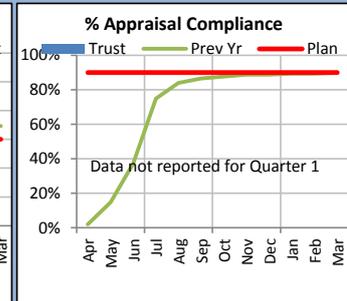
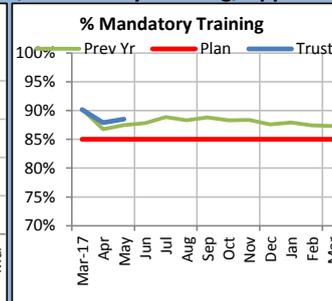
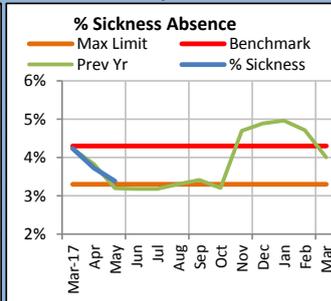
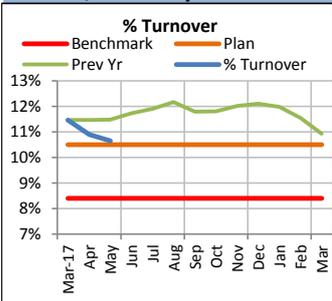
Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure



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



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



Trust Board Finance Report

Month 2
2018/19

Trust Board Finance Report for May 2018

1. Executive Summary

- a. Executive Summary
- b. Executive Summary KPI's

2. Financial Performance

- a. Consolidated I&E

3. Expenditure Analysis

- a. Run Rate Analysis £

4. Cost Improvement Programme / Financial Recovery Plan

- a. Current Month Savings by Directorate
- b. YTD Savings by Directorate
- c. Forecast Savings by Directorate

5. Balance Sheet and Liquidity

- a. Balance Sheet
- b. Cash Flow

6. Capital

- a. Capital Plan

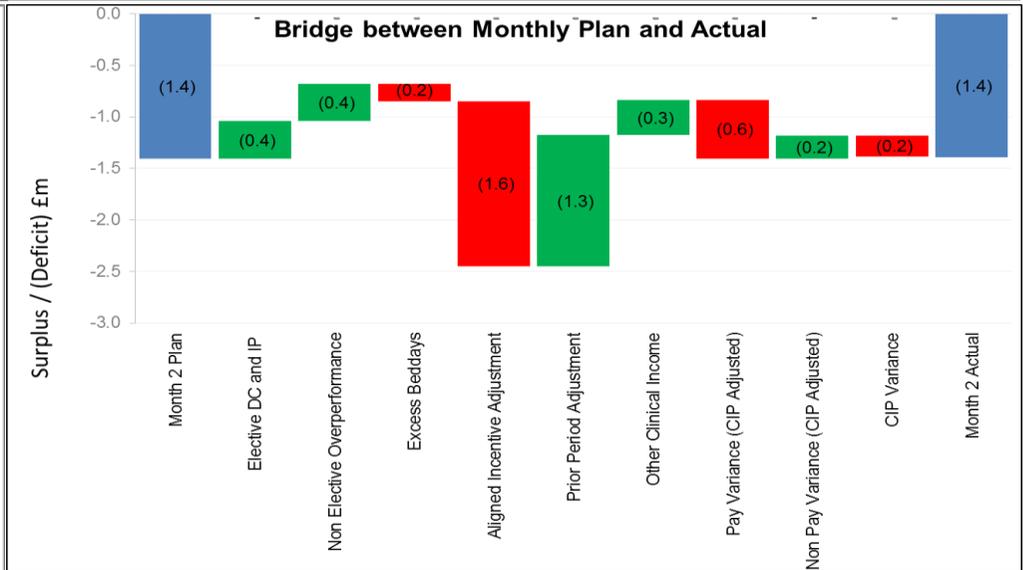
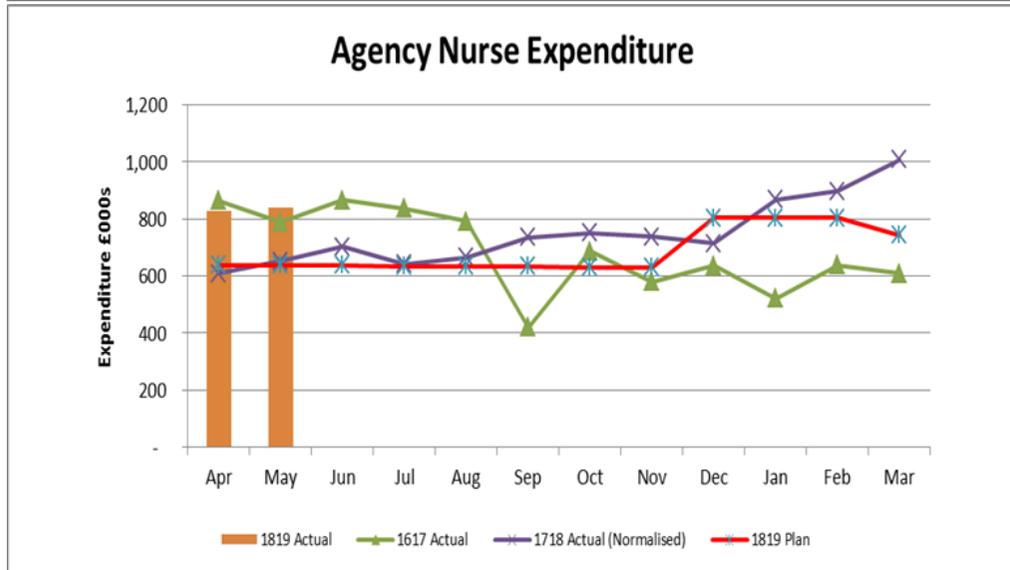
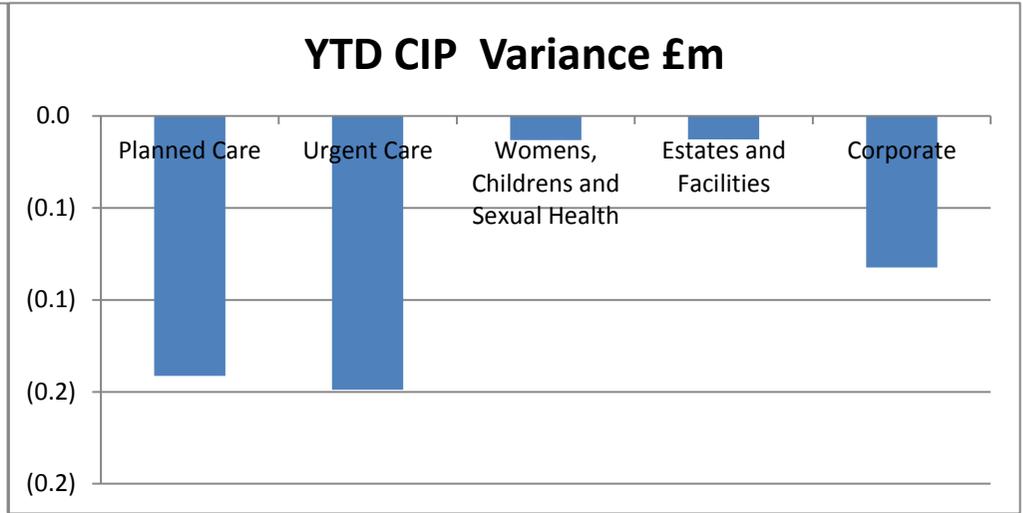
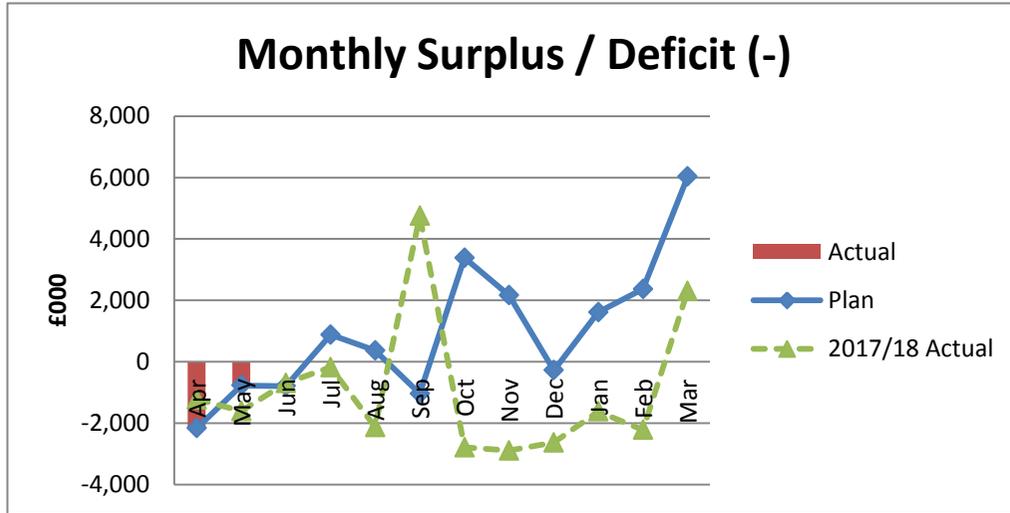
1.Executive Summary

1a. Executive Summary May 2018

Key Variances £m

	May	YTD		Headlines
Total Surplus (+) / Deficit (-)	0.0	0.0	Favourable	The Trusts deficit including PSF was £0.8m in May which was on plan, the Trust was £0.2m adverse against the CIP plan which was offset by income overperformance. The level of pay expenditure remains the main area of concern, high usage of temporary staffing to cover vacant posts is causing the main overspend (£0.6m) with a further £0.1m adverse due to slippage in CIP. The pay pressure in May was offset by clinical income overperformance (£0.6m) which is unlikely to continue at the same level as this overperformance mainly related to a prior period adjustment to reflect final cashing up and coding.
Clinical Income	0.6	0.4	Favourable	Clinical Income excluding HCDs was £0.6m favourable to plan in May. The key favourable variances in May were Elective & Day Cases (£0.5m), Outpatients (£0.5m) and Non-Electives (£0.7m) offset by an adverse adjustment of £1.6m relating to the aligned incentive contract.
Elective IP and DC	0.4	0.1	Favourable	Elective and Day Case activity is favourable to plan in month by £0.4m and £0.1m year to date.
Provider Sustainability Fund	0	0	Favourable	The Trust achieved the financial performance and A&E trajectory in May therefore was eligible for PSF income.
Other Operating Income	(0.0)	(0.0)	Favourable	Other Operating Income is breakeven to plan although after accounting for pass-through adjustments the revised variances is £0.1m adverse. The main adverse items relate to Private Patient Income (£0.1m) which is adverse to plan in both Cancer and the Private Patient Unit.
Pay	(0.7)	(0.9)	Adverse	Pay was £0.7m adverse in the month, £0.1m adverse relating to CIP slippage and £0.6m relating to budget pressures caused by higher than planned temporary staffing costs mainly within Medical (£0.5m) and Nursing (£0.2m). Medical Staffing overspends included Surgery (£167k adverse in May) due to significant number of non consultant vacancies, Speciality Medicine (£65k adverse) due to large number of consultant vacancies (c12WTE) and Womens and Childrens (£65k) due to vacancies and the requirement for extra Middle grade doctor on the Paediatric rota. Urgent Care Division was £0.2m adverse within Nursing budget, £88k adverse within Emergency and Acute and £80k within Specialist Medicine.
Non Pay	(0.4)	0.0	Favourable	Non Pay adjusted for pass through costs was underspent by £0.2m in May this was mainly due to underspends within drugs (£0.3m net of pass through costs). The Trust was adverse to plan within Clinical Supplies by £0.2m due to higher than planned activity levels.
Other Finance Costs	(0.0)	(0.0)	Favourable	Other Finance Costs were on plan in May
CIP / FRP	(0.2)	(0.4)	Adverse	The Trust achieved £0.8m savings in May which was £0.2m adverse to plan mainly due to slippage relating to STP Medical rates (£0.1m) and Outsourcing reductions (£0.1m).

1b. Executive Summary KPI's May 2018



2. Income and Expenditure

2a. Income & Expenditure

Income & Expenditure May 2018/19

	Current Month					Year to Date					Annual Forecast		
	Actual Em	Plan Em	Variance Em	Pass-through Em	Revised Variance Em	Actual Em	Plan Em	Variance Em	Pass-through Em	Revised Variance Em	Actual Em	Plan Em	Variance Em
Revenue													
Clinical Income	29.3	28.7	0.6	0.0	0.6	56.6	56.2	0.4	0.0	0.4	351.5	351.5	0.0
High Cost Drugs	4.2	3.7	0.5	0.5	0.0	7.6	7.2	0.5	0.5	(0.0)	43.3	43.3	0.0
Total Clinical Income	33.5	32.4	1.1	0.6	0.6	64.3	63.4	0.9	0.5	0.4	394.8	394.8	0.0
PSF	0.6	0.6	0.0	0.0	0.0	1.3	1.3	0	0	0	12.7	12.7	0
Other Operating Income	4.5	4.6	(0.0)	0.0	(0.1)	9.0	9.1	(0.0)	0.1	(0.2)	58.9	58.9	0.0
Total Revenue	38.7	37.6	1.1	0.6	0.5	74.5	73.7	0.8	0.6	0.2	466.5	466.5	0.0
Expenditure													
Substantive	(18.7)	(18.6)	(0.1)	(0.0)	(0.1)	(36.9)	(37.1)	0.2	(0.0)	0.2	(221.8)	(221.8)	0
Bank	(1.0)	(1.0)	(0.0)	0.0	(0.0)	(2.0)	(1.9)	(0.1)	0	(0.1)	(12.0)	(12.0)	0
Locum	(0.6)	(0.4)	(0.1)	0.0	(0.1)	(1.1)	(0.9)	(0.2)	0	(0.2)	(5.5)	(5.5)	0
Agency	(2.1)	(1.7)	(0.4)	(0.0)	(0.4)	(4.2)	(3.4)	(0.8)	(0.0)	(0.8)	(22.1)	(22.1)	0
Pay Reserves	(0.2)	(0.2)	0.0	0.0	0.0	(0.5)	(0.5)	0.0	0	0.0	(2.3)	(2.3)	0
Total Pay	(22.7)	(21.9)	(0.7)	(0.0)	(0.7)	(44.7)	(43.8)	(0.9)	(0.0)	(0.8)	(263.6)	(263.6)	0
Drugs & Medical Gases	(4.8)	(4.6)	(0.2)	(0.5)	0.3	(9.0)	(9.3)	0.3	(0.5)	0.7	(52.9)	(52.9)	0
Blood	(0.1)	(0.2)	0.1	0.0	0.1	(0.3)	(0.4)	0.1	0	0.1	(2.4)	(2.4)	0
Supplies & Services - Clinical	(2.9)	(2.6)	(0.3)	(0.0)	(0.2)	(5.5)	(5.2)	(0.3)	(0.0)	(0.2)	(31.7)	(31.7)	0
Supplies & Services - General	(0.4)	(0.5)	0.0	0.0	0.0	(0.9)	(0.9)	0.1	0	0.1	(5.0)	(5.0)	0
Services from Other NHS Bodies	(0.6)	(0.8)	0.2	0.3	(0.1)	(1.2)	(1.6)	0.4	0.4	0.0	(9.6)	(9.6)	0
Purchase of Healthcare from Non-NHS	(0.3)	(0.2)	(0.1)	(0.0)	(0.1)	(0.7)	(0.5)	(0.2)	(0.0)	(0.1)	(5.3)	(5.3)	0
Clinical Negligence	(1.6)	(1.6)	0.0	0.0	0.0	(3.2)	(3.2)	0.0	0	0.0	(19.0)	(19.0)	0
Establishment	(0.3)	(0.3)	(0.0)	(0.0)	(0.0)	(0.6)	(0.6)	(0.1)	(0.0)	(0.0)	(3.5)	(3.5)	0
Premises	(1.8)	(1.9)	0.1	(0.0)	0.1	(3.7)	(3.8)	0.1	(0.0)	0.1	(20.9)	(20.9)	0
Transport	(0.2)	(0.1)	(0.0)	0.0	(0.0)	(0.3)	(0.3)	(0.1)	0	(0.1)	(1.3)	(1.3)	0
Other Non-Pay Costs	(1.0)	(0.8)	(0.2)	(0.3)	0.1	(2.0)	(1.7)	(0.3)	(0.4)	0.0	(9.9)	(9.9)	0
Non-Pay Reserves	(0.2)	(0.2)	0.0	0.0	0.0	(0.4)	(0.4)	0.0	0	0.0	(2.3)	(2.3)	0
Total Non Pay	(14.3)	(13.9)	(0.4)	(0.6)	0.2	(27.8)	(27.8)	0.0	(0.6)	0.6	(163.9)	(163.9)	0
Total Expenditure	(36.9)	(35.8)	(1.1)	(0.6)	(0.5)	(72.4)	(71.6)	(0.9)	(0.6)	(0.2)	(427.6)	(427.6)	0
EBITDA	1.8	1.8	(0.0)	0.0	(0.0)	2.1	2.1	(0.0)	0.0	(0.0)	38.9	38.9	0
Other Finance Costs	0.0	0.0	(0.0)	%	0.0	2.8%	2.9%	-3.6%	0.0%	-15.4%	8.3%	8.3%	0
Depreciation	(1.1)	(1.1)	(0.0)	0	(0.0)	(2.2)	(2.2)	(0.0)	0	(0.0)	(13.5)	(13.5)	0
Interest	(0.1)	(0.1)	(0.0)	0	(0.0)	(0.3)	(0.3)	(0.0)	0	(0.0)	(1.6)	(1.6)	0
Dividend	(0.1)	(0.1)	0.0	0	0	(0.2)	(0.2)	0	0	0	(1.3)	(1.3)	0
PFI and Impairments	(1.2)	(1.2)	(0.0)	0	(0.0)	(2.4)	(2.4)	(0.0)	0	(0.0)	(11.9)	(11.9)	0
Total Finance Costs	(2.5)	(2.5)	(0.0)	0.0	(0.0)	(5.1)	(5.1)	(0.0)	0	(0.0)	(28.2)	(28.2)	0
Net Surplus / Deficit (-)	(0.8)	(0.8)	(0.0)	0.0	(0.0)	(3.0)	(2.9)	(0.0)	0.0	(0.0)	10.7	10.7	0.0
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.0	0.1	1.0	1.0	0.0
Surplus/ Deficit (-) to B/E Duty	(0.8)	(0.8)	0.0	0.0	0.0	(2.9)	(2.9)	0.0	0.0	0.0	11.7	11.7	0.0
Surplus/ Deficit (-) to B/E Duty Excl PSF	(1.4)	(1.4)	0.0	0.0	0.0	(4.2)	(4.2)	0.0	0.0	0.0	(1.0)	(1.0)	0.0

Commentary

The Trusts deficit including PSF was £0.8m in May which was on plan, the Trust was £0.2m adverse against the CIP plan which was offset by income overperformance.

The Trust's normalised pre PSF run rate in May was a deficit of £2.1m, an improvement of £0.4m compared to last month. The main normalised adjustments in May related to £0.6m prior month income adjustment for cashing up and coding of activity.

Pass-through adjustments have been applied to account for: High Cost Drugs and devices, STP associated costs, Education and Training costs associated with PSF and CPD funding, Sexual Health outsourced pass-through tests and PAS AllScripts.

Clinical Income excluding HCDs was £0.6m favourable to plan in May. The key favourable variances in May were Elective & Day Cases (£0.5m), Outpatients (£0.5m) and Non-Electives (£0.7m) offset by an adverse adjustment of £1.6m relating to the aligned incentive contract.

The Trust achieved the full PSF income in May due to the delivery of the financial control total and A&E trajectory.

Other Operating Income is breakeven to plan although after accounting for pass-through adjustments the revised variances is £0.1m adverse. The main adverse items relate to Private Patient Income (£0.1m) which is adverse to plan in both Cancer and the Private Patient Unit.

Pay was £0.7m adverse in the month, £0.1m adverse relating to CIP slippage and £0.6m relating to budget pressures caused by higher than planned temporary staffing costs mainly within Medical (£0.5m) and Nursing (£0.2m). Medical Staffing overspends included Surgery (£167k adverse in May) due to significant number of non consultant vacancies, Speciality Medicine (£65k adverse) due to large number of consultant vacancies (c12WTE) and Womens and Childrens (£65k) due to vacancies and the requirement for extra Middle grade doctor on the Paediatric rota. Urgent Care Division was £0.2m adverse within Nursing budget, £88k adverse within Emergency and Acute and £80k within Specialist Medicine.

Non Pay adjusted for pass through costs was underspent by £0.2m in May this was mainly due to underspends within drugs (£0.3m net of pass through costs). The Trust was adverse to plan within Clinical Supplies by £0.2m due to higher than planned activity levels.

The Trust is forecasting to deliver the planned Surplus including PSF of £11.7m.

3. Expenditure Analysis

3a. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

		May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Change between Months
Revenue	Clinical Income	31.8	32.3	32.1	31.2	32.6	31.3	31.2	31.7	32.0	31.2	33.8	30.7	33.5	2.8
	STF	0.4	0.6	0.3	0.0	2.2	0.0	0.0	0.0	0.0	0.0	3.0	0.6	0.6	0.0
	High Cost Drugs	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)
	Other Operating Income	4.6	3.5	4.3	4.5	4.1	3.8	3.4	3.8	4.0	5.7	3.9	4.5	4.5	0.0
	Total Revenue	36.8	36.5	36.7	35.7	38.9	35.0	34.5	35.5	36.0	36.9	40.8	35.9	38.7	2.8
Expenditure	Substantive	(18.0)	(18.1)	(17.8)	(17.7)	(17.8)	(17.9)	(18.0)	(17.8)	(17.9)	(17.5)	(17.9)	(18.3)	(18.7)	(0.4)
	Bank	(0.9)	(0.9)	(0.9)	(0.7)	(1.2)	(1.0)	(0.9)	(1.2)	(1.2)	(1.1)	(1.3)	(1.0)	(1.0)	0.0
	Locum	(0.5)	(0.1)	(0.4)	(0.5)	(0.5)	(0.5)	(0.6)	(0.5)	(0.5)	(0.6)	(0.7)	(0.5)	(0.6)	(0.1)
	Agency	(1.3)	(1.8)	(1.4)	(1.7)	(1.9)	(2.0)	(1.8)	(1.9)	(2.3)	(1.8)	(2.6)	(2.0)	(2.1)	(0.1)
	Pay Reserves	(0.2)	(0.2)	(0.2)	(0.1)	1.5	(0.2)	(0.2)	(0.2)	(0.2)	(0.3)	(0.2)	(0.2)	(0.2)	0.0
	Total Pay	(21.0)	(21.1)	(20.8)	(20.8)	(20.0)	(21.6)	(21.6)	(21.6)	(22.2)	(21.3)	(22.7)	(22.0)	(22.7)	(0.6)
	Non-Pay														
Drugs & Medical Gases	(4.6)	(4.6)	(4.2)	(4.8)	(4.1)	(4.4)	(4.5)	(4.2)	(4.5)	(4.3)	(4.5)	(4.2)	(4.8)	(0.7)	
Blood	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.1)	(0.2)	(0.2)	(0.1)	0.0	
Supplies & Services - Clinical	(2.8)	(2.7)	(2.7)	(2.7)	(2.2)	(2.5)	(2.6)	(2.5)	(2.6)	(2.5)	(2.1)	(2.6)	(2.9)	(0.3)	
Supplies & Services - General	(0.5)	(0.5)	(0.5)	(0.3)	(0.5)	(0.5)	(0.5)	(0.5)	(0.4)	(0.5)	(0.6)	(0.4)	(0.4)	0.0	
Services from Other NHS Bodies	(0.7)	(0.6)	(0.7)	(0.7)	(0.7)	(0.6)	(1.3)	(0.9)	(0.7)	(0.7)	(0.3)	(0.6)	(0.6)	0.1	
Purchase of Healthcare from Non-NHS	(0.5)	(0.2)	(0.3)	(0.3)	(0.3)	(0.4)	(0.4)	(0.4)	(0.2)	(0.2)	(0.3)	(0.3)	(0.3)	0.0	
Clinical Negligence	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.6)	(1.6)	0.0	
Establishment	(0.3)	(0.3)	(0.3)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.0)	
Premises	(2.3)	(1.6)	(1.7)	(1.9)	(1.5)	(1.8)	(1.8)	(2.2)	(1.8)	(3.8)	(3.0)	(1.9)	(1.8)	0.1	
Transport	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.2)	(0.1)	(0.2)	(0.2)	(0.2)	(0.0)	
Other Non-Pay Costs	(1.1)	(0.7)	(1.4)	(1.6)	(0.5)	(1.5)	(0.0)	(1.0)	(1.1)	(1.1)	(0.2)	(1.0)	(1.0)	(0.0)	
Non-Pay Reserves	(0.1)	(0.1)	0.2	0.0	0.3	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.2)	(0.2)	0.0	
Total Non Pay	(14.9)	(13.5)	(13.6)	(14.4)	(11.7)	(14.1)	(13.4)	(14.2)	(13.7)	(15.4)	(13.2)	(13.5)	(14.3)	(0.8)	
Total Expenditure	(35.9)	(34.6)	(34.3)	(35.2)	(31.6)	(35.7)	(35.0)	(35.8)	(35.8)	(36.7)	(35.9)	(35.5)	(36.9)	(1.4)	
EBITDA	0.9	1.9	2.4	0.4	7.3	(0.6)	(0.5)	(0.3)	0.2	0.2	4.9	0.4	1.8	1.4	
	2%	5%	6%	1%	19%	-2%	-1%	-1%	1%	1%	12%	1%	5%		
Other Finance Costs	Depreciation	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(0.8)	(1.1)	(1.0)	(1.2)	(1.1)	(1.2)	(1.1)	(1.1)	(0.0)
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	Dividend	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.5	(0.1)	0.2	(0.1)	(0.1)	0.0
	PFI and Impairments	(1.2)	(1.2)	(1.2)	(1.1)	(1.1)	(1.1)	(1.2)	(5.2)	(1.1)	(1.2)	17.5	(1.2)	(1.2)	0.0
	Total Other Finance Costs	(2.5)	(2.6)	(2.6)	(2.6)	(2.6)	(2.2)	(2.5)	(6.4)	(1.9)	(2.5)	16.3	(2.5)	(2.5)	(0.0)
Net Surplus / Deficit (-)	(1.6)	(0.7)	(0.2)	(2.2)	4.7	(2.8)	(2.9)	(6.7)	(1.7)	(2.2)	21.2	(2.2)	(0.8)	1.4	
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.0	0.0	0.0	(18.9)	0.0	0.0	0.0	
Surplus/ Deficit (-) to B/E Duty Incl STF	(1.6)	(0.7)	(0.2)	(2.1)	4.8	(2.8)	(2.9)	(2.6)	(1.6)	(2.2)	2.3	(2.2)	(0.8)	1.4	
Surplus/ Deficit (-) to B/E Duty Excl STF	(2.0)	(1.3)	(0.4)	(2.1)	2.5	(2.8)	(2.9)	(2.6)	(1.6)	(2.2)	(0.7)	(2.8)	(1.4)	1.4	

4. Cost Improvement Programme

4a. Current Month Savings by Directorate

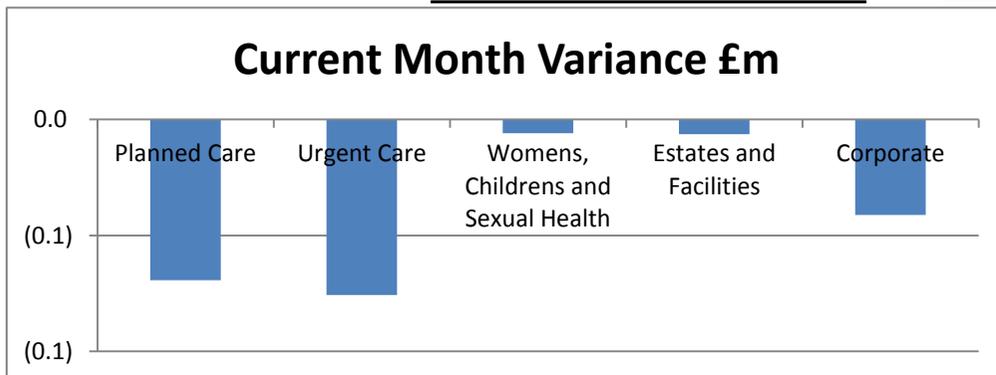
	Current Month		
	Actual £m	Original Plan £m	Variance £m
Cancer	0.1	0.1	(0.0)
Critical Care	0.2	0.2	0.0
Diagnostics	0.1	0.0	0.0
Head and Neck	0.0	0.0	(0.0)
Surgery	0.0	0.1	(0.0)
T&O	0.2	0.2	(0.0)
Patient Admin	0.0	0.0	(0.0)
Private Patient Unit	0.0	0.0	0.0
Planned Care	0.5	0.6	(0.1)
Urgent Care	0.1	0.2	(0.1)
Womens, Childrens and Sexual Health	0.1	0.1	(0.0)
Estates and Facilities	0.1	0.1	(0.0)
Corporate	0.1	0.1	(0.0)
Total	0.8	1.0	(0.2)

Comment

The Trust achieved £0.8m savings in May which was £0.2m adverse to plan, this is mainly due to STP Medical rate slippage (£0.1m) and Outsourcing reduction slippage (£0.1m).

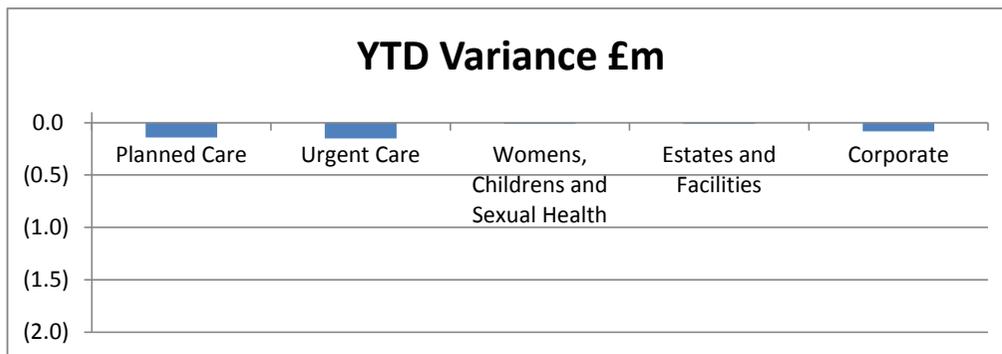
Planned Care: £0.1m adverse compared to the CIP plan this is mainly due to STP Medical rate slippage (£41k), £25k slippage relating to outsourcing reduction within T&O and £13k associated with reduction in Surgery Medical locums.

Urgent Care: £0.1m adverse compared to the CIP plan this is mainly due to STP Medical rate slippage (£68k).



4b. Year to Date savings by Directorate

	YTD		
	Actual £m	Original Plan £m	Variance £m
Cancer	0.11	0.12	(0.01)
Critical Care	0.34	0.33	0.00
Diagnostics	0.10	0.09	0.01
Head and Neck	0.04	0.06	(0.02)
Surgery	0.08	0.15	(0.06)
T&O	0.32	0.38	(0.07)
Patient Admin	0.01	0.01	(0.00)
Private Patient Unit	0.00	0.00	0.00
Planned Care	1.00	1.15	(0.14)
Urgent Care	0.21	0.36	(0.15)
Womens, Childrens and Sexual Health	0.19	0.20	(0.01)
Estates and Facilities	0.11	0.12	(0.01)
Corporate	0.10	0.19	(0.08)
Total	1.62	2.02	(0.40)



Comment

The Trust year to date has delivered £1.6m savings which is £0.4m adverse to plan, this is mainly due to STP Medical rate slippage (£0.2m) and Outsourcing reduction slippage (£0.2m).

Planned Care: £0.14m adverse compared to the CIP plan this is mainly due to STP Medical rate slippage (£80k), £50k slippage relating to outsourcing reduction within T&O and £26k associated with reduction in Surgery Medical locums.

Urgent Care: £0.15m adverse compared to the CIP plan this is mainly due to STP Medical rate slippage (£136k).

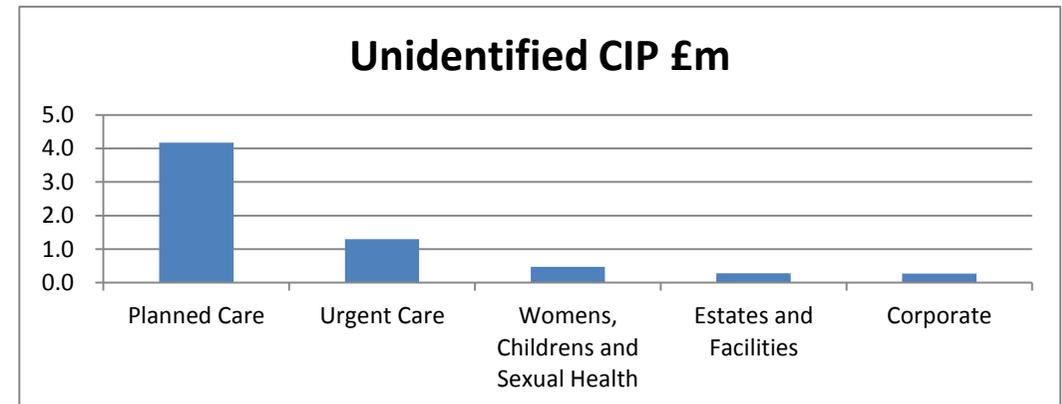
Corporate: £0.1m slippage relating to Outsourcing more than planned levels.

4c. Forecast savings by Directorate

Directorate Performance

	Forecast Savings			
	Risk Adjusted Forecast (Delivery)	Unidentified (Risk Adjusted)	Plan	% Unidentified
	£m	£m	£m	
Cancer	0.8	0.5	1.3	35%
Critical Care	1.7	0.6	2.3	26%
Diagnostics	0.6	0.2	0.7	23%
Head and Neck	0.9	0.7	1.6	46%
Surgery	1.1	0.5	1.6	34%
T&O	4.6	1.2	5.8	21%
Patient Admin	0.1	0.0	0.1	14%
Private Patient Unit	0.5	0.5	1.0	50%
Planned Care	10.2	4.2	14.4	29%
Urgent Care	2.2	1.3	3.5	37%
Womens, Childrens and Sexual Health	1.6	0.5	2.1	23%
Estates and Facilities	2.9	0.3	3.1	9%
Corporate	0.7	0.3	1.0	27%
Total	17.6	6.5	24.1	27%

Savings as per 10th May



The Trust has a £24.1m CIP plan for 2018/19 which has been fully identified however the current PMO delivery risk adjusted forecasted savings is a shortfall of £6.5m (27%).

Planned Care Division have a risk adjusted shortfall of £4.2m (29%).

Urgent Care Division have a risk adjusted shortfall of £1.3m (26%).

Womens, Childrens and Sexual Health Division have a risk adjusted shortfall of £0.5m (21%).

Estates and Facilities have a risk adjusted shortfall of £0.3m (9%) however the subsidiary (£1.75m) is rated as green therefore forecasting full delivery under the risk adjusted method.

Corporate directorates have a risk adjusted shortfall of £0.3m (27%)

5. Balance Sheet and Liquidity

5a. Balance Sheet

May 2018

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

Em's	May			April
	Reported	Plan	Variance	Reported
Property, Plant and Equipment (Fixed Assets)	292.4	292.7	(0.3)	293.3
Intangibles	2.5	2.4	0.1	2.5
PFI Lifecycle	0.0	0.0	0.0	0.0
Debtors Long Term	1.2	1.2	0.0	1.2
Total Non-Current Assets	296.1	296.3	(0.2)	297.0
Current Assets	0.0	0.0	0.0	0.0
Inventory (Stock)	7.6	8.2	(0.6)	7.8
Receivables (Debtors) - NHS	20.0	30.9	(10.9)	29.0
Receivables (Debtors) - Non-NHS	12.3	13.7	(1.4)	16.3
Cash	20.2	13.9	6.3	12.9
Assets Held For Sale	0.0	0.0	0.0	0.0
Total Current Assets	60.1	66.7	(6.6)	66.0
Current Liabilities				
Payables (Creditors) - NHS	(4.3)	(6.5)	2.2	(6.2)
Payables (Creditors) - Non-NHS	(36.7)	(42.3)	5.6	(37.2)
Deferred Income	(21.4)	(20.4)	(1.0)	(24.4)
Capital Loan	(2.2)	(2.2)	0.0	(2.2)
Working Capital Loan	(16.9)	(16.9)	0.0	(16.9)
Other loans	(0.1)	(0.1)	0.0	(0.1)
Borrowings - PFI	(5.0)	(5.0)	0.0	(5.0)
Provisions for Liabilities and Charges	(1.8)	(1.8)	0.0	(1.8)
Total Current Liabilities	(88.4)	(95.2)	6.8	(93.8)
Net Current Assets	(28.3)	(28.5)	0.2	(27.8)
Borrowings - PFI > 1yr	(192.2)	(192.2)	0.0	(192.7)
Capital Loans	(10.1)	(10.1)	0.0	(10.1)
Working Capital Facility & Revenue loans	(26.1)	(26.1)	0.0	(26.1)
Other loans	(0.6)	(0.6)	0.0	(0.6)
Provisions for Liabilities and Charges- Long term	(1.0)	(1.0)	0.0	(1.1)
Total Assets Employed	37.8	37.8	0.0	38.6
Financed By:				
Capital & Reserves				
Public dividend capital	207.3	207.3	0.0	207.3
Revaluation reserve	29.8	29.8	0.0	29.8
Retained Earnings Reserve	(199.3)	(199.3)	0.0	(198.5)
Total Capital & Reserves	37.8	37.8	0.0	38.6

Commentary:

The month 2 balance sheet position is consistent with the plan that was submitted in April. The overall working capital within the month results in a reduction of both debtors and creditors compared to the plan, and an increase in the cash balance held at the end of the month.

Non-Current Assets -

Capital additions of £14.5m are planned for 18/19 and £0.7m on donated assets. The planned depreciation for the year is £13.5m. The month 2 capital spend is £0.3m against a plan of £0.9m.

Current Assets -

Inventory of £7.6m is a reduction from the planned value. The main stock balances are pharmacy £2.9m, TWH theatres £1.5m, Materials Management £1.1m and Cardiology £0.7m.

NHS Receivables have decreased from the month 1 position by £9m to £20m. The reduction is primarily due to NHS England paying £7.4m over performance and £2m Qtr 1 PFI funding. Of the £20m reported balance, £8.8m relates to invoiced debt of which £3.9m is aged debt over 90 days. Invoiced debt over 90 days has increased slightly by £0.2m from the mth 1 reported position. The remaining £11.2m relates to uninvoiced accrued income including work in progress partially completed spells. Due to the cash pressures of many neighbouring NHS bodies regular communication is continuing and arrangements are being put in place to help reduce the level of debt.

Non NHS Receivables have decreased by £4m from the month 1 reported position. Included within this balance is trade invoiced debt of £3m and private patient invoiced debt of £0.6m. Prepayments and accrued income totalling £6.6m. Prepayments primarily relate to rates & annual service maintenance contracts, which will reduce throughout the year as they are expensed. The cash balance of £20.2m is higher than plan by £6.3m, this is due to the Trust receiving £7.4m over performance which was not included within the plan as year end discussions were ongoing at the time.

Current Liabilities -

NHS payables have decreased from the April's reported position by £1.9m. Non-NHS trade payables have also decreased by £0.5m to £36.7m.

Of the £41m combined payables balances, £12.7m relates to actual invoices and £28.3m relates to uninvoiced accruals. The accruals include expected values for tax, NI, Superannuation and PDC payments.

Deferred income of £21.4m primarily is in relation to c£17.1m advanced contract payment received from WK CCG in April, which reduces by £2.28m over each of the remaining 11 months. £16.9m working capital loan is repayable in February 2019

Other loans for both current and non current liabilities relate to the Salix loan which has been taken out to improve the energy efficiency of the Trust.

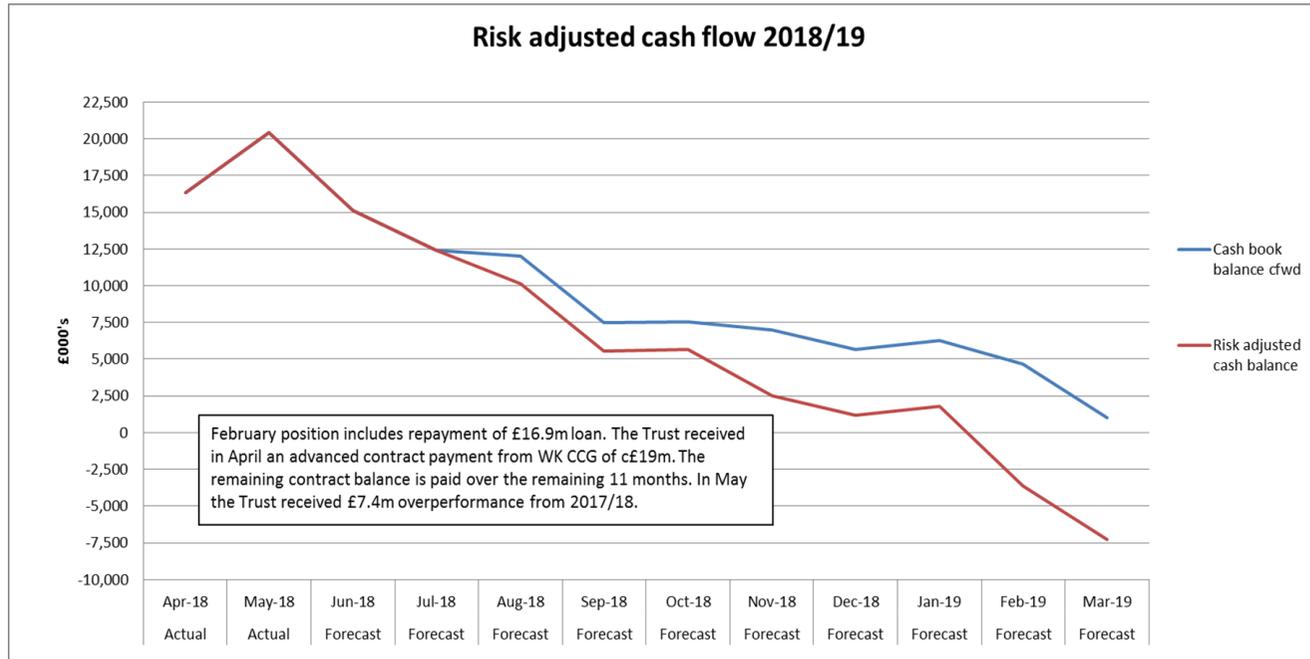
Long term Liabilities-

The PFI liability reduces each month as the Unitary Charge includes financing repayments. The working capital and revenue loans relate to - £12.132m repayable in October 19, the remaining balance is a combination of 3 working capital loans totalling £13.990 taken out in 2017/18 and are repayable in 2020/21.

Capital and Reserves-

For each area within this element for month 2 are consistent with the plan.

5b. | Cash Flow



Commentary
The blue line shows the Trust’s cash position for 2018/19 and the red risk adjusted line shows the position if the relevant risk items are not received.

The Trust’s cash flow is based on the Income & Expenditure (I&E) plan and working capital adjustments from the Balance sheet. If the I&E starts to move away from the plan, this will effect the Trust’s cash position.

In May the Trust received £7.4m over performance which related to 2017/18. This was not included within the plan cash flow as negotiations were ongoing.

The risk adjusted items relate to:
PSF funding which is received if certain targets are met. The cash flow has three quarters included as the income is received in arrears. Quarter 4 will be included within 2019/20 cash flow.

The Trust needs to repay the Single currency interim loan of £16.9m in February in order to repay this the Trust will need to request further working capital financing of £6m. If the PSF funding is not received and if the I&E position move adversely from the plan, the Trust will need to implement strategies to ensure the loan can be repaid before increasing the value of the working capital loan request.

The Trust has asset sales planned for January of £2.4m, if these are not achieved the associated capital expenditure will also not happen.

Also within quarter 4 the Trust has external loan capital financing of £2.5m, if the funding is not received the capital expenditure will not be spent.

The Trust has planned to receive PDC funding of £1.8m in March as part of the Linac replacement programme. If the funding is not received the Linac will not be purchased.

Information on loans:

	Rate	Value £m's	18/19 Annual Repayment £m's	18/19 Annual Interest Paid £m's	Repayment Date
Revenue loans:					
Interim Single Currency Loan	3.50%	16.908	0.00	0.25	18/02/2019
Interim Revolving Working Capital Facility (IRWCF)	3.50%	12.132	0.00	0.43	19/10/2019
interim working capital loans	3.50%	13.990	0.00	0.49	18/03/2021
Capital loans:					
Capital investment loan	2.02%	12.000	1.20	0.06	15/09/2020
Capital investment loan	3.91%	11.000	0.73	0.19	15/19/2025
Capital investment loan	4.73%	6.000	0.24	0.16	15/19/2035
Salix loan (interest free) £1.2m to be rec in 18/19	0	0.738	0.15	0.00	01/04/2024



6. Capital

6a. Capital Programme

Capital Projects/Schemes

	Year to Date			Annual		
	Actual	Plan	Variance	Plan	Forecast	Variance
	£000	£000	£000	£000	£000	£m
Estates	83	215	132	5,788	5,788	0
ICT	83	166	83	1,002	1,002	0
Equipment	117	434	317	6,501	6,501	0
PFI Lifecycle (IFRIC 12)	0	0	0	471	471	0
Donated Assets	0	84	84	700	700	0
Total	282	899	617	14,462	14,462	0
Less donated assets	0	-84	-84	-700	-700	0
Asset Sales (net book value)	0	0	0	-2,402	-2,402	0
Contingency Against Non-Disposal	0	0	0	0	0	0
Adjusted Total	282	815	533	11,360	11,360	0

The Trust has an approved Capital Plan of £14.5m, which is financed by Capital resources of £13.5m depreciation; proposed asset sales of £2.4m (Maidstone Residences); donated assets of £0.7m; national funding for the next replacement Linac of £1.7m (LA5); a proposed Capital Investment Loan for critical imaging equipment of £2.5m; a proposed Salix loan of £1.2m for the additional Energy Infrastructure work; less £7.6m of existing loan repayments.

The business case for Estates Backlog Maintenance programme of works has been approved and schemes are underway, with other Estates projects and renewals being prioritised by the Estates Department. A major scheme for the Energy Infrastructure has an approved Salix loan of £755k for Phase 4 and agreement from DH to provide the necessary Capital resource cover is being obtained by NHSI. A further loan application will be made at a later stage. The ICT schemes have been prioritised and approved by the ISG in principle but will require IAG Business case sign off. The equipment schemes are being prioritised and the final list will go to TME and Execs for approval subject to individual Business case preparation as required. Linac 4 replacement at Maidstone was delivered in early May and commissioning the equipment will begin and be ready for clinical use by Oct 18. Linac 5 replacement funding has now been agreed with NHSE as additional PDC from the national programme. The donated equipment plan is mainly made up of the remaining Cardiology legacies, and a large donation for Urology/Oncology equipment.

Trust Board Meeting – June 2018



6-10	The recovery plans for the 62-day Cancer waiting time target	Chief Op. Officer / Trust Lead Cancer Clinician / Assoc. Dir. of Op's, Cancer & Clin. Supp't
-------------	---	---

Summary / Key points

It was agreed at the Trust Board meeting on 24/05/18 that the June 2018 Trust Board meeting should receive “The recovery plans for the 62-day Cancer waiting time target” report that is scheduled to be reviewed by the Finance and Performance Committee on 26/06/18”.

A short presentation is enclosed and the Trust Lead Cancer Clinician and Associate Director of Operations, Cancer & Clinical Support will attend the meeting for consideration of this item.

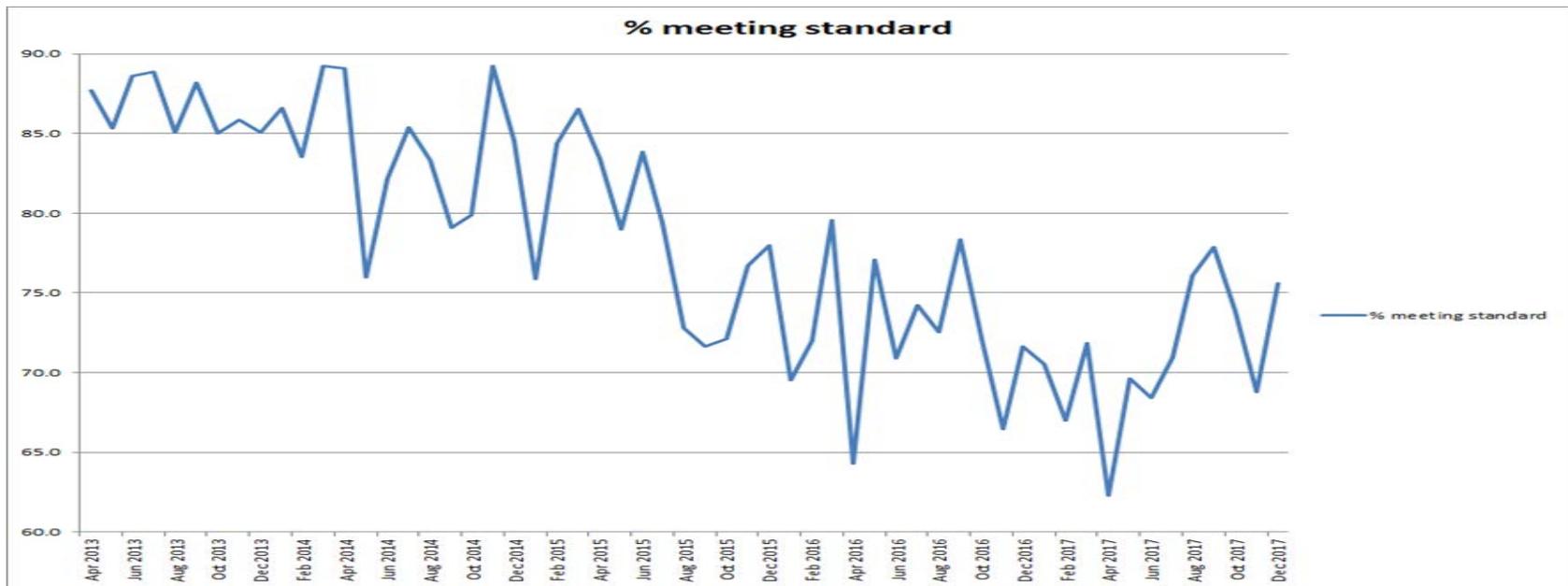
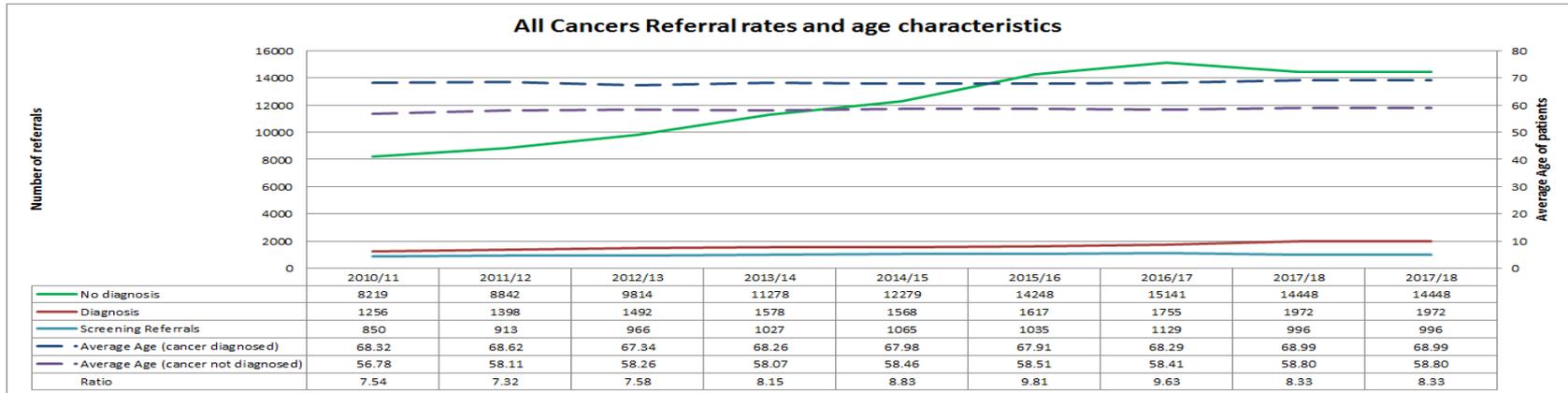
- Which Committees have reviewed the information prior to Board submission?**
- Finance & Performance Committee (26/06/18)
 - Trust Management Executive (20/06/18)

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

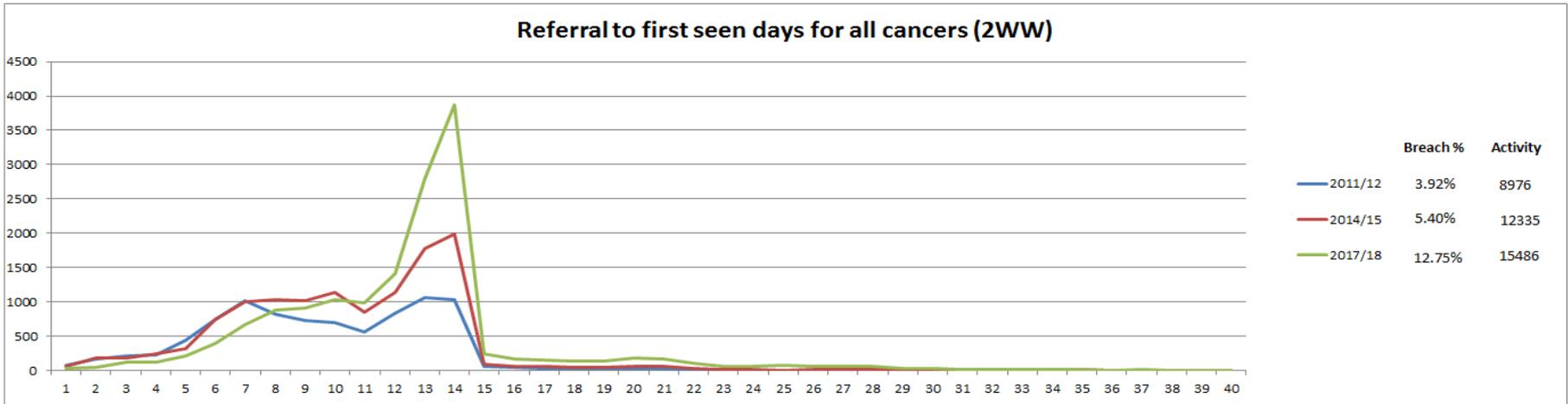
¹ All information received by the Board should pass at least one of the tests from ‘The Intelligent Board’ & ‘Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients’: the information prompts relevant & constructive challenge; the information supports informed decision-making; 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

All Cancers – Service trends

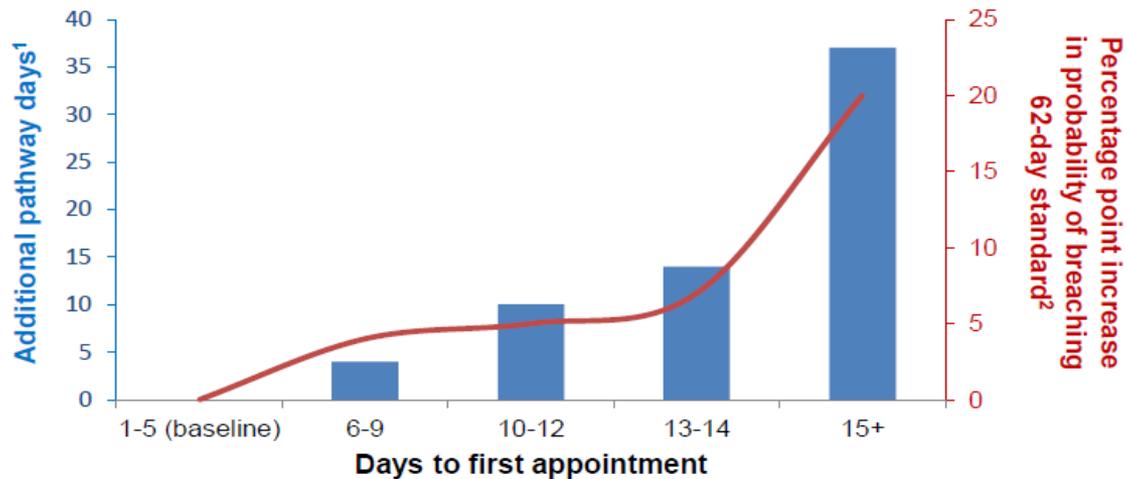
Item 6-10. Attachment 5-- Cancer Waiting Times Standards Recovery Plan



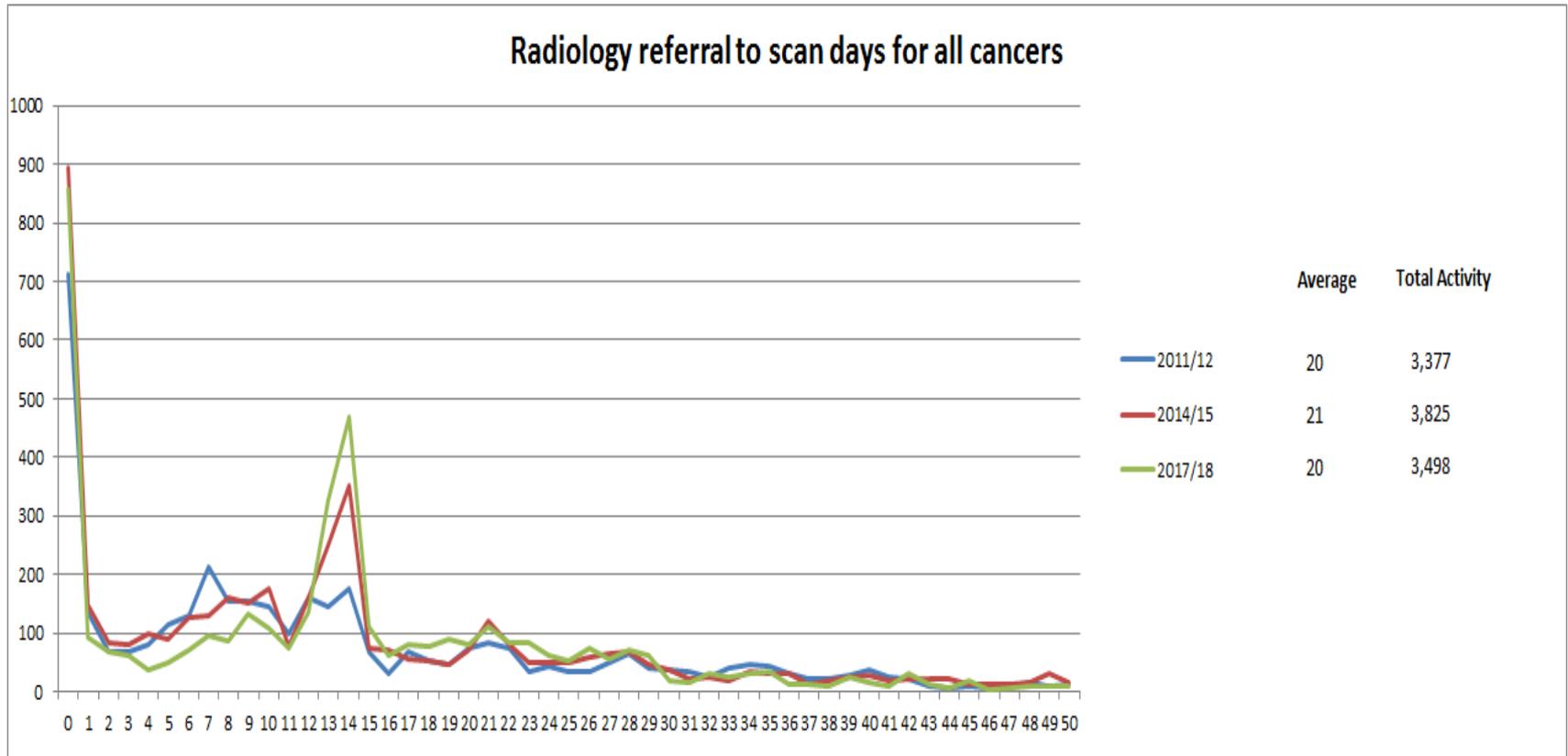
All Cancers – Time to First Seen



Effect of time to first appointment on pathway length / probability of breaching



All Cancers – Radiology Request to Imaging



Concentrate On Cancer

1. Demonstrate extra capacity requirement along each pathway (e.g. first seen appointment and diagnostics)
2. Re-set the system – short-term additional capacity (bring first seen and diagnostics tests to 7 days and reduce PTL size)
3. Long-term sustainability/cultural change (clinical leadership of MDT, education, “2WW” and orange dot processes)

Trust Board meeting - June 2018



6-11 Update from the Best Care Programme Board

Chief Executive

Enclosed is an update from the Best Care Programme Board

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 26/06/18

Reason for receipt at 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

Best Care Programme

Trust Board – June 2018

Summary



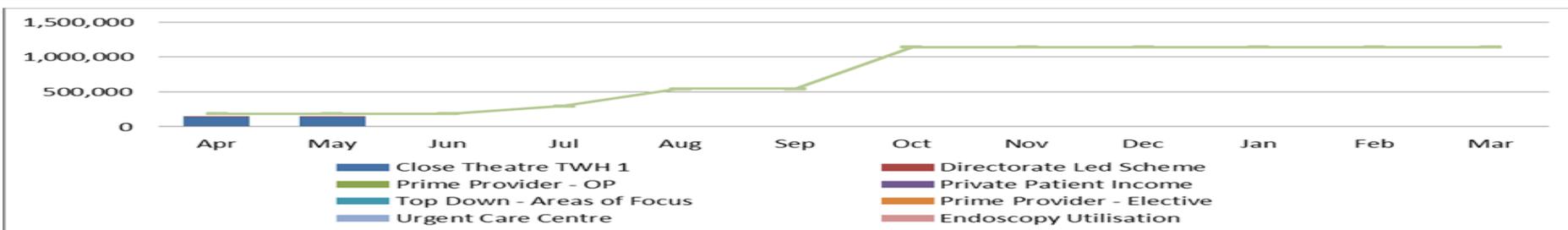
- Maternity Safer Births compliance achieved, submission to NHS Resolution on 29th June. Subject to acceptance, 10% reduction of CNST will be realised.
- Human Factors Training approved, with first cohort training scheduled for June/July.
- Frailty Unit at TWH successfully opened ahead of plan.
- Workforce recovery plan agreed including personalised plans in place for top 10 medical locums.
- Aligned Incentives Contract (AIC) / Joint Programme Management Office (JPMO) workshop held on the 13th June, with 72 attendees from across 5 NHS organisations, reflecting on lessons learned and successes from the last 12 months collaborative programmes and captured ideas for system wide quality improvements

PROJECTS	MILESTONE ACTUAL	DELIVERY RAG		FORWARD VIEW: KEY MILESTONES TO TAKE PLACE IN THE NEXT 4 WEEKS
		LAST MONTH	THIS MONTH	
Complex Needs	<p>Delirium - snapshot delirium audit has taken place to determine resource requirement for project Audit showed 8% of patients at TWH & 6% of patients at Maidstone had a delirium diagnosis on 16/5/18.</p> <p>Transition - data gathered regarding admission of 16/17 year olds across MTW for past 2 years. Neighbouring Trust's admission criteria analysed and compared to MTW admission criteria – all Trusts, like MTW, currently admit until 16th Birthday. 2 cohorts of 16/17 year olds identified to start to focus on. 16 / 17 year olds with Cystic Fibrosis and Diabetes – these have been chosen as there is a tariff attached to these cohorts.</p> <p>Dementia:- Cross referencing PID and objectives with Quality Strategy ensuring that objectives align. Preliminary conversations had to identify dementia patients and their carers' to represent on patient experience groups/PLACE audits. Ongoing audit of patients admitted from Nursing and Residential Homes to ascertain frequent admissions.</p> <p>MCA/DoLS: MCA policy and procedure up for review – being reviewed Investigating training options involving KCC/Capsticks</p>			<p>Delirium: Discussion to be had with AKI team re: identification of delirium. /Identification of project objectives and scope.</p> <p>Transition Electronic solution for daily monitoring of 16/17 year old admission Identify nos and potential £ value of 16 / 17 year old being cared for by paed diabetes and cystic fibrosis services rather than adult services</p> <p>'Transition wards' to be identified so that Safeguarding champions can begin to be appointed – starting on these wards – liaising with site practitioners.</p> <p>Equate how many bed days these 700 16/17 year olds are holding</p> <p>Engagement with Kent Youth Forum to gain user opinion</p> <p>Dementia: Scope the requirement for drop in / nurse led clinics from stakeholders e.g. People with dementia / carers; GP's. Scope the requirement of emergency services colleagues for information / training re: support services to manage people with dementia and their carers'. Identification of project/delivery group for this project – Dementia Strategy group or other?</p> <p>MCA policy revision going to safeguarding committee in June. MCA Deep dive taking place at Quality Committee in June</p>
Experience and Engagement	<p>PPEE (Pateint and Public Experience and Engagement) - Proposal for co producing PPEE strategy working with patients, carers and public groups agreed at Best Quality Board (events in September and November). Contact database established and updated. Option appraisal for future patient governance and representation prepared.</p> <p>Staff Engagement Staff engagement strategy identifying high level implementation plan taken to Execs by HR Director</p>			<p>PPEE – Agree preferred option for future patient representation and governance. Target participants for invitation and sign off draft invitation ready for sending in July. / Incorporate pilot work with Healthwatch focusing on patients with Parkinsons and medicines management into plan</p> <p>Staff Experience and Engagement Develop detailed implementation plan for strategy identifying milestones and responsibilities by month</p>
Quality Improvement	<p>Meetings of Quality Improvement Group now up and running and overseeing progression of response to CQC report. Action Plans in place all 17 should do's. All should do's are progressing therefore RAG rated at Amber except for Should do 3 regarding estates which has been completed, and therefore RAG Rated as Green. First CQC engagement day arranged with a focus on maternity</p>			<p>Transition to BAU – monthly Quality improvement committee – first wider group meeting taking place 14/06/2018. Review 2017 tracker to triangulate ongoing actions and new do's</p> <p>Agree focus areas for Quality rounds</p>
Effectiveness and Excellence	<p>CNST - MTW now confident of full compliance with NHSR safe births criteria following targeted action and updated NHSR guidance.</p> <p>Crowborough – confirmation of full funding of improvement works by Friends of Crowborough. Preparation of business case and detailed SMART plan, formal letter sent to Friends of Crowborough</p> <p>CQUINS - CQUIN Board meeting took place 22/05/2018 and continues on a monthly basis CQUIN meetings progressing as normal – reliance on Directorate Leads to provide milestone updates and taken forward any key actions required.</p> <p>#EndPJPParalysis: Champions identified for specialist medicine wards on both sites Presentation given to Trust Board 22/05/2018. Successful roll out on wards: Edith Cavell, Mercer, Whatman, Chaucer, Stroke unit, W20 & W22 – acute areas to follow in the next 2 weeks. Averaging 15-18 patients each ward getting dressed and 18-20 up and moving 11 volunteers recruited</p> <p>Criteria Led Discharge : Background work done with Matrons – senior review with corporate nursing team</p>			<p>Maternity Safer Births / CNST – secure June Trust Board sign off of NHS Resolution compliance declaration and submit to NHS Resolution on 29 June</p> <p>Crowborough – secure Exec sign off of business case for improvement works, complete specification of works, profile likely increase in births for remainder of year and identify pipeline schemes from W&C to meet any shortfall in financial target, undertake filming with service users for video vignettes./ letter to NHS Property Services confirming readiness to progress with refurb /Hard copy leaflet prepared</p> <p>CQUINS: Production of plan to deliver CQUINS. Plan with a particular focus on the delivery of 2 new CQUINS (Concerning 'Risky Behaviours' and Neonatal 2 year f/up appointments)</p> <p>#EndPJPParalysis: Analysis of data on pilot wards – e.g. falls / LOS / Readmission rates / pressure ulcers / complaints / Successful roll out on all Specialist Medicine wards by 26/06/2018</p> <p>Continuous data collection internally - work out how we maintain this especially during busy periods. / To target ward areas beyond PDN remit – surgical areas / oncology. Marketing larger stores once more for clothes donations (NL has already personally spoken & written to store managers prior to the launch) / Media campaign to promote our success at the end of the national initiative 26/06/18</p> <p>Criteria led discharge: First refreshed kick off meeting to take place week commencing 18th June</p>

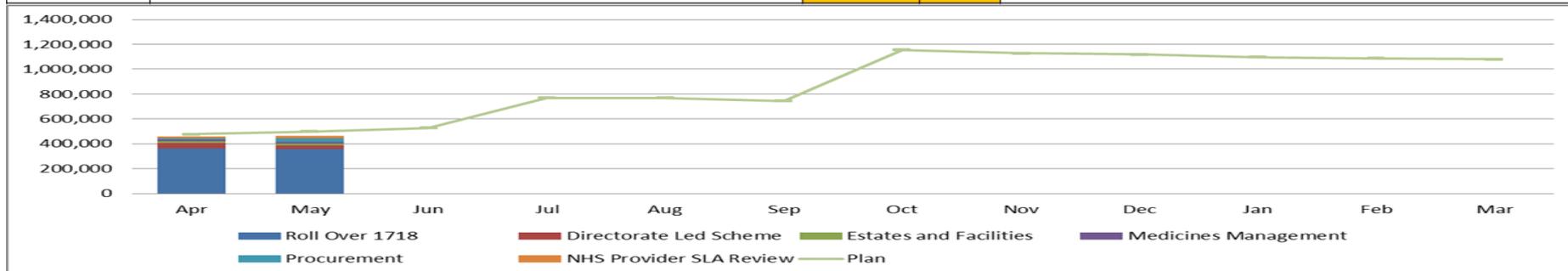


PROJECTS	ACTIONS/MILESTONES COMPLETED SINCE PREVIOUS MEETING	DELIVERY RAG		FORWARD VIEW: KEY MILESTONES TO TAKE PLACE IN THE NEXT 4 WEEKS
		LAST MONTH	THIS MONTH	
7 Day Services	Steering group held on 09/05/2018 with a focus on Urgent Care. Preferred options paper being drafted by Urgent Care Division incorporating GI bleed 24/7 rota requirements (Deadline 30/06/2018 now extended to 31.07.18 to allow for the TW model to be completed.). 24/7 GI Bleed rota being worked up by Clinical Director. T&O and Women's Health being proposed for compliance in principle with Standards 2 & 8 at the Quarterly Review Meeting with representatives from the CCG and NHSE on 12.6.18. Urology are implementing rota changes for weekends and have achieved implementation of their Consultant of the Week (COW) rota (went live 14.5.18. Surgery have implemented a second daily Consultant Ward Round (went live 04.06.18) and their proposals for new roles continue to be developed. Audit in progress with Haem-Onc and ICU – request for deadline to be set (for report to September Quarterly Review) has been discussed with the Divisional Director of Operations. Stocktake has been completed in association with the NHSE Regional lead. National 7DS survey underway (directorates currently reviewing casenotes).			T&O are very close to compliance for standards 2 & 8 this will be presented to the 7DS Quarterly Review meeting on 12th June 2018, for consideration for full compliance rating for the 4 priority standards. ENT are close to compliance – the 7DS Clinical Lead is to discuss the outcome of the audit with Carole Jones (CD) to determine whether delegated care is confirmed against their protocols. If so, the Team will be proposing 'compliance in principle', for ratification by NHSE and the CCG on 12th June 2018. W&C – good progress and a proposal for compliance in principle is being put forward for ratification at the 12 th June Quarterly Review Meeting. Urgent care are in production of their paper outlining options for the achievement of the 4 priority standards - delivery July 2018.
Mortality	MSG meeting continues monthly with variable divisional engagement due to operational challenge of the day and times of the scheduled meetings. This is being reviewed. Speciality reviews of the First Stage Mortality review form is increasing by speciality now that the new Mortality Coordinator is in post – January data has demonstrated a decreased backlog bringing completion from 57 - 77% in one month. New management of mortality database is showing promising reduction in recent backlog. Audit has been put in place to review a sample of 1st Stage Reviews that reported no concerns (based upon a 10% selection). The aim will be to review 10% of these deaths and is planned to take place during June & July. The audit team will oversee with support from clinicians from the MSG. The Learning Disabilities Mortality Review (LeDeR) process is being supported by the Learning Disability (LD) Nurse who checks all patients reported as having an LD on the Community register. If LD confirmed she then liaises with the Community Matron to ensure that the death is reported appropriately.			Learning from deaths review group due to meet on 07/06/2018 to review progress across all areas. Meetings have been scheduled to take place monthly until September whilst there is a focus on development and improvement, when they will revert to their monthly cycle if expected progress has been achieved.
Preventing Harm	<u>1. Long Elective Waits (RTT >18 weeks)</u> - Audit of 1,100 case notes underway. Period of review is October 2017 and involves all Consultants with breached cases (Elective or Outpatient) in study period. 687 cases reviewed to date. All case notes were requested in February 2017. The initial closing date was 31 March 2018 but has been extended to aim to get all cases reviewed. Each Consultant with outstanding case notes has been written to asking for the case notes to be reviewed. Three chase requests have been carried out to date. Once the audit has reached critical mass, the audit results will determine the design of the project (if the audit proves conclusive). <u>2. Documentation and Record Keeping</u> - Project in review with Programme Board (6.6.18) - front end of project design being discussed. <u>3. Acute Kidney Injury</u> - Project orientation ongoing. Meeting arranged with senior nursing leads who are conducting the task & finish group - 12/06/2018. Background research taking place with Chief Nurse. Project brief being confirmed at Programme Board 6.6.18 <u>4. Consent</u> - Discussed at Best Safety Workstream Board 06/06/2018 following initial scoping exercise which took place on 05/06/2018. Actions agreed for next steps which include a review of the consent policy with a subgroup involving a wide range of clinicians to support.			Full analysis of final audit returns for Long Elective Waits. The documentation and record keeping sub-project requires a front end design review and confirmation of scope. This can then go live and it is hoped that this will take place following the Best Safety Board on 6.6.18. The Acute Kidney Injury sub-project requires further research with the two lead nurses from ICU at TW and the Chief Nurse (in respect of the Nerve-Centre aspects). Once this has taken place (mid June) then the proposals and scope for the sub-project can be presented to the July Best Safety Programme Board. A decision will then be made upon its future. Finally, the consent sub-project is being scoped by the Clinical Lead and the Programme Lead. This will be discussed at the next Best Safety Board in July.
Quality Mark	4 options identified on longlist. Staff comms drafted for selection of preferred option - Staff engagement communication regarding options withheld as options re-reviewed. Core team meeting to reviewed the options on 05/06/2018 and the staff communication was held due to further review of scope. Core Team re-examined the original brief and need to link to Learning Lessons Project. Review of original aims by Core Group has re-designed the proposals to the Best Safety Board. Decision made to propose a 5 th Option to the Best Safety Board that links the Quality Mark to the Trust's Quality Strategy, with an award-based Quality Mark offered against achievements in delivery of the 22 Quality Strategy Goals. Best Safety Board (6.6.18) endorsed the recommendations - for further work up by Core Team.			Core Team now have confirmed brief from Best Safety Board – for further work-up and progression of project by Core Team.
Learning Lessons	Roll out of Human Factors training approved at TME on 16.5.18 and recruitment of delegates underway to first cohort of training days (June & July 2017). Progress made with the Action Planning and Database aspect of the project – Core Team reviewed all deliverables on 30.5.18. Initial definitions of learning levels scoped for the broader Learning Lessons Project. Outline draft of new core Directorate Clinical Governance (DCG) meeting agenda has been developed for further discussion with Core Team Clinical Leads and then to be presented to the Best Safety Board in July. Draft template reports currently being developed by clinical governance team leaders. Datix action notifications are not functioning correctly and administrator is unable to access email template to rectify - meeting tba with Datix early June to address. Core team meeting held 30.5.18 – meeting to be arranged with new Datix Area Manager (following his return from leave in early June). SMART action guidance under development Project Timeline being developed by Project Lead			Learning levels - meeting being arranged in June to test the levels against definitions & agree guidance for users. Clarification requested regarding KPI's (being discussed at Best Safety Programme Board on 6.6.18).

