Maidstone and Tunbridge Wells NHS Trust

Trust Board Meeting (Part 1)

27 June 2019, 09:45 to 13:00
Pentecost / South Rooms, Academic Centre, Maidstone Hospital

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

Agenda

06-1

To receive apologies for absence

David Highton

06-2

To declare interests relevant to agenda items

David Highton

06-3

Minutes of the Part 1 meeting of 23rd May 2019

David Highton

Board minutes 23.05.19.pdf (10 pages)

06-4

To note progress with previous actions

David Highton

Actions log.pdf (2 pages)

06-5

Safety moment

Claire O'Brien

Safety Moment.pdf (1 pages)

06-6

Report from the Chair of the Trust Board

David Highton

Chair's report.pdf (1 pages)

06-7

Report from the Chief Executive

Miles Scott

CEO report.pdf (2 pages)

Patient Experience

06-8

A patient’s experience of the Trust’s services

Claire O'Brien & colleagues

06-9

Integrated Performance Report for May 2019

Miles Scott

Integrated Performance Report (M2).pdf (59 pages)

06-9.1

Finance and Performance Committee, 25/06/19

Neil Griffiths

Summary of Finance and Performance C'ttee 25.06.19.pdf (2 pages)

06-9.2

Effectiveness / Responsiveness

Sean Briggs

06-9.3

Well-Led (finance)

Steve Orpin

06-9.4

Patient Experience Committee, 10/06/19

Maureen Choong

Patient Experience Cttee, 10.06.19.pdf (2 pages)

06-9.5

Safe / Effectiveness / Caring (incl. update on progress with the Perinatal Mortality Review Tool; notification of recent Never Event; and planned and actual ward staffing for May 2019)

Claire O'Brien

06-9.6

Safe / Effectiveness (incl. mortality)

Peter Maskell

06-9.7

Safe (infection control)

Sara Mumford

06-9.8

Workforce Committee, 23/05/19

Non-Executive Director

Workforce Cttee, 23.05.19.pdf (1 pages)

06-9.9

Well-Led (workforce)

Simon Hart

06-10

Update from the Best Care Programme Board

Miles Scott

Best Care (Trust Board).pdf (30 pages)

06-11

Review of the Board Assurance Framework 2019/20

Kevin Rowan

Board Assurance Framework 2019-20 (21.06.19).pdf (16 pages)

Quality items

06-12

Approval of Patient and Carer Strategy

Claire O'Brien / Gemma Craig

Patient and Carer (Making it Personal) Strategy.pdf (24 pages)

06-13

Update on the response to the issues raised during the “A patient’s experience of the Trust’s services” item at the Trust Board meeting on 25/04/19

Claire O'Brien

Update on Patient experience item (May 2019).pdf (2 pages)

06-14

Approval of Quality Accounts, 2018/19

Claire O'Brien

Quality Accounts, 2018-19 (for approval).pdf (120 pages)

06-15

Quarterly mortality data

Peter Maskell

Mortality Report.pdf (9 pages)

06-16

Findings of the national inpatient survey 2018

Claire O'Brien

National Inpatient Survey.pdf (20 pages)

Planning and strategy

06-17

Winter planning and Operational Resilience 2019/20

Sean Briggs

Winter Planning and Operational Resilience 2019.pdf (19 pages)

06-18

Six-month review of the implementation of the plans to develop a clinically led organisation

Amanjit Jhund

Clinically led organisation-6 month review.pdf (4 pages)

Reports from Trust Board sub-committees

06-19

Audit and Governance Committee, 23/05/19

Maureen Choong

AGC, 23.05.19.pdf (1 pages)

06-20

Workforce Committee, 23/05/18: Quarterly report from the Guardian of Safe Working Hours

Non-Executive Director

Workforce committee - Quarterly Guardian of Safe Working Hours report.pdf (4 pages)

06-21

Rainbow Badge pledge

Peter Maskell

Rainbow Badge pledge.pdf (4 pages)

06-22

To consider any other business

David Highton

06-23

To receive any questions from members of the public

David Highton

06-24

To approve the motion (to enable the Board to convene its 'Part 2' meeting) that:

David Highton

In pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 19 60, representatives of the press and public be excluded from the remainder of the m eeting having regard to the confidential nature of the business to be transacted, pub licity on which would be prejudicial to the public interest

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 23RD MAY 2019, 9.45A.M, AT TUNBRIDGE WELLS HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Neil Griffiths	Non-Executive Director	(NG)
	Naz Hussain	Non-Executive Director	(NH)
	Peter Maskell	Medical Director (from item 5-7)	(PM)
	Claire O'Brien	Chief Nurse	(COB)
	Steve Orpin	Chief Finance Officer	(SO)
	Miles Scott	Chief Executive	(MS)
In attendance:	Simon Hart	Director of Workforce	(SH)
	Amanjit Jhund	Director of Strategy, Planning & Partnerships	(AJ)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Emma Pettitt-Mitchell	Associate Non-Executive Director	(EPM)
	Kevin Rowan	Trust Secretary	(KR)
	Suzanne O'Neil	Transformation Programme Director (for items 5-7 and 5-8)	(SON)
	Sue Burgin	Development Advisor, NHS Improvement (NHSI) / NHS England (NHSE) (for items 5-7 and 5-8)	(SBu)
	Chloe Kastoryano	Trust Relationship Lead, NHSI/NHSE (for items 5-7 and 5-8)	(CK)
Observing:	Alice Farrell	General Manager, Cancer Performance	(AF)
	Claire Cochrane-Dyet	Interim Deputy Medical Director, NHSE and NHSI – South East Region	(CCD)
	Sean Laird	Member of the public (for items 5-7 to 5-9)	(SL)

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

5-1 To receive apologies for absence

No apologies were received.

5-2 To declare interests relevant to agenda items

No interests were declared.

5-3 Minutes of the 'Part 1' meeting of 25th April 2019

DH referred to Attachment 2 and noted that the minute of item 4-8 had been agreed with the patient's relative who had attended the meeting. The minutes were then 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 action was discussed in detail:

- **3-13b ("Arrange for a scoping exercise to be undertaken in relation to mortality reviews for patients with a Do Not Attempt Cardiopulmonary Resuscitation order in place, and include the outcome within the "Mortality update" report to the next 'main' Quality Committee).** In PM's absence, SM reported that work continued on Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) patients' mortality, but the issue was not straightforward. SM added that the next mortality report to the 'main' Quality Committee would include the relevant information. DH therefore confirmed the action could be closed.

5-5 Safety moment

COB referred Attachment 3 and highlighted the following points:

- The theme for May was pressure ulcer prevention
- The annual inspection of mattresses, which was a significant task, had been undertaken. The Trust had a range of mattresses, some of which were of a higher specification, and which therefore negated the need for the traditional use of air-based pressure-relieving mattresses
- The efforts regarding patients' nutritional status was focused on the use of the Malnutrition Universal Screening Tool (MUST), and the Trust's Nutrition Steering Group would be reconvened in the coming weeks

5-6 Report from the Chair of the Trust Board

DH referred to Attachment 4 and highlighted the following points:

- DH would like to thank the catering team for their support for the series of staff 'thank you' events that had been held, and consideration should be given as to how more such events could be held in the long-term, rather than just mark the end of a successful year
- The Trust had appointed a Consultant Haematologist

5-7 Report from the Chief Executive

MS referred to Attachment 5 and highlighted the following points:

- The aforementioned staff 'thank you' events had been very well received and aligned well with the Trust's efforts to celebrate International Nurses Day
- The Midwife-led unit at Crowborough had held an opening event, which involved fantastic engagement with local people, local mothers and the local MP. Further thought was needed as to how to encourage even more women to use the birthing units at Crowborough and Maidstone
- The development of the West Kent Integrated Care Partnership (ICP) was progressing. The first meeting of the Development Board had been held and the Chair of the Trust Board at Kent Community Health NHS Foundation Trust had chaired the meeting. The importance of the liaison between the Trust and partner organisations was demonstrated by the dementia awareness item described in Attachment 5
- The Trust's Director of Estates and Facilities would be leaving in June and an interim would join on 03/06/19 for nine months, to enable the future role to be properly considered

COB added that it had been both fun and humbling to serve tea and cake to nursing staff during International Nurses Day, and she was pleased that the celebrations would be further developed, as it was important to take time to praise the work of staff within the whole clinical team, not just nurses. The point was acknowledged.

5-8 Trust Board commitment to the 'Exceptional People, Outstanding Care' programme

DH welcomed SBu, CK and SON to the meeting. SBu then commenced a presentation which highlighted the following points:

- Culture, as demonstrated by 'the way an organisation behaves when no one was looking' was a key aspect of the "Developing People, Improving Care" programme
- The key focus of all of the work was patient care and patient experience, and research showed that there was a link between different aspects of patient care and teamworking, culture and leadership
- The programme contained five key building blocks/conditions, one of which was teamwork
- A real team was not just a group of people who worked together i.e. physical proximity was not enough. Shared principles and engagement was required
- Research had demonstrated the positive effects that real teamworking and engagement had in terms of patient mortality and staff sickness absence
- The five cultural elements in the programme were "vision and values"; "goals and performance"; "support and compassion"; "learning and innovation"; and "teamwork"
- SBu and her colleagues been working on the inclusion strand of the Workforce Race Equality Scheme (WRES), and the programme was being recommended as a means of achieving that aspect of the WRES

- The programme used the leadership behaviours slightly different to the NHS Healthcare Leadership Model

CK then continued the presentation by highlighting the following points:

- The programme had been piloted with three Trusts, was linear, and was intended to be embedded in organisations i.e. it was not about making culture a priority, it was about embedding it within the agenda
- The programme was focused on three phases: “discover”, “design” and “deliver”
- Phase 1, “discover”, involved six diagnostic tools, such as Board interviews, culture focus groups, and a leadership behaviours survey, and the use of all six tools was recommended
- The change team involved 10 to 15 people, including at least one executive sponsor. A member of the communications team should also be involved. The change team would need to allocate an average commitment of two days per month, and would need to cover different areas, levels of seniority, and demographics
- Trust Board support was fundamental, and it was important to have a sponsor from the Board. The sponsor for the Trust had been confirmed as MS
- Manchester University NHS Foundation Trust had linked their programme to the Well-Led framework, and had used the programme to manage the cultural risks associated with a merger with another organisation
- The support provided by NHSE / NHSI would involve liaison with the NHS Leadership Academy and included helping to build the change team, training the change team, and facilitating the synthesis workshop
- Circa 60 Trusts were using the programme and an additional 15 were receiving support to start
- Lincolnshire Partnership NHS Foundation Trust had used all six diagnostic tools and had recruited and developed an internal change team. Positive changes had been seen, which included reduced sickness absence and improved staff survey results
- The Royal Cornwall Hospitals NHS Trust had introduced their “ImproveWell” programme to empower their staff to get involved, and they produced some videos which were available on YouTube

MS asked to what extent the Care Quality Commission (CQC) understood the model, and whether CQC inspectors were familiar with the programme. MS also noted that the next Trust Board ‘Away Day’ was scheduled to consider Board evaluation methods, and wondered whether it was possible to use the programme as the means to undertake the Board’s appraisal for that year. SBu replied that the CQC had been part of the original advisory group, so it was aware of the programme, although the CQC would not ‘badge’ the programme, and were not involved in its design. SBu added that the CQC had also approved a mapping between the programme and the Well Led framework, but could not guarantee the CQC inspectors’ awareness of the programme.

CK then stated that in terms of board evaluations, she wanted to ensure that the programme aligned with other initiatives, and it was therefore possible to use the Trust Board interviews within the programme as part of such an evaluation. MS initially suggested that he and KR discuss the issue further with CK and SBu outside the meeting, as his question was very specific, but SBu then confirmed that she believed the programme could be used as a method of board evaluation.

DH remarked that it was good that the programme was evidenced-based, and although it was likely to be mandated in the future, he would not support the Trust’s participation unless the organisation was fully committed. The point was acknowledged.

SDu then remarked that the NHS was increasingly dependent on a non-UK workforce and asked what research had been done on cultural differences between nurses who had arrived in the UK with different cultural expectations. SBu stated that she would have to look for specific research on that subject, but acknowledged that the diversity of a workforce could be challenging. SBu added that work had however been done (which SBu could share) on Black and Minority Ethnic (BME) staff, accepting that such staff were from the UK, and the importance of work on Human Resources and behaviours had been acknowledged. SBu added that it was also important to raise awareness of cultural differences, rather than change them. SDu acknowledged the point but asked for assurance that the programme recognised the issue and would embrace all staff, rather

than rely on the engagement of the usual staff who participated. SBu clarified that the Trust set its own objectives for the programme and therefore if that was felt to be an important issue it could be reflected in the programme's design.

NG asked for the extent to which the Trusts already involved had imprinted their own identify on the programme. SBu confirmed it was possible for Trusts to imprint their own identify if that was the right approach for that organisation. NG opined that this was important for ownership.

AJ noted that much of the programme was focused on deep self-reflection, but it would be important to know the organisations that were further ahead in the process, to consider whether any 'quick wins' could be identified. CK stated that 'quick wins' were usually identified via the surveys & individual reflection on behaviour and leadership style. CK did however also emphasise that Trusts were encouraged to focus on the outcome of the diagnostic and not think too far ahead.

SBu then reiterated the importance of Board engagement & commitment, and illustrated the point by relating the experiences of the Trust Board interviews that the change team had undertaken at Manchester University NHS Foundation Trust. SBu also noted that one of the tools was leadership workforce analysis and although it was difficult, SBu would recommend that tool be used.

SO emphasised that the programme would be the Trust's project, in all of the phases, and therefore he would encourage the Trust to consider not what the programme could do for the Trust, but what the Trust could do via the programme. The point was acknowledged.

NH then asked what NHSE/NHSI was doing in relation to wider integration i.e. beyond the Trust. CK gave assurance that discussions regarding that issue were being held, including with Clinical Commissioning Groups. SBu added that the programme was considering the impact of Integrated Care Systems. SON added further details about the Trust's efforts to train partners across the local health economy in change methodology.

MS then summarised that he believed the presentation and discussion had identified four things that needed to be pursued:

1. Ensuring that cultural awareness was incorporated into the programme
2. Obtaining confirmation regarding the local branding of the programme i.e. whether the Trust would be allowed to refer to the programme as "Exceptional People, Outstanding Care"
3. Considering how the Trust could learn from the other Trusts that had participated in the programme
4. Considering how the Trust's work with partners organisations could be could reflected / incorporated within the programme

DH pointed out that the fact that implementation of the clinically led organisation plans had only been in place for five months needed to be borne in mind when the diagnostic results were given. The point was acknowledged.

DH then asked for the Trust Board's confirmation of its support for the Trust's participation in the programme. The support was duly given.

DH concluded by thanking SBu, CK and SON for attending.

[NB: During the meeting, SBu and CK distributed copies of three promotional booklets relating to the programme: "Developing People – Improving Care", "Why is culture important? – Phase 1: Discover" and "Diagnostics – Phase 1: Discover"]

5-9 Integrated Performance Report for April 2019

MS referred to Attachment 6 and highlighted that one of the important governance questions was how the Trust was performing, given that it was effectively two months into 2019/20.

Finance and Performance Committee, 21/05/19

NG then referred to Attachment 7 and highlighted the following points:

- The “Performance moment” had been introduced for the first time and had been focused on performance against the Emergency Department (ED) access standard
- Review of performance at month 1 had noted the emerging pressure in surgery and it was agreed that the Committee should consider the support required by that Division by asking them to attend the next meeting
- The revised Integrated Performance Report would hopefully enable a more forward looking approach
- The Business Case for the proposed development of the Acute Medical Unit (AMU) at Maidstone Hospital was considered within the context of the Trust’s capital position, which would be discussed during the ‘Part 2’ Trust Board meeting scheduled for later that day. The Business Case was however supported, subject to such considerations

Effectiveness / Responsiveness

SB then referred back to Attachment 6 and highlighted the following points:
- The month 1 performance on the A&E 4-hour waiting time target was 92.03%. Performance in month 2 had been challenging but the Trust was still in the top range of national performers
- Performance in May was currently circa 91.8%, which was below the trajectory, and was considered disappointing by the team
- The performance for Tunbridge Wells Hospital (TWH) was as expected, despite the challenges of increased attendances
- Some additional funding had been offered to the Medicine and Emergency Care Division and their plans would be presented w/c 27/05/19

DH asked about Length of Stay. SB explained the dynamics involved and noted that he regarded the workforce issues at TWH to be a significant part of the solution. SB then continued, and highlighted the following points:
- The final Referral to Treatment (RTT) position for April had now been confirmed and the waiting list size was at 28,268, which compared to the trajectory of 29,152. The RTT performance for April was 84.05%, compared to the trajectory of 83.5%. SB was very impressed with the work that the Chief of Service and Divisional Director of Operations for Surgery had done on reducing the waiting list and improving RTT standard compliance
- For cancer, May had been an interesting month, as the backlog was now circa 100 and it had been recognised that it needed to be at circa 40 to 50 to achieve sustainable performance. NHSI had therefore agreed to a change in the Trust’s strategy, to continue to focus on the backlog rather than on achieving the 62-day waiting time standard. It was hoped that the backlog would be reduced to the level needed within one or two months

NG referred to the latter point and highlighted that continuing to focus on reducing the backlog would adversely affect performance against the waiting time standard. MS agreed, and asked SB to elaborate on why eliminating the backlog would help deliver the waiting time standard on a sustained basis. SB explained that patients who had waited longer than 62 days would not be counted as a breach of the target until they were booked for treatment by the Trust. SB continued that such patients would therefore have an adverse impact on future performance, so it was important to address the backlog. SB added that the backlog had been cleared by having close oversight of individual patients’ pathways and NHSI’s recent review of cancer at the Trust had highlighted the need to make transformational changes that did not rely on such detailed oversight.

SDu queried why there had been an increase in breaches in the lung tumour site, despite SB noting that sustainable changes had been made. SB explained that the lung pathway relied on performance at other Trusts, although some rules changes were being introduced that would assist the Trust’s position in that regard. MS acknowledged the point but emphasised that such patients were the Trust’s and the Trust was therefore responsible for liaising with partner organisations.

DH then reiterated that the patients that had exceeded the 62-day cancer waiting time target would be counted as a breach of the target at some future point. The point was acknowledged.

Well-Led (finance)

SO then referred to Attachment 6 and highlighted the following points:

- The financial position at end of 2019/20 was a surplus of just over £20m
- The plan had been achieved through some non-recurrent means, so there was a challenge to ensure the Cost Improvement Programme (CIP) for 2019/20 was delivered on a recurrent basis
- The CIP phasing was important, as was the need for tight budgetary management from month 1
- At month 1, there were some emerging budgetary pressures within Surgery
- The CIP had not been delivered to plan at month 1. The largest element of non-delivery was income from the Prime Provider contract for Planned Care, which was lower than that planned. Some outsourcing of activity was taking place, but this was also lower than the level planned
- The Divisions had been asked to deliver to a 'stretch' target that was over and above what was required in the Trust's annual plan and some external resource had been engaged to provide oversight and challenge of CIP delivery as well as the generation of ideas for CIP schemes
- The latest Divisional Performance Reviews (DPRs) had been held on 22/05/19
- In summary, there were some concerns but the Trust's performance was in accordance with its plan. A forecast would be developed in the next two months

NG added that the Finance and Performance Committee had acknowledged that the July meeting would be important in considering any action to be taken to address non-delivery against the plan.

DH then referred to the medical staffing pressures with surgery and paediatrics and asked for an update on overseas recruitment. SH confirmed there was a steady influx, but SO added that the timescales for such recruitment had been slower than envisaged in the plan.

EPM asked for the status of income from private patients. SO confirmed that the Trust was behind its plan but explained the actions intended to address the situation, including a proposed change in the leadership for the work.

Quality Committee, 08/05/19

SDu then referred to Attachment 8 and highlighted that the Committee had agreed revised Terms of Reference. KR clarified that the Trust Board would be asked to approve those Terms of Reference under item 5-15.

Safe / Effectiveness / Caring (incl. planned and actual ward staffing for March 2019)

COB then referred to Attachment 6 and highlighted the following points:
- Twenty-two of the total of 140 falls had occurred on one particular ward, which was subject to detailed focus. Actions to address wider falls issues included checking whether staff had requested the appropriate levels of enhanced care, if that was required
- Performance on pressure ulcers was satisfactory, but the total number of Deep Tissue Injuries (DTIs) was being reviewed. There were some workforce gaps among the Tissue Viability Nurses but Milene Teixeira should be commended for enabling the service to be maintained

DH asked whether Urinary Tract Infection was a factor in falls and pressure ulcers. COB confirmed that was the case. COB then continued, and highlighted the following points:
- Friends and Family Test (FFT) performance had been discussed as part of the aforementioned DPRs and more work was need on the iPad-related solution
- Complaints response performance had not achieved the 75% target. Part of that was due to a workforce gap in the Central Complaints Team and although a new individual had been appointed, they would not start in post until July. However, it was intended to engage a retired colleague from another Trust to provide some temporary support. COB would also meet with the Trist's Complaints lead and Associate Director, Quality Governance to consider what more could be done

COB then referred to the "Safe staffing" section and highlighted that changes continued to be made to the format of the report, in response to feedback, including that made at the last Trust Board meeting. COB then gave a detailed explanation of the columns on page 28 of 50. SDu stated that it was very helpful to have the data that COB had described and asked whether the process was automated. COB confirmed that the process was not currently automated but work was underway to increase the level of automation.

SDu then noted the occurrence of falls at night and asked whether that reflected the Trust's activity profile not recognising issues associated with elderly patients, who may wake more frequently at night. COB acknowledged the validity of the point and confirmed that nurse staffing ratios were reduced at night and such ratios were primarily focused on patient acuity rather than activity.

Safe / Effectiveness (incl. mortality)

PM then referred to Attachment 6 and highlighted that mortality continued to reduce, but work continued in relation to weekend mortality.

Safe (infection control)

SM then referred to Attachment 6 and highlighted the following points:

- The Trust was now monitoring under the new clostridium difficile definitions, and nine cases had occurred in April. Some of the community cases that were now attributable to the Trust were avoidable. There had been no cases of hospital-attributable clostridium difficile infection in May
- Attachment 6 compared the current performance to that under the previous definitions
- There was a continued focus on gram negative bacteraemia
- The influenza season had now officially ended and the Trust was no longer required to submit weekly reports to NHSI

Well-led (workforce)

SH then referred to Attachment 6 and highlighted the following points:

- The vacancy rate had increased, primarily as a result of the application of changes to the establishment following the Division's plans for 2019/20 i.e. rather than from a marked increase in staff leaving the Trust
- The Trust had a contract with a company called "Aryavarat" to appoint Objective Structured Clinical Examination (OSCE)-ready nurses, and 41 appointments had been made from India. The first tranche of those appointees would start in post in August 2019, with the second tranche starting in October. The results would not however be known until the nurses had passed their OSCE. A further trip to Kerala was planned in June, to recruit circa 75 nurses
- The Trust was considering the pastoral support needs of overseas nurses, as well as the cultural differences involved
- The Trust was beginning to see the benefit of the automatic student nurse appointments
- There had been some progress with medical recruitment
- Sickness absence data was as expected but there had been an improvement of staff on long-term sickness absence
- The Trust's staff appraisal window was now open and appraisals would now be undertaken via an electronic system. The Trust had therefore extended the time within which appraisals must be completed, to support managers' use of the new system

SDu referred to the report on overseas recruitment that had been submitted to the Workforce Committee scheduled for later that day, and noted that the report made no reference to pastoral care. NH confirmed that SDu's point would be considered at the Workforce Committee meeting. SDu added that it may be possible to operate international menus more often. The suggestion was acknowledged.

DH stated that he understood that the manager overseeing the aforementioned OSCE process would be accompanying the recruits when they came to the UK. SH confirmed that was the case.

SDu then pointed out that the Trust Performance Dashboard reported the vacancy rate target as 10% but the narrative (on page 33 of 50) referred to a target of 9%. SH clarified that the target for 2018/19 was 9%, but confirmed that he would ensure that the references in the Integrated Performance Report were consistent.

Action: Ensure that the references to the vacancy rate target for 2019/20 within the monthly Integrated Performance Report were consistent (Director of Workforce, May 2019 onwards)

5-10 Update from the Best Care Programme Board

MS referred to Attachment 9 and highlighted the following points:

- Training in Quality, Service Improvement and Redesign (QSIR) was now being implemented across the organisation
- SON, SO and MS were working with each Senior Responsible Officer (SRO) to ensure there were clear outputs with forecast trajectories
- The new format of reporting should start next month

DH noted that MS was part of the latest QSIR cohort and MS had stated that Non-Executive Directors may be able to participate in the training. MS confirmed that he and KR would arrange for the Non-Executive Directors to be invited to participate in the training.

Action: Arrange for the Trust's Non-Executive Directors to be invited to participate in Quality, Service Improvement and Redesign (QSIR) training (Trust Secretary / Chief Executive, May 2019 onwards)

Planning and strategy

5-11 Approval of revised proposed key objectives for 2019/20

AJ referred to Attachment 10 and highlighted the following points:
- The objectives for 2018/19 had been included for reference, as had the objectives that had been proposed at the April 2019 Trust Board meeting
- The wording of the proposed 2019/20 objectives had been amended to remove some of the technical language, such as references to the Provider Sustainability Fund (PSF) and Marginal Rate Emergency Tariff (MRET), and make more explicit categorisation to the PRIDE principles

SDu proposed that the text of the proposed objective relating to the "Respect" value ("We will make MTW a great place to work and ensure that we value and listen to our staff") be changed to "We will make MTW a great place to work and ensure that our staff feel valued and listened to". It was agreed to change the wording as proposed.

Action: Change the text of the 2019/20 objective relating to the "Respect" value from "We will make MTW a great place to work and ensure that we value and listen to our staff" to "We will make MTW a great place to work and ensure that our staff feel valued and listened to" (Director of Strategy, Planning and Partnerships, May 2019 onwards)

NH welcomed the inclusion of the last column, which listed who was responsible, but asked how the objectives would be communicated to the wider organisation. AJ replied that each Directorate's objectives would be linked to the PRIDE principles & Directorate posters would also be produced. AJ added that the issue would be discussed further at the Trust Board 'Away Day' in June 2019.

SB then proposed that the heading of the "Who will be responsible?" column be changed to "Who will be responsible for empowering our staff?". It was agreed to change the heading as proposed, or to an appropriate alternative heading.

Action: Change the heading of the "Who will be responsible?" column describing the 2019/20 objectives to "Who will be responsible for empowering our staff?" (or an appropriate alternative heading) (Director of Strategy, Planning and Partnerships, May 2019 onwards)

MS then pointed out that the objectives would feature as part of each Member of the Executive Teams' appraisals.

The Trust Board approved the key objectives for 2019/20 subject to the agreed changes.

5-12 Annual approval the Sustainable Development Management Plan (SDMP)

MS referred to Attachment 11 and highlighted the following points:
- The Trust was close to delivering its CO_2 emissions target
- SDu had previously raised a point about the use plastic bottles, and today's Board meeting would the last to involve plastic bottles, as jugs of water would be used in future
- It would be possible to have further details on sustainability if the Board wanted

The Trust Board approved the Sustainable Development Management Plan as submitted.

Assurance and policy

5-13 NHS Provider licence: Self-certification for 2018/19

KR referred to Attachment 12 and highlighted the following points:

- NHS Trusts had been 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 had been 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 self-certification in 2017/18 and for 2018/19, 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

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

Reports from Trust Board sub-committees

5-14 Audit and Governance Committee, 09/05/19 and 23/05/19 (to include the Committee's 2018/19 Annual Report)

NH referred to Attachment 13, which pertained to the meeting held on 09/05/19, and highlighted that the meeting was the first Audit and Governance Committee where staff had been asked to attend to explain their lack of responses to Internal Audit recommendations. NH continued that the attendances had provided good assurance, but had led to a wider discussion about how such issues should be addressed without such individuals having to address the Committee directly. SO added that the discussions had reflected the need to include any high priority Internal Audit actions within the DPRs.

DH then reported that the interviews for the new Non-Executive Director who would chair the Audit and Governance Committee had been scheduled for 26/06/19.

KR then outlined the key aspects of the Audit and Governance Committee's Annual Report.

5-15 Quality Committee 08/05/19: Approval of revised Terms of Reference (and ratification of proposed amendments to the Trust's committee structure)

SDu referred to Attachment 14 and highlighted the following points:

- The proposed change was long overdue, but she was prepared for the first meeting under the new arrangements to not be the finalised position, as the previous 18 Clinical Directorates would now need to report via five clinical Divisions
- The change would remove duplication
- SDu and MC had discussed the changes and were fully supportive

PM added that the changes would take time to embed, not least because of the need to develop the Division's clinical governance arrangements. The point was acknowledged.

The Trust Board approved the proposed amendments to the Quality Committee's Terms of Reference as submitted. The Trust Board also ratified the proposed amendments to the Trust's committee structure as submitted.

DH then referred to Appendix 1 of Attachment 14 and stated that it would be useful to consider whether the number of committees could be rationalised. PM acknowledged that would be a beneficial future exercise.

5-16 Finance and Performance Committee, 21/05/19: Quarterly progress update on Procurement Transformation Plan

NG referred to Attachment 15 and highlighted the key points. Questions were invited. None were received.

Annual Report and Accounts

5-17 Approval of the Annual Report, 2018/19 (incl. Annual Governance Statement)

MC referred to Attachment 16 and reported that the Audit and Governance Committee that had met earlier that day had agreed that the Annual Report (including the Annual Governance Statement) for 2018/19 should be recommended for approval by the Trust Board. The Trust Board duly approved the Annual Report for 2018/19 as submitted.

DH however drew attention to the presentation of the Trust's objectives for 2018/19 and noted that a more nuanced presentation had been included, following the discussion at the April 2019 Trust Board meeting.

5-18 Approval of the Annual Accounts, 2018/19

MC referred to Attachment 17 and reported that the Audit and Governance Committee that had met earlier that day had agreed to recommend that the Trust Board approve the Annual Accounts for 2018/19. The Trust Board duly approved the Annual Accounts for 2018/19 as submitted.

5-19 Approval of the Management Representation Letter, 2018/19

MC referred to the Attachment 18 and reported that the Audit and Governance Committee that had met earlier that day had agreed to recommend that the Trust Board approve the Management Representation Letter for 2018/19. SO did however point out that the Committee had agreed a minor amendment on the final page, to replace "Signed on behalf of the Governing Body" with "Signed on behalf of the Trust Board". The Trust Board duly approved the Management Representation Letter for 2018/19 subject to that amendment.

5-20 To consider any other business

KR asked that the Trust Board delegate the authority to the 'Part 2' Trust Board meeting scheduled for later that day to make decisions regarding the Trust's capital programme for 2019/20; the Business Case relating to the for the revised Acute Medical Unit at Maidstone Hospital; and the internal configuration of the Trust's current stroke service. The requested authority was duly delegated.

COB then highlighted that the next CQC engagement day, which was focused on emergency planning and patient safety, was scheduled for 06/06/19, and Trust Board Members were very welcome to join the meeting.

5-21 To receive any questions from members of the public

No questions were posed.

5-21 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.

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]
N/A	N/A	N/A	N/A	N/A
				N/A

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
4-8 (Apr 19)	Submit an update to the Trust Board in June 2019 on the response to the issues raised during the "A patient's experience of the Trust's services" item at the Trust Board meeting on 25/04/19	Chief Nurse	June 2019	An update has been submitted to the Trust Board meeting in June 2019
5-9 (May 19)	Ensure that the references to the vacancy rate target for 2019/20 within the monthly Integrated Performance Report were consistent	Director of Workforce	May 2019	It has been clarified that the vacancy rate target for 2019/20 is 9% (or less), and this has been reflected consistently in the Integrated Performance Report submitted to the June 2019 Trust Board meeting
5-10 (May 19)	Arrange for the Trust's Non-Executive Directors to be invited to participate in Quality, Service Improvement and Redesign (QSIR) training	Trust Secretary / Chief Executive	June 2019	The Trust's Transformation Programme Director has confirmed she is arranging such training directly with the Non-Executive Directors.
5-11a (May 19)	Change the text of the 2019/20 objective relating to the "Respect" value from "We will make MTW a great place to work and ensure that we value and listen to our staff" to "We will make MTW a great place to work and ensure that our staff feel valued and listened to"	Director of Strategy, Planning and Partnerships	May 2019	The requested change was made
5-11b (May 19)	Change the heading of the "Who will be responsible?" column describing the 2019/20 objectives to "Who will be responsible for empowering our staff?" (or an appropriate alternative heading)	Director of Strategy, Planning and Partnerships	May 2019	The requested change was made

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

Actions not yet due (and still 'open')

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

Safety Moment **Chief Nurse/Medical Director**

The Safety Moment for June is focused on being open / duty of candour. A summary of the key messages being shared throughout the month are as follows:

Week One 03/06/2019

Being Open is about effective communication which is a vital part of the process for dealing with errors or problems that occurs within NHS treatment. The Duty of Candour statutory requirements are in response to the issues and concerns that were identified from the reviews of both the Francis inquiry (Mid Staffs) and the Berwick Review into patient safety.

"It is vital that we learn from these appalling patient safety failings & ensure they don't happen again"

Although we provide safe and effective care to many thousands of people every year, sometimes, despite our best efforts, things can and do go wrong.

What is Duty of Candour?

- The Duty of Candour places a requirement on providers of health and adult social care ***to be open with patients when things go wrong.***
- As an organisation we need to ensure that the importance of duty of candour is embedded and that honesty and transparency are "the norm" across the Trust.

Week Two 10/06/2019

Threshold for the Legal Duty of Candour:
This is the point at which harm has occurred to such an extent that Duty of Candour actions are required.

The threshold for attracting the statutory and contractual duty of candour has been defined as **"significant harm".** That is, any incident that has caused **moderate or severe harm or death** of the patient. This includes psychological harm lasting more than 28 days.

Low harm incidents do not attract the statutory or contractual duties of candour, but clinicians do have a professional duty to discuss these with the patient.

Week Three 17/06/2019

Our commitment to our patients is to:

- Apologise for the harm caused;
  - A verbal apology must be within 48 hours
  - A written apology must be within 10 working days
- Explain, openly and honestly, what happened;
- Establish a rapport with the family
- Describe what action is being taken;
- Identify a lead person who will act as the contact for the patient and / or family throughout the incident review.

Week Four 24/06/2019

Will saying sorry mean we are opening ourselves up to litigation?
'NO'

- Saying "sorry" in the context of Duty of Candour means acknowledging that something has happened. By apologising in this way and to this extent, clinicians or the Trust are not accepting legal liability.
- Saying "sorry" allows for a continued trusting relationship between the patient, their families and us and ensures continued open communication

Reason for receipt at Board (decision, discussion, information, assurance etc.)
Information and discussion.

Report from the Chair of the Trust Board **Chair of the Trust Board**

There are some new and potential changes to the Non-Executive Directors on the Trust Board. Sadly, Nazeya Hussain has tendered her resignation as a Non-Executive Director with effect from June 21, 2019, because of a combination of work and family pressures. Nazeya has made a significant contribution to the Board during her period of office and I would like to record our thanks.

I am delighted to confirm that Karen Cox, Vice-Chancellor of the University of Kent, is joining the Board as an Associate Non-Executive Director with effect from 27th June 2019.

Further to my comments last month, the search for a Non-Executive Director to chair the Audit Committee has received some strong applicants, and the interview date has been put back two weeks until mid-July to allow the longlist to be interviewed by our search consultant prior to shortlisting on June 26.

The Board held a very useful Strategic Away Day on June 5, generating a very clear steer towards investing in and developing leadership skills at all levels of the Trust. The Board must support our staff to be the very best they can be.

Maureen Choong and I attended the NHS Providers Quality Conference on June 4, particularly hearing about the importance of adopting a Trust-wide improvement culture using a common programme methodology, and the importance of developing staff at all levels of the organisation.

I attended a very successful evening meeting of the League of Friends of Tunbridge Wells Hospital on June 3.
I was delighted to speak to our volunteers at Maidstone Hospital on June 20 to thank them for all their help and to update them about the performance of the Trust and some future developments at Maidstone Hospital.

Consultant appointments

I and my Non-Executive colleagues are responsible for chairing Advisory Appointment Committees (AACs) for the appointment of new substantive Consultants, and the Trust follows the Good Practice Guidance issued by the Department of Health, in particular delegating the decision to appoint to the AAC, evidenced by the signature of the Chair of the AAC and 2 other Committee members. The delegated appointments made by the AAC since the previous report are shown below.

AAC recommended Consultant appointments (dependant on compliance or withdrawal)					
Date of AAC	**Title**	**First name**	**Surname**	**Department**	**Potential/Actual Start date**
28/05/2019	Dr	Andriana	Michaelidou	Clinical Oncologist Head and Neck	01/07/2019
17/06/2019	Dr	Amanda	Rabone	Radiology	TBC

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Report from the Chief Executive **Chief Executive**

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

1. NHS England has published its interim People Plan, which sets out its vision for how people working in the NHS will be supported to deliver the Long Term Plan. The plan focuses on immediate actions that need to be taken as well as long term measures for growing the NHS workforce, particularly: retaining and recruiting nurses; supporting and developing leaders; and making the NHS the best place to work. Funding for the NHS five-year People Plan will not be outlined until after the government's spending review in autumn/winter.

   MTW is aligning its workforce strategy to the five key themes in the plan and has already implemented a strong programme to develop our existing and future leaders, and attract new staff to the Trust. These include:

   Making the NHS the best place to work – we want MTW to be a great place to work. We are investing in new facilities and amenities for our workforce; improving our pastoral care and support networks; such as LGBT+; enhancing our staff engagement activity with focus groups and improved visibility from leaders; and making our equality and diversity policies the best they can be. We're also rolling out an organisational development programme that will focus on creating a positive and supportive culture for staff that puts outstanding care at the heart of all that we do.

   Improving our leadership culture – we are investing in a new senior leadership development programme and implementing a talent management process to identify our future leaders. We are enhancing our existing management training to focus more on the values and behaviours we expect from our leaders.

   Addressing urgent workforce shortages in nursing – we are progressing with our Board-agreed plan to recruit over 300 additional nurses during 2019/20 and have already appointed more than 50 new staff in May with a further 75 appointments expected to be made this month (June).

   Delivering 21st century care – we are implementing innovative ways of working with multi-professional teams, developing new roles, such as Physician Associates and Advanced Clinical Practitioners, and working closely with the new Kent and Medway Medical School as well as enhancing our apprenticeship and training and development programmes, to allow us to deliver more personalised care, upskill our workforce and adapt to the changing needs of our healthcare economy.

A new operating model for workforce – we are jointly working with local health and social care organisations as well Kent and Medway Sustainability and Transformation Partnership on workforce issues, such as recruitment and temporary staffing. We will build on this good work as the role of an Integrated Care System in the region develops.

2. There has been recent media coverage regarding 62 day waiting time cancer performance in the last financial year. It is our absolute priority that we deliver the national target on waiting times and that our patients receive high standards of cancer care. We have made significant improvements and are already in a much better place than the published data shows.

   We have seen a large rise in demand with 23% more suspected cancer referrals now than this time last year. As a result, we have made changes to our systems and processes to respond to this demand as well as invested in additional staff and facilities to increase the number of patients we see, diagnose and treat. We are confident that we will hit the national 62 day wait cancer standard in the summer, in a sustainable way going forwards.

3. The Executive Directors and Chiefs of Service continue to meet weekly at Executive Team Meetings. Key areas of discussion over the past month have included:
   - Waiting time performance and improvement programme for Cancer and RTT.
   - Finance and delivery plans for Divisions for the coming months.
   - Reducing Long Length of Stay programme.

- Nurse staffing and recruitment plans.
- Temporary staffing strategy and Bank rates of pay.
- Implementation planning for the Hyper Acute Stroke Unit at Maidstone.
- Review of Serious Incidents and sharing learning.
- Discussions around the West Kent Integrated Care Partnership development.

4. MTW has rolled out the national NHS Rainbow Badge scheme across the Trust. Pop up sessions were held at both hospital sites for staff to sign the Rainbow Pledge, receive a badge and get further information about how to support LGBT+ patients, families and colleagues.

5. Our maternity team marked National Breastfeeding Celebration Week (17 – 21 June) this month with a range of fun awareness events, including a bake sale at our birth centres and Tunbridge Wells Hospital. All monies raised will fund infant feeding education and training for our staff and the families we care for.

6. We celebrated our wonderful volunteers this month as part of Volunteers' Week to recognise their invaluable contribution to our hospitals. MTW has more than 350 volunteers who give their time freely to help patients, families and staff. Some of the people were highlighted in a special week-long feature showing the diverse range of roles they get involved with. Thank you to all our volunteers for everything you do. Particular thanks to Tunbridge Wells League of Friends Chair Gary Purdy who celebrates 20 years in his role in 2019.

7. A big thank you to British Army Major Simon Dean who made a special visit to Tunbridge Wells Hospital earlier today (6 June) to personally thank a D-Day veteran for his service all those years ago. Frank Mordecai was visiting his wife when Major Dean arrived on the hospital ward to present him with a gift as a token of appreciation.

8. Congratulations to the Critical Care research team, who presented a session at the South East Critical Care Network Annual Conference about the research projects they've been undertaking in our intensive care units to improve patient care.

9. MTW marked Learning Disability Week with a series of events at both hospital sites to raise awareness about how we can ensure our services are inclusive and accessible to all, and how we can make reasonable adjustments for people who may need extra support. We welcomed learning disability experts and specialist charities throughout the week who spoke with both patients and staff about how to support people with learning disabilities.

10. Clinical areas across MTW wore their pyjamas for a week this month to celebrate our one year anniversary of introducing the #EndPJParalysis initiative. In that time we've helped more than 1,200 patients get up, dressed and moving, and recruited more volunteers to help staff run patient-centred activities on our wards. Thank you to everyone who got involved and decorated nurses' stations, baked cakes, hosted afternoon tea for their patients and set up trolleys that could be wheeled to patients to offer them day clothes, shoes and blankets. Thank you also to all those who donated clothes to help get our patients up and about.

11. Our systems and plans were tested this month in a live exercise at Tunbridge Wells Hospital, which involved a number of emergency response organisations, including Kent Fire and Rescue and Kent Police. Thank you to our Emergency Planning team and colleagues across the Trust for all their hard work in ensuring the exercise ran smoothly.

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

Integrated Performance Report, May 2019	**Chief Executive / Members of the Executive Team**

The enclosed report includes:

- An Executive Summary
- The 'story of the month' for May 2019 (including Emergency Performance (4 hour standard); Delayed Transfers of Care (DTOCs); Cancer 62 day First Definitive Treatment); Referral to Treatment (RTT)
- A Quality and Safety Report (including an update on progress with the Perinatal Mortality Review Took; and summary of recently declared never event)
- Planned and actual ward staffing for May 2019
- 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

Executive Summary – May 2019

Safe

Infection Control:

MRSA Screening improved for both the elective and non-elective pathways and there were no incidents of MRSA or CDifficile reported in May, bringing the Trust back on trajectory for the rate of CDifficile, having reported 9 cases against a maximum limit of 10 to date. The level of MSSA and E.Coli has remained fairly consistent.

Harm-Free Care:

The Trust saw improvements in delivering Harm free care with both a reduced number of hospital acquired pressure ulcers (1 category 2 pressure ulcer reported in May) as well as the rate of Falls reducing to below the maximum limit of 6.0 falls per 1,000 occupied beddays at 5.66. The number and rate of falls continues to be higher for the Tunbridge Wells site but for both sites the numbers remain fairly consistent within the Divisions. May saw a reduction in the number of Falls reported at the Maidstone site for both the Medical and Surgical Divisions. The Percentage of Harm Free Care improved further to 98.5% in May and remains consistently between 97.5% and 98.5%.

Serious Incidents (SIs):

There have been no Never Events reported year to date (YTD) (end of May). There were 15 SIs reported in May resulting in a rate of 0.71% which is above the maximum limit of 0.69%. Of the 15 reported, 6 related to Patient Falls and 3 related to treatment delays.

Patient Safety Incidents:

The number of Patient Safety Incidents that were harmful increased to 13 in May equating to a rate of 1.39 against a maximum limit of 1.23

The patient safety team are facilitating both Route Cause Analysis (RCA) and Duty of Candour training as well as refreshing staff understanding of the SI process, which has raised awareness of reporting to the Directorates. Continued education provides understanding of what constitutes an SI and encourages discussion for learning and mitigation. The SI teleconference takes place three times a week with the patient safety team and the executives which allows for discussion and where appropriate a more timely declaration of the SI, which in turn increases the numbers declared month on month.

Effective

Mortality:

The Risk Adjusted Hospital Standardised Mortality Rate (HSMR) and SHMI are both within acceptable limits and the Trust is no longer an outlier. The HSMR over the last 12 month period has been below 100 for the last three reporting periods.

Non-Elective Flow:

May 2019 was again an extremely busy month for the Trust with Type 1 A&E Attendances at a record 14,282 attendances (3.3% up on the agreed trajectory, and 5.5% higher than last May). Within this, the week ending 26-May was the busiest ever, and the week ending 19-Jun was the 3rd busiest ever. The full-year projection is now 165,350, 3.8% up on trajectory and 6.1% up on last year.

The impact of this on non-elective admissions is not at the same level. Admissions are 16% below plan YTD and 3.5% higher than the same period last year. The percentage of A&E attendances admitted to a main inpatient ward so far this year is 18.5% compared to 20.1% for the same period last year. The level of non-elective admissions that were same-day emergency care increased to 45% in May.

Over the past 12 months, the Non-Elective Length of Stay (LOS), excluding zero LOS, has remained fairly static between 6.7 and 7.3 days. There has been a slight improvement in medical specialties, but that has been offset by an increase in Trauma & Orthopaedics (T&O). Delayed Transfers of Care (DTOC) has improved to 4.1% against the target of 3.5% which equated to 27.7 beds lost due

to DTOC in May. If the Trust was at the desired 3.5% this would equate to an additional 6.2 beds. The average daily Bed Occupancy across the Trust during April and May has been 93.5% (95.2% at Tunbridge Wells Hospital and 91% at Maidstone Hospital with minimal use of escalation beds so far this year.

The Trust has continued to work with system partners to manage demand and deliver more efficient and effective discharge pathways as well as looking at implementing different patient pathways to improve patient flow. These include the Acute Frailty Units, Ambulatory Emergency Care (AEC) and Hospital at Home. In addition, in July the Trust will be implementing changes to increase the use of Same Day Emergency Care (SDEC) over a seven day period. It is anticipated that this will result in further efficiencies.

There is a National Improvement Programme to reduce Long Length of Stay (LLOS). As part of this, in June the Trust started to undertake LLOS weekly reviews (at both ward and executive level) with the intention of reducing the level of "super stranded" patients (those having a length of stay or more than 21 days) by 40% by March 2020, compared to the 1819 baseline.

Elective Flow:

In April the Trust implemented the New Prime Provider Model. It was expected that the additional demand would be around 800 per month for the Trust of which the largest proportion would be in T&O (around 400 per month). The level of referrals suggests that we are not seeing the full value of this demand as yet with the exception of T&O where referrals have increased significantly during April and May (YTD 715 (16%) higher than last year and 10% above plan). The Trust is undertaking further work to understand the level of demand for other specialties.

New Outpatient (OP) Activity in the last few months has been below the average. May activity was 7.4% lower than plan and YTD OP New Activity is 8.2% lower than plan. Specialties furthest from plan are Ophthalmology, T&O and General Surgery.

It should be noted that the activity levels in April and May will be slightly understated due to the activity being done in the independent sector not currently being recorded on the Trust Patient Administration System (PAS) in a timely manner. This is being addressed via contractual arrangements and more efficient internal processes.

The main challenges affecting the level of outpatient activity undertaken remains capacity issues in particular specialties (T&O, Ophthalmology, Ear, Nose & Throat (ENT) and General Surgery in particular) as well as some of the plans to improve efficiency in those areas not yet having been fully realised. Activity for General Surgery has also been affected by the high level of medical vacancies. Options to increase capacity further to meet demand are currently being explored.

The New Outpatient Did not Attend (DNA) rate at a Trust level has shown a downward trend since July 2018 to a low of 5.5% in May. This improvement in performance is attributed to the implementation of the text messaging service reminding patients of when to attend for appointments.

The Trust is currently implementing the Outpatient Transformation Project. The aim of this is to ensure that the team are able to achieve the system wide delivery expectations and to identify new and innovative ways to deliver quality of care to our patients, such as by reducing face to face outpatient appointments, one stop clinics and clinical pathway reviews. It is anticipated that this will provide further efficiencies in outpatients.

Overall elective activity (inpatient and day case) is 2.6% below plan YTD (6.5% below for inpatients and 2% below for day cases). However, activity in May increased in both areas and the Trust recorded the highest number of day cases in any one month. The specialties furthest from plan overall are T&O, Ophthalmology and Urology.

Both elective inpatient (IP) and day case (DC) activity showed an increasing trend through 2018/19 with much less of a dip in the winter months than in previous years

Overall Theatre Utilisation has remained fairly static. However, May has seen a 10% improvement in Theatre efficiency in both the level of sessions starting on time (within 15 minutes) and the level of sessions that started more than 30 minutes after the planned start time. This level has also been maintained so far in June. The number of operations completed in May increased to 80 cases per working day compared to an average of 75 in the previous year.

Caring

The Friends and Family Test positive feedback rates have improved further in May for all areas. Both inpatients and Maternity are now above the 95% target with A&E slightly below the 87% target. This is despite both the number of eligible patients (particularly in A&E) and the number of respondents increasing.

The level of positive feedback rates for inpatients and Maternity are showing an improving trend over the last few months, however, there is more fluctuation for Maternity.

The positive feedback rates for A&E were above the national target across both sites all year round during 2018/19. The rate showed a significant change during April at the Tunbridge Wells site. Whilst this showed an improving performance during May the percentage positive performance still remains lower than expected levels and is not back to the levels seen last year. FFT leads are aware of this reporting change and are monitoring progress and actions, particularly with the rising trend in attendances in A&E as described in the Effective Section of this report, which will be reported through the monthly review meetings.

The overall number of complaints received has remained fairly consistent month on month. This, along with the results of the Friends and Family surveys indicates a good level of satisfaction in the services we provide from our patients and relatives; however communication with patients/relatives remains a key theme within complaints, being the most frequently raised issue.

Achievement of the required complaints response times has been more challenging in May with a significant dip in performance (37.5%), which is the lowest performance reported in any one month during the last two years. This is partly due to vacancies within the complaints team, which are being addressed.

The number of complaints open between 60 and 90 or more than 90 Days continue to show improving trends since October 2019 highlighting that the focused work around clearing older cases is having a good impact and will be continued.

Responsive

4 Hour Emergency Target

Due to the record level of attendances in May the Trust achievement of the 4 hour constitutional target has proved extremely challenging, with May's performance at 91.91% against a trajectory target of 93.32%. Despite this, we remain in the top 20 performing Trusts in the country. The trajectory target for June is 94.27% and as at 11-Jun, we are at 92.74%. The Trust continues to develop processes to improve patient flow as mentioned in the efficiency section previously.

During 2018/19, despite the increase in attendances the Trust achieved a 2.78% improvement from the previous year and was significantly above the national average. Nationally we are in the top quartile of performing Trusts over the past 12 months.

Ambulance Handovers:

Delays of 30-60minutes increased to 472 in May compared to 272 in May last year. On average the numbers last year were just below 300 during the summer months but increased to an average of 485 in the winter months. The Summer/Winter split was similar in the previous year. Delays reported in April and May this year appear to be closer to the level usually seen in the winter months.

With regards to delays of more than 60 minutes the numbers have decreased in May to 59 compared to 27 in May last year. On average the numbers last year were 35 during the summer months but increased to an average of 75 in the winter months (this split was again similar in the previous year).

Following a successful trial the flow coordinator role has recently been approved and is in the process of being recruited. This role releases senior nursing time to manage clinical flow and safety through the department including Rapid Assessment Point (RAP). The Department have also requested a receptionist to speed up handovers within RAP to improve data quality (PIN entry) and reduce the administration burden during the peak times of ambulance presentation.

Referral to Treatment (RTT) Incomplete Pathway:

May performance has increased further for the Incomplete RTT Pathway constitutional target, achieving 85.17% against a trajectory target of 84.18%. The Trust Waiting List for May 2019 was slightly higher than trajectory; however the backlog was 317 lower. The over 18week backlog is continuing to show a downward trend with a further 5% reduction in May from the April position (10% reduction in the admitted pathway backlog). The majority of main specialties achieved their RTT Trajectory for May with the exception of Ophthalmology.

This performance has been achieved due to the activity levels (particularly for admitted care) being maintained during May as well as the ongoing validation work. However, one of the main factors affecting the RTT Incomplete Pathway performance is the level of new outpatient activity being undertaken which has been below average over the last few months (as mentioned earlier). The current level of validation will reduce in future months as the Patient Targeted List (PTL) becomes cleaner.

Weekly monitoring of the specialty plans for activity, diagnostics, theatre scheduling, backlog and waiting list size continues through the PTL and specialty meetings. The RTT/PTL meeting is being reformatted and will become a weekly Trust Access Performance Meeting chaired by the Chief Operating Officer.

There were 11 52 week breaches reported for May (10 New in month) although these patients have not yet been fully validated. All patients will have a harm review by the managing Consultant. No harm has been found as yet for the ones which have been completed.

The Trust RTT Data Quality Project has commenced.

Cancer Waiting Times: Two Week Wait (2WW)

April's performance for the Two Week Waiting (2WW) target decreased in April to 82.6%, against the 93% target.

Total 2WW demand has continued to rise in 2019, however the rate of growth has stabilised. The increase in the overall demand has been largely attributable to breast, breast symptom and lower GI referrals.

It is likely that capacity issues in Medway for breast and breast symptomatic referrals caused some patients to be redirected to MTW. For a two month period at the start of the calendar year, the same is also true for lower GI referrals. However, this flow of demand seems to have now subsided.

The majority of breaches were incurred in the breast and lower GI tumour sites. Despite increased one stop breast capacity, largely through outsourcing, demand not been met. A more sustainable solution is being worked through, which includes recruitment to Mammographer and Consultant Radiographer posts.

The breaches in Lower GI have been due to delays in booking outpatient appointments and CT scans following straight to test triage telephone calls. This has been addressed with the 2ww booking office team and with Radiology.

Cancer Waiting Times: 31 Day First Definitive Treatment (FDT)

April's performance for the 31 day FDT increased further in April to 96.5%, therefore achieving the 96% national target. The Trust has achieved the national target each month since October 2018 (with the exception of being 0.1% below target in January 2019).

Cancer Waiting Times: 62 Day First Definitive Treatment (FDT)

Performance against the Cancer Waiting Times Constitutional Target for the 62 Day (FDT) remains extremely challenging. April's performance was 64.5% against the trajectory target of 76.81%

The significant improvement in the 62 Day FDT target seen in March was largely due to the introduction of the revised prostate pathway and revised clinic templates which led to the performance for the Urology Tumour Site increasing by 23.5% to 62%. In April, this has improved further to 78.4% indicating that the new pathway is having a positive effect on the waiting times. However, there has been a drop in performance in other tumour sites (particularly Breast and UGI).

Further data analysis has been undertaken in order to identify actions required to remove barriers from diagnostic pathways and tumour site specific dashboards have been created that are updated and shared with the clinical teams on a monthly basis.

Backlog clearance has been continued in April and May and is expected to continue into June in order to enable a sustainable backlog position that will result in improving performance against the standard in July and August. Early indications are that May's performance will be around 70% and so performance improvement is beginning to be seen as the backlog is cleared.

The overall backlog has been decreasing (circa 100 now compared to almost double this at the end of December 2018). Patients over 104 days has also been decreasing, however the decrease in the Maidstone and Tunbridge Wells Trust (MTW) only patients has been more noticeable.

Additional funding has been secured from the CCG and Cancer Alliance to support proposed actions and the posts required to continue cancer pathway improvements.

Well Led

Workforce:

The overall Turnover Rate for the Trust has remained fairly consistent month on month below the maximum limit of 10.5%, at 9.8% for May. The methodology used to calculate turnover changed in April this year to bring the Trust in line with NHSi reporting. This will result in a higher overall number than previously reported over the course of the year.

The Trust vacancy rate has increased during April and May to a high of 13.3% (compared to consistently between 9% and 10% during 2018/19). This increase is due to the increased establishment arising from Business and Workforce planning and a revised approach to vacancy calculation agreed by the finance and HR teams. Key Vacancy risks include; nursing for medical and T&O wards at Tunbridge Wells Hospital (TWH), nursing for Emergency Departments on both sites but primarily TWH, TWH theatres, Consultant physicians, AMU and respiratory.

The Trust continues to implement a number of initiatives to increase recruitment of key staff and all divisions have plans in place for the recruitment to vacant consultant posts. The Recruitment Task and Finish group is working on a number of specific projects aimed at improving the attractiveness of the Trust to potential applicants as well as supporting retention of existing staff.

The number of bank and agency staff has increased. The use of Bank Staff across the Trust has shown an increasing trend since December 2019 to a high in May of 511 whole time equivalent (WTE) but the use of Agency staff has started to decrease from an average of 288 WTE during 2018/19 to 241 WTE in May indicating that the Trust is using Bank staff instead of higher cost Agency staff where possible but will continue to look for further opportunities to reduce the use of the Agency staff.

The nurse agency costs have reduced in April and May and YTD are 31.7% lower than the same period last year. Medical and Locum Agency Spend has increased by 10.3% and therefore the Agency spend overall is 4.6% lower than the same period last year.

The overall sickness rate is slightly above the maximum limit at 3.5% in May but remains at the average level during 2018/19. The slight increase in May is due to an increase in long term sickness absence (55.5%). Short term absence continues to fall.

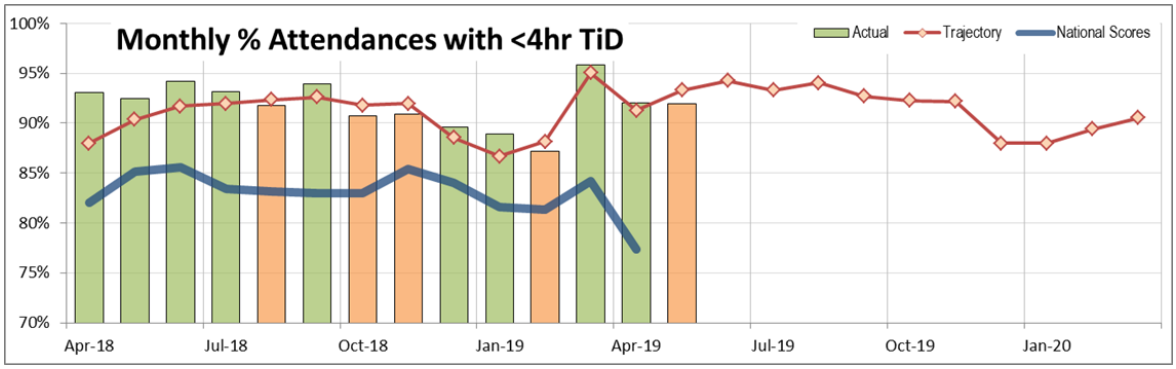
Finance:

The Trusts deficit including Provider Sustainability Fund (PSF) was £0.1m in May which was on plan. The key YTD variances against plan are: Adverse variances relating to the Cost Improvement Plan (CIP) slippage (£0.5m), underperformance in Private Patient Income (£0.4m net) and £0.4m pressure relating to Electronic Patient Records (EPR) costs that were previously planned to be capitalised. These pressures have been offset by release of prior year provisions and back dated credit notes from NHS Property Services (£0.4m), over performance relating to clinical income (£0.7m) and £0.6m underspend within expenditure budgets.

OPERATIONAL PERFORMANCE REPORT FOR MAY 2019

1. 4 Hour Emergency Target

- For the year 1819, the Trust was 0.73% above the full-year Trajectory at 91.86% - our best year since 2014/15.
- Performance in May dipped slightly to 91.91% (including MIU) against a trajectory target of 93.32% (-1.41%). Despite this, we remain in the top 20 performing Trusts in the country
- The trajectory target for June is 94.27% and as at 11-Jun, we are at 92.74%, so breaches now need to be maintained at an average of around 29.4 or less, equivalent to achieving a score of around 95.0%.



2. Ambulance Handovers

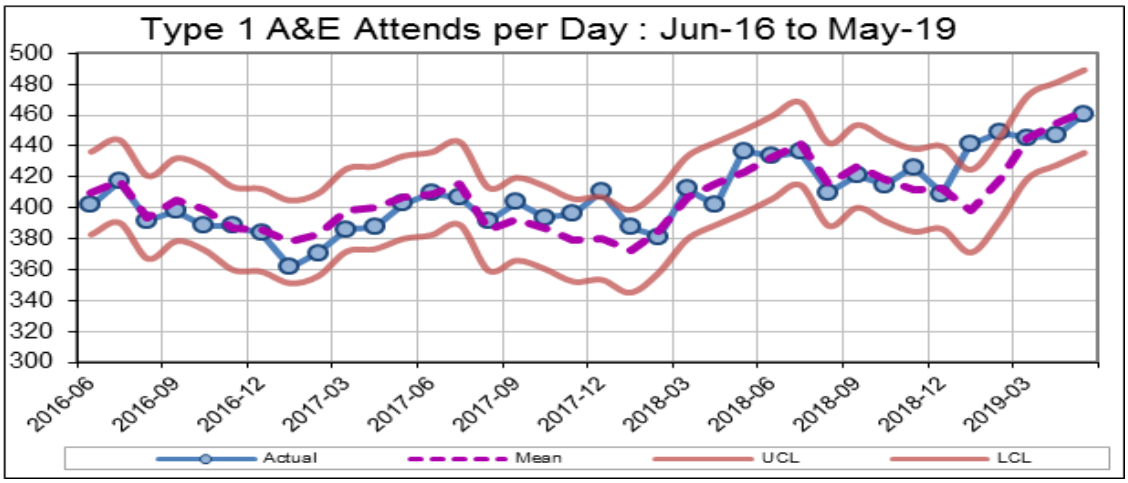
- There were 472 30-60min delays for May compared to 272 in May last year. Last year was 3,891 - a 7.3% improvement on 1718
- For 60min delays there were 59 in May compared to 27 in May last year. Last year was 596 - a 11.2% improvement on 1718

A note must be made that SECamb data sometimes reports a delay, however when reviewed Patients are triaged, seen and in a bed inside the required standards however this data is not updated on SECamb systems and therefore remains as a delay. These examples are sent back to SECamb to advise outcomes

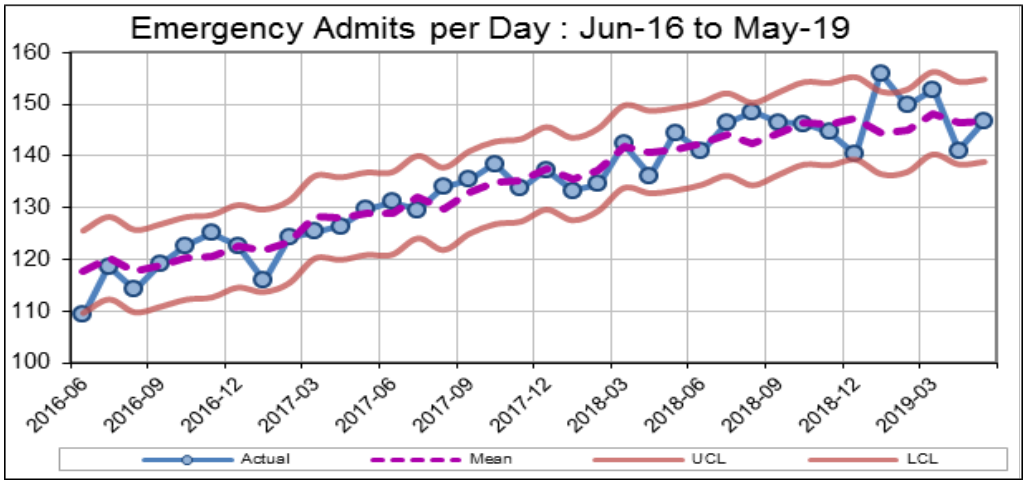
We have introduced a flow coordinator in majors improving flow through the department as well as a receptionist within RAT to speed up hand overs even more with a key responsibility to make sure pin numbers are adding in a timely fashion to improve data quality

3. ED Attendances & Emergency Admissions

- A&E Attendances continue to increase. Over the last 5 years, annualised growth has averaged 4.4%. This is against a local population increase of around 1.1% per year, and a demographic 'bulge', where the people born during the 1946-64 spike in birth rates are hitting the age when A&E attendances become more frequent.



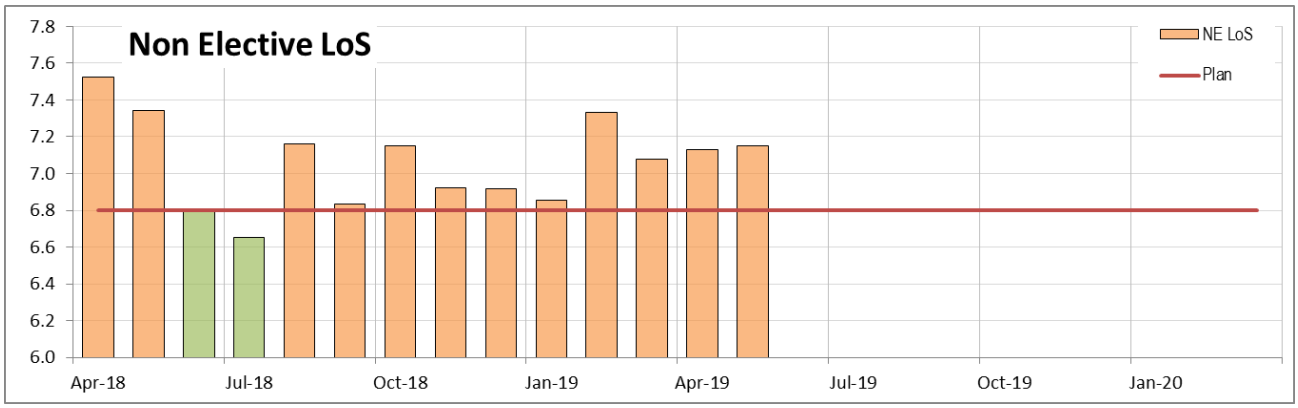
- January & February saw an unprecedented spike in attendances. January Type 1 attendances were 10.9% on model & Feb 7.4%. These two months were the busiest to date, when they are usually the two quietest months of the year. The whole year came in 7.1% higher than the previous year for type 1 attendances at 155,867. 2019/20 is currently forecast to see 165,350 type 1 attendances – 6.1% up on 2018/19
- May saw a record 14,282 type 1 attendances (0.3% down on model) and a record 17,716 when the MIUs are included (0.8% above model).
- Non-Elective Activity (excluding Maternity) was back up to more normal levels in May after dipping in April – 14.5% below plan at 4,989, though the plans have been uplifted to account for additional prime provider activity. Last year finished at 57,338 total discharges. Much of this is driven by increased use of CDU & Assessment areas – last year, 44.2% of NE admissions were same-day emergency care.



4. Length of Stay

- Non-Elective LOS was 7.15 days in May, and 7.05 for 2018/19 vs 7.51 in 1718, and a target of 6.80 days.

- NE LoS tends to increase by 0.5 to 1.0 days in the winter. This year, a small spike is observable in February, but January was actually one of the better months.



- **LOS – Super Stranded Patients:** As part of the National Improvement Programme to reduce Long Length of Stay (LLOS), LLOS Weekly Reviews have commenced in June for all patients with over 21 days LOS with the aim of introducing supportive challenge and helping ward MDTs tackle obstacles that are delaying the treatment and discharging of patients who have been in hospital for prolonged periods. Regions are also introducing an additional measure which summarises the key reasons for delay and the number of patients affected which is known as the Discharge Patient Tracking List (DTPL). MTW is scheduled to go in Phase 3 of the national rollout with a deadline of 30 August 2019 but has already started to implement the weekly reviews.

- **LOS:** Continuing to use CUR to identify delays in flow, including red and green days. Achievement of Quarter 4 CQUIN for CUR. KPIs show reduction in Medical LOS from 14.3 (April 18) to 7.2 (May 7.8 2019). Transfer of LOS schemes where appropriate to BAU in preparation for 19/20 project work. Live Bed State in place across 18 wards. Criteria Led Discharge – fully embedded to show delivery of targets. CUR linked to Smarties to show real time discharge delays. This was shown at a conference in London to other trusts as an example of good practise.

- **Frailty:** Bronze pilot continues at Maidstone and TWH until end of June 2019. Recruitment for a Band 5 and Band 6 is struggling and the jobs are being re-advertised, interviews June 2019. Successful recruitment of therapy staff. Requirement being gathered for the Primrose flag and Sunrise. CGA form development continues and will be ready for review in July 2019. The changes will enable primary and secondary care to use one form. The expected completion date is in the autumn 2019. CPMS e-learning continues to be rolled out in order to allow staff to set up user logins/ passwords.

- **AEC:** Planned Ambulatory in the community – Surgical AEC Network (SEAC) visited the Trust in May and were impressed with the project plans and buy in. A key concern was the clinical buy, which has improved. KPIs show increase in 0% medical take. KPIs show improvement in ambulance handover. KPIs show increase in SAU admissions during March. Best Flow Workshop 4.4.19: project team identified and key objectives for AEC to sit in new Same Day Emergency Care (SDEC) project under Best Flow. This will also include Frailty, SAU, EGAU, Paeds and Oncology

- **Hospital at Home**: H@H – Funding still not agreed at following at WKA exec board on 14th June 2019.

5. Delayed Transfers of Care (DTOC)

The percentage of occupied bed-days to DToC dropped in May to 4.05%.

Category	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Rolling 12
A : Awaiting Assessment	3	8	17	21	13	12	17	36	27	34	19	22	229
B : Awaiting Public Funding	-	-	4	3	-	-	2	9	3	8	2	-	31
C : Awaiting Further Non-Acute NHS Care	14	17	22	14	21	19	18	34	20	14	21	25	239
Di : Awaiting Residential Home	29	22	9	32	22	21	8	7	12	14	17	23	216
Dii : Awaiting Nursing Home	26	34	54	27	35	33	21	23	16	25	21	31	346
E : Awaiting Care Package	18	29	24	28	16	22	10	17	7	20	15	23	229
F : Awaiting Community Adaptations	6	4	8	10	7	3	3	7	3	12	4	7	74
G : Patient or Family Choice	11	9	14	9	17	9	4	10	13	15	10	7	128
H : Disputes	-	-	1	1	-	-	4	2	-	-	-	-	8
I : Housing	7	5	4	4	4	2	2	-	3	-	1	3	35
Grand Total	**114**	**128**	**157**	**149**	**135**	**121**	**89**	**145**	**104**	**142**	**110**	**141**	**1,535**
Rate	**4.39%**	**5.03%**	**4.77%**	**5.89%**	**4.52%**	**3.58%**	**3.17%**	**4.07%**	**3.79%**	**4.96%**	**4.43%**	**4.05%**	**4.39%**

The average number of G&A beds occupied by Delayed Transfer of Care patients in the whole of 2018/19 was 4.4%. The monthly DTOC percentage ranged from a low of 3.2% in December 2018 to a high of 5.9% in September 2018. So far in 2019/20, DTOC has remained at around 4.4%.

Full year 1819 was 10,853 bed days, which is the equivalent of 30.8 beds per day lost to delays

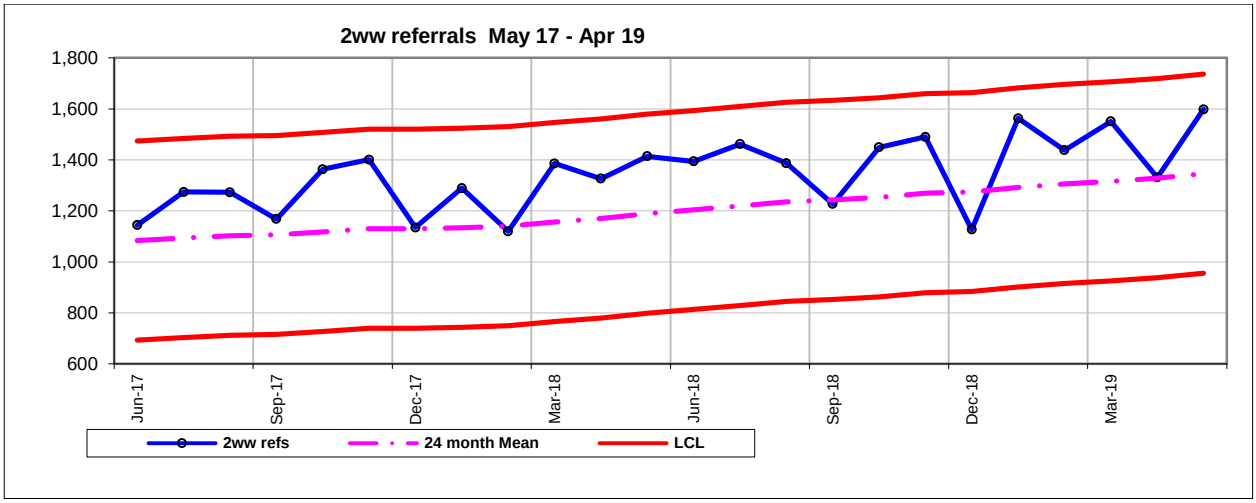
We have experienced a greater focus from external partners on the exit routes from the hospital and have now rolled out Pathway 1, 2 & 3 of the Home First initiative in full. Both sites have now got functioning frail elderly units, which has helped to reduce the number of longer stay admissions.

6. Bed Occupancy

The average daily Bed Occupancy across the Trust during April and May has been 93.5% (95.2% at Tunbridge Wells and 91% at Maidstone). There has been minimal use of escalation beds so far this year with an average of 22 per night (12 at Maidstone and 10 at Tunbridge Wells) compared to an average of 26 per night last year.

7. Cancer 62 Day First Definitive Treatment

Cancer 2 week waits

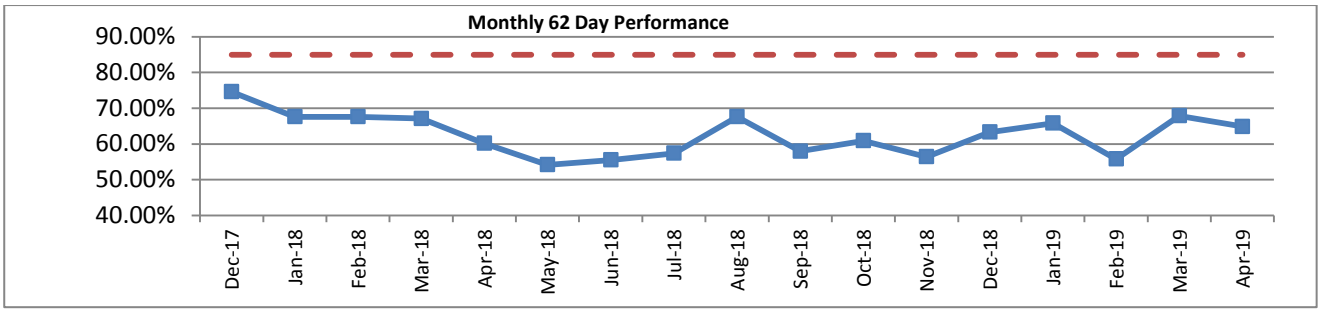


Total 2ww demand has continued to rise in 2019, however the rate of growth has stabilised. Increase in overall demand has been largely attributable to breast, breast symptom and lower GI referrals.

It is likely that capacity issues in Medway for breast and breast symptomatic referrals caused some patients to be redirected to MTW. For a two month period at the start of the calendar year, the same is also true for lower GI referrals. However, this flow of demand seems to have now subsided.

The majority of 2ww breaches in April were incurred in breast and lower GI. Additional one stop breast capacity has been put in place through a limited amount of internally created additional clinics and largely through outsourcing. A more sustainable solution is being worked through which includes recruitment to Mammographer and Consultant Radiographer posts.

The breaches in Lower GI have been due to delays in booking outpatient appointments and CT scans following straight to test triage telephone calls. This has been addressed with the 2ww booking office team and with Radiology.

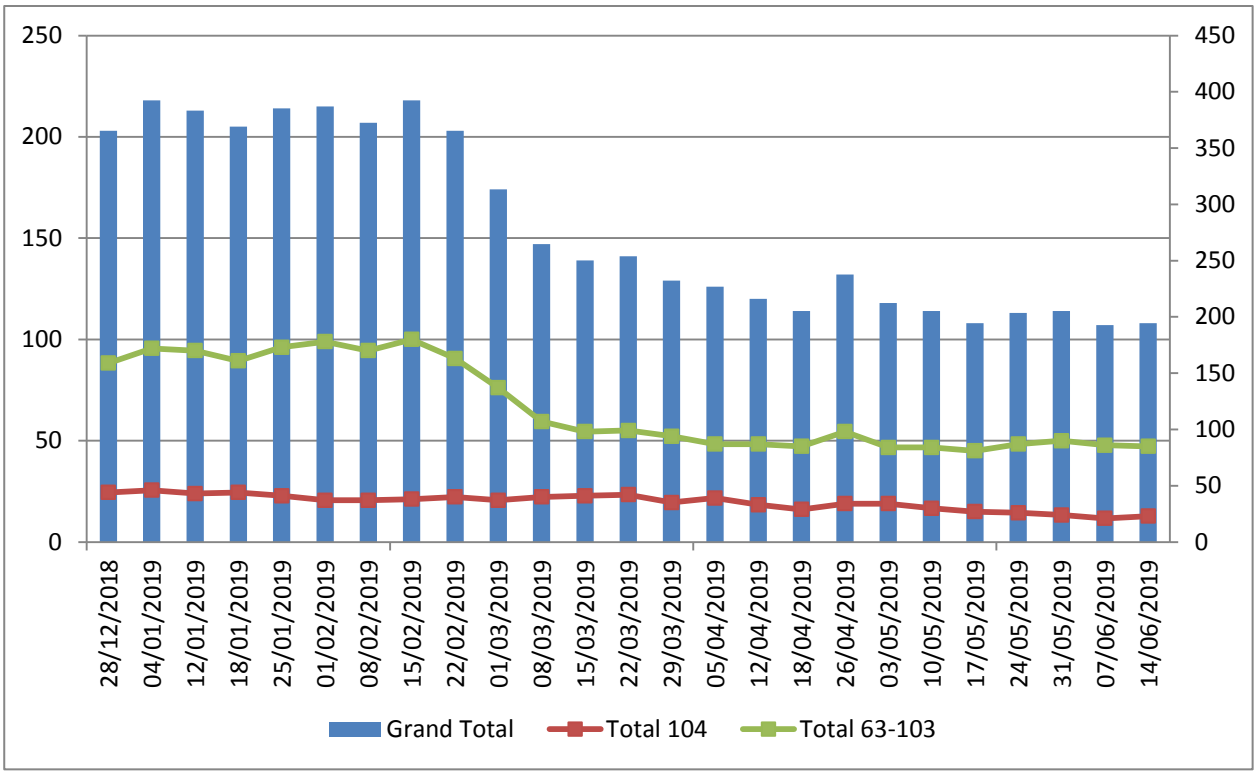


62 day performance for April was 65.2% (against a predicted performance of 76.8% in the trajectory). This has improved slightly following the national upload at the start of May.

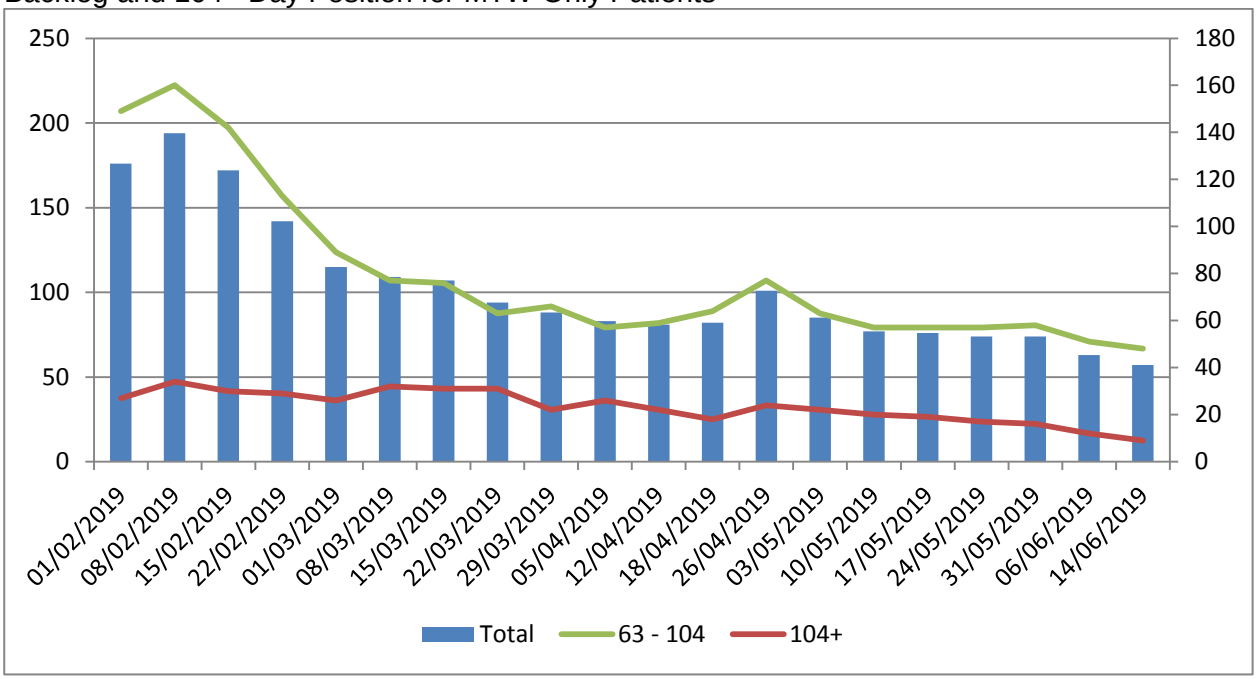
Backlog clearance has been continued in April and May and is expected to continue into June in order to enable a sustainable backlog position that will result in improving performance against the standard in July and August. Early indications are that May's performance will be around 70% and so performance improvement is beginning to be seen as the backlog is cleared.

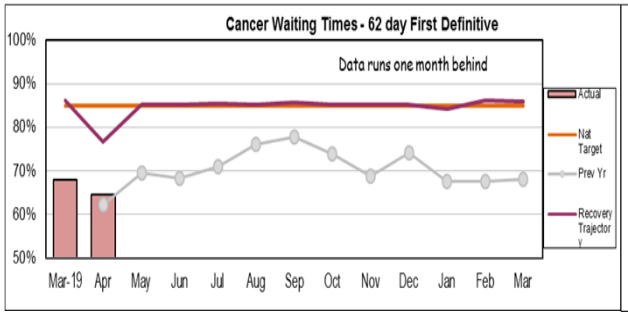
The overall backlog and patients over 104 days has been decreasing, however the decrease in the MTW only patients has been more noticeable.

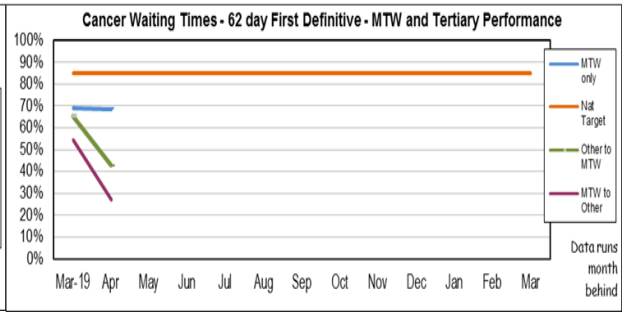
Backlog and 104+ Day Position for All Patients



Backlog and 104+ Day Position for MTW Only Patients







62 Day Performance						
April 2019	All reportable patients			MTW only patients		
	Total	Breach	%	Total	Breach	%
Breast	21.0	6.0	71.4	21	6	71.4
Gynae	10.0	1.5	85.0	8	1	87.5
Haematology	7.5	6.5	13.3	7	6	14.3
Head & Neck	6.5	2.0	69.2	3	1	66.7
Lower GI	13.0	4.5	65.4	12	4	66.7
Lung	13.0	5.5	57.7	10	3	70.0
Other	2.0	1.0	50.0	2	1	50.0
Upper GI	11.0	8.0	27.3	9	6	33.3
Urology	37.0	8.0	78.4	33	5	84.8
TOTAL	**121.0**	**43.0**	64.5	**105**	**33**	68.6

Further data analysis has been undertaken in order to identify actions required to remove barriers from diagnostic pathways and tumour site specific dashboards have been created that are updated and shared with the clinical teams on a monthly basis.

Now that the backlog is reducing to a sustainable size, further actions have been instigated in order to highlight patients with a new cancer diagnosis. Daily PTL meetings are held with each of the tumour site teams and all patients from day 20 onwards are reviewed for the next action. A new process is in place to request urgent imaging for any patient with cancer that ensures that the patient is scanned and reported with a couple of days, rather than within 2 weeks.

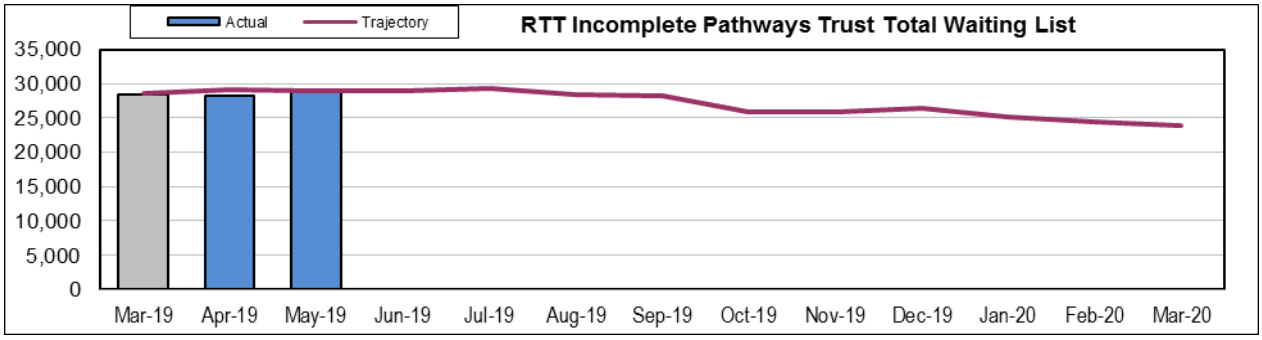
A similar process is planned for escalating patients with a cancer diagnosis to endoscopy.

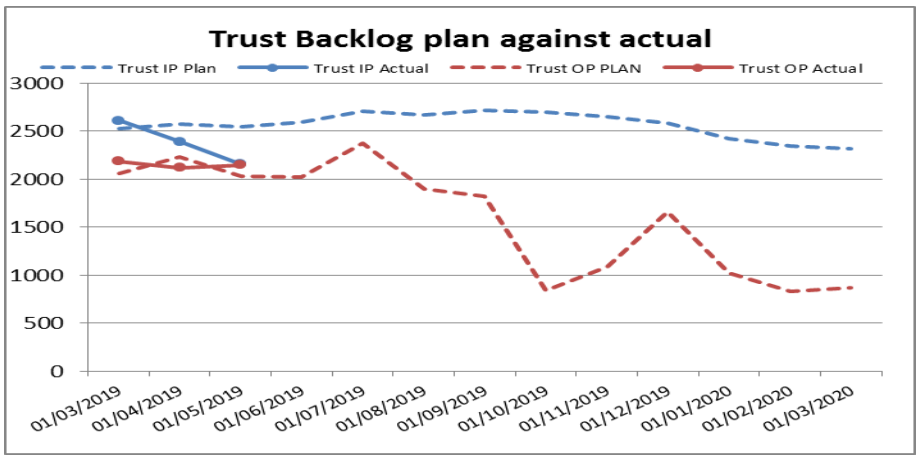
Additional funding has been secured from the CCG and Cancer Alliance to support proposed actions and posts required to continue cancer pathway improvements.

8. Referral To Treatment – 18 weeks

May performance has increased further for the Incomplete RTT performance, achieving 85.17% against a target of 84.2%. The Trust Waiting List for May 2019 is 29,027 which is 95 patients higher than the Trust submitted Trajectory of 28,932 (slight increase in General Surgery, Ophthalmology, T&O and Gynae which can be linked to the prime provider model) however, the backlog was 273 patients lower than the submitted trajectory of 4,578.

		Mar-19	Apr-19	May-19
TRUST	Trajectory Total WL	28508	29152	28932
	Actual Total Waiting List	28412	28268	29027
	Actual IP Waiting List	6494	6045	6037
	Actual OP Waiting List	21918	22223	22990
	Trajectory Backlog	4146	4806	4578
	Actual Total Backlog	4797	4510	4305
	Actual IP Backlog	2611	2391	2157
	Actual OP Backlog	2186	2119	2148
	Trajectory % Performance	**85.5%**	**83.5%**	**84.2%**
	Actual Total % Performance	**83.12%**	**84.05%**	**85.17%**





Continuous actions in progress:

- Continue to ensure achievement of Incomplete targets month on month at an aggregate level by reducing RTT backlog for Incompletes through implementation of speciality plans.
- Ensure backlog patients are booked chronologically to avoid long waits/52 week breaches.
- Weekly monitoring of the specialty plans for activity, diagnostics, theatre scheduling, backlog and waiting list size, through the PTL and specialty meetings.
- Continue weekly PTL/RTT performance monitoring to maintain overall performance.
- Continue with overarching action plan already implemented which includes improving theatre and outpatient productivity.
- Hospital at Home has been implemented to support a reduction of length of stay and release of bed capacity – monitored daily at the bed meeting.
- Review all gaps in medical rotas on a weekly basis and ensure any locum requests have been submitted.
- Data Quality project commenced.

Elective Activity and New Outpatient Activity:

OP New Activity in the last few months has been below the average. May activity was 7.4% lower than plan and YTD OP New Activity is 8.2% lower than plan. Specialties furthest from plan are Ophthalmology (-19%), T&O and General Surgery (both -8% below plan).

Both elective inpatient (IP) and day case (DC) activity showed an increasing trend through 2018/19 with much less of a dip in the winter months than in previous years. April and May have increased further with May being above the average for inpatients as well as having the highest number of day cases recorded in any one month. Day cases in May were above plan and are now 2% below plan YTD. Elective IP were slightly below plan in May and remain 6.5% below plan YTD. The Specialties furthest from Plan for Elective are T&O (-42%), Ophthalmology (-28%) and Urology (-25%). Overall Elective (IP and DC) is 2.6% below plan YTD.

The key issues that contribute to lower than planned elective work remain:

- Key vacancies in consultant and trainee posts in a variety of specialties (General Surgery, Neurology & Endocrinology)
- Capacity issues in some specialties (Ophthalmology, T&O and General Surgery)
- Plans to improve efficiency have not all yet been fully realised in some areas. Operational teams are reviewing capacity plans and looking at ways to further improve efficiency
- Activity in April and May will be slightly understated due to the activity being done in the independent sector not currently being recorded on the PAS system in a timely manner. This is being addressed via contractual arrangements and more efficient internal processes.

The majority of the RTT backlog continues to be concentrated in surgical specialties with the exception of neurology, all of which are being carefully monitored against forecasts and action plans on a weekly basis by the operational teams.

52 week breaches

Total Trust	Apr-19	May-19	YTD
RTT >52kw Breach Occurrences	9	11	20

There were 11 breaches in total for May (10 New in month) although these patients have not yet been fully validated.

All patients will have a harm review by the managing Consultant. No harm has been found as yet for the ones which have been completed. The Harm review process has agreed within the Best Safety Group.

Oversight:

- Weekly monitoring of the specialty plans for activity, diagnostics, and theatre scheduling, backlog and waiting list size, through the PTL and specialty meetings.
- All patients over 40 weeks are being monitored by the Head of Performance and Delivery, the speciality General Managers, Assistant General Managers and CAU's on a daily basis to ensure treatment occurs before 52 weeks and ensure patients are booked in chronological order.
- RTT/PTL meeting is being reformatted and will become a weekly Trust Access Performance chaired by the COO/DDO.

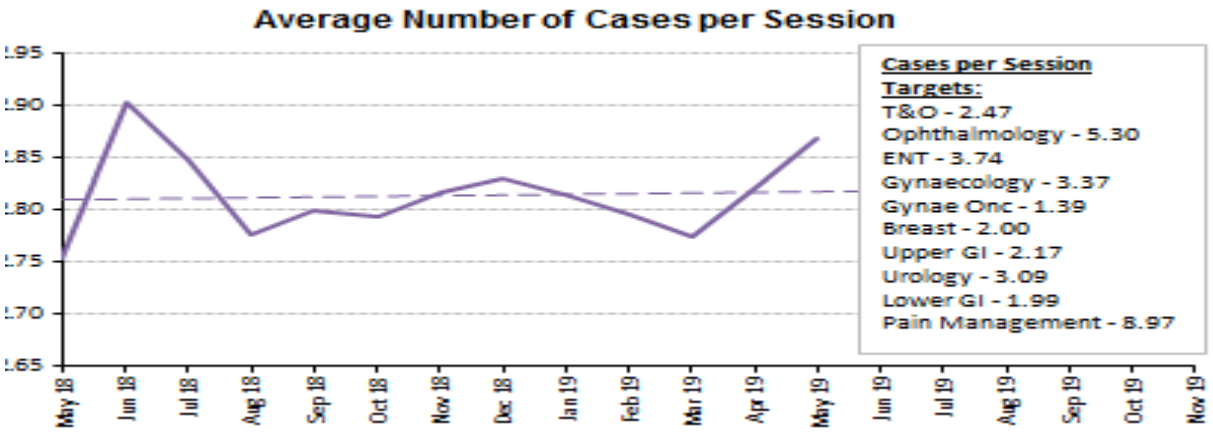
Data Quality Update

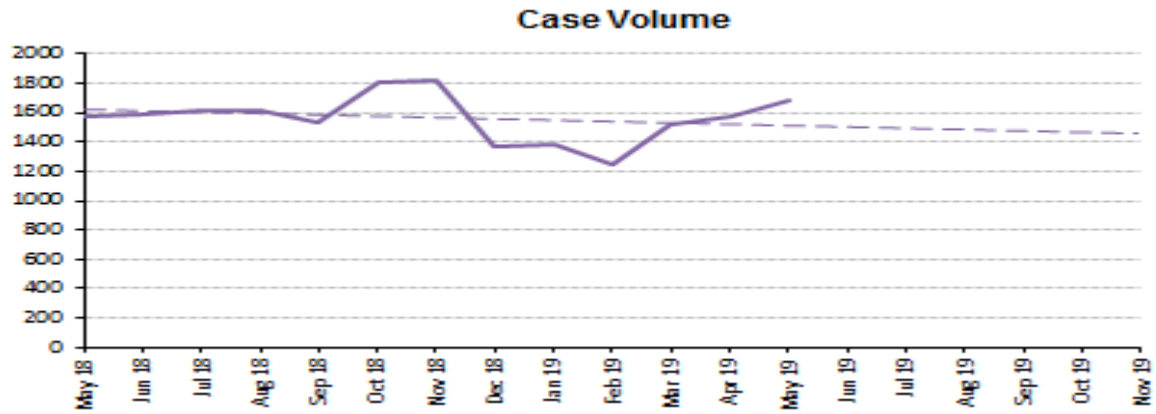
- Training needs analysis has been implemented and will format future training for Allscripts and RTT.
- Cleansing of the 5U/5T/5R data continues.

9. Theatre Productivity

The information below is taken from the internal theatre dashboard.

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019
Case Volume	1573	1594	1610	1611	1528	1799	1818	1372	1378	1241	1520	1576	1679
Cases per working day	74.9	75.9	73.2	73.2	76.4	78.2	82.4	72.2	62.4	62.1	72.4	78.8	80.0
Session Utilisation (with TAT)	86.0%	87.1%	86.4%	84.5%	87.6%	85.8%	86.4%	86.3%	85.5%	85.6%	87.5%	88.4%	86.4%
Session Utilisation (without TAT)	75.5%	76.8%	77.0%	75.1%	77.5%	75.6%	75.7%	76.8%	76.6%	77.3%	77.8%	77.8%	76.7%
On Time Starts (within 15 mins)	22%	28%	28%	23%	26%	20%	26%	24%	25%	28%	29%	28%	38%
Significant Delay > 30 mins	37%	34%	36%	37%	38%	39%	37%	31%	35%	38%	35%	38%	26%
Significant Delay > 60 mins	5%	4%	7%	7%	8%	9%	5%	4%	4%	5%	6%	7%	5%
On Time Finishes (within 15 mins)	22%	22%	24%	23%	24%	22%	25%	21%	30%	22%	20%	29%	27%
Significant UnderRun (> 30mins)	38%	39%	37%	41%	38%	42%	40%	43%	38%	34%	41%	33%	39%
Significant UnderRun (> 60mins)	24%	21%	23%	25%	20%	22%	24%	27%	22%	23%	23%	19%	24%
Significant OverRun (>30 mins)	19%	17%	16%	17%	19%	19%	15%	16%	12%	19%	17%	17%	13%
Cases per Session	2.75	2.90	2.85	2.78	2.80	2.79	2.82	2.83	2.81	2.80	2.77	2.82	2.87
Close to Cut (minutes)													
(TAT) Patient Out to Case Start (minutes)	10.3	9.8	9.0	9.6	10.7	10.5	11.1	9.3	9.3	8.6	9.4	10.4	9.4
On day Cancellation %	9.1%	8.3%	8.9%	8.9%	9.1%	10.5%	8.1%	8.4%	8.5%	9.3%	7.3%	7.4%	6.8%
On day Cancellations	158	145	157	158	153	210	161	126	128	128	120	126	123
Hospital	110	85	89	100	87	107	88	65	86	84	80	79	80
Patient	18	31	40	40	34	54	34	38	27	29	21	19	26
DNA	30	29	28	18	32	49	39	23	15	14	18	28	17
Session Util Exc Overruns (with TAT)	82.4%	83.5%	83.3%	81.9%	84.3%	82.8%	83.2%	83.3%	83.2%	82.4%	83.9%	84.7%	84.2%
Session Util Exc Overruns (without TAT)	71.9%	73.1%	73.9%	72.5%	74.2%	72.5%	72.4%	73.8%	74.3%	74.0%	74.1%	74.0%	74.5%
% Surgical Time (Cut to close)	57.9%	54.3%	55.5%	55.2%	54.2%	51.5%	52.6%	55.3%	55.2%	55.9%	55.5%	54.5%	54.1%





There have been improvements when comparing May 2018 to May 2019 which include:

- May-19 completed an extra 106 operations (1679) compared to the previous May (1573), this was also an increase of 103 operations compared to last month April 2019 (1576)
- This equated to 80 elective cases per working day being carried out in May-19 compared to 74.9 the previous year & 78.8 in April 2019
- Utilisation with TAT has dropped slightly to 86.4% from 88.4% last month
- On time starts within 15 mins has increased to 38% this month compared to 28% last month
- 26% started more than 30 mins after the planned start time which is a reduction from 38%
- On day cancellations have reduced to 6.8% but we have consistently had around 125 on day cancellations a month for the last 6 months (123 this month); 80 hospital, 26 patient & 17 DNAs
- Surgical time dipped slightly again to 54.1 in May but has averaging 55% for the previous 6 months

Quality and Safety (May)

Patient Falls incidents

In addition to the Quality and Safety report focusing on the range of complaints, incidents and the learning from previous incidents, each report will now also commence with updates on progress and actions being taken to raise awareness on the breadth of quality and safety initiatives being taken across the trust.

