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 25TH MARCH 2015

THE EDUCATION CENTRE, TUNBRIDGE WELLS HOSPITAL

A G E N D A – PART 1

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3-9	Response to the lessons to be learnt by the NHS from the Savile investigations	Director of Workforce and Communications	5	25-43
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3-18	Update on the implementation of the Kent Pathology Partnership (KPP)	Chief Operating Officer / Dir. of Inf. Prev. & Ctrl	Verbal	-
3-19	Approval of Full Business Case for the transformation of the procurement function	Director of Finance	14	109-179
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3-25	Senior Information Risk Owner update (incl. approval of the Info. Governance Toolkit submission for 2014/15)	Chief Nurse	20	188-192
3-26	Estates and Facilities Annual Report to Board	Chief Operating Officer	21	193-207
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3-29	**To consider any other business**			
3-30	**To receive any questions from members of the public**			
3-31	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 meeting: 29th April 2015, 10.30am, Education Centre, Tunbridge Wells 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 25TH FEBRUARY 2015, 10.30 A.M. AT MAIDSTONE HOSPITAL

DRAFT, FOR APPROVAL

Present:	Anthony Jones	Chairman (Chair)	(AJ)
	Avey Bhatia	Chief Nurse	(AB)
	Sylvia Denton	Non-Executive Director	(SD)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Alex King	Non-Executive Director	(AK)
	Steve Orpin	Director of Finance	(SO)
	Paul Sigston	Medical Director	(PS)
	Kevin Tallett	Non-Executive Director	(KT)
	Steve Tinton	Non-Executive Director	(ST)
In attendance:	Paul Bentley	Director of Workforce and Communications	(PB)
	Sara Mumford	Director of Infection Prevention and Control (from item 2-7 onwards)	(SM)
	Kevin Rowan	Trust Secretary	(KR)
	Stephen Smith	Associate Non-Executive Director	(SS)
	Eileen Wilcock	Patient relative (for item 2-10)	(EW)
	Mike Wilcock	Patient (for item 2-10)	(MW)
Observing:	Dorothy Wilby	PA to Medical Director and Director of Workforce and Communications (apart from items 2-9 and 2-12 to 2-20)	(DW)
	Annemieke Koper	Staff Side representative (apart from items 2-9 and 2-12 to 2-20)	(AKo)
	Darren Yates	Head of Communications	(DY)

2-1 To receive apologies for absence

There were no apologies.

2-2 To declare interests relevant to agenda items

There were no declarations of interest.

2-3 Minutes of the Part 1 meeting of 28th January 2015

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

2-4 To note progress with previous actions

The circulated report was noted. The following action was discussed in detail:

- **Item 12-7 ("Arrange for the Trust's plans in relation to workforce metrics on the Trust performance dashboard to be included within the "Plan/Limit" column"):** PB reported that the action was still in progress, and a draft would be submitted to the Workforce Committee on 06/03/14.

2-5 Chairman's report

AJ reported that a number of items on the agenda had arisen as a result of activity from the NHS nationally, including the NHS staff survey, the Care Quality Commission (CQC) inspection, and the annual planning process, including the impact of the current situation regarding the payment tariff. AJ added that in addition, some internal performance issues required discussion and debate.

AJ also highlighted that reports of Board members' visits to clinical areas had not been circulated recently and requested that Board members circulate a report of any visits they undertook.

2-6 Chief Executive's report

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

- The Trust's hospitals, and the wider NHS, had been very busy during the recent period
- The Trust was making investments towards the provision of "24/7" services, particularly in relation to Pharmacy
- The Trust had been awarded the contract for delivering sexual health services by Kent County Council. The service would be cross-county, in partnership with Kent and Medway NHS and Social Care Partnership Trust. GD encouraged Board members to meet with the staff in the service.

SDu noted the reference to the CQC inspection report, and asked for further details of the response from staff and external stakeholders. GD replied that external stakeholders had, in general, been disappointed with the report, as they expected the Trust to fare better. GD added that such external stakeholders were supportive of the Trust and of the efforts that would now be made to improve. GD continued that staff had a mixed reception; so for example, staff in the Maternity service were very pleased, whilst others recognised that improvements were required. GD added that he was however delighted to note that every department in the Trust had been rated as 'good' for Care.

KT then referred to the planned start of the Kent Pathology Partnership (KPP), and asked whether a set of success criteria existed to be able to judge whether KPP was ready. GD confirmed that this was the case, and AG added that a shadow KPP Board was scheduled to meet soon, to consider the state of readiness. GD pointed out that he had kept himself deliberately distant from much of the KPP-related work to date, to enable him to take a more independent view when chairing the KPP board. SO added that the Annual Business Plan for KPP was scheduled to be submitted to the March 2015 Finance Committee.

2-7 Integrated Performance Report for Jan 2015 (incorporating an update on recruitment & retention)

GD referred to the circulated report and highlighted that the key issues in January were the same as for December, and elaborated that the surge of non-elective activity had resulted in a large cohort of patients that had taken time to be treated and discharged. GD remarked that the statistics did not therefore reveal the whole situation.

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

- An urgent system review meeting was held in early January, to alert the Trust's external partners about the aforementioned cohort of patients (i.e. that such patients were expected to be discharged in late January, and would need community and Social Services support)
- The indicators used to measure patient acuity showed that patients had increased acuity, which adversely affected length of stay
- Early February data had indicated that acuity had remained at a higher level
- A community outbreak of influenza had occurred, which further limited Community capacity
- A&E 4-hour waiting time performance had been adversely affected by these issues, but there had been 3 weeks of improvement, and the year-end performance was expected to be 92.8%. The trajectory agreed with the NHS Trust Development Authority (TDA) was to achieve 95% for March 2015
- All Cancer targets had been met for quarter 3
- The aggregate 18 week-wait requirements had been met, although the Trust's backlog had increased, due to adverse impact of the aforementioned pressures on elective work. However, a plan had been agreed with the TDA to treat patients with longer waits in February

ST commended the performance achieved in January, and expressed his pride in being associated with the achievement, though noting that AG and her colleagues had undertaken the work. ST then asked about the impact on staff, noting that they were likely to be tired. PB replied that sickness

absence had increased but had now reduced, and Occupational Health resource had been enhanced, to provide support in terms of counselling, and also with back pain, particularly for nursing staff.

ST also asked about reliance on Bank staff. PB stated that a cap was in place regarding the number of hours that staff were allowed to work on the Bank, to ensure compliance with the relevant regulations.

AJ remarked that the Trust's situation demonstrated the size of the issue, in that the Trust's winter plans were only just adequate when compared to the pressures the Trust faced; and community capacity was insufficient. AJ clarified that his comments were not intended as a criticism, but illustrated the need to consider whether the Trust had adequate capacity to deal with the pressures it would face in the future. GD added that capacity was a key consideration, and in particular capacity at Tunbridge Wells Hospital (TWH).

KT stated that he believed the Trust's plan worked, but only marginally, and asked whether anything had arisen following the 'Board to Board' meeting with West Kent Clinical Commissioning Group (CCG) held on 27/01/15. KT also asked whether the external partners had responded well to the provision of the notice that AG had mentioned earlier.

GD stated that he believed that the Trust's plan had worked, but acknowledged that it was very close to breaking point. GD added that there was potential for the Trust to undertake additional activity, and therefore the need to create capacity, either in terms of acute or community capacity, was of paramount importance. GD also noted that external agencies did respond well to the notice given by AG, and added that the Trust had 'crossed a line', by funding a Social Worker, but highlighted that this kind of input was likely to increase in the future.

AG pointed out that the Trust had a Resilience Plan that had been tested through a number of scenarios, and every aspect of resilience was implemented. AG continued that the Plan was therefore resilient to a certain point, but the bronchopneumonia outbreak that occurred broke the barrier in terms of what could even be unreasonably expected. AG added that the lesson for the future was to consider worst case scenarios more readily, and also to aim to implement increased flexibility. PS pointed out that GPs were doing all they could during the recent pressures, and added that similar pressures were being faced by the health service in France.

AG then highlighted that there had been a breach of the 52-week wait standard in January. AG elaborated that the breach involved an Ophthalmology patient, and the Root Cause Analysis (RCA) had identified that this was caused by a genuine human error by one of the administrative staff. AG clarified that the patient had been treated. AJ asked whether any actions could be taken to prevent future occurrence. AG outlined some of the steps that had been implemented.

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

- Care and quality had been maintained during the recent periods of pressure, on a range of indicators, even with the number of additional beds open
- However, there were 3 occasions where Mixed Sex Accommodation breaches occurred, due to operational pressures. However, all were as a result of conscious decision-making

PS then referred to the circulated report and highlighted that crude mortality had increased in the last month, and was a reflection of the aforementioned pressures, but a similar situation had occurred at other comparable Trusts.

SM then reported that there had been 3 cases of Clostridium difficile in February, and 28 cases as at 25th February, but the rate remained low, relative to the high volume of clinical activity.

AJ commented that the "forecast" figure for Clostridium difficile was still listed as 35, although the year-end figure was expected to be lower. AJ also noted that the reported forecast of 75% for "Stroke:% to Stroke Unit <4hrs" performance was unlikely to be met, and asked for someone to undertake a 'sense check' of the data within the Performance report. The point was acknowledged.

SDu asked for an explanation of the apparent increase in Pressure Ulcers. AB replied that the cases involved were Grade 2 Ulcers, and not Grades 3 or 4. AB added that there had been an increase in Pressure Ulcers in the facial areas, related to non-invasive ventilation, and also on heels. AB gave assurance that action had been taken to address the increases, and clarified that none were related to, for example, patients waiting on trolleys.

AJ then noted that the response rate for the Friends and Family Test (FFT) was reducing, and asked for an explanation. GD and AB stated that this was likely to be a reflection of the aforementioned capacity issues, which were also reflected in the FFT scores.

AJ also commended the improvement in the percentage of patients receiving their Stroke care on a Stroke Unit.

SO then referred to the circulated report and highlighted the following points:
- In-month, there had been a surplus of £648k against a planned deficit of £384k
- Year to date, the Trust was slightly behind plan, by £200k
- Costs had been impacted significantly because of escalation pressures. There had also been an increase in consumables, and in temporary staffing costs
- An agreement had been reached with West Kent CCG for the remainder of 2014/15, which has enabled the impact on income to be mitigated. Therefore, the focus was now on maintaining cost control, as well as managing the Trust's activity portfolio
- The latest available data suggested that cost control was moving in the right direction
- Delivery of the Cost Improvement Programme (CIP) had been very good, and the year-end achievement will be higher than plan
- The cash position was expected to improve during March
- Capital expenditure had increased in month, but was behind the plan for year to date. There had been some slippage on IT and estates, but medical equipment purchases were being accelerated, as capital could not be carried forward into 2014/15

KT asked whether the capital slippage was planned or unplanned, and also asked for further details of the cash position. SO replied that the capital slippage was unplanned, but clarified that the slippage was in terms of weeks rather than months, and there had only been £700k of slippage on a £12m programme. SO also answered that a number of actions were being taken regarding the cash position, and there was now confidence that this would recover.

PB then referred to the circulated report and highlighted the following points:
- There had been a significant dependence on both Nursing Agency and Medical Locum staff during January
- Sickness absence had increased in December, but had reduced in January
- Staff turnover had reduced from the previous year

AJ asked for further details on the increase in Sickness absence. PB replied that such absence was divided almost equally between long term and short term sickness, and was affected by illnesses circulating in the community. AJ asked for details of the uptake on influenza vaccination. PB answered that this was 42% of front line staff, which was lower than the previous year.

PB then gave a presentation on the findings from the NHS Staff Survey 2014, and highlighted the following points:
- The presentation focused on the findings, whilst an action plan in response would be submitted to the Board in April 2015
- The findings had already been presented to the Trust Management Executive
- The survey took place whilst the CQC were undertaking their inspection, and also whilst there was sporadic industrial action. The survey was also a sample, and was not issued to all staff
- The Trust had a 51% response rate, which was in the highest 20% of acute Trusts
- Overall, the survey showed an improved set of results since the 2013 survey
- Of the 29 key findings, 16 were better than national average, 8 were average, and 5 were worse than average

- Of the 13 'at a glance' findings, 7 were better than average, 2 were average, and 4 were worse than average. The Trust had also improved on 9, stayed the same on 1 and reduced on 2 (the one other indicator was new)
- The Trust's top ranking scores included the percentage of staff in receipt of an appraisal
- The Trust's bottom ranking scores included the percentage of staff working extra hours (though this included staff who had been paid to undertake extra hours); the proportion of staff experiencing physical violence by other staff (a recurring theme); and diversity issues
- GD had emailed the findings to all staff on 24/02/15, and a more detailed report would be considered at the Workforce Committee on 05/03/15
- Nationally, findings have worsened, but the Trust had improved. This was therefore a good platform, which needed to be publicised; but there was also a need to emphasise the lower performing areas

KT referred to the need for overall engagement, and asked whether the survey gave more detailed information regarding this. PB stated that there was further detail available, but there also needed to be further meaningful discussions with staff.

AJ referred to the reported violence by staff, and queried whether the Trust's systems were able to identify the circumstances involved. PB replied that this was not possible via the staff survey, but the Trust's incident reporting system did enable such circumstances to be identified. PB did point out however that there had been a discrepancy between the survey findings and the number of reported incidents.

Additional quality items

2-8 Care Quality Commission inspection, October 2014

GD referred to the circulated report and highlighted the following points:
- The circulated report contained the public version of the inspection report
- A Quality Summit had been held on 29/01/15, which was supportive of the Trust and its efforts to improve
- Equality and diversity was a common theme in the report, and needed to be addressed
- By and large, the Trust had an engaged workforce, but there were concerns regarding not being able to raise incidents to the appropriate level. This needed to be addressed culturally, from the top of the organisation, and although the report recognised that this had started, it needed to be expedited
- Another theme that emerged were a number of problems related to Critical Care (although the report recognised that the outcomes from Critical Care were among the best)
- In addition, there was criticism of clinical leadership at Directorate level, which was regarded as being inconsistent. This inconsistency was also identified in terms of the application of clinical governance at local level, which required reflection and response.
- The Trust's Quality Improvement Plan (QIP) would be discussed further in the 'Part 2' (i.e. non-public) Board meeting being held later that day, and the construction of the QIP provided an opportunity to engage with staff.
- GD intended to publish the draft QIP later today, after the Board had discussed it, to seek the staff's involvement in its production
- The best response to the inspection and report would involve a cultural shift, and not just the completion of a series of actions

AJ commended the planned publication of the QIP to staff. ST reiterated that the Board's scrutiny of the draft QIP would take place within the 'Part 2' meeting to be held later that day.

SDu highlighted that the key issue that arose from the report was that the Critical Care department was not being run in accordance with the relevant core standards, and asked how the Board would be able to identify whether other departments were not meeting their respective core standards. GD acknowledged the point, and stated that the issue was not necessarily the lack of compliance with the core standards (as no other hospital in the South East had fully met the Core Standards for Intensive Care Units), but that the lack of compliance had not been documented, nor the mitigations discussed and accepted. GD stated that the issue was therefore a governance-related

failure. SDu asked what lessons needed to be learned from the experience, in terms of establishing whether other areas were meeting their respective core standards.

AJ said it was necessary to consider whether there was a proper flow of such information through to the Trust Board. GD replied that the opportunity existed for such issues to be raised, via the Directorate reports to the Quality & Safety Committee, but these opportunities had not been taken, and this was the flaw that would need to be addressed. GD added that each Executive Director had been paired with Directorates, and he had been paired with Critical Care, which would assist with efforts to resolve the aforementioned issues.

2-9 Planned & actual ward staffing for January 2015

AB referred to the circulated report and highlighted the following points:
- The report aimed to triangulate with the full range of available information
- Six areas were highlighted, including Foster Clark ward, for which risks were mitigated, and Pye Oliver ward, which had a higher level of Bank and agency staff

AJ commended the new report format.

SD asked for further details of the Ward that was supported by a Clinical Nurse Specialist (CNS), which were provided by AB.

2-10 A patient's experiences of the Trust's services

AJ welcomed MW and EW to the meeting and emphasised the Board's dismay at the incident that had affected MW. AJ repeated the apologies that MW had already received, and then asked MW to relay his experiences to the Board.

MW gave an introduction, noting that he was the subject of an incident that occurred during surgery at the Trust in September 2012. MW pointed out that he was Head of Operations at the Health and Safety Executive (HSE), and further stated he would be assuming that the sentencing remarks made by the Judge at the conclusion of the recent HSE's prosecution of the Trust had been seen by all Board members. MW added that he had deliberately distanced himself from the HSE's investigation into the incident, and he had further removed himself from involvement in any future decision-making by the HSE that was related to the Trust as much as possible. MW also made it clear that he was not present to cast blame on any individual; rather he hoped that the presentation would help the Trust learn and prevent future incidents.

MW then shared the details of his experience as follows:
- In September 2012, MW was admitted for an operation to remove a cyst from his left kidney. Prior to the surgery, MW was completely healthy, apart from the cyst
- The surgery had progressed well, but on waking after the operation, MW complained of a pain in his buttock. This was initially dismissed by staff, and MW then returned to sleep. Upon waking, MW again complained of a pain in his buttock, and could feel the area was wet and blistering. On this second occasion, a staff member examined the area, and confirmed that MW had suffered a burn. MW heard a member of staff remark 'there's a claim in that', and MW replied "Do you know what I do for a living?"
- The discovery of the burn resulted in what could be described as "all hell breaking loose"

EW then shared the details of her experience as follows:
- EW telephoned the ward to which MW was expected to be transferred after surgery, and upon discovering that MW was not there, asked ward staff whether there was any problem. The staff replied that they were unaware of any such problems, and EW asked the ward staff to contact her by telephone when MW arrived.
- EW was not telephoned but eventually returned to the ward, was told that MW had arrived, and was directed to his bed without any indication of the incident. EW found MW in obvious pain and was informed of his burn by MW himself. EW regarded the staff's failure to inform her as unprofessional.

- A doctor came to review MW in relation to the cyst operation, and commented on the burn that 'these things often look worse than they are'. The doctor also stated that a Specialist Burns Nurse would be asked to review MW the following morning.
- It was then found that MW had not been given pain relief prescribed, that the ice applied to the burn had melted, and there were problems finding extra ice – as "the place to get it was closed". However EW later learned that ice should not be applied to second and third degree burns
- EW left the hospital confused and feeling that there was a lack of urgency being shown by staff
- The following day, EW asked when she telephoned whether the Specialist Burns Nurse had been to see MW. The staff stated that they had no knowledge of this. The Specialist Burns Nurse had still not attended by the time EW arrived in the ward in the early afternoon.
- The Specialist Burns Nurse eventually came to review MW in the late afternoon, and undertook a depression test, to assess blood flow. The test showed that there was no blood flow, which meant the burn was severe. EW and MW were advised that more detailed tests would need to be undertaken at Queen Victoria Hospital (QVH) in East Grinstead. The Specialist Burns Nurse dressed the burn.
- EW informed the Specialist Burns Nurse that she had been expected to review MW that morning, but the Nurse stated that she had only been asked to review MW as she was about to leave the hospital i.e. almost in passing
- MW was discharged to enable him to travel to QVH. Some pain medication was provided, but none was provided for MW to take overnight, as staff stated that the hospital Pharmacy was closed
- The car journey to QVH was very stressful. EW regarded that staff had given very little thought to her or his safety during the journey, or the option of transferring MW by ambulance
- The following day at QVH, a full assessment concluded that MW's burns were 'full thickness' i.e. third degree, and further surgery was scheduled
- The care and level of engagement at QVH was in stark contrast to that provided at Maidstone and Tunbridge Wells NHS Trust (MTW). EW gave an example of the Surgeon waiting behind after their shift had ended to explain the surgery. In addition, QVH staff emphasised that they should be contacted at any time if they had any questions, however minor
- MTW staff telephoned EW every few days to ask how MW was doing, but EW regarded such contact as unhelpful, as this did not provide any practical support, although she did recognise that staff at MTW were clearly upset and concerned.
- EW felt that MTW staff were fearful of being open. MW's healthcare records were not sent to QVH for some time, and only took place after EW had pursued the matter. When the records did arrive, they were incomplete.
- EW recognised that individual staff members did care about MW's condition, but their telephone calls were unhelpful, and eventually staff were requested to stop making such calls
- No one was able to tell EW what happened on the day of the incident, despite requests to do so. In addition, MTW did not inform MW's GP of the incident

MW then continued, and highlighted the following:

- MW's second surgical procedure at QVH (i.e. his third surgery within a week) involved a cardiac event, which resulted in Angiography tests having to be performed at MTW. Although MW was pleased to be eventually told there was no underlying cardiac issue, two incidents occurred at MTW during that time which concerned MW.
- Firstly, after the first Angiography test, MW was not advised to avoid contact with children, due to the radiation involved in the test. MW was only advised of this when he attended for the second Angiography test, sometime later. In addition, MW was not provided with an explanation of the conclusion from the later Angiography tests.
- Secondly, during this time, MW discovered the healthcare records of another patient in the file with his own records. MW handed the records back to a staff member, who apologised and dealt with the matter professionally at the time.

MW then referred to the formal letter he received from the Trust, which although may have been legally "correct", was upsetting and impersonal. MW wondered if this reflected a fear by staff of individual litigation; however MW stated he had made it clear to GD and PS that he was not interested in placing the blame on any individual.

EW then referred to the aforementioned letter, which was sent in March 2013. EW stated that at that point, EW was providing regular care for MW, in terms of dressings, application of silicone gel, physiotherapy exercises etc. EW stated that such care took 4 hours each day, and added that MW was still in pain, was unable to drive, was awaiting the Angiogram, and was very tired and depressed. EW continued that MW had been told his recovery would be slow, and would take between 18 months and 2 years, and therefore at that stage, the future was filled with fear and uncertainty. EW stated that she was upset by the letter, as it appeared to state that the Trust accepted little or no responsibility for MW's injury. EW added that she did not understand how a hospital could be so insensitive to send such a letter to a person that they had injured.

MW then noted that he had still not been told the full details of what happened, in terms of the incident, or the cardiac event. MW added that the guilty plea made by the Trust following the HSE's prosecution meant that in order for MW to access the full reports, he had to make a Freedom of Information (FOI) Act request to the HSE, and they then needed to seek the Trust's permission to release the information. MW added that although he had now been provided with the HSE's internal report, a number of documents had not been provided. MW pointed out that the Trust had recently declined a request to disclose these documents, and this apparent unwillingness to be open had almost led to MW withdrawing his acceptance of the invitation to attend the Board meeting.

MW then concluded by expressing gratitude for the apologies that had been given in Court and at the meeting, and added that the manufacturers of the 'Hot Dog' equipment, Augustine Biomedical + Design, had sent MW a letter in which a number of allegations were made against the Trust. MW stated that he had provided the Trust with a copy of that letter, but clarified he would not be taking forward any of these allegations. MW contrasted his open approach to sharing this letter with MTW compared to the formal refusal to release papers as a result of his FOI request.

MW then highlighted that he did not want the incident to be forgotten by the Trust, and referred to the 2014 BBC Reith Lectures given by Dr Atul Gawande. MW noted that the Lectures referred to systematic check lists used by some hospitals, and queried whether this or a similar approach could be beneficial to MTW. MW clarified that he did not regard equipment-related issues to be the sole cause of the incident, and emphasised the importance of good safety culture in organisations as the primary driver of good health and safety performance. MW stated that there were disparities between the written records of the incident contained in his healthcare records, what was said in court and what he was told personally, and he wondered if this was a further indication that procedures and behaviours followed by some staff were what the Board expected. MW continued that humans tended to do what they think is right, and queried whether the Board was assured that their intentions and policies were applied as expected by Trust staff. MW referred to the concept of inversion of expected behaviours by staff within large organisations, and highlighted that tools existed to determine whether this was taking place in organisations and to measure levels of staff engagement and safety culture. MW closed by saying that he believed both staff and patients could play a powerful supportive role, and offered to be a patient advocate, if appropriate at a later date.

AJ again apologised on behalf of the Board for everything that had happened to MW, and invited comments from Board members.

KT stated that MW's story had been sobering, and left him annoyed and shocked. KT added that he had heard more detail about the events from MW than had previously been made known to him. ST concurred with KT's comments, and noted that MW had provided an insight which would be invaluable in assisting the Trust to address the issues raised by the incident, and its' aftermath.

PS remarked that he had noted a number of issues on which he would like to respond to MW, and the Board, and stated that he intended to do so in the near future.

GD remarked that culture was clearly important, and although this was not universally poor at the Trust, MW's experiences had clearly revealed some issues that needed to be addressed

GD then referred to the aforementioned FOI request and stated that he was content to provide MW with any information he wished to see, adding that the refusal of the request was most likely related to the complexities of the FOI process, rather than a desire to prevent disclosure.

[Post-meeting note: MW has subsequently requested that GD provide the Trust's final investigation report of the incident]

MW then pointed out that a Safety Climate tool was available, which would enable the safety climate at the Trust to be measured and would probably confirm that culture was better in some areas or departments compared to others but could help a Board prioritise their actions. MW also referred to the Institute of Directors' publications regarding the duties and responsibilities of Directors, and stated that he was aware that the Institute would be willing to work with the Trust to assist in increasing such understanding. MW also referred to the concept of 'crucial conversations', and illustrated this with an example. MW added that he had identified a number of critical points that could assist the Trust, and stated he could provide further details of these to PS.

[Post-meeting note: MW gave a copy of the critical points to AJ, GD and PS after the meeting]

AJ stated that although he did not believe MW's experiences to be typical, they clearly indicated that the Trust had issues that needed to be addressed. AJ added that further contact would continue to be made with MW, primarily via PS, but also probably by himself and GD. AJ also gave assurances that efforts would be made to prevent a similar incident from occurring. EW stated that this was a very important consideration.

KR confirmed that he would provide a draft of the minute of the agenda item to MW, to confirm its accuracy. AJ added that he wished for a detailed note of the discussions to be provided to Board members.

AJ thanked EW and MW for attending the Trust Board.

2-11 Medical Devices – details of improvements and latest purchases

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

- A number of changes had been implemented since the incident
- The Medical Devices Group did now report to the Standards Committee
- The report outlined details of some of the devices that were being processed at present

AJ asked for assurance that every piece of equipment was now processed in accordance with the Trust's medical devices policy. PS replied that local Departments would no longer be able to purchase equipment in the way that some equipment had been purchased previously. AJ asked for further clarification that no equipment would be purchased without the knowledge or endorsement of the Medical Devices Group. SO replied that the Procurement department had been told to ensure that any equipment purchases were undertaken with the knowledge of the Electro-Medical Engineering (EME) department. SO added that it had been made more difficult to purchase equipment without the knowledge of the Procurement department, noting that there had been examples of some such purchases that had been made. SO elaborated that this would change in the future, as part of the wider strategy to improve procurement processes.

KT remarked that the system sounded like it was dependent on the behaviour of a number of parties, and noted that it should be recognised that retrospective purchase orders existed in the Trust, as was the case with most large organisations. KT also remarked that the Trust should consider engaging an external review, by an organisation such as DuPont, to provide the assurance that AJ was seeking. AJ stated that he had previously suggested that University Hospital Southampton Foundation Trust be approached, to establish details of their own systems. AJ proposed that PS seek the views of other organisations. This was agreed.

Action: Seek the views of other organisations in relation to the management (including procurement) of medical devices (Medical Director, February 2015 onwards)

Board Members were asked to consider whether they wished to receive further updates on medical devices purchases, and if so, at which frequency. It was agreed that details of medical device

purchases did not need to be received by the Board in the future, but that the Board should receive a further report, outlining PS's conclusions from the aforementioned action.

Action: Submit a report to a future Trust Board meeting containing the conclusions arising from the liaison with other organisations in relation to the management of medical devices (Medical Director, TBC)

Planning and Strategy

2-12 Update on the Trust's planning submissions, 2015/16 (including approval of the latest submission to the NHS Trust Development Authority)

SO reported that the initial planning timetable required a financial (and other matters) submission by 27/02/15, but as problems had arisen regarding the national tariff, the February submission of the financial plan had been withdrawn, and therefore only activity plans were required to be submitted by 27/02/15. SO added that the next detailed submissions would be due in April and May i.e. within a week of the March and April 2015 Board meetings respectively.

It was noted that this item would be discussed further during the 'Part 2' Board meeting scheduled for later that day.

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

2-13 Audit and Governance Committee, 12/02/15

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

- The Board was being asked to agree to the role of the Audit and Governance Committee in overseeing the Board Assurance Framework
- The Committee was concerned at the limited assurance conclusion regarding Consultant Job Planning, which was the fourth time in succession that such a conclusion had been reached

AJ asked about the nature of the limited assurance conclusion. KT stated that this related to the inability to access the relevant completed documentation.

PS stated that he was responding to the concerns raised by Internal Audit and offered to submit a report to the next Audit and Governance Committee. This was agreed.

