Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD MEETING

Formal meeting, to which members of the public are invited 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

10.30am – c.1pm WEDNESDAY 28TH JANUARY 2015

THE EDUCATION CENTRE, TUNBRIDGE WELLS HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment	Page
1-1	To receive apologies for absence	Chairman	Verbal	-
1-2	To declare interests relevant to agenda items	Chairman	Verbal	-
1-3	Minutes of the Part 1 meeting of 17th December 2014	Chairman	1	1-9
1-4	To note progress with previous actions	Chairman	2	10-11
1-5	Chairman's report	Chairman	Verbal	-
1-6	Chief Executive's report	Chief Executive	3	12
1-7	Integrated Performance Report for December 2014 (incorporating updates on winter pressures and recruitment & retention)	Chief Executive	4	13-27
	Additional quality items			
1-8	Planned & actual ward staffing for December 2014	Chief Nurse	5	28-31
	Presentation from Clinical Director			
1-9	Diagnostics, Therapies and Pharmacy	Clinical Director	Presentation	-
	Reports from Board sub-committees (and the Trust Management Executive)			
1-10	Quality & Safety Committee, 15/12/14 & 21/01/15	Committee Chair	6	32-33
1-11	Trust Management Executive, 14/01/15	Committee Chair	7	34
1-12	Finance Committee, 19/12/14 & 26/01/15	Committee Chair	8 & 9 (to follow)	35
1-13	Charitable Funds Committee, 26/01/15	Committee Chair	Verbal	-
	Assurance and policy			
1-14	Review of the Board Assurance Framework, 2014/15	Trust Secretary	10	36-46
1-15	Emergency Planning update (annual report to Board)	Chief Operating Officer	11	47-52
1-16	Approval of compliance oversight self-certification	Trust Secretary	12	53-63
1-17	**To consider any other business**			
1-18	**To receive any questions from members of the public**			
1-19	To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted	Chairman	Verbal	-

Date of next meetings:

- 25th February 2015, 10.30am, Academic Centre, Maidstone Hospital
- 25th March 2015, 10.30am, Education Centre, Tunbridge Wells Hospital
- 29th April 2015, 10.30am, Education Centre, Tunbridge Wells Hospital
- 27th May 2015, 10.30am, Academic Centre, Maidstone Hospital

Anthony Jones,
Chairman

Maidstone and Tunbridge Wells NHS
NHS Trust

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 17TH DECEMBER 2014, 10.30 A.M. AT MAIDSTONE HOSPITAL

DRAFT, FOR APPROVAL

Present:	Anthony Jones	Chairman (Chair)	(AJ)
	Paul Bentley	Director of Workforce and Communications (representing the Chief Executive)	(PB)
	Sylvia Denton	Non-Executive Director	(SD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Alex King	Non-Executive Director	(AK)
	Kevin Tallett	Non-Executive Director	(KT)
	Steve Tinton	Non-Executive Director	(ST)
	Avey Bhatia	Chief Nurse	(AB)
	Angela Gallagher	Chief Operating Officer	(AG)
	Steve Orpin	Director of Finance	(SO)
	Paul Sigston	Medical Director	(PS)
In attendance:	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
	Elizabeth Dobson	Patient's Relative (for item 12-9)	(ED)
Observing:	Darren Yates	Head of Communications	(DY)
	Chris Barrass	Senior Business Development Manager, British Gas	(CB)
	Pam Croucher	Member of the public (also member of the Trust's Patient Experience Committee)	(PC)

12-1 To receive apologies for absence

Apologies were received from Glenn Douglas (GD), Chief Executive.

It was also noted that Stephen Smith (SS), Associate Non-Executive Director, would not be in attendance.

12-2 To declare interests relevant to agenda items

There were no declarations of interest.

12-3 Minutes of the Part 1 meeting of 26th November 2014

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

12-4 To note progress with previous actions

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

- **Item 11-7: Liaise with councillor colleagues in Kent and East Sussex County Councils to assist in identifying a resolution to the current high levels of Delayed Transfers of Care seen at the Trust**
  AK reported that he had held conversations with Social Services and understood that the Accountable Officer for West Kent Clinical Commissioning Group (CCG) was arranging a meeting between East Sussex and Kent Social Services, to seek a resolution to the current issues. AK added that if AG had some statistics to provide, to inform such discussions, this would be beneficial. AG agreed to provide AK with some statistics. AK suggested that AG may wish to add his name to circulation list of any routine emails that were sent on the matter.

AG then reported that the number of Delayed Transfers of Care had now peaked. AK noted that Anne Tidmarsh, the Director for Kent County Council (KCC) Director for Older People and Physical Disability, had given a commitment to resolve the situation. AG welcomed this, but noted that at present, detailed input on a daily basis was required. AG added that the ability to apply Care Packages to patient's homes was also a key factor.

12-5 Chairman's report

AJ highlighted that two major reports had been published recently: the "NHS Five Year Forward View" from NHS England, and "The Dalton review" ("Examining new options and opportunities for providers of NHS care"). AJ also noted that the consultation on the tariff for 2015/16 was underway. SO added that the consultation on the tariff would continue until 24/12/14.

12-6 Chief Executive's report

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

- GD attended a national conference, "The Future of Health", and had observed that there appeared to be very little difference in principle between the views of the two main political parties, in terms of health policy
- The Trust had seen very low levels of Clostridium difficile, which were now below the national average
- The Trust had been asked to submit a response to the tender relating to the provision of services at Crowborough War Memorial Hospital. PB clarified that the Crowborough Birthing Unit was not part of the tender, but the Trust had expressed an interest in managing that Unit, should the opportunity to do so arise.

ST referred to the tender submission, and asked whether it would be possible to submit a 'non-compliant' bid, in addition to a compliant bid. ST elaborated that the purpose of the 'non-compliant' bid would be to offer to operate the whole service, including the Crowborough Birthing Unit. KT added his support to such an approach, which he regarded as a 'value added' bid. PB replied that the Trust's intentions regarding the Crowborough site were known to the relevant parties, and stated that consideration would therefore be given to such an approach.

AJ then noted that the Academic Centre at Maidstone Hospital (MH) would be hosting the National Institute for Health and Care Excellence (NICE) on 21st January. KR agreed to provide Board members with further details of the events being held by NICE on that date.

Action: Provide Board members with further details of the National Institute for Health and Care Excellence's (NICE) public Board Meeting and "Question Time" session being held at Maidstone Hospital on 21st January 2015 (Trust Secretary, December 2014)

12-7 Integrated Performance Report for November 2014

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

- There had been high levels of attendances and admissions, which had resulted in significant pressure on bed capacity. 40 escalation beds had been open in November, and 50 such beds were open at the present time
- However, the quality of care provided at the Trust was not showing any diminution despite such pressure

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

- Patient falls remained an issue of concern, but the year to date position still showed a downward trend
- Complaints management had been scrutinised at the last Quality & Safety Committee 'deep dive' meeting, which included a discussion of the factors affecting complaints response times

KT asked for clarification that the number of falls was still forecast to be as per the plan. AB confirmed this was the case, and added that there had been progress made in reducing the harm arising from falls. AB outlined some of the measures that were being implemented and/or

considered, and noted that these would be discussed in further detail at the next 'main' Quality & Safety Committee in January 2015.

AG then referred to Attachments 4 and 5, and highlighted the following points:
- The performance recovery trajectories had been submitted to the NHS Trust Development Authority (TDA), and the TDA were using these to monitor the Trust's performance on a monthly basis
- The Trust was on trajectory for all 18-week-wait and cancer-wait targets, but was below trajectory for A&E 4-hour waiting time target performance
- 999 bed days had been lost in November, which was the highest number for the year

ST noted that the BBC's website outlined the Trust's performance on the A&E 4-hour waiting time target, and asked whether there were any reasons for the troughs in performance. AG replied that such troughs had been affected by peaks in activity, which had affected bed capacity. AG added that the Trust had experienced a prolonged period of high levels of activity, but noted that recovery plans were in place, and there was a focus on length of stay (LOS), to ensure that the Trust optimised the LOS for each patient. AG elaborated that plans for this included a high impact team in place at Tunbridge Wells, which had started that week, to manage patients outside of hospital, with the aim of preventing hospital readmissions. AG added that other hospitals in the region had also seen increases in clinical demand, but it was felt that demand had now peaked, and improved patient flows were expected circa 23/12/14. AG also noted that all of the usual plans that were deployed at times of escalation were in effect.

SD commended the achievement of the Executive Team in managing the high level of pressure being faced. AJ concurred with the commendation, but reiterated his view that there were failings within the wider system that prevented patients from leaving hospital when they no longer needed acute hospital care. AG added that only five of the NHS Trusts overseen by the TDA were performing above the 95% A&E 4-hour waiting time target, and the Trust, which was usually a top-rated performer, was now ranked 36th.

AJ then asked about the planned decline in 62-day cancer waiting time performance. AG reminded Board members that the Trust's intention was to prioritise treatment for Cancer patients that had waited longer than 62 days, and highlighted that the Trust's 62-day cancer waiting time performance would therefore be adversely affected until such patients had been treated.

PB then referred to the circulated report and highlighted the following points:
- There had been an increase in Bank and Agency usage in the month (by 50 WTEs)
- Sickness absence had also risen, to 4.2%
- Recruitment would be discussed further, under item 12-12, but the Trust establishment had increased by circa 100 over the past year

KT referred to the performance dashboard and remarked that the Trust's plans relating to the various workforce metrics were not included within the "Plan/Limit" column. KT requested that these therefore be added. PB agreed.

Action: Arrange for the Trust's plans in relation to workforce metrics on the Trust performance dashboard to be included within the "Plan/Limit" column (Director of Workforce and Communications, January 2015 onwards)

SO then referred to the circulated report and highlighted the following points:
- The financial position was above plan by £1m in the month, as a result of the receipt of the pro-rata non-recurrent deficit funding. The year to date position was therefore a £1.6m deficit compared to a planned £9.7m deficit i.e. £8.1m above plan
- The month had been positive for income, day cases, and non-elective activity
- Pay expenditure was above plan for the month, and for the year to date, and the causes of this were related to the capacity pressures discussed earlier in the Board meeting
- Outsourcing (of day cases and elective inpatients) was below plan
- There was a small adverse variance regarding transport, which related to funding of the bus service required as part of the PFI planning conditions
- The Cost Improvement Programme (CIP) was now forecast to deliver £2m more than plan

- The cash position remained tight, but no recourse to external borrowing was anticipated
- There had been £3m of capital expenditure at the end of month 8, but expenditure was expected to be within plan by the year end
- Agreement had been reached with High Weald, Lewes and Haven CCG on outstanding contractual items, and this was expected to result in payment within the current calendar month
- There remained some outstanding contractual items with West Kent CCG and Specialist Commissioning. The issues with the latter may need to be escalated.
- The process of monthly reconciliation was continuing
- There was still no agreement on the reinvestment of marginal tariff emergency admissions funds

AJ noted that some of the matters highlighted by SO would be discussed further in the 'Part 2' meeting of the Trust Board scheduled for later that day.

SM then reported that Public Health England had now recommended that antiviral medication now be released for the treatment of influenza, in response to the recent prevalence of influenza, which was predicted to be higher than the previous year.

ST asked whether GPs were providing appropriate levels of support, in terms of patients with influenza. SM replied that GPs had vaccinated many patients in September and October, which were the appropriate months for such vaccinations.

AJ then commended the achievement of the low number of Clostridium difficile cases. PS noted that having a small number of cases enabled a more targeted focus, which would in turn assist in the Trust's efforts to improve further.

12-8 To note the Trust's Performance Recovery Trajectories (for A&E 4-hour wait, 18 week RTT wait and Cancer 62-day wait for first definitive treatment)

It was noted that this item was covered under item 12-7.

Additional quality items

12-9 A patient's experiences of the Trust's services

AJ welcomed ED to the meeting and asked her to relay her experience to the Board. ED shared the details of the experience of her daughter, Lydia Dobson (LD), as follows:

- LD was admitted to Tunbridge Wells Hospital (TWH) on 01/10/14, and passed away on 05/10/14. The staff throughout LD's inpatient stay were excellent, and this prompted ED to write to the Trust expressing her gratitude
- LD had profound disabilities and her care was shared between LD and foster carers. Staff respected the wishes of both equally
- ED was used to staff asking her to repeat the details of LD's condition, and was therefore pleasantly surprised when the Consultant introduced himself by stating that he had read the Healthcare records. ED added that she was able to judge that this statement was truthful, as the Consultant subsequently made reference to the content of such records
- The clinical team outlined the options for enabling LD's passing, and emphasised that the family should not feel any guilt
- A number of clinical staff were involved in LD's care, and ED was very impressed with the quality of the staff handover, as staff did not ask questions which had already been asked by other members of the team
- The staff were also very good at answering questions, and were very patient in doing so
- The hospital was clean, which ED had never witnessed while at other hospitals
- All staff were helpful, including, for example, those working in the canteen, and the staff she encountered when she needed directions. ED elaborated by giving an example of a staff member accompanying ED and LD's foster mother back to where they needed to be (i.e. rather than just giving them directions)
- LD did not have a Designated Nurse, but this was not necessary, as the communication with the family and carers was excellent

- ED lived two hours away from the hospital, and on the day LD died, ED received a phone call stating that LD was critical. ED was asked to attend the hospital as soon as possible. ED arrived a few moments after LD had passed away, and ED's sons arrived later that day. However, the family were not rushed, and were able to spend the time they wished to with LD

AJ expressed gratitude for the bravery exhibited by ED, and asked whether ED knew the name of the Consultant to which she referred. ED confirmed she did not know their name, but the Consultant was male, whilst the Registrar was female. AJ stated that efforts would be made to identify the Consultant and Registrar, to enable ED's compliments to be passed on.

Action: Identify the Consultant and Registrar referred to in the 'patient story' that was heard at the December 2014 Board meeting, and pass on the compliments received regarding their behaviour (Medical Director, December 2014 onwards)

AJ remarked that he expected every staff member would provide the level of care that ED and her family received. AJ then invited further comments or queries.

KT commented that the key aspects that made a difference seemed to be the small things that the staff did. ED agreed, and stated that the hospital felt like a community, with everyone playing a role.

PS noted that he worked in Intensive Care, and it was important to hear from ED the importance of clinical teams making decisions regarding patients' passing, to relieve the family of any guilt.

AJ also commended the quality of the handover between staff, not just in terms of medication and treatment, but in preventing the family having to repeat relevant details in difficult circumstances.

SD remarked that the importance of communication was recognised at the Trust, and she was therefore very pleased to hear that this worked well in LD's case.

AB then returned to the absence of a Designated Nurse, and asked LD whether she felt such a Nurse was required. ED reaffirmed her view that this was not necessary because the communication was good, but added that if such communication was not as good as it had been, there may have been a need for a Designated Nurse.

AJ concluded that he would like the positive behaviours of the staff involved in LD's care to be communicated, to promote such behaviours among other staff. AJ proposed that AB and PS be asked to consider how this should be achieved. This was agreed.

Action: Consider how the positive behaviours of the staff referred to in the 'patient story' that was heard at the December 2014 Board meeting should be communicated, to promote such behaviours among other staff (Chief Nurse / Medical Director, December 2014 onwards)

12-10 Planned & actual ward staffing for November 2014

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

- The threshold for exception reporting will in future be raised to 90%, from the current 80% level
- The report demonstrated that the Trust staffed its areas safely
- The pattern of staffing in ICU was similar to that of previous months, and a review of establishment will therefore be undertaken
- Some of the staffing issues within Hedgehog Ward would be addressed in the business case relating to the emergency paediatric pathway

AJ asked whether there was a problem in recruiting Clinical Support Workers (CSWs). PB replied that there was no problem in recruiting CSWs across either site, though such recruitment was slightly easier at MH than at TWH. AB added that Disclosure and Barring Service (DBS) checking took longer for CSWs.

12-11 Board members' ward visits

KR referred to the circulated report and invited questions. None were received.

AJ encouraged Board members to make as many visits as they could.

SDu stated she had been asked by Matrons to remind Board members to participate in the Care Assurance Audits, particularly when these were taking place in Board members' link areas. AJ encouraged such participation, and asked KR to provide Board members with the relevant details.

Action: Provide Board members with the details of the scheduled Care Assurance Audits (Trust Secretary, December 2014 onwards)

KT pointed out that feedback had been provided from the visits he had made, and therefore the "No" within the "Formal feedback provided?" column should in fact be a "Yes". KR acknowledged the point.

Planning and strategy

12-12 The recruitment of substantive staff

PB referred to the circulated report and gave a presentation highlighting the following points:

- The report and presentation was a variation on a theme of that provided to the Workforce Committee and Trust Management Executive in December
- The Trust had 469 vacant posts at present, which equated to a vacancy rate of 8.7%. However, over 40 posts were consciously being held as a result of changes within the Kent and Medway Health Informatics Service (HIS) and back office, so the true vacancy rate was 7.4%
- Temporary medical and nursing staff usage had increased.
- In terms of pay rates, the Nurse bank paid at mid-point of the scale.
- Medical vacancies were relatively low, but there had been an increase in the number and cost of Medical Locums (who were engaged via the Trust's Bank) and Agency staff. The reasons for this had been explored in detail among the Executive team, and a number of factors were involved.

ST commented that the situation called into question the Trust's assumption that clinical demand would reduce. ST then asked why there had been a marked increase in medical agency in recent months. PS replied that this reflected a wider shift towards staff choosing to work via Agencies, coupled with difficulties in recruiting to particular specialities.

AJ asked whether it was possible to increase the use of Medical Locums, to reduce the use of medical Agency staff. PS confirmed this was being explored.

SD asked for details of the premium involved in Agency rates. PB stated that the premium was circa 40%, but SO added that the premium for particular Consultant posts could be as high as 100%, depending on their pattern of work.

PB then continued, and highlighted the following:

- Retention was important, as higher retention negated the need to recruit at higher levels
- The Trust, like others, has a skewed bell distribution chart which meant that if staff stayed at the Trust beyond two years, they were more likely to stay for a longer period
- Options such as loyalty bonuses had been considered, but would not be taken forward
- It was important not to superimpose any individual views as to why staff left employment, and therefore the intention was to consider a range of options
- In terms of recruitment, 'golden welcomes' had been considered, but would not be pursued, although another local Trust did operate such a scheme
- It was acknowledged that recruitment processes needed to be expedited
- Residential accommodation was important, particularly for 'hard to recruit and retain' staff. Work was therefore being undertaken to understand staff housing needs
- Bursaries were also recognised as important
- Proposed options that had been agreed were to aim to increase the bank fill rate, by paying bank shifts at differential rates; and increasing the hourly rate to combat the payment of 'London weighting' by other Trusts
- 'Kitchen sink' recruitment would be applied, to include all options i.e. national press recruitment, Job Fairs, Open days, overseas recruitment (from new locations), targeted invites to local

persons on the Nursing and Midwifery Council's (NMC) Register, and increased use of social media
- 'Next steps' included: focus groups on both sites; a detailed cost analysis of options; a review of Trust accommodation; engagement with specialist overseas recruitment agencies; communication with existing students regarding employment commitment; the finalisation of a business case for a new system to enable staff to book bank shifts; business planning 2015/16; and the finalisation of the Trust's 2015/16 recruitment plan

PB proposed that the recruitment plan be submitted to the Trust Board as part of the business plan. AJ welcomed the proposal.

AB then conveyed the experiences of a colleague from a London Trust, who had recruited from within the European Union, and who had stated that the two largest challenges in such recruitment were language and accommodation. AB added that the same Trust had also recruited from the Philippines, and had been able to overcome work permit issues, but were experiencing difficulties with the NMC.

KT welcomed the ideas within the presentation, but appealed for innovation to continue to be explored. ST appealed for the Trust to recruit ahead of its budget, and to be aggressive in its marketing among potential employees.

SDu suggested that consideration of whether the Trust was regarded as a place to which medical trainees wished to return, to work, could be explored further under the Patient Safety Think Tank agenda item within the Part 2 meeting to be held later that day.

AJ thanked PB for the presentation, and proposed that a regular update on recruitment and retention be submitted to each Board meeting for the coming months. This was agreed.

Action: Submit an update report on recruitment and retention to each Board meeting for the coming months (Director of Workforce and Communications, January 2015 onwards)

12-13 Update on the Trust's 2015/16 planning process (including the NHS Planning Timetable, 2015/16)

SO referred to the circulated report and gave a presentation highlighting the following points:
- The process was continuing, and two timetables were enclosed: the Trust's internal timetable, and the NHS external timeline
- The process commenced circa two months ago, and a small subsection of the Executive Team were meeting with Directorates to review their business plans in detail
- Half of such review sessions had taken place this far, and these would be completed by the end of 2014, with one exception
- The initial planning submission would need to be made to the TDA on 13/01/15

AJ highlighted that when making the initial submission to the TDA, it should be emphasised that it had not yet been seen by the Board or Trust Management Executive. SO pointed out that he had proposed that the Board delegated the authority to finalise the initial submission to the Chief Executive. AJ replied that he wished to understand how much of the initial submission was unchangeable, as he did not want to ask the Board to approve a business plan at a later point that had, in effect, already been submitted to the TDA. SO acknowledged the point. AJ therefore suggested that, if possible, the initial plans should be circulated to Board members for comment, prior to 13/01/5.

SDu highlighted that the CCG's commissioning plans would be a key aspect of the Trust's own plans. SO agreed, and noted that at present, the CCGs had only provided a high-level, generic view of service developments, and added that he did not anticipate receiving any further detail from the CCGs before the 13/01/15 submission deadline.

AJ confirmed that the Board was content to delegate the authority to make the initial plan submission to GD, but proposed that it should be made clear to the TDA that the initial plan had

not been reviewed by the Board, and the Board would therefore reserve its position on the content of the plan. This was agreed.

SD then noted that the details of the 2015/16 tariff were expected to be published in January 2015, and asked whether any details were known at this stage. SO explained that a consultation was currently underway regarding the details of the tariff.

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

12-14 Audit and Governance Committee, 20/11/14 (incl. approval of revised Terms of Reference)

KT referred to the circulated report and invited queries or comments. None were received.

The revised Terms of Reference were approved as circulated.

12-15 Workforce Committee, 04/12/14 (to include findings from the staff Friends and Family Test)

KT referred to the circulated report and highlighted that Director of Medical Education had submitted a useful report on medical workforce.

12-16 Patient Experience Committee, 04/12/14

SD referred to the circulated report and invited queries or comments. None were received.

12-17 Trust Management Executive, 10/12/14

PB referred to the circulated report and invited comments or queries.

SM referred to the comment that "The backlog in Radiology reporting was now under control", and clarified that this only related to a backlog in the reporting of chest x-rays. The point was acknowledged.

PS highlighted that one of the Trust's medical staff would soon be travelling to Sierra Leone to assist in the efforts against the Ebola outbreak.

SDu noted that "Integrated Care 24 Ltd" (IC24) would soon be moving its base to Tunbridge Wells Hospital and asked where they would be moving from. AG clarified that IC24 were currently based at the MH site, but the comment in the report referred to a move from Tonbridge Cottage Hospital, to the Outpatient area in TWH. SDu welcomed the development. PS agreed, but cautioned that the move may not prevent admissions from A&E.

12-18 Quality & Safety Committee, 15/12/14

SD reported that the Committee was a 'deep dive' meeting, and covered the plans regarding emergency paediatric pathway, and the management of complaints. SD added that a further report on the emergency paediatric pathway would be received at the next 'deep dive' meeting, whilst the findings of a 'gap analysis' regarding the Trust's complaints process would also be reviewed.

Assurance and policy

12-19 Approval of compliance oversight self-certification

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

- The compliance status was unchanged from the previous month
- Changes to the "Evidence of Trust compliance" from the previous month had been highlighted.

KT asked for an explanation of the Band 4 "Priority banding for inspection". KR explained that there were 6 bands, and the Trust had previously been allocated to Bands 5 and 3, but the Trust was not actually awarded a Band once they had been subject to an inspection by the Chief Inspector of Hospitals.

The oversight self-certification was approved as circulated.

12-20 Response to the Fit and Proper Persons Regulations

KR referred to the circulated report and highlighted that the recommendation was to introduce an additional 5-point process for Board members, involving: a self-declaration; an "Enhanced with list" DBS check; due diligence checks; annual appraisal confirmation; and review of contracts of employment.

The recommendations within the report were approved as circulated, but AJ invited Board members to provide any further comments they had on the process to KR.

12-21 Approval of 2013/14 Ann. Report & Accounts of Maid. and Tun. Wells NHS Trust Charitable Fund

AJ referred to the circulated report and invited comments or queries. ST confirmed his support for the changes, in his capacity as chair of the Charitable Funds Committee.

The amendments to the 2013/14 Annual Report and Accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund were approved as circulated.

12-20 To consider any other business

There was no other business.

12-21 To receive any questions from members of the public

There were no questions.

12-22 To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted

The motion was approved.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – January 2015

1-4 Log of outstanding actions from previous meetings — Chairman

Actions due and still 'open'

Ref.	Action	Person responsible	Deadline	Progress [1]
12-7 (Dec 14)	Arrange for the Trust's plans in relation to workforce metrics on the Trust performance dashboard to be included within the "Plan/Limit" column	Director of Workforce and Communications	January 2015 onwards	Additional data has been added to the "Forecast" and "Bench Mark" columns, and work is continuing to populate the "Plan/Limit" column.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
11-7 (Nov 14)	Arrange for the 'main' Quality & Safety Committee to receive assurance that there are plans for the appropriate level of Consultant Obstetrician cover to be in place, should the number of births at the Trust exceed 5000 p.a.	Medical Director / Chief Nurse	November 2014 onwards	The issue was discussed at the 'main' Quality & Safety Committee in January 2015, as part of the Women's and Sexual Health Directorate report
12-6 (Dec 14)	Provide Board members with further details of the National Institute for Health and Care Excellence's (NICE) public Board Meeting and "Question Time" session being held at Maidstone Hospital on 21st January 2015	Trust Secretary	December 2014	The details were circulated to Board members via email on 18/12/14
12-9 (Dec 14)	Identify the Consultant and Registrar referred to in the 'patient story' that was heard at the December 2014 Board meeting, and pass on the compliments received	Medical Director	December 2014 onwards	The staff have been identified, and the compliments received regarding their behaviour have been passed on.