June has commenced with Dietitians Week. The dietetics team used the opportunity to send out daily bulletins across the trust to raise awareness of the diversity of their role. These included

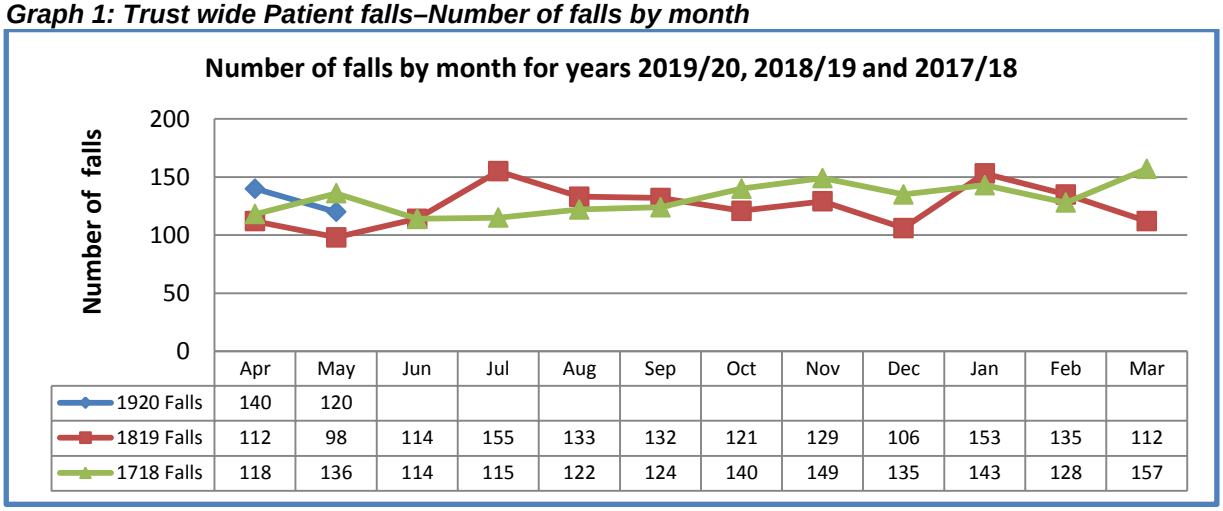
- Mental health and recovery; Diet and nutrition can play a key role in both preventing and managing mental ill health
- Rehab and enablement; Dietitians provide rehabilitation to people who have been unwell (such as after an operation or having a stroke). Support from a dietitian can provide symptom relief, reduce risks of further illness and prevent admissions to hospital.
- Public Health and primary prevention; Good nutrition and hydration are fundamental to good health. Dietitians help the public at large to stay healthy which helps prevent illness and diet related conditions such as malnutrition or obesity

The Trust is celebrating Learning Disability week between the 17th - 21st June with a focus this year on sports and inclusion. The Learning Disability Liaison Nurse (LDLN) is passionate about ensuring the hospital is accessible and is inclusive to all. This is facilitated by empowering staff to provide reasonable adjustments (Equality Act 2010) to people with learning disabilities. During the week, it is planned that a variety of guests will be coming into the Trust to support the week; including KCHFT Community Learning Disability Team and people who are experts by experience, there will be a stall in the Woodlands Unit at TWH focussing on transition as well as a walk round the wards and departments.

Patient Falls incidents

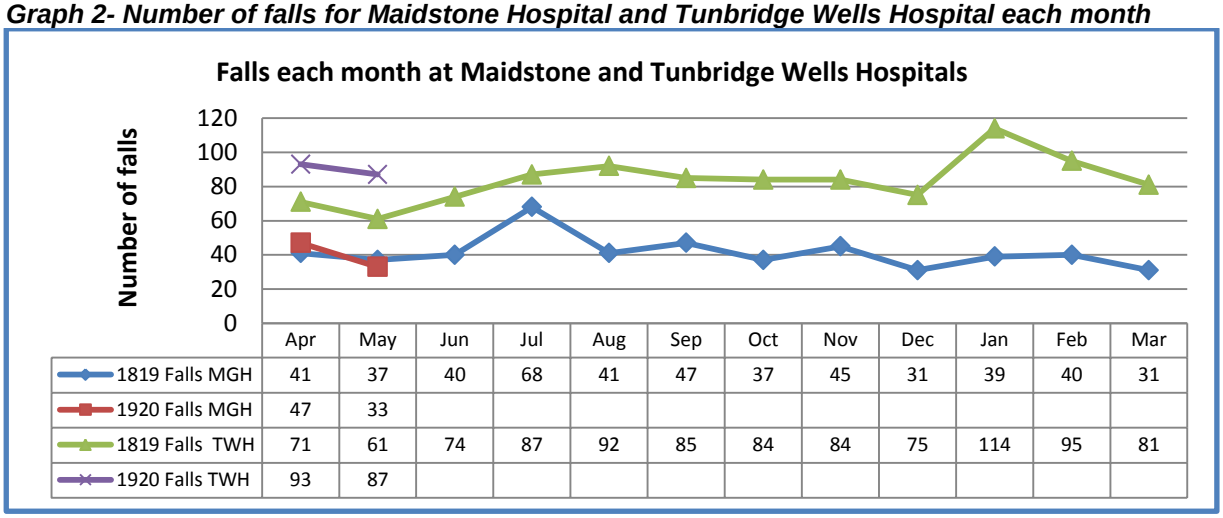
There were 120 falls incidents reported for May 2019, compared to 140 for April 2019. The monthly figures in Graph 1 provide a comparison for each month and for the same period on the previous year. The breakdown of incidents by site in May equates to 33 falls at Maidstone and 87 at Tunbridge Wells as shown in Graph 2. There was a decrease in the number of falls at both sites when compared to April 2019.

Graph 1: Trust wide Patient falls–Number of falls by month



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1920 Falls	140	120										
1819 Falls	112	98	114	155	133	132	121	129	106	153	135	112
1718 Falls	118	136	114	115	122	124	140	149	135	143	128	157

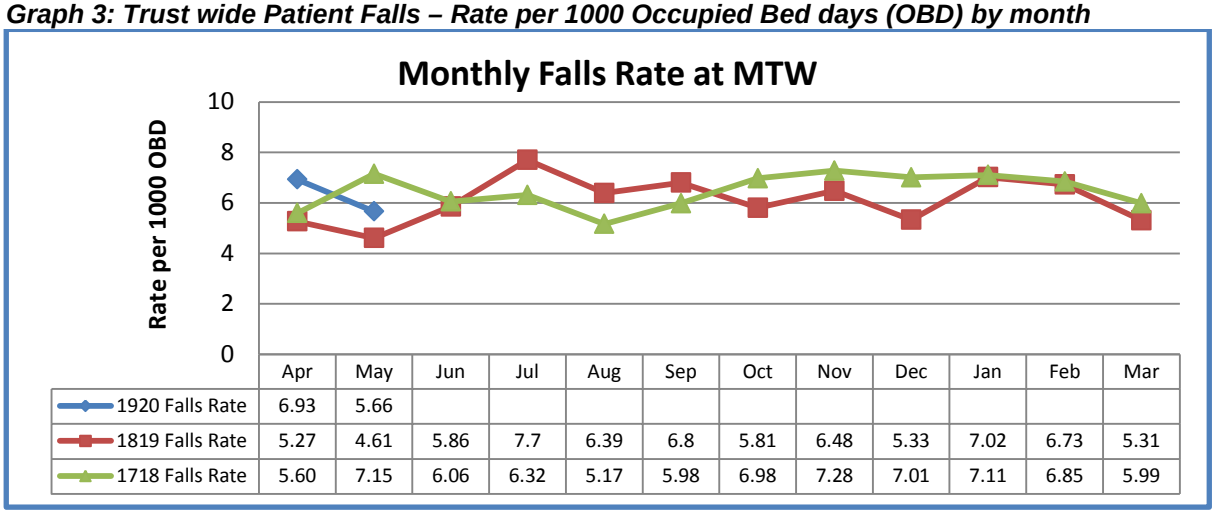
Graph 2- Number of falls for Maidstone Hospital and Tunbridge Wells Hospital each month



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1819 Falls MGH	41	37	40	68	41	47	37	45	31	39	40	31
1920 Falls MGH	47	33										
1819 Falls TWH	71	61	74	87	92	85	84	84	75	114	95	81
1920 Falls TWH	93	87										

The monthly falls rate per 1000 occupied bed days (OBD) for May 2019 was 5.66. The threshold for year 2019/20 is set at 6.0. Comparison for previous months and months in previous year can be seen in Graph 3. Year to date falls rate is at 6.28 per 1000 OBD.

Graph 3: Trust wide Patient Falls – Rate per 1000 Occupied Bed days (OBD) by month



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1920 Falls Rate	6.93	5.66										
1819 Falls Rate	5.27	4.61	5.86	7.7	6.39	6.8	5.81	6.48	5.33	7.02	6.73	5.31
1718 Falls Rate	5.60	7.15	6.06	6.32	5.17	5.98	6.98	7.28	7.01	7.11	6.85	5.99

In May four falls resulted in serious injury and were declared as Serious Incidents (SI). One for subdural bleed at Maidstone Hospital and two incidents resulted in fractured hips and one subdural haemorrhage at Tunbridge Wells Hospital.

We are currently rolling out the NHSi Falls Collaborative project. The roll out focus is on the compliance of lying and standing blood pressure measurement for patients who are at risk of falls as part of their admission assessment. All adult inpatient areas will be part of the roll out. Lying and standing blood pressure is one element of the three key high impact actions for prevention of falls in hospital identified by NHS England in their National CQUIN programme for 2019/20.

Pressure Ulcers

There were 4 patients who developed pressure ulcers in May compared to the 7 from last year for the same period. All 4 were Deep Tissue Injuries affecting; sacrum, heel, spine and ankle.

There is continued work in conjunction with the Continence care service and the Practice Development Nurses to focus on the reduction of Moisture Associated Skin Damage (MASD). MASD is not related to pressure, but increases the risk of pressure ulcers because the skin is already damaged. Promoting education and the need for a full body assessment and monitoring even on independent patients is always relevant.

The Policy and procedure for the prevention and treatment of pressure ulcers was ratified by the Policy Ratification Committee in May and will be published on the Trust Intranet imminently.

Trust wide training for Tissue viability continues which includes care of pressure areas at risk and pressure ulcer management.

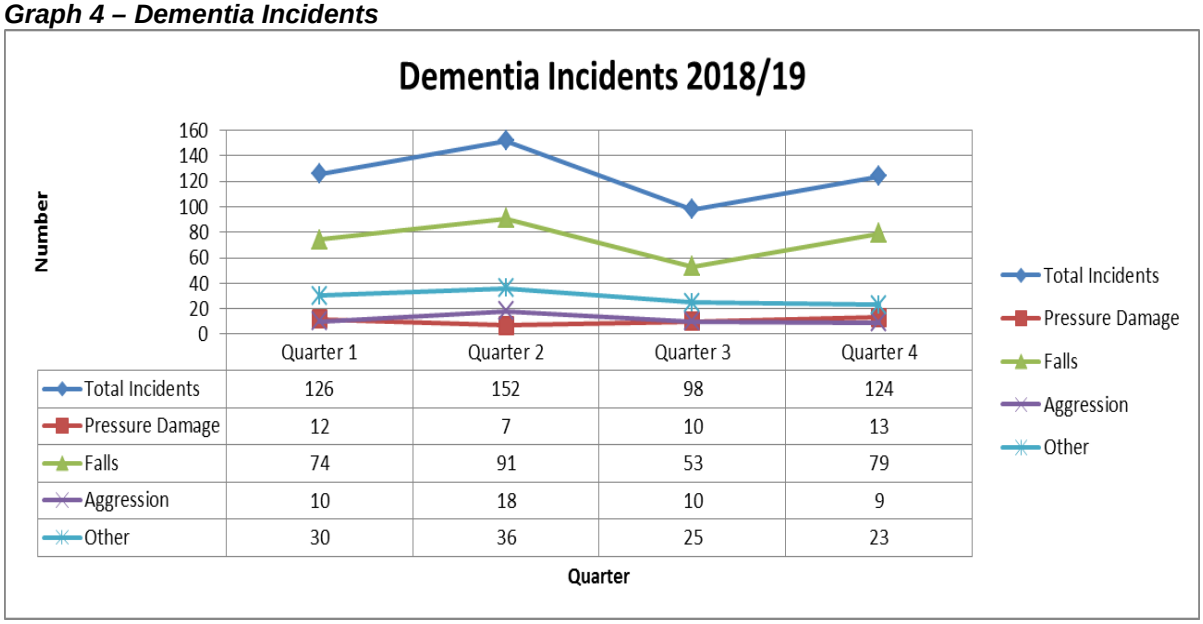
The prevalence audit took place in May; the data is now being processed by the Clinical Audit department. In addition the Yearly Mattress audit will take place in June for the Maidstone site and July for the Tunbridge Wells site.

Incidents relating to inpatients with Dementia

As part of the Trust's Dementia Strategy (2013 – 2016) one of the objectives was to monitor the number of incidents relating to inpatients with dementia in our hospitals. In the Strategy for 2017 – 2020 one of the strategic aims is to modernise our approach to monitoring falls in patients with dementia and identify ways to reduce these. In the process for delivery it states we will: Monitor all incidents associated with dementia patients and report to the dementia strategy group.

The incidents have been analysed by the Lead Nurse for Dementia Care, following a search on the Datix system of all incidents relating to patients with dementia. The identification of patients with a known diagnosis of dementia is via the Datix form and this has been validated by the Lead Nurse for Dementia through the flagging system on Allscripts. The incidents have been split into 4 categories: Pressure Damage; Falls; Aggression and Other. Incidents included in the Other category include issues such as drug omissions/errors, patient transfer, communication issues between wards and similar low harm incidents.

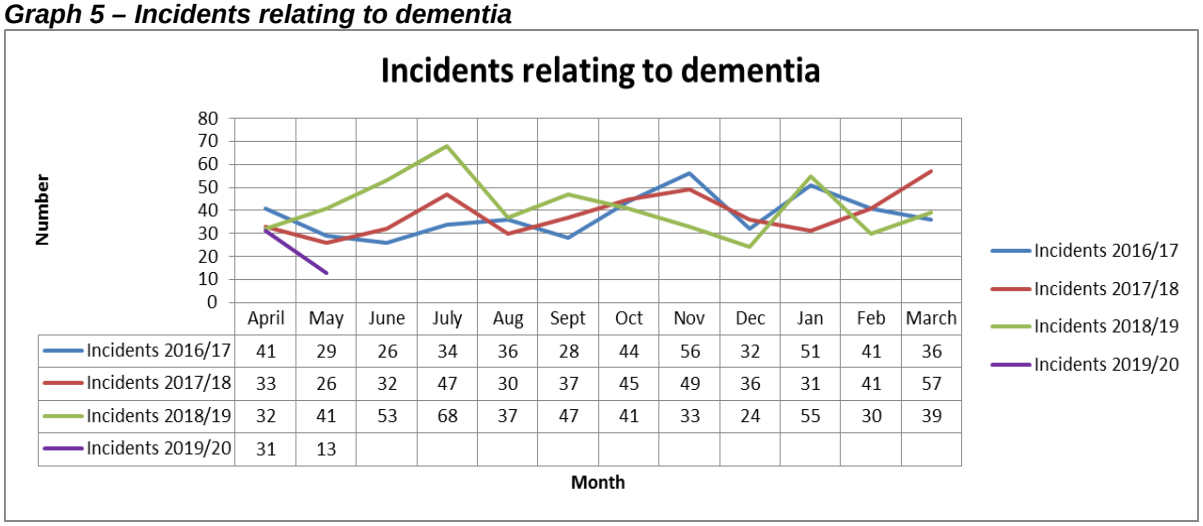
Graph 4 – Dementia Incidents



	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Total Incidents	126	152	98	124
Pressure Damage	12	7	10	13
Falls	74	91	53	79
Aggression	10	18	10	9
Other	30	36	25	23

Graph 4 demonstrates the number of incidents per category that occurred during Quarter's 1, 2, 3 & 4 (2018/19). We continue to see a decrease in total incidents since Quarter 1, although we have seen an increase in pressure damage and falls and a decrease in aggression and other incidents. The quarterly report will be updated next month at the end of Quarter 1 for 2019/20.

Graph 5 – Incidents relating to dementia



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Incidents 2016/17	41	29	26	34	36	28	44	56	32	51	41	36
Incidents 2017/18	33	26	32	47	30	37	45	49	36	31	41	57
Incidents 2018/19	32	41	53	68	37	47	41	33	24	55	30	39
Incidents 2019/20	31	13										

Graph 5 plots the number of incidents relating to dementia patients per month for 2016/17; 2017/18; 2018/19 and 2019/20. In May there were 13 incidents all at TWH and 0 at Maidstone, of these falls continues to be the main cause of incidents totalling 6 (6 at TWH and 0 at Maidstone). This is the lowest number of incidents reported in relation to dementia patients, and no incidents were reported on the Maidstone site.

This data is collected and reviewed quarterly by the Dementia Strategy Group and findings were presented to the Trust Clinical Governance Committee as part of the Safeguarding Adults Group.

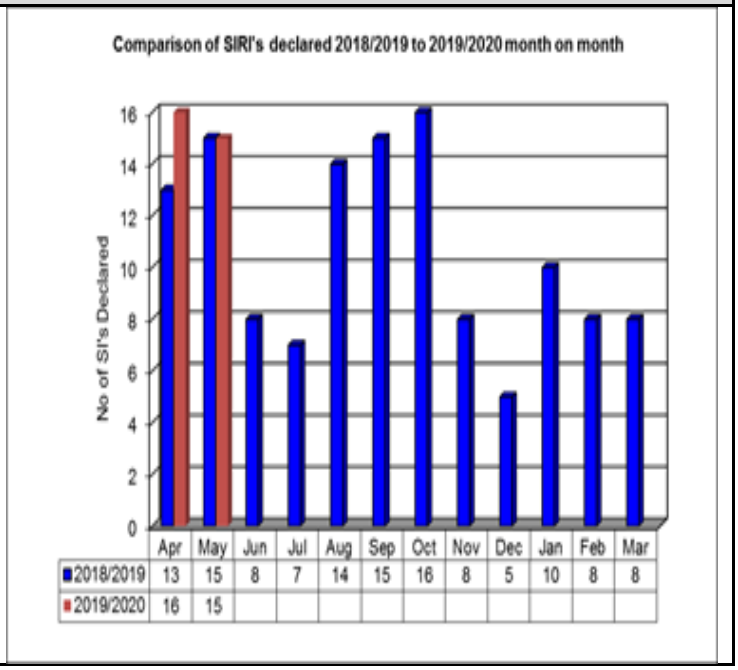
Additionally, as part of a proactive strategy between agencies and services during Dementia Action Week, the trust hosted the first collaborative 'West Kent Emergency Services Dementia Event' at the Academic Centre in Maidstone.

Serious Incidents (SI's)

- There were 15 Serious Incidents reported in May 2019 (4 at MGH and 11 at TWH)
- Of these 15, 4 have also been recorded as complaints and 1 will be going to inquest
- During the month of May 2019, 9 SI's were closed (two of these were downgraded)

Total SIs Declared

	18/19	19/20	with d/g
April	13	17	16
May	15	15	15
June	8		
July	7		
August	13		
September	15		
October	16		
November	8		
December	4		
January	10		
February	7		
March	8		
TOTALS	**124**	**32**	**31**



7 Main SI's in Directorates:

- Acute Medicine and Geriatrics (1)
- General Surgery (2)
- Medical Specialties (1)
- Orthopaedics (1)
- Women's Services (2)

1 Pressure Damage – reported in Outpatients (Fracture Clinic)

6 Falls – **reported in directorates**

- Acute Medicine and Geriatrics (4)
- Medical Specialties (1)
- Oncology (1)

This includes 2 falls resulting in injury from April but declared as SI's in May.

1 Safeguarding – reported in Medical Specialties also subject to a police investigation

During the month of May 2019 2 SI's were downgraded:

2018/21238	WEB69111	TWH	Emergency Medicine	Acute Medical Unit	Downgraded
2019/2948	WEB74116	TWH	Women's Services	Delivery Suite	Downgraded

Learning from the Learning and Improvement Main SI Panel

- Importance of clear, legible and complete documentation in patient notes to be reiterated at team meetings
- The importance of regularly monitoring of patients who are awaiting further investigations or tests.

Learning from the Falls Panel

- Importance of fully completed falls risk assessments for patients

Learning from the Safeguarding

- No Learning and Improvement SI Panel in May

Learning from the VTE Panel

- VTE Panel Meeting – No VTE SI's declared for this period

Sharing the learning from SI's across the directorates

Each directorate utilises different styles or methods to ensure that there is Trust-wide dissemination of learning of SIs across Directorates. The Medical and Emergency care division distribute a newsletter with key messages and case studies, their May edition focused on documentation, utilisation of new of equipment and a clinical case study.

The Surgical division make use of posters each month to draw the attention of staff to salient findings from investigations. In May, this focused on the necessity of forward planning to ensure that the correct equipment is in the right site or location when needed and reminding staff of their responsibility in regard to the duty of candour following recognition that an incident has occurred.

Single sex compliance

There were 21 incidences of mixed sex accommodation reported during the month of March. 17 of these occurred in ITU and 4 in ASU at Maidstone. These were due to clinically unwell patients who required the beds in these areas, therefore no breaches were declared.

Friends and Family Test

Overall response rates for May have shown an increase for inpatient (IP) and Accident & Emergency (A+E) responses but a further decrease in maternity. There continues to be fluctuating consistency with response rates which is highlighted at the monthly review meetings to explore any new / recurrent engagement or process issues. It is acknowledged that the increased demand on services and staffing levels are impacting on ensuring a consistent approach.

There continues to be a significant reduction in rejected forms and the dedicated IPads are being encouraged. Uptake of this has been impeded due to a fault with the IWGC app which IT and IWGC are working on to find a solution. This has impacted on reporting online numbers however, once this is resolved will provide an additional platform in which patients and service users can feedback on their experiences. During May a total of 16 reviews were completed online and 16 via the tablets.

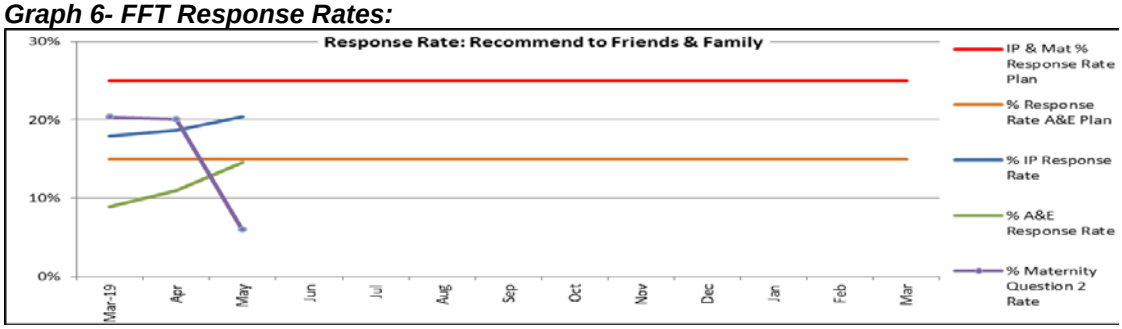
Response rates for May IP: increased from 18.7% in April to 20.4% in May. A&E (now including children) increased further from 11% in April to 14.6% in May and Maternity Q2 has decreased from 20.1% in April to 6.0% in May.

Following a review of issues reported in previous months for OP, the FFT data process is now running correctly and response rates have realigned to expected levels. A further increase has been seen in May with 7599 responses.

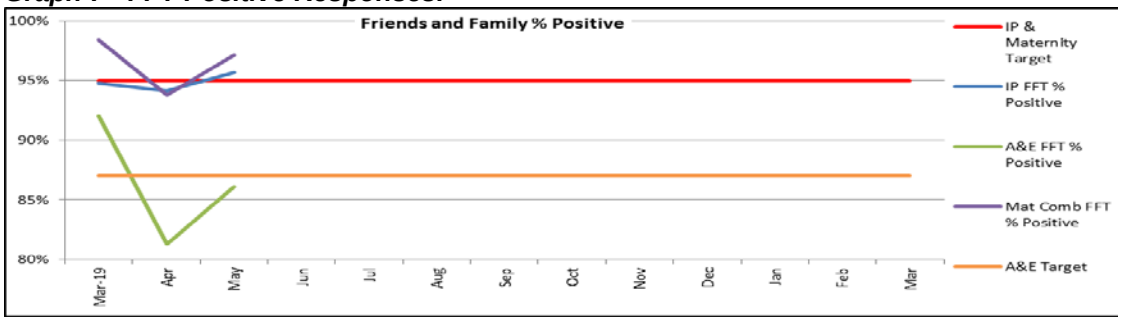
For the % Positive for May, inpatients has increased from 94.2% in April to 95.6% in May, A&E increased from 81.2% in April to 86.1% in May and Maternity (all 4 combined) increased from 93.8% in April to 97.1% in April .

May % Positive: 95.6% for IP, 86.1% for A&E, 97.1% for Maternity Q2.
19/20 YTD Positive: 95.0% IP, 84.1% A&E, 95.0% Mat
18/19 % Positive: 94.4% IP, 91.3% A&E, 93.8% Mat

Graph 6- FFT Response Rates:



Graph 7 - FFT Positive Responses:

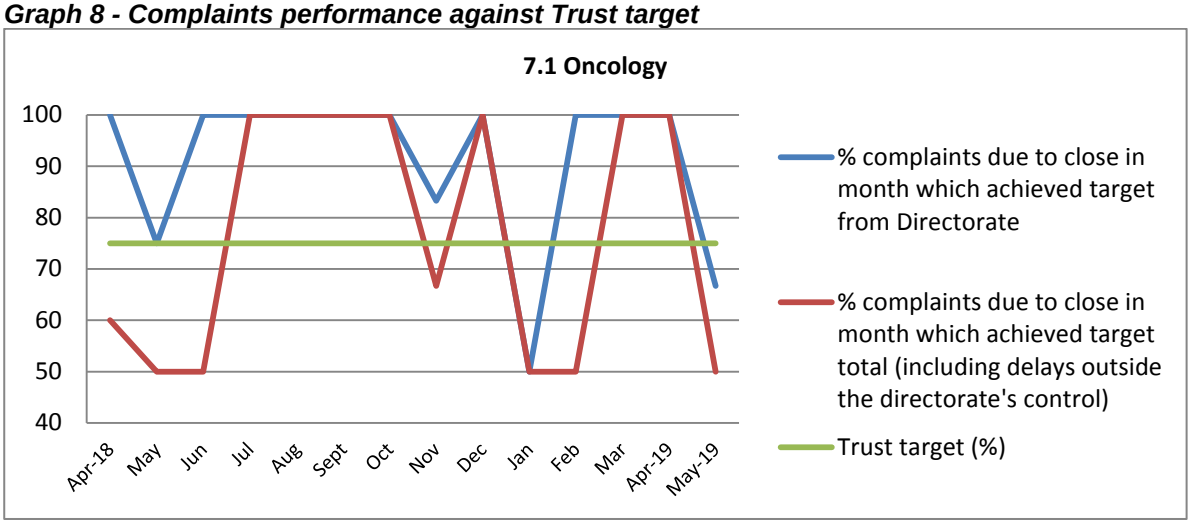


Complaints

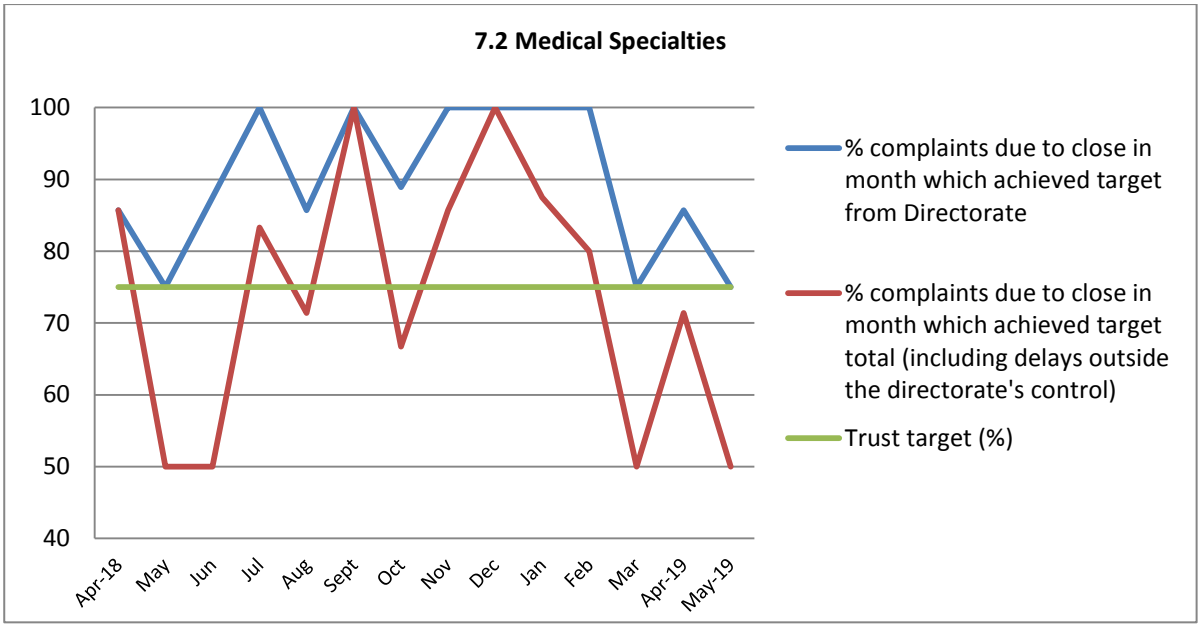
There were 47 new complaints reported for May which equates to a rate of 2.21 new complaints per 1,000 occupied bed days. This is a decrease compared to 2.28 for April. There were 173 open complaints at the end of May, compared to 155 in April.

35.7% of complaints were responded to within deadline compared to a target of 75%. Graphs 8.1 to 8.11 (below) provide information on the performance year to date for each directorate.

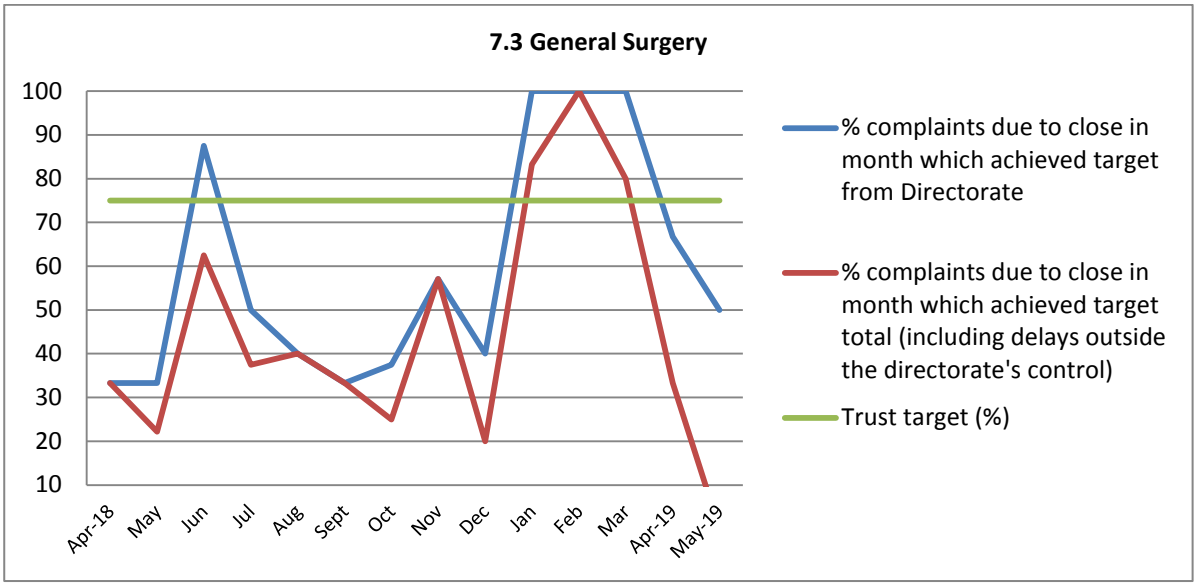
Graph 8 - Complaints performance against Trust target



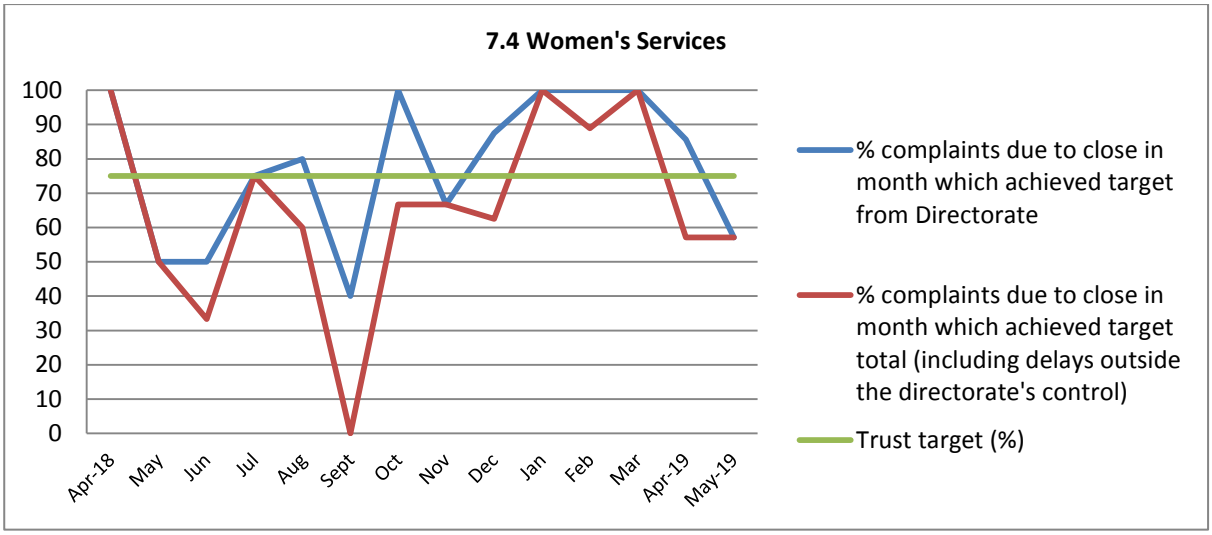
Oncology	Apr 18	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr -19	May
Number of complaints due to close in month	5	4	2	2	2	1	2	6	1	4	4	3	2	6
Number of complaints responded to in month	5	5	2	2	4	2	4	7	2	2	5	2	2	4



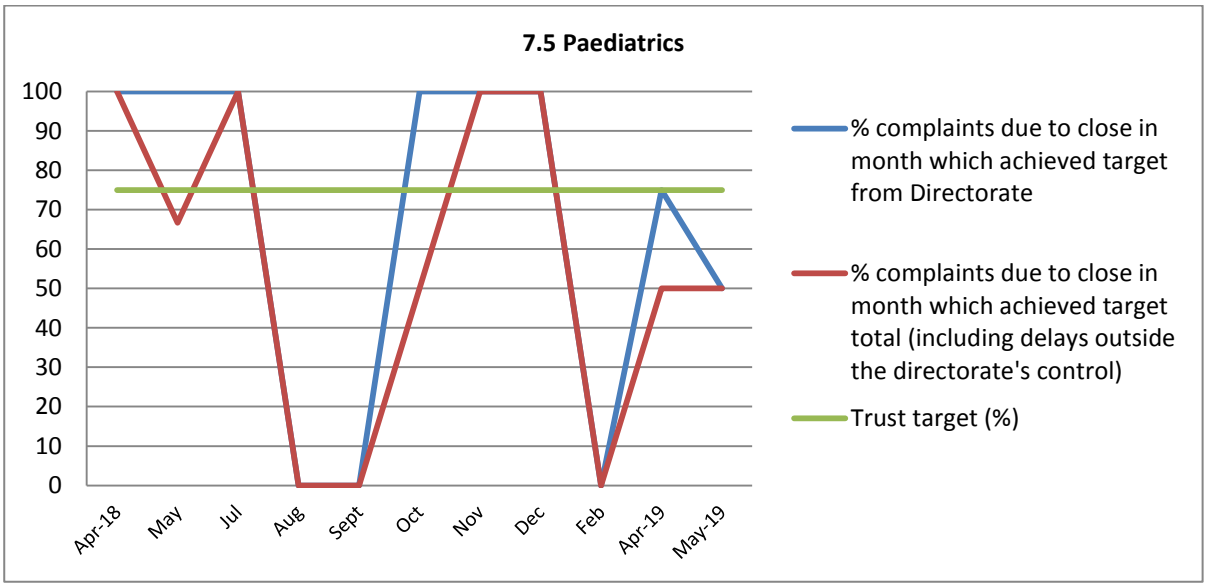
Medical Specialties	Apr -18	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr -19	May
Number of complaints due to close in month	7	12	8	6	7	7	9	7	1	8	5	4	7	4
Number of complaints responded to in month	17	7	11	10	15	9	12	8	3	10	6	2	7	3



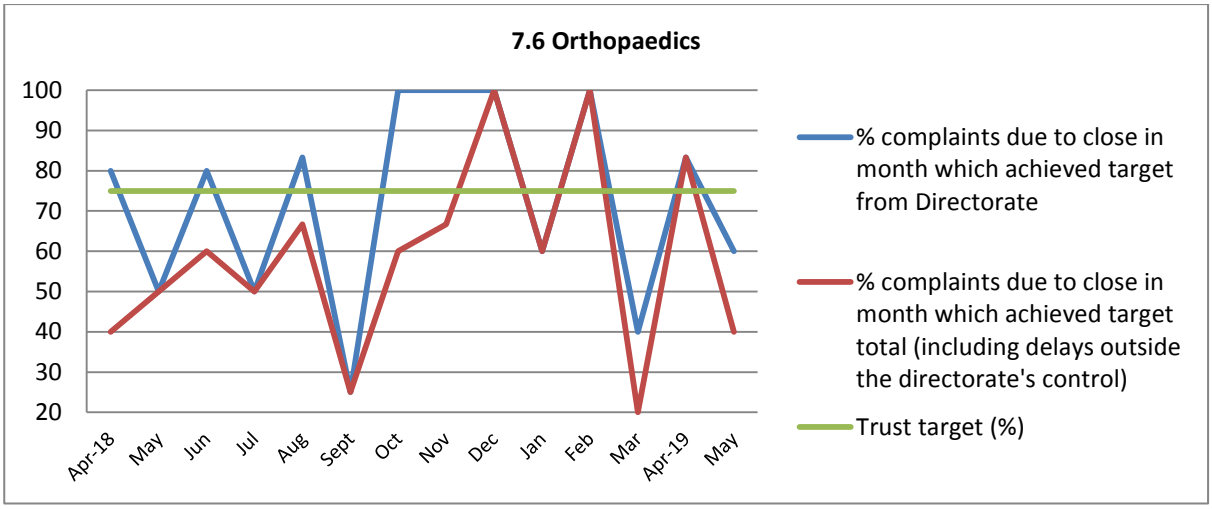
General Surgery	Apr -18	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr -19	May
Number of complaints due to close in month	6	9	8	8	5	3	8	7	5	6	6	5	3	4
Number of complaints responded to in month	12	6	9	5	10	4	10	12	6	10	7	5	2	1



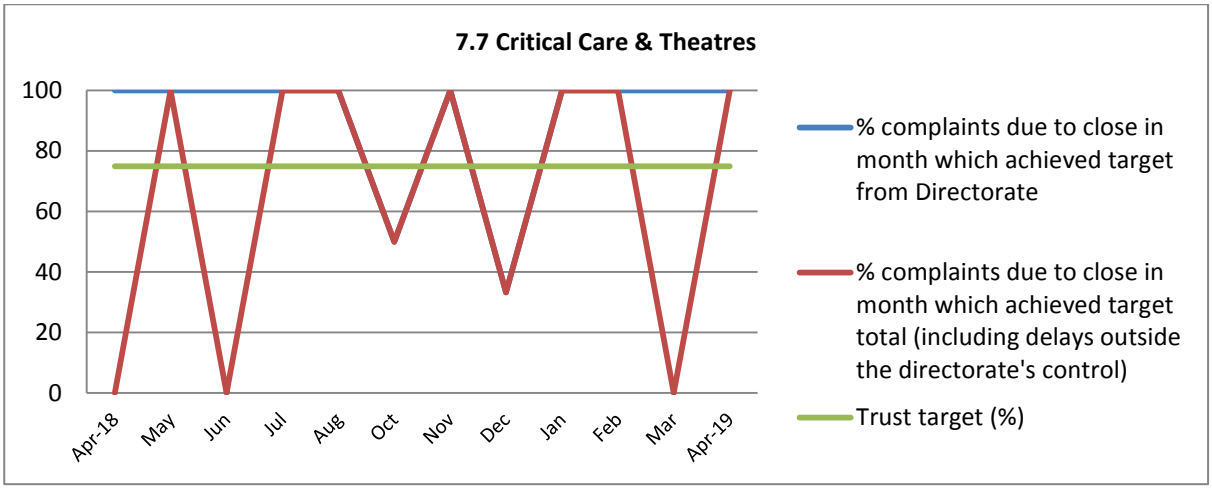
Women's Services	Apr -18	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr -19	May
Number of complaints due to close in month	5	2	6	8	5	5	3	3	8	8	9	5	7	7
Number of complaints responded to in month	8	5	9	10	8	13	11	10	6	10	9	5	5	6



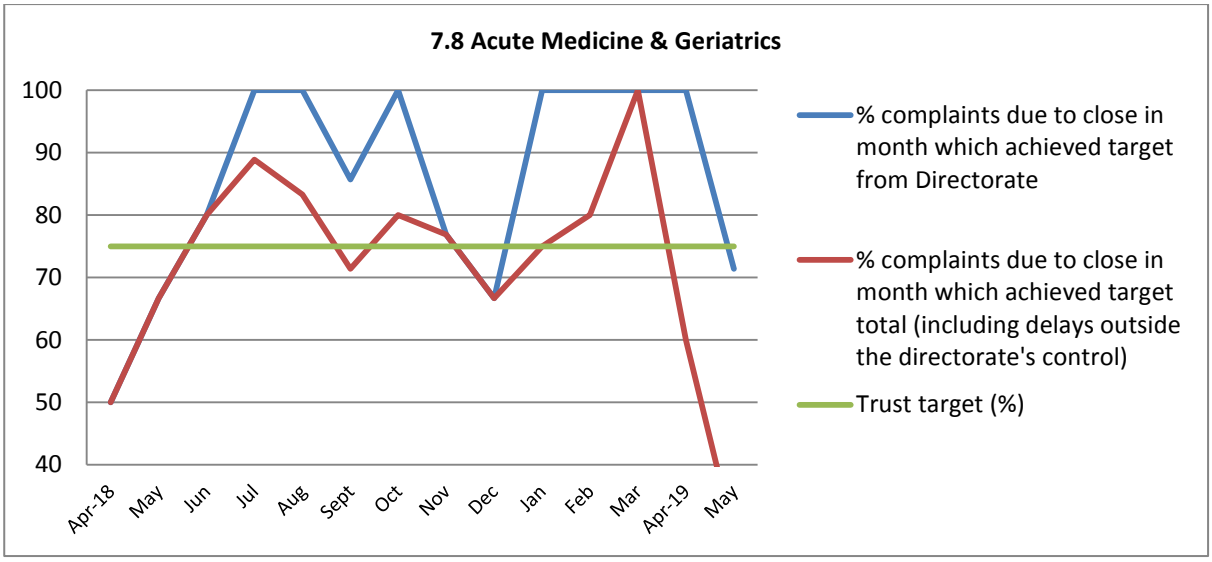
Paediatrics	Apr -18	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr -19	May
Number of complaints due to close in month	3	3	0	3	0	0	2	4	2	0	1	0	4	2
Number of complaints responded to in month	7	2	0	3	1	2	4	2	3	0	0	1	2	3



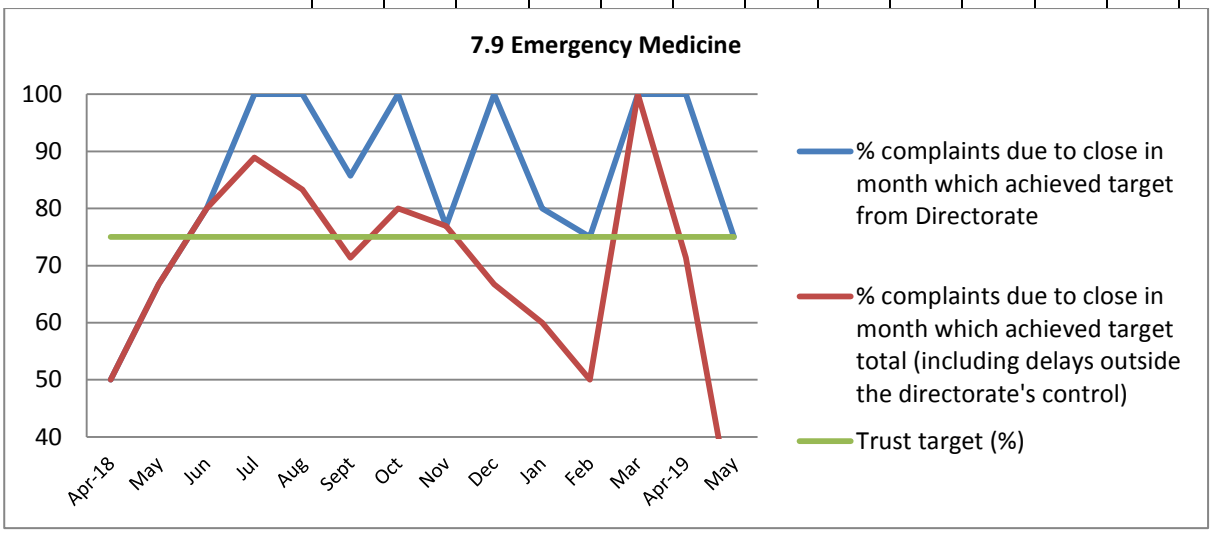
Orthopaedics	Apr -18	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr -19	May
Number of complaints due to close in month	5	2	5	4	6	4	5	3	3	5	1	5	6	5
Number of complaints responded to in month	8	3	3	6	8	3	8	4	3	6	2	4	5	3



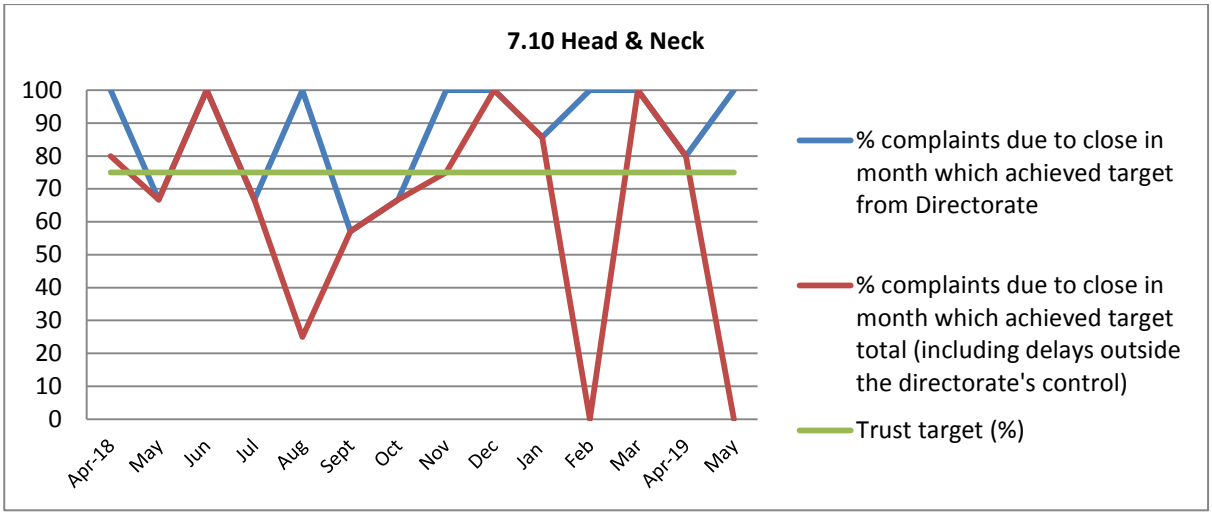
Critical Care & Theatres	Apr -18	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr -19	May
Number of complaints due to close in month	1	3	1	2	3	0	2	1	3	5	2	1	1	0
Number of complaints responded to in month	0	3	2	2	4	2	1	2	1	7	1	1	1	1



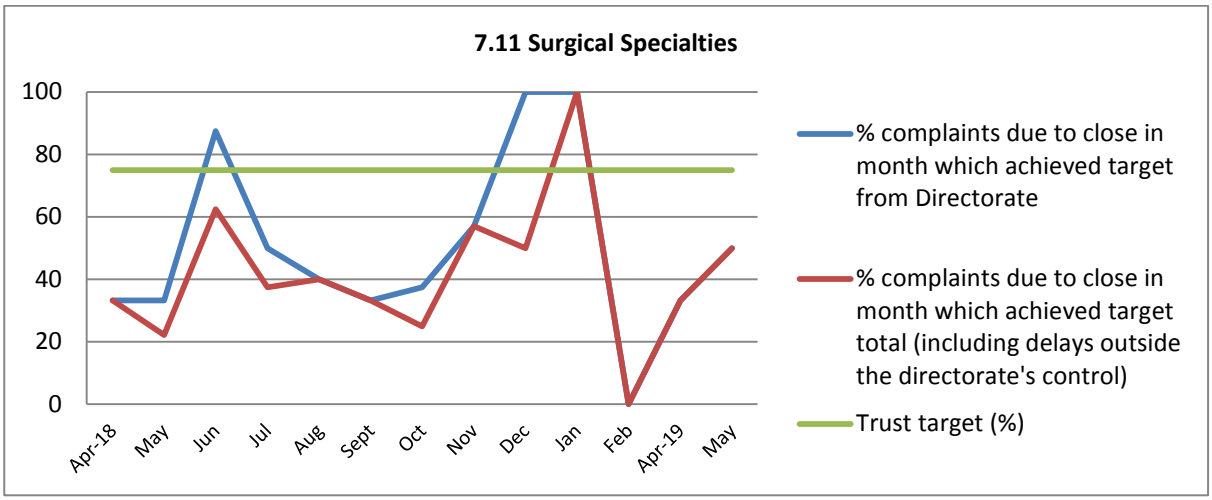
Acute Medicine & Geriatrics	Apr-18	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr-19	May
Number of complaints due to close in month	4	9	5	9	6	7	10	13	3	4	5	1	5	7
Number of complaints responded to in month	6	7	7	7	5	10	12	13	3	8	10	1	4	9



Emergency Medicine	Apr-18	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr-19	May
Number of complaints due to close in month	4	9	5	9	6	7	10	13	3	5	4	5	7	4
Number of complaints responded to in month	6	7	7	7	5	10	12	13	1	6	2	3	9	2



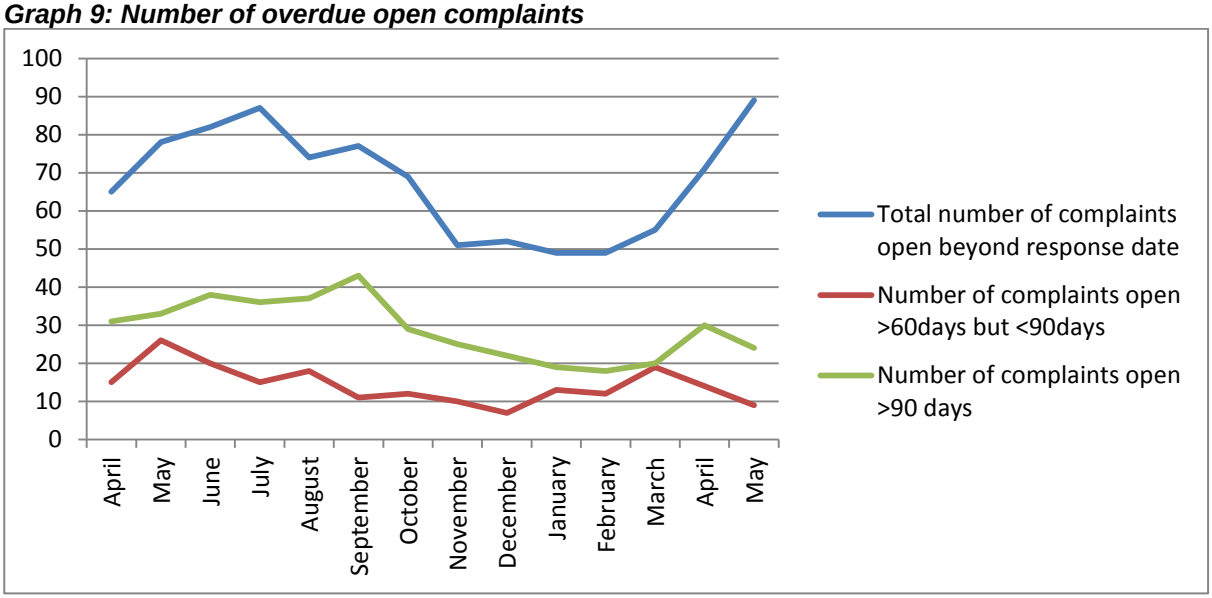
Head & Neck	Apr -18	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr -19	May
Number of complaints due to close in month	5	6	4	3	4	7	3	4	2	7	1	5	5	2
Number of complaints responded to in month	6	4	4	1	3	0	5	7	1	9	4	4	3	1



Surgical Specialties	Apr -18	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr -19	May
Number of complaints due to close in month	6	9	8	8	5	3	8	7	2	5	1	0	6	2
Number of complaints responded to in month	12	6	9	5	10	4	10	12	3	5	2	2	4	3

The only directorate to meet the 75% performance target in May was Corporate Services, which achieved 100%.

Graph 9: Number of overdue open complaints



Focused work continues around clearing older cases, using protected working periods and overtime to support this, although the complaints team remains stretched. There were unexpected staffing challenges in the complaints team towards the end of May, which has presented challenges not only in regard to maintaining performance in May but in the processing of new complaints being received. Regrettably, due to Agenda for Change regulations, the start date for the appointed Complaints Lead had to be deferred to July and a banding decision is pending on the newly created job description for the Deputy Complaints & PALS Manager role. Temporary support has been agreed utilising bank staff to help deliver the 75% target for May. However, the most significant impact on performance in May was the 17 complaints which missed their response date due to delays within the directorates. This accounted for 35% of lost performance.

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.

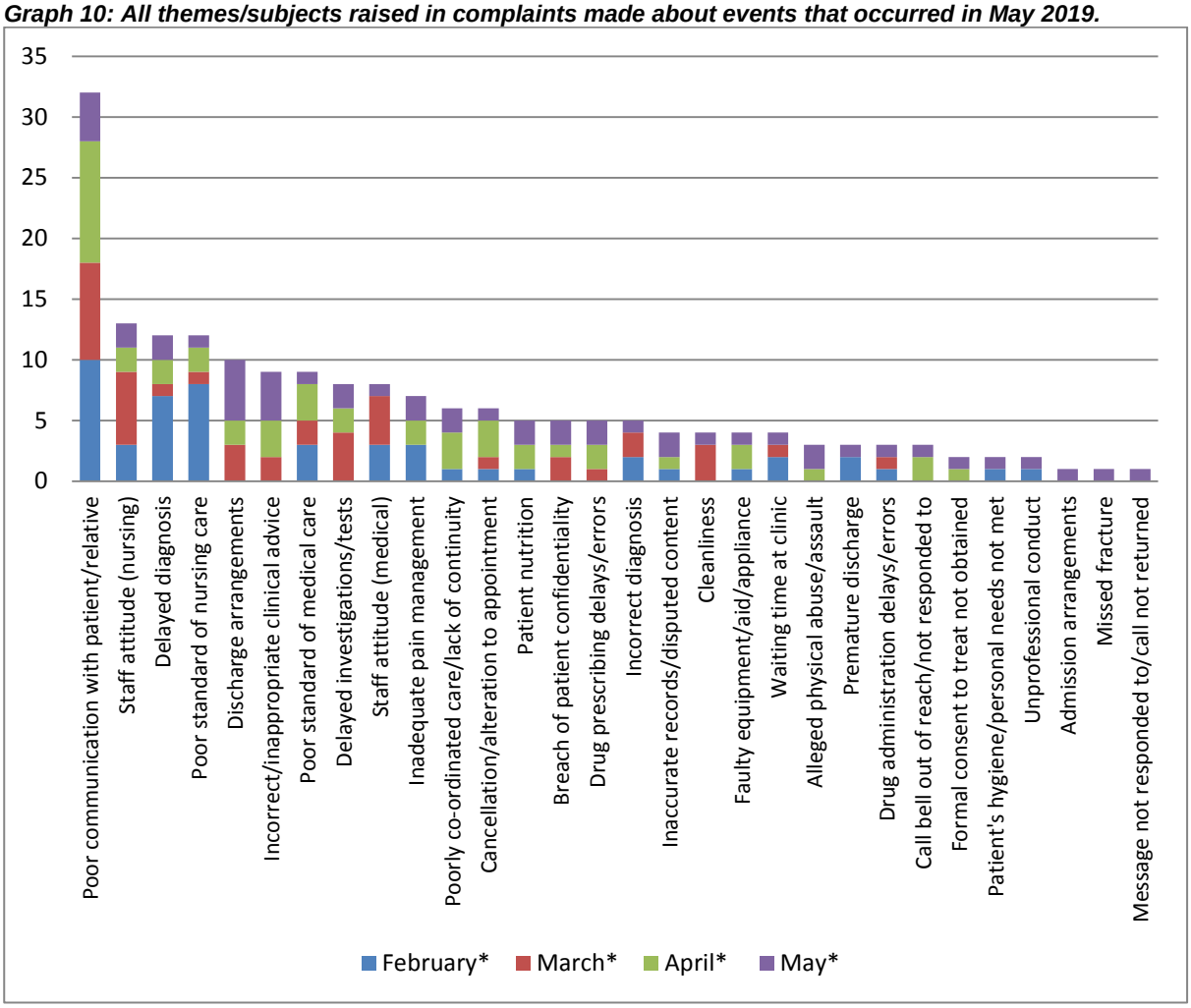
Complaints by Sub-subject – most frequently raised in May 2019

	February*	March*	April*	May*
Discharge arrangements	**0**	**3**	**2**	**5**
Incorrect/inappropriate clinical advice	**0**	**2**	**3**	**4**
Poor communication with patient/relative	**10**	**8**	**10**	**4**

*reflects the date of the event being complained about

The following graph (Graph 10) shows an expanded view of the themes of complaints that occurred in May 2019.

Graph 10: All themes/subjects raised in complaints made about events that occurred in May 2019.



As with previous reports, communication with patients/relatives remains a key theme within complaints, being the most frequently raised issue in the reporting period (February – May), although shows a reducing trend.

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

- Discharge arrangements
- Incorrect/inappropriate clinical advice
- Delayed investigations/tests
- Poorly coordinated care/lack of continuity
- Cancellation/alteration to appointment
- Breach of patient confidentiality
- Drug prescribing delays/errors
- Patient nutrition
- Alleged physical abuse/assault
- Inaccurate records/disputed content
- Call bell out of reach/not responded to
- Faulty equipment/aid/appliance
- Formal consent to treat not obtained
- Message not responded to/call not returned
- Missed fracture
- Admission arrangements

All other subjects listed in graph 10 show stable or reducing trends. 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.

Reviewing the complaints responded to in May 2019, the following table illustrates the most frequently upheld/partially upheld sub-subjects.

Most frequently upheld/partially upheld sub-subjects in complaints responded to in May 2019

	PARTUP	UPHEL	TOTAL
Cancellation/alteration to appointment	0	4	4
Poor standard of nursing care	4	0	4
Poor communication with patient/relative	2	1	3
Patient fall/injury	0	2	2
Drug prescribing delays/errors	0	2	2

Perinatal Mortality Review Tool (PMRT) report

This quarterly report will:

- Provide assurance that the service is meeting the requirement to report all eligible cases and review cases using the tool
- Assure the board that relevant key indicators in the CNST incentive scheme is being met

This report is in response to key clinical audit requirements as set by MBRRACE and is supported by the maternity services commitment to investigating all cases of stillbirth over 22 weeks.

Data on perinatal deaths in England, Scotland and Wales are collected by MBRRACE-UK (Reducing Risk through Audits and Confidential Enquiries across the UK). MBRRACE-UK is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to run the national Maternal, Newborn and Infant clinical Outcome Review Programme (MNI-CORP) which continues the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths.

MBRRACE have developed and established a national standardised Perinatal Mortality Review Tool (PMRT) which aims to standardise the review of perinatal deaths and encourage parent involvement and provide an opportunity for external scrutiny and challenge

The tool supports:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care;
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process;
- A structured process of review, learning, reporting and actions to improve future care;
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided;
- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented;
- Other reports from the tool which will enable organisations providing and commissioning care to identify emerging themes across a number of deaths to support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable;
- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nation-wide system of reviews.
- Parents whose baby has died have the greatest interest of all in the review of their baby's death. Alongside the national annual reports a lay summary of the main technical report will be written specifically for families and the wider public. This will help local NHS services and baby loss charities to help parents engage with the local review process and improvements in care.

The PMRT has been designed to support the review of the following perinatal deaths:

- Late fetal losses where the baby is born between 22+0 and 23+6 weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g;
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life;
- All neonatal deaths where the baby is born alive from 22+0 but dies up to 28 days after birth;
- Post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere

1. Process

The maternity service reports stillbirths, perinatal deaths and infant deaths via the MBRRACE-UK online reporting system.uk. All stillbirths and neonatal deaths from 22 weeks gestation will be notified to the directorate by datix. All cases are referred to the bereavement team for the families to be supported. The families are told that a review of the care will take place and they have the opportunity to ask questions that will be included in the investigation terms of reference.

The online perinatal mortality tool requires information to be inputted about the mother and the pregnancy. This is usually done by one of the bereavement or risk team midwives.
PMRT meetings will be held monthly in the Trust. The membership of this meeting is multidisciplinary and includes midwives, obstetricians, neonatal nurses, ANNPs and Neonatologists. There should also be an invited healthcare professional from another trust to aid transparency.

The case will be discussed in a round table discussion and the answers to questions in the review tool will be inputted into the online database. A report is then produced with recommendations that will also be shared with the family.

3. Eligible cases

The Trust has been required to report all perinatal deaths on the online database and review the care given using the Perinatal Mortality review tool from 12th December 2018. The maternity service started using the tool from January 2018. Below is a table of all cases from 12th December 2018.

Date 2019	Case type	SI declared	RCA	On PMRT	Report completed or PMRT panel date	Parents informed and consented to investigation
Jan	25w Intrauterine death (IUD)	No	No	Yes	PMRT tool completed	Yes
Jan	Term IUD	Yes	Yes	Yes	PMRT tool completed	Yes
Feb	26+6w IUD	No	No	Yes	PMRT tool completed	Yes
Mar	Term TOP for fetal anomaly	No	Yes	Yes although this was started in error as fetal anomalies are excluded		
April	Term IUD at home	Yes	Yes	Yes	09.07.2019	Yes
April	Term IUD	No	Yes	No	09.07.2019	Yes
May	22+1w Neonatal Death (NND)	No	No	Yes	PMRT tool completed	Yes
May	25+1w IUD	No	No	No	30.07.2019	Yes
May	29w IUD	Yes	Yes	No	30.07.2019	Yes
June	36w IUD	No	Yes	No	10.09.2019	Yes

4. **Progress against inputting data**

There are currently 9 cases that fit the criteria to be reviewed using the PMRT model that will be included in the CNST incentive programme. Four have been completed (three within the 4 month timeframe). Four will be completed prior to the data submission date of 15th August 2019 (panel dates are 9th July 2019 and 30th July 2019). The remaining case will have been started on PMRT and will go to panel on the 13th October 2019. This means that of the nine cases that we have reported from 12th December, seven will have had their report completed by the submission date of 15th August with one still being eligible to be completed by 13th October 2019.

5. Summary

The maternity service at Maidstone Tunbridge Wells NHS Trust aims to embed the use of the PMRT tool into the risk process as standard. The requirement by CNST incentive scheme mandates that all eligible cases from December 2018 should be inputted on the database within 4 months of each death. Unfortunately one case was out of time for the four month deadline but the eight other cases are due to being completed within the four month timeframe. All cases were started on the database within 4 months which equates to 100% compliance with the CNST standard.
There are monthly meetings booked and external representation as recommended has been arranged.

Summary of recently declared Never Event

During the month of June we have declared a Never Event that occurred in the Neonatal unit in February, 2019. Although it is evident that the wrong baby underwent a planned procedure we would wish to assure the Board that ultimately no harm occurred to either baby.

Summary:-

Type of incident: Procedure on wrong patient (12/02/2019)

Description of what happened: Lumbar puncture (LP) performed on wrong baby.
Two babies met the criteria for sepsis screening due to a history of maternal sepsis and prolonged rupture of membranes. Both babies were called to the neonatal unit from Postnatal ward to have bloods taken to check for raised inflammatory markers (C-Reactive Protein). Baby 1's markers were raised and required a LP. Baby 2's blood results did not indicate the need for a LP. Parents of both babies were told there may be a need to perform a LP.

Baby 2 was taken back to the neonatal unit and underwent a LP, C-Reactive protein was 5 prior to lumbar puncture (CRP over 20 requires a lumbar puncture), post procedure the CRP was 72 which would have indicated the need for a LP. Baby 1 subsequently had a lumbar puncture the following day; this delay has not caused any harm.

Immediate action taken for the patient: Baby remained well throughout and commenced antibiotics as indicated for the raised CRP.

Recommendations and Actions:-

Immediate actions including mitigation to prevent recurrence:

1) An Email was sent to all staff (nursing and consultants to cascade to trainees): "All babies requiring a Lumbar Puncture need to have their name band checked with the results on the Neonatal Unit and documented in the medical notes. Reason for CRP (c-reactive protein test) and Lumbar Puncture to be documented in the notes at this time".
2) A guideline for undertaking a Lumbar Puncture on the neonatal unit has been written and is in draft. This has initially been circulated to specific Consultants for comment and then will be more widely distributed for consultation and sign off.
3) A draft parent information leaflet has also been written and will then be taken to the NNU guideline group during the first week of July 2019.

Serious Incident Declared – 05/06/2019
Duty of Candour Letter sent – 07/06/2019

Safe staffing: Planned versus actual (May)

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for May 2019. 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 include:

Cornwallis: Reduced RN fill rate in line with bed occupancy range between 13 - 19 throughout the month. Increased CSW fill rate at night due to enhanced care requirements.

John Day: 3 falls above threshold. Increased CSW rate to support patients at high risk of falls. Fill rate included 36.6% of temporary staffing of which 51.3% were agency. Temporary RN staffing demand for the month equivalent to 10.86 WTE.

Whatman: Increased fill rate reported during the month due to ward escalation to meet demand. Fill rate included 51.8% of temporary staffing of which 29.8% were agency. Temporary staffing demand for the month equivalent to 8.37 WTE

Lord North: Increased CSW fill rate to support increased acuity and dependency levels of patient's on the ward.

UMAU (MDGH): Increased fill rate at night due to ongoing escalation. 169 requests for registered nurses. Overall fill rate consisting of 43.1% temporary staff of which 54.5% were agency staff.

Ward 22: Reduced fill rate due to vacancies levels and shifts not covered with a lack of available temporary staffing throughout month. 248 requests for RN's were made during April. Fill rate includes 38.7% fill by temporary staffing of which 32.6% were agency. Temporary RN staffing demand for the month equivalent to 15.04 WTE.

Gynaecology / Ward 33: 2 falls above threshold. Reduced fill rate in care support workers due to lack of available temporary staff and increased service demand extending EGAU to 24hrs.

MAU (TWH): Significant improvement in falls rate this month remaining within threshold. Reduced fill rate due to vacancies and lack of available temporary staff to fill shifts throughout the month. 241 RN requests were made during the month. Fill rate includes 32.1% of temporary staff of which 30.5% were agency. RN Requests equivalent to 17.07 WTE. QuESTT score improved at 7.

Ward 32: Reduced RN fill rate with high vacancy rate on ward and unable to fill due to lack of available temporary staff throughout the month. Skill mix adjustment to support with increased CSW rate. Final fill rate included 41.8% of temporary staff of which 31.5% were agency. RN temporary requests equivalent to 9.35 WTE.

Ward 11: 2 falls above threshold. Reduced RN fill rate due to sickness and vacancies. Skill mix adjustment to increase CSW fill rate to support staffing levels. Improvement in falls rate remaining within threshold. Reduced RN fill rate due to sickness and vacancies. Skill mix adjustment to increase CSW fill rate to support staffing levels.

Ward 12: Increase in fall to 5 above threshold. Reduced fill rate due to vacancies and lack of available temporary staff resulting in unfilled shifts. 138 RN requests were made. Total fill rate supported by 34.8% of temporary staffing of which 30.8% were agency. RN temporary requests equivalent to 8.86 WTE

Ward 20: Increase in falls to 10 above threshold. Increased CSW fill rate at night to support enhanced care requirements. QuESTT score 12 to include newly appointed ward manager.

Ward 2: 7 falls above threshold. Reduced RN fill rate due to lack of available temporary staff and AFU escalated on 7 occasions. 145 RN requests made to support staffing.

Maternity: Reduced fill rate due to lack of available temporary staff. Delivery suite prioritised to ensure safe staffing levels. High level of maternity leave within service contributing to reduced fill rate.

Neonatal Unit: High level of admissions recorded in May with 6 days in black escalation.

SSSU: Increased fill rates due to unit escalation throughout the month. Bed occupancy fluctuated between 11 – 24. 143 RN and 92 CSW temporary staffing requests made. Fill rate therefore inclusive of 51.2% temporary staffing of which 22.6% were agency. Temporary staffing request equivalent to 9 WTE. Data shows improvement for the month.

A+E (MH + TWH): MH- Reduced RN fill rate due to uncovered shifts. Fill rate inclusive of 28.6% temporary staffing of which 40.5% were agency. Actual demand for RN covers with 257 requests. TWH- Reduced RN and CSW fill rates due to lack of available temporary staff and vacancies through the month. This fill rate includes 46% temporary staffing of which 56.2% were agency. A total of 475 RN requests were made making an equivalent of 32.47 WTE.

Planned vs. Actual

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

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

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

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

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

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

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

The successful roll out of Health roster enables for further scrutiny of PvA through the Key Performance Indicators to include:

Roster Score	Unfilled Roster	Duties With Warnings	Partially Approved Rosters	Fully Approved Rosters	Roster Approval (Partial) Lead Time
Roster Approval (Full) Lead Time	Net Hours Balance	Bank / Agency Use	Annual Leave	Total Avoidable Cost Per WTE	

For example Annual leave; the headroom allowance for in patient departments is set at 21%. Annual leave parameters should fall between 11 – 15%. Where there is a reduced fill rate in month the KPI will identify if Annual leave is an influencing factor.
With the introduction of apprenticeships and the start for the new Trainee Nursing Associates (TNAs) this will impact on the current workforce structure. This will require a revised methodology

when considering our workforce needs to ensure consideration to the future structure of new learners, apprentice's and the introductions of TNA's leading to the Nursing Associate role.

Bank / Agency Demand: Registered Nurse / Midwife and Care / Midwifery Support Worker
Bank / Agency usage data monitoring
WTE Temporary request demand RN/M

As described in the Planned V Actual commentary the fill rate percentage is the actual hours used compared to the hours set in the budgeted establishment. In addition to this information, it is known that nationally and internationally there is an increasing shortage of registered nurses to maintain levels of fill rate. Maidstone and Tunbridge Wells NHS Trust have worked collaboratively with NHS improvement on a focused recruitment and retention plan and continues this high priority focus with new ways of working, new roles and safe staffing reviews. To more fully appreciate the complexities of fill rates and how these rates are delivered, new data set has been introduced to this report to provide the following detail:

- Percentage rate of overall fill rate supported by temporary staffing
- Percentage rate of temporary staffing fill rate by external agencies.
- Demand data for fill rates for registered nurses and midwives in numbers to provide depth of meaning to percentage data
- Whole Time Equivalent Demand of temporary staffing for registered nurses and midwives
- Temporary Demand data for unfilled requests.

These figures do not take into account the daily movement of staff that is managed by our Matrons and DDNQs in line with demand nor does it reflect the contribution of direct clinical care provided by our matrons who are frequently supporting care delivery in our wards to ensure safe staffing.

Care Hours per Patient Day

Updated information has been communicated by NHS Improvement in June 2018 (CHPPD) Guidance for Acute and Acute Specialist Trusts.

CHPPD is a measure of workforce deployment that can be used at ward, service or aggregated to Trust level. The safe staffing paper uses the CHPPD at ward / department level where service leaders and managers can consider the workforce deployment over time, with comparable wards within a trust or at other trusts as part of a review of staff deployment and overall productivity.
To calculate CHPPD, monthly returns for safe staffing along with the daily patient count at midnight, which is the total number of patients on the ward at 23:59 are aggregated for the month.

Calculation:
Day Shift Hours + Night Shift Hours Worked by both Nursing Support Staff and Registered Nurses & Midwives

_____
Approximation of Every 24 Hours of In-Patient Admissions by Taking a Daily Count of Patients in Beds at 23:59

The updated guidance references CHPPD for ward-based AHPs and other clinical staff:
'Ward-based Allied Health Professionals (AHPs) and other clinical staff who provide patient care in multi-disciplinary teams alongside nursing or midwifery staff can be included in the Safe Staffing returns for the purposes of calculating CHPPD. This only relates to staff that are part of the ward roster and are included in the ward establishment. Registered clinical staff can be reported alongside registered nursing and midwifery staff. Non-registered clinical staff can be recorded alongside healthcare support workers.'

MTW have looked proactively at AHPs in traditional nursing roles and as such, has successfully appointed an Occupational Therapist to the role of Ward Manager to MAU (TWH). This role will be included in the CHPPD calculation.

Current guidance does not yet include the patient facing hours that centrally deployed AHPs provide to a ward / department on any given day, into the CHPPD metric, as we would not be counting like with like.

QuESTT:

The QuESTT score seeks to offer a more objective approach to the safety and effectiveness of a ward to reflect aspects of good leadership and multi-professional engagement with care. Nurse sensitive indicators and included alongside the QuESTT score.

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 RAG rating for QuESTT is rated as:
Green: 0 - 11
Amber: 12 – 15 Trend analysis and further enquiry
Red : 16 + Immediate enquiry and action to be taken

The Quality, Effectiveness & Safety Trigger Tool (QuESTT) collection tool continues to be available to all wards. Completion and review rate has returned to 100% compliance for submission (not including maternity) for the month of May. QuESTT continues to be further embedded into the monthly reporting systems and promoted through the Chief Nurse's senior team. Safe staffing information requested as an agenda item for the Senior team to review.

A trigger of Amber of Red will initiate a "Quality Review" relating to the quality indicators over a nominated period of time. This will be a minimum of a one quarter annum period to identify any themes or trends arising. The indicators for review include:
Falls
Complaints
FFT
Workforce KPIS including sickness, vacancy, turnover
Performance
Financial performance
E roster KPIs
Other patient safety incidents

Table 1

QuESTT: Quality, Effectiveness and Safety Trigger Tool		
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 *monthly* 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.
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.

Indicators	True?	Score if True
New or no line manager in post (within last 6 months)		1
Vacancy rate higher than 3%		3
Unfilled shifts is higher than 6%		2
Sickness absence rate higher than 3.5%		2
No monthly review of key quality indicators by peers, e.g. peer review or governance team meeting		3
Planned annual appraisals not performed		2
No involvement in Trust-wide multi-disciplinary meetings		2
No formal feedback obtained from patients during the month, e.g. questionnaires or surveys		3
2 or more formal complaints in a month (Wards) or 3 or more (A&E or OPD) or 1 or more (CCU & ICU		3
No evidence of resolution to recurring themes		3
Unusual demands on service exceeding capacity to deliver, e.g. national targets, outbreak		2
Hand hygiene audits not performed		3
Cleanliness audits not performed		3
Ward/Department appears untidy		2
No evidence of *effective* multi-disciplinary/multi-professional team working		1
Ongoing investigation or disciplinary investigation (including RCA's & infection control RCA's)		2
Overall Score:		

Insert comments below (if appropriate):

May-19		DAY		NIGHT		TEMPORARY STAFFING		Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled -RM/N (number of shifts)	Overall Care Hours per pt day	Nurse Sensitive Indicators						Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Bank/Agency Usage	Agency as a % of Temporary Staffing					FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	QuESTT Score	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	101.6%	91.1%	99.2%	145.7%	34.2%	44.9%	103	7.10	2	8.1	44.5%	100.0%	2	0	4	Increased fill rate at night due to enhanced care requirements recorded across 19 occasions	155,571	147,111	8,460
MAIDSTONE	Cornwallis (M) - NS959	85.9%	81.1%	74.2%	129.0%	26.7%	16.0%	43	2.71	2	7.2	0.0%	0.0%	0	0	2	Reduced RN fill rate in line with bed occupancy range between 13 - 19 throughout the month and supporting bed management for operational flow. Increased CSW fill rate at night due to enhanced care requirements.	80,936	103,514	(22,578)
MAIDSTONE	Culpepper Ward (M) - NS551	101.2%	91.7%	100.0%	96.8%	13.9%	14.6%	42	2.93	0	10.9	81.3%	100.0%	1	0	2	Escalated by +1 on 2 occasions and by +2 on 3 occassions. Supported by CCU.	118,151	108,215	9,936
MAIDSTONE	John Day Respiratory Ward (M) - NT151	91.5%	122.3%	97.4%	104.8%	36.6%	51.3%	156	10.86	15	6.1	46.5%	97.0%	8	0	5	3 falls above threshold.Increased CSW fill rate to support patients at risk of increased falls.	143,284	136,779	6,505
MAIDSTONE	Intensive Care (M) - NA251	90.9%	52.2%	85.6%	-	2.7%	0.0%	15	1.10	4	28.1			0	0	1	Reduced fill rate in line with lower bed occupancy.	162,182	158,184	3,998
MAIDSTONE	Pye Oliver (Medical) - NK259	103.0%	95.0%	103.1%	92.5%	26.9%	52.6%	108	7.47	6	5.9	14.1%	88.9%	3	1	7		116,923	123,230	(6,307)
MAIDSTONE	Whatman Ward - NK959	108.2%	83.7%	143.4%	172.6%	51.8%	29.8%	128	8.37	14	7.4	0.0%	0.0%	3	0	3	Increased fill rate at night due to ward escalation throughout the month.	85,888	125,079	(39,191)
MAIDSTONE	Lord North Ward (M) - NF651	92.5%	160.1%	100.3%	87.3%	25.9%	13.5%	65	4.34	9	6.7	69.8%	100.0%	2	0	2	Increased CSW fill rate to support increased acuity and dependency levels of patient's on the ward.	88,181	94,434	(6,253)
MAIDSTONE	Mercer Ward (M) - NJ251	102.2%	98.0%	100.0%	96.8%	16.0%	44.7%	71	4.54	5	5.9	33.3%	88.9%	5	1	1		117,854	105,368	12,486
MAIDSTONE	Edith Cavell (M) - NS459	99.1%	105.4%	106.5%	95.6%	14.7%	17.9%	32	1.99	1	5.7	112.5%	100.0%	2	0	2		91,562	75,617	15,945
MAIDSTONE	Acute Medical Unit (M) - NG551	99.2%	92.2%	128.0%	193.5%	43.1%	54.5%	169	11.12	26	9.0	4.9%	100.0%	5	0	4	1 fall above threshold Unit remained escalated at night requiring increased fill rate throughout the month	122,943	149,117	(26,174)
TWH	Ward 22 (TW) - NG232	74.2%	96.9%	96.1%	104.3%	38.7%	32.6%	248	15.04	74	9.4	136.4%	93.3%	6	0	7	Reduced fill rate due to vacancies and shifts not covered with a lack of available temporary staffing throughout month.	158,503	138,964	19,539
TWH	Coronary Care Unit (TW) - NP301	98.1%	87.8%	100.3%	-	39.6%	34.7%	94	5.72	5	10.6	159.3%	95.3%	1	0	3	1 fall above threshold Reduced CSW fill rate due to staff moves to support safe staffing across the Trust	69,051	69,813	(762)
TWH	Ward 33 (Gynae) (TW) - ND302	93.9%	83.6%	100.0%	86.5%	17.7%	7.6%	65	4.01	16	10.8	32.0%	94.9%	2	0	0	2 falls above threshold. Reduced fill rate in care support workers due to lack of available temporary staff and increased service demand extending EGAU to 24hrs.	84,641	95,421	(10,780)
TWH	Intensive Care (TW) - NA201	100.8%	120.5%	99.2%	103.3%	2.2%	7.4%	15	0.99	1	28.7			2	0	2	2 falls above threshold	192,626	189,030	3,596
TWH	Acute Medical Unit (TW) - NA901	79.6%	92.7%	96.2%	96.1%	32.1%	30.5%	241	17.07	62	7.8	35.7%	93.6%	2	0	7	Reduced fill rate due to vacancies and lack of available temporary staff to fill 59 shifts throughout the month.	184,811	188,552	(3,741)
TWH	Surgical Assessment Unit (TW) - NE701	93.3%	86.8%	100.0%	96.8%	17.7%	12.4%	23	1.64	1	10.7			1	0	0	1 fall above threshold Escalated on 8 occasions throughout the month.	61,354	60,195	1,159
TWH	Ward 32 (Wells Suite) (TW) - PP010	69.6%	121.4%	99.8%	93.0%	41.8%	31.5%	137	9.35	29	5.9	21.2%	78.6%	6	0	9	Reduced RN fill rate with high vacancy rate on ward unable to fill due to lack of available temporary staff throughout the month. Skill mix adjustment to support with increased CSW rate.	153,972	114,228	39,744
TWH	Ward 10 (TW) - NG130	95.3%	99.2%	83.6%	167.2%	45.8%	29.9%	163	9.85	25	6.5	43.6%	100.0%	2	0	5	Increased CSW fill rates at night due to enhanced care requirements. Skill mix adjustment a considered risk by the ward team in line with a high dependency and moderate acuity.	117,919	121,852	(3,933)
TWH	Ward 11 (TW) - NG131	83.2%	110.2%	98.9%	150.5%	41.7%	37.2%	157	10.64	24	6.4	14.5%	100.0%	6	0	3	2 falls above threshold Reduced RN fill rate due to sickness and vacancies. Skill mix adjustment to increase CSW fill rate to support staffing levels.	122,488	133,228	(10,740)
TWH	Ward 12 (TW) - NG132	85.3%	96.9%	99.7%	87.9%	34.8%	30.8%	138	8.86	29	5.7	82.2%	93.3%	11	0	11	5 falls above threshold Reduced fill rate due to vacancies and lack of available temporary staff resulting in unfilled shifts. In addition, Staff moves to support safe staffing across the Trust.	146,413	110,315	36,098
TWH	Ward 20 (TW) - NG230	91.5%	109.9%	97.8%	130.1%	45.9%	18.0%	112	7.78	10	5.7	7.1%	50.0%	17	0	12	10 falls above threshold Increased CSW fill rate due to enhanced care requirements throughout the month.	117,249	105,435	11,814
TWH	Ward 21 (TW) - NG231	84.7%	108.5%	102.8%	112.9%	29.2%	53.0%	166	10.71	53	6.1	20.6%	100.0%	6	1	7	Redcued RN fill rate due to STS and vacancies with lack of available temporary staffing to cover. Skill mix adjustments at night to support ward and increased CSW fill rate.	144,755	149,630	(4,875)
TWH	Ward 2 (TW) - NG442	78.7%	97.0%	105.4%	97.8%	30.0%	46.0%	145	9.97	40	6.5	22.0%	76.9%	14	0	11	7 falls above threshold Redcued RN fill rate due to lack of available temporary staff. AFU escalated on 7 occassions.	143,052	124,690	18,362
TWH	Ward 30 (TW) - NG330	92.4%	106.7%	101.1%	97.8%	38.5%	29.9%	162	10.50	29	5.9	0.0%	0.0%	4	0	2		119,617	121,854	(2,237)
TWH	Ward 31 (TW) - NG331	96.5%	85.5%	105.6%	101.1%	35.3%	46.5%	170	10.61	25	6.5	50.0%	90.0%	3	1	9	Reduced CSW fill rate due to sickness and lack of available temporary staff. Altered skill mix to support ward.	131,209	130,658	551
Crowborough	Crowborough Birth Centre (CBC) - NP775	97.6%	96.8%	89.9%	96.8%	12.0%	0.0%	20	1.01	2		21.6%	97.1%		0			63,751	70,511	(6,760)
TWH	Midwifery (multiple rosters)	81.6%	63.3%	94.8%	76.9%	14.6%	9.0%	457	27.40	49	20.5			0	0		Reduced fill rate due to lack of available temporary staff. Delivery suite prioritised to ensure safe staffing levels. High level of maternity leave within service.	683,952	671,735	12,217
TWH	Hedgehog Ward (TW) - ND702	90.1%	44.1%	106.6%	-	18.8%	44.0%	172	11.24	28	12.2	5.4%	100.0%	0	1	6	Additional RMN requirements throughout the month. Reduced CSW fill rate due to lack of paediatric cover.	207,394	188,731	18,663
MAIDSTONE	Maidstone Birth Centre - NP751	105.4%	79.4%	98.0%	93.5%	20.8%	0.0%	25	1.42	0		69.4%	100.0%	0	0		Reduced MSW fill rate due to vacancy and lack of available temporary staff	68,187	66,909	1,278
TWH	SCBU (TW) - NA102	80.9%	73.0%	102.8%	-	11.6%	1.4%	80	4.49	3	13.0				0	2	Most admission per month recorded in May with 6 days in black escalation.	170,647	173,311	(2,664)
MAIDSTONE	Short Stay Surgery Unit (M) - NE751	102.9%	112.6%	91.1%	-	22.5%	15.3%	33	2.24	5	11.2			0	0	0	Increased fill rate to support additional theatre lists.	43,595	43,505	90
TWH	Short Stay Surgical Unit (TW) - NE901	108.8%	127.0%	111.0%	200.0%	66.6%	34.1%	143	9.42	16	7.3			2	0	7		87,651	91,339	(3,688)
MAIDSTONE	Accident & Emergency (M) - NA351	84.7%	102.7%	97.1%	93.7%	28.6%	40.5%	257	16.41	44		5.0%	85.9%	1	0		MH - Reduced fill rate recorded across 22 shifts. TWH - Reduced RN day fill and CSW night fill rate due to multiple unfilled shifts due to vacancies and lack of available temporary staff.	207,836	209,970	(2,134)
TWH	Accident & Emergency (TW) - NA301	89.7%	91.4%	94.8%	72.1%	46.0%	56.2%	475	32.47	60		23.3%	86.1%	2	0			359,447	346,623	12,824
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	67.1%	55.3%	79.0%	-	26.4%	58.4%	53	3.77	3				0	0	7	Reduced fill rate due to a combination of lack of available temporary staff and episodes of low bed occupancy with ward closed on 6 occasions	43,693	61,144	(17,451)
MAIDSTONE	Peale Ward (M) - NE959	92.8%	125.5%	100.2%	96.8%	12.8%	44.7%	43	2.81	4	9.5	13.2%	100.0%	0	0	2	Increased CSW to support SPNs and new SN.	81,332	64,885	16,447
																	Total Established Wards	5,248,620	5,148,953	99,667
																	Additional Capacity beds Cath Labs	40,411	42,822	-2,411
																	Whatman	0	-13,659	13,659
																	Other associated nursing costs	2,980,584	2,843,927	136,657
																	Total	8,269,615	8,022,044	247,571

RAG Key

Under fill

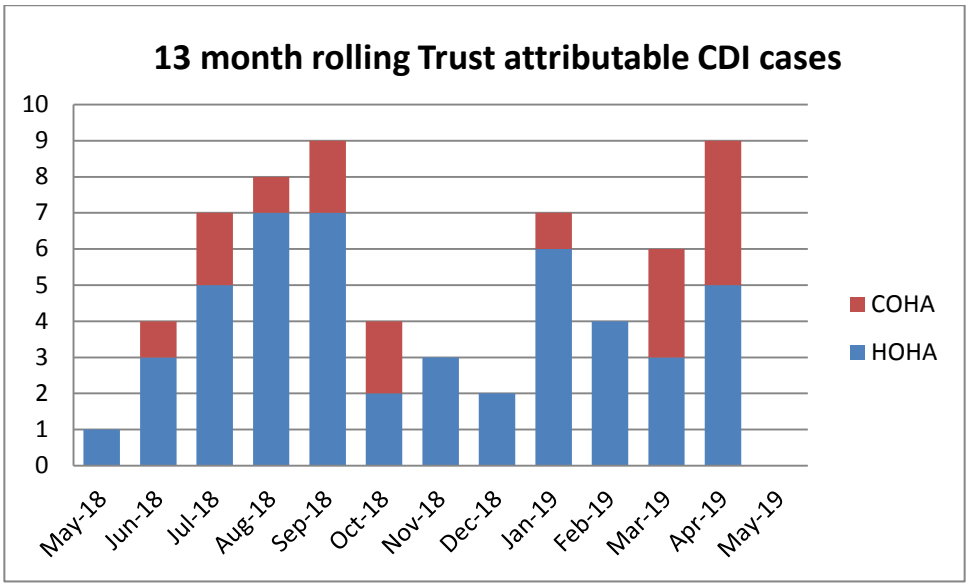
Overfill

Infection Prevention and Control (May)

MRSA

There were no cases of MRSA blood stream infection in May

C. difficile

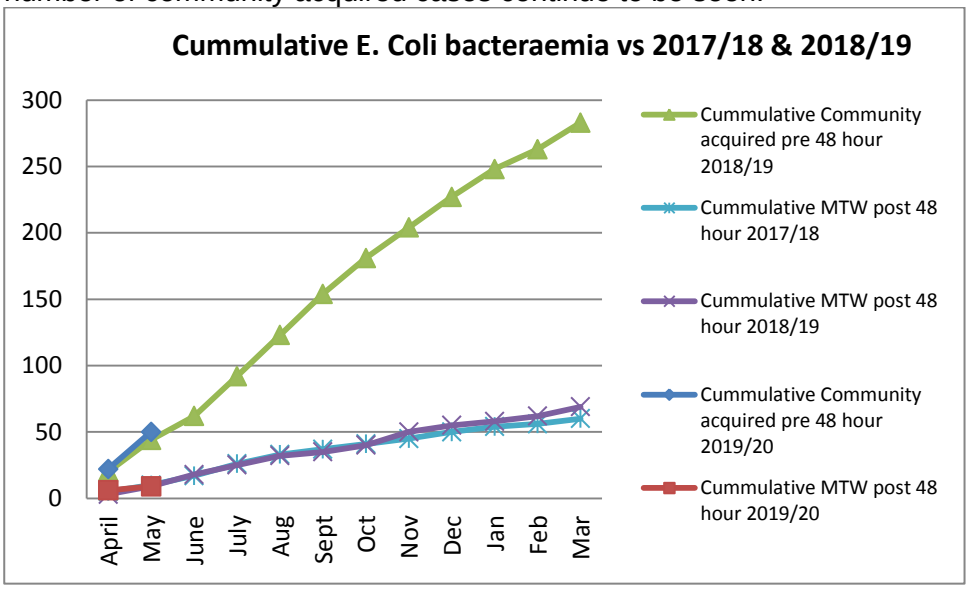


The trust objective for C. difficile this year is 55 cases

No cases of hospital-attributable C. difficile were seen in May. This brings the trust back in line with the trajectory to achieve the objective.

Gram negative bacteraemia

Four cases of hospital-attributable gram negative blood stream infection were seen in May. Three cases were due to *E. coli*, none due to *Klebsiella* and one due to *Pseudomonas* species. A high number of community acquired cases continue to be seen.



All cases of gram negative sepsis are subject to epidemiological data collection and full RCA is completed where lapses of care are identified. The Trust submits all mandatory and voluntary data on gram negative blood stream infections to Public Health England.
A task and finish group has been set up under the leadership of the Consultant Nurse in Infection Control to implement measures to further control hospital acquired gram negative bacteraemia

Methicillin sensitive *Staphylococcus aureus* bacteraemia

Three cases of hospital-attributable MSSA blood stream infection were seen in May. All cases are subject to root cause analysis and are presented at the C. difficile panel for additional scrutiny.

Financial commentary (May)

- The Trusts deficit including PSF and MRET funding was £0.1m in May which was in line with the plan.
- The Trusts normalised run rate in May was £1.2m deficit pre PSF which was £0.2m higher than plan.
- In May the Trust operated with an EBITDA surplus of £2.5m which was in line with the plan.
- The key YTD variances against plan are: Adverse variances relating to CIP slippage (£0.5m), underperformance in Private Patient Income (£0.4m net) and £0.4m pressure relating to EPR costs that were previously planned to be capitalised. These pressures have been offset by release of prior year provisions and back dated credit notes from NHS Property Services (£0.4m), over performance relating to clinical income (£0.7m) and £0.6m underspend within expenditure budgets. The Trust has increased the reserves held by £0.5m relating to the CIP stretch target.
- The key current month variances are as follows:
    - Total income net of pass-through related income is £0.5m adverse to plan which related to under delivery operating income (£0.3m) and under delivery of clinical income (£0.2m). Clinical Income excluding HCDs was £0.2m adverse in May. The key favourable variance s in A&E (£0.2m) and Outpatients (£0.3m), this is offset by adverse variances in Day Cases (£0.3m) and Adult Critical Care (£0.3m).The adverse position within Other Operating Income (£0.3m) was due to £0.3m slippage within Private Patient income due to lower activity levels than the business case, this plan is not incorporated within the CIP as this was included within the baseline position.
    - Pay budgets adjusted for pass-through items underspent by £0.4m in May. The key favourable variances relate to £0.1m release of old year provision, underspend within Cancer and RTT Reserves £0.1m and underspends within Admin and Clerical budgets (£0.2m), STT Staffing (£0.1m) and Nursing budgets (£0.1m). The key adverse variances within pay relate to Medical overspends within Acute and Geriatric (£0.1m), Gynae (£0.1m) and Paediatrics (£50k).
    - Non Pay budgets adjusted for pass though items underspent by £0.1m in the month. The key adverse variances relate to CIP slippage (£0.5m) mainly relating to prime provider (£0.3m) and EPR (£0.2m) funding pressure resulting from the full EPR costs being charged to revenue pending confirmation of additional capital funding support. The Trust benefitted in the month by £0.1m old year credit notes from NHS Property services for disputed invoices and underspent within Cancer and RTT recovery plan reserves by £0.5m however this underspend is offset by a corresponding income under delivery.
- The Trust achieved £1m savings in May which was £0.1m adverse to plan but an improvement of £0.3m between months. The key adverse variances were Prime Provider slippage (£0.33m) and Estates and Facilities slippage (£0.1m) relating to Energy procurement and catering changes. These pressures were partly offset by workforce over performance (£0.3m) within Women's and Children's (£0.2m) and Cancer and Diagnostics divisions (£0.1m).
- The Trust held £39.5m of cash at the end of May which is slightly lower than the plan of £40.2m. The high cash balance relates to £8.4m cash carried forward from the Maidstone residencies asset disposal which the Trust is waiting for confirmation from NHSI that this can fund capital projects in 2019/20 and also the advance contact payment received in April from WK CCG and High Weald CCG. Within the 2019/20 cash plan the Trust has some pressure points which will see the cash balance carried forward reduce as these materialise, the main pressure point is in February 2020 when the Trust needs to repay its Single Currency Working Capital loan of £16.9m. The cash flow forecast includes quarters 1,2 and 3 of PSF income totalling £4.97m, which if the relevant targets are not achieved the Trust will not receive this income putting additional pressure on the cash flow. The Trust is continuing to work closely with neighbouring NHS bodies and where possible "like for like" arrangements are organised with local providers. MTW usually receives a benefit as we a net provider of services so we seek a proportionate arrangement to bring the debtor/creditor positions in line with each other.
- The Trusts revised capital plan for 2019/20 is £14.4m which reflects the agreed capital plan submitted in May 2019. The Trust Programme includes £6.4m relating to funding carried forward from 2018/19 as cash from the Maidstone Residences asset sale. This funding has not yet been

approved as capital resource by NHSI/E and the Trust is working with the capital lead at NHSI/E to take this forward.