Action: Submit a report to the next Audit and Governance Committee responding to the concerns arising from the latest Internal Audit review of Consultant Job Planning (Medical Director, May 2015)

ST highlighted that he had expressed his views at the Committee that the Trust's Risk Management processes were not fit for purpose. KR outlined that although ST had made such points at the Committee, contrary views had also been expressed. KR also highlighted that the Trust's External Auditor had identified that if the Board genuinely felt that the Board Assurance Framework (BAF) and Risk Management processes were not fit for purpose, this would need to be explicitly identified within the Trust's annual Governance Statement. KR added that he did not agree with ST's assertions regarding the efficacy of such processes. AJ clarified that the matters being debated related to the need to continually improve the processes, and he therefore would not expect any issues needing to be identified within the Governance Statement for 2014/15. The clarification was acknowledged.

PB then referred to the proposed role of the Audit and Governance Committee in inviting Executive Directors to attend to discuss the management of the risks to objectives on the BAF. KT agreed that this step would need to be re-considered in the light of the aforementioned debate regarding the Trust's risk management process.

2-14 Trust Management Executive, 18/02/15

GD referred to the circulated report and highlighted that an update on the Southern Acute Programme (SAcP) had been given.

AJ asked for details of the Trust's Reference Cost Index. SO replied that this was 101 and added that the details were discussed at the Finance Committee in January 2015.

2-15 Finance Committee, 23/02/15

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

Assurance and policy

2-16 Approval of compliance oversight self-certification

KR referred to the circulated report and directed attention towards Board statement 10. The Board confirmed that a compliance status of "Yes" was appropriate for the statement, on the basis that the Trust's plans were sufficient to deliver the 4-hour A&E waiting time target, even though the target would not actually be met.

The remainder of the submission was approved as circulated.

2-17 Trust response to the "Freedom to Speak Up" review

PB referred to the circulated report and invited comments on the recommendations being proposed.

The recommendations within the report were agreed, but AJ highlighted that the personnel within the identified roles could be changed, should more specific guidance be received in the future. The point was acknowledged.

2-18 To consider any other business

SD referred to an email exchange regarding an internal Safety Alert pertaining to the traceability of an infusion device following a recent incident. SD stated that she was concerned that a faulty device was now in circulation. PS replied that he understood that the faulty device had been identified, but the Alert was highlighting the fact that the EME department had to review all devices in order to identify the faulty device, as a result of the faulty device not being properly identified on the incident report. SD asked for confirmation that the incident had therefore been addressed. PS gave such assurance.

2-19 To receive any questions from members of the public

There were no questions, but AJ highlighted that a negative letter had been published in the local press that made some inaccurate statements regarding the Trust, and in particular an inaccurate claim that staff who had been commended in the CQC report had not been thanked. DY agreed to review the letter, and consider whether a response from the Trust was warranted. KT suggested that posting a message on the Trust's website may be more appropriate. DY agreed to consider the suggestion.

2-20 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 – March 2015

3-4 Log of outstanding actions from previous meetings — Chairman

Actions due and still 'open'

Ref.	Action	Person responsible	Deadline	Progress [1]
2-11 (Feb 15)	Seek the views of other organisations in relation to the management (including procurement) of medical devices	Medical Director	February 2015 onwards	The issue will be discussed via a Medical Directors' network meeting on 19/03/15
2-11 (Feb 15)	Submit a report to a future Trust Board meeting containing the conclusions arising from the liaison with other organisations in relation to the management of medical devices	Medical Director	TBC	A report will be submitted to the Trust Board in April 2015, following the outcome of the discussions at the Medical Directors' network meeting on 19/03/15 (see above)
2-13 (Feb 15)	Submit a report to the next Audit and Governance Committee responding to the concerns arising from the latest Internal Audit review of Consultant Job Planning	Medical Director	May 2015	The item/report has been scheduled for the Audit and Governance Committee on 6th May

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
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	A draft workforce dashboard was discussed at the Workforce Committee on 06/03/14, and this will be incorporated into the Integrated Performance Dashboard for the 2015/16 year

Actions not yet due (and still 'open')

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

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - March 2015

3-6	Chief Executive's update	Chief Executive

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

1. I visited a number of wards and departments this month as part of my informal meetings with colleagues throughout MTW. These included Wards 10 and 11, pharmacy, theatres, outpatients, surgical assessment, admissions and critical care. I met with our directorate clinical leads and senior managers as part of my planned meetings to discuss patient experience and key objectives. This collectively continues to be a valuable means of assessing our performance and ensuring we understand and address our staff and patient needs.
2. I attended a meeting at Kent County Council attended by Simon Stevens, Chief Executive of the NHS. The meeting brought together Kent's healthcare providers and showcased some of our collective work, and lead role we play, in providing patients with integrated health services.
3. We have given members of Kent County Council Health Overview and Scrutiny Committee an update on our clinical strategy, Care Quality Commission (CQC) rating and on-going work to improve stroke services for patients in the south of West Kent and north East Sussex.
   - We have submitted plans to the CQC outlining the positive changes we are making for our patients in areas where we do not consistently achieve the same high standards that are visible in other areas of our Trust. The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015 have introduced a new "Requirement…to display…performance assessments". From 1st April 2015, any provider in receipt of ratings from the CQC must display them in: their main place of business; on their website; and in all premises where a 'regulated activity' is being delivered (this includes, for example, premises from which occasional clinics are provided). The most up-to-date ratings must be displayed. We see the inspections as a positive opportunity to showcase excellence, and help identify and drive through changes for the better. It is important this context is reflected in our ratings, to provide patient and public confidence. The Communications & Governance teams will ensure compliance with the new requirement, which will involve posters of the Trust's ratings being displayed at circa 13 locations.
   - Ensuring we understand and meet people's changing health needs is crucial as demand for NHS services increases and changes shape to reflect a more elderly population. Jim Lusby joins us at the end of April as Deputy Chief Executive concentrating on the development of our Clinical Strategy. He takes over the role Jayne Black fulfilled before she left. Sarah Overton also joins us as Head of Strategy. They have an absolute focus on ensuring we shape the best possible future for MTW in-line with our patients' needs and clinical views.
   - Our clinicians are now supporting a wider review of stroke services in Kent and Medway. We started to review our stroke services in 2014 to improve outcomes for patients. This work will now form part of the wider Kent and Medway review. We will continue to seek improvements to our services while the review is carried out.
4. The results of the 12th annual national Staff Survey were in the main positive for MTW and reflect on-going improvements. We now outperform the national average in 16 out of 29 key findings, and have seven areas where we are in the top 20% of best performing trusts in the country. Our picture is very much one of overall improvement and includes an increase in the number of our colleagues who would recommend MTW as a place to work and if necessary receive treatment (again outperforming the national average in this area).
5. We are implementing further phases of our ward improvement plans at Maidstone Hospital. This is a significant investment of £3m and will lead to improvements in privacy and dignity.

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 – March 2015

3-7	**Integrated Performance Report for February 2015** (incorporating an update on recruitment and retention)	**Chief Executive**

Although attendances and emergency admissions are similar to last year's levels, we have continued to see an increase in the age and acuity of patients admitted. This is reflected both by a longer length of stay overall, a high bed occupancy rate but a much reduced level of zero length of stay activity. The reduction in zero length of stay demonstrates effective interventions in A&E not to admit patients who don't need to be and can be managed through another pathway. A key contribution to the current poor performance on the A&E 4 hour standard is the increase in the level of delayed transfer of care and medically fit for discharge patients who remain in acute beds. This has been escalated within the system and clear actions are in place to manage the issue on an on-going basis.

Unfortunately a 12 hour trolley breach occurred in February on the Maidstone site, which involved an expected haematology patient who although was seen appropriately, had investigations undertaken and was allocated an appropriate bed, the communication between, A&E, the site team and the medical team failed to reconcile to facilitate the patient's move in time. The case is being investigated under the serious incident process, but the patient was cared for appropriately in a side room during her time in A&E.

During February we increased our elective and day case activity compared to previous months, achieved the RTT aggregate total and reduced the overall backlog of over 18 week waiters to 524 (39 less than the January total).

We have also now had 2 x 52 week breaches of the elective waiting time standard, both involving issues with the administration processes in ophthalmology which are being reviewed and addressed. Both patients were awaiting routine procedures and their health was not adversely affected by the longer wait.

In relation to the workforce, the month saw a continued reliance on temporary staff, in both medical and nursing. This is a reflection of the continued levels of escalation and an increase in the establishment of the Trust (c2.5% year on year). Whilst we have increased the numbers of substantive staff throughout the year, we have not been able to keep pace with the establishment increase, this is a reflection of some national shortages in some professional groups and some groups where geographical factors mitigate against the Trust in filling posts. As previously debated by the Board a set of initiatives to improve recruitment and retention are in place. The retention-based ones are improving with a significant reduction during the year. As anticipated during the February Board meeting, sickness absence levels for January showed a reduction of c.1%.

The enclosed report 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, 17/03/15

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

TRUST PERFORMANCE DASHBOARD **Position as at:** **28th February 2015**

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 Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
'1-01	Hospital-level Mortality Indicator (SHMI)	Prev Yr: July 12 to June 13		100.3	101.5	1.2	1.5	*100*		100
'1-02	Standardised Mortality (Relative Risk)	Prev Yr: April 13 to Mar 14		104.2	103.9	-0.3	3.9	*100*		100
'1-03	Crude Mortality	1.3%	1.2%	1.3%	1.3%	0.0%				
'1-04	Safety Thermometer % of Harm Free Care	97.2%	97.8%	95.3%	96.6%		1.6%	95.0%		0.0%
'1-05	*Rate C-Diff (Hospital only)	11.0	20.5	15.7	13.7	-2.1	-3.8	*15.7*	15.1	15.7
'1-06	Number of cases C.Difficile (Hospital)	2	4	32	29	-3.0	-8.0	*35*	35	35
'1-07	Number of cases MRSA (Hospital)	1	0	3	1	-2	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%	99.0%	95.0%	99.0%		4.0%	95.0%	99.0%	
'1-10	**Rate of Hospital Pressure Ulcers	1.6	2.1	2.4	2.3	-0.1	-0.7	*3.0*	2.3	3.0
'1-11	****Rate of Total Patient Falls	7.5	6.36	7.2	6.2	-1.0	-0.5	6.75	6.2	
'1-12	****Rate of Total Patient Falls Maidstone	6.1	5.82	6.3	5.1	-1.2	-1.6	6.75	5.1	
'1-13	****Rate of Total Patient Falls Tunbridge Wells	8.7	6.76	7.9	7.0	-0.9	0.3	6.75	7.0	
'1-14	Falls - SIs in month		3		31	31				
'1-15	MSA Breaches	0	0	10	68	58	68	0	68	
'1-16	Total No of SIs Open with MTW	21	21			0				
'1-17	Number of New SIs in month	12	10	120	102	-18	-8			
'1-18	Number of Never Events	0	0	1	2	1	2	*0*	2	
'1-19	Number of CAS Alerts Overdue	9	0			-9	0	*0*		
'1-20	*****Readmissions <30 days: Emergency	11.6%	10.9%	11.2%	11.6%	0.4%	-2.0%	*13.6%*	11.6%	14.1%
'1-21	*****Readmissions <30 days: Elective	4.6%	5.0%	5.7%	5.5%	-0.2%	-0.8%	*6.3%*	5.5%	6.8%
'1-22	***Rate of New Complaints	3.6	5.15	5.0	4.10	-0.9	-2.16	*6.26*	4.11	6.26
'1-23	% complaints responded to within target	79.1%	75.0%	57.8%	67.9%	10.0%	-7.1%	75.0%	68.5%	
'1-24	IP Resp Rate Recmd to Friends & Family	16.2%	39.4%	17.3%	40.6%	23.3%	10.6%	**30% Q4**	40.4%	36.1%
'1-25	A&E Resp Rate Recmd to Friends & Family	10.8%	18.0%	4.5%	18.2%	13.6%	-1.8%	**20% Q4**	18.1%	20.1%
'1-26	Mat Resp Rate Recmd to Friends & Family	New	15.4%	New	18.7%	New	-1.3%	15%	18.7%	22.9%
'1-27	IP Friends & Family (FFT) Score	77	74	76	77	1	5	72	77	72
'1-28	A&E Friends & Family (FFT) Score	68	60	66	63	-3	6	57	63	57
'1-29	Maternity Combined Q1 to Q4 FFT Score	New	92	New	84	New	12	72	84	72
'1-30	Five Key Questions Local Patient Survey	91.8%	88.0%			-3.8%		90%	88.0%	
'1-31	VTE Risk Assessment	95.3%	95.5%	95.3%	95.2%	0.0%	0.2%	95%	95.2%	95%
'1-32	% Dementia Screening	98.5%	97.1%	99.0%	98.6%	-0.3%	8.6%	90%	98.6%	
'1-33	% TIA with high risk treated <24hrs (Dec)	80.0%	No data	63.6%	75.2%			60%	75.2%	
'1-34	% spending 90% time on Stroke Ward (Jan)	82.1%	82.9%	76.4%	83.3%	7.0%	3.3%	80%	80.1%	
'1-35	Stroke:% to Stroke Unit <4hrs (Jan)	New	28.3%	New	39.0%	New	New	55.0%	39.0%	
'1-36	Stroke: % scanned <1hr of arrival (Jan)	New	52.8%	New	43.4%	New	New	43.0%	43.4%	
'1-37	Stroke:% assessed by Cons <24hrs (Jan)	New	70.4%	New	73.7%	New	New	85.0%	73.7%	

Responsible Committee: Finance, Treasury & Investment

	Finance & Efficiency	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Average LOS Elective	2.9	2.8	3.3	3.2	-0.1	-0.1	*3.3*	3.3	3.3
3-02	Average LOS Non-Elective	6.6	7.5	6.8	6.9	0.0	1.2	*5.7*	6.8	5.7
3-03	New:FU Ratio	1.62	1.62	1.71	1.54	-0.17	0.03	*1.52*	1.52	
3-04	Day Case Rates	81.6%	83.1%	79.8%	83.6%	3.9%	3.6%	80.0%	80.0%	82.19%

	Finance & Efficiency	Latest Month *Plan*	Latest Month Curr Yr	Year to Date *Plan*	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan	Year End Forecast	Bench Mark
3-05	Income	29,788	33,507	347,990	363,750	6.1%	4.5%	380,127	399,764	
3-06	EBITDA	1,169	1,955	21,236	30,302	41.7%	42.7%	24,718	34,800	
3-07	Surplus (Deficit) against B/E Duty	(1,903)	(898)	(12,570)	(1,710)			(12,303)	5	
3-08	CIP Savings	2,119	1,736	20,301	21,679	17.0%	6.8%	22,400	23,492	
3-09	Cash Balance	10,235	20,371	10,235	20,371	240.8%	99.0%	926	926	
3-10	Capital Expenditure	0	542	13,131	5,533	-27.4%	-57.9%	*16,683*	13,386	
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.

Responsible Committee: Finance, Treasury & Investment

	Performance & Activity	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	**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)	95.1%	88.0%	95.5%	92.2%	-3.3%	-2.8%	95%	92.5%	94.6%
2-03	Emergency A&E >12hr to Admission	0	1	0	2	2	2	0	2	
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%	90.2%	91.8%	91.5%	-0.3%	1.5%	90%	90.0%	
2-07	18 week RTT - non admitted patients	96.7%	97.9%	96.6%	96.9%	0.3%	1.9%	95%	95.0%	
2-08	18 week RTT - Incomplete Pathways	93.3%	96.6%	93.3%	96.6%	3.3%	4.6%	92%	92.0%	
2-09	18 week RTT - Specialties not achieved	3	7	31	26	-5	26	*0*	26	
2-10	18 week RTT - 52wk Waiters	0	1	0	2	2	2	*0*	2	
2-11	18 week RTT - Backlog 18wk Waiters	847	524	847	524				500	
2-12	% Diagnostics Tests WTimes <6wks	100.0%	99.87%	100.0%	99.96%	0.0%	1.0%	99.0%	99.96%	
2-13	Cancer WTimes - Indicators achieved	8	6	9	8	-1	-1	9	8	
2-14	*Cancer two week wait	94.7%	95.5%	94.7%	96.1%	1.4%	3.1%	93%	93.0%	95.5%
2-15	*Cancer two week wait-Breast Symptoms	89.0%	94.4%	89.0%	94.6%	5.6%	1.6%	93%	93.0%	
2-16	*Cancer 31 day wait - First Treatment	98.5%	97.8%	98.5%	98.3%	-0.2%	2.3%	96%	96.0%	98.4%
2-17	*Cancer 62 day wait - First Definitive	86.6%	75.9%	86.6%	82.5%	-4.1%	-2.5%	85%	82.0%	87.1%
2-18	Delayed Transfers of Care	3.9%	4.3%	3.2%	4.0%	0.8%	0.5%	3.5%	4.0%	
2-19	Primary Referrals	7,919	8,180	86,381	85,038	-1.6%	0.0%	93,129	102,382	
2-20	Cons to Cons Referrals	3,138	2,937	39,295	33,990	-13.5%	-12.3%	42,433	40,752	
2-21	First OP Activity	12,538	10,285	134,503	130,856	-2.7%	5.7%	135,344	143,318	
2-22	Subsequent OP Activity	21,235	18,695	231,041	236,455	2.3%	3.5%	250,125	258,975	
2-23	Elective IP Activity	627	647	8,069	7,011	-13.1%	-20.4%	9,584	7,679	
2-24	Elective DC Activity	2,682	3,040	31,325	34,111	8.9%	-3.5%	38,602	37,360	
2-25	Non-Elective Activity	3,817	3,557	42,522	43,160	1.5%	3.9%	*45,404*	47,166	
2-26	A&E Attendances (Calendar Mth)	9,409	9,549	113,970	119,458	4.8%	4.3%	*125,139*	130,545	
2-27	Oncology Fractions	5,252	5,381	61,217	64,060	4.6%	3.1%	67,876	70,006	
2-28	No of Births (Mothers Delivered)	415	421	4,917	5,201	5.8%	6.9%	5,310	5,674	
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)	26.5%	27.6%	25.6%	27.4%	1.8%	2.4%	25.0%	25.0%	
2-31	% Mothers initiating breastfeeding	83.4%	80.5%	82.2%	81.5%	-0.7%	3.5%	78.0%	81.5%	
2-32	Intra partum stillbirths Rate (%)	0.0%	0.0%	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.

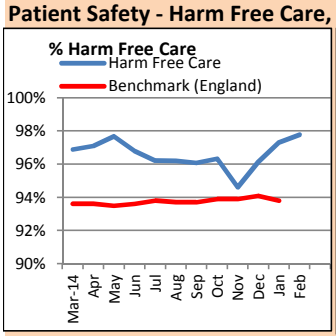
Responsible Committee: Workforce

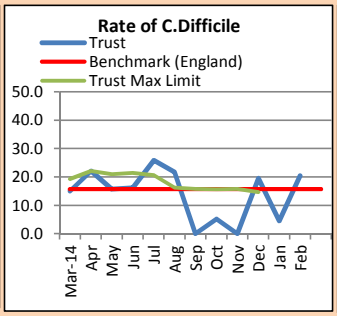
* Stroke & CWT run one mth behind, *** Ambulance Handover is unvalidated

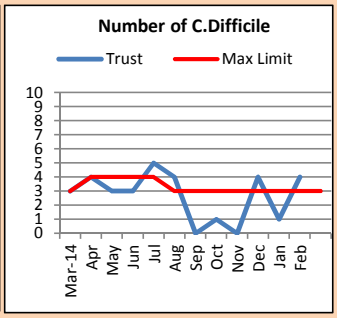
	Workforce	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ Limit	Year End Forecast	Bench Mark
4-01	Establishment (Budget WTE)	5,365.2	5,493.2	5,365.2	5,493.2	2.4%	0.0%	*5,490.5*	5,490.5	
4-02	Contracted WTE	4,974.9	4,981.5	4,974.9	4,981.5	0.1%	-5.5%	*5,271.5*		
4-03	**Contracted not worked WTE		0.0		0.0					
4-04	Locum Staff (WTE)	21.4	20.1	21.4	20.1	-6.0%				
4-05	Bank Staff (WTE)	226.2	279.1	226.2	279.1	23.4%				
4-06	Agency Staff (WTE)	113.8	211.8	113.8	211.8	86.1%				
4-07	Overtime (WTE)	59.0	72.4	59.0	72.4	22.8%				
4-08	Worked Staff WTE	5,285.6	5,494.9	5,285.6	5,494.9	4.0%	-0.9%	*5,536.7*		
4-09	Vacancies WTE	390.3	511.7	390.3	511.7	31.1%			539.6	
4-10	Vacancy %	7.3%	9.3%	7.3%	9.3%	28.1%			9.8%	
4-11	Nurse Agency Spend	(275)	(595)	(3,733)	(5,035)	34.9%			(5,650)	
4-12	Medical Locum & Agency Spend	(691)	(849)	(7,367)	(9,174)	24.5%			(10,054)	
4-13	Staff Turnover Rate	11.1%	8.6%		9.32%	-2.5%	-1.9%	*10.5%*	9.32%	8.4%
4-14	Sickness Absence	3.8%	4.2%		4.1%	0.4%	0.9%	*3.3%*	4.1%	3.7%
4-15	Statutory and Mandatory Training	86.7%	84.7%		84.7%	-2.0%	-0.3%	85.0%	85.0%	
4-16	Appraisals	82.4%	80.6%	76.3%	80.6%	-1.8%	-9.4%	90.0%	85.0%	

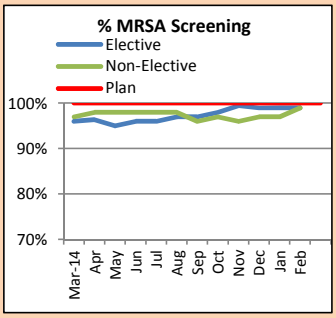
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

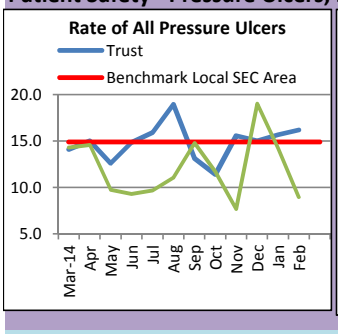


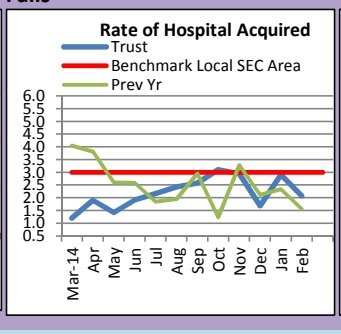


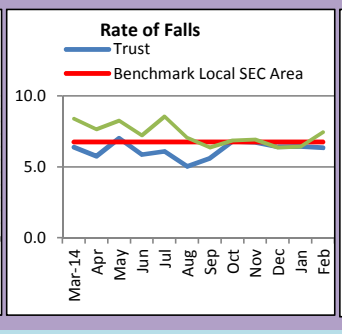


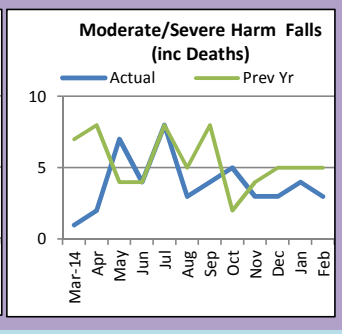


Patient Safety - Pressure Ulcers, Falls

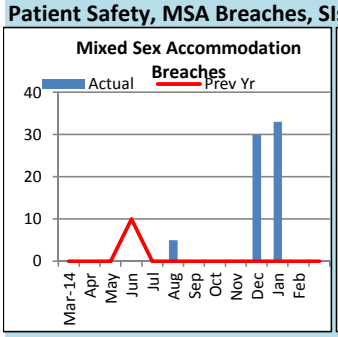


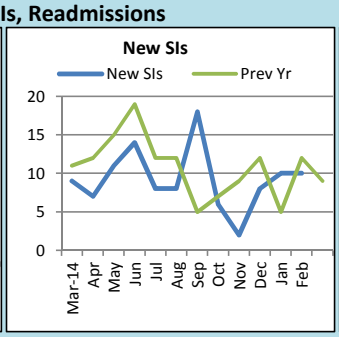


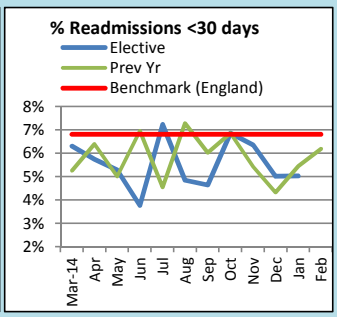


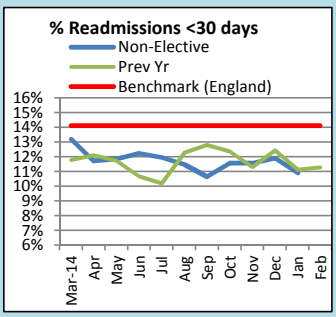


Patient Safety, MSA Breaches, SIs, Readmissions

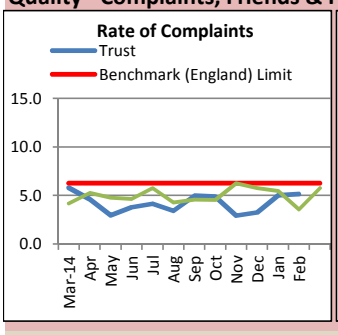


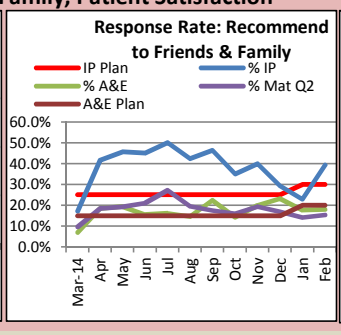


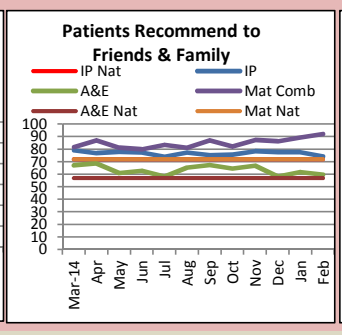


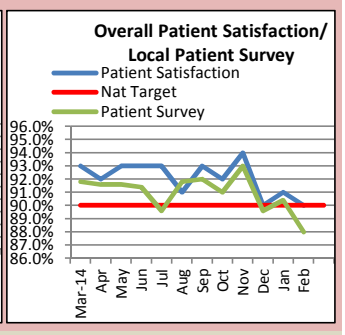


Quality - Complaints, Friends & Family, Patient Satisfaction

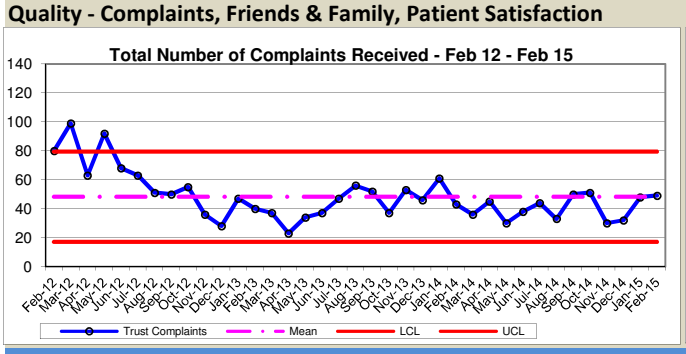


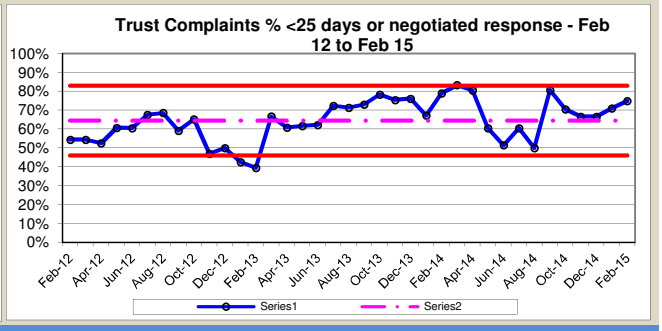




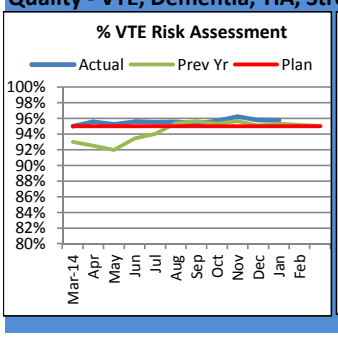


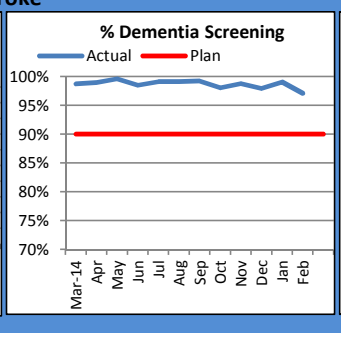
Quality - Complaints, Friends & Family, Patient Satisfaction