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	regarding their behaviour			
12-9 (Dec 14)	Consider how the positive behaviours of the staff referred to in the 'patient story' that was heard at the December 2014 Board meeting should be communicated, to promote such behaviours among other staff	Chief Nurse / Medical Director	December 2014 onwards	The story will be publicised via a range of means (the Governance Gazette, Intranet etc.), and will be discussed via a range of internal forums (including Directorate meetings)
12-11 (Dec 14)	Provide Board members with the details of the scheduled Care Assurance Audits	Trust Secretary	December 2014 onwards	The details were circulated to Board members via email on 15/01/15
12-12 (Dec 14)	Submit an update report on recruitment and retention to each Board meeting for the coming months	Director of Workforce and Communications	January 2015 onwards	An update has been submitted to the January 2015 Board as part of the Integrated Performance Report for December 2014. Further updates have been scheduled to be received at the February and March 2015 Board meetings (again, as part of the part of the Integrated Performance Report)

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Deadline	Progress
N/A	N/A	N/A	N/A	
				N/A

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - January 2015

1-6	Chief Executive's update	Chief Executive

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

1. Similar to other acute hospitals, we have experienced unprecedented levels of A&E attendances, ambulance conveyances, and unplanned hospital admissions during December. This has continued into January, A&E attendances were 7.3% higher in December than the same month the year before. There was a 21% increase in ambulance attendances over the same period and emergency admissions increased by 12%. Many patients are aged over 75.
   - 1.1 The Exec team have been working closely with our clinical teams throughout this period, & I want to personally thank all of our staff for the incredible efforts they have made to maintain the highest standards of patient care & safety in difficult and unforeseeable circumstances
   - 1.2 Unfortunately, we were unable to see all patients in A&E within the 4 hour standard & have rescheduled a number of planned procedures to provide safe care for our emergency patients
   - 1.3 I have discussed with our clinical leads the need to look at how we deliver services in the future given the changing needs of our ageing population. We must work with our healthcare partners to ensure models of care aimed at treating more patients at home reduce hospitalisation, and help lead in the development of other initiatives that meet patient needs, given the steady growth in A&E attendances and admissions we have seen occur over many months and the pressure this has placed on the finite number of hospital beds available in our Trust.
2. A Safety Climate Survey developed by doctors and nurses on our Patient Safety Think Tank has shown that while the majority of our staff feel able to speak up and challenge clinical issues, and work in an environment that promotes patient safety, too many staff feel we don't always learn and improve from the concerns they raise. We are looking at practical ways to address this issue, which is a key area of our on-going journey to improve standards of care.
3. We are engaging with our clinicians, local GPs, the public and patients on new stroke standards of care as part of our on-going work to improve stroke outcomes and reduce disability. Our stroke services are improving, but we have further to go to fully achieve the benefits we want to see for around 600 stroke patients who use our hospitals each year.
4. Our clinical teams have won the Most Consistent Top Performing Acute Provider Award, which covers all hospitals in Kent, Surrey and Sussex, for consistently enhancing the quality of care received by patients suffering from heart failure and pneumonia, and for enhancing the recovery of patients following planned surgery for orthopaedic, colorectal and gynaecological procedures. This is an outstanding achievement. Our Kangaroo Care team were finalists in the Enhancing Innovation through Collaboration Award, for collaboration between the MTW team and KangaWrap/Trade4life - our charitable project that supports maternal and child health in low income settings.
5. Finally, we are hosting a visit from the Chinese Health Department in February to see Kangaroo care in action at our Trust. This has been organised through Save the Children. The visit is likely to include us showing how Kangaroo care can make a difference for transitional care babies and within the theatre environment for women undergoing elective caesarean sections.

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – January 2015

1-7	**Integrated Performance Report for December 2014** (incorporating updates on winter pressures and recruitment and retention)	**Chief Executive**

The enclosed report provides information on the increase in emergency demand and acuity of patients during late December / early January.

The information includes an update on recruitment and retention (staffing issues), as was requested at the Board in December 2014.

The report also includes, as usual, the Trust performance dashboard; integrated performance charts; and financial performance overview.

Which Committees have reviewed the information prior to Board submission?

- Executive Team, 20/01/15

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

Discussion and scrutiny

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

1. Summary

The Trust in line with the rest of the NHS was severely affected by the increase in emergency demand and acuity of patients during late December / early January. This has affected the emergency access standards, elective activity, use of temporary staffing and finance.

2. Operational Issues

The key factors that have affected the emergency / NEL pathway at MTW over the winter period are:

- The number of ambulance conveyances,
- The age profile of patients attending,
- Level of acuity and the number of patients with respiratory conditions presenting and being admitted
- Geographical areas that patients have been coming in from.
- Insufficient bed capacity to keep pace with demand for admissions
- Increased levels of staff sickness compounded by spread of escalation areas to cover
- Limited availability of medical and surgical teams during the holiday period. Although rotas were supplemented as part of the Christmas plan this was not sufficient to cover the surge in demand and the level of escalation needed.

3. Analysis of the demand surge

The analysis shows four key issues:

1. In December 2014, **ambulance arrivals, elderly patients** and **respiratory illness** were all significantly higher than would be expected, and all disproportionately higher than would be expected from a simple rise in patient volumes.
2. In December, ambulance arrivals were around 5% above what we would have expected, even after accounting for the usual Christmas increases
3. The 3 weeks from 21st December have averaged 373 patients aged over 80, when we would be expecting around 320
4. Late December saw around 50-75 respiratory attendances and 20-40 admissions per week more than we would have expected in a normal winter. The week ending 04-Jan-2015 saw 157 respiratory admissions, this is the most ever admitted in a single week.

4. Staffing issues

The increase in activity during the month led to an increase in the overall total staff base (November 5437 WTE), to December 5490. The month saw an increase in substantive staff (12 WTE), a reduction in the number of bank staff (311 WTE November to 293 WTE December), however the increase arose from the increase in agency and locum staff used from November 185 WTE to December 243 WTE. The increase in staff was a reflection of the high levels of beds which were staffed, at one point over 100 escalation beds open and staffed, the increase of 0.4% month on month of levels of sickness absence and the increased levels of leave taken in clinical areas which required 'back fill'.

During the period of high activity the Trust took actions to increase the availability of our bank staff, we varied the level of absolute remuneration between Christmas and New Year, and introduced an incentive scheme for the month of January to incentivise our staff to work extra bank shift hours, whilst remaining within total hours legislation.

Substantive recruitment has continued and focus groups are now established to consider alternate proposals. A successful Nurse open day took place at TWH on 17th January which enabled 12 offers of permanent employment to be made. Finally the Chief Nurse and Director of Workforce and communications are pursuing partnerships with other non-Kent based NHS providers to enable nursing rotations to be offered to staff coming from overseas.

5. Actions Taken to manage the immediate issues

- Escalation triggers and actions in place on 26th December [Friday]
- Red escalation from Saturday 27th at Tunbridge Wells Hospital (TWH) & system wide review undertaken with remedial interventions

- Senior Clinical and Operations Team deployed across both sites to oversee safe patient flows and maintain patient safety in all areas. Each site led by 1 or 2 Associate Directors.
- Named matrons aligned to all escalation areas
- Executive presence daily.
- Ambulance cohort area identified and set up
- Escalation areas identified and staffing booked & arranged – catheter laboratory recovery, Wells Suite and short-stay surgery at TWH.
- Further escalation areas identified as contingency from Monday 29th December, i.e theatre recovery areas.
- Maidstone was placed on red escalation on Sunday 28th December & the planned winter escalation ward, Whatman was brought forward from Monday 5th January and opened on Tuesday 30th December.
- By 1st January across both sites 107 escalation beds open, with 12 – 20 patients with decisions to admit in A&E at all times.
- Additional staff booked and allocated across all areas – some staff returned early from leave to cover their wards, plus bank and agency staff. Facilities staff were organised to provide cover to all escalation areas.
- Daily System-wide teleconference were undertaken to deal with general and specific issues relating to patient flows and risks in the system.

6. Clinical & Operational Impact

- Cohorting of ambulance patients in A&E continued daily until from 27th December until 5th January – ranged from 5 – 12 patients but mostly around 6 at all times.
- Staffing – all staff groups affected in terms of the volume and intensity of the acute work as well as the number of areas to cover. This involved not just nursing, medical and allied health professionals but also admin and ancillary / support services.
- Equipment – Physical beds were hired at short notice for both sites.
- The main effect on quality 30 mixed-sex breaches in escalation areas – all actions were taken to avoid where possible and to minimise the time that patients were mixed.
- All elective surgery cancelled at TWH and very limited activity done at Maidstone, from 29th December – 11th January.
- Inability to undertake any cardiac intervention work at TWH due to the escalation of the cath-lab recovery area.
- The impact of elective cancellations will cause some longer waiting times for routine procedures and our ability to meet the referral to treatment standards for all specialties.
- Impact on finance as more outsourcing planned in quarter 4 as well as the drop in expected income for month 9 – this is covered in the finance section.

7. Further actions planned re resilience planning.

- Continue the LOS action plan to achieve and maintain further improvements to flows.
- Agree changes to the bed configuration by specialty across both sites to match demand more specifically with capacity and enable the delivery of
  - Frail elderly assessments
  - Expanded Ambulatory pathway
  - Ortho-geriatric rehabilitation
  - Effective trauma pathways
  - Medical high-dependency area
  - Protected elective capacity
- Established and effective use of the Therapy Assisted Discharge (TADs) & High Impact Team (HIT) at both sites
- Clear escalation plan & identification of escalation areas on both sites [with triggers for when to initiate].
- Create additional bed capacity at TWH both for acute and step-down patients
- Bed mapping across Acute and Community services to ensure capacity matches expected demand is taking place.

TRUST PERFORMANCE DASHBOARD **Position as at:** **31st December 2014**

Governance (Quality of Service): **2.0** **Amber/Red**

Finance: **TDA** **Red**

Responsible Committee: Quality & Safety

	Delivering or Exceeding Target
	Underachieving Target
	Failing Target

Please note a change in the layout of this Dashboard with regard to the Finance & Efficiency and Workforce Sections

	Patient Safety & Quality	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
'1-01	Hospital-level Mortality Indicator (SHMI)			101.26	100.3	-0.96	0.3	*100*		100
'1-02	Standardised Mortality (Relative Risk)			91.3	102.1	10.8	2.1	*100*		100
'1-03	Crude Mortality	1.5%	1.5%	1.2%	1.2%	-0.1%				
'1-04	Safety Thermometer % of Harm Free Care	96.0%	96.1%	94.9%	96.3%		1.3%	95.0%		0.0%
'1-05	*Rate C-Diff (Hospital only)	10.7	14.7	17.5	13.4	-4.1	-4.7	*15.7*	15.3	15.7
'1-06	Number of cases C.Difficile (Hospital)	2	3	29	23	-6.0	-8.0	*35*	35	35
'1-07	Number of cases MRSA (Hospital)	0	0	2	1	-1	0	*0*	1	
'1-08	Elective MRSA Screening	0.0%	99.0%	0.0%	99.0%		1.0%	98.0%	99.0%	
'1-09	% Non-Elective MRSA Screening	95.0%	97.0%	95.0%	97.0%		-1.0%	95.0%	97.0%	
'1-10	**Rate of Hospital Pressure Ulcers	2.1	1.7	2.5	2.2	-0.2	-0.8	*3.0*	2.2	3.0
'1-11	****Rate of Total Patient Falls	6.4	6.40	7.3	6.2	-1.1	-0.6	6.75	6.1	
'1-12	****Rate of Total Patient Falls Maidstone	5.3	3.24	6.4	5.1	-1.3	-1.6	6.75	5.0	
'1-13	****Rate of Total Patient Falls Tunbridge Wells	6.8	8.52	7.9	6.9	-1.0	0.2	6.75	6.9	
'1-14	Falls - SIs in month		3		26	26				
'1-15	MSA Breaches	0	30	10	35	25	35	0	35	
'1-16	Total No of SIs Open with MTW	25	14			-11				
'1-17	Number of New SIs in month	12	8	103	82	-21	-8			
'1-18	Number of Never Events	0	0	1	2	1	2	*0*	2	
'1-19	Number of CAS Alerts Overdue	20	0			-20	0	*0*		
'1-20	*****Readmissions <30 days: Emergency	11.9%	11.4%	11.0%	11.6%	0.6%	-2.0%	*13.6%*	11.6%	14.1%
'1-21	*****Readmissions <30 days: Elective	5.6%	6.3%	5.8%	5.6%	-0.1%	-0.7%	*6.3%*	5.6%	6.8%
'1-22	***Rate of New Complaints	5.8	3.38	5.1	3.85	-1.3	-2.41	*6.26*	3.92	6.26
'1-23	% complaints responded to within target	76.1%	66.7%	57.8%	66.5%	8.6%	-8.5%	75.0%	68.6%	
'1-24	IP Resp Rate Recmd to Friends & Family	21.3%	29.4%	16.6%	42.6%	26.0%	17.6%	25%	38.7%	37.6%
'1-25	A&E Resp Rate Recmd to Friends & Family	7.7%	23.2%	2.5%	18.2%	15.8%	3.2%	15%	17.3%	19.6%
'1-26	Mat Resp Rate Recmd to Friends & Family	New	17.0%	New	19.6%	New	-0.4%	15%	19.6%	21.3%
'1-27	IP Friends & Family (FFT) Score	75	78	75	77	2	4	73	77	73
'1-28	A&E Friends & Family (FFT) Score	71	58	64	64	0	9	55	64	55
'1-29	Maternity Combined Q1 to Q4 FFT Score	New	86	New	83	New	12	71	83	71
'1-30	Five Key Questions Local Patient Survey	93.2%	89.6%			-3.6%		90%	89.6%	
'1-31	VTE Risk Assessment	95.3%	95.5%	95.2%	95.2%	0.0%	0.2%	95%	95.2%	95%
'1-32	% Dementia Screening	98.9%	97.9%	99.1%	98.8%	-0.3%	8.8%	90%	98.8%	
'1-33	% TIA with high risk treated <24hrs (Oct)	50.0%	No data	61.8%	72.1%			60%	72.1%	
'1-34	% spending 90% time on Stroke Ward (Nov)	83.8%	86.3%	74.4%	83.5%	9.1%	3.5%	80%	80.1%	
'1-35	Stroke:% to Stroke Unit <4hrs (Nov)	New	53.4%	New	41.6%	New	New	75.0%	75.0%	
'1-36	Stroke: % scanned <1hr of arrival (Nov)	New	32.2%	New	43.8%	New	New	43.0%	43.0%	
'1-37	Stroke:% assessed by Cons <24hrs (Nov)	New	66.1%	New	73.6%	New	New	85.0%	85.0%	

Responsible Committee: Finance, Treasury & Investment

	Finance & Efficiency	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
3-01	Average LOS Elective	3.3	3.0	3.3	3.2	-0.1	-0.1	*3.3*	3.3	3.3
3-02	Average LOS Non-Elective	6.2	7.1	6.8	6.8	-0.1	1.1	*5.7*	6.5	5.7
3-03	New:FU Ratio	1.61	1.60	1.72	1.55	-0.18	0.03	*1.52*	1.52	
3-04	Day Case Rates	79.3%	83.0%	79.3%	83.3%	4.1%	3.3%	80.0%	80.0%	82.19%

	Finance & Efficiency	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Plan	Curr Yr	*Plan*	Curr Yr	From Prev Yr	From Plan	Plan	Forecast	
3-05	Income	31,631	33,169	286,832	295,617	6.0%	3.1%	380,827	398,821	
3-06	EBITDA	2,464	2,738	17,379	24,842	74.7%	42.9%	24,718	34,868	
3-07	Surplus (Deficit) against B/E Duty	(608)	82	(10,283)	(1,502)			(12,303)	5	
3-08	CIP Savings	2,050	1,619	16,042	17,505	39.7%	9.1%	22,400	23,020	
3-09	Cash Balance	11,308	6,545	11,308	6,545	438.2%	-42.1%	926	926	
3-10	Capital Expenditure	4,088	636	14,321	3,676	-42.2%	-74.3%	*13,516*	13,396	
3-11	**Monitor Continuity of Service Risk Rating**	New	3	2	3	New	1	2	2.5	

** Contracted not worked WTE including Maternity/Long Term Sickness etc.

	Performance & Activity	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
2-01	**Monitor Indicative Risk Rating**	**1.0**	**2.0**	**1.0**	**2.0**	**Amber/Red**		**Amber/Red**		
2-02	Emergency A&E 4hr Wait (SITREP Wks)	95.0%	84.7%	95.7%	93.7%	-2.0%	-1.3%	95%	93.0%	94.6%
2-03	Emergency A&E >12hr to Admission	0	0	0	1	1	1	0	1	
2-04	***Ambulance Handover Delays >30mins	New	No data	New	No data	New		365	No data	
2-05	***Ambulance Handover Delays >60mins	New	0	New	0	`	0	0	0	
2-06	18 week RTT - admitted patients	91.9%	94.4%	91.7%	91.5%	-0.2%	1.5%	90%	90.0%	
2-07	18 week RTT - non admitted patients	96.4%	97.2%	96.5%	96.7%	0.2%	1.7%	95%	95.0%	
2-08	18 week RTT - Incomplete Pathways	94.0%	95.4%	94.0%	95.4%	1.5%	3.4%	92%	92.0%	
2-09	18 week RTT - Specialties not achieved	2	0	26	15	-11	15	*0*	15	
2-10	18 week RTT - 52wk Waiters	0	0	0	0	0	0	*0*	0	
2-11	18 week RTT - Backlog 18wk Waiters	873	394	873	394				250	
2-12	% Diagnostics Tests WTimes <6wks	100.0%	100.00%	100.0%	99.98%	0.0%	1.0%	99.0%	99.98%	
2-13	Cancer WTimes - Indicators achieved	8	8	9	8	-1	-1	9	8	
2-14	*Cancer two week wait	96.7%	96.7%	96.7%	96.2%	-0.6%	3.2%	93%	93.0%	95.5%
2-15	*Cancer two week wait-Breast Symptoms	94.6%	96.8%	94.6%	95.1%	0.5%	2.1%	93%	93.0%	
2-16	*Cancer 31 day wait - First Treatment	99.0%	100.0%	99.0%	98.4%	-0.6%	2.4%	96%	96.0%	98.4%
2-17	*Cancer 62 day wait - First Definitive	86.1%	89.2%	86.1%	82.7%	-3.5%	-2.3%	85%	80.0%	87.1%
2-18	Delayed Transfers of Care	3.1%	3.6%	3.2%	4.1%	0.9%	0.6%	3.5%	4.0%	
2-19	Primary Referrals	7124	7,251	69996	76,538	9.3%	9.4%	93,129	101,916	
2-20	Cons to Cons Referrals	3173	2,829	32571	30,454	-6.5%	-4.4%	42,433	36,637	
2-21	First OP Activity	10929	11,475	103278	108,860	5.4%	6.5%	135,344	144,956	
2-22	Subsequent OP Activity	19874	21,243	194453	195,360	0.5%	3.9%	250,125	260,137	
2-23	Elective IP Activity	692	616	6802	5,902	-13.2%	-19.7%	9,584	7,859	
2-24	Elective DC Activity	2628	2,652	25689	28,166	9.6%	-3.9%	38,602	37,505	
2-25	Non-Elective Activity	4015	4,024	34691	35,816	3.2%	4.7%	*45,404*	47,538	
2-26	A&E Attendances (Calendar Mth)	10342	11,083	94453	99,724	5.6%	5.8%	*125,139*	132,361	
2-27	Oncology Fractions	5253	6,000	50291	52,863	5.1%	3.4%	67,876	70,164	
2-28	No of Births (Mothers Delivered)	419	436	4,054	4,287	5.7%	7.6%	5,310	5,716	
2-29	Midwife to Birth Ratio	New	1:28	New	1:28	New	0.00	1.28	1:28	
2-30	C-Section Rate (elective & non-elective)	24.1%	30.0%	25.5%	27.4%	1.9%	2.4%	25.0%	25.0%	
2-31	% Mothers initiating breastfeeding	82.8%	80.5%	82.0%	81.7%	-0.3%	3.7%	78.0%	81.7%	
2-32	Intra partum stillbirths Rate (%)	0.2%	0.9%	0.4%	0.3%				0.3%	

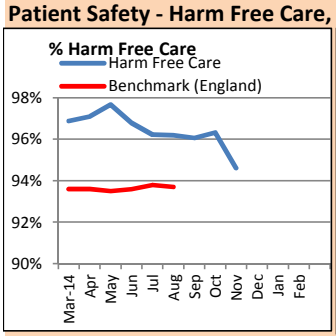
* Rate of C.Difficile per 100,000 Bed days, ** Rate of Pressure Sores per 1,000 admissions (excl Day Case), *** Rate of Complaints per 1,000 Episodes (incl Day Case), **** Rate of Falls per 1,000 Occupied Beddays, ***** Readmissions run one month behind.

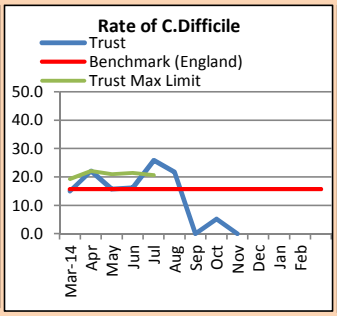
Responsible Committee: Workforce * Stroke & CWT run one mth behind, *** Ambulance Handover is unvalidated

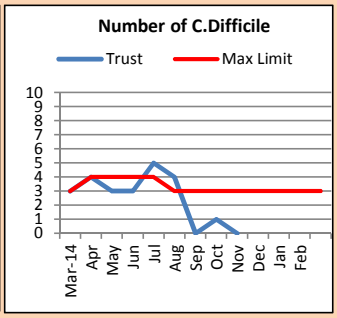
	Workforce	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ Limit	Forecast	
4-01	Establishment (Budget WTE)	5,356.4	5,423.6	5,356.4	5,423.6	1.3%	0.0%	*5,480.2*	5,511.8	
4-02	Contracted WTE	4,962.6	4,952.5	4,962.6	4,952.5	-0.2%	-4.7%	*5,261.3*	5,066.60	
4-03	**Contracted not worked WTE		(97.7)		(97.7)				(102.1)	
4-04	Locum Staff (WTE)	27.7	38.7	27.7	38.7	39.6%			30.2	
4-05	Bank Staff (WTE)	278.9	293.3	278.9	293.3	5.1%			273.4	
4-06	Agency Staff (WTE)	117.6	205.8	117.6	205.8	75.0%			171.8	
4-07	Overtime (WTE)	66.3	73.9	66.3	73.9	11.4%			71.9	
4-08	Worked Staff WTE	5,346.3	5,490.8	5,346.3	5,490.8	2.7%	0.4%	*5,523.5*		
4-09	Vacancies WTE	393.8	471.0	393.8	471.0	19.6%			400/100	
4-10	Vacancy %	7.4%	8.7%	7.4%	8.7%	18.1%			7.8%	9.4%
4-11	Nurse Agency Spend	(319)	(763)	(3,090)	(3,853)	24.7%			(5,822)	
4-12	Medical Locum & Agency Spend	(649)	(1,057)	(6,120)	(7,326)	19.7%			(10,087)	
4-13	Staff Turnover Rate	10.7%	9.3%		9.43%	-1.4%	-1.2%	*10.5%*	9.43%	8.4%
4-14	Sickness Absence	3.9%	4.5%		4.0%	0.6%	1.2%	*3.3%*	3.3%	3.7%
4-15	Statutory and Mandatory Training	86.0%	84.2%		84.2%	-1.8%	-0.8%	85.0%	85.0%	
4-16	Appraisals	85.2%	75.1%	76.3%	75.1%	-10.0%	-14.9%	90.0%	90.0%	84.0%

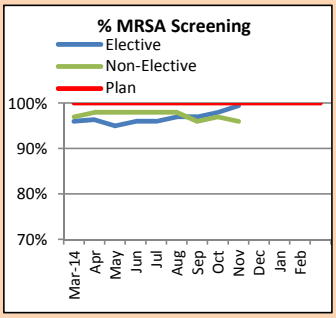
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