- The Trust is forecasting to deliver the plan but has following key risks:
  - Prime Provider: The Trusts plan includes 12 months of elective and outpatient Prime Provider activity however due to the timeline from referral to elective procedure it is likely that the Trust will start to see the conversion into elective activity from cJuly 2019 resulting in a reduced CIP delivery of c£1m.
  - EPR Capital Funding: The Trusts plan assumed costs associated with the EPR project would be capitalised, £1.5m via additional funding from NHS digital and £1.8m through internally generated funds. The Trust has not yet been notified about the additional funding support and due to pressures within capital budgets the full (£3.3m) costs are being charged to revenue
  - Private Patient Income: The level of Private patient income continues to be lower than planned levels, if the activity continues as current rate this would equate to £2.4m pressure.
  - Operational Efficiencies CIP assumed the Trust would 'cap' the additional investment to fund service developments to £10m, the current forecast for this investment is £2.8m more.
- To mitigate these risks the Trust is focusing on identifying further CIPs with Bi-weekly meetings taking place with Divisions and external support as well as focussing on financial management controls with Divisions reviewing all cost centres monthly variances and detailing action plans to address any overspend as well as identifying if underspending cost centres will / can continue to underspend in future months. The Trust will also have to release contingency reserves and review investment decisions where funding is not secured.

Workforce Commentary (May)

Key Workforce Risks & current actions to note:

Trust Vacancy Rate 13.2% (Target <9%)
The vacancy rate increased significantly from that reported in April (9.1%). This increase is due to the increased establishment arising from Business and Workforce planning and a revised approach to vacancy calculation agreed by the finance and HR teams.

Trust Turnover Rate 9.79% (Target <10%)
The methodology used to calculate turnover changed w.e.f. April of this year to bring the Trust in line with NHSi reporting. This will result in a higher overall number than previously reported over the course of the year.

Key Vacancy risks include:

- Nursing for medical and T&O wards at TWH
- Nursing for ED on both sites but primarily TWH
- TWH theatres
- Consultant physicians, AMU and respiratory
- Areas with high vacancy rates continue to put pressure on agency rates, particularly nursing in ED.

Current Actions

- Collating preferences for 3rd year student automatic job offers
- 41 offers made in May via the Aryavarat pilot for OSCE ready nurses. Subject to visa processing these will be expected to join the Trust from August.
- 102 offers made in Kerala in June for nurses who will require OSCE support on arrival.
- A further recruitment trip to Manilla and Cebu planned for September
- A task and finish group has been set up to oversee the professional and pastoral support needed to support these recruits
- Recruitment presence at a range of events in Kent over the summer including the Kent Show, War and Peace, Tunbridge Wells Race for Life
- Surgery recruitment day held on 22nd June
- Ongoing programme of skype interviews for overseas nurses
- Ongoing specialty doctor recruitment for paediatrics, surgery, medicine and ED
- All divisions have plans for the recruitment to vacant consultant posts
- The communications team are working with colleagues from KCHFT to develop a trust marketing and advertising strategy
- Recruitment Task and Finish group to work on a number of specific projects aimed at improving the attractiveness of MTW to potential applicants as well as supporting retention of existing staff. Projects identified from recruitment workshop held with senior staff on 12/4/19

Sickness Absence 3.5% (Target =<3.3%)
Sickness absence is currently slightly above the Trust target but reducing and remains much lower than the same period last year (3.7%). The slight increase in May is due to an increase in long term sickness absence. Short term absence continues to fall.

Short term Absence 44.5%, Long term absence 55.5%
Key challenges in

- Facilities (5.3%)
- Women's Services (4.84%)

Current Actions

- HR are providing line managers with updates on staff hitting absence triggers and are following up to ensure that sickness meetings are held and OH referrals made.

- HR staff are working with line managers to ensure that all those on long term absence have a management plan in place.

Mandatory Training 84.5% (Target 85%)

Current Actions

- Individual e-reminders to all staff now automatically issued by the Learning Management System
- Particular focus in Information Governance training
- System reconfigured to reflect revised organisational structures to allow directorate based report generation
- Data cleansing following transfer of information from the old to the new system

Appraisals (Target 90%)

- The current appraisal window is now open and as such appraisal data is not reported during this period
- New electronic appraisal system launched at the beginning of April along with a longer appraisal window should improve compliance and ease of completion for line managers. Training is available for managers to support improved quality of appraisals.

Trust Performance Dashboard

Position as at: 31 May 2019

Delivering or Exceeding Target	
Underachieving Target	
Failing Target	

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

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

	Safe	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
'1-01	*Rate C-Diff (Hospital only)	4.70	0.0	4.7	44.6	39.9	20.5	22.4	21.7	
'1-02	Number of cases C.Difficile (Hospital)	1	0	2	9	7	- 1	55	54	
'1-03	Number of cases MRSA (Hospital)	1	0	1	0	-1	0	0	0	
'1-04	Elective MRSA Screening	99.0%	99.1%	99.0%	99.1%	0.0%	1.1%	98.0%	99.1%	
'1-05	% Non-Elective MRSA Screening	No data	92.0%	No data	92.0%		-6.0%	98.0%	98.0%	
'1-06	**Rate of Hospital Pressure Ulcers	2.19	0.16	1.94	0.42	- 1.52	- 2.59	*3.01*	0.46	3.00
'1-07	***Rate of Total Patient Falls	4.61	5.66	4.94	6.28	1.34	0.28	*6.00*	6.00	
'1-08	***Rate of Total Patient Falls Maidstone	4.93	4.18	4.78	5.06	0.28			5.16	
'1-09	***Rate of Total Patient Falls TWells	6.27	6.53	5.62	6.99	1.36			7.07	
'1-10	Falls - SIs in month	3	6	4	9	5				
'1-11	Number of Never Events	0	0	0	0	0	0	*0*	0	
'1-12	Open SIRIs	68	59			- 9				
'1-13	Number of New SIs in month	20	15	33	32	- 1	12			
'1-14	***Serious Incidents rate	0.94	0.71	0.78	0.77	- 0.00	0.71	*0.0584 - 0.6978*	0.69	*0.0584 - 0.6978*
'1-15	Rate of Patient Safety Incidents - harmful	1.22	1.39	1.33	1.22	- 0.11	- 0.01	*0 - 1.23*	1.22	*0 - 1.23*
'1-16	Number of CAS Alerts Overdue	0	2			2	2	*0*		
'1-17	VTE Risk Assessment - month behind	97.0%	96.9%	97.0%	96.9%	0.0%	1.9%	95.0%	96.9%	95.0%
'1-18	Safety Thermometer % of Harm Free Care	97.2%	98.5%	97.2%	98.0%	0.8%	3.0%	95.0%		93.4%
'1-19	Safety Thermometer % of New Harms	2.24%	1.51%	2.45%	1.93%	-0.52%	-1.1%	*3.00%*	1.93%	
'1-20	C-Section Rate (non-elective)	14.4%	19.0%	13.7%	17.7%	4.05%	2.7%	*15.0%*	17.7%	

	Effectiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	Hospital-level Mortality Indicator (SHMI)******			1.0440	1.0296	- 0.0144	0.0296	Band 2	Band 2	1.0
2-02	Standardised Mortality HSMR			103.7	97.2	- 6.5	- 2.8	Lower confidence limit		100.0
2-03	Crude Mortality	0.9%	0.8%	0.9%	0.9%	0.0%		to be <100		
2-04	****Readmissions <30 days: Emergency	11.0%	15.1%	12.9%	15.5%	2.7%	1.9%	*13.6%*	13.6%	14.1%
2-05	****Readmissions <30 days: All	10.5%	14.5%	12.3%	14.9%	2.6%	0.3%	*14.7%*	14.9%	14.7%
2-06	Average LOS Elective	3.04	3.30	2.77	3.10	0.33	-	*3.10*	3.10	
2-07	Average LOS Non-Elective	7.35	7.15	7.52	7.13	- 0.39	-	*7.13*	7.13	
2-22	NE Discharges - Percent zero LoS	42.6%	45.0%	42.1%	44.0%	1.9%	-	-	44.0%	
2-08	******FollowUp : New Ratio	1.46	1.56	1.45	1.58	0.13	-	1.53	1.53	
2-09	Day Case Rates	87.8%	87.6%	87.9%	87.7%	-0.3%	0.0%	87.7%	87.2%	
2-10	Primary Referrals	11,150	9,405	22,142	19,829	-10.4%	-11.7%	139,143	136,512	
2-11	Cons to Cons Referrals	6,647	5,442	12,813	11,576	-9.7%	38.2%	51,898	55,097	
2-12	First OP Activity	18,407	17,074	35,588	33,516	-5.8%	-8.2%	226,133	223,148	
2-13	Subsequent OP Activity	26,852	26,559	51,579	52,895	2.6%	-5.5%	346,844	343,741	
2-14	Elective IP Activity	534	588	1,007	1,119	11.1%	-6.6%	7,426	7,346	
2-15	Elective DC Activity	3,850	4,168	7,346	7,944	8.1%	-2.0%	50,210	50,049	
2-16	**Non-Elective Activity	5,409	5,560	10,358	10,728	3.6%	-16.2%	76,778	74,710	
2-17	A&E Attendances (Calendar Mth) Excl Crowbo	13,536	14,282	25,585	27,683	8.2%	2.6%	159,252	165,278	
2-18	Oncology Fractions	5,353	6,397	11,384	13,204	9.7%	3.7%	67,260	79,224	
2-19	No of Births (Mothers Delivered)	457	504	457	919	101.1%	-5.9%	5,857	5,514	
2-20	% Mothers initiating breastfeeding	82.5%	83.8%	82.5%	83.6%	1.1%	5.6%	78.0%	83.6%	
2-21	% Stillbirths Rate	0.0%	0.39%	0.00%	0.43%	*0.4%*	*0.0%*	*0.47%*	0.43%	0.47%

	Caring	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Single Sex Accommodation Breaches	0	0	0	0	0	0	0	0	
3-02	*****Rate of New Complaints	2.02	-	2.12	1.11	-1.0	- 0.21	*1.318-3.92*	1.11	
3-03	% complaints responded to within target	55.6%	37.5%	74.3%	37.0%	-37.3%	-38.0%	75.0%	75.0%	
3-04	****Staff Friends & Family (FFT) % rec care	77.6%	89.0%	77.6%	89.0%	11.5%	10.0%	79.0%	89.0%	
3-05	*****IP Friends & Family (FFT) % Positive	93.3%	95.6%	93.3%	95.0%	1.6%	0.0%	95.0%	95.0%	
3-06	A&E Friends & Family (FFT) % Positive	91.2%	86.1%	91.2%	84.1%	-7.1%	-2.9%	87.0%	87.0%	
3-07	Maternity Combined FFT % Positive	94.9%	97.1%	94.9%	95.0%	0.1%	0.0%	95.0%	95.0%	
3-08	OP Friends & Family (FFT) % Positive	83.2%	82.5%	83.2%	82.5%	-0.7%			82.5%	

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

***** New :FU Ratio is now both consultant and non-consultant led for all specialties -plan still being agreed so currently last year plan

	Responsiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year/Qtr to Date Prev Yr	Year/Qtr to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
4-01	******Emergency A&E 4hr Wait	90.74%	91.91%	91.14%	91.97%	0.83%	-0.35%	91.67%	92.02%	77.36%
4-02	Emergency A&E >12hr to Admission	0	0	0	0	0	0	*0*	0	
4-03	Ambulance Handover Delays >30mins	260	472	512	909	397			4,288	
4-04	Ambulance Handover Delays >60mins	27	59	71	116	45			641	
4-05	RTT Incomplete Admitted Backlog	2,652	2,154	2,652	2,154	- 498	- 391	2,315	2,315	
4-06	RTT Incomplete Non-Admitted Backlog	4,048	2,149	4,048	2,149	- 1,899	117	872	872	
4-07	RTT Incomplete Pathway	79.4%	85.17%	79.38%	85.17%	5.79%	0.99%	86.71%	86.71%	
4-08	RTT 52 Week Waiters (New in Month)	2	10	2	16	14	16	*0*	16	
4-09	RTT Incomplete Total Backlog	6,700	4,303	6,700	4,303	- 2,397	- 275	3,186	3,186	
4-10	% Diagnostics Tests WTimes <6wks	99.1%	99.1%	99.1%	99.1%	0.0%	0.1%	99.0%	99.1%	
4-11	*Cancer WTimes - Indicators achieved	1	3	1	3	2	- 6	9	1	
4-12	*Cancer two week wait	83.4%	82.6%	83.4%	82.6%	-0.7%	-10.4%	93.0%	93.0%	
4-13	*Cancer two week wait-Breast Symptoms	65.8%	56.4%	65.8%	56.4%	-9.4%	-36.6%	93.0%	91.5%	
4-14	*Cancer 31 day wait - First Treatment	92.1%	96.5%	92.1%	96.5%	4.4%	0.5%	96.0%	96.0%	
4-15	*Cancer 62 day wait - First Definitive	61.6%	64.5%	61.6%	64.5%	2.9%	-17.7%	85.0%	85.0%	
4-16	*Cancer 62 day wait - First Definitive - MTW	64.7%	68.6%	64.7%	68.6%	3.9%		85.0%		
4-17	*Cancer 104 Day wait Accountable	18.0	10.5	18.0	10.5	-7.5	10.5	*0*	126.0	
4-18	*Cancer 62 Day Backlog with Diagnosis	81	99	81	99	18				
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	59	90	59	90	31				
4-20	Delayed Transfers of Care	4.34%	4.05%	4.45%	4.24%	-0.21%	0.74%	3.50%	3.50%	
4-21	% TIA with high risk treated <24hrs	66.7%	60.6%	72.5%	64.7%	-7.8%	4.7%	60%	64.7%	
4-22	*******% spending 90% time on Stroke Ward	89.7%	No data	89.7%	No data	2.0%	11.7%	80%	No data	
4-23	*******Stroke:% to Stroke Unit <4hrs	53.8%	71.9%	50.0%	65.0%	15.0%	5.0%	60.0%	65.0%	
4-24	*******Stroke: % scanned <1hr of arrival	51.3%	71.9%	50.0%	71.8%	21.8%	23.8%	48.0%	71.8%	
4-25	*******Stroke:% assessed by Cons <24hrs	86.7%	85.2%	84.9%	85.5%	0.5%	5.5%	80.0%	85.5%	
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	3	7	7	0	7	*0*	7	

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

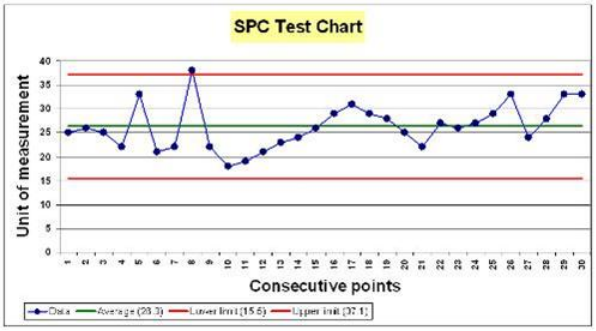
**CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory*

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

	Well-Led	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
5-01	Income	41,400	41,400	81,550	81,550	0.0%	-0.8%	502,732	502,806	
5-02	EBITDA	2,452	2,452	2,992	2,992	0.0%	-0.5%	37,810	37,810	
5-03	Surplus (Deficit) against B/E Duty	33	(71)	66	(2,072)			6,897	6,897	
5-04	CIP Savings	894	1,012	1,704	1,815	6.5%	-20.3%	22,328	22,328	
5-05	Cash Balance	20,190	39,537	20,190	39,537			3,000	3,000	
5-06	Capital Expenditure	68	45	496	403			*14,848*	14,848	
5-07	Establishment WTE	5,576.0	5,891.0	5,576.0	5,891.0	5.6%	0.0%	5,891.0	5,891.0	
5-08	Contracted WTE	5,033.8	5,104.7	5,033.8	5,104.7	1.4%	-4.0%	5,315.0	5,315.0	
5-09	Vacancies WTE	542.3	786.3	542.3	786.3	45.0%	36.5%	575.9	575.9	
5-11	Vacancy Rate (%)	9.7%	13.3%	9.7%	13.3%	3.6%	4.3%	9.0%	9.8%	
5-12	Substantive Staff Used	4,944.4	5,018.8	4,944.4	5,018.8	1.5%	-5.7%	5,320.3	5,320.3	
5-13	Bank Staff Used	361.7	510.9	361.7	510.9	41.3%	44.8%	353	352.7	
5-14	Agency Staff Used	302.0	240.8	302.0	240.8	-20.3%	10.5%	217.9	217.9	
5-15	Overtime Used	46.2	37.4	46.2	37.4	-19.0%				
5-16	Worked WTE	5,654.3	5,807.8	5,654.3	5,807.8		-1.4%	5,891.0	5,891.0	
5-17	Nurse Agency Spend	(839)	(563)	(1,668)	(1,140)	-31.7%				
5-18	Medical Locum & Agency Spend	(1,623)	(1,699)	(3,042)	(3,355)	10.3%				
5-19	Temp costs & overtime as % of total pay bill	17.0%	16.1%	16.9%	16.1%	-0.8%				
5-20	Staff Turnover Rate	0.0%	9.8%		9.5%		-1.0%	*10.5%*	9.5%	11.05%
5-21	Sickness Absence	3.4%	3.5%		3.3%	0.1%	0.0%	*3.3%*	3.3%	4.3%
5-22	Statutory and Mandatory Training	88.5%	84.5%		84.0%	-4.0%	-1.0%	85.0%	85.0%	
5-23	Appraisal Completeness	Data Not Reported for Quarter 1								
5-24	Overall Safe staffing fill rate	98.1%	94.2%	98.5%	94.5%	-4.0%		93.5%	94.5%	
5-25	****Staff FFT % recommended work	48.7%	82%	48.7%	82%	33.5%	20.2%	62.0%	82%	
5-26	***Staff Friends & Family -Number Responses	263	146	263	146	-117				
5-27	*****IP Resp Rate Recmd to Friends & Family	27.2%	20.4%	27.2%	19.6%	-7.6%	-5.4%	25.0%	25.0%	
5-28	A&E Resp Rate Recmd to Friends & Family	14.2%	14.6%	14.2%	12.8%	-1.3%	-2.2%	15.0%	15.0%	
5-29	Mat Resp Rate Recmd to Friends & Family	29.8%	6.0%	29.8%	12.3%	-17.5%	-12.7%	25.0%	25.0%	

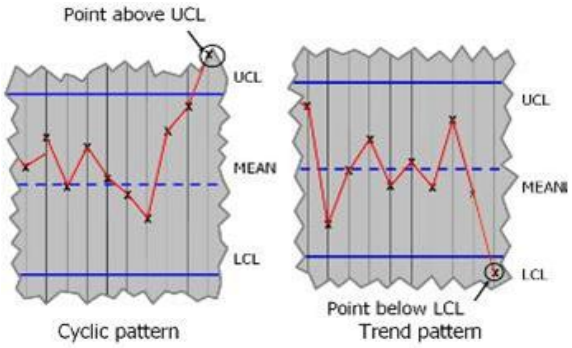
Explanation of Statistical Process Control (SPC) Charts

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

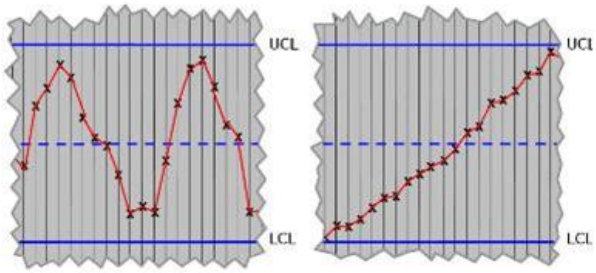


SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system.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

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

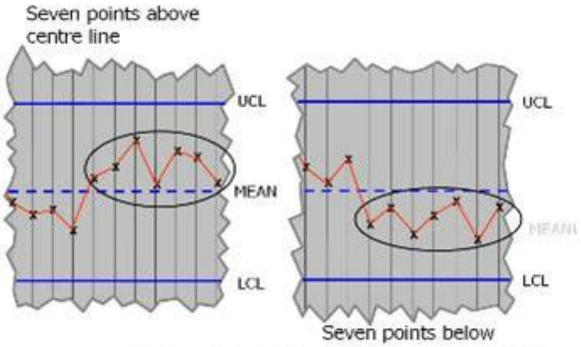


Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key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

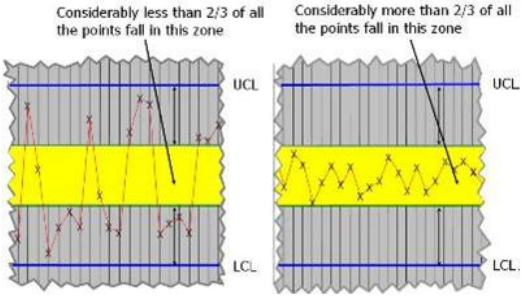


Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

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

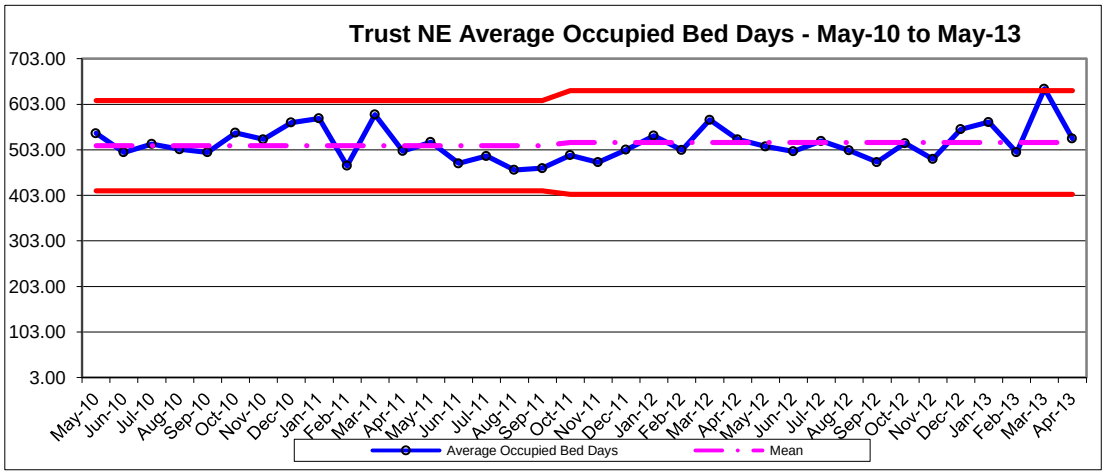


Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable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

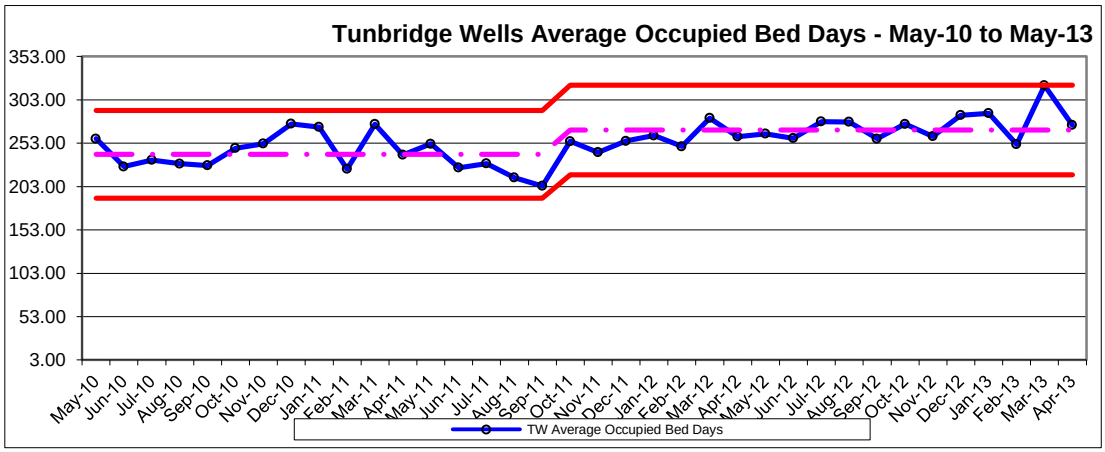


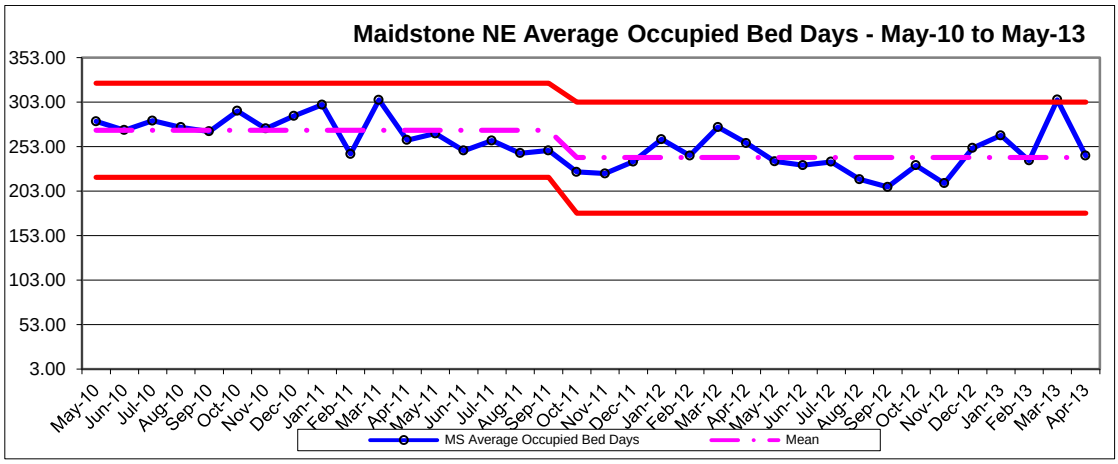
Changes to Control Lines

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



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

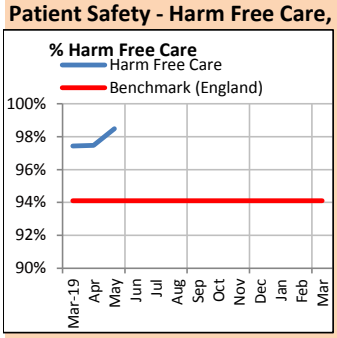


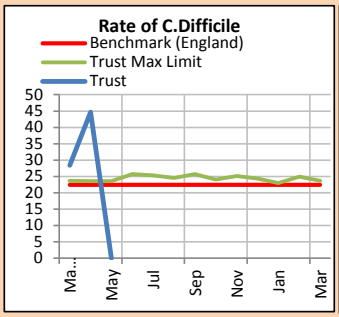


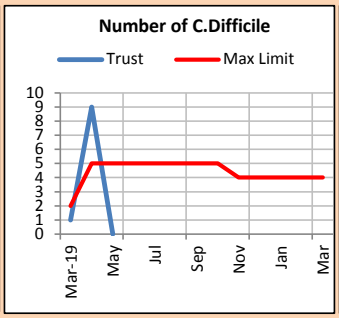
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

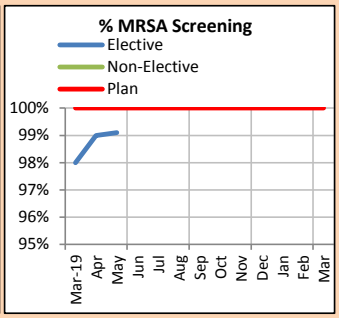
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

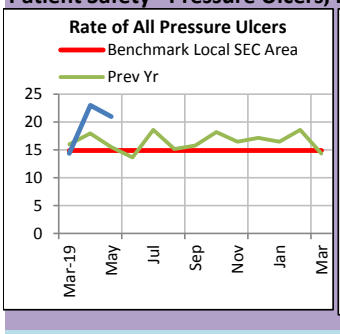


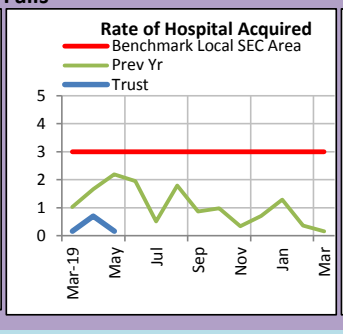


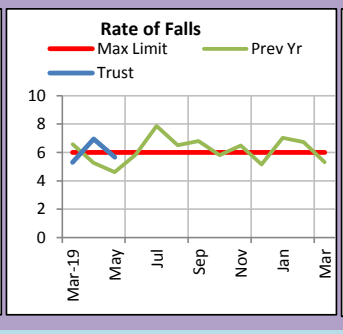


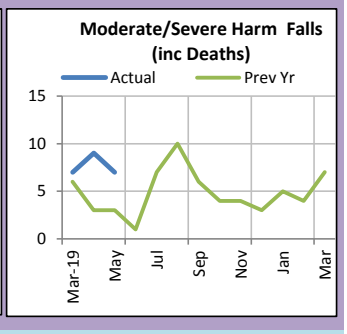


Patient Safety - Pressure Ulcers, Falls

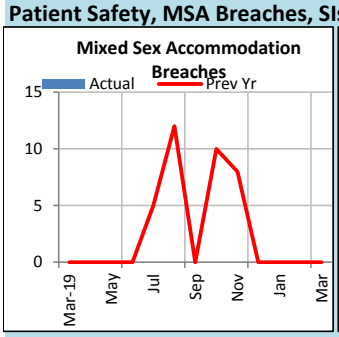


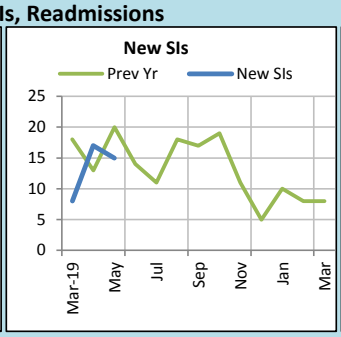


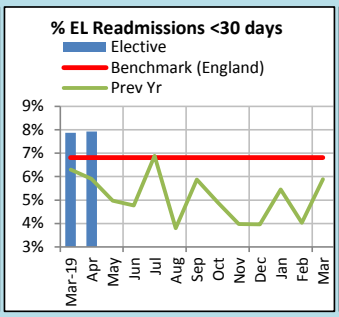


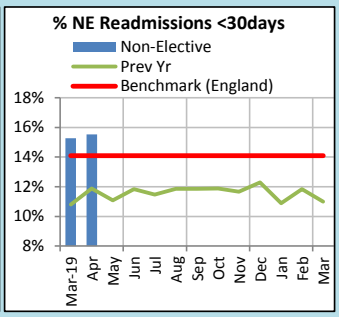


Patient Safety, MSA Breaches, SIs, Readmissions

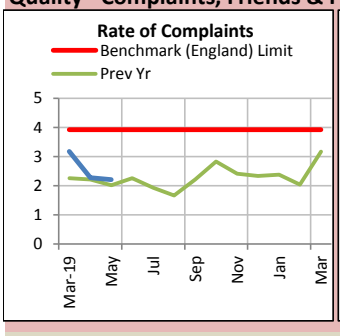


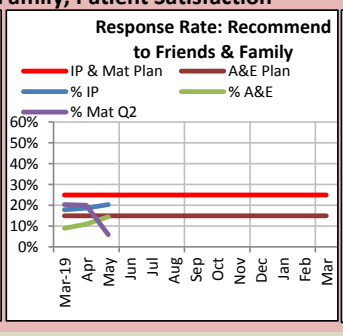


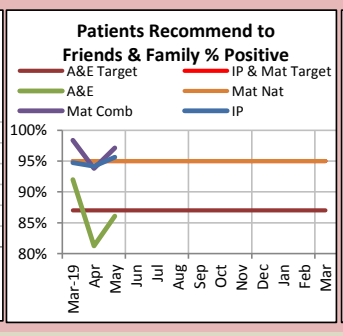


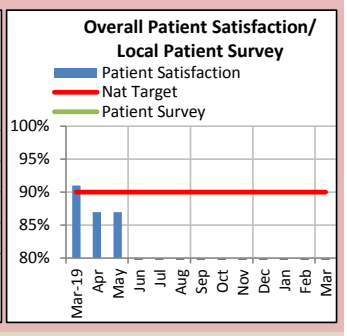


Quality - Complaints, Friends & Family, Patient Satisfaction

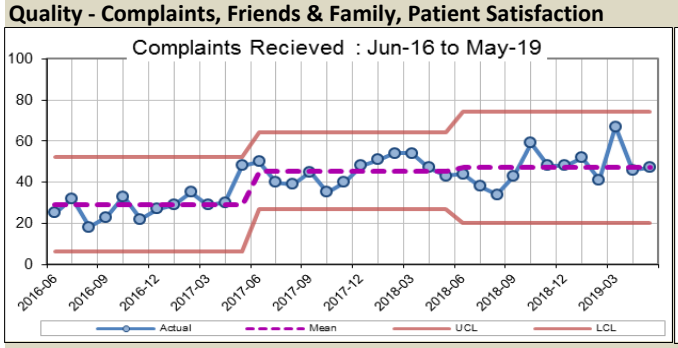


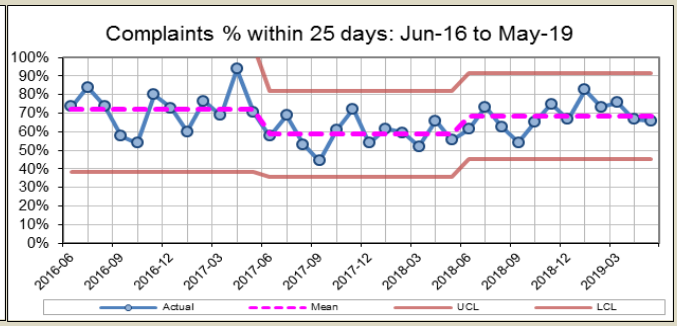




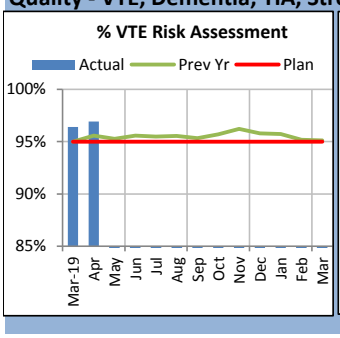


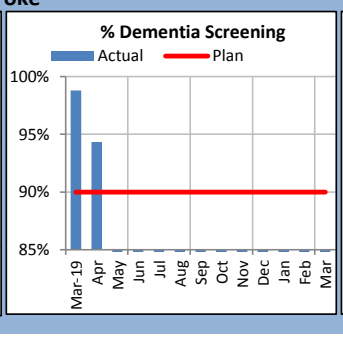
Quality - Complaints, Friends & Family, Patient Satisfaction

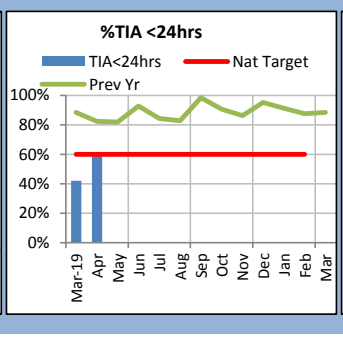


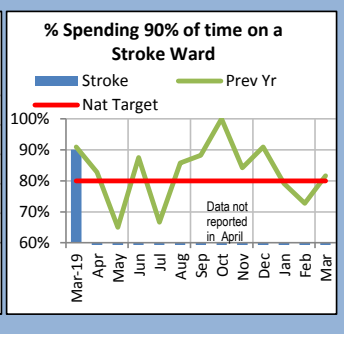


Quality - VTE, Dementia, TIA, Stroke



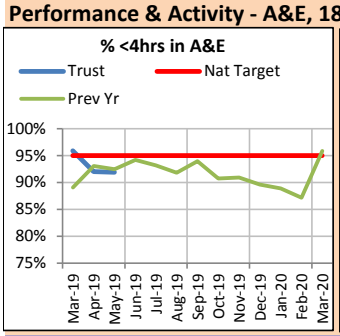


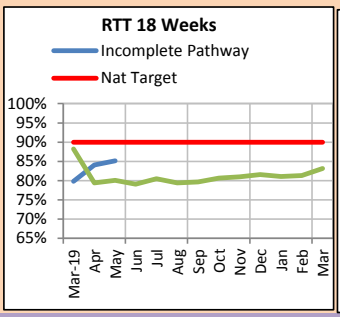


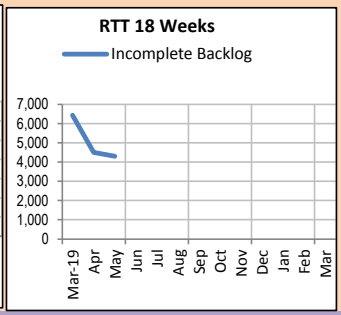


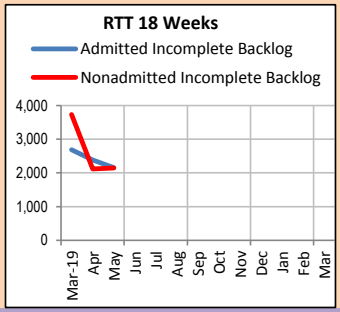
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

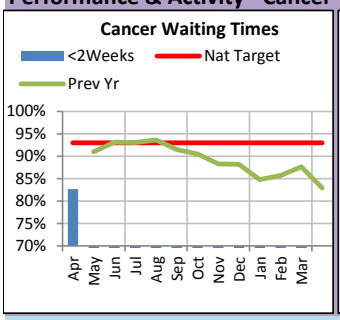


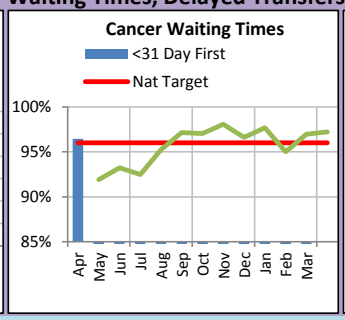


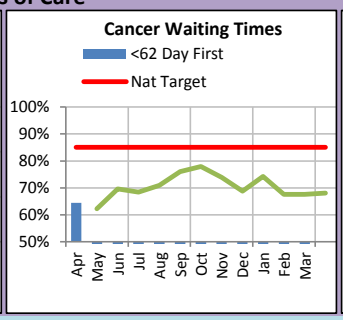


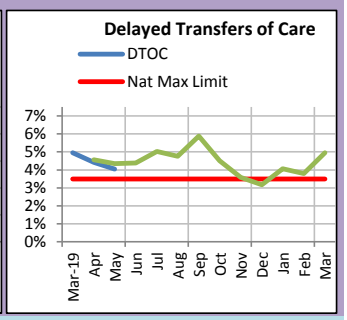


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

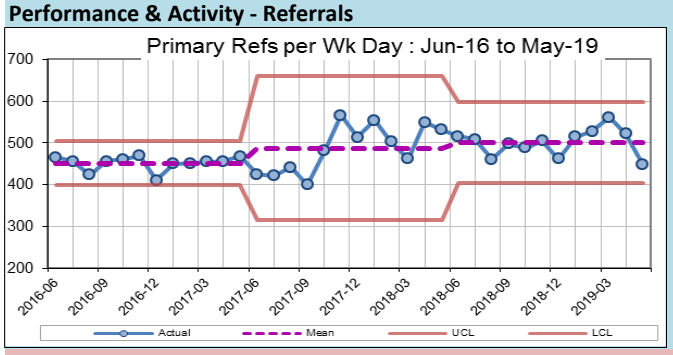


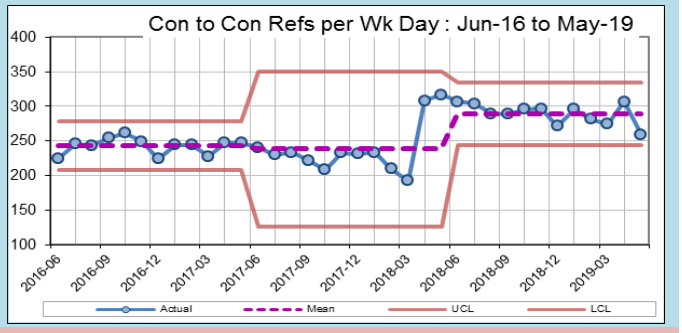




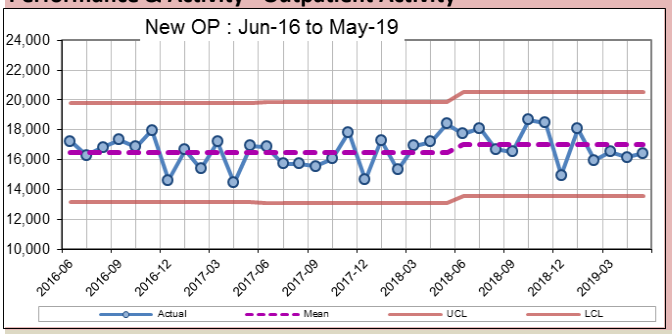


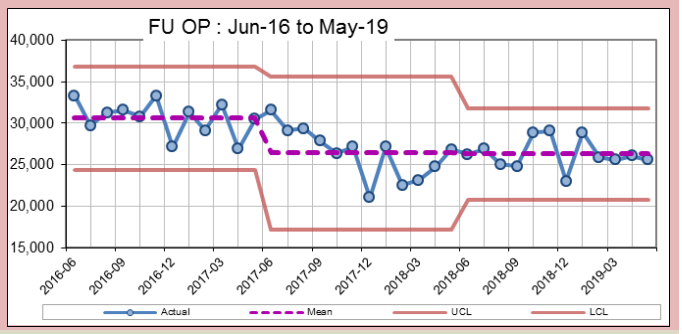
Performance & Activity - Referrals



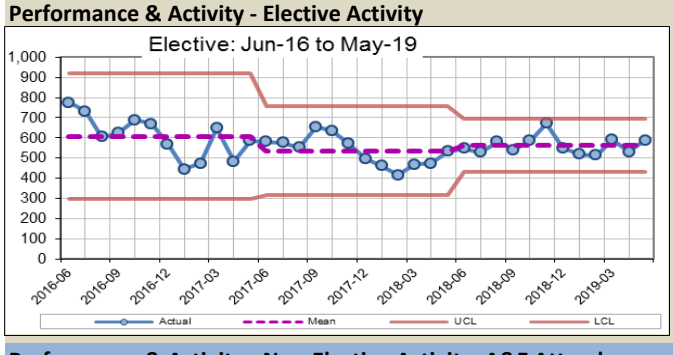


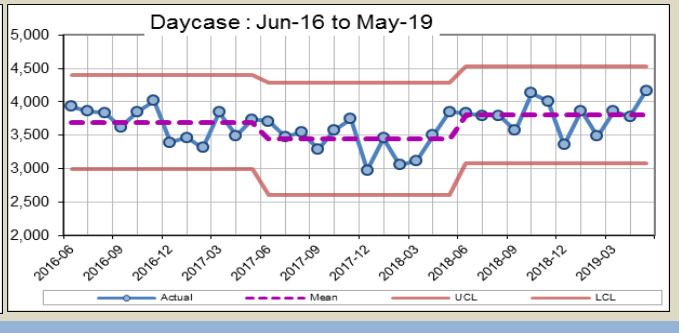
Performance & Activity - Outpatient Activity



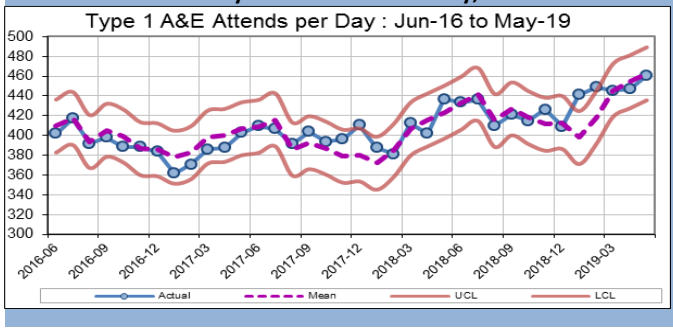


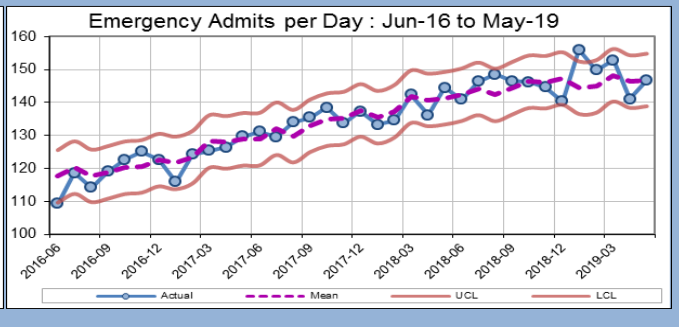
Performance & Activity - Elective Activity





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

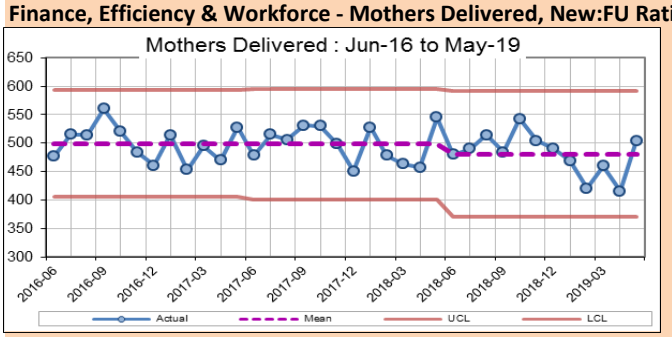


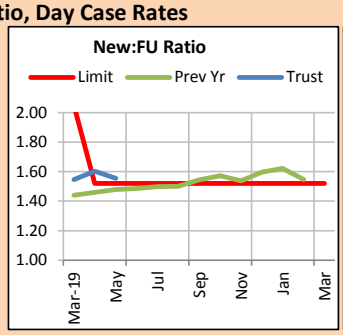


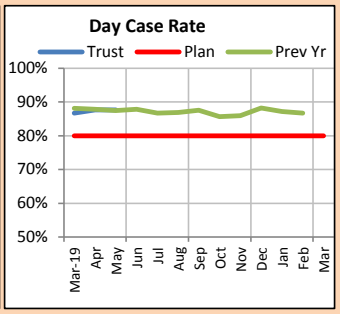
These have been changed to show actual against model, since emergency activity is subject to both growth and seasonal variation. Control limits are 2 standard deviations of variance, so a count outside the control limits will be expected around one month in 20.

INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

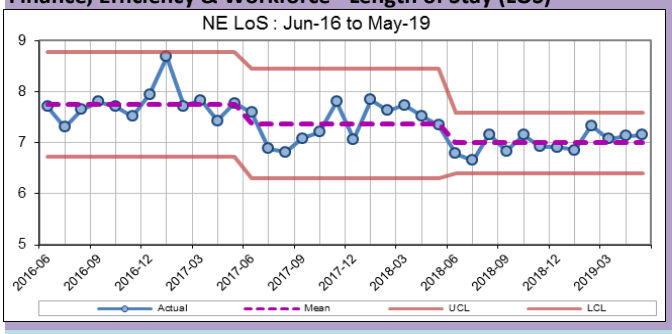
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

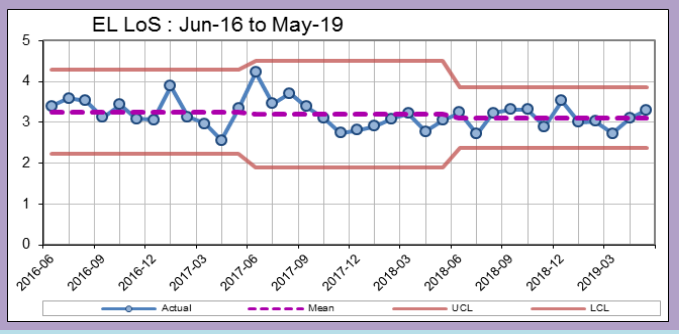




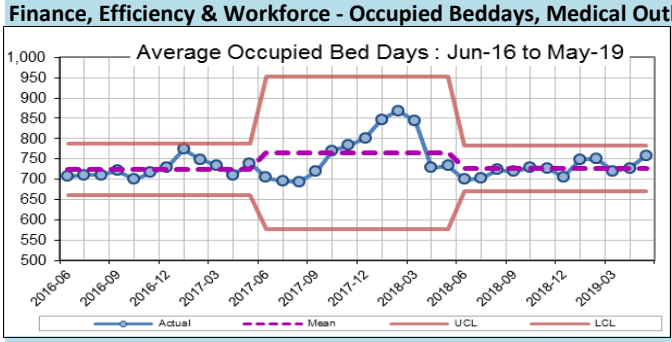


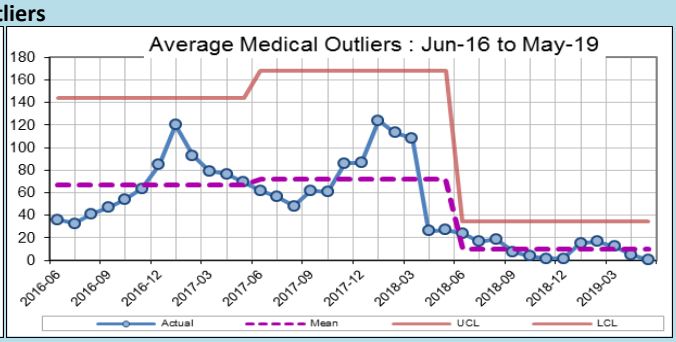
Finance, Efficiency & Workforce - Length of Stay (LOS)



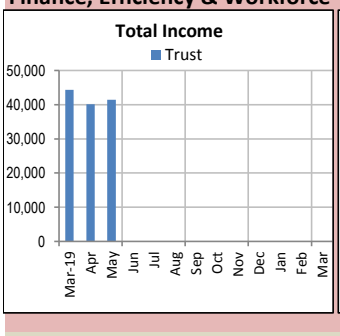


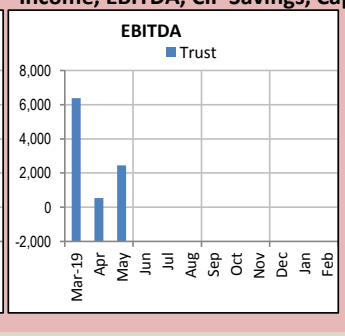
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

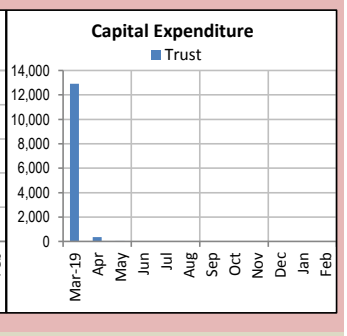




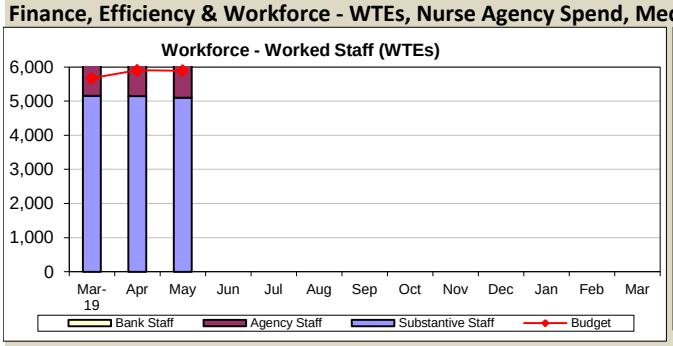
Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

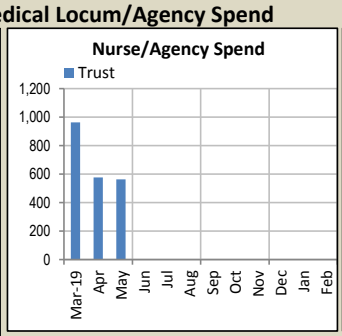


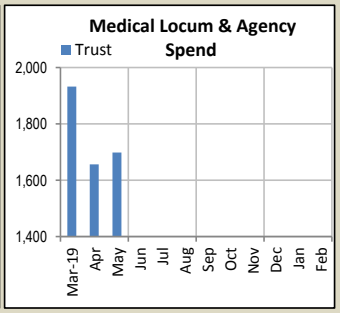




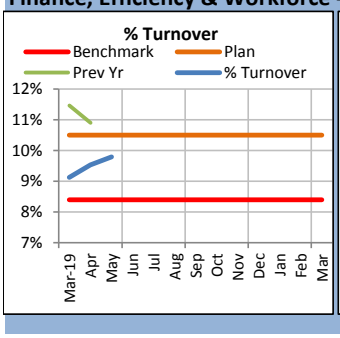
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

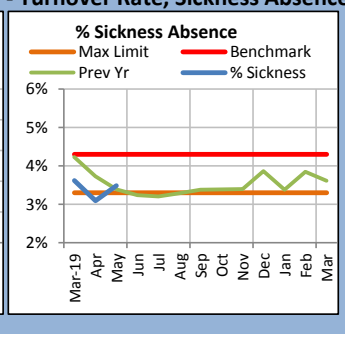


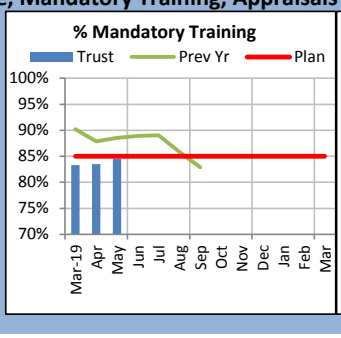


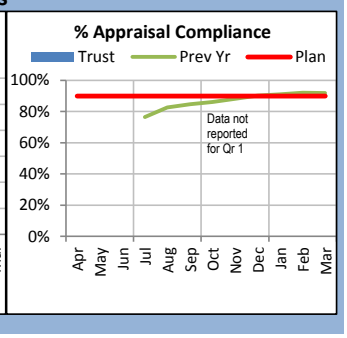


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report

Month 2
2019/20

Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Report for May 2019

1. Executive Summary

a. Dashboard

b. I&E Summary

2. Financial Performacne

a. Consolidated I&E

b. I&E Run Rate

3. Cost Improvement Programme

a. Savings by Division

4. Balance Sheet and Liquidity

a. Balance Sheet

b. Cash Flow

c. Capital Plan

1a. Dashboard

NH t

May 2019/20

	Current Month						Year to Date						Annual Forecast			
	Actual £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*RAG*	*Actual* £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*RAG*	*Actual* £m	*Plan* £m	*Variance* £m	*RAG*
Income	41.4	41.8	(0.4)	0.1	(0.5)		81.6	82.2	(0.7)	0.2	(0.9)		502.8	502.8	0.0	
Expenditure	(38.9)	(39.3)	0.4	(0.1)	0.5		(78.6)	(79.2)	0.7	(0.2)	0.9		(465.0)	(465.0)	0.0	
EBITDA (Income less Expenditure)	2.5	2.4	0.0	(0.0)	0.0		3.0	3.0	(0.0)	(0.0)	(0.0)		37.8	37.8	0.0	
Financing Costs	(2.6)	(2.5)	(0.0)	0.0	(0.0)		(5.1)	(5.1)	(0.0)	0.0	(0.0)		(32.0)	(32.0)	0.0	
Technical Adjustments	0.0	0.0	0.0	0.0	0.0		0.1	0.0	0.1	0.0	0.1		1.1	1.1	0.0	
Net Surplus / Deficit (Incl PSF and MRET)	**(0.1)**	**(0.1)**	**0.0**	**(0.0)**	**0.0**		**(2.1)**	**(2.1)**	**0.0**	**(0.0)**	**0.0**		**6.9**	**6.9**	**0.0**	
CIPs	1.0	1.1	(0.1)		(0.1)		1.8	2.3	(0.5)		(0.5)		22.3	22.3	0.0	
Cash Balance	39.5	40.2	(0.7)		(0.7)		39.5	40.2	(0.7)		(0.7)		3.0	3.0	0.0	
Capital Expenditure	0.0	0.2	0.1		0.1		0.4	0.6	0.2		0.2		14.8	14.8	0.0	
Capital service cover rating							4	4					4	4		
Liquidity rating							3	3					4	4		
I&E margin rating							4	4					1	1		
I&E margin: distance from financial plan								1					1	1		
Agency rating							3	3					3	3		
Finance and use of resources rating							3	3					3	3		

Summary:

- The Trusts deficit including PSF was £0.1m in May which was on plan. The key YTD variances against plan are: Adverse variances relating to CIP slippage (£0.5m), underperformance in Private Patient Income (£0.4m net) and £0.4m pressure relating to EPR costs that were previously planned to be capitalised. These pressures have been offset by release of prior year provisions and back dated credit notes from NHS Property Services (£0.4m), over performance relating to clinical income (£0.7m) and £0.6m underspend within expenditure budgets. The Trust has increased the reserves held by relating to the CIP stretch target (£0.5m).
- The Trust has spent £0.95m more (40%) than the YTD agency ceiling set by NHSI (£11.8m per annum)

Key Points:

- The Trusts normalised run rate in May was £1.2m deficit pre PSF which was £0.2m adverse to plan (pre PSF).
- The Trust delivered the financial control target for May and therefore achieved the criteria for PSF funding (£0.4m in the mo nth)
- The main pressures (excluding CIP) in the month related to Private Patient income which was £0.2m (net) below the plan, Medi cal staffing pressures within Acute and Geriatrics (£0.1m) due to Agency covering consultant sickness and unfunded AEC service as well as £0.1m pressure within Womens and Childrens divisions. The adverse med ical pressure in Childrens (£40k) is due to 2 Hybrid consultants who had been planned to start, have withdrawn resulting in the continuation of agency staff and £80k pressure in Gynae due to increase in agency c osts although this includes an increase in a provision due to data differences between directorate and HR reports. The Trust has incurred £0.3m of EPR project costs that were previously planned to be capitalised, the Trust is still waiting additional funding confirmation from NHS Digital therefore until

Risks:

- The Trust has following key risks: The Trusts plan includes 12 months of elective and out patient Prime Provider activity however due to the timeline from referral to elective procedure it is likely that the Trust will start to see the conversion into elective activity from cJuly 2019 resulting in a reduced CIP delivery of c£1m. The Trusts plan assumed costs associated with the EPR project would be capitalised, £1.5m via additional funding from NHS digital and £1.8m through internally generated funds. The Trust has not yet been notified about the additional funding support and due to pressures within capital budgets the full (£3.3m) costs are being charged to revenue. The level of Private patient income continues to be lower than planned levels, if the activity continues as current rate this would equate to £2.4m pressure. The Operational Efficiencies CIP assumed the Trust would 'cap' the additional investment to fund service developments to £10m, the current forecast for this investment is £2.8m more.
- To mitigate these risks the Trust is focusing on identifying further CIPs with Bi-weekly meetings taking place with Divisions and External support as well as focussing on financial management controls with Divisions reviewing all cost centres monthly variances and detailing action plans to address any overspend as well as identifying if underspending cost centres will / can continue to underspend in future months. The Trust will also have release contingency reserves and review investment decisions where funding is not secured.

2a. Income & Expenditure

Income & Expenditure May 2019/20

	Current Month					Year to Date					Annual Forecast		
	Actual £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m
Clinical Income	32.3	32.6	(0.3)	0.0	(0.3)	63.6	63.9	(0.2)	0.0	(0.2)	390.0	390.0	0.0
High Cost Drugs and Devices	4.2	3.8	0.4	0.3	0.1	8.0	7.6	0.4	0.4	(0.0)	45.2	45.2	0.0
Total Clinical Income	**36.4**	**36.4**	**0.1**	**0.3**	**(0.2)**	**71.6**	**71.5**	**0.2**	**0.4**	**(0.2)**	**435.1**	**435.1**	**0.0**
PSF and MRET	0.9	0.9	0.0	0.0	0.0	1.8	1.8	0.0	0.0	0.0	13.8	13.8	0
Other Operating Income	4.1	4.5	(0.4)	(0.1)	(0.3)	8.1	9.0	(0.8)	(0.2)	(0.7)	53.8	53.8	0.0
Total Revenue	**41.4**	**41.8**	**(0.4)**	**0.1**	**(0.5)**	**81.6**	**82.2**	**(0.7)**	**0.2**	**(0.9)**	**502.8**	**502.8**	**0.0**
Substantive	(19.5)	(20.4)	0.9	0.1	0.8	(39.7)	(41.5)	1.9	0.1	1.7	(251.9)	(251.9)	0
Bank	(1.1)	(0.9)	(0.2)	0.0	(0.2)	(2.4)	(1.9)	(0.5)	0.0	(0.5)	(10.1)	(10.1)	0
Locum	(0.9)	(0.8)	(0.1)	0.0	(0.1)	(1.7)	(1.5)	(0.1)	0.0	(0.1)	(8.1)	(8.1)	0
Agency	(1.7)	(1.6)	(0.1)	0.1	(0.1)	(3.3)	(3.3)	(0.0)	0.1	(0.1)	(16.7)	(16.7)	0
Pay Reserves	(0.3)	(0.3)	(0.0)	0.0	(0.0)	(0.6)	(0.6)	(0.0)	0.0	(0.0)	(3.6)	(3.6)	0
Total Pay	**(23.5)**	**(24.0)**	**0.5**	**0.1**	**0.4**	**(47.7)**	**(48.9)**	**1.2**	**0.3**	**1.0**	**(290.3)**	**(290.3)**	**0**
Drugs & Medical Gases	(4.6)	(4.3)	(0.4)	(0.3)	(0.1)	(9.3)	(8.6)	(0.7)	(0.5)	(0.2)	(51.3)	(51.3)	0
Blood	(0.2)	(0.2)	(0.0)	0.0	(0.0)	(0.4)	(0.4)	(0.0)	0.0	(0.0)	(2.2)	(2.2)	0
Supplies & Services - Clinical	(2.7)	(2.9)	0.2	0.0	0.2	(5.4)	(5.8)	0.4	0.1	0.3	(33.6)	(33.6)	0
Supplies & Services - General	(0.4)	(0.4)	0.0	0.0	0.0	(0.8)	(0.9)	0.0	0.0	0.0	(5.3)	(5.3)	0
Services from Other NHS Bodies	(0.8)	(0.8)	0.0	(0.0)	0.1	(1.8)	(1.7)	(0.1)	(0.1)	(0.0)	(10.2)	(10.2)	0
Purchase of Healthcare from Non-NHS	(1.7)	(1.7)	0.0	0.0	0.0	(3.2)	(3.5)	0.2	0.0	0.2	(14.7)	(14.7)	0
Clinical Negligence	(1.5)	(1.5)	(0.0)	0.0	(0.0)	(2.9)	(2.9)	(0.0)	0.0	(0.0)	(17.6)	(17.6)	0
Establishment	(0.3)	(0.3)	0.0	0.0	0.0	(0.4)	(0.5)	0.1	0.0	0.0	(3.3)	(3.3)	0
Premises	(2.2)	(2.1)	(0.1)	0.0	(0.2)	(4.5)	(4.2)	(0.2)	0.0	(0.3)	(26.2)	(26.2)	0
Transport	(0.1)	(0.1)	(0.0)	(0.0)	(0.0)	(0.2)	(0.3)	0.0	(0.0)	0.0	(1.5)	(1.5)	0
Other Non-Pay Costs	(0.5)	(0.5)	(0.0)	(0.0)	(0.0)	(1.0)	(1.0)	(0.0)	(0.0)	0.0	(5.8)	(5.8)	0
Non-Pay Reserves	(0.4)	(0.4)	0.0	0.0	0.0	(0.8)	(0.6)	(0.2)	0.0	(0.2)	(3.0)	(3.0)	0
Total Non Pay	**(15.4)**	**(15.3)**	**(0.2)**	**(0.3)**	**0.1**	**(30.9)**	**(30.3)**	**(0.5)**	**(0.5)**	**(0.1)**	**(174.7)**	**(174.7)**	**0**
Total Expenditure	**(38.9)**	**(39.3)**	**0.4**	**(0.1)**	**0.5**	**(78.6)**	**(79.2)**	**0.7**	**(0.2)**	**0.9**	**(465.0)**	**(465.0)**	**0**
EBITDA	**2.5**	**2.4**	**0.0**	**(0.0)**	**0.0**	**3.0**	**3.0**	**(0.0)**	**(0.0)**	**(0.0)**	**37.8**	**37.8**	**0**
	0.0	*0.0*	*(0.0)*	*%*		*3.7%*	*3.7%*	*2.5%*	*0.0%*	*1.9%*	*7.5%*	*7.5%*	
Depreciation	(1.1)	(1.1)	(0.0)	0.0	(0.0)	(2.2)	(2.2)	0	0.0	0	(13.5)	(13.5)	0
Interest	(0.1)	(0.1)	(0.0)	0.0	(0.0)	(0.3)	(0.3)	(0.0)	0.0	(0.0)	(1.6)	(1.6)	0
Dividend	(0.1)	(0.1)	0.0	0.0	0	(0.3)	(0.3)	0	0.0	0	(1.6)	(1.6)	0
PFI and Impairments	(1.2)	(1.2)	(0.0)	0.0	(0.0)	(2.4)	(2.4)	(0.0)	0.0	(0.0)	(15.4)	(15.4)	0
Total Finance Costs	**(2.6)**	**(2.5)**	**(0.0)**	**0.0**	**(0.0)**	**(5.1)**	**(5.1)**	**(0.0)**	**0**	**(0.0)**	**(32.0)**	**(32.0)**	**0**
Net Surplus / Deficit (-)	**(0.1)**	**(0.1)**	**(0.0)**	**(0.0)**	**(0.0)**	**(2.1)**	**(2.1)**	**(0.0)**	**(0.0)**	**(0.0)**	**5.8**	**5.8**	**0.0**
Technical Adjustments	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.0	0.1	1.1	1.1	0.0
Surplus/ Deficit (-) to B/E Duty Incl PSF and MRET	**(0.1)**	**(0.1)**	**0.0**	**(0.0)**	**0.0**	**(2.1)**	**(2.1)**	**0.0**	**(0.0)**	**0.0**	**6.9**	**6.9**	**0.0**
Surplus/ Deficit (-) to B/E Duty Excl PSFand MRET	**(1.0)**	**(1.0)**	**0.0**	**(0.0)**	**0.0**	**(3.9)**	**(3.9)**	**0.0**	**(0.0)**	**0.0**	**(7.0)**	**(7.0)**	**0.0**

Commentary

The Trusts deficit including PSF was £0.1m in May which was on plan .

The Trusts normalised run rate in May was £1.2m deficit pre PSF which was £0.2m higher than plan.

Pass-through adjustments have been applied to account for: High Cost Drugs and devices, STP associated costs, and Research and Development costs.

Clinical Income excluding HCDs was adverse to plan in May by £0.3m and £0.2m year to date. The key favourable variance s in A&E (£0.2m) and Outpatients (£0.3m), this is offset by adverse variances in Day Cases (£0.3m) and Adult Critical Care (£0.3m).

The Trust delivered the year to date PSF value and MRET funding (£1.8m YTD).

Other Operating Income excluding pass-through costs was £0.3m adverse in the month this was due to £0.3m slippage within the Private Patient Unit as activity levels are below agreed business case assumptions .

Pay budgets adjusted for pass-through items underspent by £0.4m in May. The key favourable variances relate to £0.1m release of old year provision, underspend within Cancer and RTT Reserves £0.1m and underspends within Admin and Clerical budgets (£0.2m), STT Staffing (£0.1m) and Nursing budgets (£0.1m). The key adverse variances within pay relate to Medical overspends within Acute and Geriatric (£0.1m), Gynae (£0.1m) and Paediatrics (£50k).

Non Pay budgets adjusted for pass though items underspent by £0.1m in the month. The key adverse variances relate to CIP slippage (£0.5m) mainly relating to prime provider (£0.3m) and EPR (£0.2m) funding pressure resulting from the full EPR costs being charged to revenue pending confirmation of additional capital funding support. The Trust benefitted in the month by £0.1m old year credit notes from NHS Property services for disputed invoices and underspent within Cancer and RTT recovery plan reserves by £0.5m however this underspend is offset by a corresponding income under delivery.

The Trust is currently forecasting to deliver the planned surplus of £6.9m including PSF and MRET funding.

3a. Cost Improvement Plan

Savings by Division

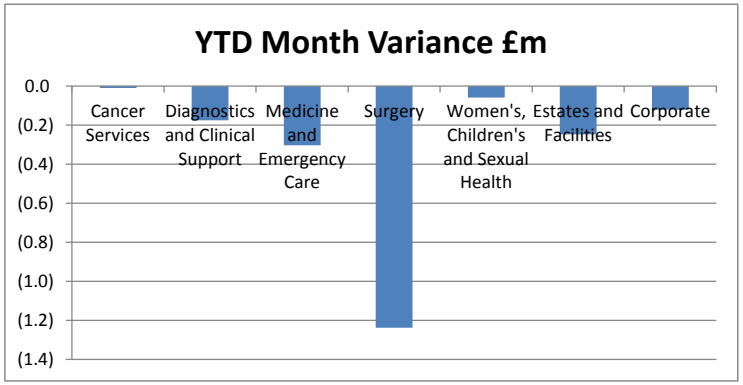
	Current Month			Year to Date			Forecast (Risk Adjusted)		
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer Services	0.14	0.12	0.02	0.23	0.24	(0.01)	1.29	1.45	(0.16)
Diagnostics and Clinical Support	0.20	0.30	(0.09)	0.40	0.57	(0.17)	2.77	3.11	(0.35)
Medicine and Emergency Care	0.14	0.30	(0.16)	0.29	0.59	(0.30)	4.85	5.46	(0.61)
Surgery	0.07	0.69	(0.61)	0.13	1.37	(1.24)	7.24	8.15	(0.90)
Women's, Children's and Sexual Health	0.27	0.21	0.06	0.36	0.42	(0.06)	2.28	2.56	(0.28)
Estates and Facilities	0.07	0.21	(0.15)	0.18	0.43	(0.25)	2.04	2.30	(0.26)
Corporate	0.11	0.17	(0.05)	0.21	0.33	(0.12)	1.85	2.09	(0.23)
Total	**1.01**	**1.98**	**(0.98)**	**1.81**	**3.96**	**(2.15)**	**22.33**	**25.12**	**(2.79)**
Internal Savings Plan stretch	0.01	(0.84)	0.85	0.01	(1.68)	1.69	0.00	(2.79)	2.79
Total	**1.01**	**1.14**	**(0.13)**	**1.82**	**2.28**	**(0.46)**	**22.33**	**22.33**	**0.00**

Savings by Subjective Category

	Current Month			Year to Date			Forecast (Risk Adjusted)		
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	0.45	0.21	0.24	0.67	0.40	0.27	4.58	4.58	0.00
Non Pay	(0.71)	(0.32)	(0.39)	(1.38)	(0.63)	(0.75)	2.54	2.54	0.00
Income	1.27	1.25	0.02	2.52	2.51	0.01	15.20	15.20	0.00
Total	**1.01**	**1.14**	**(0.13)**	**1.82**	**2.28**	**(0.46)**	**22.33**	**22.33**	**0.00**

Savings by NHSI RAG

	Current Month			Year to Date			Forecast (Risk Adjusted)		
	Actual	*Original Plan*	*Variance*	*Actual*	*Original Plan*	*Variance*	*Forecast*	*Original Plan*	*Variance*
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Green	0.69	0.89	(0.20)	1.30	1.77	(0.47)	14.41	14.41	0.00
Amber	0.28	0.16	0.12	0.43	0.32	0.11	3.06	3.06	0.00
Red	0.04	0.09	(0.05)	0.08	0.18	(0.10)	4.86	4.86	0.00
Total	**1.01**	**1.14**	**(0.13)**	**1.82**	**2.28**	**(0.46)**	**22.33**	**22.33**	**0.00**



Comment

The Trust was £0.1m adverse to plan in the month, £0.5m adverse YTD.
The key adverse variances were Prime Provider slippage (£0.33m) and Estates and Facilities slippage (£0.1m) relating to Energy procurement and catering changes. These pressures were partly offset by workforce over performance (£0.3m) within Womens and Childrens (£0.2m) and Cancer and Diagnostics divisions (£0.1m).

The Trust has an internal CIP plan of £25.1m with an external plan of £22.3m, therefore creating a savings stretch of £2.8m.

The operational efficiencies savings (£5.8m) included within the CIP and the internal savings stretch (£2.8m) have been phased into divisions in twelfths with a corresponding adjustment back to the submitted CIP phased plan reported out side if the divisions position (£0.8m in May, £1.7m YTD).

Divisions are completing an I&E and CIP year end forecast for month 3, at the moment the Trust is forecasting to deliver £22.3m savings and not the £25.1m stretch CIP target.

4a. Balance Sheet

May 2019

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

£m's	Reported	May Plan	Variance	April Reported	Full year Plan
Property, Plant and Equipment (Fixed Assets)	290.7	290.6	0.1	291.7	307.6
Intangibles	3.1	3.2	(0.1)	3.2	2.8
PFI Lifecycle	0.0	0.0	0.0	0.0	0.0
Debtors Long Term	1.5	1.4	0.1	1.4	1.4
Total Non-Current Assets	**295.3**	**295.2**	**0.1**	**296.3**	**311.8**
Current Assets	0.0	0.0	0.0	0.0	0.0
Inventory (Stock)	7.5	7.7	(0.2)	7.6	7.8
Receivables (Debtors) - NHS	34.9	33.4	1.5	32.5	24.7
Receivables (Debtors) - Non-NHS	15.0	12.7	2.3	14.9	9.2
Cash	39.5	40.2	(0.7)	41.3	3.0
Assets Held For Sale	0.0	0.0	0.0	0.0	0.0
Total Current Assets	**96.9**	**94.0**	**2.9**	**96.3**	**44.7**
Current Liabilities					
Payables (Creditors) - NHS	(5.4)	(4.6)	(0.8)	(5.8)	(5.1)
Payables (Creditors) - Non-NHS	(47.0)	(46.8)	(0.2)	(45.3)	(31.1)
Deferred Income	(23.8)	(22.1)	(1.7)	(25.0)	(2.6)
Capital Loan	(2.2)	(2.2)	0.0	(2.2)	(2.2)
Working Capital Loan	(17.1)	(16.9)	(0.2)	(17.0)	(26.1)
Other loans	(0.4)	(0.4)	0.0	(0.4)	(0.4)
Borrowings - PFI	(5.4)	(5.4)	0.0	(5.4)	(5.3)
Provisions for Liabilities and Charges	(1.5)	(1.5)	0.0	(1.5)	(1.5)
Total Current Liabilities	**(102.8)**	**(99.9)**	**(2.9)**	**(102.6)**	**(74.3)**
Net Current Assets	(5.9)	(5.9)	(0.0)	(6.3)	(29.6)
non-current liabilities: Borrowings - PFI > 1yr	(186.5)	(186.6)	0.1	(187.0)	(182.2)
Capital Loans	(8.1)	(8.0)	(0.1)	(8.0)	(6.6)
Working Capital Facility & Revenue loans	(26.3)	(26.1)	(0.2)	(26.2)	0.0
Other loans	(1.5)	(1.5)	0.0	(1.5)	(1.3)
Provisions for Liabilities and Charges- Long term	(0.9)	(1.0)	0.1	(1.0)	(1.0)
Total Assets Employed	**66.1**	**66.1**	**(0.0)**	**66.2**	**91.1**
Financed By:					
Capital & Reserves					
Public dividend capital	211.8	211.8	0.0	211.8	213.3
Revaluation reserve	31.8	31.8	0.0	31.8	46.2
Retained Earnings Reserve	(177.5)	(177.5)	0.0	(177.4)	(168.4)
Total Capital & Reserves	**66.1**	**66.1**	**0.0**	**66.2**	**91.1**

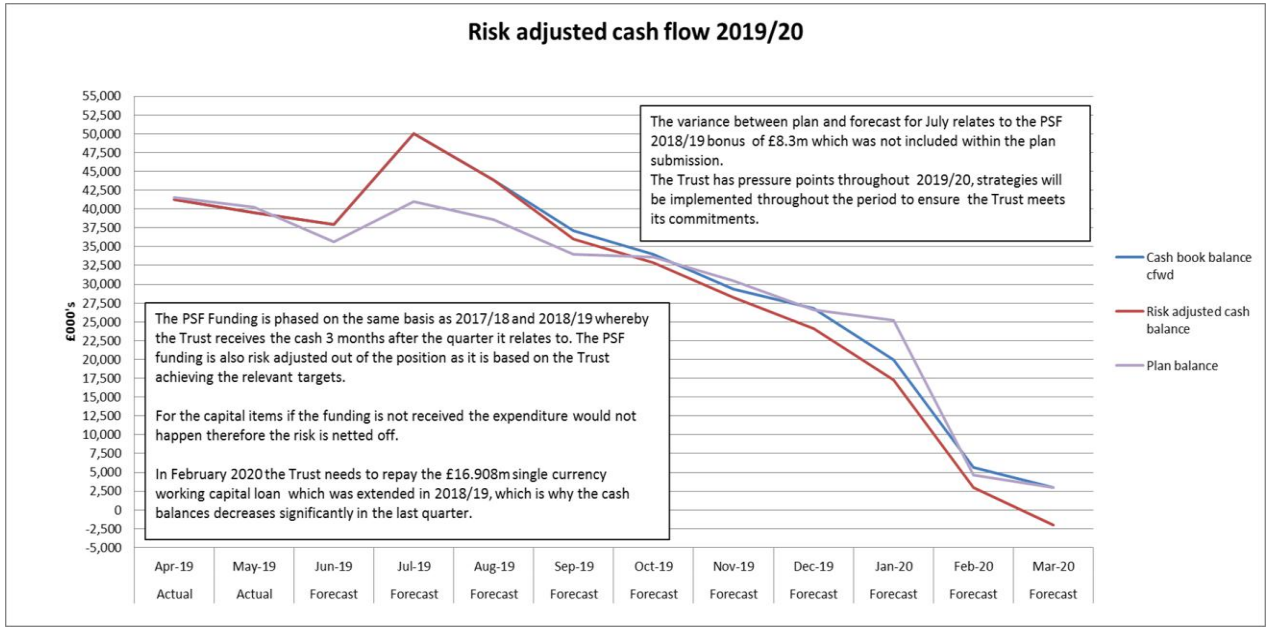
Commentary:
The overall working capital within the month results in a slight increase in both debtors and creditors compared to the revised plan submitted on the 15th May. The cash balance held at the end of the month is slightly lower than the plan by £0.7m.

Non-Current Assets -
Capital additions for 2019/20 based on the plan submitted on 15th May are £14.8m with depreciation of £13.5m. Included within the capital additions are £0.4m donated assets. The planned spend for May was £0.2m with actual spend of £0.1m.

Current Assets -
Inventory of £7.5m is in-line with the planned value of £7.7m. The main stock balances are pharmacy £2.6m, TWH theatres £1.4m, Materials Management £1m and Cardiology £0.9m.
NHS Receivables have increased from Aprils position by £2.4m to £34.9m. Of the £34.9m reported balance, £11.9m relates to invoiced debt of which £2.1m is aged debt over 90 days. Invoiced debt over 90 days has slightly reduced by £0.1m from the reported Aprils position of £2.2m. The remaining £23m relates to uninvoiced accrued income including PSF year end bonus £8.3m, Qtr 4 PSF funding £4.45m, work in progress - partially completed spells £2.7m. 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 increased by £0.1m to £15m fro the reported April position of £14.9m . Included within the £15m balance is trade invoiced debt of £2.3m and private patient invoiced debt of £0.4m. Also included within the £15m are prepayments and accrued income totalling £11.3m. Prepayments primarily relate to rates & annual service maintenance contracts, which will reduce throughout the year as they are expensed. The Trust is currently using a company called Patient Billing Ltd which are supporting the PPU department with improving the quality of invoices and debt collecting.
The cash balance of £39.5m is in-line with the plan of £40.2m. The Trust carried forward £8.4m proceeds from the asset sale which the Trust is waiting confirmation from NHSI that this can be used to fund capital projects in 2019/20. In April the Trust received an advanced contract payment received from WKCCG of c£20m.

Current Liabilities -
NHS payables have decreased from Aprils reported position by £0.4m to £5.4m. Non-NHS trade payables have increased by £1.7m giving a combined payables balance of £52.4m.
Of the £52.4m combined payables balances, £16.6m relates to actual invoices of which £10m are approved for payment and will be released when they fall due, the remaining balance of payables of £35.8m relates to uninvoiced accruals.
Deferred income of £23.8m primarily is in relation to £18.5m advance contract payment received from WKCCG, £1.9m maternity pathway with CCG's and £1m Health Education Income.
The Trust has 3 working capital loans totalling c£43m. £16.9m working capital loan is in current liabilities as due to be repaid in February 2020, the remaining two are due to be repaid in 20/21, £12.132m which is due to be repaid in October 2020 and the remaining £13.99m loan is based on a phased repayment plan throughout 2020/21 and are in non-current liabilities.
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.
The public dividend capital increases by the end of the financial year by £1.5m. This is in relation to ICT - EPMA project expected to be received in quarter 4.
The increase between years for the revaluation reserve relates to the Trust forecasting a 5% increase in values on its building and land assets totalling £14.4m.

4b. | Cash Flow



Commentary

The blue line shows the cash Trust's cash position for 2019/20 which is in line with the plan (purple line). 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.

The closing cash balance at the end of May 2019 was £39.5m which is in line with the plan value of £40.2m. The reason for the high cash balance is due to the Trust carrying forward £8.4m from the asset sales to fund capital projects in 2019/20 and in April the Trust received an advance contract payment from WK CCG of c£20m and High Weald CCG £2m.

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 2020/21 cash flow.
Within quarter 3 the Trust has external loan capital financing of £0.85m, if the funding is not received the capital expenditure will not be spent.
The Trust has planned to receive PDC funding of £1.48m in quarter 4, the £1.48m relates to ICT - EPMA project. The funding is not received the capital expenditure will not be spent.

Last year the Trust received an extension of a year in respect to repaying the single currency interim loan of £16.9m. The loan will need to be repaid in February 2020 which is the reason as to the reduction in cash balance between January and February on the graph.

Information on loans:

	Rate	Value £m's	19/20 Annual Repayment £m's	19/20 Annual Interest Paid £m's	Repayment Date
Revenue loans:					
Interim Single Currency Loan	1.50%	16.908	0.00	0.25	18/02/2020
Interim Revolving Working Capital Facility (IRWCF)	3.50%	12.132	0.00	0.43	19/10/2020
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
Other loans:					
Salix loan (interest free)	0.00%	2.217	0.37	0.00	2024/25

4c. Capital Programme

Capital Projects/Schemes

	Year to Date			Forecast			*Committed & orders raised
	Plan	*Actual*	*Variance*	*Plan*	*Actual*	*Variance*	
	£000	£000	£000	£000	£000	£000	£000
Estates	35	114	-79	6,588	6,588	0	498
ICT	460	259	201	4,103	4,103	0	306
Equipment	60	21	39	3,163	3,163	0	55
PFI Lifecycle (IFRIC 12)	0	0	0	594	594	0	594
Donated Assets	0	0	0	400	400	0	318
Total Including Donated Assets	**555**	**394**	**161**	**14,448**	**14,448**	**0**	**1,453**
Donated Assets	0	0	0	-400	-400	0	
Total Excluding Donated Assets	**555**	**394**	**161**	**14,048**	**14,048**	**0**	

The figures above reflect the agreed capital plan resubmitted in May 2019. The Trust Programme includes £6.4m relating to funding carried forward from 2018/19 as cash from the Maidstone Residences asset sale. This funding has not yet been approved as capital resource by NHSI/E and the Trust is working with the capital lead at NHSI/E to take this forward.

*Committed = actual Year to Date spend/accruals/purchase orders & known contractual commitments

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Finance and Performance Committee, 25/06/19	Committee Chair (Non-Exec. Director)

The Finance and Performance Committee met on 25th June 2019.

1. The key matters considered at the meeting were as follows:

- An update was given on the proposed development of the Acute Medical Unit at Maidstone Hospital, and the additional costs associated with the option to hire, rather than purchase, the Unit (and thereby incur revenue, rather than capital, costs) were noted. It was agreed that the Chief Finance Officer should submit a report to the 'Part 2' Trust Board meeting on 27/06/19, to enable the Board to determine the decision-making process to be applied if NHS Improvement replied to the Trust's request to extend its 2019/20 Capital Resource Limit before the Board meeting on 25/07/19. The discussion also led to an agreement that the Chief Finance Officer should check and confirm whether it was possible for the Trust to repay its working capital loans early (and if so, confirm the terms that would apply)
- The outcome of the research into the Finance and Performance Committees of Trusts rated as "Outstanding" by the Care Quality Commission was considered, and it was concluded that whilst there was no particular practice that should be adopted to improve the committee's functioning, work was continuing on the development of the Trust's monthly performance report, and that work was expected to lead to improvements
- The "Finance or performance moment" item was focused on the Surgery Division, and there was a useful discussion on the Division's challenges, mainly regarding financial performance, but which also included comparatively poor productivity in some specialties and the plans to address these. The hard work of the Divisional management team was recognised. It was agreed to schedule a further session with the Division in the coming months given the overall impact on Trust wide performance.
- The month 2 financial performance was reviewed, and it was noted that the main issue affecting income was the variance in private patient income from that stated in the Business Case that had been approved previously. The latest monthly update on Wells Suite income was then considered and the potential change in the leadership model was noted.
- The financial aspects of the Best Care programme were noted with revised programme reporting confirmed as taking place from next month
- A one-off analysis of the efficiency of non-Ward-based Nursing staff was considered (this related to an action from earlier in 2019), but it was confirmed that no further work needed to be taken on the issue.
- The month 2 non-finance related performance was discussed, which included the A&E 4-hour, Referral to Treatment (RTT) and 62-day Cancer waiting time targets. An update on the RTT data quality work programme was also considered
- The update on the Lord Carter efficiency review (incl. SLR) was noted
- The latest 6-monthly "Post-project review of approved Business Cases" report was reviewed. The report contained details of the proposed revised Business Case process, which had arisen from the Quality, Service Improvement and Redesign (QSIR) programme
- The relevant aspects of the Board Assurance Framework were reviewed, and the recent findings from relevant Internal Audit reviews were noted
- The Interim Director of IT and Programme Director for EPR (Sunrise) and Digital Transformation attended for an update on IT strategy and related matters (including a refresh of the Trust's IT strategy, and an update on the implementation of the Electronic Patient Record (EPR)). The revised 'go live' date for the upgrade of the Patient Administration System (PAS) (which has moved back the 'go live' date for the EPR Phase 1) was noted, & the proposed changes made to the IT Strategy approved by the Board in January 2019 were supported (the revised Strategy will be submitted to the July Board meeting, for approval)
- The methodologies for the Trust's National Cost Collection returns were approved
- 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:**
   - The Chief Finance Officer should consider whether Divisional and Directorate management teams would benefit from further education and training in financial/budgetary management
   - The Chief Executive, Chief Finance Officer and Chief Operating Officer should liaise to consider the subject of the “Finance or performance moment” at the next meeting

3. The issues that need to be drawn to the attention of the Board are as follows: N/A

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

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

Summary report from the Patient Experience Committee, 10/06/19	Committee Chair (Non-Executive Director)

The Patient Experience Committee (PEC) met on 10th June 2019. The meeting was chaired by the Committee's Vice Chair.

The key matters considered at the meeting were as follows:

- The status of actions raised at previous meetings was noted, which included agreement that the action plan in response to the Cancer Patient Experience Survey 2017, due for dissemination to PEC members, should be reviewed with a view to including more aspirational objectives prior to its circulation
- The PEC ToRs were reviewed with a view to considering how support for the Patient and Carer Experience Strategy might be incorporated into their remit. Agreement was reached on several minor changes, but it was decided that any more substantive changes should be considered as part of a PEC workshop which would replace the standard PEC meeting scheduled for 04/09/19 (it was agreed that agenda items scheduled for that meeting would be deferred unless they were of particular significance or time critical in nature); circulation of revised PEC ToRs to the Trust Board for approval would therefore be deferred until after the planned workshop. The workshop would consider the wider remit, functioning and membership of the PEC and would include a review of the material to be circulated for future meetings (in response to comments received at the meeting about the volume, quality and clarity of reports circulated), as well as consideration of the frequency of future meetings
- The Programme Director for EPR (Sunrise) and Digital Transformation gave a presentation on the plans to introduce an Electronic Patient Record system within the Trust
- Members considered a proposal that information on tissue and organ donation be included in the material provided to patients and carers as part of the Swan model (for end of life care patients). The End of Life Care Clinical Nurse Specialist undertook to consider the comments received in the ensuing discussion; these included a proposal to use the forthcoming change in law requiring opt out of organ donation as an opportunity to highlight this issue to patients/carers, as well as engaging with End of Life Care patients on the matter
- Feedback was received on the proposed Trust Mission and Vision Statements and it was agreed that the Director of Strategy, Planning and Partnerships should provide an update to PEC members on the Statements once agreed
- An update was received on the Patient and Carer Strategy, which was due for consideration and approval at the Trust Board in June. It was agreed that the approved strategy would be circulated to PEC members
- A proposed new process for undertaking internal patient surveys, to mirror the process for undertaking clinical audits, was endorsed
- The Communications Manager from Healthwatch Kent gave a presentation about the work of Healthwatch which included details of what had been achieved as a result of its work with the Trust. The Trust's "open door" policy for Healthwatch was commended
- The Head of Midwifery and Quality presented the findings of the National Maternity Survey 2018 and the actions taken by the Trust in response
- An update was received on the latest Sentinel Stroke National Audit Programme (SSNAP) data for the Trust, confirming an improvement for TWH from a C to B rating
- The draft Quality Accounts were received prior to final submission and members invited to submit comments to the Associate Director Quality Governance by end of 14/06/19
- The Complaints and PALS Annual Report was received
- The outcome of the latest Quality Assurance Rounds was noted and an update from the Patient-Led Assessments of the Care Environment (PLACE) Action Group received
- The latest update on the work of the Patient Information and Leaflets Group (PILG) was noted and it was agreed to circulate the updated End of Life Care leaflet to PEC members once finalised
- The Deputy Chief Pharmacist/ chair of the Patient and their Medicines Working Group gave an update on the group's work, including the development of plans for a pilot of patient self-

administration of medicines in Parkinson's Disease patients
- A report from the Quality Committee meetings on 13/03, 10/04 and08/05/19 was noted
- Members were invited to comment on the proposed versions of wording for the Overseas Patient banner (including submission of further comments outside of the meeting by end of 14/06/19)

In addition to the actions noted above, the Committee agreed: N/A

The issues that need to be drawn to the attention of the Board are as follows:
- N/A

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

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

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

Workforce Committee, 23/05/19	**Committee Chair (Non-Exec. Director)**

The Workforce Committee met on 23rd May 2019.

- **The key matters considered at the meeting were as follows:**
  - The actions from previous meetings were reviewed,
  - The committee reviewed and agreed the risk register of the workforce committee and noted actions taken to mitigate the potential risk of a newly implemented clinically led organisational structure
  - The committee noted the presentation of the current workforce indicators and discussed in detail the vacancy challenges faced by the trust and actions being taken to address them
  - The Guardian for Safer Working presented his report for January – March 2019. The improvements in the number of exception reports for surgery was noted, particularly in light of their recent deanery visit. The Guardian for Safer Working noted the positive impact that Physician Associates had on junior doctor workload and capacity. Paediatrics was reporting a number of issues as a result of ongoing rota gaps and further support was being targeted to ensure that trainee issues were promptly addressed.
  - The committee noted the report of the Director of Medical Education and in particular the outcome of the recent deanery visit to Surgery. A number of issues remained outstanding however the majority of actions had been completed and positive feedback was received from trainees.
  - The committee reviewed the progress of the Trust towards meeting the BMA Rest and Fatigue charter. Hot food dispensers were now available at MGH and would be available at TWH subject to fire safety checks. Work to improve the junior doctor's mess was also noted.
  - The committee welcomed the introduction of Schwartz rounds into the organisation. Attendance at the first two events had been high. Future events would focus on understanding the service from the perspective of a patient or carer.
  - The committee reviewed the actions being taken to improve workforce rostering systems and practice with the view of achieving further cost savings through more efficient deployment of staff, reduced bank and agency usage and application of trust policies
  - The committee welcomed the actions taken to increase the supply of overseas nurses with interviews in Kochi in May for 41 OSCE ready nurses and further interviews planned for June in India alongside ongoing recruitment via Skype. The committee focused on the need for a robust programme of pastoral and professional support to ensure that the efforts to recruit were not undone by a failure to retain. The committee also noted the in year cost pressure that would result from the overseas recruitment but recognised the quality impact that this would have as well as savings in future years achieved via the reduction in agency expenditure.

The issues that need to be drawn to the attention of the Board are as follows: N/A

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

NHS Maidstone and Tunbridge Wells NHS Trust

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?

- -

Reason for receipt at 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

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MTW Best Care

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Trust Board
Best Care Programme 19/20
June 2019

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Maidstone and Tunbridge Wells NHS Trust

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    d. Best Quality
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1a. Executive Summary

Workstreams Update

KEY **PROGRESS**

Best Patient Flow – Cancer Transformation structure in progress to prioritise Cancer transformation projects. MY POA scheduled to go live on 22nd May. Online Outpatients platform 'Attend Anywhere' planning underway with NHSI and clinical divisions, phase 1 scheduled with Sexual Health and Phase 2 with Specialist Medicine. Outpatients survey resulted in 80% return from patients, data currently being analysed. Out of Hospital - #NOF Pathway change to be signed off at next meeting in June 2019. SDEC – Surgical division signed up to cohort 4 of National Surgical Ambulatory Emergency care network. Medical AEC – first patient seen / treated at Tonbridge Cottage Hospital.

SDEC excellent engagement with National team for Surgical SDEC work at SAU. Detailed plans in place to increase throughput in TW AEC from 24.6.19. Recruitment underway to support increased provision of Frailty services. LOS - work continues to try to ensure engagement across all Divisions to support LOS projects, working on PDSA for EDN process. Out of Hospital Capacity - Project plans and teams have been established and analysis has begun, with repeat PDSA for Frailty bed in the community. Planned Day Care Delay in kick starting project, gaining in clinical leads and analysis of data.

Best Safety – GIRFT Programme continues as planned, we are currently arranging visits for Acute Medicine and Geriatrics. The SSI audit has commenced.

Best Workforce – The Medicines & Emergency Care agency medical bank is now recentralised into the Staff Bank, which will see an improvement to retrospective bookings and improve transparency. Three agencies now engaged for overseas nursing recruitment in order to help fill our vacancies with 278 in the recruitment pipeline. Survey issued to determine what staff are working at Advance Clinical Practice in the trust and due to close on 1 July.

KEY RISKS

Best Patient flow – Funding not yet in place for H@H following WKA Exec meeting 14.6.19. Recruitment of skilled staff continues to be an issue across all workstreams. There is a significant risk that increased non elective demand will continue to rise beyond the agreed levels for 19/20. In addition there is a financial risk to the Divisional CIPs related to Best flow.

Best Safety – Medical Productivity - not all divisions have signed off job plans and have missed the 29th March deadline. This has been escalated and raised at the Divisional Performance reviews held week commencing 20th May and 77% have been signed off. The other are activity being chased. Sufficient resources to meet 7DS still remains an issue.

Best Workforce – Nursing vacancy numbers still high, however overseas recruitment in India and local recruitment events starts to see numbers increasing. Financial gap to CIP target not yet covered but meetings are taking place with Divisions to show the potential benefit of roster management improvements, which include CIPs. Final meetings due to conclude in July with potential CIPs agreed.

Workstreams Update

KEY **PROGRESS**

Best Quality – #EndPJParalysis –Birthday celebrations took place week of the 3rd June. Improved engagement and Increase in patients getting up and dressed.

Dementia – Dementia Emergency services Event hosted by MTW took place on the 21st May. Increased referrals to Crossroad Care have been reported since the event

Best Use of Resources – Pharmacy Outsourcing is progressing with the application to NHSI, meetings have been schedule with non executive directors to discuss and provide advise on the Business side of things, meeting also held on the 11th June with Pharma@Sea to review NHSI specifications and scope. Submission to NHSI is planned for the end of June 2019.
Send away Tests – Baseline data now collected for MTW, initial draft of specification has also completed, this now needs to be signed off by the clinical sub group be the end of June 2019.
Post – contract wen out to tender and closed at the end of May, team are now collating and evaluating responses which will continue till the end of June 2019.
NPEx - Project kick off meeting held on the 10th May 2019, with project timeline agreed, Contract & Data sharing Agreement completed and pending submission to the Head of Information Governance for sign off.
Estates Staff Consultation - consultation paper have been reviewed and updated, and awaiting finalised cost from finance by the end of June.
Consultation paper will be disseminated to Staff Side Chair on the 17th June 2019, and to affected staff for information and preparation for consultation on the 29th June, 30 days consultation process starts on the 24th June with group consultation meetings planned for 24th, 26th and 28th June.
Procurement – delivered £162K savings across the Trust in M2 against their plan of £193K, but this gap has already been covered from M1 where they made a saving of £296K against their plan of £184K.
Lucentis Price reduction – confirmed savings of £100K FYE starting from June 2019.