DESCRIPTION	ACTIONS / MILETONES COMPLETED	DELIVERY RAG		FORWARD VIEW: KEY MILESTONES TO TAKE PLACE IN THE NEXT 4 WEEKS
		LAST MONTH	THIS MONTH	
Frailty at TWH	TW AFU opened ahead of schedule 4.6.18 to provide up to 16 spaces per day			Frailty manager in place and Specialty Matron in place start date 16/7/18
Out of Hospital Capacity	CHC Fast track (FT) - report completed highlighting delays and solutions, SOP created and distributed. Reduced average LOS of FT patients by 41% across site. Super stranded patient project continuing with downward trajectory (Daily average numbers 146 across site for April 18 down to 121 for May 18) . Community hospital pathways and home treatment service processes projects commenced. Ward20 project in progress revealing delays with EDN and Pharmacy			Community hospital pathways and home treatment service processes projects commenced end of May to yield data end of June.
Length of Stay	Agreement from NHSE that 17/18 CUR CQUIN target met. Team is working on further key milestones, i.e. implementation of red to green at ward level, detailed weekly review of stranded patients, and embedding of SAFER			CUR Implementation Mgr and Flow coordinators posts shortlisted with interview dates 8 th -14 th June
AEC	Agreement gained by cross site clinical leads for existing 10 ambulatory protocols to be identical. Agreement gained cross site of hybrid nurse led/ doctor led ambulatory model			Agreement from Exec Lead to increase no. of ambulatory bays at TW - awaiting decision from Best Care Programme Board in order to continue and to release ENP to lead on work (due 21/5/18).
Non-Elective Surgical LOS	Project board established with good attendance including clinical director attendance. Project plans established, task and finish groups commencing.			Identification of improvements in our gift in relation to discharge; incl. clinical criteria discharge forms, virtual diagnostics (wait at home for tests) and future virtual ward.
Private patient	Analysis of current PP has shown that most income has already been captured – against financial plan. PP OPA income not significant.			Increase of PP activity necessary for financial target. A paper is drafted for a potential PPU to enable an increase of day case procedures such as CCL/ IR; increasing income
Prime Provider	A slight drop in theatre utilisation has slightly recovered. OP vacant slot report launched to improve utilisation. Request to open 8 th theatre.			Intensive support is being given to the booking teams for theatres. CAU Effectiveness board re-established. Netcall 2 way SMS to be launched late July for cancellations.

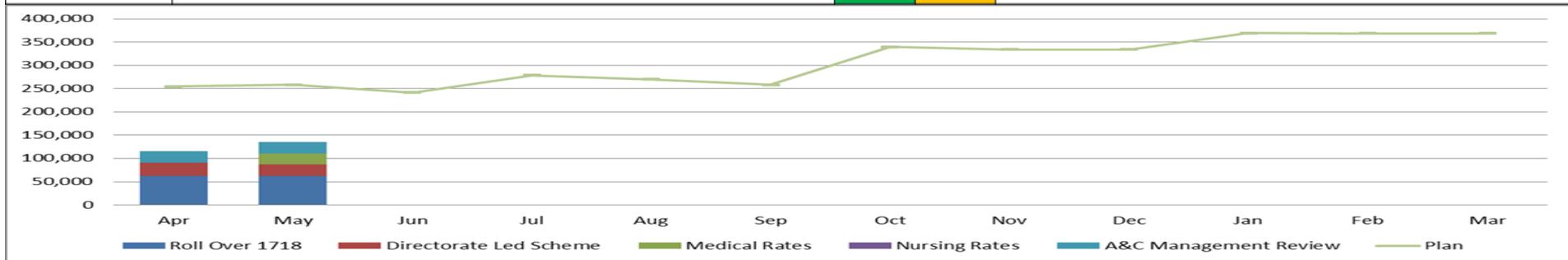


DESCRIPTION	ACTIONS/MILESTONES COMPLETED	DELIVERY RAG		FORWARD VIEW: KEY MILESTONES TO TAKE PLACE IN THE NEXT 4 WEEKS
		LAST MONTH	THIS MONTH	
Estate & Facilities	NHSI approval received for Energy Efficiency scheme, and work have commenced. Model Hospital changes incorporated into the Energy Efficiency work ongoing. E&F change paper presented to Trust Executives, who agreed next steps.			E&F Change – Update paper and re-present to Trust Board meeting in June. Patient Transport – JB and SON to meet to ascertain PMO support needed.
Procurement	31 Products Trials completed. QIA for general tenders and product trials approved.			STP Project work is progressing very slowly, list of actions tasked to all leads to move plans forward with and to submitted at next group meeting, date TBC. Further QIA's for product switches and tenders to be completed and signed off, explore further opportunities to plug the current gap of £500K. There is one additional project on hearing aids which has identified a potential £120,000. This has been agreed with the department and will significantly support the gap of £500,000. Savings will only be realised from August. Procurement are supporting a number of initiatives in the other best care programmes but these savings are not counted against the procurement target.
ICT	Cessation of excess mileage payments and Patient Centre contract implemented and delivering as planned. Cessation of associated storage contract is still in progress, and planned delivery for end of Q2 is in place.			Storage contract scheme – complete and sign off QIA.
Medicine Management	Outsourcing - finalising the recruitment of PM, vacancy request form to go to Exec panel week commencing 11th June, meeting to discuss work plan with prospective PM and temp staff recruitment lead arranged for 11th June 2018. Plan for PM to start end of June.			Etherncept TW roll out – letters go out to patients week commencing 11 th June and roll out planned for 1 st July. Tranzuzimab - confirm product choice by end of Q1 when all data will become available. CQUIN period starts Q2. Drug Contract Changes (Wave 11) - planned start for Q2, Near Patient Dispensing on Peale Ward go live planned for 20/06/2018, pilot already on going at TW. Dossett Boxes / MAR Charts – pilot date commencement TBC.
AIC Pathology	Vit D tests request data now updated up till Oct 2017, and in comparison with 16/17 figures, shows a drop in figures. The following changes have been made to the Pathology report: URATE Auto comments added, HbA1c - auto comments live, LFT - review requesting and guidance completed and to be published on DORIS, ESR - removed from DMARD monitoring, Url - request guidance added unto Pro – BNP			Obtain similar data for LFT, FLP, FBC, Thyroid tests
AIC Diabetes	DSN Funding Agreed 4/6/18 allows recruitment drive commence. Confirmation of contractual arrangements due end 06/18			Diabetes Implementation Group and Financial Meeting scheduled to address and monitor set actions via plan



Best Workforce has been put into recovery status, as delivery is adverse to plan. The SRO and Workstream Lead meet with Best Care Executive SRO and Programme Director on a weekly basis to review specific delivery against the recovery plan.

DESCRIPTION	Actions/Milestones completed	DELIVERY RAG		FORWARD VIEW; KEY MILESTONES TO TAKE PLACE IN THE NEXT 4 WEEKS
		LAST MONTH	THIS MONTH	
Temporary Staffing Controls Group	A new dashboard development has started and data gaps identified/rectified Review of Bank rates has identified differences across directorates at same grades Discussions commenced with Top 4 Agencies for Med Locums to reduce rates	Red	Red	<ul style="list-style-type: none"> Agree revised authorisation process in line with revised NHSi rules (currently being drafted) Agree that all non framework agency usage will cease MD/DMDs to approve all Medical Override Shifts Review and plan for each high cost Locum, Nurse and AHP Communications to be sent out regarding Q2 rate step down Model finances to standardise bank rates for all medical staff.
New Roles and Apprenticeships	RAG status changed as a result of Best Workforce Board confirming approach for project Introduction to Apprenticeships given to GMs/AGMs First Engagement Session held with ED on 4 June As at 31 May 2018 60 apprenticeships signed up to commence in 2018 40 responses received in response to Management Training with 16 due to sign up to Apprenticeships Confirmation money in levy account expires after 24 months, any transaction paid in May 17 will expire in May 19.	Yellow	Green	<ul style="list-style-type: none"> Next Engagement Session to be held with Specialist Medicine and Therapies on Mon 11 June with all other areas to have sessions completed by end July First Nursing Associates are planning for September start - approximately 20. Set KPI's and targets once requirements identified for new roles and apprenticeships
Directorate CIP's	All schemes are now Green with the exception of (Add in which ones) and subject to final agreement that full QIAs are not required for the smaller schemes. RMO Model agreed Recharge for East Sussex still outstanding	Yellow	Yellow	<ul style="list-style-type: none"> RMO starting from 10th June and savings modelled through. Update re unpaid invoice from East Sussex
Medical Productivity	Policy and associated document changes agreed with JMCC—subject to final ratification. Continued working with the directorates to add job plans onto the system. Solutions found for issues with W&C and ED job plans and approved by project working group. Local PAAT developed and now being discussed with the directorates. Funding agreed for BI Analyst - although delays to appointment risk D&C work	Green	Yellow	<ul style="list-style-type: none"> Continue to support directorates in loading and signing off all job plans onto the e-job planning system. Work with the directorates to sign off local PAAT Develop recruitment plan for BI Analyst to support Demand and capacity work



During this reporting period 17 QIAs have been signed off by the Chief Nurse and Medical Director, from the following workstream:

- Best Safety (4)
- Best Use of Resources (3)
- Best Patient Flow (10)

A QIA deep dive process will be completed against the following projects:

- Vacancy Review
- STP Medical Locum Rates

The deep dive will be independent assurance that management and clinical actions have been sufficient, timely or widespread.

By conducting the independent deep dive, is not acknowledgment that something has gone wrong, but to provide assurance that the implemented project/change achieved the rating of the approved Quality Impact Assessment.

Success Story



The 'Out of Hospital Capacity Project group' within the 'Best Patient Flow Work stream' has concentrated on making small improvements to discharge related pathways in ways to benefit both patients and MTW.

There are 10 different projects running, ranging from super stranded patient focus, to community hospital processes in West Kent and enablement services in East Sussex. An early success story has been a reduction in the timeline for CHC Fast track patients. This patient group are more often than not in the last 100 days of their life, so it is imperative that we expedite their transfer from Hospital to their preferred destination if appropriate.

The average length of stay from fast track decision to discharge was 11 days at Maidstone and 12 days at Tunbridge Wells prior to the commencement of this project.

The team have worked to improve internal standards and re-audited; resulting in a reduction to 8 days at Maidstone and 6 days at Tunbridge Wells.



Trust Board meeting – June 2018

6-12	Update on the compliance status of the 10 maternity safety actions in the CNST incentive scheme	Chief Nurse
-------------	--	--------------------

As part of DH's Maternity Safety Strategy, the CNST incentive scheme seeks to reward providers of maternity services who improve maternity safety. The CNST incentive scheme identifies 10 maternity safety actions against which Trusts are invited to evidence progress and compliance.

At its meeting on 24th May 2018, the Trust Board considered a report demonstrating progress (with evidence) against each of the 10 actions using the template Board report for result submission. A full pack of evidence was circulated as a supplementary report to Trust Board members. The Chief Nurse reported at the meeting that further changes to the Trust's submission were required, as communication regarding the specific criteria to be applied had been received subsequent to its circulation and this would affect the submission in respect of Standards 8 and 10.

As it was noted that there was one further Trust Board meeting before the submission deadline, the submission for Standards 1 to 7 and 9 were approved as circulated, and it was agreed that the status of Standards 8 and 10 should be confirmed at the June 2018 Trust Board meeting, prior to submission to NHS Resolution (with all relevant supporting documentation) by Friday 29 June 2018.

The updated submission is now enclosed for sign off.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

The Board is invited to sign off and self-certify the report to NHS Resolution that will be submitted by 29/06/18

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

Maternity : Safer Births - NHS Resolution Self Certification Report

Final Update

For decision – the Board is invited to sign off and self-certify the report to NHS Resolution that will be submitted by Friday 29 June.

As part of DH's Maternity Safety Strategy, the CNST incentive scheme seeks to reward providers of maternity services who improve maternity safety. The CNST incentive scheme identifies 10 maternity safety actions against which Trusts are invited to evidence progress and compliance.

This report has been prepared using the template specified by NHS Resolution. Trust Boards are tasked with assessment and self -certification of the evidence provided.

Further information about the CNST incentive scheme is provided in Appendix A and detail about each of the 10 NHS Resolution criteria is provided in Appendix B.

Board report on Maidstone & Tunbridge Wells NHS Trust progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

Date: June2018

SECTION A: Evidence of Trust's progress against 10 safety actions:

We have achieved the required standard in all 10 criteria

The Chief Nurse and Head of Midwifery is meeting 21/6/18 to review the detail of the evidence and once Board approval is given we will submit to meet the deadline of 29/6/18

Please note that trusts with multiple sites will need to provide evidence of each individual site's performance against the required standard.

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
<p>1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?</p>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.</i></p> <p><i>NHS Resolution will also use data from MBRRACE to verify the Trust's progress against this action.</i></p> <p><i>completed</i></p>	<p>yes</p>
<p>2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?</p>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.</i></p> <p><i>NHS Resolution will also use data from NHS Digital to verify the Trust's progress against this action.</i></p> <p>Data submitted in time</p>	<p>yes</p>

<p>3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?</p>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.</i></p> <p><i>NHS Resolution will cross-check trusts' self-reporting with Neonatal Operational Delivery Networks to verify the Trust's progress against this action.</i></p> <p>At MTW we have Transitional Care Facilities on the Post Natal Ward</p> <p>We have a Band 7 Transitional Care Lead</p> <p>ATAIN meetings are multidisciplinary and meet monthly</p> <p>Staff also represent the Trust at Regional Neonatal meetings</p> <p>No additional information required for this meeting</p>	<p>yes</p>
<p>4). Can you demonstrate an effective system of medical workforce planning?</p>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document. This should include reference to the Royal College of Obstetricians and Gynaecologists (RCOG) workforce monitoring tool template</i></p> <p>Completed and submitted to RCOG</p>	<p>yes</p>
<p>5). Can you demonstrate an effective system of midwifery workforce planning?</p>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance slides.</i></p> <p>Birthrate plus review on going – results available in August 2018</p>	<p>yes</p>

<p>6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?</p>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.</i></p> <p><i>NHS Resolution will cross-check trusts' self-reporting with NHS England.</i></p> <p>No additional information to add to this meeting</p>	<p>yes</p>
<p>7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?</p>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.</i></p> <p>No additional information to add for this meeting</p>	<p>yes</p>
<p>8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?</p>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document. This should include completion of a local training record form.</i></p> <p>We have achieved 90% of all staff groups doing emergency training including CTG monitoring</p> <p>Additional training sessions were put on to capture the remaining staff to meet the necessary compliance of 90%</p>	<p>yes</p>

<p>9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?</p>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.</i></p> <p>No additional evidence required for this criteria</p>	<p>yes</p>
<p>10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?</p>	<p><i>Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.</i></p> <p><i>8 case in 2017/18</i></p> <p><i>9 cases in 2018/19</i></p> <p><i>Letter approved and personalised for each family</i></p> <p><i>Each family will be called this week</i></p>	<p>Yes</p>

SECTION B: Further action required:

If the Trust is unable to demonstrate the required progress against any of the 10 actions, please use this section to set out a detailed plan for how the Trust intends to achieve the required progress and over what time period. Where possible, please also include an estimate of the additional costs of delivering this.

The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the Trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund. If made, any such reimbursement must be used by the Trust for making progress against one or more of the 10 actions.

SECTION C: Sign-off

.....

For and on behalf of the Board of Maidstone & Tunbridge Wells NHS Trust confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B**

Position:

Date:

We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm's length body/NHS System leader.

.....

SECTION D: Appendices

Please list and attach copies of all relevant evidential appendices:

Trust Board meeting – June 2018

6-13 Quarterly mortality data	Medical Director
<p>Summary / Key points</p> <p>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).</p> <p>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).</p> <p>This report is based upon the Trust’s most recent data, published by Dr Foster for the period March 2017 to February 2018.</p>	
<p>Which Committees have reviewed the information prior to Board submission?</p> <ul style="list-style-type: none"> ▪ N/A 	
<p>Reason for submission to the Board (decision, discussion, information, assurance etc.) ¹</p> <p>Information, assurance and discussion</p>	

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

June 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 March 2017 to February 2018 show our HSMR to be 103.7, which is an improvement against last month's position of 104.8.

Figure 1. Rolling 12 Month view

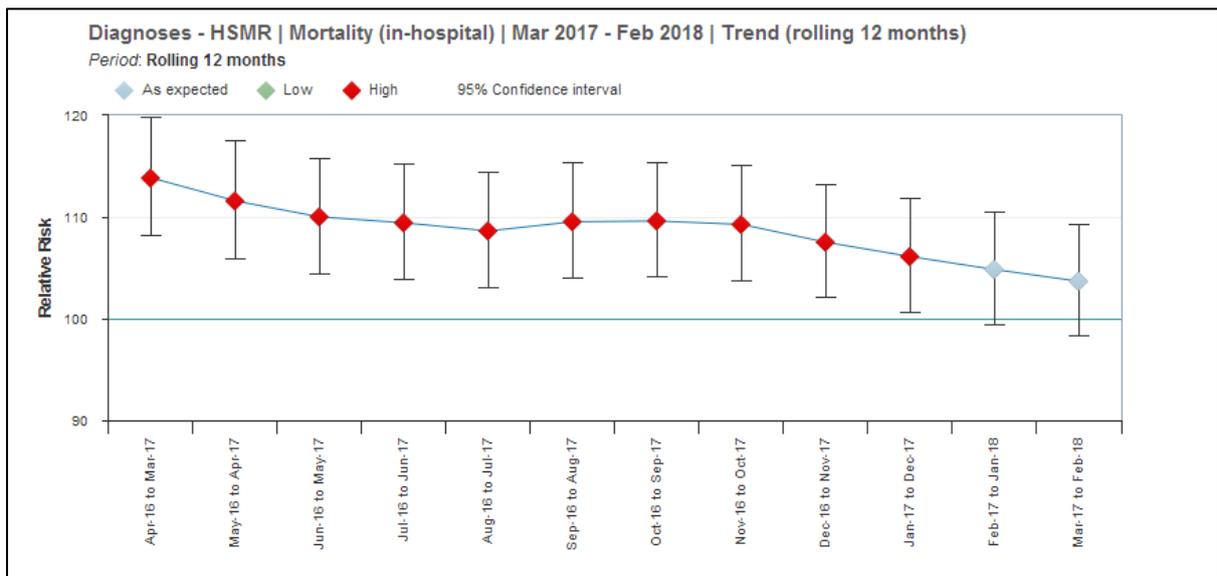


Figure 2 (overleaf) shows a monthly view of our HSMR performance. The latest month should be viewed with caution as this often shows a false position due to the lag in coding activity. Viewing the previous month, so February 2018 in this case, it shows that the Trust's position has improved to 88.5 from 105.9 in January 2018.

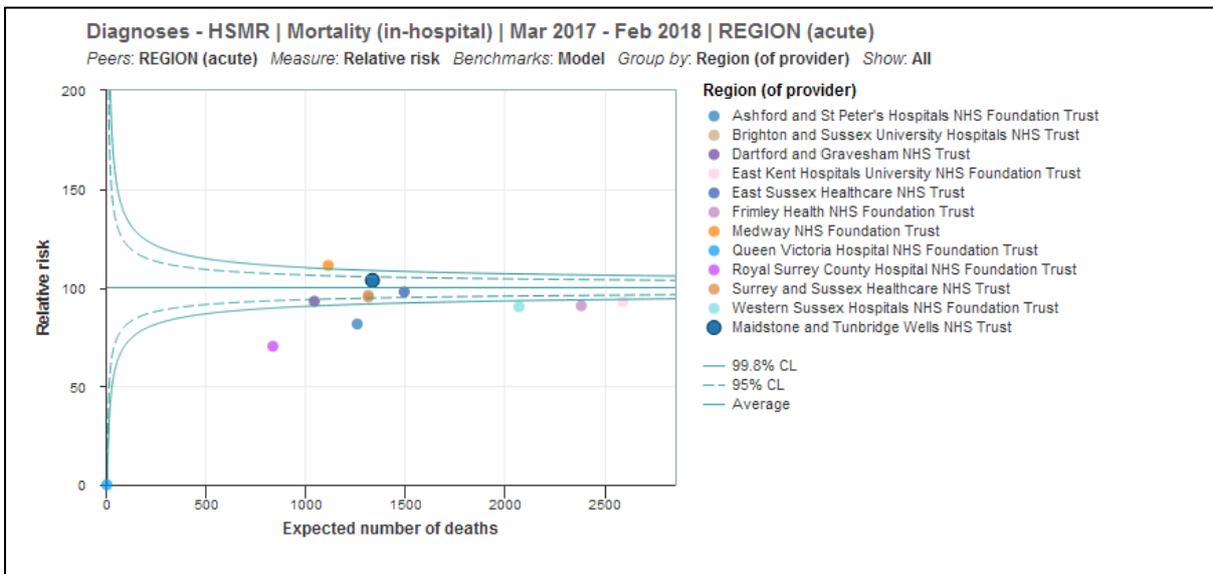
Figure 2. Monthly view



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 Figure 3. This shows the Trust is no longer a major outlier against this group; Medway is the next outlier trust for this period.

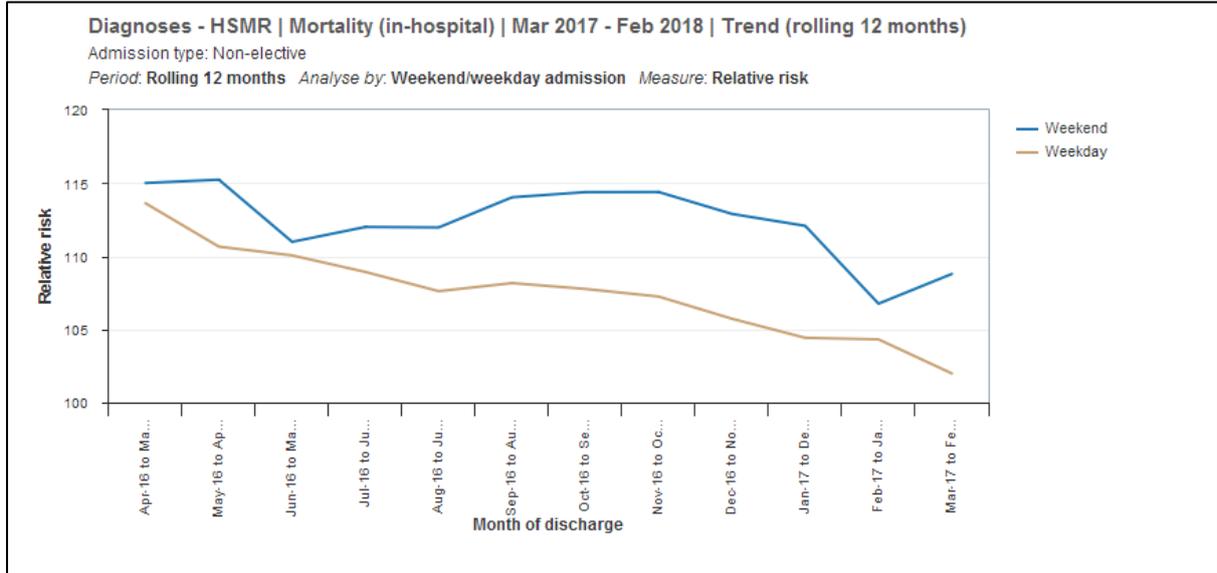
Figure 3. Benchmarking against our regional acute peers



c. HSMR – Weekend vs. Weekday 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 108.8 (up from 106.5) for weekends and 101.9 (down from 104.3) for weekday admissions, both of these rates are significantly lower than where the Trust was at the beginning of the year, but the weekend rate has shown an increase for the latest period.

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



An area previously highlighted as carrying a higher than expected Relative Risk was the death of patients admitted on Friday, particularly those with a LOS of 1-2 days, however the latest analysis highlights that patients admitted on a Thursday have a higher relative risk of death as shown in Figure 5.

Figure 5: Relative Risk by Day of Admission

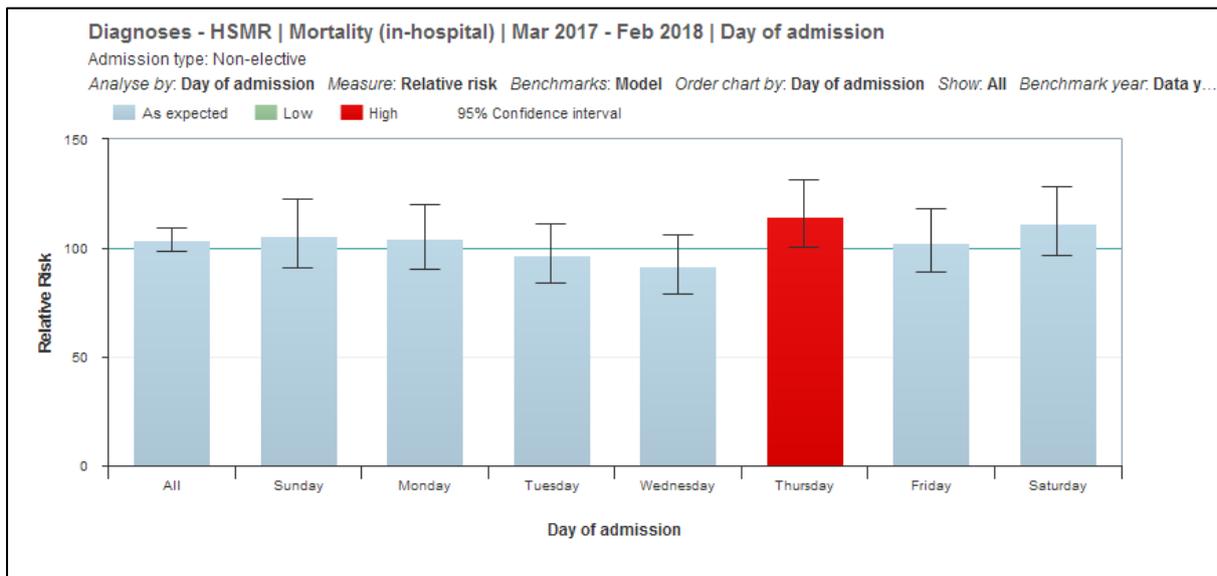
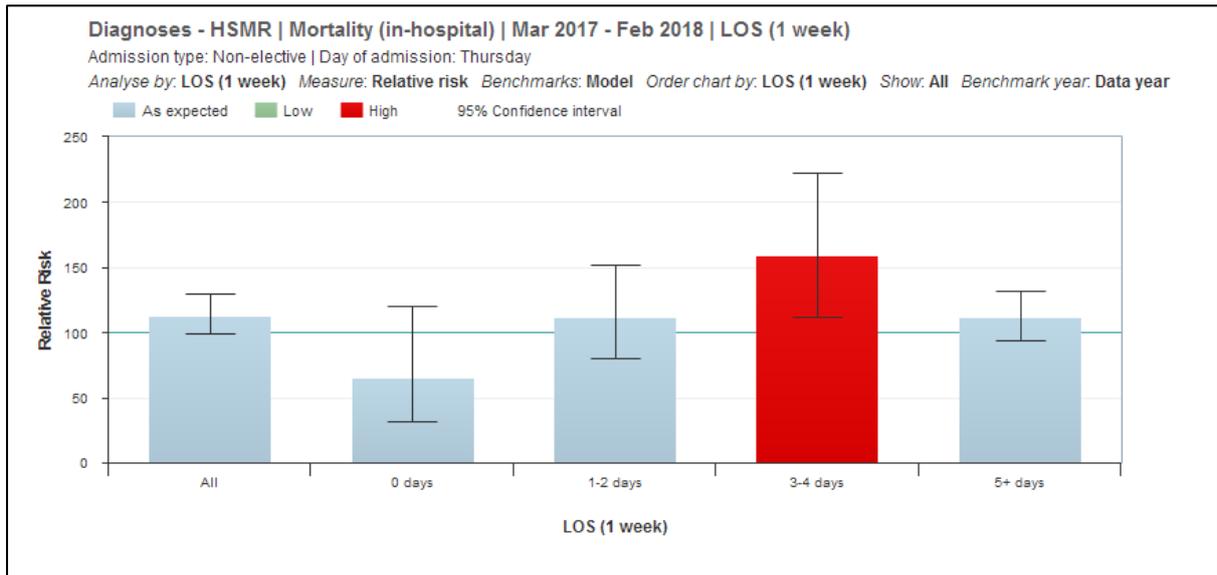
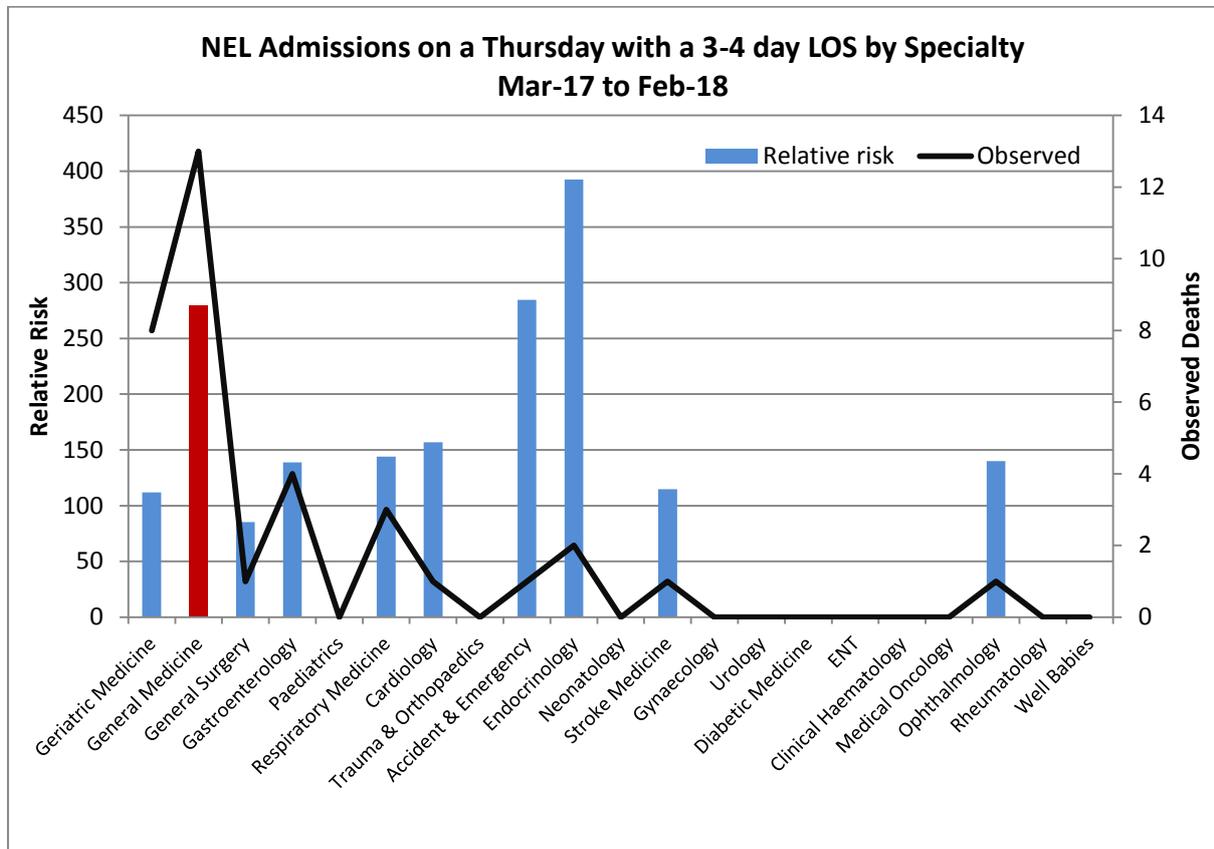


Figure 6: Thursday admissions by LOS



When this cohort of patients are analysed it seems that those with a 3-4 day LOS carry a higher relative risk of death (shown in Figure 6). These deaths have been broken down by specialty of discharge in the following graph and as can be seen General medicine carries the highest risk rating for these criteria.

Figure 7: Thursday admissions with a 3-4 day LOS by Specialty

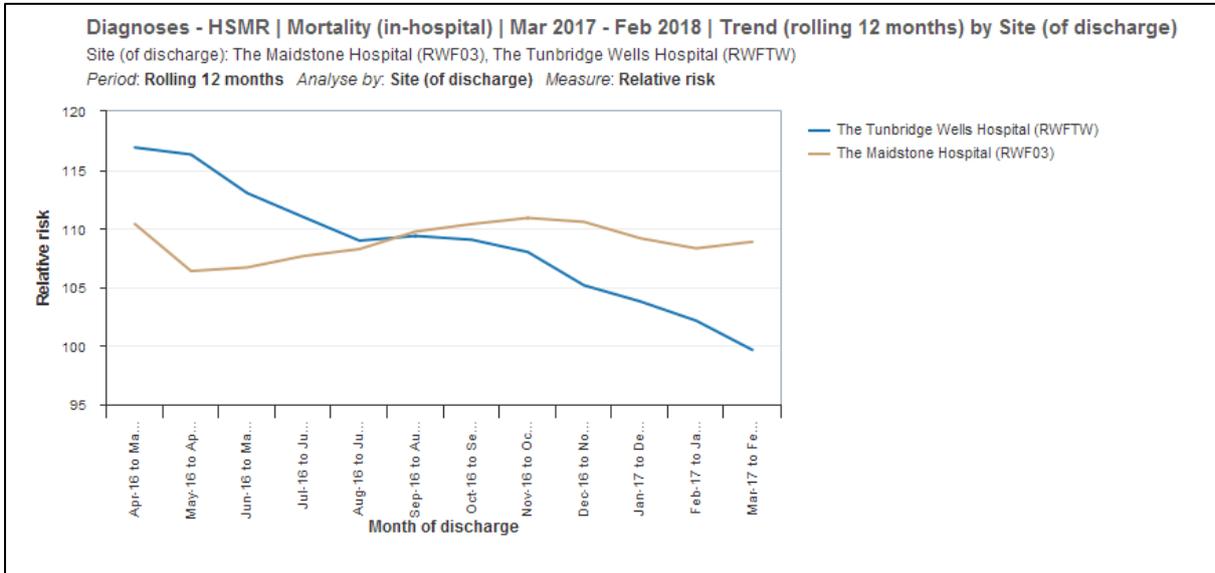


It is recommended that a sample of these deaths are audited for assurance purposes and feedback given to the MSG.

d. HSMR – by site

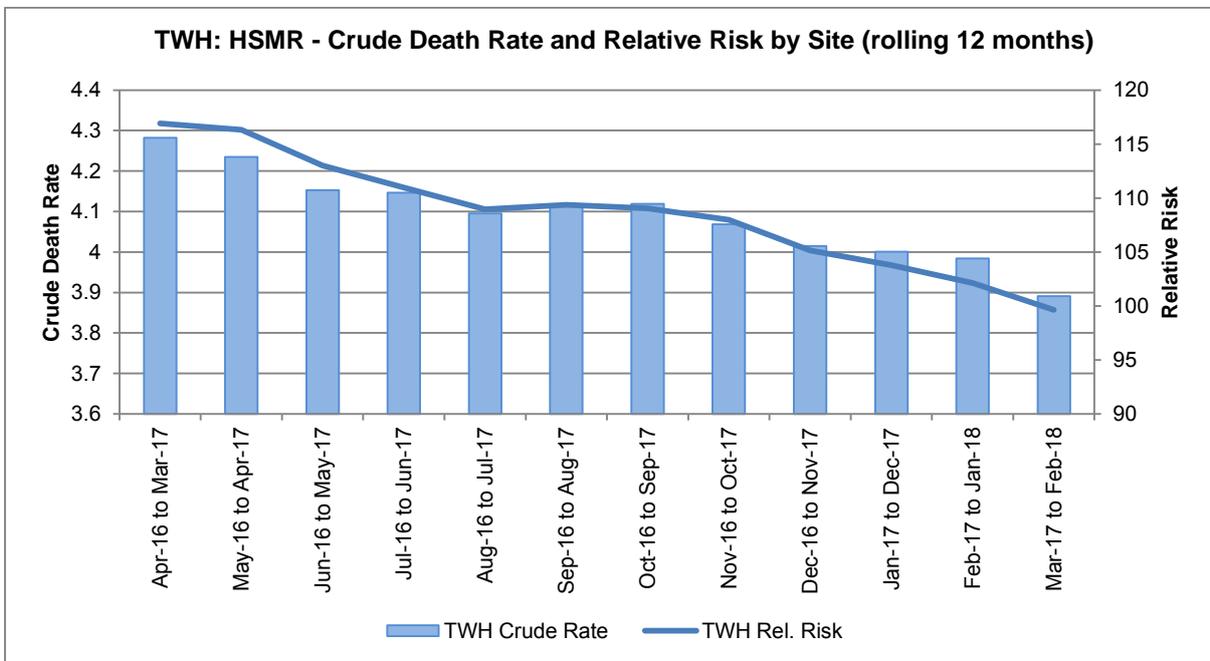
Figure 8 shows the HSMR split by site. The HSMR at the Maidstone site has risen in the most recent report to 108.9 from 108.3 to January 2018; the Tunbridge Wells site has continued to improve during the same period dropping to 99.6.

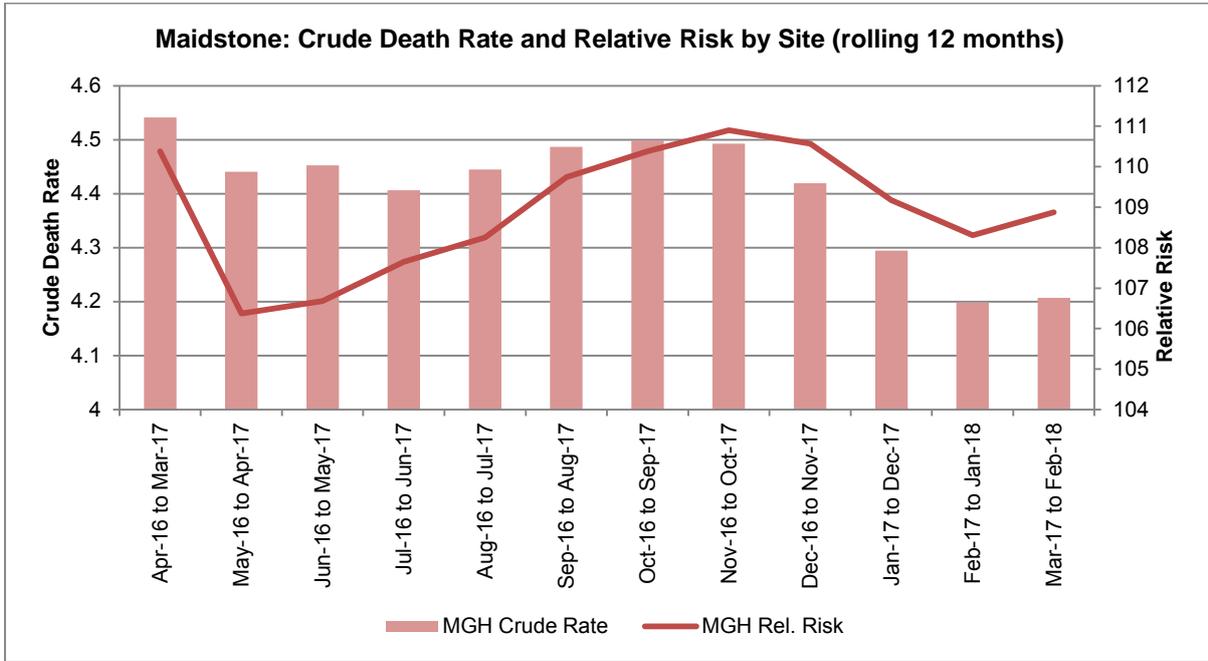
Figure 8. HSMR by site



Figures 9 & 10. HSMR Crude Rate v Relative Risk Rate by site

The graphs below show that the crude mortality rate tracks the relative risk rate at the both sites. The latest month for Maidstone shows a minor increase in both rates, whereas Tunbridge Wells continues to show a reduction in both.





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 1383 deaths recorded in the period March 2017 to February 2018, 277 had no comorbidities recorded (20%).

Figure 11. Deaths with a Charlson score of zero recorded by age

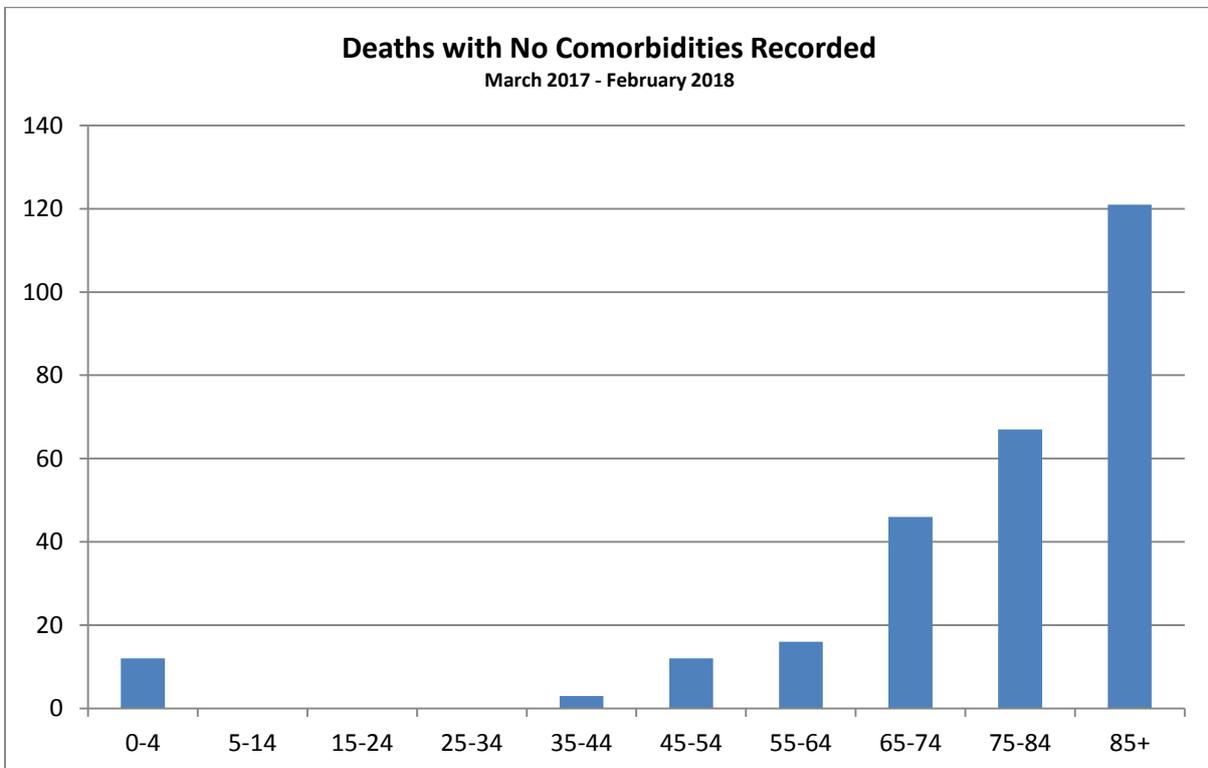
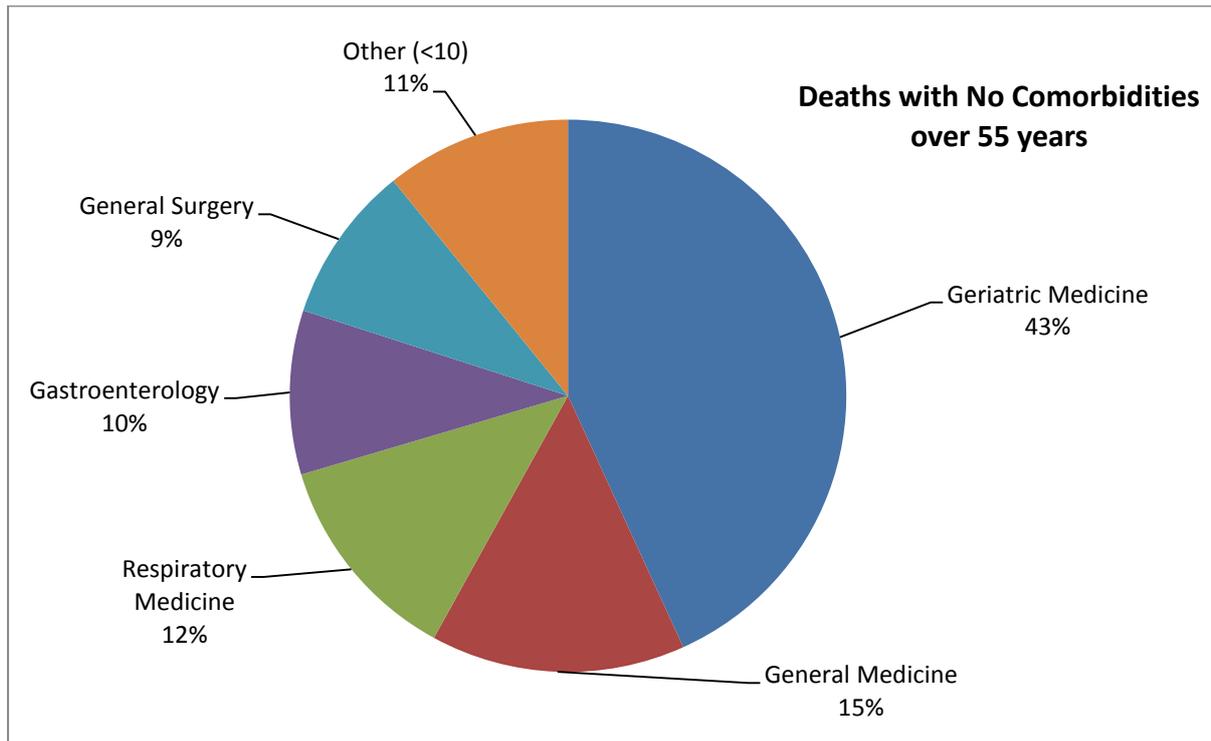


Figure 12. Deaths (>55 years) with a Charlson score of zero recorded by speciality (at discharge).



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. After audit of the geriatric medicine it shows that there are zero co-morbidities as the majority of the patients did not have the complex co-morbidities listed on the Charlson Index.

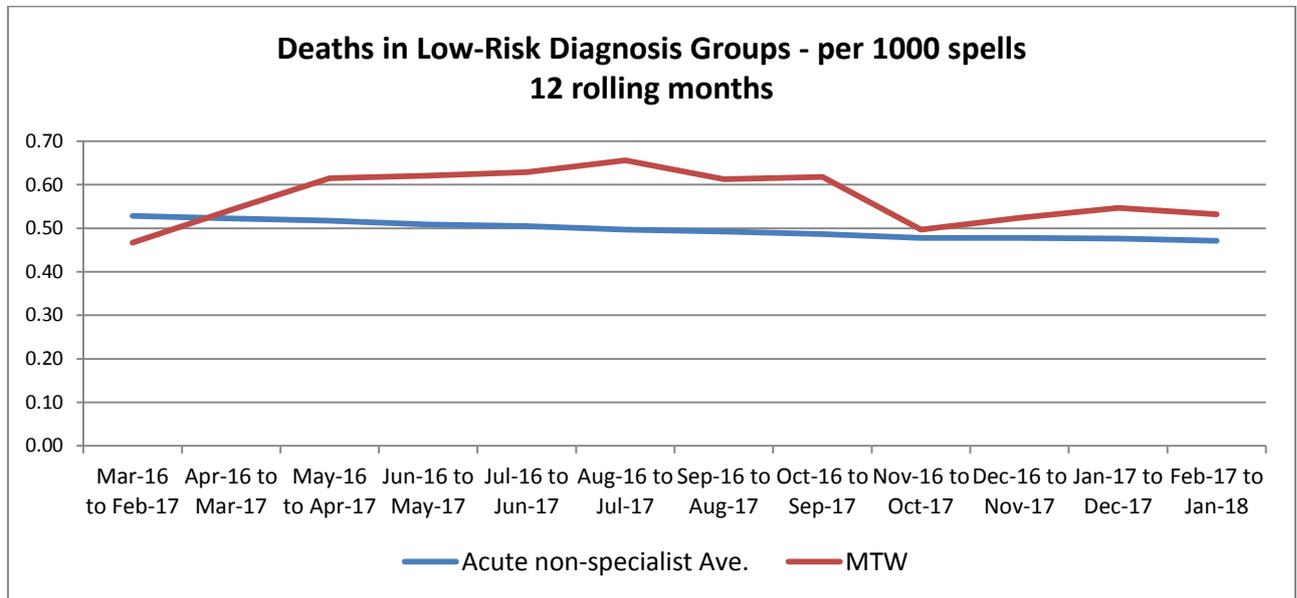
Regional Benchmarking of deaths with Zero Comorbidities - 75 Year +

Trust (local acute peers)	Zero Comorbidities	All deaths	%
Surrey and Sussex Healthcare NHS Trust	60	909	6.60%
East Kent Hospitals University NHS Foundation Trust	155	1712	9.05%
Medway NHS Foundation Trust	108	847	12.75%
Ashford and St Peter's Hospitals NHS Foundation Trust	106	776	13.66%
Dartford and Gravesham NHS Trust	103	719	14.33%
East Sussex Healthcare NHS Trust	156	1080	14.44%
Frimley Health NHS Foundation Trust	233	1565	14.89%
Western Sussex Hospitals NHS Foundation Trust	220	1421	15.48%
Maidstone and Tunbridge Wells NHS Trust	188	1046	17.97%
Brighton and Sussex University Hospitals NHS Trust	176	903	19.49%
Royal Surrey County Hospital NHS Foundation Trust	81	408	19.85%
All	1586	11386	13.93%

Deaths in Low Risk Diagnosis Groups

Currently MTW is showing as an outlier when looking at deaths in low risk diagnosis groups compared to the Acute, non-specialist trust average, however it has been improving over the last 5 months after it peaked at an average of 0.66 during September 2016 – August 2017. The current average is 0.53. This is a metric used by the CQC in their insight report and MTW has flagged as being worse than average for this measure, hence its inclusion in this report.

Figure 13. Deaths in Low Risk Diagnosis Groups



There were 21 deaths in a low risk group in the last 12 months, these deaths breakdown as follows.

Diagnosis group	Total
Other nervous system disorders	4
Abdominal hernia	3
Oesophageal disorders	3
Poisoning by psychotropic agents	2
Viral infection	2
Abdominal pain	1
Nonspecific chest pain	1
Spondylosis intervertebral disc disorders other back problems	1
Regional enteritis and ulcerative colitis	1
Headache including migraine	1
Osteoarthritis	1
Sprains and strains	1
Grand Total	21

The 21 records concerned are being audited by the coding department. Results will be presented back to the MSG. Audit of these notes has found the coding on a number of these needed to be amended. In order to improve the data quality of mortality coding all deceased patient will be coded by staff holding the National Clinical Coding Qualification and a process of internal audit is being implemented.

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. 14 Diagnosis with negative CUSUM Alerts

Relative risk & CUSUM alerts										
Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	6	104658	1670	1698.0	1.6	104.5				
HSMR (56 diagnosis groups)		34315	1383	1334.0	4.0	103.7				
Cancer of liver and intrahepatic bile duct	1	35	8	3.4	22.9	237.3				
Cancer of prostate		341	8	3.1	2.3	260.6				
Conduction disorders		183	7	2.8	3.8	254.4				
Congestive heart failure, nonhypertensive	2	629	99	67.6	15.7	146.5				
Diseases of white blood cells		35	2	0.2	5.7	1243.2				
Fracture of neck of femur (hip)	1	572	34	36.0	5.9	94.4				
Residual codes, unclassified	4	3259	79	42.1	2.4	187.7				
Secondary malignancies	1	625	43	28.3	6.9	151.9				
Senility and organic mental disorders	1	231	24	15.5	10.4	154.5				
All Procedures	4	68443	875	907.1	1.3	96.5				
Compensation for renal failure	1	14	5	2.0	35.7	253.6				
Percutaneous puncture of kidney	2	77	7	2.4	9.1	297.2				
Reduction of fracture of neck of femur	1	76	6	2.5	7.9	243.9				
Surgical arrest of bleeding from internal nose	1	67	2	0.4	2.3	537.5				

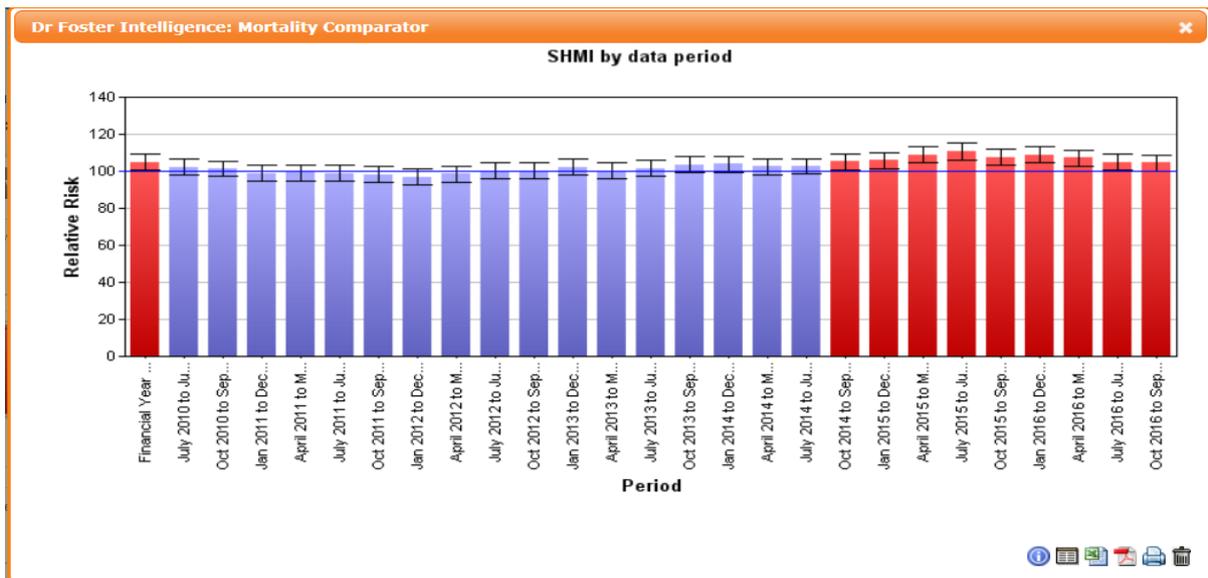
The patient level backing data for these alerts is supplied to the mortality leads to review.

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 October 2016 – September 2017 shows SHMI as 1.0440 which is banded as level 2 “as expected”.

Figure 11. SHMI



Publication of the next data series for the period January 2017 - December 2017 will be published in June 2018.

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	4.3	19
Dartford and Gravesham NHS Trust	3.0	15
East Kent Hospitals University NHS Foundation Trust	3.5	13
Maidstone and Tunbridge Wells NHS Trust	4.6	19
Medway NHS Foundation Trust	4.5	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	292,595	91,403	92,055	31.2	31.5
Dartford and Gravesham NHS Trust	1,611	782	782	48.5	48.5
East Kent Hospitals University NHS Foundation Trust	4,204	1,083	1,083	25.8	25.8
Maidstone and Tunbridge Wells NHS Trust	2,429	774	774	31.9	31.9
Medway NHS Foundation Trust	1,867	532	532	28.5	28.5

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 3.2% of our deaths fall in quintile 1 'most deprived', whereas 37.8% 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	20.3	20.0	20.4	19.7	17.3	2.3
Dartford and Gravesham NHS Trust	9.3	21.4	19.9	26.3	21.7	1.4
East Kent Hospitals University NHS Foundation Trust	15.5	21.3	26.3	28.9	7.3	0.8
Maidstone and Tunbridge Wells NHS Trust	3.2	7.2	20.4	30.8	37.8	0.7
Medway NHS Foundation Trust	18.1	27.3	19.7	17.1	15.7	2.1

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. 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 reported to ensure that any learning from deaths are identified and shared.

a. Trust & Specialty overview – 2018/19

Trust	Apr-18	May-18	YTD
No of Deaths	126	122	248
No of Completed Reviews	88	37	125
%age completed reviews	69.8%	30.3%	50.4%

%age completed reviews	Apr-18	May-18	YTD
Specialist Medicine	78.9%	33.8%	59.0%
Acute Medicine	58.3%	24.0%	35.1%
Surgery	62.5%	57.1%	60.0%
Trauma & Orthopaedics	33.3%	0.0%	20.0%
A&E	33.3%	20.0%	25.0%
Cancer & Haematology			
Children's			
Head & Neck			
Women's & Sexual Health	0.0%		0.0%
Trust Total	69.8%	30.3%	50.4%

The table above shows the results for 2018/19 as at 13th June 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	Mar-18	YTD
Specialist Medicine	60.2%	46.7%	51.5%	52.7%	56.3%	55.7%	52.8%	58.9%	48.5%	60.9%	80.6%	84.1%	59.2%
Acute Medicine	60.7%	66.7%	46.7%	33.3%	38.1%	38.9%	10.0%	28.6%	40.9%	51.4%	76.0%	81.5%	52.3%
Surgery	100.0%	85.7%	100.0%	87.5%	75.0%	60.0%	66.7%	66.7%	11.1%	43.8%	63.2%	78.6%	69.6%
Trauma & Orthopaedics		66.7%	100.0%	25.0%	0.0%	0.0%	50.0%	0.0%	0.0%	0.0%	100.0%	60.0%	31.3%
A&E	50.0%	78.6%	33.3%	50.0%	20.0%	14.3%	69.2%	45.5%	73.7%	44.4%	50.0%	73.3%	57.1%
Cancer & Haematology	0.0%	0.0%	0.0%	0.0%		66.7%	0.0%			50.0%	100.0%	100.0%	42.1%
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%	55.1%	55.4%	49.2%	52.4%	51.2%	52.1%	54.1%	46.6%	56.0%	76.1%	81.5%	58.0%

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.

5. 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.

Organisation	Maidstone & Tunbridge Wells NHS Trust
Financial Year	2017-18
Month	March

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



Learning from Deaths Dashboard

Purpose of the dashboard

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

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

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

Guidance on individual fields

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

How to update the dashboard

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

To update the dashboard with new data:

- 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
- Change the month and year on the Front Sheet tab to the most recent month of data.
- 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 - March 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
160	146	127	117	4	3
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
501	425	355	208	12	8
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1720	1	997	976	26	18

Time Series: Start date 2016-17 Q1 End date 2017-18 Q4



Total Deaths Reviewed by RCP Methodology Score

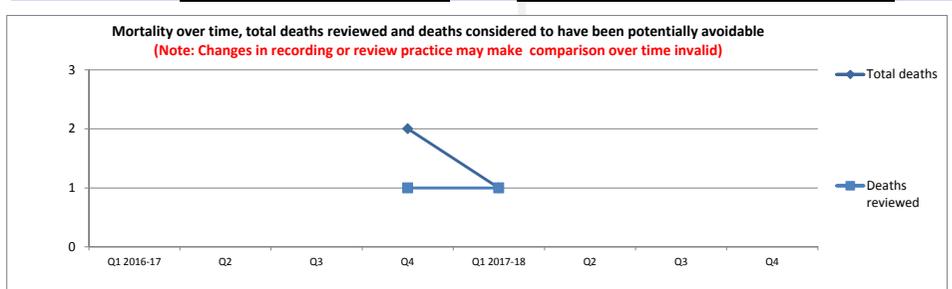
Score 1	Score 2	Score 3	Score 4	Score 5	Score 6
Definitely avoidable	Strong evidence of avoidability	Probably avoidable (more than 50:50)	Probably avoidable but not very likely	Slight evidence of avoidability	Definitely not avoidable
This Month	This Month	This Month	This Month	This Month	This Month
0	4	0	0	9	100
0.0%	3.5%	0.0%	0.0%	8.0%	88.5%
This Quarter (QTD)	This Quarter (QTD)	This Quarter (QTD)	This Quarter (QTD)	This Quarter (QTD)	This Quarter (QTD)
0	12	0	0	27	299
0.0%	3.6%	0.0%	0.0%	8.0%	88.5%
This Year (YTD)	This Year (YTD)	This Year (YTD)	This Year (YTD)	This Year (YTD)	This Year (YTD)
0	23	3	0	86	867
0.0%	2.3%	0.3%	0.0%	8.8%	88.6%

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 Q4



Trust Board meeting – June 2018

6-14 Findings of the National Inpatient Survey 2017

Chief Nurse

The purpose of this report is to provide members of the Board an update and summary of the 2017 Adult Inpatient survey which was published on 13 June 2018. (attached as an appendix to the report).

For the 2017 National Inpatient Survey, the month sample was fixed to July and will remain fixed for all future surveys. There were 70 core questions. The results reflected views from patients who had an inpatient stay at either site of the Trust. The sample size for the audit was 1,243 patients. The total number of patients who completed surveys for MTW was 588, which was a response rate of 47%.

Comparison is made from the 143 NHS acute and NHS Foundation trusts who took part in the Adult inpatient Survey. Each trust has been assigned one of five bands: 'much worse than expected', 'worse than expected', 'about the same', 'better than expected' or 'much better than expected'. MTW is not contained in the 'Identification of Outliers within Trust Level Results' and has received the overall rating 'about the same'

Key facts about the 588 responses:

- 22.90% of patients were on a waiting list/planned in advance and 74.06% came as an emergency or urgent case.
- 49.15% were male; 50.85% were female.
- 97.73 % of patients felt they were treated with respect and dignity
- 97.02% felt members of staff worked well together
- 95.95% of patient felt the hospital staff did everything they could to help control pain (71.65% Yes definitely / 24.30% yes to some extent - CQC action plan)
- 82.46% of all respondents rated their overall experience at 7 or greater: scores were rated between I had very poor experience: 0 and I had a very good experience: 10

Overall, there were 31 questions in which the Trust scored higher than in 2016, 8 questions scored the same, 9 questions with no comparison scores due to a modification in the 2017 survey questions and, 14 questions in which the Trust scored lower than in previous years. However, of these results statistical significance is only noted within 6 questions scoring outside of the expected range as determined by the CQC. This includes 3 questions the Trust has scored higher than 2016 and above expected range and, 3 questions the Trust has scored lower than 2016 and below the expected range as follows:

Higher:

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

Q14: Were you ever bothered by noise at night from other patients?

Q15: Were you ever bothered by noise at night from hospital staff?

Lower:

Q6: How do you feel about the length of time you were on the waiting list before your admission to hospital?

Q17: Did you get enough help from staff to wash or keep yourself clean?

Q19: How would you rate the hospital food?

The total of 14 Questions in which the Trust scored slightly lower than in previous years include: (Highest Trust Score (HTS), Maidstone and Tunbridge Wells NHS Trust Score (MTW) and Lowest Trust Score (LTS)).

Q6: How do you feel about the length of time you were on the waiting list before your admission to hospital?

HTS: 9.7 MTW: 7.1 LTS: 6.3

Q8: In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?

HTS: 9.6 MTW: 8.6 LTS: 8.3

Q17: Did you get enough help from staff to wash or keep yourself clean?

HTS: 9.3 MTW: 7.8 LTS: 7.0

Q19: How would you rate the hospital food?

HTS: 9.3 MTW: 5.5 LTS: 4.7

Q20: Were you offered a choice of food?

HTS: 9.7 MTW:8.3 LTS: 7.8

Q21: Did you get enough help from staff to eat your meals?

HTS: 9.9 MTW: 9.4 LTS: 8.9

Q29: In your opinion, were there enough nurses on duty to care for you in hospital?

HTS: 9.1 MTW:7.6 LTS: 6.5

Q30: Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)

HTS: 8.7 MTW:6.2 LTS: 5.4

Q34: Were you involved as much as you wanted to be in decisions about your care and treatment?

HTS: 8.5 MTW: 7.1 LTS: 6.6

Q37: Did you find someone on the hospital staff to talk to about your worries and fears?

HTS: 7.7 MTW:5.2 LTS: 4.3

Q38: Do you feel you got enough emotional support from hospital staff during your stay?

HTS: 8.6 MTW:6.7 LTS: 6.1

Q48: Did you feel you were involved in decisions about your discharge from hospital?

HTS: 8.5 MTW:6.6 LTS: 6.1

Q58: Did a member of staff tell you about medication side effects to watch for when you went home?

HTS: 7.6 MTW:4.7 LTS: 3.7

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

HTS: 3.6 MTW:1.7 LTS: 0.7

The Trust values and actively engages with the National In Patient Survey to utilise the results as an opportunity to review practice and processes not only for areas highlighted within the inpatient survey results but in ALL survey questions; to improve our positive responses compared with the National highest scores. The 14 questions highlighted for areas of particular focus will be addressed in our action plan that we will be developing.

The inpatient survey results will be presented at the next patient experience committee with the intention of seeking support in identifying key actions that we need to address. Responsibility for delivery against actions within the action plan will be with the relevant Divisional Management teams with progress against agreed actions reviewed at directorate level each month. This will feed into the new Quality improvement Committee chaired by the Chief Nurse to ensure monitoring of progress forming part of the transitional work of the Trusts approach with the CQC into a business as usual approach and aligned to the transformational work of the Best care programme through the relevant work streams.

The Trust has been one of the early adopters to be part of the changes to the Care Quality Commission's (CQC) new inspections and framework strategy which is now an annual process using a new framework around the five Key Ley Lines of Enquiries (KLOEs); Is the practice SAFE, Is the practice EFFECTIVE, Is the practice CARING, Is the practice RESPONSIVE and Is the

practice WELL-LED. As we work to embed the new ways of working with our regulatory body into the Trusts business as usual approach the development of the action plan will align itself to the Key Lines of Enquiries to demonstrate key initiatives and proposed actions that will be feed into the new quality improvement committee.

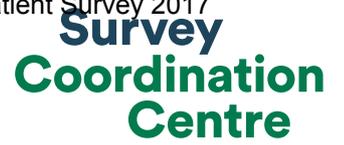
Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 20/06/18

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



Patient survey report 2017

Survey of adult inpatients 2017
Maidstone and Tunbridge Wells NHS Trust

NHS Patient Survey Programme Survey of adult inpatients 2017

The Care Quality Commission

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

Survey of adult inpatients 2017

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

The fifteenth survey of adult inpatients involved 148 acute and specialist NHS trusts across England. Responses were received from 72,778 people, a response rate of 41%. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Trusts sampled patients discharged during July 2017¹. Trusts counted back from the last day of July 2017, including every consecutive discharge, until they had selected 1250 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1st January 2017). Fieldwork took place between September 2017 and January 2018.

Surveys of adult inpatients were also carried out in 2002 and annually from 2004 to 2016. They are part of a wider programme of NHS patient surveys, which cover a range of topics including emergency departments, children's inpatient and day-cases, maternity services and community mental health services. To find out more about our programme and for the results from previous surveys, please see the links contained in the further information section.

The Care Quality Commission will use the results from this survey in our regulation, monitoring and inspection of NHS acute trusts in England. We will use data from the survey in our system of CQC Insight, which provides inspectors with an assessment of performance in areas of care within an NHS trust that need to be followed up. Survey data will also be used to support CQC inspections. NHS England will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health and Social Care will hold them to account for the outcomes they achieve. NHS Improvement will use the results to guide its work to improve the quality of care provided by NHS Trusts and Foundation Trusts.

Interpreting the report

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

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

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

¹37 trusts sampled additional months because of small patient throughputs.

Standardisation

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

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

Scoring

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

It is not appropriate to score all questions in the questionnaire as not all of the questions assess the trusts. For example, they may be descriptive questions such as Q1 asking respondents if their inpatient stay was planned in advance or an emergency; or they may be 'routing questions' designed to filter out respondents to whom following questions do not apply. An example of a routing question would be Q44 "During your stay in hospital, did you have an operation or procedure?" For full details of the scoring please see the technical document (see further information section).

Graphs

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

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

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

Methodology

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

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

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

Tables

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

Scores from last year's survey are also displayed. The column called 'change from 2016' uses arrows to indicate whether the score for this year shows a statistically significant increase (up arrow), a statistically significant decrease (down arrow) or has shown no statistically significant change (no arrow) compared with 2016. A statistically significant difference means that the change in the results is very unlikely to have occurred by chance. Significance is tested using a two-sample t-test.

Where a result for 2016 is not shown, this is because the question was either new this year, or the question wording and/or the response categories have been changed. It is therefore not possible to compare the results as we do not know if any change is caused by alterations in the survey instrument, or variation in a trust's performance. Comparisons are also not able to be shown if a trust has merged with other trusts since the 2016 survey, or if a trust committed a sampling error in 2016. Please note that comparative data are not shown for sections as the questions contained in each section can change year on year.

Notes on specific questions

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

All trusts

Q36: Two new response options, "I was not given any information about my treatment or condition" and "Don't know/ can't remember", were added to question 36 ("How much information about your condition or treatment was given to you?"). As a result data is no longer comparable to the same question in 2016.

Q50 and Q51: The information collected by Q50 "On the day you left hospital, was your discharge delayed for any reason?" and Q51 "What was the main reason for the delay?" are presented together to show whether a patient's discharge was delayed by reasons attributable to the hospital. The combined question in this report is labelled as Q51 and is worded as: "Discharge delayed due to wait for medicines/to see doctor/for ambulance."

Q52: Information from Q50 and Q51 has been used to score Q52 "How long was the delay?" This assesses the length of a delay to discharge for reasons attributable to the hospital.

Q53 and Q56: Respondents who answered Q53 "Where did you go after leaving hospital?" as "I was transferred to another hospital" were not scored for question Q56 ("Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?"). This decision was taken as there is not a requirement for hospital transfers.

Trusts with female patients only

Q11: If your trust offers services to women only, a trust score for Q11 "While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?" is not shown.

Trusts with no A&E Department

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

Questions added and removed for 2017

The following questions are new for 2017 and will therefore have no comparative results:

Q11: "While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?"

Q13: "Did the hospital staff explain the reasons for being moved in a way you could understand?"

Q22: "During your time in hospital, did you get enough to drink?"

Q31: "Did you have confidence and trust in any other clinical staff treating you (e.g. physiotherapists, speech therapists, psychologists)?"

Q43: "If you needed attention, were you able to get a member of staff to help you within a reasonable time?"

Q63: "Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?"

Q71: "Did you feel well looked after by the non-clinical hospital staff (e.g. cleaners, porters, catering staff)?"

The following questions were removed from the 2017 questionnaire (2016 numbering):

Q13: "After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?"

Q14: "While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?"

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

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

Q44: "How many minutes after you used the call button did it usually take before you got the help you needed?"

Q46: "Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?"

Q47: "Beforehand, did a member of staff explain what would be done during the operation or procedure?"

Q50: "Before the operation or procedure, were you given an anaesthetic or medication to put you to sleep or control your pain?"

Q51: "Before the operation or procedure, did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain in a way you could understand?"