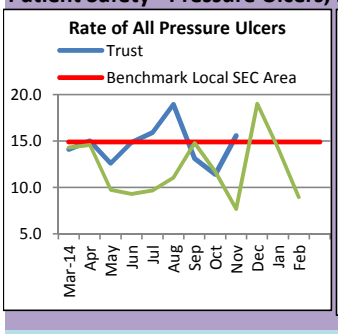


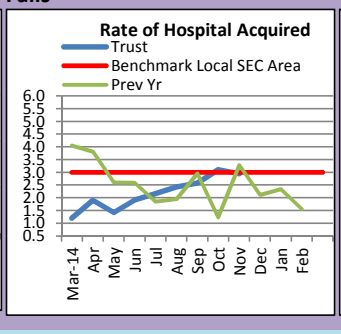


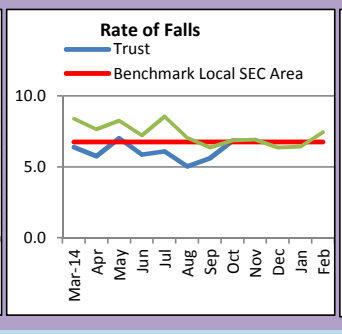


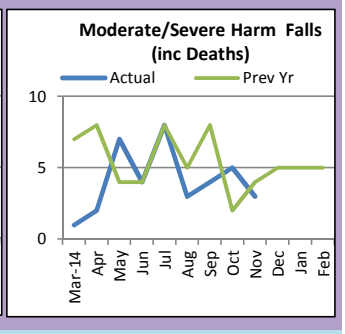


Patient Safety - Pressure Ulcers, Falls

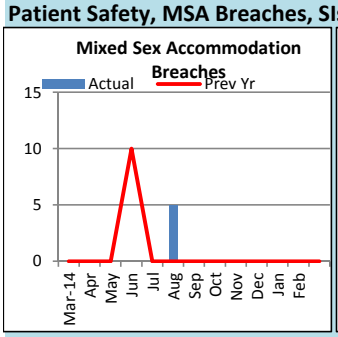


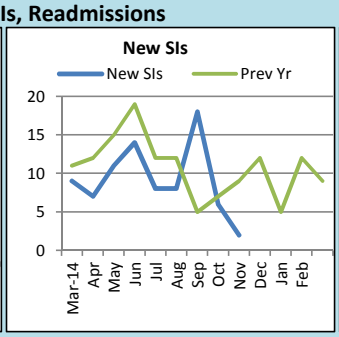


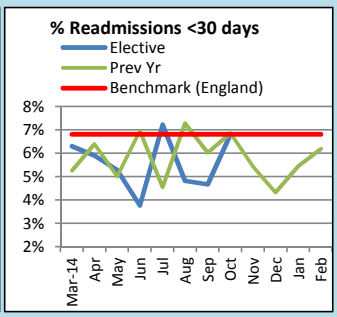


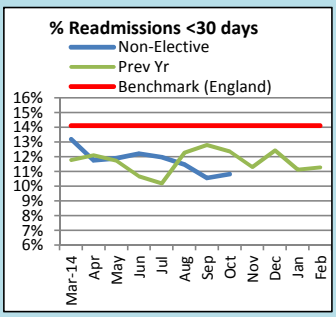


Patient Safety, MSA Breaches, SIs, Readmissions

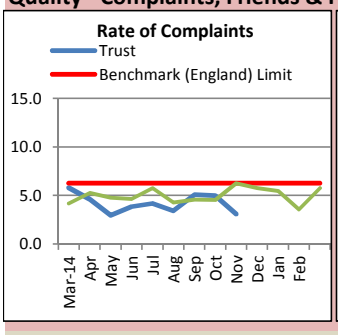


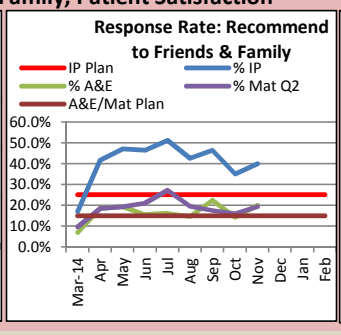


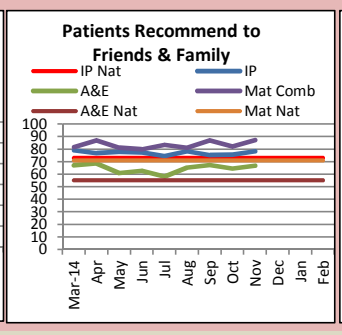


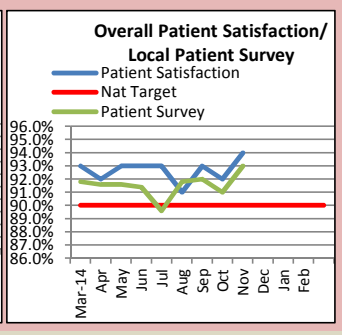


Quality - Complaints, Friends & Family, Patient Satisfaction

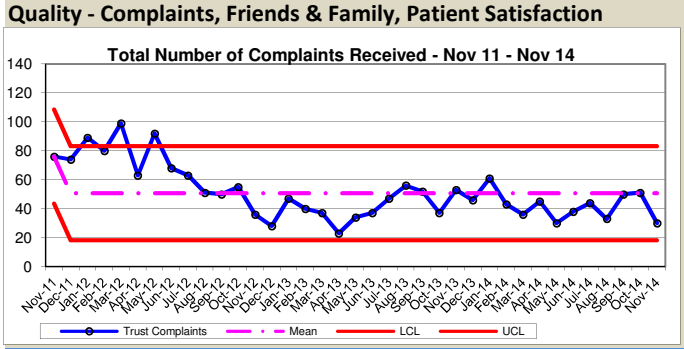


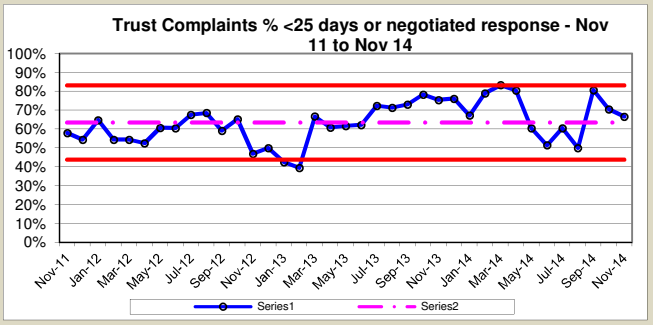




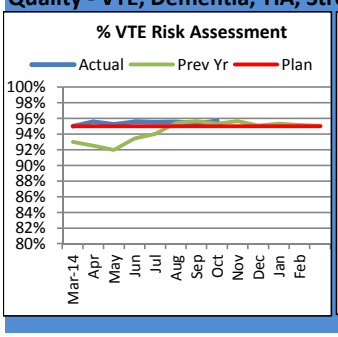


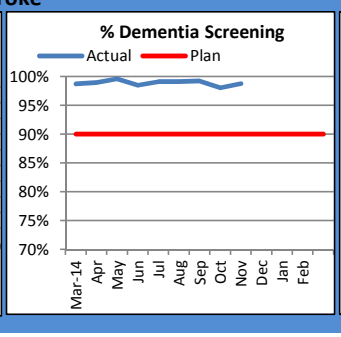
Quality - Complaints, Friends & Family, Patient Satisfaction

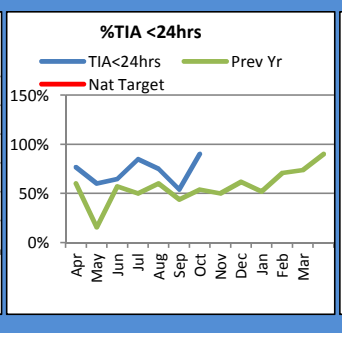


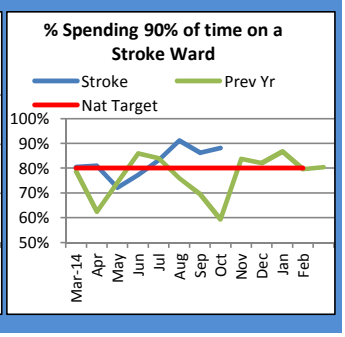


Quality - VTE, Dementia, TIA, Stroke



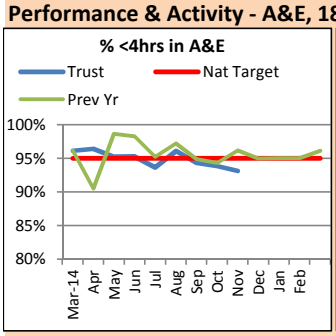


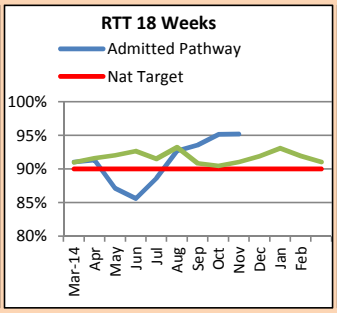


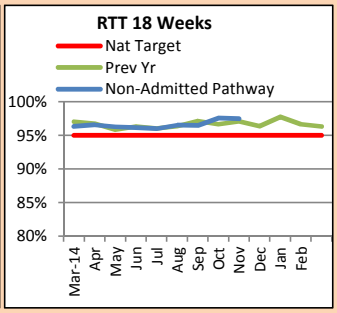


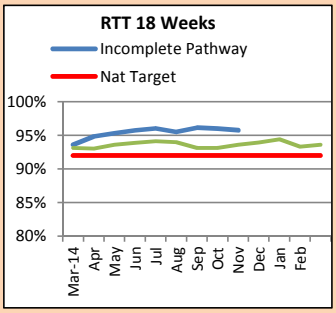
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

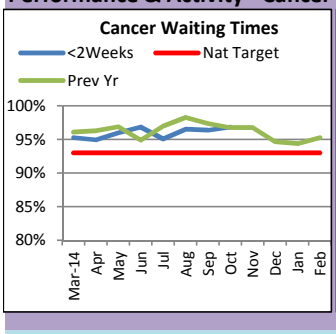


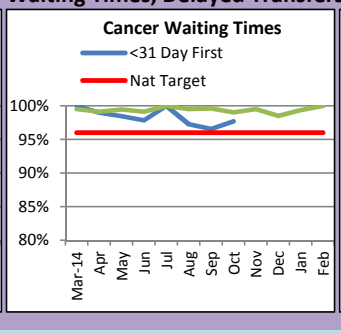


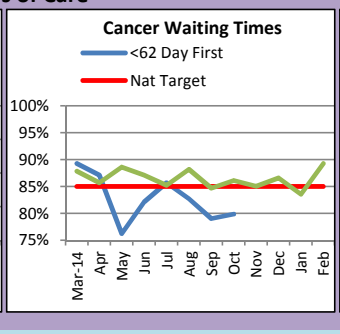


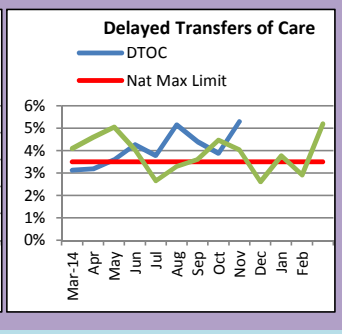


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

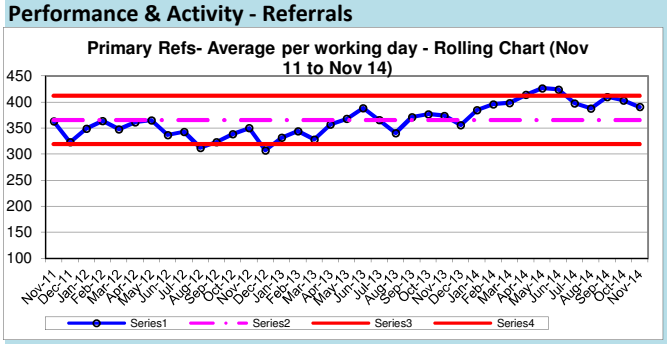


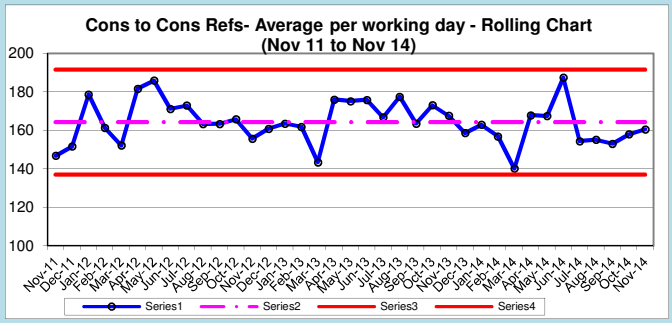




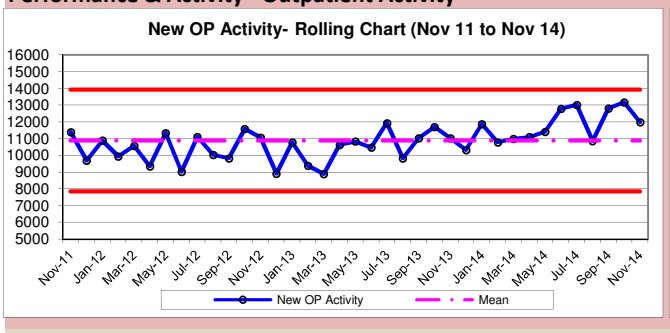


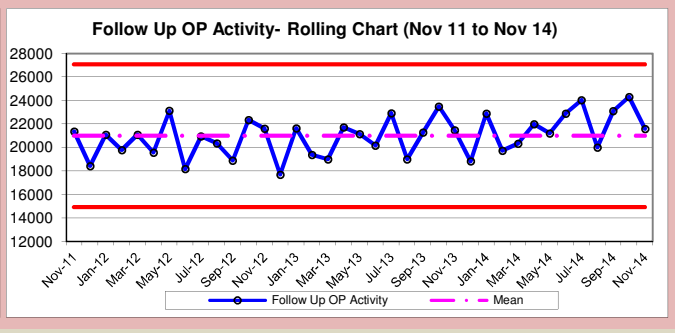
Performance & Activity - Referrals



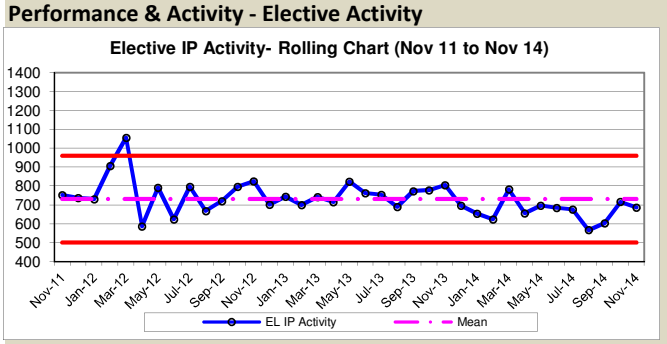


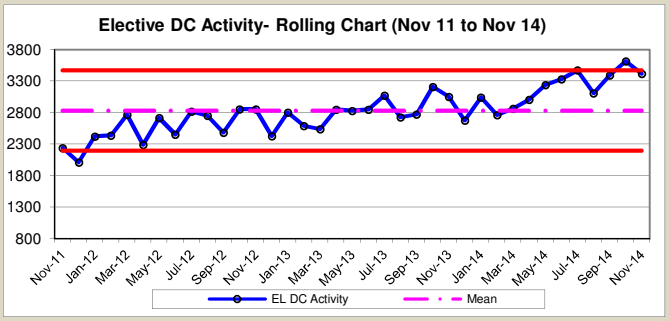
Performance & Activity - Outpatient Activity



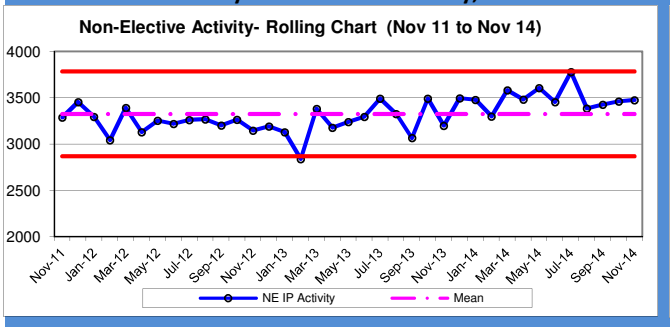


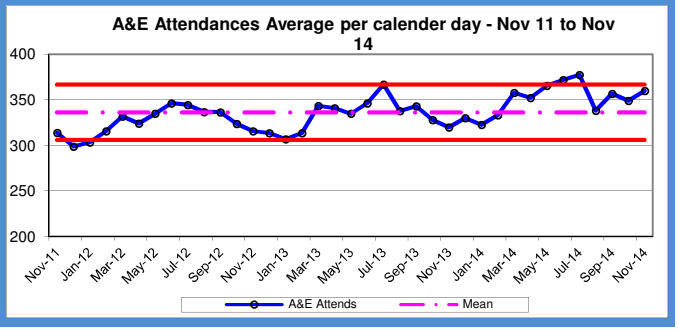
Performance & Activity - Elective Activity





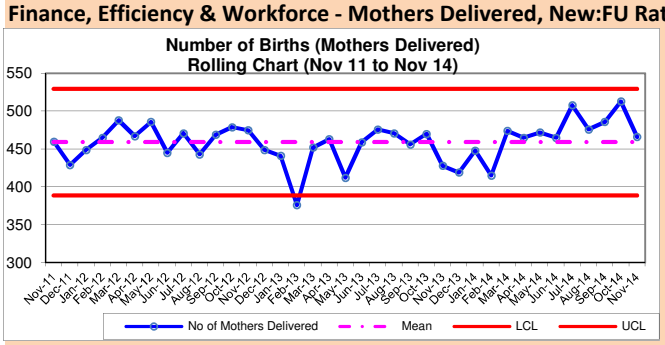
Performance & Activity - Non-Elective Activity, A&E Attendances

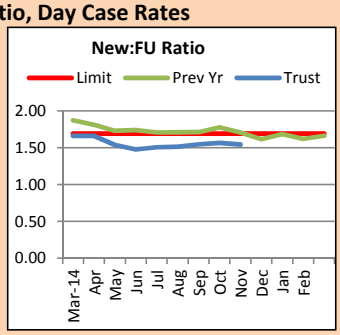


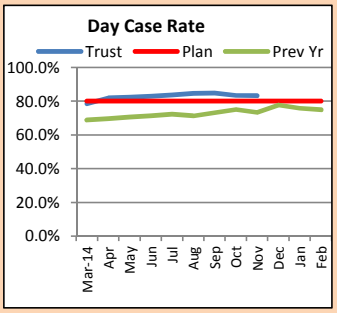


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

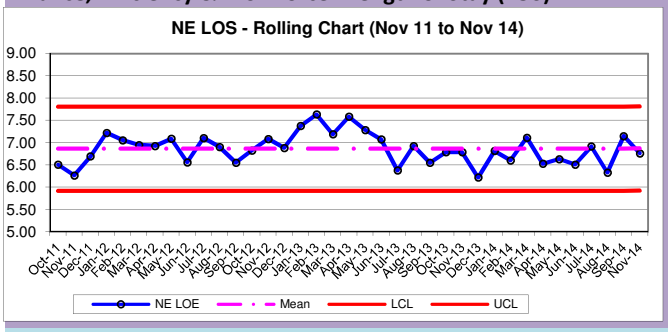
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

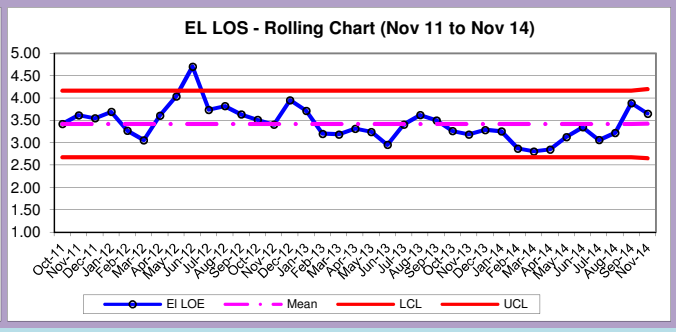




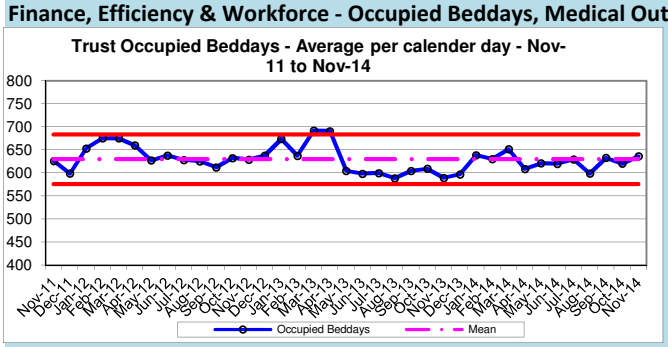


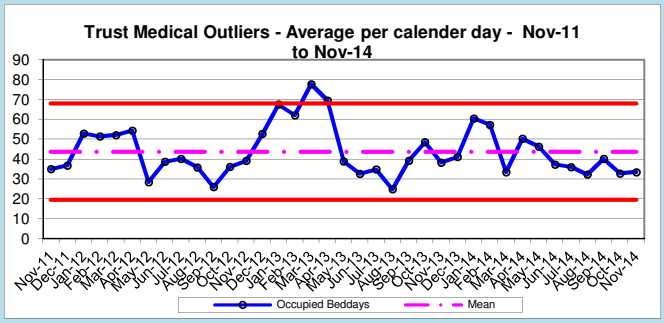
Finance, Efficiency & Workforce - Length of Stay (LOS)



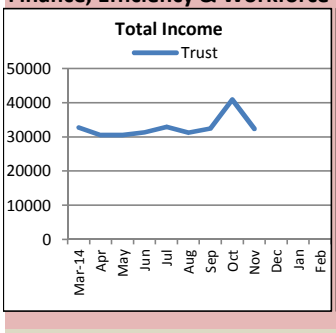


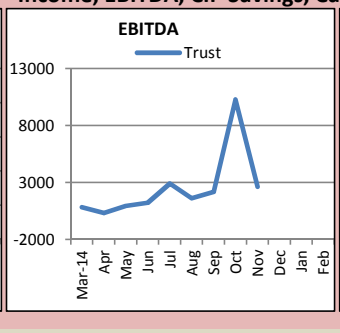
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

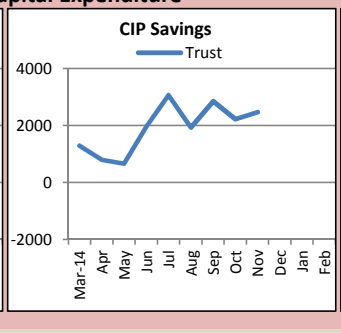


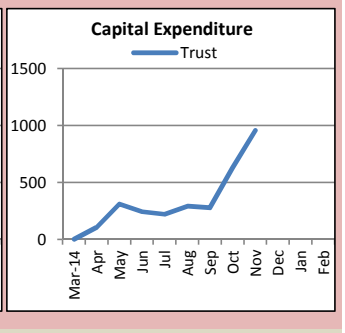


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

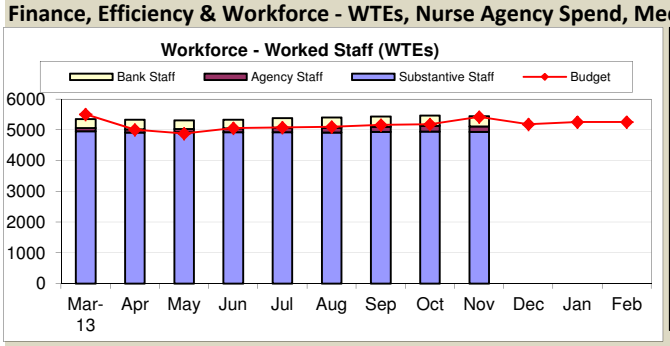


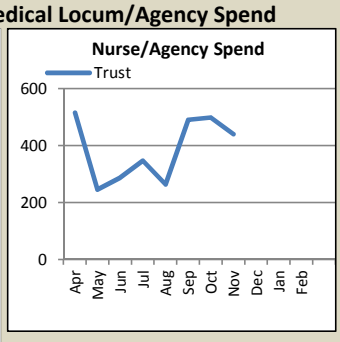


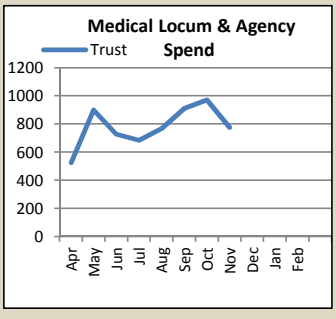




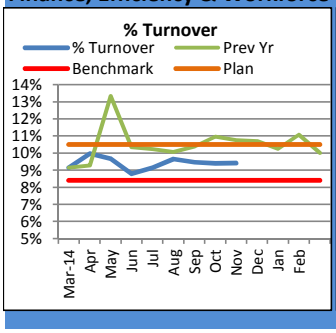
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

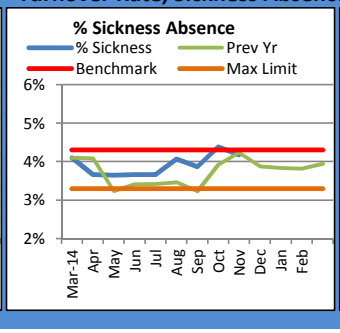


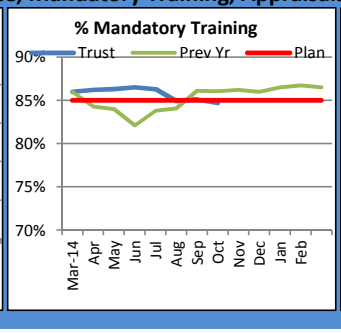


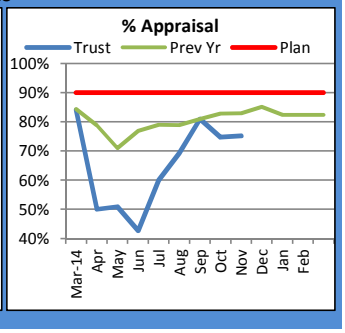


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Briefing paper – Trust Board

Stephen Orpin - Director of Finance

M9 Financial Performance overview

1. Overview of the Financial Position at M9 2014/15

1.1. This written summary provides an overview of the financial position at M9 of 2014/15. It should be read alongside the finance pack.

1.2. The Finance pack shows for month 9 an in month surplus of £0.1m against a plan of a (£0.6m) deficit (£0.7m favourable movement) resulting in a year to date deficit of £1.5m against a planned deficit of £10.3m, a favourable variance of £8.8m. The provision for £1.0m for additional costs included at month 8 has been fully removed within the Month 9 position and therefore the underlying trend has deteriorated this month.

1.3. The in month favourable movement of £0.1m includes £1m related to inclusion of 1/12th of the £12m non-recurrent deficit support funding as notified by the TDA. The £12m additional income has resulted in a year to date improvement of £9m; being 9/12ths of the £12m.

1.4. The total year to date total income is £295.6m against a budget of £286.8m; an overperformance of £8.8m, (£1.5m overperformance in the month). The month 9 favourable variance relates to £1.0m being 1/12ths of the £12m deficit support funding as highlighted in 1.3 above, the inclusion of £0.3m additional operational resilience funding and £0.1m other income released into the position relating to last financial year . The main variances on income are outlined below :

- Excluding the £9m deficit support funding, SLA income is overperforming by £0.1m year to date (overperformance of £0.1m in the month), but the outsourcing plan (daycases and elective inpatient) is underperforming £2.3m, therefore the SLA is still overperforming on non outsourced activity (predominantly outpatient activities) by £2.4m.
- All applicable contractual deductions and penalties have been applied and a provision has been made for challenges.
- Antiveg activity is the main over performance in other activities.
- Private Patient income is underperforming by £1.5m however this is offset by NHS activity performed and by lower than planned expenditure in both pay and non-pay.