KEY RISKS

Best Quality – Patient Experience and Engagement Project is delayed due to a lack of resource. Business Case has been approved and Job description to go to panel which will mitigate the risk. Patient Experience Strategy now transformed into a formal strategy document, to be presented at Trust Board 26/06/2019.
No schemes yet identified to plug the current CIP gap of £160k

Best Use of Resources – Process for obstetric scanning not yet agreed. Team will now benchmark against other trusts and present to CO'B/PM for final acceptance.

Unable to source replacement parts for 2 old CT scanners presently used in the department, which may result in loss of activity.

Delay with provider solicitor signing off legal requirements for Energy Procurement VAT savings, workstream is adverse to plan by £50K due to delay.

2a. Best Use of Resources

Best Use of Resources is focused on reducing waste and improving value on the products and services we buy across the Trust.

The workstream has started with five key areas to achieve best value in by reviewing costs and identifying opportunities for savings, whilst ensuring quality of service and patient experience is not comprised and continues to improve.

The key areas are:

- **Estates and Facilities**
- **Procurement**
- **Medicines Management**
- **Aligned Incentive Contracts**
- **STP pathology review**
- **West Kent Diabetes Community Clinics**

Best Use of Resources

Maidstone and Tunbridge Wells NHS Trust

Summary of Progress

Explanation of Status:
Reason for red status is due to slippages in the following schemes
Estates & Facilities
- Energy procurement - delay in signing off legal papers from the providers solicitors, this has been escalated to the providers and will be escalated to MTW CEO.
- Patient Catering TWH workforce opportunity - delay with the release of capital to fund the project with.
- Unidentified CIP (£62K) - team are currently working on a new scheme around domestic staff efficiencies and will explore other schemes such as retail opportunities in Maidstone Hospital

Diagnostics
- Repartriation of send away tests -delay in obtaining baseline data of current volumes and prices of test sent away, as timeliness has been poor till date.

Issues to escalate to Board:
- Energy Procurement

Summary Information

Overall Status	Amber	Timescale Status	Amber	Budget Status	Amber
Quality Status		Resource Status		Benefit Status	

Project Status

Project Name	Last Month	This Month
Estates & Facilities	Amber	Red
ICT	Green	Green
Procurement	Green	Green
EME	Green	Green
Dignostics	Red	Red
Medicines Management	Amber	Green

Top Issues

Unique Identifier	Description	Action	RAG
MM-01	Avastin - Outcome of judicial process in September 2018 went in in favour of CCGs involved, but there may be other factors that may prevent / delay the implementation of Avastin and any planned savings.	Await MHRA national advice around medicines law, also establish clear guidance around the sustainability of supply to accommodate the number of patients as it increases.	Red
ICT01	ED Contract renewed with Symphony for another year till end of March 2020, therefore planned savings from M7 will not deliver.	Get assurance that Symphony will not be needed in parallel with Sunrise due to accessing existing records, then approach EMIS to see if the contract can be ended earlier and request a refund.	Red
EFM-01	Capital funding for 2019/20 schemes yet to be released by the Trust, these has delayed the delivery of some projects.	Review alternatives to capital funding.	Red
EFM-02	Delay with signing off legal requirements for Energy Procurement VAT savings	Escalate to MTW CEO	Red

Top Risks

Unique Identifier	Description	Mitigation	RAG
DIAG-01 - Radiology MES Contract	Unable to source replacement parts for 2 old CT scanners presently used in the department, which may result in loss of activity.	Temporary use of mobile scanners, but these cannot accommodate the current capacity of work, which will result in reduction in capacity and increase in waiting list.	Red
EFM-03 - Extra car park funding	Extra car park funding - funding expected from extern source may fall through which will delay or halt project	Source alternative joint venture	Red
DIAG-05 - Repatriatoon of send away tests	Obtaining baseline data of current volumes and prices of tests sent away	Timeline for final completion by all labs has been revised to 11/05	Red
DIAG-07 - Repatriation of sends away tests	Time for numerous operational decisions e.g lotting of tests, TAT, transport requirements, reporting mechanism required by pathology management to enable procurement to tender has been challenging and delays in obtaining the		Red

Best Use of Resources

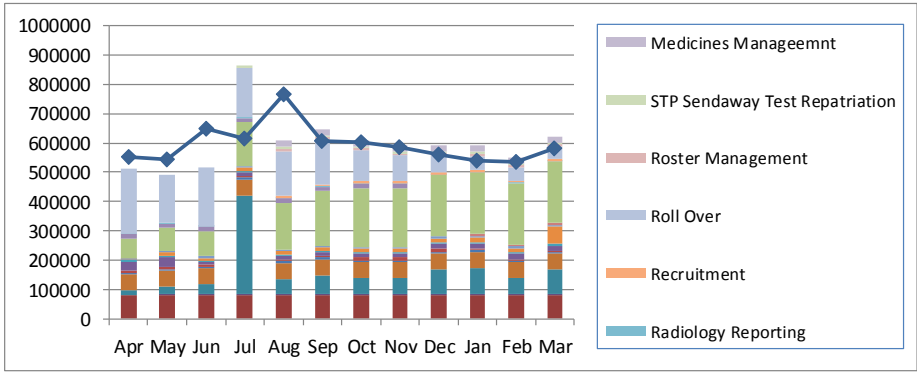
NHS Maidstone and Tunbridge Wells NHS Trust

Milestones Missed				
ID	**Entity Name**	**Milestone**	**Expected Date**	**RAG**
EFM-31	Estates & Facilities - Energy Procurement	Sign off Legal Papers with PFI Partners	19/04/2019	Red
EFM-57	Estates & Facilities - Estates Staffing	Finalise costings for Estates staffing consultation	31/05/2019	Amber
PROC-15	Procurement - IT Hardware	Finanlise STP specification for IT Hardware	31/05/2019	Amber
DIAG-62	Diagnostics - MRI Tender	Agree preferred option on MRI	31/05/2019	Amber

Milestones Due in next Reporting Period				
ID	**Entity Name**	**Milestone**	**Expected Date**	**RAG**
MM-08	Medicines Management	Outsourcing - Meet with NEDs to review application and provide support for application	20/06/19	Green
MM-10	Medicines Management	Outsourcing - Commence negotiations with Pharma@Sea	28/06/19	Green
MM-13	Medicines Management	Outsourcing - submit application to NHSI	02/07/19	Green
EFM-25	Estates and Facilities	Amend food orders to ED areas	30/06/19	Green
EFM-50	Estates and Facilities	Secure finance from externaal third party for extra car park	30/06/19	Green
EME-05	EME	Successful candidates in post to expediate income opportunities work	01/07/19	Green
DIAG-62	Diagnostics	Agree preferred option and quantify financial benefit for MRI	30/06/19	Green

Metrics / KPI						
Unique Identifier	**KPIs**	**Baseline**	**Target**	**Last Month**	**This Month**	**Trend**
	Transaction lines on e-catalogue	95.00%	95.00%	95.20%	95.30%	↑
	Invoice (by value) on purchase order	90%	90%	84.10%	97.50%	↑
	Invoice (by no) on purchase order	90%	90%	80.70%	91.20%	↑

Financial Information



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2b. Best Workforce

Best Workforce is devising innovative strategies to develop new roles and attract and retain staff to the Trust. Implementing more efficient processes to help make people's jobs easier and reviewing temporary staffing are the key areas of focus for Best Workforce.

The workstream's priority areas are:

- **Recruitment**
- **Temporary Staffing**
- **New Roles and Apprenticeships**
- **Workforce Productivity**
- **Attract and Retain**

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Best Workforce

NHS Maidstone and Tunbridge Wells NHS Trust

Summary of Progress
Reason for status: - eRostering reporting a red status due to delays in completing corrections to roster templates (31 March due date) as alignment to establishment and safe staffing levels taken longer than planned. Final meetings due to take place in July, then CIPs can be calculated based on the improvements. Expected to be completed by 31 July. - New Roles and Apprenticeships reporting a red status due to key project resource being on long term sick leave with no backfill and additional apprenticeship resource requested to undertake promotion activities still to be approved by Best Care Board. A business case has been approved for two band 5 apprenticeship resources - expected to be recruited in July. **Decision Required by Board:** - Approve resource requested for fixed term contracts for a Nursing Lead, AHP Lead, Roster Lead and Business Analyst.

Summary Information					
Overall Status	Red	Timescale Status	Red	Budget Status	Red
Quality Status		Resource Status		Benefit Status	

Project Status		
Project Name	**Last Month**	**This Month**
eRostering	Amber	Red
New Roles and Apprenticeships	Red	Red
Recruitment	Amber	Amber
Temporary Staffing Controls	Amber	Amber

Top Issues			
Unique Identifier	Description	Action	RAG
BWF-01	Significant change is required to MTW Workforce systems, processes, practices and establishment control (vacancies). Currently there is no clear strategy or road map on how we will achieve this over the next 3 years. As a result there is pressure to do everything now.	KB to present paper on prioritising initiatives to July Best Workforce Board. SH should consider aligning MTW Workforce Strategy with new NHS People Plan.	Red
BWF-03	Request for additional resource to support the Best Workforce Programme has not yet been approved at Best care Board, impacting ability to achieve objectives.	SH to raise with SO and if required to Best Care Board, asking what additional information is required for approval.	Red

Top Risks			
Unique Identifier	Description	Mitigation	RAG
NRA-04	Loss of apprenticeship levy - there is a risk that we will not spend the apprenticeship levy by July 2019. If this happens we will lose unspent funds.	Resource request submitted to Best Care Board to aid in apprenticeship promotion and increase in uptake. Approval needed. Also setting up levy transfers with KCHFT and SECAMB.	Red

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Best Workforce

Maidstone and Tunbridge Wells NHS Trust

Top Issues (continued)			
eR-12	Divisions have not signed-up to Workforce 19/20 KPIs on rostering improvement.	Workforce lead to complete triangulation with safestaffing, roster templates, finance establishment and continue to review plans with Divisions in order to improve confidence.	Red
Rec-02	Nursing Vacancies - significant nursing vacancies in medicine at TWH.	Nursing vacancy workshop held on 12 April to identify obstacles and objectives. Priority was given to securing marketing expertise and to set-up a Task & Finish Group, with latter established.	Red
Rec-03	Marketing expertise - procurement of marketing expertise delayed, impacting promotion of job vacancies, recruitment along with EPOC and QSIR.	SON met with KCHFT to explain MTW's requirements. SON to determine requirements to engage dedicated expertise.	Red
Rec-04	Delays to medical recruitment are occurring due to significant scale and pace of change required by team to meet objectives.	Escalated to SH, who is closely monitoring team. Staff member who was on long term sick has now left the Trust and the MSM is recruiting to that	Red
Rec-16	Due to significant vacancies in nursing, capacity not available to interview, support and induct new nurses on wards. Only 8 out of a potential 50 job ready nurses appointed via MSI.	Escalated to SH. SH and COB to escalate to Execs.	Red
NRA-01	Resource constraints - limited staffing resources are appropriately focused on the apprenticeships programme. Key apprenticeship resource also on long term sick as of 24th April without back-fill.	Apprenticeship resource not backfilled, however business case has been approved to recruit 2 band 5 apprenticeship resources (interviews expected to take place in July).	Red
TSC-05	Full Panel not meeting to review medical temporary staffing requests. High cost locums therefore may be working in the trust, causing issues with fairness and equity of pay.	SH, SB, SM to meet to discuss handing over accountability of panel and breakglass process to MLAG. KB to set-up.	Red

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Best Workforce

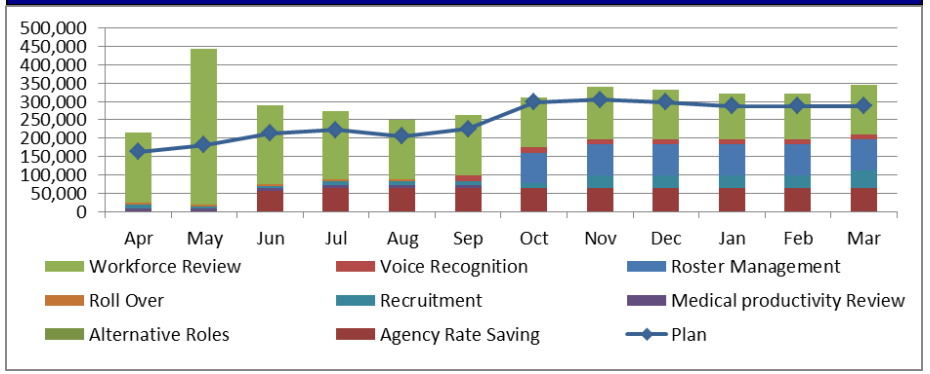
Maidstone and Tunbridge Wells NHS Trust

Milestones Missed				
ID	Entity Name	Milestone	Expected Date	RAG
eR-24	eRostering	Rostering resource approved	20/05/2019	Red
eR-30	eRostering	KPIs and CIPs approved by divisions	29/03/2019	Red
eR-49	eRostering	Initiation Phase Complete	20/05/2019	Red
eR-54	eRostering	Project Team established	10/06/2019	Red
eR-80	eRostering	Reporting and Monitoring System established	30/04/2019	Red
Rec-52	Recruitment	Medical shortlisting improved	05/04/2019	Red
Rec-58	Recruitment	Medical Recruitment Improvement Opportunities Implemented	31/05/2019	Red
Rec-68	Recruitment	Decision to engage external expertise	15/04/2019	Red
Rec-73	Recruitment	Dedicated External Marketing Provider Starts	03/06/2019	Red
NRA-61	New Roles and Apprenticeships	Apprenticeship professional lead resources approved	20/05/2019	Red
NRA-74	New Roles and Apprenticeships	Levy Transfer Plan Complete	31/05/2019	Red
TSC-15	Temporary Staffing Control	Business Analyst resource approved	20/05/2019	Red

Milestones Due in next Reporting Period				
ID	Entity Name	Milestone	Expected Date	RAG
eR-74	eRostering	Plan Roster Performance Improvement Complete	28/06/19	Red
eR-82	eRostering	eRostering Planning Phase Complete	28/06/19	Red
eR-113	eRostering	Training and support material developed	21/06/19	Red
eR-114	eRostering	Ready for Roster Performance Improvement Rollout	21/06/19	Red
Rec-39	Recruitment	Medical Recruitment Process Improvements implemented	12/07/19	Red
Rec-80	Recruitment	Recruitment Marketing Strategy approved	16/07/19	Red
NRA-70	New Roles and Apprenticeships	Project Team established	17/06/19	Red
NRA-113	New Roles and Apprenticeships	Trust-wide Roles Working Groups Established	14/06/19	Green
NRA-131	New Roles and Apprenticeships	Commence reporting of data on trust-wide roles	05/07/19	Amber
NRA-204	New Roles and Apprenticeships	Advanced Clinical Practice Survey Closes	12/07/19	Green

Metrics / KPI						
Unique Identifier	KPIs	Baseline	Target	Last Month	This Month	Trend
KPI 1a	Increase of Substantive Staff - Nursing and Midwifery	1,332.75	1,415.13	1323.27	1333.41	↑
KPI 1b	Increase of Substantive Staff - Medical	631.98	670.15	635.06	641.76	↑
KPI 5a	Temporary Staffing Requirements Sent to Bank 6 Weeks in Advance - Nursing and Midwifery	19.7%	100.0%	32.3%	28.5%	↓
KPI 5b	Temporary Staffing Requirements Sent to Bank 6 Weeks in Advance - Medical	34.7%	100.0%	23.0%	28.5%	↑

Financial Information



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2c. Best Flow

The Best Flow workstream aims to promote best patient flow across the system, to reduce stranded patients, reduce red days and improve the patient journey.

Demand continues to increase for acute beds without an equal increase in capacity or resources. The rationale for this workstream is to increase overall capacity and ensure that the right patient is in the right place at the right time.

The transformational projects include:

- **Length of Stay**
- **Same Day Emergency Care (SDEC)**
- **Planned Day Case**
- **Out of Hospital Capacity**

The Divisional Improvement projects include:

- **Stroke**
- **Outpatient Productivity**
- **Data**
- **Theatre Transformation (My POA)**
- **Cancer Transformation**
- **Outsourcing**
- **Private Patients**

Best Flow Transformational

NHS Maidstone and Tunbridge Wells NHS Trust

Summary of Progress
Reasons for Status: - **SDEC GREEN -** excellent engagement with National team and medicine SDEC/ Frailty project teams in place, - **LOS** - Green, work continues to try to ensure engagement across all Divisions to support LOS projects. **- Out of Hospital Capacity** - Amber - Project plans and teams have been established and analysis has begun, with repeat PDSA for Frailty bed in the community. H@H - Red- Await confirmation of funding for 19/20 following WKA Exec meeting 14.6.19. **- Planned Day Care** - Red - Delay in kick starting project, gaining in clinical leads and analysis of data. **Decisions for Board:** None.

Summary Information					
Overall Status	Amber	**Timescale Status**	amber	**Budget Status**	amber
Quality Status		**Resource Status**		**Benefit Status**	

Project Status		
Project Name	**Last Month**	**This Month**
Length of Stay	AMBER	GREEN
Digital Transformation	GREEN	GREEN
EDD	AMBER	AMBER
EDN	AMBER	AMBER
Out of hospital capacity includes: Sunhill Flat, Long Stay Wednesday, Community Frail bed, Carehome Admittance	AMBER	GREEN
Planned Day Care	AMBER	RED
SDEC	GREEN	GREEN
Acute Frailty MTW	AMBER	AMBER
Surgical SDEC	GREEN	GREEN
Medical SDEC	GREEN	GREEN

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Best Flow Transformational

NHS Maidstone and Tunbridge Wells NHS Trust

Top Issues			
Unique Identifier	**Description**	**Action**	**RAG**
PDC - 20	Gain agreement on clinical buy in to Planned Day Case project.	Meeting arranged for the 13.06.2019, to agree clinic leads.	GREEN
OOHC - 70	Sunhill Agree patient criteria for flat	Meeting arranged for 13.06.2019 to understand issues, then work through to agreement of patient criteria to use the flat.	GREEN
PDC-21	Analyse data to identify trends, demands and supply for services.	Agree the scope and criteria of the project at meeting: 13.06.2019. Request data from BI and leads to coordinate analysis.	GREEN

Top Risks			
Unique Identifier	**Description**	**Mitigation**	**RAG**
OOHC-01	There is a risk that the community will not have enough capacity to support the timely discharges/ transfers of patients.	Projects set up to achieve targets. Key opportunities identified to target improvements for appropriate patients. Cross working across community and acute.	RED
SDEC-02	There is a risk that substantive skilled staffing will not be available to support the new SDEC pathways	development of new roles and responsibilities, working with Best Workforce	RED
OOHC-05	There is a risk that staff groups both in and out of the acute hospital will not engage with the schemes being developed, or will find the array of schemes confusing and will refer to the wrong scheme.	Work across organisations to join up schemes. Increase communication. Ensure that referral processes are simple. Development of Single Point of Access.	RED
LSO-2	There is a financial risk to delivery of the financial CIPs related to Flow, which are held at Divisional level.	Assurance group to monitor reporting and hold programmes to account concerning delivery of the best practice.	RED
LSO-4	There is a significant risk that increased non elective demand will continue to rise, beyond the agreed levels for 19/20.	Project have been set up to assist with reducing LOS, enabling patients to either continue their treatment at home or in the community. This will assist with improving patient flow, but will not resolve the issue of increased non elective demand.	RED

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Best Flow Transformational

Maidstone and Tunbridge Wells NHS Trust

Milestones Missed

ID	Entity Name	Milestone	Expected Date	RAG
PDC - 20	Planned Day Care	Gain agreement on clinical buy in	25.06.2019	RED
OOHC- 7(	Sunhill Court Flat	Agree patient criteria for flat	31.05.2019	RED
PDC - 21	Planned Day Care	Analyse data to identify trends, demand and supp	30.07.2019	RED

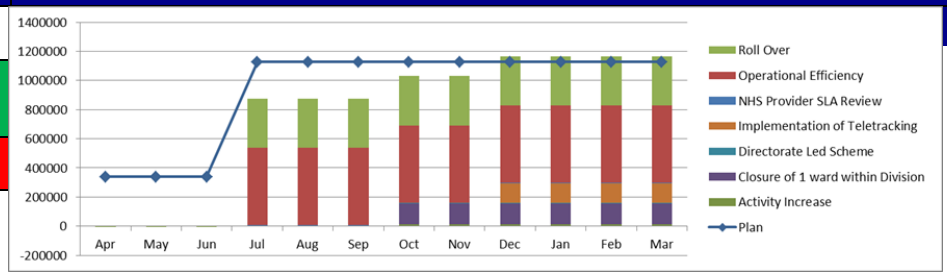
Milestones Due in next Reporting Period

ID	Entity Name	Milestone	Expected Date	RAG
PDC-18	Planned Day Care	PID complete and approved	12/07/19	GREEN
PDC-39	Planned Day Care	Create Action / Project Plans	21/06/19	GREEN
OOHC-66	Out of hospital capacity	Analyse reporting to identify patients and how many beds are required.	12/07/19	GREEN
OOHC-70	Out of hospital capacity	Gain Clinical Buy / Stakholders	01/07/19	GREEN
SDEC-AFU- 5	Review of Frailty Bronze Pilot	Review of what worked well in the bronze pilot	10.07.2019	GREEN
SDEC-AFU-6	Review of Carehome data through A&E	Review of the patients who come to A&E and which Carehomes they ceom from, to identify how we can assist with preventing frail patients coming to an Acute setting.	30.06.2019	GREEN
LOS-45	meet with doctors (Medicine W21) to review process for EDD	Gain Approval and clinical buy for the EDD.	15.07.2019	GREEN
LOS-46	add improvements for EDN process	EDN improvements are implemented and used.	30.07.2019	GREEN

Metrics / KPI

Unique Identifier	KPIs	Baseline	Target	Last Month	This Month	Trend
-1	Percentage of non elective take seen within 0 LOS		25	20.2	20.9	↑
-3	Non elective LOS in Medicine		7.4	7.9	7.9	

Financial Information



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WORKSTREAM	Best Patient Flow	BEST CARE PROGRAMME BOARD DATE	17.06.2019
WORKSTREAM LEAD	Sean Briggs	TRANSFORMATION SUPPORT	

DESCRIPTION	ACTIONS / MILESTONES COMPLETED	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD
		LAST MONTH	THIS MONTH	
DIVISIONAL IMPROVEMENT PROJECTS (led by Divisions)				
Outpatient Transformation – lead Kym Sullivan	• Respiratory Sprint: Practitioner Kinesis "Go Live" due to start 28/06/19 • Clinical validation w/c 07/05/19 underway. • Gastro Sprint: Clinical Lead role recruited and meeting 22/05/19 • Patient survey forms completed from ENT department . • NHSI Task and Finish Group weekly meeting arranged. QIA drafted and for presenting 29/05/19. DPIA initial draft prepared. Project leads assigned. • NHS Benchmarking visit to East Kent agreed for 28/06/19. Allscripts/ERS question list initially drafted.	G	G	• Respiratory Sprint : Review clinical validation and initial findings on kinesis • Gastro Sprint: meeting scheduled to look at next steps. • Patient survey. JPMO to review and analyse ENT department completed surveys. Sexual Health and Oncology forms to be completed.. • NHSI Attend Anywhere Project lead training dates to be agreed. DPIA to be developed. IT walkrounds to test equipment/areas fit for purpose. • NHS benchmarking visit date to be agreed with Royal Free re: OPD remodelling/structure learning. Confirmation of final question lists for both visits.
	• Combined KPI dashboard – MTW KPIs agreed and baselined – WKCCG KPIs to be baselined.	R	R	• Combined KPI dashboard new and FU appt KPI targets and financial methodology to be discussed in 24/5/19 WKA Operational Grp.
Stroke – Jo Cutting	• The stroke reconfiguration is progressing to the development of 3 HASU/ASU sites in Kent at Tunbridge Wells Hospital, Darent Valley Hospital and Ashford Hospital. • The first two are planned to 'go live' in March 2020 and the latter in 2021. • In terms of the wider programme the Decision Making Business Case has been produced by the STP. Despite the long and thorough planning process the plan was not well received in all quarters and currently there is an Independent Review by the Secretary of State for Health in train from Medway NHS Trust and two public pressure groups have instigated judicial reviews. On this basis the programme of work is progressing however the STP legal advice to the network partners is not to do anything that cannot be reversed in terms of service development and estate changes. • Within the network recruitment strategies are being developed although no recruitment can take place at present apart from to fill current vacancies within current establishments. Network operational policies are also being developed and local policies within Trusts are being compared to ensure parity between the organisations.	R	R	• Locally at MTW we have robust governance in plan and have developed and continue to refine our internal processes our estates, equipment and staffing plans to include all disciplines. Regular communications go out to stroke staff. • Whilst accepting the current level of vacancies and the increase required to deliver a HASU/ASU the staffing challenge is considerable however we are still aiming for the March 2020 deadline for HASU/ASU delivery. • The move to the MH site for all MTW stroke will necessitate considerable building work and reconfiguration. The interdependencies mean that the final estates solution will not be in place in march 2019 but we are refining a robust work around to ensure we are able to deliver at the current agreed timescale.
Data Lead Jenny Pelly	• Data analysis complete • Project plan and governance set up • Regular reports at Exec level			• No RAG given as this is reported weekly at Exec level

DESCRIPTION	ACTIONS / MILESTONES COMPLETED	DELIVERY RAG		ACTIONS FOR NEXT REPORTING PERIOD
		LAST MONTH	THIS MONTH	
DIVISIONAL IMPROVEMENT PROJECTS (led by Divisions)				
Prime Provider Lead Sarah Turner	• Robust communication pathways to GPs and SPoA services including visits • RAS templates – being used by referrers • Final draft of contracts with IS for outsourcing. • Received MOUs from IS in order to continue outsourcing whilst contracts being drafted. • Financial reporting for Prime provider will begin in mid June, 18 weeks after go live. The financial report shown at the moment is for the previous RTT reporting April, May and June 2019.	G	G	• Finalise Quattro system for electronic patient tracking to also include outpatients. • Embed KPI and performance monitoring of prime provider into current systems. • Submit operational policy to PRC for approval • Sign finalised contract variation for prime provider with WKCCG • Contracts with the IS distributed 15/05/19 for review. • The project is green as project has gone live, but still waiting to see finances.
Theatre Productivity Lead Sarah Turner	**My POA** •Reduction of clinics and crossover of old and new process agreed with the DDO and surgical specialities so activity is not affected. •Formal patient go live 22nd May 2019, over 200 patients have used the new process i.e outpatients to pre assessment clinic, using my pre op, over 1000 my pre op questionnaires have been filled in and sent to the pre assessment clinic for review and outcome. •Pre assessment team have worked incredibly hard to make the go live and project a success and continue to.	G	G	**My POA** •Monitor of new clinics and patient pathways, review and amend as requested. •Reporting data to be provided to enable the reduction of face to face pre assessment clinics and confirm reduction in Waiting list and each directorate having a pool of patients. •There is an issue with patients who do not come to pre assessment after their outpatient appointment. A proposed process has been suggested, discussion and sign off by the directorates is needed.

KEY ISSUES/RISKS TO FINANCIAL PERFORMANCE: DESCRIPTION	MITIGATION	DATE REC	LAST MONTH	THIS MONTH
Stroke – due to lack of decision around Judicial review, unable to proceed with plans or building work	Continue with detailed plans and workarounds to enable buidling works	1.4.19	R	R
Workforce – lack of suitably skilled candidates to support projects, specifically stroke	Working with Best Workforce and across STP to support transition of staff		R	R
Prime Provider – unable to review financial benefit at this stage	Will be visible in july and project team have given assurance that referrals in place		A	A
Operational pressures will impact on transformational projects	Identification of further resources required, i.e. for Acute Med and Geriatrics Directorate, for B.I. support, for nursing support	01.05.19	A	A

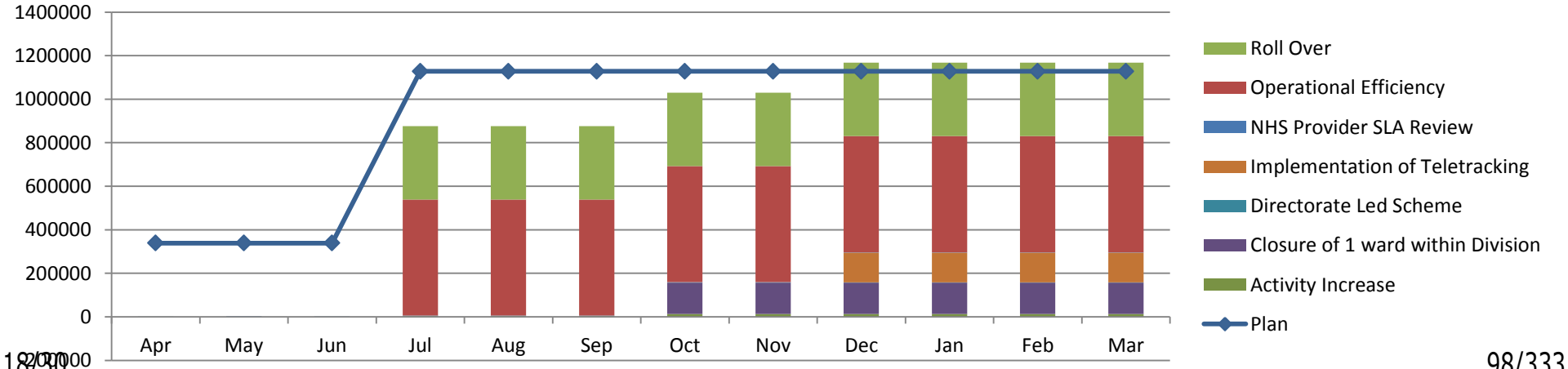
Critical Path Milestones	Milestone Date	Status	RAG Last month	RAG This month
Upload all Divisional Improvement projects to Asypre to ensure robust governance and transparency, supported by Transformation Team.	30.6.19		A	A

KPIS

	KPI	2018/19	Apr-19	May 19
New OP DNA	5%	6.0%	5.2%	Awaiting data
FU OP DNA	7%	6.1%	5.3%	Awaiting data

FINANCE NARRATIVE

The main roll over scheme related to prime provider, we are receiving the referrals but not the financial benefit yet. This will be visible in July.



2d. Best Quality

The Best Quality workstream has worked with colleagues from across the Trust to help identify four key areas of work that can really transform our patient and staff experience.

While the workstream is focused on a number of important and quite specific clinical improvements, it is also the conduit for developing new strategies for patient, staff and public engagement that support and enable future change.

The projects include:

- **Complex Needs**
- **Quality Improvements**
- **Engagement and Experience**
- **Effectiveness and Excellence**

Best Quality

NHS Maidstone and Tunbridge Wells NHS Trust

Summary of Progress
31/05/2019: **Explanation of Status:** Patient Experience and Engagement Project is delayed due to a lack of resource. Business Case approved and Job description for Lead to go to panel which will mitigate the risk. Patient Experience Strategy now transformed into a formal strategy document, to be presented at Trust Board 26/06/2019. Pressure Ulcer project is delayed due to policy ratification. Policy ratified subject changes currently being made, following this project will be green and move to BAU. CQUINs remains amber, delays to receipt of CQUINs remains a risk to CQUIN delivery. Meeting with CCG agreed Q1 submission will form baseline, future targets will be agreed following Q1 baseline submission MCA . Meetings are now in place. Governance and project objectives formally be agreed at the July meeting to present to Best Quality Workstream Board in August. **Issues to escalate to Board:** None

Summary Information					
Overall Status	Amber	Timescale Status	Amber	Budget Status	Amber
Quality Status		Resource Status		Benefit Status	

Project Status		
Project Name	**Last Month**	**This Month**
Quality Improvement Committee	Green	Green
Patients and their Medicines	Green	Green
Paediatric Transition	Green	Green
#EndPJParalysis	Green	Green
Crowborough Birthing Centre	Amber	Green
Maternity Safer Births /CNST	Green	Green
CQUINs	Amber	Amber
Pressure Ulcer	Amber	Amber
Nutrition	Amber	Green
Patient and Public Experience and Engagement	Red	Red
Staff Experience and Engagement	Green	Green
Dementia	Green	Green
Delirium	Green	Green
MCA		

Top Issues			
Unique Identifier	**Description**	**Action**	**RAG**
BQ-PPEE-01	PPEE remains unsupported without resource post project phase in BAU mode	Approval of Business case for to include provision for PPEE support. PMO Support not in place to support strategy launch.	Red
BQ-PU-03	Pressure Ulcers - Pressure Ulcer Policy has been revised to ensure compliance with NHSi Definition and Measurement document.	Ratified subject to amendments at PRC Agenda 29th May 2019	Amber
BQ-CQUIN-03(R)	Delays to receiving full details of the CQUINs, including targets leaves CQUIN leads with uncertainty about goals and caused delays to data collection.	Format for CQUINS has changed and are not as prescriptive as previous years. Workshops being held with NHSE to work through detail. Agreement with CCG that data submission for Q1 will establish the baseline, subsequently targets will be agreed. Specialist CQUIN triggers have been agreed.	Amber

Top Risks			
Unique Identifier	**Description**	**Mitigation**	**RAG**
BQ-02	Inability of projects within Best Quality to Identify Financial CIP stretch target of £160,000.00	Although Best Quality will be able to secure the money assigned to the CNST Maternity Rebate the projects do not align themselves to the stretch target aligned with the programme.	Red

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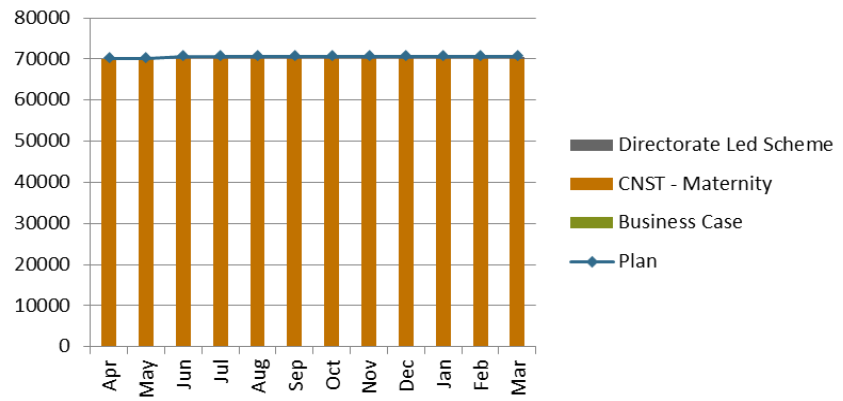
Best Quality

Metrics / KPI						
Unique Identifier	**KPIs**	**Baseline**	**Target**	**Last Month**	**This Month**	**Trend**
BQ-DEMENTIA-04	Intermediate Dementia Training Compliance	65.00%	67.90%	72.30%	78.00%	↑
BQ-DEMENTIA-05	No. of Dementia Patients admitted with more than one ward more (moving to assessment unit excluded) Historical data gathered to establish baseline for SPC tool	58	TBC	53	69	↓
BQ-PPEE-01	No. of Best Care Project with active patient representation	5	TBC	5	5	→
BQ-DELIRIUM-01	% of patients coded for Delirium with a flag on Allscripts	12.40%	TBC	16.00%	2.20%	↓

Financial Information



SPC (XmR) tool

Chart title	Dementia Pts 2 or more ward moves	Target	2.0
Team/unit name	MTW	Maximum number	90.0
Your measure	Ward Moves	Start date	01/09/17 (please select date <= 28th)
What does improvement look like?	Low is good	Planned duration (days, weeks, months)	50 Months
		Set baseline (choose baseline period 12 - 20*)	20 Months

Date	Ward Moves	Date	Ward Moves	Date	Ward Moves	Date	Ward Moves
Sep 17	51.0	Jan 20					
Oct 17	55.0	Feb 20					
Nov 17	50.0	Mar 20					
Dec 17	64.0	Apr 20					
Jan 18	46.0	May 20					
Feb 18	39.0	Jun 20					
Mar 18	42.0	Jul 20					
Apr 18	56.0	Aug 20					
May 18	55.0	Sep 20					
Jun 18	45.0	Oct 20					
Jul 18	60.0	Nov 20					
Aug 18	46.0	Dec 20					
Sep 18	48.0	Jan 21					
Oct 18	62.0	Feb 21					
Nov 18	59.0	Mar 21					
Dec 18	71.0	Apr 21					
Jan 19	77.0	May 21					
Feb 19	61.0	Jun 21					
Mar 19	60.0	Jul 21					
Apr 19	53.0	Aug 21					
May 19	69.0	Sep 21					
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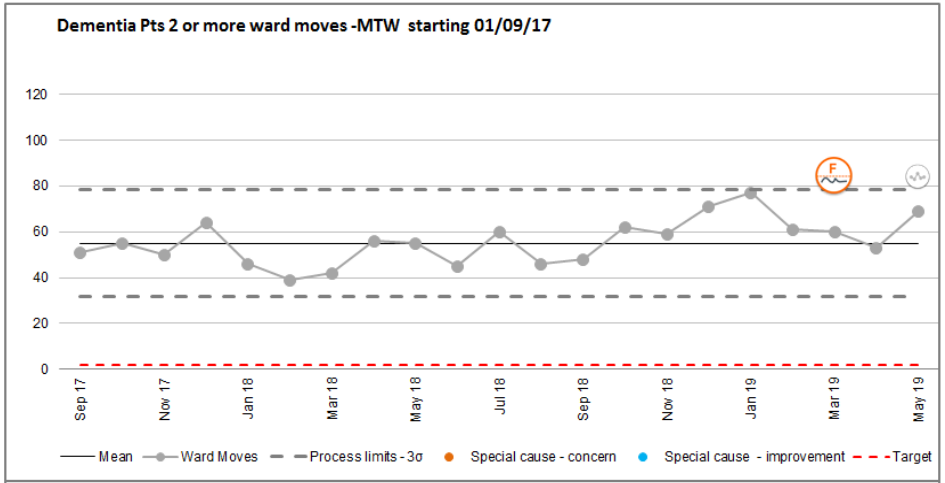
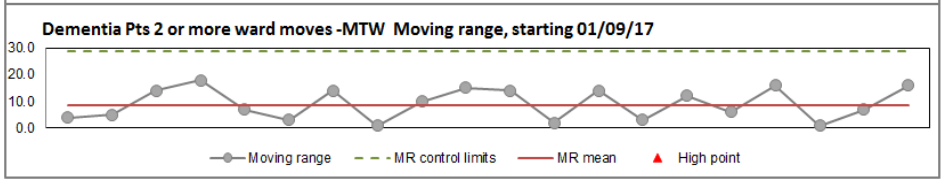
Dec 19							





2e. Best Safety

Providing consistently safe standards of care for all of our patients is at the centre of everything we do at MTW and it's at the heart of the Best Safety workstream.

The worksteam is leading on seven safety improvement programmes in 2018/19, with the aim of collectively transforming the way we identify safety issues, learn lessons and improve our patient experience.

The projects include:

- **Preventing Harm**
- **Learning Lessons**
- **Mortality**
- **Seven Day Services (7DS)**
- **Quality Mark**
- **Medical Productivity**
- **GIRFT**

Best Safety

NHS Maidstone and Tunbridge Wells NHS Trust

Summary of Progress
Explanation for Status: Medical Productivity remains red as the delay in job planning impacts on the later stages of the project. However the team anticipate that key milestone will still be met e.g. D&C deadlines but this is putting significant pressure on the project team. 7DS remains Amber as the 7DS Steering Board has concluded that the MEC Division is unable to meet the 7DS standards by March 2020 without a significant increase in workforce (approximately 25 consultants).Documentation and Record Keeping is currently Amber whilst the objectives are reviewed by the SRO and it is decided whether to de-scope this project to form part of Clinical Audit core business. The rapid PDSA cycles will still continue. Consent is Amber as the policy is yet to be signed off. The financial status remains Amber and a risk is contained in the risk log relating the achievability of the £206k plan. The focus of job planning has been increasing productivity and not reducing PAs. However the financial plan was identified by directorates and the gap may reflect that change forms have not been completed and actioned on ESR. The financial reconciliation against ESR on completion of job plans will answer this.
Decision Required by Board: At the Medical Productivity meeting, the teams made a commitment to complete all job plans in the next two weeks (as of 12/6/19 77% signed off). The project team request continued support from the Board to question Surgical Division and Cancer Services regarding job planning progress at DPR.

Summary Information					
Overall Status	Amber	Timescale Status	Amber	Budget Status	Amber
Quality Status		Resource Status		Benefit Status	

Top Issues			
Unique Identifier	Description	Action	RAG
BS-MP07(R)	All job plans to be added to the system and signed off by Directorate Management Teams by April 2019	Continued support provided to directorates. Escalated through DPR	Red
BS 7DS-01	As previously notified to the Trust Board and the National Team, the Medicine and Emergency Care Division have reviewed the numbers of non elective medically active patients and the required workforce to review these patients within the 7DS standards due by March 2020. This project is overseen by the Chief of Service. The 7DS Steering Board has concluded that the MEC Division is unable to meet the 7DS standards by March 2020 without a significant increase in workforce (approximately 25 consultants). Despite mitigations being put in place.	Continue working with the Division on recruitment plans and moving closer to compliance.	Red

Project Status		
Project Name	**Last Month**	**This Month**
7DS	Amber	Amber
Consent	Amber	Amber
Documentation and Record Keeping	Amber	Amber
GIRFT	Green	Green
Long Elective waits	Amber	Green
Learning Lessons	Green	Green
Medical Productivity	Red	Red
Mortality	Green	Green

Top Risks			
Unique Identifier	Description	Mitigation	RAG
BS 7DS-01	7DS: Consultant numbers and recruitment constraints in Med & Emergency Division	Work ongoing with Division and Director of Workforce in respect of recruitment aids	Red

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Best Safety

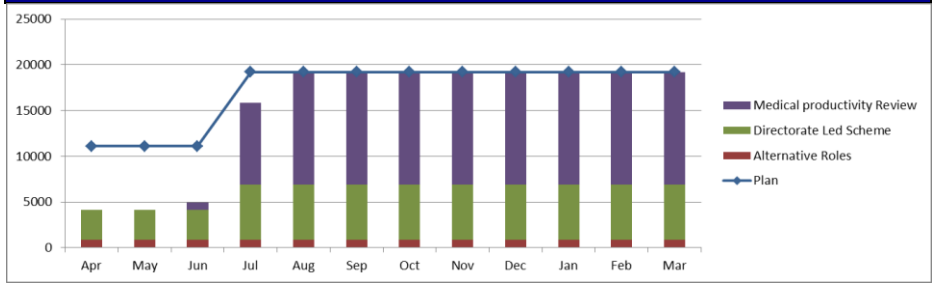
Maidstone and Tunbridge Wells NHS Trust

Milestones Missed				
ID	Entity Name	Milestone	Expected Date	RAG
BS-MP	Medical Productivity	All e-job plans completed	29/03/2019	Red

Milestones Due in next Reporting Period				
ID	Entity Name	Milestone	Expected Date	RAG
BS -MP	Medical Productivity	Reconcile job plans against ESR.	30/06/2019	Amber
BS-LEW	Long Elective Waits	Electronic Harm Review form implementation complete (52wk pt)	04/06/2019	Blue
BS-7DS	7DS	T&O compliant with all 4 7DS standards	06/06/2019	Blue
BS -DRK	Documentation and Record Keeping	Decision regarding the status of Documentation and record Keeping Project	28/06/2019	Amber
BS-Con	Consent	Consent Policy signed off at PRC	20/06/2019	Red

Metrics / KPI						
Unique Identifier	KPIs	Baseline	Target	Last Month	This Month	Trend
-1	Percentage of Job Plans signed off		95%	58%	70%	↑
-2	Percentage of Job Plans in discussion		4%	29%	22%	↑
-3	90% Compliance with all mortality forms		90%		78.80%	–

Financial Information



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3. Best Care Programme - Financial Summary

NHS
Maidstone and Tunbridge Wells NHS Trust

Comment

The Trust was £0.1m adverse to plan in the month, £0.5m adverse YTD.

The key adverse variances were Prime Provider slippage (£0.33m) and Estates and Facilities slippage (£0.1m) relating to Energy procurement and catering changes. These pressures were partly offset by workforce over performance (£0.3m) within Womens and Childrens (£0.2m) and Cancer and Diagnostics divisions (£0.1m).

The Trust has an internal CIP plan of £25.1m with an external plan of £22.3m, therefore creating a savings stretch of £2.8m.

The operational efficiencies savings (£5.8m) included within the CIP and the internal savings stretch (£2.8m) have been phased into divisions in twelfths with a corresponding adjustment back to the submitted CIP phased plan reported out side if the divisions position (£0.8m in May, £1.7m YTD).

Divisions are completing an I&E and CIP year end forecast for month 3, at the moment the Trust is forecasting to deliver £22.3m savings and not the £25.1m stretch CIP target.

MTW
exceptional people, outstanding care

4. Communication & Engagement

Best Care Key Messages

Best Workforce

Emergency Care Medical Bank

- The Emergency Care agency medical bank is now recentralised into the Staff Bank. This will help to improve transparency, reduce the number of retrospective bookings and contribute towards the objective of reducing reliance on agency in order to create a more fair and equitable set of rates across the trust.
- Highlights the need for all directorate to ensure all temporary staffing requirements are sent to bank 6 weeks in advance of when the shifts are due to be worked.

Nursing Recruitment Agencies

- Three agencies now engaged for overseas nursing recruitment in order to help fill our vacancies.
  - Clearmedi (India) – 42 nurses offered posts and are now going through OSCE training.
  - MSI (India) – 8 appointed who are job ready nurses with another 164 being interviewed in India. 4 MTW staff have travelled to India to undertake face to face interviews.
  - Medacs (Philippines) – 4 MTW representatives to attend Nurse recruitment Medacs event in the Philippines in September 2019.

Best Patient Flow

Even though we did not meet the ED trajectory for May, overall performance was an improvement on April (April 92.03% and May 92.62% despite busiest week ever on May. Long Length of Stay reviews started on both sites. Medical outliers stayed constant (figures to come from Andy Nield on Mon 10th June)

Criteria Led Discharge – there has been a dramatic improvement in late May/ early June with a 100% improvement across the Trust.

4. Communication & Engagement

Maidstone and Tunbridge Wells NHS Trust

Best Care Key Messages

Best Quality

- **Successful birthday celebrations for #EndPJParalysis took place week of the 3rd June.**
  - Great engagement from ward areas wearing their pyjamas
  - Executive walk arounds in “loungewear” and #EndPJParalysis T-shirts engaging with staff –good feedback about this
  - Strong social media presence including pictures of patients up and dressed
  - Ward 32 decorated their nurses’ station, baked cakes and hosted afternoon tea for their patients and were the winners of some neck and shoulder massages for most engagement with the initiative
  - Ward 20 got their patients up and eating lunch in the ward lounge area
  - Edith Cavell ward set up a trolley that can be wheeled to patients to offer them day clothes, shoes and blankets.
  - Mercer, Pye Oliver and the Stroke unit at Maidstone have also enthusiastically embraced #EndPJParalysis with their patients out of bed and sitting up in chairs

MTW exceptional people, outstanding care

4. Communication & Engagement

Maidstone and Tunbridge Wells NHS Trust

Best Care Key Messages

Best Quality

- **Dementia Emergency services Event hosted by MTW took place on the 21st May.**
  - More than 150 attendances
  - Coincided with Dementia Action Week 20 – 26th May
  - Feedback from the event currently being collated. Initial feedback very positive.
  - Suggestions that this become an annual event
  - Increased referrals to Crossroad Care have been reported since the event

MTW exceptional people, outstanding care

4. Communication & Engagement

Dementia Update

Maidstone and Tunbridge Wells NHS Trust

Kent Fire & Rescue Service | South East Coast Ambulance Service NHS | Maidstone and Tunbridge Wells NHS Trust | Kent Police

WEST KENT EMERGENCY SERVICES

DEMENTIA EVENT

Tuesday 21st May 2019, 10:00 – 16:00,

Academic Centre, Maidstone Hospital

A free and informative event designed to educate and empower staff in relation to pathways and support available for people living with dementia and their carers in the West Kent area.

- Presenters and speakers from a range of organisations including: Home Treatment Service; Crossroads Care; Community Wardens; KFRS; Police & Crime Commissioner; Person with Dementia; Carer of person with Dementia; Specialist Dementia Nurse.
- Networking opportunities and time for questions throughout the day
- Certificates of attendance issued
- Lunch and refreshments are included

Please register for this event via the Eventbrite link below ASAP, as spaces are limited.
https://www.eventbrite.co.uk/e/west-kent-emergency-services-dementia-event-tickets-56644448069?aff=WestKentHospitals

If you have any dietary requirements, please email rachael.spencer@kent.fire-uk.org by Friday 3rd May

CROSS ROADS CARE | age UK | Alzheimer's Society United Against Dementia | involve changing lives and communities

Kent Fire & Rescue Service | South East Coast Ambulance Service NHS | Maidstone and Tunbridge Wells NHS Trust | Kent Police

WEST KENT EMERGENCY SERVICES

DEMENTIA EVENT

Tuesday 21st May 2019, 9:15 – 16:00,

Academic Centre, Maidstone Hospital

Programme of events

9:15 – 9:45	Registration and Coffee	
9:45 – 10 00	Opening Keynote Speaker	Katie Collier
10:00 – 10:30	Home Treatment Service	Amy Heskett & Joanna Price
10:30 – 10:50	Crossroads Care	Irene Jeffrey
10:50 – 11:10	Community Wardens	Sandra Edmonds & Adam McKinley
11:10 – 11:20	Q&A	
11:20 – 11:40	**COFFEE**	
11:40 – 13:00	• Person with dementia • Carer of person with dementia • Q&A	Wayne & Lorraine Elaine Murray
13:00 – 13:45	**LUNCH**	
13:45 – 14:45	Dementia	Liz Champion
14:45 – 15:05	KFRS	Home Safety Team Leader
14:45 – 15:05	Missing Persons	Martin Pemble
15:05 – 15:15	Q&A	
15:15 – 15:40 15:40 – 15:50	Police Overview Q&A	Matthew Scott – Police and Crime Commissioner
15:50 – 16:00	Evaluation and Close.	

With thanks to the following for funding this event:

Kent Police & Crime Commissioner | Kent Fire & Rescue Service | Maidstone and Tunbridge Wells NHS Trust | bluebird care

4. Communication & Engagement

Best Care Key Messages

Best Safety

- Best practice visit to Trust from NHSI Head of Clinical Quality, Kent Surrey Sussex Improvement Team to review the Trust's electronic Patient Harm Review process. We were advised that we have an example of really good practice which demonstrates the Trust's commitment to being open and transparent.

- The T&O service have now reached full compliance with all four of the 7DS Priority Standards, supported by job plans.

- The Consultant and SAS Doctor Job Planning process deadline of 31st May for sign off of all job plans has not been met. 22% (approximately 70) Doctors have still not agreed their plans to allow these to progress to management signoff. Remedial action is in progress.

Review of the Board Assurance Framework 2019/20 **Trust Secretary**

The management of the Board Assurance Framework (BAF) and link with the Risk Register

The BAF is the document through which the Trust Board identifies the main risks to the Trust meeting its objectives, and to ensure adequate controls are in place to manage those risks. The BAF model applied at the Trust is based on the most accepted model of best practice[1]. The ultimate aim of the BAF is to help ensure that the objectives are met. The BAF is managed by the Trust Secretary, who liaises with the persons responsible for empowering our staff to update it through the year. The BAF differs from the Risk Register as the BAF only includes risks that pose a threat to the achievement of the Trust's objectives (and the risks listed on the BAF are not required to be subject to a detailed risk assessment/risk-rating). There are therefore some red-rated risks on the Risk Register that are not referenced in the BAF. These are however managed via the Risk Register. However, the selection of objectives took into account the risks faced by the Trust.

Objectives for 2019/20, and summary of year-to-date position

The objectives in the BAF were approved by the Trust Board on 23/05/19. The latest summary rating of the twelve objectives from the person responsible for empowering our staff (in terms of the confidence of achievement by year-end is as follows):

Objective (measure of success)	Confidence[2]
1. Reduce our falls rate while in hospital to 6 per 1'000 bed days	Amber
2. Reduce E. coli blood stream infections to 21.5 per 100'000 bed days by March 2020	Amber
3. Improve complaints performance to 75% across all divisions and directorates by March 2020	Amber
4. Improve our vacancy rate to 9% by March 2020	Amber
5. Achieve staff engagement score of ≥ 7.2 within 2019/20	Amber
6. Establish functioning Digestive Diseases Unit by October 2019	Amber
7. Build new AMU to enable a new Hyper Acute Stroke Unit (HASU) by winter 2019	Amber
8. Ensure that 85% or more of cancer patients are treated within 62 days	Amber
9. Ensure that 86.7% or more of patients wait no longer than 18 weeks from referral to treatment	Green
10. Ensure that 91.67% or more of people presenting to our Accident and Emergency Departments wait no longer than 4 hours	Green
11. Deliver a surplus of £6.9m in 2019/20 so that we can invest back into patient care	Green
12. Ensure that our Hospital Standardised Mortality Ratio (HSMR) is <100	Green

Review by the Trust Board

This is the first time during 2019/20 that the Trust Board has seen the populated BAF. Trust Board members are asked to review and critique the content, by considering the following prompts:

- Are the objectives appropriately described? Should the wording of any be amended?
- Do the RAG ratings of confidence that the objective will be achieved reflect the situation as understood by the Board (and its sub-committees)?
- Is the Board assured that actions reported as being undertaken are satisfactorily evidenced?
- Does any of the content require further explanation?
- Does the format of the BAF need to be amended?

The Board is reminded of the options available to it, in terms of a response, which include:

- Accepting the information or requesting amendments, to objectives, risks, ratings &/or content
- Requesting further information on any of the BAF items
- Requesting that a Trust Board sub-committee review the risks to an objective in more detail

Review by other forums

The full BAF is usually reviewed at the Executive Team Meeting before being considered at the Trust Board, but the timings did not allow such a review this time. The objectives relevant the Finance and Performance Committee's role are reviewed at that forum before the full BAF is considered at the Trust Board. It had previously been agreed, following a request by the Audit and Governance Committee, that the BAF should be considered by that before being submitted to the Trust Board. However, as the objectives were not finalised until the May 2019 Trust Board meeting, it was not possible to submit the populated BAF to the May 2019 meetings of the Audit

[1] HM Treasury: Assurance frameworks

[2] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20

and Governance Committee, and it was not considered appropriate that the Trust Board only receive the first populated BAF at its September 2019 meeting. In July 2018, the Board considered whether the other Board sub-committees should review the relevant objectives of the BAF and it was agreed that this was not necessary, as the Workforce and Quality Committees already reviewed the objectives as part of their routine business.

Format
Some minor amendments have been made to the format of the BAF, to reflect the format of the objectives approved by the Trust Board on 23/05/19, such as the inclusion of the relevant PRIDE value, "How will we deliver on this value in 2019/20?", and "What will success look like?" sections; and the removal of references to the CQC's domains.

Additional aspects relating to the Risk Register
A summary of the status of the Risk Register is enclosed in Appendix 1. Having reviewed the current list of red-rated risks, it is considered that the substance of each are either accounted for within the BAF (to some aspect) or are being considered by an appropriate forum. Further details supporting this conclusion are contained in Appendix 1, but the Trust Board is obviously free to challenge this.

Which Committees have reviewed the information prior to Board submission?
- Finance and Performance Committee (for objectives 8 to 11), 25/06/19

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [3]
Review and discussion (taking into account the prompts listed on page 1)

[3] 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

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☒ Respect ☐ Innovation ☐ Delivery ☐ Excellence ☐

How will we deliver on this value in 2019/20?
We will embed a culture of safety improvement that reduces harm and enhances patient experience. We will actively seek out the views of patients, relatives and visitors and use this to improve the care we provide

What will success look like?
We will reduce the number of patients experiencing a fall while in hospital

Objective (measure of success) *Objective*

1 Reduce our falls rate while in hospital to 6 per 1,000 bed days

What could prevent this objective being achieved? (including external factors) *Risks to objective*

1. Increased demand and escalation of beds resulting in patients nursed in inappropriate areas.
2. Staffing; vacancies, unfilled shifts
3. Staff training on falls prevention and associated equipment
4.

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. Revised pathways of care and improved patient flow (1)
b. Recruitment strategy: overseas and open days (2)
c. All patient facing staff have access to falls prevention training (3)

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. Continuous monitoring of incidents to identify themes and trends and implement learning.
2. KPIs for Falls report to the divisional dashboards
3. Monthly performance report submitted to Trust Board

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

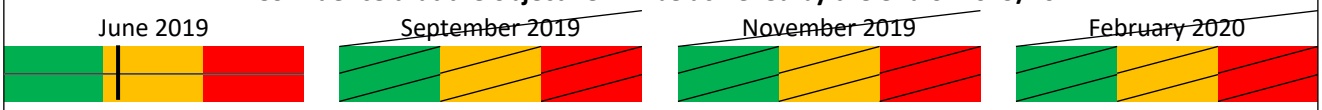
If "No", what other data is needed?

Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: The 2017/18 Internal Audit "Assurance Review of Data Quality of Key Performance Indicators" published in May 2018 reviewed the KPIs relating to falls and gave an overall conclusion of "Reasonable assurance", no recommendations, and the statement that "Testing of a sample of twenty cases confirmed timely recording of Falls incidents and that the information contained in source records and the source data system were consistent with the information reported"

Person responsible for empowering our staff: Chief Nurse

Confidence that the objective will be achieved by the end of 2019/20[4]



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The year to date rate is 6.28 per 1,000 occupied bed days
- Once the staffing fill rates have improved and the staff training is made mandatory (which is currently being discussed), the confidence rating will improve

[4] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☒ Respect ☐ Innovation ☐ Delivery ☐ Excellence ☐

How will we deliver on this value in 2019/20?
We will embed a culture of safety improvement that reduces harm and enhances patient experience. We will actively seek out the views of patients, relatives and visitors and use this to improve the care we provide

What will success look like?
We will reduce the number of patients acquiring an E. coli infection while in hospital

Objective (measure of success) *Objective*

2 Reduce E. coli bloodstream infections to 21.5 per 100,000 bed days by March 2020

What could prevent this objective being achieved? (including external factors) *Risks to objective*

1. A national heatwave causing an increased risk of dehydration and subsequent increase risk of Urinary Tract Infections (UTIs)
2. Non-compliance with antibiotic therapy for UTIs
3. Urinary catheters being inserted inappropriately and managed incorrectly
4. Non-compliance with antibiotic therapy for Endoscopic Retrograde Cholangiopancreatographies (ERCPs)
5. Poor compliance with Infection Prevention & control precautions

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. Hydration project, promoting hydration for patients to be introduced on all wards following trial (1)
b. UTI CQUIN target being supported by the Infection Prevention and Control (IPC) Team reviewing antimicrobial prescribing for UTIs (2)
c. Root Cause Analysis (RCA) investigations are undertaken on E.coli bacteraemia related to catheters and ERCPs to identify any lapses in care for shared learning (2, 4)
d. Audit of ERCP prophylaxis completed with action to improve the administration of prophylaxis. Re-audit to be undertaken in 19/20 (4)
e. Audit of compliance with the HOUDINI[5] protocol and catheter related UTIs with actions identified to improve documentation & reason for insertion (3)
f. Mandatory IPC training is provided (face to face training includes hand hygiene training) (5)
g. Triangulation audits are undertaken by the IPC Team (5)
h. Ad hoc training focusing on key issues related to IPC, such as commode cleaning (5)
i. Urinary catheter passport re-launched (3)
j. UTI reduction working group to be held, supported by Consultant Urologist (1, 2, 3)
k. Attendance and participation in the Kent and Medway IPC improvement collaborative (1, 2, 3, 5)
l. 'Focus on' posters for promoting Hydration and avoiding Catheter Associated AUTIs (CAUTIs) / UTIs developed and shared (3)

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. Directorate performance reports presented to the Infection Prevention and Control Committee (IPCC) highlighting rates of infection, IPC issues and actions taken within each Directorate
2. Audit reports and action plan are presented to the IPCC and monitored through the governance team
3. Monthly board report from the Director of Infection Prevention and Control (DIPC)

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

If "No", what other data is needed? N/A

Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: E. coli data is reported on the national data capture system (DCS) & by the laboratory through the Telepath IT system. The IPC Team also collects the data which are reported through their ICNet system (which comes via Telepath). All these systems can be accessed in order to validate the data.

Person responsible for empowering our staff: Director of Infection Prevention and Control (DIPC)

Confidence that the objective will be achieved by the end of 2019/20[6]

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
The causes of E. coli bacteraemia are often multifactorial therefore multiple interventions are required in order to have an impact on the rate. In keeping with the national picture our data shows that 50% of cases are related to the

[5] Haematuria; Obstruction/Retention; Urology surgery; Damaged skin; Input/output, fluid monitoring; Nursing care end of life/comfort care; Immobility

[6] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

urinary tract therefore this is the main focus for interventions. Further planned actions include:

- Raising awareness on the wards of when to dip / not to dip and advising not to use this as an indicator to treat UTIs
- Promote improved antimicrobial prescribing in line with the Trust policy for treatment of UTIs – following the finding of the UTI CQUIN
- Cholecystitis pathway to be reviewed to ensure consistent antimicrobial prescribing
- Re-audit of prescribing prophylaxis antibiotics for ERCPs
- Continue to promote the urinary catheter passport and monitor use

Board Assurance Framework 2019/20

PRIDE value/s Patient First ☒ Respect ☐ Innovation ☐ Delivery ☐ Excellence ☐

How will we deliver on this value in 2019/20?
We will embed a culture of safety improvement that reduces harm and enhances patient experience. We will actively seek out the views of patients, relatives and visitors and use this to improve the care we provide

What will success look like?
We will respond to complaints in a timely and consistent manner

Objective (measure of success) *Objective*
3 Improve complaints performance to 75% across all divisions and directorates by March 2020

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. Divisional performance failure to respond to complaints in a timely manner
2. Resource within complaints team
3. IT issues - age of computers (slow to respond)
4. Transition to Datix IQ Cloud, potential issues with functionality
5. Capital allocation for room expansion to be able to accommodate additional staff & provide computer
6. Serious Incident (SI) process: impact upon complaint response

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. Review of timeframes for each step of the complaints process (1)
b. Exception meetings held with Directorate leads by Chief Nurse and Assoc. Dir., Quality Governance (1)
c. Complaints closely monitored at Divisional Performance Reviews (DPRs) and Governance meetings (1)
d. Business Case approved for additional staff member (2)
e. Discussion with IT re timing of replacement of older computers (3)
f. Datix implementation group established to work through introduction of new system (4)
g. Concerns escalated to Executive leads (5)
h. Business Case approved for Patient safety team to improve on timeliness of SI investigations (6)
i. Review of pathway for complaints that are also SIs to identify key responsibilities/actions required (6)

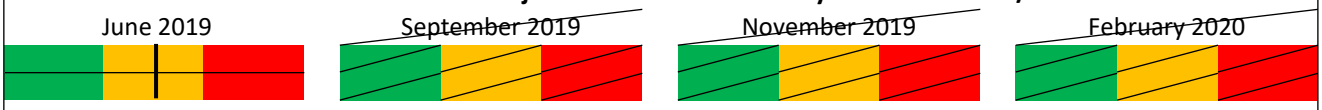
Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. Monthly Key Performance Indicators (KPIs)
2. Regular reports/updates to Directorates/Divisions
3. Complaints report to Patient Experience Committee

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed? N/A

Does specific assurance exist on the data quality of the performance information? Yes ☐ No ☒
Details: However, reviews undertaken by the Parliamentary and Health Service Ombudsman (PHSO) assure the quality of responses (for the complaints escalated to the PHSO), whilst the Trust also undertakes a complaints satisfaction survey.

Person responsible for empowering our staff: Chief Nurse

Confidence that the objective will be achieved by the end of 2019/20[7]



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- The Job Description for the new staff member has not yet been banded
- The department is currently unable to accommodate the new staff member due to constraints of rooms size
- There is a lack of capital to provide new computer and the necessary estates work
- The impact of the inability to recruit additional staff (same as above) for the Patient Safety Team- delays in SIs will negatively impact on complaints response times

[7] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☐ Respect ☒ Innovation ☐ Delivery ☐ Excellence ☐

How will we deliver on this value in 2019/20?
We will make MTW a great place to work and ensure that our staff feel valued and listened to

What will success look like?
We will reduce the number of vacant posts we have in the Trust

Objective (measure of success) *Objective*

4 Improve our vacancy rate to 9% by March 2020

What could prevent this objective being achieved? (including external factors) *Risks to objective*

1. A national shortage of certain staff groups
2. If there was a lack of clarity/focus on the key actions required
3. If there was a lack of capacity from professional groups to be able to support interviewing and professional development support of candidates at scale
4. If there was inefficiency of recruitment processes
5. If there was insufficient focus placed on retaining existing staff
6. If there was uncertainty over the status of vacancies
7. Uncertainty regarding Brexit i.e. the impact on the availability of European recruits

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. The Trust Workforce Strategy 2015-20 and associated workplan ("Recruitment & Retention" is the first of 6 workforce priorities) (1, 2, 3)
b. Agreement of a qualified nurse recruitment plan for 2019/20 (2)
c. The establishment of the Nurse Recruitment and Retention Group (Chaired by the Chief Nurse) (3, 5)
d. Recruitment KPIs derived from the TRAC IT system identify areas where process can be improved (4)
e. New Roles and Apprentices group within the Workforce workstream of the Best Care Programme identifying additional apprenticeship roles within divisions (1)
f. Establishments and workforce requirements have been reviewed and agreed as part of the Business Planning process for 2019/20 (5, 6)
g. HealthRoster KPIs have been implemented in order to report on effective rostering of staff and usage of contractual hours & to challenge poor practice (5, 6)
h. Development of further international recruitment initiatives (7)

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. The Trust Performance Dashboard, which contains the "Vacancy Rate (%)" (as well as "Vacancies WTE")
2. Reports to the Workforce Committee (which includes a commentary on the latest issues regarding the vacancy rate)
3. Directorate performance dashboards
4. The 6-monthly review of Ward and non-Ward areas submitted to the Trust Board
5. The monthly Planned and Actual Ward Staffing reports to the Trust Board (re the establishments)
6. The Nursing recruitment plan (which is monitored via the Executive Team Meeting)

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

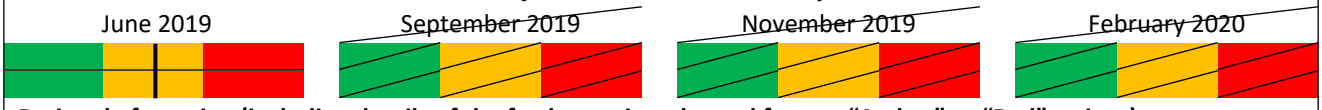
If "No", what other data is needed? N/A

Does specific assurance exist on the data quality of the performance information? Yes ☐ No ☒

Details:

Person responsible for empowering our staff: Director of Workforce

Confidence that the objective will be achieved by the end of 2019/20[8]



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The Trust vacancy rate has increased during April and May to a high of 13.3% (compared to consistently between 9% and 10% during 2018/19). This increase is due to the increased establishment arising from Business and Workforce planning and a revised approach to vacancy calculation agreed by the finance and HR teams

[8] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☐ Respect ☒ Innovation ☐ Delivery ☐ Excellence ☐

How will we deliver on this value in 2019/20?
We will make MTW a great place to work and ensure that our staff feel valued and listened to

What will success look like?
We will improve how involved, motivated and satisfied our staff are

Objective (measure of success) *Objective*
5 Achieve staff engagement score of ≥ 7.2 within 2019/20

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. Failure to implement local staff engagement plans
2. Insufficient resource to deliver staff amenities programme
3. Lack of visibility of senior leaders on shop floor
4. Insufficient communication of actions and information to staff
5. Insufficient investment in clinical leadership
6. Staff are not empowered to influence or implement service changes

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. All divisions have a staff engagement plan for 2019/20 reviewed within DPRs (1)
b. Trust engagement plan for 2019/20 agreed (1)
c. Executive and divisional leaders to have shop floor engagement identified in appraisal objectives (3)
d. Staff Amenities delivery group in place along with associated plan (2)
e. Retention and Engagement group set up chaired by Director of Workforce (1, 4)
f. Trust 'Thank you ' events (2, 3)
g. Senior leadership programme commissioned (5)
h. 'Exceptional People Outstanding Care' programme agreed by Trust Board (6)

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. National Staff Survey data
2. Divisional Performance reviews
3. Updates to the Workforce Committee
4. Minutes of the Engagement & Retention group

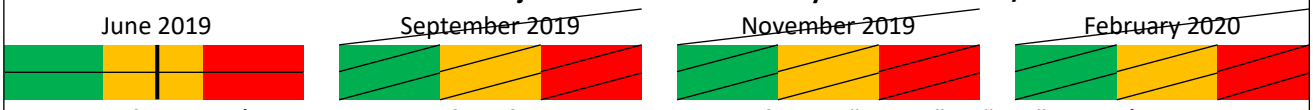
Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed?

Does specific assurance exist on the data quality of the performance information? Yes ☐ No ☒
Details:

Person responsible for empowering our staff: Director of Workforce

Confidence that the objective will be achieved by the end of 2019/20[9]

June 2019 | September 2019 | November 2019 | February 2020



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- The staff engagement score in the latest national NHS staff survey was 7.0

[9] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

PRIDE value/s Patient First ☐ Respect ☐ Innovation ☒ Delivery ☐ Excellence ☐

How will we deliver on this value in 2019/20?
We will continually improve the way we provide our services to ensure that our services meet the needs of the people we serve

What will success look like?
We will optimise the care across our two hospital sites

Objective (measure of success) *Objective*
6 Establish functioning Digestive Diseases Unit by October 2019

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. Failure to recruit staff in time for October
2. Any delays resulting in an overlap with winter
3. Failure to adequately identify and protect bed space

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. Triangulation with Stroke move to ensure bed availability
b. Mitigation plan to deliver unit in March 2020 has been developed in case of failure to identify workforce plan in time to allow for recruitment prior to winter
c. Configuration timeline created with Lynn Grey and Nick Sinclair to ensure that both original and mitigation plans do not affect winter planning
d. Agreement with COO on series of measures to protect digestive diseases bed stock

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. Surgical reconfiguration steering group (Chaired by the Clinical Director for General Surgery)

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed? N/A

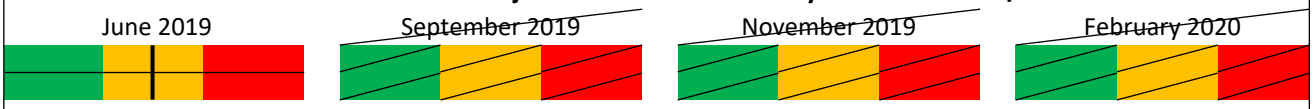
Does specific assurance exist on the data quality of the performance information? Yes ☐ No ☒

Details:

Person responsible for empowering our staff: Director of Strategy, Planning and Partnerships

Confidence that the objective will be achieved by the end of 2019/20[10]

June 2019 | September 2019 | November 2019 | February 2020



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- Progress against identified work plans continues on track through the Surgical reconfiguration steering group
- While risks to delivery have been identified mitigation plans are in place to allow for delivery of the unit by the end of 2019/20

[10] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

PRIDE value/s Patient First ☐ Respect ☐ Innovation ☒ Delivery ☐ Excellence ☐

How will we deliver on this value in 2019/20?
We will continually improve the way we provide our services to ensure that our services meet the needs of the people we serve

What will success look like?
We will work with partners to develop the best possible models of care across the region

Objective (measure of success) *Objective*
7 Build new Acute Medical Unit (AMU) to enable a new Hyper Acute Stroke Unit (HASU) by winter 2019

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. Capital funding to be released from NHS Improvement (NHSI)

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. Board level conversations between potential suppliers of new AMU and NHS England (NHSE) to resolve funding issues.

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. Update in July

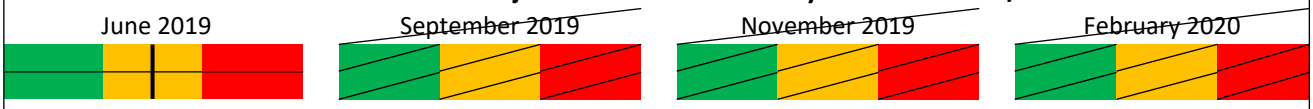
Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed? N/A

Does specific assurance exist on the data quality of the performance information? Yes ☐ No ☒
Details:

Person responsible for empowering our staff: Chief Operating Officer

Confidence that the objective will be achieved by the end of 2019/20[11]

June 2019 | September 2019 | November 2019 | February 2020



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- There is currently no confirmation of funding of the new AMU

[11] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

PRIDE value/s	Patient First ☐	Respect ☐	Innovation ☐	Delivery ☒	Excellence ☐

How will we deliver on this value in 2019/20?
We will treat people in a timely consistent manner making the best possible use of our resources to do so

What will success look like?
We will ensure that our cancer patients receive their treatment as quickly as possible

Objective (measure of success) *Objective*

8 Ensure that 85% or more of cancer patients are treated within 62 days

What could prevent this objective being achieved? (including external factors) *Risks to objective*

1. Oncology capacity shortfall due to workforce shortages.
2. Confirmation of Clinical Commissioning Group (CCG) funding into cancer to ensure we have sustainable plans in place
3. Increased service demand (higher than national average)
4. Pathway issues in Upper GI, Lung, Haematology and Head and Neck
5. Sustainable diagnostic capacity
6. Pension issues impacting additional sessions for clinicians and there flexibility to respond to increased demand

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. Daily Patient Tracking List (PTL) meetings in place with all services
b. Weekly executive performance meeting in place
c. Cancer pathway transformation plan is now in place
d. Further support from NHSI on weekly issues
e. Additional funding currently in place for key services
f. Daily review of performance from executive level
g. A Cancer performance General Manager has been appointed

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. Monthly reports to the Finance and Performance Committee and Trust Board
2. Weekly report to the Executive Team Meeting

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

If "No", what other data is needed? N/A

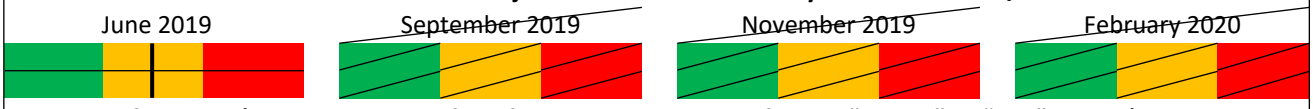
Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: The 2018/19 Internal Audit "Assurance Review of Data Quality of Key Performance Indicators" published in May 2019 reviewed the data relating to the 62-day Cancer waiting time target and gave a conclusion of "Reasonable assurance". The report stated that "The figures reported to the Trust Board for Cancer 62 Day Wait, were found to be accurately reported based on the data available from the source data system"

Person responsible for empowering our staff: Chief Operating Officer

Confidence that the objective will be achieved by the end of 2019/20[12]

June 2019 | ~~September 2019~~ | ~~November 2019~~ | ~~February 2020~~



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The quick progress in reducing the cancer backlog (which is key to hitting the 62-day performance) has been good
- Key capacity issues especially in oncology need to be resolved to be more confident at this point.
- There been a decrease in PTL by over 1,000 in the last 6 month, and a decrease in backlog to under 100 in the last 5 months.

[12] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s	Patient First ☐	Respect ☐	Innovation ☐	Delivery ☒	Excellence ☐

How will we deliver on this value in 2019/20?
We will treat people in a timely consistent manner making the best possible use of our resources to do so

What will success look like?
We will carry out elective treatments as quickly as possible

Objective (measure of success) *Objective*
9 Ensure that 86.7% or more of patients wait no longer than 18 weeks from referral to treatment

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. RTT data quality programme could impact the total size of the waiting list.
2. CCG funding still relied upon to ensure we can achieve 86.7%.

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. Data quality programme has been set up and is tracking progress on a weekly basis
b. On-going meetings with commissioners to track need for additional funding in place.

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. The monthly reports to the Finance and Performance Committee and Trust Board

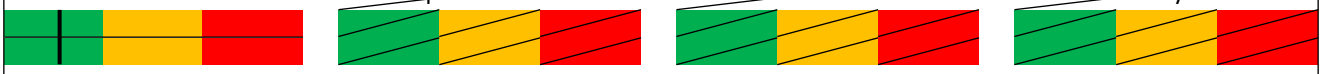
Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed? N/A

Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐
Details: The 2018/19 Internal Audit "Assurance Review of Data Quality of Key Performance Indicators" published in May 2019 reviewed the data relating to the 18 Weeks RTT Incomplete Pathway and gave a conclusion of "Reasonable assurance".

Person responsible for empowering our staff: Chief Operating Officer

Confidence that the objective will be achieved by the end of 2019/20[13]

June 2019 | ~~September 2019~~ | ~~November 2019~~ | ~~February 2020~~



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- Current performance is ahead of trajectory at 85.2%.

[13] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

PRIDE value/s	Patient First ☐	Respect ☐	Innovation ☐	Delivery ☒	Excellence ☐

How will we deliver on this value in 2019/20?
We will treat people in a timely consistent manner making the best possible use of our resources to do so

What will success look like?
We will review and treat patients in our accident and emergency room as quickly as possible

Objective (measure of success) *Objective*

10 Ensure that 91.67% or more of people presenting to our Accident and Emergency Departments wait no longer than 4 hours

What could prevent this objective being achieved? (including external factors) *Risks to objective*

1. Increased demand on services. For example May was our busiest every month as an organisation
2. Workforce shortages
3. Brexit

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. A flow programme is in place to transform same day emergency care (SDEC), Length of Stay (LOS) and out of hospital capacity, with a number of positive results so far (1)
b. Workforce group in place, and is focussing on international recruitment (2)
c. A Retention group is in place to ensure organisation supports current staff and any new ones joining (2)
d. A Brexit programme is in place working through all potential issues of a no-deal Brexit (3)

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. The monthly reports to the Finance and Performance Committee and Trust Board

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*

If "No", what other data is needed?

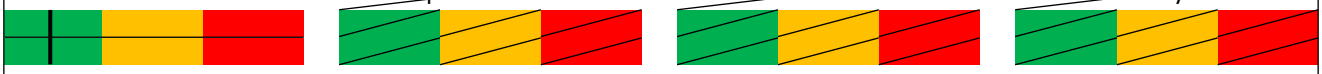
Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐

Details: The 2017/18 Internal Audit "Review of A&E Data Capture and Recording" published in December 2017 gave an overall conclusion of "Reasonable assurance", although 2 "Important" and 2 "Routine" priority recommendations were made, which have been monitored via the standard follow-up process (which is overseen by the Audit and Governance Committee)

Person responsible for empowering our staff: Chief Operating Officer

Confidence that the objective will be achieved by the end of 2019/20[14]

June 2019 | September 2019 | November 2019 | February 2020



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The Trust is currently ahead of the trajectory, and achieved the trajectory in 2018/19

[14] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☐ Respect ☐ Innovation ☐ Delivery ☒ Excellence ☐

How will we deliver on this value in 2019/20?
We will treat people in a timely consistent manner making the best possible use of our resources to do so

What will success look like?
We will spend the taxpayers money wisely to ensure that we can invest as much as possible into patient care

Objective (measure of success) *Objective*
11 Deliver a surplus of £6.9m in 2019/20 so that we can invest back into patient care

What could prevent this objective being achieved? (including external factors) *Risks to objective*

1. If there was a lack of senior leadership and commitment
2. If there were poor financial controls (or if good controls were poorly applied)
3. If there was a lack of commitment by managers
4. If the Cost Improvement Programme (CIP) schemes were not delivered (regardless of their RAG rating or identified value)
5. If the Trust's plans for 2019/20 had been developed without consideration of best practice elsewhere
6. If there was insufficient engagement with external stakeholders
7. If there is a change in the financial circumstances of commissioners, requiring them to take further action to manage demand
8. If the additional costs to improve Cancer are above the agreed funding
9. If the Trust is unable to access the CCG RTT risk reserve
10. If the upfront costs of overseas recruitment are not recouped through reduced agency by the end of the financial year.
11. If the Private Patient Income does not meet the level expected in the plan.

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. The Trust has signed up to its control total, and submitted a plan to achieve this (1)
b. Agreed Directorate budgets have been set (2)
c. A number of 'Grip and Control' measures have been implemented to ensure delivery (1, 2, 5)
d. The Performance Management Framework is now embedded (2, 3)
e. Action has been taken to engage with external stakeholders, including agreeing an Aligned Incentives Contract with West Kent CCG , which now includes Kent Community Health NHS FT (5,6) 6)
f. Delay investment to keep costs within CCG funding (8)
g. If unable to access risk reserve, activity will be limited within contract values (9)
h. The Trust has introduced a Best Care programme which seeks to bring a consistent approach to transformation and improvement across the Trust (1, 3, 4)
i. The 2019/20 CIP will be delivered by directorates, supported by the Best Care Workstreams(1, 3, 4)
j. The Trust has provided External Support to the Divisions to assist identification and delivery of CIP (4)
k. Working with private patient management to understand shortfall and develop recovery plan(11)
l. Monthly variance analysis with Divisions

Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*

1. The Monthly financial performance reports to the Best Care Programme Board, Finance and Performance Committee and Board
2. Monthly detailed Best Care Programme report to the Finance and Performance C'ttee & Trust Board
3. Monthly Divisional Performance Reviews

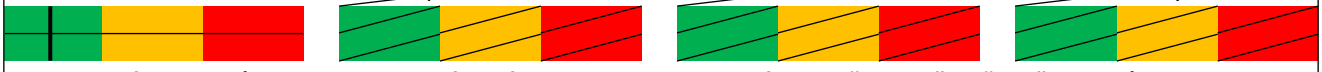
Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed?

Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐
Details: The financial position is subject to annual external review via the annual audit of the financial accounts, which is reported to the Audit and Governance Committee and Board each May. In addition internal controls are in place to ensure financial reporting is accurate & complete. This is assured through an Internal Audit process which audits the components of finance reporting & underlying transactions

Person responsible for empowering our staff: Chief Finance Officer

Confidence that the objective will be achieved by the end of 2019/20[15]

June 2019 | September 2019 | November 2019 | February 2020



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
▪

[15] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2019/20

NHS Maidstone and Tunbridge Wells NHS Trust

PRIDE value/s Patient First ☐ Respect ☐ Innovation ☐ Delivery ☐ Excellence ☒

How will we deliver on this value in 2019/20?
We will consistently go above and beyond for our patients to deliver the best care possible

What will success look like?
We will ensure that the number of patients that die in our hospital is as low as possible and remains below the level that would be expected

Objective (measure of success) *Objective*
12 Ensure that our Hospital Standardised Mortality Ratio (HSMR) is <100

What could prevent this objective being achieved? (including external factors) *Risks to objective*
1. Failure to recruit Medical Consultants to support the achievement of 7-day services
2. Failure to learn from mortality reviews
3. Weekend-related mortality worsening

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*
a. Business planning – Medicine & Emergency care (1)
b. Review of Medical rotas to enhance 24/7 site cover of services (1)
c. Investment in Datix Mortality Module (2)
d. Close monitoring of crude mortality is undertaken at the Mortality Surveillance Group (MSG)
e. Mortality reports to include shared learning (2)
f. Implementation of Medical Examiner and Medical Examiner Officers roles (2)
g. The MSG is actively monitoring the weekend-related mortality situation (3)

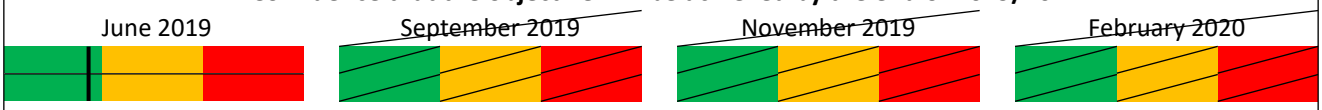
Where can assurance be obtained on the performance and actions taken to date? *Sources of assurance*
1. Minutes and reports for the MSG
2. HSMR (& Summary Hospital-level Mortality Indicator (SHMI)) data reported the Trust Board
3. The mortality update reports to the 'main' Quality Committee and Trust Board
4. Actions taken by Learning from Deaths working group

Do we have all the data needed to judge performance? Yes ☒ No ☐ *Gaps in assurance*
If "No", what other data is needed?

Does specific assurance exist on the data quality of the performance information? Yes ☒ No ☐
Details: Monthly assurance reports re quality of coding submitted

Person responsible for empowering our staff: Medical Director

Confidence that the objective will be achieved by the end of 2019/20[16]



Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
- HSMR & SHMI have consistently reduced since April 2019, currently no indicator to pre-empt this trend changing at present

[16] This is the confidence of the person responsible for empowering our staff that the objective will be achieved by the end of 2019/20. "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Appendix 1: Summary of the status of the Trust's Risk Register

Each risk on the Risk Register has a designated “Manager” and is allocated a review date. The management of the Risk Register is overseen by the Trust’s Risk and Compliance Manager, who instigates formal reviews every two months. The full Risk Register is submitted to the Audit and Governance Committee. Red-rated risks are also subject to detailed review at Executive Team Meetings each quarter, whilst Divisional and Directorate-based red-rated risks are discussed as part of the report that Divisions will in future give to the ‘main’ Quality Committee (previously such reports were given by Directorates).

The latest review of red-rated risks at the Executive Team Meeting took place on 09/04/19, and the majority of those reviewed were rated as valid as submitted, though it was noted that some could be downgraded to amber by the next review. The status of the Risk Register as of 19/06/19 was as follows:

- 18 red-rated risks
- 56 amber-rated risks
- 21 green-rated risks
- 1 blue-rated risks

The issues covered by most of the 18 current red-rated risks should be familiar to the Trust Board and its sub-committees, as these have been previously discussed at the Trust Board, Quality Committee, Finance and Performance Committee and/or Workforce Committee. These issues are as follows:

- Achieving the Cancer waiting time targets
- The cost pressures associated with the use of temporary staff
- Nursing staffing levels in Emergency Medicine
- Medical staffing shortage in Surgery impacting on inability to deliver emergency & elective care
- Risk associated with failing to learn from incidents
- Lack of capacity to assess and treat within clinically recommended timeframes in the general Ophthalmic and Medical Retinal Service
- High vacancies and turnover rates for Nursing staff in the Acute Medicine and Geriatrics and Medical Specialty Wards at TWH
- Increased risk of harm to patients and staff as a result of delays to psychiatric assessment in Emergency Medicine and Acute Medicine and Geriatrics Directorates
- Shortage of paediatric middle grade doctors on day shifts for paediatrics
- Shortage of radiotherapy therapeutic radiographers and consultant grade oncologists
- The effect of failing to maintain a quality management system in Blood Sciences
- The effect of the UK’s EU exit arrangements on the Trust’s ability to carry out its key functions.
- Pathology LIMS (IT) system age and disaster recovery
- The Medicine and Emergency Care Division also has their own EU exit risk
- Data quality issues within the reporting system for RTT
- Lapses in service contract for the maintenance of endoscopes
- Supplies for community paediatric patients

It should also be noted that the last 4 bullet points relate to red-rated risks that have not yet been validated via Executive Team Meetings (which validates red-rated risks every quarter). It is therefore possible that either the RAG rating and/or the risk score of these risks will be amended.

As was noted on the cover page of this report, it was agreed at the Audit and Governance Committee in February 2017 that the substance of all red-rated risks in the Risk Register should be accounted for in the Board Assurance Framework (BAF), or where this is not the case, that the risk is identified for separate further consideration by the appropriate forum. Having reviewed the red-rated risks listed above, it is considered that the substance of each are either accounted for in the BAF or are being considered by an appropriate forum.

Patient Experience Strategy: 'Making it Personal' Improving the experience of patients and carers	**Chief Nurse / Deputy Chief Nurse**

Improving quality and experience of care is at the core of our organisation's transformation and improvement journey; it's what successful (good /outstanding) organisations do well. It's a key enabler of the cultural shift that puts patients and staff at the heart of planning and decision making in a healthy, responsive organisation envisaged in the Trust's Quality Strategy. Patient satisfaction reflects patient's involvement in decision making and their role as partners in improving the quality of healthcare services. Listening to our patients, carers and service users through feedback obtained in an accessible way for both patients and staff will provide the essential information gathering required to be responsive to make change and improvements.

MTW's new engagement strategy: "Making it personal – improving the experience of patients and carers sets out to ensure that patient experience is everyone's responsibility with clear responsibility for the data and how we can best use this. This builds on our organisations values putting the patient at the centre of everything we do.

Our strategy has its foundation in the Trust's Corporate Strategy which is committed to the delivery of patient centred care for all patients. Patients expect to experience exceptional care which meets both their physical and emotional needs. We know from feedback that there are many examples of excellent care and experience being delivered by our staff; however there are occasions where we know this is not the case for every patient every time.

This strategy explores the 'Patient Experience,' what our patients and carers want, and what the Trust is striving to achieve. It sets out to improve, sustain and develop essential aspects of care and how we measure progress.

To produce this strategy, the Trust has involved patients, carers and partners across West Kent in setting our Patient Experience priorities, from which our Patient Experience objectives and delivery plans have been created. 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. These themes run throughout our strategy and link strongly to our corporate objectives:

- Leadership and Culture
- Engagement and Responsiveness
- Information and Communication
- Choice and Control
- Integration and Working across Healthcare Systems

It is proposed that our strategy will be delivered through our Best Care Programme, sponsored by the Board.

Which Committees have reviewed the information prior to Board submission?
Patient Experience Committee, 10/06/19

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

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

MTW
exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

‘Making it Personal’

Improving the experience of patients and carers

Patient Experience Strategy

2018/19 – 2021/22

MTW ‘Exceptional People, Outstanding Care’

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Introduction

Welcome to the Maidstone and Tunbridge Wells NHS Trust's (MTW) three year Patient Experience Strategy. This Strategy will introduce our Patient Experience objectives and discuss how these will be delivered.

Our strategy has its foundation in the Trust's Corporate Strategy which is committed to the delivery of patient centred care for all patients. Patients expect to experience exceptional care which meets both their physical and emotional needs. We know from feedback that there are many examples of excellent care and experience being delivered by our staff; however there are occasions where we know this is not the case for every patient every time.

This strategy explores the 'Patient Experience,' what our patients and carers want, and what the Trust is striving to achieve. It sets out to improve, sustain and develop essential aspects of care and how we measure progress.

To produce this strategy, the Trust has involved patients, carers and partners across West Kent in setting our Patient Experience priorities, from which our Patient Experience 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 while continuously learning lessons from our practice provides the foundation to the work that we do.

In conclusion the patient experience strategy outlines the development process, implementation and monitoring arrangements and as appendices provides information from national standards and Healthwatch.

David Highton
Chairman

Miles Scott
Chief Executive

Peter Maskell
Medical Director

Claire O'Brien
Chief Nurse

MTW
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Section 1: About Our Trust – MTW

Maidstone and Tunbridge Wells NHS Trust is a large acute hospital trust in the South East of England, providing 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 5,000 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 ensuite accommodation for inpatients in a modern, state of the art environment. It is a designated Trauma Unit, undertakes the Trust's emergency surgery and is the main site for Women's, Children's 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: Patient Experience – *Why it Matters*

Links to NHS Long Term Plan and the Trust's Strategy

Delivery of patient centred care is defined and assessed by a number of national targets and its level of success sits at the core of many national report findings. We know that patients and their relatives want health services that meet their clinical needs whilst ensuring they feel safe and cared for.

It is at the heart of the NHS Outcome Framework 2013/14 and NHS Long Term Plan that 'People will get more control over their own health and more personalised care when they need it.' It is also a key factor of what successful (CQC Rated Good & Outstanding) organisations do well.

Maidstone and Tunbridge Wells Trust Board is committed to engaging with our patients, their relatives and carers to improve patient experience and believe it is essential to the wellbeing of those in our care and to our success as an organisation. This links into the Trust vision and values – **PRIDE** (Patient, Respect, Innovation, Delivery and Excellence).

Poor health experience is strongly associated with health inequalities and poor health outcomes. Better targeted engagement of patients and communities at greatest risk of health inequalities will help us deliver the Triple Aim:

- Improving the Quality of Healthcare and experiences for patients and staff
- Improving the health outcomes of the local population.
- Making better use of our resources to achieve value and financial stability

Increasing personalisation of care provides the opportunity to proactively tackle continued healthcare inequalities and move 'upstream' by keeping people out of hospital for as long as possible and better coordinating the care of people with multiple health conditions as they move between services and providers (demographic projections forecast increasing numbers of elderly patients with more than 3 long term health conditions on shared care pathways between primary and secondary care).

Ongoing, meaningful and embedded patient engagement is strongly associated with increased levels of patient activation (People's ability to manage their own health and wellbeing). Evidence shows increased levels of health literacy, shared decision making and self-management are effective in improving treatment compliance, reducing demand on hospital services and improving health outcomes.

'Patient activation' describes the knowledge, skills and confidence a person has in managing their own health and care. Evidence shows that when people are supported to become more activated, they benefit from better health outcomes, improved experiences of care and fewer unplanned care admissions.

Patients and carers are experts in their own care and are valuable assets in care planning and redesign. Their involvement is key to unlocking savings and efficiencies, and securing financial sustainability over the next 5-10 years.

Section 3: Development of our Patient Experience Strategy

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."

The Patient Experience strategy links into our quality vision and strategy. It has been co-produced with patients, carers and MTW partners. It has been driven and shaped by their views, feedback and priorities at every stage

Steps so far…

Oct 2018	•Engagement event in Ditton •Engagement event in Tunbridge Wells •Understanding what really matters to patients and cares
Nov 2018	•Follow up engagemnet event in Ditton •Follow up engagment event in Tunbridge Wells •Co-designing improvements with patients and carers
Dec - Jan 2019	•Outreach engagement events to harder to reach groups
Feb -March 2019	•Engagement and invitation to comment on draft strategy internally and extenally including at MTW TME and Patient Experience Committee •Revewied and used existing patient experience data and engagement feedback including complaints, surveys, Healthwatch insight and reports to understand our starting point and shape our thinking about priorities for improvements
June 2019	•Presentation of strategy to MTW Trust Board
Oct 2019	•Annual Engagement events with our patients to Annual engagement events to update on current progress, review and reset priorities.

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Section 4: What our patients and carers told us

They:

- *…felt processed in a system rather than being cared for and respected as an individual with different needs and preferences*
- *…felt staff were not always kind and empathetic and didn't always look beyond the illness at the whole person.*
- *…felt hospital routines and habits sometimes frustrated their preferences to maintain their independence and control over their lives*
- *…didn't always feel involved in discussions about their own care or able to ask questions that mattered to them*
- *…didn't always feel well communicated with – sometimes they didn't know what was happening in their care or received confusing or wrong information from staff*
- *…didn't always know who was in charge and who was giving their care*
- *..felt valued and put at ease when staff chatted with them, but not all clinical staff chatted*
- *…didn't always have enough or the right information to feel in control or make plans/good decisions. Some wanted more information about the medical aspects of the illness and treatment – others wanted to know how it might affect how they lived their lives – the social and psychological elements of illness*
- *…felt processed in a system rather than being cared for and respected as an individual with different needs and preferences*
- *…felt staff were not always kind and empathetic and didn't always look beyond the illness at the whole person.*
- *…felt hospital routines and habits sometimes frustrated their preferences to maintain their independence and control over their lives*
- *…didn't always feel involved in discussions about their own care or able to ask questions that mattered to them*
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- *..felt valued and put at ease when staff chatted with them, but not all clinical staff chatted*
- *…didn't always have enough or the right information to feel in control or make plans / good decisions. Some wanted more information about the medical aspects of the illness and treatment – others wanted to know how it might affect how they lived their lives – the social and psychological elements of illness*

Section 5: Responding to what matters to patients and carers

- Patients and carers have told us that we need to change in order to improve their experience of care. Many of the changes will require staff and services to increasingly personalise the care offering so that it better meets the expressed needs and preferences of patients.
- Patients and carers want to be treated with respect and kindness at all times. We must always make sure that we do not discriminate or disadvantage anyone as a result of their religion or belief, race, disability, sexual orientation, age, sex, ethnicity, pregnancy or maternity or gender reassignment.
- Personalisation means putting the individual needs and preferences of patients and carers first; planning and delivering integrated care packages wrapped around the specific needs of individuals, rather than the needs and processes of the organisation - a huge but irresistible challenge for staff and organisation
- Responding to what matters to patients and carers will require a major cultural shift in the organisation over the next 3- 5 years. Our goal is to embed patient and carer experience and engagement at the heart of the Trust's planning, decision making and business processes.
- Although there are pockets of good practice across the organisation, we are not where we would like to be and face considerable challenge in delivering improvements at pace /consistently across the organisation. Where possible we will support the spread and adoption of existing good practice and learn from the experience of other patient / customer driven organisations. Throughout we will continue working with patients, carers and partners so that we can benefit from their expertise and insight in the improvement process.

Section 6: MTW Patient Experience Objectives and Priorities

This section outlines our specific Patient Experience 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 patient experience objectives.

- We have developed a programme of change and improvement for delivery over the next 3 years.
- The improvement programme will be split into the following 5 workstreams:

- Each workstream will have a lead and a detailed implementation plan updated annually. Performance will be overseen and coordinated through Best Quality on a monthly basis with accountability to Best Care Board (internally) and Patients , Carers and Partners (Annual Event) (externally)

The MTW Patient Experience Deliverables

Our Key areas of focus have been developed from all of the information from patients, carers and partners. These deliverables outlined below will be developed within the Best Care Programme and their delivery will be monitored through the governance arrangements of that programme.