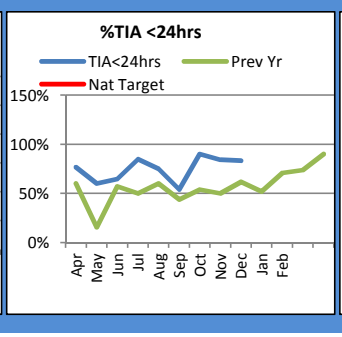


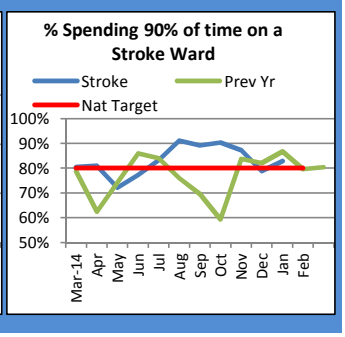


Quality - VTE, Dementia, TIA, Stroke



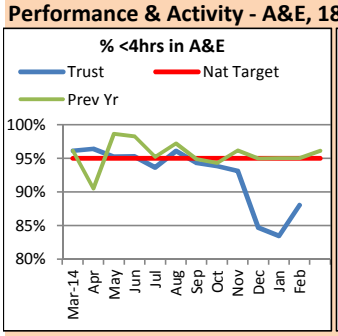


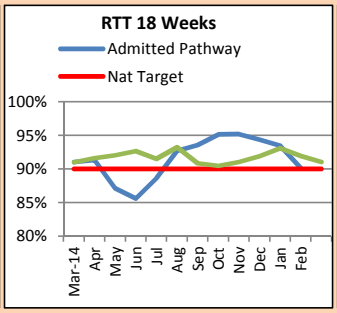


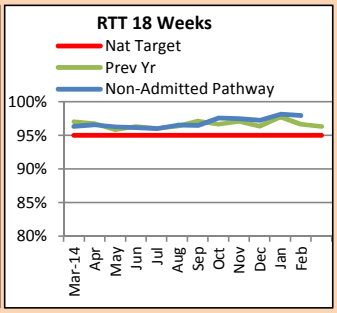


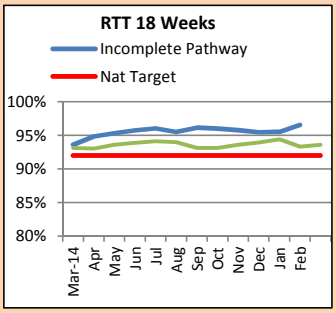
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

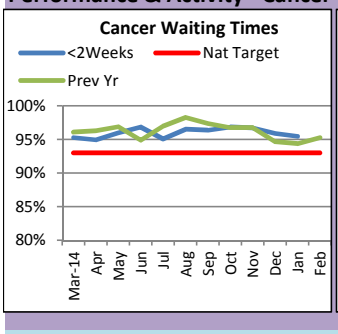


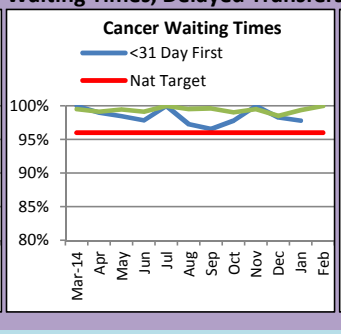


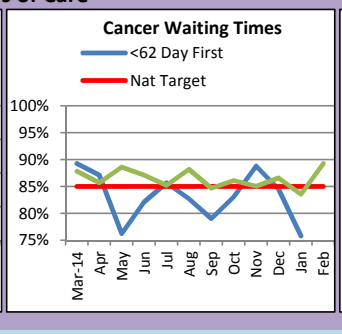


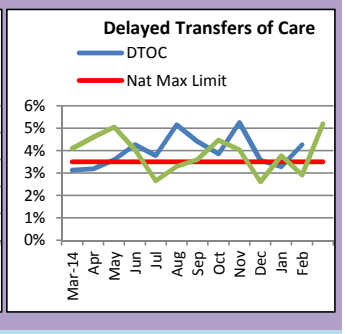


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

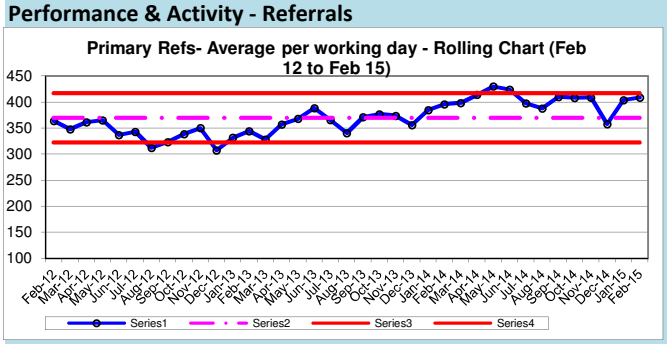


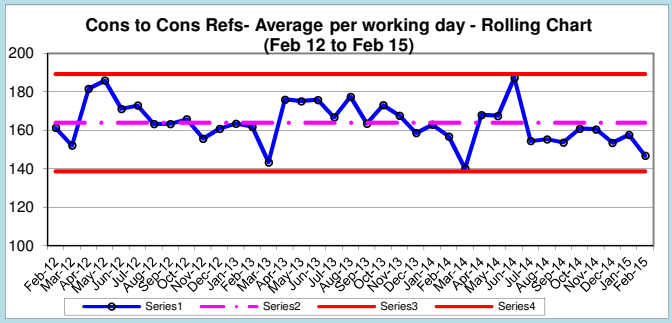




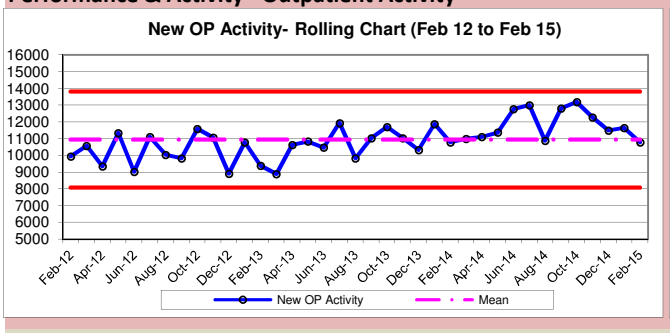


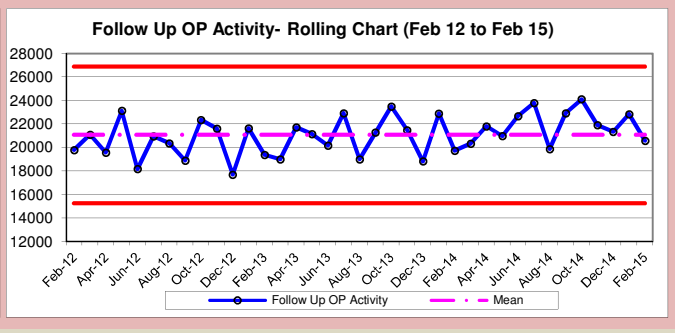
Performance & Activity - Referrals



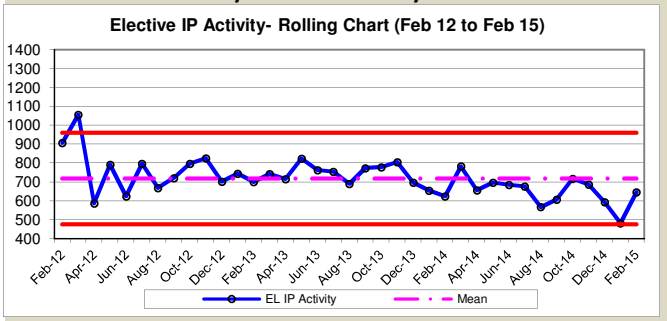


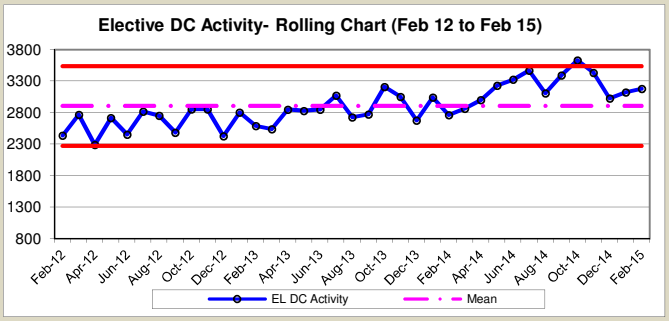
Performance & Activity - Outpatient Activity



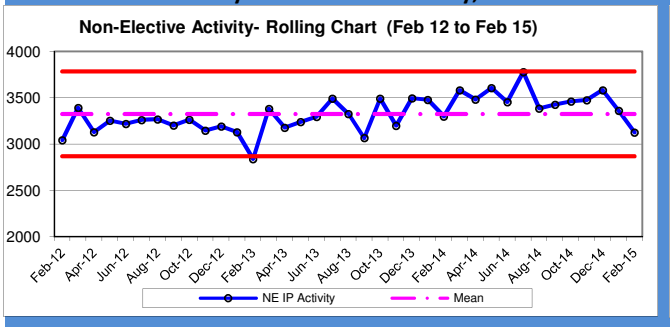


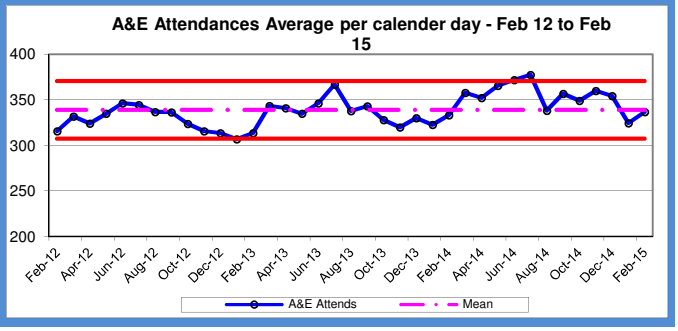
Performance & Activity - Elective Activity





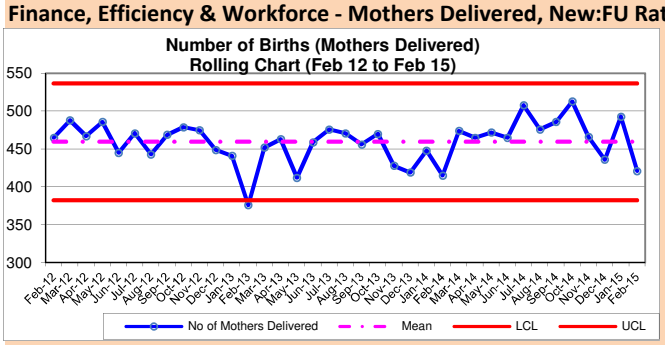
Performance & Activity - Non-Elective Activity, A&E Attendances

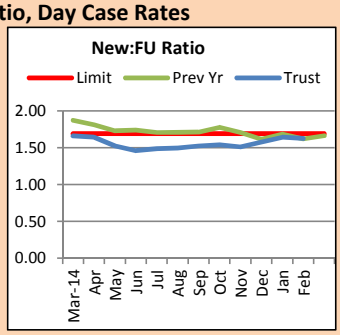


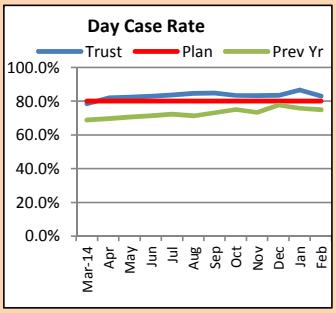


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

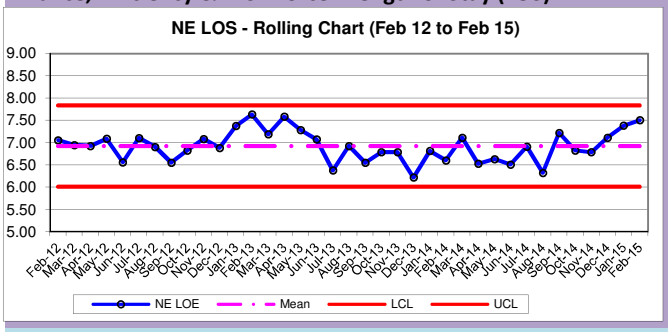
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

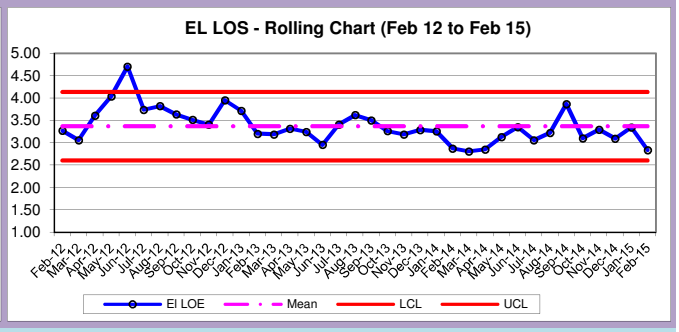




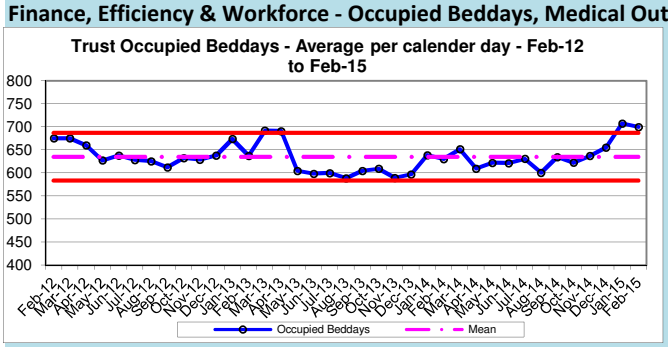


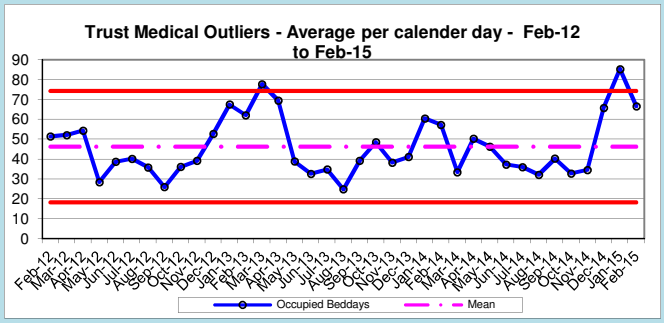
Finance, Efficiency & Workforce - Length of Stay (LOS)



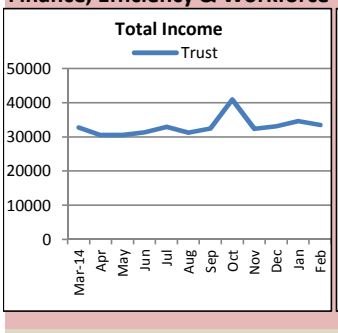


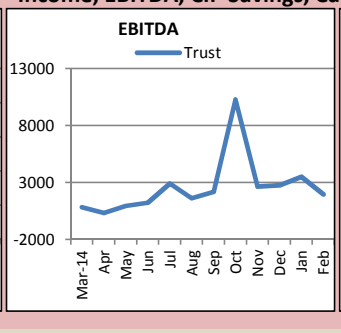
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

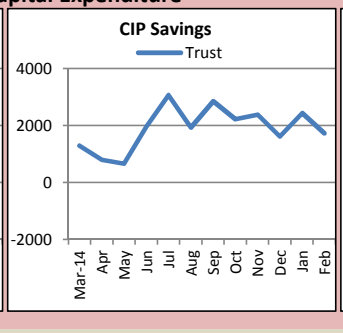


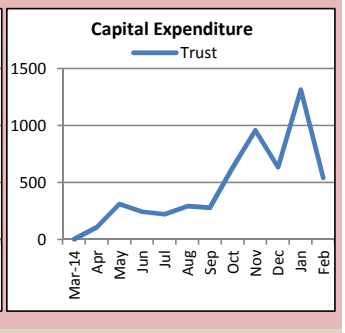


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

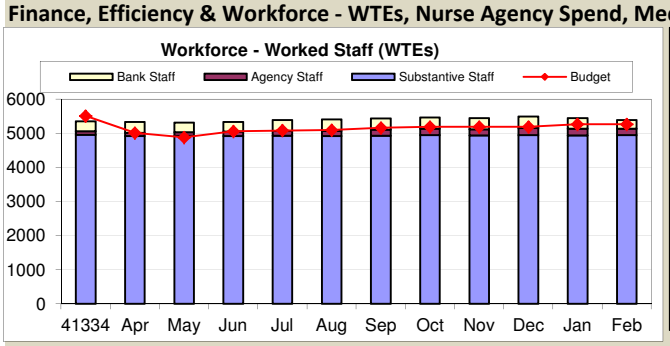


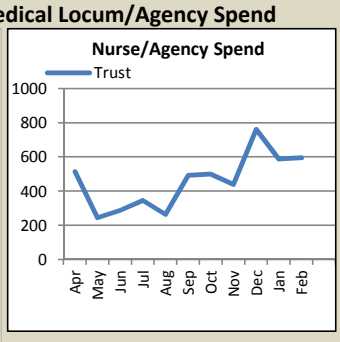


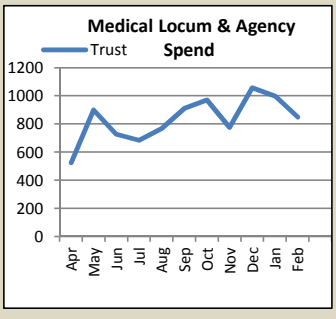




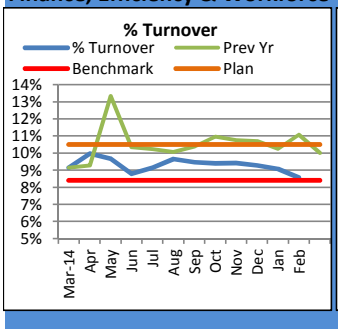
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

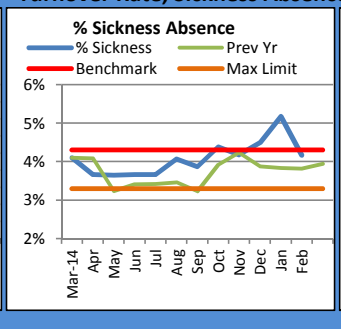


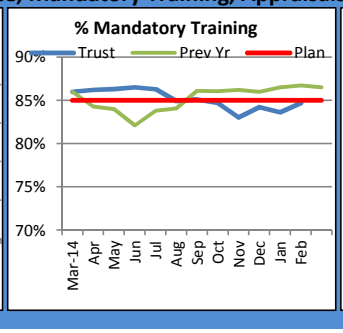


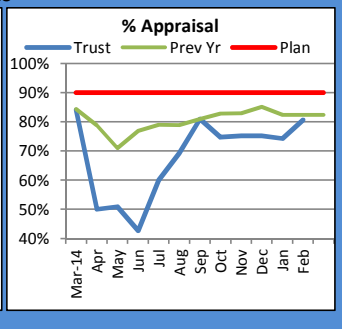


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









M11 Financial Performance overview

1. Overview of the Financial Position at M11 2014/15

1.1. This written summary provides an overview of the financial position at M11 of 2014/15. It should be read alongside the finance pack.

1.2. The Finance pack shows for month 11 an in month deficit of (£0.9m) against a plan of a (£1.9m) deficit (£1.0m favourable movement) resulting in a year to date deficit of (£1.7m) against a planned deficit of (£12.6m), a favourable variance of £10.9m.

1.3. The in month favourable movement of £1.0m 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 £11m; being 11/12ths of the £12m.

1.4. The total year to date total income is £363.8m against a budget of £348.0m; an over performance of £15.8m, (£3.7m over performance in the month). Of the Month 11 favourable variance £1.0 relates to 1/12ths of the £12m deficit support funding as highlighted in 1.3 above, a further £1.2m has been released from provisions as disputes relating to 2013/14 and contracts for 2014/15 are settled with commissioners. Private patient income was £0.2m under plan in February.

1.5. Non elective activity in month 11 was lower than the trend seen in previous months and is now 4.0% higher than the year to date plan (4.0% higher last month). A&E activity reduced against the trend again this month (5.8%) against the trend in previous months (6.3%). The increase in non-elective activity above plan is mostly paid at 30% due to the threshold applied and is now 78% above plan (6% increase in the month, compared to 5% in the previous 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 non-elective income has reduced by 10% from last month's level and is now overperforming by 4.0%. We are continuing to see a richer case mix of patients who are also staying longer. In the month of February, the Trust has experienced a 10% reduction (8 beds) in the use of escalation beds.

1.6. Elective inpatient activity increased on trend in the month. Elective activity is 20% behind plan (21% last month) whilst day case activity increased against the trend in previous months and is now 4% behind plan (0.1% up in the month). On average through February there were just over 72 escalation beds in use, this compares favourably to December and January(100 beds). The largest volatility in the number of escalation beds was seen at TWH (17 to 34 beds) but the greater overall number was seen at Maidstone (48 escalation beds per day on average).

1.7. Operating costs are £333.4m against a plan of £330.2m, an adverse variance of £3.2m (£2.0m adverse in the month); however there is a net £3.5m of savings and reserves which would reduce the plan to £326.7m if the whole amount was allocated to Operating expenditure.

1.8. Pay was overspent by £0.9m in the month and is now £2.5m overspent year to date. In actual expenditure terms the Trust experienced another month of very high pay costs £20.2m (£0.7m above the trend). 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.

1.9. Non pay overspent by £1.1m in month and is now £0.8m overspent year to date (£0.4m underspent last month). However, year to date Purchase of healthcare from non NHS bodies remains underspent if only by £2.4m (£2.8m year to date last month). Non pay

costs in Month 11 were adverse to trend by £0.6m. The Purchase of healthcare from other providers was adverse by £0.4m the additional capacity was used to achieve a reduced backlog in a context of continuing non-elective pressure. High cost drugs was also overspent to plan by £0.4m but this reflects directly the overachievement of high cost drug income. The majority of the remaining variance from plan has been driven by the recognition of legal fees £0.1m and not pay costs associated with the delivery of winter cost pressures.

1.10. EBITDA is a £30.3m surplus and is now over performing by £9.1m year to date (£0.8m in month) against the plan. This significant variance is due to the inclusion of the £11m year to date impact of the £12m deficit support funding.

1.11. The financing costs including those related to the PFI and deprecation totalled £34.2m, which is now underspent against the in year plan by £1.6m (£0.5m overspent in month). In prior months there had been favourable variances due to the recalculation of PDC, in month 11 the favourable PDC impact was seen (£0.4m) but this was more than offset by the inclusion of an impairment of fixed ICT assets (£0.9) this adjustment has been made after the normal annual review of fixed asset valuations.

1.12. The year to date CIP delivery is £21.7m against a target of £20.3m and is forecast to deliver £23.5m (no change) against the plan of £22.4m.

1.13. 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.

1.14. Cash balances of £20.4m were held at the end of M11. Discussions over the settlement of 2013/14 and 2014/15 NHS debt are being finalised, with an expectation of circa £17m in cash expected in March. As at the 13th March £12.6m of this has been received.

1.15. The operational cash flow is reliant upon the accuracy of the Income and Expenditure (I&E) forecast, any variations against the I&E forecast will be managed through debt collection and creditor management.

1.16. Total debtors are £47.8m (£60.3m in M10). The two largest debtors (invoiced) at the end of the period are WKCCG owing £13.1m (£18.2m m10) gross and NHS Commissioning who owe £9.4m (£9m m10) gross, primarily relating to invoices subject to year-end reconciliation.

1.17. Total creditors are £58.3m (£59.8m in M10). The percentage of the value of payments made within 30 days was 82.8% against a target of 95%,(85.1% in respect of trade creditors and 68.3% for NHS creditors)

1.18. Capital expenditure to month 11 was £5.5m with the revised forecast remaining at £13.3m. A number of significant capital items are planned for delivery in March

1.19. 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 11 2014/15

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

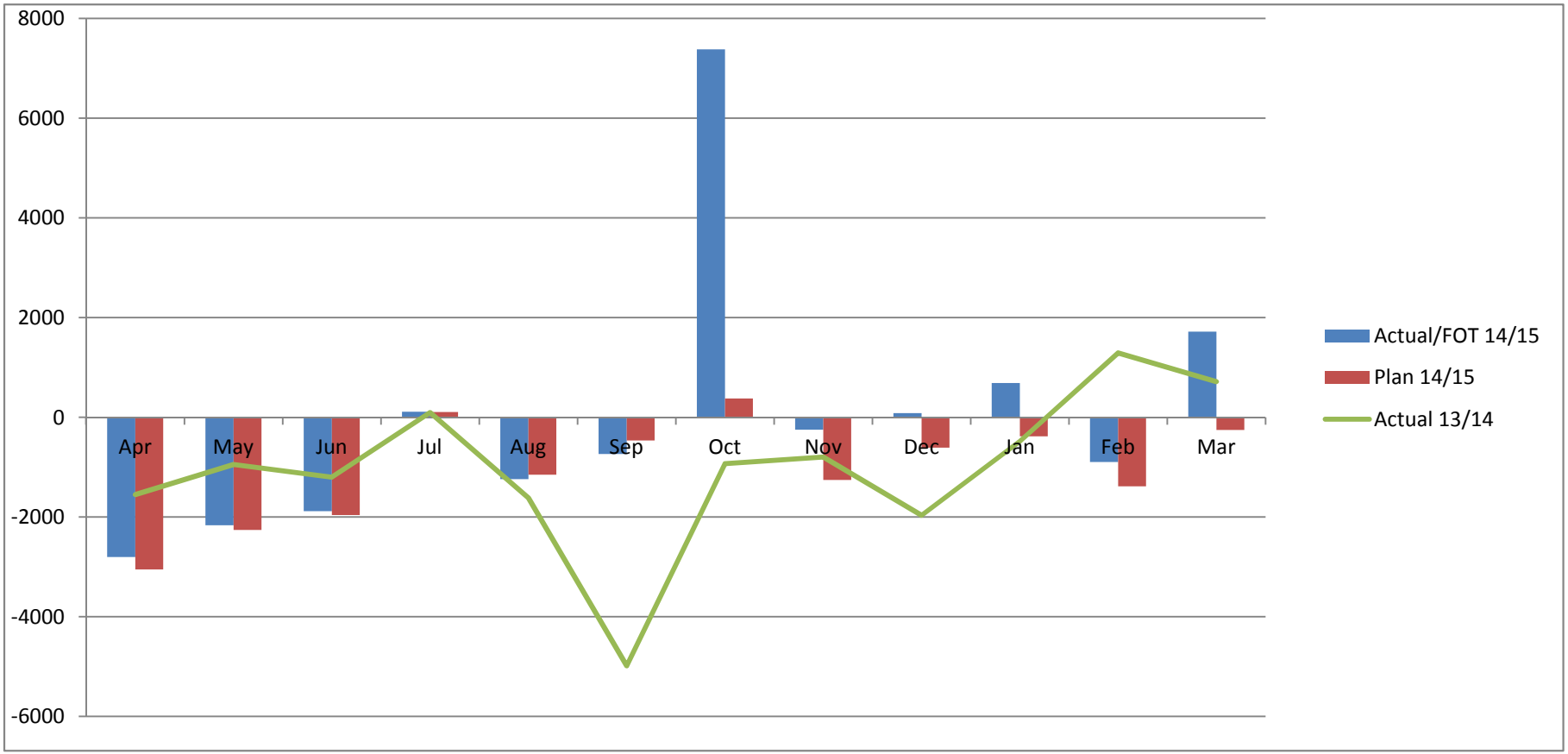
Maidstone and Tunbridge Wells NHS Trust

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	(12,049)	(1,709)	10,340	GREEN
Financial Efficiency				
2a) Actual Efficiency recurring/non-recurring compared to plan - Year to date actual compared to plan				AMBER
- Total Efficiencies for Year to Date compared to Plan	19,892	21,684	1,792	
- Recurrent Efficiencies for Year to Date compared to Plan	19,892	16,257	(3,635)	
2b) Actual Efficiency recurring/non-recurring compared to plan - Forecast compared to plan				RED
- Total Efficiencies for Forecast Outturn compared to Plan	22,400	23,493	1,093	
- Recurrent Efficiencies for Forecast Outturn compared to Plan	22,400	17,673	(4,727)	
Underlying Revenue Position				
3) Forecast Underlying surplus / (deficit) compared to Plan	(16,254)	(20,739)	(4,485)	RED
Cash and Capital				
4) Forecast Year End Charge to Capital Resource Limit	13,386	13,386	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	2.50	3.00	0.50	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 11 2014/15

	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)	84	688	(898)	1,715
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