1.5. Non elective activity in month 9 was on the trend seen in previous months and is 4.7% higher than the year to date plan (4.7% higher last month). A&E activity reduced marginally against the trend this month (5.8%) against the trend in previous months (6.0%). The increase above plan is mostly paid at 30% due to

the threshold applied and is now 65% above plan (20% increase in the month). The threshold has increased above the activity trend as the threshold is calculated on the income related to that activity and not activity itself. The income has increased by 0.8% and is now overperforming by 2.7%. The patients seen in Decemeber have a higher acuity (hence higher income this month) and are also staying longer as the activity trend has not changed this month. The Trust has therefore had to open additional escalation beds in order to cope with the non elective patients staying longer in the Trust. An analysis of the admissions in the last week of November that were discharged in December and the same for December into January has shown an increase in 50 additional patients staying in the hospital over the month end. This should mean a higher than average level of non elective discharges should be seen in January or February assuming the complexity and length of stay reduces back to previous levels.

1.6. Elective inpatient activity remained on trend in the month. Elective activity is 20% behind plan however 4.8% (down 0.6% in month) of the underperformance is caused by the outsourcing plan of 445 cases with 97 cases being achieved. Day case activity reduced against the trend in previous months and is now 3.8% behind plan (1.3% down in the month). 353 reportable cases were cancelled during the month at short notice (day before or on the day) against 33 cases last month.

1.7. Escalation bed usage increased significantly in the latter part of the month (c100 beds) above November levels (c45 beds). This reflects the increase in non elective patients staying longer in the hospital. Temporary nursing costs increased significantly above trend this and was by far the highest month of the financial year.

1.8. Operating costs are £270.8m against a plan of £271.3m, a favourable variance of £0.5m (£1.7m adverse in the month), however there is a net £1.9m of savings and reserves which would reduce the plan to £269.5m if the whole amount was allocated to Operating expenditure.

1.9. Pay was overspent by £1.1m in the month and is now £0.8m overspent year to date. In actual expenditure terms the Trust experienced the highest pay position this year £20.2m (£0.9m above the trend and £1.0m above last month). The key variances are in Nursing and Medical staff, with significant pressures being felt in premium cost temporary staffing, a large part due to increased escalation bed usage.

1.10. Non pay overspent by £0.6m in month and is now £1.3m underspent year to date (£1.9m last month). However, Purchase of healthcare from non NHS bodies is £3.0m underspent (breakeven in month) and is offset by underperformance in day case and elective income relating to the original plan for outsourcing activity of £2.3m. Non pay costs in month 9 were lower than the underlying trend (£0.5m) however month 9 included the release of the full cost provision of £1.0m and therefore was in reality £0.5m above trend. Activity related non pay spends (Drugs, Blood, Clinical Supplies and Purchase of healthcare from non NHS

organisations) increased by £0.2m this month from Month 8 which is in line with there being 1 more working than last month. Transport costs overspent this month by £0.1m taking the YTD overspend to £0.3m.

1.11. EBITDA is a £24.8m surplus and is now overperforming by £7.5m year to date (£0.3m in month) against the plan. This significant variance is due to the inclusion of the £9m year to date impact of the £12m deficit support funding.

1.12. The financing costs including those related to the PFI and deprecation totalled £27.5m, which is now underspent against the in year plan by £1.8m (£0.5m underspent in month) due to the year to date impact of the revised calculation of PDC based on the forecast statement of financial position as opposed to the original plan and the slippage in against the capital plan reducing the depreciation cost against budget.

1.13. The year to date CIP delivery is £17.5m against a target of £16.0m and is forecast to deliver £23.0m (£23.2m last month) against the plan of £22.4m.

1.14. The I&E forecast to the end of the financial year shows the Trust delivering an in year breakeven position against the NHS breakeven duty, after including the £12m deficit support funding. This is against the Trusts planned deficit of £12.3m. The financial position seen in month 9 has increased the risk to delivering the breakeven position. The details of the forecast including key assumptions and risks is subject to a separate paper to the Finance Committee this month.

1.15. Cash balances of £6.5m were held at the end of M9. Discussions with NHS organisations over the settlement of 2013/14 outstanding debt are on-going. One CCG High Weald, Lewes and Havens was settled and cash was received in December of £1.6m. There is an expectation the Trust will seek resolution of the remaining 2013/14 debt by the end of the financial year. The operational cash forecast has an expectation of receipt of this income circa £4.6m in March.

1.16. 14/15 reconciliation of overperformance activity for quarter 1 is expected to be finalised by the end of February. The operational cash forecast has receipts from WKCCG £1.5m and High Weald, Lewes and Haven CCG £0.5m expected in March. Quarter 2 has been removed from the cash forecast.

1.17. The cashflow reflects the £12m deficit support replacing the £14.3m external financing. The timings of receipt of this funding remain uncertain with a cash flow working assumption of February.

1.18. The operational cash flow matches the Income and Expenditure therefore as long as both Income and Expenditure remain per forecast the £2.3m cash shortfall (£14.3m to £12m) will be planned to be managed through debt collection and minimal supplier restrictions primarily in March.

1.19. However, due to the uncertainties surrounding the receipt of 13/14 and 14/15 overperformance included within the cash flow, managing credit payments in line

with available cash to manage the potential cash shortfall of £7m in the event this income is not received in March.

1.20. Total debtors are £53.9m (£59m in M8). The two largest debtors (invoiced) at the end of the period are WKCCG owing £17.5m (£18.5m m8) gross and NHS Commissioning who owe £9.7m (£13m m8) gross, primarily relating to invoices subject to year-end reconciliation. Included within the debtors balances are estimated 14/15 overperformance invoices for month's 1-5 activity of £11.7m. NHS over 90 day debt is £33.3m this has increased since Month 1 by £11.2m (£22.1m), but is expected to reduce significantly when the 13/14 year end position agreement is reached with commissioners, and the 14/15 quarter 1 and 2 reconciliation has been completed.

1.21. Total creditors are £50.9m (£54.1m in M8). The percentage of the value of payments made within 30 days was 88.8% against a target of 95%, this was represented by a performance 91.9% in respect of trade creditors and 70.2% of NHS creditors.

1.22. Capital expenditure to month 9 was £3.7m of the revised forecast expenditure £13.5m. This was £10.6m less than the planned expenditure at month 9 of £14.3m based on the £18.8m original plan. The plan continues to be prioritised and aligned to the Trusts strategy.

1.23. The Trust's performance against the TDA Accountability framework is Amber due to the receipt of the £12m deficit support funding.

Key Performance Indicators as at Month 9 2014/15

(A) TDA Accountability Framework and
(B) Monitor Continuity of Service Metrics

Maidstone and Tunbridge Wells NHS Trust

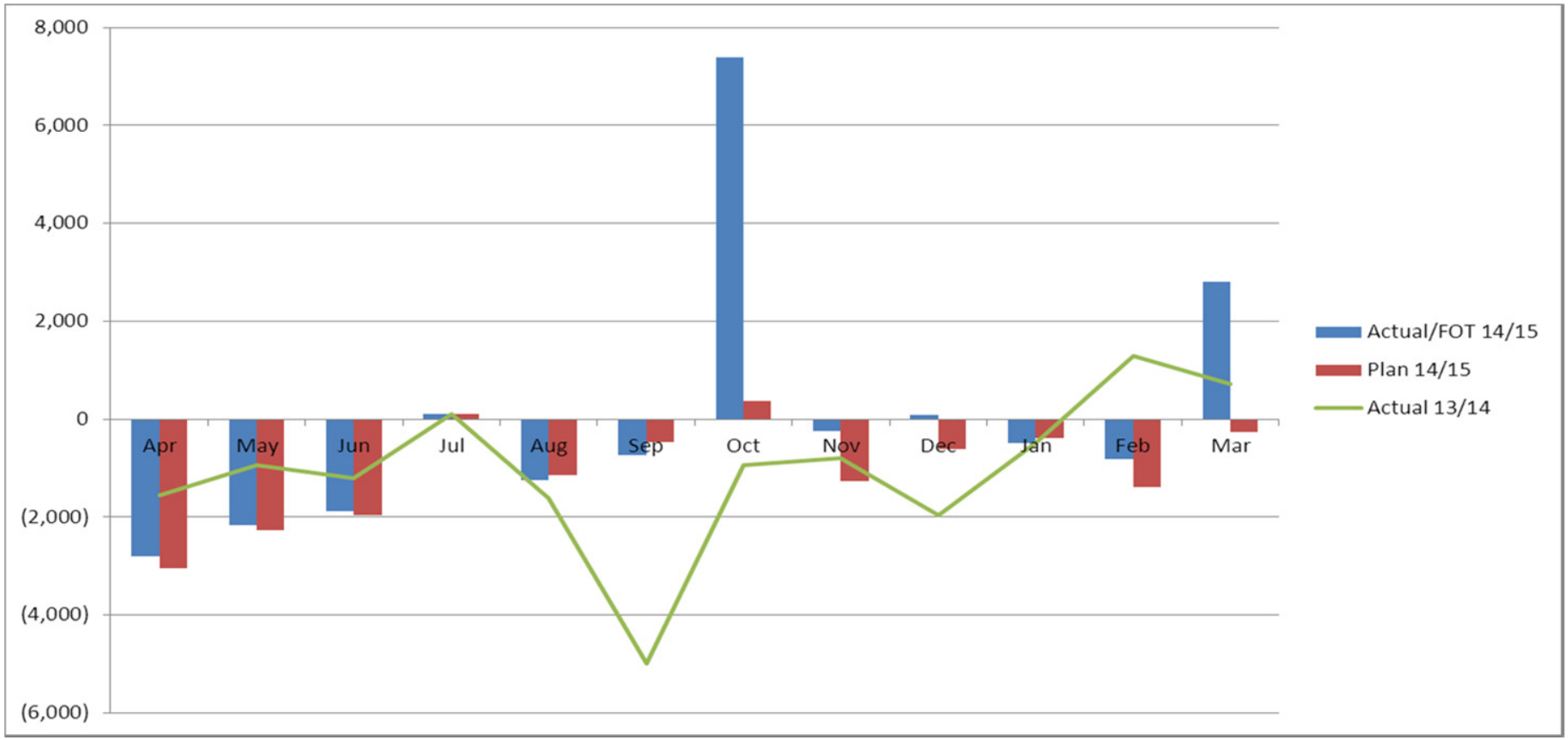
Key Metrics (A) Accountability Framework	Current Month Metrics: Plan (mc 01) £000s	Actual / Forecast (mc 02) £000s	Variance (mc 03) £000s	RAG Rating (mc 04)
NHS Financial Performance				
1a) Forecast Outturn, Compared to Plan	(12,301)	5	12,306	GREEN
1b) Year to Date, Actual compared to Plan	(10,283)	(1,502)	8,781	GREEN
Financial Efficiency				
2a) Actual Efficiency recurring/non-recurring compared to plan -				AMBER
- Total Efficiencies for Year to Date compared to Plan	14,873	17,505	2,632	
- Recurrent Efficiencies for Year to Date compared to Plan	14,873	12,862	(2,011)	
2b) Actual Efficiency recurring/non-recurring compared to plan - Forecast compared to plan				RED
- Total Efficiencies for Forecast Outturn compared to Plan	22,400	23,020	620	
- Recurrent Efficiencies for Forecast Outturn compared to Plan	22,400	17,255	(5,145)	
Underlying Revenue Position				
3) Forecast Underlying surplus / (deficit) compared to Plan	(16,254)	(19,906)	(3,652)	RED
Cash and Capital				
4) Forecast Year End Charge to Capital Resource Limit	13,396	13,396	0	GREEN
5) Permanent PDC accessed for liquidity purposes		0		GREEN
Trust Overall RAG Rating				AMBER
(B) Continuity of Service Risk Ratings				
Year to Date Rating	1.50	3.00	1.50	GREEN
Fotecast Outturn Rating	2.00	2.50	0.50	GREEN

RAG STATUS: Red	Amber	Green
A deficit position or 20% worse than plan	A position between 5% - 20% worse than plan	Within 5% or better than plan
20% worse than plan	A position between 10% - 20% worse than plan	Within 10% or better than plan
if either total or recurrent efficiencies are 20% worse than plan	if either total or recurrent efficiencies are between 0% and 20% of plan	If both total and recurrent efficiencies are equal to or better than plan
if either total or recurrent efficiencies are 20% worse than plan	if either total or recurrent efficiencies are between 0% and 20% of plan	If both total and recurrent efficiencies are equal to or better than plan
20% worse than plan	A position between 10% - 20% worse than plan	Within 10% or exceeding plan
either greater than plan or 20% lower than plan	between 10% - 20% lower than plan	Within 10% of plan
PDC accessed	Not applicable	PDC not accessed
If forecast deficit position or if three or more RED in other metrics	If one or two RED or three AMBER	No RED and less than two AMBER
If score is 2.5 or lower	Not applicable	Score of over 2.5
If score is 2.5 or lower	Not applicable	Score of over 2.5

I&E Monthly Position Graph as at Month 9 2014/15

Maidstone and Tunbridge Wells NHS Trust

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual/FOT 14/15	(2,805)	(2,163)	(1,882)	111	(1,242)	(734)	7,380	(251)	82	(495)	(813)	2,815
Plan 14/15	(3,053)	(2,261)	(1,962)	103	(1,152)	(466)	375	(1,259)	(608)	(384)	(1,382)	(254)
Actual 13/14	(1,553)	(949)	(1,201)	97	(1,616)	(4,982)	(931)	(796)	(1,968)	(480)	1,290	716

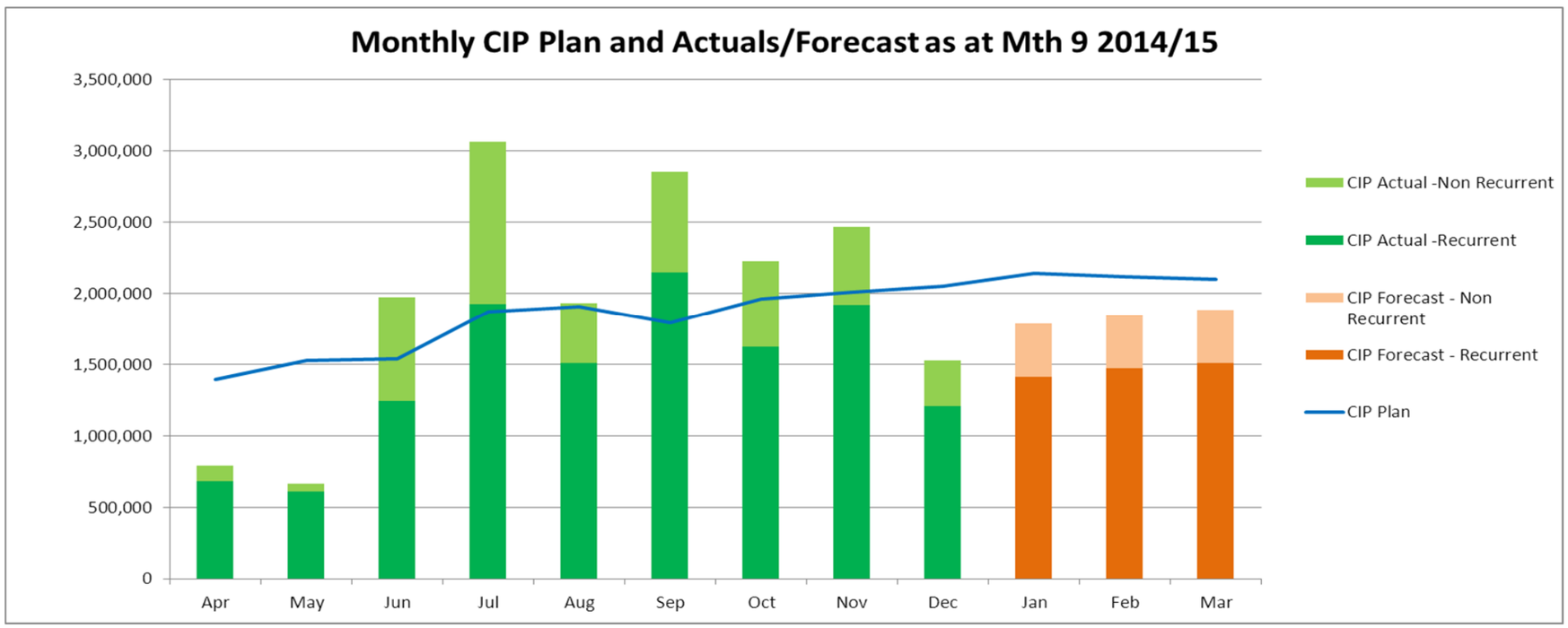


CIP Summary & Graph: as at Month 9 2014/15

Maidstone and Tunbridge Wells NHS Trust

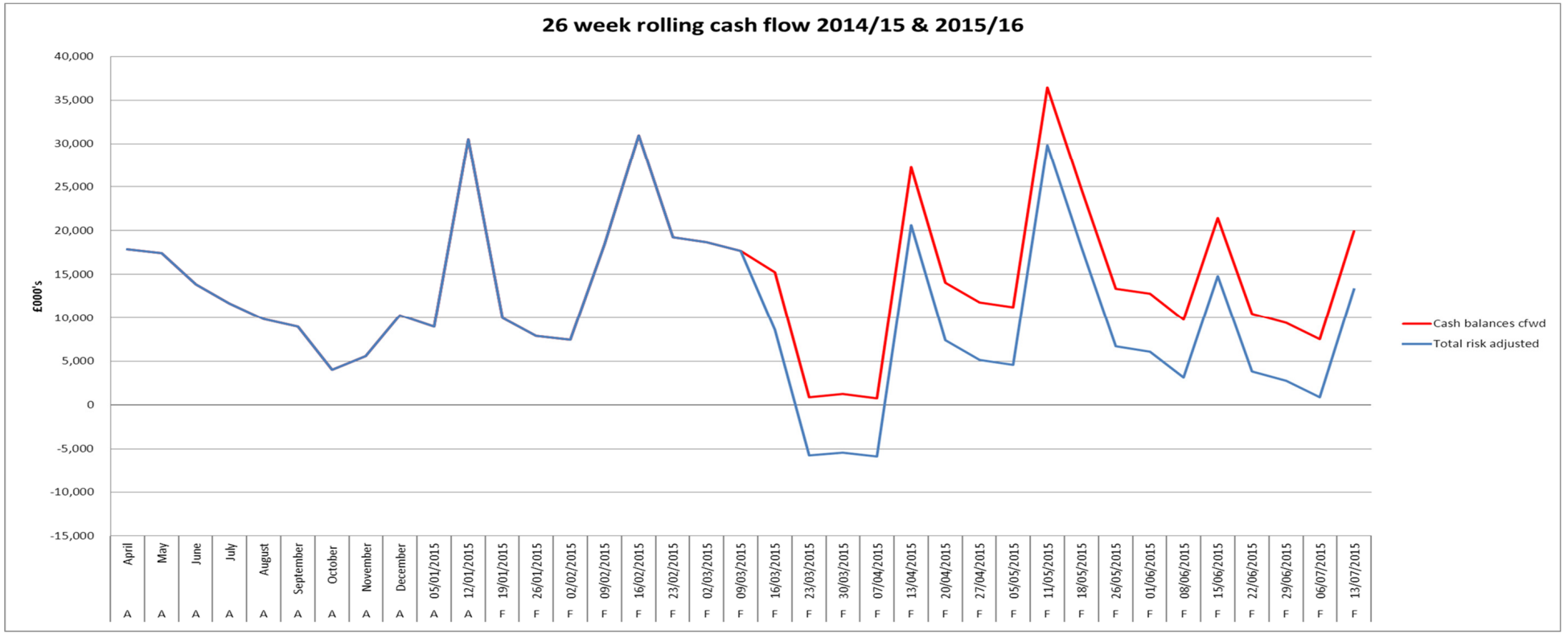
WORKSTREAMS BY DIRECTORATE BUDGET		Year To Date Plan £'000	Year To Date Actual £'000	Year To Date Variance £'000	Forecast Plan £'000	Forecast Actual £'000	Forecast Variance £'000
Back Office	Paul Bentley	3,030	2,425	(605)	4,234	3,254	(980)
Corporate (PPU)	Angela Gallagher	257	100	(157)	385	226	(159)
Surgery	Simon Bailey	1,321	1,948	627	1,804	2,791	987
Surgery (Head & Neck)	Simon Bailey	714	1,037	323	979	1,407	428
Specialist Medicine	Clive Lawson	2,307	1,448	(859)	3,328	1,915	(1,413)
Acute Medicine/A&E	Akbar Sorma	1,802	388	(1,414)	2,264	560	(1,704)
Diagnostics & Therapies	Sarah Mumford	1,528	1,651	123	2,306	2,092	(214)
T&O	Guy Slater	841	481	(360)	1,160	657	(503)
Women's & Sexual Health	M.Wilcox	1,212	1,016	(196)	1,687	1,209	(478)
Paediatrics	Hamudi Kisat	584	349	(235)	841	457	(384)
Critical Care	Richard Leech	2,012	1,318	(694)	2,690	1,846	(844)
Cancer	Sharon Beesley	1,443	2,049	606	2,068	2,213	145
Corporate Finance		0	3,295	3,295	0	4,393	4,393
Overprogramme		(1,009)		1,009	(1,346)		1,346
Total By Directorate (includes all workstreams)		**16,042**	**17,505**	**1,463**	**22,400**	**23,020**	**620**

Recurrent v Non Recurrent Analysis	YTD £'000	FOT £'000
Recurrent	12,862	17,255
Non Recurrent	4,643	5,765
Total	**17,505**	**23,020**



Maidstone and Tunbridge Wells NHS Trust

26 Week graphical presentation of cash balances up to w/c 13th July 2015, actuals at 16th January 2015



	A	A	A	A	A	A	A	A	A	A	A	F	F	F	F	F	F	F	F	F
Week commencing	April	May	June	July	August	September	October	November	December	05/01/2015	12/01/2015	19/01/2015	26/01/2015	02/02/2015	09/02/2015	16/02/2015	23/02/2015	02/03/2015	09/03/2015	
Cash balances cfwd	**17,839**	**17,445**	**13,852**	**11,677**	**9,869**	**8,953**	**4,010**	**5,620**	**10,293**	**8,987**	**30,517**	**9,948**	**7,910**	**7,478**	**18,400**	**30,955**	**19,263**	**18,703**	**17,656**	
13/14 o/performance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
14/15 o/performance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
External Financing - Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
External Financing - capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total risk adjusted	**17,839**	**17,445**	**13,852**	**11,677**	**9,869**	**8,953**	**4,010**	**5,620**	**10,293**	**8,987**	**30,517**	**9,948**	**7,910**	**7,478**	**18,400**	**30,955**	**19,263**	**18,703**	**17,656**	

	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Week commencing	16/03/2015	23/03/2015	30/03/2015	07/04/2015	13/04/2015	20/04/2015	27/04/2015	05/05/2015	11/05/2015	18/05/2015	26/05/2015	01/06/2015	08/06/2015	15/06/2015	22/06/2015	29/06/2015	06/07/2015	13/07/2015	
Cash balances cfwd	**15,251**	**926**	**1,261**	**781**	**27,247**	**14,065**	**11,804**	**11,219**	**36,464**	**24,704**	**13,356**	**12,782**	**9,797**	**21,456**	**10,488**	**9,432**	**7,552**	**19,931**	
13/14 o/performance	4,657	4,657	4,657	4,657	4,657	4,657	4,657	4,657	4,657	4,657	4,657	4,657	4,657	4,657	4,657	4,657	4,657	4,657	
14/15 o/performance	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	
External Financing - Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
External Financing - capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total risk adjusted	**8,594**	**-5,731**	**-5,396**	**-5,876**	**20,590**	**7,408**	**5,147**	**4,562**	**29,807**	**18,047**	**6,699**	**6,125**	**3,140**	**14,799**	**3,831**	**2,775**	**895**	**13,274**	

NB - although the risk adjusted line shows a negative balance, the Trust is not permitted to go overdrawn, therefore action would be taken to ensure no negative balance.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – January 2015

1-9 Safe Staffing: Planned V Actual – December 2014 Chief Nurse

Summary / Key points

The attached paper is a copy of the planned v actual nursing staffing as uploaded to UNIFY and published via NHS Choices on the Trust website for the month of December 2014.

This paper provides an exception report to the Board based on the premise that any variance from plan that is less than 90% or greater than 110% requires further commentary.

Areas that fell below the planned numbers did so in a safe manner, with significant efforts put in place to ensure patient safety was not compromised.

ICU – Maidstone site: 48.4% fill rate for un-registered staff. This had minimal impact on direct patient care, as overall acuity for the Maidstone Unit during the month was below anticipated demand.

Where possible, and appropriate, staff were re-deployed to Tunbridge Wells ICU where acuity and dependency was higher. There are no un-registered staff planned to be rostered on the Maidstone Unit at night.

ICU – Tunbridge Wells site: fill rate for un-registered staff was 67% for the night shift. This was acceptable and had minimal impact on direct patient care. RN fill rate was within acceptable limits given the acuity of patients (98.8%).

A number of wards ran at lower than planned levels as a result of unprecedented demand on in-patient beds during latter part of December. Staff were redeployed on a daily basis following review of each ward's available staff, and staffing requirements based on a Matron level assessment of acuity and dependency.

CCU Maidstone – had a reduced RN fill rate (90%) during the day. CCU's rota is combined with Culpepper, as the unit is co-located on Culpepper. Therefore staff are able to flex throughout the course of a shift to meet the changing acuity.

Cornwallis – had a reduced RN fill rate (88.6% day, 86% night) to cross-cover on Pye Oliver. Cornwallis covered the short-fall in RNs at night with additional clinical support workers (CSW). In practice this resulted in the ward running 1 RN short at night with the short-fall being covered by CSW. Cornwallis does not normally have CSWs rostered on duty at night.