Section 6.1: Leadership and Culture

Leadership & Culture

- Improving patient and carer experience and engagement included as a core thread running through all individual and team objectives
- Divisions develop and deliver annual action plans for improving patient and carer experience and engagement. Leads for Patient Experience identified for each Division.
- Targeted training and development empowering clinicians and other staff to identify and act on opportunities for improving patient and carer experience.
- Best Care Programmes and Projects make arrangements to ensure patient and carer voice is meaningfully engaged at every stage of the programme and project.
- Programmes, projects and Trust Board reports evidence how patients and carers have been engaged and how their views and preferences have been taken account of.
- Patient Experience Dashboard developed and reported quarterly to Trust Board
- Review of equality delivery system working with patients and carers

Section 6.2: Engagement and Responsiveness

Engagement & Responsiveness

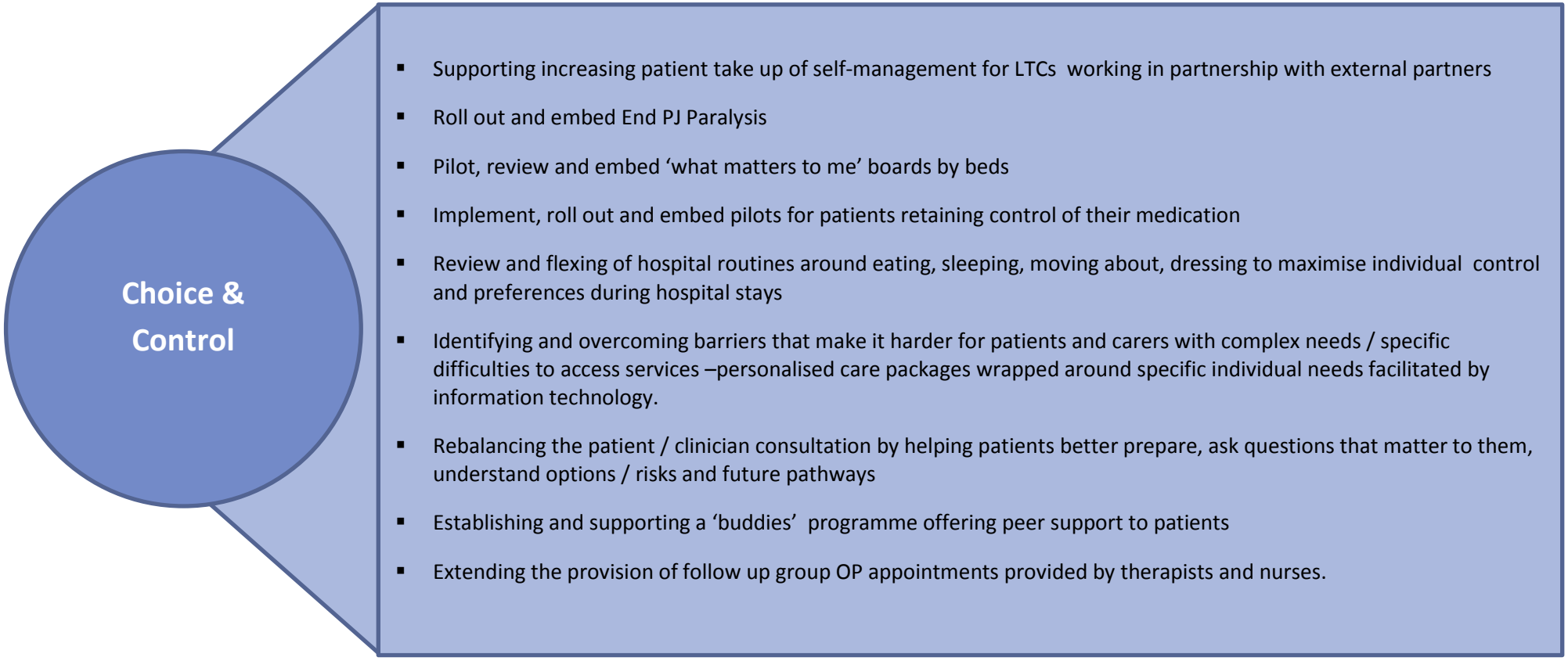
- Annual Listening and Accountability Event with patients, carers and partners including Annual Report of Responsiveness
- Establishing and supporting Patient Representatives across Best Care programmes including peer support.
- Development of relationships and information flows with patients, public, community and third sector groups, Healthwatch, PPGs, OSCs
- Increasing reach and targeting of engagement for those at greatest risk of health inequalities working with and through voluntary sector partners
- Patient Experience resource secured and acting as internal resource / expertise to embed the improvement agenda and support spread and adoption of good practice across the Trust
- Review of policy and practice for responding to patient and carer concerns -including 'how to get things put right quickly and easily' and complaints
- Integrating and synthesising the sources of feedback for wider internal use – complaints, incidents, surveys

Section 6.3: Information and Communication

Information & Communication

- Annual Listening and Accountability Event with patients, carers and partners including Annual Report of Responsiveness
- Establishing and supporting Patient Representatives across Best Care programmes including peer support.
- Development of relationships and information flows with patients, public, community and third sector groups, Healthwatch, PPGs, OSCs
- Increasing reach and targeting of engagement for those at greatest risk of health inequalities working with and through voluntary sector partners
- Patient Experience resource secured and acting as internal resource / expertise to embed the improvement agenda and support spread and adoption of good practice across the Trust
- Review of policy and practice for responding to patient and carer concerns -including 'how to get things put right quickly and easily' and complaints
- Integrating and synthesising the sources of feedback for wider internal use – complaints, incidents, surveys

Section 6.4: Choice and Control



- Supporting increasing patient take up of self-management for LTCs working in partnership with external partners
- Roll out and embed End PJ Paralysis
- Pilot, review and embed 'what matters to me' boards by beds
- Implement, roll out and embed pilots for patients retaining control of their medication
- Review and flexing of hospital routines around eating, sleeping, moving about, dressing to maximise individual control and preferences during hospital stays
- Identifying and overcoming barriers that make it harder for patients and carers with complex needs / specific difficulties to access services –personalised care packages wrapped around specific individual needs facilitated by information technology.
- Rebalancing the patient / clinician consultation by helping patients better prepare, ask questions that matter to them, understand options / risks and future pathways
- Establishing and supporting a 'buddies' programme offering peer support to patients
- Extending the provision of follow up group OP appointments provided by therapists and nurses.

Section 6.5: Integration and Working across Healthcare Systems

Integration & Working across Healthcare Systems

- Reviewing pathways of patients who move between services (within and outside MTW) to ensure transitions between departments and providers involve patients and carers in the planning and are well coordinated by staff (starting with people with dementia, elderly people and young people with complex needs)
- Development and implementation of whole system information technology solutions that facilitate information sharing so that patients and carers only have to provide personal information and clinical details once
- Implementation and roll out of criteria led discharge planning
- Strengthened partnership working and inter-professional working across the local health and care system through increased awareness / knowledge of the local system and enhanced referral / signposting (directory of services)
- Developing improved coordination and shared care arrangement for patients with multiple health needs
- Providing a single point of contact and help for carers navigating pathways / IT flag for carer responsibilities

Section 7: Patient and Carer 'Always do' Checklist

Following patient, carer, partner feedback and engagement events the Always events methodology was embraced. Through Co design and co-production we have now developed our Trust 10 'Always dos'.

This is our commitment to roll out across the Trust.

- …be kind to me, respect me and relate to me as an individual
- … ask me how I want to be addressed
- … let me know who is caring for me
- … support me to be part of the discussion about my care planning and decision making
- … make good use of my time and that of my loved ones
- … support me in retaining my independence and respecting my preferences and daily routines
- … give me accurate, tailored information about my care that helps me stay in control
- … seek out and respond to the issues and questions about my care that matter to me
- … help me navigate and move between different services and providers
- … help me stay well and out of hospital for as long as possible

Section 8: Delivering Our Strategy – Best Care Programme

Structure to deliver and monitor our Patient Experience deliverables

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

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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	• 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	• Financial Methodology agreed (Baseline position agreed/how schemes will be calculated and monitored)
3	• Quality Impact Assessment (QIA) completed by Clinical Lead/Corporate Director
4	• 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\(Quality)

Section 9: Next Steps and Accountability

All Staff and Teams

- Know about the strategy and know what it means for you and your team
- Identify how you can make changes or do things differently

MTW Managers

- Encourage and support your team (s) to discuss and make changes that improve patient and carer experience
- Make it matter by incorporating in objective setting and performance appraisal processes
- Encourage and support targeted training in patient and carer engagement

Clinical Directors

- Act as a role model for personalisation (and identify local champions for piloting SDM, Self-Management)
- Contribute to development, delivery and monitoring of Divisional Improvement plans

Divisional Chiefs

- Identify a Divisional lead for Patient and Carer Experience and Engagement
- Lead development and implementation Divisional Improvement plan and be accountable for delivery

Best Quality Board

- Provide leadership, coordination, support and monitoring of strategy implementation
- Coordinate and drive development of relationships with patients, carers, third sector and other partners
- Share good practice and learning

MTW Executive Team / Best Care Board

- Provide strategic leadership and oversight of the Trust's organisational and cultural transformation
- Embed patient and carer voice at the heart of the Trust's planning and decision making

As a Trust we will…

- We will continue to review all types of patient and staff feedback to ensure they are being used to inform redesign services for patients
- Strengthen patient engagement to ensure all improvement and redesign projects have a patient perspective from the outset
- Annual engagement events to update on current progress, review and reset priorities

Closing Comments

We are delighted to have had the opportunity to engage with patients, stakeholders and staff 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 and patient experience 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.

Appendix 1:
Healthwatch paper for MTW

healthwatch
Kent

Engagement Healthcheck for Maidstone & Tunbridge Wells NHS Trust

Compiled by Healthwatch Kent, October 2016

What is a Healthcheck?

Healthwatch Kent are offering all health and social care organisations a free one-off review of their engagement. This review will benchmark the organisations engagement activities with their patients and public against both the legal responsibilities to engage with patients and public and Healthwatch Kent's own published best practice principles.

Why do organisations have to engage?

All NHS organisations have a legal responsibility to engage with their patients and public.

This is set out in the Health & Social Care Act 2012 and reinforced in the Care Act 2014. In addition, the NHS Constitution also states that people have the following rights and responsibilities;

You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

Legalities aside, it is also good practice to involve your patients and communities in decisions about changes to services. A meaningful, two way, relationship with your communities can support the Trust during difficult times and enable you to have constructive conversations with your patients and public. If it vital that you can bring your communities with you during any period of change.

The STP and the Five Year Forward View will deliver significant change for every organisation in the coming months and years, so it is even more important that you start engaging and building relationships now, to support you in the future.

What is the role of Healthwatch?

Healthwatch has a statutory responsibility to ensure that the public are informed and involved in any change to service.

During our work to scrutinise public consultations it has become clear that the area most vulnerable to challenge and judicial review is the phase called pre-consultation. This is the phase of engagement with communities to develop your Case for Change prior to any discussion or consideration of formal options.

The Healthwatch Kent Best Practice Guide to Consultations is included at the end of this report. It summarises the legal stages you must work through for public consultations.

As well as our statutory responsibilities, Healthwatch has been working with providers and commissioners across Kent to listen and understand the challenges you all face around effective engagement. To support these concerns, Healthwatch Kent has created our Best Practice Guide to Pre-consultation & Engagement which can also be found at the end of this report.

The Healthwatch Kent Engagement Healthchecks are the next stage in our work to support organisations to better engage with their communities and to meet their legal and moral responsibilities.

Engagement within Maidstone & Tunbridge Wells NHS Trust

What do you do well?

- The Patient Experience Committee (PEC) is well established and respected
- The Deputy Chief Nurse has clear responsibility for patient experience and patient engagement
- The Communications department is very well established but need to understand or clarify the scope of their role in patient engagement.
- The Trust has a clear commitment to patient experience and a strong relationship with Healthwatch Kent.
- All Senior Execs have a responsibility for engagement in their job descriptions
- Healthwatch Kent has a presence on the PEC and presents a regular paper to the Committee
- There is a clear link between the PEC and the Board
- PLACE visits and Care Assurance visits are well embedded within the culture of the Trust
- Some individual services are engaging with communities
- The Trust actively listens and responds to the feedback from patients that Healthwatch Kent gives to the Trust
- The Trust is evidently open to change and to embracing new engagement activities

What could you improve?

- We could find no evidence of an uptodate and live engagement strategy
- Although responsibility for engagement is within some job descriptions, the Trust would benefit from identifying a lead/s who has capacity to drive and deliver a Trust wide engagement strategy
- Expand the engagement that is taking place at service level and support all staff to ensure they are aware of their responsibility to engage with patients and carers
- Although patient experience is clearly important to the Board we could find no evidence that patient feedback is considered when key decisions are being taken
- The Trust currently has no data or intelligence that we could find detailing the communities they serve including the seldom heard communities that live within their catchment.
- Increase the pool of patients and carers who currently work with the Trust. These patient representatives should represent the communities that you serve as much as possible.

Our recommendations

- Continue to build on the firm foundations of patient experience to encompass patient & public engagement. This must be Trust wide and be led from the Board
- Ensure patients are routinely involved in key decisions and that the Trust can evidence that they have acted upon the experiences and feedback from patients
- The Trust needs a working engagement strategy to address the current lack of engagement with patients and public
- As part of the strategy development, the Trust must seek to gather information and understanding about the communities it serves
- The Trust requires appropriate resource to deliver, manage and maintain an engagement programme
- Offer training and guidance to all staff to ensure they are aware of their responsibilities to engage with patients and public outside of the hospital
- Ensure Carers are routinely included as part of any engagement
- The Trust must start to develop and strengthen meaningful, constructive relationships with all parts of the community especially seldom heard groups
- Continue to work closely with Healthwatch Kent

Actions for Healthwatch Kent

- Expand the pool of Healthwatch volunteers that work with MTW
- Invite MTW to come and talk with the West Kent Healthwatch volunteers

NHS
Maidstone and Tunbridge Wells NHS Trust

Update on the response to the issues raised during the "A patient's experience of the Trust's services" item at the Trust Board meeting on 25/04/19 — **Chief Nurse**

This report provides an update on the actions discussed at the Trust Board meeting in April and relates to the presentation given by Louise Clyne.

Concerns raised by Louise Clyne (daughter) at Board:

1. Lack of privacy when Mrs Richardson was moved to a side room

A privacy sign has been agreed for use on all side rooms across the division. It is anticipated that this will be rolled out across all in patient areas for patients who are nursed in side rooms. The sign is based on a traffic light approach giving a clear indication if it is appropriate for staff and relatives to enter the room. This has been successfully rolled out at Maidstone and is the process of being introduced at TW – the delay at TW is based on printing times.

This improvement has been communicated with all staff and has full engagement. The matrons have been doing spot checks and have found that this initiative is widely supported and being used effectively. There have been no further complaints in relation to privacy and dignity since its introduction.

2. Most care delivered by CWS

Practise Development Nurses continue to work with our Clinical Support Workers (CSW) across the Division. They are continuing to do focused work with them to ensure that they have completed their care certificate. This has improved the Divisional compliance with care certificate completion to over 90% which is a marked improvement on previous compliance. The care certificate has many components that need to be completed and assessed, which include, providing evidence that all mandatory training has been completed, competing numerous workbooks, and of a requirement to be observed and assessed by a Senior Member of staff undertaking some key core clinical skills and then completing a self-reflection on the assessment. The Ward Manager then needs to sign off all their evidence, then this is reviewed by the Professional Standards team and signed off, following successful sign off the evidence is then sent off to the care certificate providers for them to agree and sign off before the care certificate is issued. The Division continues to provide in house training for its CSWs to further support their ability to provide good care for our patients. The most recent complex care study was held on the 14/6/19. Louise was invited to attend to offer her some insight into the training our Divisional CSWs undertake.

3. Poor communication between nursing staff and family members

As discussed at the previous board meeting, Ward Managers have been asked to advertise a 'Drop in Clinic' to offer the ability for family members to speak to the Ward Managers as we heard from Louise she was not always aware of who was in charge. This allows for swift intervention when concerns are raised. Our ward managers are encouraged to actively go out and speak with families to ensure that they are happy with care delivery and that they fully understand plans of care and next steps. Good communication is vital and we continue to discuss this daily with our teams. Communication has been a recent addition to the team brief and has been one of our divisional key messages.

4. Lost wedding ring

The patient property policy is currently in the process of being reviewed and updated by our legal team. Louise has been invited and has agreed to have some input into this policy. This policy is in the process of being revised; it is anticipated that this will be available for comments before the end of June. The family have been sent a cheque at an agreed sum for compensation for the lost wedding ring. On the 27/5/19 Sally Foy received an email from Zoe Sweeney (daughter of Mrs Richardson) to confirm they had received the cheque and the money had been donated to the Guide Dog charity in line with their personal wishes.

5. Side room quality rounds becoming just a tick box exercise

This is a larger piece of work across the organisation and the initial scoping is being undertaken by the Nursing, Midwifery and Allied Health professionals committee (NMAHP) committee. Once this has been agreed a task and finish group will start the process of reviewing current documentation in use and making any recommendations for change. Whilst this work is in progress we are continuing to use the documentation we already have, but will be monitoring compliance with spot checks by matrons. The checks will include the quality of the information as well as compliance with the completion of the paperwork.

For added assurance whilst this larger piece of work is being undertaken, we are changing the way our Nursing engagement and learning forums (NELF) meetings are managed, we are introducing some agreed quality KPIs that will include documentation, medicines management and complaints performance etc. The expectation is that ward managers and matrons will be required to report back to the senior nursing team. We will use this forum to further scrutinise the use of side room quality round documentation,

To conclude, this case has been discussed fully at the Ward Managers meeting and is on the agenda to be presented at July's clinical governance meeting. Whilst this was a Divisional complaint and we have presented Divisional actions it is possible that this could have occurred on any of our inpatient wards and therefore these learnings will be shared with the other divisions at our NELF meetings and within quality messages though out the organisation.

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, discussion, decision

[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

Approval of Quality Accounts, 2018/19 **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 2018/19 are therefore enclosed, for review and approval.

Earlier drafts have been reviewed by the Quality Committee and the Patient Experience Committee.

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 2018/19 Quality Account for Maidstone and Tunbridge Wells NHS Trust") which can be found at the end of the Quality Accounts document.

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, 08/05/19
- Patient Experience Committee, 10/06/19

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

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NHS Trust

Quality Accounts
2018/19

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exceptional people, outstanding care

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 2018/19 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 2019/20.

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.

About Us

Maidstone & 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.

MTW exceptional people, outstanding care

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Part One
Chief Executive's Statement

Miles Scott Chief Executive

Welcome to our Quality Accounts for 2018/19 which outlines the many actions we have taken and continue to build upon to improve the patient experience at Maidstone & Tunbridge Wells NHS Trust.

We have made significant progress in the quality and safety of our services over the past year. We have changed our organisational structure to put more frontline and clinical staff at the heart of running our services, worked better and smarter with other local healthcare partners to deliver innovation in clinical care, delivered our winter plan at a time of unprecedented demand for our services and been removed from Financial Special Measures, hitting our financial plan and delivering our first surplus in five years, meaning we can invest this back into patient care.

We are committed to building on these successes to further enhance the care we provide to our patients.

Our ambition is to become an Outstanding provider of NHS care with hospitals that we can all feel rightly proud of because they are patient-focused and clinically-led. While we recognise that we have further to go to be outstanding in everything we do for our patients, putting quality improvement at the core of our organisation is making a real difference for our patients at a time of unparalleled demand for NHS care.

Our Best Care programme brings together all our quality plans in a focused and cohesive approach that allows us to continue to improve patient care and move forward with our ongoing efforts to become a more caring, sustainable, and improvement driven organisation.

Best Care recognises that our journey of improvement needs to involve our staff, patients, public and healthcare partners in everything we do. With your help, we can shape our quality improvements to be even more of a patient-centred provider of personalised-care.

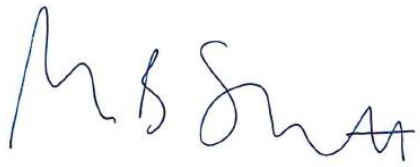
Our hardworking and hugely dedicated teams of healthcare professionals have continued to respond to this unprecedented demand year on year. As our healthcare needs evolve and change, it is important that we have the ability to quickly adapt to these changes too.

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 2018/19 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 for 2019/20 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 2019/20

Patient Safety

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

Key objectives will include:

- Creating a safety culture that embraces 'lessons learned'
- Reducing healthcare associated infections
- Improvement in outcomes for expectant mothers and their babies in line with 'Better Births' and the National Maternity Transformation work.
- Improve the care of the deteriorating patient through the promotion of early recognition, response and appropriate escalation.

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:-

- Launch and delivery of the new Patient Engagement and Experience strategy 'Making it happen'.

- Improving End of Life Care in the acute trust.
- To recognise and respond to the specific needs of our patients with complex needs

Clinical Effectiveness

To improve patient flow through the delivery of safe and effective care for patients by whichever pathway of care best meets those needs.
Key Objectives will include:-

- Improving the delivery of clinical quality standards and therefore timely treatment for our patients accessing care through both our emergency and planned pathways of care.
- Improving patient flow through the development of alternative care models/pathways.
- Reduction in cancelled operations.
- Development of new and advanced roles to improve pathways of care and raise staff morale.

We will monitor our progress against these objectives through our Divisional 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.

Maidstone Birth Centre welcomed its 3000th Baby on 4th October, 2018. The new born is pictured with her parents Abbie and Elliot Mason.

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 2018/19 the Best Safety work stream has overseen the delivery of 'Lessons Learned'. This has been instrumental in ensuring that our governance processes and procedures are redesigned in a manner that will support the meaningful flow of information. This has included the procurement of an enhanced incident reporting database and a review of the agenda for each Directorates Clinical Governance sessions. The intention is to ensure that our staff will have the ability to gain insight into the services they provide by having access to meaningful data that 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 through the process of learning.

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 and know we will act appropriately to improve patient safety as a whole organisation. Our aspiration is the transition to an organisation that demonstrates 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 and 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 continued to work with our commissioners in regard to the declaration of serious incidents (SI's). During 2017/18 we had seen an increase in the number of SI's being declared, of note SI's are being reported which following investigation is then evident that the severity of the incident wasn't as high as initially thought so they were downgraded. During 2018/19 we have seen these numbers plateau as commissioner confidence and transparency of our processes has grown. Both NHS Improvement and our CCG quality leads have attended SI Panels and contributed to this process.

We have seen the number of complaints increase; while this may seem counter-intuitive, our complaints still remain below the expected parameters for an organisation of our size. Supporting our patients to raise their concerns is important to us. This feedback helps to inform improvements to pathways of patient care for the organisation and helps inform education for our staff to support change and constant improvement.

Identified areas for improvement and progress during 2018/19

The following actions were taken in 2018/19

- During the year we have seen a degree of success with improving our incident reporting, the numbers initially did rise and have continued to remain static. However, this has not been sufficient to improve our profile nationally.
- Positively we have seen greater improvement in the investigation and closure of incidents. This has helped to ensure that staff receive timely feedback when they've made the effort to report an incident and supports organisational learning.
- Investment in our Incident reporting system has been approved with the rollout of an enhanced system due in 2019/20.
- During the course of the year we've been raising awareness of Duty of Candour and have assurance that the standard is complied with for Serious Incidents. Data capture for moderate incidents has proved more challenging and will be addressed during the upgrade of our incident reporting system.
- The Trust's Mortality Steering Group has continued to review themes and trends from both our Mortality Reviews and the data supplied by Dr Foster. Investment and improvement in our coding and requirements for seven day services (7DS) has seen a sustained improvement in both SHMI and HSMR resulting in a sustained improvement comparable to our peers.
- Human Factors training received further investment this year with 24 courses made available to all grades of staff from June 2018 – March 2019.
- Review of the Schwarz Round process resulted in a task and finish group with three clinical leads now trained in the methodology. This process is launching in April 2019 with the aim and intention of supporting our staff with the emotional and social aspects of working in healthcare.
- Investment was made in providing Root Cause Analysis workshops to support our staff to become more involved in the incident reporting and investigation process, with the benefit of learning about pathways of care external to their own Directorates.
- We have sustained our trajectory of improvement in the consistent recognition and rapid treatment of sepsis in our emergency and inpatient departments achieving all quarters with the exception of Quarter 1 which we narrowly missed for inpatients.
- Sepsis Study Day – 'Let's all talk sepsis' 11th September, 2018 which included a patient who had survived sepsis as the keynote speaker.
- Introduction and rollout of NEWS2 - the new patient at risk score to support early identification of the key triggers for sepsis, comprising of bespoke training sessions for our clinical staff.
- Introduction of a new Emergency Department sepsis screening tool for completion during triage.
- Sepsis scenario incorporated into our portfolio of Simulation training.
- 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.
- MTW are working with NHS Improvement; Maternal & Neonatal Safety Collaborative (MatNeo) and have introduced a lead matron for smoking cessation.

- MTW are part of the safety collaborative PreCePT imitative to identify Mothers who may be at risk of an imminent premature birth. This is to ensure they are given Magnesium Sulphate which is shown to improve neurological outcomes for premature babies.
- Investment and upgrade of the services at Crowborough Birth Centre to improve the choice agenda for our expectant parents.

Areas for focus and improvement during 2019/20

Key objectives will include:-

- Creating a safety culture that embraces 'lessons learned'-
    - Increasing the number of incidents that are reported to identify themes to support positive change and improvement
    - Continued focus on reducing our Trust-level mortality figures in line with the national average (HSMR/SHMI) through learning from mortality reviews
    - Supporting staff to share their patient safety experiences and to encourage their development of skills and practices to support patient safety.
    - Embed a safety culture within all departments undertaking invasive procedures which complies with the WHO surgical safety methodology.
- Reducing healthcare associated infections, in particular:-
    - Clostridium Difficile
    - Gram negative bloodstream infections
    - MRSA/MSSA bloodstream infections
- Improvement in outcomes for expectant mothers and their babies in line with 'Better Births' and the National Maternity Transformation work.
- Improve the care of the deteriorating patient through the promotion of early recognition, response and appropriate escalation.

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 improving quality and experience is fundamental in our transformation and improvement journey to become an Outstanding provider of NHS care. We also know that a key enabler of that cultural shift is in demonstrating that we put patients and staff at the heart of planning and decision making as outlined in our Trust's Quality Strategy.

We also recognise that positive outcomes for our patients are synonymous with improved levels of staff satisfaction, each impacting on the other. In September 2018, the Trust Board approved the development of a more Clinically Led Organisation with a revised reporting structure to promote greater engagement and responsibility within our clinical departments. One of the key characteristics of promoting this level of autonomy is to ensure that our services are clinically-led, patient centred and committed to excellence.

In addition, we committed to improve engagement with our patients and improve the care for our patients with complex needs which is overseen by the Best Quality workstream. This has resulted in the development of the Patient and Carer Experience Strategy, 'Making it Personal'. The strategy has been co-designed and co-produced with our patients, carers and partners identifying 10 key 'Always Do's' that would help to improve their experience whilst in our care. These include:-

- **Be kind to me, respect me and relate to me as an individual**
- **Ask me how I want to be addressed**
- **Let me know who is caring for me**
- **Support me to be part of the discussion about my care planning and decision making**
- **Make good use of my time and that of my loved ones**
- **Support me in retaining my independence and respecting my preferences and daily routines**
- **Give me accurate, tailored information about my care that helps me stay in control**
- **Seek out and respond to the issues and questions about my care that matter to me**
- **Help me navigate and move between different services and providers**
- **Help me stay well and out of hospital for as long as possible**

Aim/goal

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 2018/19

The following actions were taken in 2018/19

- Engagement events were undertaken in Ditton and Tunbridge Wells in October to understand what really matters to patients and carers. This was then followed-up in November to co-design the improvements identified.
- In December and January outreach engagement was undertaken with harder to reach groups to ensure their views were gained and incorporated.
- In February and March, engagement and invitation to comment on the draft strategy; 'Making it Personal' which also used information gained from complaints, surveys and Healthwatch insight reports.
- Healthwatch have been actively engaged with A&E site visits, attendance at the Patient Public and Engagement events and also regularly supported us with our internal assurance inspections of wards and departments. They also attended the Trust Board in December, 2018.
- The CQC have undertaken four separate engagement events over the course of the year. During these visits our staff are supported to present their services and discuss any issues that they face alongside the actions that are being taken to address these. All visits were very positively received and were an opportunity for direct questioning and feedback to be given to the staff that they met.
- Regular meetings also take place between the Executive leads and the leads from NHS Improvement; their quality lead has also attended an internal Never Events action group and a Serious Incident learning & improvement panel.
- The Quality leads for MTW, West Kent CCG and the Sussex Alliance regularly meet to discuss quality aspects of care and also are integral to the internal assurance inspection process in regard to the 'fresh eyes' approach.
- The Lead Nurse for Dementia care has been working collaboratively with the West Kent Alliance to ensure that the dementia strategy is progressed. In addition she has been attending the community dementia hubs to gain valuable feedback in regard to our patients' experiences at MTW.
- The Learning Disability Liaison Nurse has provided updates and training for a wide range of staff from A&E to Maternity to continue to raise awareness and support for patients with a learning disability (PWLD) who use our service. She has also actively supported PWLD's to attend their appointments and undergo pathways of care.

- In addition our Learning Disability Liaison Nurse has developed a sub-group of the Accessible Information Committee to review patient information for PWLD.

Areas for focus and improvement during 2019/20

Key objectives will include:-

- Embed and delivery of the Quality Improvement plan.
- Improving End of Life Care in the acute trust.
- To recognise and respond to the specific needs of our patients with complex needs including:-
    - Working with our partner organisations to deliver all aspects of the accessible information standard
    - Development of training strategies to support our staff in delivering care appropriate to their patients' needs

Executive lead: Claire O'Brien, Chief Nurse
Board Sponsor: Claire O'Brien, Chief Nurse
Implementation lead: Judy Durrant & Gemma Craig, Deputy Chief Nurses
Monitoring: Patient Experience Committee.

As the Trust takes huge strides to become even more Dementia-friendly, our colleagues on Mercer Ward have been rolling out special coloured Zimmer frames courtesy of the Maidstone Hospital League of Friends, to help our patients get up and around. It has been recognised through our Allied Health Professionals project that dementia patients find it difficult to identify objects that are all of a similar colour, such as the standard grey frames. These frames will also be beneficial for those with sight impairments helping to reduce the risk of patient falls.

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 routes 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 to our inpatient areas, ensuring the minimum length of stay possible. Additionally this will include the ongoing work to support the reduction in bed occupancy rates, achieving the A&E 4 hour quality standard, 18 week referral to treatment and the cancer quality standards.

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 for improvement and progress during 2018/19

The following actions were taken in 2018/19

- Development of streaming criteria directly to Ambulatory Emergency Care (AEC) to facilitate a timely clinical review.
- Development of direct GP and Southeast Coast Ambulance (SECAmb) conveyance to the appropriate unit i.e. AEC or Frailty units.
- Collaborative working with SECAmb and Kent Community Health Foundation Trust (KCHFT) in the development of alternative pathways of care to support patients in their own home.
- Increase of GP hours within the Emergency Department (ED).
- Continued collaboration with Kent and Medway NHS and Social Care Partnership Trust (KMPT) and SECAmb to develop plans of care which will support patients with mental health needs who frequently attend ED to seek help in the most appropriate place.
- Launch of Hospital@Home service to support patients with their care needs in their own homes. These patients are overseen by a Consultant at MTW with their care being provided by KCHFT.
- New pathway of care provided for patients recovering from a fractured hip to rehabilitate at Tonbridge Cottage hospital.

The pharmacy team has launched ward based dispensing on Ward 2 and the Acute Frailty Unit at Tunbridge Wells Hospital. This allows the pharmacy team to facilitate prompt patient discharge through dispensing some discharge medication using ward pharmacy stocks. This has proved particularly beneficial to those patients who may only require a small number of items dispensed. This dispensing would normally join the large volume of work undertaken in the hospital pharmacy and can necessitate a wait for these items before discharge is possible.

Areas for focus and improvement during 2018/19

Key objectives will include:-

- Improving the delivery of clinical quality standards and therefore timely treatment for our patients accessing care through both our emergency and planned pathways of care.
    - To ensure that an increasing number of patients are promptly seen and treated through our emergency departments
    - To reduce the number of patients waiting for their procedures on our elective waiting list whilst ensuring that they do not come to harm
    - Improvements in timeliness of diagnosis, decision making and treatment for our cancer patients
- Improving patient flow through the development of alternative care models/pathways.
- Reduction in cancelled operations.
- Development of new and enhanced roles to improve pathways of care and raise staff morale.

Executive lead: Sean Briggs, Chief Operating Officer
Board Sponsor: Sean Briggs, Chief Operating Officer
Implementation lead: Lynn Gray, Divisional Director of Operations Medicine & Emergency Care/Deputy Chief Operating Officer
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

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

The Trust is required to register with the Care Quality Commission and its current registration status is 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 2018/19.

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

During 2018/19 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 (3). The Trust has reviewed all the data available to them on the quality of care for these three NHS services.

The income generated by the NHS services reviewed in 2018/19 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 2018/19, undertaken by external organisations such as:

- 2017/18 Annual Accounts External Audit; Grant Thornton – concluded May 2018
- General Medical Council; Trainee and Trainer Survey – May 2018
- CQC Engagement Event – 6th June 2018
- HM Revenue and Customs (Tax and NI compliance inspection) – June 2018
- Environmental Health visit to catering facilities (Full 5 star hygiene rating awarded) – June 2018
- HEKSS Surgery Programme Risk-based Review – 10th July, 2018
- Pharmacy; Aseptic Units, Regional Quality Assurance – 4th September, 2018
- CQC Engagement Event – 5th September 2018

- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 17043) – SE England General Histopathology EQA scheme – September, 2018
- 2017/18 Charitable Funds independent examination by external auditors, Grant Thornton – concluded October 2018
- HEKSS Paediatrics Programme Risk-based Review – 20th November, 2018
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) – Histology and cytology – November 2018
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) – Microbiology – November 2018
- Medicines and Healthcare Products Regulatory Agency (MHRA) – Transfusion – November 2018
- CQC Engagement Event – 6th December 2018
- Human Tissue Authority – Tunbridge Wells Hospital mortuary – December 2018
- CHKS Accreditation ISO9001 –February 2019
- NHS Improvement, Kathy McClean, Medical Director – Cancer review 20th February 2019
- HEKSS Surgery Visit – Risk based review (Senior Led Conversation) – 4th March 2019
- CQC Engagement Event – 21st March 2019

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 and Sussex Alliance CCG's.
- 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.

26 November 2018, via Facebook: Thank you to the NHS staff at Pembury Hospital who treated me! Pembury hospital is clean and full of wonderful staff!

Hygiene audits to check service quality

Clinical Audit

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

During 2018/19, MTW participated in 4 (100%) relevant confidential enquiries and 55 (98%) relevant national clinical audits (1 was not submitted due to problems with software compatibility – this is currently being resolved). During the same period, MTW staff successfully completed **192** clinical audits of the **219** due to be completed (local and national) to action plan stage of the **391** audits on the programme to be undertaken during the year. The remaining audits are at various stages of completeness and will be monitored through to completion.

The national clinical audits and national confidential enquiries that Maidstone and Tunbridge Wells NHS Trust participated in during 2018/19 are presented as follows-

National Clinical Audits for inclusion in Quality Accounts 2018/19	***Participation*** Y, N or NA	***No of cases submitted***	***% cases submitted***	***Comments***
Recruited patients during 2018/19 (Any period during 01/04/2018 to 31/03/2019)				
Acute Care				
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	Y	MGH – 405 TWH- 573	100%	Continuous data collection.
Emergency Laparotomy Audit (NELA)	Y	MGH – 18 TWH – 196	100%	Continuous data collection.
Neurosurgical National Audit Programme	N/A			MTW does not provide this service
National Vascular Registry	N/A			MTW does not provide this service
Severe Trauma (Trauma Audit & Research Network) TARN	Y	MTW Trust - 330	66 - 84%	For some months there has not been dedicated input for TARN which has caused a fall in submission numbers. Data collection still open and data being submitted
National Joint Registry (NJR)	Y	MTW Trust - 715	100%	Data collection still open and data being submitted

National Clinical Audits for inclusion in Quality Accounts 2018/19	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
RCEM VTE risk in lower limb immobilisation (care in the ED) 2018	Y	MGH – 50 TWH – 50	100%	
RCEM Vital Signs in Adults (care in the ED) 2018	Y	MGH – 50 TWH – 50	100%	
RCEM Feverish Children (care in the ED) 2018	Y	MGH – 33 TWH – 50	100%	Majority of children taken directly to TWH Emergency Department
BAUs Urology Audits: Radical prostatectomy audit	Y	MTW Trust - 59	100%	
BAUs Urology Audits: Female Stress urinary incontinence audit	N/A			MTW does not provide this service
BAUs Urology Audits: Cystectomy	N/A			MTW does not provide this service
BAUs Urology Audits: Nephrectomy Audit	Y	MTW Trust - 26	100%	This is the number of cases for the Urology Consultant and includes his activity at Medway Hospital. Activity is reported by surgeon rather than site.
BAUs Urology Audits: Percutaneous Nephrolithotomy (PCNI)	Y	22	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				
Serious Hazards of Transfusion 2018 (SHOT) UK. National haemovigilance scheme	Y	MTW Trust - 20	100%	Continuous data collection.
(National Comparative Audit of Blood Transfusion Programme) Audit of massive haemorrhage	Y	MTW Trust - 2	100%	All cases submitted, major haemorrhage is rare.
(National Comparative Audit of Blood Transfusion Programme) Audit of FFP and cryoprecipitate in children and neonates.	N/A	N/A	N/A	Trust did not register to take part. Too few cases to warrant inclusion in this audit.
Cancer				
Lung Cancer (NLCA)	Y	MTW - 226	100%	Yearly rolling audit with continuous data collection. Figures up to February 2019.
Bowel Cancer (NBOCAP)	Y	MTW – data not available yet	100%	Continuous data collection. Yearly upload to website due in June 2019 -

National Clinical Audits for inclusion in Quality Accounts 2018/19	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
				final data submission has not yet taken place.
National Prostate Cancer Audit (NPCA)	Y	MTW - 400	100%	Yearly rolling audit with continuous data collection. Figures up to February 2019.
Oesophago-gastric cancer (NAOCG)	Y	MTW - 71	100%	Participation in diagnostic pathway element only – MTW does not perform major Upper GI surgery.
National audit of Breast Cancer in Older people (NABCOP)	Y	Exact numbers not available from national organisation	100%	NABCOP uses existing sources of patient data collected by national organisations including the National Cancer Registration and Analysis Service (NCRAS) in England and cannot provide data on exact numbers submitted by the trust. Trust numbers will be published in the next national report (most recent national report published in June 2018 with 2014-16 data showed 1,919 patients diagnosed from MTW during that timeframe.
Heart				
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Y	MGH – 148 TWH – 168	100%	Data collection still open and data being submitted
National Heart Failure Audit	Y	MGH – 184 TWH – 271	100%	Data collection still open and data being submitted
Coronary angioplasty/ National audit of Percutaneous Coronary Interventions (PCI)	Y	MTW - 265	100%	Data collection still open and data being submitted
Cardiac Rhythm Management (CRM)	Y	MTW: 319 - Pacemaker 46 – electrophysiology procedures	100%	Data collection still open and data being submitted
National audit of Cardiac Rehabilitation (NACR)	Y	MGH – 392 TWH – 459	100%	Data collection still open and data being submitted
National Cardiac Arrest Audit (NCAA)	Y	MTW - 137	100%	Continuous data collection.

National Clinical Audits for inclusion in Quality Accounts 2018/19	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
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) 2018	Y	N/A	N/A	Only hospital organisational data was required for 2018. These have been submitted.
National Diabetes Inpatient Audit – Harms	Y	MGH – 16 TWH – 11	100%	Data collection still open and data being submitted
National Diabetes Foot Care Audit	Y	MTW – 99	100%	Data collection still open and data being submitted
National Core Diabetes Audit (NDA) 2017-18	Y	MGH – 1693 TWH – 2243	100%	
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) – COPD Pulmonary Rehabilitation	Y Trust registered as West Kent Community Pulmonary Rehabilitation Service.	MTW - 2	100%	Data collection started 1 March 2019. Data collection ongoing
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) – COPD Secondary Care	Y	MGH – 301 TWH – 302	100%	Data collection still open and data being submitted
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) – Adult Asthma Secondary Care	Y	MGH – 53 TWH – 46	100%	Data collection started in Feb 2019. Data collection open and data being submitted
Inflammatory Bowel Disease (IBD) Programme /IBD Registry	Y	MTW – 217	100%	
National Early Inflammatory Arthritis Audit (NEIAA)	Y	MGH – 24 TWH – 22	100%	Data collection open and data being submitted
National Audit of Anxiety and Depression	N/A			MTW does not provide this service
Older People				

National Clinical Audits for inclusion in Quality Accounts 2018/19	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
Falls and Fragility Fractures Audit Programme (FFFAP)	Y	1.Inpatient Fall National Audit of Inpatient Falls (NAIF) MTW – 1 2.Fracture Liaison Service Database organisational data 3. National Hip Fracture Database MTW Trust - 512	1. 100% 2. N/A 3. 88.4%	1. Data collection started in February 2019. Only notified about 1 patient from NAIF 2. MTW does not provide this service. This is a community service. 3. Data collection still open and data being submitted
Sentinel Stroke National Audit Programme (SSNAP)	Y	1.Organisational 2. Clinical Data MGH: - 354 TWH: - 433	1. N/A 2. 100%	1. This element not required for 2018-19 2. Data collection open and data being submitted
Other				
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein	Y	MTW: Hip: 248 Knee: 190 Groin: N/A Varicose: N/A	100%	The Trust only collects data for Hip and Knee procedures
National Ophthalmology Adult Cataract Surgery Audit	N	MTW - 0	0%	Registered to participate but waiting for OpenEyes cataract module to be purchased to enable us to upload data.
National Audit of Care at the End of Life 2018 (NACEL)	Y	MTW - 60	75%	Submitted data for all available notes. Organisational data also submitted.
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 2018	Y	MTW - 69	50%	Difficulty in obtaining sufficient numbers of case notes within the timeframe set by NHS England. This issue has now been resolved at a national level for future audits.
Mandatory Surveillance of bloodstream infections and Clostridium Difficile infection.	Y	MRSA – 3 C.diff – 39 MSSA – 17 E.coli – 62 Pseudomonas-13	100%	Data from April 2018 to February 2019. Continuous data collection.

National Clinical Audits for inclusion in Quality Accounts 2018/19	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
		Klebsiella - 27		
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Antibiotic Consumption.	Y	MTW - 5,955 (total antibiotic prescribing per 1000 admissions)	On track to achieve 100%	Continuous data collection.
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Antimicrobial Stewardship.	Y	MTW- 149	On track to achieve 100%	Continuous data collection. Achieved Q1 (46%, target of 25%) Achieved Q2 (53%, target of 50%) Achieved Q3 (80%, target of 75%)
BTS National Adult Community Acquired Pneumonia (CAP) 2018-19	Y	Data still being collected		Data collection still open and data being submitted
BTS National Adult Non-Invasive Ventilation (NIV) 2019	Y	Data still being collected		Data collection still open and data being submitted
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 - 496	100%	
MBRRACE-UK; Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal morbidity confidential enquiries (reports every second year)	Y	MTW - 0	100%	The trust had no cases that met the criteria for this audit.
MBRRACE-UK; Perinatal Mortality Surveillance	Y	MTW Stillbirth: 10 Neonatal: 1 Extended	100%	

National Clinical Audits for inclusion in Quality Accounts 2018/19	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
		Perinatal: 11		
MBRRACE-UK; Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal Mortality surveillance and mortality confidential enquiries (reports annually)	Y	MTW - 0	100%	The trust had no cases that met the criteria for this audit.
MBRRACE-UK; Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Y	MTW Stillbirth: 10 Neonatal: 1 Extended Perinatal: 11	100%	
Paediatric Inflammatory Bowel Disease	Y	MTW - 33	100%	Data submitted quarterly
National Maternity and Perinatal Audit (NMPA)	Y	MTW - 6066 births	100%	Submitted automatically via NHS Digital.
National Pregnancy in Diabetes Audit	Y	MTW - 42	100%	
National Comparative Audit of Blood Transfusion Programme - Audit of the Management of Maternal Anaemia	Y	MTW - 10	100%	
Paediatric Intensive Care Audit Network (PICANet)	N/A			MTW does not provide this service
National Paediatric Diabetes Audit (NPDA)	Y	TWH: 95 MGH: 131	100%	Ongoing data submission, final date for 2018/19 data is 31/05/2019
National Audit of Seizure and Epilepsies in Children and Young Adults (Epilepsy 12)	Y	MTW - 28	100%	Continuous data submission when cases are identified.
National Confidential Enquiries				
NCEPOD: Cancer in Children, Teens and Young Adults	Y	MTW - 0	100%	The trust submitted organisational data but had no patients that fitted the inclusion criteria for this study.
NCEPOD: Perioperative Diabetes	Y	MTW 6 Surgical 5 Anaesthetic	50%	
NCEPOD: Pulmonary Embolism	Y	MTW - 4	40%	Data collection still open for Clinical Questionnaires
NCEPOD: Acute Bowel Obstruction	Y	MTW - 1	10%	Data collection still open for Clinical and Organisational Questionnaires
Child Health Clinical Outcome Review Programme: Long term ventilation in children, young people and young adults.	N/A			Not applicable as this service is not provided by the trust.

38 national audits were published in 2018/2019 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 Pregnancy in Diabetes (NPID) - our Diabetic Link Midwives have been working hard to increase access for women with type 2 diabetes to specialist support in early pregnancy. On average, 25 women had data submitted to the NPID each year from 2014 to 2017, with approximately 20% of those patients having type 2 diabetes. In 2018, we submitted data for a total of 42 patients and just over 40% of them had type 2 diabetes which shows a very encouraging improvement in type 2 diabetic women having early access to specialist support. The team is continuing to work on information for the Trust website so that more women are aware of the services we provide and also improving communication between the Trust and GPs.

National Neonatal Audit Programme (NNAP) – our Neonatal Team have managed to improve our results almost across the board. There has been a notable improvement for mothers at risk of delivering a preterm baby being given magnesium sulphate to reduce the chance that their baby will develop cerebral palsy (from 38% in the 2017 report to 70% in the 2018 report and presently we are almost fully compliant). Additionally the Trust is now fully compliant with ensuring parental consultations occur on a daily basis so that new parents are kept informed and feel supported.

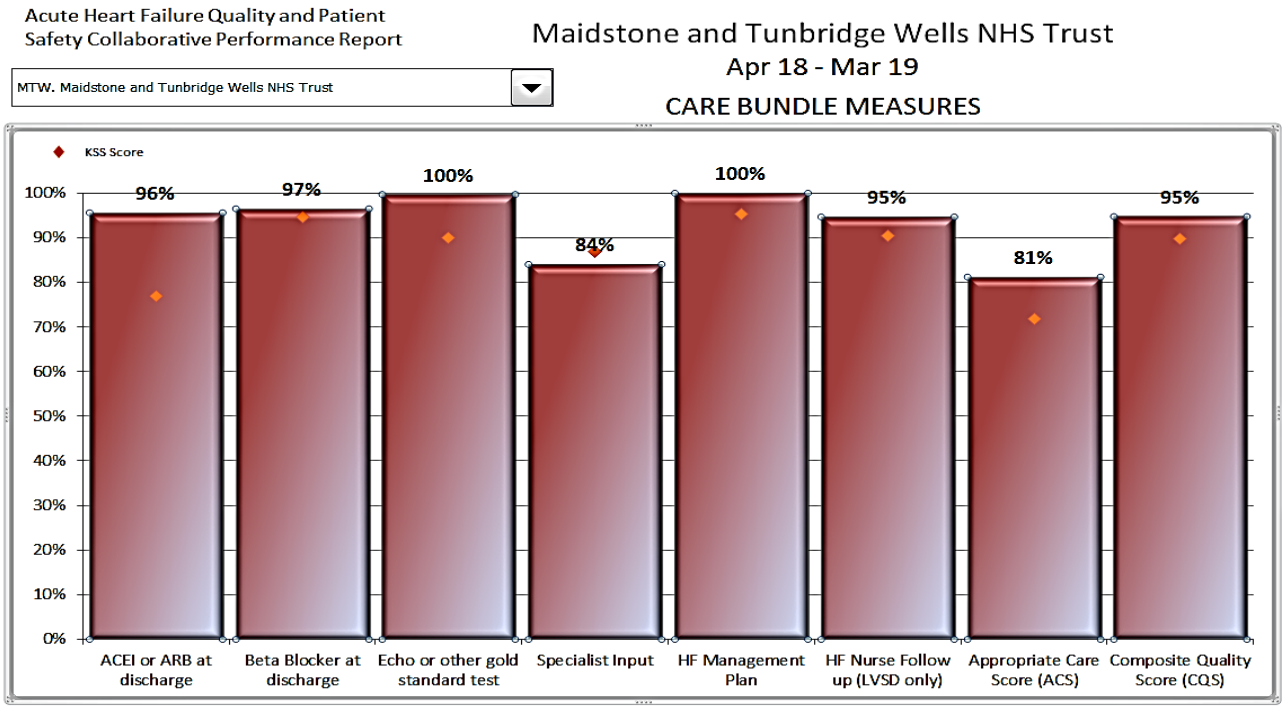
MBRRACE-UK; Perinatal Mortality Surveillance Report; UK Perinatal Death for births in 2016 – we were fully compliant with the MBRRACE recommendations from this report having previously implemented half yearly reviews of all neonatal deaths and put in place plans to undertake placental histology for all stillbirths (where parents have consented). Our results indicate that we are up to 10% lower than average for the group for stillbirths, where in the previous set of results we were up to 10% higher for the group.

National Emergency Laparotomy Audit (NELA)

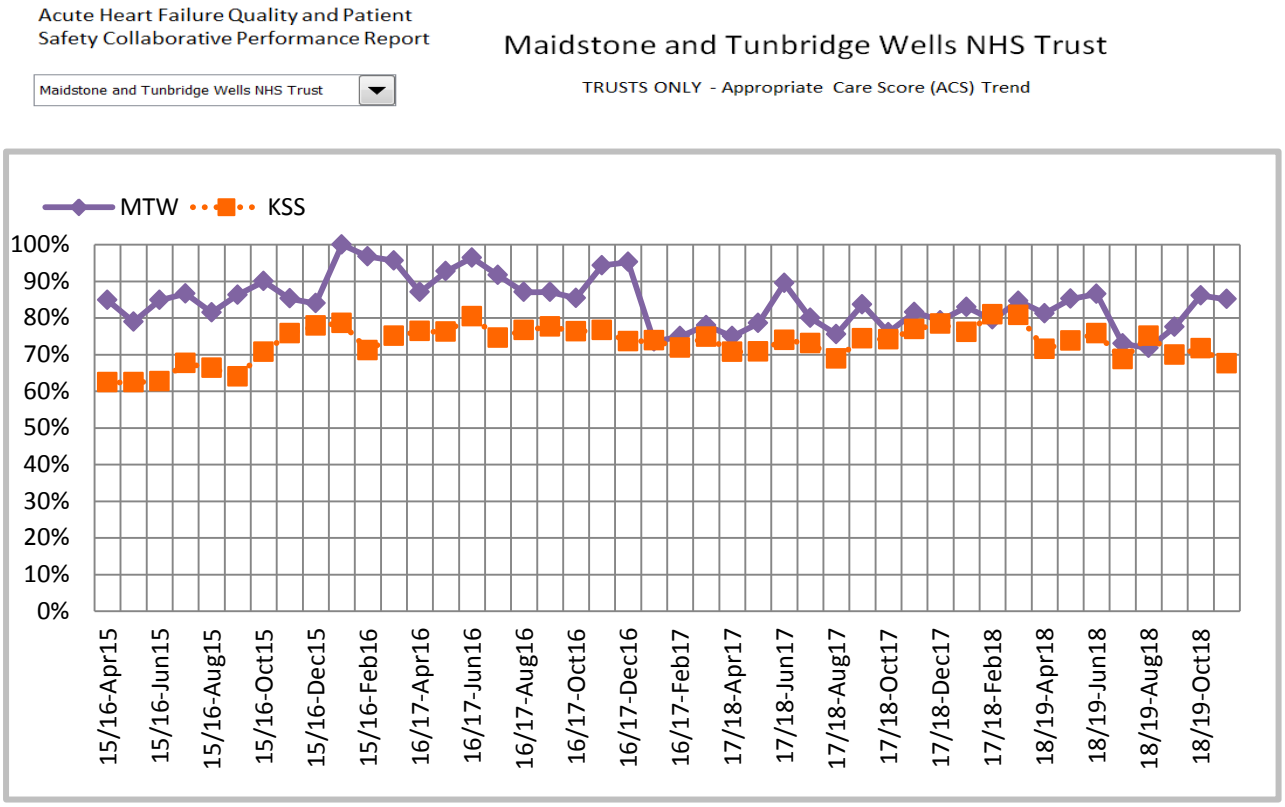
Surgical, Anaesthetics & Theatres NELA Team

We are currently within Year 6 of data collection for NELA and were proud to have the Trust surgical / theatre team appear on the cover of the Fourth Patient Report of the National Emergency Laparotomy Audit (Dec 2016 – Nov 2017) that was published in 2018. We have made great progress over the years and are one of the top performing trusts in England. We have a low mortality rate (5.6%) compared to the national average (9.5%) based on the most recent published results (2016/17). However further improvements in our performance against national standards can be made and a robust action plan to achieve this is in place.

Heart Failure – The Trust continues to participate in the Acute Heart Failure Quality and Patient Safety Collaborative with the Kent Surrey Sussex Academic Health Science Network (KSSAHSN).The chart below provides the Trust performance report for the care bundle measures for the period April 2018 – March 2019.



The Trust has continued to perform above KSS for the Acute Heart Failure Appropriate Care Score over the last 4 years.



Appropriate Care Score (ACS) - “Patient Level” The Appropriate Care Score (ACS) is a measure of the number of times patients received all the care they were eligible for. The ACS is the total number of patients that received all the care they were eligible for divided by the total number of patients eligible for the focus area. Numerator is the total number of

patients that received all the care they were eligible for. Denominator is the total number of patients that were eligible for at least one measure.

Stroke Audits - Overall compliance for data submission to the national audit has risen at both sites from Band D in 2013-14 to Band A in 2016-17 at Maidstone and from Band C in 2013-14 to Band A in 2017-18 at Tunbridge Wells following the employment of a stroke specific data entry administrator.

Nationally and Trust wide there is now a greater awareness of stroke in general and the need for prompt action in identifying patients with a suspected stroke. All nurses working on the stroke wards now have to undertake stroke specific competencies which have helped improve care of patients following a stroke. Also nurses who have been identified in the role of stroke assessors have additional training which includes being able to request a plain CT of the head for patients with suspected strokes within 1 hours of arrival. This will improve the time for scans to be carried out and reported and allow the decision to thrombolyse to be made quicker and benefit patients' treatment.

Please see Appendix A for full details of progress against each of the reported national audit results 2018/19.

Improvements to clinical practice from local audits

A number of improvements have been made as a result of the **145** completed local clinical audits, across all Directorates, in 2018/19, **65** 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 2018/2019	Trust Actions
NICE CG190 Re-audit of massive obstetric haemorrhage (PPH) Obstetrics	Haemorrhage (predominantly postpartum haemorrhage) is a leading cause for maternal mortality. The introduction of a simplified escalation policy following the last round of this audit appears to have had a significant effect on senior staff involvement, with the Obstetric Consultant and Anaesthetic Consultant documented as being present, attending, or informed about 100% of cases in the second cycle (previously 48%). Since the original audit took place, much of the data is now collected on E3 (Electronic maternity database). The team also now continuously monitor the monthly severe PPH rate (>1500 ml) via the Maternity dashboard. Their clinical team frequently run reports on E3 looking at risk factors, etc. All of the information that cannot easily be obtained from E3 is regularly reviewed at the weekly Maternity Risk meetings, where the team review the notes for all major PPHs (>1000 ml).
ECG labelling practice Cardiology	ECGs are a vital investigation that forms part of clinical diagnosis in cardiac emergencies and in decision making for life saving interventions. Unlabelled ECGs pose a risk that incorrect clinical decisions may be made based on findings on ECGs which do not belong to the relevant patient, leading to possible missed diagnosis or inappropriate treatment. Following the first round of this audit an education programme and ward posters were put in place to remind staff of the need to record patient identifiers when undertaking ECGs. The re-audit has shown significant improvements in documentation thereby reducing risks of incorrect decision making based on ECG results that do not relate to the patient.
Large volume paracentesis Acute Medicine	Large-volume paracentesis (LVP) is a safe and effective clinical treatment used for removal of 4 - 6 litres or more ascetic fluid (build-up of fluid between two layers of the peritoneum) in a single session. This procedure reduces intra-abdominal pressure and relieves the associated breathing difficulties, abdominal pain, and early satiety resulting from ascites of different conditions such as cirrhosis of the liver, cardiac failure or malignancy. Following the first round of this audit a LVP proforma was introduced with prompts to review diuretics and advise on dietary salt restriction. They also found maintenance of the standard in regards to sectors such as consent taking, using aseptic technique, platelet transfusion in appropriate patient, use of albumin for volume expansion leading to improved patient care / outcome.
Extended VTE prophylaxis General Surgery	The General Surgical Team carried out a re-audit of patients who undergo major abdominal surgery due to malignant disease who should be prescribed extended VTE prophylaxis postoperatively for 28 days to reduce the risk of DVT, PE and re-admission. Changes implemented include the specification of extended VTE on the patients' postoperative plan. The patient list also now includes a reminder to check histopathology from perioperative sampling. The re-audit found that VTE compliance has improved dramatically with all patients with confirmed malignancy on histopathology now receiving

Actions taken following local audits 2018/2019	Trust Actions
	extended pharmacological VTE thus reducing the risk of patients developing DVT, PE and re-admission.
Audit of Annual Cervical Cytology Uptake by HIV Positive Women Who Attend MTW HIV Clinics Sexual Health	The last audit carried out by the Sexual Health team showed that 53% of the HIV +ve women attending their clinics have a history of having an abnormal smear test. All HIV +ve women are therefore encouraged to have had a smear test in the preceding 12 months prior to their appointment. Following the first round of the audit an “Action List” was added to the GP’s letters to highlight those patients who had declined to have the test at the GUM Clinic and would require a smear test in the primary care setting. At every follow-up appointment, cervical smears are now discussed and the dates of the last tests are documented in the dedicated screening table, if a patient is offered a smear and declines it, it is documented in their notes. 98% of patients have now had a smear test in the preceding 12 months or have it documented that the test was offered and they chose to decline.
Insertion of and ongoing care of nasogastric tubes ITU/HDU	Incorrect placement of nasogastric feeding tubes can result in serious complications including death and is consider a 'never event' in the NHS. Complications are largely due to either misplaced tubes entering the lungs or a failure to carry out standard levels of ongoing care. Changes actioned include an NG tube placement e-Learning course undertaken by staff to highlight best practice. Documentation on the ITU chart and the Nursing Care Plan continues to be used, as does changing the NG tube dressing and securing it every 24 hours and dating it daily. This re-audit has shown improvements in documenting care given to patients in the medical notes and recording the management of the NG tube when in situ in the bedside folders.
Pain assessment with diagnosis of dementia Chronic Pain	Dementia patients are at risk of misdiagnosis of medical conditions and the under treatment of pain leading to suffering if not appropriately assessed. The Pain Management Team introduced a standardised validated pain assessment tool for patients with dementia (Abbey Pain Scale) into the Maidstone and Tunbridge Wells NHS Trust and training for clinical support workers in assessment of pain. The re-audit has shown an improvement in the number of patients who now have their pain assessed with an appropriate pain assessment tool and who have a care plan for cognitive impairment in place. Following this audit the team will be introducing additional training sessions for clinical support workers which they feel will benefit patient care as staff will be more informed and hopefully feel more confident in assessing a patient’s pain.
Documentation of obstetric anaesthetic chart Anaesthetics	Following a litigation case which found poor documentation, a specific obstetric anaesthetic chart was developed and put into use on the labour ward at Tunbridge Wells Hospital. Since the introduction of the new chart, documentation has shown significant improvement and quality of information recorded is now better across all criteria measured. The chart has been designed to ask specifically whether the patient was comfortable throughout, and if not, whether additional analgesia or GA was offered.
Glaucoma Audit Ophthalmology	Chronic open angle glaucoma (COAG) is a common and potentially blinding condition. Once diagnosed people with COAG need lifelong monitoring so that any progression of visual damage can be detected. Controlling the condition to prevent or minimise further damage is crucial to maintaining a sighted lifetime. It is essential that patients are fully informed at all stages of their consultation (written or verbally) in order to keep them informed of their condition and the treatment required. Patients now receive an information leaflet at their first visit to

Actions taken following local audits 2018/2019	Trust Actions
	supplement verbal explanations about their condition and treatment therefore ensuring patients are better informed at all stages of their care.
Ward Round documentation audit - Urology	Good documentation is important for safe and effective patient care and is also a medical-legal requirement. Ward round documentation forms an essential part of the continuity of patient care and in the communication between colleagues. A specialty specific proforma has been developed for the use on urology wards to act as a prompt and incorporate all the required elements of ward rounds and handover. Results showed an overall improvement with the documentation particularly with the recording of clinical data which will improve communication between colleagues about the care provided and the decision making process. Accurate and full documentation of clinical care and results of investigations will improve the safe and effective delivery of patient care.
An Observational Re-Audit; Skin Preparation for Trauma Cases Orthopaedics	Preparation of skin intra-operatively is a key measure to reducing incidence of surgical site infection (SSI), removing debris and minimising microorganism translocation into the wound. This re-audit highlights the improvements made in skin preparation with regards to pre-cleaning of skin reducing the risk of SSI. This was due to extra swabs being available on the prepared scrub trays and a copy of the guidelines being placed on the wall in the trauma theatre.
Re-audit of Are we following the Emergency Care Pathway for Urology patients? Urology	Following the original audit it was recommended to have a Consultant of the Week system and emergency urology pathway to ensure the decision making process and timings of decisions are accurately recorded and that patients receive a consultant review within 24 hours of admission. As a result of the new consultant of the week system there has been a significant improvement in the proportion of patients receiving a consultant review within the recommended 24 hours of admission. Delay in receiving a consultant review has the potential to affect patient care and delay discharges. Further actions planned include the introduction of an afternoon ward round to capture the day's admission and the cancellation of other commitments for the Consultant of the Week to further increase the number of patients that receive a consultant review.
Re-Audit : Elective inpatient treatment on Lord North Ward Haematology	During the initial round of the audit, the Service Improvement Team identified increasing length of stays for haematology patients. An audit of the inpatient treatment regimens was undertaken. Actions were implemented to ensure ward clerks retrieve notes and the last two clinic letters prior to admission and to move regimens of five days or less outside Lord North Ward to outpatient settings. Where practical, all patients are now being discharged home between treatments. All patients now have a recorded reason for admission to hospital due to clinical need, or for a regime that has not been determined to be safe for the day case setting. Ensuring an appropriate patient pathway is in place reduces length of stay for patients.

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 2018/19 there have been a total of **1581** NICE guidance documents disseminated to the specialty leads throughout the Trust since guidance began to be published in 2005. Of those, **1462 (93%)** have been evaluated. **479 (33%)** 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.

Guidance published from 1 April 2018 to 31 March 2019.

Guidance Type	Published	Evaluated	Relevant
Clinical Guidelines (CG/NG)	**29**	**20**	**13**
Interventional Procedures (IPG)	**33**	**26**	**2**
Technology Appraisals (TA)	**50**	**28**	**17**
Others (DG, HST, MIB, MTG)	**16**	**9**	**4**
Totals	**128**	**83**	**36**

Please see Appendix C for full details of Trust compliance with guidance that has been audited and completed during 2017/18.

RESEARCH

Research Performance

Maidstone and Tunbridge Wells NHS Trust (MTW) have recruited 3,023 people to research projects during 2018/19 that were approved by the research ethics committee, against an annual plan of 1372. This achievement meant more local people than ever before chose to participate in a trial either for their own or the greater benefit. Thanks to the Trusts participation in the national 'Meningitis Be on the Team – Teenagers Against Meningitis' study, over 1,000 young people between the ages of 16 and 19 directly benefitted from research last year.

Research Staff at Invicta Grammar School, Maidstone for the Meningitis- Be on the Team Study

The number of studies opened at MTW continued to rise during the period with the trust being in the top three trusts in the Kent, Surrey and Sussex region for number of studies open. At the end of the financial year the trust had 93 active studies and still maintains a balanced portfolio of studies on offer to patients including interventional, commercial, large scale and observational. Notable studies delivered and completed in 2018/19 include the National 100,000 Genomes Study which is run in collaboration with Guys and St Thomas Hospital, the Trust's first skin cancer study looking at treatments for stage 3 unresectable and metastatic melanoma, opened by Dr O'Hanlon-Brown, and the world's first study into Meningitis B in teenagers, in collaboration with the University of Oxford.

2018/19 also saw the expansion of studies into new treatment areas, most notably in intensive care and anaesthetic services across both hospital sites, an increase in neurological studies including studies into Parkinson's disease and Multiple Sclerosis and within sexual health services, in particular studies of HIV.

How quickly can we open studies to offer to patients?

All NHS trusts are monitored on the time it takes to set up and deliver commercial and non-commercial trials to ensure that we remain attractive to industry as a place to conduct research. The National Institute for Health Research (NIHR) national target is 80% of all studies to be delivered within the agreed recruitment time frame (agreed with the sponsor and usually 40 days) and to recruit the agreed number of participants. At the beginning of the year MTW's year-end predicted compliance was 36% of studies meeting the time to

target metric, falling far short of the national target. However, through work led by the Trust Lead Research Nurse in collaboration with the local research network, the end of year compliance was nearer 50%. The Trust continues to work hard to address the barriers to get study opportunities to patients as quickly as possible.

Developing our own research studies at MTW

A number of Trust staff have successfully developed their own research projects throughout the year and these are in various stages of delivery. Most notable are studies into how acupuncture could shorten labour and increasing the involvement of radiology staff in detecting cancer in the lymph nodes of women with breast cancer. Both studies, led by clinical research leads at the Trust, plan to be delivered in 2019/20 with the aspiration of bringing direct improvements to the delivery of care to patients.

Research Staffing

The research department has recruited a number of new staff this year including a Research Costing and Contracts Officer. The post holder provides oversight of all research invoicing, contracting and costing processes and is already having an impact on securing income and receiving research income in a timely manner into the department which enables the Trust to deliver more research for patients.

Research Practitioners- Banher Sandhu, Rutendo Nyagumbo, Maureen Williams, Bethany Jones.

The delivery section of the Research and Development Department has also welcomed a number of Research Practitioners to their team. This role reflects the changing and diverse studies adopted by the Trust which requires a flexible workforce. Many trials that do not involve a medicinal product do not require a qualified research nurse to lead the trial. This change has allowed staff to work more flexibly across specialties on a wide range of studies.

A growing number of Trust clinical staff have joined the Research and Development team in a job share and/or part-time capacity to increase delivery capability and to give staff experience of being research active whilst maintaining their substantive role. The initiative which has been running since April 2018 is now gaining in popularity. The Research and Development Department now employ staff from critical care, midwifery, physiotherapy and ophthalmology nursing staff who work alongside the substantive research team.

All research staff are now in research uniform including the oncology research nurses, physiotherapists, radiologists and practitioners. The uniform allows both staff and patients/visitors to recognise research staff and strengthens the professional identity of

research staff. This is of particular importance when delivering research studies in the local community.

Delivery of the Research and Development Strategy 2018-2021

During the past 12 months delivery of the MTW Trust Research and Development five year strategy has been fast-paced with a number of key objectives developed and delivered in-year.

Key areas of improvement have included:-

- Opening more trials that widen recruitment potential to include the local community
- Functioning as a single research team across the organisation, promoting research as a strong, dynamic, efficient professional team
- Encouraging open dialogue within and across research teams to share knowledge and expertise and create a research communication culture
- Ensuring trust staff and the public have access to performance data on the Trust website and increasing staff access to research information
- Use of a Research Patient Questionnaire which is used to report patient feedback to our research teams on a quarterly basis.

The focus for 2019/20 will be:-

- To maintain areas of improvement and to build on the work already undertaken to include research as a core business in job planning and developing collaborative posts with the new Kent and Medway Medical School
- Improve income potential
- Continue engagement with academic institutions to encourage students to gain experience of working in research

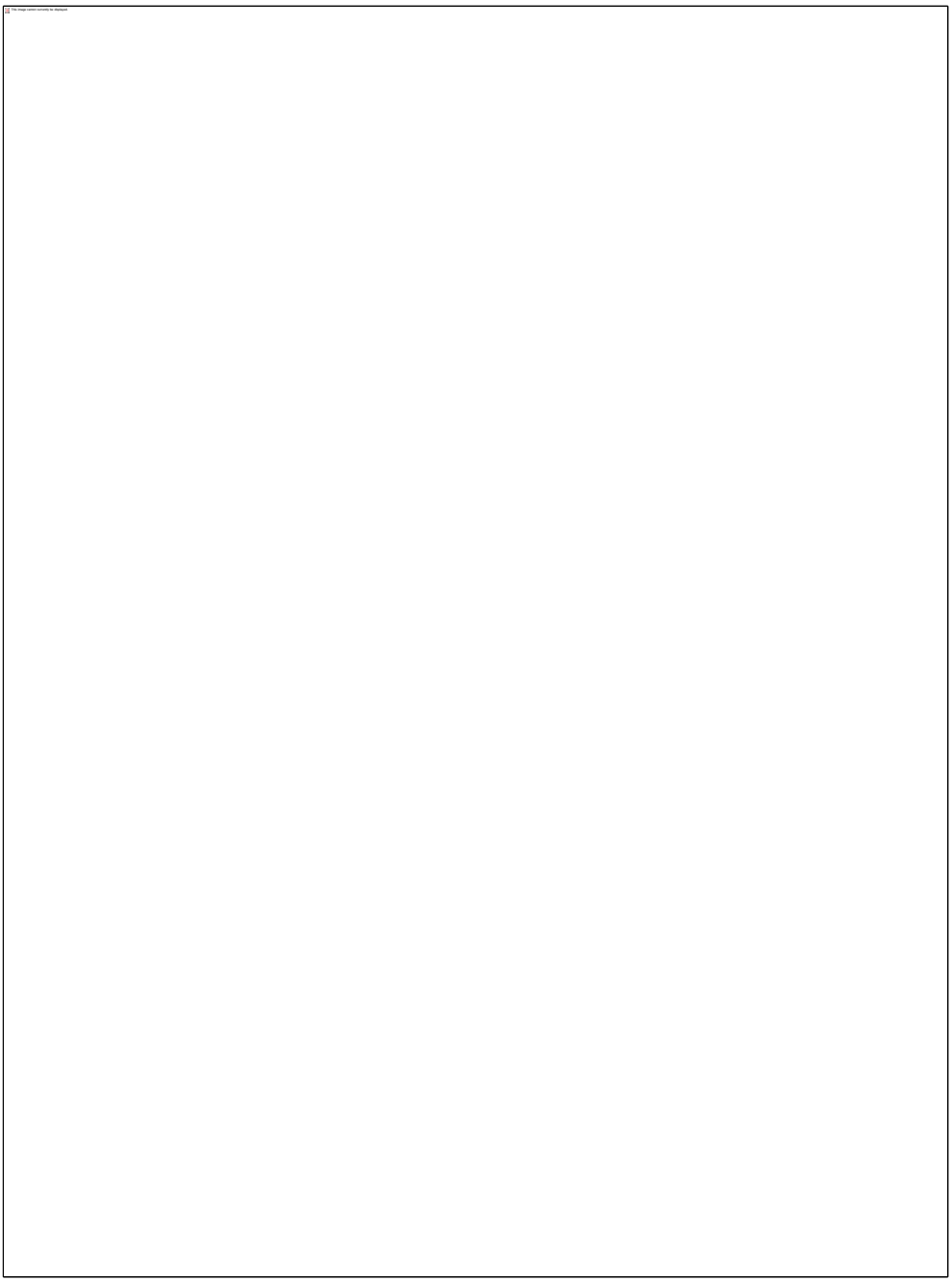
Other Research Achievements 2018-2019

Maidstone and Tunbridge Wells NHS Trust hosted a Shoulder and Elbow symposium on Friday 22nd March at the Academic Centre Maidstone, organised by the Research Extended Scope Practitioner, Jayanti Rai. This event was an opportunity for orthopaedic staff to network and share research ideas and was well attended. As a result of the symposium, a number of collaborations are in place to increase research in trauma and orthopaedics in the coming year.

Speakers at the Shoulder and Elbow symposium, organised by Research and Development

We are also extremely fortunate at MTW to have a very active Research Volunteers Group made up of Research Ambassadors.

This year they hosted a research event at the Academic Centre on the Maidstone hospital site in January 2019 to promote research to members of the public. Research patients spoke about their experiences of being on a trial and what it meant to them. Many members of the audience were researchers who found the patient stories very moving.



The Research and Development team attended the Trust Careers Fair in March 2019 to raise the profile of a career in research to secondary school students. Research staff have also visited local schools to talk about a career in the NHS and research.

MTW have also hosted the Renal, Benign Urological and Uro-gynaecological Disease Research meeting in early March 2019. The event allowed key research-active clinicians to share their work and network and develop ways in which to increase research activity across the region.

The Trust Lead Research Nurse was asked to talk at the Medway Community Healthcare Research Day in March 2019 to share her experiences of setting up a commercial research study in a primary care setting. She has also been asked to join the panel of judges at the 2018/19 Nursing Times Awards.

National recognition of Maidstone and Tunbridge Wells NHS Trust Research.

The ophthalmology study 'Star' was featured in the local press during March 2019 with one of their patients giving her personal account of how the study had helped her to keep her sight by receiving radiotherapy treatment. She also explained that the treatment was more beneficial as the conventional treatment regime included eye injections which she had found to be very uncomfortable.

The critical care research team at Tunbridge Wells Hospital at Pembury were recently congratulated on being the second highest recruiter in the country for the Poetics 2 study. This study seeks to develop a prognostic score for specifically very elderly, critically ill patients (defined as patients over 80 years). Age-specific information about the elderly patient such as frailty, cognitive function, activity of daily life and co-morbidity, in addition to organ failure score is gathered.

The trauma and orthopaedic research team at Tunbridge Wells hospital were commended for being the highest recruiting site to the Proximal Fracture of the Humerus study out of 22 sites taking part across the country.

The Research and Development Department were congratulated by the University of Oxford for successfully recruiting over 1000 local students to the MenB meningitis study during 2018/19 and have successfully vaccinated over 250 students against Meningitis B so far.

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 2018/19 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 providers (West Kent CCG and CCGs in Sussex and East Surrey) therefore no financial penalties ultimately apply. All other commissioning contracts are subject to the standard CQUIN process and payment is based on % achievement. This does not detract from the main intention or purpose of CQUIN's which are to improve the quality of care provided to our patients, as such delivery of these remains a high priority for the Trust.

Within the commissioning payment framework for 2018/19 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	0%	Red
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 28th February	78.1%	Green
Timely identification of sepsis in emergency departments; percentage of eligible patients screened for sepsis.	90% for each Quarter	Q1=100% Q2=97% Q3=95.5% Q4=93.8%	Green
Timely treatment for sepsis in emergency departments.	90% for each Quarter	Q1=90% Q2=90%	Green

CQUINs	Target	Achieved (local data)	RAG Rating
		Q3=91.3% Q4=92.3%	
Timely identification of sepsis in acute inpatient settings; percentage of eligible patients screened for sepsis.	90% for each Quarter	Q1=89% * Q2=90.6% Q3=90.1% Q4=91.4%	Green*
Timely treatment for sepsis in acute inpatient settings.	90% for each Quarter	Q1=85% Q2=100% Q3=92.3% Q4=100%	Green*
Assessment of clinical antibiotic review between 24-72hrs of patient with sepsis who are still inpatients at 72hrs.	Q1=25% Q2=50% Q3=75% Q4=90%	Q1=46% Q2=53.3% Q3=80% Q4=90%	Green
Reduction in antibiotic consumption per 1000 admissions 1) Total antibiotic usage 2) Total usage of carbapenem 3) Total usage of piperacillin-tazobactam.	Reduction of 2% against baseline 1. Failed 2. Achieved 3. Achieved	66.6%	Amber
Improving services for people with mental health needs who present to A&E in selected cohort group. The number of attendances for 17/18 cohort remains at 20% or less than the baseline level in 2016/17 20% reduction in the 2018/19 among the new cohort of frequent attenders from the baseline level in 2017/18	20% reduction in A&E attendances for those in cohorts 1 & 2	Cohort 1= 46% 2017/18 45% 2018/19 Cohort 2= 51% 2018/19	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 Advice & Guidance achieves a turnaround time of two working days against a target of 80%	84% 85.7%	Green
Risky Behaviours focuses on identifying and, where required, providing advice and offering referral to specialist services for inpatients who require support with reducing or cessation of smoking and alcohol consumption.	Collaborative working with KCHFT ('OneYou'- smoking cessation services) and CGL (Care Grow Live- alcohol cessation services), trajectory of improvement in regard to numbers of referrals made by MTW during 2018/19.	Achieved	Green
NHS England Specialist CQUINs			
Optimising Palliative Chemotherapy Decision	Review of practice, improvement plan	92.3%	

CQUINs	Target	Achieved (local data)	RAG Rating
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.	developed and review of audit against plan.		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	83%	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). Reviewing and switching of applicable existing patients to appropriate regimen treatments in line with NHS England agreed policy/ consensus guidelines, e.g. HIV, MS, (except if standard treatment course is < 6 months).	Trigger 1 Trigger 2 Trigger 3 Trigger 4 Trigger 5	Achieved Achieved Partial Achieved Achieved 91.5%	Amber
Two year Outcomes for very preterm infants	Q2 Trigger: 60% Q4 Trigger: 75%	Q2 69% Q4 76%	Green

*Sepsis screen achieved for inpatients as CQUIN reliant on combined figures with ED, combined figures >90%

Commentary

In this section we highlight some of the CQUIN improvements and developments in 2018/19, including what we have achieved and what has challenged us.

National CQUINs:

Achieving the Sepsis CQUIN has once again been challenging, at the end of 2017/18 we declared a serious incident following the death of a young man who we failed to screen for sepsis and to therefore appropriately treat. Following this we then failed to achieve the first quarter for the screening and treatment within one hour for inpatients (89% and 85% respectively against the target of 90%).

Key messages were shared across MTW by our clinical leads who have remained committed to raising awareness and improving the standard of care for our patients. The Sepsis Committee and the Sepsis leads and champions have continued to drive this hugely important agenda throughout the year. Some of this year's initiatives include:-

- The lessons learned from the serious incident used to create simulation training scenario
- Revision of the A&E sepsis screening tool and its incorporation into the casualty assessment card for use during triage
- Following a safety alert the trust changed its track and trigger system from PAR (Patient at Risk) to NEWS2 (National Early Warning score) in December 2018
- The Observation chart & Nervecentre (IT system for recording observations) have been updated and are now aligned to the Resuscitation council (UK) ABCDE.

A further element of this CQUIN was a 2% reduction in antibiotic usage, of which three milestones were set. The reduction of Carbapenem, Tazocin and the overall use of antibiotics. We achieved the reduction in both Carbapenem and Tazocin but unfortunately in reducing these we conversely increased our overall use of antibiotics to provide a broader spectrum cover. This was particularly noticeable in the overall usage in Quarters 3 and 4, mainly as a result of an increase in the presentation of patients with respiratory conditions.

Our Chief Executive leading by example

During 2018/19 we were delighted to have achieved 78.1% of our frontline staff immunised for flu, and to be recognised by NHS England as the fifth best acute trust in the South (Kent, Surrey & Sussex). Our Occupational Health team were proactive in the recruitment of a number of immunisers who worked across the organisation and competitively worked to be the immuniser who administered the greatest number of flu jabs. In addition, they worked collaboratively 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.

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), Kent Community Health Foundation Trust (KCHFT) and Care Grow Live (CGL).

For the CQUIN 'Improving services for people with mental health needs who present to A&E' we have been able to build on last year's experiences and together with KMPT and SECAmb a further cohort of patients were selected who would benefit from the joined up approach to their care needs in working with both KMPT and SECAmb. 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 45% for cohort 1 and 51% for cohort 2 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 collaboratively with KCHFT and CGL in regard to the delivery of the Risky Behaviours CQUIN. The delivery of this CQUIN has been disadvantaged by the introduction of our new Patient Administration system and as such was delayed; despite the increase in referrals achieved we unfortunately have not realised the numbers initially anticipated. During the course of the year we have been working with our IT Sunrise leads in the development of assessment pathways for smoking and alcohol. It is our intention to introduce this at the point of admission for all patients during 2019/20 instead of reliance on referral for those who overtly require these services.

NHS England CQUINs

Optimising Palliative Chemotherapy decision making has necessitated the need to create an additional field in our Kent Oncology Management system (KOMS). This new field has encouraged 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; however, during the course of 2018/19 we have ensured that our nursing staff record the additional field which has supported our ability to provide the required evidence.

During 2018/19 MTW has been committed to the application of the Clinical Utilisation Review (CUR) and has succeeded in using the information that it produces to support the Best Flow workstream. MTW have developed their own interactive CUR reporting tool which updates hourly, as reviews are completed. The tool has a number of filter options and is accessible to matrons, GM's, service leads and operational staff. The tool can highlight delays including '**Red Days'** by speciality, ward and/or by estimated day of discharge (EDD).

Red to **Green** is a simple initiative that helps turn patients' '**red days**' into value-adding '**green days**' which help to facilitate a safe discharge from hospital. A **red day** is when a patient does not receive an intervention to

		Red or green day		
		Green	Red	Total
Specialty	Haemotology	12	1	13
	Medicine	206	114	320
	Surgery	54	0	54
	T&O	25	31	56
	Total	297	146	443

support their pathway of care. For example, a planned diagnostic is not undertaken.

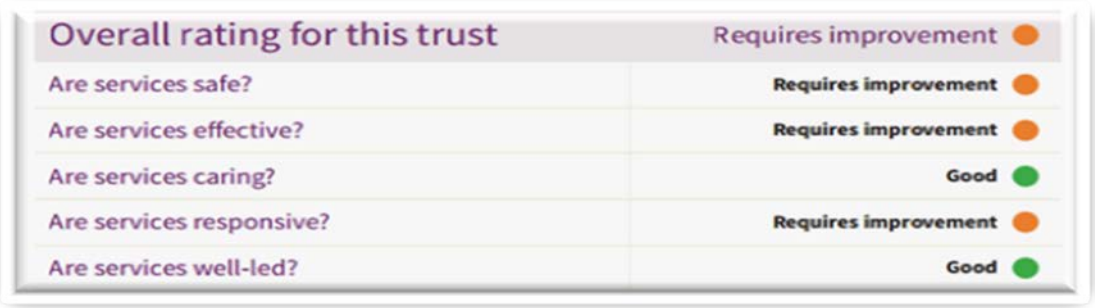
The ‘non-qualified’ rate has reduced 22% over the financial year and was reported as 24.6% in Quarter 4, coinciding with the success of our new Hospital @ Home service, Acute Frailty Unit, expanding Ambulatory Emergency Care pathways and introduction of ward flow coordinators.

In addition a repeat audit of our diagnostics project, as published in the CUR Transformation directory has shown the average inpatient wait for an echocardiogram has now reduced by one working day all of which help to ensure that patients receive timely treatment with limited delays.

The Medicines Optimisation CQUIN was split into three triggers, moving appropriate patients onto Biologics, recording data on Pharmex and moving appropriate patients onto the homecare method of dispensing. The benefit of the latter objective is realised through the vat savings that are derived from this method of delivery. The Trust is actively planning to develop an outsourced pharmacy model, which would derive the same savings as the homecare model, but has the added benefit of a much wider application. To maximise the benefit of this the pharmacy department decided not to move our patients to the homecare model in favour of including them in the outsource model, when its implemented. We therefore did not meet the required milestone within the CQUIN which we reasoned was the right thing to do for our patients.

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 although we have been rated as 'Requires Improvement', 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 received 17 specific recommendations from the CQC and work has been underway to ensure these actions are completed. Our Quality Improvement Committee, which is chaired by the Chief Nurse and reports to the Best Quality workstream, has been pivotal in overseeing timely delivery. These have included:-

- Ensuring that our staff keep up to date with their mandatory training – a new IT learning database has subsequently been introduced.
- Ensuring that we respond promptly to patient complaints, compliance has now been reached in Quarter 4.
- Minimising the amount of time our patients are kept nil by mouth for surgery – new policy and process have been approved.
- A proactive recruitment process to ensure staff vacancies are filled – Recruitment and retention strategy group is operational.

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 progressed with implementation of the Data Quality Strategy during the year, continuing to focus on data quality as a priority across the organisation. A number of governance groups are now in place to ensure our vision set out within the strategy is delivered. Our 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 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):

- 99.60% (99.0% 17/18) for Admitted Patient Care;
- 99.8% (99.4% 17/18) for Outpatient Care; and
- 98.1% (96.0% 17/18) for Accident and Emergency Care.

Which included the patient's valid General Medical Practice code was:-

- 100% (100% 17/18) for Admitted Patient Care;
- 99.9% (99.7% 17/18) for Outpatient Care; and
- 100% (100% 17/18) for Accident and Emergency Care.

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

Data Security and Protection Toolkit

The Data Security and Protection Toolkit is a performance tool produced by the NHS Digital (formerly the Health and Social Care Information Centre) which sets out the National Data Guardian's (NDG) data security standards. The Toolkit is a self-assessment and is completed by providing evidence and judging whether the assertions are met and demonstrates that the Trust is working towards or meeting the NDG standards. The Trust submitted a Standards Met Toolkit providing evidence against 100 mandatory evidence items and confirming 40 out of 40 assertions.

In addition to completing the Toolkit 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 Senior Information Risk 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 2018/19 a Clinical Coding audit and process review was undertaken by Maxwell Stanley Ltd on behalf of MTW which was released in January 2019. 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%	**98.00% Level 3**
Secondary Diagnosis	>=80%	>=90%	**96.28% Level 3**
Primary Procedures	>=90%	>=95%	**100.0% Level 3**
Secondary Procedures	>=80%	>=90%	**99.57% Level 3**

The report made three recommendations for further improvements and these will be actioned during 2019/20. These include:-

- Liaison with the Endoscopy departments to raise awareness of the need to use the drop down co-morbidities function on their report
- Additional training provided to coders to further appreciate and understand endoscopy procedures
- Additional training provided to coders in regard to national standards relating to ultrasound gynaecological procedures and workshops procured for oncology, T&O, ENT and respiratory
- Standard of data entry regularly reviewed with corrective action taken and feedback relayed to the relevant department as required. Quick reference guides and training provided to raise standards

Part Three

Results and Achievements for the 2018/19 improvement initiatives

Patient Safety

Aim/Goal

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

Action	Update
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.	

	Q1	Q2	Q3	Q4
Number of Incidents Reported	*646*	*↑709*	*↓668*	*↑684*
Number of Incident investigations completed	*687*	*↑700*	*↑769*	*↓595*
Number of Incidents closed	*502*	*↑616*	*↑829*	*↓582*

Duty of Candour (Incidents and Serious Incidents) Apr-Mar 2019				
Overall	**Moderate**	**Serious**	**Catastrophic**	**Total**
Acute Med and Geriatrics	*47*	*19*	*6*	*72*
Children's Services	*9*	*0*	*2*	*11*
Clinical Haematology	*0*	*0*	*0*	*0*
Corp Services	*1*	*0*	*0*	*1*
Emergency Medicine	*12*	*12*	*6*	*30*
External Agencies	*1*	*0*	*0*	*1*
Facilities	*1*	*0*	*0*	*1*
General Surgery	*17*	*5*	*3*	*25*
Head and Neck	*1*	*1*	*0*	*2*
Imaging	*5*	*1*	*0*	*6*
Medical Specialties	*40*	*9*	*6*	*55*
Oncology	*6*	*2*	*0*	*8*
Orthopaedics	*10*	*3*	*2*	*15*
Pathology	*2*	*0*	*0*	*2*
Pharmacy	*0*	*0*	*0*	*0*
Planned Care	*1*	*2*	*1*	*4*
Sexual Health	*0*	*0*	*0*	*0*
Theatres and Critical Care	*6*	*2*	*0*	*8*
Therapies	*1*	*0*	*0*	*1*
Urology, Gynae-oncology, Breast and Vascular Surgery	*1*	*2*	*0*	*3*

Women's Services	*16*	*2*	*1*	*19*
	177	*60*	*27*	*264*

	Q1	Q2	Q3	Q4
Crude Mortality	0.9%	1.0%	0.9%	1.1%
SHMI	1.044	1.022	1.028	1.039
HSMR	103.9	105.7	102.8	100.9

- *Business Case approved to employ Interim Datix administrator to upgrade and revise incident reporting system*
- *Purchase of additional mortality and performance modules and upgrade to Datix IQ approved*
- *Revision of agenda's for clinical governance meetings to promote 'lessons learned' agenda*
- *Investment in RCA training – five modules*
- *Dates for incident training and Duty of Candour training published*
- *Schwarz rounds due to commence April 2019*

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.

- *One Serious Incident declared in Quarter 4 and zero declared in Quarters 1, 2 & 3 as a result of a delayed diagnosis of Sepsis.*

Compliance of 90% Standard (Q's 1-4):-

- *Screening for Sepsis ED- 100%, 97%, 95.5% & 93.8%*
- *Screening for Sepsis Inpatients- 89%, 90.6%, 90.1% & 91.4%*
- *Treatment for Sepsis ED- 90%, 90%, 91.3% & 92.3%*
- *Treatment for Sepsis Inpatient- 85%, 100%, 92.3% & 100%*

Full compliance with the standard for screening and treatment was met during Q's 2, 3 & 4 although we narrowly missed this for inpatients during Q1.

Raising the profile of Sepsis remains high on the Trust Agenda with the :-

- *'Let's all talk sepsis' Study day 11th September, 2018*
- *Sepsis Introduction and rollout of NEWS2 - the new patient at risk score to support early identification of the key triggers for sepsis. This has included bespoke training sessions for our clinical staff.*
- *Sepsis scenario used in Simulation training.*

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

Metric	Q1 Avg.	Q2 Avg.	Q3 Avg.	Q4 Avg.
Unanticipated admissions to NNU >37 wks	11	14	15	14
Number of Stillbirths >24wks	0.7	1	0.3	1.3
Number of 3rd/4th degree tears	7	11	12	11
Unexpected number of Postnatal Readmissions	6.7	7	10	6.7

KPI's-

MTW are also working with the NHS Improvement Maternal & Neonatal Safety Collaborative (MatNeo) whose aims are to provide "support for front line staff to create the conditions for continuous improvement, a safety culture and a national

3rd and 4th degree tears. • Reducing the number of unexpected readmissions to the post-natal unit.	*maternal and neonatal learning system".* *Through this work a project have been identified and is moving forward:-* • *Reducing smoking in pregnancy (specifically increasing the number of women who stop smoking between booking and delivery)* • *In addition to this we are increasing the administration of Magnesium Sulphate to women in whom we anticipate imminent premature birth. MgSO4 has been shown to improve neurological outcomes in premature babies and is part of the PreCePT initiative that is supported by the safety collaborative. Compliance in Q4 achieved 100%* • *We are also continuing to drive the ATAIN work forward in an attempt to reduce the amount of term admissions into the neonatal unit.*

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
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.	• *Patient engagement and experience continues as a high priority work stream monitored within the Best Quality programme board. The first draft of the engagement strategy (having been shared with the engagement network and external partners including Healthwatch Kent) has received positive feedback and comments which are being incorporated into the strategy.* • *Launch and delivery of the strategy is currently being mapped into a series of key requirements over a 3 year timeframe. Following a gap in support there is now a new Project Management lead and the business case has also been approved to recruit a new role that will lead on Patient Engagement / Experience and implement the strategy and further embed patient engagement and experience across the organisation.*
Continued work with external partners such as Healthwatch, NHSI, CQC and West Kent CCG to help inform the board of areas for concern including the Internal Assurance inspection programme.	• *MTW continue to engage regularly with external partners and receive feedback to help improve patient pathways. Recent work has included A+E and audiology site visits by Healthwatch, and Healthwatch representation at the Patient Public and engagement events. Healthwatch also attended the December 2018 Trust Board following the previous review against the Accessible Information Standard (AIS).* • *Four successful CQC engagement days have*

	taken place with core service presentations given by staff members in Maternity, Outpatient services, End of Life care, Complaints, Safeguarding leads, Oncology, Radiology, and Pathology services. All were well received and the days were supported by both Executive and Non-Executive Directors. • *Work with the CCG continues through the quality review group and the internal assurance programme. This has been collaboratively scheduled to agree key areas of focus with members of the CCG Quality team integral to the inspection team. The inspection schedule has been agreed for 2019 which remains on track and the updated SOP has been shared with the CCG for review.* • *NHS Improvement leads have also undertaken service reviews including Cancer services, Serious Incident Review Panel and participation in Never Events working group.*
To recognise and respond to the specific needs of our patients with complex needs including- • Continue with existing dementia strategy action plan; with a particular focus on engagement with and support for carers (formal and informal). • Developing strategies to improve engagement with people with Learning disability.	• *A new monthly Dementia Hub has been launched by the Alzheimer's Society in Sevenoaks to support people with dementia and their carers both formally and informally. The Lead Nurse for Dementia Care represents MTW at this hub, and provides advice and support as well as gaining feedback on experiences and new concepts – in Quarter 4 the medilock box was taken to gain feedback from the perspective of the patient with dementia and their carers and fed back to the Patients and their own medications work stream of Best Quality.* • *Work continues in collaboration with the Aligned Incentive Contract (West Kent Alliance) and the Best Quality Work Stream as well as Dementia Strategy Group.* *The Learning Disability Liaison Nurse (LDLN) has:-* • *Co-ordinated an event for World Down Syndrome Day in March 2019, this was celebrated across the Trust.* • *In the past year facilitated learning disability training for 353 staff including; clinical, non-clinical and volunteers, some have completed the half day course, others have completed the 15 minute "key points" training.* • *Developed a Venepuncture pathway for people with learning disabilities which has been approved by Emergency Department staff at Consultant and Matron Level. The LDLN aims to have this pathway implemented during 2019-20* • *Continued to flag patients via our Patients administrative system to ensure our clinicians are aware of their LD diagnosis, we now have 260 people on this system.* • *Supported patients with a LD to attend the trust to access their health care including supporting individualised meetings for people with learning*

	disabilities such as safeguarding panel meetings and case conferences, best interest meetings and discharge planning meetings. • *Continues to work with the Accessible Information Committee to review patient information and has developed a sub-group for service users with LD.*

Clinical Effectiveness

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.