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

For more information on questionnaire redevelopment and the rationale behind adding or removing individual questions please refer to the Survey Development Report, available here:

<http://www.nhssurveys.org/survey/2008>

Further information

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

<http://www.cqc.org.uk/inpatientsurvey>

The results for the adult inpatient surveys from 2002 to 2016 can be found at:

<http://www.nhssurveys.org/surveys/425>

Full details of the methodology of the survey can be found at:

<http://www.nhssurveys.org/surveys/1084>

More information on the programme of NHS patient surveys is available at:

<http://www.cqc.org.uk/content/surveys>

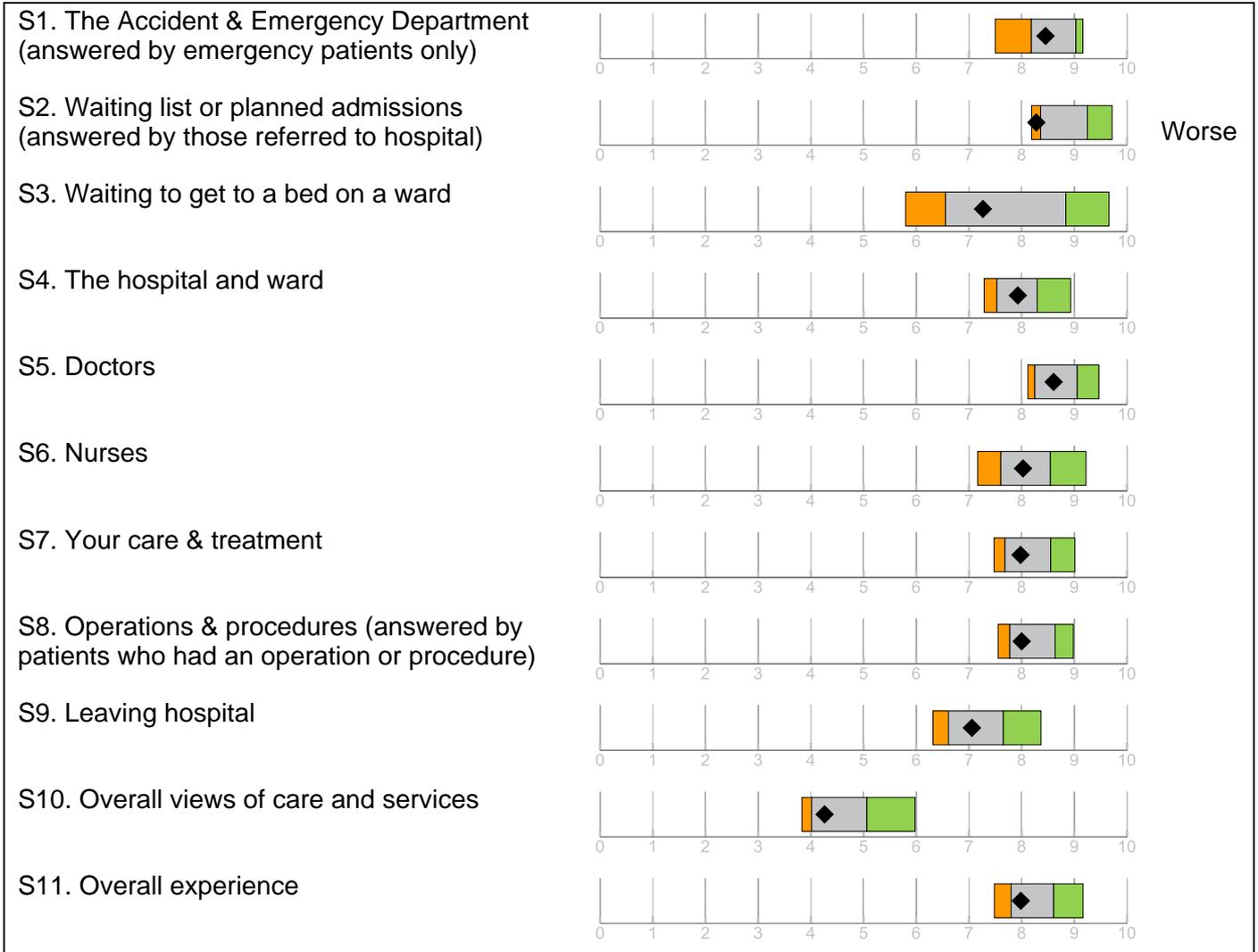
More information about how CQC monitors hospitals is available on the CQC website at:

<http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-nhs-acute-hospitals>

Survey of adult inpatients 2017

Maidstone and Tunbridge Wells NHS Trust

Section scores

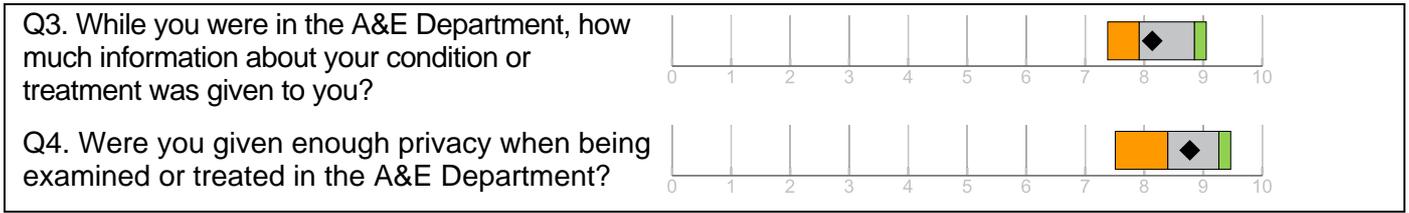


	Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
	About the same		
	Worst performing trusts		
			This trust's score (NB: Not shown where there are fewer than 30 respondents)

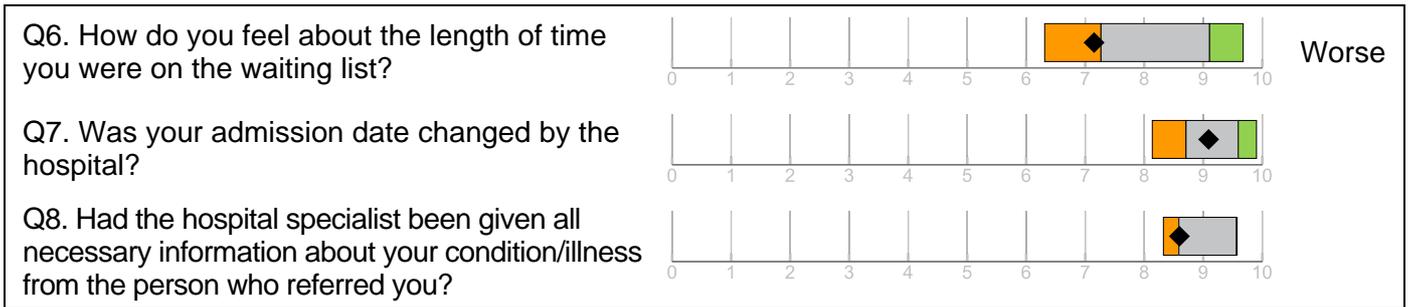
Survey of adult inpatients 2017

Maidstone and Tunbridge Wells NHS Trust

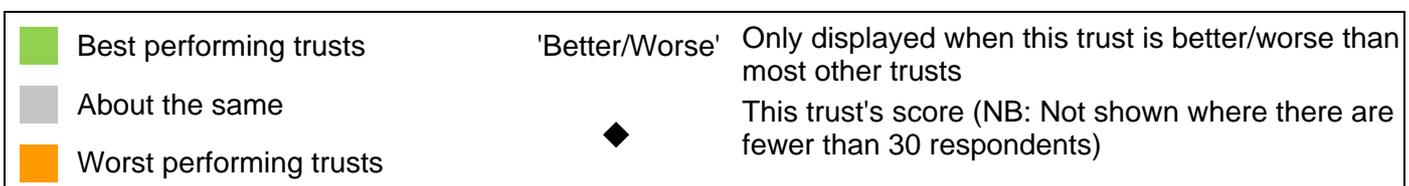
The Accident & Emergency Department (answered by emergency patients only)



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

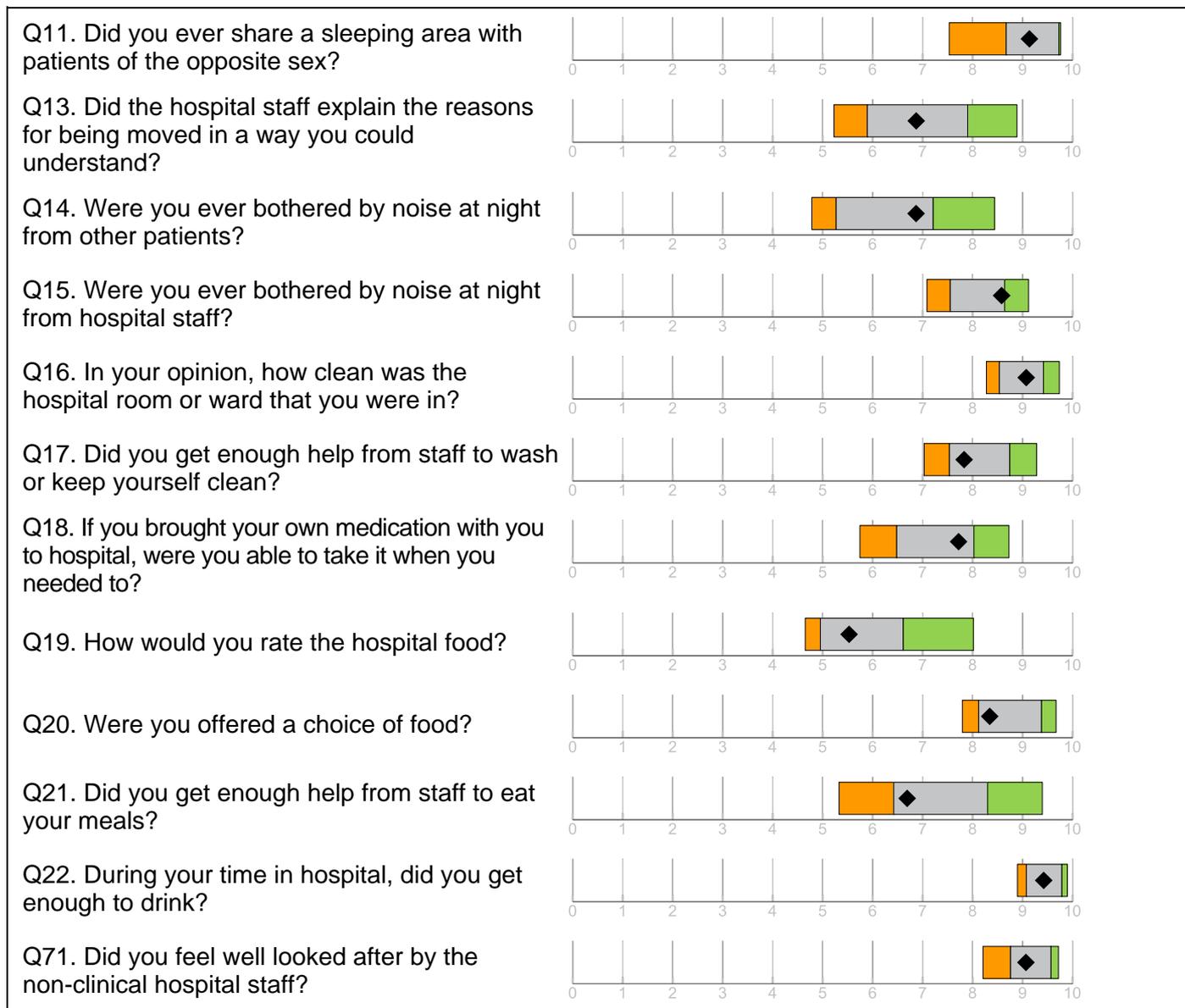


Waiting to get to a bed on a ward

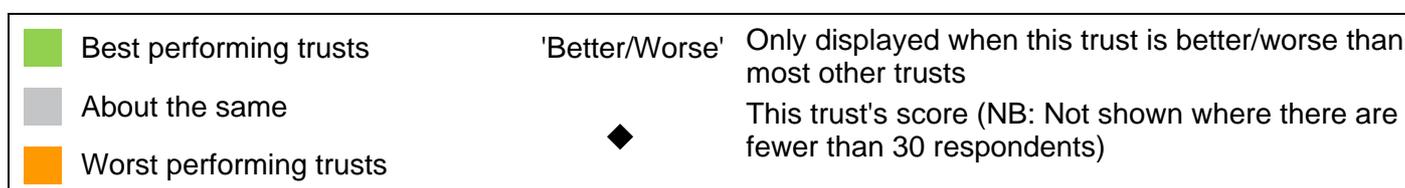
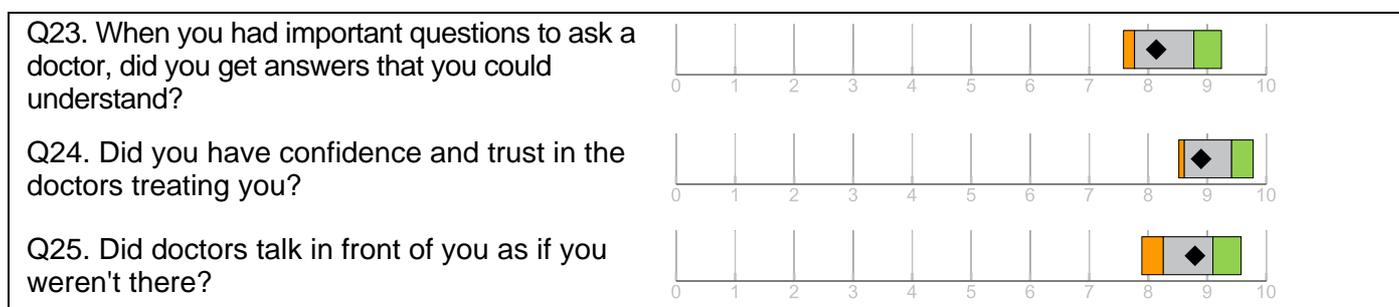


Survey of adult inpatients 2017 Maidstone and Tunbridge Wells NHS Trust

The hospital and ward



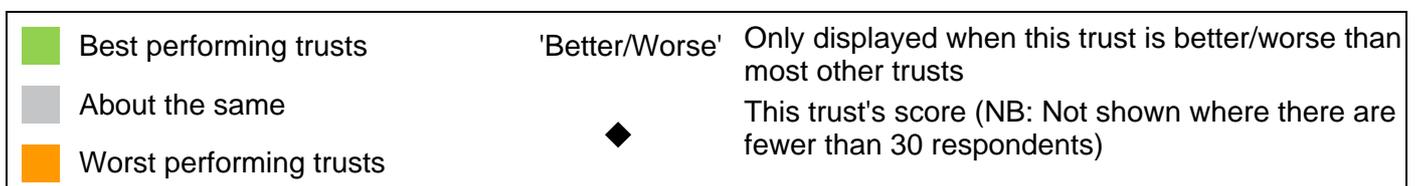
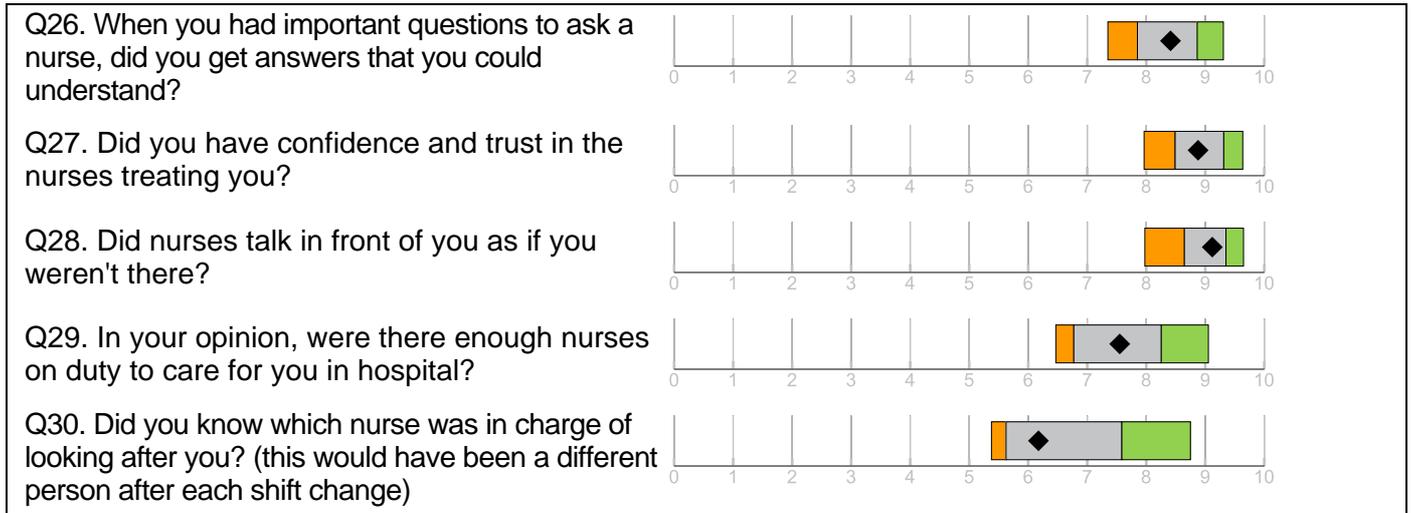
Doctors



Survey of adult inpatients 2017

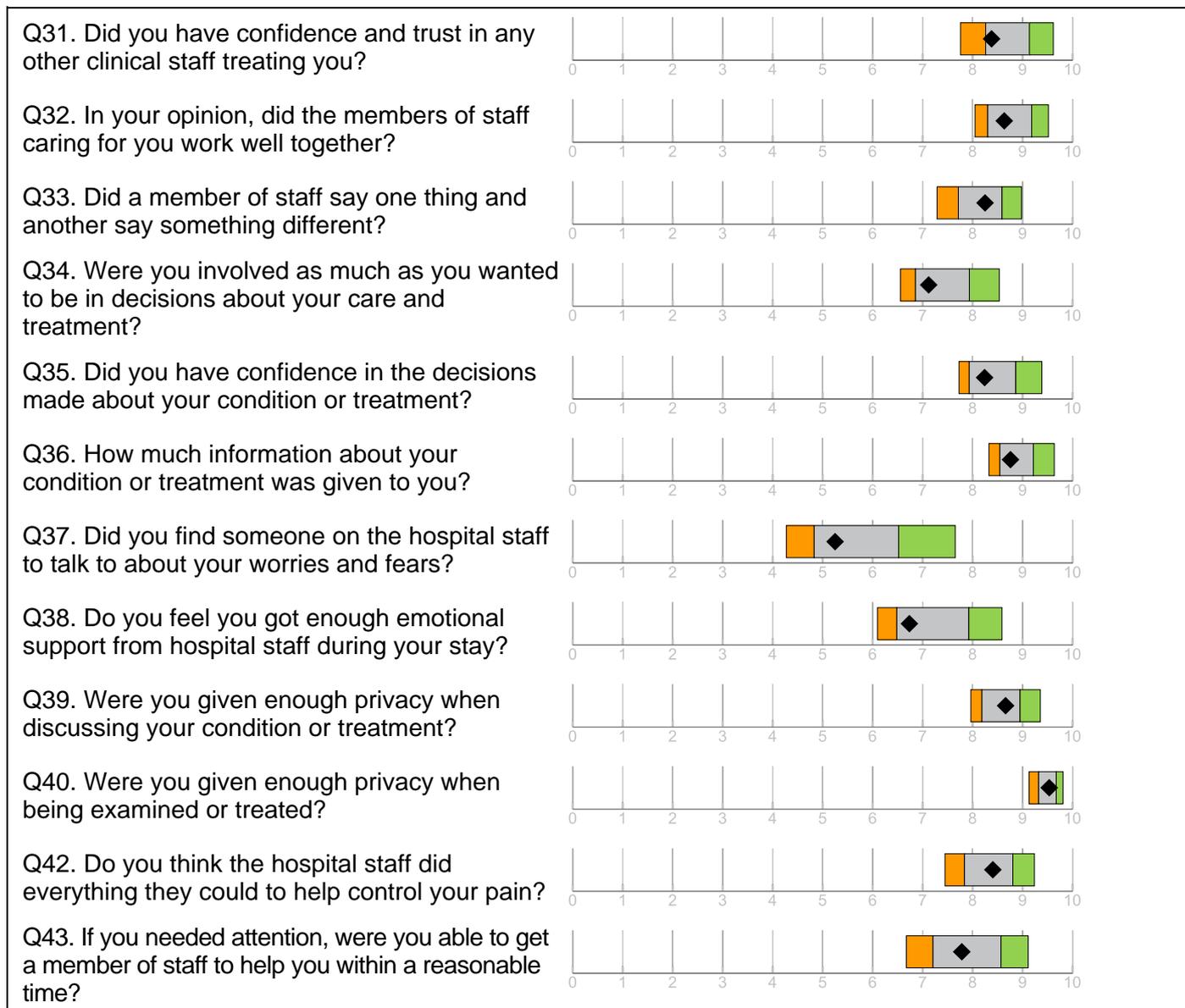
Maidstone and Tunbridge Wells NHS Trust

Nurses

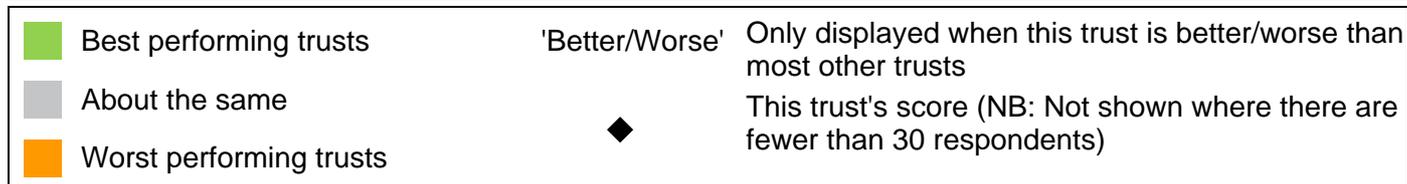
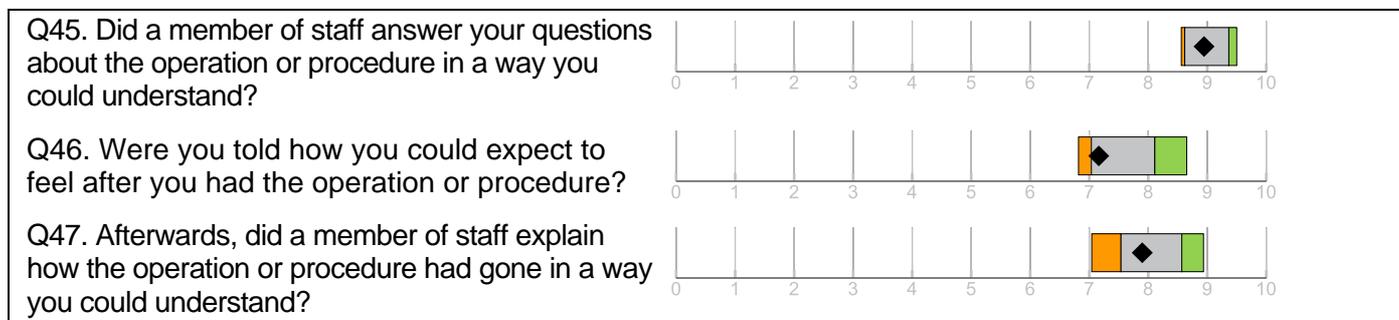


Survey of adult inpatients 2017 Maidstone and Tunbridge Wells NHS Trust

Your care & treatment

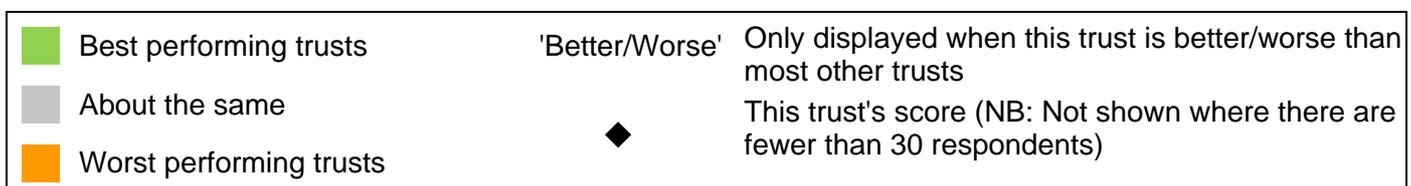
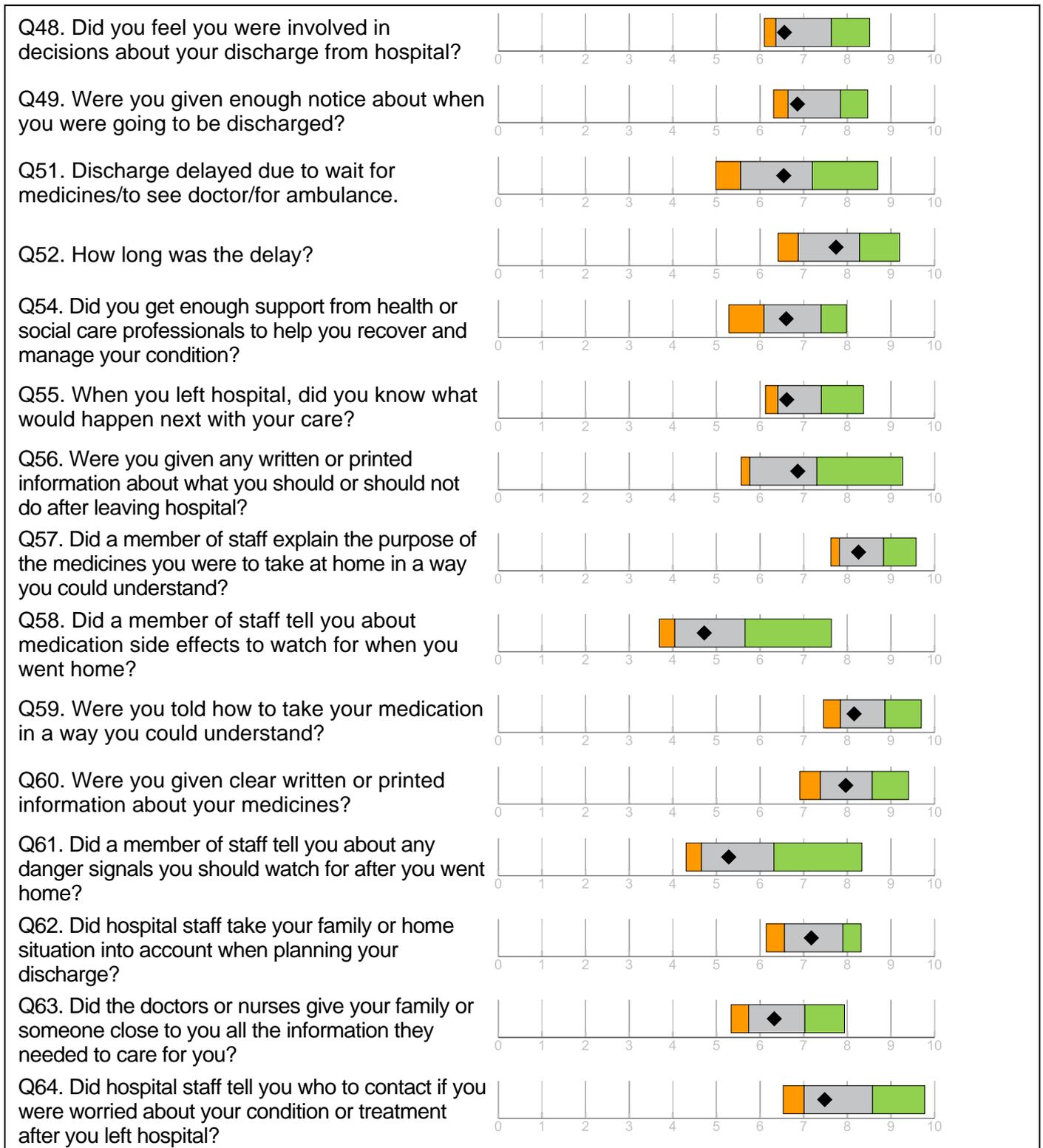


Operations & procedures (answered by patients who had an operation or procedure)



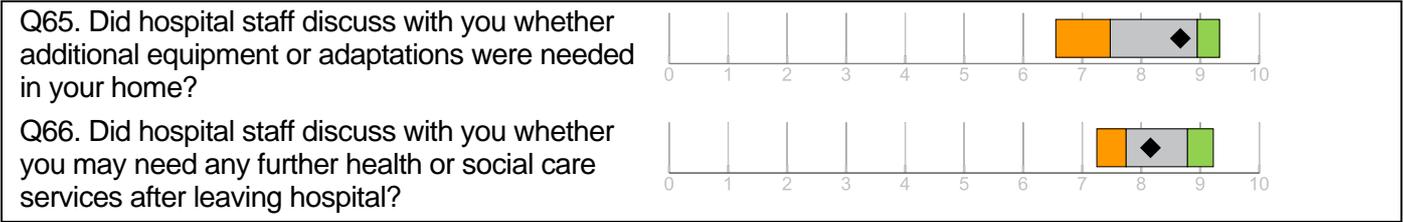
Survey of adult inpatients 2017 Maidstone and Tunbridge Wells NHS Trust

Leaving hospital

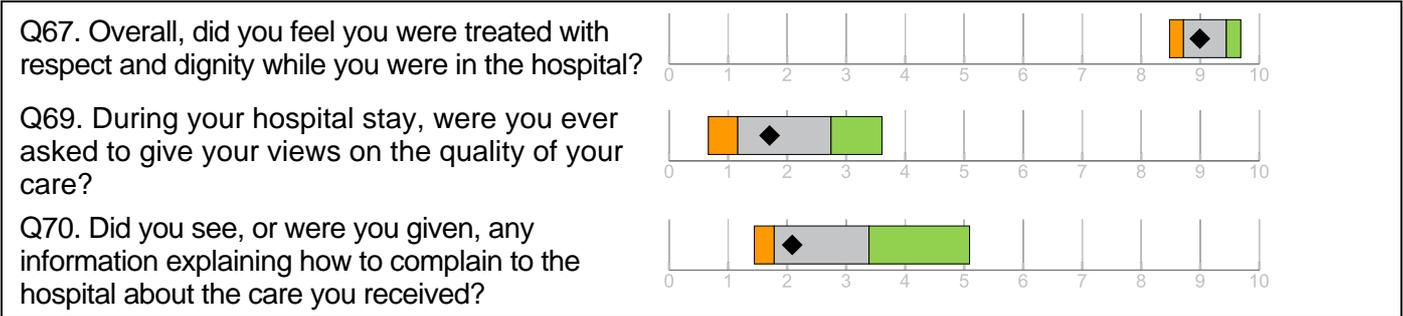


Survey of adult inpatients 2017

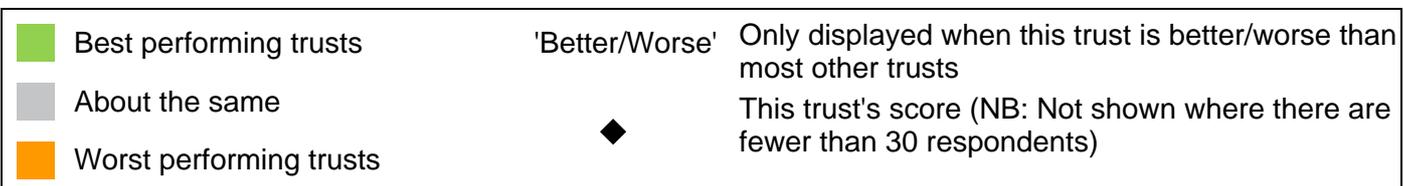
Maidstone and Tunbridge Wells NHS Trust



Overall views of care and services



Overall experience



Survey of adult inpatients 2017

Maidstone and Tunbridge Wells NHS Trust

	Scores for this NHS trust			Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
	Lowest trust score in England	Highest trust score in England				
The Accident & Emergency Department (answered by emergency patients only)						
S1	Section score	8.5	7.5	9.2		
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.1	7.4	9.1	349	7.9
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	8.8	7.5	9.5	384	8.7
Waiting list or planned admissions (answered by those referred to hospital)						
S2	Section score	8.3	8.2	9.7		
Q6	How do you feel about the length of time you were on the waiting list?	7.1	6.3	9.7	146	8.0 ↓
Q7	Was your admission date changed by the hospital?	9.1	8.1	9.9	148	9.0
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	8.6	8.3	9.6	143	9.2
Waiting to get to a bed on a ward						
S3	Section score	7.3	5.8	9.7		
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	7.3	5.8	9.7	576	6.5 ↑

↑ or ↓ Indicates where 2017 score is significantly higher or lower than 2016 score (NB: No arrow reflects no statistically significant change)
Where no score is displayed, no 2016 data is available.

Survey of adult inpatients 2017

Maidstone and Tunbridge Wells NHS Trust

	Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
The hospital and ward						
S4 Section score	7.9	7.3	8.9			
Q11 Did you ever share a sleeping area with patients of the opposite sex?	9.1	7.5	9.8	573		
Q13 Did the hospital staff explain the reasons for being moved in a way you could understand?	6.9	5.2	8.9	118		
Q14 Were you ever bothered by noise at night from other patients?	6.9	4.8	8.4	567	6.3	↑
Q15 Were you ever bothered by noise at night from hospital staff?	8.6	7.1	9.1	565	8.0	↑
Q16 In your opinion, how clean was the hospital room or ward that you were in?	9.1	8.3	9.7	578	9.0	
Q17 Did you get enough help from staff to wash or keep yourself clean?	7.8	7.0	9.3	354	8.4	↓
Q18 If you brought your own medication with you to hospital, were you able to take it when you needed to?	7.7	5.7	8.7	309	7.3	
Q19 How would you rate the hospital food?	5.5	4.7	8.0	539	6.1	↓
Q20 Were you offered a choice of food?	8.3	7.8	9.7	557	8.5	
Q21 Did you get enough help from staff to eat your meals?	6.7	5.3	9.4	124	7.2	
Q22 During your time in hospital, did you get enough to drink?	9.4	8.9	9.9	553		
Q71 Did you feel well looked after by the non-clinical hospital staff?	9.1	8.2	9.7	498		
Doctors						
S5 Section score	8.6	8.1	9.5			
Q23 When you had important questions to ask a doctor, did you get answers that you could understand?	8.1	7.6	9.2	506	7.8	
Q24 Did you have confidence and trust in the doctors treating you?	8.9	8.5	9.8	570	8.7	
Q25 Did doctors talk in front of you as if you weren't there?	8.8	7.9	9.6	568	8.7	

↑ or ↓

Indicates where 2017 score is significantly higher or lower than 2016 score
(NB: No arrow reflects no statistically significant change)
Where no score is displayed, no 2016 data is available.

Survey of adult inpatients 2017

Maidstone and Tunbridge Wells NHS Trust

	Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
Nurses						
S6 Section score	8.0	7.2	9.2			
Q26 When you had important questions to ask a nurse, did you get answers that you could understand?	8.4	7.3	9.3	488	8.2	
Q27 Did you have confidence and trust in the nurses treating you?	8.9	8.0	9.6	573	8.7	
Q28 Did nurses talk in front of you as if you weren't there?	9.1	8.0	9.6	570	8.9	
Q29 In your opinion, were there enough nurses on duty to care for you in hospital?	7.6	6.5	9.1	566	7.8	
Q30 Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	6.2	5.4	8.7	562	6.6	

↑ or ↓

Indicates where 2017 score is significantly higher or lower than 2016 score
(NB: No arrow reflects no statistically significant change)
Where no score is displayed, no 2016 data is available.

Survey of adult inpatients 2017

Maidstone and Tunbridge Wells NHS Trust

	Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
Your care & treatment						
S7 Section score	8.0	7.5	9.0			
Q31 Did you have confidence and trust in any other clinical staff treating you?	8.4	7.8	9.6	326		
Q32 In your opinion, did the members of staff caring for you work well together?	8.6	8.0	9.5	533	8.5	
Q33 Did a member of staff say one thing and another say something different?	8.2	7.3	9.0	567	7.9	
Q34 Were you involved as much as you wanted to be in decisions about your care and treatment?	7.1	6.6	8.5	559	7.2	
Q35 Did you have confidence in the decisions made about your condition or treatment?	8.2	7.7	9.4	563	8.1	
Q36 How much information about your condition or treatment was given to you?	8.8	8.3	9.6	526		
Q37 Did you find someone on the hospital staff to talk to about your worries and fears?	5.2	4.3	7.7	315	5.7	
Q38 Do you feel you got enough emotional support from hospital staff during your stay?	6.7	6.1	8.6	319	6.9	
Q39 Were you given enough privacy when discussing your condition or treatment?	8.7	8.0	9.4	560	8.5	
Q40 Were you given enough privacy when being examined or treated?	9.5	9.1	9.8	562	9.4	
Q42 Do you think the hospital staff did everything they could to help control your pain?	8.4	7.4	9.2	320	8.4	
Q43 If you needed attention, were you able to get a member of staff to help you within a reasonable time?	7.8	6.7	9.1	504		
Operations & procedures (answered by patients who had an operation or procedure)						
S8 Section score	8.0	7.6	9.0			
Q45 Did a member of staff answer your questions about the operation or procedure in a way you could understand?	8.9	8.6	9.5	270	8.8	
Q46 Were you told how you could expect to feel after you had the operation or procedure?	7.2	6.8	8.7	299	7.1	
Q47 Afterwards, did a member of staff explain how the operation or procedure had gone in a way you could understand?	7.9	7.0	8.9	300	7.8	

↑ or ↓ Indicates where 2017 score is significantly higher or lower than 2016 score (NB: No arrow reflects no statistically significant change)
Where no score is displayed, no 2016 data is available.

Survey of adult inpatients 2017

Maidstone and Tunbridge Wells NHS Trust

	Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
Leaving hospital						
S9 Section score	7.1	6.3	8.4			
Q48 Did you feel you were involved in decisions about your discharge from hospital?	6.6	6.1	8.5	546	6.7	
Q49 Were you given enough notice about when you were going to be discharged?	6.9	6.3	8.5	567	6.9	
Q51 Discharge delayed due to wait for medicines/to see doctor/for ambulance.	6.5	5.0	8.7	533	6.0	
Q52 How long was the delay?	7.7	6.4	9.2	532	7.4	
Q54 Did you get enough support from health or social care professionals to help you recover and manage your condition?	6.6	5.3	8.0	292	6.6	
Q55 When you left hospital, did you know what would happen next with your care?	6.6	6.1	8.4	480	6.4	
Q56 Were you given any written or printed information about what you should or should not do after leaving hospital?	6.9	5.6	9.3	533		
Q57 Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.3	7.6	9.6	380	8.0	
Q58 Did a member of staff tell you about medication side effects to watch for when you went home?	4.7	3.7	7.6	330	4.8	
Q59 Were you told how to take your medication in a way you could understand?	8.2	7.5	9.7	351	8.1	
Q60 Were you given clear written or printed information about your medicines?	8.0	6.9	9.4	357	7.9	
Q61 Did a member of staff tell you about any danger signals you should watch for after you went home?	5.3	4.3	8.3	403	5.2	
Q62 Did hospital staff take your family or home situation into account when planning your discharge?	7.2	6.1	8.3	343	7.2	
Q63 Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	6.3	5.3	7.9	369		
Q64 Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.5	6.5	9.8	491	7.5	
Q65 Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	8.7	6.6	9.3	167	8.6	
Q66 Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.2	7.2	9.2	270	8.1	

↑ or ↓

Indicates where 2017 score is significantly higher or lower than 2016 score (NB: No arrow reflects no statistically significant change)
Where no score is displayed, no 2016 data is available.

Survey of adult inpatients 2017

Maidstone and Tunbridge Wells NHS Trust

	Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
Overall views of care and services						
S10 Section score	4.3	3.8	6.0			
Q67 Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.0	8.5	9.7	570	9.0	
Q69 During your hospital stay, were you ever asked to give your views on the quality of your care?	1.7	0.7	3.6	477	1.8	
Q70 Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	2.1	1.4	5.1	413	2.1	
Overall experience						
S11 Section score	8.0	7.5	9.2			
Q68 Overall...	8.0	7.5	9.2	556	8.0	

↑ or ↓

Indicates where 2017 score is significantly higher or lower than 2016 score
(NB: No arrow reflects no statistically significant change)
Where no score is displayed, no 2016 data is available.

Survey of adult inpatients 2017

Maidstone and Tunbridge Wells NHS Trust

Background information

The sample	This trust	All trusts
Number of respondents	588	72778
Response Rate (percentage)	47	41
Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	49	47
Female	51	53
Age group (percentage)	(%)	(%)
Aged 16-35	4	5
Aged 36-50	9	8
Aged 51-65	18	23
Aged 66 and older	70	64
Ethnic group (percentage)	(%)	(%)
White	93	90
Multiple ethnic group	0	1
Asian or Asian British	1	3
Black or Black British	0	1
Arab or other ethnic group	0	0
Not known	6	5
Religion (percentage)	(%)	(%)
No religion	19	16
Buddhist	0	0
Christian	76	77
Hindu	1	1
Jewish	1	0
Muslim	0	2
Sikh	0	0
Other religion	1	1
Prefer not to say	2	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	93	94
Gay/lesbian	1	1
Bisexual	0	0
Other	1	1
Prefer not to say	5	4

Trust Board meeting – June 2018

6-15 Approval of Quality Accounts, 2017/18 Chief Nurse

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

The final draft Quality Accounts for 2017/18 are therefore enclosed, for review and approval.

Earlier drafts have been reviewed by the Chairs of the Quality Committee and the Patient Experience Committee and at the Trust Management Executive meeting (on 20th June).

The Quality Accounts are required to be externally audited, and the External Auditors have provided an “unqualified” conclusion, which is explained in the Auditor’s draft opinion (“Independent Auditors’ Limited Assurance Report comments on the 2017/18 Quality Account for Maidstone and Tunbridge Wells NHS Trust”) which can be found at the end of the Quality Accounts document. At the time of circulation, the Audit work is being finalised (you will note that the detail of some of the information the Auditors review is missing) and it is expected that the External Auditors will sign off their report w/c 25th June. The full report of the External Audit is then scheduled to be reviewed at the ‘main’ Quality Committee on 4th July.

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

Which Committees have reviewed the information prior to Board submission?

- Quality Committee, Chairs Exception due to cancellation of meeting in May
- Patient Experience Committee, Chairs Exception due to cancellation of meeting in June
- Trust Management Executive (TME), 20/06/18

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

Review and approval (for publication)

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

Maidstone and
Tunbridge Wells
NHS Trust



Quality Accounts

2017/18



Quality Accounts

It is the aim of Maidstone & Tunbridge Wells NHS Trust (MTW) to provide safe, sustainable high quality care to our patients. In doing so we endeavour to be improvement driven and responsive to the needs of our patients and staff making MTW a great place to work and visit.

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

Our Quality Accounts for 2017/18 highlight the progress we have made against key priorities for the year to improve services for our patients. We also present those areas that we will be focusing on as priorities for 2018/19.

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

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

Index

Part One

Chief Executive's Statement

Part Two

Prioritising our improvements for 2018/19

Part Three

Quality Overview

Part Four

Appendices A, B and C

Part Five

Stakeholder feedback

Independent Auditors' Limited Assurance Report comments on the 2017/18 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

Statement of Directors' responsibilities in respect of the Quality Accounts

DRAFT

Part One

Chief Executive's Statement

Welcome to our Quality Accounts for 2017/18 which explains some of the many actions we have taken and continue to build upon to improve our patient experience.

Maidstone and Tunbridge Wells NHS Trust (MTW) is committed to becoming even more of a quality-driven organisation in 2018/19 and beyond.

At the start of this year, the Care Quality Commission stated that our Trust has made "significant and sustained improvements" in the quality and safety of our services and that we are a caring organisation.



Miles Scott

While we recognise that we have further to go to be outstanding in everything we do for our patients, the CQC's assessment reaffirms that our quality improvements are making a real difference for our patients at a time of unparalleled demand for NHS care.

This year, we are bringing all of our quality plans together as part of a cohesive approach to improving our patient experience that we are calling Best Care. This will continue our ongoing efforts to become a more caring, sustainable, and improvement driven organisation.

Best Care recognises that to continue our journey of improvement, we need to involve our staff, patients, public and healthcare partners in everything we do. With your help, we can continue to shape our quality improvements to be even more of a patient-centred provider of personalised-care. Patient and public engagement forms an important part of this year's Quality Accounts.

Our hardworking and hugely dedicated teams of healthcare professionals have continued to respond to unprecedented demand for NHS care year on year. As our healthcare needs continue to change, it is important that we have the ability to change too.

MTW continues to be ever-more responsive to our patients and innovative in meeting their needs. This is reflected in our Quality Accounts both in the way that we want to see our patients, and then in the quality of care that we want them to receive.

The information contained within this report represents an accurate reflection of our organisation's performance in 2017/18 and has been agreed by the MTW Trust Board.

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

Follow us on Twitter: www.twitter.com/mtwnhs

Join us on Facebook: www.facebook.com/mymtwhealthcare

Become a member of our Trust: www.mtw.nhs.uk/mymtw

Miles Scott
Chief Executive

Part Two

Quality improvement initiatives

The intention of this section of the report is to provide you with information about the areas that we have highlighted for improvement in the coming year, particularly in relation to the quality of our services and how we intend to assess progress throughout the year. We call these our quality priorities and they fall into three areas: patient safety, patient experience and improvements in clinical effectiveness by focusing improvements in our governance structures.

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

We have chosen three quality improvement priorities in 2018/19 which represent the views of our stakeholders, but are also in line with the Trust's overarching strategy for quality improvement. The quality priorities have been reviewed and agreed by the members of the Patient Experience committee, which include patient representatives and representatives from Healthwatch Kent.

Quality Improvement Priorities 2018/19



Patient Safety

To create reliable processes that will build a supportive environment to reduce avoidable harm.

Key objectives will include:

- Embedding an open and transparent culture that embraces 'lessons learned'
- We aim to achieve consistent recognition and rapid treatment of sepsis in both our emergency and inpatient departments and ultimately reduce the number of avoidable deaths.
- Improvement in outcomes for expectant mothers and their babies in line with 'Better Births' and the National Maternity Transformation work.

Patient Experience

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

Key objectives will include:-

- The development of a patient engagement strategy to ensure views are gained and triangulated with themes and trends from patient survey's, complaints etc to inform strategic direction.
- Continued work with external partners such as Healthwatch, NHSI, CQC and CCG to help inform the board of areas for concern and to address any key issues arising from our Internal Assurance Inspection programme.
- To recognise and respond to the specific needs of our patients with complex needs.

Clinical Effectiveness

To improve the management of patient flow.

Key Objectives will include:-

- Sustaining our previous work to avoid unnecessary admissions to hospital through the development of alternative care models/pathways.
- Working with our mental health partners to reduce the number of frequent attendances of patients in crisis attending our emergency departments.
- Working in collaboration with our community and local authority colleagues to further develop pathways that will support the timely discharge of patients.

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



The opening of the Acute Frailty Unit at Maidstone Hospital June 2017

Patient Safety

Maidstone and Tunbridge Wells NHS Trust is committed to the creation of an open and honest approach to patient safety. This relies on our staff feeling empowered to raise concerns and report incidents and also for our patients to feel at ease by letting us know when the care they receive falls short of expectations.

During the course of 2017/18 we have been working to further enhance our incident recording database so that meaningful data can be extracted to identify themes and trends for learning and development. Although this work is still in progress we remain committed to providing our staff with timely information that will help to direct and improve the care and safety of our patients and staff.

Aim/goal

To create reliable processes that will build and sustain a supportive environment to reduce avoidable harm.

Description of Issue and rationale for prioritising

Building a positive and strong patient safety culture takes sustained time and effort to ensure that both our patients and staff feel supported to raise their concerns. Our aspiration is the transition to an organisation that can demonstrate a 'Just Culture', where blame is eliminated and replaced instead with recognition that saying sorry is the right thing to do when we get it wrong. In addition we want to ensure that our investigations are robust and transparent in the identification of why things went wrong and to then take the most appropriate corrective action to eliminate or minimise any remaining risk to our patients or staff. This should be evidenced in the way our staff and patients are treated when mistakes are made and also by ensuring that the correct support is provided through these challenging times.

Over the course of the year we have already seen progress in the increase of the number of serious incidents and complaints reported. Although this statement may seem counter-intuitive our complaints still remain below the expected parameters for an organisation of our size and in addition we have seen over 10% of our Serious Incidents downgraded. It is however important to recognise the knowledge that is gained during this process, and to not underestimate the value in terms of learning and the improvements that we can then make to benefit patient care.

Identified areas for improvement and progress during 2017/18

The following actions were taken in 2017/18

- The WHO safety checklist has been further revised for use in Theatres to include anaesthetic nerve blocks and to refine the process for the identification and management of specimens.
- An assurance auditing process has been introduced to monitor the standard of WHO checklists.
- A review of the National and Local Standards for invasive procedures (NatSSIPs and LocSSIPs) continues, working with all Directorates and Specialities to ensure these standards are met.
- Human Factors training was delivered in March 2018 and we now have 10 staff from varying specialities and professions trained as 'Trainers'.
- It was our intention to increase the number of reported medication safety incidents, unfortunately we have been unable to achieve this with medication errors reported at similar levels as 2016/17. In addition we aimed to reduce the number of inappropriate omissions of doses of medication, again this has remained static.

- The Medicines Safety News has been regularly published on the Trust Intranet with updates on the latest guidance and learning from recent incidents and medication related issues.
- The observed mortality rates have been reduced in keeping with expected rates and MTW are no longer an outlier amongst our peers.
- Introduction of a revised mortality review process took place in October 2017 as per National Quality Board Guidance (2017) and our mortality review compliance is now demonstrating an improvement.
- We have sustained our trajectory of improvement in the consistent recognition and rapid treatment of sepsis in both our emergency and inpatient departments. These achievements have also been formally recognised and commended by the Secretary for State, for Health and Social care.
- Improving the outcomes for our expectant mothers and their babies has become part of a system wide approach through the work of the Local Maternity system. The benefits include shared learning and a joint approach for strategic improvement. Locally we have introduced a Maternity dashboard which has allowed us to establish a benchmark. Overall these outcomes have remained variable with one notable improvement evidenced in the reduction in still births (refer to pg 42 for more detailed information).

Areas for focus and improvement during 2018/19

Key objectives will include:-

- Embedding an open and transparent culture that embraces 'lessons learned'-
 - This will include increasing the number of incidents that our staff report to support the identification of key themes and trends that require action.
 - Improved monitoring and compliance with Duty of Candour.
 - Sustained effort to reduce our Trust-level mortality figures in line with the national average (HSMR/SHMI) through the improvement in compliance with mortality reviews and the identification of key issues and trends.
 - Development of the learning and training agenda to meet the needs identified.
- The aim to achieve consistent recognition and rapid treatment of sepsis in both our emergency and inpatient departments and ultimately reduce the number of avoidable deaths.
 - Investigation of deaths that we believe are as a result of delayed diagnosis of sepsis.
 - Auditing of both emergency and inpatients to ensure achievement of 90% compliance for screening and treatment of sepsis within 1 hour.
- Improvement in outcomes for expectant mothers and their babies in line with 'Better Births' and the National Maternity Transformation work by-
 - Reducing the number of unanticipated admissions to the neo-natal unit.
 - Reducing the number of still births.
 - Reducing the number of 3rd and 4th degree tears.
 - Reducing the number of unexpected readmissions to the post-natal unit.

Executive lead: Claire O'Brien, Chief Nurse

Board Sponsor: Claire O'Brien, Chief Nurse

Implementation lead: Wendy Glazier, Associate Director of Quality Governance

Monitoring: Patient Experience Committee.

Patient Experience

“How important and how simple it can be to genuinely listen to the views of patients and staff and engage them in how to improve services.” (Professor Sir Bruce Keogh).

At MTW we know that good care is linked to positive outcomes for our patients but we also recognise that a continuous cycle of improvement exists between better patient outcomes and improved levels of staff satisfaction, one impacting on the other. During the recent development of our Trust’s Quality Strategy one of the most important aspects discussed was the need to improve engagement with our patients and the need to improve the care for our patients with complex needs. We are aware and acknowledge that those least likely to complain or speak out will experience the poorest care and we aim to ensure that we live by ‘Our Values’:-

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

Aim/goal

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

Description of Issue and rationale for prioritising

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

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

Identified areas for improvement and progress during 2017/18

The following actions were taken in 2017/18

- The questions previously set have now been extended based on the CQC domains, these are now fully embedded.
- The contract with ‘Iwantgreatcare’ has been renewed. We are actively engaging with the company to ensure that the information requested and produced is meaningful and can provide direction for the service improvements required.
- The MTW Friends & Family representative group is established and are actively working to ensure consistent response rates are maintained across the specialities.
- Regular contact meetings with Healthwatch, the CQC, NHSI and West Kent CCG are in place to seek and provide assurance in regard to standards of care provided to our patients.
- The Internal Assurance Inspection programme and PLACE inspections are established with regular support from our Patient Representatives and West Kent CCG. These provide assurance in regard to the care that our patients experience and this insight helps to provide strategic direction for improvements that are required.

Clinical Effectiveness

MTW remains committed to the optimisation of patient care through the improvement of patient flow. We actively monitor and benchmark our performance to improve clinical quality and efficiency to reduce unwarranted variation with the benefit of the Getting it Right First Time (GIRFT) programme and the Model Hospital (NHSI). In addition we support 'Best Flow' as part of our Best Care Programme. This embraces both latest technology and research thereby improving efficiencies in patient care and ensuring that our patients receive the right care the first time in the most appropriate environment to meet their clinical needs.

Aim/goal

To improve patient flow through the delivery of safe and effective care for patients by whichever pathway of care best meets those needs.

These options should include a variety of options including; support for the self-management of patients with long-term conditions; speciality-led assessment units; ambulatory care pathways; onward referral to other provider organisations who are better able to meet the patients' care needs and for those who are admitted in ensuring the minimum length of stay possible. In addition this will include the ongoing work to support the reduction in bed occupancy rates, achieving the A&E 4 hour access standard, 18 week referral to treatment and cancer access standards.



New A&E Reception TWH 9th February 2018

Description of Issue and rationale for prioritising

Safe and effective care for our patients remains at the heart of this organisation's objectives. For us to be able to deliver this there is a requirement to improve the management of patient flow.

Identified areas of improvement and progress during 2017/18

The following actions were taken in 2017/18

- Ambulatory care pathway models developed within specialities to include respiratory, gynaecology, orthopaedics, general medical and surgical conditions.
- The Acute Frailty Unit opened at Maidstone in June 2017 and at the Tunbridge Wells hospital in March 2018.
- A multi-agency working group to support patients with mental health conditions who frequently attend A&E in crisis has been established and this collaboration has seen the development of recognised plans of care for the highest attending patients. This approach has helped all agencies to be consistent and has ultimately ensured that each patient is redirected to the agreed plan of care at each point of access.
- Although we have not been able to meet the benchmark for the timely access to a ward for stroke patients we have ensured that this has not impacted upon the delivery of care and treatment expected.
- Although we have failed to meet the 4 hour standard from time of arrival for patients with a fractured neck of femur to admission to an orthopaedic ward, our overall performance has remained above that of the national average and that of our peers.

- In collaboration with our community colleagues at Kent Community Health Foundation Trust we have developed the 'Home First model' which supports three discharge pathways; home with support, transfer to a community hospital for further rehabilitation and an interim placement in a nursing home.
- Reduction in delayed transfers of care from 6.72% in 2016/17 to 4.95% 2017/2018 year end.
- Improvement in the percentage of non-elective patients over 65 returned to their original place of residence; during 2016/17 we achieved 70% and for 2017/18 we've increased this to 77.3%.

7 August 2017, via Twitter: @MTWnhs just back from A&E. Very professional, reception, triage, radiology, physio – all done in 2 hours! I didn't feel a nuisance. Thanks!!

8 November 2017, via Twitter: Having spent the last 6 months in and out of hospitals, culminating in major op last month, I've experienced many aspects of the NHS. And what a fantastic service I've had. EVERYBODY has been kind, caring and very skilled. Very impressed and grateful @MTWnhs

8 January 2018, via Twitter: @MTWnhs fantastic, kind, swift treatment for my daughter in paed A&E at Pembury. Grateful for the #NHS

24 January 2018, via Google+: I went to A&E with my son who had a head injury. Had to wait a while but the nurse and drs were great. They kept checking on him every 20 minutes and dr we saw, Iggy, was just great. He rang me at home three times just to check he was ok. That's what I call 110%, just fantastic.

Excerpts from patient feedback in relation to pathways of care.

Areas for focus and improvement during 2018/19

Key Objectives will include:

- Sustaining our previous work to avoid unnecessary admissions to hospital through the development of alternative care models/pathways.
- Working with our mental health partners to reduce the number of frequent attendances of patients in crisis attending our emergency departments.
- Working in collaboration with our community and local authority colleagues to further develop pathways that will support the timely discharge of patients.

Executive lead: Angela Gallagher, Chief Operating Officer

Board Sponsor: Angela Gallagher, Chief Operating Officer

Implementation lead: Lynn Gray, Director of Operations for Urgent Care

Monitoring: Patient Experience Committee

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

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

DRAFT

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

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



- Assessment or medical treatment for persons detained under the Mental Health Act 1983 (at both hospital sites).
- Diagnostic and screening procedures (at both hospital sites).
- Family planning services (at both hospital sites).
- Maternity and midwifery services (at both hospital sites plus the Crowborough Birth Centre).
- Surgical procedures (at both hospital sites).
- Termination of pregnancies (at Tunbridge Wells Hospital only).
- Treatment of disease, disorder or injury (at both hospital sites).

No conditions or enforcement actions were applied to the registration during 2017/18.

The Nominated Individual for the Trust's Registration is Claire O'Brien, Chief Nurse.

During 2017/18 the Trust provided and/or subcontracted acute and specialised services to NHS patients through our contracts with Clinical Commissioning Groups, Kent County Council and NHS England. The available data on the quality of care for all of these NHS services has been formally reviewed.

The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or sub-contracting of, NHS services.

Reviewing standards

To ensure that we are providing services to the required standards the Trust supported a number of reviews of its services during 2017/18, undertaken by external organisations such as:

- HEKSS Pharmacy Programme Review – 11th April, 2017
- South East London, Kent & Medway- Centre for Trauma Sciences (SELKaM) Peer Review – 5th May, 2017
- Quality Surveillance Assessment –Cancer Acute Oncology Service – June 2017
- Quality Surveillance Assessment –Cancer Brain and Central Nervous System (Adult)– June 2017
- Quality Surveillance Assessment –Chemotherapy (Adult) – June 2017
- Quality Surveillance Assessment –Cancer Head and Neck (Adult) – June 2017
- Quality Surveillance Assessment –Cancer Malignant Mesothelioma (Adult) – June 2017
- Quality Surveillance Assessment –Cancer Oesophageal and Gastric (Adult) – June 2017
- Quality Surveillance Assessment –Cancer Unknown Primary – June 2017
- Quality Surveillance Assessment –Acute Oncology Service – June 2017
- Quality Surveillance Assessment –Complex Gynaecology – Specialist Gynaecological Cancers – June 2017
- Quality Surveillance Assessment - Haemato-oncology – June 2017
- Quality Surveillance Assessment - Local Breast Cancer Team – June 2017
- Quality Surveillance Assessment - Local Colorectal Services – June 2017
- Quality Surveillance Assessment - Local Lung Cancer Team – June 2017

- Quality Surveillance Assessment - Local Urology – June 2017
- Quality Surveillance Assessment – Paediatric Oncology – June 2017
- Haemato-oncology HEKSS O&G Programme Risk-based Review – 6th June, 2017
- HEKSS Medicine Programme Risk-based Review – 6th June, 2017
- HEKSS Surgery Programme Risk-based Review – 6th June, 2017
- Pharmacy; Aseptic Units, Regional Quality Assurance – 5th July & revisit 18th October 2017
- Pearson (Edexcel) – Diploma in Healthcare Support – 18th July, 2017
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) – Histology and cytology – August 2017
- West Kent & Medway Bowel Cancer Screening Assurance Visit to Endoscopy- 19th August 2017
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) – Microbiology – September 2017
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 17043) – SE England General Histopathology EQA scheme – 27th September, 2017
- Neonatal Peer Review Visit (NHSE) – 3rd October 2017
- Care Quality Commission (CQC) – Unannounced inspection (all services)– 18th -19th October, 2017
- Care Quality Commission (CQC) – Unannounced inspection (Paediatrics)– 7th -10th November, 2017
- Care Quality Commission (CQC) – Unannounced inspection (Acute & Emergency Medicine)– 16th -23rd November, 2017
- Care Quality Commission (CQC) – Full announced Well-Led inspection – 12th – 13th December 2017
- HSE inspection of CL3 laboratories (microbiology) – 6th December, 2017
- Kent police – Counter Terrorism Crime and Security Act Annual Inspection – 6th December, 2017
- Pearson (Edexcel) - Diploma in Healthcare Support – 18th December, 2017
- Emergency Care Improvement Programme (ECIP) – January & February, 2018
- Care Quality Commission (CQC) – Announced Inspection (Paediatrics) 1st February, 2018
- NHSI Intensive Support Team – review of Cancer Governance Processes- 9th February, 2018
- Kent Fire & Rescue Service – February 2018
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) - Blood Sciences – February 2018
- Emergency Care Improvement Programme (ECIP) – March, 2018
- General Medical Council; Trainee & Trainer Survey – opened March 2018
- Environment Agency (Radioactive substances regulation) – Maidstone Hospital – 19th March 2018
- Counter Terrorism Security Adviser (Oncology) – Maidstone Hospital – 19th March 2018

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

- Internal assurance inspections (CQC style) with participation from our patient representatives and Quality Leads from West Kent CCG.
- Internal PLACE reviews.
- Infection Control including hand hygiene audits.
- Corporate Quality Rounds.
- Trust Board member “walkabouts”.

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

25 July 2017, via Twitter: @MTWnhs Just wanted to say thanks and well done to the Eye Clinic team today after my first ever visit. Calm and welcoming and spotless.



Hygiene audits to check service quality

DRAFT

National Clinical Audits for inclusion in Quality Accounts 2017/18	Participation Y, N or NA	No of cases submitted	% cases submitted	Comments
BAUs Urology Audits: Nephrectomy Audit	Y	MGH – 52	100%	
BAUs Urology Audits: Percutaneous Nephrolithotomy (PCNI)	Y	MGH – 38	100%	
Specialist Rehabilitation for patients with complex needs following major injury (NCASRI)	N/A			MTW does not provide this service
BAUs Urology Audits: Urethroplasty Audit	N/A			MTW does not provide this service
Blood transfusion				
(National Comparative Audit of Blood Transfusion Programme) – Audit of red cell and platelet transfusion in adult haematology patients	Y	MTW Trust - 39	97.5%	
2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	Y	MTW Trust - 19	n/a	
Audit of Patient Blood Management in Scheduled Surgery – Re-audit September 2016	Y	MTW Trust - 22	n/a	
Serious Hazards of Transfusion (SHOT) UK. National haem vigilance scheme	Y	MTW Trust – 25	100%	Continual data collection
Cancer				
Lung Cancer (NLCA)	Y	MTW Trust - 307	100%	
Bowel Cancer (NBOCAP)	Y	MTW Trust Patient-383 Tumour-383 Surgery-217 Pathology – 152 Chemo - 129	100%	
National Prostate Cancer Audit (NPCA)	Y	MTW Trust Diagnosis- 354 Symptom-183 Treatment-120	100%	
Oesophago-gastric cancer (NAOCCG)	Y	MTW Trust Tumour – 203 CT Scan - 199	100%	
National audit of Breast Cancer in Older people (NABCOP)	Y	MTW Trust - 600	100%	
Head and Neck Cancer (DAHNO)	N	MTW Trust - 0	0%	Data is still being collected but we are still unaware of the parameters in order to quality check and submit data via infoflex-. The DAHNO project coordinator has said that there is no deadline for submitting this data.
Heart				
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Y	TWH – 180 MGH – 160		Data collection still open and data being submitted
National Heart Failure Audit	Y	TWH – 204 MGH - 191		Data collection still open and data being submitted
Coronary angioplasty/ National audit of Percutaneous Coronary Interventions (PCI)	Y	MTW Trust - 272		Data collection still open and data being submitted

National Clinical Audits for inclusion in Quality Accounts 2017/18	Participation Y, N or NA	No of cases submitted	% cases submitted	Comments
Cardiac Rhythm Management (CRM)	Y	MTW Trust- 351		Data collection still open and data being submitted.
National Cardiac Arrest Audit (NCAA)	Y	MTW Trust - 175	100%	Continuous data collection.
Adult Cardiac surgery	N/A			MTW does not provide this service
National Congenital heart disease (CHD)	N/A			MTW does not provide this service
National Audit of Pulmonary Hypertension	N/A			MTW does not provide this service.
Long Term Conditions				
National Adult Diabetes Inpatient Audit (NaDIA)	Y	TWH – 54 MGH – 45	100%	
National Diabetes Foot Care Audit	Y	MTW Trust – 47	100%	This only includes inpatients. Outpatients are submitted by the community teams.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Pulmonary Rehabilitation	N/A			No data collection in 2017-18
National Chronic Obstructive Pulmonary Disease (COPD) Audit - Secondary Care	Y	MGH = 230 TW = 161		Data collection still open and data being submitted
Inflammatory Bowel Disease (IBD) Programme /IBD Registry	Y	MTW Trust – 141		Continual data submission
Endocrine and Thyroid National Audit	Y	MTW Trust - 80	100%	
National audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	N/A			No data collection in 2017-18
National Core Diabetes Audit (NDA)	Y	TWH – 2200 MGH – 1450	100%	
National Audit of Anxiety and Depression	N/A			MTW does not provide this service
UK Parkinson's audit	Y	TWH – 40 MGH – 40	100%	
Older People				
Falls and Fragility Fractures Audit Programme (FFFAP)	Y	1. Inpatient Fall (NAIF) TWH – 30 MGH – 30	1. 100%	1. All data submitted
	N/A	2. Fracture Liaison Service Database organisational data	2. N/A	2. MTW does not provide this service. This is a community service.
	Y	3. National Hip Fracture Database MTW Trust - 503	3. 91.2%	3. Data collection still open and data being submitted
National Audit of Dementia (in General Hospitals) (Spotlight audit)	Y	Clinical data TWH – 20 MGH – 30	100%	
Sentinel Stroke National Audit Programme (SSNAP)	Y	1. Organisational 2. Clinical Data MGH: - 368 TWH: - 444	1. N/A 2. 100%	1. No Organisational collection in 2017-18 2. Data collection still open and data being submitted
Other				
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement,	Y	MTW trust: Hip: 103 Knee: 135	100%	Report received. Partial assurance.

National Clinical Audits for inclusion in Quality Accounts 2017/18	Participation Y, N or NA	No of cases submitted	% cases submitted	Comments
Groin Hernia, Varicose Vein		Groin: 32 Varicose: N/A		
National Ophthalmology Adult Cataract Surgery Audit	N	0	0%	Registered to participate. Software link received but trust not able to establish workable connection. Still in process of establishing link to enable data collection.
National Audit of Care at the End of Life (NACEL)	N/A			On quality accounts list but no data collection during this period.
National Bariatric Surgery Registry	N/A			MTW does not provide this service
Learning Disability Mortality Review Programme (LeDeR)	N/A			Staged introduction across England
National audit of Intermediate Care (NAIC)	N/A			MTW does not provide this service
NHS England 7 Day Hospital Study - March 2017	Y	MTW Trust -110	49%	Difficulty in obtaining sufficient numbers of case notes within the timeframe set.
NHS England 7 Day Hospital Study - September 2017	Y	MTW Trust - 103	57%	Difficulty in obtaining sufficient numbers of case notes within the timeframe set.
Mental Health				
Prescribing Observatory for Mental Health (POMH – UK) Prescribing antipsychotics for people with dementia	N/A			MTW does not provide this service
Prescribing Observatory for Mental Health (POMH – Assessment of side effects of depot and LA antipsychotic medication	N/A			MTW does not provide this service
Prescribing Observatory for Mental Health (POMH – UK) Monitoring of patients prescribed lithium	N/A			MTW does not provide this service
Prescribing Observatory for Mental Health (POMH – UK) Prescribing for bipolar disorder (use of sodium valproate)	N/A			MTW does not provide this service
Prescribing Observatory for Mental Health (POMH – UK) Rapid tranquilisation	N/A			MTW does not provide this service
Suicide and homicide and sudden unexplained death	N/A			MTW does not provide this service
Women's and Children's Health				
Neonatal Intensive and Special Care (NNAP)	Y	MTW: 492	100%	
MBRRACE-UK; Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal morbidity confidential enquiries (reports every second year)	Y	MTW: 0	100%	No patients fitted the criteria for selection for this study.
MBRRACE-UK; Perinatal Mortality Surveillance	Y	MTW Trust Stillbirth: 19 Neonatal:5 Extended Perinatal:24	100%	

National Clinical Audits for inclusion in Quality Accounts 2017/18	Participation Y, N or NA	No of cases submitted	% cases submitted	Comments
MBRRACE-UK; Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal Mortality surveillance and mortality confidential enquiries (reports annually)	Y	MTW: 0	100%	No patients fitted the criteria for this study.
MBRRACE-UK; Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Y	MTW Trust Stillbirth: 19 Neonatal: 5 Extended Perinatal: 24	100%	
Paediatric Inflammatory Bowel Disease	Y	MTW Trust - 53	100%	Continual data submission.
National Maternity and Perinatal Audit (NMPA)	Y	MTW Trust 6070 births	100%	
National Pregnancy in Diabetes Audit	Y	MTW Trust - 27	84%	Some cases not submitted as consent not obtained
Paediatric Intensive Care Audit Network (PICANet)	N/A			MTW does not provide this service
Paediatric Pneumonia	N/A			On quality accounts list but no data collection during this period
National Paediatric Diabetes Audit (NPDA)	Y	TWH: 107 MGH: 118	100%	Ongoing data submission, final date for 2017/18 data is 31 st May 2018.
National Audit of Seizure and Epilepsies in Children and Young Adults (Epilepsy 12)	N/A			On quality accounts list but no data collection during this period
National Confidential Enquiries				
NCEPOD: Peri-operative Diabetes	Y	MTW Trust 11	82%	Data collection still ongoing. Data collected from Surgeons and Anaesthetists.
NCEPOD: Acute Heart Failure	Y	MTW Trust 12	50%	
NCEPOD: Cancer in Children, Teens and Young Adults	Y	No patients met the inclusion criteria.	NA	Organisational data submitted. No patients met the inclusion criteria for the study.
Child Health Clinical Outcome Review Programme: Young Peoples Mental Health	Y	MTW Trust 7	43%	
NCEPOD: Pulmonary Embolism	N/A			On quality accounts list but no data collection during this period
NCEPOD: Acute Bowel Obstruction	N/A			On quality accounts list but no data collection during this period
Child Health Clinical Outcome Review Programme: Long term ventilation in children, young people and young adults.	N/A			On quality accounts list but no data collection during this period

59 national audits were published in 2017/2018 with actions taken to address areas of non- or partial compliance. A number of improvements have been made in line with national recommendations, including:-

National Emergency Laparotomy Audit (NELA) 2017 - We have continued to utilise an evidence based bundle of interventions forming our Emergency Laparotomy pathway. Additionally this year we have introduced a process of multi-disciplinary review of patients with a predicted mortality rate greater than 20%. This ensures that there is Consultant Surgeon, Anaesthetist and Intensivist involvement in the decision making process for the most high risk patients where surgery is being considered.

Trauma & Audit Research Network (TARN) - Highlighting the process in getting patients to CT scan has led to a substantial improvement in getting patients with head injuries to CT scan within the 60 minutes recommended in the NICE guidelines. This enables a quicker diagnosis and where applicable, quicker transfers to King's College Hospital for specialist treatment.

National Bowel Cancer Audit (NBOCA) 2017 - Following on from the 2016 national report actions were taken to ensure completeness of data reporting to improve NBOCA submission by entering all data following Multi-Disciplinary Team (MDT) discussions directly onto the trusts data recording system. Continual dialogue between surgeons takes place to ensure patients are fully informed of all surgical options available to them. Where cases are likely to need more community input, the individual surgeon will liaise with the GP to identify potential problems and make plans for discharge.

The Trust's mortality rates are lower than the national and regional average and we have good 90 day mortality rates compared with the regional and national figures. Our 18 month stoma rates are also better than the national average (48% v 52%) and stomas are closed at the earliest opportunity following completion of cancer treatment.

National Maternity and Perinatal Audit (NMPA) 2015-16 - From August 2016, a multidisciplinary team at MTW introduced a number of low-cost initiatives to help reduce rates of 3rd and 4th degree tears. These initiatives included slow birth techniques and warm perineal compresses. Each of these interventions were introduced as the result of research evidence and after appropriate staff training, new guidelines and information being made available to women. Rates have reduced over the last twelve months.

MBRRACE-UK; Maternal, Newborn and Infant Clinical Outcome Review Programme; National Perinatal Mortality Surveillance (reports annually) 2015 - The Trust is fully committed to addressing inequalities in neonatal mortality and is one of sixteen organisations leading the development of the Kent and Medway Local Maternity System 5 Year Plan. From May 2016 the Gap and Grow programme was introduced which ensures women at high risk of Intrauterine Growth Restriction receive serial growth scans and customised growth charts are used for all pregnancies.

Hip Fracture Database - A business case has been developed to open an additional theatre in an effort to ensure that our patients get to theatre for their procedures within the optimum 36 hour time frame. Work is currently being undertaken to identify sufficient staffing levels to enable this additional theatre to open.

National audit of Breast Cancer in Older people - MTW will be carrying out formal patient survey's to establish whether the patient felt adequately informed about their planned treatment. We will be auditing our Breast Care guidelines to establish how we fair compared to the regional results from this national audit.

HQIP National Paediatric Diabetes Audit (NPDA) 2016 - Plans are already being made to improve education with regard to transition from the paediatric team to the young adult team. A new pro forma has been developed for use at point of diagnosis to assist staff in carrying out all the required health checks including blood taking. The diabetes clinical support worker will contact those who are having annual reviews to see if they can come earlier than the appointment time in order to have their bloods taken and urine tests completed prior to the appointment.

Royal College of Emergency Medicine National Consultant Sign-Off 2016 - Patients who present at Emergency Departments (ED) with either atraumatic chest pain (30 years and over), fever (children under 1 year), or abdominal pain (70 years and over), or patients making an unscheduled return to the ED with the same condition within 72 hours of discharge should have a review by a consultant or senior level staff prior to their discharge.

Additional consultants and senior staff have been appointed to ensure that patients receive a consultant or senior review prior to discharge from the emergency department for patients with these high risk conditions. This helps to improve clinical outcomes by reducing clinical risk and ensures that patients are only admitted to hospital if there is no reasonable alternative.

There is also now a dedicated Paediatric Unit within the Emergency Department where paediatric patients under one year presenting with fever are seen by staff specifically trained in the care of children.

National audit of Dementia in General Hospitals - Additional training has been developed for the role of our ward Dementia Champions, these are members of staff who are to provide support and advice to staff 24 hours per day, 7 days a week where staff members seek this support role when they are nursing patients with dementia. The Comprehensive Geriatric assessment (CGA) is to be utilised alongside other care pathways to ensure a robust mechanism is in place for assessing delirium in people with dementia.

Please see Appendix A for full details of progress against each of the reported national audit results 2017/18

Improvements to clinical practice from local audits

A number of improvements have been made as a result of the **134** completed local clinical audits, across all Directorates, in 2017/18, **43** of these were local re-audits. Trust staff identified local areas of concern/interest, reviewed their practice and made recommendations for change. Staff actively use clinical audit as a quality improvement process to improve patient care and outcomes through a systematic review against explicit criteria. Improvements include:

Actions taken following local audits 2017/2018	Trust Actions
Radiology	An audit carried out by the radiology team to assess an efficient method of faecal tagging without the use of a full laxative regime. It was found that patients who had taken 100mls of Gastrograffin instead and followed a specific diet plan prior to their CT Colonography (CTC) had adequate tagged residual faecal matter. This confirms that Gastrograffin is extremely effective for its cathartic effect and ability to uniformly opacify faecal residue, thus maintaining the sensitivity and specificity of CTC examinations without the need for a full laxative regime thus reducing the associated side-effects and interruptions to daily routines for patients who would normally have a full laxative regime.
Radiotherapy	The Radiotherapy Team at Maidstone and Tunbridge Wells Hospital re-audited the avoidance of gaps in the radiotherapy treatment schedule for all category 1 patients. Changes implemented from the previous audit included that all staff revise the treatment prescription for patients that have missed several treatments due to being too ill to attend, and to hyperfractionate for the days rested due to a treatment re-plan. This re-audit demonstrated that full assurance was achieved.
Paediatrics	Surfactant is a proven and effective treatment for lung disease of preterm babies with surfactant deficiency lung disease and is a mainstay of neonatal intensive care management. Following the first round of this audit, a departmental guideline was introduced to ensure that preterm babies receive their doses of surfactant at the optimum times. The re-audit shows that our results have improved for babies over 28 weeks. Effective recommended doses reduce the number of doses required for our neonatal patients, reduces the duration of ventilation and the risk of ventilation induced lung injury and chronic lung disease.
Obstetrics	Caesarean section rates are increasing nationally and it is a common, but high risk procedure. We need to ensure that we are meeting nationally agreed standards in our management of these cases. Following a previous round of this audit the team implemented an E3 electronic maternity information system to improve recording of all aspects of care provided to patients. The re-audit has shown a significant improvement in the recording of information and provides a more complete picture of our management of this service.
Gynaecology	Most patients that present with post-coital bleeding have a benign diagnosis, however serious pathologies can be missed by clinicians without adequate experience. After the last audit, a Postcoital Bleeding referral pathway was developed for use by GPs and junior doctors. Significant improvements have been noted in this re-audit, with 100% of patients with abnormal bleeding now being referred to the Trust Colposcopy Clinic.
Sexual Health	Patients diagnosed with a CD4 HIV count of greater than 500 can expect to live as near-normal life expectancy compared to those without HIV. A delay in diagnosis of HIV can affect morbidity as well as mortality causing a significant reduction in life expectancy. In order to ensure that all at risk patients are identified, the Respiratory Team are now offering screening to all patients attending their clinics that are categorised as being at risk. Gastroenterology and ENT are also working with Sexual Health to develop their service to assist in diagnosing HIV at the earliest point of contact with the Trust.
Ophthalmology	Diabetic retinopathy is the leading cause of blindness in people of working age in the United Kingdom. It may affect patients with both type 1 and type 2 diabetes but prevalence is higher in type 1 diabetics. Actions from a previous

Actions taken following local audits 2017/2018	Trust Actions
	<p>round of this audit include: increased staff awareness and familiarity with the care pathway; use of a listing form for laser treatment; better communication through documentation; a dedicated team co-ordinating the treatment timeline; patients being contacted prior to their appointments as a reminder and an increase in the number of laser lists have all contributed to improvement in patient care and better utilisation of clinic slots. A business case was also put forward for equipment to deliver Pattern Scanning Laser Treatment (PASCAL) which is in the process of review.</p>
General Medicine	<p>The British National Formulary (BNF) advises that patients weighing between 10 and 50 kg should not receive more than 15mg/kg IV paracetamol every 4 to 6 hours. An audit was carried out which showed that not all appropriate patients were having the dose adjusted. Following the audit, education sessions were held for junior doctors and nursing staff highlighting the need to weigh patients and to ensure this weight is documented in the patient health record. It has also highlighted the importance of reviewing the drug chart and adjusting the dose of paracetamol according to weight. A re-audit was performed which showed that 84% of patients now had their dose adjusted, an improvement of 32%. In order to continue to improve a paracetamol prescribing flowchart is to be made available in all clinical areas and a further audit will be carried out.</p>
Respiratory	<p>The National Patient Safety Agency (NPSA) report from January 2005 to March 2008 reported a national figure of 12 deaths and 15 episodes of serious harm from chest drain insertion (NPSA, 2008). As a result of a local audit the following actions were implemented: development and use of a chest drain insertion pathway, a pre-procedure check-list for nurses and quick reference guide for doctors for wards that regularly use chest drains. Real-time imaging for the placement of chest drain for pleural effusions and teaching sessions for clinicians on the insertion and management of chest drains. This re-audit showed an improvement in the use of Ultrasound guidance, analgesia and the level of written consent gained prior to the procedure being carried out.</p>
Acute Medicine	<p>In recent years our trust has witnessed a significant rise in emergency medical admissions along with reduction in the number of hospital beds. Acute Medical Units (AMUs) provide a timely service which is supported by a multidisciplinary team. The Society of Acute Medicine has recommended that patients admitted to AMU should have an initial review by a junior doctor within 4 hours and a consultant review for patients arriving between 08:00 and 18:00 within 8 hours. An initial audit showing that 88% of patients were reviewed by a junior doctor within 4 hours and 99% of patients had a consultant review within 8 hours. Teaching sessions were held for clinicians to reiterate the importance of documenting time of patient review and updating the 'pink' handover list to ensure patients were seen appropriately. A re-audit was carried out which showed an improvement in the time of junior doctor review (now 91%) but a small dip in the time of consultant review (now 90%), it was felt this was down to documentation issues rather than lack of patient review. Timely review and good management planning by a competent decision making doctor and post-take ward round (PTWR) by consultant is vital for early identification of potentially sick/deteriorating patients or well patients for potential early discharge, thus relieving bed pressures.</p>
Tissue Viability	<p>Pressure ulcers are a complex health problem arising from many interrelated factors. Prevention and treatment are paramount to ensure patient comfort and care. Actions from the previous round of auditing include: A trust wide education campaign to reduce the overall numbers of moisture associated skin lesions; working with individual wards to raise knowledge of pressure damage prevention and treatment; a rapid review process of all category 2 ulcers by the Tissue Viability Service. These actions have led to a sustained and continued improving picture in the reduction of pressure damage and an improvement in the assessment of patients when they are admitted to hospital. This will ensure those at risk of developing pressure damage are identified and appropriate equipment and nursing support provided.</p>

Enhancing Quality

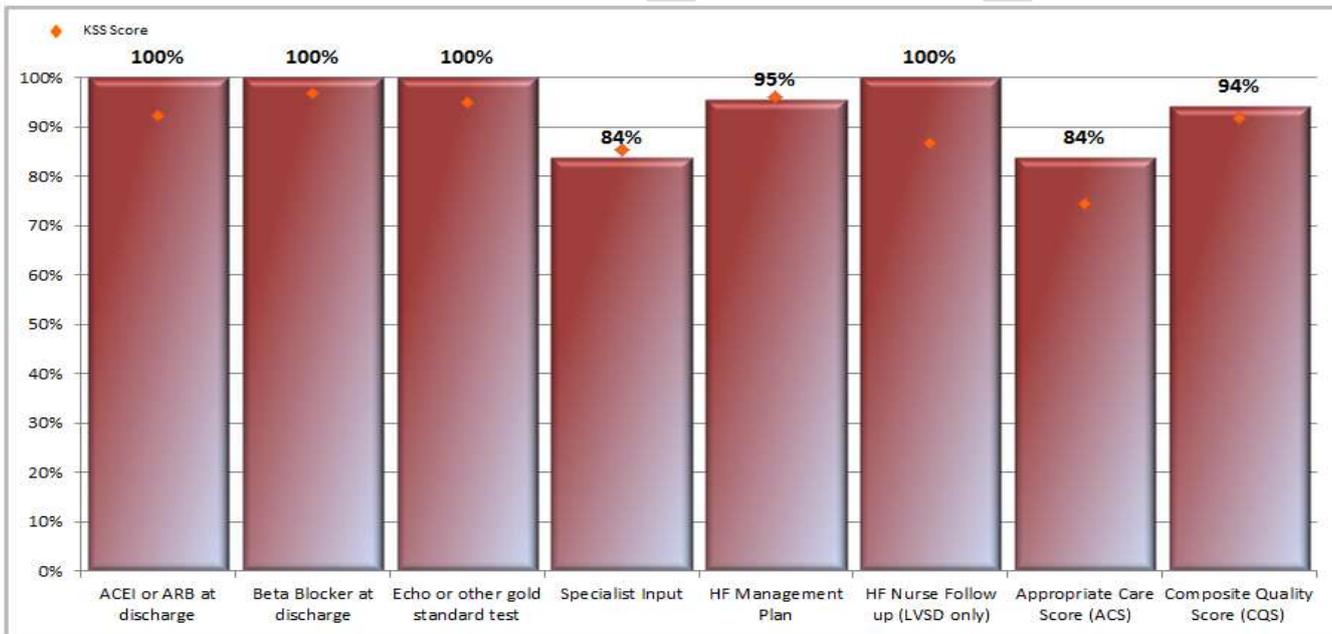
Clinical teams across Kent, Surrey & Sussex (KSS) agreed a number of key clinical interventions that should occur when a patient has been admitted across a number of clinical pathways as part of the Enhancing Quality (EQ) Programme.