The acuity and dependency of Cornwallis ward changed during the month due to the increased demand for medical beds, resulting in a decrease in the number of patients undergoing major surgery. The ward cover of 2 RNs at night was sufficient to provide safe clinical care.

Pye Oliver Ward needed the additional staff due to increased acuity over their planned/agreed numbers. The fill rate for Pye was kept above 90% as a result.

Foster Clark – had a reduced RN fill rate during the day (90.3%); this was due in part to increased acuity and wider site pressures. The ward is carrying 2.9wte RN vacancies which are being actively recruited to. The ward was supported during the day by the Respiratory Clinical Nurse Specialists and therapies ensuring there was sufficient numbers of RNs with the appropriate skills to keep the ward safely staffed for the night.

John Day – had a decreased RN fill rate (83%) during the day. This equated to an RN down for 20 shifts during the month, as a result of supporting Chaucer and Maidstone Orthopaedic Unit (medical escalation beds)/Whatman (escalation beds).

The impact of this was minimised with the shift co-ordinator taking a case load to maintain safe clinical care.

Ward 30 – had a reduced RN fill rate (86.6%) during the day. This was primarily during the morning for 20 shifts, the numbers improving for the late shift.

Ward 31 – had a reduced RN fill rate (85.5%) for the night shift.

Wards 30 and 31 work closely together and staff moved from one ward to another over the course of the month to maintain safe staffing levels. Both wards had a number of patients requiring a constant supervisory presence due to caring for patients with cognitive impairments so clinical support worker numbers were increased accordingly. The skill mix review was undertaken on a daily basis by the Matron to ensure staff were appropriately redeployed to maintain the provision of safe clinical care.

Overall in these areas, there is no indication to suggest any significant adverse impact of the reduced numbers. At the time of writing this report, there has been no increase in the number of complaints regarding in-patient care. Friends and Family scores have remained stable. Patient safety indicators have remained within expected levels except for an increase in falls at Tunbridge Wells and a reduction at Maidstone. The acuity of patients was higher on the Tunbridge Wells site.

Some areas exceeded the planned hours. These areas fall broadly into two groups.

Wards with escalation (additional capacity) beds open. These wards were:

Cornwallis – over on clinical support workers (CSW) as detailed above. This ward shows 100% fill rate; as whilst it was not planned to have CSWs on duty at night at the time of confirming the roster for December as it became apparent that the dependency was changing and the need to support Pye Oliver became clear we were able to request and fill the additional shift with bank CSWs.

UMAU – increased requirement met for staff at night, due to the trolley bays being converted to inpatient beds. This resulted in an increase from plan for both RNs and CSWs for the night shift.

Surgical Short Stay/Day Unit (SDU) – TWH and Maidstone units used for escalation, for inpatient care.

John Day – had an increased fill rate for clinical support workers, to ensure fundamental aspects of care were delivered in a timely manner under the supervision of an RN. The RN cover was sufficient to provide safe clinical care as detailed earlier in this report.

Increased acuity and dependency: Acuity refers to clinical need and skill, dependency refers to the assistance required to carry out activities of daily living such as assistance with eating, washing or mobility. These wards include

John Day required additional Clinical Support Workers at night to manage a number of patients with increased dependency.

Mercer: increased dependency and risk of falls particularly at night. High number of patients with combined risk of falls and confusional state. High level need for the delivery of personal hygiene needs during the night. Review of falls incidence data indicates that when falls occur on this ward, they tend to happen late in the evening or early in the morning.

ASU – **Tunbridge Wells site:** increased dependency, 8 nights required additional CSWs to

special a patient with cognitive impairment. This requirement was subject to matron level review.

Ward 10 – had an increased fill rate for CSWs to supervise a cohort of 4 patients with cognitive impairment for 11 nights. There was a need for a special for 1 patient for similar reasons for 4 nights (not during the same period of 11 nights as the cohort group).

Ward 11 – had an increased fill rate for CSWs to supervise a cohort of 5 patients with cognitive impairment for 4 nights.

Ward 20: required additional CSW support at night due to a high number of confused/delirious patients prone to wandering. During the course of the month there were 26 nights when there was a cohort of patients requiring additional levels of supervision due to increased risk of wandering or falls. There were 4 nights where there was one patient who required a 1:1 special, and 3 nights where RN support was required to cover the Cath Lab recovery ward for escalation beds

Wards 30 and 31 increased fill rate for CSWs as detailed earlier in this report.

The attached appendix gives the break down by ward.

Overall the Trust is able to meet the nursing care time demands, and has systems in place to allow for a flexible responsive provision of care.

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board.

Assurance

Safe Staffing: Planned v actual for December 2014.

		Day		Night	
Hospital Site name	Ward name	Average fill rate - registered nurses/midwive	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwive	Average fill rate - care staff (%)
Maidstone District General Hospital - RWF03	Acute Stroke	92.7%	130.6%	97.8%	245.2%
Maidstone District General Hospital - RWF03	Romney	93.5%	106.9%	98.9%	98.4%
Maidstone District General Hospital - RWF03	Cornwallis	88.5%	109.7%	86.0%	100.0%
Maidstone District General Hospital - RWF03	Coronary Care Unit (CCU)	90.3%		100.0%	
Maidstone District General Hospital - RWF03	Culpepper	100.0%	100.0%	95.2%	100.0%
Maidstone District General Hospital - RWF03	Foster Clark	90.3%	108.6%	106.6%	101.6%
Maidstone District General Hospital - RWF03	Intensive Treatment Unit (ITU)	94.0%	48.4%	97.2%	
Maidstone District General Hospital - RWF03	John Day	83.2%	119.4%	96.8%	154.8%
Maidstone District General Hospital - RWF03	Jonathan Saunders	100.0%	98.4%	100.0%	100.0%
Maidstone District General Hospital - RWF03	Lord North	97.4%	106.5%	93.5%	100.0%
Maidstone District General Hospital - RWF03	Mercer	97.6%	105.4%	94.6%	261.3%
Maidstone District General Hospital - RWF03	Pye Oliver	92.8%	137.1%	96.7%	171.0%
Maidstone District General Hospital - RWF03	Urgent Medical Ambulatory Unit (UMAU)	101.7%	99.1%	181.7%	274.2%
The Tunbridge Wells Hospital - RWFTW	Acute Stroke	101.1%	100.0%	97.8%	132.3%
The Tunbridge Wells Hospital - RWFTW	Coronary Care Unit (CCU)	94.6%	103.2%	107.2%	
The Tunbridge Wells Hospital - RWFTW	Gynaecology	96.8%	95.3%	100.0%	100.0%
The Tunbridge Wells Hospital - RWFTW	Intensive Treatment Unit (ITU)	100.0%	97.8%	98.8%	67.6%
The Tunbridge Wells Hospital - RWFTW	Medical Assessment Unit	91.7%	103.2%	88.7%	112.9%
The Tunbridge Wells Hospital - RWFTW	SDU	112.9%	125.8%	158.1%	106.5%
The Tunbridge Wells Hospital - RWFTW	Ward 32	100.0%	100.0%	100.0%	100.0%
The Tunbridge Wells Hospital - RWFTW	Ward 10	95.4%	102.4%	99.6%	141.9%
The Tunbridge Wells Hospital - RWFTW	Ward 11	102.3%	93.5%	96.0%	112.9%
The Tunbridge Wells Hospital - RWFTW	Ward 12	95.2%	105.4%	91.9%	116.1%
The Tunbridge Wells Hospital - RWFTW	Ward 20	97.2%	96.8%	89.5%	143.5%
The Tunbridge Wells Hospital - RWFTW	Ward 21	94.7%	101.1%	100.6%	106.5%
The Tunbridge Wells Hospital - RWFTW	Ward 22	100.0%	108.6%	96.8%	101.1%
The Tunbridge Wells Hospital - RWFTW	Ward 30	86.6%	126.7%	97.6%	127.4%
The Tunbridge Wells Hospital - RWFTW	Ward 31	108.6%	92.4%	85.5%	135.5%
Tonbridge Cottage Hospital - RWF10	Stroke Rehab	96.2%	95.2%	100.0%	100.0%
The Tunbridge Wells Hospital - RWFTW	ante-natal	100.0%	93.5%	100.0%	77.4%
The Tunbridge Wells Hospital - RWFTW	delivery suite	97.5%	100.0%	89.6%	91.9%
The Tunbridge Wells Hospital - RWFTW	post-natal	105.5%	83.9%	100.0%	89.5%
The Tunbridge Wells Hospital - RWFTW	Gynae Triage	100.0%	87.1%	100.0%	96.8%
The Tunbridge Wells Hospital - RWFTW	Hedgehog	92.5%	76.9%	113.4%	116.1%
Maidstone District General Hospital - RWF03	Birth Centre	100.0%	100.0%	100.0%	93.5%
The Tunbridge Wells Hospital - RWFTW	Neonatal Unit	101.1%	71.0%	93.5%	100.0%
Maidstone District General Hospital - RWF03	MSSU	106.1%	100.0%	115.6%	

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – January 2015

1-10	Summary report from the Quality & Safety Committee meeting, 15/12/14 & 21/01/15	Committee Chair (Non-Executive Director)

The Quality & Safety Committee met on 15th December 2014 and 21st January 2015.

The meeting on 15th December 2014 was a 'deep dive' meeting, & covered the following issues:

- **Review of the emergency paediatric pathway:** The Clinical Director for Children's Services; Directorate Matron for Acute & Emergency Services; and Paediatric Matron attended for this item. The progress in revising the pathway was discussed. It was noted that Phase One of the changes involved establishing a completely new pathway, to separate the Paediatric and adult pathways within both A&E departments. Phase One was also noted as involving some environment improvements, and a business case for Paediatric trained staff (as the pathways could not be separated without additional staff). Phase Two involved establishing a dedicated paediatric A&E at Tunbridge Wells Hospital (it was noted that most other Trusts already had a Paediatric A&E department which was staffed by Paediatric nurses, '24/7'). It was agreed to submit a further update report to the February 2015 Quality & Safety Committee 'deep dive' meeting on the implementation of the revised pathway
- **Review of the Trust's complaints process:** The Complaints & PALS Manager attended for this item, and gave a presentation highlighting that the Trust's complaints handling model involved several steps, culminating in Directorate staff investigating and submitting a draft response for the Central Complaints Team to quality check, prior to Executive review / sign off. It was noted that a number of challenges existed which affected service quality in complaints management. These included: unpredictability; misunderstanding of complaints / outcomes; competing priorities; a defensive culture; lack of independence; variation of the quality of investigation; and difficulty in evidencing change / improvement. There were mitigations to aim to address each of these, but the challenges remained. It was also noted that local resolution meetings could be effective and although these were an option from the outset of a complaint, they tended to only be offered if the complainant was unsatisfied with the first written response. The Trust was receiving fewer complaints than the national average, but the Care Quality Commission's (CQC) view was that numbers of complaints was not necessarily an indicator of poor (or good) quality. The absence of national guidance as to when a complaint should be regarded as 'upheld' was highlighted, though such guidance would be issued in April 2015. It was agreed to submit a report to the 'main' Quality & Safety Committee in March 2015 on the 'gap analysis' that was being undertaken in light of the new framework for managing complaints.
- The **February 2015 Quality & Safety Committee 'deep dive' meeting** will focus on 'surgical review' and 'the cancer pathway (with a focus on 62-day waiting time performance)'.

The meeting on 21st January 2015 was a 'main' meeting, and covered the following issues:

- A report was received on the use of **Catheters and the actions being taken to prevent Urinary Tract Infections**, and a definition of Catheter Associated Urinary Tract Infection (CAUTI) was agreed.
- The outcome and follow-up actions from **Serious Incidents (SIs) involving an allegation of abuse by staff** was discussed, and the importance of adhering to the Trust's Chaperone policy was emphasised. Mention was made of the difficulty providing chaperones when staff are on sickness absence, and it was agreed for this to be reviewed.
- The latest **Stroke care performance** was discussed, and the recent improvements that had been made were commended
- Details of the actions being taken in relation to **patient falls** were provided by the Trust's Clinical Lead for Falls. The Falls Prevention Coordinator was also in attendance. There was a request for a Non-Executive Director link for Falls.
- All the **Directorates** presented their usual reports. The key issue raised were as follows:

- **Cancer and Haematology** reported that the implementation of Chemotherapy e-prescribing was progressing according to plan, and learning visits to a hospital in Southampton, which had already implemented the same system, were being arranged. The findings from the National Cancer Patient Experience Survey were also received, and the Trust was noted as being within the top third of the 63 Trusts surveyed.
- **Children's services** reported that the nursing model had been agreed for the emergency paediatric pathway, and nurses had been appointed. In addition, Royal College approval had been granted for the hybrid Consultant posts, and the business case for the posts was currently being reviewed by the Executive team.
- **Critical Care** highlighted that there was a plan to review ICU Consultant cover, particularly at weekends. In addition, theatre staff recruitment and retention continued to be a challenge, but improvements had been made at internal & external recruitment fairs.
- **Diagnostics, Therapies & Pharmacy** reported that Cellular pathology reporting times had continued to improve, and the first week in January 2015 represented the best month in the recent period of recovery. An SI that had occurred in histopathology was also discussed in detail.
- **Emergency and Medical Services** reported that increased emergency activity during the recent period had led to the opening of a number of escalation areas. It was noted that daily reviews had been undertaken to ensure the best skill mix for all areas and this had been evaluated frequently throughout each 24 hour period. In addition, the Trust's findings from the national A&E survey 2014 were submitted and it was noted that the Trust fared well compared to other local Trusts.
- **Surgery** highlighted that nursing vacancy rates across all wards continued to be a concern due to inability to recruit sufficient numbers. It was also noted that the Directorate was working in collaboration with Oncology to improve performance with Cancer targets
- **Trauma & Orthopaedics** highlighted that their review of mortality was continuing, and the reduction of surgical site infections remained a priority.
- For **Women's and Sexual Health**, it was noted that the Consultant presence on the Labour ward was currently 76 hours per week and further increases would likely require increased staffing. It was further noted that achieving 98 hours of cover per week was aspirational, but assurance was given that the current level of cover provided was safe.

- A brief verbal update on the **CQC inspection** from October 2014 was provided.
- A written report was received on the latest media coverage / **reputational risk** issues
- The minutes of the **Quality & Safety Committee 'deep dive'** held on 15/12/14 were received
- The latest **Quality & Governance** report highlighted the need for the Directorates with lower numbers of complaints to improve their response times.
- The latest **SIs** were considered, and the recommendations from the **Patient Safety Think Tank** were received, (including the findings from the Safety Climate Survey)
- The recent findings from relevant **Internal Audit reviews** were received
- An update on the **quality aspects of the 2015/16 business plan** submission to the NHS Trust Development Authority (TDA) was received
- Reports were received from the latest meetings of the **sub-committees** i.e. Standards; Safeguarding Adults; Clinical Governance; Infection Prevention & Control; Safeguarding Children; and the Patient Environment Steering Group

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – January 2015

1-11	**Summary of the Trust Management Executive (TME) meeting, 14/01/15**	**Chief Executive**

This report provides information on the TME meeting held on the 14th January 2015. The key points from the meeting were as follows:

- Recent **hospital activity / demand pressures**, and the impact, were discussed in detail
- A brief update on **business planning for 2015/16**, including the submissions to NHS Trust Development Authority (TDA) was received
- The content of the draft reports of the **Care Quality Commission's** (CQC) October 2014 was discussed, noting that any factual inaccuracies would aim to be notified to the CQC by 16/01
- An update report on the implementation of the Trust's **INSPIRE IT strategy** was received
- The latest **performance, for month 9**, 2014/15 was reported (including the latest position regarding infection prevention and control)
- A report on the options to strengthen the Trust's **Procurement function** was received. A similar report is scheduled to be discussed at the Finance Committee on 26/01
- An update on the trial of **new medicines management system** on Foster Clarke Ward at Maidstone Hospital was provided
- The **recently-approved business cases** were noted
- Approval was granted for three **replacement Consultant posts** (a Consultant Histopathologist and two Consultant Obstetrician & Gynaecologists)
- Updates were received on the work of the **TME's sub-committees** (Capital meetings; the Health & Safety Committee Information Governance Committee and the Policy Ratification Committee). The report from the Health and Safety Committee noted that recent action had been taken regarding water quality testing, and a timetable for the receipt of further assurance reports on this matter was agreed. The report from the Information Governance Committee included notification of an information governance breach that had been reported to the Department of Health and Information Commissioner's Office. The incident will be reported in full within the Trust's Annual Report for 2014/15.
- The **Directorate reports** were deferred, to enable the meeting to focus on the activity/demand pressures & Clinical Strategy, but the following issues were raised under Any Other Business:
  - The CQC would be on site at the Trust on 19/01/15 as part of their review of local mental health services.
  - A new Head of Midwifery had been appointed
  - The Trust had been given the 'Most Consistent Top Performing Acute Provider' award by Kent Surrey and Sussex Academic Health Science Network (KSS AHSN) for its 'Enhancing Quality' (EQ) pathways - heart failure; pneumonia and enhanced recovery (elective / orthopaedic / colorectal / gynaecology).
  - The Trust's Microbiology laboratory had been the first laboratory in Kent and Medway to receive ISO 15189 accreditation, the successor to Clinical Pathology Accreditation (CPA).
  - The fact that the Trust Board had approved a proposal that the TME no longer be constituted as a sub-committee of the Trust Board was noted

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - January 2015

1-12	Summary report from Finance Committee, 17/12/14	Committee Chair (Non-Executive Director)

The Finance Committee met on 17th December 2014.

1. **The key matters considered at the meeting were as follows:**
   - Month 8 financial performance (including CIP and CQUIN) was examined
   - An update report was received on the forecast for 2014/15, including the risks and opportunities associated with the current situation
   - Progress on the Trust's 2015/16 planning process was reported
   - The financial performance of the Cancer and Haematology Directorate was scrutinised in detail (the Clinical Director and General Manager were in attendance)
   - An overview of the 2015/16 tariff was received
   - An update on the triangulation of workforce, activity and expenditure information was provided

2. **The Committee agreed that:**
   - Explanations should be provided of the relatively higher use of medical agency (rather than locum) staff in the Surgery Directorate; and the large positive variation in "Other NHS Clinical Income" at month 8
   - Board members should be provided with a précis of the key issues regarding the contract with West Kent Clinical Commissioning Group, ahead of the 'Board to Board' meeting on 27/01/15
   - A financial 'waterfall' chart should be provided, as part of the planning information for 2015/16, outlining the key areas of change from the 2014/15 position
3. **The issues that need to be drawn to the attention of the Board are as follows:**
   - None

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

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

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - January 2015

1-14 Board Assurance Framework 2014/15 Trust Secretary

The Board Assurance Framework (BAF) is the document which lists…

- The Trust's 22 objectives (as agreed by the Trust Board in September and October 2014);
- The risks to those objectives being achieved;
- The controls in place to manage such risks; and
- The assurances that provide evidence as to how such controls are working (or not)
- RAG ratings, based on the judgement of the relevant Executive Director

The Board last received the BAF in October 2014. The content has now been updated, to reflect relevant changes. New text is shown in red, whilst deleted text is shown as ~~strikethrough~~. A summary page has also been added, to highlight the latest „RAG' ratings.

Some additional words have been added to objective 2.7 ("Deliver the Trust's forecast financial position for 2014/15 of a maximum of a £12.3m deficit (excluding £12m non-recurrent deficit support)") and the Board is asked to approve this addition.

Board members are also invited to review and critique the content, by considering the following prompts:

- Do the RAG ratings of the controls reflect the situation as understood by the Board?
- Do the year-end forecast RAG ratings reflect the situation as understood by the Board and its sub-committees?
- Should the wording of any other objectives be amended?
- Are there any risks to the achievement of objectives that are not listed?
- Should any additional objectives be added (to ensure that the key priorities for the year are adequately reflected)?
- Should any objective be removed?
- Should the objectives be ordered in terms of their relative importance?

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

- Accepting the information as submitted;
- Requesting amendments (such as those referred to in the above list);
- Requesting further information on any of the BAF items;
- Requesting that a Board sub-committee review the risks to an objective in more detail

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 26/01/15 (objective 2.7 only)

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

1. Review and discussion (refer to prompts above)
2. Approve the amendment to the wording of objective 2.7 ("Deliver the Trust's forecast financial position for 2014/15 of a maximum of a £12.3m deficit (excluding £12m non-recurrent deficit support)")

[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

Board Assurance Framework (BAF) 2014/15 - Summary

Objective (summary - refer to main BAF document for specific wording)	Latest RAG ratings (see glossary for explanation) Controls	Year-end forecast
1.1 Maximum of 40 C diff cases, & sustain/decrease rate of MRSA bacteraemia	G	G↑
1.2 Implement the national guidance for multi-resistant organisms	G	G=
1.3 Enhance emergency provision for children in the Emergency Department	G	G=
1.4 Improve the response rate for the Friends & Family Test	G	G=
1.5 Increase the level of clinical services that are available 7 days a week	R	A=
1.6 Deliver the highest quality TIA and Stroke service	R	R↓
1.7 Ensure all Specialist Services operate without derogation from NHS England	G	G=
1.8 Promote a more customer-focused approach with the Trust's workforce	A	A=
1.9 Deliver a more effective flow for emergency admissions	A	A
2.1 Ensure compliance with the CQC 'fundamental standards'	A	A=
2.2 Promote a safety culture among the Trust's staff	A	A=
2.3 Ensure a workforce establishment that meets the needs of the organisation	A	A=
2.4 Reduce the Trust's dependence on temporary staff	R	R↓
2.5 Ensure Nurse staffing levels are within safe levels agreed by the Board	G	G=
2.6 Achieve at least an 'Amber-Green' 'Governance' rating on Monitor's RAF	A	R↓
2.7 Deliver the forecast financial position (£12.3m deficit, excl. non-recurrent deficit support)	A	A=
2.8 Achieve average LOS of 3.3 days (elective), and 6.6 (non-elective)	A	A↑
2.9 Ensure the KPP project milestones are achieved	G	G=
3.1 Develop a 5-year clinical and financial strategy	A	G=
3.2 Align the Estates strategy with the 5-year clinical strategy	A	A=
3.3 Ensure patients' care needs are met whatever their location	G	G=
3.4 Ensure Upper GI cancer surgery is provided in the best location for patients	G	G=

No. of 'Red' forecast ratings: 3	Number of 'Amber' forecast ratings: 9	Number of 'Green' forecast ratings: 10
Number of 'Red' control ratings: 3	Number of 'Amber' control ratings: 10	Number of 'Green' control ratings: 9

The RAG rating of the controls relates to the level of assurance that the risk is being managed effectively. The RAG rating for year-end forecast reflects the relevant Exec Director's confidence as to whether the objective will be achieved by 31/03/15