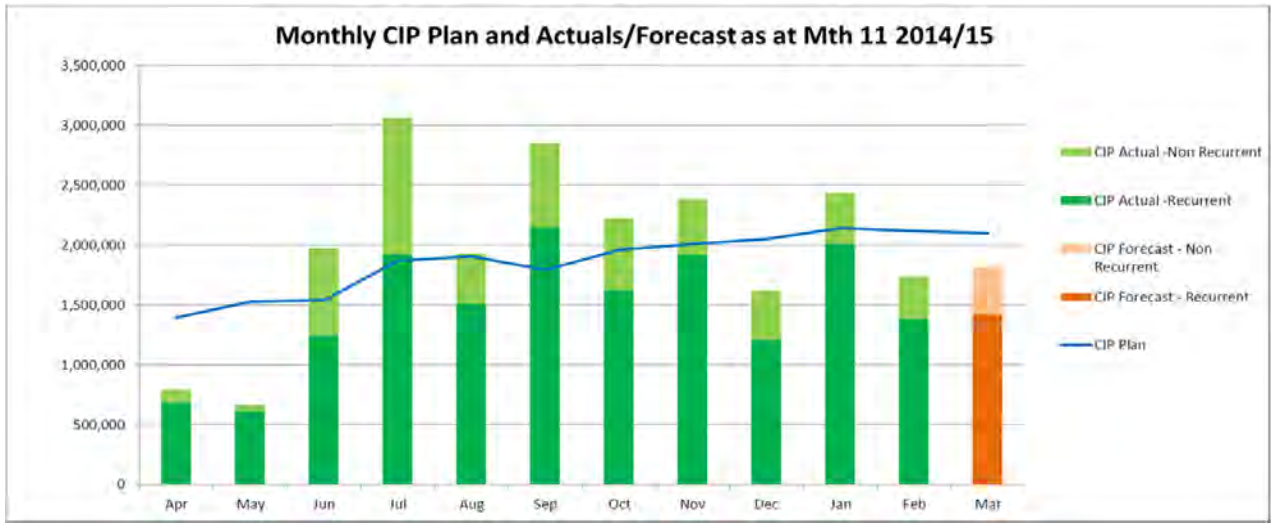


CIP Summary & Graph: as at Month 11 2014/15

Maidstone and Tunbridge Wells NHS Trust

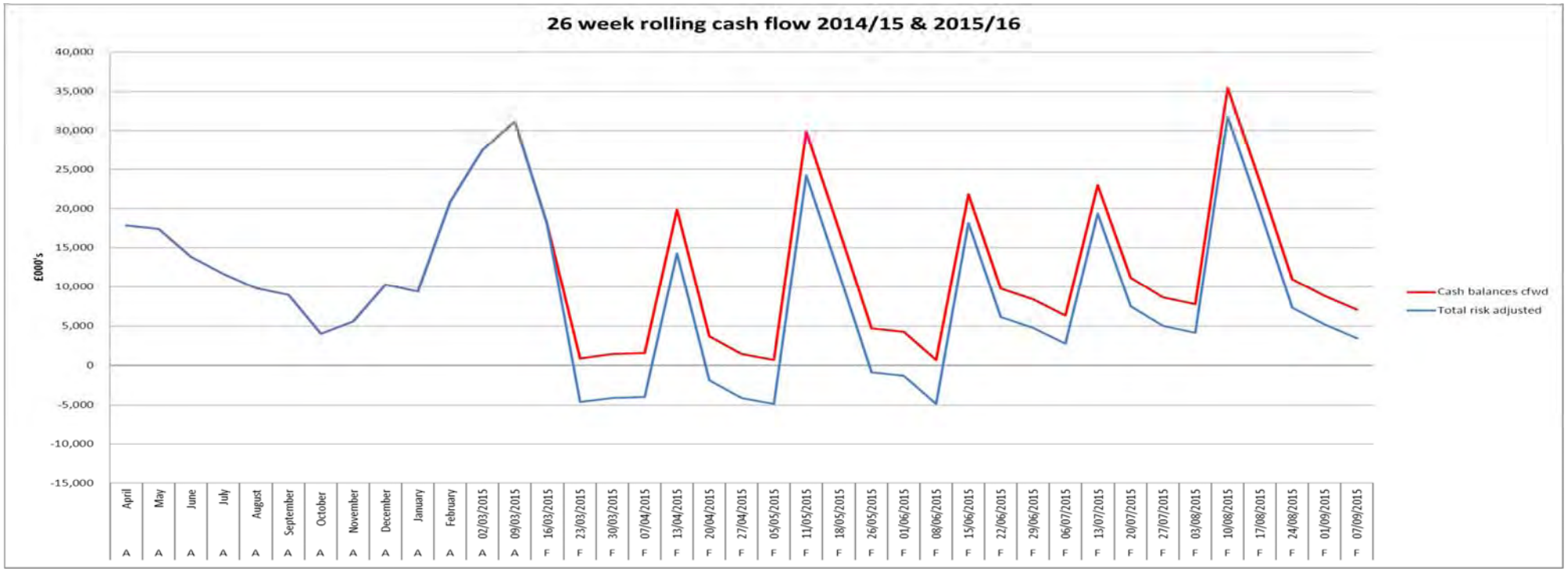
WORKSTREAMS BY DIRECTORATE BUDGET		Year To Date Plan £'000	Year To Date Actual £'000	Year To Date Variance £'000	Forecast Plan £'000	Forecast Actual £'000	Forecast Variance £'000
Back Office	Paul Bentley	3,833	3,253	(579)	4,234	3,569	(665)
Corporate (PPU)	Angela Gallagher	342	201	(141)	385	260	(125)
Surgery	Simon Bailey	1,647	2,594	947	1,804	2,873	1,069
Surgery (Head & Neck)	Simon Bailey	891	1,344	453	979	1,468	489
Emergency & Medical Services	Akbar Sorma	5,112	2,245	(2,868)	5,592	2,456	(3,136)
Diagnostics & Therapies	Sarah Mumford	2,047	2,101	54	2,306	2,230	(76)
T&O	Guy Slater	1,053	592	(462)	1,160	635	(525)
Women's & Sexual Health	M.Wilcox	1,530	1,051	(479)	1,687	1,065	(622)
Paediatrics	Hamudi Kisat	756	369	(386)	841	379	(462)
Critical Care	Richard Leech	2,464	1,760	(704)	2,690	1,973	(717)
Cancer	Sharon Beesley	1,860	2,141	282	2,068	2,190	122
Corporate Finance		0	4,028	4,028	0	4,394	4,394
Overprogramme		(1,234)	0	1,234	(1,346)	0	1,346
Total By Directorate (includes all workstreams)		**20,301**	**21,679**	**1,377**	**22,400**	**23,492**	**1,092**

Recurrent v Non Recurrent Analysis	YTD £'000	FOT £'000
Recurrent	16,257	17,673
Non Recurrent	5,427	5,820
Total	**21,684**	**23,493**



Maidstone and Tunbridge Wells NHS Trust

26 Week graphical presentation of cash balances up to w/c 7th September 2015, actuals at 13th March 2015



	A	A	A	A	A	A	A	A	A	A	A	A	A	F	F	F	F	F	F	F	F
Week commencing	April	May	June	July	August	September	October	November	December	January	February	02/03/2015	09/03/2015	16/03/2015	23/03/2015	30/03/2015	07/04/2015	13/04/2015	20/04/2015	27/04/2015
Cash balances cfwd	**17,839**	**17,445**	**13,852**	**11,677**	**9,869**	**8,953**	**4,009**	**5,619**	**10,293**	**9,392**	**20,839**	**27,477**	**31,103**	**18,071**	**927**	**1,462**	**1,569**	**19,887**	**3,743**	**1,445**
13/14 o/performance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,852	2,852	0	0	0	0
14/15 o/performance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,717	2,717	0	0	0	0
Debtors carry forward into 15/16	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5,569	5,569	5,569	5,569
15/16 o/performance	0	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	0
External Financing - capital	0	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**	**4,009**	**5,619**	**10,293**	**9,392**	**20,839**	**27,477**	**31,103**	**18,071**	**-4,642**	**-4,107**	**-4,000**	**14,318**	**-1,826**	**-4,124**

	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Week commencing	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	20/07/2015	27/07/2015	03/08/2015	10/08/2015	17/08/2015	24/08/2015	01/09/2015	07/09/2015	
Cash balances cfwd	**722**	**29,837**	**17,214**	**4,728**	**4,305**	**705**	**21,802**	**9,790**	**8,392**	**6,369**	**22,985**	**11,174**	**8,676**	**7,753**	**35,401**	**23,446**	**10,959**	**8,834**	**7,088**	
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	
Debtors carry forward in 15/16	5,569	5,569	5,569	5,569	5,569	5,569	3,624	3,624	3,624	3,624	3,624	3,624	3,624	3,624	3,624	3,624	3,624	3,624	3,624	
15/16 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	**-4,847**	**24,268**	**11,645**	**-841**	**-1,264**	**-4,864**	**18,178**	**6,166**	**4,768**	**2,745**	**19,361**	**7,550**	**5,052**	**4,129**	**31,777**	**19,822**	**7,335**	**5,210**	**3,464**	

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

Board meeting - March 2015

3-9	Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile	Director of Workforce and Communications

The publication of Kate Lampard's 'Lessons Learnt' report, details the investigations into the abuse by Jimmy Savile towards patients and staff undertaken on NHS premises. In itself this follows the report which was discussed by the Workforce Committee in September. The latest report was extensively discussed at the Workforce Committee during its meeting on 4th March, and the 'Executive summary and recommendations' is enclosed (though members of the Workforce Committee received the report in its entirety). While this discussion is reported in the presentation by the Chair of the Workforce Committee, the Board has asked for a separate report into the issues which the investigation identifies and the implications for the Trust. The investigation undertaken by Kate Lampard stands alongside 16 independent investigations undertaken by the NHS Trusts involved, including the report on Stoke Mandeville.

The Secretary of State for Health, in his speech in the House of Commons this month, announced that he will be accepting 13 of the 14 recommendations made in the report, with further consultation being undertaken to consider how these actions will be implemented.

I have provided below a summary of the key recommendations that are most relevant to the Trust and under each one outlined the approach that we will take in responding to them:

1) All NHS Hospital Trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception.

   - The Trust does not currently have such a policy and procedure in place. Therefore one will be developed promptly and circulated to all departments in the organisation.
   - The HR team will need to be the gatekeepers of the system and for ALL staff.
   - The disciplinary policy will be updated to ensure that enabling unauthorised and unsupervised visits will be an act of gross misconduct.
   - Although the Trust does not have a policy, good practice is in operation which has recently been evidenced by the request for authorisation by a manager from the Associate Director of Workforce for the recent Chinese delegation visit which ensured that no member of the delegation was left unsupervised during the visit.

2) All NHS Trusts should review their voluntary services arrangements and ensure that they are fit for purpose; volunteers are properly selected, recruited and trained and are subject to appropriate management and supervision. All voluntary services managers have development opportunities and are properly supported.

   - A comprehensive review of the Trust approach to the recruitment and management of voluntary services will be conducted. The policy and procedure will be amended accordingly.
   - The Trust Recruitment and Selection Policy and Procedure already stipulates that the recruitment of volunteers follows the same process as substantive staff, this approach will be reiterated.
   - A strategic review of the Trust arrangements for volunteering will take place.

3) All NHS Hospital Trusts should undertake regular reviews of their safeguarding resources, structures and processes (including training programmes) and the behaviours and responsiveness of management staff in relation to safeguarding issues; and that their arrangements are robust and operate as effectively as possible.

- A comprehensive review will be undertaken whereby the Workforce Committee, on behalf of the Board, will ask for assurance from the relevant Committee that the Trust has the correct training in place, sufficient resources, and process for providing regular feedback to staff around lessons learnt.
- The Trust must continue to develop the organisational culture to ensure that all staff are empowered to speak up and challenge inappropriate behaviour – at all levels.

4) All NHS Hospital Trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and, where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.

- As part of the above review, the relevant Trust Committees will be asked for input to shape the needed IT approach for the organisation. The Trust has just launched free WIFI for all visitors and the Trust approach needs to strike the right balance between individual's right to use the internet and the Trust safeguarding that no inappropriate actions take place on Trust premises.

5) All NHS Hospital Trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards; and that these are subject to monitoring and oversight by their own HR managers.

- The Trust Recruitment and Selection Policy and Procedure stipulate that the recruitment of contract and agency staff follow the same process as substantive staff.
- A limited number of breaches of this policy have taken place with the appointment of management consultants, IT specialists, estates and facilities contractors and therefore action will be taken immediately to tighten the process, including the disciplinary policy being updated to ensure that any appointments not processed through the HR department will result in gross misconduct and potentially dismissal – regardless of grade or position in the organisation.

6) All NHS Hospital Trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions; and overall responsibility for these matters rests with a single Executive Director.

- E-DBS is in the process of being implemented. The recommendation is that all staff receive a DBS on appointment and every three years thereafter.
- The Director of Workforce and Communications is the accountable officer.

Much of the story of Savile and his associations with NHS hospitals is unusual to the point of being scarcely credible. He was a famous, flamboyantly eccentric, narcissistic and manipulative television personality using his celebrity profile and his much-publicised volunteering and fundraising roles to gain access, influence and power in certain hospitals. He used the opportunities that access, influence and power gave him to commit sexual abuses on a grand scale. However features of the story have everyday implications and the Trust has to take every possible step to ensure that we protect, as best as possible, our staff and patients that use our services and learn the lessons from such a hideous episode in the NHS history.

Which Committees have reviewed the information prior to Board submission?

- Workforce Committee, 04/03/15

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

Discussion, 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

Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile

Independent report for the Secretary of State for Health

February 2015

Authors:
Kate Lampard
Ed Marsden

4. Executive summary and recommendations

Executive summary

4.1 In October 2012 the Secretary of State for Health asked me to provide independent oversight of the investigations at three NHS hospitals (Leeds General Infirmary, Stoke Mandeville and Broadmoor) and the Department of Health into the associations that the late Sir Jimmy Savile OBE, (Savile), had with those hospitals and the department, and allegations that Savile committed sexual abuses on the hospitals' premises.

4.2 Following my appointment to that oversight role and in the wake of increasing concern about the nature and enormity of Savile's activities, the Secretary of State also asked me to identify the themes that would emerge from the investigations and to look at NHS-wide procedures in light of the investigations' findings and recommendations. Subsequently, I was also asked to include in my considerations the findings of internal investigations into further allegations of abuse by Savile at various other NHS hospital sites. Reports of the investigations by 28 NHS organisations into matters relating to Savile, together with my oversight and assurance report were published on 26 June 2014. Sixteen further investigation reports are being published on the same day as this report.

4.3 I have been supported in my work by Ed Marsden, managing partner of the consultants Verita. In this report we summarise the findings of the reports of NHS Savile investigations. We describe and consider the themes and issues that emerge from those findings and the further evidence we gathered. We identify lessons to be drawn by the NHS as a whole from the Savile affair and we make relevant recommendations.

4.4 Much of the story of Savile and his associations with NHS hospitals is unusual to the point of being scarcely credible. It concerns a famous, flamboyantly eccentric, narcissitic and manipulative television personality using his celebrity profile and his much-publicised volunteering and fundraising roles to gain access, influence and power in certain hospitals. He used the opportunities that that access, influence and power gave him to commit sexual abuses on a grand scale. However features of the story have everyday implications and relevance for the NHS today. These matters are considered in this report.

4.5 In light of other recent sex abuse scandals and allegations, the lessons learnt from the Savile case must form part of a wider public conversation about how all professionals and public bodies identify abuse and act to tackle it.

Methodology

4.6 During the course of our work we maintained close contact with the many NHS Savile investigation teams and with the NHS Savile legacy unit. We also had regular contact with MPS officers leading Operation Yewtree. This allowed us to identify issues and themes as they emerged during the investigation process. We have drawn on the evidence and findings contained in all the investigation reports.

4.7 Our own evidence gathering included:

- meetings and interviews with commentators, experts and practitioners;
- a review of relevant documents, articles, research literature and reports;
- a call for evidence from NHS staff;
- a programme of hospital visits; and
- two discussion events (one with historians, described below, and one with experts in sexual offending and safeguarding).

Historical background

4.8 The need to take account of the historical background to the events and issues arising in the Savile investigations prompted us to commission History and Policy[2] to put on a discussion event for the NHS investigation team leads and us. We wanted to gain evidence and understanding of the historical culture and circumstances that would have influenced Savile's behaviour and how others responded to him. We wanted also to gain insight into how the culture and circumstances in question have altered over time so that we could identify the lessons still relevant for today's NHS.

[2] History and Policy is a national network of academic historians.

Our findings

4.9 The findings of the separate NHS investigations about the cultures, behaviours and governance arrangements that allowed Savile to gain access and influence in the various NHS hospitals, and gave him the opportunity to carry out abuses on their premises over many years are strikingly consistent. The common themes and issues that have emerged from the investigations' findings which we see as relevant to the wider NHS today can be grouped under the following general headings:

- security and access arrangements, including celebrity and VIP access;
- the role and management of volunteers;
- safeguarding;
- raising complaints and concerns (by staff and patients);
- fundraising and charity governance; and
- observance of due process and good governance.

Security and access arrangements

4.10 The investigation reports relating to Leeds General Infirmary, Stoke Mandeville, and Broadmoor, suggest that security at those hospitals has improved. This accords with what we learnt about how awareness of security and security arrangements elsewhere in the NHS have developed and improved in recent years, and particularly since the introduction in 2003 of a national strategy aimed at raising the standards and professionalism of security management in the NHS.

4.11 Hospitals should try to reduce opportunities for those without legitimate reasons from gaining access to wards and other clinical areas. Interviewees made plain to us however, that total restriction or control of public access across a whole hospital site is neither desirable nor achievable. Hospitals are public buildings and significant employers in their localities. The public regard their local hospital as their "facility" and they have many and varied reasons for wanting access to it.

4.12 The Leeds investigation report shows that Savile was an accepted presence at Leeds General Infirmary for over 50 years. He wandered freely about the hospital and had access to wards and clinical areas during the day and at night. The Stoke Mandeville

investigation report shows that the circumstances of Savile's access within that hospital were similar to those at Leeds General Infirmary.

4.13 In the case of most NHS hospitals, high-profile celebrity or VIP visitors are rare. Organisations told us this was why they had not thought to draw up formal policies for managing them. However, many organisations told us they hoped in future to increase their revenue from fundraising, which would entail developing associations with celebrities and VIPs. Regardless of whether they had a formal policy, most organisations told us that in practice all celebrity or VIP visitors were accompanied while on hospital premises.

4.14 The failure to draw up a policy for managing celebrity and VIP visits leaves hospital organisations vulnerable to mismanagement of approaches from celebrities and VIPs for such visits and of the visits themselves. Staff must be adequately supported to ensure that they feel able to keep relationships with VIPs and celebrities on an appropriate footing and to supervise and regulate their visits. To this end, they need clear and accepted policies and procedures.

Role and management of volunteers

4.15 Savile's relationships with Leeds General Infirmary, Stoke Mandeville and Broadmoor hospitals arose out of a number of volunteer roles: he helped with the hospital radio at Leeds General Infirmary, he was a volunteer porter at Leeds General Infirmary and Stoke Mandeville and he supervised entertainments at Broadmoor. In addition, Savile became well known for fundraising for these and other NHS organisations.

4.16 We examined whether NHS hospitals today have arrangements to ensure that volunteers are properly managed and operate within defined and acceptable parameters.

4.17 Our interviews with those involved in managing NHS hospital volunteer services not only made plain how the numbers of volunteers have increased in recent years but also how the profile of volunteers and the type of work they do have changed and expanded. Nearly all of the hospitals we had contact with told us they had plans to increase their volunteer numbers.

4.18 The scale of the volunteer presence and the extent and nature of the work they do means that the arrangements for managing volunteers, and the risks associated with their presence in hospitals, need to be robust and command public confidence.

4.19 Effective management of volunteers requires board level commitment and leadership. Organisations need to take a strategic approach to planning their volunteer schemes. Managing a scheme properly demands resources and has a cost.

4.20 The management arrangements for volunteer schemes in NHS hospitals vary widely in the commitment and resources devoted to them. Some hospitals we visited demonstrated that their volunteer schemes were overseen at board level, were subject to strategic planning processes and that their voluntary service managers had appropriate support. However we also encountered hospital voluntary services that did not appear to be strategically planned or led, and where the voluntary services manager worked in isolation with little or no connection to the wider management system of the hospital, and with little or no management or adminstrative support.

4.21 Hospitals told us that their recruitment processes for new volunteers included interviews and obtaining references, and in some cases occupational health checks. They also told us they undertook enhanced record checks via the Disclosure and Barring Service (DBS).

4.22 Hospitals told us that they gave new volunteers induction training. In most cases the induction training included safeguarding training but it was not always of high quality. The training volunteers receive needs to impart the values of the organisation as a whole, and the expectations and responsibilities of volunteers, including the part they play in safeguarding patients, visitors and colleagues.

4.23 There is also an issue with hospitals not requiring volunteers to have their training updated and refreshed. Volunteers should be given regular safeguarding training to ensure that they are equipped to identify safeguarding isuues and respond to them appropriately.

4.24 We were impressed by the extent of volunteer schemes in NHS hospitals and the many ways volunteer schemes in hospitals improve the patient experience as well as benefiting those who volunteer and the wider community. We share the view of many we

spoke to that volunteers in NHS hospitals are a force for good. We should not place unnecessary barriers in the way of well-intentioned people who wish to volunteer in hospitals. Nevertheless, having large numbers of volunteers working in hospital settings involves risks and the Savile case has clearly highlighted the need to ensure reasonable precautions to protect vulnerable people from those who might seek to do them harm under the guise of volunteering.

Safeguarding

4.25 Social attitudes and public policy in relation to the protection of children and young people have changed and developed significantly since the time that Savile first started volunteering in NHS hospitals. In keeping with these wider societal developments, awareness among NHS staff of the issue of safeguarding and of their obligations to protect patients, especially children and young people, from abuse, harm, and inappropriate behaviour has increased markedly in recent years. There is some concern however that while staff may be aware of the issues raised by recent scandals, they may not necessarily recognise the implications of these issues for themselves and their own organisations.

4.26 All the hospitals we visited, and most of those who responded to the call for evidence, told us that all their staff, both clinical and non-clinical, received mandatory induction training that included safeguarding, with higher levels of safeguarding training being mandatory for all clinical staff working with children and vulnerable adults. Nevertheless we received evidence that not all hospitals deliver safeguarding training of a high quality. We also learnt of hospitals that did not ensure that all staff updated their safeguarding training.

4.27 Our investigations showed that numbers of dedicated safeguarding staff varied widely in different NHS hospitals and in some cases staff resources were stretched. The numbers of staff in dedicated safeguarding roles is not the only key to effective safeguarding, but it is essential that all staff should be trained to identify safeguarding issues and should be able at all times to access specialist support and advice if necessary.

4.28 We considered what makes for an effective safeguarding system from the particular perspective of trying to prevent a recurrence of events similar to the Savile case. We identified the need for hospital leadership that promotes the right values:

boards and individual leaders of organisations must be clear about their intention to take safeguarding seriously and put in place mechanisisms that allow concerns to be raised and dealt with properly. Effective safeguarding requires organisations to encourage openness and listening when people, including children, raise concerns. It also requires senior staff to be approachable and well informed about what is happening in their organisations: we heard of good examples of senior managers spending time on wards and how this allowed them to pick up on issues of concern.

4.29 It is an essential part of an effective safeguarding system that safeguarding messages are reinforced through regular training and communication with staff. As part of this, organisations also need to demonstrate and give feedback to staff to show that they respond appropriately to specific safeguarding concerns.

Specific safeguarding issues

DBS checking

4.30 We looked at the current legislative framework governing record checks for those who work or volunteer in NHS hospitals.

4.31 The Discloure and Barring Service (DBS) maintains lists of people barred from engaging in "regulated activity". An organisation engaging staff and volunteers in "regulated activity" can access a barred list check by requiring those staff and volunteers to undertake an enhanced DBS check (previously known as a CRB check) together with a barred list check. It is unlawful for any employer to require an enhanced DBS check with barred list information for any position other than one that is "regulated activity" as defined by Safegauarding Vulnerable Groups Act 2006 (as amended by the Protection of Freedoms Act 2012).[3]

4.32 In the context of NHS hospital settings, what amounts to "regulated activity" in relation to adults differs significantly from that relating to children. With adults, only

[3] An organisation engaging staff and volunteers not in "regulated activity" can only require standard or enhanced DBS checks without a barred list check if those staff or volunteers are eligible for such checks because of their activities. This includes work or volunteering with vulnerable groups including children.

those staff or volunteers with direct hands-on or close contact with adult patients can be required to undergo a barring list check, and this applies whether they undertake the activity in question once or more frequently, and whether or not they are supervised in it. With respect to children, staff and volunteers with less intimate contact can be required to undergo a barring list check but checks can only be required where the activity in question is undertaken frequently and is unsupervised.

4.33 Most of those we interviewed who had experience of safeguarding issues told us of their concerns about the present limitations on barring list checks for staff and volunteers working in NHS hospital settings and elsewhere and the risks this poses. Many staff and volunteers in NHS hospitals who do not fall within the present definitions of "regulated activity" have legitimate reasons and opportunities for being in close proximity to adult and child patients and their visitors. The concerns are compounded by the fact that people in hospital are more vulnerable and likely to be at greater risk than others from the attentions of those inclined to commit sexual assault.

4.34 The barring lists clearly do not provide a comprehensive list of all those who might pose a threat of abusing people in hospital. Nevertheless we believe it would be proportionate and justified to require all those who work or volunteer in hospitals and have access to patients or their visitors to be subject to barring list checks.

4.35 Under the present DBS system, criminal record and barring list checks on staff and volunteers are required only when they are first engaged, with no requirement for retrospective or periodic checks. It is naïve to assume that a risk based approach, rather than mandatory periodic checks, offers greater assurance in relation to record checking. Large organisations are unlikely to have the resources or the opportunities to immediately identify each employee who might at a given time present a risk to others and whose records ought to be checked. We believe there should be DBS checks on NHS hospital staff and volunteers every three years.

NHS engagement with wider safeguarding systems

4.36 We interviewed a number of chairs of local safeguarding boards. They all raised concerns about how far NHS hospital trusts engaged with local safeguarding boards and local safeguarding arrangements.

4.37 A number of interviewees raised with us their concerns about how far NHS hospitals fulfilled their obligations to make referrals to the local authority desginated officer (LADO) and to the Disclosure and Barring Service (DBS) in respect of staff who had harmed or posed a risk of harm to children or adults vulnerable to abuse.

4.38 Local multi-agency working arrangements to protect children and vulnerable adults are compromised if NHS organisations do not share information about those who pose a threat. Equally, it undermines the barring system if NHS organisations do not refer to DBS persons who ought to be included on a barring list. We believe NHS organisations should be fully aware of their obligations in relation to these matters.

Internet and social media access

4.39 We learnt of incidents relating to the use of the internet and social media on hospital premises that raised safeguarding concerns. They caused us to question whether NHS hospitals had adequate arrangements in place to protect people in their care, particularly children and young people, from the risks posed by modern information technology.

4.40 The evidence we gathered shows that some NHS hospitals do not have a clear and consistent policy on managing internet and social media access by patients and visitors. Hospital organisations need such a policy, to protect people on their premises from the consequences of inappropriate use of information technology, the internet and social media. Without one, staff do not have the guidance and support they need to deal with difficult issues. They may also be exposed to pressure and complaints from patients and their families, some of whom may wish to use the internet and other technology in a way that could be offensive or harmful.

The management of human resources

4.41 Many people working on NHS premises, including many estates and security personnel, are employed by third-party contractors. A number of people with experience of safeguarding matters raised with us their concerns about whether contractors do in fact

follow appropriately rigorous recruitment and employment processes (including DBS checking). They also questioned whether contract and agency staff received appropriate training.

4.42 The Leeds investigation, and our own investigations, showed that in some hospitals responsibility for certain employment and human resources matters lies elsewhere than with the hospital's HR department. For instance, some contract staff are managed by facilities and estates departments. Recruitment, checking and training of staff including contract and agency staff should be managed professionally and consistently across a hospital trust. HR processes expected of third party contractors should be devised and compliance with them should be monitored by a hospital's professional HR managers. Overall responsibility for HR matters and board assurance in relation to HR matters should ultimately rest with a single executive director.

Raising complaints and concerns

4.43 The difficulties that Savile's victims had in reporting his abuse of them are evident in particular from the reports of the Leeds and Stoke Mandeville investigations.

4.44 Preventing abusive and inappropriate behaviour in hospital settings requires that victims, staff and others should feel able to make a complaint or raise their concerns and suspicions, and that those to whom they report those matters are sensitive to the possible implications of what is being reported to them and escalate matters to managers with authority to deal with them. We identified a number of specific matters, set out below, that we believe will encourage staff, patients and others to raise the alarm about sexual abuse and other inappropriate behaviours.

Policies and using the right terminology

4.45 Many people we interviewed told us that the term 'whistleblowing' to cover policies aimed at encouraging staff and others to speak out about matters of concern was unhelpful. They said the term implied a public challenge to an organisation and an assumption that the organisation or part of it would not respond positively to the matters being raised.

4.46 Most of the organisations we visited and many of those who responded to the call for evidence recognised the problem with using the term 'whistleblowing' and had changed the name of their policy to 'raising concerns policy' or were using the term 'raising concerns' in conjunction with 'whistleblowing'. All NHS organisations should ensure that the title and content of their policy make clear that it applies to raising all concerns, whether or not they amount to matters some might describe as 'whistleblowing'.