<table>
<tr><th>Action</th><th>Update</th></tr>
<tr><td>Sustaining our previous work to avoid unnecessary admissions to hospital through the development of alternative care models/pathways.</td><td>• Increase of 0 LOS pathways (i.e. patients do not stay overnight). While this technically creates an admission to hospital, there is no overnight stay.
• Development of streaming criteria directly to AEC to improve management of patients in a timely manner.
• Development of direct GP admissions and direct Secamb conveyance to the appropriate unit within the hospital, i.e. Ambulatory Emergency care (AEC) or Frailty Unit.
• Creation of further ambulatory pathways to further increase 0 length of stay.
• Regular links with Secamb to ensure that only appropriate patients are transferred to A&E
• Working with external partners (eg KCHFT) to support patients/ GPs to allow patients to remain in their usual place of residence
• Roll out of CPMS (Care Plan Management System) at MTW to give greater patient information on patient's care in the community.
• Development of offsite ambulatory clinics in conjunction with KCHFT.
• Approval of additional hours for GP's within ED.</td></tr>
<tr><td>Working with our mental health partners to reduce the number of frequent attendances of patients in crisis attending our emergency departments.</td><td>• Following last year's success in reducing the number of attendances for a cohort of 25 patients by 43%, a further 25 patients have been selected.
• The Multidisciplinary and professional team that includes Secamb and KMPT are currently reviewing the plans of care for these patients to ensure that a consistent and cohesive approach is applied by all providers to support their ongoing care needs.
• WKCCG 'Frequent Attenders' funded post has now been increased to support two members of staff due to the impact this has had on patient experience.
<table>
<tr><th>Cohort</th><th>Previous Years Total No of Attendances</th><th>Q1 No of Attend-ances</th><th>Q2 No of Attend-ances</th><th>Q3 No of Attend-ances</th><th>Q4 No of Attend-ances</th></tr>
<tr><td>2017/18</td><td>705 (Av 176 per Quarter)</td><td>↓86</td><td>↓106</td><td>↑119</td><td>↓74</td></tr>
</table>
</td></tr>
</table>

	<table><tr><td>2018/19</td><td>698 (Av 175 per Quarter)</td><td>↓109</td><td>↓120</td><td>↓65</td><td>↓43</td></tr></table> • *Overall achievement for Cohort 1 has been a sustained reduction from 17/18 of 43% plus an additional 2.9% during 18/19.* • *Overall achievement for Cohort 2 has been a reduction of 51%*
Working in collaboration with our community and local authority colleagues to further develop pathways that will support the timely discharge of patients.	*Continue to work with our partners in regard to the timely discharge of our patients. Including :-* **Pathways 1,2,3** • *Seasonal variation of capacity - 25% increase in capacity for pathway 1 over winter period and expected Brexit period* • *Alternative pathways into community hospitals with the possibility of specialisation* • *Increase capacity for P3 beds in nursing homes, ongoing discussions with WKCCG in regard to medical cover to maintain improved utilisation* • *Development of pathway for patients recovering from a fractured neck of femur to transfer to Tonbridge Cottage for rehabilitation* **Rapid Response, Home treatment service** *Working with external partners to amalgamate a variety of services so that referrers have a single access portal and referrals are triaged efficiently the first time. New process is currently being piloted with therapy services* **Virtual ward/ Hospital at home** *Hospital at home has been implemented, high level of Intravenous antibiotic administration pathways being facilitated. 1 year funding to be agreed to fully evaluate outcomes and level of service required.* *Ongoing conversations continue with East Sussex CCG's re parity of access for all MTW patients.*

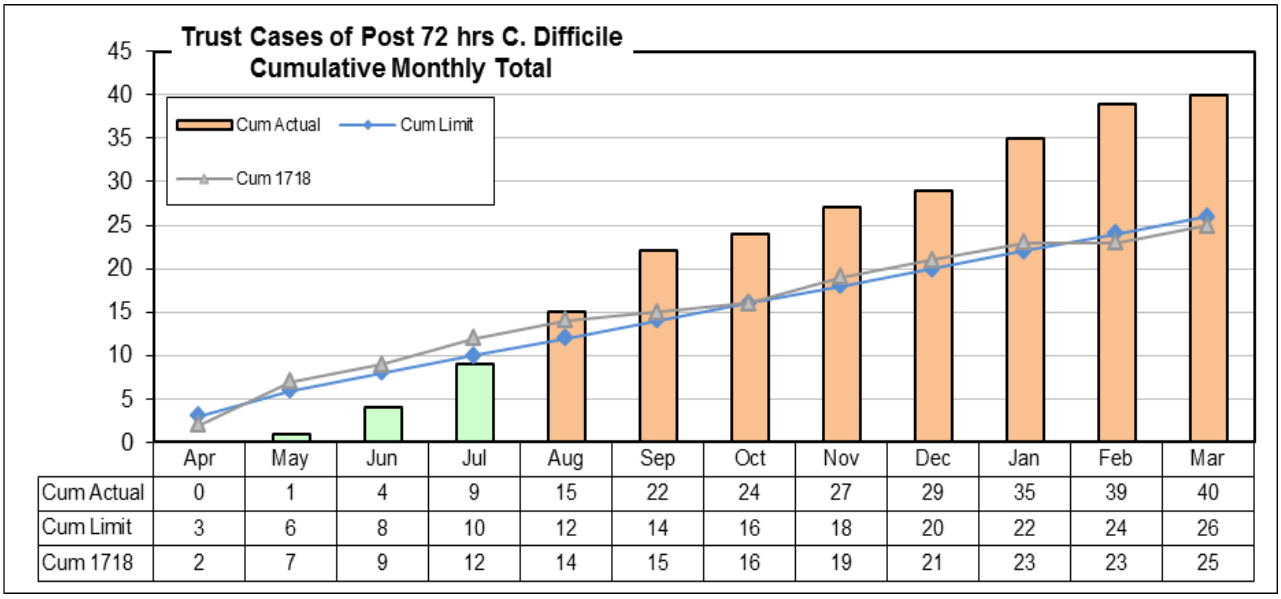
16 March 2019, via Twitter: shout out tonight for the team there for looking after T today. Kind, gentle and first rate, from the all stars in A&E to the A team in the Acute Medical Unit. And Shirley, of course.

18 February 2019, via Twitter: Very impressed by your Xray department today. Very efficient, running on time and kind to my elderly parents. Thank you.

11 March 2019, via Twitter: Just been to Maidstone Hospital, got seen, had blood test and left all before my appointment time.

Review of Quality Performance

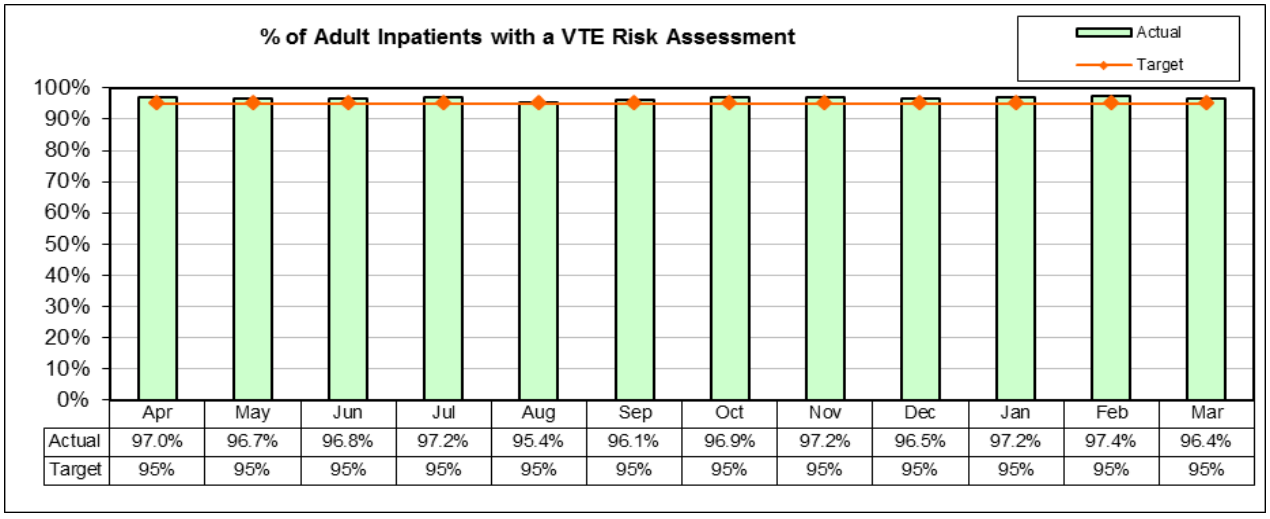
Infection Control – Clostridium Difficile cases – The Trust did not achieve this standard with 40 cases against a maximum of 26 cases for the year equating to a rate of 15.6 C-Difficile Case per 100,000 occupied bed days



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cum Actual	0	1	4	9	15	22	24	27	29	35	39	40
Cum Limit	3	6	8	10	12	14	16	18	20	22	24	26
Cum 1718	2	7	9	12	14	15	16	19	21	23	23	25

Infection Control – MRSA Bacteraemia cases – The Trust did not achieve this standard with 3 cases of post 48 hr MRSA bacteraemia through the year.

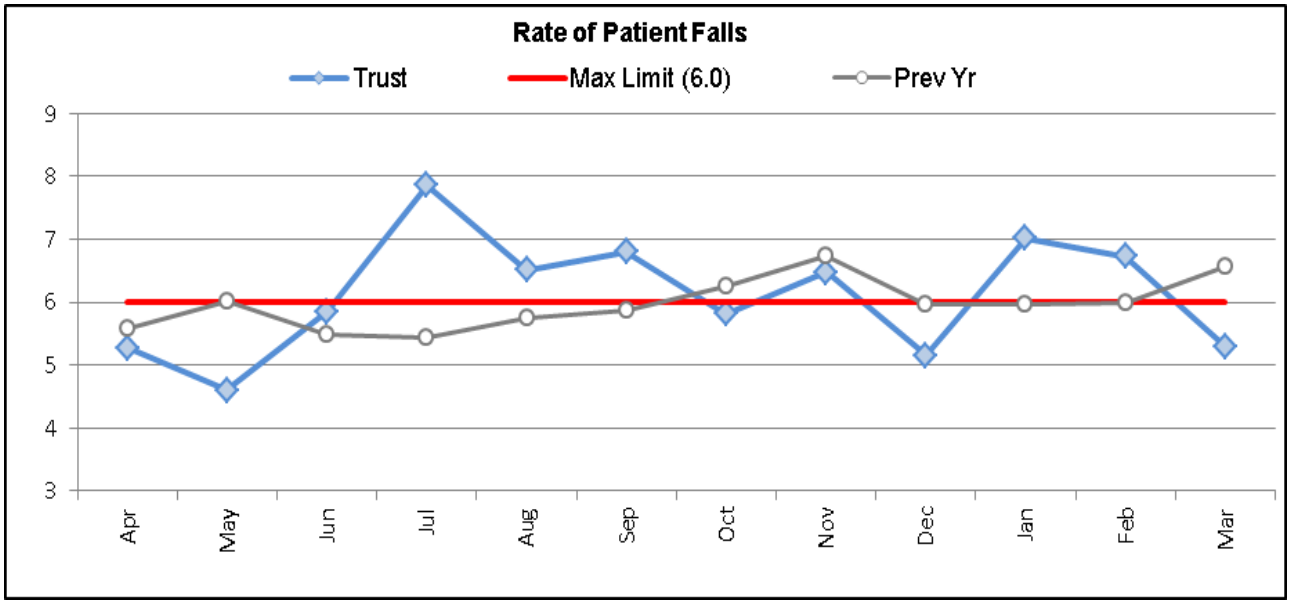
% Patients VTE Risk Assessment – The Trust ensured that 95% of patients were given a VTE Risk Assessment in 2018-19 at 96.7%.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	97.0%	96.7%	96.8%	97.2%	95.4%	96.1%	96.9%	97.2%	96.5%	97.2%	97.4%	96.4%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Reducing the number of patient falls

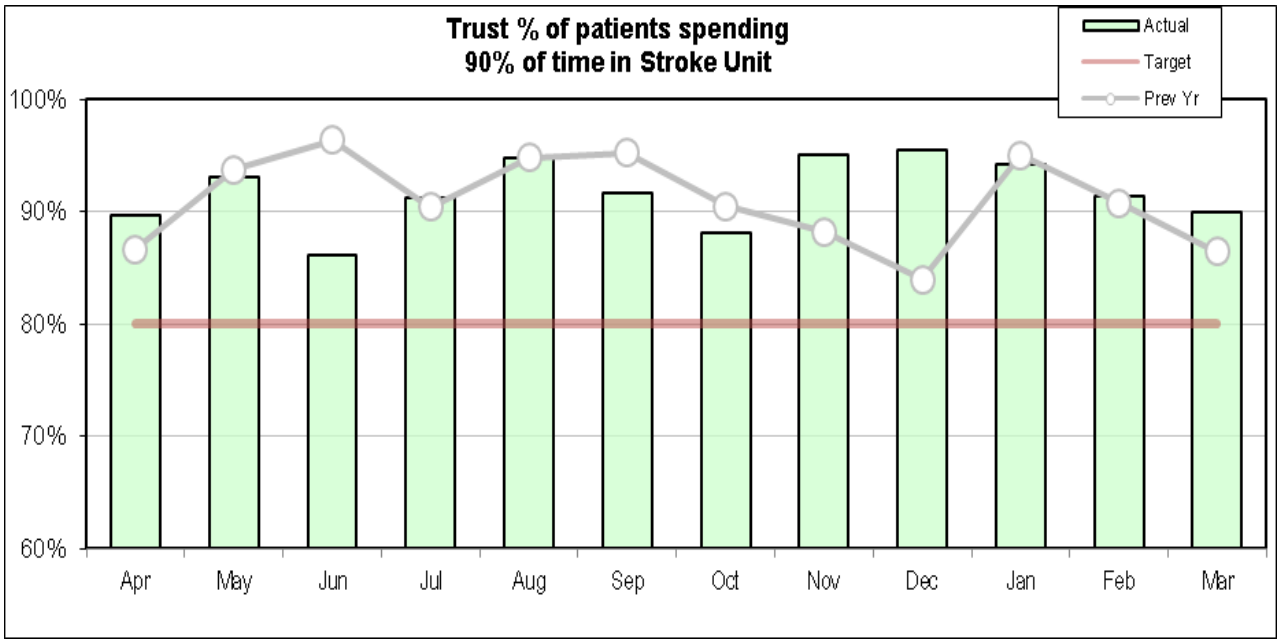
Rate of Falls – The Trusts' rate of Falls per 1,000 Occupied Bed days is slightly above the Trust maximum limit of 6.0 at 6.10 at year end (5.98 for the previous year).



CLINICAL EFFECTIVENESS

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

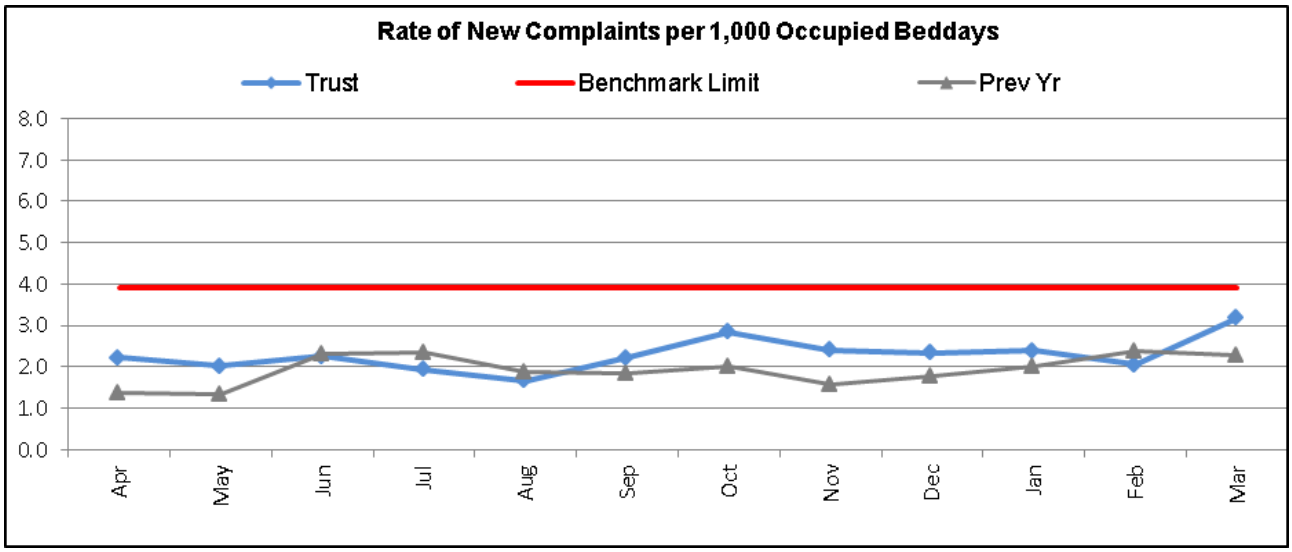
80% of patients spending 90% of time on the Stroke Unit - The Trust achieved this standard of 80% of stroke patients to spend 90% of their time on a dedicated stroke ward in 2018-19 at 91.67% compared to 91.08% in 2017-18.



PATIENT EXPERIENCE

Complaints management

Rate of New Complaints- The Trust's rate of New Complaints per 1,000 occupied bed days is within the expected range of between 1.318 and 3.92 at 2.30 for the year (1.93 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: *It is clear you have investigated thoroughly and we are satisfied that you have followed up our concerns and taken action to make sure the issues we identified will not happen to others. Thank you for confirming that our complaints were upheld and for the apologies within the response. My brother and I were gratified by the thoroughness and sincerity of the letter you sent and thank you for dealing with our concerns in such a professional and thoughtful way.*

Complainant

During 2018/19 we received 550 new complaints compared to 503 during 2017/18. The rate of complaints per 1,000 occupied bed-days was 2.30 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 60.8% of complaints within the agreed timescale against a target of 75%. Meeting our target has been challenging this year due to 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 following trials, we recognise that improvements can be made to our policy and procedure to further support the consistent achievement of our response target 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.

Patient Surveys

National Patient Surveys

During 2018/19 the Trust participated in five National Patient Surveys. Picker Europe led on four of these national surveys on behalf of the CQC. We have undertaken the following surveys in house:-

- Maternity Department Survey
- Adult Inpatient Survey
- Urgent and Emergency Care Survey
- Children and Young People Survey

The Maternity Department survey had its final data submission on the 31st August 2018. The results were published on the CQC website on 29th January 2019.

2018 Maternity Survey
Respondents & Response Rate
• **230** Maidstone and Tunbridge Wells NHS Trust maternity service users responded to the survey • The response rate for Maidstone and Tunbridge Wells NHS Trust was **48.83%**
Banding
MTW's results were better than most trusts for **8** questions.

MTW's results were worse than most trusts for **1** question. 1. C12. Did the staff treating and examining you introduce themselves? MTW's results were about the same as other trusts for **42** questions.
Comparisons with last year's survey
*MTW's results were significantly higher this year for **2** questions* B4. Were you offered any of the following choices about where to have your baby? B12. During your antenatal check-ups, did a midwife ask you how you were feeling emotionally?
*MTW's results were significantly lower this year for **5** questions* C12. Did the staff treating and examining you introduce themselves? C14. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you? C16. If you needed attention during labour and birth, were you able to get a member of staff to help you within a reasonable time? D5. If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you within a reasonable time? D6. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?
Actions
The action plan for the Maternity survey will be overseen by the Maternity Board

The Adult Inpatient Survey data was submitted to CQC/Pickers Europe in January 2019 and the results are due to be published in May/ June 2019.
The Urgent and Emergency Care Survey data was submitted to CQC/Pickers Europe on the 26th March 2019 and the results are due to be published in August 2019.
The Children and Young Persons Survey data collection is still ongoing. The CQC/Pickers Europe co-ordination centre are yet to release the excel spreadsheet needed to enter the data.

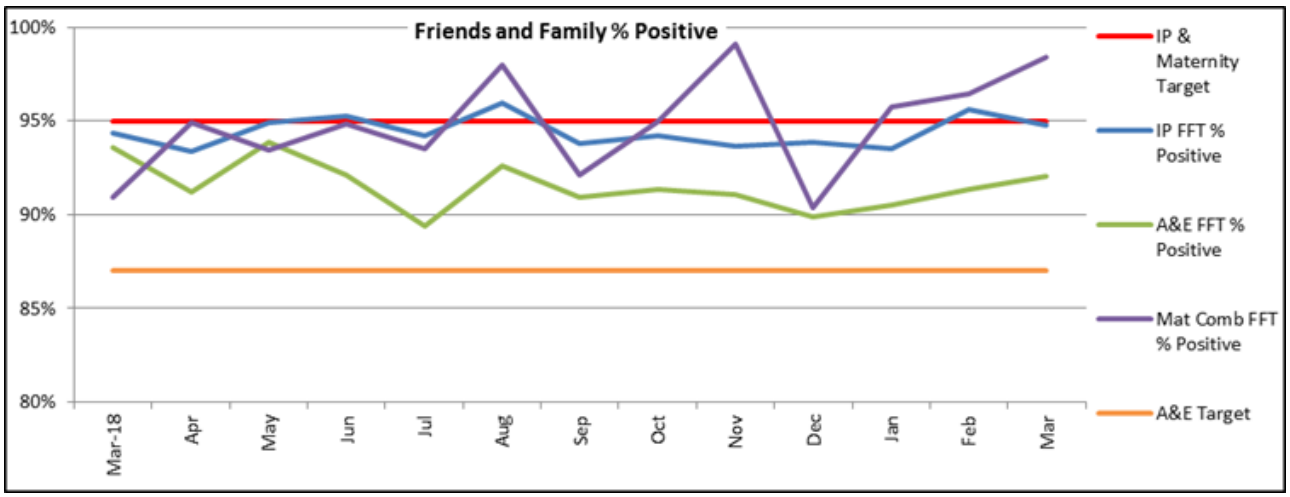
The Trust also participated in the National Cancer Patient Experience Survey and achieved a 68% response rate. This national survey is undertaken by Quality Health on behalf of NHS England. The data collection phase has recently closed and the results are yet to be published.

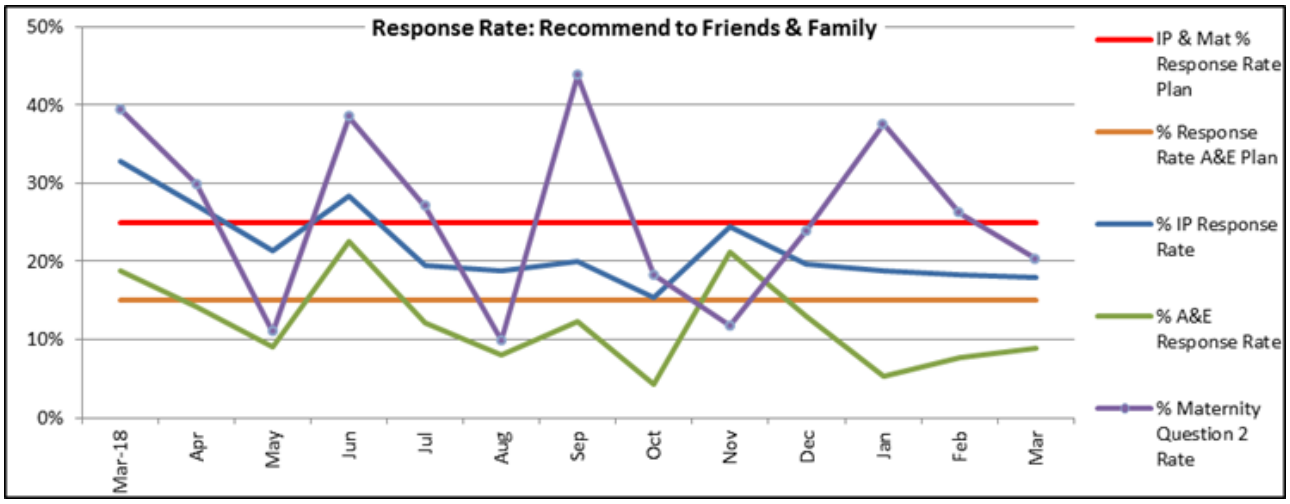
Friends and Family

The A&E positive response rate has continued to exceed the Trust plan achieving a 91.3% positive response against a plan of 87% and, exceeding the national benchmark of 85.5% indicating patients would recommend these services to their Friends and Family. Inpatient and Maternity positive responses at 94.4% and 94.9% respectively narrowly missed the Trust plan and subsequently fell short of the national benchmark of 95.8% and 95.6% correspondingly.

Response rates did not achieve the Trust Plan with Inpatients at 20.9% against a target of 25%, A&E 11.5% against a target of 15% and Maternity (Question 2) 24.5% narrowly missing the 25% target.

MTW Friends and Family scoring





Staff Survey 2018

This section outlines our most recent staff survey results for indicators Q13c (percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months), Q14 (percentage of staff believing that the Trust provides equal opportunities for career progression or promotion) and Q13b (percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months) for the Workforce Race Equality Standard.

Q13c Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

White: 26.9% (2017 findings - 25.7%) – National average for acute Trusts 26.4%
BME: 25.7% (2017 findings – 24.6%) – National average for acute Trusts 28.6%

Q14 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

White: 83.9% (2017 findings – 90.7%) – National average for acute Trusts 86.5%
BME: 67.0% (2017 findings – 77.8%) – National average for acute Trusts 72.3%

Q13bPercentage of staff experiencing discrimination at work from manager/team leader in the last 12 months

White: 6.8% (2017 findings - 8.0%) – National average for acute Trusts 6.6%
BME: 13.3% (2017 findings – 18.3%) – National average for acute Trusts 14.6%

NHS National Staff Survey Actions

The 2018 NHS National Staff Survey has seen a significant reduction in the number of BME staff experiencing harassment, bullying or abuse from managers/team leaders since 2017. However, there has been a slight increase in the percentage of BME staff experiencing this from colleagues since 2017 and a more significant increase in the number of BME staff believing that the Trust provides equal opportunities for career progression. The Corporate Action Plan from this survey will ensure that B&H training is offered to both staff and managers, that cases of B&H reported through Datix are followed up through the HR Business Partnering team and that communications demonstrating zero tolerance for B&H from staff, managers, patients and visitors will be highly visible throughout the Trust. The Trust promotes the role of the Freedom to Speak Up Guardian to all staff within the Trust.

Workforce Race Equality Standard (WRES)

The WRES data for 2018 was published in July, along with an action plan overseen by the Cultural Diversity Network. The plan focusses on validation of data around White and BME staff being shortlisted, appointed and within leaver data. B&H training is being designed and reviewed by all staff networks including Staff Side to ensure that it is fit for purpose along with supporting communications.

Cultural Diversity Network (CDN)

The Cultural Diversity Network hosted Black History Month in October 2018 – an event that heard from four inspirational black female speakers about how they have succeeded in their lives – Mrs Rantimi Ayodele, Consultant Paediatric T&O Surgeon at MTW, Mildred Johnson, Chief Pharmacist at MTW, Preeya Baillie, Chief Procurement Officer at NHSi (formerly of MTW) and Professor Jacqueline Dunkley-Bent, Head of Midwifery at NHS England.

The Cultural Diversity Network Chair was involved in a review of disciplinary cases which demonstrated that ethnic origin did not appear to be an influence in terms of the investigations and outcomes for each case. They were also involved in a joint review by staff network leads of Bullying & Harassment Cases where all investigations and

outcomes were felt to be appropriate. It was recognised that the Trust could do more in ensuring that staff know the correct channels for raising issues and concerns.

The CDN presented their annual action plan to the Trust Board for the first time and will report on progress on an annual basis.

Freedom to Speak Up (FTSU) Guardian

During 2018 MTW interviewed and appointed a new FTSU Guardian. The role is to ensure our patients are cared for in a safe way. Where staff have concerns that they feel are not being heard or feel they can't raise with management, our FTSU Guardian will listen to them in confidence, take on board their concerns and raise the issue through the appropriate channels. This might involve instructing an investigation and providing feedback to the staff member. The FTSU Guardian has the authority to escalate to the highest levels if he feels appropriate action hasn't been taken.

Contact can be made directly to the FTSU Guardian by phone or by confidential phone-line with answer machine, by email mtw-tr.freedom2speak@nhs.net; through the anonymous reporting incident reporting system, post boxes available in both staff restaurants or via a web page on the Trust intranet.

Implementing the Role - The key issues of developing robust recording keeping and a database has been addressed to ensure the valuable information provided by staff raising concerns is effectively captured for learning and improvement, as well as for governance and audit. A feedback form has been created to capture the experience of staff using the FTSU Guardian to enable continued learning, development of the role / process and support offered.
A new policy has been drafted along with FTSU Aims and Strategy. The FTSU self-review tool has been presented to the Workforce Committee and is subsequently being reviewed before submission to the Board.

Re-Writing the Policy (Freedom to speak up: raising concerns policy and procedure)
A new policy has been drafted to replace the “Speaking Out Safely (SOS) policy and procedure” which uses the National Guardian’s template as its basis to provide assurance that the Trust is following national best practice.

The new policy purposely avoids using the term “whistleblowing” as this is seen to have negative connotations and can in itself be a barrier to staff speaking up. The focus is very much on encouraging staff to talk about genuine “concerns” they have within the remit of the FTSU Guardian.

Freedom to Speak Up Ambassadors - The FTSU Guardian has also created the role of FTSU Ambassadors to support the FTSU agenda. To date we have recruited one Ambassador with more envisaged during early 2019/20 to further grow and support the service.

Rota Gaps

In August 2018 we identified six rota gaps at Foundation Year 2 level. The Medical Workforce team have adapted a pro-active approach in the early advertisement of these roles which takes place before receipt of the final confirmation from the Deanery and prior to the second round of recruitment. This is undertaken in collaboration with the Directorate leads to ensure that financial agreement has been confirmed to mitigate the risk of over-establishment, in the knowledge that this would be balanced out by the reduced use of agency doctors.

In addition we have a number of key initiatives supported by our Post-graduate Centres-

- WAST (Widening Access to Specialty Training) – national Health Education England scheme for overseas doctors to gain experience in the UK in order to better prepare them for application to their chosen specialty training programme. Whilst these doctors have limited or no understanding of the UK/NHS system, they are diligent and keen to learn, and have worked hard to fill their educational gaps. WAST doctors initially spend six months in Psychiatry before moving to the Acute Trust to work in Medicine. One WAST doctor will be joining the Trust in August and we have indicated that we can take additional doctors under this scheme.
- Fellow Posts with help undertaking Post-Graduate Certificate (PG Cert):
  Emergency Medicine have recruited Educational Fellows and are advertising for similar roles in Leadership and Management, Simulation and Trauma. Three Simulation Fellows were appointed in Anaesthetics with funding for PG Cert course fees and backfill of posts while attending University sessions at Canterbury Christ Church University. Similarly, one Education Fellow was appointed in Emergency Medicine with funding to support a PG Cert at Brighton and Sussex Medical School. These appointments have been going well. We have been informed that there will be no further funding for the Education Fellow, but it is hoped that funding from Canterbury Christ Church University will again be available.
- Chief Registrar Role in Medicine: 50% management
  Darzi Fellowship: - The Trust along with local NHS partners has been successfully shortlisted to be a Darzi Sponsor to drive forward “Interface Geriatrics” across West Kent. The Medical Director is the Clinical Sponsor. Unfortunately, on this occasion the Trust was not matched with a suitable candidate.
- Medical Training Initiative (MIT) - training Overseas Doctors in the NHS in a number of Departments including Anaesthetics, Paediatrics, O&G, Medicine etc.
- Physician Associate and Advanced Practitioner roles are also being recruited to provide multi-professional support to our services and rotas.

This approach is ongoing and will continue for the medical intake in August 2019, updates are provided on a quarterly basis to the Trust’s Workforce Committee.

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 154 SI's in 2018/2019 compared to 173 the previous year.

Of the 154 SI's, the completed investigations demonstrated 27 occasions where no significant learning for the Trust was required 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. These were subsequently downgraded bringing our total incidents reported down to 127 during 2018/19. This number has the potential to reduce further as we continue to investigate those that remain open.

Although there has been a decrease in the number of SI's being reported during 2018/19, this has been attributed to an increasing maturity and confidence in the reporting process in addition to increased clarity from the national agenda i.e. the Early Notification Scheme for Maternity and Learning from Deaths. In addition the Trust SI and incident investigatory processes have matured to an extent where both course of action equally provide a fair and transparent investigation that gives the patient and reporter the confidence that their concerns have been managed effectively. In addition the Trust has welcomed both West Kent Clinical Commissioning Group and NHS Improvement quality leads to the Trust's Learning and Improvement panels this year to gain feedback and assurance of our processes.

Actions and learning from SI's are key to improving patient care and ensuring patients are safe and provided with high quality care. In 2018/2019 learning and actions included:-

- Publication of training dates for all staff on the importance of incident reporting on our incident reporting database, Datix
- Publication of training dates for all staff on Duty of Candour (DOC) and the key requirements that must be undertaken following awareness that an incident has occurred
- Revision of the accident & emergency assessment (CAS) card to include an updated sepsis screening tool
- Reissue of the Standard Operating Procedure to all staff in contact with prescription pads, to familiarise themselves with the correct process/procedures in handling FP10's (prescriptions that can be dispensed by local pharmacists)
- Issue of new guidance for administrative staff on the process to follow for typing and sending out of clinic letters
- Update provided to ensure the process for receipt and storage of patient identifiable data is followed at all times

- Clear guidance on referral process for staff following violent and aggressive incidents to be included in the form of a flowchart to relevant policies with appropriate designation of staff duties
- Introduction of competencies that support extended roles for experienced clinical staff
- Mental capacity assessment to be undertaken before considering use of chemical restraint
- Raised awareness of the need to adhere to guidance and policy relating to blood transfusion and prohylaxsis to prevent blood clots, i.e. Haemoglobin checks
- Ensure complete and accurate documentation of risks and associated risks of the clinical procedure to ensure adequate and complete consent has been obtained
- To promote good practice to others on robust consenting and documentation
- Importance of clear and accurate record keeping regarding involvement of medical staff opinion, time, printed name, designation and signature

Never Events

There was 1 Never Event declared during 2018/2019, a full root cause analysis was undertaken and presented to the Executive Led Panel and findings shared with NHS Improvement to ensure wider learning.

This never event was identified in July 2018 – retained foreign object post procedure
Patient had undergone an instrumental delivery with suturing and subsequently developed a post-partum haemorrhage which was treated appropriately with patient being discharged home three days later.

Six weeks later the patient presented to the hospital having discovered a 'string' following vaginal examination. She had been feeling unwell and had received two courses of antibiotics from her General Practitioner.

Through the course of the investigation it is believed that this string was the 'red tag' used to bundle together 5 swabs in each theatre pack.

A number of factors contributed to this incident:-

- Failure to count the red tag as part of the swab and instrument count
- The red tag is believed to have inadvertently caught on a swab that was placed in the vagina during the management of the patient's haemorrhage post-delivery.

Actions taken include:-

- Revision of the guidance for swab counting to include red tags in Obstetrics
- Dissemination of learning throughout Obstetrics and Theatres

Duty of Candour

Since April 1st 2015 all registered providers are required to meet Regulation 20 of the Health and Social Care Act 2008 (regulated activities): 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

154 Serious Incidents were declared in 2018/19.

During 2018/19, we have demonstrated an improvement in compliance with the 3 elements of meeting Duty of Candour for patients involved in a Serious Incident (SI).

According to our current data 5.19% of patients involved in a SI did not receive an initial Duty of Candour letter in 2018/19 in comparison to 17.4% the previous year.

At the time of this report, 23% of the declared SI's remain open and under investigation. Of the 61% that were completed, 50.5% have been sent the final outcomes of the investigation. This is compared to 48.9% compliance during 2017/18 and demonstrates that communicating the outcome of the investigation to the relevant person increases compliance.

Of note

- SIs completed and linked to a complaint = 7.37%
- SIs where patient/next of kin/carer do not wish to receive the outcome of investigation = 21%

Incidents

Excluding Serious Incidents, 207 incidents were reported on the incident reporting system which also met the criteria for Duty of Candour. 8.7% of these had evidence that an initial Duty of Candour letter was sent to the patient / relevant person. Of these 8.7%, 38.9% 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.

Of note: (compliance currently recorded on Datix)

- Was the Duty of Candour process followed for this incident? = 70.5% (146)
- Is it documented in the medical notes? = 32.4% (67)

Actions for 2019/20 to achieve compliance

In addition to Root Cause Analysis training sessions arranged for 2019, the Trust is undertaking a training needs analysis of departmental managers to ensure their training needs are revising the training agenda accordingly.

A review of all documentation is to be undertaken by the Patient Safety team in regard to the standard of information being sent to our patients and carers to ensure that the necessary compliance is met. This 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 Interim Datix Administrator to look at the newly procured upgrade to the incident reporting system to ascertain whether it is able to act as a repository for the evidence for Duty of Candour and also to look at the possibility of flagging and escalating the incidents which meet the criteria and improve compliance.

A quarterly report will continue to be provided to help support improvement with monitoring and provide assurance to the Quality Committee.

Dates for Duty of Candour training have been circulated for 2019 and will be regularly evaluated to gain feedback from our staff whilst triangulating this with alternative opportunities for training and education.

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 and are:-

- Standard 1: Patient Experience
- **Standard 2: Time to Consultant Review**
- Standard 3: Multi-Disciplinary Team Review
- Standard 4: Shift Handover
- **Standard 5: Diagnostics**
- **Standard 6: Consultant Directed Interventions**
- Standard 7: Mental Health
- **Standard 8: On-going review in high dependency areas**
- Standard 9: Transfer to primary, community and social care
- Standard 10: Quality Improvement.

**Those highlighted in bold are the priority standards.*

Request:- Providers of acute services are asked to include a statement regarding progress in implementing the priority clinical standards for seven day hospital services. This progress should be assessed as guided by the Seven Day Hospital Services Board Assurance Framework published by NHS Improvement.

Response:- Significant progress has been made within the Trust's Seven Day Services (7DS) project since its inception in January 2017. Almost full compliance is being achieved against the 4 priority standards during the weekdays and weekends across the majority of the Surgical, Critical Care and Women's and Children's Directorates. A small compliance issue remains in respect of standard 2 in some of these services (ENT, Urology, General Surgery). This occurs during part of the weekend when these consultants are not currently routinely job planned to be resident (between mid - late afternoon on a Saturday and 08.00hrs on a Sunday), for which mitigating arrangements are in place until full compliance can be achieved to comply with the March 2020 national requirement. With respect to Acute and Geriatric Care and Specialist Medicine, full compliance has been achieved with standard 2, but there is a significant consultant workforce challenge in respect of standard 8 and thus, these services will be very unlikely to be in a position to achieve full compliance by March 2020. Acute and Geriatric Care and Specialist Medicine services are also in the process of implementing a 24/7 GI Bleed rota which will ensure full compliance with this element of standards 5 and 6. The remainder of the Trust are fully compliant for standards 5 and 6. The project now reports via the Best Care Programme (Best Safety Workstream).

Compliance Status

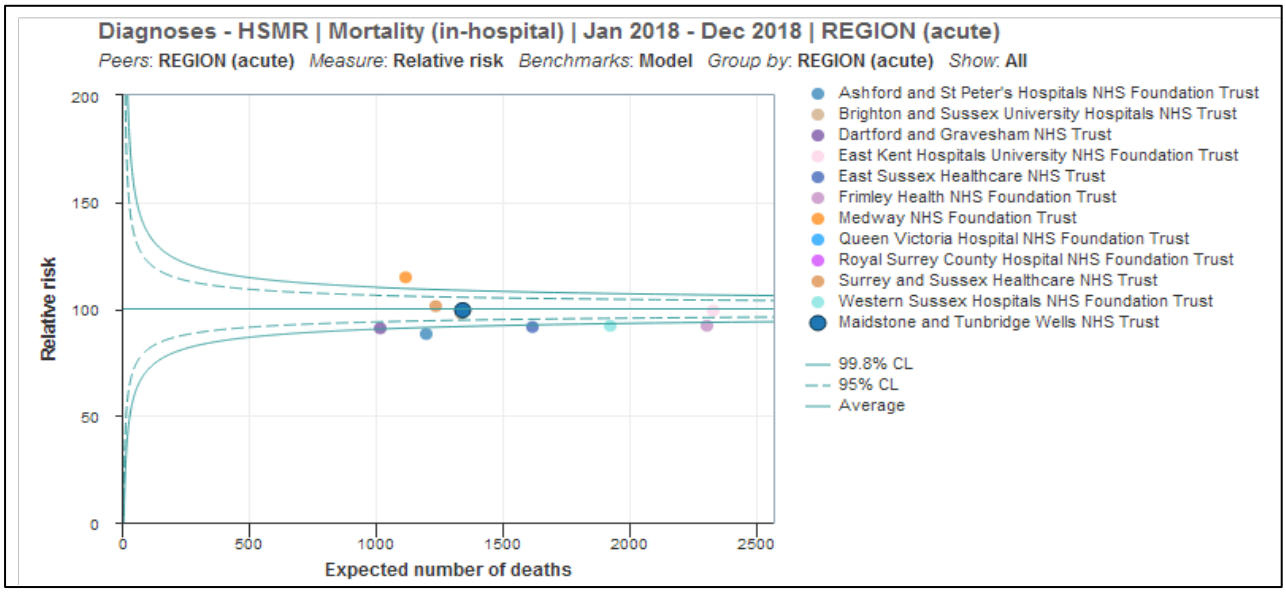
'Exempt' relates to services that do not have non-elective (NEL) patients under the direct care of the specialty consultant, but are under the primary care of another service (normally a physician due to co-morbidities).

Service	Std 2	Std 5	Std 6	Std 8	Comment/Actions in progress
Surgery	✓ (w/day) X (w/end)	✓	✓	✓	There is not a resident consultant on site on Saturdays and Sundays from 14.00hrs – 08.00hrs (consultants are on call from home). There are on average 8.5 non-elective admissions each day Saturday & Sunday which could be medically active. Service reconfiguration is the longer term solution. Mitigation in the meantime is the implementation of a virtual ward round between 18.00 and 20.00hrs on Saturday and Sunday, (went live on 21.1.19) and further exploration of potential for a face to face evening post-take ward round from existing consultant staff via changes to working patterns prior to reconfiguration.
Urology	✓ (w/day) X (w/end)	*N/A	✓	✓	The gap relates to a small number of NEL admissions (who could be potentially medically active) on Saturday and Sundays (a total of 1.2 – 1.4 patients per weekend, on average). A business case for a 6th Consultant has been submitted which will allow full implementation of the standards. Pathways are being finalised for all medically optimised patients. Mitigation for the NEL patients is the implementation of a virtual ward round during the evenings on Saturday and Sundays (requires confirmation of w/e shifts of all middle grades prior to implementation).
Women's Health	✓ (w/day) X (w/end)	✓	*N/A	✓	Principle for an exception pathway for a very small cohort of patients (<1 per weekend) has been informally agreed via the Challenge Event with NHSI/E/CCG in October 2018. – To sign off at Quarterly Review with NHSI/E/CCG on 14.3.19 – Please see appendix 3.
T&O	✓	*N/A	✓	✓/X	This service is technically compliant but the CD made decision to declare non-compliance for standard 8 until re-escalation processes have been assured for all patients who may become or revert back to a medically active status throughout their length of stay (LOS). A Standard Operating Procedure (SOP) has been drafted by the Clinical Director and this is being implemented. This includes piloting a new rota for 2 months from April which will release the Consultants time to be able to see all medically active patients as per SOP. The results of the implementation will be reviewed in May 2019.
ENT	X	*N/A	N/A	X	The NEL activity for this service has been identified and is on average 2.5 patients per day. Work is in progress with the Ear, Nose & Throat (ENT) Team to identify the medically active cohort who are under the direct care of an ENT surgeon and not under the care of a physician due to comorbidities. Once fully understood, a mixture of consultant-delivered assessment/review and pathway delivered care is required. Discussions are taking place with the ENT Team to increase the number of daily ward rounds from 3 days per week to daily and to implement a virtual ward round each evening as a mitigating measure in the interim.
Acute and Geriatric Care and Specialist Medicine	✓	X (Endos-copy)	X (Interve-ntional Endos-copy)	X	Non complaint for standards 5 & 6 until the 24/7 GI Bleed rota is implemented – plans in progress to implement this by the end of quarter 2 of 2019/20. There is a major compliance issue for standard 8 – the main contributory factor is consultant numbers. *(Please see appendix 2 for full detail).*
Paediatrics	✓	*N/A	✓	✓	Compliant
Critical Care	✓	*N/A	✓	✓	Compliant
Ophthal-mology	Exempt	*N/A	*N/A	Exempt	Exempt: All medically activity patients are under the care of a Physician.
Clinical Haemat-ology	✓	*N/A	*N/A	Exempt	Nature of casemix – patients are known to the service. Audit undertaken to demonstrate.
Emergency Medicine	Exempt	*N/A	✓	Exempt	Standards commence from point of admission

** Note: N/A means that the service is not responsible for providing that part of the standard and is thus compliant by default*

Learning from Deaths (Mortality Reviews)

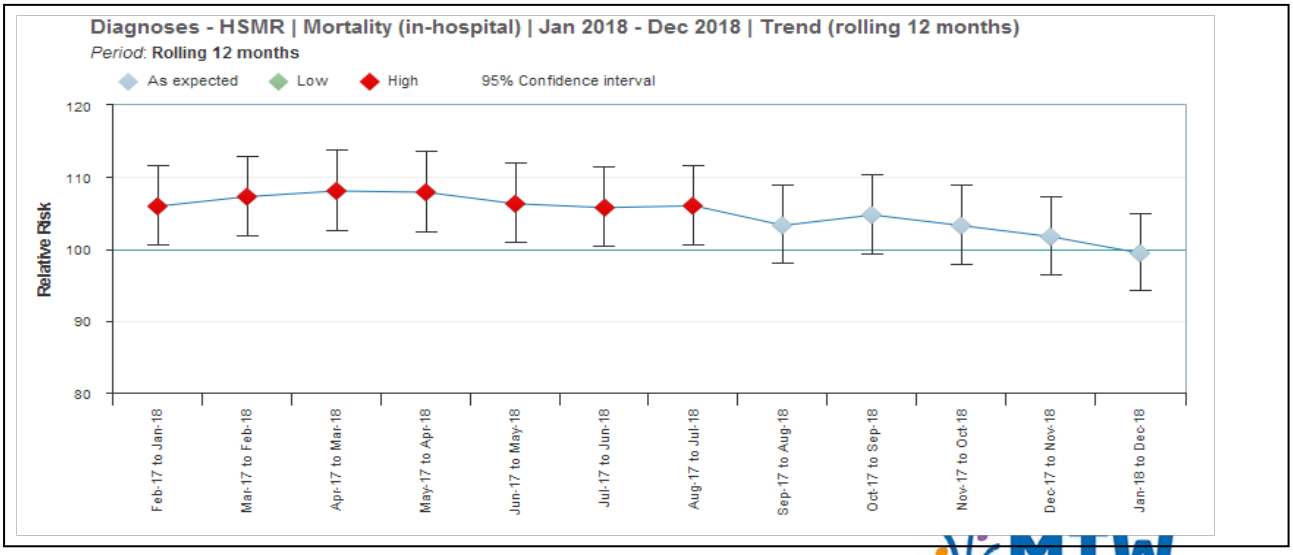
During 2018/19 MTW has progressively seen mortality rates reduce, to the extent that at year end MTW were no longer considered to be an outlier amongst their peers and compliance is at a sustained acceptable level.



The Trust Mortality Surveillance Group (MSG) has been operational since January 2016 and meets monthly to review all hospital related mortality data, identify trends and share learning. This group subsequently 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 Chief of Service for the Medicine & Emergency Care Division.

The MSG closely monitors both local and national data in an effort to identify themes and trends that may impact on our patients care. In particular we use the Hospital Standardised Mortality Rate (HSMR). This is a key indicator that benchmarks 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 2018 our HSMR was recorded as 105 (a ratio of the actual number of deaths to the expected number of deaths) and in March we reported 99.4, the expected rate is 100 or below.

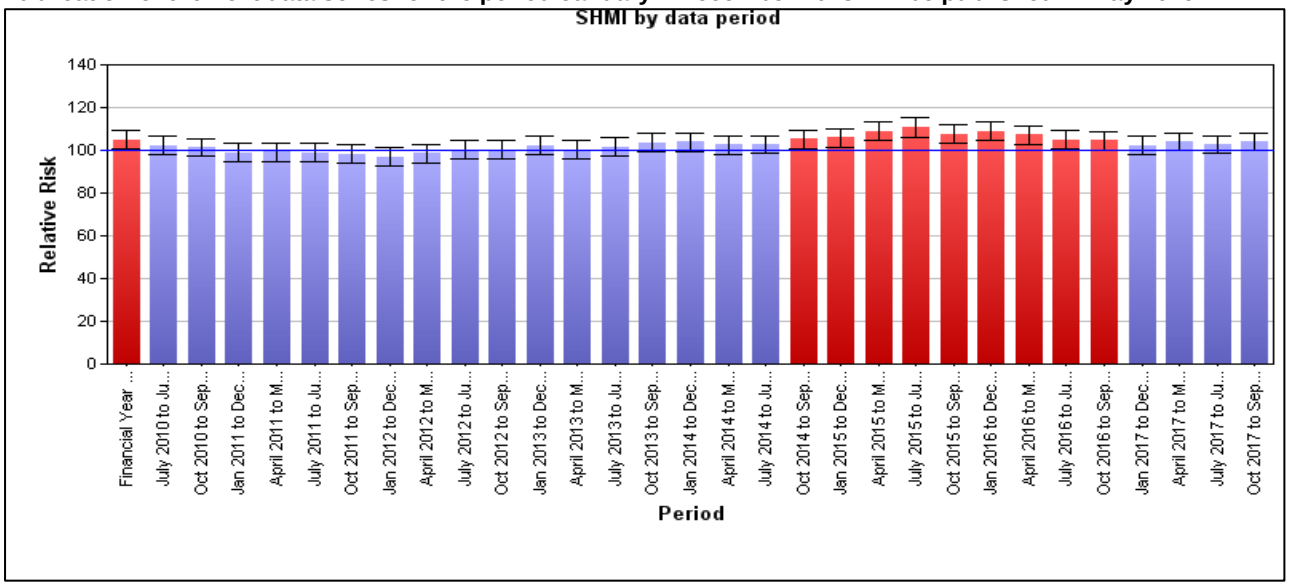
Rolling 12 Month view- data from January-December 2018.



Further evidence of improvement in Mortality at MTW is seen in the Standardised Hospital Mortality Indicator (SHMI), this is a measure of mortality and performance which includes all deaths in hospital regardless of diagnosis, in addition it includes all those individuals who die within 30 days of discharge from hospital.

SHMI published by the Health & Social Care Information Centre (HSCIC) for the period October 2017 – September 2018 shows MTW's SHMI as 1.0391 which is banded as level 2 'as expected' (1.0492 in March 2018).

Publication of the next data series for the period January – December 2018 will be published in May 2019.



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 when concerns are identified with the care provided these deaths are then allocated for a more in-depth review (structured judgement review).

During 2018/19 MTW recorded 1600 patients who had died. 1484 inpatient (Inpt) deaths and 116 in Accident & Emergency (A&E). The process for undertaking mortality reviews has been revised this year in an effort to make explicit all aspects of good practice and elements for learning. The current process has been recognised as being labour intensive with learning having to be manually extracted, however a business case had been approved to purchase the Mortality Module for Datix with the understanding that themes and trends could be automated and used to support the 'Lessons Learned' agenda.

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 Trust processes and procedures to make the necessary changes as a result of lessons learned.

Each Directorate has a nominated Mortality Lead with the key objective of ensuring that the Mortality review process is embedded locally and that deaths that have raised concern are fed-back to the MSG and vice versa that learning is shared from MSG to the Directorates.

Reporting Period April 2018 – March 2019

Trust	Q1	Q2	Q3	Q4	Total
No of Deaths	379	398	358	465	1600
No of Completed Reviews	338	340	301	375	1354
%age completed reviews	**89.2%**	**85.4%**	**84.1%**	**80.6%**	**84.6%**
SJRs Requested	30	22	15	23	90
SJRs Completed	17	11	7	6	41
%age SJRs requested of all deaths	7.9%	5.5%	4.2%	4.9%	5.6%

90 Structured Judgement Reviews representing 6% of the 1600 patient deaths that have occurred during 2018/19 where requested during this time frame. Of these 48% have been completed to date equating to 3% of all deaths having had an in-depth review undertaken of the care that they received. Reviews are undertaken for several reasons which include concerns with care provided, in addition the review process will also make this judgement. Of the 41 reviews undertaken the judgements in regard to care provided were:-

- Very poor care- 3
- Poor care- 4
- Adequate care - 11
- Good care - 20
- Excellent care - 3

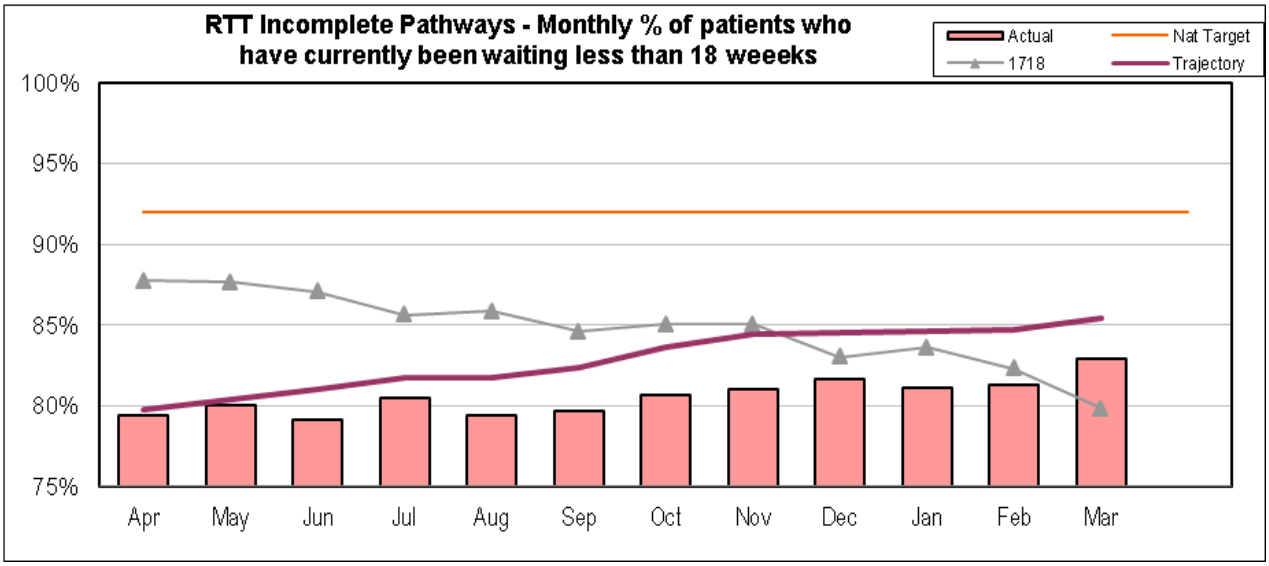
Learning identified from Mortality Reviews during 2018/19 includes the need for:-

- Improved communication with patient and/or family re decision making for Do not Attempt Cardiopulmonary Resuscitation (DNACPR)
- Improved documentation re decision making of ceiling of care and plan for palliation
- Prompt senior oversight of decision making re End of Life Care (EOLC), to include review of DNACPR form signed by Consultant lead
- Prompt referral to palliative care team when decision made for EOLC
- When discharging patient home for EOLC ensuring that the family know what to expect i.e. what death looks like and prompt review by Hospice palliative care team
- Consideration in regard to the appropriateness of clinical treatment i.e. scans, blood test and antibiotics for a patient at the end of their life
- Consideration of fluid and nutritional replacement when patient nil by mouth due to inadequate swallow, prompt referral to Speech & Language Team and Dietetics and consideration re feeding at risk.
- Patients clearly dying should, wherever possible, be fast-tracked to a side-room with clear communication with receiving ward so staff aware of imminent death.

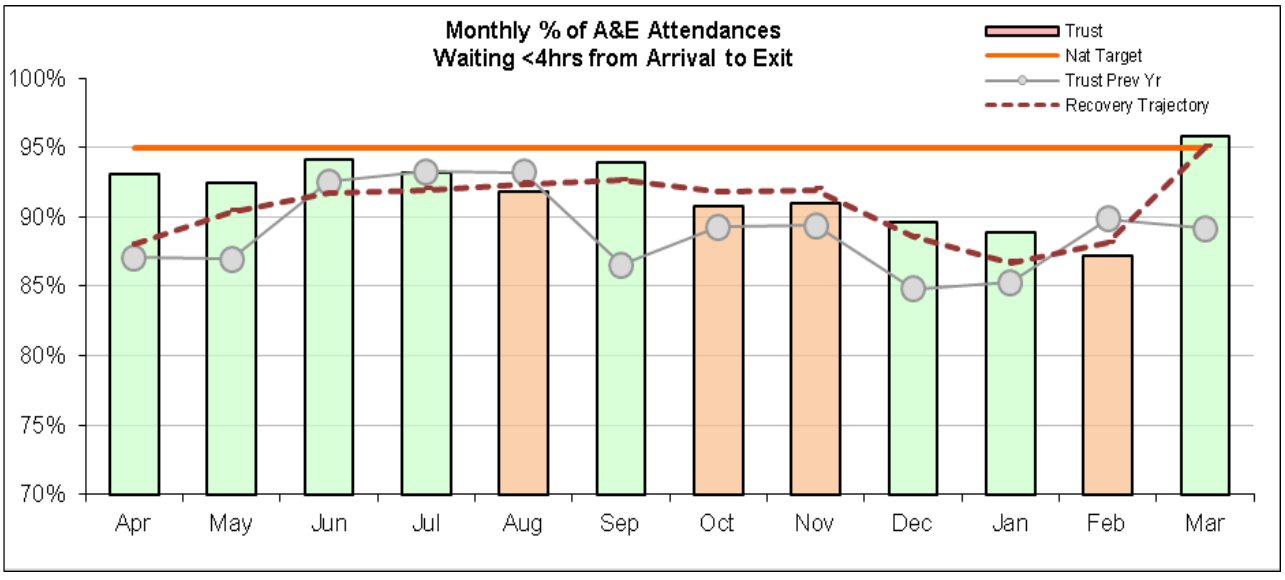
Other Quality Monitoring and Improvement Standard

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

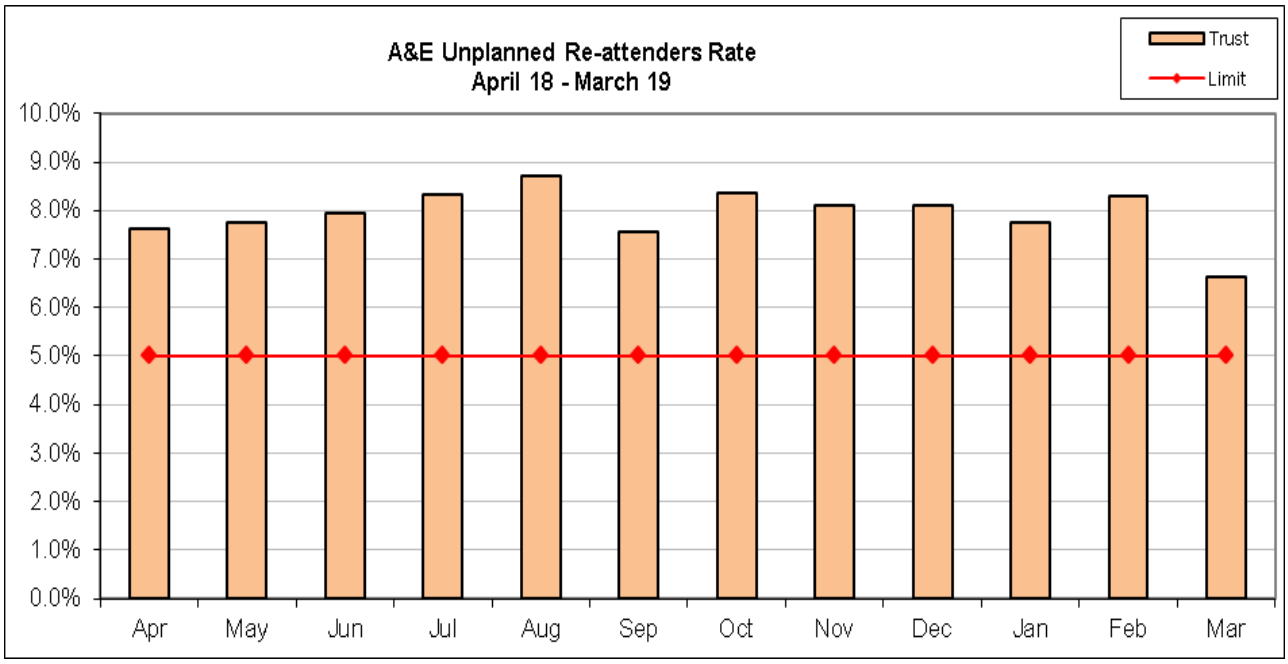
18 weeks standard – The Trust did not achieve this standard at an aggregate Trust level of at least 92% of patients on an Incomplete Pathway waiting less than 18 weeks.



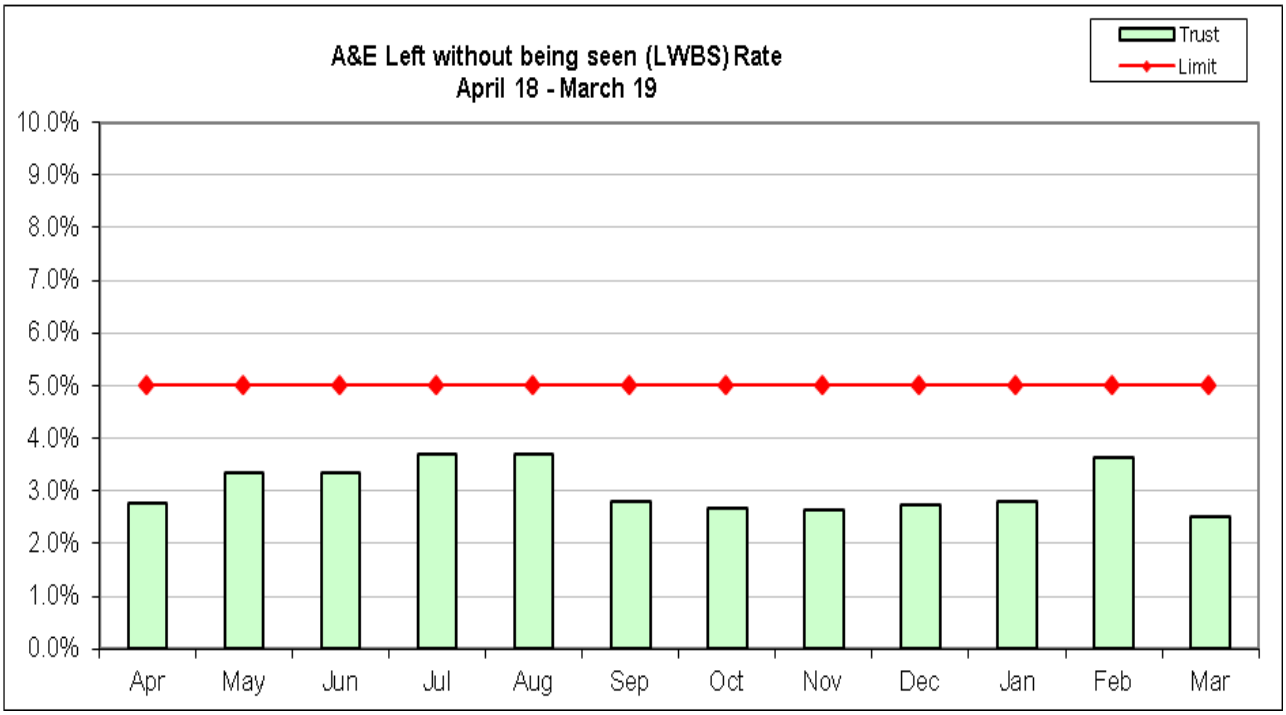
Emergency 4 hour access – The Trust did not achieve this standard of 95% of patients being seen, treated, admitted or discharged within 4 hours of arrival in its A&E departments in 2018-19. However, the Trust did achieve our Trust Recovery Trajectory for each of the quarters of the year (slightly under for Quarter 3) as well as achieving 95% compliance in March 2019. The Performance for the year of 91.9% is a 2.9% improvement on 2017-18 despite a 7.1% increase in Type 1 A&E Attendances compared to 2017-18.



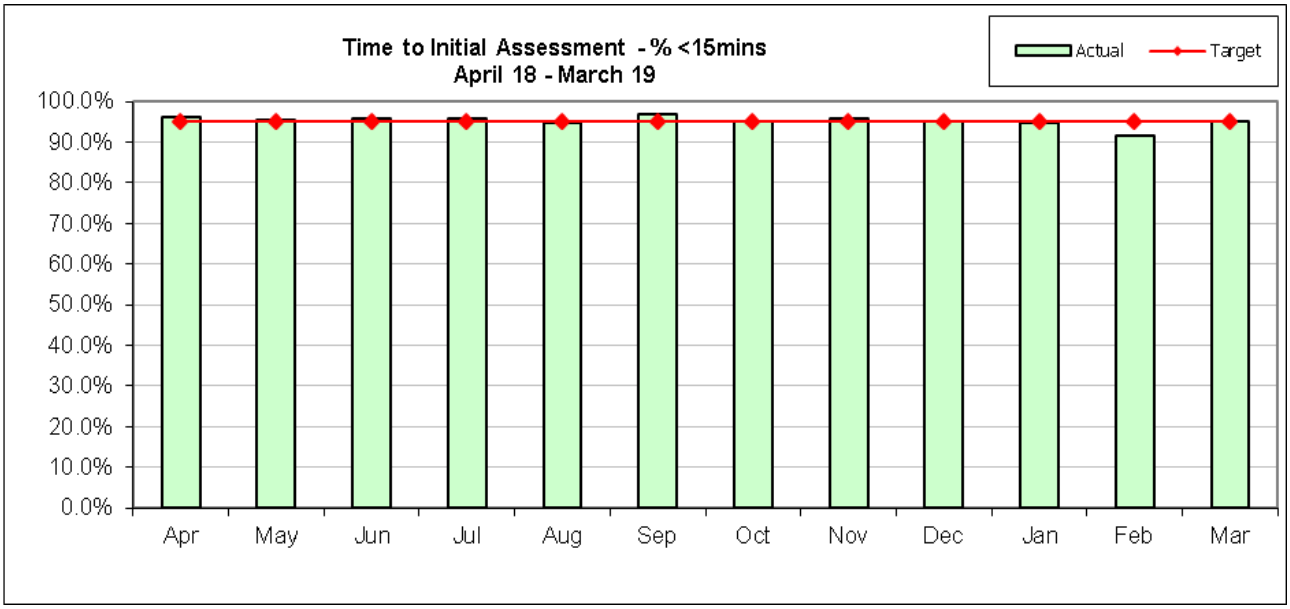
A&E Unplanned Re-attendance Rate – The Trust did not achieve this standard of less than 5% unplanned re-attendance rate at 8%.



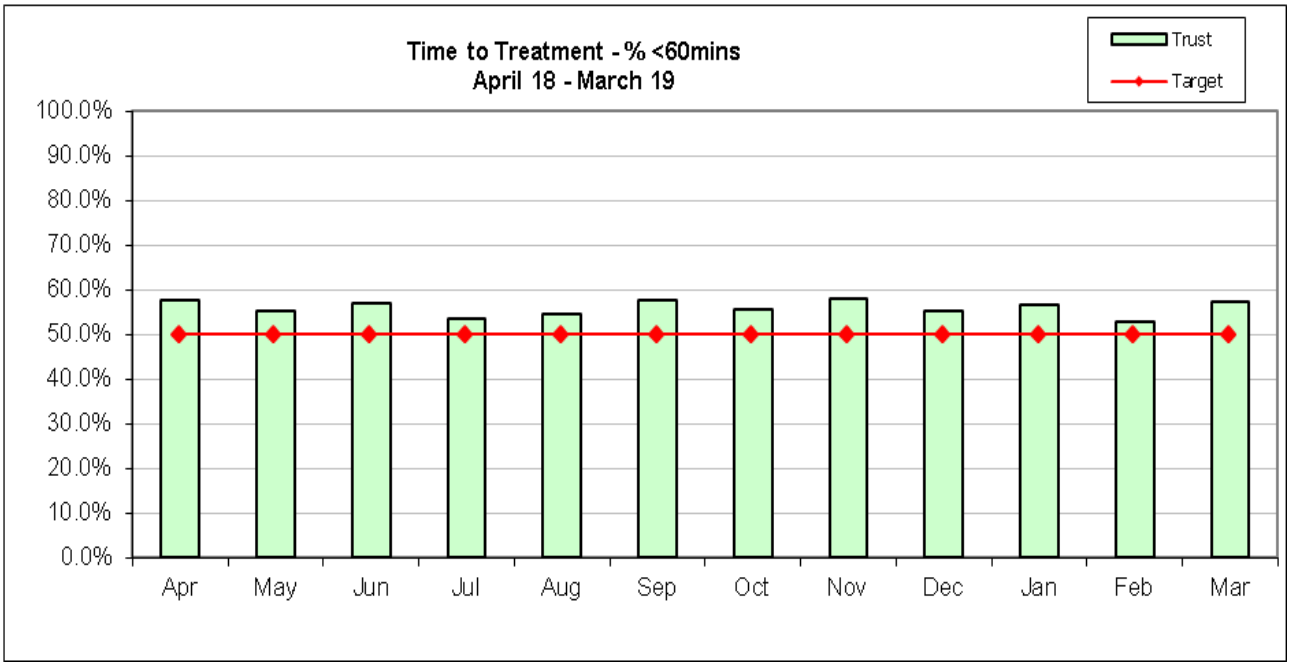
A&E Left without being Seen Rate – The Trust achieved this standard of less than 5% of patients leaving its A&E Departments without being seen.



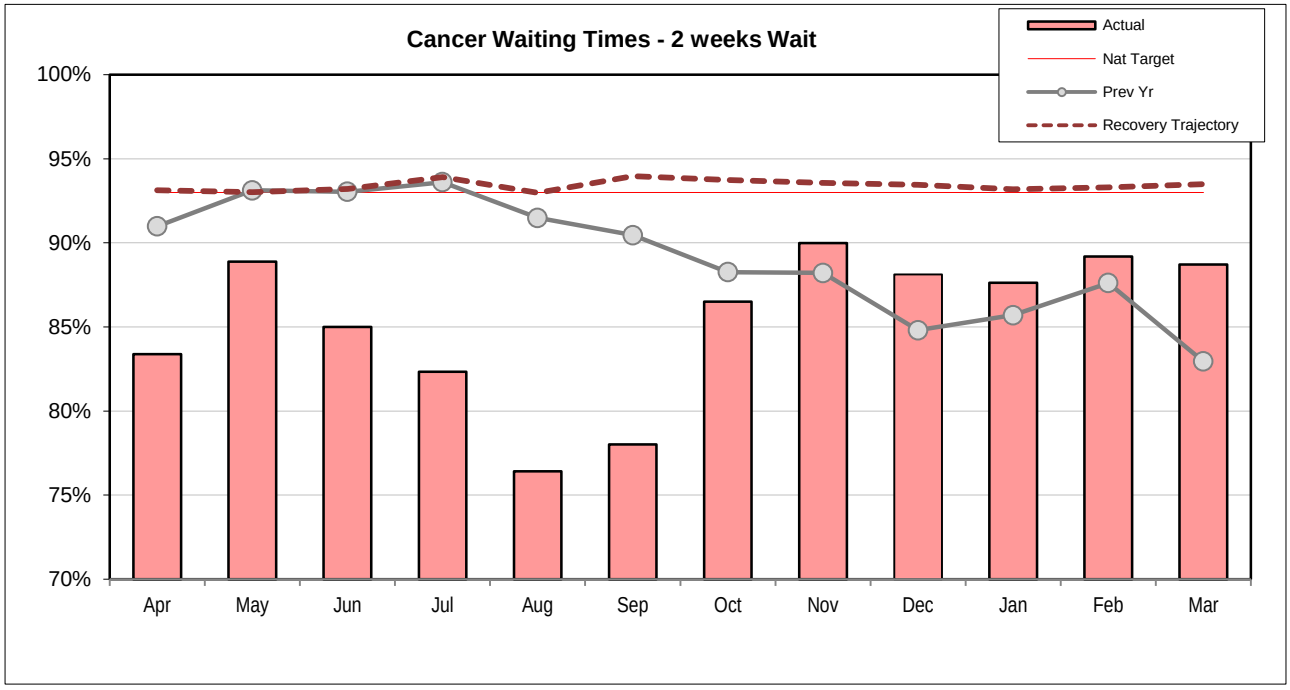
A&E Time to Initial Assessment <15 minutes – The Trust achieved this standard of 95% of patients arriving in its A&E Departments being assessed within 15 minutes of arrival.



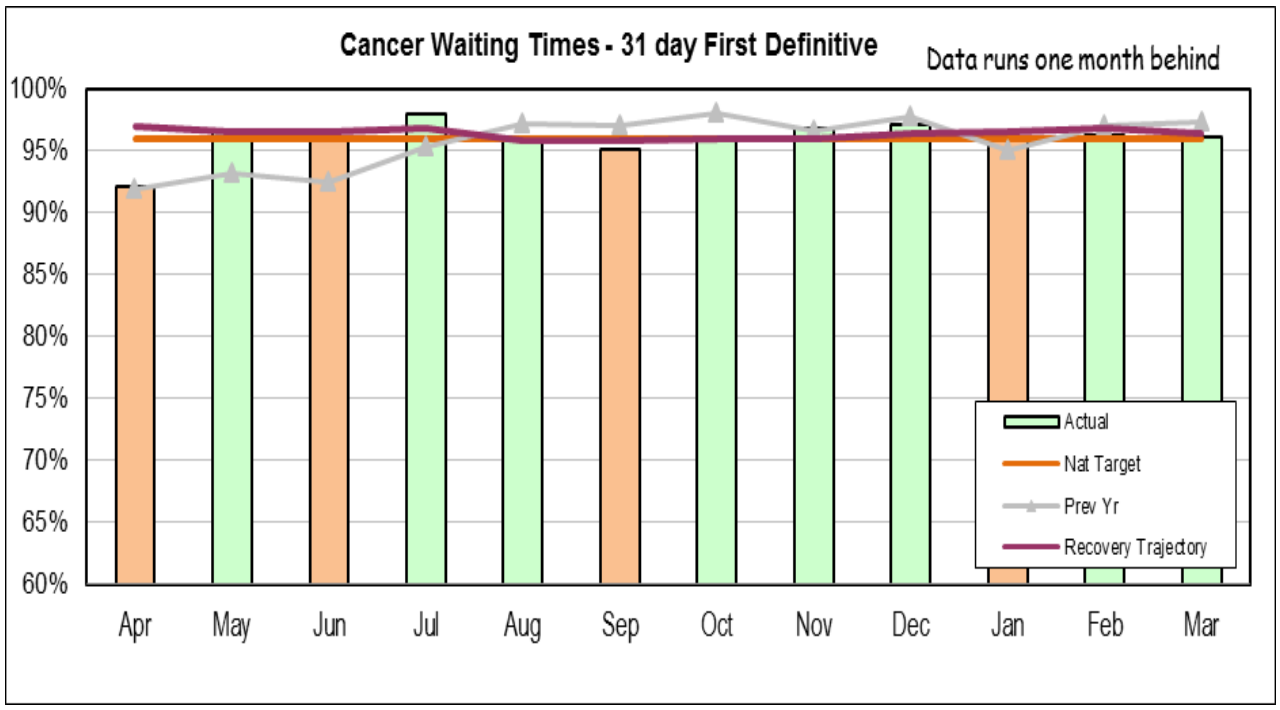
A&E Time to Treatment <60 minutes – The Trust achieved this standard of 50% of patients arriving in its A&E Departments being treated within 60 minutes of arrival at 55.9%. This is no improvement on last year.



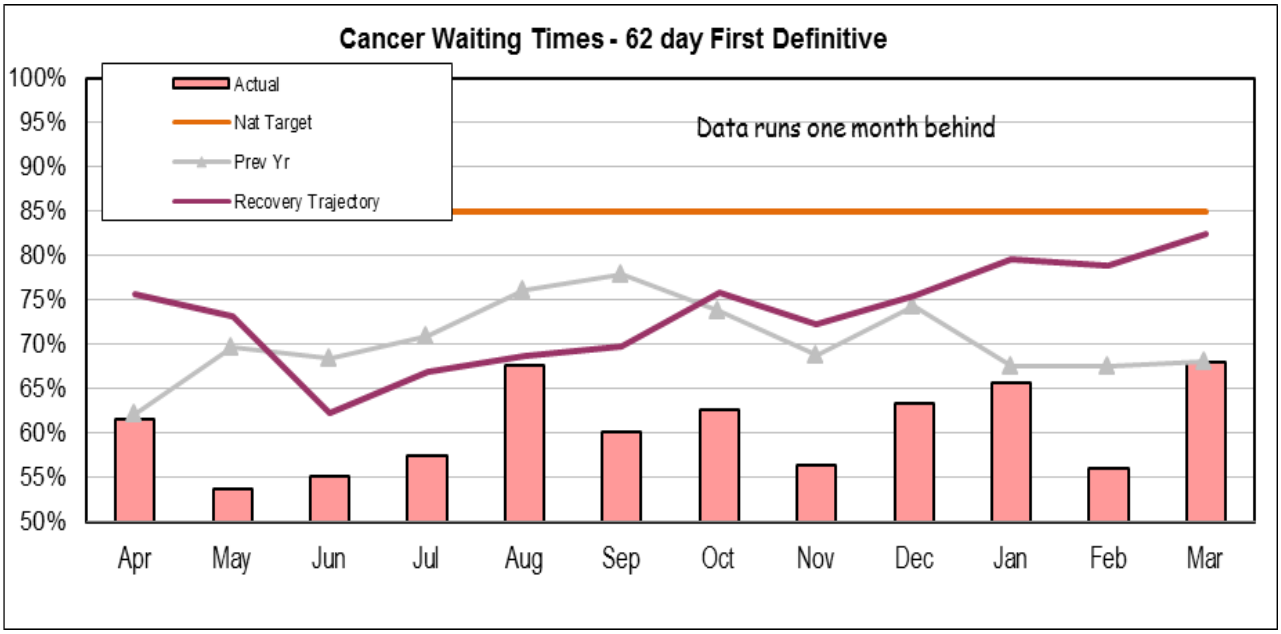
Cancer Waiting Time Targets - 2 weeks from referral – The Trust did not achieve this standard of ensuring that 93% of patients with suspected cancer were seen within two weeks.



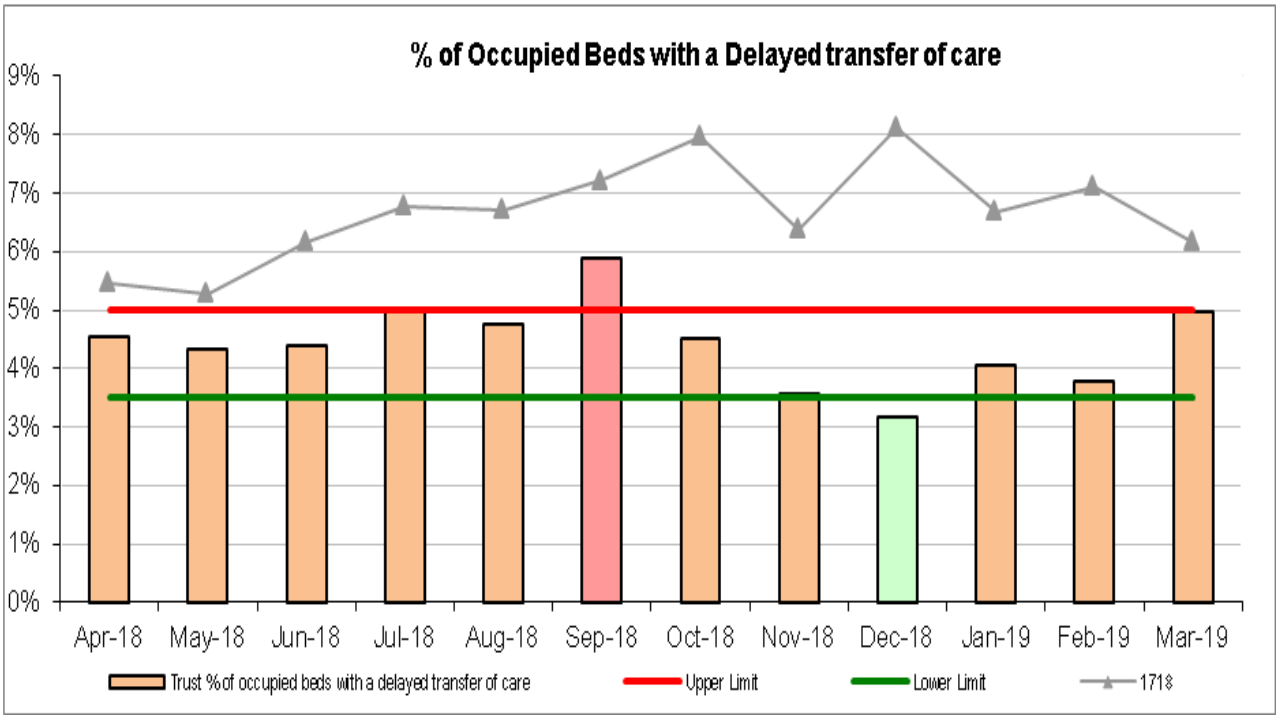
Cancer Waiting Time Targets – 31 Day First Definitive Treatment – The Trust has achieved this standard ensuring that 96% of patients who needed to start their treatment within 31 days did so.



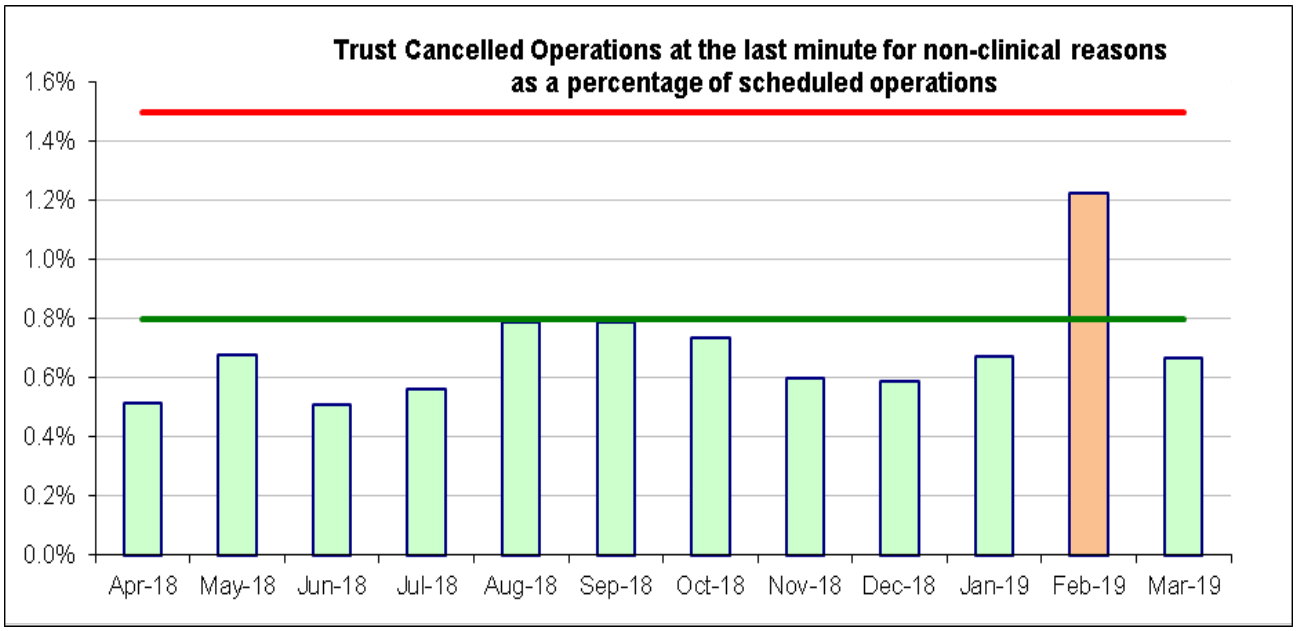
Cancer Waiting Time Targets – 62 day First Definitive Treatment – The Trust did not achieve this standard of 85% of patients who needed to start their first definitive treatment within 62 days.



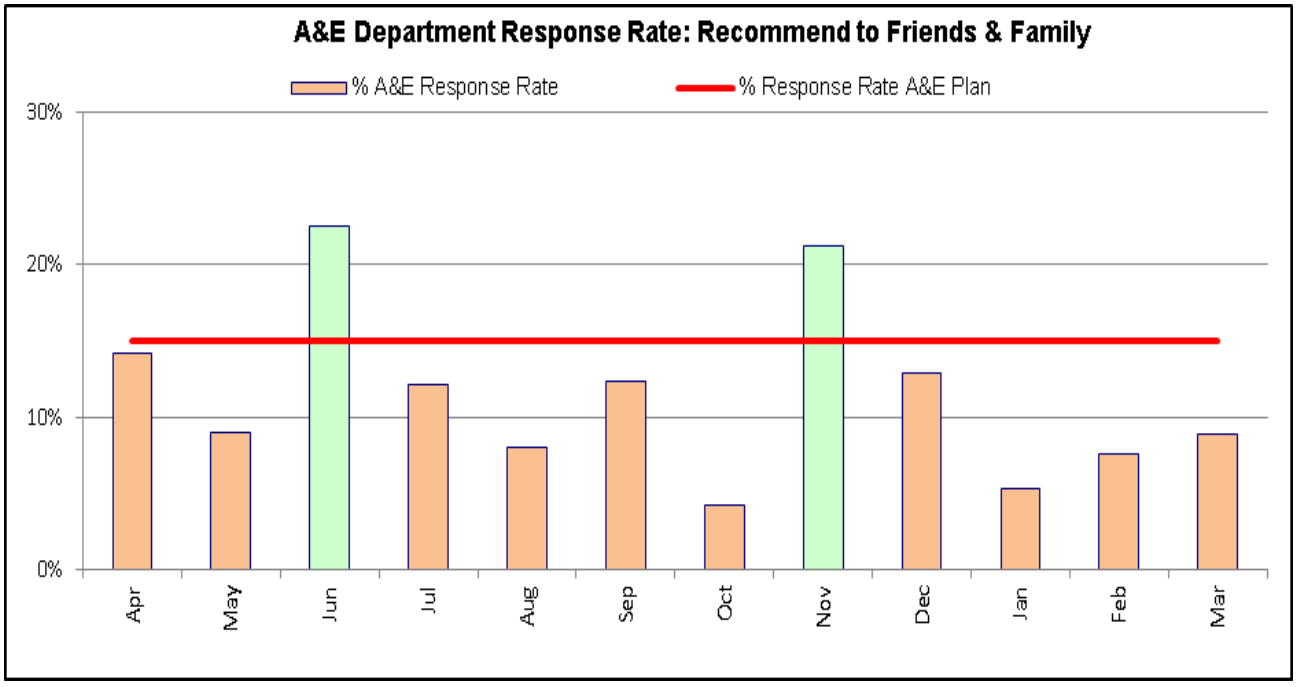
Delayed transfers of care – The Trust did not achieve this standard of Delayed transfers of care remaining below the national limit of 3.5% for the year. However, at 4.42% this is a 0.53% improvement on 2017-18.



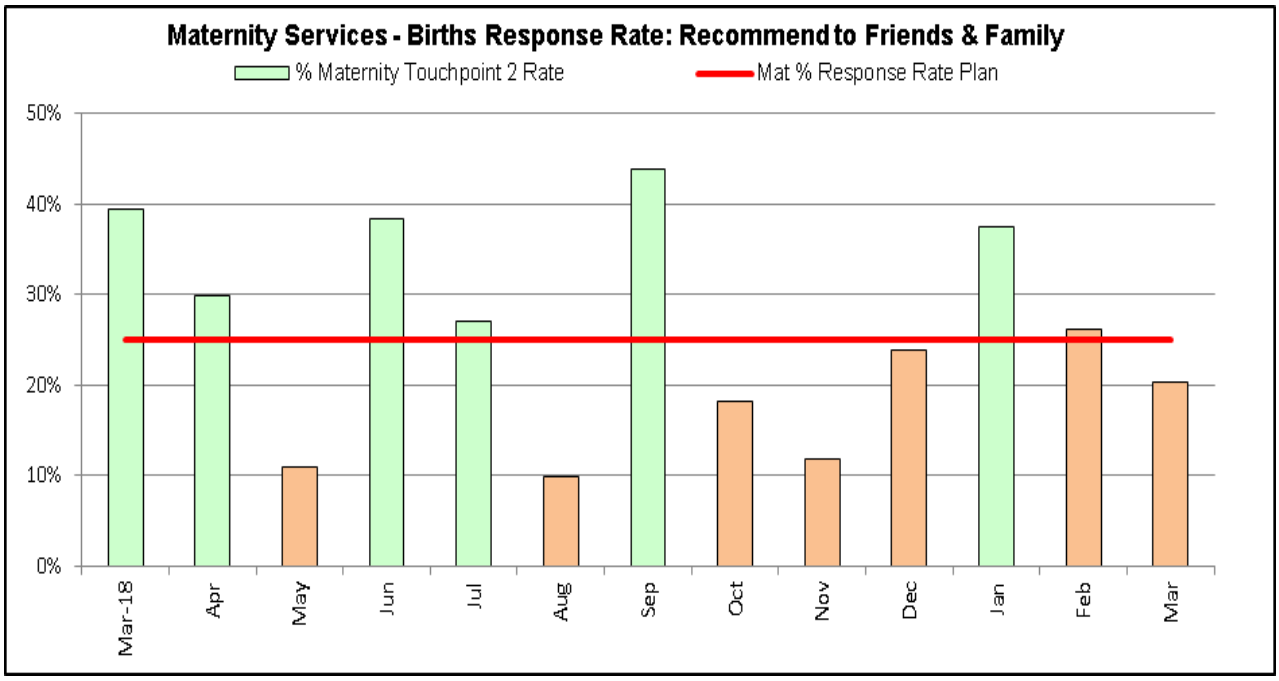
Cancelled operations – The Trust achieved this standard with 0.69% of operations cancelled at the last minute against the national maximum limit of 0.8%.



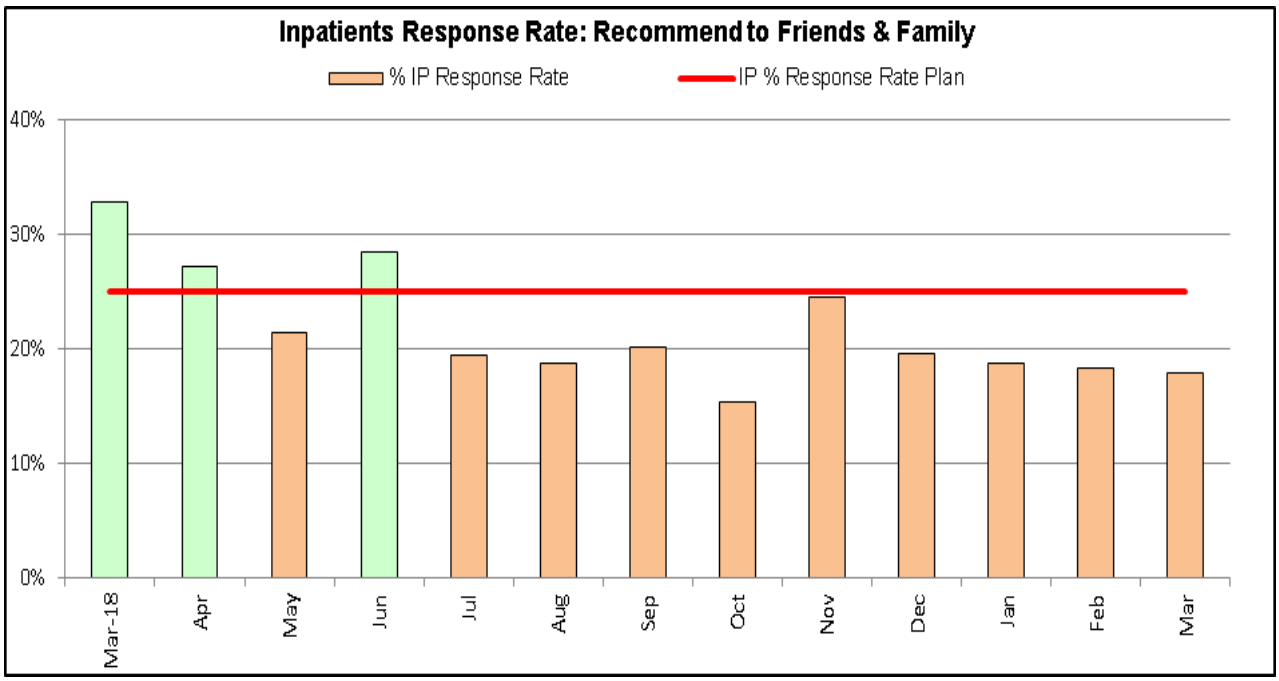
Friends and Family Test Response Rate A&E- The Trust did not achieve the target of 15% response rate for the Friends and Family Test given to patients in the A&E Departments at 11.5%. Of the responses received 91.3% were positive.



Friends and Family Test Response Rate Maternity- The Trust did not achieve the target of 25% response rate for the Friends and Family Test given to patients after giving birth at 24.5%. Of all the responses received for patients accessing Maternity Services 94.9% 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 20.9%. Of the responses received 94.4% 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 submitted a 'standards met' Data Security and Protection Toolkit. As part of this process audits of clinical coding and non-clinical coding have been undertaken as well as completing the "completeness and validity checks".

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

The NHS Outcomes framework has 5 domains:

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

Domain	**Prescribed data requirements The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to —**	**2018/19 local and national data**	**2017/18 local and (national) data**	**National average**
1 & 2	(a) the value and banding of the Summary Hospital-level Mortality Indicator ("SHMI") for the Trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. *The palliative care indicator is a contextual indicator.	1.0391 (Band 2 – "As Expected" 30.7 Oct 2017 – Sept 2018	1.0371 (Band 2 – "As Expected" 28.6 April 2017 – March 2018	1.00 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)*	0.100 No data 0.466 0.329 (Apr 17-Mar 18)	0.128 No data 0.463 0.298 (Apr16-Mar 17)	0.089 No data 0.458 0.337 (Apr 17-Mar 18)

Domain	Prescribed data requirements The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to —	2018/19 local and national data	2017/18 local and (national) data	National average
3	the percentage of patients aged— i) 0 to 15; and (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** 3.3%*1 **Non-Elective** 4.8%*1 **Elective** 7.2%*1 **Non-Elective** 16.5%*1	**Elective** 5.1%*1 **Non-Elective** 4.9%*1 **Elective** 6.0%*1 **Non-Elective** 14.8%*1	Update is expected in April/May 2019 following methodology review
4	The Trust's responsiveness to the personal needs of its patients during the reporting period	90% (Local audit)	90% (Local audit)	No national data available
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.	89.0%*2	71.4%*2	82% 2017-18
5	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	96.7%*3	95.4%	95.6% 2018/19 Q3 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.	16.3 *4	10.6	13.7 2017/18
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	8,113 80(0.98%)	7,423 128(1.72%)	0.5% (Oct 17-Sept 18)

*1 2018/19 data is Apr-18 – Feb- 19 as March not currently available. Data taken from local tables and readmissions within 30 days (not 28 days)
*2 Based on Quarter 4
*3 Q4 not yet published so taken from local data.
*4 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.

Data published in February 2018 (based on April 2017 to March 2018) shows all 3 surgical procedures showing an improvement in health gain following an operation.

Figure 1: Adjusted average health gain on the EQ-5DTM Index by procedure

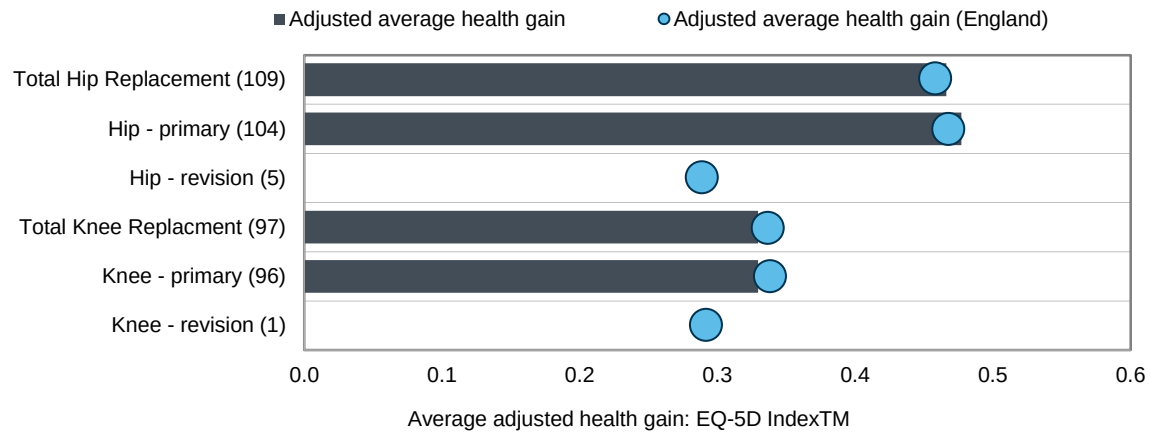


Figure 2: Adjusted average health gain on the EQ-VAS by procedure

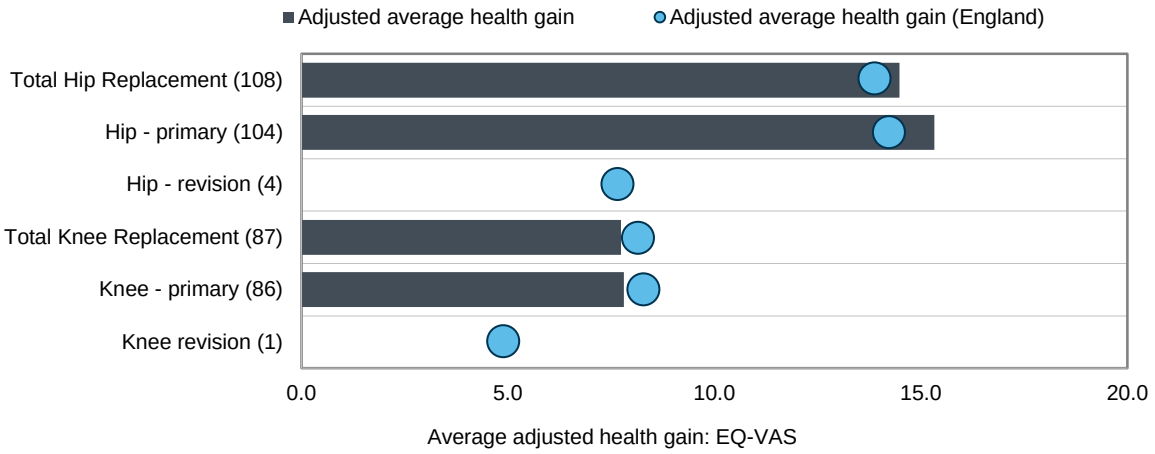
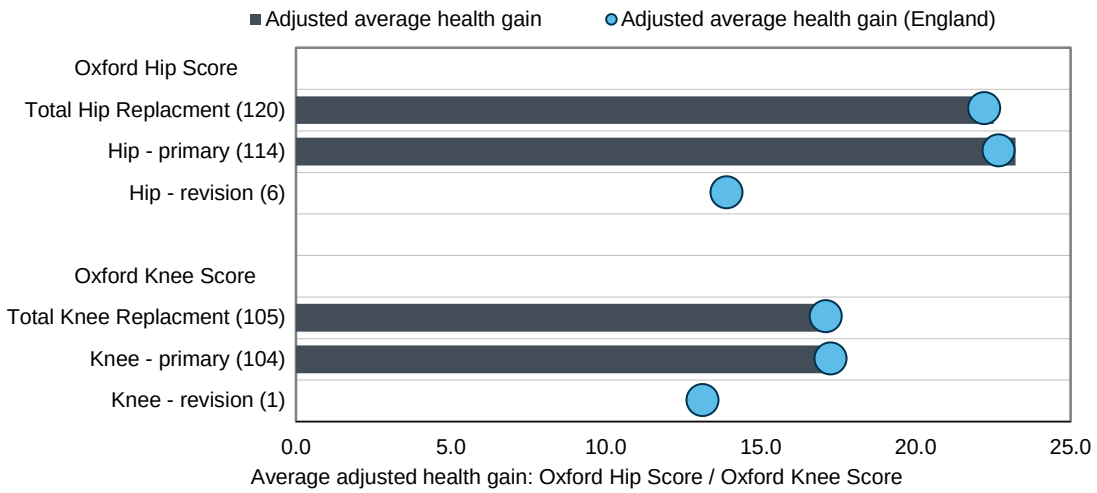
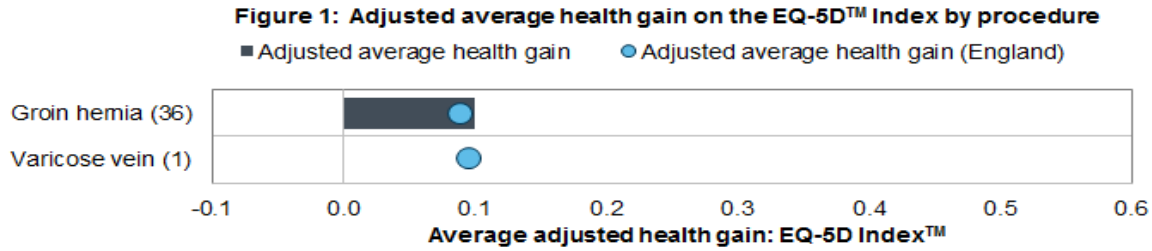


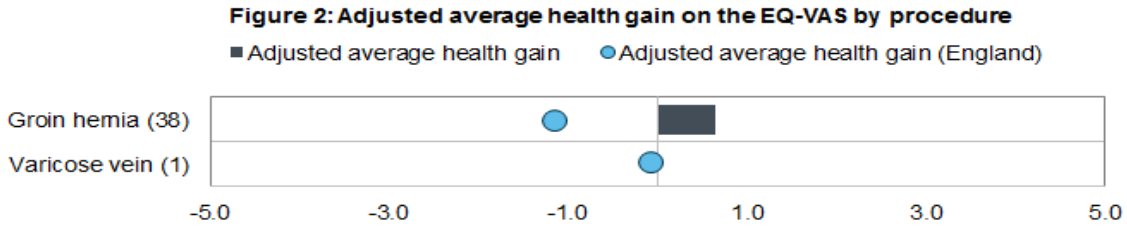
Figure 3: Adjusted average health gain on the Oxford Hip Score / Oxford Knee Score by procedure



Groin Hernia

Procedures in the period April 2017 – September 2017. Data published June 2018.