Enhancing Quality (EQ)

The Enhancing Quality pathways include Heart failure (Acute), Chronic Obstructive Pulmonary Disorder (COPD) and Emergency Laparotomy. For each of these pathways there are a number of performance measures to attain that demonstrate compliance of the key quality indicators. These quality measures pulled together are regarded collectively as a ‘care bundle’. It has been clinically proven that delivery of the full ‘care bundle’ improves the patients’ outcomes. The Composite Quality Score (CQS) is the proportion of all clinical measures which were successfully delivered.

Heart failure (Acute)

Maidstone and Tunbridge Wells trust is one of the highest performers for this national audit and is performing in line or better than the regional score. The CQS is 94%. MTW performed slightly above the regional average.



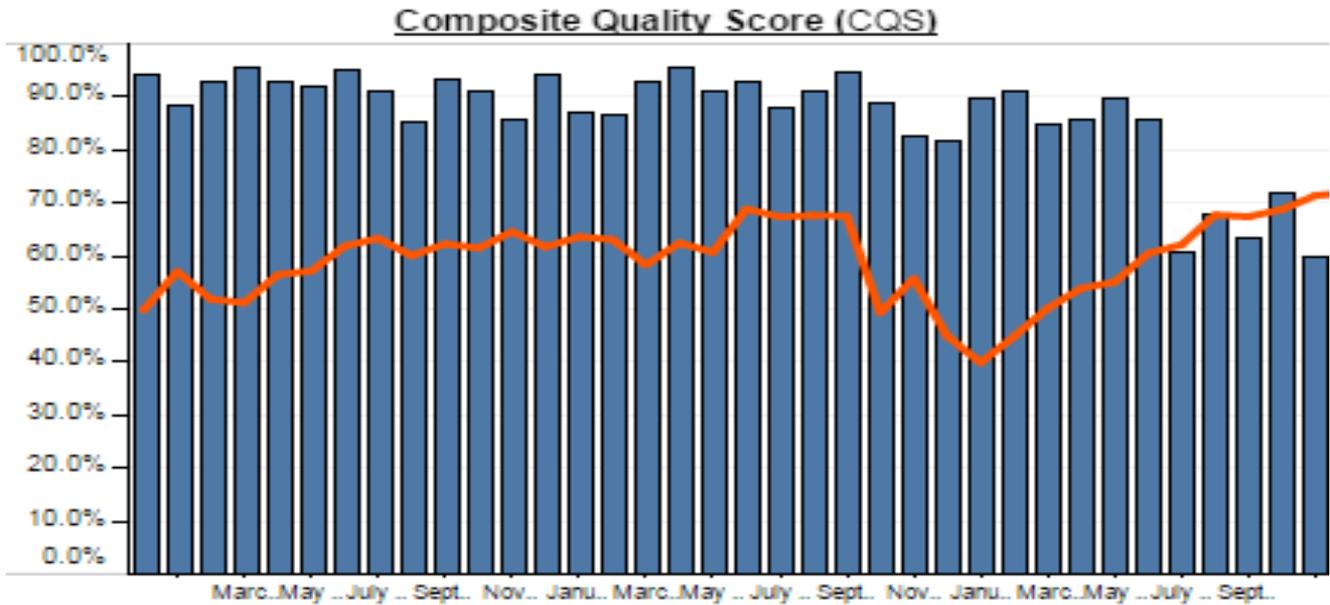
Chronic Obstructive Pulmonary Disorder (COPD).

MTW performance since implementation of the programme has been significantly above the regional average in this pathway.

- Length of stay has continued to reduce but remains above the regional average: 5.63 –v- 5.28 days.
- 30 day re-admission rate was better than the regional average: 26.3% -v- 28.4%.
- In hospital mortality has continued to reduce and is now in line with the regional average: 4.1% -v- 4.1%.

COPD - Discharge Bundle Measure Trends

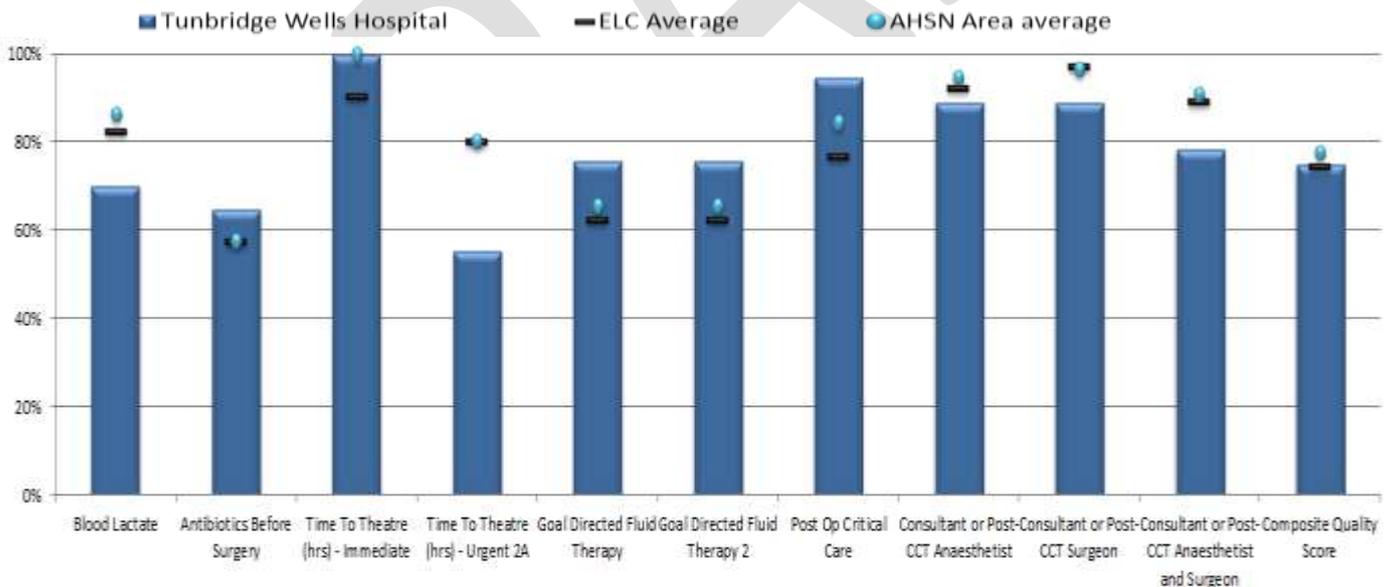
Key: ■ KSS Average ■ Trust Average



March 2015-Sept 2017

Emergency Laparotomy

The Emergency Laparotomy Collaborative (ELC) is led by the Kent, Surrey & Sussex Academic Health Science Network (KSS AHSN) with an aim to provide support in improving emergency laparotomy care and also to deliver quality improvement training. The following table shows results up to Q3 2017/18.



MTW CQS performance was above average for the ELC region (75.1% -v- 74%)
 MTW average length of stay is of 17.7 days which is slightly above the national average of 16.2 days.
 Crude Mortality for MTW was 2.7%. The KSS average is 8.5%

NICE Guidelines

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



MTW review all published guidelines produced by NICE to identify those which are relevant to the care we provide to our patients. Clinical audits are then undertaken on those guidelines identified as being relevant to assess the Trust's compliance. These clinical audits focus on a number of key quality standards; that are designed to drive measurable service improvement to enhance practice and the care of patients.

By the end of 2017/18 there have been a total of **1324** NICE guidance documents disseminated to the specialty leads throughout the Trust since guidance began to be published in 2005. Of those, **1202 (90.8%)** have been evaluated. **370 (30.8%)** of these evaluated guidance are considered to be relevant to the Trusts activities. Each Directorate is regularly updated of the actions required to meet compliance and monitoring of their progress is overseen by the Trust Clinical Governance Committee.

The breakdown is shown in the table below.

Guidance Type	Published	Evaluated	Relevant
Clinical Guidelines (NICE CGs/NGs)	276	246	116
Interventional Procedures (NICE IPGs)	544	523	70
Technology Appraisals (NICE TAs)	504	433	184
Totals	1324	1202	370

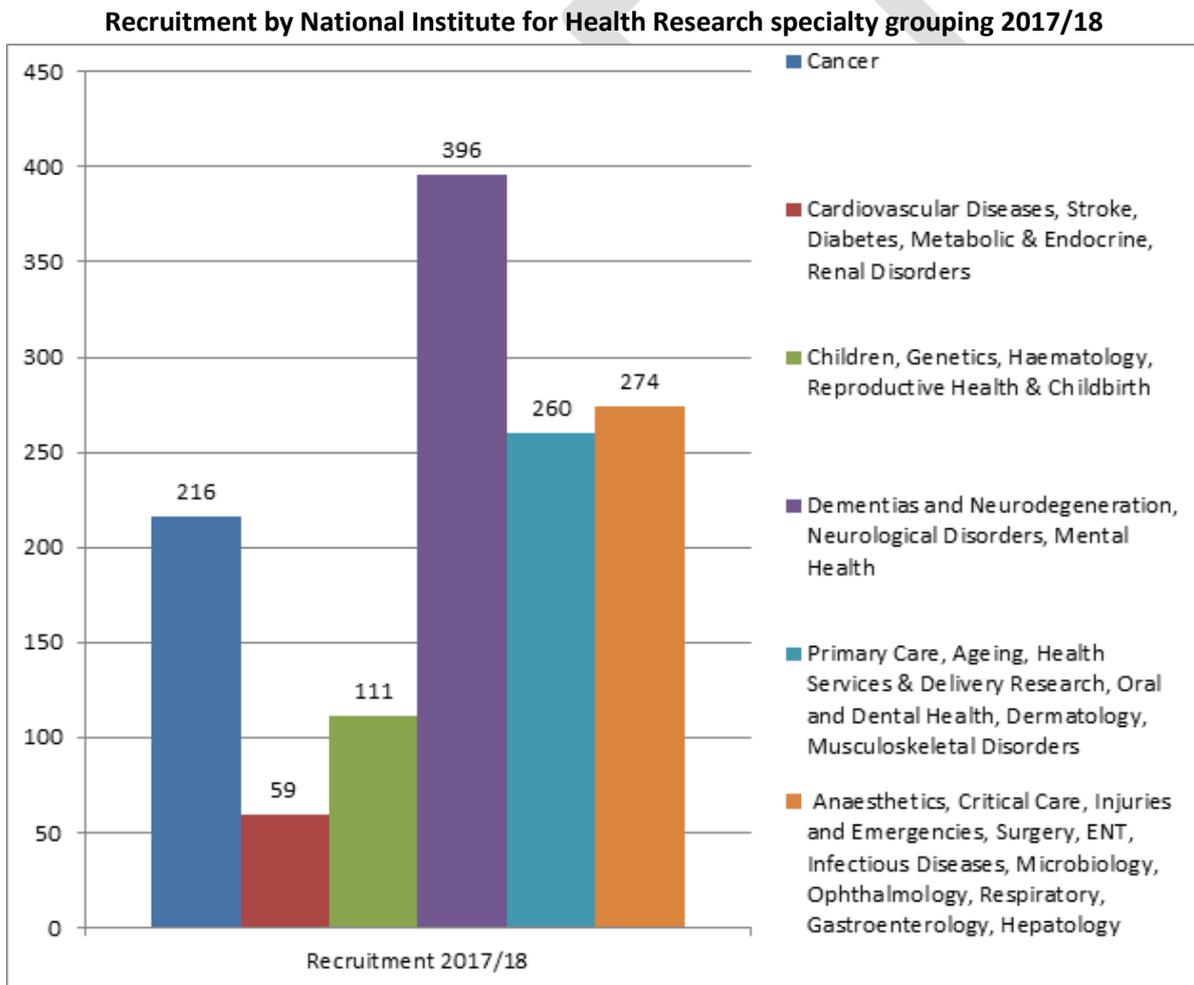
Please see Appendix C for full details of Trust compliance with guidance that has been audited and completed during 2016/17.

Research

Increasing opportunities for patients participating in clinical research

Maidstone and Tunbridge Wells NHS Trust aims to provide the highest, consistent quality care to our patients and recognises that participation in national and local clinical research is an important contributor to improving patient care and services. Research is central to the development of specialist services and treatments, and our aim is to increase the opportunities for participants to access our research in all specialities.

Participation in clinical research at Maidstone and Tunbridge Wells NHS Trust has increased. We exceeded our set target of 1276 and recruited 1316 participants in 2017/18 compared to the recruitment of 1250 participants (against a plan of 1174) in 2016/17. The Trust played a key part in delivering the national research agenda and met its recruitment target for this year, as set by the Kent Surrey and Sussex Clinical Research Network (KSSCRN). In addition all research participants were recruited to studies that have been approved or reviewed by the National Research Ethics Service. This means that our patients had access to ethically approved new treatments, interventions and medicines.



The successful recruitment during the year has been as a result of a dedicated delivery team supported by motivated clinical trial administrators and governance staff. Improvements were demonstrated in speedier expression of interest and streamlining study set-up and the commitment of our service support departments, general managers and clinical directors in supporting research activity.

Maidstone and Tunbridge Wells NHS Trust is recognised across Kent, Surrey and Sussex for the quality and the delivery of the national clinical research that we host. The University of Oxford invited the Trust, for the second time, to collaborate in the ‘Teenagers Against Meningitis’ research study, which involves local secondary schools both in Maidstone and Tunbridge Wells and the wider catchment area of Ashford and Folkestone. The Research and Development team recruited 215 teenagers in the first recruitment wave with positive feedback and support from the Heads’ of the Schools.

Maidstone and Tunbridge Wells NHS Trust recruited 1316 participants in 2017/18. The highest recruiting research studies were the (i) Enhancing Mental Health Awareness in Emergency Services (The Enhance Study), (ii) Investigation of wellbeing interventions of NHS staff and (iii) Developing and validating a new self-report measure of compassion.

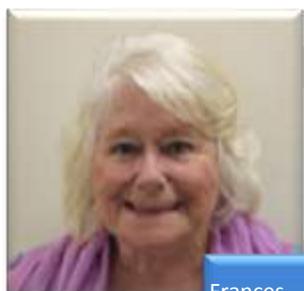
Trust Lead Research Nurse for Research and Development

Maidstone and Tunbridge Wells NHS Trust successfully appointed a new Trust Lead Research Nurse for Research and Development. Claire Pegg, joined the team in January 2018 with 10 years ITU and critical care experience and more recently setting up research in the community. Claire is a Good Clinical Practice (GCP) facilitator and works closely with the NIHR workforce development team looking at new courses and further training for research. Claire is looking forward to working with the different teams in developing the research portfolio across the Trust.



Claire Pegg – Lead Research Nurse

Patient and Public Involvement at Maidstone and Tunbridge Wells NHS Trust



Frances Mossie has been working within the Trust for four years now as the Volunteer Patient Research Ambassador. Frances provides an active role in raising awareness of research taking place within the Trust and talking to patients, carers’ and relatives.

During 2017/18 Frances has been engaged in a number of activities, including supporting the International Clinical Trials Day in May 2017 and playing an active role in promoting and disseminating research across the Trust through foyer presentations and publications across the Trust.

Also during 2017 Frances presented at a number of national and local meetings with the Kent, Surrey and Sussex Comprehensive Research Network (KSSCRN) and National Institute for Health Research (NIHR) Clinical Research Network (CRN) in London and Sussex. Frances is abreast of new developments in Patient and Public Involvement within the NIHR and helps to implement innovative ideas to further enhance patient and public involvement in research at MTW.

In November 2017 the Research and Development Department worked together with Frances to further expand the Volunteer Service of the Trust. Representatives from patients and the community were recruited as Volunteer Patient Research Ambassadors to “spread the word” about research within the Trust and to provide support to the Research Nurses. This support has been in various forms such as meeting and greeting participants, ‘hand holding’ and providing study information sheets to patients, carers’ and relatives to support the principal investigators’ and research nurses.

The Research and Development Department believe that patients, carers' and their relatives should be partners in research activity and play a central role in protocol development, study set-up and delivery of research. During December 2017 various own account projects were developed by staff from the Research and Development team. These all involved patients at the earliest stage to ensure patients were at the heart of what we do. Some of the projects developed by MTW include shoulder pain in Trauma and Orthopaedics, head injury management in Accident and Emergency and acupuncture for treatment of delay in labour.

The EPOP 2 surgical project continues to be supported by patients and clinicians working together. Regular communication and input from patients ensure the project's aims are fulfilled. This project uses the expertise of one of our consultant surgeons, alongside a university professor and our Research and Development team. The project is as a result of collaborative working and strategic planning.

A strong research delivery team.

The research and delivery team continues to grow in strength with the recruitment of 3 oncology nurses during 2017 and early 2018 and a newly advertised vacancy for an additional haematology nurse to further expand research at Tunbridge Wells Hospital to be filled during 2018/19. The growth of the team will support the increasing recruitment to a diversity of studies.

The delivery team now comprises experienced research nurses in new areas such as Intensive Care, Accident and Emergency and Midwifery. A research practitioner was appointed to the team in February 2018 as the lead for the Genomes 100,000 project. This project was endorsed by the Government back in 2012, looking into genomic medicine and patient specific treatment.

Research governance is supported by an experienced team of two governance officers and one governance coordinator. With the support of the central clinical trial administrators they focus on ensuring compliance with legislation and GCP and manage the resources to deliver the studies, safely, timely and effectively. Proposals are being considered to further strengthen the central team.

Within oncology and haematology research, two new nurses have been appointed to the oncology unit in February/March 2018. This ensures each tumour group now has a dedicated team of research nurses and a dedicated Clinical Trial Administrator to facilitate the speedy opening and effective delivery of trials.



Introduction of New Research Nurse Uniform

In October 2017, the Trust introduced a new research uniform for research nurses. The uniform promotes the professional identity of the research nurse and raises the profile of research and development. It is important that research nurses are recognized for the work they do and feel part of the wider trust clinical team delivering services to patients.

Tracey Nolan, Sue Lord, Stephanie McKinley

Awarding excellence in research

Maidstone and Tunbridge Wells NHS Trust was recognised for providing high quality quarterly research financial returns to the Kent, Surrey and Sussex Clinical Research Network in March 2018 and was awarded £500.00 from the KSSCRN. Dave Shelton, Research and Development Finance Manager, was acknowledged for the exceptional financial management in research.



Julie Knowles, Denise Day, Dave Shelton, Hazel Everest, Clare Calvert, Kevin Bishop

New Research Café



The Research Café was launched in January 2018 as a new initiative in partnership with the Academic Library and Maidstone Hospital and was opened by Miles Scott, Chief Executive.

Working collaboratively with the library, staff are encouraged to develop innovative, trust grown research and to promote the areas where research is already active. The drop in sessions have proved successful with the addition of seminars on research topics such as how to get started in research, how to write your research question and where to apply for funding.

Goals agreed with commissioners

CQUINS

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

In 2017/18 2.5% of the contract value was dependent on achieving the CQUIN targets for CCGs and 2.0% was for NHS England in line with the CQUIN payment framework. However Maidstone & Tunbridge Wells NHS Trust operate through an aligned incentive contract with our main provider (West Kent CCG) therefore no financial penalties ultimately apply. All other contracts however are subject to the standard penalties. This does not detract from the main intention of the purpose of CQUIN's however which are to improve the quality of care provided to our patients, as such delivery of these remains a high priority.

Within the commissioning payment framework for 2017/18 quality improvement and innovation goals were set as indicated in the table below.

CQUINs	Target	*Achieved (local data)	RAG Rating
National CQUINs (CCGs)			
Improvement of health and wellbeing of NHS staff- achieving a 5% point improvement in two of three staff survey questions on health & wellbeing, musculoskeletal injury and stress.	5% Improvement in 2 / 3 staff survey Questions	25%	Amber
Healthy Food for NHS Staff, visitors and patients; reduction in % of sugar/salt products displayed; increase in healthier alternatives; avoidance of overt promotion.	Delivery of three outcomes agreed with WKCCG	100%	Green
Improving the uptake of flu vaccinations for frontline clinical staff.	70% Uptake by 28 th February	71.1%	Green
Timely identification of sepsis in emergency departments; percentage of eligible patients screened for sepsis.	90% for each Quarter	Q1=94% Q2=95% Q3=96.9% Q4=98.3%	Green
Timely treatment for sepsis in emergency departments.	Q1&Q2 = 85% Q3&Q4 = 90%	Q1=88% Q2=91% Q3=90.1% Q4=91.3%	Green
Timely identification of sepsis in acute inpatient settings; percentage of eligible patients screened for sepsis.	Q1=75% Q2=80% Q3=85% Q4=90%	Q1=78% Q2=81% Q3=88.3% Q4=85.1%	Amber
Timely treatment for sepsis in acute inpatient settings.	Q1=70% Q2=75% Q3=80% Q4=90%	Q1=78% Q2=75% Q3=90% Q4=90.9%	Green
Assessment of clinical antibiotic review between 24-72hrs of patient with sepsis who are still inpatients at 72hrs. Empiric reviews to be performed; % of cases in the sample	Q1=25% Q2=50% Q3=75% Q4=90%	Q1=67% Q2=83% Q3=80% Q4=90%	Green

CQUINs	Target	*Achieved (local data)	RAG Rating
Reduction in antibiotic consumption per 1000 admissions 1) total antibiotic usage 2) Total usage of carbapenem 3) total usage of piperacillin-tazobactam.	Reduction of 1% against baseline	33.3%	Amber
Improving services for people with mental health needs who present to A&E in selected cohort group.	20% reduction in A&E attendances for those in cohort	43%	Green
Offering Advice and Guidance (A&G)- to set up and operate A&G services for non-urgent GP referrals, allowing GP's to access consultant advice prior to referring patients into secondary care	75% of GP referrals are made to elective outpatient specialities which provide access to A&G services	100%	Green
NHS e-Referrals; GP referrals to consultant-led 1 st outpatient services only and the availability of services and appointments in the NHS e-Referral service	100% of Referrals to 1 st O/P Services able to be received through e-RS	100%	Green
Supporting proactive and safe discharge; increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place or residence within 7 days of admission by 2.5% points from baseline whilst monitoring readmission rates.	Baseline (Q3&4 2016/17)=70% Target=72.5%	77.3%	Green
NHS England Specialist CQUINs	Target		
Optimising Palliative Chemotherapy Decision Making-To ensure optimal care is appropriate that, in specific groups of patients, decisions to start and continue further treatment should be made in direct consultation with peers and then as a shared decision with the patient.	Review of practice, improvement plan developed, review of audit against plan.	100%	Green
Clinical Utilisation Review (CUR) –optimising patient flows and move out of acute settings	Data submission, daily use of CUR, reduction in % of NQ patients	100%*	Green
Activation System for Patients with Long Term Conditions (LTC's)- Chronic Obstructive Pulmonary Disease (COPD) and Irritable Bowel Syndrome (IBD) ; Year 2 re-testing of patients in cohort, improvement in PAM scores, improvement in adherence and reduction in non-elective attendances/admissions, aggregate improvement in patient reported health outcomes.	Review of patients surveyed in 2016/17 re disease progression-delays in patient response to be evidenced	100%*	Green
Hospital Medicines Optimisation – adoption of best value generic/biologic products in 90% of new patients within one quarter of guidance being made available; adoption of biologics in 80% of applicable existing patients within one year of being made available; submission of HCD data; increase use of cost-effective dispensing routes for outpatient medicines; improve data quality associated with outcome databases (SACT and IVIg).	Trigger 1 Trigger 2 Trigger 3 Trigger 4	Achieved Partial Achieved Achieved 91.5%	Amber

*Revised Milestone part of CQUIN to be delivered in Q1 2017/18 due to database interface challenges

Commentary

In this section we highlight some of the CQUIN improvements and developments in 2017/18, including what we have achieved and what has challenged us.

National CQUINs:

Achieving the Sepsis CQUIN has once again been challenging, missing the final milestone for the screening of inpatients in quarter 4 (85.1% against the target of 90%). Despite this disappointment we were commended by the Secretary of State for Health and Social Care, the Right Honourable Jeremy Hunt earlier this year for the delivery of the previous milestones. This life threatening condition which affects 260,000 people in the UK every year causes 44,000 deaths but is relatively easy to treat if diagnosed and promptly treated. The Sepsis Committee and the Sepsis leads have continued to drive this hugely important agenda throughout the year and have introduced the latest guidance and revised the Sepsis flow charts for use on the wards. We have also recruited Sepsis Champions to our wards and departments to help in the education and development of our staff which will ultimately improve patient care and experience.

The main challenge was the reduction of antibiotic use, of which three milestones were set. The reduction of carbapenem; Tazocin and the overall use of antibiotics. Unfortunately we missed this on two elements, the reduction of the use of carbapenem and the overall use of antibiotics. This was particularly noticeable in the overall usage in Quarters 2 and 3, mainly as a result of an increase in the presentation of patients with respiratory conditions.



During 2016/17 we were pleased to have achieved 66.6% of our frontline staff immunised for flu due to the competitive spirit raised between professions, this year we saw the opportunity to push this further. The Occupational Health department ensured that we had local immunisers trained in each speciality/department and liaised with our Communications team to ensure that our staff were regularly reminded of the benefits of having their vaccinations for both their own protection and that of our patients. This strategy helped us to successfully vaccinate 71.1% of our frontline clinical staff.

Our Finance Director leading by example

Collaborative working

An additional benefit of this year's CQUINs has been the opportunity to work in collaboration with our colleagues in Kent and Medway NHS and Social Care Partnership (KMPT), South East Coast Ambulance Service (SECamb) and Kent Community Health Foundation Trust (KCHFT).

For the CQUIN 'Improving services for people with mental health needs who present to A&E' we worked with both KMPT and SECamb to select 25 patients who most attended A&E that the team felt would most benefit from a coordinated approach. Together with the patient a plan of care was developed with all parties signing up to the delivery of this plan. The intention was to ensure that the patient received a consistent approach to their care needs and thereby reduced the number of times that they presented to A&E. The patients selected ultimately reduced their attendances by

43% during the course of the year but more importantly they are receiving the right support to self-manage their symptoms.

In addition we have worked with KCHFT to support proactive and safe discharge of patients over the age of 65 to their usual place of residence within 7 days of admission. The ethos of this CQUIN was to ensure that we optimise our patient's independence and also to reduce the risk of further harm from hospital acquired infections etc. Working collaboratively we ensured that those patients who needed additional support at home were supported by KCHFT community teams and optimised towards full independence. During this time we also closely monitored the risk for readmission for this cohort of patients and are pleased to report that these levels also reduced during this timeframe, therefore successfully delivering on all aspects of this CQUIN and supporting more of our patients to remain independent for longer.

NHS England CQUINs

This year's specialist CQUIN's have been of particular challenge, mainly due to our ability to supply the required evidence as a result of both IT interface and database issues, which have since been resolved.

Optimising Palliative Chemotherapy decision making has necessitated the need to create an additional field in our Kent Oncology Management system (KOMS). This new field encourages our nursing staff to record that a peer review of decision making has taken place ie that the patient, consultant and wider team are in agreement and support a palliative chemotherapy treatment regime. This process previously took place in paper format making auditing of the process difficult, our new challenge is to now ensure that our nursing staff record the additional field to provide the required evidence.

During 2017/18 MTW has been committed to the full rollout of Clinical Utilisation Review (CUR) and has succeeded in implementing the system in all adult inpatient wards. This took place by September 2017. We have a CUR Operational Group in place which meets monthly and a Senior Site Practitioner was released from 50% of her duties in order to ensure that this implementation took place. All ward managers and Junior Sisters/Charge Nurses have been trained and it is now mandatory for CUR to be completed on all wards by lunchtime every day. The Trust also implemented a new Patient Centre database (Allscripts) during 2017; CUR was switched off during this time as there were technical issues which needed to be resolved. Our overall compliance with CUR has therefore not reached the proposed 85%. NHSE have agreed that our year-end target can be moved to the end of June 2018 in recognition of the challenges we have faced. On a positive note we have been able to demonstrate a reduction in the number of unqualified patients (those whose care needs can be met outside of an acute hospital setting).

For the management of Long-term conditions, this year's objectives were to re-survey the patient's surveyed last year to review the progression of their illness and see how they have been self-managing their illness. These included patients with Chronic Obstructive Pulmonary disease (COPD) and Irritable Bowel Disease (IBD). The response rate from this group of patients has been particularly low with many declining to participate. We have also continued to experience challenges with the data requested and entering it into the database, we continue to meet with NHSE to discuss and attempt to resolve. Due to the challenges faced this CQUIN is also being extended into 2018/19.

Statements from the CQC



The Trust underwent an inspection during the period 18th October, 2017 to the 1st February, 2018 with the report published in March 2018.

The overall rating for the Trust was 'Requires Improvement'

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

The CQC reported that they had seen significant improvements since our previous inspection three years ago and while the CQC has rated us as 'Requires Improvement' for now, they acknowledged that significant and sustained improvements had been made and we were moving towards a 'Good' rating. In fact, the Trust has been 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. In addition the report saw no individual standards rated Inadequate, compared to six in 2015.

Each one of our inspected services was rated 'Good' in the caring domain. We are hugely encouraged that the inspectors recognised that we put quality at the heart of everything we do, and that we have improved numerous areas of patient care at a time of unprecedented operational and financial pressure across the NHS as a whole.

The report also highlights that Maidstone and Tunbridge Wells NHS Trust (MTW) has made improvements in several service areas since the last inspection, in particular in the areas of critical care, medical care and services for children and young people.

We have received 17 specific recommendations from the CQC and work is already underway to ensure we complete these actions as soon as possible. Our Quality Improvement Plan has been updated to reflect the key actions that are now required which include:-

- Ensuring that our staff keep up to date with their mandatory training.
- Ensuring that we respond promptly to patient complaints.
- Minimising the amount of time our patients are kept nil by mouth for surgery.
- A proactive recruitment process to ensure staff vacancies are filled.
- Proactive assessment and response to patient's pain.
- Sharing the learning from complaints and incidents.

This action plan will be overseen by the Quality Improvement committee that has superseded the CQC Project team meetings. This will be chaired by the Chief Nurse and will report into the Best Quality Workstream which is part of the Best Care Programme

The full report can be accessed via the CQC website - <http://www.cqc.org.uk/provider/RWF>

In addition Maidstone & Tunbridge Wells NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Improving data quality at MTW

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

Specifically, MTW needs to ensure its information is:

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

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

The Trust has developed a new Data Quality Strategy during the year, which has subsequently been launched, creating a renewed focus on data quality across the organisation. A number of governance groups have also been established to ensure the vision set out within the strategy is delivered. The vision is 'to ensure that we adhere to all relevant local and national data standards and applicable best practice guidance to support the delivery, commissioning and regulation of high quality and safe healthcare service at MTW'.

These groups will focus on the following areas:

- Governance and leadership
- Policy
- Systems and processes
- People and skills
- Data use and reporting

Progress on the work plan linked to the new strategy will be reported quarterly to Trust Management Executive and onward to the Board as appropriate.

NHS Number and General Medical Practice Code Validity

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

which included the patient's valid NHS number was (as at Month 11):

- 99.0% (99.1% 16/17) for Admitted Patient Care;
- 99.4% (99.3% 16/17) for Outpatient Care; and
- 96.0% (97.1% 16/17) for Accident and Emergency Care.

Which included the patients valid General Medical Practice code was:-

- 100% (99.9% 16/17) for Admitted Patient Care;
- 99.7% (99.8% 16/17) for Outpatient Care; and
- 100% (99.8% 16/17) for Accident and Emergency Care.

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

Information Governance Toolkit

The Information Governance Toolkit is a performance tool produced by the NHS Digital (formerly the Health and Social Care Information Centre). It draws together the legal rules and central

guidance related to Information Governance. The Trust achieved a score of 74% (74% in 2016/17) satisfactory (Green in the toolkit grading scheme) against the Information Governance Toolkit Version 14.1, and achieved 10 (10 in 2016/17) of the 45 requirements at level 3. The remaining requirements were achieved at level 2 as required by the NHS Standard Contract (2017-19).

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

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

Clinical Coding

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

In 2017/18 a Clinical Coding audit and process review was undertaken by Maxwell Stanley Ltd on behalf of MTW which was released in February 2018. The audit scored the Trust at Level 3 using the IG Toolkit's scoring mechanism. The recommendations within the audit report have been fed into an action plan to address the issues identified.

Area	Level 2	Level 3	Trust % Correct
Primary Diagnosis	>=90%	>=95%	98.98% Level 3
Secondary Diagnosis	>=80%	>=90%	97.38% Level 3
Primary Procedures	>=90%	>=95%	96.40% Level 3
Secondary Procedures	>=80%	>=90%	97.27% Level 3

The report made three recommendations for further improvements and these will be actioned during 2018/19.

Part Three

Results and Achievements for the 2017/18 improvement initiatives

Patient Safety

Aim/Goal

To create reliable processes that will build a supportive environment to reduce avoidable harm.

Action	Update																				
<p>We will demonstrate that we have embedded a safety culture within all departments undertaking invasive procedures which comply with the World Health Organisation (WHO) surgical safety methodology.</p> <ul style="list-style-type: none"> ○ Agree a programme of audits on WHO compliance to all areas undertaking invasive procedures and monitoring of compliance. ○ Promotion of 'Human Factors' training and methodology. 	<ul style="list-style-type: none"> • <i>Establishment of a WHO compliance working group which is led by the Associate Director of Nursing for Planned Care. The main objective of this group has been to ensure all areas comply with National Guidance and that they have a process in place for the monitoring of progress and required actions are taken.</i> <ul style="list-style-type: none"> ○ <i>Regular meetings in place.</i> ○ <i>Action plan has been drafted for further discussion and sign-off at the next meeting.</i> ○ <i>WHO checklists have been reviewed to ensure they meet national compliance.</i> ○ <i>Trust wide WHO audit registered and due for completion in August 2018.</i> ○ <i>Work with each Directorate and Speciality is in place to ensure that they have processes in place to meet full compliance with the National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive procedures (LocSSIPs).</i> • <i>Human Factors training took place in March 2018- 10 staff are now trained across directorates and across professions.</i> 																				
<p>We will improve the reporting of medication errors within the Trust and reduce the number of inappropriate omissions of medication doses.</p> <ul style="list-style-type: none"> ○ Monthly reporting of medication safety incidents and raised awareness through Governance meetings and Medicines Safety News. 	<table border="1"> <thead> <tr> <th>Metric</th> <th>Quarter 1</th> <th>Quarter 2</th> <th>Quarter 3</th> <th>Quarter 4</th> </tr> </thead> <tbody> <tr> <td><i>Number of incidents reported</i></td> <td>217</td> <td>199</td> <td>182</td> <td>170</td> </tr> <tr> <td><i>Omitted doses</i></td> <td>5.3%</td> <td>22.2%</td> <td>4.6%</td> <td>12.5%</td> </tr> <tr> <td><i>Omitted doses of time critical medicines</i></td> <td>6.0%</td> <td>17.4%</td> <td>4.6%</td> <td>7.5%</td> </tr> </tbody> </table> <p><u>Comments on Metrics</u></p> <ul style="list-style-type: none"> • <i>Number of medication related incidents –despite initial success in Q1 we have been unable to establish an increase in reporting.</i> • <i>Omitted doses – Although the % of omitted doses and omitted doses of time critical medicines has remained variable, with some success evident, again we have not been able to</i> 	Metric	Quarter 1	Quarter 2	Quarter 3	Quarter 4	<i>Number of incidents reported</i>	217	199	182	170	<i>Omitted doses</i>	5.3%	22.2%	4.6%	12.5%	<i>Omitted doses of time critical medicines</i>	6.0%	17.4%	4.6%	7.5%
Metric	Quarter 1	Quarter 2	Quarter 3	Quarter 4																	
<i>Number of incidents reported</i>	217	199	182	170																	
<i>Omitted doses</i>	5.3%	22.2%	4.6%	12.5%																	
<i>Omitted doses of time critical medicines</i>	6.0%	17.4%	4.6%	7.5%																	

	<p><i>establish the level of reduction anticipated. We have however firmly established the Medicine Safety News which is regularly published on the Trust Intranet. This is used to disseminate learning, themes and trends from incidents. During 2017/18 we have published articles in regard to:-</i></p> <ul style="list-style-type: none"> <i>o Initiation of aminophylline infusion and the need to ensure levels are checked at 4-6hrs</i> <i>o The need to take care when prescribing Direct Oral anticoagulants for patients with liver disease following admission of patient with GI bleed</i> <i>o Sedation in older people: If sedation is absolutely necessary, start low, take it slow.</i> <i>o Prescribing, administering or supplying Lithium? Always think LEVEL!</i> 																																
<p>We will reduce our observed mortality rates to be in line with expected rates according to speciality.</p> <ul style="list-style-type: none"> <i>o By the end of March 2018 every in hospital death will have been reviewed (in line with prevailing guidance)</i> 	<p><i>The Mortality Surveillance Group continues to work with Dr Foster and the Communities of Practice for the Southeast to support an appropriate level of scrutiny and to share learning. Through the increased understanding of our data we have been able to make significant progress in reducing our rates in line with those of our peers.</i></p> <table border="1" data-bbox="821 907 1484 1070"> <thead> <tr> <th></th> <th>Quarter 1</th> <th>Quarter 2</th> <th>Quarter 3</th> <th>Quarter 4</th> </tr> </thead> <tbody> <tr> <td>Crude Mortality</td> <td>1.20%</td> <td>1.10%</td> <td>1.20%</td> <td>1.20%</td> </tr> <tr> <td>SHMI</td> <td>1.088</td> <td>1.072</td> <td>1.049</td> <td>1.044</td> </tr> <tr> <td>HSMR</td> <td>106.8</td> <td>104.6</td> <td>106.4</td> <td>103.1</td> </tr> </tbody> </table> <p><i>In October 2017 we introduced a revised mortality review process in line with National Quality Board Guidance. The introduction of this revised process has resulted in a slowing down of reviews as the new paperwork embedded. This has negatively impacted on our intention to achieve 100% compliance of every patient death having undergone a Mortality Review of the care provided during 2017/18. However the latter months are now demonstrating improvements which are evidenced in our year-end figures in comparison to 2016/17.</i></p> <table border="1" data-bbox="821 1444 1484 1585"> <thead> <tr> <th>Trust</th> <th>YTD 2016/17</th> <th>YTD 2017/18</th> </tr> </thead> <tbody> <tr> <td>No of Deaths</td> <td>1877</td> <td>1854</td> </tr> <tr> <td>No of Completed Reviews</td> <td>806</td> <td>882</td> </tr> <tr> <td>%age completed reviews</td> <td>43%</td> <td>47.6%</td> </tr> </tbody> </table>		Quarter 1	Quarter 2	Quarter 3	Quarter 4	Crude Mortality	1.20%	1.10%	1.20%	1.20%	SHMI	1.088	1.072	1.049	1.044	HSMR	106.8	104.6	106.4	103.1	Trust	YTD 2016/17	YTD 2017/18	No of Deaths	1877	1854	No of Completed Reviews	806	882	%age completed reviews	43%	47.6%
	Quarter 1	Quarter 2	Quarter 3	Quarter 4																													
Crude Mortality	1.20%	1.10%	1.20%	1.20%																													
SHMI	1.088	1.072	1.049	1.044																													
HSMR	106.8	104.6	106.4	103.1																													
Trust	YTD 2016/17	YTD 2017/18																															
No of Deaths	1877	1854																															
No of Completed Reviews	806	882																															
%age completed reviews	43%	47.6%																															
<p>We aim to achieve consistent recognition and rapid treatment of sepsis in both our emergency and inpatient departments and ultimately reduce the number of avoidable deaths.</p> <ul style="list-style-type: none"> <i>o Through the work of the Sepsis Committee we aim to achieve the National CQUIN. This will be monitored monthly through the CQUIN Board and reported to the Patient Experience Committee.</i> 	<p><i>Timely identification of Sepsis in Emergency Department and acute inpatient settings-</i></p> <ul style="list-style-type: none"> <i>o A&E - achieved</i> <i>o Inpatients – partial achievement; failed trajectory for Q4</i> <p><i>Timely treatment for sepsis in emergency departments and acute inpatient settings-</i></p> <ul style="list-style-type: none"> <i>o A&E - achieved</i> <i>o Inpatients – achieved</i> <i>• Sepsis committee firmly established with developed action plan.</i> <i>• Review of the guidance for Sepsis has been undertaken to ensure that MTW are following the National agenda. Red Flag and Amber Flag sepsis protocols are being reviewed.</i> 																																

<p>We will improve the outcomes for expectant mothers and their babies in line with the Maternal and Neonatal Health Safety Collaborative.</p> <ul style="list-style-type: none"> The work of the National Maternity Safety Improvement plans will be reported through the Maternity Board and the Key Performance Indicators (KPI's) will be monitored to inform their progress. 	<ul style="list-style-type: none"> <i>Development of the role of Ward Sepsis Champions to support the sepsis agenda.</i> <p><i>The Maternity service has been selected by NHSE to be a centre for the Choice pioneer work in regard to personalisation of patient care with many of our patients joining the pilot.</i></p> <p><i>In addition work is ongoing to reduce:-</i></p> <ul style="list-style-type: none"> <i>Perineal trauma through the introduction of slow birthing techniques; warm perineal compresses and good birth positioning.</i> <i>Unanticipated admission to NNU- introduction of the Bobble hat is currently being trialled following positive results in another organisation (see pg 74 for further detail).</i> <i>Stillbirths- review of gap and grow training; move to face to face training from online.</i> <p><i>KPI's-</i></p> <table border="1" data-bbox="810 712 1497 936"> <thead> <tr> <th>Metric</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> <th>Q4</th> </tr> </thead> <tbody> <tr> <td>No of deliveries</td> <td>1476</td> <td>1552</td> <td>1486</td> <td>1469</td> </tr> <tr> <td>Post-Partum Haemorrhage >2000mls</td> <td>17</td> <td>13</td> <td>15</td> <td>15</td> </tr> <tr> <td>3rd/4th degree tears</td> <td>25</td> <td>28</td> <td>35</td> <td>27</td> </tr> <tr> <td>Postnatal Readmissions</td> <td>12</td> <td>21</td> <td>16</td> <td>24</td> </tr> <tr> <td>Total Stillbirths</td> <td>5</td> <td>9</td> <td>4</td> <td>4</td> </tr> <tr> <td>Unanticipated admission to NNU</td> <td>33</td> <td>39</td> <td>39</td> <td>34</td> </tr> </tbody> </table>	Metric	Q1	Q2	Q3	Q4	No of deliveries	1476	1552	1486	1469	Post-Partum Haemorrhage >2000mls	17	13	15	15	3rd/4th degree tears	25	28	35	27	Postnatal Readmissions	12	21	16	24	Total Stillbirths	5	9	4	4	Unanticipated admission to NNU	33	39	39	34
Metric	Q1	Q2	Q3	Q4																																
No of deliveries	1476	1552	1486	1469																																
Post-Partum Haemorrhage >2000mls	17	13	15	15																																
3rd/4th degree tears	25	28	35	27																																
Postnatal Readmissions	12	21	16	24																																
Total Stillbirths	5	9	4	4																																
Unanticipated admission to NNU	33	39	39	34																																

Patient Experience

Aim/goal

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

Action	Update
<ul style="list-style-type: none"> Implementation of the revised Friends and Family Test methodology to provide a more targeted focus on 5 questions relating to the patient's overall experience. 	<ul style="list-style-type: none"> <i>The extended question set based on the CQC domains is now fully embedded and seeks to provide richer data and deeper insight on the quality of care and safety in the trust.</i> <i>The 'iWantGreatCare' (IWGC) contract has now been extended following a review of the functionality provided. The additional benefits are a new dashboard 'Iris' which is an early warning system for monitoring</i> <i>MTW's representative group are looking to work collaboratively with IWGC to further develop the monitoring system for quality and safety issues and to align the new design of the dashboard to the CQC's key lines of enquiry (KLOE).</i>
<ul style="list-style-type: none"> To achieve consistent monthly response rates to the Friends and Family Test. 	<ul style="list-style-type: none"> <i>The MTW Representative group continues to meet regularly to review the project pathways, data analysis and to maintain a raised awareness of the Friends and Family question. Following the Winter period and escalation, work is now progressing to re-engage with the speciality nominated leads to have representation at these meetings.</i> <i>The meetings continue to focus and review how to</i>

	<p><i>embed the process of collecting feedback into daily routines and sharing good practice.</i></p> <ul style="list-style-type: none"> • <i>Standing agenda item for the meetings include an opportunity to review areas, a review of 'red' word clouds and to promote innovations and their progress.</i> • <i>'Word Clouds' are now being produced monthly and can be accessed via the N-Drive.</i> • <i>The group continue to explore the feasibility of establishing e-mail alerts to enable earlier response to feedback. The collection dates have now increased to weekly to facilitate this change.</i> • <i>There was a drop in inpatient response rate during February (now including day case and children) however, the response rate increased from 17.4% in February to 32.7% in March with over double the number of respondents from the previous month. For A&E (now including children) it increased from 9.07% in February to 18.82% in March, again more than doubling the previous month's respondents. For Maternity Q2 (as nationally they will not publish response rates for Q1, Q3 and Q4 anymore) it increased from 15.2% in February to 39.42% in March. All supporting a refocus on patient feedback.</i> • <i>For the % Positive for March, the Inpatient data demonstrates a minimal statistical change from 94.9% last month down to 94.4%, A&E from 90.3% last month to 93.6% and Maternity (all 4 combined) from 92.7% last month to 90.9%.</i> • <i>Work is progressing between IT and the Paediatric lead for IWGC to review the IWGC app within Children's services which will seek to promote an increase in feedback.</i>
<ul style="list-style-type: none"> • To work with external partners such as Healthwatch, NHSI, CQC and CCG to identify key themes of good practice and emerging issues that may give cause for concern. Activities may include engagement with compliance Assurance, formal and informal PLACE assessments, engagement with service improvement initiatives and patient experience improvement groups. 	<ul style="list-style-type: none"> • <i>Review of Patient Discharge processes undertaken by Healthwatch.</i> • <i>Bimonthly Quality Review Group meetings with WKCCG.</i> • <i>PLACE assessments undertaken in March and April 2018. Dates are shared with health care professionals and our Patient representatives.</i> • <i>The Trusts Internal Assurance programme has been updated reflecting a new reporting format. A schedule of assurance visits is mapped throughout 2018/19.</i> • <i>The Quality Governance Associate for NHSI has supported the Trust with a review of Governance processes.</i> • <i>A series of unplanned and planned CQC inspections were undertaken between October 2017 and February 2018 and consisted of 12 separate visits. This included a Well Led Inspection on 12-13th Dec 2017. Five core services at our hospitals were inspected in total.</i> • <i>The final report was published on 9th March 2018.</i> • <i>The Trust's overall position remained as 'Requires Improvement' however, the report identifies 'significant and sustained improvement throughout</i>

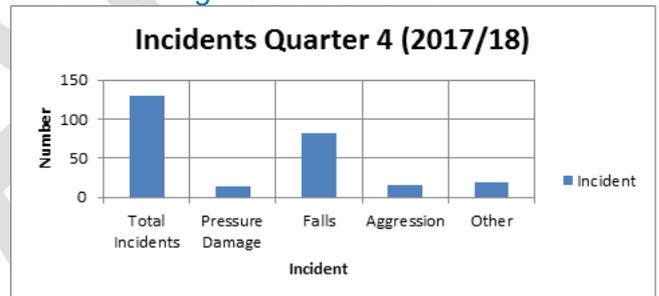
the Trust' since the last inspection report in 2015.

Key highlights:

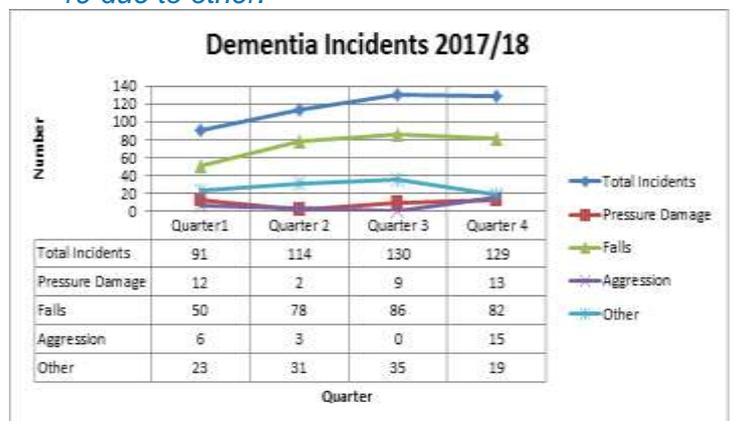
- *Rated 'Good' in over two thirds of the CQC standards across the five core services that were inspected – a significant increase from less than a third in 2015.*
- *All inspected services rated 'Good' in the caring domain.*
- *No individual standards rated 'Inadequate', compared to six in 2015.*
- *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 improved 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.*

- Develop a framework to report and monitor the incidence of harm affecting those with cognitive impairment (dementia).

- *Framework for reporting devised via the Dementia Strategy Group.*
- *Incidents are identified via Datix and are made up of four categories; pressure damage, falls, aggression and other. Of the overall Trust reported incidents the table below represents those patients who had a diagnosis of dementia.*



- *A total of 129 incidents were reported for dementia patients, of these 13 were due to pressure damage; 82 due to falls; 15 due to aggression and 19 due to other.*



- *Of note is that falls continue to be the main cause of incidents for patients with dementia. There was a rise in aggressive incidents in Quarter 4 due to 2 particularly challenging patients.*

Clinical Effectiveness

Aim/Goal

To improve the management of patient flow

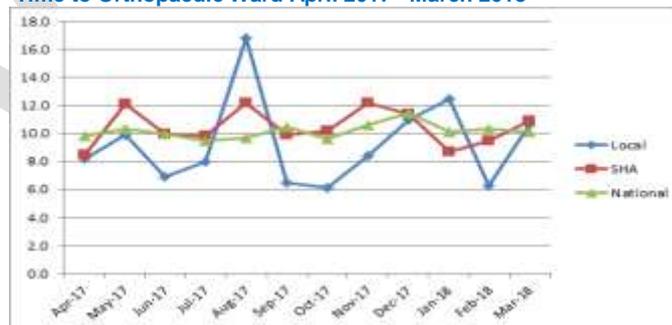
Action	Update
<ul style="list-style-type: none"> • Avoiding unnecessary admissions to hospital through the increased use of ambulatory pathways of care for patients who attend our emergency departments. <ul style="list-style-type: none"> ○ Increase of specialities available on the ambulatory pathway model. • Development of frailty units on both the Tunbridge Wells and Maidstone hospital sites. 	<ul style="list-style-type: none"> • <i>Ambulatory pathways in place.</i> • <i>Following a 4 week intensive project at TWH, the Ambulatory Emergency Care (AEC) bay opened on the Acute Medical Unit (AMU) on Thursday 14th December, accepting all non-elective ambulatory patients. This has provided 4 spaces which have been configured as 3 trolleys and 3 chairs. In addition the Ambulatory (Amb) score (identifying suitable ambulatory patients) has been embedded into ED at TWH and is recorded on Symphony. This allows visibility of suitable patients in ED and in AMU. AMU nurses and doctors have been very proactive in improving patient flow to the AEC bay on AMU. This was supported by the introduction of the nurse led service answering GP phone calls with GP referrals from 20th December. Despite considerable pressures over the Christmas bank holidays, the AEC bay has remained de-escalated and continues to improve the patient flow from ED.</i> • <i>Acute Frailty Unit for Maidstone site opened June, 2017. Working with clinicians to develop Frailty pathways on W2 at TW with the lead clinician. Capacity and staffing challenges have prevented the opening of a full Frailty Unit at this stage (see pg 75 for further details).</i> • <i>Acute Frailty Unit for Tunbridge Wells opened March 2018.</i>
<ul style="list-style-type: none"> • Work with our mental health partners to reduce the frequency of patients in crisis attending our emergency departments. <ul style="list-style-type: none"> ○ As part of the national CQUIN we aim to improve the pathways of care for patients with mental health needs by reducing the frequency of these attendances by 20%. 	<ul style="list-style-type: none"> • <i>Multi-Agency Project Group has been established with attendance from KMPT, SECamb, Mental health Liaison (CCG funded) and MTW.</i> • <i>Individualised care plans developed with those identified in selected cohort.</i> • <i>Regular review of patient list to ensure that those who are no longer attending are investigated and for those attending more frequently that their plan of care is reviewed.</i> • <i>For year end 17/18 a 43% reduction in attendances was reported for the 25 patients, who had been identified, who would most benefit from a targeted multi-professional approach of their health needs.</i>
<ul style="list-style-type: none"> • Improved access to ring-fenced beds for Stroke and fractured neck of femur patients. <ul style="list-style-type: none"> ○ We will work with the speciality leads 	<p><i>The indicators shown below are based on real-time data entry. Please note that these are not official results and may be different from official calculations in RCP SSNAP reporting.</i></p>

for both Stroke and Hip Fracture pathways of care to make sustained improvements in the national key performance indicators for each speciality and improve the standards of care.

Time to Stroke Unit- April to March 2018 (Target within 4 hrs)				
	Time (hours)			
	Site		Average	
Month	MGH	TWH	Trust	National
Apr-17	3hrs 26mins	3hrs 52mins	3hrs 39mins	3hrs 47mins
May-17	3hrs 6mins	4hrs 1min	3hrs 34mins	3hrs 47mins
Jun-17	2hrs 50mins	3hrs 51mins	3hrs 21mins	3hrs 47mins
July-17	4hrs 54mins	13hrs 30mins	9hrs 13mins	3hrs 31mins
Aug-17	3hrs 50mins	7hrs 28mins	5hrs 39mins	3hrs 31mins
Sept-17	6hrs 14mins	16hrs 39mins	11hrs 27mins	3hrs 31mins
Oct-17	6hrs 8mins	8hrs 15mins	7hrs 12mins	3hrs 31mins
Nov-17	10hrs 11mins	15hrs 39mins	12hrs 75mins	3hrs 31 mins
Dec-17	8hrs 21mins	12hrs 30mins	10hrs 25mins	3hrs 31mins
Jan-18	4hrs 26mins	4hrs 58mins	4hrs 42mins	Not available
Feb-18	4hrs 4mins	4hrs 23mins	4hrs 43mins	Not available
Mar-18	4hrs 32mins	4hrs 54mins	4hrs 43mins	Not available

Although we have failed to meet the 4hr target consistently since July, this is not dissimilar to the National picture re increase in attendances to A&E. Since January, 2018 a culmination of other admission avoidance and discharge pathways are beginning to take affect to improve this picture. Despite this delay the plan of care is continued as per protocol.

Time to Orthopaedic Ward April 2017 –March 2018



Admission to the Orthopaedic unit at TWH has also been challenged during the course of the year and follows a similar pattern to Stroke (TWH site only) with 6hrs being the earliest timeframe for admission. As with Stroke patients every effort is made to deliver the standard pathway of care during this time.

- Development of pathways that will support the timely discharge of patients.
 - To work in partnership with our Community Trust and Social care partners to develop alternative models of care for our patients.
 - To improve the percentage of non-elective patients over 65 who return to

- Collaboration with KCHFT to support the timely discharge of patients back into primary care.
- Delayed Transfers of Care – Q1 5.9%; Q2 5.1%; Q3 5.2%; Q4 4.95% (national average is 3.5%).
- Establishment of 'Home First' Model which consists of 3 pathways:-
 - Pathway 1 – focuses on discharging the patient home with an emphasis on enablement and

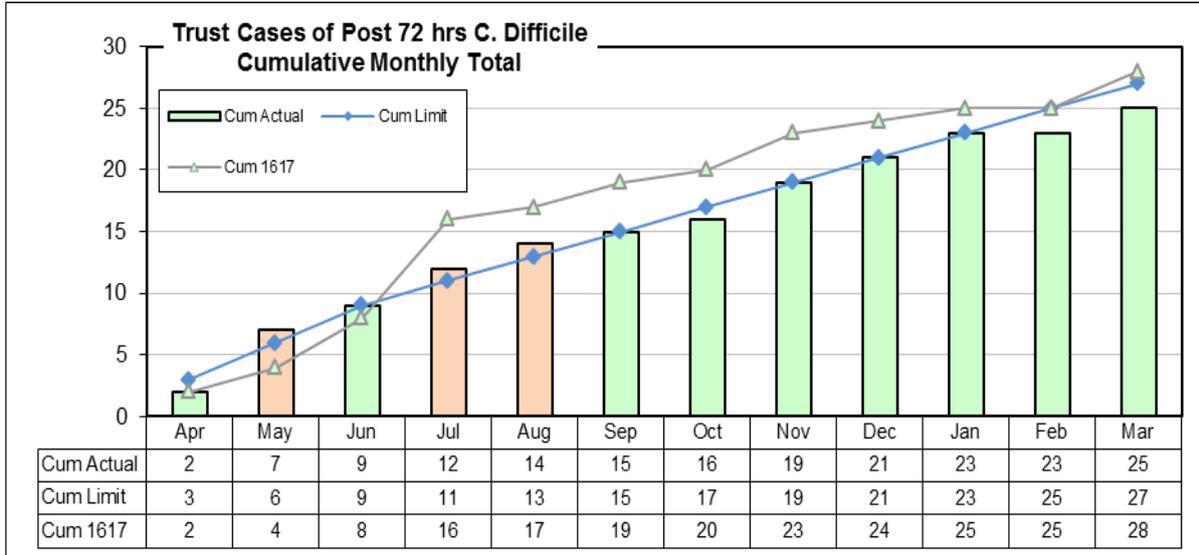
<p>their original place of residence by 2.5%.</p>	<p><i>independence now fully operational on both sites, capacity to take 47 patients per week who need care at home.</i></p> <ul style="list-style-type: none">○ <i>Pathway 2 – aimed at those needing ongoing rehabilitation in an inpatient setting before going home- using 12 beds at Tonbridge Cottage hospital to focus on patients who need therapy but no nursing care.</i>○ <i>Pathway 3- for individuals who are likely to require ongoing long-term care, probably in a care home. Proof of concept completed and now agreed to full scale trial.</i>● <i>Work with local borough councils to establish a housing and health role to assist patients with housing needs, tenure neutral. This includes those who are homeless.</i>● <i>Baseline for 17/18 was 70% therefore the target was set at 72.5%; Year-End achieved at 77.3%.</i>● <i>Readmission rate for patients discharged home is also reducing – from 25.23% baseline period 2016/17 to 23.33% 2017/18.</i>
---	---

DRAFT

Review of Quality Performance



Infection Control – Clostridium Difficile cases – The Trust achieved this standard with 25 cases against a maximum of 27 cases for the year equating to a rate of 9.5 CDifficile Case per 100,000 occupied bed days.

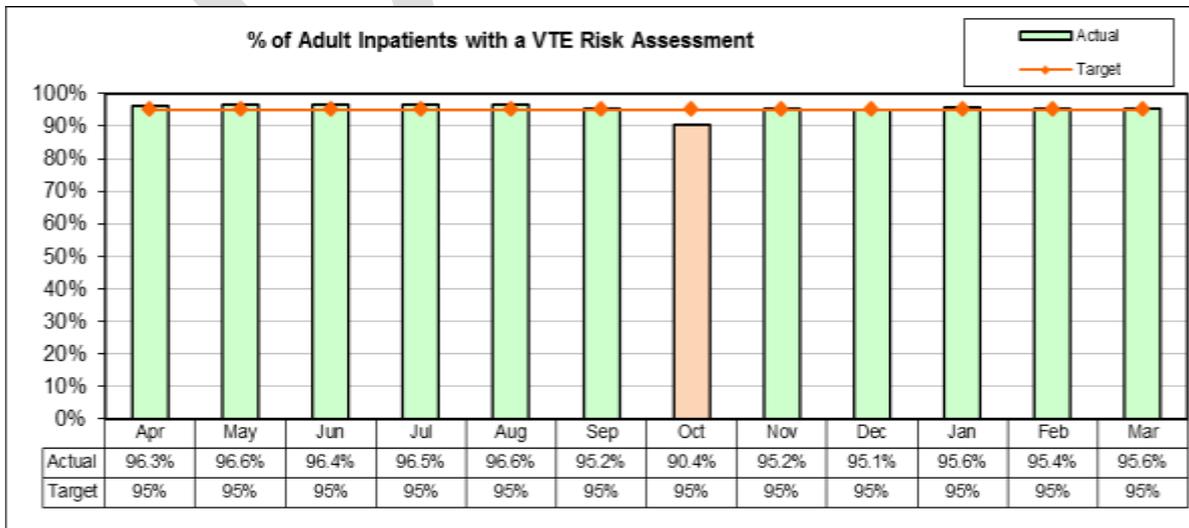


Infection Control – MRSA Bacteraemia cases – The Trust achieved the standard with zero cases of post 48 hr MRSA bacteraemia through the year.

Prevention of blood clots or venous thromboembolism (VTE)



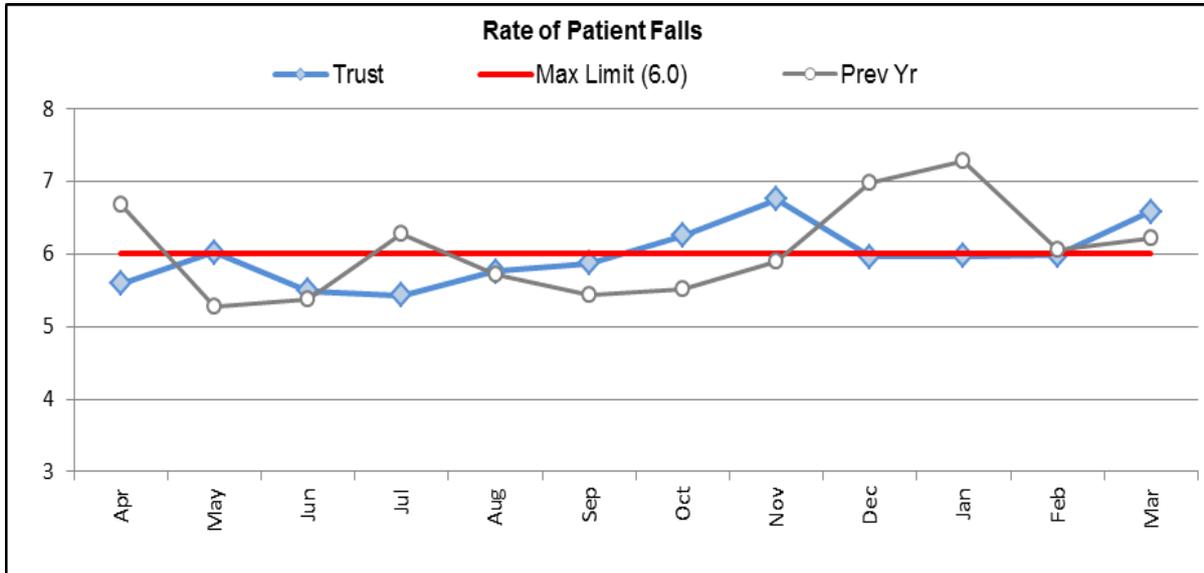
% Patients VTE Risk Assessment – The Trust ensured that 95% of patients were given a VTE Risk Assessment in 2017-18 at 95.4%.



Reducing the number of patient falls



Rate of Falls – The Trusts’ rate of Falls per 1,000 Occupied Bed days is below the Trust maximum limit of 6.0 at 5.98 at year end (6.07 for the previous year).

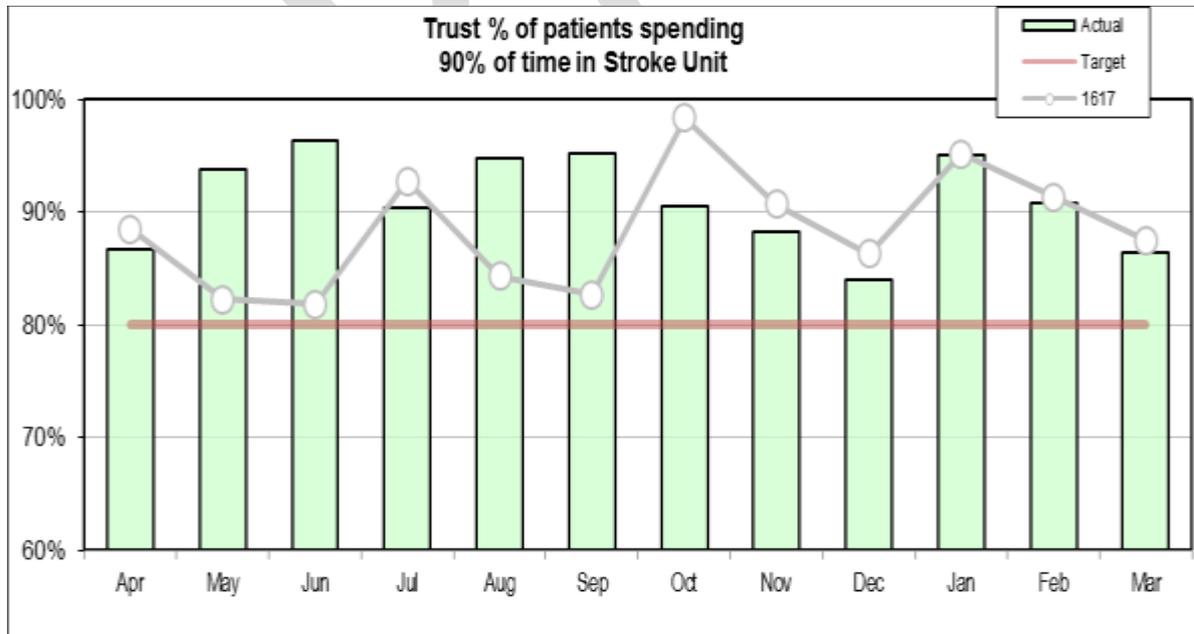


CLINICAL EFFECTIVENESS

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



80% of patients spending 90% of time on the Stroke Unit - The Trust achieved this standard of 80% of stroke patients to spend 90% of their time on a dedicated stroke ward in 2017-18 at 91.08% compared to 88.5% in 2016-17.

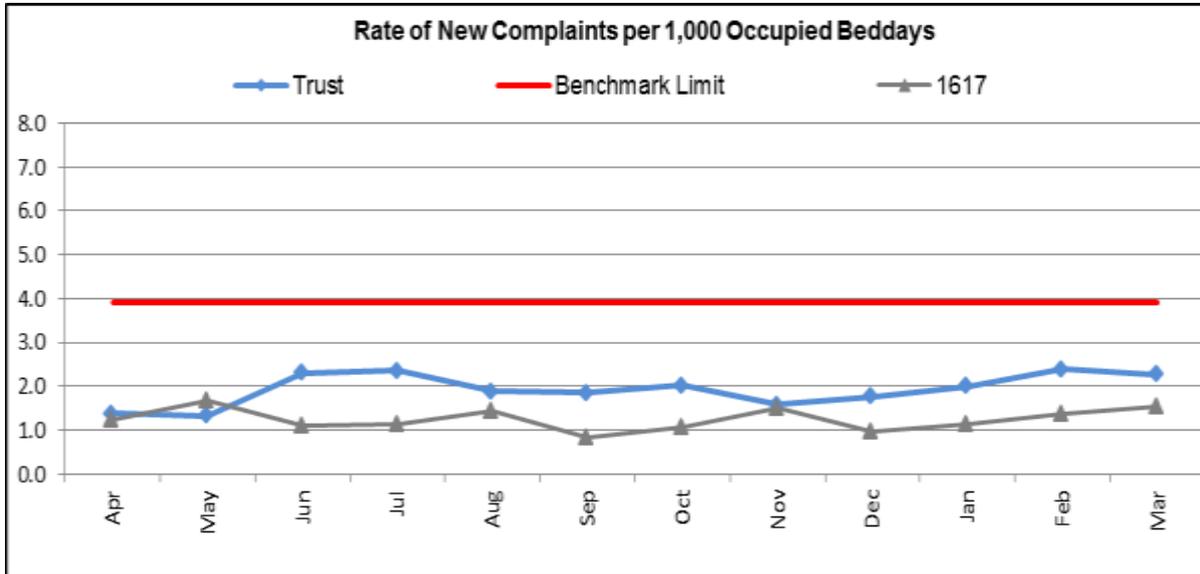


PATIENT EXPERIENCE

Complaints management



Rate of New Complaints- The Trust's rate of New Complaints per 1,000 episodes is within the expected range of between 1.318 and 3.92 at 1.93 for the year (2.47 for the previous year).



Complaints report summary

(Regulation 18 of the Local Authority, Social Services and NHS Complaints (England Regulations 2009)).

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

QUOTE: *Following our meeting on Wednesday, 11th October, 2017, I will begin by expressing that I felt our concerns over the nursing care of our Mother.....whilst a patient with you, were accurately listened to and we were shown sincere empathy.*

Complainant

During 2017/18 we received 503 new complaints compared to 332 during 2016/17. The rate of complaints per 1,000 occupied bed-days was 1.93 for the year (lowest/highest decile range of 1.32 to 3.92). It is our aim to investigate and provide a full response to all formal complaints within an agreed timeframe of either 25 or 60 working days of the complaint being received, depending on the severity of the complaint. We responded to 60.2% of complaints within the agreed timescale against a target of 75%. Meeting our target has been challenging this year due to a combination of recruitment challenges within the central complaints team and significant and sustained levels of operational activity, resulting in prioritisation of the delivery of clinical care over other responsibilities. We are confident in our complaints handling approach; however we recognise that complaints requires greater focus within the clinical directorate teams in order to improve our response times and meet the expected standards in 2018/19.

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

DRAFT

Patient Surveys

National Patient Surveys

During 2017 the Trust undertook three National Surveys. Although they are led by Picker Europe and the CQC we have been undertaking these in house. The surveys include the following:

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

The Maternity Department survey previously was undertaken on a bi-annual basis, the last audit performed prior to 2017 was in 2015. The 2017 results were published on the CQC website on the 30th January 2018. The Children and Young Persons Survey was a further survey added to the NHS Patient experience survey programme. The results were published on the CQC website on the 28th November 2017. The Inpatient Survey is run on an annual basis. The data was submitted to CQC/Pickers Europe in January 2018 and the results are yet to be published. Responses to these questions are also regularly collected as part of our local patient survey and the corresponding actions plans are monitored by the Patient Experience Committee.

Adult Inpatient Survey 2016

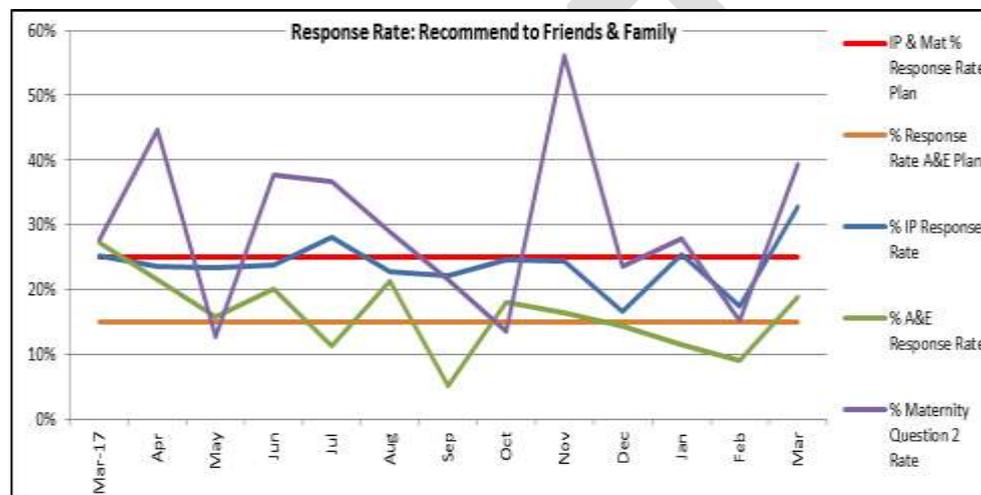
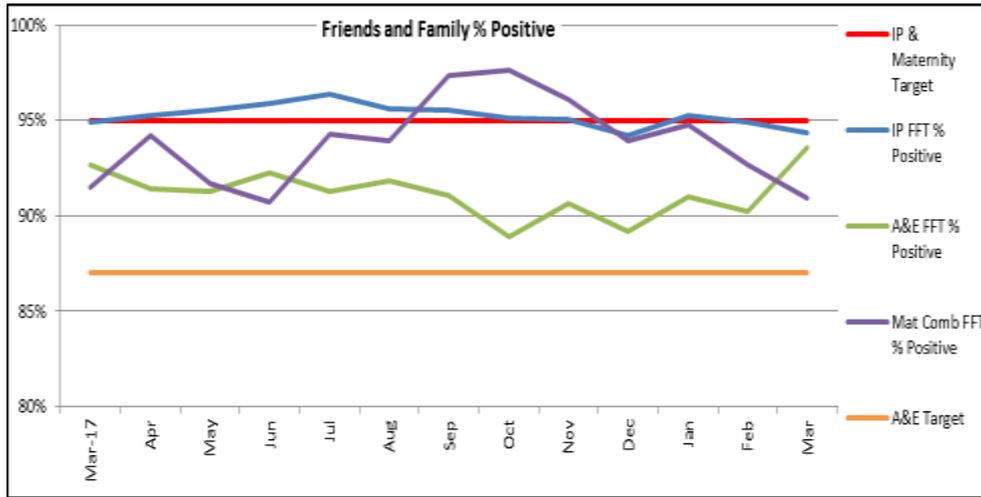
Focus questions from National Inpatient Survey		National Inpatient Survey	Local Survey	Local Survey
		2016	2016/17	2017/18
1	Were you involved as much as you wanted to be in decisions about your care and treatment?	91.0%	88.0%	89.0%
2	Did you find someone on the hospital staff to talk to about your worries and fears?	47.7%	92.0%	94.0%
3	Were you given enough privacy when discussing your condition or treatment	92.8%	96.0%	97.0%
4	Did a member of staff tell you about medication side-effects to watch for when you went home?	39.4%	80.0%	85.0%
5	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	66.3%	87.0%	87.0%

Friends and Family

The Inpatient and A&E positive response rates (95.3%, 91.2% respectively) have exceeded the Trust plan indicating that patients would recommend the Trust to their Friends and Family. However the Inpatient positive response rate narrowly missed the national benchmark of 95.8% at 95.3%. Maternity did not meet either the Trust target of 95% or the national benchmark of 95.6% at 93.9%.

Maternity and A&E response rates however both exceeded the planned Trust rate and the national benchmarks at 29.5% and 15.3% respectively, whereas the Inpatient response rate did not achieve either at 23.9%.

MTW Friends and Family scoring



Staff Survey 2017

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



KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

This is reported at 26% which is a 1% increase from the 2016 survey findings and is 1% higher than the National 2017 average for acute Trusts.

The unweighted scores for KF 25, 26 and 21 split between White and BME staff is as follows:

White	26%	(2016 findings – 25%)	(National average for acute Trusts – 25%)
BME	25%	(2016 findings – 21%)	(National average for acute Trusts – 27%)

KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.

This is reported at 90% which is the same as the 2016 survey findings and is 5% higher than the National 2017 average for acute Trusts.

The unweighted scores for KF21 split between White and BME staff is as follows:

White	91%	(2016 findings – 89%)	(National average for acute Trusts – 87%)
BME	78%	(2016 findings – 91%)	(National average for acute Trusts – 75%)

NHS National Staff Survey Actions

One of the key findings from the 2017 NHS National Staff Survey is an increase in the reports of staff experiencing harassment, bullying or abuse from patients and the public. This is reflected in the Trust's action plan which sets to launch a Zero Tolerance campaign with visible signage around the Trust sites, action warnings and provision of support for staff. Alongside this will be the publishing of reporting mechanisms including the use of Freedom to Speak Up Guardians, staff networks and champions.

Workforce Race Equality Standard (WRES)

The WRES for 2017 was published in July along with an action plan which is overseen by the Cultural Diversity Network and progress reported to the Workforce Committee. The action plan focuses on recruitment which includes ensuring a positive inclusion statement is seen in all MTW job advertisements, unconscious bias training is built into the recruitment training programme and a review of selected recruitment outcomes occurs annually to ensure fair process. In addition, a review of selected disciplinary cases has been undertaken which shows evidence of fair process in all decisions.

Cultural Diversity Network

A range of activities marked the launch of the Trust's Cultural Diversity Network in June 2017. The Trust hosted talks from NHS Employers, which prompted discussion about what diversity means to individuals, a powerful and poignant talk from a senior member of staff about resilience and a panel consisting of staff, the NHS Leadership Academy and NHS Digital which profiled cultural differences and inclusion within the NHS. Periodically during the year, the Network produces articles relating to belief and religious festivals including "12 days of Christmas – a look at how Christmas is celebrated by different cultures", Chinese New Year, Diwali, Easter, Ramadan and May Day.

Learning from Serious Incidents / Never Events

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

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

The Trust declared 173 SI's in 2017/2018 compared to 100 the previous year.

Although there has been an increase in the number of SI's being reported during 2017/18, we have attributed a proportion of these to changes in the National agenda ie the Early Notification Scheme for Maternity and Learning from Deaths. In addition we also believe that the SI investigatory process has matured to an extent where a fair and transparent process is evident to both our patients and staff supporting them to raise appropriate concerns that warrant further investigation.