Board Assurance Framework 2014/15

No.	Objective *What the Trust aims to deliver (and/or what outcome is intended to be achieved)*	Principal risks *What could prevent this objective being achieved?*	Key controls *What effective controls/systems are in place to manage the identified risks?*	Sources of assurances on key controls *Where can we get evidence regarding the effectiveness of our controls?*	Assurance status *What do the assurances tell us?*	Gaps in control *Are other controls needed?* *Do we need to strengthen existing controls?*	Gaps in assurance *Are we unable to tell whether our controls / systems are effective?*	Responsible Director	Committee responsible for oversight of the objective	RAG rating of controls - baseline (May 14)	RAG rating of controls - Jul 14	RAG rating of controls - Sep 14	RAG rating of controls - Oct 14	RAG rating of controls - Jan 15	RAG rating of controls - Mar 15	Forecast year-end achievement
										Controls should not be rated G if the year-end assessment is R, or if there are marked gaps in control or assurance						
Annual objective theme 1: To transform the way we deliver services so that they meet the needs of patients																
1.1	Meet the nationally-set objective of having a maximum of 40 Clostridium difficile cases, and sustain or decrease the rate of MRSA bacteraemia	1. Prevalence of patients with complex conditions and high risk factors 2. Prevalence in the community 3. Patients with infection transferred from other Trusts 4. Workload pressures of staff and high occupancy etc. leading to potential breakdown of good practice 5. Prolonged length of stay (over 30 days) 6. Risk of key infection information not being documented in the appropriate place in the healthcare records 7. Multiple ward movements 8. Non-compliance with antimicrobial policy **Relevant Risk Register entries:** 2215 ("Control and prevention of health care associated infections including C.Difficile and multi resistant organisms for 2014/15") - current risk rating = Low	a. Infection Prevention Team (IPT) b. Proactive MRSA screening programme c. Auditing of Infection prevention & control practises d. Monitoring and oversight by the Infection Prevention and Control Committee and Trust Management Executive e. Infection Prevention Link Nurse programme (monthly meetings) f. Induction of new doctors in training g. Proactive use of isolation facilities h. Joint working with Kent Community Healthcare NHS Trust and local CCGs i. Root cause analysis is carried out for all C difficile infections and MRSA bacteraemias j. Overview of C difficile RCAs by C. Diff Panel k. 'Green Card' system (credit card sized card given to all C. difficile patients and carriers) l. Audits of antibiotic usage / anti-microbial prescribing policy (bi-monthly) m. HCAI action plan (and review of progress via Infection Prevention and Control Committee) n. Antibiotic Strategy Group (chaired by DIPC)	1. Monitoring of Clostridium difficile & MRSA bact. rate 2. Agenda, minutes and reports to Infection Prevention and Control Committee and Trust Management Executive (including progress with HCAI action plan) 3. Audits of Infection prevention & control practises (including antibiotic usage / anti-microbial prescribing) 4. Annual Report from DIPC to Trust Board 5. Weekly infection control reports (issued to key clinical and managerial staff) 6. Monthly infection control reports (issued to Consultants) 7. Infection control data is reported on the Trust website **Formal external assessments:** CQC CIH inspection, October 2014 **Included in integrated performance report?** Yes	a. Year to date (to end of ~~September~~ December 2014): Clostridium difficile = ~~19~~ 23 cases; rate (per 100,000 bed days) = 13.5. The rate for the 2013/14 year was 15.7 (based on 35 cases) b. Year to date (to end of December 2014): MRSA bacteraemia = 1 case; rate (per 100,000 bed days) = 0.6. The rate for the 2013/14 year was 1.3 (based on 3 cases) c. Annual Report from DIPC received at Trust Board in September 2014	None	None	Sara Mumford	Infection Prevention and Control Committee	**N/A - Objectives agreed at Trust Board, 24/09/14**	**G**	**G**		**G↑**
1.2	Implement the appropriate national guidance regarding the prevention and control of multi-resistant organisms	1. Lack of awareness of multi-resistant organisms 2. Patients with infection transferred from other Trusts 3. Patients with infection transferred from healthcare facilities abroad (or who have received health care abroad in the last 3 months) **Relevant Risk Register entries:** 2215 ("Control and prevention of health care associated infections including C.Difficile and multi resistant organisms for 2014/15") - current risk rating = Low	a. A new policy for 'Control and Management of carbapenemase-producing Enterobacteriaceae (CPE) and carbapenemase-resistant Enterobacteriaceae (CRE)' was ratified at the 'main' Quality & Safety Committee in September 2014 b. Enhanced infection control procedures for relevant patients c. Policy for Control and Management of Multi-Resistant Organisms (Excluding MRSA and CRE) d. HCAI action plan (and review of progress via Infection Prevention and Control Committee) e. CRE screening for high-risk patients f. All CRE isolates are sent to the PHE Reference Laboratory, for analysis g. Training programme for the new policy for 'Control and Management of carbapenemase-producing Enterobacteriaceae (CPE) and carbapenemase-resistant Enterobacteriaceae (CRE)' (completed in December 2014)	1. Policy for 'Control and Management of carbapenemase-producing Enterobacteriaceae (CPE) and carbapenemase-resistant Enterobacteriaceae (CRE)' 2. Policy for Control and Management of Multi-Resistant Organisms (Excluding MRSA and CRE) 3. Electronic records relating to the 3 imported cases of CRE that the Trust saw in 2013/14 **Formal external assessments:** CQC CIH inspection, October 2014 **Included in integrated performance report?** No	a. A training programme for the new policy for 'Control and Management of carbapenemase-producing Enterobacteriaceae (CPE) and carbapenemase-resistant Enterobacteriaceae (CRE)' is being introduced b. There have been no cases of Trust-acquired CRE c. The 3 imported CRE cases in 2013/14 did not result in cross-infection d. There has been 1 imported case (in December 2014) which was managed in accordance with Trust Policy	~~The training programme for the new policy for 'Control and Management of carbapenemase-producing Enterobacteriaceae (CPE) and carbapenemase-resistant Enterobacteriaceae (CRE)'will be completed by the end of December 2014~~ None	None	Sara Mumford	Infection Prevention and Control Committee	**N/A - Objectives agreed at Trust Board, 24/09/14**	**A**	**G**		**G=**
1.3	Enhance the emergency provision for children within the Emergency Department, by ensuring a separate paediatric emergency pathway at both hospital sites, and then introduce a dedicated paediatric emergency department at Tunbridge Wells Hospital	1. Physical refurbishment works required at Tunbridge Wells Hospital 2. Capital costs may limit aspirations 3. There may be physical building constraints 4. The cost of the business case for hybrid Consultants is significant (circa £400k) and needs to be incorporated into the Trust's financial plans **Relevant Risk Register entries:** 2254 ("Paediatric Pathways") - current risk rating = ~~High~~ Mod	a. Emergency Paediatric Pathway Working Group b. A business case has been approved, to enable a separate paediatric pathway at both Maidstone and Tunbridge Wells Hospitals, with support of Paediatric Nurses to triage and care for paediatric patients c. Paediatric patients with medical concerns are fast-tracked to the Riverbank Unit d. Two Consultant Paediatricians are on-call for the Trust out of hours e. Adult nurses assessed as competent to care for children f. Good safeguarding children controls are in place g. Business case for 4 x hybrid Consultant Paediatrician posts (currently being reviewed by the Executive Team)	1. Reporting on progress to Trust Management Executive, Quality & Safety Committee (this was the subject of the 'Deep Dive' meeting on 15/12/14) and Trust Board 2. Emergency paediatric dashboard 3. Audit of compliance against RCPCH paediatric standards **Formal external assessments:** CQC compliance inspection reports **Included in integrated performance report?** No	a. Recruitment to posts within the business case is underway (for nursing staff) b. An audit has confirmed the Trust as compliant against RCPCH paediatric standards (Consultant presence in hospital is achieved during peak times of activity but the feasibility of consultant cover till 10pm is being explored)	None	None	Avey Bhatia (supported by Angela Gallagher)	Trust Management Executive and Quality & Safety Committee	**N/A - Objectives agreed at Trust Board, 24/09/14**	**G**	**G**		**G=**

The in-year RAG rating rates the level of assurance that the risk is being managed effectively. It is not a risk rating, but an assessment of the controls, of the assurances that controls are effective.

Board Assurance Framework 2014/15

No.	Objective *What the Trust aims to deliver (and/or what outcome is intended to be achieved)*	Principal risks *What could prevent this objective being achieved?*	Key controls *What effective controls/systems are in place to manage the identified risks?*	Sources of assurances on key controls *Where can we get evidence regarding the effectiveness of our controls?*	Assurance status *What do the assurances tell us?*	Gaps in control *Are other controls needed?* *Do we need to strengthen existing controls?*	Gaps in assurance *Are we unable to tell whether our controls / systems are effective?*	Responsible Director	Committee responsible for oversight of the objective	RAG rating of controls - baseline (May 14)	RAG rating of controls - Jul 14	RAG rating of controls - Sep 14	RAG rating of controls - Oct 14	RAG rating of controls - Jan 15	RAG rating of controls - Mar 15	Forecast year-end achievement
										Controls should not be rated G if the year-end assessment is R, or if there are marked gaps in control or assurance						
Annual objective theme 1: To transform the way we deliver services so that they meet the needs of patients																
1.4	Significantly improve the Trust's response rate for the Friends & Family Test (from 2013/14 levels), whilst maintaining the overall Net Promoter score	1. Lack of prioritisation and focus **Relevant Risk Register entries:** N/A	a. Returns presented and recorded on daily site reports b. Weekly tally of returns feedback to each clinical area	1. Performance reporting to Quality & Safety Committee and Trust Board **Formal external assessments:** No **Included in integrated performance report?** Yes	a. Year to Date (~~August~~ December 2014), the FFT response rate is ~~45.8%~~ 42.6% (inpatients); ~~16.8%~~ 18.2% (A&E); and ~~18.5%~~ 19.6% (Maternity) b. Year to Date (~~August~~ December 2014), the FFT score is 77 (inpatients); ~~63~~ 64 (A&E); and ~~82~~ 83 (Maternity)	None	a. Need weekly report for each area on responses received against the number of discharges (however, this gap is not regarded as significant enough to affect the RAG rating of the controls)	Avey Bhatia	Quality & Safety Committee	**N/A - Objectives agreed at Trust Board, 24/09/14**	G	G		G=
1.5	Increase the level of clinical services that are available seven days a week	1. Limitations within the Consultant contract (i.e. Consultants may not be obliged to undertake elective weekend working) 2. Recruitment to medical, AHP and nursing vacancies 3. Reluctance to change practice **Relevant Risk Register entries:** 2022 ("Physiotherapy service capacity to provide 7 day service") - current risk rating = Mod; 2206 ("Inability to provide evidence of safe stroke care") - current risk rating = High	a. One of the four clinical strategy workstreams is focusing on 7-day working b. Trust Management Executive review of all business cases and replacement Consultant appointments	1. Internal Audit review ('Consultant Job Plans Follow Up') 2. Agenda, minutes and reports from Trust Management Executive **Formal external assessments:** High Intensity Speciality Led Acute Care (HiSLAC) audit and benchmarks **Included in integrated performance report?** No	a. 7-day working is not yet consistent across specialities b. The High Intensity Speciality Led Acute Care (HiSLAC) audit findings are not yet available	Recruitment is a major concern (as well as the limited control over the Consultant contract)	None	Paul Sigston	Trust Management Executive and Quality & Safety Committee	**N/A - Objectives agreed at Trust Board, 24/09/14**	R	R		A=
1.6	Ensure that the Trust delivers the highest quality Transient Ischaemic Attack (TIA) and Stroke service, via the safe implementation of a revised Stroke pathway	1. Resistance to change by Trust Stroke clinicians 2. Recruitment to vacancies 3. The timing of decisions regarding the potential future of the service **Relevant Risk Register entries:** 2206 ("Inability to provide evidence of safe stroke care") - current risk rating = High	a. A Stroke Improvement Group has been established to address the key issues of time to scan; interval between arrival and admission to a stroke ward and interval between admission and review by a Stroke physician b. Changes have been made regarding the initial assessment in A&E and ring-fencing a stroke bed on both hospital sites c. An action plan to address the key issues has been developed d. Engagement with external stakeholders regarding the future options for Stroke delivery at the Trust e. Advice has been sought from the National Clinical Director for Stroke at NHS England	1. Reports to Quality & Safety Committee and Trust Board regarding current Stroke performance and future options for Stroke 2. Sentinel Stroke National Audit Programme (SSNAP) **Formal external assessments:** Sentinel Stroke National Audit Programme (SSNAP); CQC CIH inspection, October 2014 **Included in integrated performance report?** Yes (current performance)	a. Year to date (~~August~~ October 2014) performance: % TIA with high risk treated <24hrs = ~~71.9%~~ 72.1% b. Year to date (~~June~~ November 2014) performance: % spending 90% time on Stroke Ward = ~~77.3%~~ 83.5%; % to Stroke Unit <4hrs = ~~37.3%~~ 41.6%; % scanned <1hr of arrival = ~~46.4%~~ 43.8%; % assessed by Cons <24hrs = ~~73.7%~~ 73.6% c. The Regional Clinical Networks have published "Quality Standards" which will be cross-referenced with regards to options for future Stroke provision. d. The Trust Board ~~is on trajectory to develop~~ is scheduled to receive an options paper ~~by the end of October~~ in May 2015 e. The latest overall SSNAP grade is "D" at both hospitals (A is highest & E lowest) f. The latest SNAP "Organisational Audit" score are D (Maidstone) and C (Tunbridge Wells)	1. Recruitment is a major concern 2. Decisions regarding the potential future of the service will not be taken until the summer of 2015	None	Paul Sigston (supported by Angela Gallagher)	Trust Management Executive and Quality & Safety Committee	**N/A - Objectives agreed at Trust Board, 24/09/14**	R	R		R↓
1.7	Ensure that all Specialist Services provided by the Trust operate without derogation (from NHS England) with regards to compliance with national service specifications	1. Delay in implementation of Chemotherapy eprescribing solution (this is required by March 2015 to meet the requirements of the NHS England derogation) **Relevant Risk Register entries:** N/A	a. Project Management approach in place for the implementation of Chemotherapy eprescribing (i.e. collaborative Oncology eprescribing Programme Board (Chaired by the MTW Chief Operating Officer) and a Commercial Group) b. Review and oversight of Chemotherapy eprescribing business case by Finance Committee and Trust Board	1. Agenda, minutes and reports to Finance Committee 2. Agenda, minutes and reports to Trust Board 3. Monthly reports to the Chief Executives within the collaborative (from the Chair of the Oncology eprescribing Programme Board) **Formal external assessments:** NHS England will authorise the eprescribing solution **Included in integrated performance report?** No	a. The Trust Board approved the OBC for Chemotherapy eprescribing in January 2014 b. ~~A~~ The FBC for Chemotherapy eprescribing has been approved by ~~submitted to~~ the NHS Trust Development Authority ~~for approval (Sep 2014)~~, and the Trust has committed the capital and revenue as per the FBC c. Chemo ePrescribing is scheduled to 'Go Live' with the first Tumour Group in March 2015	~~The Trust is unable to control the mechanism by which the TDA will review (and approve) the FBC. However, the Trust is undertaking all the actions it can to ensure such approval is obtained by the end of October, to enable the contract to be signed~~ None	None	Angela Gallagher	Trust Management Executive	**N/A - Objectives agreed at Trust Board, 24/09/14**	G	G		G=

Board Assurance Framework 2014/15

No.	Objective *What the Trust aims to deliver (and/or what outcome is intended to be achieved)*	Principal risks *What could prevent this objective being achieved?*	Key controls *What effective controls/systems are in place to manage the identified risks?*	Sources of assurances on key controls *Where can we get evidence regarding the effectiveness of our controls?*	Assurance status *What do the assurances tell us?*	Gaps in control *Are other controls needed?* *Do we need to strengthen existing controls?*	Gaps in assurance *Are we unable to tell whether our controls / systems are effective?*	Responsible Director	Committee responsible for oversight of the objective	RAG rating of controls - baseline (May 14)	RAG rating of controls - Jul 14	RAG rating of controls - Sep 14	RAG rating of controls - Oct 14	RAG rating of controls - Jan 15	RAG rating of controls - Mar 15	Forecast year-end achievement
										Controls should not be rated G if the year-end assessment is R, or if there are marked gaps in control or assurance						
Annual objective theme 1: To transform the way we deliver services so that they meet the needs of patients																
1.8	Promote a more customer-focused approach with the Trust's workforce, through a Trust-wide education programme (and demonstrated by improved findings from patient surveys and the Friends and Family Test)	1. Operational pressures reducing ability for staff to be released to attend training 2. Leadership behaviour not promoting required culture for learning 3. Funding **Relevant Risk Register entries:** N/A	a. Development of 1/2 day customer care programme designed around organisational needs and feedback from patients. Programme to be facilitated by Canterbury Christchurch University and will start in January 2015 b. Implementation of new online induction (from January 2015) c. Middle manager development programme (launched in autumn 2014)	1. Staff / FFT Surveys 2. Patient Surveys 3. Complaints 4. Agenda, reports and minutes of the Workforce Committee 5. Evidence from thematic reviews of appraisal feedback **Formal external assessments:** No **Included in integrated performance report?** Yes (FFT)	a. Year to Date (~~August~~ December 2014), the FFT response rate is ~~45.8%~~ 42.6% (inpatients); ~~16.8%~~ 18.2% (A&E); and ~~18.5%~~ 19.6% (Maternity) b. Year to Date (~~August~~ December 2014), the FFT score is 77 (inpatients); ~~63~~ 64 (A&E); and ~~82~~ 83 (Maternity)	1. Staff champions are intended to be introduced 2. Development of MTW Cultural Barometer - Board to Ward (~~as noted at Trust Board in September 2014~~) 3. A new e-learning bespoke customer care programme will be developed 4. Attendance at Customer Care programme is not mandated for staff	Change programme will take time to deploy and benefits to be realised. Changing culture takes 3-5 years. However development of cultural barometer will help with triangulation and providing board with assurance by area	Paul Bentley	Workforce Committee	**N/A - Objectives agreed at Trust Board, 24/09/14**	A	A		A=
1.9	Improve the non-elective pathway to deliver a more effective flow for emergency admissions	1. Inability to reduce length of stay (LOS) to top quartile national performance 2. Inability to affect discharge for patients with a complex / delayed Transfer of Care need 3. Inability of clinical capacity to keep pace with demand **Relevant Risk Register entries:** 2099 ("Failure to ensure timely patient discharges resulting in unsatisfactory patient experience and ineffective use of capacity") - current risk rating = Mod	a. LOS action plan b. LOS Steering Group (multi-disciplinary group, chaired by the Chief Operating Officer) c. Weekly named patient reviews (multidisciplinary reviews of patients with a LOS over 7 days) d. Escalation process with other agencies (social care and health) regarding individual patients (to facilitate their discharge) e. A Lead Matron has now been appointed to coordinate LOS standards across all clinical areas	1. LOS action plan 2. Agenda, minutes and reports to LOS Steering Group 3. Monthly data on: LOS (elective and non-elective); 4-hour A&E waiting time target performance; 12-hour A&E wait breaches; non-elective activity **Formal external assessments:** No **Included in integrated performance report?** Yes	a. Average LOS for non-elective patients for the year to date (December 2014): 6.8 days b. A&E 4-hour wait performance is 93.7% for the year to date (December 2014) c.. There has been 1 (one) 12-hour A&E wait breach for the year to date d. Non-Elective Activity for the year to date (December 2014) is 4.7% above plan	1. Engagement / ownership among clinical teams is variable	None	Angela Gallagher	Trust Management Executive	**N/A - Objective only agreed at Trust Board, 26/11/14**	A		A

The in-year RAG rating rates the level of assurance that the risk is being managed effectively. It is not a risk rating, but an assessment of the controls, of the assurances that controls are effective.

Board Assurance Framework 2014/15

No.	Objective *What the Trust aims to deliver (and/or what outcome is intended to be achieved)*	Principal risks *What could prevent this objective being achieved?*	Key controls *What effective controls/systems are in place to manage the identified risks?*	Sources of assurances on key controls *Where can we get evidence regarding the effectiveness of our controls?*	Assurance status *What do the assurances tell us?*	Gaps in control *Are other controls needed?* *Do we need to strengthen existing controls?*	Gaps in assurance *Are we unable to tell whether our controls / systems are effective?*	Responsible Director	Committee responsible for oversight of the objective	RAG rating of controls - baseline (May 14)	RAG rating of controls - Jul 14	RAG rating of controls - Sep 14	RAG rating of controls - Oct 14	RAG rating of controls - Jan 15	RAG rating of controls - Mar 15	Forecast year-end achievement Controls should not be rated G if the year-end assessment is R, or if there are marked gaps in control or assurance
Annual objective theme 2: To deliver services that are clinically viable and financially sustainable																
2.1	Ensure compliance with the Care Quality Commission essential standards of quality and safety (and their successor, 'fundamental standards')	1. Failures to adhere to Trust policies and procedures by all staff at all times 2. Ability to recruit and retain staff with the required skills in all areas 3. Failure to learn from incidents and make sustainable improvements across the whole organisation **Relevant Risk Register entries:** ~~N/A~~ There are none specific to the objective, though many of the risks on the Trust's Risk Register relate to the CQC's essential standards	a. Three action plans have been developed following the CQC's previous compliance inspections - 1. Emergency paediatric pathway, 2. Safe Management of Medicines, and 3. Other matters (governance, paediatric staffing and pathway, monitoring and reporting of data by Consultant, Consultant job plans, consistency of post-operative observations, privacy and dignity within the admission lounge, blood sciences staffing and blood tracking system and learning from serious incidents) b. Monitoring and oversight of progress with the action plans, via Quality & Safety Committee and the Trust Management Executive	1. CQC compliance inspections 2. Internal Audit review of Trust's in-house process ("CQC Process Review - MTW131421") 3. Progress reports on action plan implementation **Formal external assessments:** CQC CIH inspection, October 2014 **Included in integrated performance report?** No	a. The CQC's compliance inspection at Tunbridge Wells Hospital in November 2013 found that the Trust was non-compliant with 2 standards ("Management of medicines"; and "Staffing") b. The CQC's compliance inspection at Maidstone Hospital in February 2014 found that the Trust was non-compliant with 3 standards ("Care and welfare of people who use services"; "Staffing"; and "Assessing and monitoring the quality of service provision") c. The Internal Audit review of the Trust's in-house process (MTW131421) concluded 'limited assurance' (though this outcome was anticipated, in light of the acknowledged need to revise the process)	1. The action plans from the previous CQC compliance reports are not yet fully implemented 2. The findings of the CQC inspection to be held in October 2014 are unknown (the report is expected in January 2015)	None	Avey Bhatia	Trust Board / Quality & Safety Committee	**N/A - Objectives agreed at Trust Board, 24/09/14**	**A**	**A**		**A=**
2.2	Promote a safety culture among the Trust's staff, via ensuring that the recommendations of the Patient Safety Think Tank are considered and endorsed by the Board (and then delivered in the Trust)	1. Lack of engagement 2. Embedding blame free culture at all levels within the organisation **Relevant Risk Register entries:** ~~N/A~~ There are none specific to the objective, though many of the risks on the Trust's Risk Register are connected to cultural issues in some way	a Different ways of communicating safety messages i.e. Governance Gazette, Never Event postcards b. Patient safety video being considered c. Sign up to national patient safety campaign d. Holding staff to account but ensuring no blame e. 'Roadmap' for the future actions of the PSTT	1. Terms of Reference of Patient Safety Think Tank 2. Reports from PSTT to Quality & Safety Committee (12/11/14), Trust Management Executive (10/12/14) and Trust Board (17/12/14) **Formal external assessments:** No **Included in integrated performance report?** No	a. Patient Safety Think Tank has started to meet b. A 'Safety Climate' Survey was undertaken in Oct/Nov c. A 'Roadmap' has been developed, to focus efforts in Reporting and Learning; Education and Support; and Human Factors, Leadership and Collaboration	~~It is not yet clear what the recommendations from the Patient Safety Think Tank will be~~ The detail underlying the actions and intentions within the Roadmap is not yet finalised (including the establishment of measurable indicators)	None	Avey Bhatia (supported by Paul Sigston and Paul Bentley)	Quality & Safety Committee	**N/A - Objectives agreed at Trust Board, 24/09/14**	**A**	**A**		**A=**
2.3	Ensure the Trust has a workforce establishment that meets the needs of the organisation (specifically, setting an establishment, and reviewing this in-year; recruiting to that establishment; and reducing vacancies by 15% from 2013/14 levels)	1. Continue review and increase in establishment through 'safe staffing' 2. Recruitment availability of clinical staff 3. Clinical Strategy **Relevant Risk Register entries:** 2240 ("Blood Sciences Severe Staff shortages resulting in unsafe service") - current risk rating = High; 2188 ("Sonographer Recruitment and Retention") - current risk rating = Mod; 2072 ("Locum doctors in A&E") - current risk rating = Low	a. Business Planning 2014/15 b. Triangulation of workforce, finance and activity by Finance and Workforce Committee c. Recruitment Plan 2014/15 d. Chief Nurse bi-annual safe staffing reports to Trust Board e. A discussion on options to improve substantive recruitment (and retention) has been held at the Workforce Committee (04/12/14), TME (10/12/14) and Trust Board (17/12/14). These options are being tested with focus groups and actions are already being taken.	1. Performance reporting on vacancy rate 2. Workforce benchmark reports 3. Reduction in use of temporary staff 4. Reports to Workforce Committee, TME and Trust Board in December 2014 **Formal external assessments:** No **Included in integrated performance report?** Yes	a. Year to Date (~~August~~ December 2014), the vacancy rate is ~~8.9%~~ 8.7%) b. There has been an increase in the use of temporary staff. Temporary staff usage for the year to date (December 2014) is 293WTE (bank) , 206 WTE (agency) and 39 (locum). This is primarily a result of the additional escalation capacity opened in late December and January	1. Development of new establishment control process. 2. Development of Trust intelligence function and data warehouse 3. Some benchmarking is undertaken, but this is inconclusive, and further work will be taken to strengthen this	No	Paul Bentley	Workforce Committee	**N/A - Objectives agreed at Trust Board, 24/09/14**	**A**	**A**		**A=**
2.4	Reduce the Trust's dependence on temporary staff, whilst maintaining safe services (specifically, reducing usage of temporary staffing by 15%)	1. Number of open escalation beds 2. Continued increase in establishment caused by safe staffing reviews 3. Increased activity due to unstable local healthcare environment 4. National shortages of professionally qualified staff 5. Increasing public / media expectations of safe staffing **Relevant Risk Register entries:** 2205 ("Need to strengthen the process for managing temporary medical staff") - current risk rating = ~~Mod~~ Low; 2204 ("Need to be assured that there is control over the budget for temporary staff employment") - current risk rating = Mod	a. Temporary booking process b. Implementation of temporary workforce audit action plan (medical bookings) c. Weekly flash reports to execs. d. Recruitment plan 2014/15 e. Recruit to turnover f. Nurse Recruitment and Retention Group g. CIP Programme to reduce Length of Stay	1. Weekly flash reports 2. Trust Monthly Performance Dashboard 3. Workforce Quarterly Report **Formal external assessments:** No **Included in integrated performance report?** Yes	a. Year to Date (~~August~~ December 2014), temporary staff usage is ~~325~~ 293 WTE (bank) ~~and 150~~ 206 WTE (agency), and 39 (locum)	1. Need for greater use of intelligence from 'Roster Pro' system for nursing staff 2. Need to increase scrutiny of requests	~~No~~ a. Improved ability to analyse information (for example, by having real-time reports) would be an advantage. This would require different temporary staffing system software, and a business case is being developed regarding this	Paul Bentley	Workforce Committee	**N/A - Objectives agreed at Trust Board, 24/09/14**	**A**	**R**		**R↓**