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 Oxford Knee score for Knee Replacements, but fell below the national average for the other two outcome measures. As can be seen for Groin Hernia, the trust scored favourably for both measures against the adjusted average health gain.

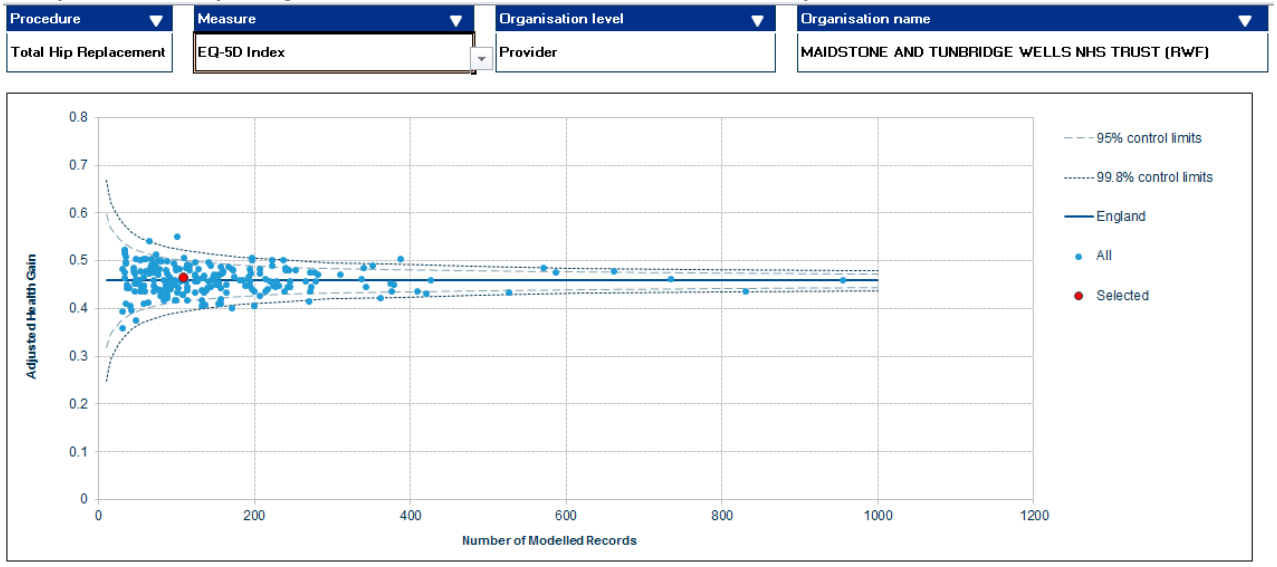
MTW considers that the outcome scores are as described for the following reasons:-

Nationally it is recognised that recovery from a total knee replacement is slower in comparison to that of a total hip replacement as a knee replacement will require the patient to undertake a strict physiotherapy regime to gain the ultimate benefits in terms of flexibility of the joint. Review of these pathways of care have highlighted that a higher percentage of patients, in comparison to the previous year, are not attending 'Hip and

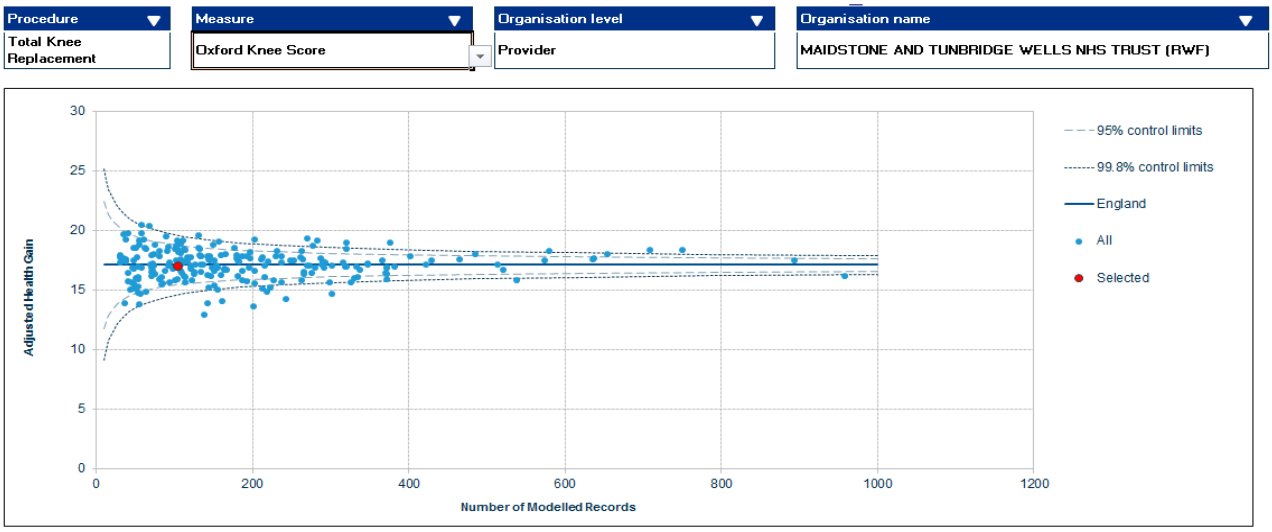
Knee' classes. These classes are invaluable in educating our patients as to what they can expect following their surgery and to explain that the benefits of a knee replacement are slower to recognise than those of a hip replacement.

MTW have recognised the increasing non-compliance with attendance to the 'Hip and Knee' classes and are now working with the administration unit to ensure that patients are given advance warning of their need to attend and to ensure that surgery is not booked until attendance has been confirmed. It is anticipated that this will help to address this year's lower scores and thereby improve the quality of its services and improve patient expectations.

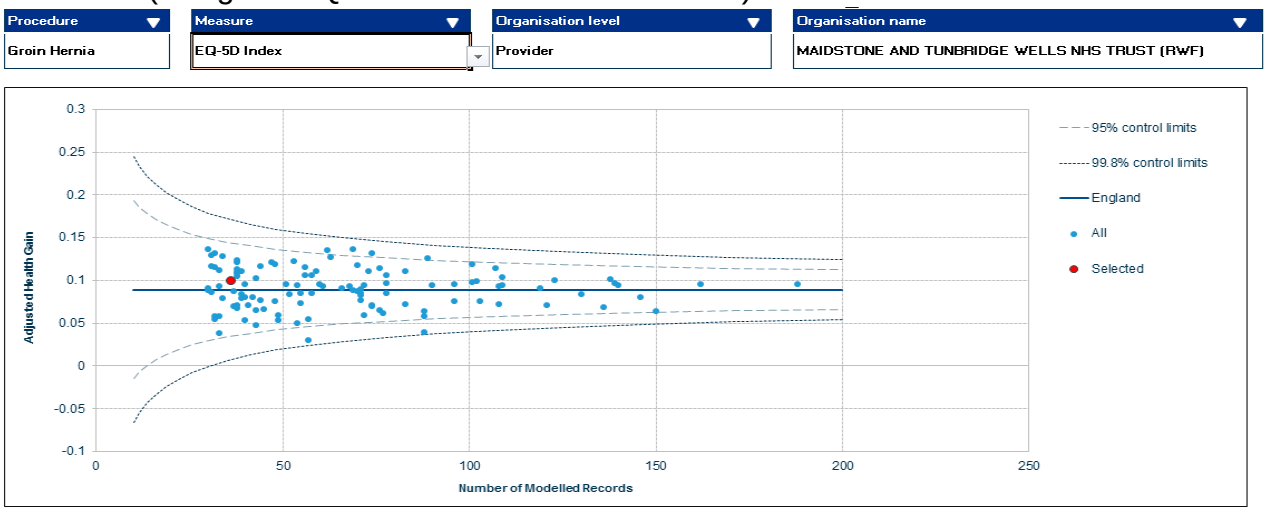
Hip Replacement – 109 returns of which 102 reported an improvement in health following the procedure (using the EQ-5D Index PROMS Measure).



Knee Replacement – 105 returns of which 102 reported an improvement in health following the procedure (using the Oxford Knee Score PROMS measure).



Groin Hernia – 36 returns of which 19 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 2018/19 was 0.98% (1.72% 2017/18). This is calculated by dividing the number of serious and catastrophic incidents (80) reported by MTW by the total number of patient safety incidents 8,113 (7,423 for 2017/18).

The latest report from the National Reporting and Learning System (NRLS), which was published in March 2019 and covers the period of 01/04/18 to 30/09/18, provided a reporting rate of 31.06 compared to 23.70 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, of note MTW continues to make improvements in their number of incidents reported and are now graded as 'no evidence for potential under-reporting'.

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 cause 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 the 'Learning Lessons' workstream remains operational and continues to strengthen and formalise this approach across MTW. Their objectives have included purchase of an upgrade of the

incident reporting database, review of the Clinical Governance agenda's and further investment in human factors training for 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 Divisional Performance review with the Executive leads. These meetings monitor compliance through the Divisional dashboards. In particular the Medicine & Emergency Care Division has responsibility for the Accident & Emergency four-hour access standard, the Surgical Division has responsibility for the 18 week referral to treatment access standard and Cancer Services has responsibility for the Cancer standards. The Chiefs of Service, Divisional Director of Operations and the Divisional Directors of Nursing & Quality 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

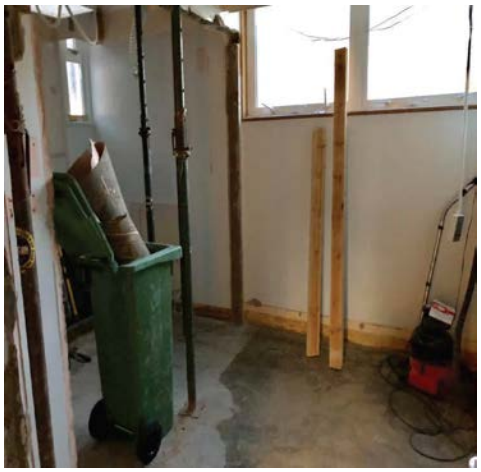
Along with the key priorities for the year these indicators are scrutinised by the relevant governance committees, Trust Management Executive and the Quality Committee.

Additional areas of significant improvement during 2018/19

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 Division

Crowborough Birth Centre Refurbishment



A major project to refurbish the birthing centre at Crowborough was undertaken during 2018/19 with the aim of improving the physical services and ensure that the service meets the needs of the community. The opportunity was also taken to ensure that safety standards were improved in line with other maternity units within the NHS.

Whilst the building works took place the centre continued to operate whilst making every effort that disruption to service was minimised. The new look centre was unveiled at the end of January and is to be used as the pilot site for Continuity of Carer teams.

Surgical Services Division

Urology Directorate

The Trust has begun using a ground-breaking procedure for patients with prostate cancer after a £355,000 donation from a local family funded innovative equipment. Our specialist Urology team treated its first patient at Maidstone Hospital earlier this year using tiny gold markers to more accurately deliver radiotherapy for prostate cancer. We are the first in the UK to routinely offer this technique.

The procedure allows surgeons to insert special gold markers known as 'Fiducial markers' inside the prostate, enabling

radiotherapy to be focussed on the area and minimising radiation to the surrounding, healthy organs. The usual method in which the Fiducial markers are placed in position can possibly lead to a risk of infection, but MTW urologists have now developed a special technique of inserting the gold markers through the skin. The technique significantly reduces the risk of infection and has been shown to be safe in other studies around the world. The equipment to carry out the procedure was funded by Roy and Margaret Sutcliffe, from Maidstone, who gifted the money to MTW's Kent Oncology Centre in August 2018, after Mr Sutcliffe was treated by the Trust for bladder cancer.

The Wells Suite– Private Patients Day Unit

Last week, our private patient service re-opened its doors, with a new clinical and administration team leading the unit. The day unit has undergone a refurbishment, with improvements made to patient accommodation and waiting areas. The day unit will offer outpatient consulting rooms including a room for ultrasound scanning, pre-operative assessments, such as blood tests and swabs, as well as providing three ensuite rooms for patients to recover following day case procedures, such as imaged-guided biopsies, cardiac catheter lab procedures and minor surgical procedures. The new day unit supports our plans to improve patient flow across our hospitals. All surpluses from private patient services are reinvested in NHS services in the Trust.

Medicine & Emergency Care Division

Edith Cavell trials Coloured Blankets

Edith Cavell at Maidstone Hospital is handing out coloured and patterned blankets to elderly patients as part of a trial to see if it helps reduce falls. The first blankets were given to two patients on the ward this week and were received very positively by them and their families.

The blankets help older patients, particularly those with dementia, find their way back to bed more easily. They also allow patients to see the edge of the bed more clearly, when getting up and down,

and provide a more homely feel to the ward.

The scheme has been successful at other NHS hospitals and was picked up by the ward team and Karen Carter, Directorate PA for Specialist Medicine, to see if it worked at MTW. So far, nine blankets have been knitted or donated. Due to infection control, blankets are single use items and are taken home with the patient, following discharge.

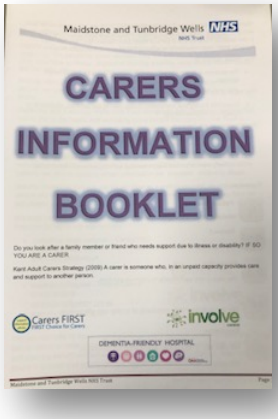
Corporate Services

Dementia-Friendly Care

As an organisation we are signed up to the Dementia Friendly Hospital Charter. www.dementiaaction.org.uk/dementiafriendlyhospitalscharter. This means we have made a commitment to people with dementia, their families and friends, in respect of what to expect during a stay at MTW.

We are progressing well with these commitments and work will continue to embed these in 2019/20, they include:-

- Ensure our staff and volunteers understand and are skilled in dementia care – this training is mandated across the organisation for all clinical staff.
- Actively involve patients, families and friends as essential partners in providing care and planning discharge – this is encouraged and we also have a Carer's information booklet as well as Carer's organisations on both sites to provide support and guidance.



- Provide family and friends with flexible visiting times, including overnight stays where possible – we are signed up to John's Campaign https://johnscampaign.org.uk/#/
- Use information that patients, families and friends have provided to us – we actively encourage the use of the 'This Is Me'.
- Provide access to dementia specialists to whom patients, families and friends can talk to and provide feedback.
- Seek to ensure that the surroundings of where patients stay are as friendly, comforting and accessible as possible; work continues to enhance our environments.

Looking ahead to 2019/20 we wish to further progress our work in relation to:-

- Respect patients' rights to make decisions themselves or decisions made on their behalf by families and friends – to place more emphasis on training and education for staff on the Mental Capacity Act and Best Interest decisions and ensuring these are clearly documented.
- Provide assistance to patients with eating and drinking – further work is being embedded by our nutritional steering group.
- Minimise the number of times patients are moved during their hospital stay.

We will also continue our work as part of the West Kent Alliance and Aligned Incentive Scheme in collaboration with our partner organisations and through our Best Quality Work Stream.

Professional Standards Team - Skills for Health Quality Mark

MTW has, once again, been awarded the Skills for Health Quality Mark. The Skills for Health Quality Mark endorsement means that MTW is meeting the nationally recognised benchmark which epitomises the health sector's ethics and values, whilst demonstrating a commitment to develop a safe and competent workforce.

The programmes assessed by Skills for Health were the Clinical Support Worker (CSW) Induction Programme and the Care Certificate which are facilitated by the Professional Standards Team.

The training delivery for these programmes has been verified as being in alignment with OFSTED requirements. Positive feedback was received from the Skills for Health Assessor, Kathryn Attwood, for the training delivery of both programmes. Feedback demonstrated that CSWs felt supported by trainers, employers and assessors on their learning journey. Feedback from the surveys sent to the CSWs and their managers, confirmed that CSWs are prepared well during the CSW induction programme, which helps confidence, self-esteem, aspirations and improved patient care. One comment was, 'outstanding support, always on hand to help and guide'.

Part Four
Appendices A, B and C

Appendix A

38 National reports were published where the topic under review was relevant to the Trust in 2018/19 with action to be taken in 2018/19

National Report Published April 2018 to March 2019	*Report received*	Date report due
Acute Care		
National Cardiac Arrest Audit (NCAA)	**Y**	**Full report received July 2018** Quarterly reports generated and reviewed by the resuscitation team to evaluate performance. The trust figures perform well with national comparisons and show higher than national survival rates.
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	**Y**	**Full report due March/April 2019** Quarterly reports are 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 November 2018** We have continued to implement our Emergency Laparotomy Pathway to improve patient care. This consists of a bundle of evidence based interventions to improve the care and outcomes provided to these patients. Over the course of this year we have formalised our pathway and the Code Laparotomy CT request protocol. Those patients at higher levels of risk now trigger a multi-disciplinary discussion between Surgical, Anaesthetic and Intensive Care Consultants to ensure optimal levels of care. Our outcomes remain amongst the best in the country, with the most recent NELA Annual Report demonstrating a risk-adjusted mortality of 5.6% compared to a national average of 9.5%.
Severe Trauma (Trauma Audit & Research Network) TARN	**Y**	Quarterly dashboards and 3 injury specific reports are published annually and reviewed by the A&E Consultant Lead. Patients are reviewed and discussed at Trauma Board meetings to ensure best quality of care. Any patients with a high injury severity score have their cases reviewed on an individual basis
National Joint Registry (NJR)	**Y**	**Report received September 2018** Review of 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. 660 procedures were recorded on the 2018 annual report (2017 data) with a consent rate of 97%, which is above the national average. This is an ongoing national audit which our trusts continually participates in year after year
RCEM Pain in Children 2017	**Y**	**Report published May 2018** There were two fundamental standards which both had excellent results for the trust. These were for the pain score to be assessed within 15 minutes of arrival and patients in severe pain (pain score 7 to 10) receiving appropriate analgesia within 60 minutes of arrival or triage. A paediatric-trained nurse is to be appointed at Maidstone Emergency Department to address the nursing skill mix between the two sites.
RCEM Procedural Sedation 2017	**Y**	**Report published May 2018** Patients undergoing procedural sedation should have documented evidence

National Report Published April 2018 to March 2019	*Report received*	Date report due
		of ASA grading, prediction of difficult airway management and pre-procedural fasting status, the low compliance is deemed to be a reflection of lack of documentation rather than poor working practices. Procedural sedation should take place in a room with resuscitation facilities was fully met. Procedural sedation requires the presence of a sedationist, second doctor, Emergency or Advanced Nurse Practitioner and a nurse. Monitoring during sedation must be documented to have included non-invasive blood pressure, pulse oximetry, capnography and ECG. Both sites fall short likely due to the lack of use of capnography. Following sedation, patients should only be discharged after formal assessment of return to baseline level of consciousness, vital signs with normal limits for patient, absence of respiratory compromise, absence of significant pain and discomfort and written advice. Results showed poor documentation with this statement. A procedural sedation proforma to be implemented on both sites to ensure documentation of all required elements for this procedure.
RCEM Fractured Neck of Femur 2017	**Y**	**Report published May 2018** There were two fundamental standards which both had excellent results. These were for the pain score to be assessed within 15 minutes of arrival and patients in severe pain (pain score 7 to 10) receiving appropriate analgesia within 60 minutes of arrival or triage. A programme initiation on practice of fascia iliaca blocks will improve early effective analgesia.
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
National Comparative Audit of Blood Transfusion Programme		
(National Comparative Audit of Blood Transfusion Programme) Red cell and platelet transfusion in adult haematology	**Y**	**National report published in June 2018** Local hospital guidelines continue to be discrepant and lag behind national guidelines contributing to inappropriate transfusion practice. Compliance is similar across all levels of care. Routine regular audit of use is unlikely to be achieved without an IT solution. Single unit red cell transfusions continue to be less common than 2 unit transfusions and multiple units continue to be given to low weight patients. This practice is unsafe because it puts patients at risk of Transfusion Associated Circulatory Overload (TACO).
(National Comparative Audit of Blood Transfusion Programme) Comparative audit of transfusion associated circulatory overload 2017	**Y**	**National report published in June 2018** Patients are not always weighed on admission to hospital and if they are, it is not usually done in the context of blood transfusion. Patient Blood Management (PBM) covers a multitude of recommendations across all aspects of Blood Transfusion and is gradually being introduced in the Trust. Blood Transfusion is already a part of Clinical Induction and Mandatory Training and covers some aspects of PBM. Appropriate Transfusion Project was launched in March 2017 to promote empowerment of nurses and BMS's. A review after every unit is encouraged but not enforced. Observations are performed during every transfusion and escalated to

National Report Published April 2018 to March 2019	*Report received*	Date report due
		senior staff when appropriate. Any patient who experiences worsening symptoms during a transfusion is assessed clinically. All cases reported to the Transfusion Team are reported to Serious Hazards of Transfer (SHOT)
(National Comparative Audit of Blood Transfusion Programme) Audit of the patient blood management in scheduled surgery re-audit	**Y**	**Report received 23 October 2018** The HTC (Hospital Transfusion Committee) and Pre-Assessment Teams are currently working together to establish testing and treatment pathways for patients who are found to be anaemic at the Pre-Assessment Clinics. Pre-Assessment bloods are reviewed by the Pre-Assessment Team. ICAG (Informed Consent Action Group) Consent Pad introduced in the Trust in October 2017 to help in the consent process for blood transfusion. Appropriate Transfusion Project launched in March 2017 with the aim to empower lab staff to query requests that fall outside of the NICE guidelines and to educate the clinical staff in the recommendations contained within the NICE guidelines. PBM (Patient Blood Management) workshops run for the doctors and nurses in October and November 2016 including local audit results.
Serious Hazards of transfer (SHOT) UK. National haemovigilane scheme	**Y**	**Report received September 2018** 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. Overall, transfusion components themselves are very safe. All Blood Transfusion Lab staff follow an extensive competency assessment program. All clinical staff undergo mandatory training updates every 2 years. Electronic blood tracking system is in place for blood collection and completion of the validation process for the new Kiosks and handheld equipment from Microsoft is underway.
Cancers		
National audit of Breast Cancer in Older People (NABCOP)	**Y**	**Report published September 2018** 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. Due to lack of time and staff, results in the 2018 annual report show data is not being uploaded onto the national registration services from which the NABCOP draw their data.
National Audit of Lung Cancer (NLCA)	**Y**	**Report received June 2018** The National Lung Cancer Audit revealed the trust showed good local practice in comparison with national standards. Our surgical resection rate at 22.3% is above the national audit standard set of 17%. Since 2016 significant progress has been made to improve the lung cancer pathway. We are very keen to implement a lung nodule Multi-Disciplinary Meeting, but as yet there are no plans to separate the diagnostic part of the MDM from the confirmed cancers.
National Audit of Bowel Cancer (NBOCAP)	**Y**	**Report received 14 December 2018** The report showed that MTW is fully compliant in all of the recommendations made and our mortality rates are lower than the national and regional average.

National Report Published April 2018 to March 2019	*Report received*	Date report due
		MTW has good 90 day mortality rates compared with the regional and national figures and our two year mortality rate is consistent with the national average. All patients seen at MTW are considered for chemotherapy based on local and national guidelines irrespective of postcode. MTW's 18 month stoma rates are better than the national average (48% v 52%) and stomas are closed at the earliest opportunity following completion of cancer treatment.
Head & Neck Cancer (DAHNO)	**N/A**	The national report has been delayed while the contact is being re-negotiated.
National Prostate Cancer Audit 2017	**Y**	**Report received 14 February 2019** This is currently with the team for assessment.
Oesophago-gastric cancer (NAOCG)	**Y**	**Report received on 14 September 2018** 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. The annual report shows that the Trust submitted 175 tumours records which equates to 90% case ascertainment rate. 23 patients of the 175 were diagnosed after emergency admissions (14.6%). Patients with an unknown referral source totalled 14 (8%). CT scans were performed on 98% of patients. The number of patients receiving palliative treatment at MTW was 96 (54.86%). The number of patients receiving a CT scan was 199 giving us a case ascertainment of 98%.
BAETS - Endocrine and Thyroid National Audit	**N/A**	There are continuing delays with publishing the national reports. The sixth and seventh reports are awaited. No publication dates given by provider.
National Ophthalmology Database Audit Project	**N/A**	The Trust was unable to submit data to this national audit due to software issues. We are still waiting for the OpenEyes package to be purchased. This is underway.
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 2018** Report is with the urology team to assess the trusts compliance and develop an action plan if needed.
BAUS Urology Audits: Cystectomy	**N/A**	The Trust does not provide this service
BAUS Urology Audits: Nephrectomy Audit	**Y**	**Report received 14 December 2018** Report is with the urology team to assess the trusts compliance and develop an action plan if needed.
BAUS Urology Audits: Percutaneous Nephrolithotomy (PCNL)	**Y**	**Report received 14 December 2018** Report is with the urology team to assess the 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**	The trust does not provide this service - Primary Care Only
Renal Replacement Therapy (Renal Registry)	**N/A**	The Trust does not provide this service
Heart		
Cardiac Rhythm Management (CRM) 2016-17	**N/A**	**Report publication delayed until 2019-20 by national body**
Coronary Angioplasty / PCI 2016-17	**Y**	**Report published November 2018.** This report is with the Cardiology team for review and action plan development.
MINAP 2016-17	**Y**	**Report published November 2018.** This report is with

National Report Published April 2018 to March 2019	*Report received*	Date report due
		the Cardiology team for review and action plan development.
Heart Failure 2016-17	**Y**	**Report published November 2018.** This report is with the Cardiology team for review and action plan development.
Cardiac Rehabilitation 2016-17	**Y**	**Report published November 2018.** The Trust is fully compliant with national recommendations. All applicable patients are offered cardiac rehabilitation. Nationally there is a low uptake for female patients. At MTW the majority of females are elderly with co-morbidities and therefore less likely physically able to participate. To address this, two new programmes are being promoted (home and walking). There are also ongoing discussions with the local Clinical Commissioning Group for funding to expand the service to include heart failure patients.
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
Long-term Conditions		
National Diabetes Audit (NDA) Core audit 2017-18	**N/A**	**National report publication delayed until May 2019**
National Adult Diabetes Inpatient Audit (NaDIA) 2018 (Hospital Characteristics only)	**N/A**	**National report publication delayed until May 2019**
National Adult Diabetes Inpatient Audit – Harms (NaDIA-Harms) 2018	**N/A**	**National report publication delayed until May 2019**
National Diabetes Foot Care Audit (NDFA) 2014-18	**N/A**	**National report publication delayed until July 2019**
National Diabetes Transition Audit 2011-2017	**Y**	**Report published January 2018** This report is with the Diabetes team for review and action plan development.
Inflammatory Bowel Disease (IBD) Programme – IBD registry, Biological Therapies Audit 2016-17	**Y**	A National comparative quarterly report has been received by the specialty and is being reviewed for action plan development. The Trust has not subscribed to the additional funding for the national reporting element of the service. IBD Registry confirmed that no data for MTW will be published in the national report for 2016-17.
Neurosurgical National Audit Programme	**N/A**	Trust does not provide this service
Falls and Fragility Fractures Audit Programme (FFFAP)	**N/A**	**1. Inpatient Falls (NAIF).** No national report published in 2018-19
	N/A	**2. Fracture Liaison Service** MTW does not provide this service. This is a community service.
	Y	**3. National Hip Fracture database (NHFD)** **Report published September 2018** The NHFD is a standing item at the Orthopaedic department Clinical Governance and directorate meetings. MTW were compliant with all recommendations, but scored below the national average for eligible patients being treated with Total Hip Replacement. MTW score of 22.8% compared to a national average of 31.4%. All patients are discussed at the daily trauma meeting and total hip replacement

National Report Published April 2018 to March 2019	*Report received*	Date report due
		considered where appropriate. Regular Neck of Femur fracture meetings are held to discuss any issues. This is an ongoing National audit which our trusts continually participates in year after year
National audit of Dementia Spotlight audit 2017 (Delirium screen and assessment**)**	**Y**	**National Report Published August 2018** This report is with the specialty for review and action plan development.
National Patient Reported Outcome Measures (PROMs) Programme Elective surgery Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein* * not performed at MTW)	**Y**	**Report published December 2018** Before a patient undergoes primary hip replacement or a primary knee replacement at Maidstone & Tunbridge Wells NHS Trust they are offered a questionnaire for completion at pre-operative assessment. (Data for groin hernia no longer collected) 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. The report is with the Divisional Director of Nursing and Quality to assess trust compliance and develop an action plan if needed. Validity and completeness is consistently above the national average for both Hip and Knee Replacement. The Trust will continue with promotion of PROMS questionnaires to patients in pre-op setting to increase the number of questionnaires returned.
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 Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal Mortality Surveillance 2016 (reports annually)	**Y**	**Report received 15 June 2018** The Trust is fully compliant with MBRRACE recommendations. There were 5,890 births in 2016 within our Trust. Stillbirths = 19, 3.23 per 1000 births (MTW up to 10% lower than average for group), Neonatal Death = 5, 0.85 per 1000 births (MTW are up to 10% lower than average for group) Extended Perinatal death = 24, 4.07 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 2014-16 including Confidential Enquiries into women who died from mental health conditions, thrombosis and thromboembolism, malignancy and homicide(reports annually)	**Y**	**Report received and distributed 1 November 2018** The Trust is partially compliant. The Trust has plans to develop a standard operating procedure or guideline to address the needs of pregnant and postpartum women presenting to the emergency department. Additionally there are plans to set up a local audit to assess if thromboembolism risk assessments were performed and whether the calculated risk score was correct.
MBRRACE-UK; Serious Maternal Morbidity - Saving Lives, Improving Mother's Care ; Women with major	**Y**	**Report received and distributed 1 November 2018** The Trust is partially compliant and is working hard to improve the care it offers mothers with particular focus on

National Report Published April 2018 to March 2019	*Report received*	Date report due
obstetric haemorrhage (2014-2016)		reducing the incidence of post-partum haemorrhage (PPH). A working group has been set up to fully review the pathway and the PPH proforma. Additionally the Trust is putting in place a formal documentation process for the debriefing of severe PPH patients.
National Maternity and Perinatal Audit (NMPA)	**Y**	Sprint reports for Maternity Admissions to Intensive Care and Neonatal Research **received and distributed 11 January 2019**. Full NMPA report not published to date. The sprint reports are being reviewed by the Maternity Team.
Paediatric Inflammatory Bowel Disease; Biologics Round 2 (IBD Programme)	**N/A**	IBD Registry confirmed that no national report will be published for the 2017-18 data for MTW as the Trust has not subscribed to the additional funding for this element of the service.
National Paediatric Diabetes Audit (NPDA**)**	**Y**	**Report received and distributed 13 July 2018** The Trust is partially compliant with results for overall health checks and patients receiving all 7 health checks, this is just above the national average. Ongoing interface problems with the data submission software (Twinkle) and the Trust's electronic patient records system continue to effect data quality. Plans are in place to improve documentation and to increase screening for psychological co-morbidities include ensuring all clinic staff have access to Twinkle and booking psychologist assessments as part of the patient's annual review in MDT consultant led clinics.
Neonatal Intensive and Special Care (NNAP)	**Y**	**Report received and distributed 1 October 2018** The Trust is partially compliant. Continued issues with data entry into the data submission software (Badger). Badger Champions are now checking and validating the Neonatal Unit (NNU) data entry. Improvements to E3 (maternity electronic patient records) will allow improved interface with Badger including some new mandatory fields to ensure complete data capture. The Neonatal Unit was awarded Unicef Baby Friendly Initiative Level 1 in September 2018 and is working towards Level 2 for assessment in September 2020.
Paediatric Intensive Care (PICANet)	**N/A**	The Trust does not provide this service
Confidential Enquiries		
Failure to Function - Acute Heart Failure	**Y**	**Report received 22 November 2018** Report disseminated and with specialties for assessment
On the right course - Cancer in Children, Teens and Young Adults	**Y**	**Report received 13 December 2018** The trust is compliant with all recommendations within this national report. Protocols and Pathways are in place so that any patients requiring critical care are referred to the Royal Marsden. Any patients requiring Paediatric Intensive Care Unit (PICU) are sent to St Georges University Hospital. All patient information is fully documented in the patient's case notes and discussed with patient and/or relatives / referring clinician and admitting critical care consultant. Nursing assessments are undertaken before each cycle of chemotherapy, these are done formally by nurses and intermittently by the doctors. Patients can receive chemotherapy treatment on the Tunbridge Wells Day Care Unit staffed by a multidisciplinary team. A fully trained Paediatric Oncology Trained Nurse administers the treatment on the unit. The trust holds regular Morbidity & Mortality meetings looking at mortality relating

National Report Published April 2018 to March 2019	*Report received*	Date report due
		to systemic anti-cancer therapies (SACT). Results of these discussions are recorded and are available. The trust does not have transition from paediatric, teenage and young adult to adult teams. Paediatrics are managed by the Paediatric Services (Royal Marsden, Great Ormond Street (for <1 years of age) Teenagers and Young Adults (TYA) are managed by the TYA Centre (University College Hospital London Teenage Unit)
Highs and Lows - Perioperative Diabetes	**Y**	**Report received 13 December 2018** Report disseminated and with specialties for assessment
Others		
NHS England 7 Day Hospital Study Spring 2018	**Y**	**Report received October 2018** The trust was partially compliant with the standards audited. 67% of patients were seen and assessed by a consultant within 14 hours of admission.100% of patients who required a twice daily (High Dependency needs) consultant review received them. 91% of patients who required a once daily review received one. This was in line with SE Region and National results for weekdays and above SE region and national results for weekend reviews. The trust continues to work towards the NHS England 7 day hospital working agenda. A trust programme plan has been produced and work is on target to meet the key performance criteria.

Appendix B

Updated actions on reports received during March 2017 to April 2018. 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 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. Audit results shared at Clinical Governance sessions and in the Trust's Governance Gazette. Staff will be reminded of the need to complete the cardiac arrests forms.
Adult Critical Care Case Mix Programme 2016 (ICNARC) (CMP)	**Y**	**Full report received June 2018** Quarterly reports generated and regularly reviewed by team. No areas of concern were identified and therefore no major changes required.
Emergency Laparotomy Audit (NELA)	**Y**	**Report received - 13 October 2017** This audit has now moved to a Best Practice Tariff and we continue 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 is in place, with dedicated time in job plans to support decision making.
Severe Trauma (Trauma Audit & Research Network) TARN	**Y**	Quarterly dashboards and 3 injury specific reports are published annually and reviewed by the A&E Consultant Lead. 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. Maidstone 90%, Tunbridge Wells 100%, national average 48%.
RCEM Severe Sepsis and	**Y**	**Report published May 2017**

National Report Published April 2017 to March 2018	*Report received*	Date report due
Septic Shock 2016		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 has been 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 downloaded and is with the specialty for review and action plan development. **Update:** Patients are being risk assessed prior to surgery so that those patients at high or moderate risk are proactively admitted to critical care facilities. Patients who are initially managed conservatively receive close assessment to ensure that the obstruction is resolving, if not then patients may need to proceed to surgery. A local policy is being developed to ensure that all patients have a nutritional assessment within 24 hours of admission. Discussions are also being had with the radiology team to optimize the timing of CT scans.
RCEM Adult Asthma 2016	**Y**	**Report published May 2017** 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 has been 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 has taken place to ensure all patients admitted to the Acute Medical Unit (AMU) have an Early Warning Score (EWS) measured upon arrival and reviewed by a competent decision maker within 4 hours of admission.
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 continue to complete drug prescription chart for all patients requiring emergency oxygen. The Nerve Centre database has been updated to allow oxygen saturation target parameters to be entered for each patient. Some SpO_2 ear probes were purchased for the Respiratory Wards but over time have been borrowed by other areas so they continue with the finger monitors.
National Comparative Audit of Blood Transfusion Programme		
(National Comparative Audit of Blood Transfusion Programme) Red cell and platelet transfusion in adult haematology	**Y**	**Report publication delayed and not available at time of 2017/18 report.** **Update: Report published January 2018** The team are implementing a number of actions to improve our compliance. The Clinical Guideline for the Use of Blood Components and Alternative Treatments will have a section

National Report Published April 2017 to March 2018	*Report received*	Date report due
		added on how to manage transfusions in patients at high risk of Transfusion-related circulatory overload (TACO). The team are raising awareness of the Informed Consent Action Group (ICAG) Pad and auditing its use. They are also moving to the use of electronic issue for cross-matching bloods. They are encouraging the lab staff to only issue one unit of red cells for routine top-up transfusions and to only release subsequent units on repeat Hb.
(National Comparative Audit of Blood Transfusion Programme) Comparative audit of transfusion associated circulatory overload 2017	**Y**	**Report publication delayed and not available at time of 2017/18 report.** **Update: Report published in June 2018**. The team are implementing several actions to ensure our compliance. A Transfusion-related circulatory overload (TACO) checklist will be developed and approved, implementing electronic issue and updating the Trust's Transfusion Policy.
(National Comparative Audit of Blood Transfusion Programme) Audit of the patient blood management in scheduled surgery re-audit	**Y**	**Report received 23 October 2017** The Hospital Transfusion Team and Hospital Transfusion Committee teams are implementing a number of actions to improve our compliance. To establish testing pathways for patients found to be anaemic at Pre-Assessment Clinics. The team will establish Trust Guidelines for the investigation and treatment of anaemia. They will continue to perform local audits on blood use and its appropriateness and feedback the findings through regular workshops. There is also a move towards using Electronic Issue in the Blood Bank which will facilitate issuing one unit at a time in non-bleeding patients and insisting on a repeat Hb after every unit.
(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. A new geriatrician has been appointed and it has been built into the job role that they would review elderly surgical patients on wards, via the care of the elderly referral.
Serious Hazards of transfer (SHOT) UK. National haemovigilane scheme	**Y**	**Report received September 2017** The team are promoting the key messages of using the handover log, communicating effectively, and raising issues promptly to reduce the risk of errors. 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	**Y**	**Report received 24 January 2018**

National Report Published April 2017 to March 2018	*Report received*	Date report due
(NLCA)		This report is currently with the clinical team for assessment of compliance and action planning. **Update:** Actions have been put in place for entries to be checked during data entry validation. Detailed case note review will be performed for patients who did not receive curative treatment. Multi-Disciplinary Meeting (MDM) leads will continue to review the weekly list of patients. The MDM aim is to adopt a national optimum lung cancer pathway and endeavour to discuss patients only once if possible. The MDM lead will discuss funding with management for a pulmonary nodule MDM.
National Audit of Bowel Cancer (NBOCAP)	**Y**	**Report received 14 December 2017** The team is regularly reviewing the morbidity and mortality cases to include emergency bowel cancer presentations. There have been improvements in liaison between the hospital and community teams regarding patients who might need additional support post operatively.
Head & Neck Cancer (DAHNO)	**N/A**	Delays with publishing national report. Put on hold while contract is renegotiated.
National Prostate Cancer Audit 2017	**Y**	**Report received 22 November 2017** The prostate cancer team continue to work with the urology team, through Multi-disciplinary Meetings, to identify those patients who will potentially benefit from treatment for locally advanced disease.
Oesophago-gastric cancer (NAOCG)	**Y**	**Report received on 14 December 2017** We remain fully compliant with most recommendations, but the team are continuing to review the protocols in place for HGD (high grade dysplasia) patients being presented at Multi-Disciplinary Teams.
Endocrine and Thyroid National Audit	**N/A**	Continuing delays with national reports being published. No proposed publication dates provided.
National Ophthalmology Database Audit Project	**N/A**	The Trust was unable to submit data to this national audit due to software issues. Awaiting purchase of the Open Eyes module.
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. **Update:** MTW performance is in line with national standards and full assurance was achieved. No actions were required and the urology team continue to submit annual returns to this national audit.
BAUS Urology Audits: Urethrolasty audit	**N/A**	The Trust does not provide this service
Chronic Kidney Disease in	**N/A**	The Trust does not provide this service - Primary Care Only

National Report Published April 2017 to March 2018	*Report received*	Date report due
Primary Care		
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** The Trust performs significantly above national average and equitably between both sites. Logistical issues still persist with outliers and lack of beds on cardiology wards. All patients received an ECHO and were discharged on the appropriate medication. Not all heart failure patients have been able to participate in cardiac rehabilitation due to lack of funding from the CCG to increase this service.
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 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
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 (NDFA) 2016-17	**Y**	**Report published 14 March 2018** The Trust is largely compliant with national targets. Our results only include inpatients with more severe ulceration rather than out-patients attending clinic. Nearly 50% of patients are seen by the foot MDT team within 2 days of presentation compared to 14% nationally. 53% of patients are still having persistent ulceration at 12 weeks compared to 44% nationally and 24% at 24 weeks (equalling national results). On reviewing the results it demonstrates that our diabetic patients have more severe infection, greater depth and size.
National Core Diabetes Audit (NDA) 2015-16	**Y**	**Report published July 2017** The Trust is compliant with the national recommendations.

National Report Published April 2017 to March 2018	*Report received*	Date report due
		All Type 1 patients are offered structured education (DAFNE) and all Type 2 patients are offered community run education (DERIK). MTW is the biggest single Diabetes Pump Service in the whole of Kent. Patients with Type 1 diabetes who meet NICE criteria for insulin pump therapy are assessed using the 'pre-pump assessment pathway'.
National Core Diabetes Audit (NDA) 2016-17	**Y**	**Report published 14 March 2018** The Trust is compliant with the national recommendations. All Type 1 patients are offered structured education (DAFNE) and all Type 2 patients are offered community run education (DERIK). Young adult patient clinics are available as well as a Facebook patient page administered by MTW.
National Diabetes Transition audit (NDTA) 2003-14	**Y**	**Report published July 2017** This is the first published report for the National Diabetes Transition audit (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 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 indicates that key indicator assessment for delirium, measurement of lying and standing blood pressure and medication that increases risk of falls are areas that require work to improve. Actions include education of medical staff to ensure that they carry out delirium screening while the patient is still in the Emergency Department. To relaunch the RCP clinical practice tool which will standardise practice and prompt staff to carry out all necessary assessments and medication reviews.
	N/A	**2. Fracture Liaison Service.** MTW does not provide this service. This is a community service.
	Y	**3. National Hip Fracture Database (NHFD)** **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** **Update:** This was in essence a public report that detailed QIP projects that had been carried out by participating trusts. No results or recommendations were included.
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. **Update:** MTW were partially compliant with national

National Report Published April 2017 to March 2018	*Report received*	Date report due
		recommendations. All patients had a review at 6-12 month intervals and had communications individually tailored for their needs. For those patients that have sudden onset of sleep, it is not always documented that they have been advised not to drive and to consider occupational hazards.
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 have been 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 being 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. **Update:** Received August 2018 and reviewed in Appendix A
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 and Children		
MBRRACE-UK Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal Mortality Surveillance	**Y**	**Report received 22 June 2017** There were 5,700 births in 2015 within our Trust. Stillbirths = 22, neonatal death = 2, extended perinatal death = 24, 4.21 per 1000 births (MTW are up to 10% lower

National Report Published April 2017 to March 2018	*Report received*	Date report due
2015 (reports annually)		than average for group). Training schedule set up to ensure staff are able to give relevant information regarding post-mortems and placental histology to bereaved parents sensitively.
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** The Trust is almost fully compliant. To improve prevention and treatment of sepsis, staff attend mandatory PrOMPT emergency training days annually and team has completed a local audit and continues to raise awareness of importance of investigation and prompt treatment of sepsis amongst team for all patients to include the critically ill pregnant women.
MBRRACE-UK Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal Mortality and morbidity confidential enquiry (reports every second year)	**Y**	**Report received 28 November 2017** The Trust is partially compliant; a review of midwifery staffing was completed using Birthrate Plus and multidisciplinary training in situational awareness and human factors to be undertaken by all staff who care for women in labour being implemented. Bereavement checklists are already in use and an email was sent out to all consultants and secretaries to ensure seamless care for parents following intrapartum related deaths.
MBRRACE-UK; Serious Maternal Morbidity - Saving Lives; Women with severe epilepsy (October 2015 to March 2017)	**Y**	**Report received 7 December 2017** This report was been reviewed by the Maternity Team, the Trust is partially compliant, with ongoing work to share good practice across Kent and Medway continuing, a new mother and baby unit has been set up in Dartford that allows new mothers with mental health issues to stay with their babies whilst they receive treatment. Due to financial constraints, the Trust is unable to provide flu vaccination clinics for pregnant women but all pregnant women are advised to be vaccinated at their GP Surgery.
National Diabetes Audit – Adults Pregnancy in Diabetes	**Y**	**Report received 12 October 2017** The Trust is partially compliant, ongoing work on raising awareness with primary care teams of the benefits of all pregnant diabetic patients attending the combined multidisciplinary team clinic before ten weeks. A clear pregnancy pathway is being developed for GPs and Practice Nurses to ensure pregnant women with diabetes are referred early to the multidisciplinary Diabetes Service.
National Maternity and Perinatal Audit (NMPA)	**Y**	**Report received and distributed 10 November 2017** The Trust has worked hard to reduce the number of 3rd/4th degree tears by sharing and implementing good practice. All grades of tears are recorded on E3 (maternity electronic patient record system) and the statistics generated are closely monitored. A detailed review of postpartum haemorrhage >1500 ml has been completed and our PPH guideline has been updated and published.
Paediatric Inflammatory Bowel Disease; Biologics (IBD Programme)	**N**	MTW NHS Trust has not received the annual report as we do not subscribe to this service.
National Paediatric Diabetes Audit (NPDA**)**	**Y**	**Report received and distributed 10 October 2017** The Trust continues to have problems with data entry and is currently benchmarking their service against similar local services and this includes a review of other Trust's systems and how they manage the interface issues with Twinkle (electronic paediatric diabetes patient records system).
Neonatal Intensive and Special Care (NNAP)	**Y**	**Report received 31 October 2017** The Trust was partially compliant with some data entry

National Report Published April 2017 to March 2018	*Report received*	Date report due
		issues and some problems with the interface between Badger (neonatal unit electronic patient record system) and E3 (maternity electronic patient record system). Significant work has since been completed to improve these issues including making some fields on both systems mandatory. The Trust has been awarded Unicef Baby Friendly Initiative level 1 compliance.
Paediatric Intensive Care (PICANet)	**N/A**	The Trust does not provide this service
National BTS Paediatric Pneumonia Audit 2016	**Y**	**Reports received July 2017 and January 2018** Results showed that there had 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 all suspected community acquired pneumonia cases now start treatment without the need for x-rays. Oral antibiotics are used more often as the first line of treatment; those requiring IV antibiotics still continue to have blood cultures sent for testing as good practice.
Confidential Enquiries		
NCEPOD: Inspiring Change (Non-Invasive Ventilation)	**Y**	**Report received 13 July 2017** Trust was found to be largely compliant with clinical care and levels of staff training provided. The Trust needs to appoint a Consultant NIV Lead; the recruitment process for this is currently underway. All issues relating to NIV are reported and reviewed via the NIV Steering Group. NIV is delivered within 1 hour when blood gas measurements identify the need. A proforma for an NIV prescription chart is awaiting ratification and when in place will record all changes to ventilator settings. Vital signs are monitored via the use of the National Early Warning Score as recommended.
NCEPOD: Each and Every Need (Chronic Neurodisability)	**Y**	**Report received 8th March 2018** Report disseminated and with specialties for assessment.

Appendix C

Summary of local audits undertaken during 2018/19 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 CG110; Re-audit of the management of pregnancy & complex social factors	Fully compliant	All required standards for this audit were met with 100% compliance for the notes reviewed. Since this audit was last carried out in 2015, the Trust now has a Deputy Named Midwife for Safeguarding Children in post who reviews all concern and vulnerability forms completed and advise the midwives accordingly. There is also now the Maternity Safeguarding Hub which is held every month to discuss complex cases.
NICE NG81; Glaucoma Re-Audit	Fully compliant	Actions implemented from the previous audit were to ensure that patients receive an information leaflet at their first visit and/or verbal communication about their condition and treatment. All standards were met this round of the audit and no clinical concerns or risks identified.
NICE CG152; The rate of surgical recurrence in Crohn's disease	Fully compliant	This audit aimed to review the outcome from our Crohn's resections and specifically the 5 years surgical recurrence rate. The results confirm that our practice conforms to published data and patients received optimal medical therapy. Therefore no changes are required to our current practice.
NICE TA460; Use of Steroid Intravitreal implant (Ozurdex) for Uveitis	Fully compliant	The aim of this audit was to examine the outcomes following administration of Ozurdex implant to treat non-infectious uveitis. Whilst the clinical standards were fully met, the audit did identify that some patients were not attending or missing their follow up appointments. A protocol is being developed to set the postoperative expected time points for scheduling these follow-ups.
NG78 Cystic Fibrosis - Paediatric (QS168)	Fully compliant	This audit identifies good performance in the delivery of quality care (diagnosing and managing cystic fibrosis in infants, children, young people and adults) to our paediatric cystic fibrosis patients. We meet all standards relevant to our service listed in NICE QS168 Cystic Fibrosis.
NICE TA204 Osteoporosis Biologics (Denosumab) Criteria 2 only re-audit round 2	Fully compliant	This audit demonstrated that current practice in using denosumab for the secondary prevention of osteoporotic fractures in postmenopausal women was fully compliant with the NICE guidelines. No changes in practice were required.
TA495: Palbociclib use in ER1 and HER2 - locally advanced/ metastatic breast cancer audit.	Fully compliant	In summary, Kent Oncology Centre has followed the NICE Guideline TA495 correctly in the majority of cases since Palbociclib has been funded by NICE. There were some errors initially when Palbociclib w new, but these have become much less recently. Looking at the patients that were outside of the guidance, they were all within the firs months of the guidance being issued, meaning that Palbociclib is beir

		used appropriately as we have got used to prescribing it.
NICE TA305; All Anti VEGs for treating visual impairment caused by Macular oedema secondary to Central Retinal Vein Occlusion (CRVO)	Partially compliant	This audit has highlighted delays in initiating treatment which has the potential to cause a degree of irrecoverable visual loss which is a serious concern. Additionally, patients are not always being given the three doses of injections (94%) as per NICE Guidelines because they seem to show significant recovery without receiving the full three doses. Anti-Veg injections given as monthly doses was 94% and partially compliant with the guidelines. A business case is being produced to implement designated CRVO clinics and increase the number of injection clinics to reduce the length of waiting times for patients.
NICE CG174; Re- audit of the prescription of IV fluids - a trustwide audit	Partially compliant	Following an intervention of teaching sessions to healthcare professionals and publication of intravenous fluid guidelines, fluid prescription has improved. Further interventions are needed and will include additional teaching sessions, fluid therapy handouts / stickers, and online prescribing to automatically calculate how much electrolytes are being administered. Patients will receive the fluids required and aid a reduced length of stay.
NICE CG 124 A Clinical Audit to improve time to theatre for patients with Neck of Femur Fracture (#NOF)	Partially compliant	From the first round of the audit we identified the cause for delays to theatre in #NOF patients, generated a business case and through appointing a trauma fellow with a dedicated trauma list, rapidly improved time to theatre for these vulnerable patients. We will continue prioritising NOF's in list planning during trauma meetings to ensure that this group of patients receive early surgery as evidence indicates that this will lead to improvements in functional outcomes, reduce post-op complications and reduce length of stay.
NICE CG129 & QS46; Re-audit of Antenatal Care of Twin Pregnancies (Round 2)	Partially compliant	At present the Trust requires a more robust reporting system in order to provide evidence of compliance and a better method of relaying important information specific to multiple pregnancies to our patients. We intend to introduce specific standard documentation on E3 (Maternity Electronic record system), review our patient pathways and write a patient information leaflet to achieve a higher level of compliance
NICE CG190; Re-audit of Massive Obstetric Haemorrhage (PPH) - Incidence and Management	Partially compliant	Significant improvements have been made to the documented standard of care for major severe PPH. The introduction of a simplified escalation policy appears to have had a significant effect. We now also continuously monitor the monthly severe PPH rate (>1500 ml) via the Maternity dashboard. Recently, the Trust has introduced a new Maternity risk dashboard, which has adopted the National Maternity and Perinatal Audit standard for severe PPH of blood loss greater than 1500 ml. It has been agreed going forward that this will be the auditable standard used at the Trust. A formal documentation process for debriefing of severe PPH patients is required. Our recommendation is that this should be documented on the Euroking maternity system and re-audited once established.
NICE IPG104 - Re-audit of Impedance-controlled endometrial ablation for menorrhagia Novasure)	Partially compliant	The audit showed that Novasure endometrial ablation, with correct selection of patients, is an appropriate treatment for women with menorrhagia in MTW. There is a high patient satisfaction rate (100%). We are considering the possibility of Novasure being moved to the outpatient setting.
NICE CG94 & CG130 Management of patients with ACS (acute coronary syndrome).including Hyperglycaemia and GRACE Scoring re-audit	Partially compliant	Overall care was good in the majority of areas assessed. The audit found that all patients were appropriately treated with dual antiplatelet therapy and Fondaparinux on admission and all were appropriately treated with 12 months of DAPT therapy. The audit did find some areas of minimal documentation and risk stratification of patients being admitted with ACS (acute coronary syndrome). New processes are being put in place to improve documentation of GRACE scores for suspected ACS patients.
Audit to review NICE CG124 guidelines for day 0 mobility post elective TKR and THR surgery	Partially compliant	This audit looked at whether patients were mobilised on day 0 following elective total hip or total knee replacements. Multiple reasons were documented for not meeting this target (62%) including patients returning late to the ward from theatre, patients declined to stand and levels of pain. Results showed that when patients did stand on day 0 the average length of stay was between 2-3 days rather than an average of 5+ for the small group of patients that did not stand on day 0. The physiotherapy team

		plan to increase education on wards to encourage day 0 mobility for elective joint replacements.
NICE CG144 Appropriateness of adult CT pulmonary angiogram requests at Maidstone and Tunbridge Wells Hospitals.	Partially compliant	There is no direct patient risk identified by those standards not met in the audit; however appropriate use of the diagnostic tools available to the clinician and calculation of the pre-test probability may result in a decrease in the number of CTPA scans being performed. Radiologists have requested that all patients should have a Wells score calculated and documented on the electronic ordering system prior to CTPA discussion with a radiologist.
NICE TA305; All Anti VEGs for treating visual impairment caused by Macular oedema secondary to Central Retinal Vein Occlusion (CRVO)	Partially compliant	Central retinal vein occlusion (CRVO) is a common cause of reduced vision as a result of retinal vascular disease. This audit has highlighted delays in initiating treatment and 6% patients are not always being given the three doses of injections (94% received 3 doses) as per NICE Guidelines because they seem to show significant recovery without receiving the full three doses. The team plans to improve the service provided at our trust by making designated CRVO injection clinics to improve waiting times for patients and increasing the total number of injection clinics.
Audit to assess the outcomes of Gleason 7 prostate cancer treated with low-dose rate brachytherapy (IPG 132)	Partially compliant	This audit against NICE IPG132 found that we partially met one standard and fully met the other standard. The PSA nadir level is slightly lower than the standard as per NICE guidance (82% -v- 86%) IPG 132, however this has had no adverse outcome on overall survival or progression-free survival for the patients treated with low-dose rate brachytherapy. Therefore no clinical concern has been identified. The 5 year overall survival rate was 94.7% against a standard of 93%. No patients died due to their prostate cancer, but 9 patients died of unrelated causes. The team plans to continue to offer patients with prostate cancer, who are suitable to have low-dose rate brachytherapy, this treatment option.
NICE CG103: Re-audit - Delirium screen and prevention: A reflective practice.	Partially compliant	This audit has shown significant improvement. 100% of ICU pharmacists are now reviewing the patient's prescription charts and advise clinicians regarding the use of delirogenic drugs, the level of patients with moderate to severe pain scores has also decreased significantly which shows that pain is being better controlled. Compliance has improved across all standards audited except one - it was disappointing to find that that only 80% of patients are being screened for delirium which can cause delays in the early recognition and prompt intervention in this group of patients. The Intensive Care Delirium Screen checklist is to be disseminated to all members of the ICU staff and training sessions will be held for all new members of the team to ensure that staff know what is required of them regarding the delirium screening to ensure high levels of patient care.
NICE NG29; Intravenous (IV) fluid therapy in children & young people in hospital	Partially compliant	This audit found that five of the six standards were met. Clear evidence was provided (100%) on utilising the correct calculation for fluid replacement with children and young people having their electrolytes checked within 24 hours. The audit did show that there was poor documentation in the medical records of the initial dehydration status / assessment tool used. At the time of the audit the fluid charts used were not adapted to incorporate the new standards and the failings noted were lack of evidence for strict fluid output monitoring as not documented in mls / kg. New documentation of fluid management is being implemented to support this standard which will enable improved compliance with the standards.
NICE CG37; Re-audit of Management of routine postnatal care of women & their babies (Safeguarding Children) (QS37)	Partially compliant	This audit showed improvement in the level of compliance with 6 of the 9 standards now being fully met. Women and main carers of babies are now better being informed of symptoms and signs of potentially life-threatening conditions. Other information on risks of co-sleeping, programmes that encourage breast feeding, bottle feeding and emotional wellbeing showed high levels of compliance. Monthly audits will be undertaken using the E3 maternity database to continue to improve documentation and therefore consistent information being imparted to women.

NICE CG190; Re-audit of the management of Intra-partum care	Partially compliant	The audit reflects that there needs to be a general improvement in the documentation in the handheld notes and the data captured on E3 (maternity Database) to reflect the conversations midwives and obstetricians are having with women regarding birth planning. The audit identified that there needs to be a refocus on normal birth in the delivery suite setting. The relaunch of Take 5 at handovers can be used to inform the team of improvements in normalising care and remind the midwives to improve the accuracy of their documentation.
NICE CG50 (partial) - Audit of adherence to Trust Escalation Policy (Anaesthetics)	Not compliant	This audit has demonstrated that on a trust-wide basis, escalation for deteriorating patients only occurred in 67% of patients whose PAR score reached a level that should mandate a medical review. Only 45% of patients who triggered for escalation had their care escalated to an appropriate level of seniority as determined by the Trust Patient at Risk Score Algorithm. Planned actions are upgrading the current NerveCentre electronic observations system to enable clinical prompts. Improved recognition and escalation of deteriorating patients will improve the standard of patient care that staff provide
NICE NG89; Re-audit: VTE Thromboprophylaxis and AES stockings for Surgical Patients	Not compliant	VTE prophylaxis is important because it significantly reduces an element of risk associated with surgical admissions. The most deficient area of care assessed was completion of the second VTE risk assessment within 24 hours of admission. Compliance could be improved by making it the responsibility of the post taking team to ensure that a second assessment is completed. Actions are planned to Include a talk about VTE prophylaxis during the new F1s induction. Posters have been designed and displayed in the teams meeting rooms to remind juniors of their responsibility regarding VTE prophylaxis. The trust policy is to be updated to show that when a patient's care is taken over by a new team they should have a new VTE risk assessment carried out.
NICE NG38; Fractures (non-complex); Audit of management of distal radial fractures	Not compliant	The audit identified a good performance in documentation of clinical assessment at presentation, appropriate initial radiographic assessment, referral to fracture clinic and correct position of plaster application. Areas identified as requiring improvement: Use of regional anaesthesia rather than haematoma block when manipulation is indicated and inadequate assessment of bone health and falls risk. Additional teaching and training/simulation sessions have been implemented. A pathway has been developed to help doctors determine who is indicated for bone health assessment. This will help raise awareness of the importance of investigating bone health in fracture patients.
NICE CG124; Does access to pre-prepared equipment pack for Fascia Iliaca Nerve Block increase the provision of pre-operative nerve blocks for patients?	Not compliant	This audit found that although the Introduction of pre-prepared packs for Fascia Iliaca Nerve Block (FIB) did not appear to improve provision of nerve blocks for hip fracture patients, pre-operatively it did cut time from admission to block from an average of 1 hour 50mins to 42 mins. Notably, patients were twice as likely to receive a block if admitted during the day. It was decided to continue with pre-prepared FIB packs as they benefit admission-to-block time. Additional training courses have been implemented and the hip fracture proforma has been amended so that it will be quicker to indicate contraindications to nerve block. The overall aim is for patients to receive better pain relief for their #NOF.
NICE CG176; Re-audit of Paediatric Neurological Documentation (Round 3)	Not compliant	Although there was an improvement in performing, recording and documenting the correct neurological observations the standards were still not fully met. The team plans to create a proforma which should start with the patient when admitted and remain with the patient throughout their admission. Neuro observation charts are to be made available in A&E departments on both hospital sites and on Woodlands and Riverbank wards. Head injury/neuro observation procedures to be included in paediatric and A&E induction and teaching updates.

NICE CG137; Re-audit of the Use and Utility of EEG in the Diagnosis of Epilepsy in Children (Round 2)	Not compliant	This re-audit was carried out by the paediatric team following staff education in respect of ordering EEGs for this group of patients. The results showed that EEGs are often used as an exclusion tool rather than to support a diagnosis of epilepsy, this can lead to unnecessary investigations / interventions. The team will include EEGs in the department teaching programme to lead to a reduction in inappropriate referrals and the number of requests for EEG's.
NICE CG160; Re-audit of Paediatric Fluid Balance Charts – 2017	Not compliant	This audit found that fluid charts were not always being started on all paediatric patients who require a fluid chart upon their admission. A new fluid chart is in the process of being designed and trialled before introduction to the unit. Staff will find the new fluid chart more intuitive and therefore easier to complete. Improvement in patient care pathway.
NICE CG109 Syncope audit and re-audit	Not compliant	Following the last round of this audit a poster was designed to help prompt the initial medical clerking and assessment and details of investigations required. While improvements were identified in most criteria audited, the quality of history taking was overall sub-standard according to guidelines. There was an overall improvement in recording the clinical examination but still sub-standard. The team plan to insert the syncope flow chart into the Junior doctor's handbook and additional teaching sessions ad induction in order to improve the initial assessment of these patients.
NICE CG84; Re-audit of the management of Diarrhoea and Vomiting (D&V) in children	Not compliant	Results showed that we are effective at introducing oral rehydration therapy and encouraging parents to keep it going. We also perform well with sending only necessary investigations and keeping parents updated about the next steps of treatment. The team is working towards improving documentation of treatment provided and ensuring that the use of NG tube administration of oral fluid therapy is embedded in practice with all relevant staff completing the required competencies associated with NG enteral feeding tubes.
NICE CG75; Re-audit Metastatic spinal cord compression (MSCC) in adults: risk assessment, diagnosis and management	Not compliant	This audit highlighted that investigations and treatment took place outside the recommended time frames. It is not clear if this is due to a failure in the MSCC service or if the results reflect poor documentation. Initially the team want to prioritise improved documentation by developing a proforma for use with the medical department to facilitate compliance and to develop an electronic record to document MSCC in oncology records; they also plan to update local acute medicine guidelines on the management of MSCC.
NICE CG99, QS62; Audit of Constipation in Children	Not compliant	The results show that there is likely to be poor documention of the assessment of paediatric patients visiting our Trust for diagnosis and treatment of constipation. Only one patient out of eighteen being fully documented as having a full assessment before being diagnosed. However children diagnosed with constipation are appropriately treated as per the NICE guidelines. The audit did find that many of these patients are not being reviewed once their treatment plans have started at the appropriate time. Parents are also not being given the information that they need when the children start laxative treatment. The team have put in place information for parents by providing information leaflets on Riverbank and Woodlands. Follow up appointments are to be booked at the commencement of treatment for constipation. Teaching sessions are to be undertaken to improve the assessment of children with constipation

Part Five

Stakeholder feedback

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

West Kent Clinical Commissioning Group comments on the 2018/19 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

We would like to thank Maidstone and Tunbridge Wells NHS Trust (MTW) for submitting their quality accounts and for working closely with the quality team within the CCG to support your quality improvement. As the main provider of acute NHS services for the population in West Kent, the CCG Quality Team is proud to support the trust in their aspirations and vision to provide safe, sustainable high quality care to their patients. Welcoming their endeavour to be improvement driven, and responsive, to the needs of their patients and staff.

We recognise and are encouraged by the good work that has gone into many areas within the trust in relation to sepsis management, CQC improvement plan, the 7 day standard, audit and research, Accident and Emergency targets, hospital@home service and CQUIN submission.

It has been delightful to see the trust have continued their work in their 'Best safety' work stream that focus's the importance of learning through incidents and improving the flow of this information to all staff. The new digital solutions and review of agenda's has supported the trust to gain insight into themes and trends. The CCG embraces their no blame culture and their vision of a 'just culture' initiative. We are heartened by their continued investment for the coming year into embracing the lessons learnt work stream and encouraging staff to share. We are also assured by their focus in the coming year in reviewing how they can improve their Infection Prevention and Control elements, which are supported by this year's CQUINS, as this has continued to be a challenge for the teams.

As the trust have alluded too, it is essential in any quality improvement that patient experience is central. It is encouraging to see that the trust has aligned improved patient outcomes with staff satisfaction. The CCG are confident that with the Best Quality strategy that includes the initiative 'make it personal', though at present in its infancy, will make a difference in the coming year. FFT responses in some areas have remained a challenge but the CCG are encouraged to note the continued work to improve this.

MTW continue to recognise and focus on the importance of patient flow and its relationship with delivery of safe and effective care. We are enthusiastic about the plan of new roles for staff within the trust to support the flow with enhancement of pathways and models of care. They continue to be challenged in the RTT and cancer pathways however the CCG are encouraged by the improved harm review process's and look forward to supporting the improvement in 19/20. The CCG are delighted that there has been a significant reduction in mortality rates for the trust that they are no longer classed as an outlier amongst their peers. This is a credit to the staffs hard work and resilience in mortality review and shared learning.

In conclusion the CCG are delighted with the improvement to patient care and outcomes in the previous year and encouraged by the continued commitment of the trust to learn from incidents and individualising the care their patients receive. The narrative in the report goes just a small way to show the commitment of the staff to ensure that they are able to provide safe and sustainable high quality care to all of its patients. We look forward to continue to build relationships, work collaboratively and continue the improvement to outcomes in the coming year.

Paula Wilkins
Chief Nurse for Medway, North and West Kent Clinical Commissioning Group

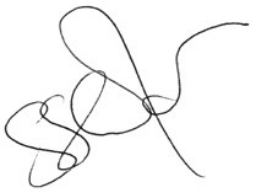
Health Overview and Scrutiny Committee – Kent County Council comments on the 2018/19 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

Thank you for offering Kent County Council's Health Overview and Scrutiny Committee the opportunity to comment on the Maidstone & Tunbridge Wells NHS Trust's Quality Account for 2018-19. HOSC has received a number of similar requests from Trusts providing services in Kent, and we may well receive more.

Given the number of Trusts which will be looking to KCC's HOSC for a response, and the window of 30 days allowed for responses, the Committee does not intend to submit a statement for inclusion in any Quality Account this year.

Please be assured that the decision not to comment should not be taken as any reflection on the quality of the services delivered by your organisation and as part of its ongoing overview function, the Committee would appreciate receiving a copy of your Quality Account for this year once finalised.

Kind regards



Sue Chandler
Chair, Health Overview and Scrutiny Committee Kent County Council

kent.gov.uk

Healthwatch Kent response to the Maidstone and Tunbridge Wells NHS Trust Quality Account

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'd like to support the Trust by setting out the areas we have worked together on in the past year:

- We met with the deputy Chief Nurse regularly to share the feedback we have heard.
- We regularly meet with patients within the hospitals to gather feedback about particular services including Outpatients, Oncology and Ophthalmology.
- We attend the Patient Experience Committee to share what the public have told us about services that the Trust provide
- Following our report detailing people's experience of being discharged from hospital we have worked with the Trust to capture the changes and improvements that have been made in response to our recommendations. Highlights include support being available for patients who need help to make space for medical equipment at home, more physiotherapy is provided within the hospital and more patients are being discharged before lunchtime.
- We have been working with the Trust to improve care for Parkinson's patients following an individual experience of a patient. This has meant that staff within the Trust have now been trained to be more aware of the support Parkinson's patients may need. We are currently working with the Trust to implement a new medicine box to enable patients to remain in charge of their own medication during a hospital stay.
- Together with colleagues at Healthwatch East Sussex we visited A&E at Tunbridge Wells Hospital to gather feedback from patients. A key recommendation includes not leaving patients for too long on bed pans and commodes.
- We visited Maidstone Hospital in partnership with The Kent Association for the Blind to understand what support was available for partially sighted patients. Our volunteers found a number of issues which we are working with the Trust to improve. Improvements so far include an audit of hearing loops across both hospitals and better training for staff on the needs of patients.
- We have been encouraging and supporting the Trust to develop a new strategy for involving and hearing from patients across West Kent.

We look forward to continuing our constructive working relationship with the Trust in the next year.

Healthwatch Kent May 2019

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

We have been engaged by the Board of Directors of Maidstone and Tunbridge Wells NHS Trust to perform an independent assurance engagement in respect of Maidstone and Tunbridge Wells NHS Trust's Quality Account for the year ended 31 March 2019 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

Scope and subject matter
The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the following indicators:

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

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

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

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

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

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

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

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

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

- Board minutes for the period 1 April 2018 to 26 June 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 26 June 2019
- feedback from commissioners dated 21 May 2019;
- feedback from local Healthwatch organisations dated 24 May 2019;
- feedback from the Overview and Scrutiny Committee dated 3 May 2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated 26 November 2018;
- the national patient survey dated 29 January 2019;
- the national staff survey dated December 2018
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 9 May 2019;
- the annual governance statement dated 23 May 2019;
- the Care Quality Commission's inspection report dated 9 March 2018;
- any other information obtained during our limited assurance engagement.

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

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

Assurance work performed

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

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

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

Limitations

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

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

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

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

Our audit work on the financial statements of Maidstone and Tunbridge Wells NHS Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Maidstone and Tunbridge Wells NHS Trust's external auditors. Our audit reports on the financial statements are made solely to Maidstone and Tunbridge Wells NHS Trust's directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to Maidstone and Tunbridge Wells NHS Trust's directors those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of [Maidstone and Tunbridge Wells NHS Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Maidstone and Tunbridge Wells NHS Trust and Maidstone and Tunbridge Wells NHS Trust's directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

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

Grant Thornton UK LLP
Chartered Accountants
2nd Floor, St Johns House
Haslett Avenue West
Crawley
West Sussex
RH10 1HS, United Kingdom.

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

Miles Scott
Chief Executive

NHS
Maidstone and Tunbridge Wells NHS Trust

Quarterly mortality data **Medical Director**

Summary / Key points

This report is submitted in line with guidance from the National Quality Board, March 2017. This stipulates that Trusts are required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public board meeting in each quarter to set out the Trust's policy and approach and publication of the data and learning points. This report also provides an update into the further actions that have subsequently been taken to understand and improve our Trust position, as a previous outlier, in regard to the Hospital Standardised Mortality Ratio (HSMR).

This report is based upon the Trust's most recent data, published by Dr Foster for the period of March 2018 – February 2019.

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

Information, assurance and discussion.

Mortality Surveillance Report

Hospital Standardised Mortality Ratio (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 2018 to February 2019 show our HSMR to be 92.7, which is a decrease compared to last month's position of 97.0.

Figure 1. Rolling 12 Month view

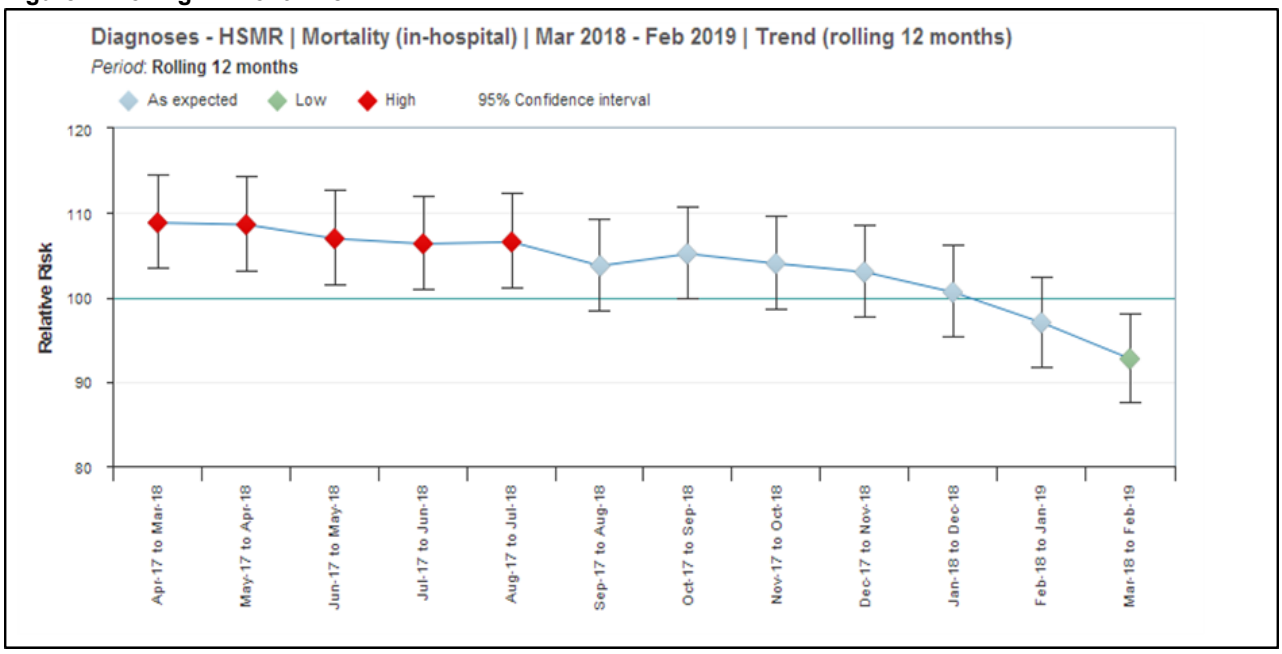
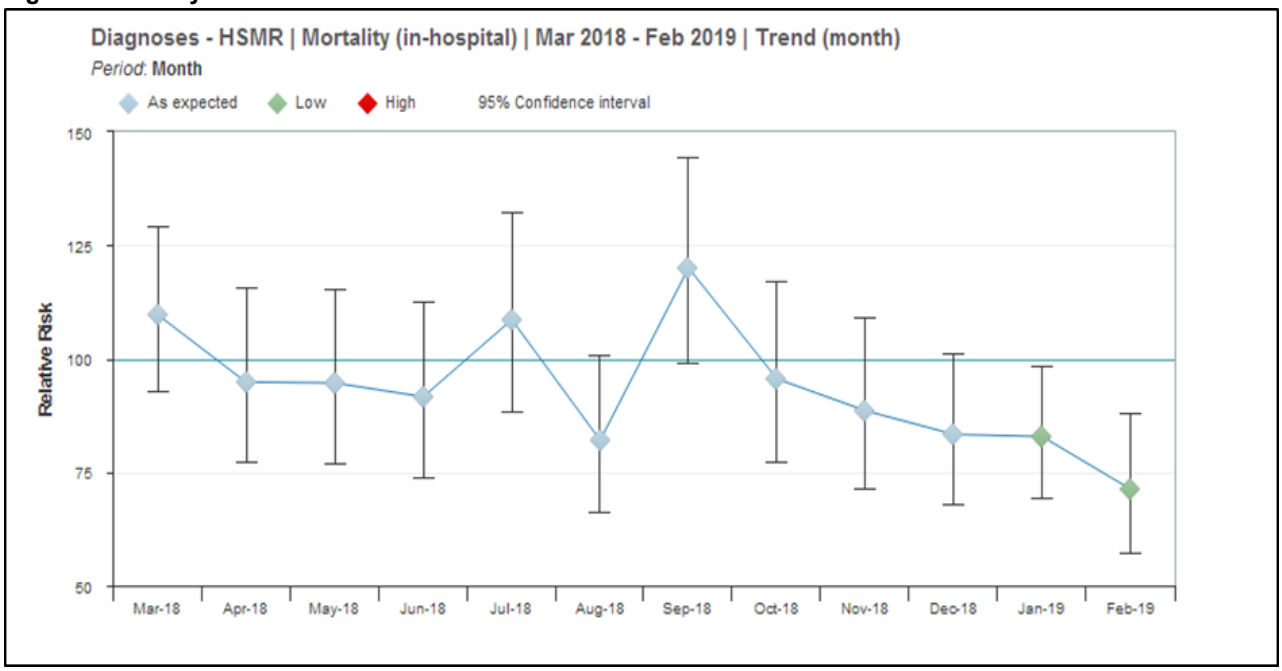


Figure 2 shows a monthly view of our HSMR performance. The latest month should be viewed with caution as this often shows a false position due to the lag in coding activity. Viewing the previous month, so January 2019 in this case, shows that the Trust's position has decreased slightly to 82.8 from 83.3 in December 2018.

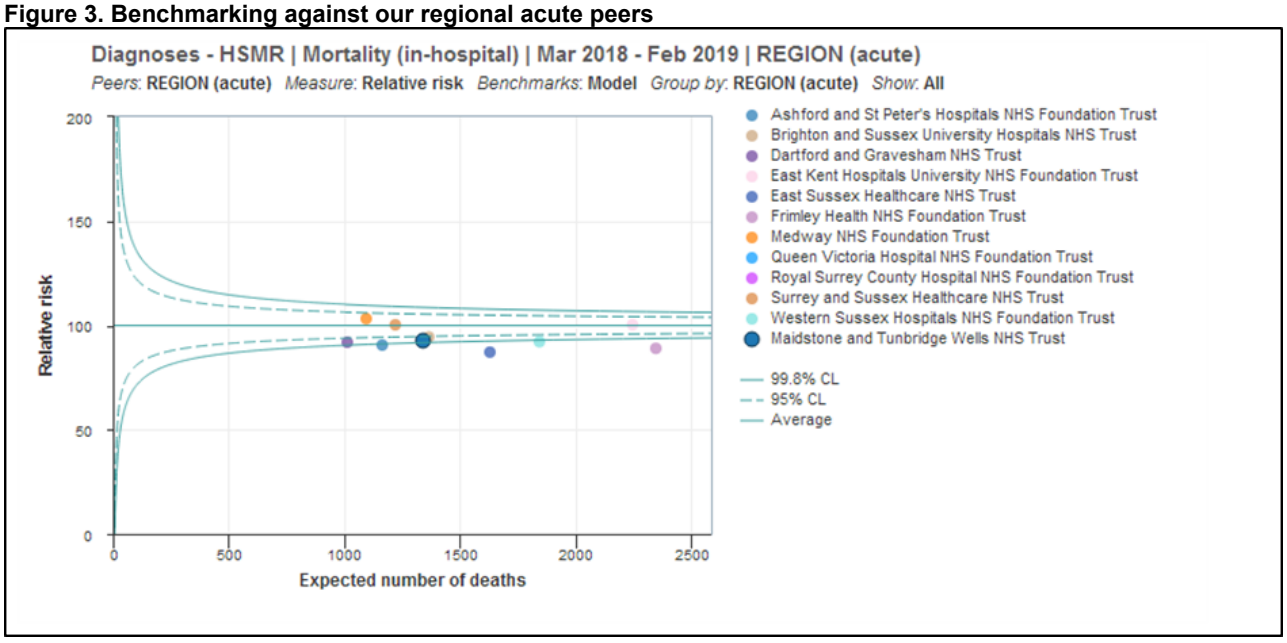
Figure 2. Monthly view



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 & Ashford & St Peter's are the next outlier trusts for this period.

Figure 3. Benchmarking against our regional acute peers



Understanding and Improving upon HSMR

It is evident from figures 1 – 3 that the Trust has made a sustainable reduction in our HSMR and are now in a much better position amongst our peers, having moved from above the confidence limit to below on the funnel plot which has been the main objective of the Mortality Surveillance Group (MSG) during 2018/19.

A further concern that has become evident to the MSG has been in regard to an anomaly between weekday and weekend admissions. In an effort to gain greater understanding of our data we invited a representative from Dr Foster to attend MSG during April to support us in the analysis of this anomaly. In March the data was evident that Saturday admissions were of concern, in particular that death occurred within 48hrs of admission.

Figure 4 Relative Risk by Day of Admission

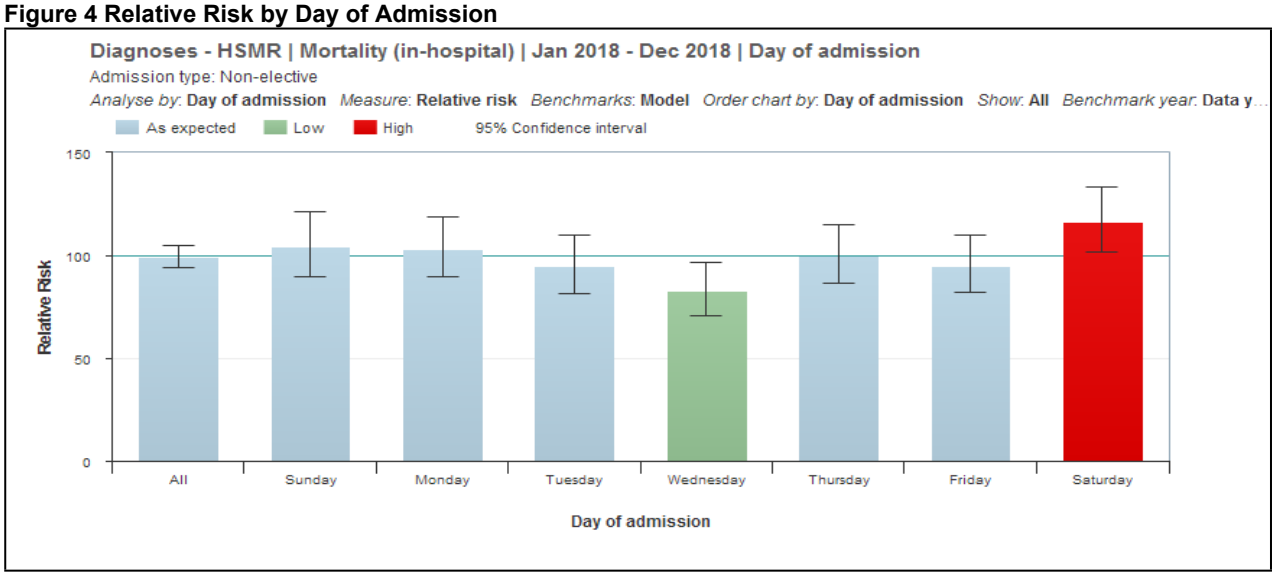
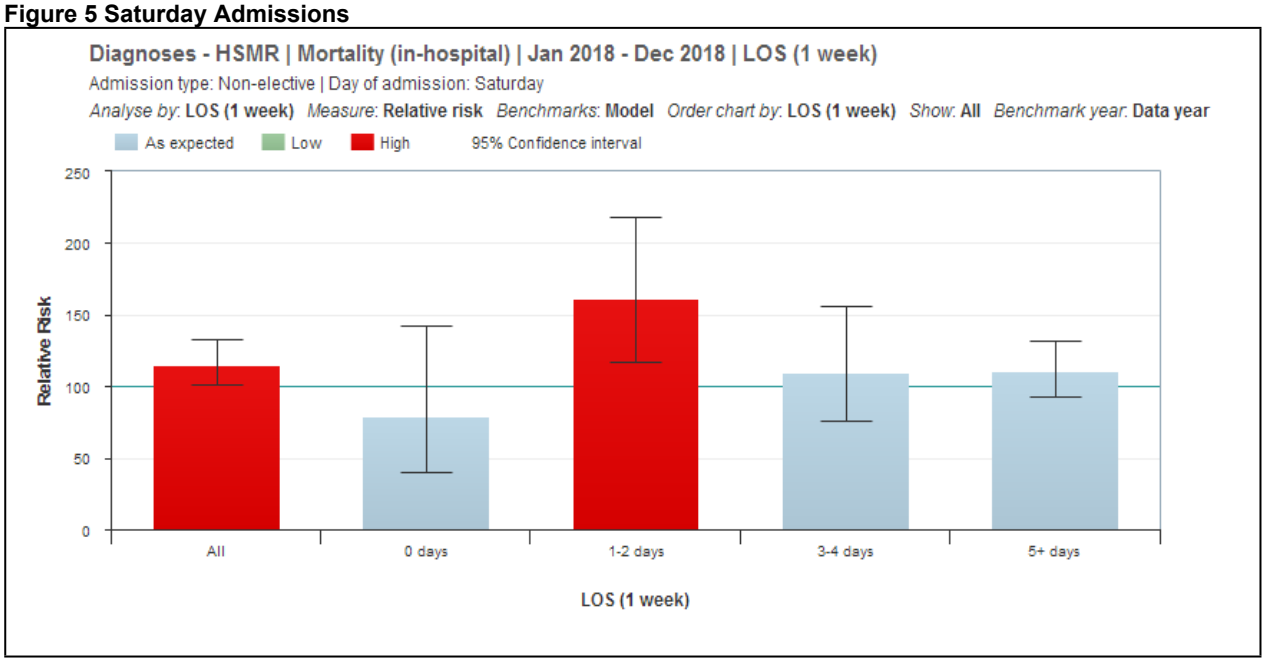


Figure 5 Saturday Admissions



The speciality with the highest relative risk for death is for patients under the care of General and Respiratory medicine, whereas the highest number of deaths are in Elderly care. These are also the specialities with the largest volume of spells.

Specialty (of discharge)	Spells	Observed
Geriatric Medicine	1485	158
General Medicine	953	72
Respiratory Medicine	359	60
General Surgery	1185	32
Gastroenterology	461	19
Cardiology	237	15
Trauma & Orthopaedics	217	11
Endocrinology	112	11

In regard to diagnosis the highest relative risk is for patients diagnosed with Pneumonia, Aspiration Pneumonitis food/vomitus and Acute and unspecified renal failure. The highest number of deaths is for pneumonia, which has the largest volume of spells.

The Medicine & Emergency care division have already taken action to address this anomaly by increasing the weekend on call team, having acknowledged the challenge with increased attendances and the need to cover the wards without impacting on prompt patient assessment in ED. There is also acknowledgement that further work is required to ensure that the requirements for seven day services (7DS) are met and consistent effort is being taken to recruit to the vacant Consultant posts and to attract trainees.

It is extremely encouraging however that with the continuing reduction in the Trust's mortality rate alongside the improvements being made in regard to coding for co-morbidities, which impacts upon our relative risk, that the report published in June has seen MTW also improve upon the weekend/weekday risk.

As you will see in figures 6 & 7 the weekday HSMR has seen a steady decline since May 17 – Apr 18, however the decline for weekend HSMR was not consistently evidenced until Nov 17 – Oct 18.

Figure 6 Weekday HSMR – Spells vs. Deaths

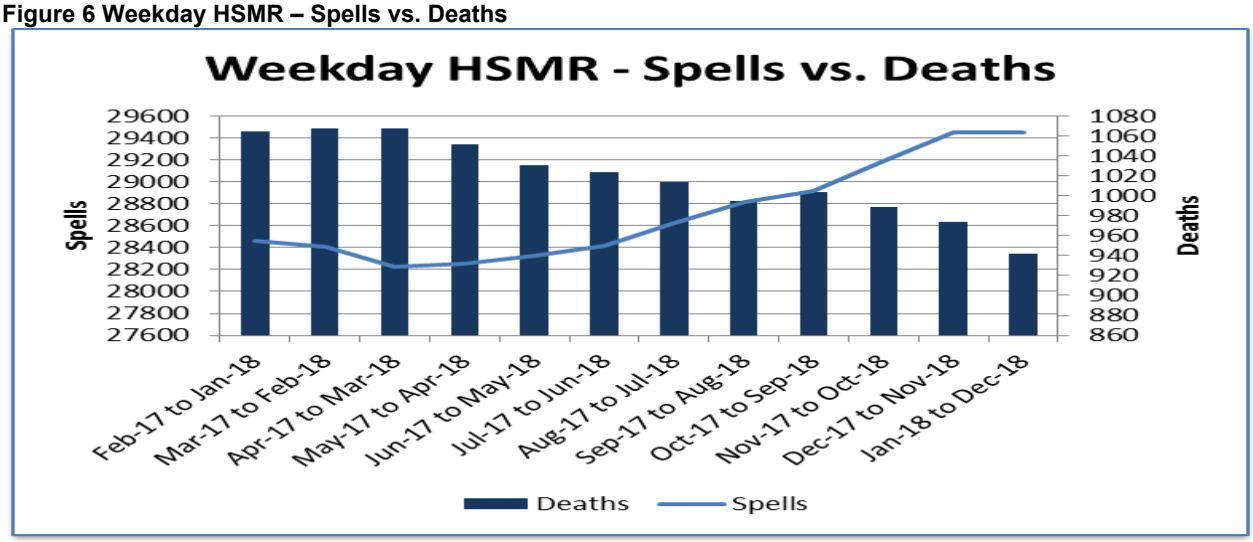
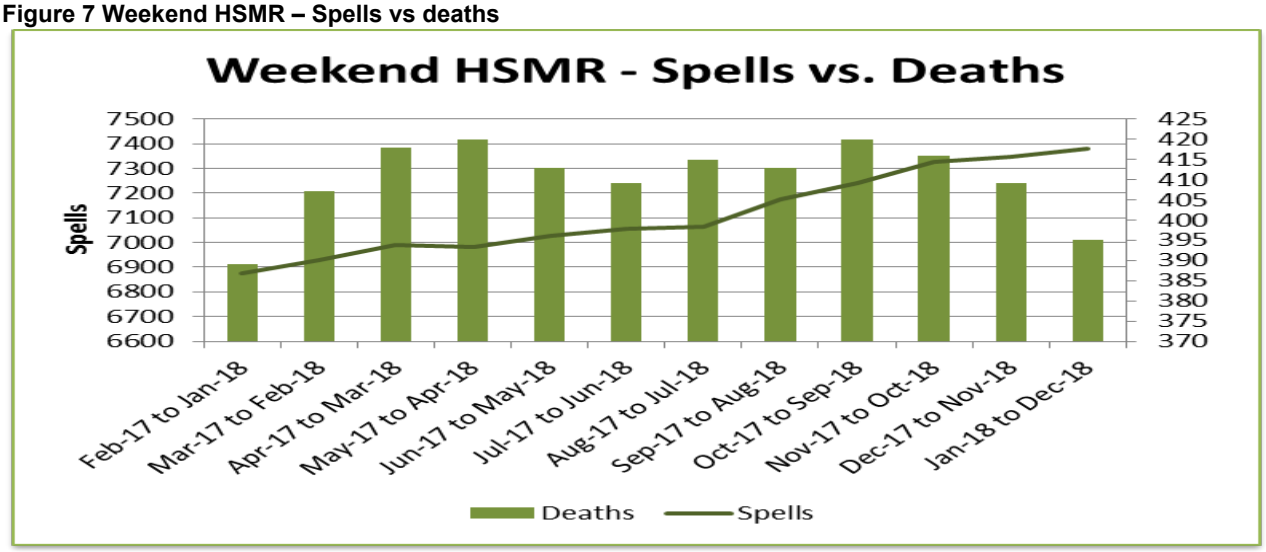


Figure 7 Weekend HSMR – Spells vs deaths



The latest analysis shows that patients admitted to the Trust any day of the week has an 'as expected' or 'low' level of relative risk of death, although Saturdays remains currently above 100 there is now a growing confidence that this will continue to reduce.

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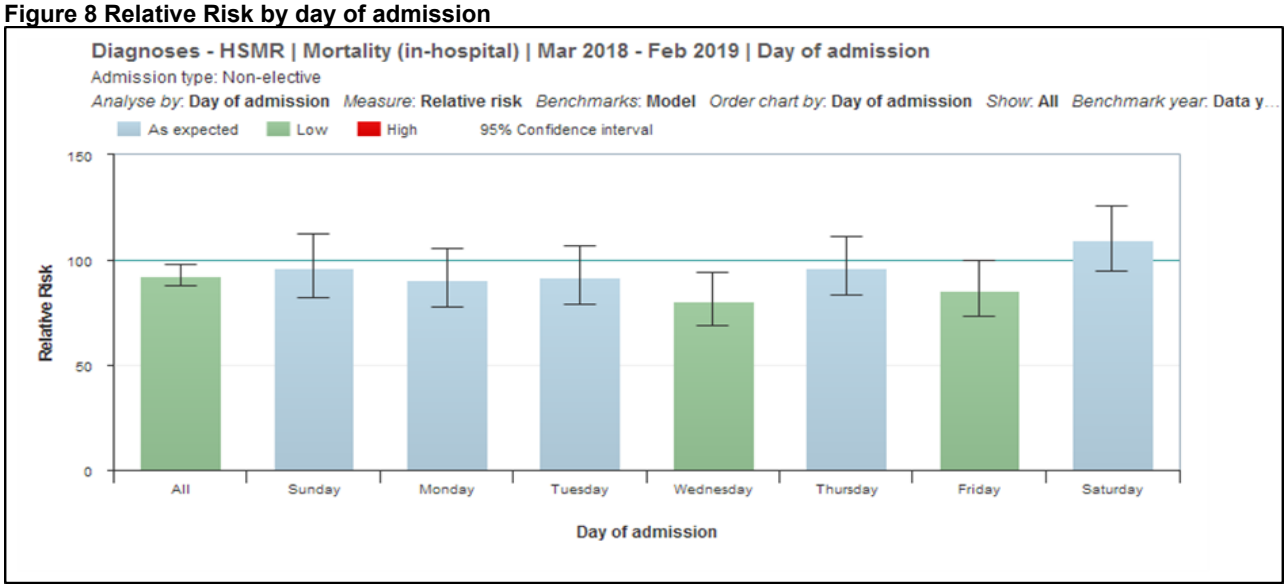
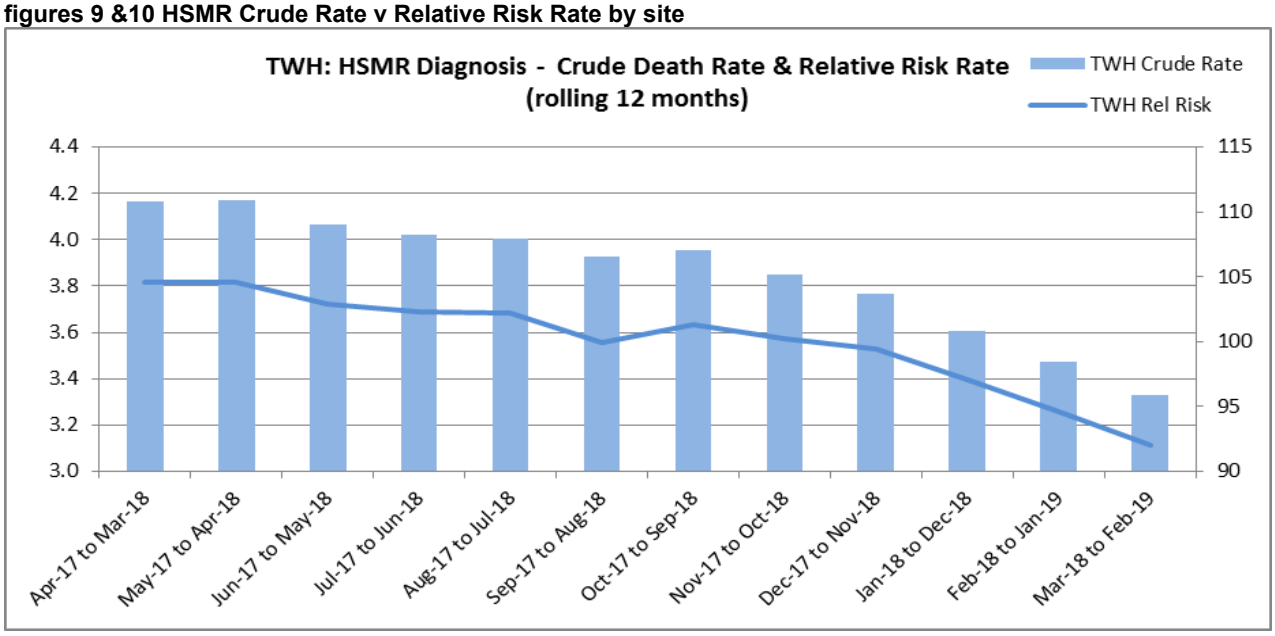
Figure 8 Relative Risk by day of admission



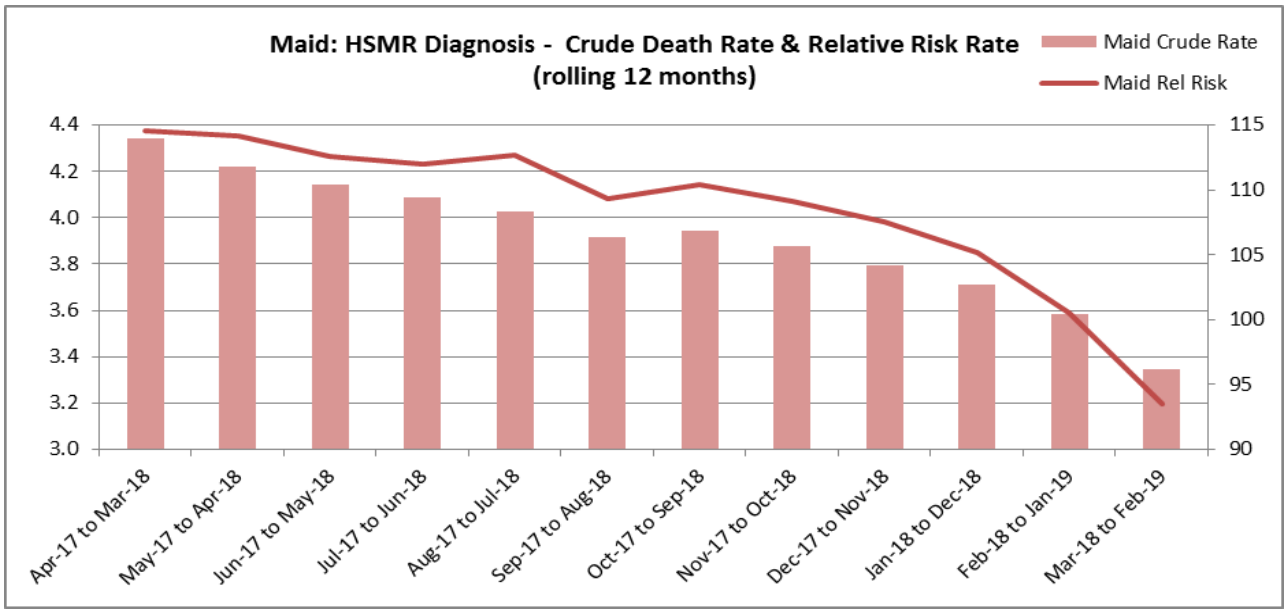
It is also promising to see the continued improvements in regard to hospital site.