As a result of the 173 SI's declared, 23 were subsequently downgraded following completion of the investigation. It was identified that there was no significant learning for the Trust and all appropriate actions were already in place. These cases were discussed with the West Kent Clinical Commissioning Group Quality Leads who substantiated our findings that these cases no longer met the SI criteria. This has reduced our total incidents reported down to 150 during 2017/18. This number has the potential to reduce further as we continue to investigate those that remain open.

Actions and learning from SI's are key to improving patient care and ensuring patients are safe and provided with high quality care. In 2017/2018 learning and actions included:-

- Revision of the WHO safety checklist to include:-
 - a section for anaesthesia; 'Stop Before You Block'.
 - Central Venous Access (CVA) line insertions.
 - clarification and a change of wording to make explicit the number of specimens with suitable descriptors.
- 'Stop Before You Block' to become mandatory practice.
- Revision of specimen standard operating procedure to include verbalisation of detached specimen by surgeon and recording of said specimen on practitioners swab count board.
- Relaunch of the Swab, Sharps and Instrument policy and procedure to ensure good communication to all theatre staff.
- Relaunch of the Sepsis policy and procedure, Screening and action plan in the Emergency Department.
- Standard Operating Procedure implemented for the delivery, receipt and supply of external prescriptions (FP10s).
- Education to all staff on the importance of incident reporting on Datix.
- Creation of the perfect Accident & Emergency assessment (CAS) card to include:-
 - amendments to the prescription section and time at which medication is prescribed.
 - column to record the time of initial observations.
- Training for staff on the Gap and Grow pathway.
- Review of capacity for scanning and creation of additional scanning slots.

- Development of a clear pathway for scans required within 72 hours.
- Review of the Standard Operating Procedure for the Birth Centre to ensure allocation of substantive staff during periods of short notice vacancies.
- Training on 'informed consent'.
- Importance of quality communication between teams.
- Importance of the quality of documentation in the patients records.

the 173 SI's declared in which the investigations had completed, it was identified that there was no significant learning for the Trust and all appropriate actions were already in place for 23 of these. These cases were discussed with the West Kent Clinical Commissioning Group Quality Leads who substantiated our findings that these cases no longer met the SI criteria. These were subsequently downgraded bringing our total incidents reported down to 150 during 2017/18. This number has the potential to reduce further as we continue to investigate those that remain open.

Never Events

There were 4 Never Events during 2017/2018, a full root cause analysis was undertaken and presented to the Executive led panel and findings shared with NHS Improvement to ensure wider learning.

The first Never Event was identified in October 2017 – Wrong side shoulder nerve block

A patient was admitted for a sub-acromial decompression and arthroscopy on their **left** shoulder. The patient had been previously seen for pre-assessment checks and advised of the risks and benefits. The surgical site was marked appropriately as part of the pre-operative checks and the patient was subsequently induced for Anaesthesia. Following this a **right** sided interscalene nerve block was performed.

A number of factors contributed to this incident:-

- The anaesthetic chart was not completed at the same time as the patient was assessed prior to their surgery, this was recorded afterwards and there was a reliance on memory. Subsequently the patient's notes were marked with the incorrect side.
- The marking of the surgical site (upper forearm) was not visible at the time of the block having been covered up by the patient's gown.
- The anaesthetist performing the block was not present at the time of the WHO surgical checklist procedure and there was no formal 'Stop Before You Block' check prior to the regional block being administered.

The second Never Event was identified in November 2017 – Retained swab

The patient was admitted for an elective right hemicolectomy and defunctioning loop ileostomy for Crohn's disease at Maidstone Hospital in August 2017 under the care of the Lower Gastrointestinal team. He later attended an outpatient appointment during October 2017 to discuss a reversal of the ileostomy and underwent a CT scan which highlighted that in the right upper quadrant some dense material could be seen. This was discussed with the patient and he was booked for a closure of ileostomy and removal of foreign body in November 2017. During this procedure the dense material in the patient's abdomen was found to be a retained swab.

The contributing factors were:-

- The challenge of the initial surgery due to the longstanding history of Crohns having unsuccessfully tried various courses of medication.
- Lack of consistency in performing the swab counts with several circulating practitioners participating with the scrub practitioner. Compounded by the lack of consideration given to the fact that the second theatre practitioner was scrubbing for the next case and would

need to leave the theatre early.

- 3 x 4 swabs do not have tags sewn into them so they cannot be clipped onto the sterile field as a precautionary measure.
- A clear plastic bag was used for the countdown of the swabs leaving the sterile field, difficulty in clarifying the number of swabs in each bag, challenge of checking number once initial count performed.

The third Never Event was identified in January 2018 – Medication Incident

Currently under investigation, the details known to date include:-

- Administration of oral oxycodone via a subcutaneous syringe driver rather than injectable oxycodone.

Actions immediately taken:-

- Duty of candour - apology given to relatives.
- Staff members concerned supported via Practice Development Nurse and line manager.
- Reflective accounts undertaken.

The fourth Never Event was identified in January 2018 – Patient underwent wrong procedure

Currently under investigation, the details known to date include:-

- Patient was consented for a flexible sigmoidoscopy using consent form 4 (for adults who are unable to consent to investigation or treatment).
- Patient underwent an oesophago-gastro duodenoscopy (OGD).
- Wrong procedure was identified by the ward on handover from endoscopy staff.

Actions immediately taken:-

- Duty of candour - apology given to relatives.
- Memo sent to all endoscopy staff highlighting issue and extra vigilance with checking procedures.

Duty of Candour

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

Serious Incidents

173 Serious Incidents were declared in 2017/18.

During this financial year, we have demonstrated a decreased compliance with the 3 elements of meeting Duty of Candour for patients involved in a Serious Incident (SI).

According to our current database 17.4% of patients involved in a SI did not receive an initial Duty of Candour letter in 2017/18 compared to 10% the previous year.

At the time of this report, 15% of the declared SI's remained open and under investigation. Of the 85% that were closed, 48.9% have been sent the final outcomes of the investigation. This is

compared to 55% compliance during 2016/17 and means that communicating the outcome of the investigation to the relevant person has also demonstrated a decrease in compliance.

Incidents

Excluding Serious Incidents, 294 incidents were reported on the incident reporting system which also met the criteria for Duty of Candour. 44% of these had evidence that an initial Duty of Candour letter was sent to the patient / relevant person. Of these 44%, 54.6% were within the 10 day standard. At present, we are not able to ascertain the number of verbal apologies or shared outcome of investigations that have occurred as there is presently no reliable way of capturing this data.

Actions for 2018/19 to achieve compliance

In addition to Root Cause Analysis training sessions arranged for 2018, we are reviewing the education required for departmental managers and will be launching a revised training agenda.

A review of all initial letters by the central team in terms of quality whilst ensuring that the standard meets the level of compliance required. The central team will also ensure that there is an identified person and relevant address to support communication of the outcome of that investigation.

Dedicated time has also been established to concentrate on these levels of incidents which meet the Duty of Candour criteria in order to improve compliance with these requirements.

Engagement is being sought with our database administrators to look at the incident reporting system as a repository for the evidence for Duty of Candour and also to look at the possibility of flagging the incidents which meet the criteria.

A quarterly report will be implemented during 2018/19 to help support improvement with monitoring and provide assurance to the Trust Clinical Governance Committee.

Duty of Candour training will also be revisited to ensure that the maximum number of staff requirements can be met through a variety of approaches, both formal and informal.

Seven Day Services- 7DS

The national Seven Day Services Programme (7DS) is designed to ensure that patients who are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. Ten clinical standards for seven day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh which involved a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges on consultant-delivered acute care. These standards define what seven day services should achieve, no matter when or where patients are admitted.

The aim is to deliver a faster diagnosis to patients, faster diagnostic testing and for patients to spend less time in hospital. The standards focus upon the time between the patient's admission to hospital and their first review by a Consultant, the timing of consultant-led ward rounds, the protocols and arrangements that must be in place for patients who do not require consultant-delivered care, standards regarding the timing of diagnostic tests, and other standards covering patient experience and quality, the content and timing of shift handovers, the involvement of the multidisciplinary team and some standards for primary, community and mental health provider colleagues. Four of these standards were designated as priority standards. These are the minimum set of clinical standards needed to tackle variation in mortality, patient flow and

experience and focus mainly on the consultant-delivered and diagnostic aspects of the standards outlined above.

MTW has a mature project in place to oversee the implementation of the 10 National Clinical Standards and during 2017/18 the project team have:-

- Forged formal links with the national team.
- Engaged a lead from West Kent CCG.
- Identified the CCG's monitoring requirements and submitted monthly reports.
- Created and regularly updated the MTW 7DS programme plan.
- Completed the National survey – September 2017.
- Met compliance for the 4 priority standards in both Ophthalmology and Children's services.
- Instigated an evening Ward Round in Orthopaedics.

Preparation is underway for the next round of auditing, the results of which will help inform the further development of the action plan and team objectives. Regular updates are provided to the Trust Management Executive which monitors and supports the project's schedule for delivery.

Learning from Deaths

Following guidance published by the National Quality Board (NQB) in March 2017 and the CQC (Learning, Candour and accountability Report) in December 2016, a Learning from Deaths Review Group was established. Its purpose was to oversee and support the key deliverables of the Mortality Surveillance Group, thereby ensuring that a robust process was established to review each death attributable to MTW.

The key deliverables of the Learning from Deaths Review group included:-

- Introduction of a Revised Policy & Procedure for undertaking Mortality Case record reviews.
- Revision of the mortality review documentation in line with recommendations from the Royal College of Physicians.
- Establish a reporting process and structure.
- Production of a Duty of Candour patient information leaflet.
- Review of the trust Mortality review database and potential for alternative solutions that would support the process to be timely and accessible.

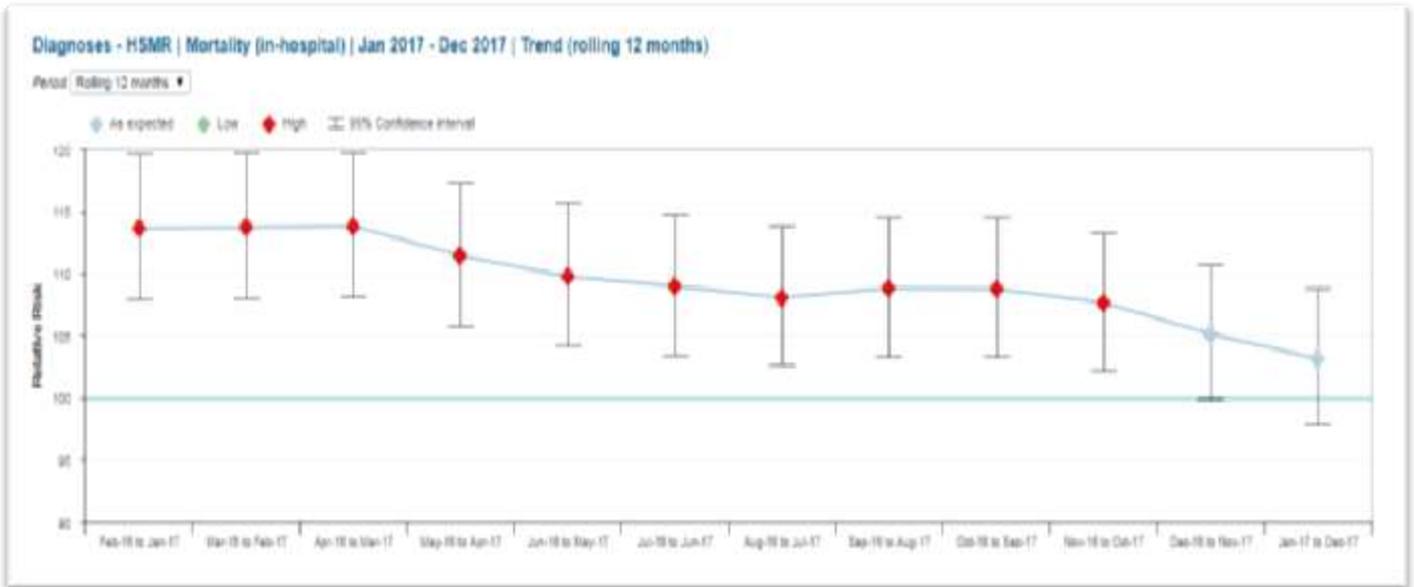
The Trust Mortality Surveillance Group (MSG) has been in place since January 2016 and meets monthly to review all hospital related mortality data, identify trends and share learning.

The MSG reports bi-monthly to the Trust Clinical Governance Committee and in addition regular reports are submitted to the Quality committee and Trust Board. The chair of this Group is the Deputy Medical Director.

The MSG closely monitors both local and national data and interrogates these to identify themes and trends that may be impacting upon our patient care. In particular we use the Hospital Standardised Mortality Rate (HSMR). This is a key indicator that compares us with our peers. When tracked over time the HSMR can indicate how successful a hospital has been in reducing deaths and improving care. In April 2017 our HSMR was recorded as 110 (a ratio of the actual number of deaths to the expected number of deaths) and in March we reported 103.1, the expected rate is 100 or below.

2 May 2017, via email (excerpt): ... My father sadly died today following a 4 week hospital stay at Maidstone Hospital, initially on Pye Oliver and then ICU. We are very quick to criticise but not very good at praising those professionals that go above and beyond in the most difficult of situations. I would like to thank all the staff including critical care nurse Tanya, ICU staff and consultant, the ward sister on Pye Oliver and consultant Dr Barnardo who took time throughout my father's stay to keep us informed...

Rolling 12 Month view- data from January-December 2017.



During 2017/18 the MSG has reviewed several conditions that were red flagged by Dr Foster as outliers against our peers. These included Fractured Neck of Femur; Pneumonia, Non-Hodgkins lymphoma and phlebitis. As a result of these audits actions taken include:-

- Opening of Theatre 6 at TWH. The audit revealed delays experienced by patients with hip fractures getting to surgery within 36-48hrs as per national guidance, this is known to negatively impact on mortality.
- Review of education for Junior doctors when completing death certificates. From the pneumonia audit there was recognition that in some cases this was not the most likely cause of death. As a result -
 - Training package was developed;
 - Inquest training day was arranged with support from the local Coroner;
 - Revised documentation made explicit that the Cause of Death must always be discussed with a Consultant or Registrar.
- Undertaking an audit of coded co-morbidities. As a result we have ensured that Senior coders review all deaths due to the complexities of order of codes required. This will ensure that the Charlson indicators are captured where appropriate. <http://www.drfooster.com/wp-content/uploads/2014/09/HSMR Toolkit Version 9 July 2014.pdf pg 36>.

Subsequent to these actions being taken these conditions no longer present with red flags.

In addition to monitoring national and local data the MSG also appraises the mortality reviews both in terms of compliance but also those reviews that warrant a more indepth investigation.

Each death that occurs in hospital is a sad and distressing event for the loved ones and staff involved in that person's care. For those deaths that are considered to be unexpected it is even more so. At MTW we recognise our responsibility to review the care that was provided to our patients and during September 2017 the methodology for these reviews was revised in line with national guidance (NQB) to follow a Structured Judgement Review (SJR) methodology endorsed by the Royal College of Physicians (RCP).

During 2017/18 MTW recorded 1858 patients who had died. 1732 inpatient (Inpt) deaths and 126 in Accident & Emergency (A&E). The revised process for undertaking mortality reviews was instigated in October 2017, at which point we moved from the old review system to the new. The previous process was labour intensive with a requirement for in depth reviews for all patients;

however there were low compliance rates. The findings from those reviews resulted in gradings of suboptimal or no suboptimal care (as demonstrated below). The new process involves a preliminary screen to determine those patients who require a more indepth review (SJR), the classification system previously used (Q1 & Q2) is no longer recorded, this transition is evident in the table below and reflected in Quarter 4*. The backlog in regard to reviews being undertaken is also demonstrated with new paperwork being completed for patients who had died in Quarter 2^.

Reporting Period April 2017 – March 2018

Maidstone & Tunbridge Wells NHS Trust	Q1	Q2	Q3	Q4	YTD
No of Deaths	448	396	470	544	1858
No of Completed Reviews	258	202	242	390	1092
%age completed reviews	57.6%	51.0%	51.5%	71.7%	58.8%
Unavoidable deaths, No Suboptimal Care	224	139	33	0*	396
Unavoidable Death, Suboptimal care	30	12	2	0*	44
Suboptimal care, possible Serious Incident	1	2	0	0*	3
Suboptimal care, a Serious Incident	1	0	0	0*	1
Unknown Classification	2	7	9	221	239
Preliminary Form Completed - SJR Not Requested	0^	23	96	61	180
Preliminary Form Completed - SJR Requested	0^	8	18	27	53
First Stage Review - SJR Not Requested	0^	9	67	66	142
First Stage Review - SJR Requested	0^	1	11	11	23
SJR Completed	0^	1	6	4	11
%age Unavoidable deaths, No Suboptimal Care	87%	69%	14%	0%	36%
%age Unavoidable Death, Suboptimal care	12%	6%	1%	0%	4%
%age Suboptimal care, possible Serious Incident	0%	1%	0%	0%	0%
%age Suboptimal care, a Serious Incident	0%	0%	0%	0%	0%
%age Preliminary Form Completed - SJR Not Requested	0%	11%	40%	16%	16%
%age Preliminary Form Completed - SJR Requested	0%	4%	7%	7%	5%
%age First Stage Review - SJR Not Requested	0%	4%	28%	17%	13%
%age First Stage Review - SJR Requested	0%	0%	5%	3%	2%
%age SJR Completed	0%	0%	2%	1%	1%

The purpose of the mortality review is to determine any death were it is considered that sub-optimal care has been provided, at which point the Serious Incident process is followed and Duty of Candour is instigated. This is an opportunity to then review our processes and procedures to make the necessary changes as a result of lessons learned.

During 2017/18 we identified 15 patients (0.8%) of the patient deaths who were judged to be more likely than not to have been due to problems in the care provided. In relation to each quarter this consisted of:-

- 2 representing 0.45% for the first quarter;
- 3 representing 0.76% for the second quarter;
- 6 representing 1.27% for the third quarter;
- 4 representing 0.74% for the fourth quarter.

Of the SJRs completed these deaths were considered to be:-

- Probably avoidable x 1
- Possibly avoidable but not very likely x 1
- No evidence of avoidability x 5
- Ungraded x 8

Subsequent to the release of the NQB Dashboards the RCP issued guidance that grading of deaths was not a requirement, at which point this practice ceased and is no longer collected.

In addition during 2017/18 221 reviews were undertaken between April – September 2017 which related to patients who had died in 2016/17. Of these 5 patient deaths were judged to be more likely than not to have been due to problems in the care provided to the patient

In an ongoing effort to improve the efficacy of the MSG and to learn lessons from the review process during 2017/18 we have:-

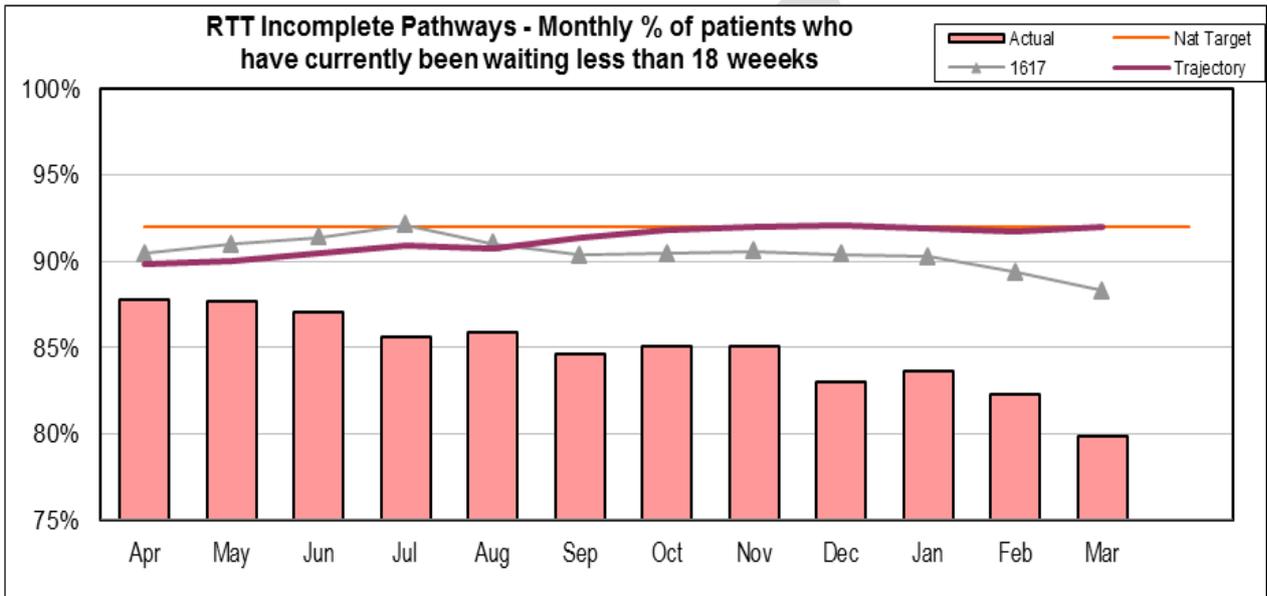
- Invited the local Dr Foster representative to attend our Mortality Surveillance Group to help us understand our data in more depth.
- Developed our own internal reporting framework for MSG to provide an integrated mortality report highlighting themes and trends for further investigation and assurances.
- Integrated Mortality Reviews with sub-optimal care with our Serious Incident process.
- Undertaken an external visit to a neighbouring acute trust to share information, processes and learning.
- Collaborated with Kings college hospital in the Amber Care Bundle research for Care of the dying patients.
- Benchmarking of our organisation with local trusts in regard to the coding list that is used to record co-morbidities to satisfy the requirements of Dr Foster.
- Local learning for Acute & Emergency medicine following declaration of SI following Mortality review:-
 - Revise the process for reviewing blood gases, local audit to be undertaken.
 - Frequency of observations, assurance required, local audit to be undertaken.
 - Adherence to VTE thromboprophylaxis guidelines and raised awareness in regard to the need to escalate concerns and report on Datix.
- Local learning for specialist medicine following declaration of Serious Incident following mortality review:-
 - Guidance to be shared at clinical governance meeting re the potential for hiatus hernias to strangulate and rapidly deteriorate.

Other Quality Monitoring and Improvement Standard

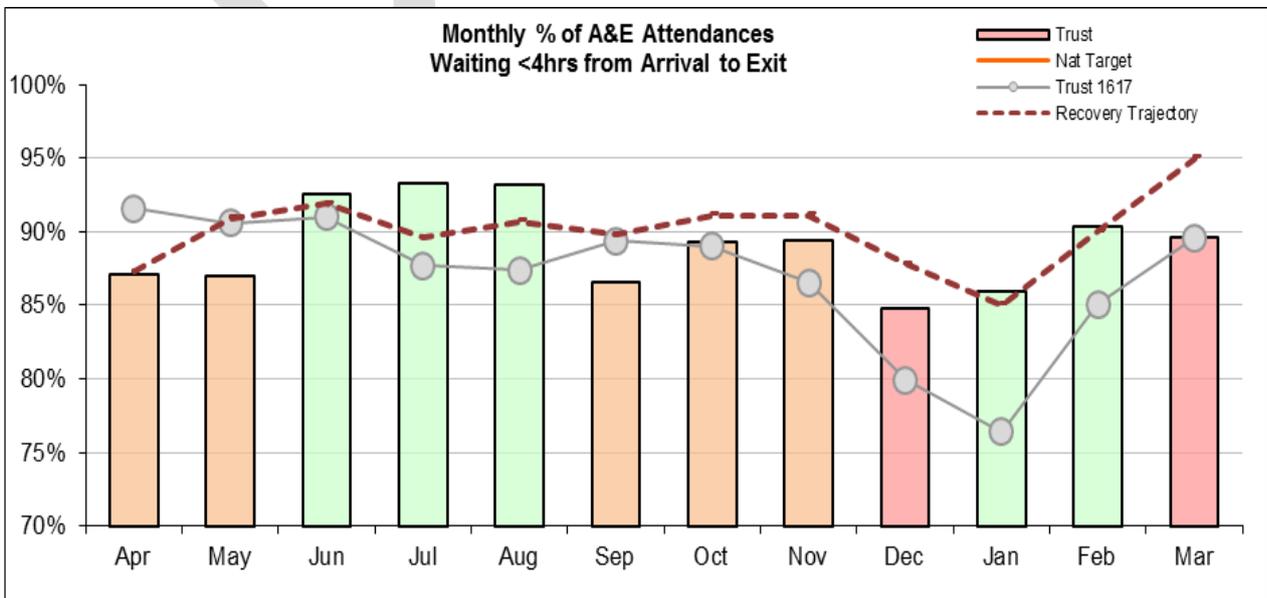
The following Standards are reported to the Trust Board on a monthly basis with ongoing action approved.



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

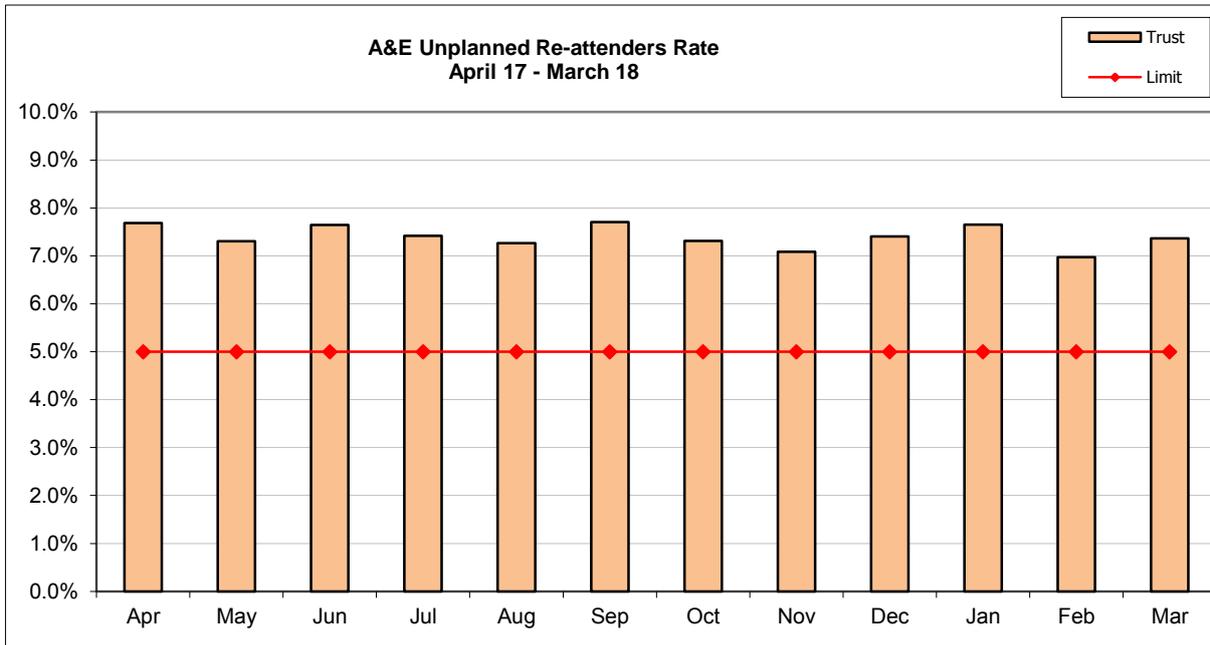


Emergency 4 hour access – The Trust did not achieve this standard of 95% of patients being seen, treated, admitted or discharged within 4 hours of arrival in its A&E departments in 2017-18. However at 89.1%, this is a 2% improvement on 2016-17.

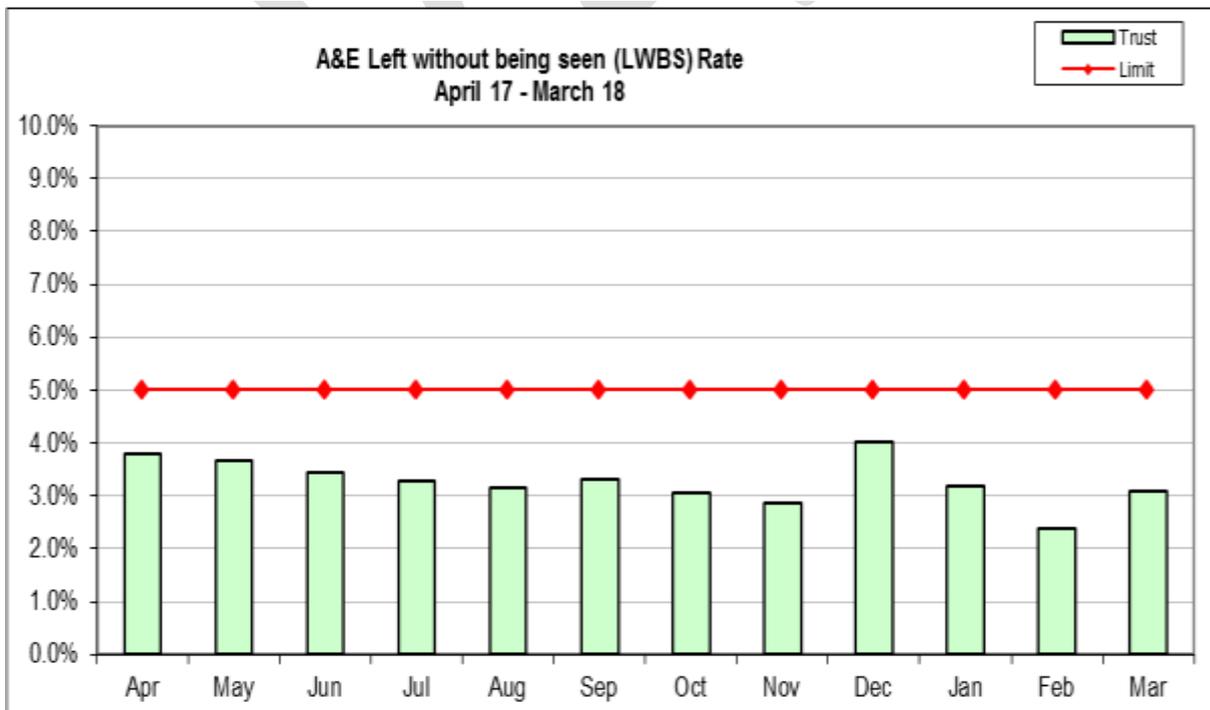




A&E Unplanned Re-attendance Rate – The Trust did not achieve this standard of less than 5% unplanned re-attendance rate at 7.4%.

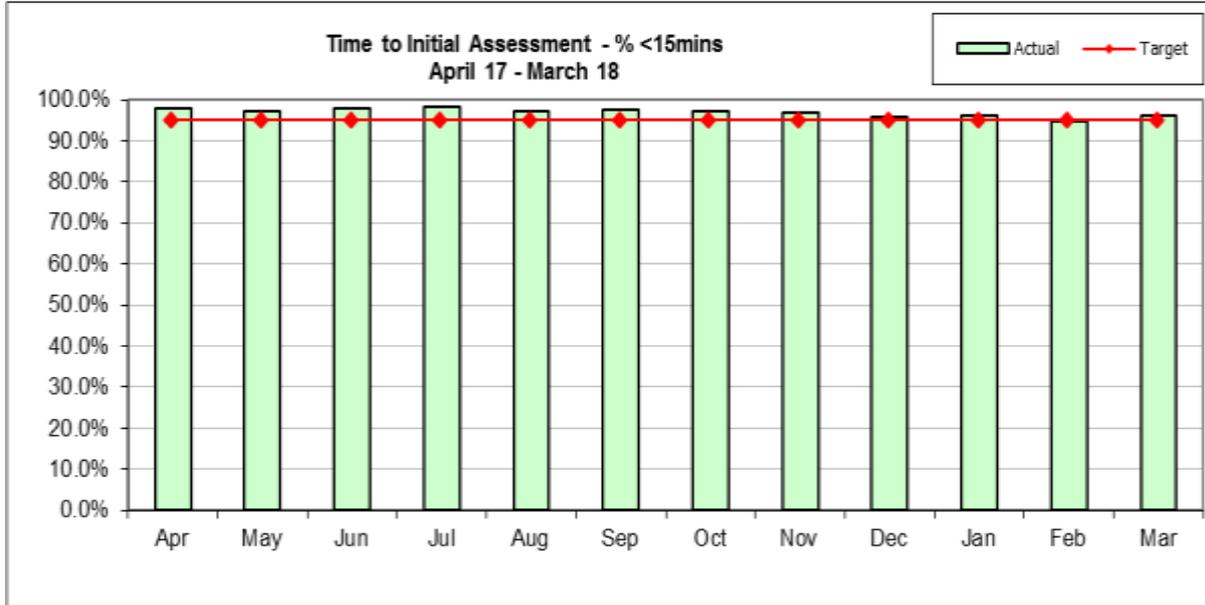


A&E Left without being Seen Rate – The Trust achieved this standard of less than 5% of patients leaving its A&E Departments without being seen.

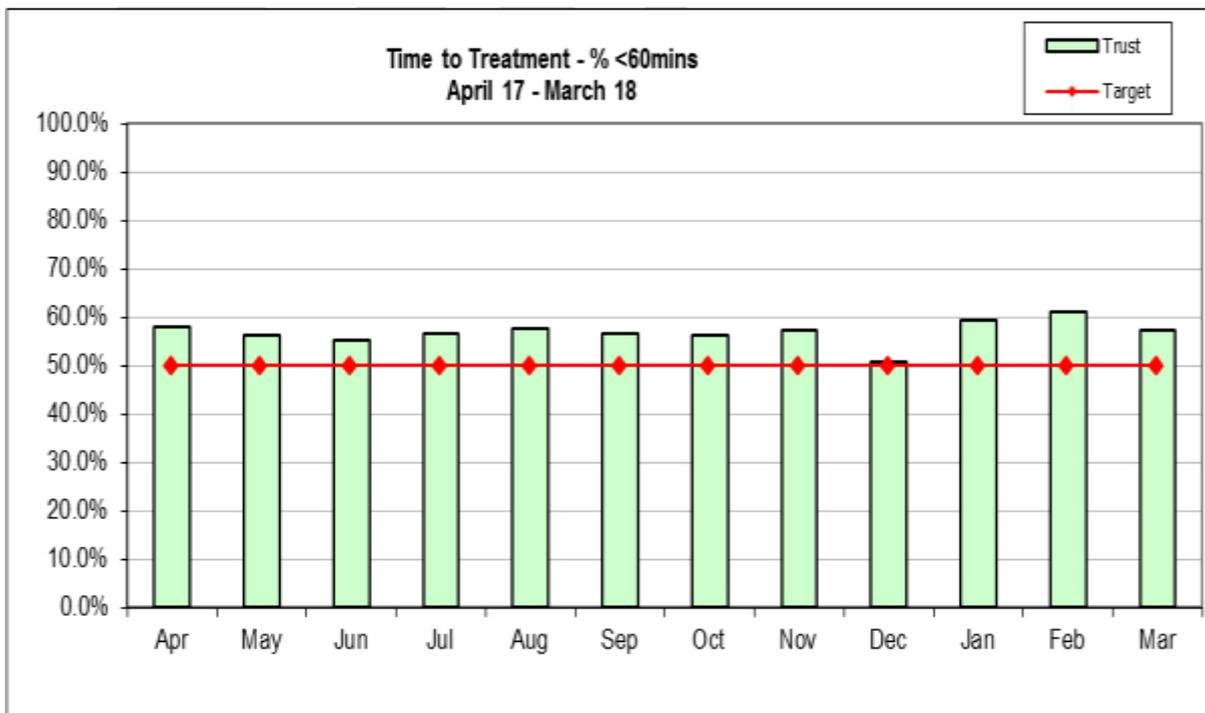




A&E Time to Initial Assessment <15 minutes – The Trust achieved this standard of 95% of patients arriving in its A&E Departments being assessed within 15 minutes of arrival.

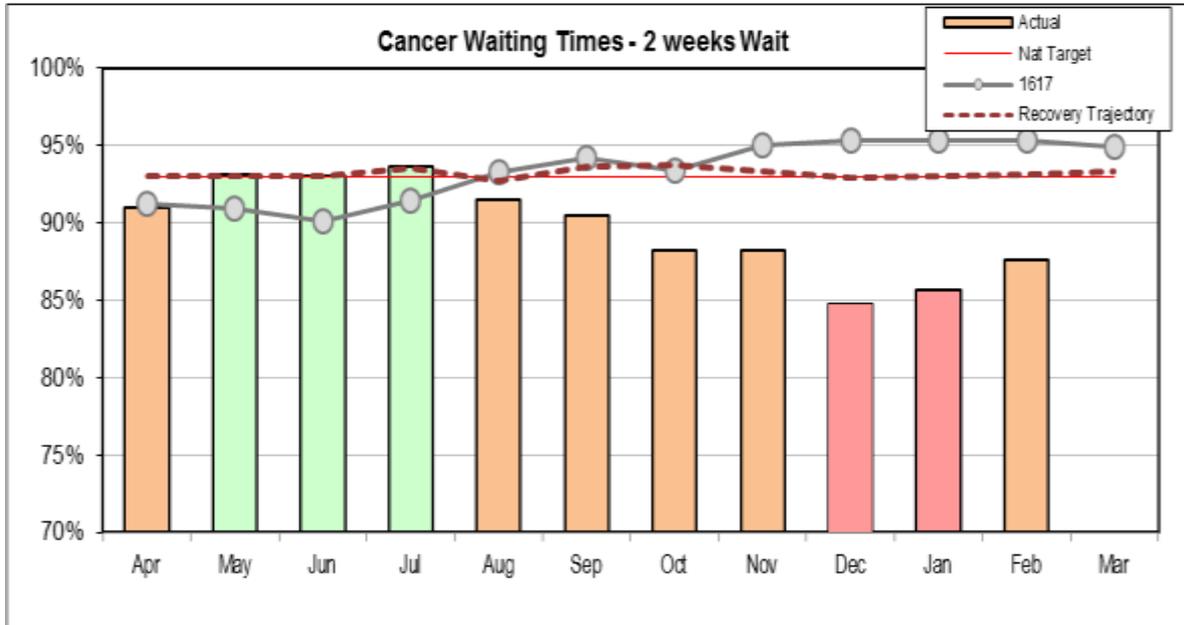


A&E Time to Treatment <60 minutes – The Trust achieved this standard of 50% of patients arriving in it's A&E Departments being treated within 60 minutes of arrival at 56.8%. This is no improvement on last year.

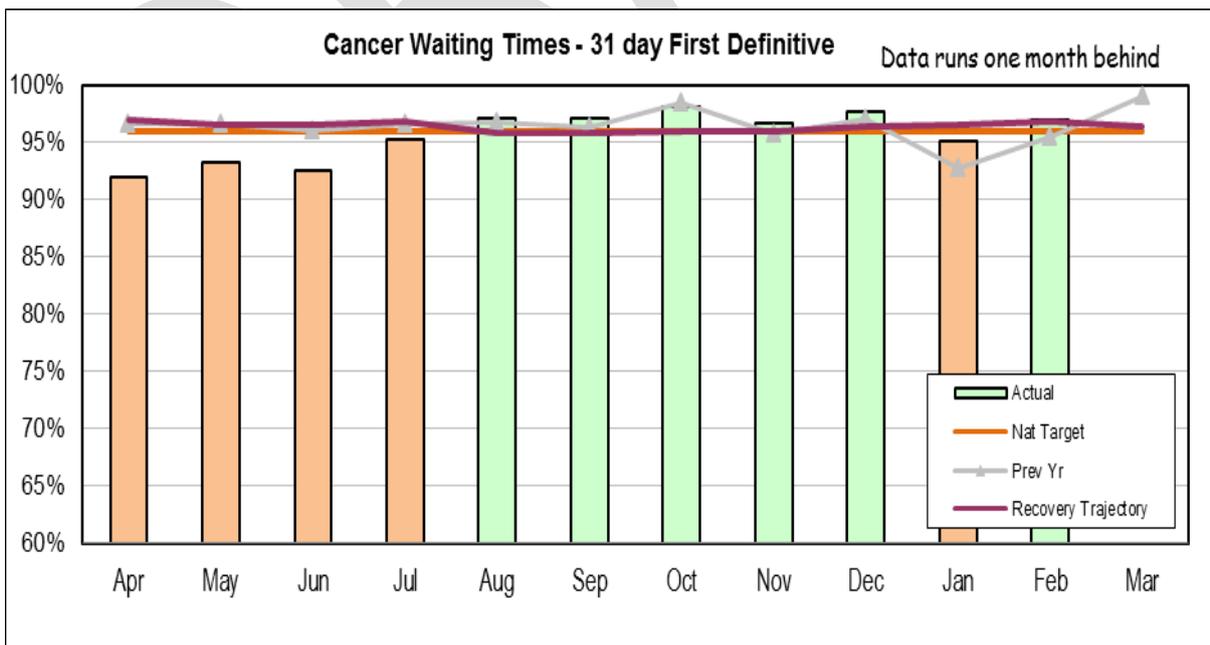




Cancer Waiting Time Targets - 2 weeks from referral – The Trust did not achieve this standard of ensuring that 93% of patients with suspected cancer were seen within two weeks.

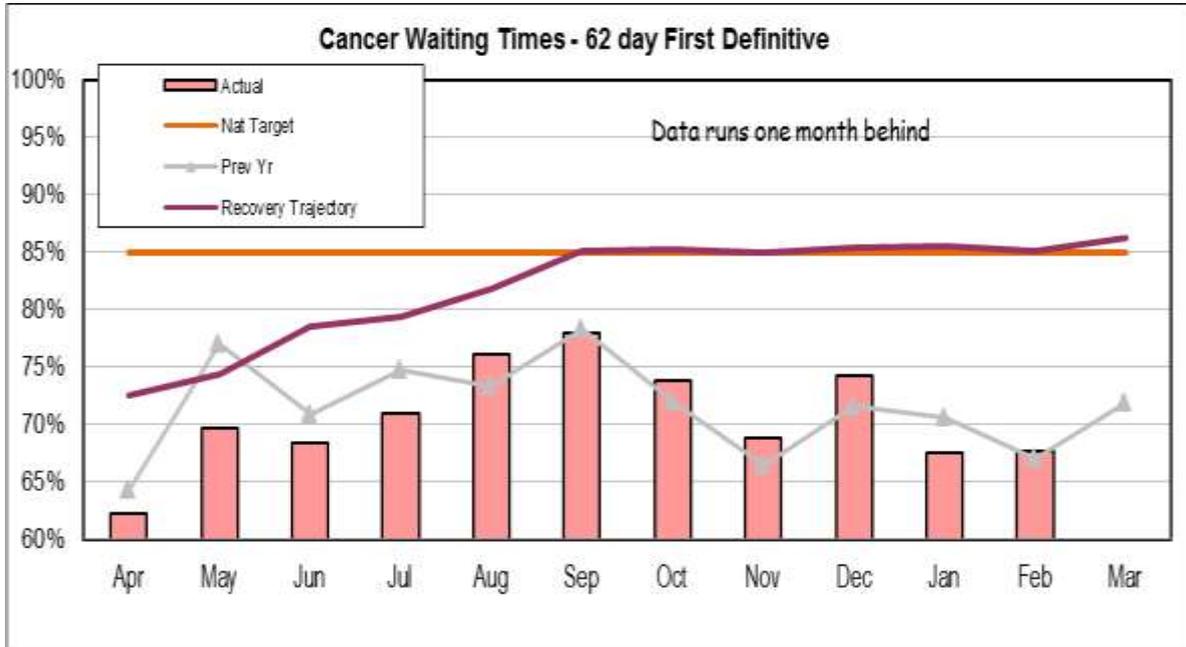


Cancer Waiting Time Targets – 31 Day First Definitive Treatment – The Trust has achieved this standard ensuring that 96% of patients who needed to start their treatment within 31 days did so.

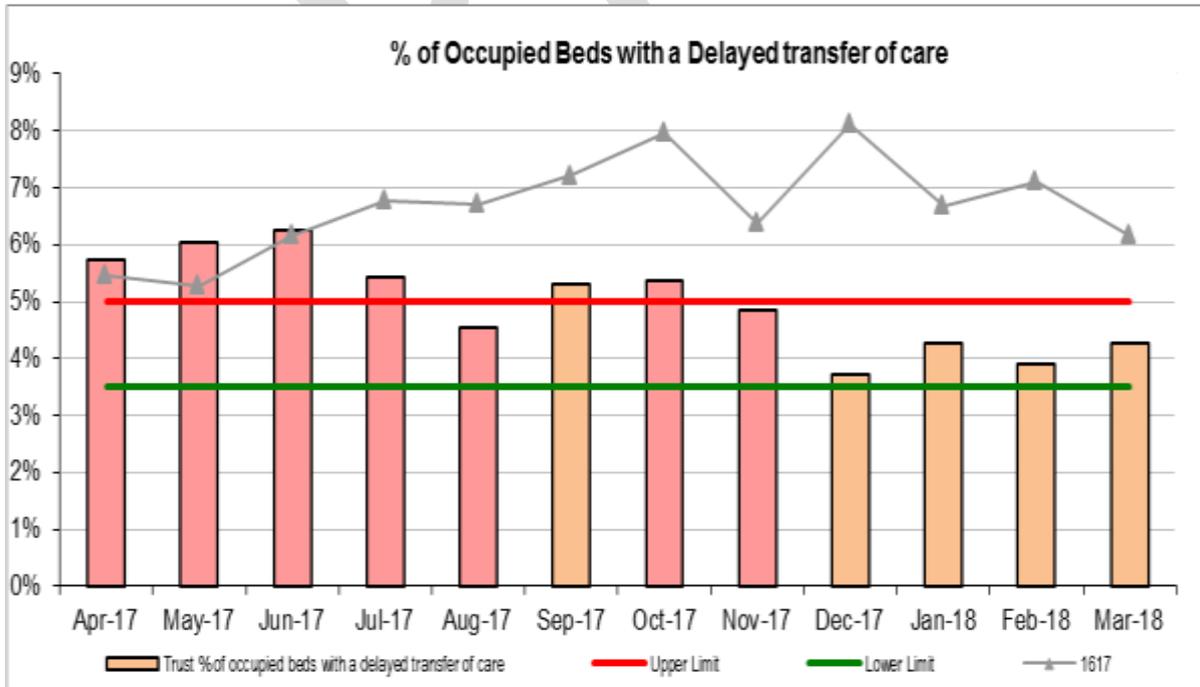




Cancer Waiting Time Targets – 62 day First Definitive Treatment – The Trust did not achieve this standard of 85% of patients who needed to start their first definitive treatment within 62 days.

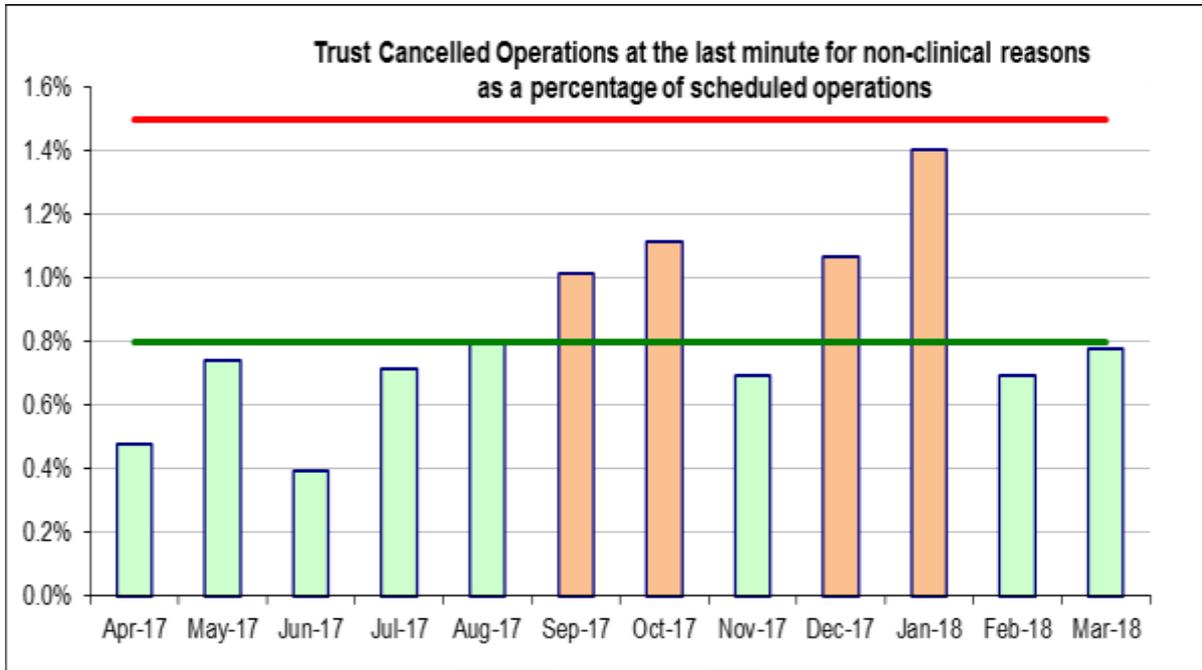


Delayed transfers of care – The Trust did not achieve this standard of Delayed transfers of care remaining below the national limit of 3.5% for the year. However, at 4.95% this is a 1.72% improvement on 2016-17.

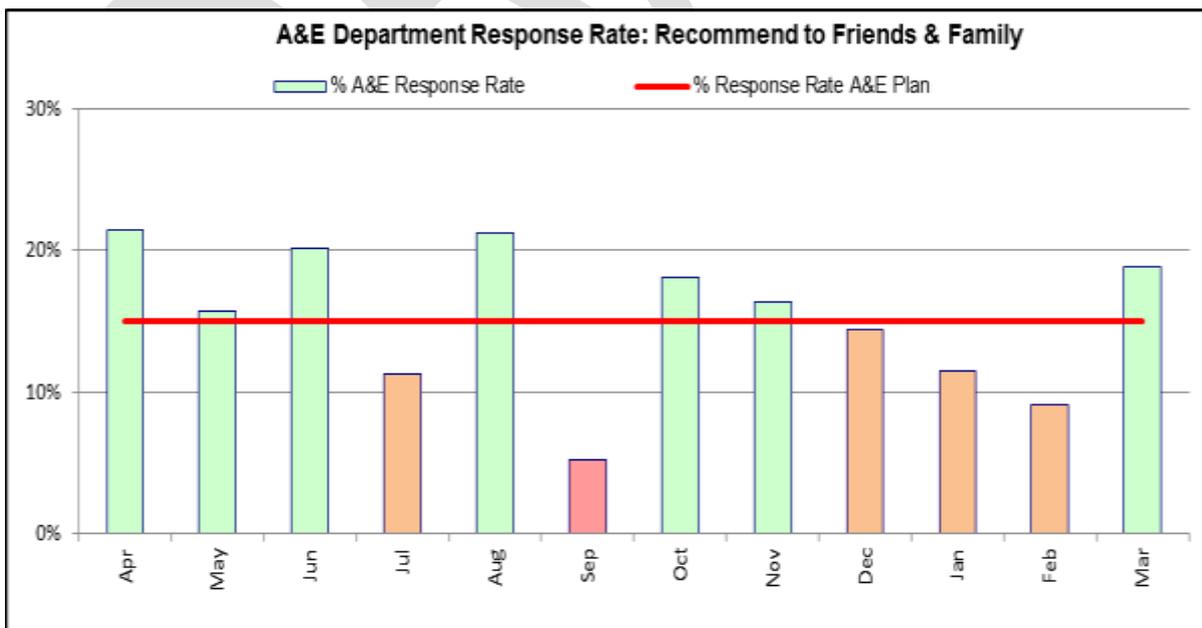




Cancelled operations – The Trust achieved this standard with 0.8% of operations cancelled at the last minute against the national maximum limit of 0.8%.

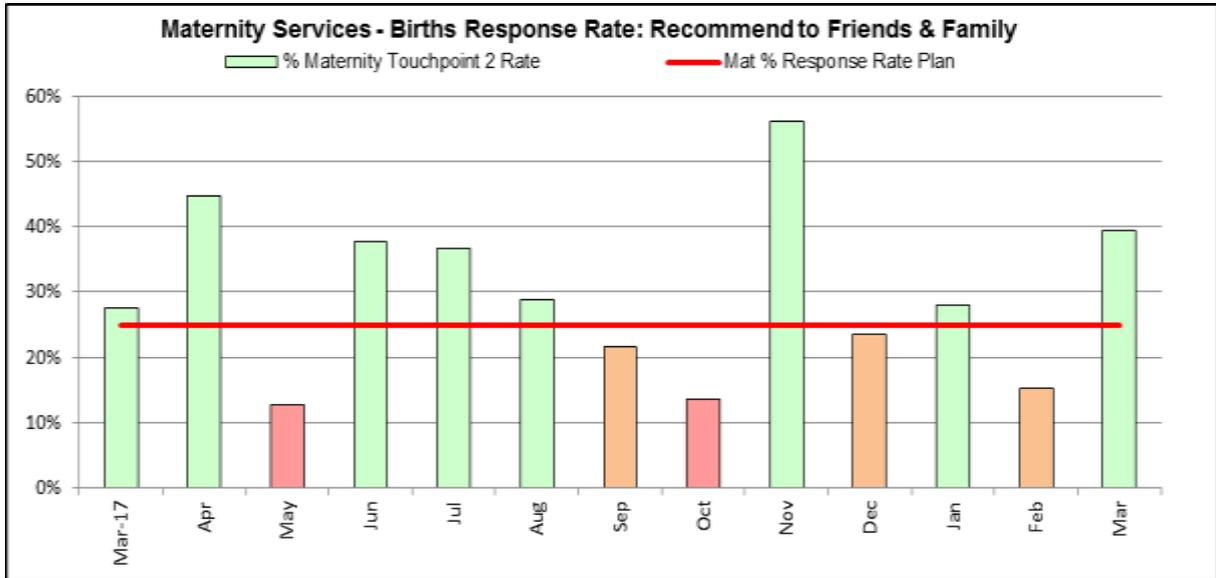


Friends and Family Test Response Rate A&E- The Trust achieved the target of 15% response rate for the Friends and Family Test given to patients in the A&E Departments at 15.3%. Of the responses received 91.2% were positive.

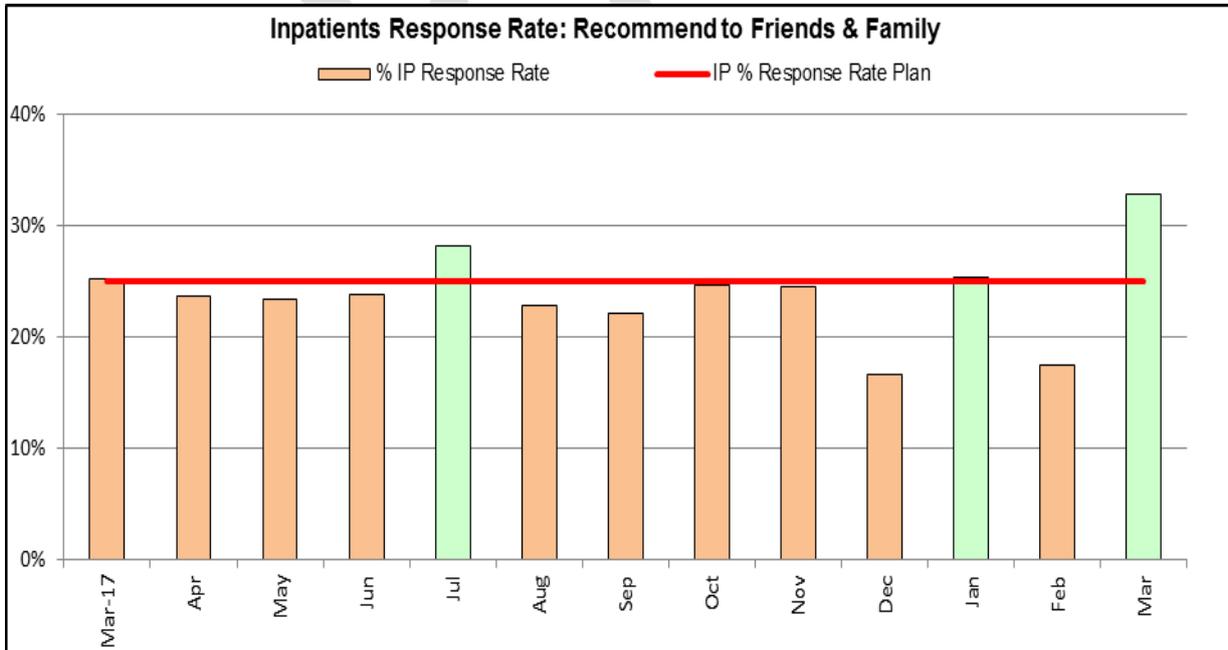




Friends and Family Test Response Rate Maternity- The Trust achieved the target of 25% response rate for the Friends and Family Test given to patients after giving birth at 29.5%. Of all the responses received for patients accessing Maternity Services 93.9% were positive.



Friends and Family Test Response Rate Inpatients- The Trust did not achieve the target of 25% response rate for the Friends and Family Test given to inpatients at 23.9%. Of the responses received 95.3% were positive.



National Indicators

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

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

The Trust has achieved a satisfactory rating of 74% for the Information Governance Toolkit. As part of this process audits of clinical coding and non-clinical coding have been undertaken as well as completing the “completeness and validity checks”.

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

The NHS Outcomes framework has 5 domains:

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

Domain	Prescribed data requirements	2017/18 local and national data	2016/17 local and (national) data	National average
	The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to —			
1 & 2	(a) the value and banding of the Summary Hospital-level Mortality Indicator (“SHMI”) for the Trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. *The palliative care indicator is a contextual indicator.	1.044 (Band 2 – “As Expected” 31.9 Oct 2016 – Sept 2017	1.0762 (Band 2 – “As Expected” 29.0 (29.7) Oct 2015 – Sept 2016	100 31.5
3	PROMS i) groin hernia surgery ii) varicose vein surgery iii) hip replacement surgery iv) knee replacement surgery during the reporting period (See below for explanation of reporting data)	0.128 No data 0.463 0.298 (Apr 16- Mar 17)	0.074 No data 0.442 0.337 (Apr15- Mar 16)	0.086 No data 0.437 0.323
3	the percentage of patients aged— i) 0 to 15; and	Elective 5.1%*1 Non-Elective 4.7%*1	Elective 3.9% Non-Elective 5.0%	Elective 4.1% Non-Elective 9.4%

Domain	Prescribed data requirements	2017/18 local and national data	2016/17 local and (national) data	National average
	The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to —			
	(ii) 16 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	Elective 3.4%*1 Non-Elective 13.4%*1	Elective 2.9% Non-Elective 14.5%	Elective 3.8% Non-Elective 14.0%
4	The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	75.2	82.1	69.93% 2017
5	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	95.4%*2	95.4%	95.53% 2015/16 Q4 data
5	The rate per 100,000 bed days of cases of C. Difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	9.5 *3	10.5	13.85 2017/18 tbc
5	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, The number and percentage of such patient safety incidents that resulted in severe harm or death. (See below for explanation of reporting data)	7,423 128(1.72%)	7,716 78(0.99%)	Data currently unavailable

*1 2017/18 data is Apr-17 – Jan- 18 as Feb & March not currently available

*2 Q4 not yet published so taken from local data.

*3 Figure based on local data as national data not published at time of report. National denominator figure derived from HES data, local denominator derived from KH03 return.

Patient Reported Outcome Measures (PROMs)

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

There are three surgical procedures for which PROMs data is captured; Hip and Knee replacements as well as Groin Hernia and up to three measures are used to assess the outcomes of these procedures (only two are used for the Groin Hernia). Results are uploaded on the NHS Digital website from which the graphs below are provided.

The data published in February 2018 (based on April 2016 to March 2017), shows all three surgical procedures showing an improvement in health gain following an operation.

Adjusted average health gain

Figure 1: Adjusted average health gain on the EQ-5D™ Index by procedure

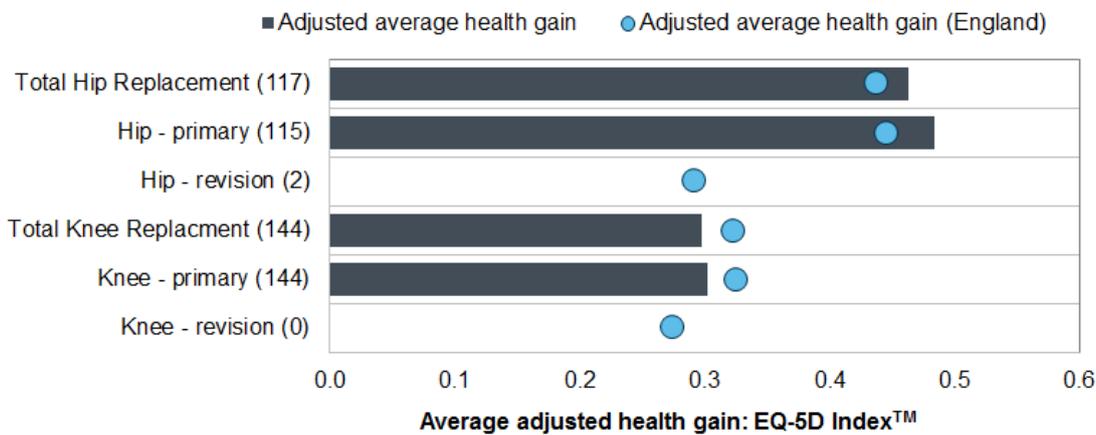


Figure 2: Adjusted average health gain on the EQ-VAS by procedure

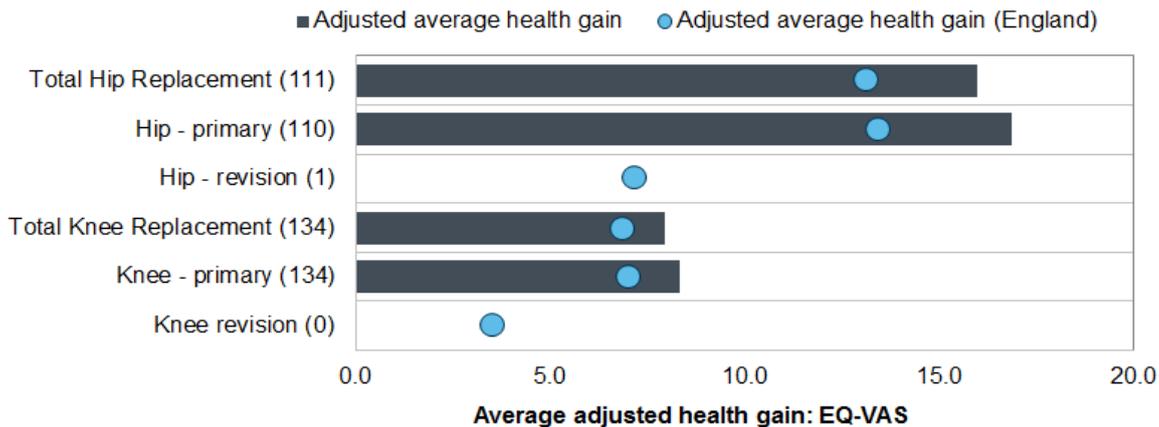


Figure 3: Adjusted average health gain on the Oxford Hip Score / Oxford Knee Score by procedure

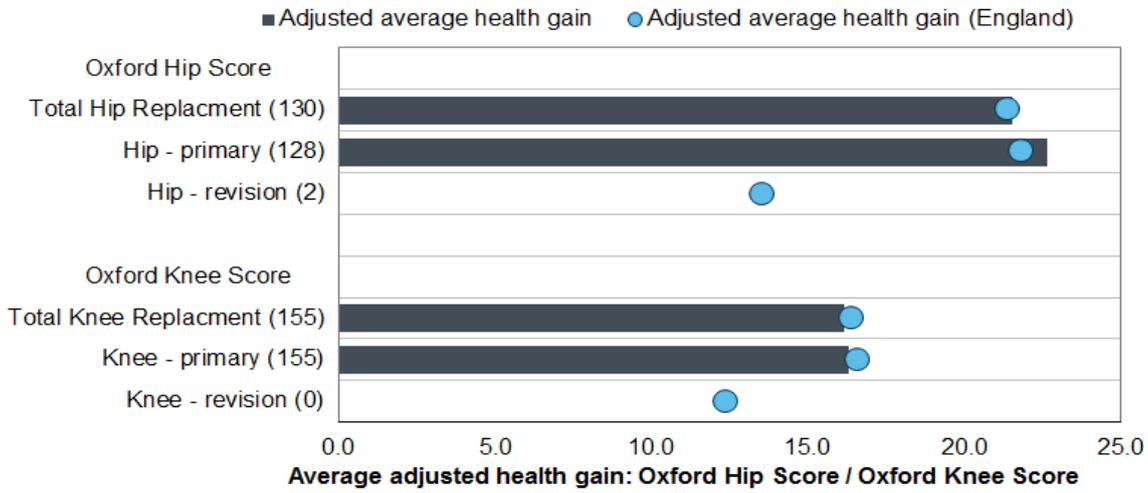


Figure 4: Adjusted average health gain on the EQ-5D Index procedure

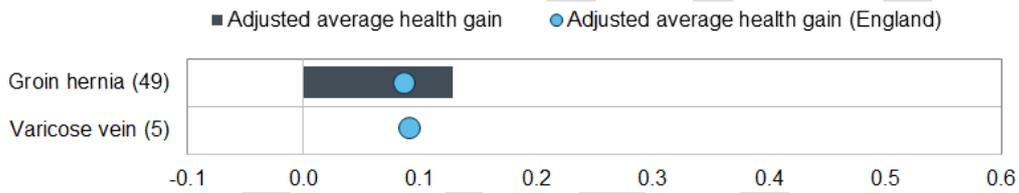
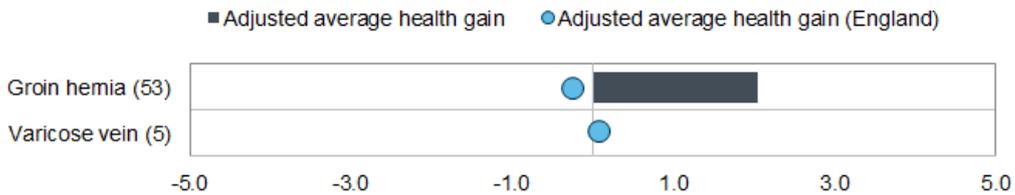
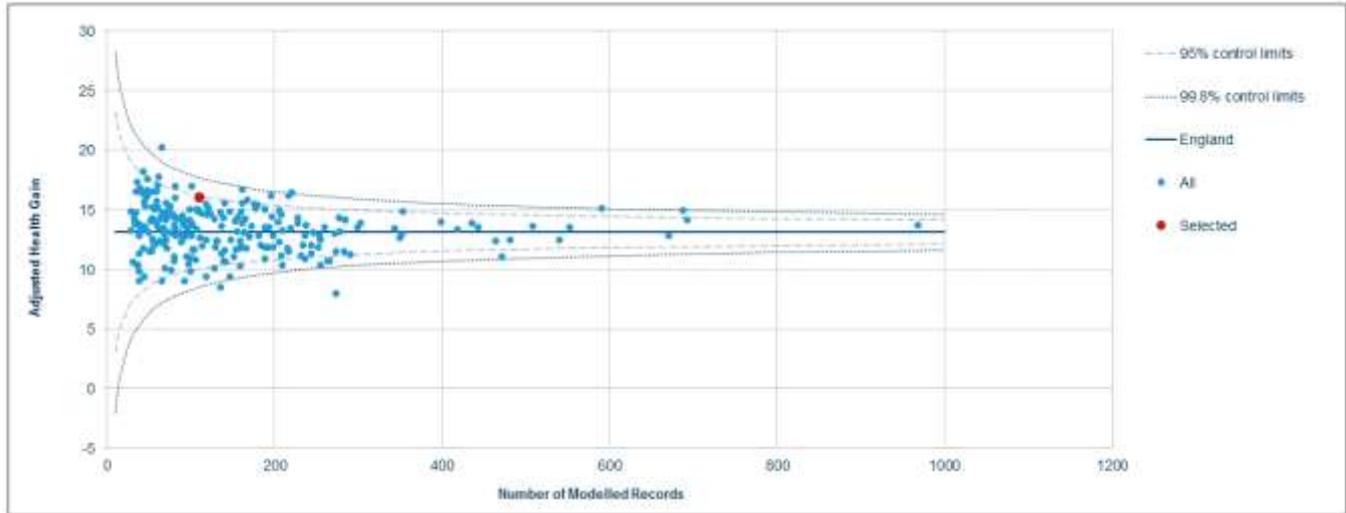


Figure 5: Adjusted average health gain on EQ-VAS by procedure

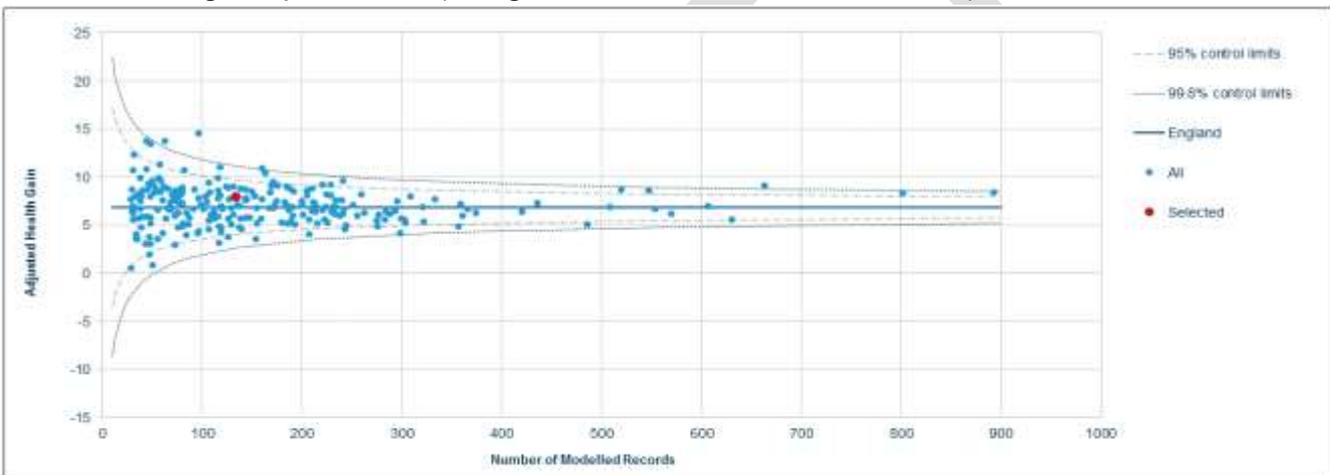


As can be seen, the Trust scored favourably when compared to the national average for all three measures for Hip replacements and also for the EQ-VAS measure for Knee Replacements but fell below the national average for the other outcome measures. In addition, for Groin Hernia, the Trust scored favourably for both measures against the adjusted average health gain.

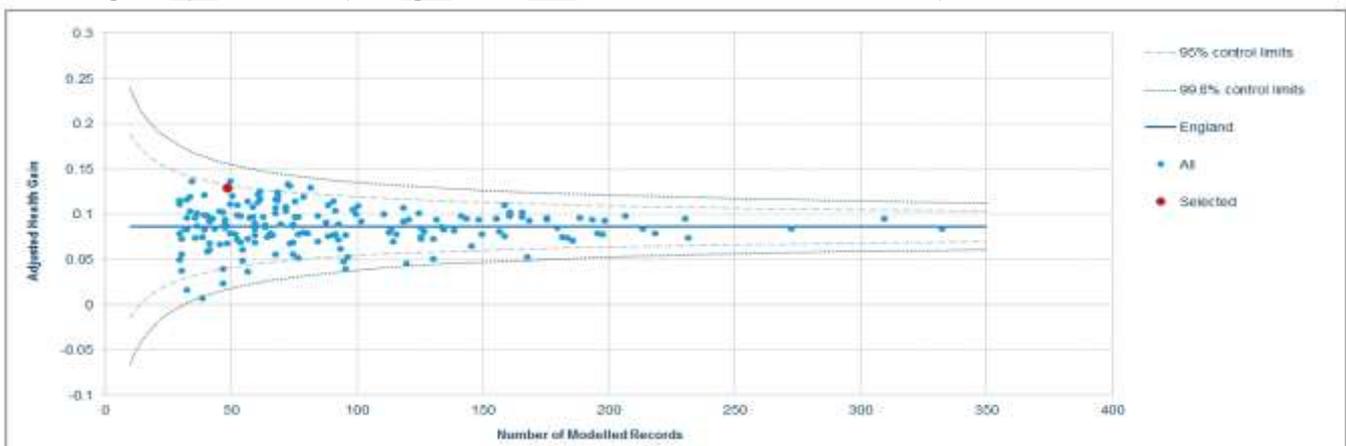
Hip Replacement – 111 patient questionnaires were returned. 84 reported an improvement in health following the procedure (using the EQ-5D Index PROMS Measure).



Knee Replacement – 134 patient questionnaires were returned. 80 reported an improvement in health following the procedure (using the EQ VAS PROMS measure).



Groin Hernia – 49 patient questionnaires were returned. 31 reported an improvement in health following the procedure (using the EQ-5D Index PROMS Measure).



Patient Safety Incidents

The proportion of Patient Safety Incidents which resulted in severe harm or death for 2017/18 was 1.72% (0.99% 2016/17). This is calculated by dividing the number of serious and catastrophic incidents (128) reported by MTW by the total number of patient safety incidents 7,423 (7,716 for 2016/17).

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

The latest report from the National Reporting and Learning System (NRLS), which was published in March 2017 and covers the period of 01/04/17 to 30/09/17, provided a reporting rate of 23.70 compared to 26.32 for the same period last year. The rate of incidents reported is per 1,000 bed days. This places the Trust within the lowest 25% of reporters and a position we continue to improve upon.

Improving performance

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

These meetings include:-

Serious incidents pertaining to severe harm and death are investigated using Root Cause Analysis methodology and are monitored via an executive-led panel which meets monthly. This group reviews all serious incident investigations and considers the root causes of incidents to identify learning and ensures that actions can be put in place to mitigate the risk of recurrence of similar events. The learning is disseminated across the Trust through the Directorate and Trust clinical governance committees. In addition a 'Learning Lessons' workstream has been initiated during 2017/18 with the intention of strengthening and formalising this approach across MTW. The objectives include a review of- the incident reporting database; the role and format of the clinical governance meetings and further roll-out of human factors training to our staff.

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

Each Division is required to undertake a regular Executive Performance review. These meetings monitor compliance through the Divisional dashboards. In particular Urgent Care have responsibility for the Accident & Emergency four-hour access standard and Planned Care responsibility for the 18 week referral to treatment access standard. The Director of Operations and the Clinical Directors of these Divisions also work in collaboration with our commissioning teams to address non-compliance and to look at the implications of the wider health economy to ensure that our patient's needs are met.

Scrutiny

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

Additional areas of significant improvement during 2017/18

This section will provide a summary update on further initiatives that have been undertaken during the last year:-

Women's, Children's and Sexual Health

Bobble Hat Campaign

Bobble Hat care is an initiative which has been created and piloted at the Royal Surrey County Hospital and has shown to prevent unnecessary admissions to the Neonatal unit. Babies can get cold rapidly and have a large surface area on their heads. Putting a hat on a baby as soon as possible following birth will aid in preventing them getting cold and requiring medical intervention.



Following birth all babies are provided with a bobble hat which will be red, yellow or green. The colour represents how much care that the baby requires following delivery. This is based on several different factors such as: whether the baby was full term or premature, type of birth and any additional observations that a baby may require.

It can take up to 24 hours for babies to stabilise their temperatures following birth, so our babies keep their bobble hats on for either 24 hours or until they go home, whichever happens first.

Breaking Bad News

A quiet room for parents-to-be who need privacy has been refurbished thanks to a generous donation from the Sands Group in Tunbridge Wells and the hard work of our staff. The room, which is located in the Women's and Children's Outpatients' area at Tunbridge Wells Hospital, was officially opened in January 2018.

"When a fetal abnormality is detected by an ultrasound scan, the screening tests reveal a high risk result or ultrasound confirms the death of a baby at any gestation in pregnancy, a quiet area provides privacy and space for parents who are shocked, distressed and need time to take in information," said bereavement midwife Ruth Paul.

Feedback from our parents suggested that the décor was previously tired and unwelcoming so with generous support from the local Sands group in Tunbridge Wells this room has undergone a much needed makeover. We are now looking to do something similar on the Maidstone site.



Jan Pullinger, Antenatal & Newborn Screening & Ruth Paul, Bereavement Support Midwives

Urgent Care

Acute Frailty Unit

The development of two Acute Frailty units at MTW in the last 6 months have been instrumental in providing the best quality of care for a group of acutely frail patients. Clinicians, nurses, Allied Health Professionals and managers have joined forces to create Acute Frailty Units on both sites with excellent results, providing improved quality of care for patients, co working with patients' families, improving staff experience and supporting these patients to go home.

What do we mean by an 'acute frailty unit'? An Acute Frailty Unit offers a multidisciplinary approach to care for older hospitalised patients with four key elements:

- specially designed environment
- patient-centred care
- focus on planning for discharge
- review of medical care by a multidisciplinary team.