Board Assurance Framework 2014/15

No.	Objective *What the Trust aims to deliver (and/or what outcome is intended to be achieved)*	Principal risks *What could prevent this objective being achieved?*	Key controls *What effective controls/systems are in place to manage the identified risks?*	Sources of assurances on key controls *Where can we get evidence regarding the effectiveness of our controls?*	Assurance status *What do the assurances tell us?*	Gaps in control *Are other controls needed?* *Do we need to strengthen existing controls?*	Gaps in assurance *Are we unable to tell whether our controls / systems are effective?*	Responsible Director	Committee responsible for oversight of the objective	RAG rating of controls - baseline (May 14)	RAG rating of controls - Jul 14	RAG rating of controls - Sep 14	RAG rating of controls - Oct 14	RAG rating of controls - Jan 15	RAG rating of controls - Mar 15	Forecast year-end achievement
										Controls should not be rated G if the year-end assessment is R, or if there are marked gaps in control or assurance						
Annual objective theme 2: To deliver services that are clinically viable and financially sustainable																
2.5	Ensure that Ward and Specialist Nurse staffing levels are within safe levels agreed by the Board, and endorsed through external review, and based on patient volumes and acuity as well as Trust operating protocols and physical environment	1. Ability to recruit suitable staff 2. Additional capacity 3. Temporary staff availability to meet increasing care needs at short notice **Relevant Risk Register entries:** 123 ("Lack of specialist nurses in Breast care") - current risk rating = Mod; 2262 ("Pye oliver nursing staff establishment") - current risk rating = High (however, this risk reflects vacancies on Pye Oliver ward, not the budgeted establishment)	a. Staffing review process established (involving meetings with Ward Managers) b. Triangulation applied, using a review of incidents, by ward, on falls, pressure ulcers and medication errors, as well as a Quality, Effectiveness and Safety Trigger Tool (QuESTT)	1. Monthly reports to Trust Board on planned Vs. actual staffing 2. 6-monthly review reports to Trust Board on ward nursing establishment 3. Internal Audit reviews ('Compliance with Nursing Rotas') **Formal external assessments:** No **Included in integrated performance report?** No	a. The latest monthly reports to Trust Board (~~September~~ December 2014) shows that overall the Trust is able to meet the nursing care time demands, and has systems in place to allow for a flexible responsive provision of care with the support and use of temporary staffing. b. The latest 6-monthly reports to Trust Board (September 2014) also showed that overall ward establishments are broadly in line with requirements, and meet the currently agreed principles, but 6 wards were recommended for change and further investment (Foster Clark, Ward 21, John Day, Lord North, Mercer, Ward 20), along with the Stroke Unit at Maidstone Hospital	None	None	Avey Bhatia	Quality & Safety Committee	**N/A - Objectives agreed at Trust Board, 24/09/14**	**G**	**G**		**G=**
2.6	Achieve a rating of at least 'Amber-Green' on the indicative 'Governance' rating under Monitor's Risk Assessment Framework	1. Insufficient capacity to meet elective and non-elective demand 2. Failure to achieve the limit for delayed transfers of care 3. Failure to achieve the Trust's targets for Length of Stay 4. The adverse impact of non-elective demand 5. The adverse impact of system-wide issues **Relevant Risk Register entries:** N/A	a. Capacity Management Group (chaired by the Chief Operating Officer) b. Length of Stay Steering Board c. Trust Wide Patient Tracking List (PTL) Meeting (for elective capacity and demand) d. Systems-wide Resilience Group involving Primary Care, Social Services and Community Care (chaired by the CCG) e. Urgent Care Board (chaired by CCG) f. Performance recovery trajectories for Planned and Unscheduled Care have been submitted to the NHS Trust Development Authority (TDA), and will be used to monitor the Trust's performance through to the end of 2014/15	1. Monthly reports on performance (to Trust Management Executive and Trust Board) 2. Agenda, minutes and reports from Length of Stay Steering Board, PTL Group, Systems-wide Resilience Group, and Urgent Care Board 3. Performance recovery Trajectories (Dec 2014) **Formal external assessments:** No **Included in integrated performance report?** Yes	a. Year to date (~~August~~ December 2014), the rating is "Amber/Red", primarily as a result of the Trust's performance on the Cancer 62 day wait - First Definitive Treatment and A&E 4hr Wait targets	1. There are currently some vacancies in key posts (i.e. A&E Consultant, Care of the Elderly Consultant, General Managers, Matrons) ~~2. System-wide issues are affecting the Trust's performance~~ 2. Need to review overall capacity to manage clinical activity (in terms of staffing and physical space)	None	Angela Gallagher	Trust Management Executive	**N/A - Objectives agreed at Trust Board, 24/09/14**	**A**	**A**		**R↓**
2.7	Deliver the Trust's forecast financial position for 2014/15 of a maximum of a £12.3m deficit (excluding £12m non-recurrent deficit support)	1. Failing to deliver required income levels across all contracts 2. Not receiving full payment for patient activity performed 3. Failure to contain costs within the budgets allocated 4. Failure to deliver the CIP programme in full 5. Impact of increased emergency activity through the winter period **Relevant Risk Register entries:** 2255 ("Failure to deliver financial plan, including recurrent cost improvement programme") - current risk rating = High	a. Cash flow forecast being reviewed on a weekly basis b. CIP Executive performance review on a weekly basis. c. Comprehensive reporting of the financial position to Executive Team, Trust Management Executive, Finance Committee and Trust Board on a monthly basis d. Regular performance meetings with commissioners e. The Winter and Operational Resilience Plan	1. Reporting of year to date financial performance 2. Agenda, minutes and reports of Finance Committee 3. Internal audit reviews ('CFA', 'Income Streams', 'Cost Improvement Plans', 'Contract Management') 4. External audit of accounts (Value for Money and Use of Resources conclusion) 5. The winter and operational resilience plan ~~(to be~~ reviewed by the Trust Board in October 2014) **Formal external assessments:** External audit of accounts **Included in integrated performance report?** Yes	a. Year to date (~~August~~ December 2014), the Trust has a deficit of ~~£8m~~ £1.5m against a planned deficit of ~~£8.3m~~ £10.3m. This incorporates 9/12 of the £12m non-recurrent deficit support funding received from the TDA b. Year to date (~~August~~ December 2014) CIP delivery is ~~£8.3m~~ £17.5m against a target of ~~£8.2m~~ £16.0m c. An Internal Audit review of "Critical Financial Assurance – Financial Accounting & Non Pay" (MTW131416) concluded 'significant assurance' d. Internal Audit review of "Critical Financial Assurance – Payroll" (MTW131418) concluded 'significant assurance' e. No significant issues were raised by External Audit with regards to the 2013/14 Accounts process	1. The financial impact of additional emergency activity may require further savings to be made 2. The use of, and expenditure for, temporary staffing requires improved control	None	Steve Orpin	Finance Committee / Trust Board	**N/A - Objectives agreed at Trust Board, 24/09/14**	**A**	**A**		**A=**

Board Assurance Framework 2014/15

No.	Objective *What the Trust aims to deliver (and/or what outcome is intended to be achieved)*	Principal risks *What could prevent this objective being achieved?*	Key controls *What effective controls/systems are in place to manage the identified risks?*	Sources of assurances on key controls *Where can we get evidence regarding the effectiveness of our controls?*	Assurance status *What do the assurances tell us?*	Gaps in control *Are other controls needed?* *Do we need to strengthen existing controls?*	Gaps in assurance *Are we unable to tell whether our controls / systems are effective?*	Responsible Director	Committee responsible for oversight of the objective	RAG rating of controls - baseline (May 14)	RAG rating of controls - Jul 14	RAG rating of controls - Sep 14	RAG rating of controls - Oct 14	RAG rating of controls - Jan 15	RAG rating of controls - Mar 15	Forecast year-end achievement
										Controls should not be rated G if the year-end assessment is R, or if there are marked gaps in control or assurance						
Annual objective theme 2: To deliver services that are clinically viable and financially sustainable																
2.8	Achieve an average length of stay (LOS) of 3.3 days for elective patients, and 6.6 for non-elective patients, through pathway improvements and process changes	1. Failure to plan the discharge of patients leaving hospital 2. Timeliness of input from other agencies 3. The adverse impact of system-wide issues **Relevant Risk Register entries:** 2016 ("Failure to ensure consistently safe, patient discharges which are promptly communicated to the patient's GP") - current risk rating = Mod; 2099 ("Failure to ensure timely patient discharges resulting in unsatisfactory patient experience and ineffective use of capacity") - current risk rating = Mod; 2207 ("Lack of an effective and efficient non-emergency transport service") - current risk rating = Mod"	a. Length of Stay Steering ~~Board~~ Group (multi-disciplinary group, chaired by the Chief Operating Officer) b. Improving Discharge Group c. Discharge policy and procedure d. Monitoring of high level KPIs for quality and timely patient discharges e. New Discharge Team is in place f. Weekly escalation of complex patients to Social Services (via teleconference) g. A Lead Matron has now been appointed to coordinate LOS standards across all clinical areas h. Length of stay drop-in sessions for nursing staff i. LOS action plan j. Weekly named patient reviews (multidisciplinary reviews of patients with a LOS over 7 days)	1. Reporting of performance each month to Trust Management Executive and Trust Board 2. Agenda, minutes and reports from the Length of Stay Steering Board and Improving Discharge Group **Formal external assessments:** No **Included in integrated performance report?** Yes	a. Year to date (~~August~~ December 2014), average LOS is ~~3.1~~ 3.2 (elective) and ~~6.6~~ 6.8 (non-elective)	1. There are currently some vacancies in key posts (i.e. A&E Consultant, Care of the Elderly Consultant, General Managers, Matrons) ~~2. System-wide issues are affecting the Trust's performance~~	None	Angela Gallagher	Trust Management Executive	**N/A - Objectives agreed at Trust Board, 24/09/14**	**A**	**A**		**A↑**
2.9	Ensure the milestones within the agreed Project Plan (September 2014) for the Kent Pathology Partnership (KPP) are achieved	1. Insufficient resources allocated to KPP (if business case cost estimations prove to be optimistic) 2. Delays due to review by competition authorities **Relevant Risk Register entries:** N/A	a. KPP Project Board established and meeting regularly, informed by the output of specific workstreams b. KPP Project Manager in post c. KPP Managing Director in post d. Legal advice sought with regards to competition-related risks	1. Agenda, minutes and reports to KPP Project Board 2. Update reports on progress with KPP to Trust Board **Formal external assessments:** No **Included in integrated performance report?** No	a. The Trust Boards at MTW and EKHUFT approved the Collaboration Agreement for the KPP in September 2014 b. KPP will come into existence on 01/04/15 c. The first transfers of services (of MTW Molecular Pathology to William Harvey Hospital; and of Microbiology to Maidstone Hospital) are scheduled for mid-April 2015	None	None	Angela Gallagher	Trust Board	**N/A - Objectives agreed at Trust Board, 24/09/14**	**G**	**G**		**G=**

Board Assurance Framework 2014/15

No.	Objective *What the Trust aims to deliver (and/or what outcome is intended to be achieved)*	Principal risks *What could prevent this objective being achieved?*	Key controls *What effective controls/systems are in place to manage the identified risks?*	Sources of assurances on key controls *Where can we get evidence regarding the effectiveness of our controls?*	Assurance status *What do the assurances tell us?*	Gaps in control *Are other controls needed?* *Do we need to strengthen existing controls?*	Gaps in assurance *Are we unable to tell whether our controls / systems are effective?*	Responsible Director	Committee responsible for oversight of the objective	RAG rating of controls - baseline (May 14)	RAG rating of controls - Jul 14	RAG rating of controls - Sep 14	RAG rating of controls - Oct 14	RAG rating of controls - Jan 15	RAG rating of controls - Mar 15	Forecast year-end achievement
										Controls should not be rated G if the year-end assessment is R, or if there are marked gaps in control or assurance						
Annual objective theme 3: To actively work in partnership to develop a joint approach to future local health care provision																
3.1	Develop a 5-year clinical and financial strategy that meets patient needs and delivers a sustainable future for the Trust	1. Failure to deliver financial plan, including recurrent Cost Improvement Programme 2. Lack of engagement and support from clinicians 3. Changes/challenges which may affect the Trust from other surrounding providers 4. Securing support from our local commissioners 5. The uncertainty of the future tariff structure 6. Increasing capacity / demand pressures (which challenge the assumptions on which the strategy is based) **Relevant Risk Register entries:** 2255 ("Failure to deliver financial plan, including recurrent cost improvement programme") - current risk rating = High	a. Clinical Strategy Transformation Group (CSTG) established, with clinical representation b. The 4 strategy workstreams (Emergency, Centres of Excellence, 7 Day working, and Integration / Collaboration) have identified clinical leads c. Oversight of progress by the Trust Management Executive and Trust Board d. Internal and external engagement process e. Membership of CCG/GPs in strategy forums/groups f. Planned updates to governing bodies and clinical strategy groups g. Development of an agreed engagement plan/strategy h. CCG members of joint engagement group	1. Strategy update reports to the Trust Management Executive and Trust Board (the latest draft Strategy will be discussed at the January 2015 meetings) 2. Agenda, minutes and reports to CSTG 3. Engagement log **Formal external assessments:** CQC CIH inspection, October 2014 **Included in integrated performance report?** No	a. The Trust commenced a market based business analysis in June 2014 to support and inform the development of the strategy b. Engagement work has commenced (presentations, setting out the key messages, have been made to Kent HOSC; West Kent CCG clinical strategy and governing body meetings; the Trust's Patient Experience Committee and general staff open sessions) c. A 'Have your say' leaflet has been issued to all staff, and was provided to all attendees of the 2014 AGM d. The latest draft of the Trust's 5-year strategy ("Moving forward") was issued on 23/12/14	1. Requires more defined involvement of patients / public in development of strategy 2. Assumptions need to be reviewed in the light of recent capacity / demand pressures	None	~~Jayne Black~~ Glenn Douglas	Trust Board	**N/A - Objectives agreed at Trust Board, 24/09/14**	**A**	**A**		**G=**
3.2	Align the Trust's Estates strategy with the 5-year clinical strategy	1. Absence of a final clinical strategy 2. Lack of financial resource to implement the strategy 3. Relevant planning permissions not being granted, or resulting in delay **Relevant Risk Register entries:** 2253 ("Condition of the hospital blocks at Maidstone Hospital") - current rating = Mod; 2032 ("Whole Site infrastructure Maidstone") - current risk rating = Mod; 2247 ("Long term actions required to address condition of clinical estate areas Maidstone Hospital") - current risk rating = Mod	a. The Capital Programme is overseen via the Director of Finance and Finance Committee b. The Estates and Facilities Directorate is able to engage external consultants regarding potential costs c. The Estates and Facilities Directorate has experience in dealing with Planning Authorities, and has developed good working relationships with Planning Officers d. Estates Work Plan	1. Internal estates update reports (e.g. to Trust Management Executive in September 2014) 2. Estates and Facilities Annual Report to Trust Board **Formal external assessments:** No **Included in integrated performance report?** No	a. The Trust's existing Estates Strategy was agreed by the Trust Board in 2012, and lasts until 2017 (but will need to be updated) b. The latest draft of the Clinical Strategy was issued in December 2014, and was discussed at the January Trust Management Executive. It will also be discussed at the January 2015 Trust Board	The Director of Estates and Facilities has not been involved in the development of the clinical strategy to any great extent to date (this could be addressed by reviewing the membership of the Clinical Strategy Transformation Group and associated workstreams)	None	Angela Gallagher	Trust Board	**N/A - Objectives agreed at Trust Board, 24/09/14**	**A**	**A**		**A=**
3.3	Provide strategic direction, with our clinical partners, to ensure our patient's care needs are met whatever their location, minimising, where appropriate, secondary care admission	1. Strategic direction not aligned with commissioners 2. Strategic direction not aligned to local patient needs **Relevant Risk Register entries:** N/A	a. Clinical Strategy Transformation Group (CSTG) established, with clinical representation b. The 4 strategy workstreams (Emergency, Centres of Excellence, 7 Day working, and Integration / Collaboration) have identified clinical leads c. Oversight of progress by the Trust Management Executive and Trust Board d. Internal and external engagement process e. Membership of CCG/GPs in strategy forums/groups f. Planned updates to governing bodies and clinical strategy groups g. Development of an agreed engagement plan/strategy h. CCG members of joint engagement group j. Board to Board meeting with West Kent CCG (scheduled for 27/01/15)	1. Strategy update reports to the Trust Management Executive and Trust Board 2. Agenda, minutes and reports to CSTG 3. Engagement log **Formal external assessments:** CQC CIH inspection, October 2014 **Included in integrated performance report?** No	a. The Trust commenced a market based business analysis in June 2014 to support and inform the development of the strategy b. Engagement work has commenced (presentations, setting out the key messages, have been made to Kent HOSC; West Kent CCG clinical strategy and governing body meetings; the Trust's Patient Experience Committee and general staff open sessions). The latest such engagement included the Chief Executive attending the HOSC meetings at both East Sussex and Kent County Councils at the end of November 2014	None	None	~~Jayne Black~~ Glenn Douglas	Trust Board	**N/A - Objectives agreed at Trust Board, 24/09/14**	**G**	**G**		**G=**

Board Assurance Framework 2014/15

No.	Objective *What the Trust aims to deliver (and/or what outcome is intended to be achieved)*	Principal risks *What could prevent this objective being achieved?*	Key controls *What effective controls/systems are in place to manage the identified risks?*	Sources of assurances on key controls *Where can we get evidence regarding the effectiveness of our controls?*	Assurance status *What do the assurances tell us?*	Gaps in control *Are other controls needed?* *Do we need to strengthen existing controls?*	Gaps in assurance *Are we unable to tell whether our controls / systems are effective?*	Responsible Director	Committee responsible for oversight of the objective	RAG rating of controls - baseline (May 14)	RAG rating of controls - Jul 14	RAG rating of controls - Sep 14	RAG rating of controls - Oct 14	RAG rating of controls - Jan 15	RAG rating of controls - Mar 15	Forecast year-end achievement
										Controls should not be rated G if the year-end assessment is R, or if there are marked gaps in control or assurance						
Annual objective theme 3: To actively work in partnership to develop a joint approach to future local health care provision																
3.4	Work with our clinical partners (tertiary, primary and specialist commissioning) to ensure Upper GI cancer surgery is provided in the best location for patients, taking into account outcomes and patient experience	~~1. If the Trust wishes to provide Upper GI Cancer surgery in the future, a new clinical leader will need to be recruited~~ 1. The decision-making process in relation to the long-term future of the service is led by NHS England, and therefore progress is reliant on that organisation **Relevant Risk Register entries:** ~~N/A~~ 2271 ("loss of major UGI cancer activity") - current rating = High	a. The Trust established a Clinical Advisory Group (CAG), which ~~will be~~ was used as the basis for future decision-making by NHS England (via an NHS England Upper GI pathway Advisory Group) b. The NHS England Advisory Group (NAG) was agreed to be established with the aim of establishing when and whether the UGI service could be reinstituted at MTW, both in terms of the quality of service offered and in the light of the revised commissioning arrangements	1. Update reports to Trust Board and Quality & Safety Committee **Formal external assessments:** No **Included in integrated performance report?** No	a. The Clinical Advisory Group (CAG) established by the Trust had its final meeting on 16th July 2014. b. The NHS England Upper GI pathway Advisory Group has yet to meet ~~c. NHS England, with Trust, to decide on the Trust's ability to deliver the service~~ c. In November 2014, the Trust Board approved a recommendation that the Trust not undertake Upper Gastrointestinal Cancer surgery in the future d. The Local Area Team of NHS England will be holding discussions regarding the future commissioning of the service, and which specialist provider/s should be engaged. The Trust will be involved in such discussions, to ensure that Kent and Medway patients received the best model of care	None	None	Paul Sigston	Trust Board	**N/A - Objectives agreed at Trust Board, 24/09/14**	**G**	**G**		**G=**

The in-year RAG rating rates the level of assurance that the risk is being managed effectively. It is not a risk rating, but an assessment of the controls, of the assurances that controls are effective.

Board Assurance Framework (BAF) 2014/15 - Glossary

The purpose of the BAF

The Board Assurance Framework (BAF) is the document through which the Trust Board identifies the principal risks to the Trust meeting its objectives and to ensure adequate controls and measures are in place to manage those risks.

The objectives listed in the BAF are those agreed by the Board. The ultimate aim of the BAF is to help ensure that the objectives agreed by the Board are met.

The management of the BAF

The BAF is managed by the Trust Secretary, on behalf of the Chief Executive and the Executive Team. The Trust Secretary liaises with each Responsible Director to ensure that updates are carried out, in relation to risks, controls and assurances.

RAG ratings of controls

A 'R' (red) rating indicates that there are **significant** concerns (in the judgement of the Responsible Director) over the adequacy/effectiveness of the controls in place in proportion to the risks. For example, this could be indicated by an Internal Audit review concluding 'limited assurance'.

An 'A' (amber) rating indicates that there are **some** areas of concern (in the judgement of the Responsible Director) over the adequacy/effectiveness of the controls in place in proportion to the risks.

A 'G' (green) rating indicates that the controls in place are assessed (by the Responsible Director) as adequate/effective and in proportion to the risks. Controls should not be rated 'G' if the year-end forecast is "R", or if there are significant gaps in either controls or assurances.

This rating system is adapted from the HM Treasury guidance "Assurance Frameworks" (Dec 2012).

RAG ratings of forecast year-end achievement

A 'R' (red) rating indicates that the Responsible Director does not expect that the objective will be achieved by year-end. 'R↓' means the rating has gone 'down' from 'A' or 'G' (i.e. worsened), whilst 'R=' means the rating has stayed the same, since the previous rating.

An 'A' (amber) rating indicates that the Responsible Director has significant doubts as to whether the objective will be achieved by year-end. 'A↓' means the rating has gone 'down' from 'G' (i.e. worsened), 'A=' means the rating has stayed the same, whilst 'A↑' means the rating has gone 'up from 'R' (i.e. improved), since the previous rating.

A 'G' (green) rating indicates that the Responsible Director expects the objective to be achieved by year-end. 'G=' means the rating has stayed the same, whilst 'G↑' means the rating has gone 'up' from 'A' (i.e. improved) since the previous rating.

Link with the Risk Register

The BAF differs from the Risk Register in that the latter can be considered a register of all risks that exist within the Trust. The BAF should only contain a sub-set of these risks - those that pose a direct threat to the achievement of the Trust's stated objectives. However, the BAF does contain cross-references to relevant Risk Register entries (where these exist), in the "Principal risks" column. In such cases, the risk reference number is listed, along with the risk title and the current risk rating (either "Low", "Mod"(erate) or "High").

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - January 2015

1-15 Emergency Planning update (annual report to Board) Chief Operating Officer

Summary & Key points

- Activities of the Emergency Planning Team over the past twelve months are summarised
- Emerging risks are discussed
- Details of the resilience programme of training & exercising are detailed
- The organisation is resilient but further work is needed to ensure all managers and directors attend training and exercises

Which Committees have reviewed the information prior to Board submission?

- N/A

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

The Board are asked to note the work of the Emergency planning Team and the position of the Trust with regard to compliance with national legal and NHS standards

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

1 Introduction

1.1 This report summarises the work of the Emergency Planning Team, key aspects of the organisations emergency preparedness over the past year and how the Trust maintains its readiness to prepare, respond and recover from both emergencies and disruptive challenges.

1.2 The Trust as a Category One responder under the Civil Contingencies Act 2004 has specific statutory duties in relation to emergency planning and response. In addition, the organisation has other obligations as required by contracts and performance standards set by NHS England.

1.3 Throughout the year a continuous process of exercising, testing, training, assurance has taken place.

2. Incidents

2.1 On the 25th of February Maidstone Hospital (MH) suffered a complete power failure resulting in activation of business continuity plans. Subsequently the whole Trust suffered loss of IT and phone services. As a result of extensive planning and strong leadership the Trust was able to remain functioning and provide services to patients. Whilst there were lessons identified and actions taken after the incident, the plans worked.

3. Training & Exercising

3.1 Exercise Spring Day – 4th April – This tabletop exercise tested Trust wide business continuity and recovery plans particularly amongst Estates and Facilities directorates following a major fire. It also spent time looking at recovery from the incident.

3.2 Exercise Rocking Horse – 12th June – This tabletop exercise focused on Women & Children's Directorate involving nursing, support and medical staff.

3.3 Exercise Beacon – This tabletop exercise focused on the critical service that the Switchboard provides looking at single points of failure and resilience.

3.4 Exercise Bell – 3rd September - This live exercise focused on testing actions highlighted as a result of Exercise Beacon. It included relocating Switchboard to alternative accommodation whilst maintaining services.

3.5 Exercise Umbrella – 24th September – This tabletop exercise focused on the services provided by the Workforce directorates.

3.6 Exercise Windy Corner - 12th September - This tabletop exercise focused on the services within Oncology Day Care at MH.

3.7 Exercise Smash – 17th September - This tabletop exercise focused on the Emergency Department at TWH and the need to evacuate the department.

3.8 Exercise Equinox – 23rd September– This was a Trust wide Communications Exercise activated by the South East Coast Ambulance service and tested Trust wide communications cascades.

3.9 Exercise Harvest 1 – 1st October– This was a live exercise at MH focussed on the response to a Hazardous Materials Incident and involved Kent Fire & Rescue Service, South East Coast Ambulance Service and Kent Police.

3.10` Exercise Harvest 2 – 1st October – This was a live exercise at TWH focussed on the response to a Hazardous Materials Incident and involved Kent Fire & Rescue Service , South East Coast Ambulance Service and Kent Police.

3.11 Exercise Polar – This tabletop exercise looked at Winter Resilience Plans for the organisation in conjunction with West Kent CCG, out of hours providers and social care.

4. Command, Control and Decision Making Exercises & Training

4.1 Working in partnership with Kent Fire & Rescue Service Training School a series of four one day sessions were put on to provide innovative training and experience in the skills required to make decisions with partners and to practice the challenges of working with partner agencies. This included a practical multi agency exercise with Police, Ambulance and Fire. The training was provided equally to Fire Brigade Commanders and Hospital Incident Managers.

4.2 The sessions also provided experience to use the national decision making model and understand other agencies needs. Excellent training was also provided by the Trusts Medical Physics Team so that managers and multi agency partners understood the nature of the hazard particularly in a fire incident.

4.3 The Trust has also supported a pilot national training course targeted at Silver Level Managers designed to meet the requirements of the National Occupational Standards where staff will understand the principles of command and control and crisis decision making. This will be repeated in 2015 with East Kent Hospitals to allow networking between managers and experiences to be shared.

5. Media and Social Media

5.1 Emergency Planning in conjunction with Communications held two Part 1 Media training sessions for staff looking at how the Trust manages media in emergencies including writing and issuing holding statements, social media and practical points to consider. Those who have completed Part 1 are then eligible to go on and take part in Part 2 Media Training which is practicing speaking to camera and radio.

5.2 Recognising the importance of social media especially in emergencies Emergency Planning has worked to recruit a social media support team who can be called upon to support the Communications Team in an emergency. They are staff who are well practiced at using Twitter and Facebook and will undergo training to use the Trust accounts in an emergency enabling the organisation to be more responsive and informative to staff, patients, visitors and partners.

6. Portfolios

6.1 The new NHS core standards require those with management roles in an emergency to have a portfolio of training and how they meet the national occupational standards. Working with Health Resilience we have adapted an e portfolio for managers which will also produce a compliance score for use in appraisals and to identify further training needs.