4.47 Staff should also be trained and encouraged to report any matters which indicate a risk of harm to others even if such matters appear to amount only to suspicion, innuendo or gossip.

A culture that supports and encourages people to make complaints and raise concerns

4.48 Our visits to hospitals showed us that organisations continued to face a challenge in empowering staff to feel able to raise concerns. People do not feel comfortable challenging those they see as in positions of authority and hierarchies within hospitals are a barrier to staff raising concerns. It is important in encouraging hospital staff to overcome or question the behaviour of others that managers are present within the hospital and approachable. Managers need to be trained to deal positively and appropriately when matters of concern are reported to them.

4.49 Another important element in encouraging and supporting staff and patients to raise concerns is for organisations to ensure that they feel protected from threats or other adverse consequences if they do so.

4.50 Many people we spoke to were certain that in relation to sexual harassment and sexually inappropriate behaviour in the workplace awareness and attitudes had improved markedly in recent times.

Providing opportunities for staff, patients and others to raise concerns

4.51 Most of the hospitals we visited demonstrated that they understood the need for flexibility in the way that staff and others can raise their concerns; that they needed to offer many and varied opportunities to ensure that they captured significant issues and concerns that posed a risk to their organisation, their patients and their staff. All organisations must continue to think imaginatively and share ideas about how they encourage feedback and the raising of concerns by staff and patients.

Mandatory reporting

4.52 Mandatory reporting of information and suspicions relating to abuse is an issue on which opinions differ and are deeply held. It would have significant implications for the way that professionals involved in safeguarding work. We do not think it is appropriate for us to come to conclusions on mandatory reporting purely in the context of the lessons to be drawn from one particular, historical, sex abuse scandal.

Fundraising and charity governance

4.53 The Savile case raises the question of how NHS hospitals manage their charitable funds, their fundraising arrangements and the role of celebrities and donors who play a part in fundraising for NHS organisations.

4.54 Most NHS hospitals have their own associated charities, which hold charitable funds for furthering the aims of the hospital. These are known as NHS charities. They are governed by the NHS Act 2006 as well as charity law. In most cases the hospital's board acts collectively as trustee of the charitable property given to it.

4.55 The question of the most appropriate governance structure for NHS charities has recently been the subject of a review by the Department of Health. As a result of the review the government will now permit all NHS charities to transfer their charitable funds to new, more independent charitable trusts regulated by the Charity Commission under charity law alone. However, NHS bodies will be able to continue to act as corporate

trustee of their charitable funds established and regulated under NHS legislation if they wish to do so.

4.56 Savile's charitable fundraising was undertaken via two charities, the Jimmy Savile Charitable Trust and the Jimmy Savile Stoke Mandeville Hospital Trust. These charities were separate from the NHS organisations to which they made charitable donations. Many individual charitable trusts, like those established by Savile, raise funds for NHS organisations but sit outside the governance arrangements of the NHS.

4.57 We considered how NHS hospitals and their associated NHS charities ensure that their fundraising is subject to good governance, and how they ensure appropriate management of their relationships with independent charitable trusts, such as those Savile established, and with individual donors and celebrities.

4.58 The first element of best practice in charitable fundraising is proper risk management to ensure not only the protection of charitable assets and funds raised but also the good name and reputation of the charity. In considering the risks to an NHS charity and the organisation it seeks to benefit, trustees and hospital managers must look at the hospital's and the charity's relationships with celebrities, major donors, commercial partners and other charitable organisations.

4.59 Most of the NHS organisations we had contact with did not have clear documented policies and risk assessment processes for managing these relationships and for protecting the organisation's brand and reputation. Some said they had no need of formal arrangements because of the limited nature of their fundraising activity. However we believe that staff with little or no experience of managing relationships with celebrities and major donors are at greatest risk of being "star struck" and of mishandling such relationships. They must be able to refer to guidance in a formal policy.

4.60 Nearly all the NHS organisations we spoke with said they would like to increase their income from charitable fundraising, especially given likely future pressure on budgets. In the event of increased charitable fundraising by NHS organisations, brand and reputation management and protection will become all the more pertinent.

4.61 Best practice also requires NHS charitable trusts to be managed and structured so that they act independently in the best interests of the charity and its purposes, with no

one trustee or group of trustees dominating decision making or acting other than in the interests of the charity. There needs to be a shared understanding between hospital management and the NHS charity of the service needs and priorities of the hospital. This demands good communication and constructive behaviours.

The observance of due process and good governance

4.62 Savile's involvement with Broadmoor and Stoke Mandeville hospitals was supported and facilitated by government ministers and senior civil servants. It is not within our terms of reference to investigate and pronounce on the weighty issue of when and on what terms it is ever justified for those at the heart of government to waive the machinery and procedures of good governance or invite outsiders including celebrities to engage in public service management. However, in the context of NHS hospitals, the Savile case vividly illustrates the dangers of allowing an individual celebrity to have unfettered access or involvement in management, and of not ensuring that good governance procedures are followed at all times and in all circumstances.

4.63 We make recommendations in this report aimed at dealing explicitly with some of the shortcomings in hospital governance processes at a local level that allowed the Savile scandal to occur. Ministers and officials have a responsibility to ensure that hospital managers are able to implement and adhere to these recommendations. They should not undermine the processes of good governance and local management.

Recommendations

Our recommendations for NHS hospital trusts are also addressed to Monitor and the Trust Development Authority under their duties to regulate NHS hospital trusts. Most of them are also addressed to:

- the Care Quality Commission under its duties and powers to regulate and assure the quality and safety of hospital services; and
- NHS England under its duties and powers to promote and improve the safeguarding of childen and adults.

R1 All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception.

R2 All NHS trusts should review their voluntary services arrangements and ensure that:

- they are fit for purpose;
- volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and
- all voluntary services managers have development opportunities and are properly supported.

R3 The Department of Health and NHS England should facilitate the establishment of a properly resourced forum for voluntary services managers in the NHS through which they can receive peer support and learning opportunities and disseminate best practice.

R4 All NHS trusts should ensure that their staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years.

R5 All NHS hospital trusts should undertake regular reviews of:

- their safeguarding resources, structures and processes (including their training programmes); and
- the behaviours and responsiveness of management and staff in relation to safeguarding issues

to ensure that their arrangements are robust and operate as effectively as possible.

R6 The Home Office should amend relevant legislation and regulations so as to ensure that all hospital staff and volunteers undertaking work or volunteering that brings them into contact with patients or their visitors are subject to enhanced DBS and barring list checks.

R7 All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.

R8 The Department of Health and NHS England should devise and put in place an action plan for raising and maintaining NHS employers' awareness of their obligations to make referrals to the local authority designated officer (LADO) and to the Disclosure and Barring Service.

R9 All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.

R10 All NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.

R11 NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.

R12 NHS hospital trusts and their associated NHS charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect such risks.

R13 Monitor, the Trust Development Authority, the Care Quality Commission and NHS England should exercise their powers to ensure that NHS hospital trusts,(and where applicable, independent hospital and care organisations), comply with recommendations 1, 2, 4, 5, 7, 9, 10 and 11.

R14 Monitor and the Trust Development Authority should exercise their powers to ensure that NHS hospital trusts comply with recommendation 12.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - March 2015

3-10	The investigation into maternity and neonatal services at University Hospitals Morecambe Bay NHS Foundation Trust	Chief Nurse / Medical Director

The Morecambe Bay Investigation, led by Dr. Bill Kirkup CBE, was established by the Secretary of State for Health in September 2013, to review the management, delivery and outcome of care provided by the maternity and neonatal services at Furness General Hospital (FGH) between January 2004 and June 2013. FGH is one of five sites now run by University Hospitals Morecambe Bay NHS Foundation Trust (FT).

The report was published on 3rd March, and made 44 recommendations for the Trust and the wider NHS. The Executive Summary of the report is enclosed, along with the recommendations for the wider NHS.

The report and its recommendations were discussed in detail at the recent Joint Women's and Children's Services Clinical Governance meeting (which was attended by the Chief Nurse). It was agreed that a detailed 'gap analysis' against the relevant recommendations would be undertaken, and discussed at the next Clinical Governance meeting.

The Trust Board is therefore asked to note the enclosed, but also to agree that the gap analysis should be submitted to the 'main' Quality & Safety Committee, after it has been discussed at the Maternity and Paediatric Clinical Governance meetings.

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
1. Information and assurance; and
2. To consider the proposal that the gap analysis be received at the 'main' Quality & Safety Committee

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

The Report of the Morecambe Bay Investigation

Dr Bill Kirkup CBE

March 2015

Executive summary

1. The Morecambe Bay Investigation was established by the Secretary of State for Health to examine concerns raised by the occurrence of serious incidents in maternity services provided by what became the University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust), including the deaths of mothers and babies. Relatives of those harmed, and others, have expressed concern over the incidents themselves and why they happened, and over the responses to them by the Trust and by the wider National Health Service (NHS), including regulatory and other bodies.

2. We have carried out a thorough and independent investigation of these events, covering the period from 1 January 2004 to 30 June 2013. The Investigation Panel included expert advisors in midwifery, obstetrics, paediatrics, nursing, management, governance and ethics. We reviewed 15,280 documents from 22 organisations, and we interviewed 118 individuals between May 2014 and February 2015. Family members of those harmed were invited to attend interviews and Panel meetings as observers.

3. Our findings are stark, and catalogue a series of failures at almost every level – from the maternity unit to those responsible for regulating and monitoring the Trust. The nature of these problems is serious and shocking, and it is important for the lessons of these events to be learnt and acted upon, not only to improve the safety of maternity services, but also to reduce risk elsewhere in NHS systems.

4. The origin of the problems we describe lay in the seriously dysfunctional nature of the maternity service at Furness General Hospital (FGH). Clinical competence was substandard, with deficient skills and knowledge; working relationships were extremely poor, particularly between different staff groups, such as obstetricians, paediatricians and midwives; there was a growing move amongst midwives to pursue normal childbirth 'at any cost'; there were failures of risk assessment and care planning that resulted in inappropriate and unsafe care; and the response to adverse incidents was grossly deficient, with repeated failure to investigate properly and learn lessons.

5. Together, these factors comprised a lethal mix that, we have no doubt, led to the unnecessary deaths of mothers and babies. We reviewed cases, including all the maternal deaths and deaths of babies in the period under investigation, using a validated method, and found 20 instances of significant or major failures of care at FGH, associated with three maternal deaths and the deaths of 16 babies at or shortly after birth. Different clinical care in these cases would have been expected to prevent the outcome in one maternal death and the deaths of 11 babies. This was almost four times the frequency of such failures of care at the Royal Lancaster Infirmary.

6. These problems did not develop overnight, and the first sign of their presence occurred in 2004, when a baby died from the effects of shortage of oxygen, due to a mismanaged labour. Serious incidents happen in every health system because of the nature of healthcare, and no blame should be attached to staff who make mistakes. It is, however, vital that incidents are properly investigated, in order to identify problems and prevent a recurrence. The investigation in 2004 was rudimentary, over-protective of staff and failed to identify underlying problems.

7. Between 2004 and the end of 2008, there was a series of further missed opportunities to identify problems in the unit. Between 2006 and 2007, five more serious incidents occurred that showed evidence of problems similar in nature to the 2004 incident; investigations followed the same inadequate process and failed to identify problems. At this time, the failures of working relationships, approach and clinical competence affecting the maternity service must have been clear to senior and experienced unit staff, but we could find no attempt to escalate knowledge of this to the level of the Trust executives and Board.

8. A cluster of five serious incidents occurred in 2008: a baby damaged by the effects of shortage of oxygen in labour; a mother who died following untreated high blood pressure; a mother and baby who died from an amniotic fluid embolism; a baby who died in labour due to shortage of oxygen; and a baby who died from unrecognised infection. All showed evidence of the same problems of poor clinical competence, insufficient recognition of risk, inappropriate pursuit of normal childbirth and failures of team-working, as seen previously. Initial investigation was again deficient and failed to identify manifest problems.

9. The 2008 incidents, however, did signal unmistakably to the Trust executives and Board that all was not well with the unit. A letter from a consultant obstetrician set out concerns raised by one of the incidents to the clinical director and medical director, but failed to prompt any documented reaction. A complaint arising from another incident that was felt likely to generate adverse publicity was reported to the Board, and an external investigation was commissioned. Although this was based only on written statements and clinical records and therefore missed some important points, it did unequivocally identify systemic failings for the first time.

10. Many of the reactions of maternity unit staff at this stage were shaped by denial that there was a problem, their rejection of criticism of them that they felt was unjustified (and which, on occasion, turned to hostility) and a strong group mentality amongst midwives characterised as ‘the musketeers’. We found clear evidence of distortion of the truth in responses to investigation, including particularly the supposed universal lack of knowledge of the significance of hypothermia in a newborn baby, and in this context events such as the disappearance of records, although capable of innocent explanation, concerned us. We also found evidence of inappropriate distortion of the process of preparation for an inquest, with circulation of what we could only describe as ‘model answers’. Central to this was the conflict of roles of one individual who inappropriately combined the functions of senior midwife, maternity risk manager, supervisor of midwives and staff representative.

11. We make no criticism of staff for individual errors, which, for the most part, happen despite their best efforts and are found in all healthcare systems. Where individuals collude in concealing the truth of what has happened, however, their behaviour is inexcusable, as well as unprofessional. The failure to present a complete picture of how the maternity unit was operating was a missed opportunity that delayed both recognition and resolution of the problems and put further women and babies at risk. This followed the earlier missed opportunities to identify underlying problems in 2004 and 2006/07.

12. By the early part of 2009, there was clearly knowledge of the dysfunctional nature of the FGH maternity unit at Trust level, but the response was flawed, partly as a result of an inadequate flow of information through professional and managerial reporting lines. Clinical governance systems throughout the Trust were inadequate. The 2008 incidents were treated as individual unconnected events, and no link was made with previous incidents. Inappropriate reliance was placed on poor-quality internal investigations and, in one case, on a report on cause of death prepared for the coroner. Supervisor of midwives investigations were flawed, relying on poor-quality records that conflicted with patients’ and relatives’ accounts. An external review of the governance of the unit was carried out. Although tangential to the underlying issues, this identified the dysfunctional nature of professional relationships in the unit.

13. At the same time, in early 2009, the Trust was heavily focused on achieving Foundation Trust (FT) status, and this played a significant part in what transpired. As part of the application, the Trust listed its current serious untoward incidents, and declared 12, five in FGH maternity services. This alerted Monitor, which informed the North West Strategic Health Authority (NW SHA) and the newly formed Care Quality Commission (CQC). Monitor deferred the FT application, pending a response to its concerns about the Trust's maternity services.

14. A member of NW SHA staff questioned whether there was a gap in understanding of the five 2008 incidents, and whether they should be investigated. These were the right questions, but in implementing what became the Fielding review, the Trust not only shifted the emphasis away from what had happened and onto current systems, but also instructed Dame Pauline Fielding not to investigate the incidents. Despite stating that the review had not re-examined the incidents, the Fielding Report unwisely stated that they appeared "*coincidental rather than evidence of serious dysfunction*". This was easily misread as a finding of the review, and was widely misunderstood as a result.

15. The review report was produced in draft in March 2010, but what was described as minor redrafting took until August 2010 to finalise. It contained significant criticisms of the Trust's maternity care, including dysfunctional relationships, poor environment and a poor approach to clinical governance and effectiveness. The report was given very limited circulation within the Trust, and was not shared with the NW SHA until October 2010, or with the CQC and Monitor until April 2011. Although we heard different accounts, and it was clear that there was limited managerial capacity to deal with a demanding agenda, including the FT application, we found on the balance of probability that there was an element of conscious suppression of the report both internally and externally. This was a further significant missed opportunity.

16. The NW SHA adopted a developmental approach to Trusts in its region, and was significantly less effective at intervening when problems emerged. This shaped its dealings with the Trust, and it accepted assurances that there were no systemic problems and that action plans were in place following the governance review and the external investigation of the most high-profile 2008 case. Crucially, it also accepted the view that the 2008 incidents were 'coincidental' and it erroneously regarded the Fielding Report, when it finally received it, as confirming this view. This view formed the basis of the NW SHA's briefing, including to the Department of Health (DH). Had it adopted a more 'hands-on' approach, it is likely that both the implementation of action plans and the unconnected nature of the incidents would have been challenged. This was another missed opportunity.

17. When Monitor suspended the Trust's FT application in 2009, it looked to the CQC as the arbiter of clinical quality, including patient safety. The CQC, a new organisation at that point, adopted a generic approach to utilising its staff, many of whom were from a social care background, and its North West team had little experience of the NHS. It referred the Trust to the central CQC office for a potential investigation into the maternity incidents. The CQC investigation team declined the referral, principally on the grounds that the five incidents were deemed unconnected on the basis of superficial information on cause of death, but also because it was not thought that there were systemic problems. Had the investigation progressed to the next stage of information-gathering, it would have become clear that both assumptions were mistaken. This was a further missed opportunity.

18. Nevertheless the North West CQC team still had concerns about the Trust and gave it a 'Red' risk rating, which kept the FT application suspended, and Monitor told the Trust that the rating had to be 'Green' to restart the application.

19. At this point in 2009, the Parliamentary and Health Service Ombudsman (PHSO) was considering a complaint from James Titcombe, the father of Joshua, who had died in 2008 as a result of infection that was missed for almost 24 hours in FGH, despite clear signs. The Ombudsman formed the correct view that this constituted clear evidence of systemic problems in the maternity unit, and that the CQC was better placed to investigate this than the PHSO. What followed was a series of failed communications between the PHSO and the CQC – and, more significantly, within the CQC – which led the PHSO to believe that the CQC would take robust action and that a PHSO investigation of the complaint would add nothing significant. With hindsight, a CQC investigation would not have addressed Mr Titcombe's concerns, which calls into question the linking of the Ombudsman's decision not to investigate with the CQC's intentions. This was another missed opportunity.

20. Towards the end of 2009, it was clear that the North West CQC's concerns about the Trust were declining, and the Trust's risk rating was reduced from 'Red' to 'Amber' on the basis that the 2008 incidents were unconnected and that action plans were in place. In December 2009, the CQC was still signalling that it would use the registration process to ensure robust action by the Trust. All NHS providers were required to register with the CQC from April 2010, and where there were significant concerns, this was made conditional on further action and inspection, as happened with 22 Trusts out of a total of 378. By March 2010, however, there had been a striking change of approach, which coincided with the arrival of a new North West CQC head, and the Trust was put forward for registration with only minor concerns. Although this was challenged by the CQC's central registration panel on the grounds of the recent significant concerns, the regional team maintained that the problems were being addressed. On the basis of this poor appraisal of the position, the Trust was registered without conditions from April 2010, another missed opportunity.

21. The CQC reduced the Trust's risk rating to 'Green' in the following month, and the FT application process restarted. As the application had been deferred in 2009, rather than rejected, the Trust did not go through the quality assessment newly introduced by the DH in the aftermath of the Mid Staffordshire affair, and the DH received legal advice that it should not intervene, as the application had already received the Secretary of State's approval in 2009. Monitor approved the Trust for FT status in September 2010. This was another missed opportunity to ensure an effective assessment of service quality.

22. Four events in 2011, partly interrelated, changed this position and brought the significant problems in the Trust unmistakably to wider attention. First, the CQC and Monitor obtained the Fielding Report, which confirmed the existence of systemic problems. Second, the coroner's verdict in the inquest into the death of Joshua Titcombe was strongly critical not just of the failures of care, but also of the dysfunctional relationships between staff groups, of the collaboration between staff in preparing their evidence, and of the loss of a significant observation chart. Third, a police investigation was commenced, and subsequently widened, to examine other deaths. Fourth, other families came forward in response to the police investigation, revealing that many more families had been affected than had been thought.

23. The result was a significant upturn in the external level of concern in the Trust, and an intense period of intervention from 2011 into 2012. Monitor deemed the Trust to be in breach of its terms of authorisation as a Foundation Trust, and commissioned two major external reviews. One was critical of dysfunctional clinical working, the other of inadequate and ineffective clinical governance. The CQC also reviewed the Trust, and the NW SHA called a 'Gold Command'. The outcome, from mid-2012 onwards, was an almost entirely new senior management team in the Trust, and a new approach.

24. We found welcome signs of significant recent improvement in the Trust, including its maternity services and governance, and we believe that external systems are much better placed to detect failed services and to intervene, including particularly the CQC. Nevertheless, significant progress remains to be made in our view, and it is essential that change is sustained and built upon.

25. Our conclusion is that these events represent a major failure at almost every level. There were clinical failures, including failures of knowledge, team-working and approach to risk. There were investigatory failures, so that problems were not recognised and the same mistakes were needlessly repeated. There were failures, by both maternity unit staff and senior Trust staff, to escalate clear concerns that posed a threat to safety. There were repeated failures to be honest and open with patients, relatives and others raising concerns. The Trust was not honest and open with external bodies or the public. There was significant organisational failure on the part of the CQC, which left it unable to respond effectively to evidence of problems. The NW SHA and the PHSO failed to take opportunities that could have brought the problems to light sooner, and the DH was reliant on misleadingly optimistic assessments from the NW SHA. All of these organisations failed to work together effectively and to communicate effectively, and the result was mutual reassurance concerning the Trust that was based on no substance.

26. We found at least seven significant missed opportunities to intervene over the three years from 2008 (and two previously), across each level – from the FGH maternity unit upwards. Since 2008, there have been ten deaths in which there were significant or major failures of care; different clinical care in six would have been expected to prevent the outcome. We have made recommendations for both the Trust and the wider NHS that will, if implemented, ensure that the lessons that are clear are acted upon to reduce risk and improve the quality of maternity and other services.

Recommendations for the wider NHS

Many of these recommendations are for other Trusts, but we have generally indicated the bodies responsible for leading and ensuring that action is completed.

19. In light of the evidence we have heard during the Investigation, we consider that the professional regulatory bodies should review the findings of this Report in detail with a view to investigating further the conduct of registrants involved in the care of patients during the time period of this Investigation. Action: the General Medical Council, the Nursing and Midwifery Council.
20. There should be a national review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe services under these conditions. In conjunction, a national protocol should be drawn up that defines the types of unit required in different settings and the levels of care that it is appropriate to offer in them. Action: NHS England, the Care Quality Commission, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Paediatrics and Child Health, the National Institute for Health and Care Excellence.
21. The challenge of providing healthcare in areas that are rural, difficult to recruit to or isolated is not restricted to maternity care and paediatrics. We recommend that NHS England consider the wisdom of extending the review of requirements to sustain safe provision to other services. This is an area lacking in good-quality research yet it affects many regions of England, Wales and Scotland. This should be seen as providing an opportunity to develop and promote a positive way of working in remote and rural environments. Action: NHS England.
22. We believe that the educational opportunities afforded by smaller units, particularly in delivering a broad range of care with a high personal level of responsibility, have been insufficiently recognised and exploited. We recommend that a review be carried out of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them. Action: Health Education England, the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health, the Royal College of Midwives.
23. Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. We believe that there is a strong case to include a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review, and should certainly be framed to exclude conflicts of interest between staff. We recommend that this build on national work already begun on how such a process would work. Action: the Care Quality Commission, NHS England, the Department of Health.
24. We commend the introduction of the duty of candour for all NHS professionals. This should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results. Action: the Care Quality Commission, NHS England.
25. We recommend that a duty should be placed on all NHS Boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor. The Care Quality Commission should develop a system to disseminate learning from investigations to other Trusts. Action: the Department of Health, the Care Quality Commission.

26. We commend the introduction of a clear national policy on whistleblowing. As well as protecting the interests of whistleblowers, we recommend that this is implemented in a way that ensures that a systematic and proportionate response is made by Trusts to concerns identified. Action: the Department of Health.
27. Professional regulatory bodies should clarify and reinforce the duty of professional staff to report concerns about clinical services, particularly where these relate to patient safety, and the mechanism to do so. Failure to report concerns should be regarded as a lapse from professional standards. Action: the General Medical Council, the Nursing and Midwifery Council, the Professional Standards Authority for Health and Social Care.
28. Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, the General Medical Council, the Nursing and Midwifery Council, all Trusts.
29. Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non-executives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, all Trusts.
30. A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. This should include, but not be limited to, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. Action: NHS England, the Care Quality Commission.
31. The NHS complaints system in the University Hospitals of Morecambe Bay NHS Foundation Trust failed relatives at almost every turn. Although it was not within our remit to examine the operation of the NHS complaints system nationally, both the nature of the failures and persistent comment from elsewhere lead us to suppose that this is not unique to this Trust. We believe that a fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints. Action: the Department of Health, NHS England, the Care Quality Commission, the Parliamentary and Health Service Ombudsman.
32. The Local Supervising Authority system for midwives was ineffectual at detecting manifest problems at the University Hospitals of Morecambe Bay NHS Foundation Trust, not only in individual failures of care but also with the systems to investigate them. As with complaints, our remit was not to examine the operation of the system nationally; however, the nature of the failures and the recent King's Fund review (*Midwifery regulation in the United Kingdom*) lead us to suppose that this is not unique to this Trust, although there were specific problems there that exacerbated the more systematic concern. We believe that an urgent response is required to the King's Fund findings, with effective reform of the system. Action: the Department of Health, NHS England, the Nursing and Midwifery Council.
33. We considered carefully the effectiveness of separating organisationally the regulation of quality by the Care Quality Commission from the regulation of finance and performance by Monitor, given the close inter-relationship between Trust decisions in each area. However, we were persuaded that there is more to be gained than lost by keeping regulation separated in this way, not least that decisions on safety are not perceived to be biased by their financial

implications. The close links, however, require a carefully coordinated approach, and we recommend that the organisations draw up a memorandum of understanding specifying roles, relationships and communication. Action: Monitor, the Care Quality Commission, the Department of Health.

34. The relationship between the investigation of individual complaints and the investigation of the systemic problems that they exemplify gave us cause for concern, in particular the breakdown in communication between the Care Quality Commission and the Parliamentary and Health Service Ombudsman over necessary action and follow-up. We recommend that a memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap. Action: the Care Quality Commission, the Parliamentary and Health Service Ombudsman.
35. The division of responsibilities between the Care Quality Commission and other parts of the NHS for oversight of service quality and the implementation of measures to correct patient safety failures was not clear, and we are concerned that potential ambiguity persists. We recommend that NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility. Action: the Care Quality Commission, NHS England, Monitor, the Department of Health.
36. The cumulative impact of new policies and processes, particularly the perceived pressure to achieve Foundation Trust status, together with organisational reconfiguration, placed significant pressure on the management capacity of the University Hospitals of Morecambe Bay NHS Foundation Trust to deliver against changing requirements whilst maintaining day-to-day needs, including safeguarding patient safety. Whilst we do not absolve Trusts from responsibility for prioritising limited capability safely and effectively, we recommend that the Department of Health should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required. Action: the Department of Health.
37. Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. We recommend that an explicit protocol be drawn up setting out how such processes will be managed in future. This must include systems to secure retention of both electronic and paper documents against future need, as well as ensuring a clearly defined transition of responsibilities and accountability. Action: the Department of Health.
38. Mortality recording of perinatal deaths is not sufficiently systematic, with failures to record properly at individual unit level and to account routinely for neonatal deaths of transferred babies by place of birth. This is of added significance when maternity units rely inappropriately on headline mortality figures to reassure others that all is well. We recommend that recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts. Action: NHS England.
39. There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot

understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay. Action: the Department of Health.

40. Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer. Action: the Department of Health.
41. We were concerned by the ad hoc nature and variable quality of the numerous external reviews of services that were carried out at the University Hospitals of Morecambe Bay NHS Foundation Trust. We recommend that systematic guidance be drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them. Action: the Academy of Medical Royal Colleges, the Royal College of Nursing, the Royal College of Midwives.
42. We further recommend that all external reviews of suspected service failures be registered with the Care Quality Commission and Monitor, and that the Care Quality Commission develops a system to collate learning from reviews and disseminate it to other Trusts. Action: the Care Quality Commission, Monitor.
43. We strongly endorse the emphasis placed on the quality of NHS services that began with the Darzi review, *High Quality Care for All*, and gathered importance with the response to the events at the Mid Staffordshire NHS Foundation Trust. Our findings confirm that this was necessary and must not be lost. We are concerned that the scale of recent NHS reconfiguration could result in new organisations and post-holders losing the focus on this priority. We recommend that the importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. Action: NHS England, the Department of Health.
44. This Investigation was hampered at the outset by the lack of an established framework covering such matters as access to documents, the duty of staff and former staff to cooperate, and the legal basis for handling evidence. These obstacles were overcome, but the need to do this from scratch each time an investigation of this format is set up is unnecessarily time-consuming. We believe that this is an effective investigation format that is capable of getting to the bottom of significant service and organisational problems without the need for a much more expensive, time-consuming and disruptive public inquiry. This being so, we believe that there is considerable merit in establishing a proper framework, if necessary statutory, on which future investigations could be promptly established. This would include setting out the arrangements necessary to maintain independence and work effectively and efficiently, as well as clarifying responsibilities of current and former health service staff to cooperate. Action: the Department of Health.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board – March 2015

3-11 Quality And Safety Report **Chief Nurse**

Summary / Key points

The attached report draws the Board's attention to three key issues.