Maidstone Hospital

The Frailty Unit opened in June 2017 on Chaucer Ward and is known as CAFU (Chaucer Acute Frailty Unit). Many of the team who are part of the unit's every-day running were instrumental in its development and implementation and all are absolutely committed to providing the best service, care and environment possible to elderly patients. The staff are determined to ensure that older patients are always given the most appropriate care and treatment, that they are respected, listened to and supported at all times. This has been evidenced through our Friends and Family survey responses where our patients rate the staff, the care and the service highly.

The unit offers 11 assessment spaces and is open from 9am to 8pm Monday to Friday. The ward also offers 14 short-stay inpatient beds should our patients need to stay for up to 48 hours. The pathway promotes national best practice, and supports rapid turnover and admission avoidance where it is safe and appropriate to do so. The unit sees up to 12 patients a day with 35% of these discharged home with personalised support to prevent further hospital admissions.

18 September 2017, via Twitter: Big thanks to all the staff in Chaucer Ward and A&E. First time in a hospital dad's dementia and elderly age has been understood and respected.

Because the unit has its own speciality we have been able to recruit staff with specialist skills and promote a positive working environment for staff which has had a positive effect on retaining staff within the organisation. Visiting times are largely unrestricted so family members can come in at a convenient time to them which supports their involvement in decision making with that patient and gives them confidence that the patient has the correct support services to remain independent at home.

Tunbridge Wells Hospital

Following the successful implementation of the unit at Maidstone, development of a further frailty unit commenced in March 2018. Building works have been necessary with completion expected in June 2018. In the interim a temporary "pop up" Acute Frailty Unit has been set up to provide improved quality of care for this group of patients. The unit is currently based in Ward 2 at TWH providing care to emergency patients who fit the criteria for acute frailty on a small scale, this will increase to 10 patients once building works have been completed.

These patients are reviewed by a multi-disciplinary team including the support of a senior geriatrician, nursing, therapy, pharmacy and the Integrated Discharge Team (IDT), to offer rapid intervention and safe and timely discharge. Patients who are not discharged are subsequently transferred to short stay beds on another ward and then discharged accordingly.

The feedback for the Chaucer Acute Frailty Unit (CAFU) has been extremely positive and comments include:

- “All the staff were professional, caring and compassionate. Nothing was too much trouble and they made every effort to ensure that that my stay was a good experience”.
- “The attention was good that the staff gave when asked any questions about my illness”.
- “Most genuine people I have ever met. Treated really well as part of the family”.
- “Nurses very kind. Doctor very patient and took time to explain everything”.

This service improvement is only the beginning of an important change in the way acute hospital care is wrapped around our frail and elderly patients. The acute frailty unit will continue to develop its links with community service providers to ensure that our patients can benefit from services traditionally delivered in a hospital environment whilst remaining in their own home. In contrast those community services will work in partnership with the hospital to ensure that frail patients only remain in hospital where absolutely necessary and when fit to do so return to their home seamlessly and without delay. Going forward a 7 day service remains the focus of continuing the service development.

Planned Care

Innovations- the Air Glove

The Kent Oncology Centre continues to be actively involved with the Innovations committee and the development and design of the Air Glove. This is a unique warming system used to heat arms which promotes easier access to our patient's veins to be able to deliver intravenous drugs including chemotherapy. Patients undergoing cancer treatment with cytotoxic drugs are known to have difficulty with venous access. The Air Glove is a unique air warming sytem which ensures the arm is heated safely allowing vasodilation and therefore more successful cannulation.

Previously patients with difficult venous access had to have their arms heated with hot water or heat packs. This in itself was difficult to maintain. The original idea for the heated Air Glove came from the chemotherapy staff and management teams working within the Oncology Centre. Together with Green Cross Medico and NHS Innovations we were able to put our ideas into the final product Air Glove.



Over the past year we have taken part in a successful service evaluation which has

supported us to use the air glove with patients and to obtain their feedback. The feedback was mainly positive and it has changed the practice within the chemotherapy unit. It demonstrated an 87.7% successful cannulation rate following 'warming' with the Air Glove.

Pactosafe

Early research has highlighted the risk to oncology health care workers who are handling cytotoxic drugs. A three month trial evaluation was undertaken at the Kent Oncology Centre to implement an innovative air tight waste disposal system within the chemotherapy day unit to reduce the risk of vapour, environmental and surface exposure.

Through implementation of the innovative Pactosafe system, key benefits were highlighted to include improved patient and staff safety, cost efficiencies and ultimately a greener environment. In addition to staff and patient health benefits and improving the environmental footprint, an estimated 50% cost efficiency saving is forecast with the plan to further roll this initiative out across the cancer directorate.

In the absence of further research to substantiate the early evidence of exposure risks in the handling of cytotoxic drugs, all organisations and oncology healthcare workers have a duty of care to ensure accidental exposure is minimised.



The new PET-CT Centre

The new PET-CT scanner was opened in February 2018 at Maidstone Hospital. Alliance Medical, in partnership with MTW and the Kent Oncology Centre, have invested in the provision of the first purpose-built static PET-CT centre in Kent, which adjoins the Nuclear Medicine Department. The service was previously provided using mobile scanners.



This form of scanning provides a combination of Positron Emission Tomography (PET) and CT information to show the physiological aspects of cancer tumours, infection and other conditions in addition to the response to treatment and simultaneous anatomical information.

Having a static scanner in Maidstone will improve both the quality and the availability of PET-CT. The newly built centre is more spacious and

comfortable for patients and has increased capacity. In addition the facility will facilitate future national research.

Part Four

Appendices A, B and C

DRAFT

Appendix A

59 National reports were published where the topic under review was relevant to the Trust in 2017/18 with action to be taken in 2017/18

National Report Published April 2017 to March 2018	Report received	Date report due
Acute Care		
National Cardiac Arrest Audit (NCAA)	Y	Full Report received July 2017. Quarterly reports generated and reviewed by the resuscitation team to review performance. The trust figures compare well in national comparisons and shows higher than national survival rates.
Adult Critical Care Case Mix Programme 2016 (ICNARC) (CMP)	Y	Full report received June 2018 Quarterly reports generated and regularly reviewed by team. Re-admission rates are very low across the trust, some delay in discharging the patient from the unit to a general ward due to operational pressures. No areas of concern were identified.
Emergency Laparotomy Audit (NELA)	Y	Report received - 13 October 2017 Continued to perform well against the majority of national recommendations. There is a clear pathway of evidence based interventions in place for the management of all patients undergoing an emergency laparotomy. Trust level change to ensure adequate Consultant Geriatricians in place with dedicated time in job plan to support decision making.
Severe Trauma (Trauma Audit & Research Network) TARN	Y	Quarterly dashboards are received and reviewed by the T&O team. 3 injury specific reports are published March, July and November reviewed by team. Data submission for the trust is very good and is well above the regional numbers. Patients are reviewed and discussed at Trauma Board meetings to ensure best quality of care was met. Any patients with a high injury severity score all have their cases reviewed on an individual basis.
National Joint Registry (NJR)	Y	Report received September 2017 The NJR is a standing item at the Orthopaedic department Clinical Governance and directorate meetings. Our trust is not an outlier during this audit year. Our audit of NJR completeness against Hospital Episode Statistics data scored very well. 904 procedures were submitted to the NJR with a consent rate of 98%. This is an ongoing National audit which our trusts continually participates in year after year.
Royal College of Emergency Medicine (RCEM) Consultant Sign Off 2016	Y	Report received May 2017. Significantly better than national results across both sites in all four standards. This continues the trend of increased consultant sign off at Maidstone Hospital and Tunbridge Wells Hospital that has occurred over the last five years. Tunbridge Wells continue to have slightly better results as they often have more senior staff within the hospital site. This reflects the patient cohort (higher volume and sicker patients at Tunbridge Wells). Review of children under one year of age presenting with fever is significantly better than national averages due to the dedicated Paediatric Unit in the Emergency Department.

National Report Published April 2017 to March 2018	Report received	Date report due
		Maidstone 90%, Tunbridge Wells 100%, national average 48%.
RCEM Severe Sepsis and Septic Shock 2016	Y	Report published May 2017. There were three fundamental standards which all had excellent results compared to both the national medians and the expected standards of 100%. These were for a complete set of observations on arrival, obtaining intravenous crystalloid fluid with 4 hours and obtaining intravenous antibiotics with 4 hours. A sepsis proforma to be made available along with regular teaching sessions for clinicians to remind them of the importance of treating patients in a timely manner.
National Audit of Small Bowel Obstruction (NASBO)	Y	Report published December 2017 Report is with the specialty for review and action plan development.
RCEM Adult Asthma 2016	Y	Report published May 2017. This was a complex audit, involving 15 separate standards. The Trust was partially compliant against these standards. Whilst we fared well in giving patients oxygen and ensuring vital signs were measured on arrival, it was felt that the timings for these was not always documented appropriately. A standardised Asthma proforma is to be introduced to ensure all asthma patients are treated appropriately and in a timely manner.
National SAMBA 17 (Society for Acute Medicine Benchmarking Audit)	Y	Report received September 2017. The Trust is partially compliant. Trust-wide education to take place to ensure all patients admitted to AMU have an Early Warning Score (EWS) measured upon arrival at AMU and reviewed by a competent decision maker within 4 hours of admission.
National Potential Donor Audit- NHS Blood and Transplant	Y	Report published in November 2017. In the first six months of the year, from 6 consented donors, the Trust facilitated 4 actual organ donations resulting in 9 patients receiving a life-saving or life-changing transplant. There were no occasions where a Specialist Nurse for Organ Donation was not present.
UK Cystic Fibrosis Registry (Paediatric and Adult)	N/A	The Trust does not provide this service.
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	N/A	The Trust does not provide this service.
Use of Emergency Oxygen (BTS)	Y	Report received May 2016. Trust is partially compliant. Respiratory Clinical Nurse Specialists to continue drug prescription chart for all patients requiring emergency oxygen. Implementation of Nerve Centre database to allow for target parameters to be entered for each patient. Explore purchasing of ear SpO2 probes to ensure appropriate monitoring equipment is available in all clinical areas.
National Comparative Audit of Blood Transfusion Programme		
(National Comparative Audit of Blood Transfusion Programme) Red cell and platelet transfusion in adult haematology	N/A	Report publication delayed to April 2018.

National Report Published April 2017 to March 2018	Report received	Date report due
(National Comparative Audit of Blood Transfusion Programme) Comparative audit of transfusion associated circulatory overload 2017	N/A	Report publication delayed to April 2018.
(National Comparative Audit of Blood Transfusion Programme) Audit of the patient blood management in scheduled surgery re-audit	Y	Report received 23 October 2017. Report currently with blood transfusion team for assessment of compliance and action planning.
(National Comparative Audit of Blood Transfusion Programme) Use of blood in lower GI bleeding	Y	Report received May 2017. Both hospitals are linked with St Thomas' Hospital who provide an acute 24/7 hotline covered by a consultant level doctor. Improvements have been made to facilitate the care of elderly patients admitted under the surgical teams, and there is now a referral system with time built into job plan.
Serious Hazards of transfer (SHOT) UK. National haemovigilance scheme	Y	Report received September 2017 We have the lowest rate for serious adverse reactions compared to the other 13 regions, but have a higher than anticipated rate of near misses. Following SHOT's focus on human factors, a number of questions were added to the questionnaires to learn more about staffing levels and training. Overall, transfusion components themselves are very safe. The regular use of a bedside checklist is planned for implementation.
Cancers		
National audit of Breast Cancer in Older People (NABCOP)	Y	Report published September 2017 We have 8 dedicated Breast Cancer operating lists per week. The following patients are always discussed at Breast Cancer MDT meetings; new patients with biopsy confirmed Breast Cancer, new patients with metastatic disease and previous Breast Cancer patients with metastatic disease and patients requiring palliative care input. The Care of the Elderly team is involved with Breast Cancer patients on a Case by Case basis. A patient survey is needed to establish if patients feel they have been adequately involved. A further local project is planned to establish length of stay and a policy regarding Mental Capacity and WHO scoring is to be written.
National Audit of Lung Cancer (NLCA)	Y	Report received 24 January 2018 This report is currently with clinical team for assessment of compliance and action planning.
National Audit of Bowel Cancer (NBOCAP)	Y	Report received 14 December 2017 This year MTW is fully compliant in all of the recommendations made, our mortality rates are lower than the national and regional average which demonstrates the high quality provided by this service.
Head & Neck Cancer (DAHNO)	N/A	National Report due later in year 2018.
National Prostate Cancer Audit 2017	Y	Report received 22 November 2017 Overall this audit demonstrates a very good level of care and treatment for our patients. There are no outlying results when benchmarked across the country. The patient reported outcomes show that patients are generally very pleased with the overall quality of care.
Oesophago-gastric cancer (NAOCC)	Y	Report received on 14 December 2017. Overall the results are positive and demonstrate

National Report Published April 2017 to March 2018	Report received	Date report due
		that MTW performed better than the national average with patients being discussed at MDT meetings and MTW patients reported to have a CT scan. All NHS trusts / local health boards in England and Wales achieved similar outcomes after curative surgery, and the overall rates of mortality continue to improve.
Endocrine and Thyroid National Audit	N/A	Report due January 2018 Delay in publishing this national report.
National Ophthalmology Database Audit Project	N/A	The Trust was unable to submit data to this national audit due to software issues. It is anticipated that this IT issue will be resolved so that trust data can be submitted for the next round of this audit.
Urology		
BAUS Urology Audits: Female Stress Urinary Incontinence Audit	N/A	The Trust does not provide this service.
BAUS Urology Audits: Radical Prostatectomy Audit	Y	Report published September 2017 Results are very good compared with the National averages. Low number of low grade cancer reflects, use of brachytherapy and active surveillance and is a positive factor.
BAUS Urology Audits: Cystectomy	N/A	The Trust does not provide this service.
BAUS Urology Audits: Nephrectomy Audit	Y	Report received 14 December 2017 MTW is better than the National average in all domains and full assurance was achieved.
BAUS Urology Audits: Percutaneous Nephrolithotomy (PCNL)	Y	Report received 14 December 2017 Report with the urology team to assess trusts compliance and develop an action plan if needed.
BAUS Urology Audits: Urethrolasty audit	N/A	The Trust does not provide this service.
Chronic Kidney Disease in Primary Care	N/A	Primary Care Only.
Renal Replacement Therapy (Renal Registry)	N/A	The Trust does not provide this service.
Heart		
Acute coronary syndrome or Acute myocardial infarction (MINAP) 2015-16	Y	Report published June 2017. Trust is partially compliant with national recommendations. The majority of patients are seen by a member of the cardiology team during their hospital stay, matching national averages. Slight dip in figures for patients receiving secondary prevention medication for this year. This has been identified as a data collection issue and should show as an increased number in 2016-17 results. The average length of stay at Maidstone Hospital is slightly higher than at Tunbridge Wells (Maidstone 7 days, Tunbridge Wells 4 days). This is thought to be due to the need to transfer patients to Tunbridge Wells due to bed shortages.
Heart failure Audit 2015-16	Y	Report published August 2017. This report is with the cardiology team for review and action plan development.
Cardiac Rhythm Management (CRM) 2015-16	Y	Report published April 2017. Trust is fully compliant with national recommendations. Overall performance on both sites was good with particularly good data on physiological (dual chamber) pacing for SSS. CRT and ICD implant rates are in line with national performance.
Coronary angioplasty/ National audit of PCI 2015	Y	Report published September 2017. The Trust is largely compliant with the national recommendations. The specialty continues to develop radial access experience amongst local

National Report Published April 2017 to March 2018	Report received	Date report due
		PCI operators and plans to open a recovery area for TWH catheter lab.
Adult Cardiac surgery	N/A	The Trust does not provide this service.
Congenital heart disease (Adult cardiac surgery)	N/A	The Trust does not provide this service.
Congenital heart disease (Paediatric cardiac surgery)	N/A	The Trust does not provide this service.
Pulmonary Hypertension	N/A	The Trust does not provide this service.
National Vascular Registry	N/A	The Trust does not provide this service.
COPD Audit – Pulmonary Rehabilitation	N/A	Date of publication of national report still to be confirmed by national body.
National diabetes inpatient audit (NaDIA) 2017	Y	Report published 14 March 2018 This report is with the Specialty for review and action plan development.
National Diabetes Audit – Adults Foot Care Audit (N DFA) 2016-17	Y	Report published 14 March 2018 This report is with the Specialty for review and action plan development.
National Core Diabetes Audit (NDA) 2015-16	Y	Report published July 2017. This report is with the specialty for review and action plan development.
National Core Diabetes Audit (NDA) 2016-17	Y	Report published 14 March 2018 This report is with the Specialty for review and action plan development.
National Diabetes Transition audit (NDTA) 2003-14	Y	Report published July 2017 This is the first published report for the NDTA and has linked data from the National Paediatric Diabetes Audit (NPDA) and National Diabetes Audit (NDA) for the audit period 2003-04 to 2013-14 which focusses on young people with type 1 diabetes. This report reflects national findings only. Clear transition pathways already exist at MTW and we continue to review these, with a view to improving the process to ensure it is user-friendly and flexible according to the needs of the patient.
Inflammatory Bowel Disease (IBD) Programme – IBD registry, Biological Therapies Audit 2016-17	N/A	IBD Registry confirmed that no national report will be published for the 2016-17 data for MTW as the Trust has not subscribed to the additional funding for this element of the service. Charts for local trust data are available from their website (currently not working) to download but no national comparative data is available.
Neurosurgical National Audit Programme	N/A	Trust does not provide this service.
Falls and Fragility Fractures Audit Programme (FFFAP) pilot	Y	1. Inpatient Falls (NAIF). Report published November 2017. This report is with the Specialty for review and action plan development.
	N/A	2. Fracture Liaison Service MTW does not provide this service. This is a community service.
	Y	3. National Hip Fracture database Report received 3 October 2017 MTW were compliant with all recommendations, apart from participating in the Physiotherapy Hip Fracture Sprint Audit in the previous year, this is now being undertaken for the 2018/19 programme year.
Sentinel Stroke National Audit Programme (SSNAP)	Y	Report published November 2017. This report is with the specialty for review and action plan development.
National UK Parkinson's 2017	Y	Site specific reports published 27 March 2018. This report is with the specialty for review and action plan development.

National Report Published April 2017 to March 2018	Report received	Date report due
National Audit of Dementia in General Hospitals	Y	National Report published July 2017 Carers rated information, communications and patient care as above the national average. Action is planned to integrate the Dementia Care pathway with the Stroke Pathway and the Fractured Neck of Femur pathway. Dementia champions are to be identified within the trust so that there is support available to staff 24 hours per day, 7 days a week. Comprehensive Geriatric assessment (CGA) is to be utilised alongside pathways to ensure robust mechanisms are in place for assessing delirium in people with dementia.
National audit of Dementia Spotlight audit 2017 (Delirium screen and assessment)	N/A	Report Due March 2018 National report publication delayed.
National Patient Reported Outcome Measures (PROMs) Programme Elective surgery Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein*	Y	Report published January 2018 Before a patient undergoes one of the three PROMs procedures, for Maidstone & Tunbridge Wells NHS Trust - groin hernia, primary hip replacement or a primary knee replacement – they are offered a questionnaire for completion at pre-operative assessment. After three or six months, depending on procedure, the contractor posts out the follow-up post-operative questionnaire to the patient's home. The questionnaires are used to assess improvement in health as perceived by the patients themselves. Hip – MTW are slightly above the England average for the adjusted average health gain. Knee – Slightly below England average for the adjusted average health gain. Groin - Slightly below England average for the adjusted average health gain. The Trust will continue with promotion of PROMS questionnaires to patients in pre-op setting to increase the number of questionnaires returned. (* not performed at MTW).
Mental Health		
Prescribing Observatory for Mental Health (POMH)	N/A	The Trust does not provide this service.
Suicide and homicide in mental health (NCISH)	N/A	The Trust does not provide this service.
Prescribing Observatory for Mental Health (POMH-UK): Prescribing anti psychotics for people with dementia	N/A	The Trust does not provide this service.
Prescribing Observatory for Mental Health (POMH-UK): Monitoring of patients prescribed lithium	N/A	The Trust does not provide this service.
Women & Children		
MBRRACE-UK Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal Mortality Surveillance 2015 (reports annually)	Y	Report received 22 June 2017 There were 5,700 births in 2015 within our Trust. Stillbirths = 22, 3.86 per 1000 births (MTW up to 10% higher than average for group) Neonatal Death = 2, 0.35 per 1000 births (MTW are more than 10% lower than average for group) Extended Perinatal death = 24, 4.21 per 1000 births (MTW are up to 10% lower than average for group).
MBRRACE-UK Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal Mortality Surveillance of Deaths in the UK 2013-15 (reports annually)	Y	Report received 7 December 2017 This report has been reviewed by the Maternity Team, the action plan is being completed.
MBRRACE-UK Maternal, Newborn and Infant	Y	Report received 28 November 2017

National Report Published April 2017 to March 2018	Report received	Date report due
Clinical Outcome Review Programme Perinatal Mortality and morbidity confidential enquiry (reports every second year)		The Trust is partially compliant; the Trust is working hard to reduce the incidence of perinatal mortality and has just finalised its action plan to improve its service further. A Consultant from Kings recently visited the Trust to pass on advice on helping bereaved families to understand their loss and on obtaining consent for post-mortems. Meetings are set up to review all cases on a six monthly basis.
MBRRACE-UK; Serious Maternal Morbidity - Saving Lives; Women with severe epilepsy (October 2015 to March 2017)	Y	Report received 7 December 2017 This report has been reviewed by the Maternity Team, the action plan has been prepared and is being finalised.
National Diabetes Audit – Adults Pregnancy in Diabetes	Y	Report received 12 October 2017 This report has been reviewed by the Maternity Team, the action plan has been prepared and is being finalised.
National Maternity and Perinatal Audit (NMPA)	Y	Report received and distributed 10 November 2017. The trust is Partially compliant, with higher than expected numbers for a site of this size for instrumental births, 3 rd /4 th degree tears and small for gestational age (SGA) at 40 weeks. We were lower than expected for inductions. Actions have already been taken to address 3 rd /4 th degree tears, improvement seen already. SGA being further addressed by ongoing Growth Assessment Protocol (GAP) implementation, induction rates also improving with GAP. MDT review of instrumental deliveries in progress.
Paediatric Inflammatory Bowel Disease; Biologics Round 2 (IBD Programme)	N/A	IBD Registry confirmed that no national report will be published for the 2016-17 data for MTW as the Trust has not subscribed to the additional funding for this element of the service. Charts for local trust data are available from their website (currently not working) to download but no national comparative data is available.
National Paediatric Diabetes Audit (NPDA)	Y	Report received and distributed 10 October 2017. The trust results were hampered by issues with data submission software. Meetings with the software provider have taken place to resolve these issues. Action has been taken to improve the transition between children and adult diabetic services.
Neonatal Intensive and Special Care (NNAP)	Y	Report received 31 October 2017 This report is with the paediatric Team for review and action planning.
Paediatric Intensive Care (PICANet)	N/A	The Trust does not provide this service.
National BTS Paediatric Pneumonia Audit 2016	Y	Reports received in July 2017 and January 2018. Results show that there has been an improvement in planning follow-ups for this group of patients. The team is continuing to work on decreasing the use of chest x-rays and blood cultures for the diagnosis of paediatric pneumonia. A Poster for paediatric pneumonia management has been designed and distributed in acute and ward settings.
Confidential Enquiries		
NCEPOD: Treat as One (Adult Mental health in Acute hospitals)	Y	Report received 26 January 2017. The Trust and the Psychiatric Liaison Services are largely compliant with the recommendations. The Psych Liaison team is fully integrated into the hospital but the out of hours teams are not. To

National Report Published April 2017 to March 2018	<i>Report received</i>	Date report due
		<p>achieve compliance would require both national and local money to be in place and then to find staff to provide the service. Liaison Managers are in discussion with the trust and the CCG on how to best use the resources currently available.</p> <p>Liaison Services are not Psychiatric Accreditation Liaison Network (PALN) Accredited. Essentially due to the cost implications of registering with the network. However the PALN guidance is used when developing services. A new admission and discharge documentation has been developed within ITU to ensure that mental health is included and documented when patients are admitted to critical care. There is no centralised system in use for patients detained under the Mental Health Act within the Acute Trust. There may be one for DOLS within the Mental Health Capacity Act. Clinical lead (County Liaison Services) is currently drawing up processes across Kent to implement this. An SLA will need to be developed once agreed.</p>
NCEPOD: Inspiring Change (Non-Invasive Ventilation)	Y	Report received 13 July 2017. Report disseminated and with specialties for assessment.
NCEPOD: Each and Every Need (Chronic Neurodisability)	Y	Report received 8th March 2018. Report disseminated and with specialties for assessment.
Others		
NHS England 7 Day Hospital Study – March 2017	Y	<p>Report received May 2017.</p> <p>76% of patients were seen and assessed by a consultant within 14 hours of admission.</p> <p>100% compliant when acutely ill patients require a twice daily consultant reviews.</p> <p>75% compliant documented where patients require a once daily consultant review.</p> <p>100% compliant with patients having 7 day access to diagnostic services and also to Consultant directed interventions.</p> <p>The trusts performance was in line with or above the national and SE regional mean. The trust is continuing to work towards the NHS England 7 Day hospital working agenda.</p>
NHS England 7 Day Hospital Study – September 2017	Y	<p>Report received December 2017. Only one Standard was audited for this round of the study: the proportion of MTW patients seen and assessed by a consultant within 14 hours of admission is 74%. No national comparative data was provided this round by NHS England. The trust is continuing to work towards the NHS England 7 Day hospital working agenda.</p>

Appendix B

Updated actions on reports received during March 2016 to April 2017. These were awaiting review or had previously been reviewed and action plans developed. These reports have been reviewed and the table below shows which actions have been completed and implemented or where reviews are still outstanding.

National Report Published April 2015 to March 2016	Report received	
Acute Care		
National Cardiac Arrest Audit (NCAA)	Y	<p>National report received June 2016 Local reports with national comparative data. Reviewed and reported to the Trusts Resuscitation Committee. There were no abnormal variants regarding age, sex or location. The Trusts survival to discharge rate is better than the predicted figures for similar hospitals. To continue to submit data to this national audit.</p>
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	Y	<p>Report received July 2017. Annual ICNARC Report for 1 April 2016 to 31 March 2017 was presented and discussed. Generally results were very encouraging for both Units when benchmarked against similar Units. Excellent SMR for both Units. Areas of concern were delayed admissions at TWH, delayed discharges on both sites. A business case to increase the dependency at TWH to 8 which should improve delayed admissions considerably. High levels of high risk sepsis admissions on both sites were thought to be due to the case mix the Units see i.e. Emergency abdominal surgery at TWH and Haem/Oncology at Maidstone.</p>
National Ophthalmology Audit	Y	<p>National report received May 2016 and reviewed by specialty. Plan to enter data for next round of the audit if the problem with the Electronic Medical Records system has been resolved – still have a software problem but we're getting close to it working and being able to participate.</p>
Emergency Laparotomy Audit (NELA)	Y	<p>5 July 2016 Report received and disseminated to team for review and assessment. Audit results regularly reviewed and assessed at clinical sessions.</p>
Severe Trauma (Trauma Audit & Research Network) TARN	Y	<p>July 2017 (Orthopaedic Injuries) / November 2017 (Head & Spinal Injuries) March 2017 (Thoracic and Abdominal Injuries) These are reviewed by the Clinical Lead for Trauma and discussed at Trauma Board. Any areas of underperformance are highlighted and actions for improvement identified. A report highlighted a lower than average percentage of patients with head injuries getting to CT scanning within 60 minutes of admission. Prioritising these patients for CT has led to improved results.</p>
National Joint Registry (NJR)	Y	<p>Report received November 2016. Annual NJR Report for 1 January to 31 December 2015. The report shows overall great compliance of 99% for the Trust. Our Trust is not an outlier.</p>
Smoking Cessation	Y	<p>Comparative data received 7 December 2016. The Trust is partially compliant. Patients are appropriately referred to Smoking Cessation Services. Doctors are aware of the availability of</p>

National Report Published April 2015 to March 2016	Report received	
		Nicotine replacement Therapy and prescribe as necessary.
Vital Signs in children (care in the emergency department)	Y	National report received 31 May 2016. Site specific reports received June 2016. Both sites performed well in the taking and recording of vital signs with 97% compliance. Results for Maidstone were slightly better than TWH but this should show an improvement with the opening of a specific Paediatric Emergency Department.
VTE Risk in lower limb immobilisation (care in emergency department)	Y	National report received 31 May 2016; site specific reports received June 2016. Both sites performed well: Maidstone 97% and TWH 100%. Need to ensure there is evidence that patient information leaflets are being given to all patients.
HQIP National SAMBA 16 (Society for Acute Medicine Benchmarking Audit)	Y	Report received January 2017 with specialty for assessment. The Trust is partially compliant. Trust-wide education to take place to ensure all patients admitted to AMU have an Early Warning Score (EWS) measured upon arrival at AMU and reviewed by a competent decision maker within 4 hours.
Procedural sedation in Adults (Care in emergency department)	Y	National report received 31 May 2016. Site specific reports received June 2016. The Trust is partially compliant. Implementation of new sedation proforma to ensure all relevant observations are taken and recorded.
UK Cystic Fibrosis Registry (Paediatric and Adult)	N/A	The Trust does not provide this service.
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	N/A	The Trust does not provide this service.
Use of Emergency Oxygen (BTS)	Y	Report received May 2016. Trust is partially compliant. Respiratory Clinical Nurse Specialists to continue drug prescription chart for all patients requiring emergency oxygen. Implementation of Nerve Centre database to allow for target parameters to be entered for each patient. Explore purchasing of ear SpO2 probes to ensure appropriate monitoring equipment is available in all clinical areas.
National Comparative Audit of Blood transfusion Programme		
(National Comparative Audit of Blood Transfusion Programme) Red cell and platelet transfusion in adult haematology 2017	Y	Report received August 2016. Haematological patients are high blood users and those with chronic Bone Marrow Failure (BMF) receive more blood than those with reversible BMF. Single unit red cell transfusions are uncommon and prophylactic single unit platelet transfusions would almost certainly be increased if counts were performed prior to transfusions of further units. Local hospital guidelines are frequently discrepant with national guidelines and contribute to inappropriate transfusion practice. Compliance is similar across all levels of care.
Use of blood in lower GI bleeding	Y	Report received May 2016 with the speciality awaiting assessment completion. Update – The results show that more work is needed in areas such as improving out of hours cover and exploring the recruitment of more interventional radiologists. We like other Trusts struggle with the lack of elderly care physicians with time built into their job plans to deliver this service, but improvements have been made to facilitate

National Report Published April 2015 to March 2016	Report received	
		appropriate care of elderly patients admitted under the surgical teams and there is now a referral system in place with time built into job plan.
Audit of patient blood management in scheduled surgery	Y	Report received January 2017. The Trust performance was below national average on delivering the recommendations within Patient Blood Management (PBM) in surgical patients. The results are being discussed and managed at a Trust-wide level.
Serious Hazards of transfer (SHOT) UK. National haemovigilance scheme	N/A	No report available this year.
Cancers		
National Cancer Diagnosis Audit	N/A	Primary Care Audit only.
Lung Cancer (NLCA)	Y	National Report received 25 January 2017. With speciality for assessment, assessment should be completed by end April 2017. Update - Out of the 15 recommendations MTW was fully compliant in 9 domains and partially compliant in 1. 4 of the recommendations are not currently applicable to the published report as they are new for the 2017 NLCA audit. Therefore there are no current results to be analysed. MTW was not compliant in 1 domain. This was due to an extended period where there was no lung pathway co-ordinator in post and as a result some data was missed and not entered.
Bowel Cancer (NBOCAP)	Y	National Report received January 2017. With speciality for assessment. Assessment due for completion end April 2017 Update - The audit confirms that, although we are one of the busiest colorectal units in the country, our outcomes are good. There are no circumstances highlighted where we are a negative outlier and in fact this year's data has seen a significant improvement in some regards (such as data capture).
Head & Neck Cancer (DAHNO)	N/A	February 2017 – No report from DAHNO yet. Update -delayed report due March/ April 2018 – date TBC.
National Prostate Cancer Audit	Y	National Report received January 2017. Update - audit demonstrates a very good level of care and treatment for our patients. There are no outlying results when benchmarked across the country. There is some room for improvement in communicating choice and decision making for patients.
Oesophago-gastric cancer (NAOCG)	Y	National Report received January 2017. Maidstone & Tunbridge Wells NHS Trust has not performed major upper gastrointestinal cancer surgery since 2013. However the Trust participates in the diagnostic pathway for this group of patients. Update - The audit highlighted that we are not compliant regarding the number of new diagnoses of OG cancer that have a staging CT scan – at the moment this is only 52%. This could be due to poor reporting – mechanisms have been put in place to ensure this information is captured in the future e.g. at time of MDT meetings.
Urology		
BAUS Urology Audits: Female Stress Urinary Incontinence Audit	N/A	The Trust does not provide this service.
BAUS Urology Audits: Radical Prostatectomy	N/A	No report available.

National Report Published April 2015 to March 2016	Report received	
Audit		
BAUS Urology Audits: Cystectomy	N/A	The Trust does not provide this service.
BAUS Urology Audits: Nephrectomy Audit	N/A	No report available.
BAUS Urology Audits: Percutaneous Nephrolithotomy (PCNL)	N/A	No report available.
BAUS Urology Audits: Urethrolasty audit	N/A	The Trust does not provide this service.
Chronic Kidney Disease in Primary Care	N/A	Primary Care Only.
Renal Replacement Therapy (Renal Registry)	N/A	The Trust does not provide this service.
Heart		
Acute coronary syndrome or Acute myocardial infarction (MINAP) 2014-15 data (202)	Y	National report received 30 January 2017. With Specialty for assessment. The Trust is fully compliant and better than national average with heart attack patients being seen by a cardiologist. However there are issues with patients not being admitted to cardiology wards and length of stay. Further work is being carried out to investigate reasons for this.
Heart failure Audit 2014-15	Y	National report received August 2016. Performance at both sites is above national average. Both hospitals have a designated Heart Failure Nurse Service for inpatients, excellent echocardiogram services, cardiologist support for inpatient referrals and regular multi-disciplinary heart failure meetings.
Cardiac Rhythm Management (CRM) 2014-15	Y	National report received 3 August 2016. Overall performance on both sites was good with particularly good data on physiological (dual chamber) pacing for SSS. CRT and ICD implant rates are in line with national performance.
Coronary angioplasty/ National audit of PCI 2014	Y	National report received 1 April 2016. Radial access to be established as default access route for PCI, compliance increases year on year. Data completeness to be improved for patient diabetic status and renal function.
Adult Cardiac surgery	N/A	The Trust does not provide this service.
Congenital heart disease (Adult cardiac surgery)	N/A	The Trust does not provide this service.
Congenital heart disease (Paediatric cardiac surgery)	N/A	The Trust does not provide this service.
Pulmonary Hypertension	N/A	The Trust does not provide this service.
National Vascular Registry	N/A	The Trust does not provide this service.
National Pregnancy in Diabetes Audit 171	Y	National report received 1 November 2016. Our numbers were too small to be included in some of the analysis of this report. MTW were better than National and Regional results for Glucose Control, along with Folic acid supplement prior to pregnancy. However, we were lower with our Antenatal Care. MTW are to continue regular contact with local GP's and maintain the leaflets in the surgeries. Consider development of a preconception clinic. 28th March 2018, actions still outstanding.
National diabetes inpatient audit (NaDIA) 2016	Y	National report received 8 March 2017. With specialty for assessment.
National Core Diabetes Audit (NDA) 2015-16	Y	Report published 31 January 2017. Downloaded April 2017, report missed due to double reporting by NDA. Currently with specialty for assessment.
Inflammatory Bowel Disease (IBD) Programme – IBD registry 2015-16	Y	National report received 23 September 2016, The Trust partially compliant. IBD specialist nurses

National Report Published April 2015 to March 2016	Report received	
		now in place to assist with ensuring patients are followed up within appropriate timescale.
Rheumatoid and early inflammatory arthritis (NCAREIA) 2015-16	Y	National report received 24 July 2016. Overall the Trust is partially compliant. Poor GP referrals make it difficult to triage patients into appropriate ESYN (early synovitis) clinics. GP referral database (DORIS) is available but not always used. Additional clinic capacity required to ensure patients are seen within 3 weeks of referral. Advice line available for direct access to department. 24 hour answer phone service with calls returned within 48 hours.
Neurosurgical National Audit Programme	N/A	Trust does not provide this service.
Falls and Fragility Fractures Audit Programme (FFFAP) pilot	N/A	1. Inpatient Falls (NAIF) No report this year.
	N/A	2. Fracture Liaison Service MTW does not provide this service. This is a community service.
	Y	3. National Hip Fracture Database Report Received October 2017. Received and discussed within the team. Designated #NOF nurse is now in post to identify areas where the patient journey can be shortened. Hip fracture lists are now performed every weekday morning to allow timely orthogeriatric review and physiotherapy post-op. The Fracture Liaison Service is still in development within the Trust and not able to accept patients as yet.
Sentinel Stroke National Audit Programme (SSNAP)	Y	National report received October 2016 With specialty for assessment.
UK Parkinson's	Y	National report received August 2016. The Trust is partially compliant with the recommendations made. More clinic time is to be allocated to allow sufficient time for for discussions and anticipatory care planning. Need to be more aware of the management of bone health particularly in patients that have had a fall.
Elective surgery (National PROMS Programme) Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein	Y	National Report received August 2016 MTW are to review the promotion of the PROMS questionnaires to patients in the pre-operative setting and reviewing the data that is being collected internally.
Mental Health		
Prescribing Observatory for Mental Health (POMH)	N/A	The Trust does not provide this service.
Suicide and homicide in mental health (NCISH)	N/A	The Trust does not provide this service.
Prescribing Observatory for Mental Health (POMH-UK): Prescribing anti psychotics for people with dementia	N/A	The Trust does not provide this service.
Prescribing Observatory for Mental Health (POMH-UK): Monitoring of patients prescribed lithium	N/A	The Trust does not provide this service.
Women and Children		
MBRRACE-UK; National Surveillance of perinatal deaths (Late foetal losses)	Y	Report received May 2016 Each Cause of Death is checked by the Bereavement Midwives or Maternity Clinical Risk Manager before signing off. It's also discussed at Risk meeting if no post mortem was performed.
MBRRACE-UK; National Surveillance and confidential enquiries into maternal deaths	Y	Report received 7 December 2016 Plan to extend the Emergency Gynaecology

National Report Published April 2015 to March 2016	Report received	
		Assessment Unit to 12 hours a day. A business case is in place for scanning at the weekend. Update 6th April 2018 , scanning now available for longer hours on weekdays, but business case for weekend scanning has not been approved. Currently working on providing clinicians to perform emergency scans where clinically indicated, Trust still has work to do on this including ensuring availability of chaperones for the patient/doctor.
MBRRACE-UK; Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	N/A	The Trust does not provide this service.
Paediatric Inflammatory Bowel Disease; Biologics Round 2 (IBD Programme)	Y	Report received September 2016. Biological therapies are safe. Treatment rates for Ulcerative Colitis have increased substantially in the past year. Plan to switch patients already on Remicade to Biosimilars. New starters to only be prescribed Biosimilars.
National Paediatric Diabetes Audit (NPDA) 2015	Y	Report received June 2016 Overall the Trust was higher on a number of treatment regimens and met the criteria best practice for children with adjusted percentage HbA1c. The remaining criteria indicate the Trust outcomes were slightly lower than the National average and this is due in part to a problem with the data quality. Remedial actions have been put in place to improve data quality. Update 29/03/18 meetings with HiCom the data software provider have taken place and the quality of the data we submit has since improved.
Neonatal Intensive and Special Care (NNAP) 2015	Y	Report received September 2016 Trust performance is in line with national figures. Baby Friendly training starts April 2017 to be Baby Friendly Initiative compliant at Level 2 for all Neonatal Unit staff. All Dr's, NNU nursing staff and night staff to complete information on Badger information system to improve the quality of data entry.
Paediatric Asthma	Y	Report received March 2016 The Trust is largely compliant with the national standards. More of our patients are given steroids and antibiotics than the national average. Asthma awareness training sessions are to be set up and new guidelines and information to be uploaded to intranet.
Paediatric Intensive Care (PICANet)	N/A	MTW does not provide this service.
Confidential Enquiries		
NCEPOD: Acute Pancreatitis (Treat the Cause)	Y	Report received 7 July 2016. Trust mainly compliant with recommendations. A Business Case for more dedicated theatre lists (hot lists) is being discussed to enable more timely access to theatres. Planning to reinstate the system of GP referral letter post-discharge advising of the need to refer patient to support services (Alcohol Support Services) as this service is provided by another Trust and will require referral by the patients GP.

Appendix C

Summary of local audits undertaken during 2017/18 against NICE Guidelines

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

Compliance has been assessed as:

Fully compliant if all standards have been met.

Partially compliant when >50% of the standards have been met.

Non-compliance is where less than 50% of the standards have been met.

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

NICE Guidance	Level of Compliance	Summary results and Actions
NICE CG86 Early recognition and diagnosis of coeliac disease in adults re-audit	Fully compliant	No clinical concerns identified. Standards have been met Re-audit to cover a wider spectrum of patients for example GP referrals and those with negative serology.
NICE CG137 - Epilepsy- adult criteria only	Fully compliant	No clinical concerns as standards met.
NICE QS20; Colorectal Cancer Follow-up (Kent & Medway Cancer Collaborative network audit)	Fully compliant	No clinical concerns identified. Standards have been met. Continue to monitor the follow up compliance through the peer review process to ensure adherence.
NICE CG 171; Audit of intravesical Botox outcomes	Fully compliant	No risks identified as improvements noted and standards met. Actions developed for next round of the audit: All patients to have antibiotic prophylaxis stat dose (Gentamycin, or per C&S of prior UTI, or empirically Nitrofurantoin / Trimethoprim 3-5/days). New patients with Botox to have 100U if Idiopathic overactive bladder (IDO) and 200U if NDO
NICE CG175; How accurate is MRI in picking up clinically significant prostate cancer?	Fully compliant	Audit shows good current level of Multi-Disciplinary Team practice with expected portfolio of treatment options. Standards have been achieved.
NICE CG144 & TA287; Diagnosis, management and follow-up of patients with PE (pulmonary emboli) at TWH re-audit	Partially compliant	Wells scores are inadequately utilised and documented in notes. Action: e-learning teaching to assist junior doctors when they are discussing thrombolysis with patients. Readily accessible guideline on a system doctors like to use (Focus group to identify this). Change D-Dimer request system when the replacement for iSoft goes online (Already discussed and prototyped with IT but changeover delayed)
NICE CG 92. Thromboprophylaxis re-audit	Partially compliant	Despite the slight drop in performance since the last audit in general these results are encouraging. Action: Consultants and registrars to re-inforce trust policy within their teams. Re-visit implementation of a Post-Take Ward Round checklist within medicine and emergency surgery. To be piloted and then included in the speciality proforma. Raise further awareness of missed anticoagulation doses during mandatory training sessions on VTE prevention. All ward managers to ensure staff are aware of their responsibilities in relation to mechanical thromboprophylaxis (compression).

CG144. QS 29: Suspected DVT and administration of interim therapeutic anticoagulation if investigation will take over 4 hours to occur	Partially compliant	90% patients are either having their scan or receiving treatment anticoagulation within 4 hours of the scan being requested. Action: Raise awareness of the importance of commencing treatment anticoagulation for suspected VTE as part of the re-launch of the trust policy. The importance of commencing treatment anticoagulation for suspected VTE to be included in induction / training programmes for the new junior doctors commencing at MTW this summer.
CG 179: Prevalence Audit - April 2017	Partially compliant	Hospital acquired damage (HAD) has increased slightly to 3.2% which is over the trust target of 3%. Damage to the sacrum and heel areas has increased from the last round of the audit. Action: Continued formal and informal training ward based training by the Tissue Viability Team. Training on recognising and preventing moisture associated skin lesions. Root cause analysis on all category 2+ ulcers.
CG 32: Insertion and ongoing care of naso gastric tubes	Partially compliant	The majority of audited care scenarios met 70-80% of the expected standards, with 30% of the cohort demonstrating 100% compliance Action: NG tube in house learning delivery, to highlight best practice and adherence to Trust NG practice. Review unit access to current guidelines on placement and ongoing care (including flow charts). Presentation on ITU chart and/or Saving Lives form to show failed aspiration, nostril side, PH/length and need for repeat CXR.
NICE CG130: Delirium screen and prevention: A reflective practice.	Partially compliant	Pain was higher than 3 (0-10 scale) in half of the patients' population. Early rehabilitation and mobilisation, reorientation strategies recommended are being achieved Action: CPOT scoring to be implemented for non-verbal patients e.g. ventilated patients. Bowel Guideline to be updated and disseminated across staff.
NICE QS63 Delirium Round 3 re-audit	Partially compliant	We found no evidence that de-escalation techniques had been used. 48% of patients who were diagnosed with delirium didn't have their diagnosis communicated to GP on their electronic discharge summary. Action: Mandatory teaching to junior doctors about delirium. Visit wards to make sure ward managers know about the delirium leaflet. Education of new junior doctor intake about the need to communicate results to GP regarding diagnosis of delirium.
NICE TA188; Re-audit of the Human Growth Hormone (somatropin) Treatment of Growth Failure in Children	Partially compliant	A sticker was produced to be added to the patient's notes to prompt staff regarding giving information to patients and parents/carers. Full compliance in care standards but failing in audit standards with regards giving awareness on the "understanding of NICE guidance booklet". Action: To include the link to "understanding of NICE guidance booklet" on the leaflet that patients/parents are given at discussion of growth hormone commencement.
NICE CG151; Re-audit of Febrile Neutropenia Patients (Round 3)	Partially compliant	85% of children seen received antibiotics within 1 hour however all children did receive antibiotics by 75 minutes. Action: Continue use of Oncology Admission pro-forma and continue staff support/education Continue ward based education for the immediate care of an unwell child who is receiving chemotherapy.
NICE CG 162 Are realistic goals being identified for stroke patients on the acute stroke units at MTW?	Partially compliant	The main clinical concerns are the inconsistent recording and the inconsistent use of the correct goal setting paperwork. Action: Put goal setting advice sheet including information on prognostic indicators on the current goal paperwork. Key worker to ensure correct paperwork is used. Fortnightly goal setting meetings with patients included on stroke unit timetables. MDT teaching on the use of the prognostic indicator tool.
NICE CG92; Audit of post-operative extended thromboprophylaxis for patients undergoing major abdominal surgery for Cancer	Partially compliant	Compliance rates of 85.5 % for elective and 45.5 % for emergency patients. Action: Place posters in strategic areas of the wards and doctor's offices, along with banners above every computer in the department. The Thrombosis Committee who are currently in the process of debating a newly proposed algorithm to be included in the electronic discharge summary software. The purpose of the algorithm is to give a decision tree to aid the doctor completing it to arrive at the appropriate extended thromboprophylactic treatment on discharge.
NICE NG:24 Audit of Tranexamic acid use in developmental Dysplasia of the hip surgery to reduce blood loss	Partially compliant	Action: We would advise Tranexamic acid's continued use in cases where there is higher risk of bleeding until further high powered evidence is available and anaesthetists and surgeons sought to decide on a case based basis. Tranexamic Acid to be administered for all open DDH surgeries where blood loss >10% is anticipated. Re-audit not required as now standard practice in this type of surgery.

NICE CG124 & 161; Are we providing written information to our Hip Fracture patients?	Partially compliant	Standard has improved to 68% since the last round of this audit. Having a new NOF nurse has been key factor for improvement, as this role that will provide continuity of practice throughout the year Action: Neck of femur nurse should provide information booklets to newly diagnosed #NOF patients on the daily ward round. A Tick box has been added to the SHO printable on call template as a prompt to give information leaflets to patients. NOF booklets to be kept in the trauma room and no Ward 31.
NICE CG124 & QS49; Reducing Surgical Site Infections (SSI) rates in Neck of Femur (#NOF) Fractures - Sutures or Staples?	Partially compliant	These results (although only small numbers) indicate a greater risk of complications associated with clips for skin closure in hip fractures (0% - Sutures. 10.4% Clips). Action: A prospective trial will be commenced to further evaluate the perceived benefit of suture closure vs clips. Routine Daily Wound Reviews and senior review prior to discharge.
NICE CG132 - Re-audit of indications, categories and surgeons for Caesarean Section in Maidstone & Tunbridge Wells NHS Trust	Partially compliant	Completion of operation notes has improved with the introduction of the E3 operating system, but remains suboptimal. Action: E3 training at induction for all new doctors (at every level). Ensure Obstetric team aware of indications for and mode of referral to Birth Choices clinic. Ensure Obstetric team aware of indications for and mode of referral to Birth Choices clinic.
NICE TA377 Improving the monitoring of toxicities associated with the use of Abiraterone and Enzalutimide	Partially compliant	This project identified the shortcomings of toxicity monitoring of both these agents. Actions: We have developed a simple nurse led checklist with each of the monitoring parameters identified. This checklist can also be used by physicians and supporting medical professionals who see patients in clinics. The primary benefit will be to serve as not only a memory aid of the monitoring requirements required at the relevant timelines but will also serve as a place to document this information in one place. The ultimate aim will be to have the checklist available on the online KOMS database.
NICE CG16; Re-audit of the management of Deliberate self-harm in children who present to the Emergency Department	Not compliant	Lack of documentation regards needs assessment. Improved documentation of referral to CAMHS. Action: Education of all ED staff regarding paediatric self-harm and taking an effective psychiatric history. Training to be delivered by CAMHS as part of clinical governance. Targeted staff training (Paediatric ED staff (Medical and Nursing) followed by staff in adult areas. DSH Checklist to be circulated, available and included in the ED handbook. Checklist and Safeguarding checklist to be completed for all patients presenting with DSH.
NICE CG75; Metastatic spinal cord compression in adults: risk assessment, diagnosis and management	Not compliant	This audit demonstrated that many patients fall outside of the treatment window from diagnosis to treatment. Action: Update and/or change local guidelines at Maidstone hospital to allow for quicker response for patients.
NICE CG68; Carotid Doppler Ultrasound audit	Not compliant	Only half of the patients audited had an early Carotid US imaging within the recommended timeframe. Only a third of the patients audited had a CEA within the recommended time frame. Action: Improving the knowledge of junior doctors about the importance of the carotid imaging for the prognosis and further management of patients with non-disabling stroke/TIA. Improving availability of carotid Doppler to ensure that patients can be scanned within 48hours. Lack of US availability is due to insufficient staffing. More staff currently being trained. Clear, simple but robust and straightforward referral pathway to Vascular team, Online referral form to be developed.
NICE CG152 Crohn's Disease	Not compliant	37% of cases were patients with a first presentation or a single inflammatory exacerbation of Crohn's disease in a 12 month period are offered monotherapy with a conventional glucocorticosteroid Action: Patients starting steroids for Crohn's disease should be discussed in the virtual biologics and immunosuppression clinic and reviewed in the nurse-led clinic at the end of the course of treatment.
NICE CG141; Management of Upper Gastrointestinal Bleeds re-audit	Not compliant	49% underwent Blatchford score at initial assessment. 0% of patients received a Rockall assessment score post endoscopy. 50% of stable patients had an endoscopy within 24 hours Audit: Mandatory use of electronic endoscopy requests to ensure uniformity in the clinical information provided by the requesting doctor, and especially to encourage the use of the Blatchford score. iSOFT request will be required for all endoscopies to proceed. Completion of a post-endoscopy Rockall score to be a mandatory field.

NICE CG186 - Multiple sclerosis - management of multiple sclerosis in primary and secondary care	Not compliant	<p>We are not identifying patients with a potential diagnosis of MS reliably from referral letters (GPs, A&E and other specialities) so they cannot be fast-tracked into Urgent slots.</p> <p>Action: All neurology consultants to read the referral letters and mark as URGENT so appropriate clinic slots can be arranged. Consultant to mark test as URGENT either on paper form or by phone call with MRI. Beds to be made available on AMU at Tunbridge Wells to enable LPs to be performed. Proforma to be developed for completion at follow-up appointments to act as an aide to ensure all potential symptoms are reviewed.</p>
NICE CG124; Insufficient Orthopaedic Theatre Time Audit	Not compliant	<p>73% of patients receive their operation within 36 hours of diagnosis. Not meeting best practice targets for NOF's. Large number of bed days used as a result of cancellations & prolonged inpatient waiting.</p> <p>Action: Business case to support Orthopaedics using theatre 6 when it re-opens in June along with opening at weekends.</p>
NICE CG132 & NG15; Re-audit of anti-microbial prescribing in the Obstetric & Gynaecology departments within MTW (Round 2)	Not compliant	<p>The lack of documentation of duration of antibiotic courses leaves patients at greater risk of receiving unnecessary doses of antibiotics. There was a general problem with unclear documentation of the indication for antibiotics in the medical notes</p> <p>Action: Teaching on antimicrobial prescribing during local departmental induction at the beginning of each block.</p> <p>A single document on the intranet (Q pulse) with antibiotic guidelines listed, compared to currently having to search pages of separate documents. Produce a sheet on the guidelines and documentation needed on a drug chart concerning antimicrobial prescribing.</p> <p>Laminate the sheet and put up around Delivery Suite, Postnatal Unit & Gynaecology wards across the trust.</p>
NICE CG 171 Re-audit for the outcomes and procedures of TVT/TVT-O 592	Not compliant	<p>Consenting standards have improved since the last round of this audit however there still remains an issue with failing to document all risks. Only 53% of patients are having the recommended 3 months supervised physiotherapy before being recommended the procedure.</p> <p>Action: Staff were reminded to document if physiotherapy has been recommended and taken up. If not taken up then staff to document the reason why the patient declined. All clinics to have the appropriate leaflets available and clinicians to document when the leaflet has been given to patients. A standard consent sticker and leaflet reminder has been produced and distributed for use in clinics to improve the level of documentation.</p> <p>A Urogynaecology MDT is to be set up to review and document all cases.</p>

Part Five

Stakeholder feedback

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

DRAFT

West Kent Clinical Commissioning Group comments on the 2017/18 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

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

Patient Safety

Learning from incidents and embedding change is an essential part of a safety culture. We look at how MTW learns and shares from serious incidents as part of our incident closure process, identifying themes and trends to help provide greater scrutiny in some areas. It is pleasing to note that several changes have been implemented this year including the further development of the WHO checklist and the delivery of human factors training. Observed mortality rates have continued to decline throughout the year.

Patient Experience

Listening to feedback from patients and their relatives is essential to enable improvements in care. The CCG is pleased to see that the Trust is committed to improving the response rates from the Friends and Family Test to influence their changes and welcome their continued commitment to include service user engagement.

Clinical Effectiveness

Effective patient flow is conducive to improved patient care and outcomes and remains a large focus of the work within MTW. We are working with all stakeholders to support MTW in reducing the length of stay and facilitating effective discharge, the opening of the acute frailty unit has ensured some of the most vulnerable patients attending the ED receive the most appropriate care to allow them to return home.

The recent CQC inspection noted the Trusts significant and sustained improvement which the CCG has also recognised and fully support them in aiming for good or outstanding in their next inspection.

Paula Wilkins

Chief Nurse
West Kent CCG

May, 2018

Health Overview and Scrutiny Committee – Kent County Council comments on the 2017/18 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

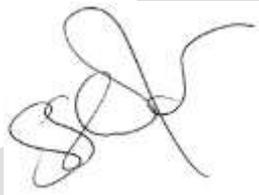
Maidstone & Tunbridge Wells NHS Trust Quality Account 2017/18

Thank you for offering Kent County Council's Health Overview & Scrutiny Committee (HOSC) the opportunity to comment on the Maidstone & Tunbridge Wells NHS Trust's Quality Account for 2017/18.

As the Committee did not formally scrutinise any services directly provided by the Trust in 2017/18, the Committee will not be making any comments on the Trust's Quality Account this year.

As part of its ongoing overview function, the Committee would appreciate receiving a copy of the finalised Quality Account for this year and hope to be able to become more fully engaged in next year's process.

Kind regards



Sue Chandler

**Chair, Health Overview and Scrutiny
Committee Kent County Council**

9th May, 2018

Healthwatch Kent comments on the 2017/18 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust



Healthwatch Kent is the independent champion for the views of patients and social care users in Kent. Our role is to help patients and the public get the best out of their local Health and Social Care services.

For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers).

This takes up a large amount of time, so we have taken the decision to prioritise our resource on making a difference to services rather than reading Quality Accounts.

However, we would like to support the Trust with a comment which reflects some of the work we have undertaken together in the past year.

We have seen that Maidstone and Tunbridge Wells value and understand our role as a “critical friend” which has translated into a good working relationship. Some of our involvement with the Trust this year has included:-

- Being a proactive member of the Patient Experience Committee and supporting the group’s development
- Meeting regularly with the Director and Deputy Director of Nursing to discuss involving and listening to patients and families
- Gathering feedback from over 100 patients about their experience of being discharged from hospital in West Kent.
- Working with the Trust to amplify the experience of a Parkinson's patient. This patient has shared her story directly with the Board and is now working with us and the Trust on some of the issues she raised.
- The Trust regularly invites us into the hospitals to listen to patients about their experience and acts upon our findings.
- This year we will be visiting the Trust to test out how they are implementing the Accessible Information Standard.

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

Healthwatch Kent

May 2018

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

DRAFT

Statement of Directors' responsibilities in respect of the Quality Accounts

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

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

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

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

By order of the Board

Trust Board meeting – June 2018



6-16	Approval of revised Quality Strategy	Chief Nurse
<p>Enclosed for review and consideration for approval is the Maidstone and Tunbridge Wells NHS Trust (MTW) Quality Strategy 2018/2019 – 2020/21.</p>		
<p>Which Committees have reviewed the information prior to Board submission?</p> <ul style="list-style-type: none"> ▪ 		
<p>Reason for submission to the Board (decision, discussion, information, assurance etc.) ¹ Approval</p>		

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 (MTW)

Quality Strategy

2018/2019 – 2020/21

MTW “Caring, Sustainable and Improvement Driven”



Draft V24.0 – 22.06.18



Our vision is 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.



Contents

Foreword and our Quality Objectives	4
Section 1: About Our Trust	5
Section 2: Quality at the centre of all we do	6-10
• Synergy with the Trust’s Strategy	6
• Our Quality Vision	7
• MTW – An Improvement Driven Organisation	8-10
Section 3: Defining Quality and Our Quality Ambitions	11-26
• MTW Quality Objectives and Priorities	11
• The MTW Quality Focus Areas	12
○ Creating a Safety Culture and Learning Lessons	13-17
○ Improving Patient Experience (Personalised Care)	18-20
○ Clinical Effectiveness and Tailored Pathways	20-23
○ Supporting our Staff to be the Best	23-25
○ Recognising and Responding to Complex Needs	25-27
Section 4: Our Quality Objectives and Goals	28-34
Section 5: Delivering Our Strategy	35-37
• Structure to deliver and monitor our quality goals	35-37
Closing Comments	38
Glossary of Terms	39-40

Foreword - Chairman and Chief Executive's introduction

Welcome to the Maidstone and Tunbridge Wells NHS Trust (MTW) three year quality strategy which introduces our five quality objectives, the underpinning quality priorities, our quality goals and demonstrates how we will deliver these. Our strategy has its foundation in the Trust's Corporate Strategy which is driven by quality and improvement. The Quality Strategy is underpinned by the following five high level quality objectives:-

CREATING A SAFETY CULTURE & LEARNING LESSONS

To provide the safest possible services to our patients via an open, blame free culture which promotes and enables learning the lessons from our practice and preventing harm within a supportive environment. This will be achieved via the 5 projects within the Best Safety workstream of the Best Care Programme which will deliver by 2019-20.

IMPROVING PATIENT EXPERIENCE (PERSONALISED CARE)

To provide truly personalised care to our patients, reflecting what patients want, delivered in the right environment with kindness and empathy, listening to patient and carer feedback, focussing upon clear and helpful communication at all stages in the patient pathway. This will be achieved via the Experience & Engagement Project within the Quality Workstream of the Best Care Programme and will deliver during 2018/19.

CLINICAL EFFECTIVENESS AND TAILORED PATHWAYS

To review our pathways, ensuring that they are truly patient-centred, matched to care needs, encompass the needs of patients with co-morbidities and complex needs, reflect innovation, research and audit and focus upon flow and patient outcomes. This will be achieved via all 4 of the projects within the Quality Workstream and the Best Flow Workstream of the Best Care Programme and will deliver during 2018-20.

SUPPORTING OUR STAFF TO BE THE BEST

We will attract, support, develop, invest in and retain the best staff to deliver the best care in line with our quality objectives, empowering staff to support the needs of the patient to enable truly personalised care. This will include the development of new roles. This will be delivered through the Workforce Workstream within the Best Care Programme and deliver during 2018/19.

RECOGNISING AND RESPONDING TO COMPLEX NEEDS

To recognise and respond to the specific needs of different patient groups, ensuring that the patient's voice is heard, focussing upon a key worker philosophy to tailor care. This will be delivered via the Complex Needs project within the Quality Workstream of the Best Care Programme and will deliver during 2018-20.

To produce this strategy, the Trust has involved staff, patients, families and carers in setting our quality priorities, from which our quality objectives and delivery plans have been created. Our thanks are extended to all of those who devoted their time, views and expertise. Key themes that have emerged throughout the production of this strategy relate to the provision of truly patient-centred, personalised care, demonstrating kindness, compassion and empathy, communicating effectively and responding appropriately where there are complex needs. You will see that these themes run throughout our strategy and link strongly to our corporate objectives. Our strategy will be delivered through our Best Care Programme, sponsored by the Board. Our delivery process is described later in this document. Providing safe and effective services whilst continuously learning lessons from our practice provides the foundation to the work that we do. Attracting, supporting, developing and retaining the best staff to provide the best care is a key priority to assure the highest possible standards of treatment and care delivery. Our strategy focusses upon what is important to MTW, its patients, families and carers now, and provides a forward look to our perceived priorities over the next 3 years, as well as focussing upon our important regulatory and must do activities.



David Highton
Chairman



Miles Scott
Chief Executive



Peter Maskell
Medical Director



Claire O'Brien
Chief Nurse

Section 1: About Our Trust – MTW

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

The Trust employs a team of over 5000 staff. It operates from two main sites but also has services at Canterbury and Crowborough hospitals and outpatient provision at several community locations. It has over 800,000 patient visits a year, 150,000 of these coming through our Emergency Departments which are accessible on the main sites. Maidstone Hospital has 325 overnight beds and Tunbridge Wells Hospital has 475 overnight beds.

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



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

The Maidstone site also has a state of the art birth centre, a new £3 million dedicated ward for respiratory services and an impressive academic centre with a 200 seat auditorium. With the academic centre at Tunbridge Wells, and its full resuscitation simulation suite, the Trust is able to offer excellent clinical training. The Trust has strong clinical, academic and research links with London hospitals, including joint appointments and a growing research capability. Many staff are also nationally recognised for excellence in their fields.

Section 2: Quality at the Centre of All We Do

2.1: Synergy with the Trust's Strategy

The Trust has recently developed its 5 year Corporate Strategy which has quality at its centre. The Trust's overall objectives to be a caring, sustainable and improvement driven organisation encompass our three core quality objectives of creating a safety focussed culture, continuously improving patient and staff experience with clinically effective services, learning the lessons from our care delivery within a blame-free culture. Providing safe, high quality health services to ensure the best overall experience for our patients, staff and public is at the heart of all we do at MTW. We believe that patients have the fundamental right to receive the very best care. This should be provided to them in the most appropriate setting, by teams of highly skilled and expert healthcare professionals who care passionately about the care they provide. Our quality strategy builds upon the Trust Strategy and sets out our quality priorities for the next three years. Our five core quality objectives run through the document, driving our safety, patient and staff experience and clinical effectiveness agendas.

Our Quality Objectives and Organisational Delivery



Section 2: Quality at the centre of all we do

2.2: Our Quality Vision

“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.”

MTW Trust Vision

By being more responsive and focused on improvement, MTW can fulfil its potential and be the high performing organisation its patients and staff deserve. Our aim is to be a Trust where patients choose to be treated and the best people aspire to work. The health system is changing around MTW due to the increasing pressure on health and social services and the need for sustainability. MTW must be ready to adapt to meet local and regional health needs in order to maintain high levels of service. This will involve further supporting community based services and collaborating more closely with neighbouring secondary care trusts and other health providers.

MTW Vision for Quality

We will work as a team to provide our patients with the safest care, tailored to their personal and clinical needs, delivering the best patient outcomes. We will support our staff to be the best, to deliver care with kindness, understanding and empathy. We will recognise patients with complex needs, designing our pathways to be responsive to their care requirements within clinically effective and safe frameworks that support our patients, their families and carers and our staff. We will operate within an open, blame-free learning culture and demonstrate innovation and research in our service planning and delivery.



Patient First

Respect

Innovation

Delivery

Excellence

MTW Quality Strategy 2018/21

Section 2: Quality at the Centre of All We Do

2.3: MTW – An Improvement Driven Organisation

Quality improvement is important at MTW.

“Quality improvement in healthcare is based on the principle of health care organisations and staff continuously trying to improve how they work and the quality of care and outcomes for patients. This requires a systematic approach based in iterative change, continuous testing and measurement and the empowerment of frontline teams (Ross and Naylor 2017). Fundamental to the principle of quality improvement is an understanding that those closest to complex quality problems (frontline teams, patients and carers) are often best placed to find the solutions to them. Many NHS organisations have started to explore quality improvement through discrete projects focussed on specific clinical services. A smaller, but growing number have developed more systematic, organisation wide programmes to ensure that continuous improvement happens at scale and as part of their standard way of working.”

*The Kings Fund
Embedding a culture of quality improvement
November 2017*

At MTW, we are embracing the improvement agenda

“Staff driven change will be empowered through a recognised improvement function within the Trust, linked to our Best Care Programme. This will be key in maintaining a focus on tomorrow as well as today. It will advocate effective change processes to help with cross-trust solutions. As well as giving support it will also provide a clear framework within which improvements can be made by staff in a timely fashion. Improvement should be an everyday focus from ward to board. Success should be championed and failures accepted, with learning and without judgement”.

*MTW Strategy
November 2017*



Section 2: Quality at the Centre of All We Do

2.3: MTW – An Improvement Driven Organisation

MTW's approach to improvement

MTW utilises a number of initiatives and methodologies to support Quality Improvement, some of the most significant being:

- Listening into Action (LiA)
- BMJ quality improvement platform
- Advancing Change & Transformation (ACT) Academy's Quality, Service Improvement and Redesign Practitioner Programme

Our improvement values will sit across all of these initiatives:

- all change should be clinically led but improvement is everyone's business
- we celebrate success and ensure a focus on sustaining positive changes
- we take the time to understand the specific actions that led to a positive change – what made the difference
- we recognise the value of testing our ideas and putting them into action quickly
- we use recognised quality improvement methods and tools
- we invest in capacity and skills for improvement across the Trust

Listening into Action

Listening into Action (LiA) is a new way of working for MTW that puts more of our staff, especially our frontline staff, at the forefront of our thinking when it comes to improvements in patient care and the services we deliver. Our aim is to engage and empower more of our staff to make the changes they feel are important to improving the patient experience and the work of the Trust. LiA is a proven approach which has been successfully used by many other high performing NHS Trusts to largely deliver clinically driven and patient-focused improvements in a timely manner. LiA is designed to be simple, compelling and different. The project management of LiA improvements is kept intentionally light to encourage staff to focus on their ideas rather than process. It focuses on:

- Connecting all the right people around a common mission and outcomes they care about
- Collaborating around good ideas to improve things for patients and staff"

BMJ Quality Improvement Platform

The BMJ Quality platform has offered access to a tool that provides a step by step framework for Quality Improvement. It has acted as a repository for Quality Improvement Projects taking place within MTW and has allowed mentors to guide staff through their quality improvement journey. The platform provided an outlet for staff to share their projects with others and allowed for comparisons.

BMJ Quality platform was "rebranded" in 2018 which led to a change in functionality. MTW currently has an in-house platform which is overseen by the Medical Education Department."

The Trust has started to utilise Life QI, which is a web platform built to support and manage Quality Improvement (QI) projects, allowing easy dissemination of ideas and lessons learned.

Section 2: Quality at the Centre of All We Do

2.3: MTW – An Improvement Driven Organisation

MTW’s approach to improvement

Quality, Service Improvement and Redesign Programme

To develop skills for improvement across the Trust, we are investing in the Advancing Change and Transformation (ACT) Academy’s Quality, Service Improvement and Redesign Practitioner Programme (QSIR Practitioner Programme) developed by NHS Improvement. QSIR is a nationally recognised successful quality and service improvement programme that has been delivered over many years to thousands of NHS staff. It covers the breadth of universal quality and service improvement skills (for example, elements of Lean, Six Sigma, Model for Improvement). It takes an action based learning approach with participants delivering an improvement project during the programme.

MTW is currently sponsoring eight members of Trust staff from a diverse mix of professional backgrounds to complete the QSIR practitioner programme by the end of May 2018. A sub-group will go on to become QSIR College associates by the end of October 2018, accredited to deliver the QSIR practitioner programme internally to Trust staff. In this way, the QSIR programme supports NHS organisations to build their capacity and capability for improvement through an internal teaching faculty which can be self-sustaining. MTW will commence an internal programme of courses in the autumn of 2018. We are actively engaging with and learning from other Trusts who have adopted QSIR as to how to maximise the impact of the Programme, including which support mechanisms we could put in place to provide practical help, advice and coaching to staff engaging in improvement work. This will be in addition to the ongoing support from the ACT Academy.



Section 3: Defining Quality and our Quality Ambitions

3.1: MTW Quality Objectives and Priorities

This section outlines our specific quality priorities and examines the detail of what we aim to deliver through this strategy. The document describes our key areas for focus and explains our planned activities to realise our five quality objectives.

Our desire to deliver the highest quality services is driven by a range of local and national factors including:

Creating a Safety Culture & Learning Lessons

- Investing in our learning and clinical governance systems (including human factors)
- Improving our management of actions from incidents and complaints and the consequent learning
- Embedding a safety culture via the development and implementation of the MTW 'charter mark'
- Ensuring that patients do not come to harm whilst on waiting lists for intervention:
- Being open, transparent and candid about quality with mature Duty of Candour processes
- Implementing 7 day working via the 10 national clinical standards
- Meeting of regulatory requirements (e.g. Care Quality Commission – CQC)
- Reducing observed rates of mortality
- Improving the reporting of medication errors
- Elimination or reduction of hospital acquired infections to least harm
- Improve recognition and treatment of sepsis

Improving Patient Experience Personalised Care

- Knowing what matters most to our patients, the public and our staff
- Responding to patient and carer feedback and concerns
- Understanding patients' needs and expectations, what they think and how they feel
- End PJ (pyjama) paralysis
- Improving our communications with patients and their carers
- Patient involvement in decision making
- Reduce waiting and delays and inform patients if this is unavoidable
- Manage patient expectations with clear communication & information
- Improving outcomes and experience for expectant mothers and their babies
- Drive progress and change that will improve Stroke services for our patients
- Ensuring women feel confident that they have high quality, safe maternity care
- Improving the Friends and Family methodology (consistent response rate and improved experience)
- Make our services accessible to all patients
- Developing and improving our discharge processes

Clinical Effectiveness & Tailored Pathways

- Redesigning pathways that are truly patient-centred, which can be personalised where appropriate
- Developing pathways for comorbid patients
- Striving for clinical excellence through adopting the 'Getting It Right First Time' (GIRFT), model hospital
- Innovation, research and audit embedded in our service planning and delivery
- Delivering cancer standards and improving survival rates
- Accurate and timely assessment of patients for risk factors i.e. VTE/falls/Pressure sores
- Avoiding unnecessary admissions and promotion of ambulatory pathways
- Improving flow and the 4 hour ED standard
- Increasing access for timely assessment by the most appropriate clinicians who are able to meet our patients' needs
- Commissioning for Quality and Innovation Scheme (CQUINS) a driver for improved outcomes in pathways of care

Supporting our Staff to Be the Best

- Attract, retain, support and develop the best staff
- Empower and support our staff to work in a blame-free culture where reporting of incidents and learning from mistakes is supported and invested in
- Provide a culture that supports staff to treat patients safely with evidence-based medicine, whilst treating them as an individual
- Invest in protected staff time across all multidisciplinary groups to attend clinical governance sessions and provide time for learning
- Provide the right environment and culture for our staff to work within and develop
- Develop new and extended roles to support new ways of working within the correct support framework
- Listen to staff and encourage feedback, empowering staff to respond (LiA)
- Develop objectives at Directorate and Divisional level for staff to aspire to

Recognising and Responding to Complex Needs

- Empowering staff to support the needs of complex patients, enabling them to personalise the patient's care within a safe governance framework
- Enabling patient and carer involvement with the coordination, decision-making, communication and negotiation of care arrangements for patients with dementia
- Improving access for patients with learning disabilities
- Improving care for mental health patients who frequently attend in crisis by working collaboratively with mental health care providers
- Develop a system to report and monitor the incidents of harm for patients with dementia
- Delivery of the mental health standards

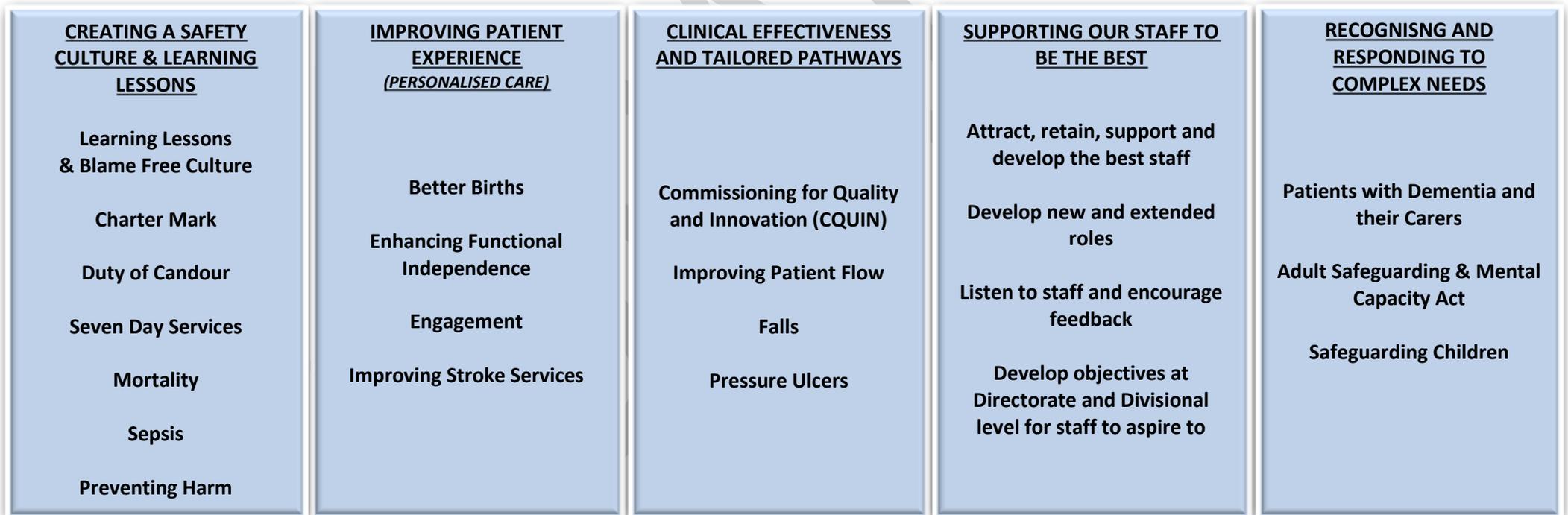
Defining Quality and our Quality Ambition

3.2: The MTW Quality Focus Areas

From all of the rich data collected to produce this strategy (which includes the views of our staff and key stakeholders), the priorities outlined in the section above have been distilled into 20 quality goals. The quality goals (outlined in section 4) are component parts of larger projects within the Best Care Programme and their delivery will be monitored through the governance arrangements of that programme.

Each of the quality goals aligns to one of MTW’s five quality objectives which are demonstrated below.

The following section will explain each of the quality goals in detail and section 4 will demonstrate how each of the goals will map to a Best Care Project for delivery.



Defining Quality and our Quality Ambition

3.2: The MTW Quality Focus Areas

3.2.1: Objective 1: *CREATING A SAFETY CULTURE & LEARNING LESSONS*

Learning Lessons (*Goal 1*)

Learning from our practice is a key component of the Trust's Quality Strategy. We need to learn from our successes and, when things don't go so well, from our mistakes. The Secretary of State for Health and Social Care, the Right Honourable Jeremy Hunt, has taken a key interest in learning lessons from practice and developing a blame-free culture. He has recently stated "in the NHS, we need to ask what is blocking the development of the supportive, learning culture we need to make our hospitals as safe as they should be. We must explore the profound culture change necessary if we are to complete this journey - the change from a blame culture to a learning culture".

During the Autumn of 2017, a wide section of staff met over a number of weeks to explore some key questions, including, how do we learn as an organisation, do we share learning across and between Directorates, do we learn from the more generic, cross-cutting themes and issues, how do we benchmark ourselves in relation to our incidence of recurrence of big issues and what is happening across the rest of the NHS in respect of learning? Following their research, the group made a set of recommendations, some of which are set out below. This work has evolved to become one of the Trust's Best Care Projects which sits within the Best Safety Workstream.