7. Emerging Risks

7.1 Ebola

Although Ebola and other Viral Haemorrhagic Fevers have been around for some time the spread in parts of Africa and the increased potential for cases in the UK has led to an increase in awareness. The risk remains low but Emergency Planning in partnership with the Infection Control Team has run two walk through exercises in both Emergency Departments in the Trust to check on preparedness' and awareness information has been made available to managers and clinicians. The Trust already had enough stocks of Personal Protective Equipment as a contingency. On the 3rd of November the Trust was well represented at the Kent Resilience Forum exercise to look at county wide preparedness.

7.2 Industrial Action

Throughout this report period the Emergency Planning Team has worked with the HR and workforce teams in horizon scanning for industrial action both in the Trust and in services that affect the Trust including teachers and fire-fighters action. Emergency Planning has been liaising with NHS England and providing Situation Reports during NHS Industrial Action as required by the Department of Health.

7.3 Mass Casualties – Further work across agencies and Health Organisations will look at Mass Casualty events and the Board will be briefed about these later in 2015.

8. Public Safety and Partnerships

8.1 LHRP

The Trust continues to be represented at the Local Health Resilience Partnership (LHRP) with other parts of the Kent & Medway Health Economy contributing where required.

8.2 LRF

The Trust continues to support the activities of the Kent Local Resilience Forum through membership of sub groups and working groups to support multi agency planning, training and response.

8.3 SAG

The Trust continues to represent the NHS on local authority safety advisory groups in Sevenoaks District Council, Tonbridge & Malling, Maidstone and Tunbridge Wells Borough Councils. These groups contribute to community safety by screening licensing for large public events, allowing the NHS to monitor medical provision and crowd welfare and thus reduce the potential affects to A&E as well as other admission avoidance measures such as recommending on site pharmacy provision or inclement weather precautions.

8.4 EP Group

The Trust continues to meet and engage with other NHS emergency planning teams across Kent, London and East Sussex. It also remains part of NHS England's Area Team emergency planning group.

8.5 Railcare

The team has continued to support Railcare Volunteers in their work to provide support to victims of railway incidents. This included input into Eurostar training for the Kent & Medway Area.

8.6 Trauma Network

Emergency Planning remain a core member of the Trust Trauma Board and also work with the Trauma Network. An excellent relationship with Emergency Planning Staff at Kings College Hospital is starting to identify key actions needed as the network matures and develops.

8.7 Emergency Services

The team continues to work closely with both Kent and East Sussex Emergency Services in training, exercising, planning and response.

8.8 Helipad

The team continue to manage the helipad plan as required under the Department of Health HTM and work with Kent Surrey and Sussex Air Ambulance, RAF, HM Coastguard and other providers such as the Children's Air Ambulance to ensure safe use of the landing points in the Trust.

9. Assurance

9.1 Self Assessment

The recent self assessment undertaken for NHS England revealed a couple of issues to work on – mainly around portfolios for managers and some work around whole site evacuation. This is within the work plan for the next twelve months.

9.2 CCG Audit of BC Plans

During the year the Trust Business Continuity Plans were audited by Kent & Medway Commissioning Support organisation who scored the Trust 100%. Emergency planning is awaiting internal audit to look at some of the plans in more detail to give further assurance.

9.3 National Capabilities Survey

The Trust will be taking part in the National Capabilities Survey run by the Cabinet Office which assesses resilience of the public services.

10 New Major Incident plan

10.1 The revised and updated Major Incident Plan was produced and approved by the Resilience Committee and ratified by the Policy Ratification Committee. There were no major changes to the plan over the year apart from organisational changes within the Trust.

11 Royal Visit

11.1 On September 26th HRH The Countess of Wessex visited the Tunbridge Wells hospital and saw members of the CBRN/Hazmat Team. She was interested to hear about the training scheme and the levels of PPE the team use. She also met partners in the emergency services and voluntary sector that the Trust works with.

12 CBRN/Hazmat Team

12.1 The Trust has had a CBRN/Hazmat team for over twelve years trained to deal with hazardous incidents. Training is on going and the team can respond and work across West Kent. Considerable time is spent ensuring that this team receive quality training and that the approach is safe.

12.2 It is extremely important that the Emergency Departments take time to ensure all ED staff are booked on to the training and that this is planned throughout the year. The Emergency Planning Team will continue to recruit staff from outside the ED and managers are asked to continue to support releasing staff to attend training.

13 CQC Inspection

13.1 During the recent CQC inspection a live exercise was underway and was observed by a CQC Inspector who was able to talk to CCG representatives and emergency services about their relationship with the Trust.

14 Business Continuity

14.1 During the past year considerable progress has been made in developing business continuity plans across the organisation leading to an excellent CCG audit report.

In particular Switchboard and IT have made good progress.

14.2 A concerted effort needs to be made by managers to ensure plans are kept up to date with departmental changes. The Emergency Planning Team will randomly pick areas to test during the next year.

14.3 The Trust overarching Business Continuity Plan is currently undergoing revision and will be sent for ratification by the end of 2014.

15. Risk Assessment

15.1 The team have reviewed all risks on the Community Risk and National Risk Register along with specific risks locally and updated the Trust Risk Register.

15.2 The highest risk remains a Flu Pandemic and work has started to review Trust plans in the light of new national guidance.

16 Future developments

16.1 Exercises & Training

The Trust will undertake two large tabletop exercises in 2015 with partner agencies to test preparedness in some key areas. In addition two Communications Exercises will take place as required by NHS England. The Emergency Planning Team will also look to maximise opportunities to train and exercise with other agencies including further Command training in conjunction with Emergency Services. Testing of four departmental business continuity plans will also take place.

16.2 Although extensive training and excising is carried out it is difficult to get Directors and some senior managers to attend due to the workload. The team will continue to seek innovative ways to solve this problem which is not unique to MTW.

17 Conclusion

17.1 The Trust remains well prepared for emergencies.

17.2 The Board is asked to support the concept that staff must be released for training and attendance at training is regarded as a key priority.

17.3 The Trust remains in strong position but can only maintain this with continued adequate funding and commitment from the Directorate Senior Management teams. Directorates need to ensure that Business Continuity and Resilience is high up on their Directorate Work plans.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – January 2015

1-16	Oversight Self-Certification, Month 9, 2014/15	Trust Secretary

The enclosed schedule sets out the proposed oversight self-certification submission for month 9, based on performance as at 31st December. This submission must be sent to the NHS Trust Development Authority (TDA) by the end of January (i.e. by 30th).

Significant changes from the previous report and submission, which was agreed at the Board meeting in December 2014, are highlighted.

As Board members are aware, each month the Trust Board is required self-assess against the questions contained in two self-certification documents under the TDA oversight process:
1. Monitor licence conditions; and
2. Board statements

The Trust is not required to provide supporting evidence (as listed in the "Evidence of Trust compliance" columns), and is just required to respond to each statement with "Yes" (i.e. compliant), "No" (i.e. not compliant) or "Risk" (i.e. at risk of non-compliance). If "not compliant" or "at risk of non-compliance" is selected, a commentary on the actions being taken, and a target date for completion (in dd/mm/yyyy format), is required in order for the submission to be made. The proposed self-assessment (and responses where required) for the latest submission are included in the compliance column. The "Evidence of Trust Compliance" document has incorporated amendments agreed at previous Trust Board meetings.

In relation to the Monitor licence conditions, there are some items which, as an aspirant Foundation Trust, the Board does not need to consider at the present time. These will however need to be understood and implemented as part of the trajectory to submit a Foundation Trust (FT) application. As with the previous month's self-assessment, and as was agreed at the Board Forum meeting in February 2014, it is proposed that, where appropriate, where the Trust continues to declare non-compliance, and that the date by which the Trust will become compliant should be listed as 31st March 2016.

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
The Board is asked to:
- Review the evidence presented to support the self-assessment (and amend if required);
- Consider whether the "latest assessment" accurately reflects the current situation regarding compliance;
- Approve the self-assessment for the forthcoming submission to the TDA

[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

Oversight Self Certification – Monitor Licence Conditions applicable to aspirant Foundation Trusts

General conditions

Condition	Evidence of Trust compliance / Commentary	Latest assessment
G4 – Fit and proper persons as Governors and Directors No unfit persons – undischarged bankrupts – imprisoned during last 5 years – disqualified Directors	All Trust Directors are "fit and proper" persons; confirmed through appointment process. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were approved by Parliament on 6th November 2014. These are the Regulations that will introduce a new requirement that Directors (or equivalent) of health service bodies be "fit and proper persons". The Care Quality Commission (CQC) will be able to insist on the removal of Directors that fail this test. Specifically, Directors should not be "unfit", which equates to not being an undischarged bankrupt; not having sequestration awarded in respect of their estate; not being the subject of a bankruptcy restrictions order; not being a person to whom a moratorium period under a debt relief order applies; not having made a composition or arrangement with, or granted a trust deed for, creditors; not being included in the children's barred list or the adults' barred list; and not being prohibited, by or under any enactment, from holding their office or position, or from carrying on any regulated activities[2]. In addition Directors need to be "of good character"[3], and have the health, qualifications, skills and experience to undertake the role. Finally, Directors should not have "been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity…". This latter restriction will enable the CQC to decide that a person is not fit to be a Director on the basis of any previous misconduct or incompetence in a previous role for a service provider. This would be the case even if the individual was working in a more junior capacity at that time (or working outside England). The Regulations apply to all directors and "equivalents", which will include Executive Directors of NHS Trusts and Foundation Trusts. It will be the responsibility of the provider and, in the case of NHS bodies, the chair, to ensure that all Directors meet the fitness test and do not meet any of the 'unfit' criteria. The Chair of a provider's board will need to confirm to the CQC that the fitness of all new Directors has been assessed in line with the new regulations; and declare to the CQC in writing that they are satisfied that they are fit and proper individuals for that role. The CQC may also	Compliant

[2] Regulated activities are listed in Schedule 1 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They are: 'Personal care'; 'Accommodation for persons who require nursing or personal care'; 'Accommodation for persons who require treatment for substance misuse'; 'Treatment of disease, disorder or injury'; 'Assessment or medical treatment for persons detained under the Mental Health Act 1983'; 'Surgical procedures'; 'Diagnostic and screening procedures'; 'Management of supply of blood and blood-derived products etc'; 'Transport services, triage and medical advice provided remotely'; 'Maternity and midwifery services'; 'Termination of pregnancies'; 'Services in slimming clinics'; 'Nursing care'; and 'Family planning services'. Any provider carrying on any of these activities in England must register with the Care Quality Commission.

[3] In determining whether a Director is "of good character", consideration should be given as to whether the person has been convicted in the UK of any offence; or whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

Condition	Evidence of Trust compliance / Commentary	Latest assessment
	ask the provider to check the fitness of existing Directors and provide the same assurance to them, where concerns about such Director come to the CQC's attention. Although the Regulations will not, strictly speaking, be applied retrospectively, the Trust will likely need to ensure current Board members meet the Regulations' requirements for being "fit and proper". The Trust Secretary is currently liaising with the Chairman and the Human Resources team to consider how best to respond to the new requirements. ~~A proposal to respond to the new Regulations has been submitted to the December Trust Board.~~ A proposed approach to the new Regulations was approved at the December 2014 Trust Board, and will be implemented in the coming weeks/months.	
G5 – Having regard to Monitor guidance – guidance exists or is being developed on: ▪ Monitors enforcement ▪ Monitors collection of cost information ▪ Choice and competition ▪ Commissioners rules ▪ Integrated Care ▪ Risk Assessment ▪ Commissioner requested services ▪ Operation of the risk pool	Monitor guidance is at varying degrees of progress through the consultation process. Trust response: **As an aspirant Foundation Trust, the guidance has not yet been fully reviewed and embedded. However the Trust will receive a summary of Monitor guidance requirements so that it can ensure compliance at a time appropriate to its foundation trust application trajectory.**	Not Compliant Compliant by 31/03/16
G7 – Registration with the Care Quality Commission	The Trust has full registration with the CQC. The Trust is registered to deliver the following regulated activities at both main hospital sites: ~~(i)~~ 'Treatment of disease, disorder ~~and~~ or injury'; ~~(ii)~~ 'Surgical procedures'; ~~(iii)~~ 'Diagnostic and screening procedures'; ~~(iv)~~ 'Maternity and midwifery services'; ~~(v) termination of pregnancy; (vi)~~ and 'Family planning'. In addition, the Trust is registered to undertake 'Termination of pregnancies' at Tunbridge Wells Hospital. ~~A recent application had been made to the CQC to amend the Trust's registration to reflect the fact that all these activities occur at both of the Trust's hospital sites (at present, (v) and (vi) do not apply to Maidstone Hospital. This application resulted in the CQC undertaking a site visit to Maidstone Hospital on 10th September. Following discussion with the CQC team on the day, it was agreed that the Trust would withdraw its request to register "Termination of Pregnancies" (this was always understood as an anticipated outcome, and does not cause any problems, as this service can still continue to be provided at Tunbridge Wells Hospital). For the "Family Planning" registration, the main CQC assessor will assemble his report alongside his two colleagues and progress with the application. The Trust has provided all information requested by the CQC regarding the application, and a decision is still awaited from the CQC.~~	Compliant
G8 – Patient eligibility and	The Referral and Treatment Criteria (RATC) which apply from 1st April 2014 are published on the West	Compliant

Condition	Evidence of Trust compliance / Commentary	Latest assessment
selection criteria (for services and accepting referrals) ▪ Criteria are transparent ▪ Criteria are published	Kent CCG website ("Kent and Medway clinical commissioning groups' (CCGs') [sic] schedule of policy statements for health care interventions, and referral and treatment criteria").	

Pricing conditions

Condition	Evidence of Trust compliance	Latest assessment
P1 – Recording of Information (about costs) to support the Monitor pricing function by the prompt submission of information	Trust response: **As an aspirant Foundation Trust, the requirement has not yet been fully reviewed and embedded. However the Trust will receive a summary of the Monitor pricing condition so that it can ensure compliance at a time appropriate to its foundation trust application trajectory** An action plan is required to ensure readiness to comply with all Monitor Pricing conditions at the required time (the Director of Finance will be responsible for leading on this).	Not Compliant *Compliant by 31/03/16*
P2 – **Provision of information** to Monitor about the cost of service provision	Trust response: **As an aspirant Foundation Trust, the requirement has not yet been fully reviewed and embedded. However the Trust will receive a summary of the Monitor information condition so that it can ensure compliance at a time appropriate to its foundation trust application trajectory**	Not Compliant Compliant by *31/03/16*
P3 – Assurance report on submissions to Monitor. To ensure that information is of high quality, Monitor may require Trusts to submit an assurance report	Trust response: **As an aspirant Foundation Trust, the requirement has not yet been fully reviewed and embedded. However the Trust will receive a summary of the Monitor assurance reporting condition so that it can ensure compliance at a time appropriate to its foundation trust application trajectory**	Not Compliant Compliant by *31/03/16*
P4 – Compliance with the national tariff (or to agree local prices in line with rules contained in the National tariff)	The Trust is compliant with the national tariff and where local tariffs are applied, are subject to negotiation and agreement with the CCG/Commissioners.	Compliant
P5 – Constructive engagement concerning local tariff modifications The aim is to encourage local agreement between commissioners and providers where it is uneconomical to provide a service at national tariff; thereby minimising Monitors need to set a modified tariff.	The Trust is compliant with the national tariff and where local tariffs are applied, are subject to negotiation and agreement with the CCG/Commissioners.	Compliant

Competition conditions

Condition	Evidence of Trust compliance	Latest assessment
C1 – Right of patients to make choices Providers must notify patients when they have a choice of provider, make information about services available, and not offer gifts/inducements for patient referrals. Choice would apply to both nationally determined and locally introduced patient choices of provider.	The Trust complies with the philosophy of patient choice, with regards to choice of provider. The Trust has not taken any actions to inhibit patient choice. The development of private patient services, the development of a birthing centre and the response to the KIMS private hospital are examples where the Trust has increased patient choice.	Compliant
C2 – Competition Oversight Providers cannot enter into agreements which may prevent, restrict or distort competition (against the interests of healthcare users).	The Trust does not seek to inhibit competition.	Compliant

Integrated care conditions

Condition	Evidence of Trust compliance	Latest assessment
IC1 – Provision of Integrated Care Trusts are prohibited from doing anything that could be regarded as detrimental to enabling integrated care. Actions must be in the best interests of patients.	The Trust seeks to become an integrated care provider and is in discussion with the CCG about integration initiatives. The Trust does nothing to inhibit integration and positively advocates it where integration is in the patient's best interests.	Compliant

Oversight Self Certification – Board Statements

Statement	Evidence of Trust compliance	Latest assessment
For clinical quality, that: 1. the Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	▪ The Trust's integrated performance dashboard is reviewed monthly and includes the TDA's "routine quality & governance indicators" ▪ A "Clinical Quality & Patient Safety Report" report is submitted to the Trust Board ▪ The Quality & Safety Committee, and its sub-committees, provides a focus on quality issues arising from Directorates. A summary of each Quality & Safety Committee meeting is reported to the Board ▪ The Patient Experience Committee provides a patient perspective and input ▪ The Chief Nurse, a Board member, is accountable for quality ▪ There are dedicated complaints and Serious Incidents (SI) management functions ▪ Ongoing conduct of Family and Friends Test is reported through the Trust performance dashboard ▪ Patient stories are heard at Trust Board meetings ▪ SI report summaries are circulated to all Board members ▪ Board member visits to wards and departments enable triangulation of quality and other performance indicators. Pairings of NED and Executive Board members, to further promote such visits, have now been issued. Board members also participate in the conduct of Care Assurance Audits ▪ Systems investment (e.g. Q-Pulse, Symbiotix, Dr Foster) supports effective quality information/data management ▪ Quality Accounts have been developed in liaison with stakeholders ▪ Quality Impact Assessments conducted on all CIP initiatives ▪ Priority of patient care reflected in Trust values & embedded in staff appraisal The independent assessment of the Trust's Quality Governance Framework has largely endorsed the Trust's self-assessment and gave a validated score of 3.5; an action plan has been drafted to	Compliant

Statement	Evidence of Trust compliance	Latest assessment
	achieve further improvements. Further improvements include: - strengthening the processes through which learning is shared and embedded has been recognised, and - developing further benchmarks to support the assurance & target setting process The latest CQC Intelligent Monitoring data was published by the CQC in December 2014. The Trust was not issued with a "Priority banding for inspection" because the Trust was "Recently Inspected". However, the overall risk score was 8 which approximately equates to a Band 4. The publication of the final report of the Trust's inspection by the Care Quality Commission in October 2014 is awaited.	
For clinical quality, that: 2. the board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements	The Trust has full registration with the CQC. ~~The Trust is registered to deliver the following regulated activities: (i) treatment of disease, disorder and injury; (ii) surgical procedures; (iii) diagnostic screening procedures; (iv) maternity and midwifery services; (v) termination of pregnancy; (vi) family planning. An application was made to the CQC to amend the Trust's registration to reflect the fact that all of these activities occur at both of the Trust's hospital sites (apart from (v) termination of pregnancy, which is only undertaken at Tunbridge Wells Hospital). This application has now been approved, which means that the "Family Planning" regulated activity can be carried out at Maidstone Hospital. The Trust's relevant pages on the CQC website have been updated to reflect the CQC's decision.~~ The Trust is registered to deliver the following regulated activities at both main hospital sites: 'Treatment of disease, disorder or injury'; 'Surgical procedures'; 'Diagnostic and screening procedures'; 'Maternity and midwifery services'; and 'Family planning'. In addition, the Trust is registered to undertake 'Termination of pregnancies' at Tunbridge Wells Hospital. A CQC inspection of Tunbridge Wells Hospital reported in January 2014 concluded 'moderate concerns' about the Management of Medicines and Staffing outcomes. Actions are underway to address the areas of concern identified by the inspection, and the latest position was reported to the Trust Management Executive on 17th	Compliant

Statement	Evidence of Trust compliance	Latest assessment
	September. A Care Quality Commission inspection of Maidstone Hospital was undertaken in February 2014. Actions are underway to address the areas of concern identified by the inspection, and the latest position was reported to the Trust Management Executive on 17th September. ~~The outcome of the inspection by the CQC's Chief Inspector of Hospitals in October 2014 is awaited.~~ The publication of the final report of the Trust's inspection by the Care Quality Commission in October 2014 is awaited.	
For clinical quality, that: 3. the board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	The Medical Director is the responsible officer for medical practitioner revalidation. The Trust Board in May 2014 received the 2013/14 Annual Report from the Responsible Officer, and approved a 'statement of compliance' confirming that the Trust, as a designated body, was in compliance with the regulations governing appraisal and revalidation.	Compliant
For finance, that: 4. the board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time	Trust response: The Trust reported a deficit for 2013/14 and the financial situation is under ongoing review with the TDA. The Trust was recently awarded £12m of non-recurrent funding by the TDA for 2014/15. The Trust continues to operate as a going concern.	Compliant
For governance, that 5. the board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times	The NTDA accountability framework aims to ensure that Trusts have a real focus on the quality of care provided. Under this framework, quality focus is achieved through: (i) Planning – the Trust conducts an annual process of service and budget planning and the Board reviews and agrees the IBP (ii) Oversight – the Trust participates fully in the oversight model (self-certification, review meetings) (iii) Escalation – The Trust welcomes support from the TDA and will cooperate fully with escalation decisions. The Trust, has fully engaged with a risk summit of performance issues (c.diff, surgical trainees, A&E) (iv) Development – the Trust will embrace the development model as appropriate. The Trust has committed to development programmes for (i) Board members; (ii) Executive team, (iii) Clinical Directors and (iv) General Managers/Matrons.	Compliant

Statement	Evidence of Trust compliance	Latest assessment
	(v) Approvals – the Trust is fully engaged in the FT application process and is awaiting dialogue with the TDA on the timetable towards authorisation. Trust values and priorities mirror the TDA's underpinning principles: ▪ local accountability – e.g. liaison with CCGs, Patient Experience Committee, patient satisfaction monitoring, whistleblowing & complaints management ▪ openness and transparency – e.g. embedded in Trust value on respect; duty of candour in Board Code of Conduct; open approach to Public Board meetings (which now take place each month) and both external &, internal communications channels; a growing membership ▪ making better care easy to achieve – the Trust's stated priority, above all things, is the provision of high quality & safe care to patients (Patient First). ▪ an integrated approach to business – the Trust has adopted an integrated governance approach including an integrated performance dashboard.	
For governance, that: 6. all current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.	See 5 above. In addition: ▪ The Trust monitors performance each month in accordance with the TDA Quality and Governance indicators. A Board Assurance Framework and Board level risk register, supported by an overall Risk management Policy, are established and scrutinised by accountable Executive Directors~~, and reported~~ ▪ Risks receive ongoing scrutiny and assurance ▪ Mitigating actions have agreed dates for delivery ▪ An annual Internal Audit plan is agreed and focuses on areas of key risk ▪ A professional Trust Secretary is employed ▪ A dedicated Risk Manager is employed ▪ The Trust fully participates in the TDA Oversight process ▪ The independent assessment of the BGAF & QGF was conducted in July 2013 and the positive results reported to the Trust Board in September 2013; a follow up review conducted in December 2103 re-affirmed the assessment.	Compliant

Statement	Evidence of Trust compliance	Latest assessment
For governance, that: 7. the board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance	See 6 above. In addition: All risks are RAG rated according to severity and likelihood; mitigating actions are monitored and reported. Key risks to the Trust's agreed objectives are reported via the Board Assurance Framework. The Trust Management Executive (EDs and CDs) is the designated risk management committee of the Trust and provides summary reports of its activity to the Trust Board.	Compliant
For governance, that: 8. the necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	The Board and its sub-committees are involved in the development of the Trust's annual plans, including specific aspects as required (financial, winter pressures, infection control, health and safety etc.). Key risks to the Trust's agreed objectives are reported via the Board Assurance Framework. The Audit and Governance Committee, like all Board committees, provides a report to the Board following each meeting which is presented by the Committee Chair (a NED). The Board is fully engaged to the development of the IBP and the Clinical Strategy that underpins it.	Compliant
For governance, that: 9. an Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	The Annual Governance Statement 2013/14 was agreed by the Trust Board in May 2014.	Compliant
For governance, that: 10. the Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward	Quality and governance indicators are monitored by the Board each month through the integrated performance dashboard. The Board is committed to achieving all targets and has set the vision of being in the best 20% of acute trusts nationally. The Trust is currently performing against the requirements of the NTDA oversight model.	Compliant
For governance, that: 11. the trust has achieved a minimum of Level 2 performance	The Trust has achieved IG toolkit level 2 for 2013/14	Compliant

Statement	Evidence of Trust compliance	Latest assessment
against the requirements of the Information Governance Toolkit		
For governance, that: 12. the board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.	A Trust Board Code of Conduct is in place which confirms the requirement to comply with the Nolan principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership. A register of interests is maintained and Board members are invited to declare any interests relevant to the agenda at the beginning of each Board meeting, and each Board sub-committee. A new Non-Executive Director commenced in September 2014, which means that all formal Board positions are now filled substantively.	Compliant
For governance, that: 13. the board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	▪ The composition and operation of the Board has been debated in Board development activity and a paper produced to enable the further review of Board composition when vacancies occur. ▪ A launch session for the Board development programme for 2014 took place in December 2013, facilitated by Hay Group; this will synchronise with separate Executive Director, Clinical Director, General Manager/Matron development programmes. ▪ The Remuneration Committee reviews the performance of Executive Directors. ▪ The TDA has conducted a review of the Trust Board. ▪ The Trust continues to adhere to the Oversight process ▪ A proposed approach to the new 'fit and proper persons' Regulations was approved at the December 2014 Trust Board, and will be implemented in the coming weeks/months	Compliant
For governance, that: 14. the board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan	▪ All Executive Director (and Clinical Director) positions are filled. ▪ The objectives of Executive Directors cascade from the Trust's corporate objectives which are agreed by the Trust Board. The Trust Board agreed the Trust's objectives for 2014/15 in September 2014, and agreed that these objectives should also apply for the 2015/16 year (subject to minor amendments regarding specific targets)	Compliant