1. Francis Report initial response and action plan update
2. Deprivation of Liberty Safetguards (DoLS)
3. Duty of Candour

The Francis report published in 2013 resulted in a number of key priorities for action. The resultant action plan has now come to a natural conclusion with all but two of the 16 points fully implemented. The remaining two points are now incorporated into the CQC Quality Improvement Plan (staff introducing themselves to patients) and the 2015/16 CQUIN (care plans available to patients and carers).

It is, therefore proposed that the current iteration of the Francis initial response action plan be formally closed, with the remaining points being followed through within other relevant plans.

The Deprivation of Liberty Safeguards has seen increased focus over the last year following the Supreme Court Judgement in March 2014 and the resultant 'Acid Test' for the application of deprivation of liberty safeguards. This has had significant impact on the acute care providers. MTW has previously had an average of 20 DoLS applications over the course of a year. Between January and early March there have been 92 such applications.

This has significant impact on teams in terms of additional paperwork, training and follow up.

The Duty of Candour requirement following the publication of Francis came into force at the end of last year. The process appears complex but impact on front line staff is minimal. The Duty of Candour requires a culture shift in the workforce to understand that an apology is not the same as admitting liability.The process of written follow up following an event classed as moderate or severe generates approximately 70 letters per month managed by the incident handler with support from the patient safety team.

Both the Duty of Candour and Deprivation of Liberty Safeguards application are statutory requirements.

Reason for receipt at the Board.
Decision on point 1, points 2 and 3 for information

Quality and Safety Report

This report draws the attention of the Board to three key areas.

1. Francis initial response and action plan
2. Deprivation of Liberty Safeguards
3. Duty of Candour

Whilst the quality dashboard indicates some other areas requiring improvement, notably complaints, falls and stroke; these have been subject to detailed review via the Quality & Safety Committee and the Patient Experience Committee. The board has received updates on these issues via the Committee reports.

1. Francis Report – Initial Response:

The Francis Report was published in February 2013, with a number of recommendations relevant to acute health care providers. The Executive Team agreed a number of key priority areas which were approved by the Board in March 2013.

The key actions agreed in March 2013 are now broadly complete. The updated action plan is attached (Appendix 1).

Of the 16 actions identified, two are still to be fully completed. These will now be included in new refreshed action plans.

These points are:

> Action point 9: Staff should have named badges that are clearly readable at a reasonable distance.

This action is broadly complete, however the on-going work attached to this includes a culture change of staff to ensure that they introduce themselves to patients and carers. This on-going element of the action will now be included within the CQC Quality Improvement plan (action TW43).

> Action point 11: Patients should receive a copy of their care plan….and be able to record their own comments.

Sustainable work on this has been slow to progress. Work with carers is now well underway, and this element links well with a proposed CQUIN for 2015/16 relating to the issuing of care plans to patients, cares and community teams as part of the care pathway for patients with dementia. The lessons learnt from this exercise can subsequently be replicated across other patient groups.

This action will, therefore be incorporated into the Dementia Strategy and linked to a related action point in the CQC Quality Improvement plan (action CA11).

It proposed that the current iteration of the Francis Initial Response action plan be closed, with the assurance that the remaining on-going actions are addressed as part of the improvement detail above.

2. Deprivation of Liberty Safeguards

The Supreme Court Judgement in the cases of P v Cheshire West and P&Q v Surrey County Council published in March 2014 set out the principles to be applied in determining whether or not a person was being deprived of their liberty. The clarification given was termed the “Acid Test”.

For a person who lacks the Mental Capacity to make the decision to be in hospital for care and treatment the Acid Test states that a deprivation of liberty occurs when a person is:-

- under continuous supervision and control

AND

- they would not be free to leave.

Crucially they do not have to be trying to leave or saying they wish to leave, or indeed be able to attempt to leave. This is about the individual's consent to remain in hospital. It is not about their care or treatment.

This clarification and apparent extension of application has had significant implications for providers of acute care.

Approach:
For the initial few months after the publication of the Supreme Court Judgement, the Trust took the decision to 'maintain a steady course'. Staff were already familiar with DOLS assessment and application, and at that time there was not concern that we were either under or over reporting.

The Matron for Safeguarding Adults undertook a review of the Judgement and its implications for the Trust. This review included liaison with other acute care providers and the MCA/DOLS Policy Manager for Kent County Council. Interpretation and application in the acute care setting was then sense checked with both our internal legal team and with Brachers.

Attempts have been made to apply the judgement in a pragmatic fashion for example to delay mental capacity assessment and urgent application for a DOLS until 24 hours post admission to allow for any organic and correctable cause for lack of mental capacity to be identified and treated.

Implications:
A significant number of patients in our care now fit the inclusion criteria for a DOLS.
April – December 2014, whilst considering the Trust's position 20 DOLS applications were made for patients across the Trust. January 2015 to 13th March 2015 the Trust has made 92 applications – 60 from TWH and 32 from Maidstone Hospital.

Notably increases have been seen in Acute Stroke Care, General Medicine and Intensive Care.

There are also implications for end of life care, where the individual is admitted to hospital in the end stages of life, without capacity, and without any clear expression of wishes for care at end of life.

Where a patient dies with a DOLS in place, this has the legal status of a Death in Custody. This, then, requires the case to be referred to the Coroner.

The Coroner's Offices have indicated that where the death was expected and cause known, there is unlikely to be any delays in releasing the body. The Coroner's Office is sympathetic to family needs, and will for the majority of cases only have a conversation with the attending clinician.

Process & Impact:
The DOLS process is a two stage process as far as front line clinical staff are concerned.

Stage 1 is the assessment of mental capacity for the patient's decision to be/remain in hospital, to determine whether or not a DOLS is required.

Stage 2 is the completion and submission of both an Urgent DOLS and Standard DOLS application.

The completion of the appropriate paperwork takes, on average, 30 minutes. This is assuming that the clinician understands the process and is familiar with the forms. The forms are the intellectual property of the Department of Health, so whilst the Trust can influence the review and development of the forms, we cannot make any unilateral alteration to the forms or the wider process.

Outcome of the DOLS assessment (i.e. the standard authorisation given by the supervising authority) has to be notified to the Care Quality Commission. A death whilst under a DOLS has to be notified to the Coroner's Office. The Bereavement Office now has in place systems and processes to identify which patients are subject to a DOLS, and ensure the appropriate liaison and reporting is undertaken.

Training
The Matron for Safeguarding Adults has put in place a comprehensive training programme for Mental Capacity Assessment and DOLS assessment. This programme is delivered via the clinical update sessions and clinical induction programmes for all clinical staff groups. Since the publication of the Supreme Court Judgement, additional training has been provided at ward and department level. This training is bespoke to the ward or department and is, where possible, delivered at a time to suit the team. Practical application is covered, and where possible 'live' cases are used to facilitate learning. To date 120 staff have been trained at ward level.

DOLS Office
The safeguards that should be in place once a DOLS has been applied for and authorised are that the DOLS Office (Local Authority) send out a Best Interest Assessor (BIA) and Approved Mental Health Worker (AMPH) to give external scrutiny to the patients' arrangements for care and treatment. They will also appoint a Relevant Persons Representative (RPR) – usually a family member or friend to monitor the patients' situation. If an RPR is not available they will appoint an Independent Mental Capacity Advocate (IMCA) to this role. The DOLS also gives the patient or their RPR the right to appeal if they feel that the care arrangements are inappropriate.

Since the Judgement the DOLS Office has seen an eight fold increase in applications. They do scrutinise and triage all applications on a daily basis and will prioritise those patients or residents from care homes who are persistently trying to leave, being restrained or sedated.

To date out of our 92 applications made this year the Safeguards have only been put in place for 3 of these patients.

3. Duty of Candour

The introduction of a statutory Duty of Candour is a major step towards implementing a key recommendation from the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Inquiry). The Duty of Candour places a requirement on providers of health and adult social care to be open with patients when things go wrong. Providers should establish the duty throughout their organisations, ensuring that honesty and transparency are the norm in every healthcare organisation.

The existing professional duties on doctors are to be open and honest with patients about their care, and the sanction for any failure, underpin these standards (GMC). The NMC also set out the code of practice for nurses and midwives which includes a requirement to '*provide a high standard of practice and care at all times be open and honest, act with integrity and uphold the reputation of your profession'* (NMC). These professional requirements align with the Duty of Candour requirements which set out this specific element in a structured and explicit way.

The *Candour Review* (Dalton and Williams, March 2014) had 3 recommendations:

Recommendation 1 A duty of candour requires a culture of candour, and this requires all organisations registered by the CQC to:

Train and support staff to disclose information about unanticipated events in a patient's care and to apologise when appropriate and improve the levels and accuracy of reporting patient safety incidents so that this information is used as the basis for organisational learning and not for criticism of individuals; and close the 'audit loop' by spreading and applying lessons learned into practice and publicly report these.

Recommendation 2: The duty of candour should apply to all cases of 'significant harm'. This new composite classification would cover the National Reporting and Learning System categories of 'moderate', 'severe' and 'death'; harm that is notifiable to the Care Quality Commission; and would include 'prolonged psychological harm'. This is in line with the 'Being Open' guidance.

Recommendation 3: The focus of any sanctions on organisations found to be in breach of the duty (Regulation 20) will result in compliance / enforcement action.

Threshold
In the regulations, the harm threshold for healthcare is set at the threshold recommended by Dalton/Williams to include 'moderate' harm. This means that all harm that is classified as moderate or severe or where 'prolonged psychological harm' has arisen gives rise to a Duty of Candour to the service user, or a person lawfully acting on their behalf. The Duty will also apply in cases of death, if the death relates to the incident of harm rather than to the natural course of the service user's illness or underlying condition

Duty of candour includes a duty once the explanation has been provided and apologies offered, to follow this up in written form (over and above making a note in the records).

Examples (not exhaustive)
Serious harm
Pressure Ulcer Category 3 / 4
Fall in hospital resulting in requirement for surgery / death
Allegations of abuse
Unexpected or avoidable death
Medication error that needs lifesaving or serious medical / surgical intervention
Delayed diagnosis leading to permanent harm

Moderate harm
Pressure Ulcer Category 2
Fall in hospital resulting in haematoma / laceration not requiring surgery
Injection into wrong area of the body but no permanent harm
C.Diff hospital acquired infection requiring additional treatment but no permanent harm
Delay in diagnosis resulting in additional treatment, prolonged hospital stay and significant but not permanent harm

Duty of Candour and Incident reporting (DATIX reporting)
Duty of Candour established the requirements organisations are required to adhere to when notifiable safety incidents occur. Incident reporting sits alongside this process but has a wider remit capturing a variety of different types of incidents that occur in the organisation.

Duty of Candour requirements currently only relate to *notifiable safety incidents* that have resulted in *harm*, however incident reporting relates to *all incidents* that occur *regardless whether harm has occurred or not*. Incidents cover when things happen that shouldn't, when things didn't happen that should have, errors, near misses, when risks are identified, when harm occurs, concerns are raised and where things aren't right.

Apology and legalities
An “apology” in the context of the duty of candour means an expression of sorry or regret in respect of the notifiable safety incident. By apologising in this way and to this extent, clinicians would not be exposing themselves and the Trust to legal liability. It is proposed that where moderate or severe harm has occurred the clinician providing care (nurse or doctor) should speak to the patient (or person acting legally on their behalf) acknowledge and explain what happened and what will happen next and offer an apology. In cases of death this conversation should be undertaken by a register, consultant or matron. The apology and information given to patient needs to be clearly documented in the patient’s notes

Process:
When it has been identified that an error has occurred, or something has happened that was not expected, then the doctor or nurse looking after the patient explains what has happened, provides and apology and details the next steps – i.e. an explanation of the investigation process. Where there was low level harm or no harm, a verbal apology is all that is required. This should be documented in the notes and noted on the Datix report under ‘Being Open’.

Where there has been moderate or severe harm, there is a requirement to detail the apology and a point of contact in writing to the patient or their carer. A template letter has been developed and is available to download from Q-Pulse. The point of contact should be one of the team caring for the patient. The template letter is currently being reviewed following feedback from staff. This letter should be provided to the patient within 7 days of the incident coming to light.

The Patient Experience Matron is also available as an independent point of contact. The purpose of this point of contact is to provide an additional line of communication to the patient, to keep them informed of the investigation process and to answer (or to facilitate the answering) any questions or concerns the patient may have.

The Patient Safety Team review all Datix incident reports that are reported as moderate or severe and check with the reporting team that the Duty of Candour process in being followed. A copy of the letter should be sent to the Patient Safety Team once written and provided to the patient.

Training:
Training to support the implementation of this process has been delivered in a variety of ways. It has been included in directorate level meetings, department meetings and senior team meetings. Further work is being undertaken to refine the training and broaden the accessibility, this includes exploring the provision of training at clinical induction.

Training to date has relied on a cascade approach, with support from the Associate Director of Governance, Quality & Patient Safety and the Patient Safety Team / Legal Team. The Patient Experience Matron and the Deputy Chief Nurse has also supported some training activity to nursing staff.

Impact:
The process has had a minimal increase in workload for clinical staff who are required to offer a verbal apology, document this in the notes and report the incident on Datix. All these elements would already be expected of a clinical staff as part of good practice. However, there will be an increase in workload of approximately 70 letters per month generated by incident handlers with support from the patient safety team. There will also be the same number of follow up letters from the patient safety team / handlers at the end of the process.

The statutory requirements include training for all staff and records of direct teaching have been kept. The Duty of Candour process will also be subject to internal auditing as evidence of compliance for both internal and external scrutiny.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board – March 2015

3-12 Safe Staffing: Planned V Actual – Feb'15 Chief Nurse

Summary / Key points

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for the month of February 2015. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

The report also includes some nurse sensitive indicators to support the professional judgement of safe delivery of care. Nurse sensitive indicators are those indicators that may be adversely impacted on if staffing levels are insufficient for the acuity and dependency of the ward. These indicators are supported by the Department of Health and latterly by the NICE review of ward staffing published in July 2014.

The RAG rating for the fill rate is rated as:

Green: 100% -/+ 10%
Amber <90% or > 110%
Red <80%

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

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

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

The **overall** RAG status gives an indication of the safety levels of the ward, compared to professional judgement as set out in the Staffing Escalation Policy, the thresholds for which are:

RAG	Details
	Minor or No impact: Staffing levels are as expected and the ward is considered to be safely staffed taking into consideration workloads, patient acuity and skill mix. RN to patient ratio of 1:7 or better Skill mix within recommended guidance Routine sickness/absence not impacting on safe care delivery Clinical Care given as planned including clinical obersvations, food and hydration needs met, and drug rounds on time. OR Staffing numbers not as expected but reasonable given current workload and patient acuity.

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

Which Committees have reviewed the information prior to Board submission?
None

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

Planned v Actuals February 2015

			Day		Night		Nurse Sensitive Indicators						
Hospital Site name	Ward name	Specialty	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	FFT Score	FFT Response Rate	C.Diff	Falls	PU - ward acquired	Overall RAG Status	Comments
Maidstone Hospital	Acute Stroke	300 - GENERAL MEDICINE	99.1%	106.1%	98.8%	167.9%	84	37%	2	2	0		Increased depedency at night. 18 nights required additional care staff to support confused patients
Maidstone Hospital	Romney	314 - REHABILITATION	94.0%	103.6%	103.6%	100.0%			0	2	0		
Maidstone Hospital	Cornwallis	100 - GENERAL SURGERY	96.0%	116.1%	108.3%	N/A	85	35%	0	2	0		Increased dependency over 9 days requiring additional care staff.
Maidstone Hospital	Coronary Care Unit (CCU)	320 - CARDIOLOGY	88.1%	N/A	100.0%	N/A	88	84%	0	0	0		RN fill rate coverd when required by Culpepper as CCU is co-located
Maidstone Hospital	Culpepper	320 - CARDIOLOGY	100.0%	94.6%	100.0%	92.9%	88	80%	0	0	0		
Maidstone Hospital	Foster Clark	340 - RESPIRATORY MEDICINE	96.0%	119.9%	97.3%	103.6%	57	70%	0	5	0		Increased Care staff to support combined increase in acutiy AND dependency.
Maidstone Hospital	Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE	94.2%	59.6%	96.4%	N/A	100	300%	0	0	0		Decreased dependency over 6 days resulting in decreased staffing requirements. Care (CSW) staff fill rate low, as per above. CSW role covered by RNs as primarily a runner, stock supply and bed space preparation role.
Maidstone Hospital	John Day	301 - GASTROENTEROLOGY	80.7%	144.4%	92.9%	115.4%	47	42%	0	1	0		Additional care staff to monitor confused wandering patients. 5 specials - all named and reviewed by Matron. RN/CSW split during the day at minimum tollerance.
Maidstone Hospital	Jonathan Saunders	430 - GERIATRIC MEDICINE	100.0%	141.1%	100.0%	189.3%	60	33%	0	5	0		24hr special required for 1 patient over 23 days.
Maidstone Hospital	Lord North	370 - MEDICAL ONCOLOGY	94.3%	100.0%	103.6%	100.0%	89	65%	1	2	0		
Maidstone Hospital	Mercer	430 - GERIATRIC MEDICINE	95.5%	96.4%	98.8%	192.9%	69	27%	0	8	0		Additional care staff required at night to support cognitive impairment patients and falls risks
Maidstone Hospital	Pye Oliver	100 - GENERAL SURGERY	87.9%	164.3%	84.5%	139.3%	49	44%	0	5	0		Increased numbers of non-surgical patients combined with increased dependency (not acuity). RN fill rate fell below 90% resulting some minor impacts on care; RN/CSW ratio at minimal tollerance
Maidstone Hospital	Urgent Medical Ambulatory Unit (UMAU)	180 - ACCIDENT & EMERGENCY	93.3%	93.3%	126.2%	207.1%	64	32%	0	4	0		Increased requirement above plan as trolleys converted to beds for additional capacity for 25 nights
The Tunbridge Wells Hospital	Acute Stroke	430 - GERIATRIC MEDICINE	97.6%	94.6%	101.2%	100.0%	90	91%	0	3	0		
The Tunbridge Wells Hospital	Coronary Care Unit (CCU)	320 - CARDIOLOGY	98.8%	110.7%	96.4%	N/A	91	105%	0	1	0		
The Tunbridge Wells Hospital	Gynaecology	502 - GYNAECOLOGY	95.8%	92.5%	98.2%	96.4%	70	30%	0	1	0		
The Tunbridge Wells Hospital	Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE	98.7%	100.0%	101.3%	50.0%	No Responses	0%	0	0	0		Care staff fill rate at night had minimal impact as 'runner' role covered by nurse in charge. No FFT as no patients discharged home from unit.
The Tunbridge Wells Hospital	Medical Assessment Unit	180 - ACCIDENT & EMERGENCY	100.0%	97.8%	101.2%	121.4%	69	28%	0	15	2		Increased requirement for care staff at night due to a number of patient with cognative impairment
The Tunbridge Wells Hospital	SSSU	100 - GENERAL SURGERY	105.0%	115.0%	N/A	N/A	No Responses	0%	0	1	0		Increased care staff to support over-spil from SAU. SAU ecalated and utilised some SSSU beds to maintain single sex compliance.
The Tunbridge Wells Hospital	Ward 32	110 - TRAUMA & ORTHOPAEDICS	94.6%	100.0%	100.0%	104.5%	82	69%	0	0	0		
The Tunbridge Wells Hospital	Ward 10	100 - GENERAL SURGERY	96.4%	136.6%	79.5%	167.9%	67	24%	1	1	0		Increased dependency due to confusional states. Additiona care staff required on 28 shifts. RN fill rate fell below 80% over the month; Maton confirms that whilst some care tasks were not always done to time, there was minimal impact on patient care.
The Tunbridge Wells Hospital	Ward 11	100 - GENERAL SURGERY	94.6%	127.4%	93.8%	114.3%	87	63%	0	4	0		Increased dependency; requirement for increased care staff on 24 shifts
The Tunbridge Wells Hospital	Ward 12	320 - CARDIOLOGY	90.4%	103.6%	82.9%	125.0%	86	10%	0	14	0		Whilst patient care was maintained. There was shift between RN and CSW split.
The Tunbridge Wells Hospital	Ward 20	430 - GERIATRIC MEDICINE	97.5%	101.8%	94.6%	150.0%	33	12%	0	1	1		Addional care staff required for cohort fall prevetion at night (28 nights)
The Tunbridge Wells Hospital	Ward 21	340 - RESPIRATORY MEDICINE	91.4%	104.8%	93.5%	114.3%	79	37%	0	5	0		Whilst actual met plan overall, acuity was increased. Additional support provided by Resp CNS and loss of supervisory time of shift coordinator
The Tunbridge Wells Hospital	Ward 22	430 - GERIATRIC MEDICINE	97.3%	111.9%	98.8%	97.6%	40	114%	0	5	1		Increase in care staff reflects 5 shifts where RN gap was covered by CSW
The Tunbridge Wells Hospital	Ward 30	110 - TRAUMA & ORTHOPAEDICS	96.8%	113.5%	106.3%	126.8%	100	12%	0	10	0		Ward 30 & 31 cross cover according to acutiy & dependency. Whilst overall numbers & nurse to patient ratios are within acceptable tollerances, there is a heavy reliance on temporary staffing due to high vacancy
The Tunbridge Wells Hospital	Ward 31	110 - TRAUMA & ORTHOPAEDICS	110.1%	76.4%	84.2%	109.6%	33	7%	0	5	2		
Tonbridge Cottage Hospital	Stroke Rehab	430 - GERIATRIC MEDICINE	86.3%	89.3%	100.0%	100.0%	57	175%	0	2	0		Day fill rate had minimal impact on patient care, as Supervisory RN on early shift covered. Total of 8 shifts
The Tunbridge Wells Hospital	ante-natal	501 - OBSTETRICS	92.9%	85.7%	92.9%	78.6%			0	0	0		Midwives move with women during the course of the shift to or from delivery suite. FFT is reported by touch point within care pathway, not by location.
The Tunbridge Wells Hospital	delivery suite	501 - OBSTETRICS	96.8%	101.8%	104.5%	98.2%			0	0	0		
The Tunbridge Wells Hospital	post-natal	501 - OBSTETRICS	103.8%	109.3%	99.1%	95.5%			0	0	0		
The Tunbridge Wells Hospital	Gynae Triage	502 - GYNAECOLOGY	89.3%	92.9%	98.2%	103.6%			0	0	0		
The Tunbridge Wells Hospital	Hedgehog	420 - PAEDIATRICS	91.7%	87.5%	100.6%	96.4%			0	2	0		Care staff reduced on Hedgehog to cover additional capacity on Woodlands
Maidstone Hospital	Birth Centre	501 - OBSTETRICS	100.0%	103.6%	100.0%	92.9%			0	0	0		
The Tunbridge Wells Hospital	Neonatal Unit	420 - PAEDIATRICS	104.2%	67.9%	99.4%	96.4%			0	0	0		Care staff fill rate had minimal impact on direct care, as runner/support role covered by nurse in charge
Maidstone Hospital	MSSU	100 - GENERAL SURGERY	89.6%	123.3%	115.6%	N/A			0	0	0		Addition capacity beds for 3 nights. Care staffin increased during the day to support care for non-short stay surgical patients.
Maidstone Hospital	Chaucer	180 - ACCIDENT & EMERGENCY	95.0%	114.3%	96.4%	106.3%	76	81%	0	3	1		Care staff to support denpendency. Funded additional capacity ward. Time limted funding impacts on long-term recruitment
The Tunbridge Wells Hospital	SAU	180 - ACCIDENT & EMERGENCY	116.7%	103.6%	162.5%	171.4%			0	0	0		Escalation beds used throughout the month.

Maidstone and Tunbridge Wells NHS
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Trust Board meeting - March 2015

3-13	Progress with Quality Improvement Plan	Chief Nurse

Summary / Key points

The final version of the Quality Improvement Plan (QIP) that was developed in response to findings from the Care Quality Commission (CQC) inspection in October 2014 is enclosed. The comments received at the February Board (Part 2) have been taken into account.

The QIP was submitted to the CQC on 16th March, and has also been shared with staff and external partners.

At the February Board it was agreed a report will be received each month on the implementation of the plan. The format of such assurance reports is being finalised, and the first such report will be received at the April Board.

Which Committees have reviewed the information prior to Board submission?

- Quality and Safety Committee, 11/03/15

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

Assurance

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

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CQC Quality Improvement Plan

Introduction

The CQC carried out a Chief Inspector of Hospitals announced inspection of MTW between 14 and 16 October 2014, as part of the process the CQC also undertook two unannounced visits on 23 and 24 October 2014.

A team of 41 CQC inspectors visited Maidstone Hospital, Tunbridge Wells Hospital and Stroke Rehabilitation services provided at Tonbridge Cottage Hospital. The Quality Summit took place on 29 January 2015 and the final reports were published on 3 February 2015. The Trust has been assessed overall as 'Requires Improvement' and was given 29 good ratings; 43 require improvement ratings and 6 inadequate ratings.

Although the Trust was disappointed with the overall results the report has been welcomed and will be used to drive quality improvements throughout the organisation and improve the services that we provide to our patients. The Trust is pleased that the Caring domain was rated 'good' throughout the Trust and also with the recognition of our caring and compassionate staff.

Quality Improvement Plan (QIP)

There is one enforcement action and 18 compliance actions: 'must dos' within the report. There are 49 'should do' actions which relate to the key issues within directorates and trust wide.

A comprehensive Quality Improvement Plan (QIP) has been developed following extensive discussions with our staff and stakeholders. The QIP has been divided into 3 sections: enforcement action, compliance actions and 'should do' actions. Each issue has been linked to a directorate or has been identified as a trust wide issue

Governance and Engagement

Running alongside the actions detailed within the plan the overarching issues of governance processes and engagement of staff are being addressed. With external support an overall review of organisational governance processes from ward to board is underway to achieve the implementation of effective governance framework which is clear and has the understanding and engagement of our staff.

Maidstone and Tunbridge Wells NHS
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Quality Improvement Plan – Delivery ratings

The ratings within the Quality Improvement Plan relate to overall completion of each issue identified for the compliance actions and 'should do' actions. All actions have to be completed with evidence submitted to achieve final completion.

Blue	In progress within timeframe
Amber	In progress and 4 weeks to completion
Light Green	Completed without evidence submitted
Dark Green	Completed with evidence submitted
Red	Breached expected timeframe

Governance process

Internal monitoring

Each of the compliance actions has an Executive Director Lead and Clinical Director / Operational Lead. Progress on the compliance actions within the Quality Improvement Plan will be monitored through the directorate management / governance meetings monthly. An assurance report will be produced monthly by the Associate Director Governance, Quality and Patient Safety and this report will detail progress against each action and highlight any risks to delivery and mitigation. This report will be discussed at the Trust Management Executive (TME) Chaired by the Chief Executive monthly. The Trust Board will receive progress reports monthly.

The 49 'should do' actions will be monitored through the directorate meetings / or by action lead (for corporate actions) and a monthly report will be produced by the Associate Director Governance, Quality and Patient Safety highlighting any areas or concern. Progress against these will be reported to TME / Trust Board on an exception basis. The exception reporting will include actions that have been completed and those that have not progressed as expected and detail what action is being taken to get progress back on track.

The Chief Nurse and Associate Director of Governance, Quality and Patient Safety will have complete oversight of progress with all actions.

Maidstone and Tunbridge Wells NHS
NHS Trust

External monitoring

The Quality Improvement Plan will be monitored monthly at the Integrated Delivery Meeting (IDM). The Trust will provide a written report detailing progress, highlighting any risks to delivery and mitigation in place.