Therefore, to develop the systems and culture we need at MTW to support a learning environment, we will:

- Improve our focus on effective incident identification and management with blame-free reporting, effective review and action planning.
- Use human factors principles to develop solutions that reduce the risk of the same incidents happening again.
- Implement a centralised database and action planning process to ensure monitoring and implementation of all actions and all learning identified.
- Review of the format, content, membership and structure of our clinical governance meetings to ensure that we have an effective infrastructure to disseminate the learning and are able to evidence that lessons are learned from incidents and successes.
- Implement an MTW quality mark brand that individuals, teams, wards and departments will want to sign up to, getting the culture right as a learning environment.
- Make learning attractive, identifying what is relevant to disseminate.
- Embedding the learning via cultural change and effective leadership for learning and reflective learning.

The MTW Quality Mark (Goal 2)

We are creating, in a highly visible way, an MTW quality mark with the appropriate branding and symbolism to help raise the profile of patient safety and quality in the organisation. This is an opportunity to inform, involve and ultimately reassure our patients and visitors of our desire to put patients first (our key organisational value). We are strengthening the need, importance and credibility of learning and improvement. We want to create a culture where there is a desire to be included in the initiative on the part of our staff, with a common goal of improvement for all wards and departments to strive to achieve. Our aim is also to create synergy between our strategic objectives, quality strategy, the Best Care Programme and our staff charter. We will achieve this through this highly visible brand that puts quality and safety at the heart of everything we do to improve our patient and staff experience.

A key recommendation from the Learning Lessons project is to support the further development of the Trust's learning environment and culture to be receptive to learning and improvement. The MTW Quality Mark is therefore intended to support the delivery and embedding of the learning from our practice.

The MTW Quality Mark has become a project within the Best Care Programme (Best Safety Workstream) and will aim to deliver the following:

- Develop a brand that will act as a highly visible and recognisable symbol that establishes MTW as an organisation focused on care, sustainability and improvement.
- Ensure that the process is fully inclusive by agreeing the design of the MTW Quality Mark by working with our staff to co-design the method by which the Quality Mark will be awarded from our long-list of options.
- Dependent upon the chosen design, identify the process and system to review and monitor the award process.
- Establish an oversight panel to support the decision making process for the annual Quality Mark awards process.
- Run a pilot to test the process..
- Devise a rolling programme of wards and departments to join the Quality Mark process, to lead to full establishment across the organisation by March 2020/21.

Duty of Candour (Goal 3)

Saying sorry when mistakes are made says a lot about the principles of a person, likewise being open and transparent is a measure of the integrity of an organisation. We recognise that as an organisation it is essential that we support and give clear guidance to our staff to make it easier for them to do the right thing. The duty of candour regulations came into force in November 2014 and as a result the CQC have the regulatory powers to prosecute any breach in this responsibility. We recognise that during this time we have embedded this process for all serious incidents but that our understanding and evidence for compliance with duty of candour for moderate incidents is not as robust as it could be.

Establishing a baseline audit for 2017/18 demonstrated that our ability to evidence compliance in meeting the standard of Duty of Candour lacked rigor. We know that this needs to demonstrate that the relevant person has been written to, outlining the details of the incident, incorporating a frank apology and detailing all subsequent actions to be taken following their initial meeting. Our challenge is compliance with the 10 day standard from the point of detection of the incident. At present our

systems do not easily support this process and through the Creating a Safety Culture and Learning Lessons project of the Best Quality Workstream we will ensure that we work with the Directorates to find an easy to navigate and transparent solution.

To improve assurance of our Duty of Candour processes we will instigate a:-

- Review of our Incident reporting database to support the daily triage of all incidents that are rated as catastrophic, severe and moderate and provide an evidence trail of dialogue with Directorates to ensure compliance within 10 days is met for duty of candour.
- Regular auditing programme of compliance with Duty of Candour with development of an action plan to make the required improvements.
- Regular reporting process of compliance to the Trust Clinical Governance Committee.
- Programme of training to raise awareness of when Duty of Candour is required.

Seven Day Services (7DS) – (Goal 4)

The national Seven Day Services Programme (7DS) is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. Ten clinical standards for seven day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh which involved a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven day services should achieve, no matter when or where patients are admitted. The aim is to deliver a faster diagnosis to patients, faster diagnostic testing and for patients to spend less time in hospital. The standards focus upon the time between the patient's admission to hospital and their first review by a Consultant, the timing of consultant-led ward rounds, the protocols and arrangements that must be in place for patients who do not require consultant-delivered care, standards regarding the timing of diagnostic tests, and other standards covering patient experience and quality, the content and timing of shift handovers, the involvement of the multidisciplinary team and some standards for primary, community and mental health provider colleagues. Four of these standards were designated as priority standards. These are the minimum set of clinical standards needed to tackle variation in mortality, patient flow and experience and focus mainly on the consultant-delivered and diagnostic aspects of the standards outlined above.

The Trust has a mature project in place to oversee the implementation of the 10 National Clinical Standards and as required, is currently focussing upon the 4 priority standards. The project is now part of the Best Care Programme and is being delivered via the Best Safety Workstream.

To implement these standards, we are providing:-

- A support team to assist the Directorates in the monitoring and achievement of the standards.
- A regular monthly oversight committee to monitor progress and support with any unblocking or enabling mechanisms.
- A quarterly review and assurance meeting with representatives from our Clinical Commissioning Group (CCG) and the Regional 7DS Team as members.
- An assurance process to identify when each service achieves the required components of each standard, endorsed by our CCG and the Regional 7DS Team.
- The development of robust protocols to ensure that all patients who do not need to be seen by a Consultant every day will follow a consultant-directed pathway.

- Changes to the working day within certain specialties to enable the delivery of the consultant-delivered interventions including ward rounds and first assessments.
- A review of consultant numbers in medical disciplines to ensure that we have the correct critical mass to deliver the standards.
- Twice yearly surveys to spot check compliance.

Mortality (Goal 5)

Each death that occurs in hospital is a sad and distressing event for the loved ones and staff involved in that person's care. For those that are considered to be unexpected it is even more so. We therefore have a responsibility to review the care that was provided to every patient in our care (National Quality Board, 2017). The purpose of these reviews are to determine any death were it is considered that sub-optimal care has been provided and to instigate Duty of Candour. This is an opportunity for us to then review our processes and procedures to make any necessary changes as a result of lessons learned.

In addition, each hospital is benchmarked nationally via its Hospital Standardised Mortality Rate (HSMR). This is a key indicator that compares us with our peers. When tracked over time the HSMR can indicate how successful a hospital has been in reducing deaths and improving care. In April 2017 our HSMR was 110 (a ratio of the actual number of deaths to the expected number of deaths) and in March we reported 103.1. It is our aim and intention to further reduce and sustain this below 100 during 2018-2021 with the support of the Mortality Steering Group, Learning from Deaths Implementation Group and through the delivery of 7 day services (7DS).

It is our intention to further support this learning by:-

- Refinement of the Mortality review documentation with rollout to all clinicians and departments.
- Investigating the potential for the implementation of a new database devised specifically for mortality reviews to ensure that themes and trends can be monitored, extracted and shared.
- Supporting the training and development of Clinicians trained in the Royal College of Physicians Structured Judgement Mortality Review (SJR) process to maintain a robust review process.
- Undertaking a twice yearly audit of all Mortality reviews that did not reach Structured Judgement Review criteria to provide assurance that the Mortality Review process is robust and that no cases warranting deeper investigation were missed.
- Improving the standard of Death Certification by improving training materials for Junior Doctor Induction.
- Improving the standard of coding through a series of presentations at Directorate Clinical Governance sessions.
- Refining the process of Duty of Candour through the Serious Incident process.

Sepsis (Goal 6)

Sepsis is a potentially life threatening condition caused by the body's response to an infection. It affects 260,000 people in the UK every year causing 44,000 deaths but is relatively easy to treat if diagnosed and appropriately managed early enough.

Over the course of the last 2 years we have dramatically improved our screening and treatment of patients with potential sepsis throughout MTW; in fact we have been recognised as one of the most improved Trusts in England in this respect. As a result we have consistently delivered on the targets required as part of the national Sepsis Commissioning for Quality and Innovations (CQUIN) initiative.

There is, however, still room for further improvement. Our established Sepsis Committee have revised our Sepsis policy in line with latest guidance; introduced an updated screening tool to aid rapid screening and management and have recruited a team of dedicated Sepsis Champions representing each ward and department across the trust.

To further improve our care of patients with sepsis we are now working towards:-

- Ever greater sepsis awareness and compliance with national targets for screening and timely management.
- Improved antibiotic stewardship.
- Rollout of the updated National Early Warning Score (NEWS2) system to identify deteriorating patients.
- Investment in Nervecentre electronic observation recording to facilitate rapid screening of at risk patients.
- Revising our e-learning (on-line training) for staff to be kept up to date.

Preventing harm (Goal 7)

A key element of this strategy is that our staff are advocates for patient safety and the prevention of unintended or unexpected harm (Patient Safety, NHSI, 2016). This relies on firstly recognising and reporting harm, adverse events or near misses through our incident reporting database. Themes and trends can then be identified that warrant further investigation, root cause analysis, action plan development and then ensure that learning is shared to minimise or eliminate further risk. The work of the Learning Lessons Project, Mortality Surveillance Group and improving the Duty of Candour process will all have a role to play in developing this open and transparent learning culture.

To support the optimisation of patient safety and quality of care we will:-

- Invest in the training and roll-out of 'Human Factors' training for key department leads.
- Invest in Root Cause Analysis training.
- Improve upon methods of dissemination of the learning from Serious Incidents/Complaints etc.

3.2.2: Objective 2: IMPROVING PATIENT EXPERIENCE (*PERSONALISED CARE*)

Better Births (Goal 8)

The birth of a child should be a wonderful, life-changing time for a mother and her whole family. At MTW we want to ensure we provide a positive birth experience and ensure mother and baby are fit and well for their future together. Working with colleagues in the Kent & Medway Local Maternity System (LMS) we will implement the ambitions set out in the 'Better Births' document focusing on personalised choice, safety and quality. This will help to reduce local variation and improve outcomes for women and their families.

Our overarching aims and objectives are to:-

- Work with the Maternity Voice Partnership (MVP) representing local women to ensure the maternity service meets our community needs.
- Look for further quality and safety improvements by working collaboratively with other maternity units round the country.
- Use the actions laid out in the National Stillbirth care bundle to support the Secretary of State's ambition to reduce the number of stillbirths and neonatal deaths by 20%, by 2020 and by 50% by 2025.
- Reduce the number of babies admitted to the neonatal unit, thereby keeping mother and baby together (ATAIN project).
- Increase the number of community births; homebirths or birth centre births.

Enhancing Recovery – Achieving Functional Independence (Including End PJ Paralysis) - (Goal 9)

We know that promoting patient independence is an essential element in retaining quality of life. This starts at the point of entry to MTW whether in our outpatient setting or in our Accident & Emergency departments. For patients with long-term conditions we will support 'self-care' at home with input and support from Clinical Specialists or to remain independent with touchpoints of care. These could include daily attendance as part of our ambulatory care pathways or with support from community or social care.

In addition during 2017-18 we have configured our services to develop Acute Frailty Units on each site, the intention being the clinical assessment and provision of front-line treatment that will ultimately result in the prompt discharge home with any support packages required. However if an attendance and assessment should result in an inpatient stay we also recognise that promoting functional ability should not cease. A key element developed for introduction during 2018 is to 'end PJ paralysis'. This campaign is being launched by the Chief Nursing Officer for England and Executive Director NHSE and will run from 17 April to 26 June, 2018 with the intention of getting patients up and dressed in their own clothes. For many patients wearing pyjamas reinforces being sick and prevents recovery. Studies show that three-in-five immobile, older patients in hospital had no medical reason that required bedrest and that doubling the amount of walking while in hospital also reduces the length of stay (NHSE). We also know that reducing functionality can lead to a rapid deterioration in muscle strength resulting in decreasing function, reduced appetite, increased risk of pressure sores and ultimately hospital acquired infections. Although this campaign is currently time limited, at MTW it is our aspiration to realise the benefits for our patients and to then take stock of future actions that will ultimately improve the quality outcomes for our patients.

Anticipated next steps include:-

- Review of key performance indicators that the 'end PJ Paralysis' trial aspires to realise ie the potential to –
 - reduce the number and frequency of falls,
 - reduce the number and severity of pressure ulcers,
 - improve dietary intake and therefore reduce the need for dietetic input,
 - reduce the patient's length of stay due to retention of previous level of mobility and continued independence for personal needs etc.
- Aim to make this 'business as usual' in each Ward through the realisation of improved Key performance indicators and the learning lessons methodology.

Engagement (Goal 10)

"How important and how simple it can be to genuinely listen to the views of patients and staff and engage them in how to improve services." (Professor Sir Bruce Keogh). At MTW we recognise the need to engage in a wider audience that are representative of the patient group that we provide care for. It is our intent to improve our patient engagement strategy, to work with and understand the diverse needs of the people who utilise our services and to then work in collaboration to ensure that all pathways of care and any future developments have taken into account the views of those who use the service.

In addition we will also ensure that our staff have a voice and are able to speak out freely where inequalities exist or where quality and safety of care is compromised. At present the use of patient and staff surveys are instrumental in, providing direction, however we also recognise the need for more instantaneous feedback through the use of local surveys, including Friends & Family (F&F) feedback, Twitter, Facebook, NHS Choices and anonymous reporting or 'speaking out safely'.

The next steps to improve engagement with patients, staff and public in order that patients' experience of care and our staff's experience of working for the Trust are enhanced will be to focus on:-

- Patient Experience and Engagement.
- Public Engagement.
- Staff Experience and Engagement.
- Recruitment of patients and public to working / reference group.
- Development and delivery of an action plan for tackling the top 10 themes identified by F&F test feedback.
- Holding workshop(s) with public representative groups and local third sector community groups to get their contribution and ongoing involvement in development of public engagement strategy.
- Reviewing and understanding what matters to people using existing insight that is already available via complaints, surveys, F&F Tests, Healthwatch Enter & View reports, Patient Participation Groups (Clinical Commissioning Groups).
- Identification and acting on gaps in feedback.
- Developing a draft engagement strategy using co-production with people and communities.

Improving Stroke Services (Goal 11)

We are in the process of a public consultation in regard to the provision of Stroke services within Kent & Medway. We wish to ensure that MTW remains focused on improving care and outcomes for people who have had a stroke during this period, resulting in fewer deaths and less disability. Although we cannot predict where the 3 hyper-acute stroke units will ultimately be, we will ensure that our pathways and services are developed in line with the Kent & Medway STP to ensure that our patients care needs are continuously met.

Maidstone Hospital is current meeting the Sentinel Stroke National Audit Programme (SSNAP) level B for over overall performance, whilst Tunbridge Wells hospital is scoring a C (latest national figures Aug - Nov 2017).

To ensure that our service continues to improve we will:-

- Drive improvement within Stroke services at MTW.
- Continue to performance manage SSNAP audit targets, and use these measures to continue to improve the quality of stroke care.
- Ensure that our Stroke leads at MTW work with the STP Clinical reference group and workforce planning group, to plan service delivery and implementation ahead of the final decision in regards to the placement of the Hyper acute Stroke Units.
- Continue to provide a good level of in-service Stroke training to all staff involved in the patient Stroke pathway, increasing the skills of all staff at all levels thus improving evidence based care.
- Drive innovation and new ways of service development and patient care.
- Collect patient and family feedback review on a monthly basis and use this to improve all aspects of Stroke Care.
- Work with Stroke community services and Stroke charitable organisations with the aim of providing good Stroke care post discharge.

3.2.3: Objective 3: CLINICAL EFFECTIVENESS AND TAILORED PATHWAYS

Commissioning for Quality and Innovation (CQUIN) national goals- (Goal 12)

CQUINs are a method of improvement for the quality and safety of patient care that is nationally driven and their progress is monitored by our commissioners. CQUINs have also supported MTW to instigate service changes that have ultimately benefited patient outcomes. The CQUINs for 2017-2019 currently include: improving care and treatment for patients diagnosed with Sepsis; improving the standard of care for patients presenting to A&E with Mental health conditions; improving the health and well-being of our staff; improving access for advice and guidance; improving palliative care decision making and medicines optimisation - for further details of all schemes go to- <https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/>.

As part of these goals MTW have an established CQUIN Board to oversee progress and to provide support where needed to drive change. The current CQUIN goals have encouraged a collaborative approach with both our neighbouring Mental Health and Community NHS Trust colleagues; this ensures that the care promoted for our patients is seamless with all parties aware of the intended outcomes for that plan of care. Our communications team are also invaluable in raising awareness when wider Trust focus is required but in also letting the organisation know when we are doing well and of the improvements being made.

Further objectives include:-

- Continued momentum in monitoring progress through the monthly CQUIN boards.
- Regular meetings with Mental Health and Community NHS providers to ensure that the pathways devised support improved patient outcomes.
- Regular meetings with our Commissioners to ensure that the ongoing CQUIN programme is making a quality impact on patient care and is achievable and deliverable.
- Updates provided bi-annually to the Trust Clinical Governance Committee.
- Update of achievements are provided in MTW's yearly Quality Accounts.

Improving Patient Flow (Goal 13)

When people are taken to hospital as an emergency, they want prompt, safe and effective treatment that alleviates their symptoms and addresses the underlying causes of their illness. In short, they want care that is aimed at getting them better, quickly and safely. Getting patients better, quickly and safely requires the systematic implementation of known good practice, a consistent approach by all clinicians, collaboration within and between organisations, and great leadership along the pathway (NHS England, 2013).

During 2017-18 we have experienced an increase of 3,492 (2.4%) in our emergency attendances totalling 145,527 and an increase of 29.7% in our inpatient admissions compared to 2016-17. This increase in demand has created pressure on our services and bed availability resulting in a negative impact on our ability to manage our elective waiting lists.

As a result we have reviewed our pathways of care to concentrate on minimising the need for overnight stay, whilst maintaining excellent care through the development of:-

- Ambulatory Emergency Care pathways of care with the intention of delivering a 50% reduction in hospital overnight admissions and providing appropriate care required for the patient's condition whilst allowing them to continue many aspects of their normally daily life.
- Acute Frailty Units with the intention of ensuring that the most appropriate clinical team have contact with the patient early in order to minimise their Length of Stay and promoting their return to the community.
- Home from Hospital pathways of care through the improvement of services in the community.

During 2018-2021 it is our intention to:-

- Introduce 25 additional ambulatory pathways of care.
- Introduce a frailty model of care to support our elderly patients with 12 assessment spaces on each site.
- Facilitation of seven day working throughout the Trust, in Ambulatory Emergency Care and Acute Frailty.
- Work with our community partners to increase capacity.
- Develop a virtual ward.

Falls (Goal 14)

In the short term, a fall in hospital can result in pain, distress and injury for our patients. For many patients, the longer term impact of falls is a reduction in confidence and the resultant loss of their independence. These are adverse outcomes that we want to avoid wherever possible. For our older patients (>80yrs) a fall will result in some degree of harm, but were harm does occur, it is three times more likely to be severe (Falls Report, NHSI, 2017). Hip fractures are recognised as being the leading cause of death from injury in the elderly. The percentage of preventable falls remains unclear nationally varying between 33-50%, however we do know that any fall prevented improves the outcome and experience for that patient we therefore aim to continue our focus on further reducing our patient falls per 1,000 occupied bed days to our new target of 6.00.

To achieve this key performance indicator and improve our patients' safety we will:-

- Continue to audit the falls data on a monthly basis to identify and work with priority areas.
- Participate in the National Falls audit.
- Implement a specific falls assessment form within the Emergency Department for patients with dementia and/or delirium.
- Ensure that lying and standing blood pressures (a drop in blood pressure when standing is a known cause of falls) are recorded and that this becomes embedded in practice.
- Improve compliance on assessment for medication that increase risk of falls.
- Incorporate a vision assessment into the current falls risk assessment tool.
- Improve access to mobility aids for patients, ensuring all patients requiring a mobility aid has the aid within reach.
- Work with the Directorate leads to refine and implement the Safety Huddle, to improve the focus on falls.

Pressure Ulcers (Goal 15)

Hospital acquired pressure ulcers are a key indicator of the quality and experience of patient care. They remain a significant healthcare problem with on average 700,000 patients affected nationally each year (Stop the Pressure, NHSI, 2014). Acquiring a pressure ulcer in hospital can lead to pain and suffering, an extended length

of stay, increased risk of infection, impacts on quality of life and may even be life threatening. It is estimated that 80-95% of all pressure ulcers are avoidable and we want to ensure that we are taking every step to reduce the incidence of pressure ulcers at MTW. The current national incidence is between 4.3% (National Safety Thermometer data 2016) and 7.1% published by The Tissue Viability Society in 2015 (last available data). During 2016/17 MTW successfully exceeded achievement of the set target of 3.0 as a rate of pressure ulcers per 1000 admissions (excluding daycase patients) reaching a final figure of 2.6 and are set to improve on this figure in 2017/18.

To continue to improve our patients' experience and to reduce harm in relation to pressure ulcers we aim to:-

- Enhance the Tissue Viability team by increasing available hours and the development of more effective ways of working to support the ward teams.
- Review and develop the Tissue Viability Link Nurse system to enhance the impact of the link role in clinical practice.
- Develop trust-wide improvement plans based on findings of the prevalence audit and learning from root cause analysis.
- Work with the multi-disciplinary teams to ensure preventative measures are initiated in a timely manner. This will be evidenced in a reduction of hospital acquired category 2 pressure damage.
- Review / revise the core tissue viability nursing documentation to ensure it is fit for purpose.
- Maintain prevalence audits twice per year.

3.2.4: Objective 4: SUPPORTING OUR STAFF TO BE THE BEST

Attract, Retain, Support and Develop the Best Staff (Goal 16)

Our greatest asset is our workforce. The Trust's current Workforce Strategy is fundamental to realising the corporate vision, strategy, priorities and delivering excellent patient care. To do so, we are dependent on getting the very best from our workforce; now and in the future. The contribution that each person makes either directly or indirectly to our patients at MTW is greatly valued and at the heart of our success.

At the Quality Strategy Workshop, staff highlighted many key themes that are already reflected in the Workforce Strategy, and which are referred to later in this section. In particular, the need for staff to be listened to, with time to reflect and learn, to work within a no blame and supportive culture, and for the Trust to empower staff to support the needs of the patient whilst developing a safe governance framework to enable individualised care to be realised.

MTW needs to employ more staff in some areas to ensure that our workforce requirements continue to be at the levels that accommodate safe and effective service delivery needs and reduces the dependency on variable quality and expensive temporary cover. The demographic realities of an ageing workforce and the increasingly attractive career opportunities in the London sector and outside the NHS make the recruitment and retention of staff one of the biggest challenges MTW faces. The shortage of candidates with the right skills, abilities and experience in some NHS professions has created a highly competitive market both locally and nationally. We hold a monthly recruitment and retention group to develop and monitor substantive staff appointments.

Our key objectives are:

- Develop and deliver an annual recruitment plan which is proactive, creative and generates the reduction in the number of vacant posts and the dependence upon temporary staff.
- Explore and deliver creative options to attract, recruit, motivate and retain appropriately skilled, qualified and experienced employees who share our values.

Develop New and Extended Roles (Goal 17)

In light of the challenges in recruiting staff within some key areas of the organisation, we recognise the need to make use of more creative and innovative approaches to meeting our resourcing needs.

The use of new and extended roles presents the opportunity to:-

- Provide additional resource in areas which have had challenges in recruiting to traditional roles.
- Give staff alternative career path opportunities.
- Promote the adoption of new models of care.

A number of areas have already adopted innovative roles which have been effective in delivering good quality patient care. The Best Workforce workstream incorporates a number of projects which aim to develop, evaluate and promote the use of new roles as well as to promote the adoption of apprenticeships within the organisation.

To maximise the potential that alternative resourcing approaches provide, we aim to:-

- Review the effectiveness of new roles already being used or trialled within the organisation.
- Assess the potential for innovative resourcing approaches to target hard-to-recruit areas.
- Promote the adoption of new roles and apprenticeships within the Trust.

Listen to Staff Feedback (Goal 18)

It is recognised that an efficient, safe and quality driven organisation is only possible with an engaged workforce at all levels of the organisation. Kings Fund research links high levels of staff engagement to improved patient experience, reduced mortality and morbidity, higher levels of innovation and improved recruitment and retention of staff.

Listening, and responding, to staff feedback is a key aspect of developing an engaged workforce. We use a number of tools to collect staff feedback including the annual staff survey, 'Friends and Family Tests', targeted 'pulse' surveys as well as a wide range of more informal routes. Action plans are typically created from the collated

feedback in order to ensure that staff can see the impact of their comments within the organisation. In addition, the Trust is using a Listening into Action (LiA) framework (*as outlined in section 2*) to help staff effect change and improve overall engagement.

In order to ensure that staff engagement is afforded the priority it deserves as well as provide a structured approach for development and improvement, we have developed a Staff Engagement Strategy, due to be signed off by the Board in May 2018.

The intended goals of the strategy are to:-

- Embed an organisational culture of trust and transparency so that all staff feel safe and enabled to participate in the transformation and improvement of MTW.
- Implement a structured and multi-faceted approach through which all staff can engage in an informed way with key issues and decisions MTW needs to address and to contribute their own ideas as to how this might be achieved. This will be either directly at a team and department level via LiA or indirectly via improved partnership working with trade unions and staff networks.

Develop Objectives at Directorate and Divisional Level for Staff to Aspire to (Goal 19)

As outlined above, we have adopted a range of strategic objectives and priorities, supported by our Trust values. This provides a framework within which everyone can understand how their work contributes to the organisation as a whole. To effectively run their services, the Directorates and Divisions are developing their local strategic objectives, taking their direction from the overall corporate objectives, which reflect the needs and plans of each service. This will ensure that staff can identify with the direction of travel in their local area and understand how they can continually contribute to these objectives in their day to day work. Linked to the annual business planning process, these strategic objectives will also form a key part of the Strategic Clinical Service Plans. The annual appraisal programme provides a structured means for staff to link their individual work to the high-level objective, where every individual contributes to the work of the organisation at a local, Directorate and Divisional level.

To deliver this, our Directorates and Divisions we will:-

- Develop a set of strategic objectives for their services
- Display these strategic objectives in prominent areas
- Link the Directorate and Divisional objectives to the appraisal process

3.2.5: Objective 5: RECOGNISING AND RESPONDING TO COMPLEX NEEDS

Introduction: Complex needs can refer to people with a combination of chronic conditions, mental health issues and social vulnerability and as a result this can lead to ongoing healthcare needs. We are committed to ensuring that we strive to meet these needs in a proactive manner, with appropriately trained staff that can identify

and provide the delivery of care and support in a person-centred way. To help achieve this we need to work collaboratively within our own multidisciplinary teams (nurses, doctors, therapists etc.) and with our Healthcare partners to ensure that care is seamless and person-centred whether this is for a child, young person or adult.

Patients with Dementia and their Carers (Goal 20)

One of the National Dementia Statements is:-

'We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.'

This is something we are striving to achieve at MTW and the Dementia Friendly Hospital Charter is a key driver for the work we are doing within the Trust.

To improve assurance of our compliance with the Dementia Friendly Hospital Charter we will:-

- Regularly audit that preferences for care are assessed and addressed appropriately, and a personalised approach is given through the use of the 'This Is Me' document.
- Identify and consider the needs of family carer(s) who are the main carer/supporter of the person with dementia.
- Ensure that specialist staff such as dementia specialist nurses, older peoples teams and mental health liaison teams are available to offer support, advice and assessment where required.
- Continue to work proactively with Carers Support services in identifying and supporting carers whilst the person they care for is in hospital and on discharge.
- Instigate a reporting process on dementia care to the Board.
- Participate in the National Audit of Dementia and also undertake the Triangle of Care-Carers Included audit, to identify further areas for improvement.

Adult safeguarding including Mental Capacity Assessment (MCA) and Deprivation of Liberty Safeguards (DoLS) – (Goal 21)

Making safeguarding personal is something we strive to achieve at MTW.

Adult safeguarding means making sure people are supported to get good access to healthcare and stay well whilst in our care. The Care Act sets out a legal framework of how we should protect adults at risk of abuse or neglect; this requires a multi-agency approach, so working with other Healthcare providers is essential.

Three of the six principles of safeguarding include:-

Empowerment – people being supported and encouraged to make their own decisions and informed consent.

Prevention – take action before harm occurs.

Proportionality – use the least intrusive response appropriate to the risk presented.

To improve assurance with our compliance we will:-

- Regularly audit our compliance with assessment of capacity, empowering all to make decisions in relation to their care, and supporting those who lack the capacity to make those decisions, based on previous wishes or actions.
- Ensure staff are trained appropriately to identify and support those at risk of abuse or neglect, and provide appropriate pathways of care to prevent harm occurring.
- Regularly audit compliance with the principles of 'Best Interest' decision making to ensure the least intrusive / restrictive care is provided both whilst in our care and on discharge.
- Ensure a multi-agency approach is maintained through close working relationships with other healthcare partners to ensure a seamless and continuous process.
- Ensure that specialist staff such as Vulnerable Adults nurses, Learning Disability nurses and Dementia Specialist nurses are available for support, advice and assessment where required.

Safeguarding Children (Goal 22)

At MTW, we recognise that children have unique vulnerabilities and we place the highest priority on safeguarding all children who come into contact with the Trust. This is whether the child is admitted or spends time in our hospital departments and services. The Trust expects all staff to meet their statutory responsibilities and comply with best practice guidance. The child's welfare is paramount and staff will ensure that the child's safety and welfare is their first concern.

Statutory guidance is identified in Working Together to Safeguard Children (HM Government 2015) and is applicable when working with all children up to their 18th birthday, children yet to be born, and their families / carers. All staff will have access to the Trust Safeguarding Children Policy and Procedure (2017) and the Kent Safeguarding Children Procedures which underpin all practice. The key message is "SAFEGUARDING IS EVERYONE'S RESPONSIBILITY"

Effective care and safeguarding arrangements should be underpinned by the following key principles: –

- Safeguarding is everyone's responsibility.
- All staff to be compliant with Safeguarding Children training (applicable to their role).
- A child-centred approach to care where staff work in partnership with parents/carers.
- Staff will work in partnership and collaboratively with other agencies and professionals involved in the care of the child including safeguarding professionals.
- All children admitted to the Trust (including non-Paediatric areas) will have access to staff who are trained at Level 3 Safeguarding Children (Intercollegiate Document 2014).

Section 4: Our Quality Objectives and Goals

The table below maps each of our quality goals to the relevant Best Care Project that will deliver its aims and identifies the lead staff responsible for delivery. It also provides a summary of what success will look like when the goals have been delivered through the various Best Care Projects. (Note: Goal 14 is the only exception to delivery via the Best Care Programme as this process delivers through an existing mechanism which is outside the scope of the Programme).

CQC Domains:-

Safe
 Effective
 Caring
 Responsive
 Well-Led

Goal Number	Goal Title	Leads	Location of Plan	Evidence of Success
Objective 1: Creating A Safety Culture & Learning Lessons				
1	Learning Lessons & Blame Free Culture	Complaints & PALS Manager Deputy Medical Director Head of Delivery Development	Best Care Programme, Learning Lessons Project Best Safety Workstream	Action plans are centralised and effectively implemented Central database implemented Multidisciplinary attendance at Clinical Governance Meetings Human Factors training is implemented The number of repeat incidents is significantly reduced Sustained increase in incident reporting A blame free culture where learning lessons is paramount Presence of human factors training course within the Trust Effective root cause analysis investigations via trained staff
2	Establishing the MTW Quality Mark	Deputy Chief Nurse Head of Delivery Development Associate Medical	Best Care Programme, Quality Mark Project Best Safety Workstream	High visibility to patients, staff and visitors Improved patient safety Staff reward and recognition High levels of staff engagement Quality Mark embedded and owned amongst staff

		Director		System is linked to Trust Annual Awards
3	Duty of Candour	Patient Safety Manager Associate Director of Quality Governance Deputy Chief Nurse	Best Care Programme, Learning Lessons Project Best Safety Workstream	Compliance with 10 day standard Monthly reporting of compliance to the Trust Clinical Governance Committee Training programme in place and staff awareness raised Reduced incidence of complaints
4	Seven Day Services (7DS)	Head of Delivery Development Clinical Lead for 7DS	Best Care Programme, 7DS Project Best Safety Workstream	10 national priority standards implemented Reduction in unwarranted variation by day of week Weekend effect eliminated A more even distribution of workload throughout the week
5	Mortality	Associate Director of Quality Governance Deputy Medical Director Head of Delivery Development	Best Care Programme, Mortality Project Best Safety Workstream	Improved HMSR and SHMI statistics 100% compliance with the completion of all mortality forms following a patient death Implementation of a single database Improvement in coding and the sequencing of recorded co-morbidities (Charlson index) for all deceased patients
6	Sepsis	Chair of Trust Sepsis Committee Associate Director of Quality Governance	Best Care Programme, Effectiveness & Excellence Project Best Quality Workstream	Compliance with national targets for screening and timely management Improved antibiotic stewardship Rollout of the updated National Early Warning Score (NEWS2) system to identify deteriorating patients Achievement of the rapid screening of at risk patients Staff all kept up to date via the e-learning module
7	Preventing Harm	Associate Director of Operations Planned	Best Care Programme, Preventing Harm Project	The reduction of unintended or unexpected harm Audit of patients who have breached the referral

		Care Deputy Medical Director	Best Safety Workstream	to treatment time for elective and outpatients undertaken Learning identified from audit to develop necessary actions Effective learning (facilitated by the Learning Lessons Project)
Objective 2: Improving Patient and Experience (Personalised Care)				
8	Better Births	Head of Midwifery Associate Director of Quality Governance	Best Care Programme Effectiveness & Excellence Project Best Quality Workstream	Implementation of the ambitions set out in 'Better Births'. Reduction in the number of stillbirths and neonatal deaths by 20% (by 2020) and 50% (by 2025). Services meet the needs of women in the Community. Safety improvements achieved through work with other maternity units within the NHS.
9	Enhancing Functional Independence	Deputy Chief Nurse	Best Care Programme Complex Needs Project Best Quality Workstream	Supporting patients to proactively manage their long-term conditions at home Further development of ambulatory pathways of care to support treatment without admission Development of assessment units in all specialities that will rapidly assess, treat and promote discharge with appropriate support at home. Prompt discharge home from hospital once medically optimised with support packages insitu. Implementation of the 'End PJ Paralysis' campaign aims
10	Engagement	Deputy Chief Nurse Head of Staff Engagement & Equality	Best Care Programme Experience & Engagement Best Quality Workstream	The development of an Engagement Strategy, co-designed with local people and communities An effective and representative patient experience group Regular workshops held with public representative groups

				<p>Effective use of the learning from complaints, surveys, Friends and Family Tests, and other patient participation groups</p> <p>Develop a clear communication strategy providing direction and accessibility of Executive/Senior leads to engage and support staff</p> <p>Enable staff to provide feedback/comments easily and demonstrate the actions being taken</p>
Objective 3: Clinical Effectiveness and Tailored Pathways				
11	Improving Stroke Services	<p>Associate Director of Nursing – Urgent Care</p> <p>Matron for Urgent Care (Stroke Lead)</p>	<p>Best Care Programme</p> <p>Best Patient Flow Workstream</p>	<p>Attainment of Sentinel Stroke National Audit Programme (SSNAP) level A</p> <p>Collaborative working with the STP Clinical Reference group to ensure appropriate pathways of care are in place at point of reconfiguration of services</p> <p>Use of patient feedback to improve patient experience</p> <p>Collaboration with community and charitable organisations to streamline patient care following discharge from hospital.</p>
12	Commissioning for Quality and Innovations (CQUINs)	<p>Associate Director of Quality Governance</p> <p>Head of Contracting & Income</p>	<p>Best Care Programme Effectiveness & Excellence Project</p> <p>Best Quality Workstream</p>	<p>Improvements in the quality and safety of patient care</p> <p>Service changes implemented that support improved patient outcomes</p> <p>Pathways are designed which support improved patient outcomes</p> <p>Successful implementation of the CQUIN Agenda identified for 2017-2019, and further CQUINs agreed to 2021.</p>
13	Improving Patient Flow	<p>General Manager for Acute & Emergency and Specialist Medicine</p>	<p>Best Care Programme</p> <p>Non-Elective Patient Flow</p> <p>Best Patient Flow</p>	<p>Patient access to increased number of ambulatory pathways</p> <p>Frailty models of care on both hospital sites</p>

Item 6-16. Attachment 11 - Quality Strategy

		Associate Director of Nursing Urgent Care		7 day working in both frailty units and to support ambulatory pathways Further pathways of care to facilitate supportive and timely discharge Creation of a virtual ward to support patients at home.
14	Falls	Associate Director of Nursing Planned Care Deputy Medical Director	Best Care Programme Effectiveness & Excellence Project Best Quality Workstream	A reduction in patient falls (per 1.000 occupied beddays) to at least the target of 6.00. Monthly audits in place Achievement of the identification of the triggers for falls (eg.,medications, sight, risks of) and that these are embedded into practice Increased availability of mobility aids in all areas where patients are at risk Safety huddles implemented and embedded into practice Trust-wide action plan in place.
15	Pressure Ulcers	Deputy Chief Nurse Lead Nurse for Tissue Viability	Best Care Programme Effectiveness & Excellence Project Best Quality Workstream	A reduction in the incidence of category 2 pressure damage for our patients Tissue viability Link Nurse system enhanced Improved access to Tissue Viability Team expertise through increase of hours of service Trust-wide improvement plans in place.
Objective 4: Supporting our Staff to be the Best				
16	Attract, Retain, Support & Develop Staff	Chief Nurse Simon Hart	Recruitment and Retention Strategy Group Best Care Programme Best Workforce Workstream	An increase in recruitment rates Decreased staff turnover rates / leaver rates Increased scores for staff morale within the Annual Staff Survey and local Friends and Family Tests.
17	Develop New & Extended Roles	Associate Director of Operations (Women Children and Sexual	Best Care Programme Best Workforce Workstream	An increase in recruitment rates A higher number of filled new role positions Increase in the use of apprenticeship roles within

		Health)		the organisation.
18	Listen to Staff and Encourage Feedback	Head of Staff Engagement and Equality Assistant Deputy Chief Nurse	Best Care Programme Best Quality Workstream	An increase in responses from the Annual Staff Survey and local Friends and Family Tests Lower scores for bullying, harassment and discrimination Increased scores for staff morale Better active engagement of staff at all levels with the LiA programme.
19	Develop Objectives at Directorate Level	Divisional Directors of Operations Associate Directors of Operations Clinical Directors	Best Care Programme Best Use of Resources	Each Division and Directorate have a set of well-defined strategic objectives that reflect their service improvement and development aspirations, linked to their annual business plans The appraisal process incorporates a review of each staff members' contribution to the achievement of the strategic objectives for their area Service improvement and development occurs in the context of the organisations strategic objectives and priorities.
Objective 5: Recognising and Responding to Complex Needs				
20	Patients with Dementia and their Carers	Deputy Chief Nurse Lead Nurse for Dementia	Best Care Programme Complex Needs Project Best Quality Workstream	Patients preferences for care are implemented Personalised care is in place in line with the 'This is Me' document The needs of family and carers are identified and acted upon Specialist staff are available to offer support, advice assessment when required An effective dementia care report is in place for reporting to the Board Participation with the National Dementia Audit and Triangulation of Care-Givers Audit.

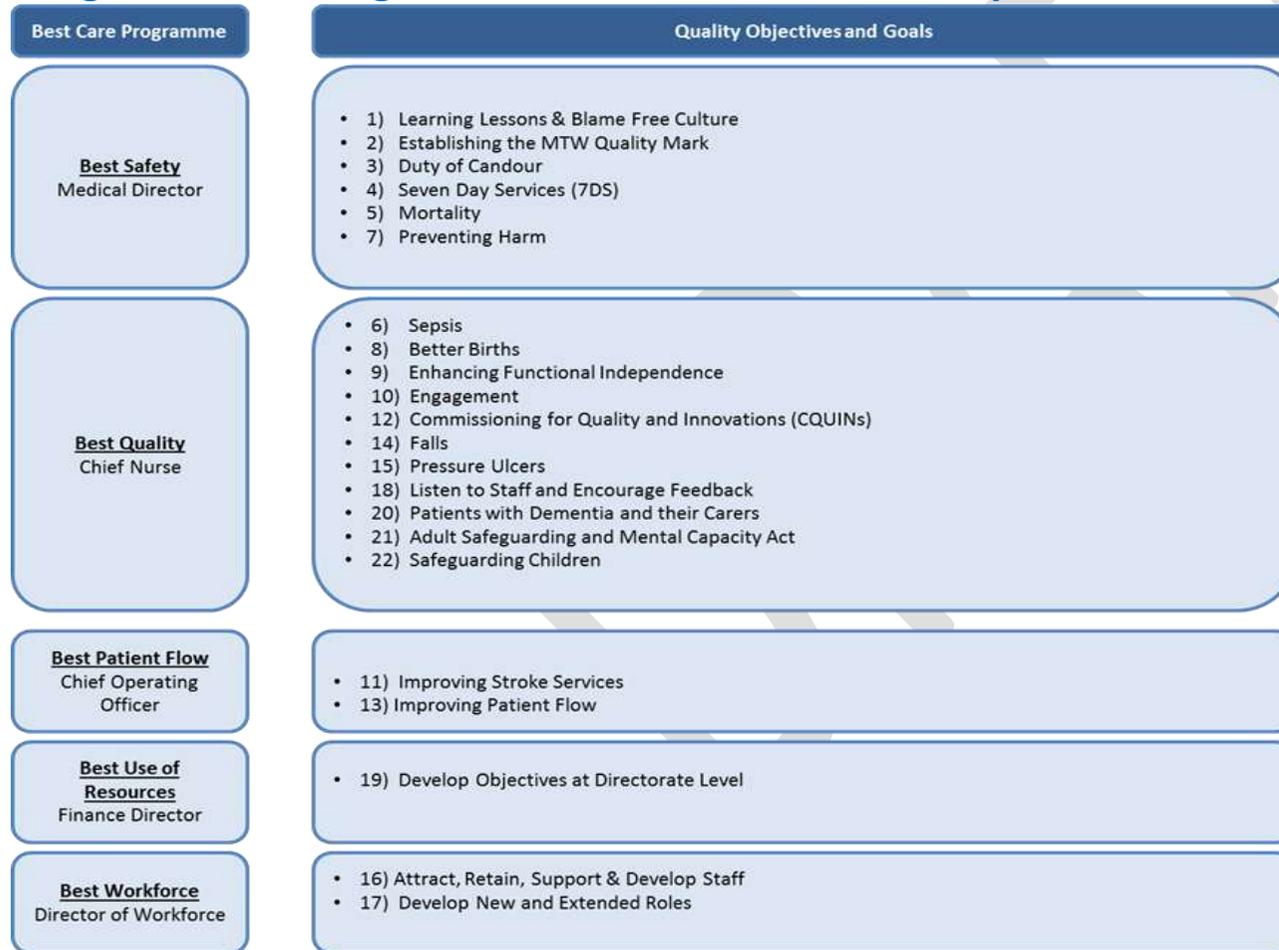
21	Adult Safeguarding and Mental Capacity Act	Deputy Chief Nurse Matron for Safeguarding Adults	Best Care Programme Complex Needs Project Best Quality Workstream	<p>Patients who lack the capacity to make decisions in relation to their care are empowered to do so</p> <p>MTW has an appropriately trained workforce who can identify and support those at risk of abuse or neglect</p> <p>Staff know how to access specialist advice and support when required</p> <p>Pathways of care are in place to prevent harm from occurring</p> <p>Effective working relationships are in place with other healthcare partners to ensure seamless services are in place.</p>
22	Safeguarding Children	Deputy Chief Nurse Matron for Safeguarding Children	Best Care Programme Complex Needs Project Best Quality Workstream	<p>All staff in the Trust are able to comply with their statutory responsibilities and comply with best practice guidance</p> <p>A child-centred approach is in place across the Trust which will include staff who are trained at Level 3 Safeguarding in non-Children's Service areas.</p> <p>The safeguarding of children will be everyone's business</p> <p>Effective working relationships are in place with other healthcare partners to ensure seamless services are in place.</p>

Section 5: Delivering Our Strategy

Best Care Programme:

Structure to deliver and monitor our quality goals

Programme Management and Governance for Improvement



Best Care has been developed by our clinical and non-clinical leads to help transform our patient and staff experience. We know that providing high quality, safe standards of care – through an unremitting focus on quality, safety and patient and staff experience – is massively cost-effective and transformational for hospital trusts. The Best Care programme is pulling together everything we do in 2018 and beyond, through five streams of work, to create a single joined up focus in MTW to achieve:

1: The safest possible overall experience for our patients and staff – **Best Safety**

2: The highest quality experience for our patients and staff - **Best Quality**

3: A seamless journey for our patients through our hospitals from admission to discharge - **Best Flow**

4: Supporting our staff to reach their potential, and do what they joined our Trust to do, to give our patients the best experience and work with their colleagues in great teams - **Best Workforce**

5: Ensuring we are all getting maximum value from everything we use and spend money on to make our staff and patient experience a good one – **Best Use of Resources**

Best Care is a collaborative approach to improvement that proactively seeks out the ongoing involvement of our staff, patients, and stakeholders to make changes for the better on a daily basis. It represents our commitment to deliver continual transformation and service improvement.

Section 5: Delivering Our Strategy - Best Care Programme:

Structure to deliver and monitor our quality goals

The programme governance for each Workstream requires monthly board meetings, with the attendance of:

- Executive Sponsor
- Clinical Lead
- Operational Lead
- Programme Management Office Lead
- Finance Management Lead
- HR Business Partner
- Business Intelligence Lead

All projects within the Best Care Programme will adhere to the standard Project Management Office (PMO) process and will achieve the following criteria below to fulfil the planning stage.

Criteria	Function
1	<ul style="list-style-type: none"> • Key Tasks identified and agreed • Tasks duration (start / end dates) identified and agreed • KPIs identified and agreed • Accountable officers confirmed • Baseline Plan signed off by Clinical Division/ Corporate Director
2	<ul style="list-style-type: none"> • Financial Methodology agreed (Baseline position agreed/how schemes will be calculated and monitored)
3	<ul style="list-style-type: none"> • Quality Impact Assessment (QIA) completed by Clinical Lead/Corporate Director
4	<ul style="list-style-type: none"> • Quality Impact Assessment (QIA) approved by Medical Director / Chief Nurse

To comply with the planning stage and to achieve a *planning* status of green, all projects must achieve all 4 of the criteria. All projects must identify and monitor KPIs and have detailed project plans showing the critical path.

The delivery of the plans and subsequent KPIs are monitored by the Executive Sponsor on a monthly basis at the Workstream Board meetings and bi-monthly at the Best Care Working Group meeting, chaired by the Best Care Executive Sponsor. Any deviation to these agreed plans are tracked and rated accordingly and is recorded as the *delivery* status.

Monthly workstream reports are produced detailing delivery against critical path, KPIs and the qualitative and quantifiable benefits and reviewed at the monthly Best Care Programme Review Board, which in turn is the key input to the update to the Trust Board.

To provide further assurance against the delivery of the benefits, KPIs are monitored in advance, so corrective plans can be evoked to proactively recover the position before the actual benefits need to be realised, in the event the KPI trajectory is not on target. Both the planning and delivery status are independently checked by the Programme Management Office (PMO) to ensure compliance to the agreed criteria.

All project documentation can be found on the following drive: Q:\FTIP Public\CIPS 18_19\MTW Programmes*(insert name of workstream)*

DRAFT

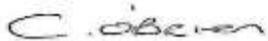
Closing Comments

We are delighted to have had the opportunity to engage with staff, patients and stakeholders to establish exactly what the real quality priorities are for MTW. We would like to thank everyone who has been part of this process for their invaluable insight, experience and comments.

Those priorities have been informed by what our patients have told us and what we already know in terms of areas on which we can improve. The finalised priorities have now been articulated into this new and exciting strategy, which we hope will give us the opportunity to ensure that we put quality at the heart of everything we do.

There are certainly challenges to come but the priorities we have are aligned to the Trust's Best Care programme and will be embedded into the fabric of how MTW operates and evolves in the future.

When the CQC visited us in late 2017, they noted the significant improvements we have made – our role now is to continue with those improvements, ensuring we engage properly with our staff, our patients and community partners, while working together to make sure that quality comes first.



Claire O'Brien
Chief Nurse



Peter Maskell
Medical Director

Glossary of Terms

A&E- Accident & Emergency

ACT- Advancing Change & Transformation

AoMRC- Academy of Medical Royal Colleges

ATAIN- Avoiding term admissions into Neonatal Units

Best Care – the name of MTW’s transformation programme

Better Births- Improving outcomes of maternity services <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

BMJ- British Medical Journal

Charlson Index- coding for comorbidities. Validated as a measure of 1-year mortality risk and burden of disease

CQC- Care Quality Commission

CQUINS- the Commissioning for Quality and Innovation

CT- computed tomography; computer-processed combinations of many x-ray measurements to produce cross-sectional images

DoLS- Deprivation of Liberty Safeguards

F&F- Friends & Family test, important feedback tool to understand whether patients are happy with the service provided

GIRFT- Getting it Right First Time <http://gettingitrightfirsttime.co.uk/>

HM- Her Majesty’s

KPI’s- Key Performance Indicators

LiA- Listening into action; a process for the direct involvement of our staff to unlock their potential to drive change and improvements

MCA- Mental Capacity Act

MTW- Maidstone & Tunbridge Well NHS Trust

MVP- Maternity voice partnership

NEWS2- National Early Warning Score, version 2; a system that rates the patients vital signs as an indicator to identify the acutely ill.

NHS- National Health Service

NHSE- National Health Service England

NHSI- National Health Service Improvement

PALS- Patient Advice & Liaison Service

PET- Position emission tomography; an imaging technique that observes metabolic processes to aid diagnosis of disease

PJ- pyjamas

PFI – Private finance initiative (funding for Tunbridge Wells hospital)

PMO- Project Management Office

QIA- Quality Impact Assessment

QI- Quality Improvement

QSIR- Quality, Service Improvement and Redesign

SJR- Structured Judgement Review; methodology for the review of mortality cases

SSNAP- Sentinel Stroke National Audit Programme

STP- Sustainability & Transformation Plan

VTE- Venous thromboembolism

7DS- Seven Day Services

DRAFT

Trust Board meeting - June 2018



6-17	Electronic Patient Record – Review of changes between the Outline Business Case (OBC) & Full Business Case (FBC)	Chief Operating Officer/ Interim Dir. HI / CClO
-------------	---	--

Following the go-live of the Allscripts PAS in October 2017, the approval to enter into a Memorandum of Understanding (MOU) with Allscripts in December 2017 and approval of the Outline Business Case (OBC) by the Trust Board, a Full Business Case (FBC) has been developed, Supply and Maintenance contracts have been negotiated and a Programme Definition Document developed for approval.

The FBC confirms the Option 4 remains the preferred option, requiring capital funding of £3.1m (£3.0m OBC) over the next 4 years.

At the request of the Trust Finance Committee the option for completing the project over 12 months has been reviewed. Combined with starting the project in July 2018 to allow the project to be completed in Q3 2019 this is now the recommended approach.

The case demonstrates net revenue saving of £5.8 (£5.7m OBC) over a 10-year investment period. However, the initial 3 years of the project would place a £3.1m (£3.6m OBC) cost pressure on the Trust, prior to cash releasing benefits being realised. The changes to the stated figures from the OBC are due to finalisation of contracted costs, following the procurement exercise, reduced implementation timescales and finalisation of the PAS Contract Reduction.

This paper outlines the significant changes made to the Business Case following the approval of the Outline Case by the Trust Board and provides the necessary assurance that implementation and associated business change capability has been established.

The Business Case has been reviewed by Stephen Dobson, Chief Digital Officer, Greater Manchester Health and Social Care Partnership (formally CIO at Wrightington, Wigan & Leigh NHS Foundation Trust where Allscripts Sunrise EPR was implemented in 2016) in order to provide assurance to the Trust Board of the validity of case with a focus on Resourcing, Options Appraisal and Benefits Realisation.

Which Committees have reviewed the information prior to Board submission?

- Finance and Performance Committee, 26/06/18

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

Approval is sought for the investment required in the EPR Full Business Case, the Supply and Maintenance Contract and the Programme Definition Document.

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

Changes to Business Case

Strategic Case

The Trust Strategy will be enabled through implementation and better utilisation of informatics.

The case for change to meet local health needs remains, with the investment addressing national objectives and drivers for change.

Economic Case

The recommended Option 4 and the alternative Option 3 have been further analysed to confirm the preferred funding arrangements: -

Option 4 - Single Supplier EPR – Fully Managed Service Model

Option 3 - Single Supplier EPR – Capital and Revenue Model

Procurement of the Allscripts Sunrise EPR has been negotiated through the SBS Direct Reward route covering both Options 3 & 4, allowing the Trust to make the decision about the appropriate funding arrangements.

Option 4 remains the preferred option due to the preferable payment schedule offered, minimising the impact on Trust cashflow and reduced Capital charges.

Option 4 - Net Cashflow

Maidstone & Tunbridge Wells NHS Trust CASH FLOW SUMMARY £000	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total
	-786	-4,568	-95	1,006	1,450	1,473	1,498	1,527	1,558	1,606	1,642	6,310

Option 3 - Net Cashflow

Maidstone & Tunbridge Wells NHS Trust CASH FLOW SUMMARY £000	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total
	-2,858	-4,600	36	1,107	1,555	1,512	1,791	1,827	1,865	1,920	2,323	6,475

Commercial Case

The systems and services considered, based on Trust needs and planned approach: -

Phase 1 – Preparation of Existing Systems

Phase 2 – Implement Foundation Systems and Preparation

Phase 3 – Implement EPR Core Systems

Phase 4 – Implement Departmental Systems

Financial Case

The recommended Option 4 has been assessed over an 18-month and 12-month implementation period, as requested.

18-month Implementation

10 Year Income & Expenditure Summary: -

Maidstone & Tunbridge Wells NHS Trust INCOME & EXPENDITURE SUMMARY	Yr 0 2018/19	Yr 1 2019/20	Yr 2 2020/21	Yr 3 2021/22	Yr 4 2022/23	Yr 5 2023/24	Yr 6 2024/25	Yr 7 2025/26	Yr 8 2026/27	Yr 9 2027/28	Yr 10 2028/29	Total
COSTS												
Revenue payments	1,236	1,897	1,175	738	721	738	755	773	790	809	331	9,962
Non-recoverable VAT on revenue	0	0	0	0	0	0	0	0	0	0	0	0
Depreciation (non-cash flow item)	3	218	332	344	347	352	359	368	381	392	380	3,476
Rate of return (non-cash flow item)	6	40	80	88	78	66	55	43	32	19	6	513
Grand total costs	1,245	2,155	1,587	1,169	1,146	1,156	1,169	1,184	1,203	1,219	717	13,952
FUNDING												
Cash releasing benefits	0	0	863	1,655	2,087	2,310	2,358	2,408	2,458	2,510	2,558	19,206
Other (specify details)												0
Grand total funding	0	0	863	1,655	2,087	2,310	2,358	2,408	2,458	2,510	2,558	19,206
NET COST TO REVENUE SOURCES	1,245	2,155	724	-487	-941	-1,153	-1,189	-1,223	-1,255	-1,290	-1,841	-5,255

10 Year Cashflow Summary, including Optimum Bias and Contingency: -

Maidstone & Tunbridge Wells NHS Trust	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total
CASH FLOW SUMMARY £000	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	
CASH OUT												
Capital payments - Maidstone & Tunbridge ¹	330	1,518	822	58	0	0	0	0	0	0	0	2,728
Capital payments - optimism bias uplift [*]	5	24	13	1	0	0	0	0	0	0	0	44
Capital contingency ^{**}	33	194	135	38	23	29	35	36	37	20	21	601
Capital payments - total	368	1,736	971	97	23	29	35	36	37	20	21	3,373
Revenue payments - Maidstone & Tunbridge	1,107	1,666	1,018	654	638	651	665	679	693	708	252	8,730
Revenue payments - optimism bias uplift [*]	18	27	16	10	10	10	11	11	11	11	4	140
Revenue contingency ^{**}	111	204	141	73	73	76	80	83	86	90	75	1,093
Revenue payments - total	1,236	1,897	1,175	738	721	738	755	773	790	809	331	9,962
VAT	287	633	359	125	110	112	114	117	119	122	30	2,129
Cash releasing benefits	0	0	-863	-1,655	-2,087	-2,310	-2,358	-2,408	-2,458	-2,510	-2,558	-19,206
Total cash out	1,891	4,266	1,642	-697	-1,232	-1,430	-1,453	-1,482	-1,512	-1,559	-2,176	-3,742
CASH IN												
Recovered VAT	287	572	318	125	110	112	114	117	119	122	30	2,026
Other (specify details)												0
Total cash in	287	572	318	125	110	112	114	117	119	122	30	2,026
NET CASHFLOW												
Net cashflow	1,604	3,694	1,324	-822	-1,342	-1,542	-1,567	-1,599	-1,631	-1,681	-2,206	-5,768
Brought forward	0	1,604	5,297	6,622	5,800	4,458	2,916	1,348	-251	-1,881	-3,562	
Carried forward	1,604	5,297	6,622	5,800	4,458	2,916	1,348	-251	-1,881	-3,562	-5,768	
Element of payments in 'cash out' that comprises inflation												
Capital	-0	35	39	5	2	3	4	5	5	4	3	106
Revenue	-0	37	47	44	57	72	88	104	121	137	62	769

12-month Implementation

10 Year Income & Expenditure Summary: -

Maidstone & Tunbridge Wells NHS Trust	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total
INCOME & EXPENDITURE SUMMARY	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	
COSTS												
Revenue payments	143	2,892	958	723	740	757	774	792	811	829	841	10,260
Non-recoverable VAT on revenue	0	0	0	0	0	0	0	0	0	0	0	0
Depreciation (non-cash flow item)	5	254	327	333	337	341	349	358	370	381	370	3,425
Rate of return (non-cash flow item)	11	51	85	86	75	64	53	42	31	19	6	523
Grand total costs	160	3,197	1,370	1,142	1,151	1,162	1,176	1,192	1,212	1,229	1,217	14,207
FUNDING												
Cash releasing benefits	0	206	1,511	1,779	2,213	2,260	2,307	2,356	2,405	2,456	2,503	19,995
Other (specify details)												0
Grand total funding	0	206	1,511	1,779	2,213	2,260	2,307	2,356	2,405	2,456	2,503	19,995
NET COST TO REVENUE SOURCES	160	2,991	-142	-637	-1,062	-1,097	-1,131	-1,163	-1,193	-1,227	-1,286	-5,787

10 Year Cashflow Summary, including Optimum Bias and Contingency: -

Maidstone & Tunbridge Wells NHS Trust	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Total
CASH FLOW SUMMARY £000	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	
CASH OUT												
Capital payments - Maidstone & Tunbridge ¹	576	1,594	496	17	0	0	0	0	0	0	0	2,683
Capital payments - optimism bias uplift [*]	9	26	8	0	0	0	0	0	0	0	0	43
Capital contingency ^{**}	58	201	103	34	23	29	35	36	37	20	21	597
Capital payments - total	642	1,821	607	51	23	29	35	36	37	20	21	3,322
Revenue payments - Maidstone & Tunbridge	128	2,556	824	641	654	668	682	696	711	726	699	8,985
Revenue payments - optimism bias uplift [*]	2	41	13	10	10	11	11	11	11	12	11	144
Revenue contingency ^{**}	13	295	121	72	75	78	81	85	88	92	130	1,131
Revenue payments - total	143	2,892	958	723	740	757	774	792	811	829	841	10,260
VAT	141	826	255	114	113	115	118	120	123	125	120	2,170
Cash releasing benefits	0	-206	-1,511	-1,779	-2,213	-2,260	-2,307	-2,356	-2,405	-2,456	-2,503	-19,995
Total cash out	927	5,333	309	-892	-1,337	-1,358	-1,380	-1,407	-1,435	-1,481	-1,522	-4,242
CASH IN												
Recovered VAT	141	765	214	114	113	115	118	120	123	125	120	2,068
Other (specify details)												0
Total cash in	141	765	214	114	113	115	118	120	123	125	120	2,068
NET CASHFLOW												
Net cashflow	786	4,568	95	-1,006	-1,450	-1,473	-1,498	-1,527	-1,558	-1,606	-1,642	-6,310
Brought forward	0	786	5,354	5,449	4,443	2,993	1,520	22	-1,505	-3,063	-4,669	
Carried forward	786	5,354	5,449	4,443	2,993	1,520	22	-1,505	-3,063	-4,669	-6,310	
Element of payments in 'cash out' that comprises inflation												
Capital	0	36	24	3	2	3	4	5	5	4	3	90
Revenue	0	57	38	43	58	74	90	107	123	141	156	889

The 12-month option demonstrates a reduction in Trust Implementation Costs and an accelerated realisation of Business Benefits.

Implementation Costs are reduced by commissioning external professional programme and project managers for a shorter period. Engineering effort will remain constant and require additional skilled resources to be engaged to enable work to be carried out more quickly. This is also the case for business change and training resources.

The implementation risks associated with delivering this project in a shorter timescale are substantial and have been reflected in the financial appraisal. Allscripts have agreed that a 12-month implementation is possible but with a reduced scope for the initial Go-Live. Scheduling of departmental systems will be benefits led. Accelerating the Go-Live will ensure that entering the Winter pressure period does not coincide with implementation dates.

Lessons learned from the previous deployment of the PAS, demonstrate the negative impact from supplier configuration and not providing enough business change, training and support

to the user community, both prior and during implementation. This has been considered and appropriate resourcing has been identified to ensure that the same issues are not experienced this time round.

Pharmacy Benefits are still being assessed by the department management team. NHS Digital suggest a target of 11% of Drug Cost Reductions from the ePrescribing solution. The department have currently identified 3%, with the Business Case including 5% savings which equates to £400k pa in cash releasing benefits.

PAS Support Contract Reduction benefits were identified in the OBC due to the removal of Order Comms and A&E function from the contract. After extensive discussions with Allscripts this benefit has reduced by 50% to £30k pa within the FBC.

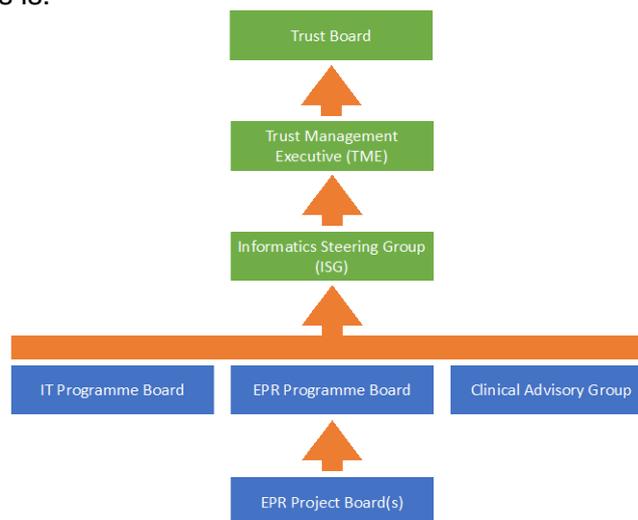
Whole Life Costs are currently below the £15m NHSi threshold, so does not require external approval.

External Funding Options: - The Trust is pursuing opportunities with NHS England for funding to support the project. The two available funding streams are not due to be awarded, prior to the FBC being considered for approval.

Management Case

The Programme will be managed under PRojects IN Controlled Environments, version 2 (PRINCE2) and Managing Successful Programmes (MSP) methodology.

The proposed structure for the EPR Programme and its integration into existing Trust governance structures is: -



Implementation and Business Change Approach

To ensure that implementation is successful, and that Clinical /Business Change are properly considered, the Clinical Advisory Group (CAG) has been established, under the chairmanship of the CCIO, who will also act as Business Change Manager within the EPR Programme Board. An NHS Clinical Change Lead has also been identified who will report into the CAG.

The Business Change workstreams will be a blend of external Business Change Managers, with experience of EPR implementations, as well as NHS Business Change Facilitators and Configuration Officers from the Trust who will be responsible for ensuring the solution meets the Trust's requirements.

Due to the significant Drug Cost Reductions envisaged, an experienced ePMA (ePrescribing) Subject Matter Expert will be sourced, either externally or from within the NHS, to ensure that the solution realises the Cash-Releasing and Quality Benefits identified.

Next steps

The Full Business Case has confirmed that there are sufficient benefits and savings from procuring and implementing the Allscripts Sunrise EPR and associated services. The recommendation is: -

- Board approve the investment to implement the Allscripts Sunrise EPR Solution under a managed service – (Option 4).
- Board approve entering into contracts with Allscripts under the Terms and Conditions provided.
- Implementation undertaken over a 12-month period with a reduced initial scope.

6-18 Winter planning and Operational resilience for 2017/18 Chief Operating Officer

Following the comprehensive and critical review of the winter plan for 2017/18, the planning for 2018/19 is now underway. This plan will take forward the lessons learnt from 2017/18 and develop them further for next winter. This is the first iteration with further versions to follow as we conclude our planning & delivery assumptions. Alongside the winter plan will be the Trust's "escalation policy" which will define the areas to be used to manage surges in demand that will need additional capacity for a period of time.

This paper offers our planning process for the winter 2018/19. It covers:

- a. Objectives of winter planning for MTW.
- b. Governance structure to deliver the plan.
- c. Activity, capacity & demand analysis – including beds, workforce and equipment and systems requirements (will include elective, non-elective and diagnostics).
- d. Areas of focus in this year's winter plan.
- e. Winter Divisional plans.
- f. KPI's to monitor the progress of improvement through the year in preparation for winter.
- g. Financial impact.

There are five consistent themes where improvement in delivery and planning would make a significant difference in helping to manage the increased flow of urgent patients during the winter period:

- Activity
- Pathways
- Workforce
- Sustainability
- Communication

In summary, some of the clinical operations initiatives which worked well to manage flow & patient safety during the winter 2017-18 and which are included in this plan for 2018/19:

- Daily safety huddle (clinical & operations)
- Dedicated "outlier" medical teams
- Post-take senior nurse reviews
- A consistent approach to site management with a clear escalation policy & plan
- Pre-emptive cancellation of elective work & movement of some of TWH elective work to Maidstone
- AEC established at TWH
- An increased nursing establishment in ED to manage periods of overcrowding
- Secure the capacity in the community to allow the flow of patients out of secondary care when medically fit e.g. increased pathway 3-bed capacity and swap the medial fit wards back to acute medical wards
- Implementation of a Virtual Ward for MTW
- Further improvement in patient flow, through the 'Best Care programme'
- To embed a clear understanding through the organisation of what all staff should do, when the organisation moves from Opel 3 to Opel 4 level
- Develop a digitalised approach to patient level activity and movement information to allow improved decision-making
- Recruit more substantive staff and reduce dependency on temporary staffing
- Secure improved flow of patients into and out from the available ITU capacity
- Work with colleagues in other units to secure an improved flow of patients to & from tertiary centres
- Implement a revised pathway for NEL surgical patients

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 20/06/18

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

to note the key areas in which the plans are being developed, the delivery structure and initial progress associated with securing winter resilience for 2018/19.

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 is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Winter planning and Operational Resilience 2018/19

1. Introduction

Following the comprehensive and critical review of the winter plan for 2017/18, it is now time to begin planning for 2018/19. This plan will take forward the lessons learnt from 2017/18 and develop them further for next winter.

This paper offers our planning process for the winter 2018/19. This covers:

Objectives

- To ensure that there are plans in place to manage the modelled increased activity scenarios and likely impact on bed capacity.
- Adopt and implement evidence-based best practice, to reduce the number of non-elective medical admissions by a combination of the extended use of ambulatory care pathways, the establishment of an acute frailty service on both sites and reduced MFFD patients and to ensure internal processes and systems are fit for purpose and resilient to meet the anticipated level of demand, in line with the Best Patient flow delivery plans.
- Maintain and optimise patient flow through the hospitals to provide safe emergency and elective care.
- To ensure that all support services have plans to meet the demand scenarios concerning increased activity throughout the hospital.
- To ensure that there is appropriate, safe escalation plans in place which reduces the risk of medical outliers and negative impact on elective activity in surgery especially when escalation occurs in the theatre recovery areas.
- To learn lessons from last year's winter plan and to apply ECIP learning.

2. Governance Structure

The planning for winter 2018/19 has already started and is being managed through the Winter Planning and Resilience group chaired by the COO, with representatives from each of the Clinical Divisions, Estates & Facilities, HR, Finance and IT. The output from this group will be reported regularly into TME. With the inclusion of Finance and Information on this group means decisions are based on improved forecasts and possible financial impact on CIPS and divisional budgets will be understood. The group will manage risks and issues and support the development of the winter plans across the Divisions.

3. Capacity & Demand Analysis

A key aspect of the plan is to understand and model the likely demand range across a number of key areas. This modelling is based on previous activity experienced and refined on a monthly basis as we move towards the winter months. It will be important to understand likely levels as well as the upper limit scenarios as appropriate delivery plans will be needed to be in place to mitigate the risk of these upper levels if they occur in a bad winter where a number of scenarios come together.

The areas to be modelled and included in our planning parameters:

- *Total A&E attendances per site:* The model will predict total weekly attendances and indicate the numbers of patients per month, week and day and show what % rise this equates to. (NB it was 6.9% higher in 17/18 compare to 16-17 with TWH experiencing 8.8% higher levels).

- *Ambulance arrivals expected* - per site, per day of the week, with scenarios of growth covering very cold weather conditions.
- *Emergency admissions* – predictions will be based on previous numbers per site but also incorporate the new ways of working with ambulatory and elderly frailty units during the year. (NB is more difficult to predict, as these no longer have a recognisable seasonal pattern).
- Age profiling covering this activity is also an important aspect in understanding and managing demand.eg last year four bands showed some unusual changes:
 - Patients under 18 are only up 2%
 - Patients in their 50s are up 25%
 - Patients in their 60s are up 10%
 - Patient in their 70s are up 27%
- The Emergency admissions will also be broken down further into HRG and disease types to see where the greatest clinical pressures lay. This will enable better understanding as to local pressure on these particular specialities and allow planning of resourcing to be in place for 2018/19.
- *Non-elective LoS (excluding zero)*. In previous years there is a tendency for the LOS to rise between half a day to a full day in the depths of winter. This year we need are looking to secure a 0.5 day average reduction in LOS and maintain it through winter and is a key component in managing patient flow and bed capacity. The Best Patient flow delivery plans are focusing on delivering achieving this.
- *Non-Elective Bed Occupancy* – bed occupancy modelled, with 85th percentile figures have been rerun with the latest activity (including winter and full year effect) and bed capacity which will identify the bed capacity required per month for both urgent care and planned care, per site for both elective and non-elective activity. This information has identified the shortfall in required beds when compared to physical bed availability within each of the hospitals. These initial scenarios will assume a 1.7 % growth over last year.

The local analysis will also consider the lessons learnt from the NHS review of key components which impacted over winter and ensure that lessons are included in the Trust's winter plan. The analysis from NHSI (looking at data from +100 Trusts) shows the following:

- **Bed occupancy** starts to affect A&E performance significantly **above 88%**, and deterioration accelerates **above 92%**.
- **Admissions volume** and **admissions variation throughout the day** both affect A&E performance. The variation is partly driven by older people and GP referrals.
- **Resilience**
 - 1) The trusts that best dealt with **surges in admissions** experienced only half the dip in A&E performance, compared to the least resilient.
 - 2) The most resilient trusts were able to **bounce back** from dips in A&E performance by the next day. The least resilient trusts took up to three days to recover.

- **Extended length of stay patients** (21+ days), have a greater effect than stranded patients (7+ days).
- **Pressure** – the gap between admissions and discharges accounts for the differences in performance by day of the week, for example worse performance on Mondays.
- High Impact on A&E performance in the South includes senior doctors in A&E (A 1% pt increase in the share of A&E staff that are senior doctors increases A&E performance by **South: 0.3% pts**)
- Bank holidays (Christmas, New Year), day of the week (Tuesdays had the worst performance in winter 17/18, followed by Mondays. This is a change from last winter when Mondays had the lowest performance).
- Similarly as for national performance, other factors which affected southern performance included - on the day and past 2 day pressure explains this day of the week difference, bed occupancy rate, extended length of stay patients (21+ days), daily admission numbers (pressure) and age of admitted patients.

The following areas have been included within this year's winter plan, but will need to ensure delivery:

- Bed occupancy - reduction
- Extended length of stay – reduction in numbers of stranded patients
- Pressure/ discharges – improved flow initiatives
- Senior doctors availability to help with patient flow and decision making.

The elective capacity planning will also consider the impact and phasing of the core elective work as well as prime provider work, which is a key component of the financial recovery plan within the Best patient flow work stream. The following assessment identifies the Trust's starting bed requirement (summer and winter), planned key initiatives and benefit realisation, how the capacity will be used and what would be considered if the key risk of higher than planned NE activity is experienced, for each of the sites.

The critical core capacity to manage increased demand following increased incidence of Flu and Nora virus will need to be planned for in relation to the Trusts capacity and that of the local network.

4. Summer Bed requirements - Maidstone

Medicine

- Demand analysis has indicated the need for **243** beds in the Summer (including 6 for elective work) for 85% bed occupancy
- At Maidstone for Medicine, there is **208 core beds** plus 6 beds for elective and another 14 beds within AMU and AEC that can be used flexibly giving a total of **228 beds**
- This gives a gap of -15 beds
- June 2018 – Mid August 2018 focus on reducing ALOS in medicine and Haematology including increasing ambulatory care will **release 15 beds**
- This will mean that Urgent care can operate out of its core bed stock during the summer with minimal impact on Surgery if NEL demand stays within current forecasts

Surgery (excludes T&O which has a dedicated ring fence bedded unit)

- Demand analysis has indicated the need for **42** beds in the Summer (including 30 for elective work) for 85% bed occupancy
- At Maidstone for Surgery, there is **40 core beds** plus 8 beds within MSSU that can be used flexibly giving a total of **48 beds**
- This provides a surplus of +6 beds
- June 2018 – Mid August 2018 focus on reducing ALOS in surgery and T&O will release another 7 beds which in turn provides more space to increase activity further across the summer

If NEL increases above forecast operationally the following could be employed to reduce the risk of cancelling elective work:

- Opening up the closed ward at Maidstone – this would also enable transfer of suitable patients at TW if required so both sites can continue with surgery – this would have a financial impact which is being calculated

5. Winter Bed requirements – Maidstone

Medicine

- Demand analysis has indicated the need for **276** beds in the winter (including 1 for elective work) with 95% bed occupancy
- At Maidstone for Medicine, there is **208 core beds** plus 6 beds for elective and another 14 beds within AMU and AEC that can be used flexibly giving a total of **228 beds**
- This gives a gap of -48 beds
- June 2018 – Mid August 2018 focus on reducing ALOS in medicine and Haematology including increasing ambulatory care will release **15 beds** continues
- Pathway 3 capacity is commissioned for winter giving **15 beds**
- Ward vacated by surgery for the Winter at Maidstone is opened giving **19 beds**
- These will mean that Urgent care can continue to operate out of its core bed stock during the summer with minimal impact on Surgery if NEL demand stays within current forecasts

Surgery (excludes T&O which has a dedicated ring fence bedded unit)

- Demand analysis has indicated the need for 62 beds in the Winter (which includes moving elective work from TW to MH) with 95% bed occupancy
- At Maidstone for Surgery, there is **40 core beds** plus 8 beds within MSSU that can be used flexibly giving a total of **48 beds**
- This provides a surplus - 14 beds
- June 2018 – Mid August 2018 focus on reducing ALOS in surgery will release **another 4 beds** which in turn provides more space to increase activity further across the summer – assumed this would continue
- In addition one of the surgical wards would swap with the currently closed ward providing **a further 9 beds**
- These initiatives give surgery a total of **61 beds** for the winter. The remaining gap would be closed by using the dedicated Orthopaedic unit at Maidstone to accommodate someday case patients to support the flow through the sites main Day surgery unit

If NEL increases above forecast operationally the following could be employed to reduce the risk of cancelling elective work:

- Beds on surgical wards would need to accommodate medical outliers which may impact on elective work which would be mitigated by plans to outsource the prime

provider work to the Independent sector as well as over performing during the summer when beds were available

6. Summer Bed requirements – Tunbridge Wells

Medicine

- Demand analysis has indicated the need for **264** beds in the Summer (including 4 for elective work) for 85% bed occupancy
- At Tunbridge Wells for Medicine, there is **205 core beds** plus another 27 beds within AMU, AEC, Cath lab and Ward 32 that can be used flexibly giving a total of **232 beds**
- This gives a gap of -32 beds
- June 2018 – Mid August 2018 focus on reducing ALOS of 0.5 days in medicine including increasing ambulatory care and frailty unit will **release 17 beds**
- This will mean that Urgent care still has a gap of -15 beds which will equate to medical outliers on surgical wards but this has been calculated to have minimal impact on Surgery if NEL demand stays within current forecasts.