The TWH graph below shows that the relative risk rate has continued to improve since October 2017 dropping to 92.0 which is now in the 'low' level of risk & the crude mortality rate has reduced to 3.3.

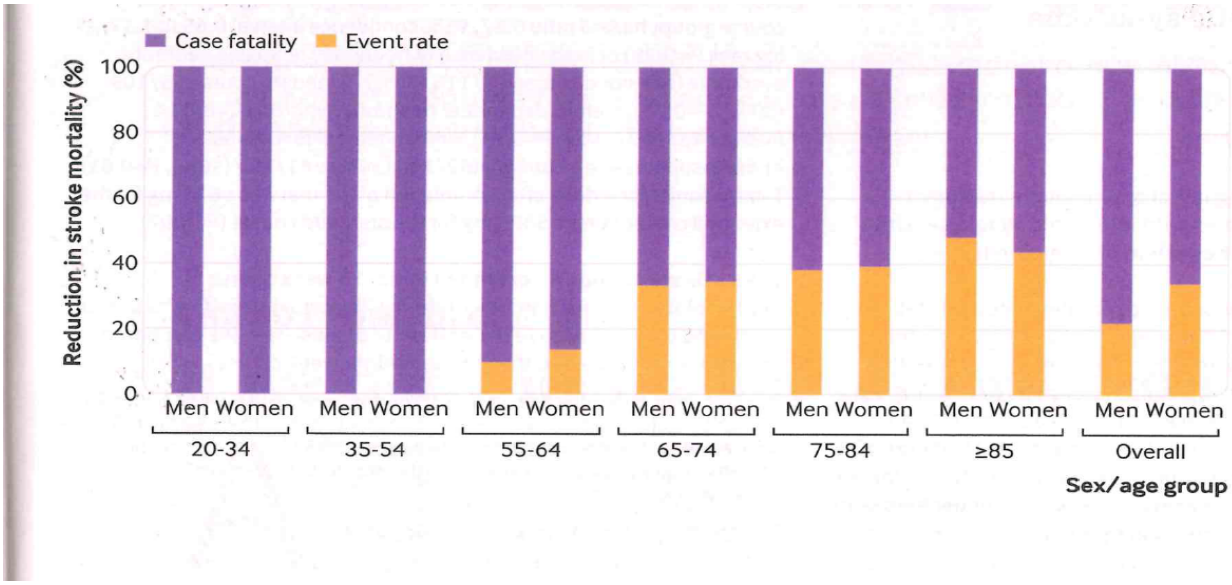
figures 9 &10 HSMR Crude Rate v Relative Risk Rate by site



The Maidstone site crude rate has continued to improve over the last 5 months to 3.3 & the relative risk rate has improved to 93.5, back to within the confidence levels.



A recent report published in the BMJ (25th May, 2019, pg 270-1) has also noted the decrease in deaths from stroke. Age standardised stroke mortality has decreased over time for men and women in all age groups. This is mainly due to a decrease in case fatality rather than stroke incidence, with stroke rates actually increasing in younger adults.



Percentage contribution of changes in stroke case fatality and stroke event rates to percentage reduction in stroke morality by age group in men and women between 2001 and 2010, England.

The Mortality Surveillance Group (MSG):-

The MSG has been operational in its current format since February 2016 and has made consistent progress in improving the reported positon of Mortality reviews, with acknowledgment that 90% compliance is this year's stretch target.

Figure 11. Trust Position of Mortality Reviews – (Apr - Apr 19)

Trust	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018/19 YTD	Apr-19
No of Deaths	127	126	126	128	122	148	126	107	125	178	142	145	1600	142
No of Completed Reviews	114	111	113	110	103	127	104	86	111	146	117	112	1354	117
%age completed reviews	**89.8%**	**88.1%**	**89.7%**	**85.9%**	**84.4%**	**85.8%**	**82.5%**	**80.4%**	**88.8%**	**82.0%**	**82.4%**	**77.2%**	**84.6%**	**82.4%**
No of Un-reviewed Deaths	13	15	13	18	19	21	22	21	14	32	25	33	246	25

The percentage of mortality reviews completed has dramatically improved since the process was changed in October 2017. At this time all Doctors completing the Death Certificate were asked to complete the preliminary screening tool and those completing the Cremation form then undertake the first stage reviews. Those deaths where a burial is preferred then have the first stage reviews completed by the Directorates. This has improved our overall compliance from 58.0% in March 2018 to 84.6% in March 2019.

Learning from Mortality Reviews includes the need for:-

- Improved communication with patient and/or family re decision making for DNACPR
- Improved documentation in regard to decision making re ceiling of care and plan for palliation
- Prompt senior oversight of decision making re End of Life Care (EOLC), to include review of DNACPR form signed by Consultant lead
- Prompt referral to palliative care team when decision made for EOLC
- Patients clearly dying should, wherever possible, be fast-tracked to a side-room with clear communication with receiving ward so staff aware of imminent death.
- To not use abbreviations on the death certificate.

- When patient chooses to self-discharge, their capacity to make that decision should be documented in the health record.
- Documentation of best interest discussions.
- DNACPR to be kept on the first page of a patient's health records.
- Records of discussions with speciality teams to be recorded in notes.
- When discharging patient home for EOLC ensuring that the family know what to expect ie what death looks like and prompt review by Hospice palliative care team
- Consideration for appropriateness of clinical treatment ie scans, blood test and antibiotics for a patient at the end of their life.

Specialist Mortality Reviews – Maternity (MBBRACE Report 2016 data)

Perinatal mortality

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)	Comparison to the average for similar Trusts & Health Boards
Stillbirth	19	3.23	3.75 (3.14 to 4.43)	Up to 10% higher
Neonatal	5	0.85	1.19 (0.81 to 1.87)	Up to 10% lower
Extended perinatal	24	4.07	4.93 (4.31 to 6.15)	Up to 10% lower

MTW has a higher than average still birth ratio, however there are some key identifiable factors for this which include:-

- national rate for women delivering over the age of 35 is 22.1%, MTW rate is 26.6%. 4.5% difference which is significant when considering the co morbidities and complexities these women will present with.
- percentage of women who delivered at 42 weeks and over was slightly raised; demonstrating a rate of 4.9% in comparison to a national percentage of 2.4.
- Causes of death demonstrates an increase in congenital and fetal related deaths (related to point 1 - age of mother)

Actions-

- Continue to benchmark our services against the Saving Babies Lives campaign
- Better Births initiative and providing continuity of carer
- Performing an additional in-depth review of the fetal losses and understand and identify if any local trends are presenting, in line with the PMRT strategy

Specialist Mortality Reviews – Learning Disability

- November 2017- September 2018, 10 Patients with Learning Disability (PWLD) deaths recorded, majority of deaths had a cause of death recorded as aspiration pneumonia.
- 7 SJR's undertaken (3 outstanding)- overall care ranged from adequate to excellent.

Good practice:-

- Appropriate quick assessment and treatment in ED
- Timely senior review at Consultant level
- Family/carer involvement

Learning & Improvement:-

- Greater awareness of what best interest decision making entails
- Timeliness of transfer from ED to ward for PWLD

Learning from Deaths Project Working Group (LFD).

The project group has been operational since May 2017 and set up in response to the National agenda for learning from deaths and last met on the 5th April, 2019. The objectives of the group include:-

- To develop a single database for all mortality data and mortality form recording (including SJR's)

- To improve compliance of completion of all mortality forms
- Implementation of the Trust-wide Mortality Coordinator role to oversee process and compliance.
- Clarifying the role and effectiveness of the MSG (including the extraction of learning from this process)
- Identify how the responsibility for Duty of Candour issues should be taken forward.
- Clarify the role of the Informatics Team in monitoring and supporting this process.
- Reducing the observed rates of mortality, by identifying the patient deaths in which there was suboptimal care and learning through our revised processes (link to Learning Lessons Project). Record the key learning themes each month.
- Review and develop the monthly mortality report produced by Business Intelligence, (after review in MSG) that feeds the Trust Clinical Governance Meeting, the Quality Committee and the Trust Board.
- Audit the notes of deceased patients who do not progress to SJR. The Trust's policy states "A random sample of expected deaths will be audited by Clinicians, supported by the Clinical Audit Department, twice yearly as a quality assurance mechanism (and reported to the MSG)". Investigate how the Trust can identify patients who die within 30 days of discharge.
- Review and identify the link/process for all 'other' deaths in more 'specialist' categories – ie., perinatal mortality, maternal deaths, child deaths, LeDeR for Learning Difficulties.

Recent achievements include:-

- All Mortality review documentation has been revised and relaunched, the revised document makes explicit the need to identify learning which can then be disseminated to the Directorates and Divisions.
- Dissemination of Divisional reports which gives greater clarity of sub-speciality risks within Directorates and Division's with a key focus on sharing the learning.
- Learning Disabilities Lead Nurse is working collaboratively with Kent Community Health Foundation Trust Learning Disability team to share learning from mortality reviews for patients with a Learning Disability. This has been reported back to MSG during May.
- Head of Midwifery has presented the outcomes and learning from the MBBRACE report in regard to neonatal deaths.

Next Steps for both MSG and LFD's project groups:-

- Await outcomes from the audits in regard to learning from deaths for patients who died of Congestive Cardiac Failure and Aspiration pneumonia.
- Work with Datix implementation group in regard to the development of the new Mortality module.
- Undertake scoping exercise in regard to the implementation of the Medical Examiner and Medical Examiner Officers roles.

Findings of the National Inpatient Survey 2018 — Chief Nurse

Enclosed is the 2018 Adult Inpatient survey (MTW results) which was published on 20th June 2019 (Appendix 1). The findings will be reviewed in detail and an action plan developed and overseen by the Patient Experience Committee.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information

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

Care Quality Commission

Survey Coordination Centre

Patient survey report 2018

Adult Inpatient Survey 2018

Maidstone and Tunbridge Wells NHS Trust

NHS Patient Survey Programme
Adult Inpatient Survey 2018

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.

Adult Inpatient Survey 2018

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 2018 survey of adult inpatient (sixteenth iteration of the survey) involved 144 acute and specialist NHS trusts. 76,668 people responded to the survey, yielding an adjusted response rate of 45%.

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 2018[1]. Trusts counted back from the last day of July 2018, including every consecutive discharge, until they had selected 1,250 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1st January 2018). Fieldwork took place between August 2018 and January 2019.

Surveys of adult inpatients were also carried out in 2002 and annually from 2004 to 2018. Although questionnaire redevelopments took place over the years, the survey results for this year are largely comparable to those from previous iterations.

The Adult Inpatient Survey is part of a wider programme of NHS patient surveys which covers a range of topics, including children and young people's services, community mental health services, urgent and emergency care services and maternity services. To find out more about the programme and to see the results from previous surveys, please see the links in the 'Further information' section.

CQC will use the results from the survey in the 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 providers to account for the outcomes they achieve. NHS Improvement will use the results to inform their oversight model for the NHS.

This research was carried out in accordance with the international standard for organisations conducting social research (accreditation to ISO20252:2012; certificate number GB08/74322).

Interpreting the report

This report shows how your trust scored for each evaluative question in the survey, compared with 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 most other trusts. For more information on the expected range, please see the 'methodology' section below. This approach is designed to help understand the performance of individual trusts, and to identify areas for improvement.

[1] 39 trusts sampled additional months because of small patient throughputs.

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 more simplified way, identifying whether a trust performed 'better', 'worse' or 'about the same' as the majority of other trusts for each question and section.

Standardisation

People's characteristics, such as age and gender, can influence their experience of care and the way they report it. For example, research shows that men tend to report more positive experiences than women, and older people more so than younger people. Since trusts have differing profiles of people who use their services, this could potentially affect their results and make trust comparisons difficult. A trust's results could appear better or worse than if they had a slightly different profile of people.

To account for this, we 'standardise' the data, which means we apply a weight to individual responses to account for differences in demographic profile between trusts. For each trust, results have been standardised by age, gender and method of admission (emergency or elective) of respondents to reflect the 'national' age-gender-admission type distribution (based on all respondents to the survey). This helps to ensure that no trust will appear better or worse than another because of its respondent profile. It therefore enables a more accurate comparison of results from trusts with different population profiles. In most cases this standardisation 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 trust. 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 the 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).

Section scoring is computed as the arithmetic mean of questions' score after weighting is applied.

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. 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 or below what would be expected. If it is within this range, we say that its performance is ‘about the same’. Where a trust is identified as 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 (and the corresponding section[2]). 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, the response rate for your trust and background information about the people that responded.

Scores from last year's survey are also displayed where available. The column called 'Change from 2017' 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 2017. A statistically significant difference means that the change in the result is very unlikely to have occurred by chance. Significance is tested using a two-sample t-test with a significance level of 0.05.

Please note that comparative data is not shown for sections as the questions contained in each section can change year on year.

Where a result for 2017 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 2017 survey, or if a trust committed a sampling error in 2017.

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

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 Q56 (“Before you left hospital, were you given any written or printed information about what you should or should not do after leaving

[2]The section score is not displayed as it would include fewer questions compared with other trusts hence it is not a fair comparison.

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, the 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.

Notes on question comparability

The following questions were new questions for 2018, and it is therefore not possible to compare with previous years:

Q66. *Was the care and support you expected available when you needed it?* (section 9 "Leaving hospital")

Q69. *During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?* (section 10 "Overall views of care and services")

The following question was removed from the 2018 questionnaire (2017 numbering):

Q59. *Were you told how to take your medication in a way you could understand?*

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://nhssurveys.org/survey/2117

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 England, and trust level results, can be found on the CQC website. You can also find a 'technical document' here which describes the methodology for analysing the trust level results:
http://www.cqc.org.uk/inpatientsurvey

The results for the adult inpatient surveys from 2002 to 2017 can be found at:
http://www.nhssurveys.org/surveys/425

Full details of the methodology for the survey, including questionnaires, letters sent to patients, instructions for trusts and contractors to carry out the survey, and the survey development report, are available at:
http://www.nhssurveys.org/surveys/1203

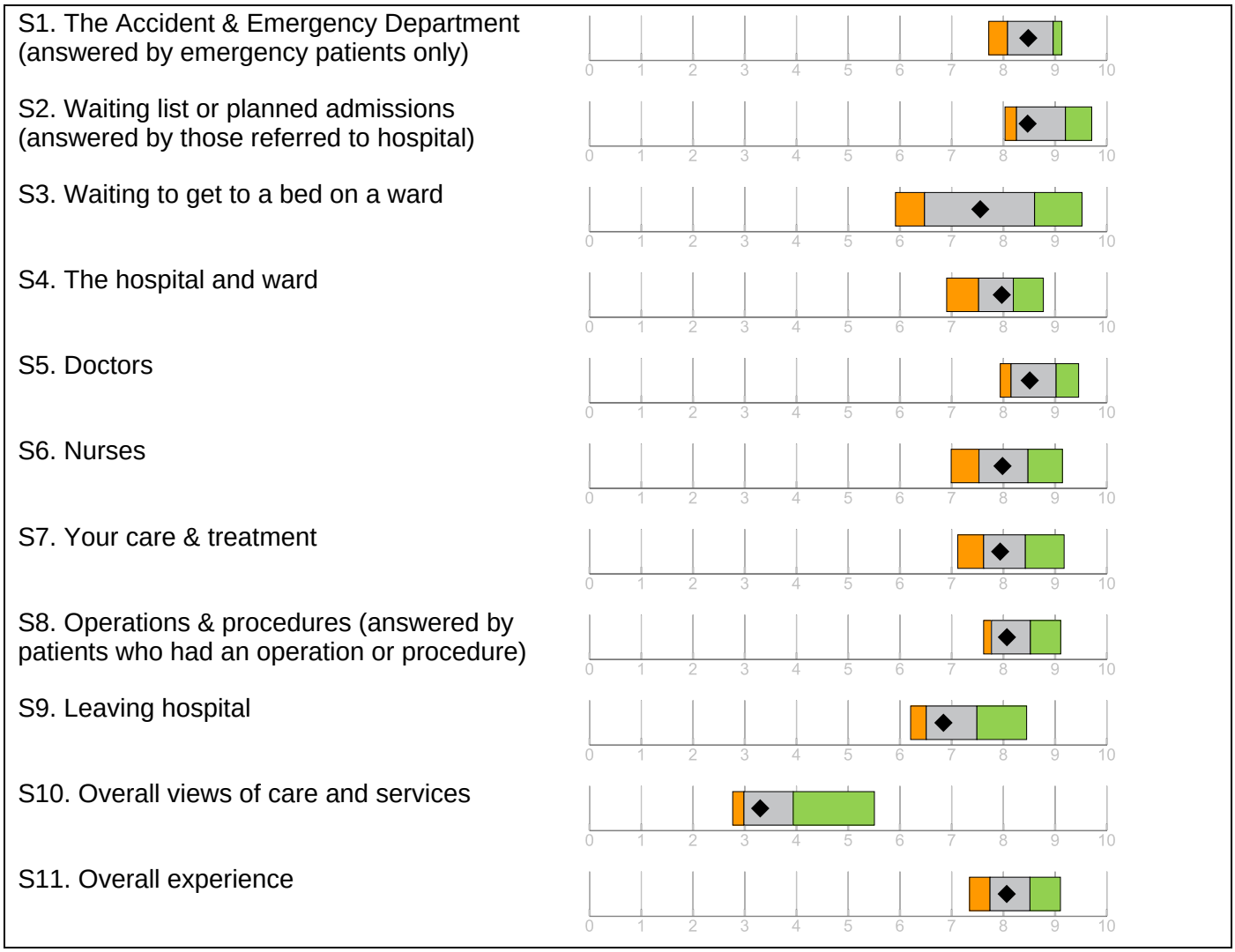
More information on the NHS Patient Survey Programme, including results from other surveys and a schedule of current and forthcoming surveys can be found at:
http://www.cqc.org.uk/content/surveys

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

Adult Inpatient Survey 2018

Maidstone and Tunbridge Wells NHS Trust

Section scores



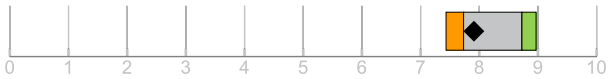
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Adult Inpatient Survey 2018

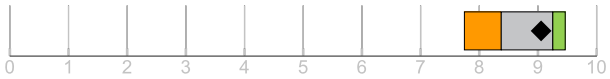
Maidstone and Tunbridge Wells NHS Trust

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

Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you?

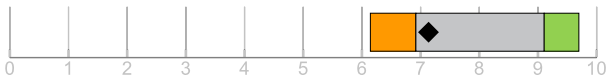


Q4. Were you given enough privacy when being examined or treated in the A&E Department?



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

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



Q7. Was your admission date changed by the hospital?

Q8. Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?

Waiting to get to a bed on a ward

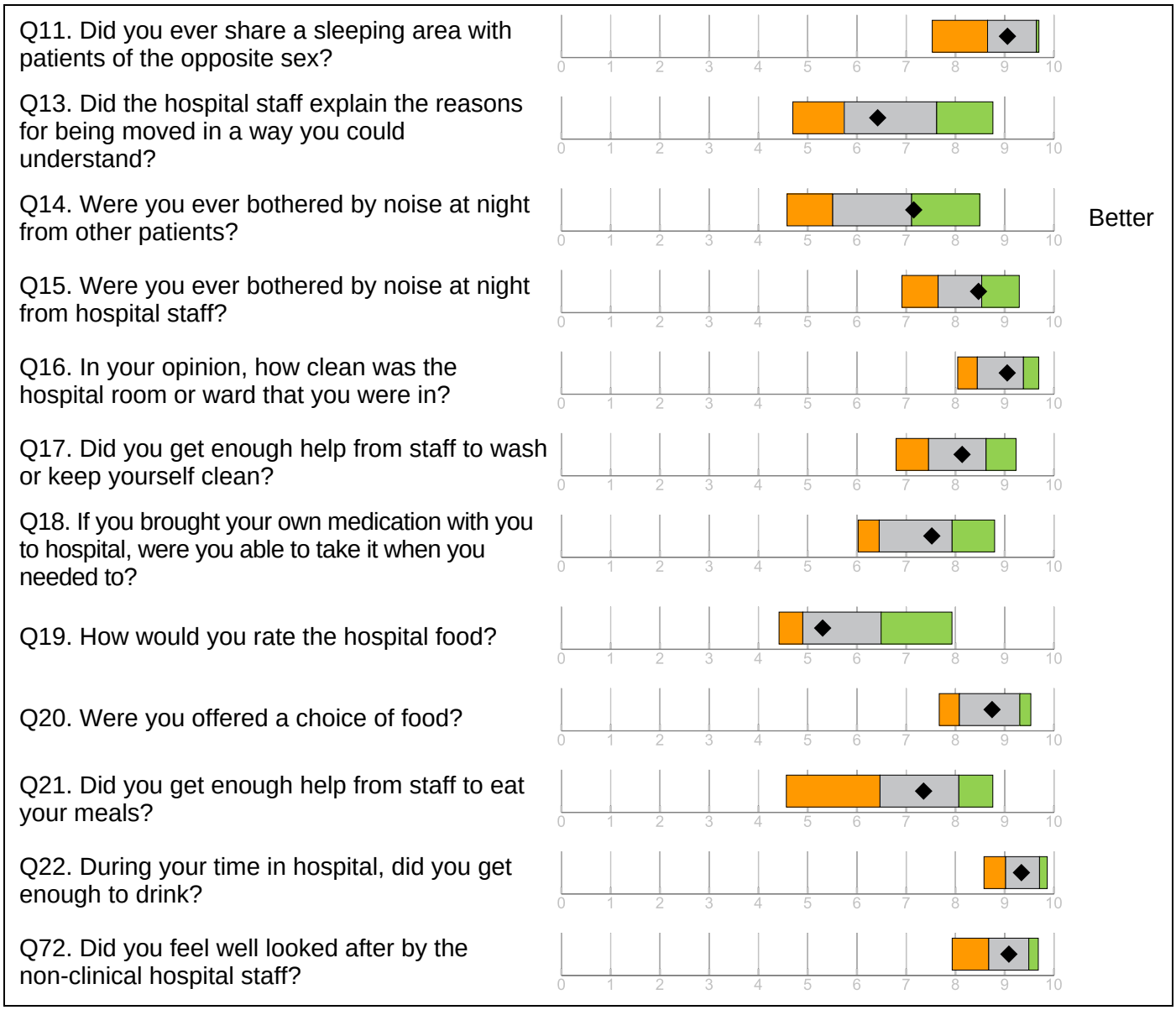
Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

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

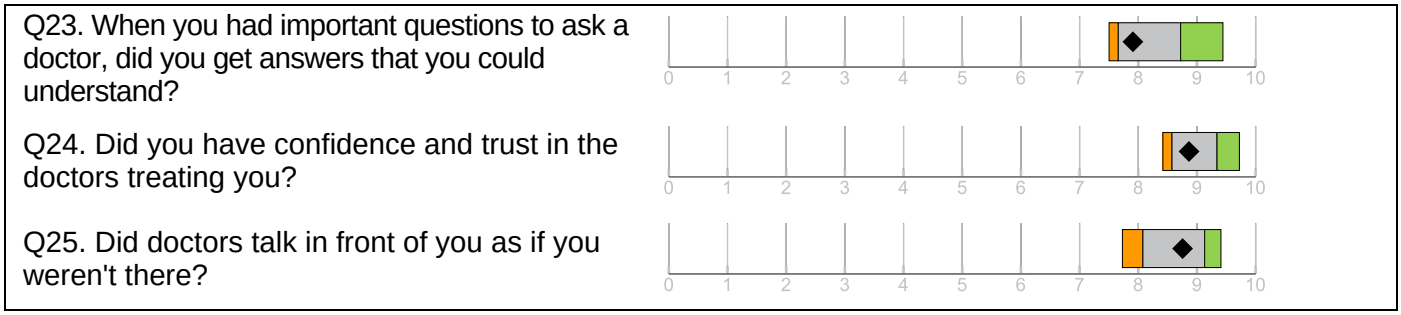
Adult Inpatient Survey 2018

Maidstone and Tunbridge Wells NHS Trust

The hospital and ward



Doctors



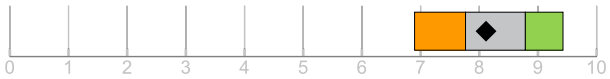
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Adult Inpatient Survey 2018

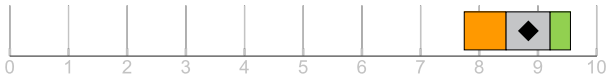
Maidstone and Tunbridge Wells NHS Trust

Nurses

Q26. When you had important questions to ask a nurse, did you get answers that you could understand?



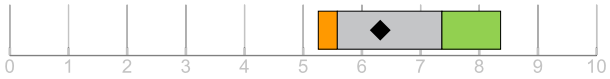
Q27. Did you have confidence and trust in the nurses treating you?



Q28. Did nurses talk in front of you as if you weren't there?

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

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



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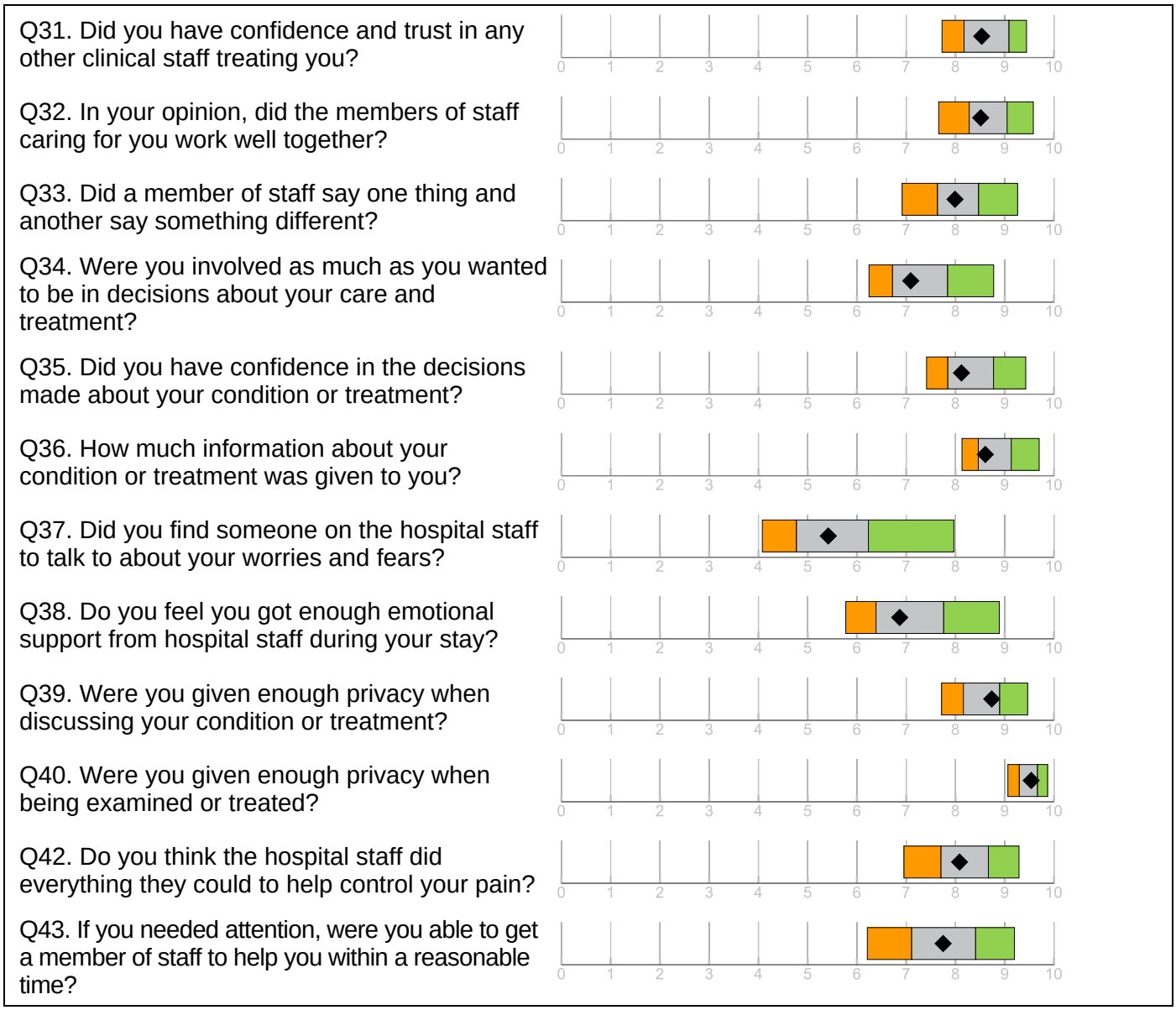
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

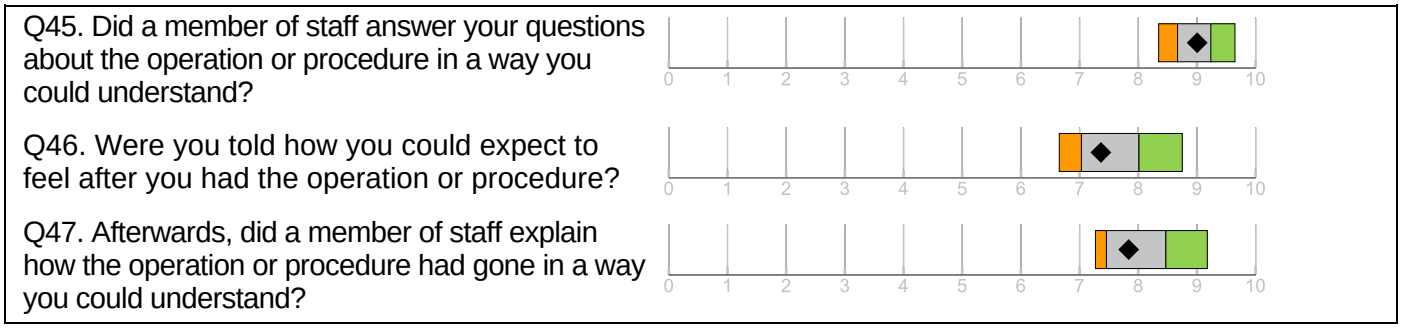
Adult Inpatient Survey 2018

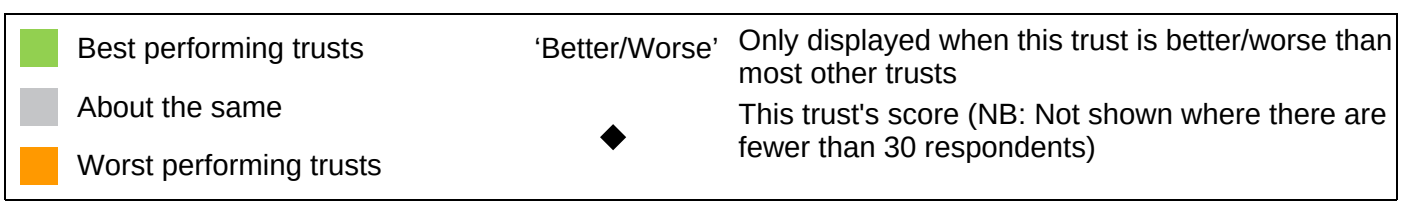
Maidstone and Tunbridge Wells NHS Trust

Your care & treatment



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

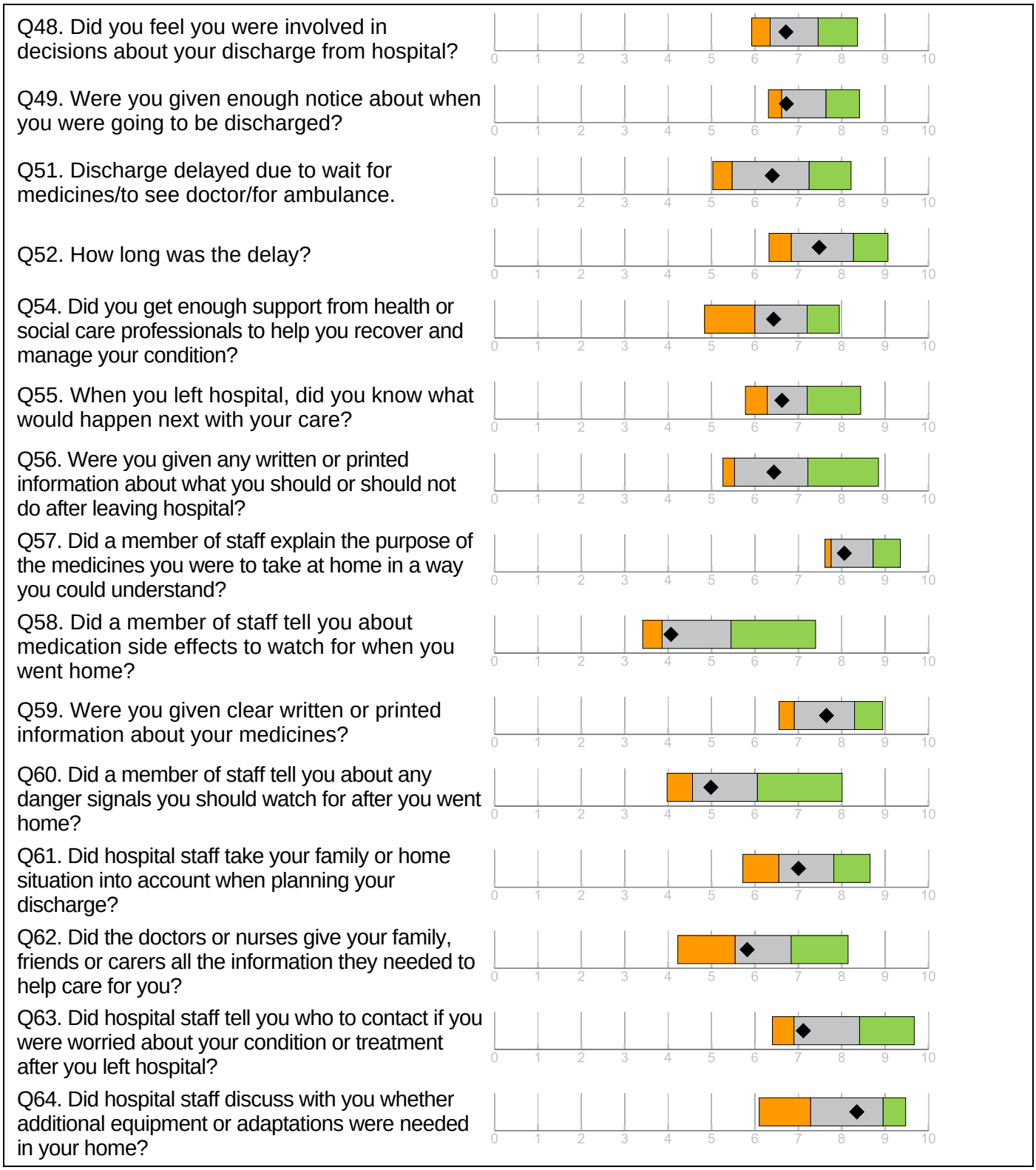




Adult Inpatient Survey 2018

Maidstone and Tunbridge Wells NHS Trust

Leaving hospital

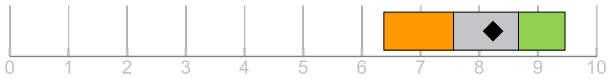


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

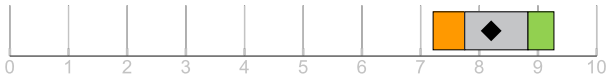
Adult Inpatient Survey 2018

Maidstone and Tunbridge Wells NHS Trust

Q65. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?



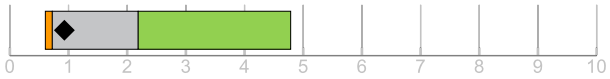
Q66. Was the care and support you expected available when you needed it?



Overall views of care and services

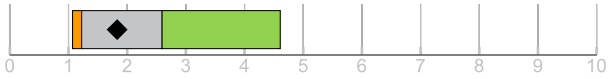
Q67. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Q69. During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?



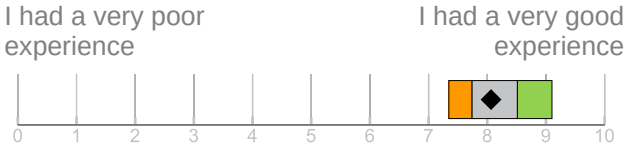
Q70. During your hospital stay, were you ever asked to give your views on the quality of your care?

Q71. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?



Overall experience

Q68. Overall...



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Worst performing trusts		

Adult Inpatient Survey 2018

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)	2017 scores for this NHS trust	Change from 2017
The Accident & Emergency Department (answered by emergency patients only)							
S1	Section score	8.5	7.7	9.1			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	7.9	7.4	9.0	366	8.1	
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	9.1	7.7	9.5	404	8.8	
Waiting list or planned admissions (answered by those referred to hospital)							
S2	Section score	8.5	8.0	9.7			
Q6	How do you feel about the length of time you were on the waiting list?	7.1	6.1	9.7	162	7.1	
Q7	Was your admission date changed by the hospital?	9.1	8.3	9.9	162	9.1	
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	9.1	7.9	9.6	154	8.6	
Waiting to get to a bed on a ward							
S3	Section score	7.6	5.9	9.5			
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?	7.6	5.9	9.5	589	7.3	

↑ or ↓	Indicates where 2018 score is significantly higher or lower than 2017 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2017 data is available.

Adult Inpatient Survey 2018

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)	2017 scores for this NHS trust	Change from 2017
The hospital and ward							
S4	Section score	8.0	6.9	8.8			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	9.1	7.5	9.7	595	9.1	
Q13	Did the hospital staff explain the reasons for being moved in a way you could understand?	6.4	4.7	8.8	112	6.9	
Q14	Were you ever bothered by noise at night from other patients?	7.2	4.6	8.5	592	6.9	
Q15	Were you ever bothered by noise at night from hospital staff?	8.5	6.9	9.3	595	8.6	
Q16	In your opinion, how clean was the hospital room or ward that you were in?	9.1	8.0	9.7	601	9.1	
Q17	Did you get enough help from staff to wash or keep yourself clean?	8.1	6.8	9.2	343	7.8	
Q18	If you brought your own medication with you to hospital, were you able to take it when you needed to?	7.5	6.0	8.8	301	7.7	
Q19	How would you rate the hospital food?	5.3	4.4	7.9	539	5.5	
Q20	Were you offered a choice of food?	8.7	7.7	9.5	557	8.3	↑
Q21	Did you get enough help from staff to eat your meals?	7.4	4.6	8.8	110	6.7	
Q22	During your time in hospital, did you get enough to drink?	9.3	8.6	9.9	559	9.4	
Q72	Did you feel well looked after by the non-clinical hospital staff?	9.1	7.9	9.7	512	9.1	
Doctors							
S5	Section score	8.5	7.9	9.5			
Q23	When you had important questions to ask a doctor, did you get answers that you could understand?	7.9	7.5	9.4	510	8.1	
Q24	Did you have confidence and trust in the doctors treating you?	8.9	8.4	9.7	574	8.9	
Q25	Did doctors talk in front of you as if you weren't there?	8.8	7.7	9.4	570	8.8	

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Adult Inpatient Survey 2018

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)	2017 scores for this NHS trust	Change from 2017
Nurses							
S6	Section score	8.0	7.0	9.1			
Q26	When you had important questions to ask a nurse, did you get answers that you could understand?	8.1	6.9	9.4	495	8.4	
Q27	Did you have confidence and trust in the nurses treating you?	8.8	7.7	9.6	575	8.9	
Q28	Did nurses talk in front of you as if you weren't there?	9.1	7.8	9.6	575	9.1	
Q29	In your opinion, were there enough nurses on duty to care for you in hospital?	7.6	6.1	9.1	576	7.6	
Q30	Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	6.3	5.3	8.4	574	6.2	

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Adult Inpatient Survey 2018
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)	2017 scores for this NHS trust	Change from 2017
Your care & treatment							
S7	Section score	7.9	7.1	9.2			
Q31	Did you have confidence and trust in any other clinical staff treating you?	8.5	7.7	9.4	333	8.4	
Q32	In your opinion, did the members of staff caring for you work well together?	8.5	7.7	9.6	544	8.6	
Q33	Did a member of staff say one thing and another say something different?	8.0	6.9	9.3	576	8.2	
Q34	Were you involved as much as you wanted to be in decisions about your care and treatment?	7.1	6.2	8.8	584	7.1	
Q35	Did you have confidence in the decisions made about your condition or treatment?	8.1	7.4	9.4	589	8.2	
Q36	How much information about your condition or treatment was given to you?	8.6	8.1	9.7	561	8.8	
Q37	Did you find someone on the hospital staff to talk to about your worries and fears?	5.4	4.1	8.0	345	5.2	
Q38	Do you feel you got enough emotional support from hospital staff during your stay?	6.9	5.8	8.9	348	6.7	
Q39	Were you given enough privacy when discussing your condition or treatment?	8.7	7.7	9.5	582	8.7	
Q40	Were you given enough privacy when being examined or treated?	9.5	9.1	9.9	588	9.5	
Q42	Do you think the hospital staff did everything they could to help control your pain?	8.1	7.0	9.3	362	8.4	
Q43	If you needed attention, were you able to get a member of staff to help you within a reasonable time?	7.7	6.2	9.2	526	7.8	
Operations & procedures (answered by patients who had an operation or procedure)							
S8	Section score	8.1	7.6	9.1			
Q45	Did a member of staff answer your questions about the operation or procedure in a way you could understand?	9.0	8.3	9.6	274	8.9	
Q46	Were you told how you could expect to feel after you had the operation or procedure?	7.4	6.7	8.7	304	7.2	
Q47	Afterwards, did a member of staff explain how the operation or procedure had gone in a way you could understand?	7.8	7.3	9.2	302	7.9	

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Adult Inpatient Survey 2018

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)	2017 scores for this NHS trust	Change from 2017
Leaving hospital							
S9	Section score	6.8	6.2	8.4			
Q48	Did you feel you were involved in decisions about your discharge from hospital?	6.7	5.9	8.4	565	6.6	
Q49	Were you given enough notice about when you were going to be discharged?	6.7	6.3	8.4	588	6.9	
Q51	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	6.4	5.0	8.2	552	6.5	
Q52	How long was the delay?	7.5	6.3	9.1	549	7.7	
Q54	Did you get enough support from health or social care professionals to help you recover and manage your condition?	6.4	4.8	7.9	276	6.6	
Q55	When you left hospital, did you know what would happen next with your care?	6.6	5.8	8.4	487	6.6	
Q56	Were you given any written or printed information about what you should or should not do after leaving hospital?	6.4	5.3	8.8	554	6.9	
Q57	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.1	7.6	9.4	398	8.3	
Q58	Did a member of staff tell you about medication side effects to watch for when you went home?	4.1	3.4	7.4	340	4.7	
Q59	Were you given clear written or printed information about your medicines?	7.6	6.6	8.9	364	8.0	
Q60	Did a member of staff tell you about any danger signals you should watch for after you went home?	5.0	4.0	8.0	434	5.3	
Q61	Did hospital staff take your family or home situation into account when planning your discharge?	7.0	5.7	8.7	371	7.2	
Q62	Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?	5.8	4.2	8.1	373	6.3	
Q63	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.1	6.4	9.7	523	7.5	
Q64	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	8.3	6.1	9.5	172	8.7	
Q65	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.2	6.4	9.5	283	8.2	
Q66	Was the care and support you expected available when you needed it?	8.2	7.2	9.3	324		

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Adult Inpatient Survey 2018

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)	2017 scores for this NHS trust	Change from 2017
Overall views of care and services							
S10	Section score	3.3	2.8	5.5			
Q67	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.0	8.2	9.8	582	9.0	
Q69	During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?	0.9	0.6	4.8	515		
Q70	During your hospital stay, were you ever asked to give your views on the quality of your care?	1.4	0.5	3.7	511	1.7	
Q71	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	1.8	1.1	4.6	482	2.1	
Overall experience							
S11	Section score	8.1	7.3	9.1			
Q68	Overall...	8.1	7.3	9.1	577	8.0	

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Adult Inpatient Survey 2018
Maidstone and Tunbridge Wells NHS Trust

Background information

The sample	This trust	All trusts
Number of respondents	624	76668
Response Rate (percentage)	52	45

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	43	48
Female	57	52
Age group (percentage)	(%)	(%)
Aged 16-35	7	5
Aged 36-50	10	8
Aged 51-65	21	23
Aged 66 and older	62	64
Ethnic group (percentage)	(%)	(%)
White	91	89
Multiple ethnic group	0	1
Asian or Asian British	2	3
Black or Black British	0	1
Arab or other ethnic group	0	0
Not known	6	5
Religion (percentage)	(%)	(%)
No religion	22	18
Buddhist	1	0
Christian	72	75
Hindu	1	1
Jewish	0	0
Muslim	0	2
Sikh	0	1
Other religion	2	1
Prefer not to say	3	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	96	94
Gay/lesbian	0	1
Bisexual	1	0
Other	1	1
Prefer not to say	3	4

Winter planning and Operational Resilience 2019/20 **Chief Operating Officer**

Following a comprehensive and critical review of the winter plan for 18/19, the planning for 19/20 is now underway. This plan will take forward the lessons learnt from 2018/19 and develop them further for next winter. This is the first iteration, with further versions to follow, as we conclude our planning and 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 require additional capacity for a period of time.

This report sets out the planning process for winter 19/20 and covers:

1. Objectives of winter planning for the Trust
2. Governance structure to deliver plan
3. Activity, capacity and demand analysis
4. Areas of focus for this winter's plan
5. KPI's to monitor the progress of improvement through the year in preparation for winter
6. 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 winter:

- Activity
- Pathways
- Workforce
- Sustainability
- Communication

In summary, some of the clinical operational initiatives which worked well to manage flow and patient safety over last winter will be included in plans for 19/20. These include:

- Ambulatory Emergency Care – progressing from 5 day to 7 day working
- Acute Frailty – progressing from 5 day to 7 day working
- Dedicated medical outlier team
- Senior nurse to support medical post take rounds
- Increased ED nursing to manage periods of surge
- Hospital @ Home - increasing caseload to 30
- Weekly Forward Planning meetings to assess position against plan and take remedial actions if required
- Daily 'safety' Huddle with clinical and operational involvement
- Review and scheduling of elective work across both sites
- Maximising of Home First pathways
- Clear escalation policy

Which Committees have reviewed the information prior to Board submission?
Executive Team Meeting, 25/06/19

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

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

Winter Planning and Operational Resilience 2019/20

1.0 Introduction

Following a critical and comprehensive review of the winter plan for 2018/19, planning for winter 2019/20 is now underway. This plan will take into account the lessons learnt from 18/19 and develop them further for next winter.

This paper offers our planning process for the winter 2019/20 and 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 maximising the use of Same Day Emergency Care units 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 surgical day unit
- To learn lessons from last year's winter plan and to apply ECIST learning

2.0 Operational Initiatives

Initiatives which worked well to manage flow & patient safety during Winter 2018/19 and which are included in this plan for 2019/20:

- Ambulatory Emergency Care – progressing from 5 day to 7 day working
- Acute Frailty – progressing from 5 day to 7 day working
- Surgical Assessment Unit – increasing 'pull' from ED
- Dedicated medical outlier team
- Senior nurse to support medical post take rounds to signpost appropriate services to prevent admission
- Increased ED nursing to manage periods of surge
- Long Length of Stay (LLOS) reviews and Executive challenge panel
- Hospital @ Home - increasing caseload to 30 and review of model
- Weekly Forward Planning meetings to assess position against plan and take remedial actions as required with performance dashboard
- Daily 'safety' Huddle with clinical and operational involvement
- Maximising of Home First pathways by securing 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
- Clear escalation policy
- Pre-emptive cancellation of elective work & movement of some of TWH elective work to Maidstone
- Further improvement in patient flow through the 'Best Care delivery programme'
- Consistent approach by senior operational staff to site management and flow
- To embed a clear understanding through the organisation of what all staff should do, if the organisation moves from OPEL 3 to OPEL 4 level. (Appendix 2 Operational Pressures Escalation Levels Framework**)** **OPEL 3 defined** as 'the local health and

social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/Sub regional teams through internal reporting mechanisms' **OPEL 4 defined** as 'pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system'

- Continue to develop digitalised approaches 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

3.0 Capacity demand analysis

A key aspect of the plan is to understand and model the likely demand range across a number of key indicators. 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 but also upper limits, as appropriate delivery plans have been identified to mitigate the risk of these upper levels if they occur in a bad winter where a number of scenarios potentially come together.

The areas to be modelled and included in our planning parameters:

1) **Total Emergency Department (ED) attendances per site:** An ED attendance model has been developed which uses historical trends to calculate expected attendances by month, week, day and even by hour. The winter of 2018/19 was unusually busy, with 6 consecutive weeks coming in more than 8.5% above model, and the whole winter (Dec to Feb) averaging 5.9% above model. The model is currently forecasting attendances 0.6% above this, but the confidence limits on this prediction are much broader than usual. Annual growth in A&E is currently running at 7.1% (last 52 weeks v previous 52 weeks)

2) **GP Streaming:** Last winter (Dec to Feb) we averaged 275 patients per week being streamed to GP across both sites. Maidstone was probably working at or close to capacity during that time. If TW saw as many patients as Maidstone, this average could be pushed up by around 60 per week.

3) **Ambulance arrivals:** Ambulance arrivals averaged 26.1% in 2018/19. They usually run a couple of percent higher over winter, but this year averaged 26.9% Dec to Feb. This tends to increase if the weather is poor, because bad winter weather tends to decrease the number of minor attendances, but increase majors. Last winter peaked at around 850 per week, and we would expect the coming winter to increase in line with A&E attendances – but a

harsh winter could push this up by another 5% or so. Long periods of cold dry weather bring in respiratory problems, whilst snow & ice bring in fractures.

4) **Emergency admissions:** Similar to ED attendance, we have a model based on historical data. Between mid-2016 and mid-2018, zero LoS admissions have more than doubled from 180-250 per week 400-520. Winter average was 468. Around 2/3 of this increase was simple increase in CDU capacity, and the rest was increased use of Frailty & Assessment units. This has levelled off over the past 6-9 months, but numbers are too volatile to make any meaningful predictions, and we are working on the assumption that numbers will remain around current levels. Non zero averaged 575 per week last winter, and the model is projecting a similar figure for next winter, though this too is volatile, and the confidence limits should be set at around 5% either way

The table below shows the modelled ED attendances & Non Elective admissions as at 16-Jun-19, and trajectory Elective admissions per week across the winter period. This does not include maternity activity or any day case work

	ED	NE Admits														Elective Admits						
	Attendances	Medical		Surgical		T&O		Women		Paeds		Other		Total								
Week Ending		Zero	Non Zero	Zero	Non Zero	Zero	Non Zero	Zero	Non Zero	Zero	Non Zero	Zero	Non Zero	Zero	Non Zero	Medical	Surgical	T&O	Women	Paeds	Other	Total
06-Oct-19	3,202	432	380	55	112	11	39	4	10	16	41	1	3	**518**	**586**	6	67	44	19	6	4	**146**
13-Oct-19	3,163	429	383	55	112	10	38	4	10	16	41	2	4	**516**	**587**	6	67	44	19	6	4	**146**
20-Oct-19	3,119	424	389	55	112	10	37	4	10	16	41	2	4	**512**	**593**	6	67	44	19	6	4	**146**
27-Oct-19	3,084	421	395	58	113	9	36	4	10	17	41	2	4	**511**	**599**	6	67	44	19	6	4	**146**
03-Nov-19	3,069	418	397	59	111	10	35	4	10	16	43	2	4	**509**	**600**	6	67	44	19	6	4	**146**
10-Nov-19	3,085	419	394	59	109	10	35	4	10	16	45	1	4	**509**	**596**	6	67	44	19	6	4	**146**
17-Nov-19	3,099	416	392	57	107	10	35	4	9	15	46	1	3	**502**	**593**	6	67	44	19	6	4	**146**
24-Nov-19	3,101	421	391	55	107	9	35	4	9	16	48	1	3	**505**	**594**	6	67	44	19	6	4	**146**
01-Dec-19	3,088	425	391	55	109	8	35	4	9	16	49	1	4	**509**	**597**	6	67	44	19	6	4	**146**
08-Dec-19	3,082	431	393	54	111	8	34	4	9	17	50	1	4	**515**	**601**	6	67	44	19	6	4	**146**
15-Dec-19	3,085	429	395	54	111	9	33	3	8	17	50	1	5	**512**	**603**	6	67	44	19	6	4	**146**
22-Dec-19	3,094	428	401	53	109	9	33	3	8	16	50	1	5	**511**	**606**	6	67	44	19	6	4	**146**
29-Dec-19	3,078	429	408	54	105	10	34	3	8	16	48	1	5	**513**	**608**	3	40	26	12	4	2	**88**
05-Jan-20	3,037	429	416	56	103	9	34	3	7	16	46	1	5	**514**	**612**	4	54	35	16	5	3	**117**
12-Jan-20	2,972	420	421	58	103	9	34	3	7	15	43	1	5	**506**	**613**	6	67	44	19	6	4	**146**
19-Jan-20	2,946	409	420	56	105	9	33	3	8	14	42	1	5	**493**	**613**	6	67	44	19	6	4	**146**
26-Jan-20	2,960	396	415	55	107	8	34	4	8	15	43	1	4	**478**	**611**	6	67	44	19	6	4	**146**
02-Feb-20	3,009	389	409	53	109	8	34	4	9	15	44	1	5	**470**	**610**	6	67	44	19	6	4	**146**
09-Feb-20	3,047	382	406	53	111	8	34	4	9	16	44	1	5	**463**	**610**	6	67	44	19	6	4	**146**
16-Feb-20	3,071	388	406	51	113	8	33	4	9	16	44	1	5	**468**	**610**	6	67	44	19	6	4	**146**
23-Feb-20	3,103	392	410	51	112	8	32	4	9	16	44	1	6	**473**	**613**	6	67	44	19	6	4	**146**
01-Mar-20	3,148	403	413	51	112	8	31	4	9	16	44	1	6	**482**	**616**	6	67	44	19	6	4	**146**
08-Mar-20	3,204	409	415	51	113	8	32	4	9	15	45	1	5	**487**	**619**	6	67	44	19	6	4	**146**
15-Mar-20	3,251	420	412	50	115	8	33	4	8	15	45	0	5	**497**	**618**	6	67	44	19	6	4	**146**
22-Mar-20	3,281	430	411	50	115	8	34	3	8	16	46	0	4	**508**	**617**	6	67	44	19	6	4	**146**
29-Mar-20	3,289	440	407	51	114	8	34	3	8	16	46	0	4	**519**	**613**	6	67	44	19	6	4	**146**

Table 1

5) **Non-elective LoS (excluding zero):** Historically, there is a tendency for the average, non-zero LoS to increase by 0.5-1.0 days in the depths of winter, though this did not happen in the winter of 2018/19, with Dec to Feb averaging 7.03 days - not significantly different to the average for the whole year of 7.05. For 1819 we need to secure a 0.5 average day reduction in LoS & maintain it through winter as a key component in managing patient flow and bed capacity. NE LoS has come down from a peak of just over 8.0 days in early 2017, but has held fairly constant. We would expect 2019/20 winter to average around 7.0 days.

6) **DToC:** This averaged 26 patient / 3.68% of beds over the winter of 2018/19. DToC has been gradually coming down over the past few years, and the target of 3.5% is equivalent to about 24 beds.

7) **Non Elective Bed Occupancy:** bed occupancy model, with 85th percentile figures will be rerun with both the latest activity (including winter & full year affect) and bed capacity, which will identify the bed capacity required per month for both urgent & planned care, per site for both elective & non-elective activity. This information will identify the shortfall in required beds when compared to physical bed availability within each of the hospitals. The outcome of this work is likely to indicate a bed shortfall across sites of circa 120 beds. This level of shortfall offers a risk to the trust in particular to the elective work flow. Further delivery of SAFER, Same Day Emergency Care unit and best practice will help in reducing this capacity shortfall, however, there is likely to still be a shortfall and therefore pressure on the system and escalation across the health economy is expected.

Table 2 below demonstrates modelling that was undertaken in December 18. Work is currently underway to re-run this modelling to include full activity from winter last year and incorporate the further planned decrease in LOS of 0.5 days across the non-elective flow anticipated under Best Flow. We are also working with NHSI Business Intelligence on a new template that has been used elsewhere and should give us a better understanding of the demand and activity for winter 19/20.

Table 2: Non Elective Plans & Bed modelling from December 2018

Non Elective	Last 12 Months	Non Zero	54,777.0	31,448.0	57.4%	**Average LoS over past 12 months**	**7.17**
		Zero		23,329.0	42.6%	**Proposed LoS Improvement**	**-**
	BPAM	Non Zero	56,353.1	32,352.8	2.9%	**BPAM Growth**	**2.82%**
		Zero		24,000.2		**Actual Growth over 3 years**	
						Beds	**579**

				No Growth				Follow Trends				Follow Plan			
Month	Days	Phasing	LoS	Admits	Bed Days Consumed	Beds Occupied	Beds Over / Under	Admits	Bed Days Consumed	Beds Occupied	Beds Over / Under	Admits	Bed Days Consumed	Beds Occupied	Beds Over / Under
Apr-19	30	102.93%	7.35	2,700	19,838	661.3	81	2,794	20,522	684.1	102	2,765	20,505	683.5	107
May-19	31	100.56%	7.24	2,638	19,105	616.3	35	2,730	20,231	652.6	71	2,701	20,035	646.3	68
Jun-19	30	101.96%	7.14	2,674	19,083	636.1	56	2,768	19,933	664.4	82	2,739	20,310	677.0	101
Jul-19	31	99.57%	7.05	2,612	18,417	594.1	16	2,703	19,709	635.8	52	2,675	19,830	639.7	67
Aug-19	31	99.16%	7.08	2,601	18,424	594.3	19	2,691	19,795	638.5	56	2,664	19,746	637.0	66
Sep-19	30	98.33%	7.03	2,579	18,119	604.0	29	2,669	19,619	654.0	72	2,642	19,581	652.7	80
Oct-19	31	98.09%	7.06	2,573	18,161	585.9	12	2,662	19,699	635.5	55	2,635	19,535	630.2	57
Nov-19	30	99.08%	6.99	2,599	18,168	605.6	27	2,690	19,509	650.3	68	2,662	19,737	657.9	82
Dec-19	31	99.45%	7.20	2,609	18,795	606.3	25	2,700	20,112	648.8	66	2,672	19,816	639.2	61
Jan-20	31	99.41%	7.29	2,608	19,004	613.0	30	2,699	20,345	656.3	74	2,671	19,808	639.0	60
Feb-20	29	101.20%	7.43	2,654	19,716	679.9	101	2,747	20,740	715.2	134	2,719	20,160	695.2	119
Mar-20	31	100.26%	7.38	2,630	19,406	626.0	48	2,722	20,611	664.9	84	2,694	19,971	644.2	69
	366.0	100.00%	7.19	**31,476**	**226,235**	**618.1**	**40**	**32,575**	**240,825**	**658.0**	**76**	**32,239**	**239,034**	**653.1**	**78**

The ‘No Growth’ scenario takes the non-zero, NE activity levels seen last year

‘Follow Trends’ uplifts the activity by 3.5%, which is the average growth seen over the past few years

‘Follow Plan’ uplifts activity by the amount agreed in the BPAM documents, which accounts for anticipated service changes

Table 3 gives the Elective modelling undertaken in December 18. The same actions apply as above in terms of continuing to work to get an accurate model for winter 19/20

Table 3: Elective Plans & Bed modelling from December 2018

Elective	Last 12 Months	Non Zero	5,987.0	5,265.0	87.9%	Average LoS over past 12 months	2.96
		Zero		722.0	12.1%	Proposed LoS Improvement	-
	BPAM	Non Zero	6,028.2	5,301.2	0.7%	BPAM Growth	1.94%
		Zero		727.0		Actual Growth over 3 years	
						Beds	52

				No Growth				Follow Trends				Follow Plan			
Month	Days	Phasing	LoS	Admits	Bed Days Consumed	Beds Occupied	Beds Over / Under	Admits	Bed Days Consumed	Beds Occupied	Beds Over / Under	Admits	Bed Days Consumed	Beds Occupied	Beds Over / Under
Apr-19	30	100.00%	2.96	438	1,302	43.4	- 8	450	1,336	44.5	- 7	453	1,321	44.0	- 8
May-19	31	99.79%	3.08	438	1,350	43.5	- 9	449	1,388	44.8	- 7	452	1,317	42.5	- 9
Jun-19	30	100.74%	3.17	442	1,401	46.7	- 5	453	1,427	47.6	- 4	457	1,332	44.4	- 7
Jul-19	31	100.33%	3.27	440	1,439	46.4	- 5	451	1,472	47.5	- 5	455	1,326	42.8	- 9
Aug-19	31	100.32%	3.23	440	1,425	46.0	- 6	451	1,457	47.0	- 5	455	1,326	42.8	- 9
Sep-19	30	100.25%	3.19	440	1,414	47.1	- 4	451	1,448	48.3	- 3	454	1,324	44.1	- 7
Oct-19	31	101.42%	3.04	445	1,363	44.0	- 7	456	1,379	44.5	- 7	460	1,341	43.3	- 8
Nov-19	30	101.58%	2.95	445	1,327	44.2	- 7	457	1,340	44.7	- 7	461	1,344	44.8	- 6
Dec-19	31	99.72%	3.01	437	1,311	42.3	- 10	449	1,349	43.5	- 9	452	1,317	42.5	- 9
Jan-20	31	98.25%	3.06	431	1,306	42.1	- 11	442	1,364	44.0	- 8	444	1,295	41.8	- 10
Feb-20	29	98.31%	3.06	431	1,309	45.1	- 8	442	1,366	47.1	- 5	445	1,296	44.7	- 8
Mar-20	31	99.29%	2.95	435	1,283	41.4	- 11	447	1,327	42.8	- 9	450	1,310	42.3	- 10
	366.0	100.00%	-	**5,261**	**16,230**	**44.3**	- 8	**5,399**	**16,654**	**45.5**	- 6	**5,437**	**15,849**	**43.3**	- 8

4.0 What has the resilience plan already delivered in 2019

a. Same Day Emergency Care units (Ambulatory and Frailty) on both sites and Surgical Assessment Unit at TW
b. Delivered a reduction in LOS of 0.5 days in 18/19 and maintained that reduction over winter for the first time
c. Increased uses of Pathways 1,2,and 3
d. Hospital @ Home service implemented
e. Greater uses of the SAFER bundle across the wards - n.b. SAFER is a practical tool to reduce delays for patients in adult inpatient wards (excluding maternity). The SAFER bundle blends five elements of best practice.

   The SAFER patient flow bundle
   S - Senior Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.
   A – All patients will have an Expected Discharge Date (EDD) and Clinical Criteria for Discharge (CCD), set by assuming ideal recovery and assuming no unnecessary waiting.
   F - Flow of patients to commence at the earliest opportunity from assessment units to inpatient wards. Wards routinely receiving patients from assessment units will ensure the first patient arrives on the ward by 10am.
   E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.
   R – Review. A systematic multi-disciplinary team (MDT) review of patients with extended lengths of stay (>7 days – also known as 'stranded patients') with a clear 'home first' mind set.

f. Increased use of CUR **-** Clinical Utilisation Review. This is a process that enables the trust to make objective, evidence-based assessments of whether patients are receiving the right levels of care in the right settings at the right time, through capturing information through specific IT software
g. Developing GP service and facilities in the front of house flow of ED patients

5.0 Key area within this year's plan

a. This includes a tactical approach this year similar to last year as we know this worked .The key aim of the following three components is to improve patient flow and in particular reduce LOS as we know LOS can increase over the winter period by up to 1 day.

b. Capacity plan -
   - Review the elective work over winter to ensure 'best fit' with the expected non-elective demand, ensuring both sites are fully utilised. This will include a detailed plan over the Christmas and New Year period to ensure escalation is safe, appropriately staffed and does not compromise the elective work wherever possible.
   - Pathway 3 – Increased use of pathway 3 and commercial beds 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 will need to be enhanced over the winter period

- Further develop Hospital @ Home Deliver to accommodate 30 patients for an extension of their acute care out of hospital. A change to the initial model is being scoped currently and the aim is to consolidate services in the community meaning that MTW patients will be discharged instead of being transferred and remaining under the care of the hospital consultant. Discussions with medical staff would indicate this would significantly drive up the activity within the service
- Manage 'stranded patients' using Long Length of Stay (LLOS) reviews. Weekly ward rounds to review all patients over 14 days are now in place and an Executive panel will be meeting weekly to review the information and escalate as appropriate from August.
- Consider holding Multi Agency Discharge Events pre and post-Christmas with support from Director level partners across health and social care partners. This was planned for last year but was poorly attended by all agencies but will be discussed at the Local A&E Delivery Board to gain better representation.

c. Workforce plan – to ensure that we have maximised use of our available staff resource groups.
    - Additional medical teams
    - Additional OOH surgical team
    - Mobilisation of CNS and corporate nurses
    - Mobilisation of volunteers
    - Flue inoculation campaign

d. Escalation plan (to be mobilised during period / episodes of Overflow)

    - Swing from surgery to medicine
    - Uses of assessment / ambulatory areas
    - Open closed capacity
    - Mobilise additional staff
    - Use day surgery areas
    - Use of non-inpatient areas
    - Supported by the Boarding Policy
    - Rebalance of Elective and NEL capacity

6.0 How is the Flow of patients going to be managed on a day to day basis?

Weekly meetings with the senior operational team have been set up from October to manage and balance the expected weekly flow from both elective and non-elective activity in order to make any necessary adjustments to the plan. This was a new initiative last winter which proved successful and we have taken the learning and reviewed to provide an improved forum for this year.

In order to ensure grip and control for patients flow and safety, there will be a designated senior clinical member of staff allocated each day over the winter period. Daily site meetings will review the previous 24hrs and ensure that there are appropriate plans in place to manage the expected flow for the next 24rhs. The senior operational management team will be available on a daily basis (as they are now) to coordinate and mange necessary decision making.

There will be clinical support identified on a day to day basis to help with decision making and ensure that there is excellent clinical involvement and ownership of the management of the patient flow through the hospitals .Clinical leadership is currently provided via the daily Huddle and the benefits of extending this practice to include surgery is being explored .

Through working with ECIST there is an ambition of 'Doing todays work today' demonstrated by ensuring that ED is cleared by Midday, of yesterday's work. In addition the Boarding guidelines (appendix 1) are now embedded and used frequently to move patients from ED to the ward but swaps the sicker patient in a room and the less ill patient, into the designated boarding area on the ward.

Additional Medical teams for medicine are seen as an absolute need to secure patient flow on a day to basis and significantly helped over the past two last winters. More frequent senior reviews are planned and delivered through the expansion of the Frailty and AEC units which will be working over the 7 day period from August 19.

More senior Specialty cover in ED will be delivered through changes to outpatient clinics, to create 'hot clinic' for urgent reviews and available to support ED.

7.0 Risk and Limitations

- Workforce vacancies – medical and nursing to manage escalated areas. There are already more nurse vacancies this year than last however the impact of the overseas recruitment is being factored in and is planned to make a considerable improvement to overall staff numbers, especially in Medical specialty areas.
- Out of Hospital capacity to secure flow of patients out from hospital
- NEL rise above planned scenarios
- Impact of Stroke service move from TW to MH
- IP capacity and ability to mitigate the bed gap of circa 120 beds
- Financial implications over escalating beyond the additional funded areas for winter in Divisional budgets
- Impact on elective work, including prime provider activity

The Risk Register from last winter is being reviewed and will be included in the next Winter Board Paper in September.

9.0 Key things which could significant impact the plans

- Even more NEL demand
- Inability of neighbouring trusts to provide current stroke services
- Snow before Christmas
- Norovirus outbreak before Christmas (or after)
- Increased sickness among staff
- Flu in the community / staff

The plan covers these issues however, any one of them or a mixture of them occurring at a significant level, will affect the organisations ability to operate and add significant pressure to the Trust. These unusual events will be managed through control meetings identified in 7 above.

10.0 Plans

Planning is in progress based on the evaluation of last year and new initiatives. They will focus on each Divisions individual plans in terms of the initiative, explanation of what is involved and the timeline involved.

a. General- Cross Divisional Plans
b. Urgent care plans
c. Planned care plans
d. W&C plans
e. Support service plans- including therapies, Pathology, Radiology, Pharmacy etc.
f. Estates and facilities plans

11.0 Key performance indicators being monitored through Divisional performance meetings:

a. The number of times which OPEL 4 is initiated offers an insight into the pressure the trust is under during the winter period
b. ED performance - Performance for the Trust in line with the agreed trajectories
c. Infection rates of patients and inoculation rates of staff
d. LOS – The Avg 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. LLOS patient to reduce by 40% on 17/18 baseline by March 20
f. Numbers and types of Patient Complaints
g. Number of SI / Never Events

12.0 Financial planning

The winter costs from last year have been already incorporated into the divisional budgets for this year. However, there is the need to understand the risk to the financial position concerning any necessary additional schemes identified by the divisions for this year, in order to manage the increased flow of patients this winter.

Appendix 1

Maidstone and Tunbridge Wells NHS
NHS Trust

BOARDING GUIDELINES
August 2018

In the context of these guidelines, a boarded patient is defined as:

"A patient residing on a ward without an allocated bed space"

Purpose and rationale for these guidelines

The purpose of these guidelines is to ensure there are robust processes in place to provide assurance that patient safety is being maintained when the Trust is experiencing increased challenges managing demand and patient flow.

These new guidelines describes the process of risk sharing across the Trust when the Emergency Department (ED) has more patients than it can safely care for and supports the sites with maintaining patient safety, the provision of high quality care and a good patient experience.

Unlike many departments the ED must remain open. When all available patient care spaces are occupied, the risk of serious incidents happening not only increases with every new patient that arrives, but is concentrated in one area.

NHSI and our own MTW data shows that mortality increases for patients with avoidable long waits in ED. Allocating one extra patient (boarding) to suitable wards will share this risk across the Trust, Improve patient outcomes and reduces the risk in ED.

MTW's Emergency Departments (ED) sees between 360 and 460 patients per day depending upon the time of week, season or weather.

At Maidstone Hospital the department has the capacity to care for 22 adult patients in trolley or bed spaces across 3 areas (majors, resuscitation, minors - excludes pediatrics).

- 9 in majors
- 2 isolation cubicle
- 4 in Resuscitation
- 7 in minors
- Pediatrics in ED have 5 care spaces
- RAP 4 spaces

At Pembury Hospital the department has the capacity to care for adult patients in 33 trolley or bed spaces across 3 areas (majors, resuscitation, minors - excludes pediatrics).

- 18 in majors
- 1 isolation cubicle

- 6 in Resuscitation
- 8 in minors.
- Pediatrics in ED have 6 care spaces
- RAP 5 spaces

When these spaces are full and ambulances are unable to offload it is recognised that there will be times when the hospital needs to operate differently.

1. TRIGGERS FOR ACTIVATING PATIENT BOARDING

The Boarding of patients should be considered when a number of the following criteria are met.

- No care space in the ED
- The Trust escalation status is OPAL 3 or 4
- The ED escalation status is RED or BLACK
- More than 20 unplaced patients waiting for a bed at 8am
- Resus is full with level 2 dependency patients with incoming priority call and no immediate allocated bed space
- There are more than 3 ambulances being held for more than 45 minutes.

2. LEVELS OF BOARDING

LEVEL ONE -
Boarding against identified discharges will be considered when ED has 20-25 unplaced patients with decisions to admit (DTA's), plus 2 of the triggers above

LEVEL TWO -
Boarding patients on wards without identified discharges when DTA's are 25-30 and one of the above triggers.

LEVEL THREE-
Boarding of patients will occur when there are 35+ patients with a decision to admit unallocated at 08:00 hrs

Note: in the first instance
Matching boarded patients to their specialty will always be considered but may be overlooked at level 3 if the number of DTA's at 08.00 hrs is plus 35

3. ACTIVATING PATIENT BOARDING

The decision to escalate and activate patient boarding is not made by one individual alone but made together with the clinical teams, Chief Operating Officer, Operations Directors, and Associate Directors of Nursing. OOH the decision is made by the Executive Director on call following discussion with the on call manger.

This decision should be considered seven days a week and should be taken as early in the day as possible, ideally at the 09.00 site meeting, however this decision may need to be made earlier in line with the triggers for boarding (as above). These decisions should be reviewed hourly by the Site Director.

4. TRANSFER OF BOARDED PATIENTS TO THE WARDS

The Site Director in conjunction with Associate Director of Nursing will decide, in conjunction with the Nurse in Charge of ED, Site Managers and the receiving ward, which patients are suitable to be moved to the wards. When a decision to board has been made it is the responsibility of the NIC of ED or senior site manager to ensure that the patient and family are aware that the patients will be boarding on a ward. There should be documentation in the notes that reflects the conversation.

5. CRITERIA FOR TRANSFERING BOARDED TO THE WARDS

- Only patients with a decision to admit (DTA) in ED or CDU will be moved to suitable wards for boarding.
- Where possible referred patients in ED should have a senior review and management plan documented by the on call registrar of the admitting team prior to transfer to the admitting ward.
- When transferring boarded patients it is the responsibility of ED staff to ensure that a comprehensive hand over is given to the nursing team. The patient must be escorted to the ward by a registered nurse.
- Only one patient per ward will be allocated. One ward named nurse (Registered or Support Worker dependent on the patient) must be allocated to care for the patient.
- Patients with cognitive impairment (e.g.delirium/dementia/mental health condition) should be given priority for a bed space.
- When the 'boarded' patient is bedded and the ward returns to its agreed bed base further patients can be admitted using the same criteria.
- The patient transferred from ED will be placed into the bed space and the patient awaiting discharge will be boarded outside the room. This allows treatments for the sickest patient to commence treatment without delay.
- The Infection control team should be made aware of any possible infection control risks.
- Screens should be available to maintain privacy and dignity of boarded patients.
- Patients-requiring non – invasive ventilation should NOT be boarded, in this instance the patient who is mapped for discharge should be boarded to allow the patient requiring urgent intervention immediate access to a bed space.
- When boarded patients are on the wards any medications with the patient should be kept in a green pharmacy transfer medication bag and either locked in the wared drugs trolley or in a locked medicine cupboard in the clinical room.
- When boarding has been agreed, site matrons will be responsible for ensuring wards are safely staffed to receive one extra patient – this may mean moving staff from other areas.

- Tracking of boarded patients should be clearly visible in the site office and documented on the daily site reports which will be managed by site managers. An update on boarded patients will be provided at each site bed meeting so that appropriate plans can be put in place.
- Any patient boarded longer than 4 hours should be escalated to site managers and specialty matron. If there are any clinical concerns during the period of boarding these should be escalated to the site managers and matrons. An incident form should be completed when the period of boarding has exceeded 4 hours.

6. MONITORING OF COMPLIANCE WITH GUIDLINES

- The frequency of activation will be monitored by operational teams and recorded on site reports and on incident reports when boarding has exceeded 4 hours.
- Speed of transfer and the provision of the additional nursing support will be monitored by the Associate Directors of Nursing.
- Care of the additional patients on the ward will be monitored by the Senior Matron for the specialty.
- These guidelines will be reviewed at the weekly Chief Nurses Midwifery team meeting in relation to impact on provision of patient quality and safety.
- Impact on safety and care of existing patients on wards by reduced staff to patient ratios will be monitored by the Senior Matrons and reported through the Trust Clinical Governance Committee into the Quality Committee.

Appendix 2 **Operational Pressures Escalation Levels Framework (NHS England published 31st October 2016)**

Note: Updated in 2018 which states only the CEO of an acute trust can trigger OPEL 4 in discussion with NHSE

Escalation status	**Status descriptor and triggers**	**Mitigating Actions**
Level Green: **(Normal working)** **OPEL One**	Demand for services within normal parameters - Trust is able to maintain patient flow and is able to meet anticipated demand within available resources	Maintain routine active monitoring of external risk factors including flu, weather Ensure all pressures are communicated regularly to all local partners
Level Amber: **(Moderate Pressure)** **OPEL Two**	Anticipated pressure in facilitating ambulance handovers within 60 minutes Insufficient discharges to create capacity for the expected elective and emergency activity Lack of beds across the Trust Opening of escalation beds likely (in addition to those already in use) ED patients with DTAs and no action plan Lower levels of staff available, but are sufficient to maintain services Infection control issues emerging Capacity pressures on intensive care and specialist beds	Undertake additional ward rounds to maximise rapid discharge of patients Clinicians to prioritise discharges and accept outliers from any ward as appropriate Implement measures in line with Trust Ambulance Handover Plan Notify CCG on-call Director to ensure the appropriate operational actions are taken Consideration given to elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases

Escalation status	Status descriptor and triggers	Mitigating Actions
Level Red: **(Extreme Pressure)** **OPEL Three**	Actions at Amber failed to deliver capacity Significant deterioration in performance against the ED 4 hour target (e.g. a drop of 10% or more in the space of 24 hours) Patients awaiting handover from SECAMB within 60 minutes significantly compromised Patient flow significantly compromised Unable to meet transfer from Acute Hospitals within 48 hours timeframe Awaiting equipment causing delays for a number of patients Significant unexpected reduced staffing numbers Serious pressures on intensive care capacity Problems reported with support services (IT, Transport, Estates, Pathology) that can't be rectified within 2 hours	ED senior clinical decision maker to be present in ED 24/7 where possible Contact on-take and ED on-call senior decision makers to offer support to staff and to ensure emergency patients are assessed rapidly Enact process of cancelling day cases and staffing day beds overnight if appropriate Open additional beds on specific wards, where staffing allows in line with escalation ladder (found at 6.1 of this document) ED to open an overflow area for emergency referrals, where staffing allows Notify CCG on-call Director so that appropriate operational actions can be taken to relieve the pressure Alert Social Services on-call managers to expedite care packages Active management of elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases
Level Black: **(Critical Pressure)** **OPEL Four**	Actions at Red failed to deliver capacity No capacity across the trust Severe SECAmb handover delays Unable to offload ambulances within 120 minutes Emergency care pathway significantly compromised Unexpected reduced staffing causing compromises	All actions from previous levels continue ED senior clinical decision maker to be present in ED 24/7, where possible Contact on-take and ED on-call Senior decision makers to offer support to staff and to ensure emergency patients are assessed rapidly Surgical senior clinical decision makers to be present on wards, in theatres and in ED 24/7,

Escalation status	Status descriptor and triggers	Mitigating Actions
	in service provision / patient safety Severe capacity pressures on intensive care beds Infectious illness, Norovirus, Severe weather and other pressures in Acute Trusts Problems reported with support services (IT, Transport, Estates, Pathology) that can't be rectified within 4 hours	where possible Executive Director to provide support to site 24/7, where possible ***An Acute Trust wishing to divert patients from ED must have exhausted all internal support options before contacting the CCG and neighbouring trusts to agree a divert**

Six-month review of the implementation of the plans to develop a clinically led organisation	**Director of Strategy, Planning and Partnerships**

Enclosed is an update on the six-month review of the implementation of the plans to develop a clinically led organisation.

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

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

NHS
Maidstone and Tunbridge Wells
NHS Trust

MTW Actions on feedback from clinically led

Trust Board 27th June 2019

MTW
exceptional people, outstanding care

In developing a clinically led structure we sought to introduce/strengthen 6 key aspects of our organisation

Maidstone and Tunbridge Wells NHS Trust

Clinically led aim	Score (1-5) of success	Rationale for score
Provide clearer authority, responsibilities and expectations of clinical leadership teams, with more dedicated support from corporate departments.	3	Services report being unclear on role definition between CoS and Executive management (e.g. COO/MD)
Offer clearer incentives for success and consequences for not delivering agreed objectives. 'Consequences' should be primarily supportive and aimed at securing improvement.	4	Services report mixed messages with need to change management behaviour to embed new lines of accountability
Emphasis upon improvement at all levels; empowering clinicians and other staff to address opportunities to improve patient and staff experience in their service.	3	Teams reported less scrutiny of directorate and divisional business at boards with less opportunity to inform service business
A more consistent and proportionate 'voice' and profile across professions and specialties, (including a greater focus on AHPs and scientists).	3	A clearer role within leadership structures for non medical staff was desired by many services
Greater investment in leadership development, talent management and succession planning.	4	While investments had been made clinical staff were still in the process of defining the help they needed and had to actively seek additional support
Time and support for greater communication/engagement between clinical leaders and their teams.	2	Current communications structures within divisions and directorates are not functioning and support services are not mature enough

To improve against our 6 key objectives we will focus on 3 priority areas

NHS Maidstone and Tunbridge Wells NHS Trust

Activity	Jul	Aug	Responsible
Clarify roles			
Identify what deliverables are expected from each triumvirate member at each level	▬		PM/SM/COB/SB/SH
Provide written detail of support offer for each role	▬		AJ/SH
Improve divisional and directorate boards			
Set clear divisional and directorate board SOPs	▬		AJ/SB
Review board effectiveness	▬		AJ
Provide tailored feedback to each board		▬	AJ
Review educational needs for directorate and divisional leaders in light of reviews		▬	SH/AJ
Improve comms and briefing structure			
Optimise team briefing through QSIR project	▬		AJ
Set clear communications structures in each division and directorate	▬		AJ/SB
Provide clear expectations of leaders at all Levels (e.g. frequency of team meetings)	▬		AJ/SB
Monitor compliance with expectations		▬	All

MTW exceptional people, outstanding care

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from the Audit and Governance Committee, 23/05/19	**Committee Chair (Non-Executive Director)**

The Audit and Governance Committee met on 23rd May 2019. A verbal update on the meeting was given at the Trust Board held later the same day, but this written report has been submitted for completeness.

1. **The key matters considered at the 'main' meeting were as follows:**
   - The final draft Annual Report and Annual Accounts for 2018/19 (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 23/05/19
   - The Audit Findings Report ('Report to those charged with governance') from the External Auditors was reviewed and no significant issues were raised
   - The 2018/19 Draft Management Representation Letter was reviewed, and it was agreed to recommend that this be approved by the Trust Board, subject to minor amendment of the signature block to reflect its signature on behalf of the Trust Board (rather than the "Governing Body" as stated). The letter was subsequently approved by the Trust Board on 23/05/19.

2. **The Committee agreed that (in addition to any actions noted above):**
   The Trust Secretary should provide a progress update on implementation of the Trust's updated "Management of Conflicts of Interest Policy and Procedure" for the Audit and Governance Committee meeting on 07/08/19
3. **The issues that need to be drawn to the attention of the Board are as follows:**
   N/A

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

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

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

NHS Maidstone and Tunbridge Wells NHS Trust

Workforce Committee, 23/05/18: Quarterly report from the Guardian of Safe Working Hours	Committee Chair (Non-Exec. Director)

Reporting Period: January – March 2019

This report covers the period January – March 2019 in which time a total of 49 exception reports were raised.

Summary

- Total of 49 Exception reports received in this period.
- Medicine raised 17 reports, Surgery 11, ENT 8 and Paediatrics 13.
- Exception reports raised in ENT and Paediatrics were each from 1 trainee.
- The majority of Surgery and Medicine reports are from FY1 trainees.
- Bank Usage £2,001,684.43
- Agency Usage £2,049,405.82

High level data January - March 2019:

- Number of doctors in training on 2016 TCS 278 (total):
- No fines were imposed in the period.
- No work schedule reviews have been undertaken in the period.

Summary:

Within the Medical directorate exception reports were raised as in previous periods for staff shortages and excessive work load.

Surgery exception reports were raised by FY1 trainees only and the issues included excessive workload, this includes a perceived understanding that FY1trainees were expected to prepare mortality & morbidity information for the directorate Clinical Governance meeting. This has resulted in trainees working extra hours. I have been in contact with the Clinical Tutor to ensure that in future trainees are given appropriate non-clinical time if they are expected to complete this work.

An FY2 in ENT filed 8 exception reports as there was a discrepancy between the working hours supplied by the directorate and the actual expected hours of work.

The rota suggested the working day for the FY2s finished at 4.30pm, however clinics finished at 5.00pm. I am waiting for the Educational Supervisor to respond regarding this issue, after which I will contact the ENT General Manager if this issue is not rectified. It is disappointing that this issue could not have been dealt with prior to the shifts starting instead of needing to generate exception reports.

Paediatrics generated 13 exception reports from 1 CT SP trainee. Issues were raised relating to workload, difficultly getting to teaching and not being allocated time to do e-portfolio matters. I have contacted the Educational Supervisor to arrange a meeting to help resolve the matters. There are additional complicating issues for this trainee, that I am sure have impacted on the volume of reports generated.

a) Exception reports (with regard to working hours)

Exception reports by department: January - March 2019				
Specialty	Carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Medicine	0	17	3	9
Surgery	0	11	1	12
T&O			4	
A&E				11
Anaesthetics			2	
Paediatrics	0	8		6
ENT	0	13		7
Total	**0**	**49**	**10**	**45**

Exception reports by grade: January - March 2019				
Grade	Carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	22	9	11
F2	0	14		
CT	0	13	1	15
SPR	0	0		19
Total	**0**	**49**	**10**	**45**

Exception reports (response time)				
Grade	48 hours	Within 7 days	longer than 7 days	Still open
F1		3	6	11
F2				
CT		1		15
SPR				19
Total		**4**	**6**	**45**

b) Work Schedule reviews January - March 2019 – None conducted

c) Locum Bookings

i) Staff Bank: January - March 2019

Specialty	**Number of shifts worked**	**Number of hours worked**	**Cost of Bank Cover £**
Accident and Emergency	1630	14090.2	£944,298.23
General Medicine / Acute Medicine	1132	9498.2	£517,966.82
Anaesthetics	99	774.9	£46,008.00
ENT	7	52	£3,376.00
General Surgery	209	1940.5	£93,386.00
Haematology/Oncology	43	343.3	£14,755
Obstetrics and Gynaecology	201	1528	£92,204.00
Occupational Health	14	104	£11,706.95
Oncology Consultants	2	7.3	£442.25
Ophthalmology	35	234.9	£21,593.75
Paediatrics	387	3193.6	£216,598.08
Radiology	35	263.4	£27,924.22
Trauma & Orthopaedics	24	218	£11,425.00
Total	**3818**	**32248.2**	**£2,001,684.43**

Grade of Doctor	Number of shifts worked	Number of hours worked	Cost of Bank Cover
F1	190	1631.5	£61,222.90
F2/ST1/ST2/CT1/CT2/CT3 (SHO LEVEL)	1705	14170.9	£770,753.56
ST3+, Specialty Doctor (Registrar Level)	1461	12494.5	£799,660.75
Consultant	462	3951.3	£370,047.22
TOTALS	**3818**	**32248.2**	**£2,001,684.43**

ii) Agency January - March 2019

Specialty	Number of shifts worked	Number of hours worked	Cost of Agency Cover
Accident and Emergency	194	1680	£95,739.53
General Medicine / Acute Medicine	1595	12760	£916,343.52
Anaesthetics	20	205	£20,497.95
Cytology			
Cardiology	17	136	£10,349.60
ENT			
General Surgery	565	5535.5	£381,196.21
GU Medicine			
Haematology/Oncology	2	16	£1,918.40
Histopathology	39	369.5	£44,750.15
Obstetrics and Gynaecology	97	1116	£89,589.66
Occupational Health			
Oncology	19	152	£15,195.44
Ophthalmology	102	816	£78,722.72
Paediatrics	131	1347.5	£103,283.70
Radiology	23	241.5	£24,147.59
Rheumatology			
Trauma & Orthopaedics	365	3366.5	£223,581.28
Urology	59	606	£44,090.10
Total	**3228**	**28347.5**	**£2,049,405.82**

Grade of Doctor	Number of shifts worked	Number of hours worked	Cost of Agency Cover
F1			
F2/ST1/ST2/CT1/CT2/CT3 (SHO LEVEL)	1322	11132.5	£560,345.26
ST3+, Specialty Doctor (Registrar Level)	1190	11069.5	£835,832.70
Consultant	716	6145.5	£653,227.86
TOTALS	**3228**	**28347.5**	**£2,049,405.82**

d) Vacancies WTE

Vacancies by month						
Specialty	Grade	Jan 19	Feb 19	Mar 19	Total gaps (average)	Comments
Accident & Emergency	FY2					
General Medicine	FY1					
General Medicine/Surgery	FY1					
General Medicine	FY2	5	5	5	5	Currently being recruited to. Overseas doctors requiring Tier 2 sponsorship
General Medicine	ST1-2	2	2	2	2	
General Medicine	ST3+					
Geriatric	ST3+					
General Surgery	ST3+					
Ophthalmology	FY2					
Ophthalmology	ST1-2					
Ophthalmology	ST3+					
Paediatrics	ST4+	3	3	3	3	
Trauma & Orthopaedics	FY2					
Trauma & Orthopaedics	ST1					
Trauma & Orthopaedics	ST3+					
Obstetrics & Gynaecology	ST1	1	1	1	1	
Obstetrics & Gynaecology	ST3+					
Medical Oncology	ST3+					
Clinical Oncology	ST3+					
				Total Vacancies	**11**	

The issues that need to be drawn to the attention of the Board are as follows: N/A

Which Committees have reviewed the information prior to Board submission?
- Workforce Committee, May 2019

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

Rainbow Badge pledge — Medical Director

In the week commencing 17/06/19 the Trust launched the roll out of the NHS Rainbow Badge Scheme. Details of the Scheme are enclosed. Trust Board members are invited to take the pledge shown on the final page.

Which Committees have reviewed the information prior to Board submission?

- -

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

Information, action

[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

Rainbow Badge Pledge

Rainbow Badges

Rainbow Badges is an initiative that gives staff a way to show that MTW offers open, non-judgemental and inclusive care for patients and their families, who identify as LGBT+ (lesbian, gay, bisexual, transgender, the + simply means that we are inclusive of all identities, regardless of how people define themselves).

The Rainbow Badge initiative originated at Evelina London Children's Hospital to make a positive difference by promoting a message of inclusion.

Sounds good – what do I need to do?

Read all of the information on this page which gives an overview of the issues and why it is important for all healthcare staff to be aware of them. If you want to take part, sign up to receive an NHS rainbow badge to wear at work.

Why wear a badge?

By choosing to wear this Badge, you are sending a message that "you can talk to me". You aren't expected to have the answers to all the issues and concerns but you are a friendly ear and will know how to signpost to the support available.

LGBT+ patients face inequalities in their experience of NHS healthcare. A recent Stonewall survey published in November 2018, estimates that 1 in 5 LGBT+ people are not out to any healthcare professional about their sexual orientation when seeking general medical care, and 1 in 7 LGBT+ people have avoided treatment for fear of discrimination.

Despite the progress made towards LGBT+ equality in recent years, many LGBT+ people still face significant barriers to leading healthy, happy and fulfilling lives, with high rates of poor mental health and challenges when accessing healthcare services a contributing factor.

We want to disprove attitudes like these….

MTW places a huge value on equality for both staff and patients. Increased awareness of the issues surrounding LGBT+ people when accessing healthcare on the part of NHS staff can make significant differences to LGBT+ people's experience and, in turn, on their physical and mental health.

Simple visible symbols, such as the Rainbow Badge, can make a big difference for those unsure of both themselves, and of the reception they will receive if they disclose their sexuality and/or gender identity.

For an overview of the challenges people can face in relation to sexuality and gender, read Stonewall's LGBT in Britain Health Report which includes a review of key research.

It's not just about wearing a badge, there are simple things we can all do to promote inclusion:

- Use inclusive language in all discussions
- Affirm the identity that a person chooses to use
- Assure confidentiality

You may be the first person someone has ever felt confident enough to open up to about how they feel. For them, it may be one of the most important moments of their life and how you respond to it is something they will remember.

What to do if a person discloses to you

The badges aren't designed as a symbol intended to prompt disclosures, but they may prompt a person to disclose information about their own sexuality or gender identity, perhaps for the first time. Wearing a badge doesn't mean you'll have all the answers but most importantly, you should be prepared to listen and signpost to relevant information.

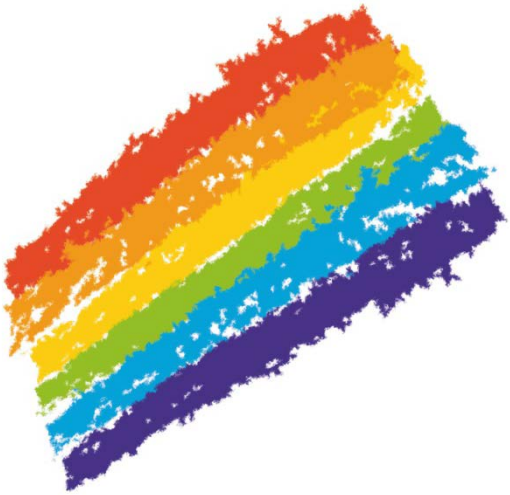
What to do if you feel you need to escalate a conversation?

Occasionally you may feel that a person's disclosure means that they need more immediate support, or that they are at risk.

There is always someone to ask for advice and we recommend contacting the LGBT+ network (mtw-tr.lgbtnetwork@nhs.net) or the Equality Lead, Jo.Garrity@nhs.net or 07770678019.

Where to signpost people for support:

- LGBT Switchboard Helpline provide an information, support and referral service for LGBT people and anyone considering issues around their sexuality and/or gender identity.
  0300 330 0630 (open 10am – 10pm)
- The charity Stonewall have excellent resources to support LGBT+ people
  www.stonewall.org.uk/help-and-advice
- Choices is a Maidstone based charity who have LGBT independent domestic violence advisors and work with male victims of domestic violence
  www.choicesdaservice.org.uk/
- Chat Youth Counselling service offer counselling, group therapy, family therapy and online counselling for young people aged 11 – 25 and their families
  www.Metrocharity.org.uk
- Trans Unite allows members of the transgender and non-binary communities to find a support group local to them – or even an online-only group.
  www.transunite.co.uk



This form must be completed by the person requesting the badge so that they fully understand what it means.

Name

Job title

Email

Location (where you work in the Trust)

I confirm that:

- I understand wearing a badge gives a positive message of inclusion and means I have a responsibility to be someone who is a friendly ear for LGBT+ people and their families
- I have read the information on this page and explored the support materials
- I understand what to do if I think a situation requires escalation

By choosing to wear this badge, you are sending a message that "you can talk to me" about issues of gender and sexuality. You aren't expected to solve all their issues and concerns but you are a friendly ear and will know how to signpost to support available.

We would like to collect information about what motivates people to wear a badge. We may use this quote anonymously to promote the badges to others. Please tell us in a few words – "I would like to wear a badge because……." (We will keep this comment anonymous unless you are happy to be named).

Signature

Date