The Quality Improvement Plan has been developed following consultation with the following

MTW Trust Staff
Julie Blumgart, Director of Quality, Trust Development Authority
Vicki Dixon, Quality Lead, Trust Development Authority
Ian Ayers, Responsible Officer, West Kent CCG
Alison Brett, Acting Chief Nurse, West Kent CCG
Ashley Parrott, Head of Quality, East Sussex CCG
Sally Allum, Chief Nurse, NHS England Area Team
Paula Wilkins, Deputy Chief Nurse, NHS England Area Team
Philippa Spicer, Health Education England
Steve Inett, Chief Executive Healthwatch Kent
Elizabeth Mackie, Health East Sussex

Enforcement Action

Enforcement Action			REF	Directorate	Issue Identified	Action /s	Lead	Date to be completed	Evidence Required	Outcome/success criteria	Delivery RATING
Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – Cleanliness and Infection Control Cleanliness and infection control 12. (1) The registered person must, so far as reasonably practicable, ensure that – (a) Service users; (b) Persons employed for the purpose of the carrying on of the regulated activity; and (c) Others who may be at risk of exposure to a health care associated infection arising from the carrying on of the regulated activity, are protected against identifiable risks of acquiring such an infection by the means specified in paragraph (2), (2) The means referred to in paragraph (1) are (a) The effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection; People who use services and others were not protected against the risks associated with health care associated infections because the trust had failed to ensure that an effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of health care associated infections, with specific regard to water quality and safety and more specifically, themanagement and control of Legionella. Regulation 12(1)(a)(b)(c)(2)(a)(c).	**Executive Lead: Glenn Douglas**	**Date compliance will be achieved by: January 2015**	**EN1**	Estates and Facilities Management	The annual water sampling for legionella was six months overdue at Maidstone Hospital	1. Internal Investigation undertaken 2. External review undertaken 3. Water Hygiene Management Action Plan developed and implemented 4. Governance around water hygiene management reviewed and new system of robust Governance implemented 5. Risk Assessments and Sampling testing undertaken 6. Authorised Engineer (Water) appointed 7. Estate Management and Audit review of processes with a number of new appointments have been made within the senior team of Estates Services ensuring Authorised Persons in each technical element. The planned preventative maintenance schedule is currently being reviewed to ensure all statutory requirements are incorporated. In addition a comprehensive schedule is being developed for audit purposes. The internal auditing will be triangulated by the inspections, risk assessments and annual report undertaken and issued by the Authorised Engineer (Water) who provides the independent assurance and validation.	Jeanette Rooke	Completed 14th January 2015	Report produced outlining Governance, testing results and audit processes External review report Certificates of sampling Ongoing Agenda and Minutes of meetings	Water hygiene Management is compliant with statutory requirements with robust governance and management in place	

Compliance actions

			REF	Directorate	Issue Identified	Action /s	Lead	Operational leadership	Overall completion date	Evidence Required	Outcome/success criteria	DELIVERY RATING
Compliance Action 1-7: Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Care and welfare of service users9.—(1) The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of— (b) the planning and delivery of care and, where appropriate, treatment in such a way as to— (i) meet the service user's individual needs, (ii) ensure the welfare and safety of the service user, (iii) reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment.		Executive lead: Glenn Douglas / Avey Bhatia	Date compliance will be achived by: August 2015	CA1	Children's services	The PEWS system had not been validated and was not supported by a robust escalation protocol that was fit for purpose and was not standardised across the children's' directorate.	PHASE 1 (to achieve compliance) 1. PEWS chart reviewed in line with tertiary referral centres (Nottingham) or PEWS from National Institute for Innovation (used in other Trusts) 2. Escalation protocol reviewed alongside the PEWS chart review 3. Once agreed, PEWS chart and escalation protocol implemented across Children's services directorate via teaching sessions, ward level meetings, A&E and Childrens services Clinical Governance meeting PHASE 2 Electronic solution (Nervecentre) for PEWS and esclation implemented (brought forward within exisiting IT plan). NB excludes paediatric A&E	Hamudi Kisat, Clinical Director	Jenny Head, Matron	PHASE 1 31/6/15 PHASE 2 31/12/15	1. Validated PEWS in place. 2. Revised escalation protocol in place 3. Staff competent and consistent in using PEWS and escalation. 4. 3 monthly audit of compliance 5. Evidence of communication via meetings 6. Compliance audit from Nervecenter	All children managed in line with PEWS and escalation used appropriately to safely manage children.	
			CA2	Critical Care	Contrary to the core standards of the Intensive Care Society: There was a lack of cover by consultants specialising in intensive care medicine at weekends; for example, one consultant covered more than 15 patients on two sites.	1. Morning week-end ward rounds on both units implemented 2. Second ward round at weekend is taking place at both units. Risk assessment undertaken with mitigations in place as required 3. The rota for the intensivists reviewed in line with the requirements of the ICS core standards 4. Business case for additional intensivists developed and considered 5. Mitigation in place for non-compliance OR 6. Recruitment achieved	Richard Leech, Clinical Director	Daniel Gaughan, General Manager	1. 1/2/15 2. 31/3/15 3. 31/3/15 4. 17/6/15 5. 30/6/15 6. 1/4/16	1. Anaesthetic electronic rota showing allocation of intensivists at weekends to site allocation 2. Business plan including risk assessment, mitigations and staffing analysis against core standards 3. TME Meeting minutes where business case considered and decision made 4. Audit of patients medical notes documenting weekend Consultant reviews	Twice daily Consultant led reviews of patients in ICU. Compliance with core standards or demonstration of mitigation in place to safely manage patients	
			CA3	Critical Care	Contrary to the core standards of the Intensive Care Society: The consultant was not always available within 30 minutes. There was only one ward round per day when there should be two to comply with core standards.	1. Travel times & distance for each consultant being reviewed to assess compliance with 30 minutes availability for each individual consultant. 2. Risk assessment to be undertaken where travel times exceed 30mins 3. Ward round compliance actions in CA2 above	Richard Leech, Clinical Director	Daniel Gaughan, General Manager	1. 31/5/15 2. 31/5/15 3. 31/3/15	1. Report from Clinical Director outlining each Consultant's travel distance and confirmation of each Consultants ability to respond within 30 minutes. 2. Any delays in responding to be reported as incidents (DATIX) 3. Audit of patients medical notes documenting weekend Consultant reviews	Consultant avaliable within 30minutes No incidents reported on DATIX relating to delays in Ward rounds twice daily	
			CA4	Critical Care	Contrary to the core standards of the Intensive Care Society: Admissions were delayed for more than four hours once the decision was made to admit a patient to the intensive care unit (ICU).	1. Consider option of ringfencing ITU bed for admission 2. Standard Operating Procedure developed relating to ITU admissions 3. Review SOP for managing critically ill patients requiring ITU, when ITU capacity is full (for e.g. in recovery) 4. ITU referrals & those patients requiring ITU will be identified and discussed at each site meeting and priorities escalated as appropriate. 5. When no prospect of ITU capacity available on either site then arrangements for transfer to another unit will be made.	Richard Leech, Clinical Director	Jackie Slingsby, Matron Lynn Gray, ADN emergency services	1. 20/5/15 2. 31/5/15 3. 31/5/15 3. 30/4/15 4. 1/4/15 5. 1/1/15	1. Minutes of TME meeting where ringfencing option discussed 2. SOP for ITU admissions, transfers and discharges. SOP for managing critically ill pt when ITU is full 3. Site report documentation 4. Monthly performance data 5. DATIX IR1 completed for each patient who has a delayed admission to ITU due to inability to move wardable patients. Investigation into each occurrence with clear lessons learnt and changes implemented	No delays in admission to ITU longer than 4 hours from DTA	
			CA5	Critical Care	Contrary to the core standards of the Intensive Care Society: Discharges from the ICU were delayed for up to a week. Of all discharges, 82% were delayed for more than 4 hours	1. Standard Operating Procedure to be developed relating to ITU discharges 2. Transfers out of ITU to be followed up on a named patient basis at each site meeting 3. To link in with Trust wide work around patient flow and delayed discharges improvement plan developed in line with D16 CQUIN and in collaboration with Chief Operating Officer and Clinical Site Management team	Richard Leech, Clinical Director	Jackie Slingsby, Matron Lynn Gray, ADN emergency services	1. 31/5/15 2. 1/4/15 3. 30/5/15	1. SOP for ITU admissions, transfers and discharges. 2. Site report documentation. 3. Monthly performance data 4. DATIX incident report completed for each patient who has a delayed discharge from ITU Investigation into each occurrence with clear lessons learnt and changes implemented	Improvements to discharge from ITU by 4hrs in line with national standards No delays in discharges from ITU longer than 24hours	
			CA6	Critical Care	Contrary to the core standards of the Intensive Care Society: Overnight discharges take place from the ICU.	1. All ward fit patients to be identified to the site team at the earliest opportunity but by 1500 at the latest each day. 2. Transfer plans to be agreed and completed by 2000 hrs at the latest. No patients to be routinely transferred from ITU after 2000.	Richard Leech, Clinical Director	Jackie Slingsby, Matron Lynn Gray, ADN emergency services	1. 1/3/15 2. 1/3/15	1. Incident (DATIX) report to be raised on all post 2000hrs transfers. Review and identification of where lessons can be learnt and improvements made	No patients transferred out of ICU after 2000hrs unless emergency	
			CA7	Critical Care	The outreach service does not comply with current guidelines (National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2011))	1. Business Case approved 2. Recruitment to posts 3. Implementation of a 24 hour 7 day out-reach service which will be fully integrated with critical care service	Richard Leech, Clinical Director	Siobhan Callanan, ADN planned care	1. 27/1/15 2. 1/9/15 3. 1/10/15	1. Rota showing 24 hour / 7day cover 2. Review of service and performance data via Directorate Clinical Governance meetings	24 hour / 7day outreach service in place. No Serious Incidents relating to sub-optimal care of deteriorating patients	
Compliance Action 8: Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010: Safety and Suitability of Premises People who use the service were not protected against the risks associated with unsafe or unsuitable premises.		Executive Lead: Glenn Douglas	Date compliance will be achieved by: APRIL 2015	CA8	Critical Care	Improvements are needed in relation to the environment in the Intensive Care Unit with regards to toilet/shower facilities for patients.	1. Conversion of an existing toilet to a patient toilet & bathroom facility at Tunbridge Wells Hospital 2. Provision of appropriate patient washing facilities within Critical Care at Maidstone Hospital	Richard Leech, Clinical Director	Jackie Slingsby, Matron	1. 1/4/15 2. 1/4/15	1. Photo of Toilet / shower facilities appropriate for patient use 2. Confirmation at Executive / Non Executive walkabout	Toilet / shower facilities appropriate for patient use	

Compliance Action 9 & 10: Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services. Regulation 17 (1)(h) HSCA 2008 (Regulated Activities), Regulations 2010: respecting and involving services users	Executive Lead: Angela Gallagher	Date compliance will be achieved by: APRIL 2016	CA9	Trust wide	The provider did not ensure that care and treatment was provided to service users with due regard to their cultural and linguistic background and any disability they may have.	1. Appoint a dedicated lead for Equality and Diversity for Trust 2. Develop an E&D awareness programme for all staff 3. Review and develop new E&D strategy for organisation, incollaboration with MTW staff and partner organisations 4. Ensure current process for accessing translation services is communicated to all staff 5. Identify an existing NHS centre of excellence and buddy with them to ensure best practice and learning implemented in a timely fashion 6. Conduct a comprehensive review of all existing Trust practices in relation to E&D requirements - for example information, translation, clinical practices, food, facilities 7. Develop links with local support groups and communities to engage them in the improvement plan for the Trust with assistance from Healthwatch 8. Ensure appropriate organisational governance with assurance to Trust Board in relation to Equality and Diversity	Richard Hayden, Deputy Director Human Resources	Richard Hayden, Associate Director of Workforce	1. 1/9/15 2. 1/10/15 3. 1/9/15 4. 1/2/15 5. 1/6/15 6. 1/6/16 7. 1/10/15 8. 1/9/15	1. Substantive E&D Lead Appointed 2. Training records against E&D awareness programme 3. New E&D Strategy 4. Detailed action plan for improvements 5. Evaluation of changes to service and feedback from staff (staff survey), patients, Healthwatch and community groups (with actions developed and monitored as required)	Overall aim: 1. to establish a culture of equality and diversity awareness and accommodate individual needs (staff and patients) 2. feedback from patients, Healthwatch and staff	
			CA10	Medical & Emergency	Dignity and privacy of patients was not being met in the Clinical Decisions Unit.	1. Options appraisal for addressing existing dignity and privacy issues in CDU (2 main options are Option 1: changing function of CDU or Option 2: provision of toilet facilities) 2. Agree preferred option and implement 3. Each patient to be tracked and discussed at each site meeting to ensure timeframes met and plan for discharge / transfer in place 4. To link in with Trust wide work around patient flow and action TW30	Akbar Soorma, Clinical Director	Lynn Gray, ADN emergency	1. 1/5/15 2. Option 1: 1/4/16 Option 2: 1/10/15 3. 1/4/15 4. 30/5/15	1. Options appraisal paper 2. Changes to CDU environment reviewed by link executives and reported at Standards Committee 3. Site report documentation	Privacy and dignity of patients in CDU met No patient in CDU beyond 23 hours	
Compliance Action 11: Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Regulation 20 (1) HSCA 2008 (Regulated Activities) Regulations 2010: records	Executive Lead: Paul Sigston	Date compliance will be achieved by: OCT 2015	CA11	Trust wide	The provider did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.	1. Reinforce requirements of Health Care Record keeping amongst multidisciplinary staff, including timely recording of actions undertaken by: 1a. Record Keeping champion for department who will be a source of information and support for record keeping standards 1b. Investigate the possibility of providing a name stamp for staff 1c. Staff involvement in record keeping audit 2. Review induction programme for new Doctors to ensure adequate training provided. 3. Multidisciplinary Task and Finish group (sub-group of health records committee) to review current notes with fresh eyes and consider where improvements can be made 4. Record keeping audit to be included in case reviews at Directorate Clinical Governance Meetings	Paul Sigston, Medical Director	Wilson Bolsover, Deputy Medical Director	1a. 1/6/15 1b. 1/6/15 1c. 1/6/15 2. 1/5/15 3. 1/6/15 4. 1/9/15	1. Minutes of Directorate Clinical Governance meetings 2. Staff audit pilot 3. Record keeping champion program and list 4. Report on name stamps for staff and recommendations 5. Induction programme for new doctors 6. Report from task and finish group on records	High quality health care records being used through out the Trust.	
Compliance Action 12: Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010: Supporting workers 2010 Records Regulation 20 (1) HSCA 2008 (Regulated Activities) Regulations 2010: records	Executive Lead: Angela Gallagher	Date compliance will be achieved by: AUGUST 2015	CA12	Trust wide	Contracted security staff did not have appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs.	1. Provide documentation outlining the joint partnership with our contractor in regards to the provision of training. 2. All contractors to attend the Trust approved and agreed Induction Training and attend the Trust mandatory training 3. Contractors to be included on the Training Needs Analysis document outlining all requirements, frequency and levels 4. Review compliance with all training requirements against existing security team 5. The Security Manager to provide training logs for the SMART Risk Assessment Training undertaken through one to one sessions with all security officers. 6. All current security staff to be booked onto and attend Mental Health Awareness Training and dementia awareness training	Jeanette Rooke, Director of Estates and Facilities	Mark Cardnell, Assistant Director of Estates	1. 1/4/15 2. 1/4/15 3. 1/5/15 4. 1/5/15 5. 1/5/15 6. 1/8/15	1. Agreed documentation on joint partnership arrangements 2. Induction Attendance / compliance report on all existing security staff to Security Group 3. TNA document 4. Report on training compliance to Security Group 5. Certificates of training 6. Certificates of training	A. Trained and competent security workforce to meet the needs of all patient/visitor groups B. Perceived improved service via Security Officers continual improvement in their NHS specific skill set regarding dealing with vulnerable patients with a range of physical and mental ill health needs. C. Enhancement of the patient, staff and visitor safety at MTW NHS Trust.	
Regulation 10 (2) (a) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Assessing and monitoring the quality of service provision The provider did not have effective operation of systems designed to enable the registered person to assess, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems set out in this part of these regulations; and (b) identify, assess and manage risks relating to the health, safety and welfare of the services provided in the carrying on of the regulated activity against the requirements set out in this part of these regulations and safety of service users and others who may be at risk from the carrying on of the regulated activity.			CA13	Trust wide	The process for incident reporting did not ensure that staff were aware of and acted in accordance with the trust quality and risk policy.	1. Staff leaflet on Trust Quality and Risk Policy, including incident reporting process to be produced in collaboration with staff and distributed to existing staff and new starters at induction 2. Governance page to be developed on the intranet and MTW website with clear signposting to Incident Reporting section 3. Incident reporting process currently under review, with full collaboration with clinical staff, to improve reporting process and investigate possibility of hosting reporting portal on mobile media 4. Education / update program on Governance, Quality and Patient Safety including incident reporting and learning lessons from incidents to be rolled out to all medical and nursing staff over next year 5. Continue to publish articles on Governance Gazette Newsletter relating to incident reporting and learning lessons. Encourage staff to write their own articles for publication.	Avey Bhatia, Chief Nurse	Jenny Davidson, Assc Director Governance, Quality and Patient Safety	1. 1/5/15 2. Intranet 1/6/15 Website 1/10/15 3. 1/6/15 4. 1/9/15 5. Monthly	1. Leaflet + audit of distribution and staff engagement through survey 2. fully implemented intranet and web page 3. Datix Staff survey + reporting figures / by profession 4. Education presentation + staff survey 5. Newsletter every month	1. Increased incident reporting 2. increased utilisation of intranet and web page 3. improvements in staff awareness seen through staff survey & informal discussions with staff 4. Newsletter visibly seen in staff areas, staff engagement in writing articles	
			CA14	Children's services	The clinical governance strategy within children's services did not ensure engagement and involvement with the surgical directorate.	1. Meeting between senior clinicians and managers Childrens services directorate and Surgical directorates to establish clear roles and responsibilites of the care of children on the paediatric ward 2. Standard Operating Procedure for care of children on surgical pathway on paediatric wards 3. Implementation of the SOP into routine daily practice 4. Trust to develop a consistent approach to Clinical Governance through MTW Clinical Governance Strategy developed in collaboration with internal and external stakeholders	Hamudi Kisat, Clinical Director Johnathan Appleby, Clinical Director	Hamudi Kisat, Clinical Director Johnathan Appleby, Clinical Director	1. 1/5/15 2. 1/6/15 3. 1/8/15 4. 1/9/15	1. Minutes of joint meeting 2. Standard Operating Procedure 3. Audit of practice 4. MTW Clinical Governance Strategy 5. Agenda, Minutes and attendance records from CG meetings	Evidence of engagement and involvement with surgical directorate and Children's Clinical Governance meetings	
			CA15	Children's services	The children's directorate risk register did not ensure that risks are recorded and resolved in a timely manner.	1. A full review of the directorate risks 2. An update session for all senior nursing and medical staff on the purpose and process of the risk register 3. Ensure review of risk register is standing agenda item at Directorate meetings / Clinical Governance meetings	Hamudi Kisat, Clinical Director	Karen Carter-Woods, Risk and Governance Manager	1. 1/5/15 2. 16/6/15 3. 16/6/15	1. Risk register shows children's section managed in a timely manner 2. Minutes of Directorate meeting / Clinical Governance meeting	The children's directorate risk register ensure that risks are recorded and resolved in a timely manner	
			CA16	Trust wide	There were two incident reporting systems, the trust electronic recording system and another developed by consultant anaesthetists and intensivists one for their own use. The trust could not have an overview of all incidents and potentially there was no robust mechanism for the escalation of serious incidents. Therefore opportunities were lost to enable appropriate action to be taken and learn lessons.	1. Anaesthetic incident reporting pilot discontinued. Those involved in running this system, and other clinical staff fully engaged with the review on the DATIX system to improve reporting process 2. Staff leaflet to include reminder about rationale for single reporting system 3. Reminders in Governance Gazette and via intranet and website about the SINGLE reporting system in the Trust. 4. Assc. Dir. Quality, Governance and Patient Safety to attend Anaesthetic CG meeting for discussion and update on reporting system	Avey Bhatia, Chief Nurse	Jenny Davidson, Assc Director Governance, Quality and Patient Safety	1. 1/2/15 2. 1/5/15 3. 1/5/15 4. 1/5/15	1. Written Confirmation from coordinator of system 2. Leaflet audit of distribution and staff survey 3. Newsletter article 4. Increased incident reporting through single reporting system from anaesthetist and intensivists	Trust has single reporting system and mechanism for escalation of SI's, review, lessons learnt and dissemination	

Compliance action 13-17 Regulation 10(1)(a)(b)(2)(c)(i)(i not protect service users, and others who may be at risk, person to: (a) regularly assess and monitor the quality of assess and manage risks relating to the health, welfare a	Executive lead: Avey Bhatia / Paul Sigston	Date compliance will be achieved by: OCTOBER 2015	CA17	Trust wide	There was a lack of engagement and cohesive approach to clinical governance. Mortality and morbidity reviews were not robust, not all deaths were discussed and there was no available documentation to support discussions.	1. Full review and collaborative process involving all stakeholders for developing and implementing a cohesive and comprehensive clinical governance system from ward to board 2. Development of a MTW Clinical Governance Strategy 3. Mortality and morbidity review process to be reviewed in collaboration with stakeholders and developed with exploration of further use of technology and clinical governance processes to improve rigor, transparency and effectiveness 4. Update for staff involved at directorate and Trust level on their role in the mortality & morbidity review process	Avey Bhatia, Chief Nurse / Paul Sigston	Jenny Davidson, Assc Director Governance, Quality and Patient Safety	1. 1/9/15 2. 1/7/15 3. 1/8/15 4. 1/10/15	1. CG strategy including clear CG process from ward to board 2. M&M review documentation of full review process and evidence of clear discussions and shared learning 3. Update outline and attendance	1. staff able to articulate the CG process, their role within it and how it links to improvements / shared learning 2. M&M review embedded within CG framework 3. senior staff able to articulate the M&M review process, their role within it and how it links to improvements / shared learning	
Compliance action 18: Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010: Medicines The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity	Executive Lead: Avey Bhatia / Paul Sigston	Date compliance will be achieved by: JULY 2015	CA18	Children's services	The arrangement for the management and administration of topical anaesthetics was ineffective.	1. Standard Operating Procedure for the administration of topical anaesthetics for children to be developed and implemented 2. Topical anaesthetics for children prescribed in all areas of the Trust 3. A number of key staff to undertake PGD training to facilitate appropriate timeliness of prescribing.	Hamudi Kisat, Clinical Director	Jenny Head, Matron	1. 1/5/15 2. 1/6/15 3. 1/7/15	1. SOP for children's services. 2. Audit of prescription charts. 3. Training records of staff undertaking PGD training	No medication to be administered without prescription / PGD	

Should do' actions

REF	Service or Directorate	Issue Identified	Action/s	Exec Lead	Lead	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	DELIVERY RATING
TW44	Children's services	Review the location of the vending machine currently located between Hedgehog ward and the Woodlands Unit.	Vending machine relocated to a non clinical area	Avey Bhatia, Chief Nurse	Hamudi Kisat, Clinical Director	Jenny Head, Matron	1. 1/2/15	Vending machine is in parents room (photographic evidence)	Vending machine is moved to more appropriate place	
TW45	Children's services	Review the managerial oversight of staff working in children's outpatients.	1. Revise, develop and implement Operational policy, outlining the responsibility of the ward managers in relation to the day to day oversight of children's outpatient areas. 2. Identify the matron for paediatrics services who has overall responsibility for the activities and services provided in Childrens Outpatients	Avey Bhatia, Chief Nurse	Hamudi Kisat, Clinical Director	Jenny Head, Matron	1. 1/5/15 2. 1/5/15	Operational policy evident within relevant area and management structure clear to all staff	Staff working in Children's outpatients are clear who they report and escalate	
TW41	Children's Services	Standardise the post-operative management and guidance of children undergoing urology surgery	1. Develop the joint work plan between the paediatric and surgical teams. Establish joint working group develop a standard clinical protocol for the post operative management of children undergoing urology surgery 2. Review and implement 'Urology surgery for children' leaflet	Avey Bhatia, Chief Nurse	Hamudi Kisat, Clinical Director	Siobhan Callanan, ADN Planned care	1. 1/7/15 2. 1/6/15	Clinical Guidelines in place and audit evidence being followed. Leaflet in place and used	Consistent compliance with clinical guideline and use of leaflet	
TW42	Children's Services	Review the process for the hand-over of pre-operative children to ensure they have support from a health care professional with whom the child and family are familiar with.	1. Department to adopt the RCN risk assessment tool for transferring children to and from theatre and other areas where they will receive care outside the children's' areas.	Avey Bhatia, Chief Nurse	Hamudi Kisat, Clinical Director	Jenny Head, Matron	1. 1/7/15	1. Minutes of A&E apediatric working group 2. Observational audit showing compliance with use of RCN risk assessment tool and presence of familiar health care professional	All children are supported appropriately preoperatively in theatres	
M4	Corporate	Ensure that up-to-date clinical guidelines are readily available to all staff.	1. Review of present system of clinical guideline / documentation access and management 2. Staff Survey relating to views on clinical guidelines accessibility 3. Identification of areas for improvement and consult on possible solutions 4. Options to be presented at TME 5. Implementation of prefered option (Task Finish Group)	Avey Bhatia, Chief Nurse / Paul Sigston, Medical Director	Paul Sigston, Medical Director	Donna Jarret, Director of Informatics Jenny Davidson Assc Dir, Gov, Quality, Patient Safety	1. 1/8/15 2. 1/3/15 3. 1/8/15 4. 1/8/15 5. 1/4/16	1. Review of current system and options appraisal paper 2. Survey of staff views 3. Minutes from TME meeting 4. Task Finish group report	Clinical guidelines up to date and accessible to staff	
M10	Corporate	Develop robust arrangements to ensure that agency staff have the necessary competency before administering intravenous medicines in medical care services.	1. Add to agency booking checklist 2. Amend local induction checklist to include declaration by both manager and staff member 3. Communication to agencies that this now forms part of the Trust checklist 4. Audit of compliance - local induction forms and booking form that show competency relating to giving of IV medicines	Paul Bentley, Director of Workforce and communications / Avey Bhatia, Chief Nurse	Richard Hayden, Deputy Director of Workforce / John Kennedy, Deputy Chief Nurse	Richard Hayden, Deputy Director of Workforce / John Kennedy, Deputy Chief Nurse	1. 1/5/15 2. 1/5/15 3. 1/5/15 4. 1/9/15	1. Booking form 2. Local induction checklist 3. Local audit findings	All agency staff that administer intravenous medicines are competent and have signed to confirm	
M18	Corporate	Ensure that patients have access to appropriate interpreting services when required.	1. Survey of current service satisfaction via service leads and members of the patient experience committee (before and after any service change) 2. Full review of current service provision and move to go to tender for current service needs once identified 3. Identification of service users who can be invited to become involved in the evaluation of service needs in terms of the interpretation service 4. Engage assistance and involvement from Healthwatch	Avey Bhatia, Chief Nurse	Jenny Davidson, Assc Director Gov, Quality and Pt Safety	Jenny Davidson, Assc Director Gov, Quality and Pt Safety	1. 1/5/15 & 1/10/15 2. 1/6/15 3. 1/5/15	1. Service leads survey results 2. Review report and outcome from tender process. 3. Service user group communications	1. Perceived improved service via survey 2. improved interpretation service as per continuous audit of performance reports 3. Service user group set up and effective at engaging in improvements	
M22	Corporate	Ensure that the provider reviews the quality of root cause analysis investigations and action plans following a serious incident or complaint and improves systems for disseminating learning from incidents and complaints.	1. Collaborative review of current patient safety staff and resources involving identified stakeholders to identify where improvements are required and agree implementation program 2. Governance page to be developed on the intranet and MTW website with section on sharing incident and complaint reviews and sharing lessons to be learnt and actions plans updated to evidence change 3. Development of the 'step up to safety' campaign with investment all staff to feel engaged and responsible for patient safety and continual learning 4. Education / update program on RCA and investigation process to all relevant staff groups (involved in investigations and reviews) 5. Continue to publish articles on Governance Gazette Newsletter relating to incident reporting, complaint reviews and learning lessons. Encourage staff to write their own articles for publication and take ownership of continual learning process 6. Embed a culture of patient safety and continual learning through placing this at the top of every meeting agenda in the organisation 7. Involve and include partner organisations in developments and implemeting changes	Avey Bhatia, Chief Nurse / Paul Sigston, Medical Director	Jenny Davidson, Assc Director Gov, Quality and Pt Safety	Jenny Davidson, Assc Director Gov, Quality and Pt Safety	1. 1/6/15 2. Intranet 1/6/15 Website 1/10/15 3. 1/6/15 4. 1/9/15 5. 1/8/15 6. 1/8/15	1. Collaborative review & proposal paper 2. Intranet & website pages 3. 'step up to safety' campaign material 4. Education / update program and signature sheets 5. Patient Safety at top of every agenda 6. Inclusion of Healthwatch in developments to improve systems	High quality root cause analysis investigations and action plans following a serious incident or complaint with improved systems for disseminating learning from incidents and complaints	
M23/TW48	Corporate	Ensure that the provider monitors transfers between sites for both clinical and non-clinical reasons. The monitoring process should include the age of the patients transferred and the time they arrived after transfer.	1. Review and update of current policy & process for managing transfers between sites and between sites to strengthen the responsibility for assessing and arranging the transfers. 2. Develop separate procedures for emergency transfers from A&E, ward transfers and paediatric transfers. 3. Implement discussion of all planned and actual transfers by named patient at the sites meetings with clarity regarding the person responsible for the dispatch and receipt of all patients. 4. Implement a weekly review of all intra-hospital transfer undertaken by the senior site manager for both sites. 5. An incident report (DATIX) will be completed as an exception report when any adverse issues are raised following a transfer between sites.	Angela Gallagher, Chief Operating Officer	Margaret Dalziel, Assc. Dir Operations	Claire Hughes, Matron A&E	1. 1/5/15 2. 1/5/15 3. 1/4/15 4. 1/4/15 5. 1/6/15	1. Formally authorised and controlled documentation of patient transfer process. 2. Directorate dashboard showing number of transfers. 3. Quarterly Audit report	MTW monitors transfers between sites for both clinical and non-clinical reasons	
M&T24	Corporate	Consider collating performance information on individual consultants. Where exceptions are identified, these should be investigated and recorded.	1. Collect data via Dr Foster for individual consultants 2. Review data monthly at directorate level via Clinical Governance Meetings and identify any exceptions 3. Clinical Directors to report mortality data and exceptions at the Trust Mortality Review Group meeting 4. Review of directorate reports,overall data, mortality exceptions at monthly Trust Mortality Review Group meeting. MRG to authorise investigations by independent clinician as required (see CA17) 5. Development of MTW Mortality Review Guidelines	Glenn Douglas, Chief Executive	Paul Sigston, Medical Director	Paul Sigston, Medical Director	1. 1/5/15 2. 1/6/15 3. 1/7/15 4. 1/8/15 5. 1/5/15	1. Agenda and minutes of directorate CG and MRG meetings 2. Report provided to MRG by Clinical Directors 3. Exception investigations by independent clinicians 4. Mortality review Guidelines	MTW collates performance information on individual consultants. Where exceptions are identified, these are investigated and recorded.	