Surgery including T&O

- Demand analysis has indicated the need for **143** beds in the Summer for NEL work with an 85% bed occupancy
- At Tunbridge Wells for Surgery, there is **153 beds core beds** plus 18 beds within SSSU and SAU that can be used flexibly giving a total of **172 beds**
- This provides a surplus of +29 beds that can be used for elective surgery (without using recovery escalation bed areas)
- June 2018 – Mid August 2018 focus on reducing ALOS of 0.5 days in surgery and T&O will release another **14 beds** which in turn provides more space to increase activity further across the summer
-

If NEL increases above forecast operationally the following could be employed to reduce the risk of cancelling elective work:

- Opening up the closed ward at Maidstone – this would also enable transfer of suitable patients at TW if required so both sites can continue with surgery – this would have the financial impact which is being calculated

7. Winter Bed requirements – Tunbridge Wells

Medicine

- Demand analysis has indicated the need for **307 beds** in the winter (including 1 for elective work) with 95% bed occupancy
- At Maidstone for Medicine, there is **208 core beds** plus 6 beds for elective and another 14 beds within AMU and AEC that can be used flexibly giving a total of **228 beds**
- This gives a gap of **-79 beds**
- June 2018 – Mid August 2018 focus on reducing ALOS by 0.5 days in medicine including increasing ambulatory care and frailty unit will release **14 beds** continues
- Pathway 3 capacity is commissioned for winter giving **15 beds**
- This will mean that Urgent Care still has a gap of **-50 beds** which will equate to medical outliers on surgical wards if no other actions are put in place. Further work is currently underway on a range of initiatives to continue to close this gap to reduce the impact to elective surgery, despite this Surgery is putting in contingency plans see below

Surgery including T&O

- Demand analysis has indicated the need for 169 beds in the Winter with 95% bed occupancy
- At Tunbridge Wells for Surgery, there is **153 beds core beds** plus 18 beds within SSSU and SAU that can be used flexibly giving a total of **172 beds**
- This provides a surplus of **+3 beds** that can be used for elective surgery (without using recovery escalation bed areas)
- June 2018 – Mid August 2018 focus on reducing ALOS in surgery and T&O will release another **14 beds** will continue
- From December to March work requiring **22 beds in total would be outsourced** and 4 theatres would be closed at TWH moving work across to Maidstone – this would facilitate a total of **36 beds** being freed up to deal with the NEL demand from Urgent care without using the recovery escalation bed areas

If NEL increases above forecast operationally the following could be employed to reduce the risk of cancelling elective work:

- Beds on surgical wards would need to accommodate medical outliers which may impact on elective work which would be mitigated by plans to outsource the prime provider work to the Independent sector as well as over-performing during the summer when beds were available and by moving the elective activity to Maidstone

In summary

The analysis demonstrates that with the delivery of the service improvement plans including further increasing elective activity across the summer, along with the associated benefit realisation of reducing LOS, the core elective planned activity plus some prime provider work is achievable. This assumes there will be no further increase in forecast non-elective demand and requires some elective outsourcing between Dec-March. Beyond a reduction of 0.5 days in LOS will deliver further bed capacity which can be utilised to increase Elective Private patient work and accommodate the existing non-elective private patients. The delivery of the required increased NE capacity through the initiatives identified in 5.1.b below will be critical in reducing the need for significant escalation and allowing elective activity to occur.

8. Areas of focus in this year's winter plan

There are five consistent themes, where improvement in delivery and planning would make a significant difference in helping to manage the increased flow of urgent patients during the winter period:

- Activity
- Pathways
- Workforce
- Sustainability
- Communication

a. Activity planning –reflected in the above summer winter bed requirement plans.

- *Non-elective activity.* As in subsequent years, it is likely that the trend of increased numbers of non-elective patients attending our A.E units would continue to rise assumed 1.7% further growth over last year. The age profile of the patients is also increasing bringing added complexity to their treatment and subsequent discharge arrangements. The elderly frailty units will help mitigate this risk.

- *Elective activity*: The ability to undertake elective activity last year improved with the transfer to Maidstone, however, still came under pressure due to non-elective escalation. The elective capacity planning will consider the impact and phasing of the core elective work as well as prime provider work, which is a key component of the financial recovery plan within the Best patient flow work stream. The pre-emptive cancellation and movement of elective patients to the Maidstone site was successful in reducing last-minute cancellations and allowing planning of beds on both sites.

b. *Improved Pathways* - Particularly on the delivery of:

- Ambulatory pathways for all specialities
- Speciality units e.g. Frail elderly at TWH
- Acute assessment units
- Required Increased capacity be secured through :
 - Virtual ward -seeking capacity to accommodate 20 – 30 patients for an extension of their acute care out of hospital but remain under the (in) direct care of their hospital consultant with their management delivered by the virtual ward team based on agreed pathway. The most likely case-mix will be made up of surgery, T&O and short-term acute medical – patients needing IVABs, dressings, wound reviews, TWOCs etc. and we want this in place and operational by 01-12-2018.
 - Pathway 3 –The provision of on average 40 beds purchased in the community, has significantly helped in the flow of patients waiting for social services support and pathway 3 type patients (22 beds are occupied under the Pathway 3 scheme and a further 24 patients are being managed through the commercial bed scheme) It is recognised that this level of additional capacity is required through the year and to be enhanced over the winter periods. Securing access to this level of community bed capacity will be central to our ongoing planning process.
 - Converting medical fit wards into acute medial wards, with current patients moved out of hospital setting
 - Securing reduction in stranded patient numbers

c. *Workforce* - This is a key issue each year, as with higher demands we have to secure increased staffing to support escalated areas often with significant financial cost, particularly if we need to use agencies.

- Identify how alternative job roles can be utilised to deliver services.
- Develop local policies which secure staff over busy periods
- In particular areas such as theatres the level of pre-planning ensured how and what to staff which led to improved safety when recovery and holding bays were escalated.
- To embed a clear understanding throughout the organisation of what staff can do when the organisation moves from Opel 3 to Opel 4 level. E.g. cancel all meetings, training sessions. Cancel OPD clinics of key staff to allow them to focus on inpatient flow, with a clear understanding and agreement of what and how they will be doing.
- Develop further the use of volunteers and use of admin staff within clinical areas, on wards and non-clinical areas- Operations Centre, which would all Clinical Site Managers to support around the hospital more effectively

d. *Sustainability* - This falls into how best we can deliver our services and the configuration of our resources to achieve it the ever growing demands and have been considered in the bed requirements and associated plans identified above

- *Bed reconfiguration -*
 - a. *concerning both surgical and medical beds,*
 - b. *escalation and de-escalation plans* to see how to best align non-elective bed requirements with those of elective activity but respecting high throughput units. A Key question of what capacity is ring-fenced and how will the operational team manage escalation will be developed and answered within the plan.
- *Bed stock and future use of space and facilities:*
National best practice concerning elderly frail units, larger multispecialty assessment units and engaging the GP service in our front of house flow of E.D patients will be developed
- *The change of use of theatres at TWH –* as part of the surgical reconfiguration review theatre use and capacity across the trust will be undertaken which also respects the bed requirements identified above in section 4 over summer/winter periods and per site.
- *Patient flow*
Each site will need to secure the correct number of discharges a day to cope with the numbers of admissions. This can only be achieved through continuous improvement in operational ways of working and reducing LOS by at least 0.5 avg days for all non-elective work in both surgery and medicine

The continued use of the daily huddles with clinicians clearly allowed improved ownership and understanding of the daily pressures across the trust and risk for the next 24hrs

Further improvement in patient flow through the 'Best Care Delivery Programme'.

Develop a digitalised approach to information to allow improved availability and access to up to date information to assist in decision making.

To work with CCG to secure an improved G4S contract as this undoubtedly caused significant delays and extra costs to the trust. The service provided was ineffective and almost non-existent during the bad weather.

e. *Communication*

- E-Mails are not an effective way of communicating. A more effective way of communicating will be found and communications are considered in the escalation policy to stop all no urgent email traffic.
- Communications consider how we get 24-hour communications out to staff proactively when they need it. This is especially important when in OPEL 4.
- There is a need to consider how and what we tell the public and staff before winter starts and when actions like the cancellation of appointments are carried out. There was considerable national interest in how the NHS coped with the winter - how to ensure patients, staff and public understand what is going on locally.

- When unplanned incidents occur, like the loss of heating, ensure that effective communication plans are in place.
- This winter severe weather warnings were issued for extreme cold, snow and ice on numerous occasions. In general, these warnings have become very accurate and therefore the trust can be more secure in making decisions based on them.
- Pre cancelling Outpatients and other activity due to the amber weather warning was the right thing to do by reducing traffic on the sites and potential for skips trips and falls.

9. Winter Divisional plans – Including Lessons learnt from Winter 17/18

Urgent Care Planning

Initiative	Explanation of what it involves	The likely benefit
1. Review Extending hours of Discharge Lounge at TW to close at 20.00hr as last year this was not fully successful	Staff consultation underway. Looking at staffing requirements and cost but expecting to be able to do this without additional resources by staggering start/finish times.	More patients will be able to be transferred to the Discharge Lounge later in the afternoon which frees up beds on the wards to support better flow.
2. Ensure that reducing OP clinics over the weeks of 17 th Dec, 24 Dec and 31 st Dec and allocating consultants and Regs to wards for additional ward rounds. comprehensively occurs.	This has been agreed by Site Leads. Clinics being cancelled.	Improved discharge profile on the key weeks leading up to and after the Xmas/New year period to support flow and safety
3. Consultants to provide their leave requests for the 3 week period from 17 th Dec to 7 th Jan to be submitted by October	Asking consultants to comply with this request (officially only need to give 6 weeks' notice)	Will allow us to roster senior decision makers to each ward as described in point 2.
4. 'Outlier' medical team to support winter resilience. Supported by both site leads and CD and management team.	A suggested team consisting of: 1 consultant 1 reg/ staff grade 2 Juniors 1 senior nurse 1 pharmacist	Better continuity in reviewing the patients by the same team would improve flow by reducing the LOS of the medical outliers
5. Senior nurse to be seconded to support the medical Post Take Ward Round each morning in ED/AMU	CSP has agreed to a 6/12 secondment to undertake this role, starting from 1 st November	Improved patient flow and reduction in Stranded Patients
6. ED improvement -is securing Internal professional standards concerning appropriate and safe reaction time and decision making to support patient flow through the department. This is supported by a newly developed breach report.	Improve timeliness of 1 st clinical assessment Breach report circulated to all specialities highlighting breach reasons on a daily basis Review of handover delays Improvement in real time tracking	Improved reaction time to patients needed specialist review within E.D

Initiative	Explanation of what it involves	The likely benefit
7. Ensure comprehensive front-door GP streaming model,	A&E departments are then free to treat for the most urgent patients. This includes the estate's changes to support this pathway following a successful capital bid.	The timely review of the most urgent patient within E.D. by diverting patients away from minors.
8. Improving flow- Embedding of SAFER and implementing a review process of the stranded patients	Review of wards against new CUR (Clinical Utilisation Review) data identifying themes/ action plans for stranded patients. A key to improving this is the process to identify stranded patients which can now occur through the Clinical Utilisation Review (CUR) software initiative. The Stranded Patient metric is to be implemented, putting a focus on all patients with a LOS of 7 days and over EDN project group working with Tele logic on final simplified EDN to be piloted on 4 wards. The rollout of electronic Day Before Actions forms on 2 wards.	Secure appropriate but well planned patient discharges in a timely way.
9. Implement red and green days as well as reducing over 7 and 21day stagnant patients initiative	<i>Red and green days will be introduced as a visual management system to improve flow and identify where patients are delayed. A Red Day is a day of no added value to the patient. A Green day is a day of value to the patient where a patient receives active medical treatment or diagnostics on the day that they have been requested. These will be monitored on a daily basis through the site meetings</i>	<i>To ensure that patients are identified and then receive timely treatment to reduce their LOS</i>
10. Secure comprehensive use and maximum benefit from Home First pathways -	<i>A model for Pathway 3 has now been identified and a Standing Operating Procedure has been developed as a guide to the processes to be used through proof of concept. This guide will be updated as the model develops through the proof of concept phase.</i>	<i>Ability to move 30 MFFD patients from acute beds into a community setting awaiting the further assessment of their future needs. This will generate physical bed capacity within the acute hospital setting</i>
11. Review The escalation and de-escalation policy to reflect the changing demands and best practice initiatives	These reflect the changes in bed availability this year compared to last year and ensure that the escalation ladder reflects the operational objectives, needs and priorities of the organisation. To	A comprehensive plan/policy which educates the organisation as to how, where and when escalation can take place. Also what it means to staff in terms of additional

Initiative	Explanation of what it involves	The likely benefit
	<p>also ensure that that agreed policies such as patient 'ward boarding' are understood and implemented</p> <p>Current available escalation capacity is Foster Clark at Maidstone, however, the use of this ward for transferred elective work from TWH would mean that Peale ward could close and then be available for escalation for non-elective activity if required, recognising that patients (possibly MFFD) would need to move between sites</p>	actions required
<p>12. Workforce – reduce the risk of Flu outbreaks affecting both staffing and patients</p> <p>-Improve the awareness and need for inoculation amongst staff groups to secure a higher rate</p> <p>- The need to ensure Isolation of suspected cases</p> <p>Improve awareness and training in the correct PPE and the establishment of onsite testing</p>	<p>–to secure 70% + inoculation rates amongst our staff and encourage risk patients to have their injections</p>	<p>Reduced risk of high staff sickness rates over the acute winter period</p>
<p>13. To review the Boarding policy to ensure that it reflects best practice</p>		

10. Planned care planning

Initiative / Plan Planned care	Explanation of what it involves	The likely benefit
<p>1. Maintaining elective activity at Maidstone</p>	<p>All Theatre lists will run as normal in Main theatres, EMU and MSSU – except lists cancelled due to AL</p> <p>MOU will be run 10 sessions per week and will not feature as part of escalation – this will involve elective</p>	<p>Ensure elective activity will continue at Maidstone at normal levels and so help maintain cancer performance</p>

Initiative / Plan Planned care	Explanation of what it involves	The likely benefit
	Orthopaedic lists being moved in addition to those currently allocated to MOU to ensure it is fully utilised and maximum elective activity is maintained	
2.Moving elective activity from TW to MH	<p>As many lists as possible will be moved across to Maidstone. Consultants are being asked to provide advance notice of leave now rather than 6 weeks ahead to ensure this is planned well in advance in order to protect as much elective activity as possible</p> <p>Plan for moving as much of gynaecology and ENT elective activity from TWH to Maidstone over the winter period to be examined and implemented if feasible</p>	To maximise as much elective activity as possible to sustain the RTT position as achieved at the end of Dec throughout Jan / Feb rather than worsen by 500 patients as has occurred in the last 2 years through cancellations.
3.Escalation plan for MH involving surgery	Up to 6 IP beds will be offered towards winter escalation for Urgent care to use as part of the wider Escalation plan	To provide medical bed space without impacting on surgical activity to support A&E performance as part of the escalation plan
4.Implementation of the bed requirement plan in section 4 with the movement of services from TWH to Maidstone	<p>If SSSU remains fully escalated and it is likely that the site needs to use Recovery 1 or 2 for escalation then only 4 theatres will be open – 3 used for emergency work and the remaining one allocated to ENT, Gynae, Ortho for cancer work or 52-week breaches. TW Orthopaedic Unit would be reallocated in full to NEL beds</p> <p>In both options above SSU will also be staffed to operate an admissions lounge process which again will help the flow of any elective activity that does take place.</p>	<p>Ensure elective activity can continue at TWH for those specialities with the highest RTT backlogs to maintain the position as at the start of winter (i.e. does not worsen) as well as maintain cancer performance.</p> <p>This also increases capacity for NEL patients especially for surgery by ensuring extra emergency theatre is in place, thus reducing pre-operative LOS</p>
5.Ambulatory care pathways for I&D and orthopaedic cellulitis/sepsis	<p>Develop ambulatory pathways so they are agreed, documented and circulated to the appropriate staff.</p> <p>Explore other possible ambulatory pathways for implementation.</p>	These pathways will assist in reducing surgical admissions and length of stay.
6.Cancelled operating lists between 23 rd Dec and 19 th Feb	<ul style="list-style-type: none"> Surgeons who have their lists cancelled in a planned way will be asked to undertake clinics instead to ensure activity and waiting times are reduced here. Those who still have their lists 	As above but focus more towards maintain OPD activity and reducing waiting times here

Initiative / Plan Planned care	Explanation of what it involves	The likely benefit
	<p>cancelled on the day will be asked to support the emergency teams in undertaking ward rounds, operating etc.</p> <ul style="list-style-type: none"> In some areas, it may be possible to allocate more surgeons/anaesthetist annual leave during this period than normal, as long as services are covered. 	
7.Increasing elective activity before 23 rd Dec across both sites	In the run-up to December extra activity at weekends and ensuring all existing sessions are fully utilised within theatres will be pushed as much as possible to mitigate any loss of activity in Q4.	Improve RTT position and reduce waiting times before head into Winter as part of the plan to return to 92% aggregate by end of November
8.Implement a Non-elective Matron for TWH only from 1 November – 31 March 2018	Matron to support all surgical specialities to optimise patients and assist with the stranded patients on a daily basis	Optimise discharges within surgery and assist with the push/pull of patients from A&E
<p>9. Critical care capacity to meet peaks in demand within the Trust and within the local network.</p> <p>14 patients required ITU admission with Influenza an average length of stay in ITU of 13.6 days</p>	<p>Escalation for physical Critical Care Capacity and patient dependency occurs on both the Tunbridge Wells and Maidstone sites during peak demand periods. Whilst Maidstone ICU is currently staffed for a dependency of 7, 14 physical bed spaces are available within the ICU to admit patients. At Tunbridge Wells Hospital the ICU is currently staffed for a dependency of 7 although there are 9 physical bed spaces and with the colocation of Non-Elective Recovery provides the use of a maximum 2 further bed spaces, an ICU bedside workstation is in place to facilitate this.</p> <p>Both Intensive Care Units submit twice daily updates to the National NHS Directory of Services (DOS) online Critical Care bed capacity system and daily to the Emergency Bed Service.</p> <p>At TWH there are 3 extra wte posts to help facilitate escalation into Recovery by providing a good core staff base to enable a critical care “staff bank” to function and cover when we need to escalate.</p>	All escalation is dependent on a suitably trained workforce and staff are utilised flexibly across the site on a daily basis to accommodate the patient need. This may be supported by the Critical Care Outreach Service if required

11. Radiology, Pharmacy, Pathology Planning

Diagnosics and Clinical Support	Explanation of what it involves	The likely benefit
1. 7-day pharmacy service will be provided	The main challenge concerns staffing levels, however, these are currently being improved prior to winter	Allow improved discharge arrangements over the weekend
2. Outsource CT Scan capacity	This will be for routine tests in the run-up to winter to ensure internal capacity free for NEL patients	To ensure 6-week diagnostic target maintained throughout winter for CT
3. Increased phlebotomy service	To increase staffing x 1 per day on both sites	To ensure capacity increased to meet demand and assist in improving flow for NEL patients
4. Increase mortuary capacity	To increase mortuary capacity internally and by working with partner organisations	To increase mortuary capacity by 100 for the winter period to cope with the potential increase in demand

12. Women's and Children's Planning

Initiative	Action	Benefit
1. <i>Maintain elective activity RTT performance</i>	<ul style="list-style-type: none"> • <i>Continue with waiting list sessions</i> • <i>Move DC and IP gynaecology to Maidstone (as theatre capacity allows)</i> • <i>Ensure compliance with ambulatory pathways</i> 	<ul style="list-style-type: none"> • <i>Ensure elective activity will continue to maintain RTT performance</i>
2. <i>Preserving elective activity –</i>	<ul style="list-style-type: none"> • <i>As per planned care</i> 	<ul style="list-style-type: none"> • <i>As per planned care</i>
3. <i>Cancel operating lists between 23rd Dec and 19th Feb</i>	<ul style="list-style-type: none"> • <i>Surgeons who have their lists cancelled in a planned way will be asked to undertake clinics instead to ensure activity and waiting times are reduced here.</i> • <i>Those who still have their lists cancelled on the day will be asked to support the emergency obstetric teams in undertaking ward rounds, operating etc.</i> • <i>In the run-up to December extra activity at weekends and ensuring all existing sessions are fully utilised within theatres will be pushed as much as possible to mitigate any loss of activity in Q4.</i> • <i>Allocate registrar to review all women on ward 33 to start discharge processes</i> 	<ul style="list-style-type: none"> • <i>As above but focus more towards maintain OPD activity and reducing waiting times here</i> • <i>Improve RTT position and reduce waiting times before head into Winter as part of the plan to return to 92% aggregate by end of November</i>

Initiative	Action	Benefit
4. Emergency gynaecology	<ul style="list-style-type: none"> To extend the opening hours of EGAU to 8 pm dependant on staffing availability when in OPAL 3/4? 	<ul style="list-style-type: none"> Help to manage the flow of these patients when the trust is experiencing high demand
5. Review Emergency Paediatrics pathways	<ul style="list-style-type: none"> 5 escalation beds on Hedgehog ward will be escalated from Nov 1st. There is an escalation policy in place. Once Hedgehog is full then further escalation occurs in Woodlands dependant on staffing. Making woodlands a staff 'B&B' when the snow came, kept staff safe and able to work consecutive shifts 	<ul style="list-style-type: none"> To manage peaks in demands Check policy shows clear actions to be taken, so able to flex when needed
6. To review bed requirements and ward configuration for Maternity flows and identify an opportunity to switch wards Switch ward 33 for the 'A&B' side of the level 3 ward –	<ul style="list-style-type: none"> Upgrade discharge lounge on the post-natal ward to encourage early vacated beds Increase ward clerk hours on delivery suite 1400-2000hrs to ensure no patient flow delays due to paperwork Follow escalation policy on Q pulse This includes network divert on a case by case basis if needed- depends on everyone else's status Working with IT to get a possible forecast of clinical numbers for maternity so able to predict activity 	<p>Did not happen as more women discharged directly from the delivery suite</p> <ul style="list-style-type: none"> Recruited to Daily 'staff huddles' to review clinical activity and agree on plans to ensure flow through maternity

13. E&F Management Planning

Initiative / Plan	Explanation of what it involves	The likely benefit
1. Internal Facilities Staff bank	Increase staff bank pool across Facilities. Employees can work multi/cross-disciplinary. Better bank provision reduces the need for overtime and agency. Recruitment and retention remain a challenge in FM.	Savings. Multi-skilled workforce. Improved morale/lower stress at busy times. Quicker response to shortages.
2. Non-Emergency Patient transport	Provision of self-managed discharge and transfer service.	Better patient experience. Faster patient discharges and moves.

Initiative / Plan	Explanation of what it involves	The likely benefit
3. Catering - emergency food provision	Additional stock of frozen meals to be held in case of inclement weather/delivery failures	Ensure continuity of catering provision to staff and patients.
4. Inter-departmental management working and support incl daily/weekly duty manager and supervisor.	Management provision takes responsibility across the full range of Hotel Services. I.e. Zone managers now support catering and portering as well as domestics. Daily nominated lead for the default 'goes to' lead, to avoid confusion.	Increased management input across services and better resilience through winter when staffing comes under pressure and weather can impede staff attendance.
5. 4 x 4 driver training A review of 4WD drive vehicles will be undertaken. A separate plan to ensure the integrity of the 6X service will to be considered especially clear early morning communications to staff – especially those waiting in freezing conditions	General Transport drivers to receive 4 x 4 training The 4WD MOU is only for use once the trust has exhausted all business continuity plans. These plans include the provision of at least two internal 4WD with drivers by estates. It may be that a full external contract is a better way of delivering this essential business continuity.	Readily available driver pool for driving 4 x 4 vehicles in inclement weather. Keep staff coming to work and maintain discharges of patients etc.
6. Winter Snow and Ice Procedure	The purpose of this document is to identify who is responsible for managing, implementing and carrying out the various aspects of maintaining the roads and pathways for the safe passage of patients, visitors and staff during periods of forecasted or unpredicted inclement weather i.e. frost, icy conditions and snow	Ensure safe access in and around the sites.

Cleaning - Even with the new UV cleaning equipment, high levels of fogging still took place which meant that rooms were out of use for up to 4hrs. A review of the latest cleaning systems is planned to help reduce this downtime prior to next winter

Plans to be in place estates & facilities by to secure rapid response to a sudden escalation of areas.

A review of temporary escalated areas to be reviewed to identify any need for fixed facilities.

The accommodation was sourced easily at Maidstone however it was slightly more challenging to get numbers at TWH as the Doctors accommodation has not been used for emergency accommodation before. An emergency accommodation SOP needs to be created to include how to block purchase hotel accommodation.

14. Staffing & Staff Welfare Planning

A review of HR policies - to ensure a consistent message about staff moving between sites and wards. A number of staff threatened to walk out if made to move wards and others just refused to do so. A review of bank staff needs to take place to identify those who simply don't turn up or walk out if asked to move wards and their bank contracts suspended.

- During OPEL 4 there will be a clear plan for managers to work shifts so the burden does not fall on the on-call managers. For example, if both sites were covered 0700 – 2200 the on-call manager would only cover the 9 hours overnight.
- During adverse weather, some staff just decide not to attend work – a more robust approach will be taken by managers on personal preparedness for adverse weather.
- The creation of a team of non-clinical staff to support wards was very successful last year. This will be replicated and include staff from HR, finance and other nonclinical staff to be ready to be automatically called upon in OPEL 4
- The trust will consider how it helps staff, especially staff new to the trust cope with the intense pressure of OPEL 4 and how all divisions and staff contribute to that pressure. There must be recognition that the extreme pressure experienced is very difficult emotionally and physically for some staff.
- Procurement will investigate how to create an easy emergency purchase system for use out of hours, especially for hotels. Effective pre-planning to negotiate good rates and discounts should be carried out in advance.

In summary, some of the Operational Initiatives which worked well to manage flow & patient safety during the winter 2017-18 and which are included in this plan for 2018/19:

- Daily safety huddle with good clinical engagement
- Dedicated "outlier" medical teams
- Post-take senior nurse reviews
- A consistent approach to site management with review of escalation policy
- Pre-emptive cancellation of elective work & moved some of TWH elective work to Maidstone
- AEC established at TW.
- surgical flow coordinator to support surgical flow & oversee escalation areas
- An increased establishment in ED to manage periods of overcrowding
- Secure the capacity in the community to allow the flow of patients out of secondary care when medically fit e.g. Increased pathway 3-bed capacity , and swap the medial fit wards back to acute medical wards
- Review and Implementation of the virtual ward
- Further improvement in patient flow, through the 'Best delivery programme'
- To embed a clear understanding through the organisation of what all staff should do, when the organisation moves from Opel 3 to Opel 4 level.
- Develop a digitalised approach to information to allow improved availability and access to up to date information to assist in decision making.
- Secure necessary staffing and reduction in vacancy levels.
- Secure improved flow of patients into and out from the available ITU capacity
- Work with colleagues in other units to secure an improved flow of patients to and from tertiary centres

15. Overall performance indicators

The following key patient-rated performance indications will be monitored on a monthly basis to ensure improved patient management when compared to the previous year.

Key indicators	16/17	17/18
Incidents reported Nov – March	Same	
Falls and falls SI Nov – March	869 with 18 SIs	850 with 14 SIs
Boarding incidents Nov – March	6	4 (with increased boarding in 17/18)
Boarding numbers	Unavailable	Approx. 38 occasions with 77 patients
Pressure damage - Nov – March	172	170
DTOC – December data	8.1 5	3.7%
ED performance Q4	83%	88.6% with 5.7 more attendances.
Staffing incidents	120	130 staffing incidents 5x higher at TW

Another key performance indicators which will be monitored:

- a. The number of times in which Opel 4 is initiated offers an insight into how the pressure the trust is under during period.
- b. A.E performance - Performance for the Trust in line with the agreed trajectories. - Q1, Q2 and Q3 must score 90% or above, then 95% in March.
- c. Infection rates of patients and inoculation rates of staff
- d. LOS – The average LOS needs to reduce by at least 0.5 days across all emergency admissions and not rise within the winter months. This is required to support Best flow and release the necessary bed capacity
- e. Percentage delayed of occupied bed-days.
- f. The number of times the Boarding policy implemented
- g. Numbers and types of Patient Complaints.

16. Financial Planning

A Financial assessment of the schemes and likely costs will be developed and a budget identified covering the winter period. All schemes requiring additional funding will be supported by a Business case which will go through the trust appraisal process.

Trust Board meeting - June 2018

6-19 Principles for Pathology reconfiguration in Kent**Chief Executive**

There is a need for the partners in Kent to commit to a set of principles which will enable the production of a high quality business case for the reconfiguration of pathology services in a way which is inclusive, modern and effective to overcome the historic resistance to delivering change we all understand needs to occur. The enclosed report sets out the principles that have been agreed by the Trust CEOs to gain commitment from partners to move forward. It is acknowledged that the partners are committed to these principles to allow the production of the business case and to move forward.

Additional information has been circulated to Trust Board members as a supplementary report to the formal 'pack' of Board Reports.

Which Committees have reviewed the information prior to Board submission?

- -

Reason for receipt at 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

Principles for Pathology Reconfiguration in Kent

Background

The opportunities for the development of clinically sustainable , high quality and lower cost pathology services in Kent are considerable when set against the national pathology benchmarking . However the route to securing these in a single network has so far been elusive for the acute Trusts and Commissioners in Kent . There has been some progress with for example the creation of the North Kent Pathology Service recently but there is much more to deliver across Kent .There is a need to now act with commitment and vigour given the considerable challenges . These are associated with a National Pathology Network strategy , an ageing pathology workforce , ageing technology platforms ,the rise of artificial intelligence and new technologies , molecular diagnostics and the financial distress in the system and the need to assist commissioners with a responsive and lower cost service for direct access work .

There is a need for the partners in Kent to commit to a set of principles which will enable the production of a high quality business case for the reconfiguration of pathology services in a way which is inclusive , modern and effective to overcome the historic resistance to delivering change we all understand needs to occur .

The importance of goal clarity

The Pathology Steering Group in May 2018 agreed a draft for comment by the CEOs and the Trust CEOs have endorsed a Goal for the programme to create a single pathology service which is :-

“ The creation of a single pathology service across Kent under a single management to deliver high quality , sustainable pathology services and embrace new technologies and diagnostics requirements of primary and secondary care . It will become a nationally leading pathology service in the areas it concentrates on by 2030 and the best place to learn , work and participate in research . The service will deliver a net £5.6m reduction in its own costs from 2017/18 and net of any investment in the new single service .This will be secured by 2020/21 and will be net of individual trust efficiency requirements for 2018/19 - 2020/21 for the pathology services .”

The four Trusts have to agreed a minimum a level of efficiency their individual services of 3% pa which will be delivered across the trusts from 2018/19 to 2020/21 to ensure coordination of the services and delivery of increased financial benefit . The net £5.6m will be delivered over and above this for the absence of doubt in 2020/21.

The CEOs have approved this goal to give clarity to the programme .The assumption based on this being secured as an agreement by the Trust CEOs ,will then enable the pathology leadership community to work on a series of draft objectives for the programme to create a single pathology service for the four CEOs approval .Any views from the CEOs on these 4-5 key objectives would be welcome since there is a session being organised to scope these draft objectives with the pathology leadership community in the next week or so . These will then be subject to CEO sign off

This is designed to ensure commitment to all partners to the programme from the outset since there has been a clear view emerging from the programme about the alignment of the four Trusts to actually being committed to the programme based on a combination of previous attempts to create more integrated pathology services , the historic difficulties with trust partnerships and organisational mistrust and suspicion which permeates to the pathology leadership community itself . We collectively have to show the will to make this happen and the shape of the solutions we expect.

A set of strategic objectives and a clear goal will help but there needs to be a agreement with the CEOs on the key principles they expect as the client of the single pathology services to see the solutions based on .

Accordingly the following set of principles have been agreed by the Trust CEOs to gain commitment from partners to move forward. It is acknowledged that the partners are committed to these principles to allow the production of the business case and to move forward .

The Proposed Key Principles

- Every Trust should benefit from the creation of the single pathology service as it is created and develops .There should be no loss from any partner entering into a single pathology service based on their current financial profit or loss in their individual pathology services .Partners will derive benefits from either cost reduction or profit margins on new income generating work additional to the base entry levels onto the single service in proportion to the their total I&E contribution to the service . In effect what Trusts put in based on their I&E proportions will determine their share of the benefits (and losses) going forward .
- there should be a single organisation which contracts with commissioners for Kent pathology services and the partnership will operate as a joint venture subsidiary of the four acute trusts irrespective of the final legal / contractual form decided .
- there should be a direct cost reduction in direct access pathology costs for commissioners in creating the pathology network over the next five years and the acute trusts should agree to this in return for five year minimum commitment from the CCGs to the open access contracts with the current trusts . Acute trusts should retain the benefit of the further savings from the creation of the single service to support their financial positions over the next five years .
- there should be a form of joint venture between the acute Trusts based on a model of shared ownership which should determine the share of profit , loss and investment in the joint venture .
- there should be an agnostic view on where direct access pathology and other services should be located but all major acute emergency centres will require an essential services laboratory .These service locations will be determined by the Target Operating Model which offers best value and meets the key requirements of the Trusts following an option appraisal at the SOC stage of the programme .
- The Target Operating Model outcome will consider as part of the options appraisal process the public/ private partnership potential in all options appraised .
- The service models will be evaluated based on two core requirements - sustainable quality delivery (e.g. turnaround times , accreditation , access) and financial and regulatory delivery . These will be set out in the detailed evaluation criteria .
- all partners should agree that there needs to be investment to secure the reconfiguration of pathology services and this should be based on the best option subject to clear benefits criteria being agreed .
- there should be an independent external project director appointed to lead on behalf of the partners the production of the business case supported by a resourced project team comprising of appropriate experts from the trust partners committing to the principles outlined . A project board will oversee the process led by executives and a CEO from the Kent system .
- the partners commit to delivering a pathology consortium by 2019 Q1 and this partners which cannot commit to these principles will be considered for joining the partnership thereafter .
- there will be support in terms development , facilitation and team working for the pathology leadership community to develop a “Team Kent Pathology “ mindset , behaviour , culture and working relationships which the Trusts will support .
- there will be approaches made to other trusts in the South who may wish to participate in the consortium .

Key requirements of the pathology network created

Against these proposed principles , the key requirements that the four Trusts have agreed and set out to the pathology leadership community as the clients of the single service are as follows :-

Quality

- A clinically led service
- A high quality pathology service that improves the provision of pathology services to the Trusts ,primary care and other users.
- Ability to maintain essential clinical contact and clinical relationships .
- Provides credible access to diagnostic test and reports at the desired time

Financial, regulatory and strategy

- Congruent with the strategic direction of the Trusts and the STP .
- Complies with the National Pathology Strategy.
- Meets national accreditation standards for pathology .
- A financially sustainable service which can generate its own resources for investment and meet the efficiency needs to the Trusts .
- An ability to develop its business potential to provide expanded existing revenue stream or new revenue streams for the Trusts e.g research , other income and expanded GP open access work .
- Ensure the effective replacement and purchase of new equipment which is financed by the network and its partners .
- Delivers an integrated information architecture to ensure a standardised , common information platform for pathology services which integrates with all trusts EPRs .
- Ensures the retention of current research and other income .

Workforce

- Ensures the ability to recruit and retain high calibre staff at all levels .
- Improves staff retention .
- Delivers effective training and development.
- The single service needs to maximise the potential of new technology to grow income and reduce costs of the workforce to maintain workforce sustainability .
- Secures high quality staff experience and satisfaction in the new organisation .

Recommendation

The CEOs have endorsed the goal , key principles and key requirements of the programme to create a single pathology service under a single management as set out above . This will create the framework on which the SOC/OBC will be created . These agreed recommendations will be shared with each Trust Board to ensure understanding and commitment to them to enable the programme to succeed .

Trust Board meeting - June 2018

6-20 Cyber security threat – assurance report

Chief Nurse

This report is presented to the Trust Board in response to a letter received from Will Smart, Chief Information Officer for Health and Social Care, NHS England and Rob Shaw, Deputy Chief Executive, NHS Digital, to provide an update in relation to cyber security awareness within the Trust and the work being undertaken to ensure our networks and systems are as robust and as safe as we can reasonably make them.

Data and cyber security has three key elements, People, Technology and Processes.

The Trust is advised that throughout 2018/19 NHS England will be leading on and working in conjunction with NHS Digital, NHS Improvement and other colleagues on Board level awareness of the cyber risk and its management.

The Trust has implemented processes to ensure information relating to cyber security is being considered at Board level and that data and cyber security is managed as an ongoing Board level risk.

Which Committees have reviewed the information prior to Board submission?

None due to time constraints. This report has been shared with members of the Information Governance Committee. However the Committee does not sit until after the date of the Board meeting.

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

Background

The Board may be aware that William Smart, the Chief Information Officer for Health and Social Care, NHS England and Rob Shaw, Deputy Chief Executive, NHS Digital, wrote to all Trust Chief Executives in April 2018 following media reports of the increased threat of cyber attacks affecting the UK.

The *Lessons Learned Review of the WannaCry Ransomware Cyber Attack*¹ set out a number of recommendations for NHS providers. Below I've detailed the Trust response to the key recommendations.

Recommendation - Leadership – All NHS organisations should ensure that every board has an executive director as data security lead, and cyber security risks should be regularly reviewed by the board.

Response - Leadership – The Board is advised that as Senior Information Risk Owner I have within my portfolio Data and Cyber Security. In this role I am supported by the Director of Health Informatics and the Head of Information Governance and together with the other Information Governance Committee members we review the risks identified in regard to both Data Security and Cyber Security.

Through the Information Governance Committee we are reviewing processes and monitoring preparedness of security against a variety of threats and vulnerabilities.

We are investing in people, processes and technology, and will continue to do so, in order to protect the Trust and ensure we are able to maintain the public trust that patient data is secure with MTW.

Where appropriate I will, of course, report risks to Board for review.

Recommendation – Capability – Boards should assure themselves that they have sufficient quality and capable IT technical resources to manage and support their local IT infrastructure, systems and services.

Response - Capability – The Trust currently has all senior IT roles and responsibilities provided by the existing IT department. There is also additional support provided by 3rd party service providers for the Trusts server, storage and network infrastructure which would be utilised for specialist support and advice when required.

In addition to the capabilities of the team in place the Trust is investing in 4 members of the IT team who, over the next 6 months, will be completing a certified ethical hacker course to further ensure that the organisation has the right support and understanding around cyber protection and resolution. The team is also focused on continuing learning around cyber threats in the future.

Recommendation – Training – In addition to mandatory and statutory training, organisations should ensure that their staff receive regular and targeted cyber and information security awareness training appropriate to their job role. Further, boards for NHS organisations should undertake annual cyber awareness training.

Response - Training – The Board will be aware that the Trust requires all staff to undergo Information Governance Training on an annual basis. The Trust has adopted the Data Security Awareness training materials provided by NHS Digital. This material incorporates basic training in cyber security. All staff are required to complete an assessment to demonstrate their understanding of the training materials and of their personal responsibility to keep the data they come into contact with during their role within the Trust safe and secure.

The Trust is aware that NHS Digital will be making additional cyber and data security training resources available which will be targeted to specific job roles. As these materials become available the Trust will incorporate these into its training programme.

In addition to the current mandatory training the Trust continues to raise awareness of data and cyber security through information pieces published in the MTW News, the Governance Gazette, the Digital Newsletter and the Intranet.

Training resources are being applied to ensure that specialist training is accessed by relevant staff in order to enhance technical capabilities.

Recommendation – Intelligence – NHS providers should ensure the relevant parties in their organisation receive CareCERT Threat Intelligence alerts and review the Information Sharing Portal² for information on emerging threats. Where they exist, NHS providers can join and collaborate with local Warning Advice and Reporting Point groups to share trusted up-to-date advice on information security, cyber threats, incidents and solutions.

Response - Intelligence – The Trust is an active member of the NHS England CareCERT programme which aims to share trusted up-to-date advice on information security, cyber threats, incidents and solutions. The organisation has a number of members assigned to receive information from this programme to ensure there is no single point of failure in the process to act upon any threat to the Trust.

The Trust also completes regular external audits on the organisations infrastructure to identify the latest cyber security risks.

Recommendation – Improvement - All NHS organisations are to develop local action plans to achieve compliance with the Cyber Essentials Plus standard by June 2021.

Response - Improvement – The organisation will need to continuously improve its IT infrastructure to reduce and mitigate the risk of cyber threats. Key to this will be to ensure the Trust achieves the Cyber Essentials Plus standard. NHS England state that this should be achieved by June 2021; however the Trust is aiming to achieve this accreditation by October 2018.

Recommendation – Contract Management – Health and social care organisations should ensure that local contracts, processes and controls are in place to manage and monitor third party contracts for local IT systems, and that the provisions for software updates and business continuity are understood.

Response - Contract Management – NHS England recently (April 2018) issued standard text for a contract addendum. The Trust has written to all suppliers requesting that they confirm the details of any processing of information undertaken on behalf of the Trust and has received c.200 responses to date (mid-June). The procurement department are taking this opportunity to update the Trust contracts database and move suppliers to standard NHS contract terms and conditions where this is not currently the position. In conjunction with this work the IT Department and local systems administrators are reviewing systems and processes for the monitoring and management of software updates and business continuity plans.

Recommendation – Response – Local organisations' business continuity and disaster recovery plans should include the necessary detail around response to cyber incidents, and must include a clear assessment of the impact of the loss of services on other parts of the health and social care system.

Response - Response – It is important that the Trust has the ability to respond to a cyber attack and is aware of the impact of the loss of services on other parts of the health and social care system. To this end the Trust is reviewing its business continuity and disaster recovery plans and will be conducting a business continuity and disaster recovery exercise in October 2018 which will focus on the fallout from a cyber incident. It is key that we test our business continuity and disaster recovery plans for this type of event and use the lessons learnt for such an exercise to further improve our systems and processes.

1 <https://www.england.nhs.uk/wp-content/uploads/2018/02/lessons-learned-review-wannacry-ransomware-cyber-attack-cio-review.pdf>

2 <https://www.carecertisp.digital.nhs.uk>

Trust Board meeting - June 2018



6-21	Outcome of review the Trust’s current policy regarding the start and end dates of the staff Annual Leave year	Director of Workforce
<p>The enclosed report sets out arrangements for annual leave and options for annual leave year beginning and ending dates.</p>		
<p>Which Committees have reviewed the information prior to Board submission?</p> <ul style="list-style-type: none"> ▪ None 		
<p>Reason for receipt at the Board (decision, discussion, information, assurance etc.) ¹</p> <p>Information</p>		

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

ANNUAL LEAVE

1. Introduction

- 1.1 Employees are legally entitled to 5.6 weeks paid statutory annual leave.
- 1.2 Employees in the NHS are entitled to additional annual leave based on length of service as set out in National Terms and Conditions of Service.
- 1.3 In the NHS public holidays are paid in addition to annual leave.

2. Current Annual Leave Year

- 2.1 The annual leave year for Trust employees begins on 01 April and ends on 31 March with the exception of junior doctors on the 2016 contract who have an annual leave year which runs from the start of their appointment (pro-rata to the length of their contract or placement if less than 12 months).
- 2.2 The Terms and Conditions – Consultants (England) 2003 and Terms and Conditions of Services – Specialty Doctors (England) April 2008 provide for the leave year to run from the anniversary date of appointment or adjusted to a common start date in force in that employment.
- 2.3 Trust contracts set out the annual leave year as April to March.

3. Carry over of Annual Leave

- 3.1 Employees must take at least 4 weeks of statutory leave during the leave year.
- 3.2 The Trust deems it important for employees to take their full leave entitlement in support of their health and wellbeing and it is expected employees take all their leave in the annual leave year.
- 3.3 Carry over of annual leave, to a maximum of one week contracted hours, should only be agreed in exceptional circumstances. No public holidays can be carried forward in any circumstances.
- 3.4 If an employee on long term sickness chooses not to take statutory annual leave during their sick leave they can carry forward untaken statutory annual leave for up to 18 months from the end of the leave year in which the leave arises.

4. Management of Annual Leave

- 4.1 Managers should ensure employees use their full leave entitlement before the end of the leave year. This should be monitored throughout the year and leave should be spread throughout the year to avoid operational difficulties towards the end of the leave year with employees wishing to take outstanding leave.
- 4.2 Employers can refuse requests for annual leave if the requested time does not suit operational needs.
- 4.3 Employers can set times when employees are unable to take their leave.
- 4.4 Annual leave was discussed at the Winter Planning and Resilience Steering Group on 11 April 2018. It was noted at the meeting local team polices can be agreed which identify periods when employees are requested not to take leave. A discussion took place with regard to the Christmas and New Year period and the first two weeks in January.

4.5 Any local policy should balance the needs of the service with the impact of implementing the policy on employee morale. Staff Side engagement when drafting a local policy would be prudent.

5. Options for Annual Leave Year

5.1 **01 April to 31 March** – The leave year April to March is well established and the Trust adopted this for Consultants and Speciality Doctors in April 2009.

5.2 **01 January to 31 December** – There are no material advantages to moving the leave year to January to December. Operational pressures typically increase over winter months particularly over the Christmas and New Year period. Employees often wish to keep a few days annual leave for unexpected events and moving the end of annual leave year to December is likely to be counterproductive in managing staffing over this period.

5.3 **Anniversary of appointment** – An annual leave year based on the employee's anniversary of appointment removes the end of leave year rush for all employees to use their outstanding leave during the same period. The Trust moved away from anniversary of appointment annual leave for senior doctors as it can be more difficult to monitor than a fixed leave year for all employees.

The Allocate Health Roster, which is currently used for some, but not all employees, can accommodate a personal annual leave year in principle but not easily in practice. At the beginning of the leave year the Health Roster Team bulk up load annual leave entitlements for the fixed leave year. Leave entitlements would have to be uploaded individually if we moved to a leave year based on anniversary of appointment. Once the annual leave date has been entered into the system it will automatically roll over each year. However, the Bank Holiday entitlement for each employee would have to be calculated and manually entered onto the HealthRoster as the dates the Bank Holidays occur change from year to year. The time and cost it would take the HealthRoster Team to manually calculate and enter the annual leave (in the first year) and Bank Holidays (annually) has not been calculated.

Management of annual leave for employees on the same leave year is easier for managers as they review the amount of leave taken for the same period of time for each employee. Health Roster calculates the percentage of annual leave taken every quarter for each employee based on the April and March leave year. This functionality is not available for an anniversary of appointment leave year.

Moving to an anniversary of appointment leave year would require a calculation for each employee to confirm their leave entitlement in their revised leave year and the carry over into their next leave year. An accrual for carried over annual leave would have to be made.

6. Conclusion

The option to change the annual leave year is open to the Trust subject to appropriate consultation. However, an annual leave year of April to March should not be problematic if managers monitor annual leave throughout the year and ensure employees take their full entitlement. A move to an alternative leave year could cause operational pressures if annual leave is not monitored throughout the year and it would not impact on the number of requests for leave at specific times of the year e.g. school holiday, Christmas, New Year. The resources required to amend the leave year to the anniversary of appointment, the requirement for financial accrual, the consultation and communication required would be disproportionate to the benefit realised. The April to March leave year is manageable with robust planning and use of Health Roster and the potential chaos of a move to an anniversary of appointment outweighs the benefits.

Trust Board meeting – June 2018

6-22 Review of the formal hosting arrangements for the Kent & Medway Sustainability and Transformation Partnership (and approval of the Trust's STP contribution) Director of Finance

The Trust Board at its meeting on 29/11/2017 approved the Business Case regarding the financial hosting of the Kent & Medway STP within Maidstone and Tunbridge Wells NHST, and also approved the recommendation “that the formal hosting arrangement is reviewed after 6 months to ensure that the objectives of the Hosting are being met as set out in this case, and that the STP and the Host are both satisfied that the service from the Host, and the protection from risk exposure afforded to the Host by the partnership agreement, are working effectively”.

The requested review is enclosed.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

- It is recommended that the Trust Board considers the review of the hosting arrangements for the K&M STP and agrees the continuation of the existing approach subject to all parties continuing to respect the arrangements around settling STP-party debt to enable payment to the ultimate creditors, and recommends a review of the financial management arrangements to ensure the STP receives the service that it requires.
- It is also recommended that the Trust Board agrees the MTW share of the contribution to the STP budget for 2018/19.

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 Report – 6 month update on arrangements for hosting the Kent & Medway STP

1. INTRODUCTION

- 1.1 The Trust Board at its meeting on 29/11/2017 approved the Business Case regarding the financial hosting of the Kent & Medway STP within Maidstone and Tunbridge Wells NHST, and also approved the recommendation “that the formal hosting arrangement is reviewed after 6 months to ensure that the objectives of the Hosting are being met as set out in this case, and that the STP and the Host are both satisfied that the service from the Host, and the protection from risk exposure afforded to the Host by the partnership agreement, are working effectively”.
- 1.2 This paper reviews the arrangements as requested.

2. BACKGROUND

- 2.1 The Kent and Medway STP had been for the most part informally hosted in terms of financial transactions by MTW since 2016/17, driven in part by the SRO being then the MTW Chief Executive, who was subsequently appointed as the STP CEO.
- 2.2 This arrangement was formalised after the MTW Trust Board approved the Business Case proposing financial hosting subject to six monthly reviews. The Business Case set out the following objectives for the arrangements:
- The provision of effective procurement and financial transaction services to the STP to enable the exercise of the approved budget levels within the appropriate governance framework to ensure accountability and transparency to all STP partners and regulators.
 - The provision of financial management and budgetary control services that support the STP management to deliver the STP work plan to budget and to plan the use of resources, including reporting of performance to budget within the level of contributions agreed by all members.
 - Ensuring that the service provision operates in a way which conforms to the Host organisation’s internal governance processes, and ensures that the Host is not disadvantaged in terms of unplanned and unfunded costs or working capital cash requirements. This requires clear agreements between all STP parties that the Host will be paid contributions in advance of the liabilities falling due to external contractors, suppliers and in-house payroll payments.
- 2.3 The main risks of hosting were identified as being:

Risks to the Host (MTW)

- Exposure to the risk of overspending of the STP budget within the Host’s financial position;
- Exposure to risk of cash shortfalls creating liquidity pressures for the Host if STP partners do not pay the agreed share of the budget funding in advance of the Host meeting external supplier liabilities;
- Workload requirements on the Host not being matched by agreed funding e.g. tendering for services through the Procurement processes; expectations of financial management support exceeding resource provided.

Risks to the STP

- Financial and Procurement services not matching the expectations or needs of STP management in quantitative terms
- The Host's overall financial position putting stress on liquidity and therefore its ability to discharge debts to STP creditors in accordance with contract terms

2.4 AGREED ARRANGEMENTS

The STP Programme Board in November 2017 agreed that it wanted to ask MTW to formally host the STP financial budgets. In order to address the governance and risk issues it was agreed that:

- MTW would be indemnified as host from costs incurred on behalf of the STP so that MTW should only be liable for its share of expenditure. In practice this would mean any net overspending would be charged back to partner organisations.
- That on agreement of the budget, invoices from MTW regarding the STP would be raised quarterly in advance and settled prior to MTW paying the liabilities falling due to external contractors, suppliers and in-house payroll payments. The invoices regarding STP finances would not be subject to normal organisation to organisation cash management approaches (e.g. "like for like" payment approaches).
- The STP would comply with the MTW's governance arrangements e.g. SFIs governing purchasing, financial authorisation and control, business case preparation where applicable, revenue and capital recognition principles and requirements around regulatory reporting (e.g. monthly and year end accounts), including the completion of any necessary approval documentation and authorisations to utilise specific Host systems.
- MTW also requested that the 2018/19 budget setting service levels take account of additional resources that might be required to fulfil the scale and pace of procurement or financial support that the STP requests to ensure that both the resource is available and that MTW is appropriately financed for this service.

3. REVIEW

Governance

- 3.1 The STP CEO and Programme Director are established on the MTW authorised signatory list with provision in the MTW Scheme of Delegation to enable them to use the appropriate systems for procurement and authorisation. The SFIs and Scheme of Delegation were updated in November 2017 to reflect the new arrangements with the STP CEO having a limit of £250k for STP only requisitions or invoices, and the Programme Director a limit of £50k. Beyond these levels approval is required through the Trust's CEO, and relevant Trust Committees and Board. No issues with these arrangements have been reported.
- 3.2 STP staff have been set up with requisition authority on the Trust's Purchasing system to enable procurement and have access to Trust Procurement staff to support use of the Trust systems. This appears to be working satisfactorily.
- 3.3 The majority of the STP budget is managed through the hosting arrangements on MTW budget reports. Where transactions are sourced in other organisation systems for historical reasons e.g. staff seconded to the STP but payrolled on "home" Trusts, these costs are recharged to MTW. The exception to this hosting arrangement relates to some Workforce work-stream staffing where a separate arrangement means that South Kent Coast CCG hosts these staff which they set off against a specific stream of funding from NHSE.

Reporting

- 3.4 In 2017/18 the Trust reported STP costs and incomes on a single cost centre budget report (AF760). The financial budgets and expenditure for the in-month and year to date position were provided to the STP Programme Director and Finance Lead by individual work-stream using a template that the STP provided on a monthly basis. This was populated using the Trust's cost centre and transactional information (including staff WTEs). The information was reviewed by the STP and any adjustments agreed with MTW Financial management.

The Financial management team did not have any increase in resources to support the STP and as a result a relatively minimal service has been provided. The financial management department is removed from the STP team and therefore is not involved in day to day operations so making informed completion of monthly accounts and forward forecasting difficult.

- 3.5 For 2018/19 the STP has requested the budget split by work-stream on individual cost centres, and the provision of the associated transactions data. The budget separation has now been actioned for month 3 reporting. A draft version of the transactions' reporting was discussed with the STP finance lead – there are concerns around the complexity of the data with the different sources of information and the journals to recharge and reallocate costs.

The amount of time that the STP work requires is increasing, more reports and information requests both internal and from FOI is also appearing to increase. Requests for information or questions regarding budgets and other details are regularly made where the management accountant simply does not have the direct understanding and knowledge on what is happening.

- 3.6 At year end the Trust reported the STP income and expenditure as part of its overall financial performance in annual accounts. It set out the view that the component elements were not sufficiently distinct, or material, from the Trust's usual business to warrant separate disclosure as a business segment, but noted the STP elements in the relevant disclosure notes on consultancy costs and Agreement of Balances. This was accepted by the Trust Auditors.

Cash and Debt

- 3.7 In the earlier part of 2017/18 MTW experienced some difficulties in receiving settlement for STP invoices raised to the partner bodies, especially relating to some CCG partners and also FTs under particular cash pressure. This was sometimes justified on the basis of the STP budget being reworked and pending the final outcome. This posed significant accumulating cash flow pressures on MTW as large invoices were falling due every month along with the element of payroll directly on MTW's systems.
- 3.8 This situation improved markedly after the revision to the STP budget was agreed in the autumn, along with agreement to the hosting approach that MTW would invoice in advance and expect settlement prior to disbursement of the related creditor obligations. By year end all the outstanding debt had been settled.
- 3.9 In cash terms in 2017/18 debt of £7,925,711 was raised and settled by STP partners, and £7,926,233 was paid out to the STP creditors (including payroll).
- 3.10 In 2018/19, following the agreement of the STP budget (£6.7m – see appendices 1 & 2), the first quarter invoices have been raised in June together with the second quarter invoices in advance. The Trust will need to ensure that it obtains immediate settlement from its STP partners on the first and second quarter debt in line with the existing agreement.
- 3.11 At present MTW is able to pay the STP creditors to terms but this will require the outstanding debt to be settled promptly per the STP hosting agreement. It also requires the

STP administration to raise the relevant Purchase Order requisitions in advance of the presentation of the invoice by the supplier – at present this often takes place after the invoice has been received, and may therefore slow down the authorisation process to enable the Trust to pay the invoice on terms.

4. RISKS

- 4.1 The main risk of liquidity pressure to MTW was addressed by the agreed approach to invoicing and settlement put into place in the final quarters of 2017/18. This agreement needs to hold good in 2018/19 to ensure that MTW are not disadvantaged from the hosting arrangement.
- 4.2 MTW requested that the 2018/19 budget setting service levels take account of additional resources that might be required to fulfil the scale and pace of procurement or financial support that the STP requests to ensure that both the resource is available and that MTW is appropriately financed for this service. The Trust has estimated that the minimum baseline service costs c. £15k to provide.
- 4.3 There is concern in the MTW Financial Management section that this review needs to be undertaken as soon as possible to ensure that the service that the STP requires can be provided – at present the developments required are not resourced within the Trust's own establishment.

It may be that the STP would benefit by recruiting its own management accountant to work directly for the STP based at Magnitude House. This would enable the individual to provide costing information, help in development of budgets, meet with budget holders, complete year end forecasts, help to provide quick responses to internal and external information requests, challenge overspends and resolve issues that occur, all of which is currently not able to be completed from the physically remote baseline service. This may not need to be a full time role but could be shared with work-streams requiring financial input.

5. MTW CONTRIBUTION 2018/19

- 5.1 The Trust's share of the budget contribution for 2018/19 is agreed at £389k including contingency (see Appendix 2). This compares with the 2017/18 contribution of £628k. The monthly invoiced sum will in the first place total £378k across the year excluding the contingency – the additional sum will only be called upon if needed and is shared out between the partners according to the agreed proportionate contributions.

6. RECOMMENDATION

- 6.1 It is recommended that the Trust Board considers the review of the hosting arrangements for the K&M STP and agrees the continuation of the existing approach subject to all parties continuing to respect the arrangements around settling STP-party debt to enable payment to the ultimate creditors, and recommends a review of the financial management arrangements to ensure the STP receives the service that it requires.
- 6.2 It is also recommended that the Trust Board agrees the MTW share of the contribution to the STP budget for 2018/19.

Appendix 1

Programme	Plan												18/19 Total
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	
Workstreams													
East Kent programme	154	154	154	154	154	154	154	154	154	154	154	154	1,850
Local Care	37	27	27	27	27	27	27	27	27	27	27	27	334
Productivity	143	68	68	68	68	68	68	68	55	55	55	55	826
Stroke	63	114	122	96	96	98	23	23	23	22	22	22	723
System Transformation	5	5	5	5	5	5	5	5	5	5	5	5	63
Clinical Strategy	19	19	19	19	19	19	19	19	19	19	19	19	226
Mental Health	25	25	25	25	25	25	25	25	25	25	25	25	295
Prevention	5	5	5	5	5	5	5	5	5	5	5	5	61
Workforce	0	0	0	0	0	0	0	0	0	0	0	0	0
Digital	13	13	13	13	13	13	13	13	13	13	13	13	156
Estates	16	16	16	16	16	16	16	16	16	16	16	16	193
Workstreams Sub Total	479	446	455	428	428	430	355	342	342	340	340	340	4,726
Overheads													
Central STP Functions	137	137	137	137	137	137	137	137	137	137	137	137	1,644
Comms & Engagement	54	54	54	82	32	32	32	32	32	32	32	32	501
Contingency	13	13	13	13	13	13	13	13	13	13	13	13	150
KCC Social Care investment	12	12	12	12	12	12	12	12	12	12	12	12	140
KCC reduction in contribution	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(140)
SECAMB contribution	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(10)
NHSE STP Funding allocation	(25)	(25)	(25)	(25)	(25)	(25)	(25)	(25)	(25)	(25)	(25)	(25)	(302)
Overheads Sub Total	178	178	178	205	155	155	156	156	156	156	156	156	1,983
Total	657	623	632	634	584	585	511	498	498	496	496	496	6,710

2018/19 STP PMO Budget Contributions

Programme	Plan												18/19 Total
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	
Commissioners													
NHS Dartford, Gravesham and Swanley CCG	29	35	36	35	31	31	22	22	22	22	22	22	327
NHS Medway CCG	29	35	36	35	31	31	22	22	22	22	22	22	327
NHS Swale CCG	29	35	36	35	31	31	22	22	22	22	22	22	327
NHS Thanet CCG	60	66	67	65	62	62	53	53	53	53	53	53	697
NHS Canterbury and Coastal CCG	60	66	67	65	62	62	53	53	53	53	53	53	697
NHS South Kent Coast CCG	60	66	67	65	62	62	53	53	53	53	53	53	697
NHS Ashford CCG	60	66	67	65	62	62	53	53	53	53	53	53	697
NHS West Kent CCG	29	35	36	35	31	31	22	22	22	22	22	22	327
Sub Total	359	401	410	400	371	373	298	298	298	297	297	297	4,098
Providers													
Maidstone And Tunbridge Wells NHS Trust	50	33	33	35	32	32	32	29	29	29	29	29	389
Medway NHS Foundation Trust	50	33	33	35	32	32	32	29	29	29	29	29	389
Dartford And Gravesham NHS Trust	50	33	33	35	32	32	32	29	29	29	29	29	389
Kent And Medway NHS And Social Care Partnership Trust	23	20	20	22	19	19	19	18	18	18	18	18	234
East Kent Hospitals University NHS Foundation Trust	81	64	64	66	62	62	62	59	59	59	59	59	759
Kent Community Health NHS Foundation Trust	28	23	23	25	22	22	22	21	21	21	21	21	271
Sub Total	283	207	207	219	198	198	198	184	184	184	184	184	2,431
Local Authorities													
Medway Council	7	7	7	7	7	7	7	7	7	7	7	7	80
KCC (gross contribution)	20	20	20	20	20	20	20	20	20	20	20	20	240
KCC (less social care investment reallocation)	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(140)
Kent County Council (net contribution)	8	8	8	8	8	8	8	8	8	8	8	8	100
Sub Total	15	180											
Total	657	623	632	634	584	585	511	498	498	496	496	496	6,710

Trust Board meeting - June 2018

6-23	Summary report from the Audit and Governance Committee, 24/05/18	Committee Chair (Non-Executive Director)
<p>The Audit and Governance Committee met on 24th May 2018. A verbal update on the meeting was given at the Trust Board held later on that same day, but this written report has been submitted for completeness.</p>		
<p>1. The key matters considered at the ‘main’ meeting were as follows:</p> <ul style="list-style-type: none"> ▪ The final draft Annual Report and Annual Accounts for 2017/18 (including the Governance Statement) was reviewed, and the Committee agreed to recommend that these be approved by the Trust Board. Trust Board Members will be aware that these were duly approved on 24/05/18 ▪ The Audit Findings Report (‘Report to those charged with governance’) from the External Auditors was reviewed and no significant issues were raised. It was agreed that, as the final version of the Audit Findings Report had not been circulated, it should be appended to the External Audit Letter for 2017/18 which was already scheduled for the Audit and Governance Committee on 08/08/18 ▪ The 2017/18 Draft Management Representation Letter was reviewed, and it was agreed to recommend that this be approved by the Trust Board (and it was, on 24/05/18) 		
<p>2. The Committee agreed that (in addition to any actions noted above): N/A</p>		
<p>3. The issues that need to be drawn to the attention of the Board are as follows: N/A</p>		
<p>Which Committees have reviewed the information prior to Board submission?</p> <ul style="list-style-type: none"> ▪ N/A 		
<p>Reason for receipt at the Board (decision, discussion, information, assurance etc.)¹ Information and assurance</p>		

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

Trust Board Meeting – June 2018

6-24 Workforce Committee, 24/05/18

Committee Chair (Non-Exec. Director)

The Workforce Committee met on 24th May 2018.

- **The key matters considered at the meeting were as follows:**

- The actions from previous meetings were reviewed,
- The committee reviewed the Workforce performance data for the preceding month. The committee were pleased to note the continued reduction in sickness absence in all parts of the organisation. The committee also welcomed the continued reduction in turnover data that was noted at the January meeting. Whilst the trend was an improving one the committee noted that in order to address the wider workforce challenges further improvement was required. The Chief Nurse and Director of Workforce had attended the launch of Cohort 3 of the NHSi Retention Programme and would be overseeing the development of a clinically led retention plan. This would be due for submission on 4th July.
- The committee noted the report from the Director of Medical Education. Whilst the amount of exception reports being generated was stable the Medical Education team were supporting a number of areas to improve the quality of their rotas to enable high quality teaching opportunities. The challenge of Allscripts and multiple system log ins was also noted as a continuing matter of concern raised by junior medical staff. The GMC survey results were due at the end of June. A small number of matters of concern had been raised with the DME in advance and these were being managed appropriately. The number of issues flagged was considerably smaller than in previous years. It was expected that there would be continued shortfall in the number of trainees supplied by the Deanery and the Medical Education and Medical Staffing teams were taking a proactive approach to filling gaps as they arose.
- The committee noted the report on the use of apprentices within the trust. In particular it noted the numbers and timescales related to the introduction of apprentice CSW and Nurse Associate roles which would help address the wider staffing challenges. The increased use of apprentices and the apprentice levy was part of the Best Workforce 'new role' programme.
- The committee noted the draft recruitment plan that set out the numbers of staff that the trust anticipated it would need to recruit over the year and reviewed the methodology that it was built upon. The committee welcomed the approach and noted the need to ensure that the plan was linked to an understood sequence of interventions that would help deliver the numbers required.
- The committee reviewed the equalities data arising from the most recent CEA round. It was agreed that a group would be convened to plan the roll out of the revised LCEA national agreement. The group would also review the equalities data and set out a plan by which all eligible consultant staff could be supported and encouraged to apply. The group would be diverse in its make up to ensure appropriate challenge of the status quo.
- The committee welcomed the review of Employment Relations Outcomes. It noted the finding of the review that there were no patterns of bias or discrimination and commended the approach taken to reach these conclusions. In particular the committee noted the involvement of the Chair of the Cultural Diversity group in the process. The approach taken would be replicated for other issues such as recruitment and bullying and harassment to ensure that MTW was taking a fair and open approach.
- The committee noted and endorsed the Listening into Action plan for the year
- The committee reviewed a proposal to alter the current Staff Long Service Awards and suggested that this be incorporated into the Staff Retention plan.

- **The issues that need to be drawn to the attention of the Board are as follows:**

none

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

Trust Board Meeting – June 2018

6-25 Summary report from Quality Committee, 19/06/18

Committee Chair
(Non-Executive Director)

The Quality Committee has met once since the last Trust Board, on 19th June 2018 (a Quality Committee 'deep dive' meeting). The Quality Committee 'main' meeting due to take place on 9th May 2018 was cancelled.

1. The key matters considered at the meeting on 19th June were as follows:

- The **progress with actions** from previous meetings was noted
- A **Review of improvements in Paediatrics** was undertaken, for which the Clinical Director, Paediatrics; General Manager, Women's and Paediatrics and Lead Matron, Paediatrics attended. The report included the following information:
 - Improvements had been made against all Care Quality Commission (CQC) domains since the last inspection and all issues raised in the last report had been addressed
 - An update on the main Paediatric Services within the Trust was given, detailing consultant Emergency Department cover; numbers of beds; and Outpatient services
 - An update was given on Clinical Commissioning (CCG) recommendations, including progress against identified safeguarding compliance actions
 - Details of the current arrangements and plans for patients transitioning from Paediatric to Adult care were provided
 - Information was provided on revised Accident and Emergency pathways, including GP streaming of Paediatric patients
 - Plans to develop a Children's Panel for engagement with adolescents/stakeholders were outlined
 - Details were given of engagement with the West Kent CCG and mental health care providers
 - An update was provided on other initiatives, including the use of play specialists for children requiring MRI scans, which had been implemented successfully at Maidstone Hospital and was due to be rolled out at Tunbridge Wells Hospital; and implementation of a Paediatric nursing rotation programme to aid nurse development and reduce agency nursing costs
 - Information was given on activity levels within the Directorate, which confirmed a significant increase in non-elective and emergency admissions, GP referrals and Neo-Natal Unit activity over the past year
 - An overview of the Directorate's financial position was given
 - An in-depth discussion of the Directorate's medical staffing issues was held, which highlighted the significant difficulty in attracting locum and substantive Paediatric medics, and the disproportionate amount of senior medical and management resource currently allocated to managing the staff rota and processing agency staff requirements. The discussion included consideration of the methods currently used to attract / retain staff; the proposed introduction of Advanced Nurse Practitioner roles (ANPs) to work on the registrar rota; the proposed introduction of a Medical Staffing Rota Co-ordinator (the Committee heard that business cases for both initiatives had been halted due to identification as a cost pressure to the department); and consideration of other potential solutions to the current staffing issues, including learning from the A&E staffing model and engagement of community consultants
 - The Committee agreed that the Directorate's current staffing arrangements were a significant concern, which should be brought to the attention of the Trust Board, and noted that, even though it supported the exploration of new non-medical roles and alternative ways of working, these were unlikely to fully resolve the issues raised as ultimate responsibility would remain with the Directorate medical staff
 - The Committee acknowledged the progress made by the Directorate and acknowledged that the issues raised were not the fault of its staff, and agreed that:
 - The Medical Director would discuss progress on streamlining the process for the repeat appointment of regular agency staff with the Director of Workforce
 - The issues about funding and staffing raised should be considered as a subject for review at a future Executive Team meeting
 - An update on the issues raised should be scheduled for either the Quality Committee (September 2018) or Quality 'deep dive' (October 2018)
- The second main item was a **Review of the last 4 Never Events and identification of any**

wider learning arising, which had been prepared by the Associate Director, Quality Governance. The presentation contained summaries of each of the 4 Never Events that were declared during 2017/18 and detailed the learning and actions from each.

- There was general discussion about the key challenges in effectively communicating and embedding learning from Never Events
- The significance of the role of Human Factors training across the Trust was noted
- It was acknowledged that the Trust was unlikely to completely eradicate Never Events, but that there was a need to maintain focus on preventing them and learning from best practice and peers
- It was noted that further work was needed in embedding a positive and preventive culture in peripheral areas
- The role of the WHO Safety Checklist in Never Events was noted and it was confirmed that a Trust-wide audit of the Safety Checklist was being conducted as part of a wider TIAA audit of Never Events
- The Committee agreed that
 - The potential for development and use of staff stories about experiences of involvement with Never Events within the Trust as part of the Never Events learning process should be explored
 - A review of the findings of the "Prevention of Never Events Advisory review" should be scheduled for a future Quality Committee 'main' meeting (after potentially being considered as a 'deep dive' subject)
 - The development of a 'before and after' audit for the core group of 10 Trust staff identified for training in Human Factors methodology should be explored
- A brief update was given on **Follow-up review of compliance with the Mental Capacity Act (MCA) 2005** which confirmed the following:
 - A business case was being developed for additional Safeguarding staff to include support for the Safeguarding Adults Matron
 - The Best Safety work stream encompassed a project reviewing the consent process and underpinning education which, it had been agreed, would link with the MCA workstream
 - Work continued to engage Consultants to champion MCA work
 - Access to multi-agency Local Authority training had been achieved
 - Links with Safeguarding Children resource were being strengthened to ensure best use of resource
 - Liaison had taken place with Kent and Medway NHS and Social Care Partnership Trust to explore collaboration of Safeguarding teams
 - An audit of MCA compliance was planned for Quarter 2 for which the terms of reference had been agreed

2. In addition to the agreements referred to above, the Committee agreed that:

The following issues should be scheduled for review at a future Quality Committee 'deep dive' meeting (timings to be confirmed to the Trust Secretary):

- A "review of the next steps arising from the Mortality Review audit, to include special categories (e.g. children and learning disabilities)"
- A "review of high risk Quality Impact Assessments (including temporary staffing)" (August 2018)
- A "review of the processes for oversight of clinical audit"
- A "review of the process for declaring Serious Incidents" (from October 2018)
- A "review of the quality impact of the Hospital at Home" model at the Quality Committee 'deep dive' (October 2018)

3. The issues from the meeting that need to be drawn to the attention of the Board are as follows:

The Committee considered that the Directorate's current staffing arrangements were a significant concern, and should be brought to the attention of the Trust Board

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Trust Board Meeting – June 2018

6-26	Summary report from the Trust Management Executive (TME), 20/06/18	Committee Chair (Chief Executive)
The TME met on 20 th June.		
<p>1. The key matters considered at the meeting were as follows:</p> <ul style="list-style-type: none"> ▪ The Safety Moment led to a discussion on the theme for the month (consent) ▪ A change to the Terms of Reference was approved, to add the “Chair of the MTW AHP Leads Forum” to the membership ▪ The proposed capital equipment prioritisation list was supported ▪ A detailed discussion was held on the development of clinical management and the proposals were well received. It was agreed to schedule an update on the plans at the July 2018 TME meeting ▪ A briefing from the Trust’s recent visit to Northumbria Healthcare NHS Foundation Trust was discussed, and the intention to undertake work in the coming weeks to enable the projects arising from the visit to be confirmed at the July 2018 TME meeting was acknowledged ▪ The Director of Finance explained the mitigations that have been developed in the event of variance from the 2018/19 plan ▪ The Chief Operating Officer gave an update on the reconfiguration of available space at Tunbridge Wells Hospital; presented the details of the winter and operational resilience plans; and fronted a detailed review of Referral to Treatment waiting time target performance ▪ The Trust Lead Cancer Clinician and Associate Director of Operations for Cancer & Clinical Support led a detailed review of 62-day Cancer waiting time target performance. It was agreed that all Cancer Tumour Group Clinical Leads would be written to, to request specific resource/actions required in response to the Trust’s current target performance; and also agreed to provisionally schedule another “Detailed review of 62-day Cancer waiting time target performance” at the July 2018 TME meeting ▪ The Director of Workforce described the proposals to develop education as a service line ▪ The key aspects of the month 2, 2018/19 Integrated performance (including infection control) were reported ▪ The Chief Clinical Information Officer gave an update on the Kent and Medway Shared Care Record ▪ The now 4 clinical Divisions (as Planned Care has been split into Surgery and Critical Care and Cancer and Clinical Support) reported on their current key issues, which included the continued challenges in recruitment substantive staff ▪ The draft Quality Accounts 2017/18 were reviewed ▪ The finding from the 2017 national NHS inpatient survey were received ▪ Updates were noted on the national 7 day service programme, “Listening into Action”, and the key issues from the Clinical Directors’ Committee and Executive Team Meetings ▪ Feedback on the recent MTW/Local Medical Committee Interface meeting was noted, as were the recently-approved Business Cases and report from the Trust Clinical Governance Committee ▪ Updates were received on some of the TME’s sub-committees (the Clinical Operations & Delivery Committee, Health & Safety Committee and Policy Ratification Committee) 		
<p>2. In addition to any agreements referred to above, the Committee agreed that:</p> <ul style="list-style-type: none"> ▪ The Director of Workforce should provide an update on progress with enacting the TME’s decision that Human Factors training be made mandatory ▪ The Director of Workforce should confirm a date on which progress on the work of the Senior Medical Recruitment Group could be reported to the TME 		
<p>3. The issues that need to be drawn to the attention of the Board are as follows: None</p>		
<p>Which Committees have reviewed the information prior to Board submission? N/A</p>		
<p>Reason for receipt at the Board (decision, discussion, information, assurance etc.) Information and assurance</p>		

Trust Board Meeting – June 2018

6-27	Summary report from Finance and Performance Committee, 26/06/18	Committee Chair (Non-Exec. Director)
The Finance and Performance Committee met on 26 th June 2018.		
1. The key matters considered at the meeting were as follows:		
<ul style="list-style-type: none"> ▪ The actions from previous meetings were reviewed, and this led to a request that the Director of Finance ensure that the STP-wide development of commercial laundry services be discussed as part of the “Update on the potential establishment of a wholly owned subsidiary for Estates and Facilities Management services” item scheduled for the ‘Part 2’ Trust Board meeting on 28/06/18. It was also agreed that the Trust Secretary should schedule a “Delivery of the Trust’s recruitment plan for 2018/19” item for the Committee in August 2018, and confirm (nearer the time) whether the Committee required the attendance of the Director of Workforce for the item ▪ Under the “Safety Moment”, it was reported that June’s theme was Consent to treatment ▪ The Director of Finance gave an update on Financial Special Measures, noting that the next review meeting with NHS Improvement was scheduled for 04/07/18 ▪ The Director of Finance and Chief Operating Officer submitted a report in response to the significant increases in temporary Medical staffing expenditure in August 2017 and March 2017 and 2018, and it was noted that the Chief Executive would liaise with the Chief Operating Officer outside of the meeting to discuss the content of the report further ▪ The month 2 financial performance was reviewed, which noted that pay costs continued to be a major factor affecting delivery of the financial plan ▪ The financial aspects of the Best Care programme at month 2 were also reviewed ▪ An update on the preparations to become the prime provider for elective activity from 01/08/18 was given, and it was agreed that the Chief Executive should escalate the apparent delay in West Kent Clinical Commissioning Group’s procurement of a Prime Provider to the CCG’s Managing Director (which subsequently occurred via a telephone call during the Committee meeting) ▪ The month 2 non-finance, non-quality, related performance was discussed. The Trust Lead Cancer Clinician and Associate Director of Operations, Cancer and Clinical Support also attended to discuss the recovery plans for the 62-day Cancer waiting time target ▪ The Interim Director of Health Informatics attended to report on the changes between the Outline Business Case and Full Business Case (FBC) for an Electronic Patient Record (which will be considered under a separate agenda item and report at the Trust Board), and the Committee confirmed it was content to recommend that the Board approve the FBC ▪ The recent findings from relevant Internal Audit reviews (which is considered at the Committee every 6 months) were highlighted by the Director of Finance ▪ The standing “breaches of the external cap on Agency staff pay rate” report was noted 		
2. In addition the agreements referred to above, the Committee agreed that: N/A		
3. The issues that need to be drawn to the attention of the Board are as follows:		
<ul style="list-style-type: none"> ▪ The Committee confirmed it was content to recommend that the Board approve the Full Business Case for an Electronic Patient Record 		
Which Committees have reviewed the information prior to Board submission?		
<ul style="list-style-type: none"> ▪ N/A 		
Reason for receipt at the Board (decision, discussion, information, assurance etc.)		
Information and assurance		