M&T25	Corporate	Provide written information in a format that is accessible to people with learning difficulties or disabilities	1. Appoint a dedicated lead for Equality and Diversity for Trust (cross reference CA9) 2. Identify an existing NHS centre of excellence and buddy with them to ensure best practice and learning implemented in a timely fashion 3. Conduct a comprehensive review of all existing material avaliable for people with learning difficulties or disabilites 4. Develop links with local support groups, Healthwatch and communities to engage them in the improvement plan for the Trust	Avey Bhatia, Chief Nurse	John Kennedy, Deputy Chief Nurse	John Kennedy Deputy Chief Nurse / Karen Davis Lead Matron, Adult Safeguarding	1. 1/9/15 2. 1/6/15 3. 1/4/16 4. 1/10/15	1. Appointment of Equality and Diversity lead (CA9) 3. Gap analysis and revised material 4. Feedback from users and staff. Named representative and minutes / outputs from minutes and groups	Feedback that written information is accessible to people with learning difficulties or disabilities	
TW33	Corporate	Review the quality of root cause analysis investigations and action plans following a serious incident or complaint and improve systems for the dissemination of learning from incidents and complaints.	1. Undertake a review of SI and complaint investigations to ascertain quality of RCA and completion of action plans and evidence As per M22: 2.Governance page to be developed on the intranet and MTW website with section on sharing incident and complaint reviews and sharing lessons to be learnt and actions plans updated to evidence change 3. Education / update program on RCA and investigation process to all relevant staff groups (involved in investigations and reviews) 4. Continue to publish articles on Governance Gazette Newsletter relating to incident reporting, complaint reviews and learning lessons. Encourage staff to write their own articles for publication and take ownership of continual learning process 5. Involvement from external partners in developing improvements	Avey Bhatia, Chief Nurse	Avey Bhatia, Chief Nurse	Jenny Davidson, Assc Director Gov, Quality and Pt Safety	1. 1/6/15 2. Intranet 1/6/15 Website 1/10/15 3. 1/9/15 4. 1/8/15 5. 1/6/15	1. Review report of Quality of RCA / SI / complaint investigations 2. Webpages 3. Education programme outline schedule and sign in sheets 4. Governance Gazette newsletter 5. Involvement and feedback from partners such as Healthwatch	Assurance that complaint and SI investigations and RCA process is of high quality and evidence of sharing learning through various methods. Improved staff awareness of the lessons learnt from incidents and complaints	
TW38	Corporate	Review the ways in which staff can refer to current clinical guidance to ensure that it is easily accessible and from a reputable source.	see M4 above. In addition: 1. Develop Trust guidelines on the development and management of clinical guidelines, protocols, policies and documents to ensure agreement on expected standards 2. Audit to these standards	Avey Bhatia, Chief Nurse	Paul Sigston, Medical Director	Paul Sigston, Medical Director	1. 1/8/15 2. 1/12/15	1. Trust Guidelines on the development and management of clinical guidelines, protocols, policies and documents 2. Audit to standards	Staff are able to access high quality clinical guidance	
TW43	Corporate	Ensure that all staff introduce themselves and wear name badges at appropriate times.	1. Reminder to all staff via Trust wide communication 2. Communication to all managers to monitor compliance in areas 3. Inclusion in customer care training: 'hello my name is…' 4. Joint working with Healthwatch to provide feedback from enter and view visits	Paul Bentley, Director of Workforce and communications	Richard Hayden, Deputy Director of Workforce	Richard Hayden, Deputy Director of Workforce	1. 1/4/15 2. 1/4/15 3. 1/6/15 4. 1/6/15	1. Communication to staff and managers 2. Spot check. Feedback reports from Healthwatch visits and assurance reports to Workforce Committee (actions where required)	All staff wearing name badges at all times and introduce themselves	
TW49	Corporate	Have clarity about the definition of what constitutes an Serious Incident Requiring Investigation (SIRI) or Never Event in relation to the retained swabs.	1. Staff leaflet on including incident reporting process and what constitutes an SI and Never event to be produced in collaboration with staff and distributed to existing staff and new starters at induction. 2. Review of SI policy and ensure clarity. 3. Governance page to be developed on the intranet and MTW website with clear signposting to what constitutes and SI and Never event including in relation to retained swabs 4. Education / update program on Governance, Quality and Patient Safety including incident reporting and learning lessons from incidents to be rolled out to targeted medical and nursing staff over next year. This will include a section on what constitutes an Serious Incident or Never Event in relation to the retained swabs. 6. Publish article on Governance Gazette Newsletter relating to what constitutes a Serious Incident or Never Event in relation to the retained swabs	Avey Bhatia, Chief Nurse	Avey Bhatia, Chief Nurse	Jenny Davidson, Assc Director Gov, Quality and Pt Safety	1. 1/5/15 2. 1/5/15 3. Intranet 1/6/15 Website 1/10/15 3. 1/4/16 4. 1/6/15	1. Staff leaflet and SI policy 2. Intranet & Website 3. Education / update program and attendance 4. Newsletter article	Staff can articulate about the definition of what constitutes an Serious Incident (SI) or Never Event. In areas where swabs are used this will include in relation to the retained swabs	
TW50	Corporate	Ensure policies that have not been reviewed and impact on current evidenced-based knowledge/care are updated.	1. Audit of policies in terms of timely review and on compliance with current evidence 2. Address all outstanding policies to ensure they are updated with current evidence based knoweldge	Avey Bhatia, Chief Nurse	Paul Sigston, Medical Director	Jeff Harris, Risk and Compliance Manager	1. 1/6/15 2. 1/12/15	Report to Standards committee referring to policies and review Audit of policies to ensure they are compliant with current evidence	All policies should be within their review dates and reflect current evidence based knowledge / care	
M20	Critical Care	Consider reviewing the processes for the capturing information to help the service better understand and measure its overall clinical effectiveness.	1. Review of the Terms of reference for clinical governance meetings to understand its role and to comply with the requirements for multidisciplinary discussion and ability to monitor actions against what is agreed. 2. Review of both quantitative and qualitative measures to measure clinical effectiveness within the Clinical Governance Meeting. Inclusion of evidence of triangulation of data	Paul Sigston, Medical Director	Richard Leech, Clinical Director	Jackie Slingsby, Matron	1. 1/4/15 2. 1/6/15	Terms of reference for CG meetings. Action log completed. Minutes CG meetings.	Service can demonstrate where and how data is captured to assess clinical effectiveness	
M8	Critical Care	Review the current provisions of the ICU outreach service, to ensure that the service operates both day and night, in line with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations.	Plans to implement a 24 hour service are in development - see CA7	Glenn Douglas, Chief Executive	Richard Leech. Clinical Director	Jackie Slingsby, Matron	1. 1/10/15	24hour service implemented. Audit showing compliance with NCEPOD recommendations	Fully operational 24hr outreach service at national standards level	
M1	Diagnostics Therapies and Pharmacy	Arrange for the safe storage of medicines so that unauthorised access is restricted.	1. see M12 2. The annual Medicines Safety Audits will continue to be done with specific ward and departmental action plans which are continually monitored throughout the year	Paul Sigston, Medical Director	Sara Mumford, Clinical Director	Jim Reside, Chief Pharmacist John Kennedy, Deputy Chief Nurse	1. 1/6/15	Annual Medicines Safety Audit	Compliance with safe storage of medicines so that unauthorised access is restricted.	
M12	Diagnostics Therapies and Pharmacy	Ensure that systems are in place to ensure that the system of digital locks used to secure medicines storage keys can be accessed only by authorised people.	1. Update the Medicines Policy to include use and control of digital locks and a Policy statement 'The use of wall-mounted digital locks is permissible on wards and departments to store non-controlled drug cupboard or fridge keys' Wards/ depts. using digital locks must ensure the key code is given to only those delegated members of staff with permissible access. All codes for digital locks must be changed regularly. 2. Implement records in wards/ depts. of staff access to digital locks and a log of key code date changes 3. Audit of digital locks to the medicines security audit	Paul Sigston, Medical Director	Sara Mumford, Clinical Director	Jim Reside, Chief Pharmacist John Kennedy, Deputy Chief Nurse	1. 1/5/15 2. 1/5/15 3. 1/7/15	1. Trust Medicines Policy updated 2. Audit of digital lock compliance with Medicines Policy added to medicines security audit criteria and checklist	1. Medicines Policy in place 2. Regular audit of security of medicines to include key pad access	

M13	Diagnostics Therapies and Pharmacy	Develop systems to ensure that medicines are stored at temperatures that are in line with manufacturers' recommendations.	1. Purchase of 30 digilok medicine fridges with audible temp alarm were purchased for use in wards/ departments. 2. Implementation of replacement programme of remaining key-lock fridges to include the replacement with digilok fridges Actions to be undertaken: 3. Implement documented daily temp monitoring and resetting of all fridges in wards/depts. 4. Implement system of Wards/depts. to logging and escalating all temp excursions immediately with EME or Pharmacy. 5. *Monitoring Temp of rooms where medicines are stored* Development of joint EME and Pharmacy Business Case with options to monitor room temperatures 6. Consideration of business case at TME	Paul Sigston, Medical Director	Sara Mumford, Clinical Director	Jim Reside, Chief Pharmacist John Kennedy, Deputy Chief Nurse	1. 1/10/14 2. 1/4/14 3. 1/2/15 4. 1/3/15 5. 1/6/15 6. 1/8/15	1. Purchase order confirmation from procurement 2. Replacement programme confirmation from Directorate lead 3. Data from daily fridge monitoring and escalation to EME / pharmacy 4. Business Case 5. Minutes of TME where buisness case considered	Systems in place to ensure that medicines are stored at temperatures that are in line with manufacturers' recommendations.	
TW36	Diagnostics Therapies and Pharmacy	Develop systems to ensure that medicines are stored at temperatures that keep them in optimal condition.	see M13	Paul Sigston. Medical Director	Sara Mumford, Clinical Director	Jim Reside, Chief Pharmacist John Kennedy, Deputy Chief Nurse				
TW28	Emergency and Medical Services	Make appropriate arrangements for recording and storing patients' own medicines in the CDU to minimise the risk of medicine misuse.	1. Development of Standard Operating Procedure in relation to arrangements for recording and storing pateints own medicines in the CDU 2. Implement provision of lockable fixed drug cupboard in CDU by each bed at TWH. At Maidstone 1 lockable cupboard is needed. 3. Once in place,pharmacy and nursing staff to audit cupboard on a daily basis to ensure compliance with SOP 4. Use of checklist to ensure no drugs remain in CDU follwoing transfer or discharge of patient	Paul Sigston, Medical Director	Akbar Soorma, Clinical Director	Claire Hughes, Matron A&E	1. 1/5/15 2. 1/9/15 3. 1/10/15 4. 1/5/15	1. Appropriate equipment in place to safely store patients' own drugs 2. Evidence of checklists completed to ensure no drugs remain on CDU following transfer or discharge of patient 3. SOP	No patient safety incidents relating to mismanagement of patients' own drugs in CDU	
M26	Emergency and Medical Services	Reduce delays for clinics and reduce patient waiting times.	1. Identify clinics in which there are high levels of DNA's , delays and waiting times. 2. Review clinic templates with clinicians within each specialty identified as having issues and set out realistic times 3. Employ medical record personnel to obtain patient records for slots required at 0 - 4 days 4. Review booking system / reminder system 5. Joint working with Healthwatch using enter and view visits to provide feedback	Paul Sigston, Medical Director	Margaret Dalziel, Assc. Dir Operations	Margaret Dalziel, Assc. Dir Operations	1. 1/5/15 2. 1/6/15 3. 1/8/15 4. 1/6/15	1. Report on review of clinics DNA and templates 2. Appropriate booking of all clinic profiles 3. implementation of revised booking / reminder system 4. Feedback from Healthwatch	Reduced waiting times and delays	
TW35	Emergency and Medical Services	Develop systems to ensure the competence of medical staff is assessed for key procedures.	1. Identify a list of key procedures for all medical staff 2. Review SI's and complaints to identify any particular procedures that have caused harm to patients to support prioritisation of this work Process for ensuring competency: 3. Implement process for SHO's and Middle Grades to have each key procedure signed off during induction and clinical supervision meetings. 4. Implement process for those staff who do not hold ATLS to ensure thier attendance at the Thoracic Ultrasound course. 5. Implement process for all medical staff to have forms completed and logged for levels of competence for key procedures Sharing best practice across the Directorate: 6. Clinical Director to speak to specialist medicine department lead to disucss and agree standardisation of approach. 7. Development of document outlining agreed standards and process for the assessment of compenency for identified key procedures for all medical staff	Avey Bhatia / Paul Sigston	Akbar Soorma, Clinical Director	Akbar Soorma, Clinical Director	1. 1/7/15 2. 1/7/15 3. 1/9/15 4. 1/9/15 5. 1/9/15 6. 1/8/15 7. 1/9/15	1. List of key procedures produced 2. Copies of signed competency documents 3. agreement between CD and Specialist medicine department lead on standardisation approach 4. Document outlining agreed standards and process for the assessment of compenency for identified key procedures for all medical staff	No patient safety incidents caused by a lack of operator skill or knowledge Systems in place to ensure the competence of medical staff is assessed for key procedures.	
M14	Emergency and Medical Services	Ensure within medical care services that patients' clinical records used in ward areas are stored securely.	1. Review current practice in all areas 2. Reinforce good housekeeping in relation to ensuring patient records are replaced in the notes trolley after use in clinical areas. 3. Remind office based staff about the need to minimise patient records being kept in offices and ensure office is secured when empty 4. Discuss (and minute) at following forums: • Ward Manager meetings • Quality & Safety Directorate Board • Clinical Governance 1/2 days • CAU meetings 5. Undertake spot audits quarterly to ensure compliance with above	Avey Bhatia / Paul Sigston	Akbar Soorma, Clinical Director	Akbar Soorma, Clinical Director Lynn Gray, ADN Emergency care	1. 1/4/15 2. 1/5/15 3. 1/5/15 4. 1/5/15 5. 1/9/15	Report on current practice Results of spot audits Evidence of communication with staff and minutes of meetings	Adhere to record keeping guidelines and maintain patient confidentiality	
M16	Emergency and Medical Services	Review the ways in which staff working in medical care services can access current clinical guidance to ensure it is easily accessible for them to refer to.	1. All actions in conjunction with actions identified in M4. In addition: 2. Review of access and management of clinical guidance / protocols / documents 3. All current clinical guidance will be available online via departmental intranet page	Avey Bhatia Chief Nurse / Paul Sigston, Medical Director	Akbar Soorma, Clinical Director	Donna Jarret, Director of Informatics Jenny Davidson Assc Dir, Gov, Quality, Patient Safety	2. 1/5/15 3. 1/6/15	1. Report on review of current clinical guidance 2. Update on departments pages of intranet	Medical staff aware of where to find clinical guidelines	
M17	Emergency and Medical Services	Review the way in which in medical care services it authorises and manages urgent applications under the Deprivation of Liberty Safeguards.	1. Implement training for all relevant staff by the Matron for Safeguarding Adults 2.Provide ongoing support to staff to enable them to follow the published Policies and Procedures 3. Review compliance against requirements at Directorate Quality & Safety Board	Avey Bhatia, Chief Nurse / Paul Sigston, Medical Director	Akbar Soorma, Clinical Director	Karen Davies, Matron for Safeguarding Adults Lynn Gray, ADN Emergency care	1. 1/8/15 2. 1/8/15 3. 1/9/15	1. Appropriately completed MCA and DOLS documentation 2. Staff able to describe the need to assess mental capacity and the DOLS safeguards 3. Q&S committee minutes	DOLS documentation appropriate to patients needs	

M&TW2	Emergency and Medical Services	Make sure that medical staff complete training in safeguarding children at the level appropriate to their grade and job role (TW Specific for A&E)	1. Review of training requirements for all grades of medical staff (Training Needs Analysis) 2. Ensure all staff booked or have attended required training 3. Ensure all required training is completed and recorded at induction 4. Ensure all training records are kept centrally and are updated in a timely fashion	Paul Bentley, Director of WorkForcea nd communicait on	Akbar Soorma, Clinical Director	Jo Howe, Lead Nurse for Childrens Safeguarding	1. 1/6/15 2. 1/7/15 3. 1/9/15 4. 1/9/15	1. Report on review of medical staff training (TNA) 2. Documentation to support attendance at training 3.Medical staff able to describe key elements of Child Protection	Appropriate actions taken to protect vulnerable children All staff appropriately trained in safeguarding of children	
M3	Emergency and Medical Services	Make sure that a sufficient number of consultants are in post to provide the necessary cover for the ED	1. Change to consultant rota to increase ward / area presence on both sites. 2. Advertise for 2 new substantive consultant posts (already approved) 3. Recruitment of 2 consultants	Angela Gallagher, Chief Operating Officer	Akbar Soorma, Clinical Director	Akbar Soorma, Clinical Director	1. 1/4/15 2. 1/5/15 3. 1/9/15	1. Consultant rota (planned and actual) showing necessary cover. 2. Confirmation of recruitment and start dates	Improved patient flow through ED by earlier senior intervention Sufficient number of consultants are in post to provide the necessary cover for the ED	
M&TW5	Emergency and Medical Services	Review the arrangements for meeting the needs of patients presenting with mental health conditions, so they are seen in a timely manner.	1. Improved Psychiatric Liaison service with extended hours in both ED's. Issues remain around patients assessed and waiting for an in patient mental health bed due to limited capacity. 2. Review data from the Psychiatric Liaison Team to understand if time to assess patients has improved since extending the service. 3. Regular meetings between KPMT and MTW	Angela Gallagher, Chief Operating Officer	Akbar Soorma, Clinical Director	Akbar Soorma, Clinical Director Claire Hughes, Matron A&E	1. 1/4/15 2. 1/6/15 3. 1/4/15	1. 'Time to assess' data from KPMT with actions and evidence of addressing issues if arising 2. Report on the impact of the extended service	No patient waiting more than 2 hours for an assessment or 24 hours for an inpatient mental health bed	
M&TW6	Emergency and Medical Services	Review the way complaints are managed in the ED to improve the response time for closing complaints	1. Undertake a review of the current process in conjunction with the central complaints team with defined timeframes for each step. 2. Implement a revised process 3. Communicate the revised process to all ED staff and the central complaints team 4. Monthly monitoring of response timeframes at Directorate Clinical Governance meetings and Standards Committee	Angela Gallagher, Chief Operating Officer	Akbar Soorma, Clinical Director	Claire Hughes, Matron A&E	1. 1/4/15 2. 1/5/15 3. 1/5/15 4. 1/6/15	1. Documentation of agreed process and timeframes 2. Evidence of communication with staff 3. Audit of compliance with agreed process and timeframes 4. Minutes from monthly directorate clinical governance meeting and Standards Committee	Service delivered meets patients expectations All complaints responded to within 25 days	
M7	Emergency and Medical Services	Review the governance arrangements for nursing staff in the ED to ensure effective leadership and devolution of responsibilities.	1. Review of Roles and Responsibilities for all nursing staff to in relation to governance and leadership 2. Communicaiton of Improvement plan to all relevant nursing staff 3. Introduction of an education, support and leadership program will be introduced to embed changes	Angela Gallagher, Chief Operating Officer	Lynn Gray, ADN Emergency care	Claire Hughes, Matron A&E Cliff Evans, Consultant Nurse	1. 1/4/15 2. 1/4/15 3. 1/6/15	1. Summary of education / support and leadership program for staff with attendance sheets 2. Roles and responsibilities for each designated role within ED documented 3. Staff able to describe how their role and other roles within the ED work together to ensure safe and effective patient flows	Effective nurse leadership in place	
M9	Emergency and Medical Services	Ensure that medical care services comply with its infection prevention and control policies.	1. Evidence performance on dashboard and report to Infection Control Committee. 2. Review IPPC Link Nurses for all areas within Directorate and ensure they are given time to cascade information and audit local practice. 3. Audit local practice against infection prevention and control policies + actions developed where not compliant 3. Ensure IPPC is a standing agenda item at Directorate Clinical Governance meetings	Angela Gallagher, Chief Operating Officer	Akbar Soorma, Clinical Director	Lynn Gray, ADN Emergency Care	1. 1/4/15 2. 1/4/15 3. 1/5/15 4. 1/5/15	1. Agenda and Minutes of ICC, Directorate Clinical Governance & Link Nurse Forums 2. Local audit + action plans where not complaint	IPPC rates below Trust trajectory and show evidence of continual reduction	
M11	Emergency and Medical Services	Develop systems within the directorate of specialty and elderly medicine to ensure that the competence of medical staff for key procedures is assessed.	See TW35	Angela Gallagher, Chief Operating Officer	Akbar Soorma, Clinical Director					
M15	Emergency and Medical Services	Ensure that the directorate of specialty and elderly medicine further monitors and embeds a robust system of medical handover that ensures patients' safe care and treatment.	1. Implementation of robust and consistent handover process with multidisciplinary input and documented plan 2. Audit of handover process and documentation 2.Introduction of IT solution to support improved communication with the medical teams at night and improve patient care	Angela Gallagher, Chief Operating Officer	Akbar Soorma, Clinical Director	Lynn Gray, ADN Emergency Care	1. 1/10/15 2. 1/12/15 3. 1/12/15	1. Evidence of handovers taking place via auditing 2. Reduced number of deteriorating patients that require ICU admission	Safe and effective handovers embedded throughout the Trust	
M19	Emergency and Medical Services	Ensure that the directorate of specialty and elderly medicine reviews its capacity in medical care services to ensure capacity is sufficient to meet demand, including the provision of single rooms.	1. Corporate review of demand and capacity requirements for 15/16 and beyond, with recmmonedations / plan 2. Review of operational Surge Plans to support management of peaks in demand, particularly over Bank Holiday periods, with recommendations / plan	Angela Gallagher, Chief Operating Officer	Akbar Soorma, Clinical Director	Margaret Dalziel, Assc. Dir Operations Lynn Gray, ADN Emergency Care	1. 1/5/15 2. 1/5/15	1. Report on corporate demand and capacity review submitted to TME (+ minutes from meeting) 2. Report on Surge plans submitted to TME (+minutes from meeting)	Patients admitted under the care of Emergency & Medical Services are cared for within the designated bed base and in the most appropriate ward for their condition.	
TW27	Emergency and Medical Services	Ensure the protocol for monitoring patients at risk is embedded and used effectively to make sure patients are escalated in a timely manner if their condition deteriorates.	1. Implement teaching for all relevant staff regarding use of PAR scores. 2. Ensure staff are aware of the relevant protocol for monitoring patients at risk + timely escalation communicated through team meetings and electronic reminders 3. Introduction of new cas card with the PAR scores on them. 4. Undertake monthly audits to monitor compliance. 5. Implementation of on-going Education programs for all relevant staff groups to ensure regular updates on PAR scoring.	Angela Gallagher, Chief Operating Officer	Akbar Soorma, Clinical Director	Lynn Gray, ADN Emergency Care	1. 1/5/15 2. 1/5/15 3. 1/5/15 4. 1/7/15 5. 1/7/15	1. Audit showing compliance with observations recorded and escalated appropriately as needed 2. Education attendance lists 3. communication with staff 4. new CAS card 5. outline of new education	Deteriorating patients identified, escalated and treated without delay	

TW29	Emergency and Medical Services	Respond to the outcome of their own audits and CEM audits to improve outcomes for patients using the service.	1. Implement process that the Clinical Leads for each department will assume responsibility for the conduct of audits and responding to their results. 2. Ensure results presented and discussed at Directorate Clinical Governance meetings. 3. Formulate action plans and re-audit at three months, after intervention, where improvements are required. 4. Specifically regarding the last CEM audit round – Symphony used to highlight high-risk patient groups for senior review and increased consultant cover will improve compliance. 5. Weekly review of pain scores and safeguarding questionnaires results by Clinical Leads and Clinical Director with performance issues addressed where necessary and extra support provided for individuals where required	Angela Gallagher, Chief Operating Officer	Akbar Soorma, Clinical Director	Akbar Soorma, Clinical Director	1. 1/4/15 2. 1/5/15 3. 1/8/15 4. 1/5/15 5. 1/5/15	1. Communication to Clinical leads on their responsbilities and expectations on response / actions 2. Minutes of Directorate Clinical Governance Meetings with evidence of completed action plans and improvements in further audits 3. Weekly review documentation	Improved repsonse to own audits and CEM audits to improve outcomes for patients	
TW30	Emergency and Medical Services	Review the management of patient flow in the ED to improve the number of patients who are treated and admitted or discharged within timescales which meet national targets.	1. Undertake a diagnostic review to understand where delays are currently occurring. 2. Agree actions to improve these areas. 3. Clarify roles and responsibilities for all staff involved in patient flows within ED. 4. Monitor and evaluate actions taken to understand if they are having the expected outcomes, if not, undertake the cycle again. 5. Joint working with Healthwatch who will use enter and view visits to gather patient experience views and evaluate actions undertaken	Angela Gallagher, Chief Operating Officer	Akbar Soorma, Clinical Director	Claire Hughes, Matron A&E Emma Yales, General Manager	1. 1/5/15 2. 1/5/15 3. 1/5/15 4. 1/8/15 5. 1/8/15	1. Report on diagnostic review and action plan 2. Communication about clear roles ad responsibilities of all staff 3. Sustained improvement seen in 4 Hour Access Target 4. Feedback reports from Healthwatch + response and actions	Improved patient care and experience Management of patient flow in the ED in relation to patients who are treated and admitted or discharged within timescales which meet national targets	
TW31	Emergency and Medical Services	Review the systems in place in the ED for developing, implementing and reviewing plans on quality, risk and improvement.	1. Review of Governance structures within ED to ensure appropriate capacity to undertake quality improvement work. This work will be undertaken alongside the Trust wide improvements in the Clinical Governance framework 2. Clarify roles and responsibilities with regards to the Governance agenda, document and communicate to all staff. 3. Review strategy of communicating to staff regarding care delivered in ED, what is done well and what needs improving. 4. Agree how all staff can become engaged with this and produce a plan to implement	Angela Gallagher, Chief Operating Officer	Akbar Soorma, Clinical Director	Claire Hughes, Matron A&E Christy Lowe, Lead Cons for Clinical Governance	1. 1/6/15 2. 1/6/15 3. 1/6/15 4. 1/6/15	1. Documented Clinical Governance structure that will allow for the development, implementation and review of plans on quality, risk and improvement and improved staff engagement. 2. Clinical Governance framework consistent with MTW clinical Governance strategy	Improved patient care, staff engagement and knowledge regarding the ED performance on quality issues	
TW32	Emergency and Medical Services	Ensure there is strategic oversight and plan for driving improvement.	1. Review ED Strategy for 2015-2017 2. Ensure strategy is developed in collaboration with all relevant stakeholders including a multidisciplinary approach	Glenn Douglas, Chief Executive	Akbar Soorma, Clinical Director	Akbar Soorma, Clinical Director Cliff Evans Consultant Nurse	1. 1/5/15 2. 1/5/15	1. Documented ED Strategy in place including evidence of consultation with multidisciplinary staff 2. Evidence of communication of strategy to all relevant staff	Continuous and sustained improvement in all ED key performance areas	
TW34	Emergency and Medical Services	On the Medical Assessment unit the trust should ensure that point of care blood glucose monitoring equipment is checked. It should also consider how this checking should be managed to be integrated as part of an overall policy that forms part of a pathology quality assurance system.	1. Develop and submit Business Case for procurement for Blood Glucose Monitors across the Trust. 2. Document daily checking of current blood glucose monitors in all ward areas. 3. Checking process to be integrated as part of overall policy related to pathology related equipment	Angela Gallagher, Chief Operating Officer	Akbar Soorma, Clinical Director	Lynn Gray, ADN Emergency Care	1. 1/3/15 2. 1/5/15 3. 1/10/15	1. Business case and then procurement of BGM 2. Daily checking forms audit report + action log 3. Pathology Related Equipment Policy	Glucose Monitor equipment checked Minimised risk of inaccurate blood glucose readings being acted on	
TW37	Emergency and Medical Services	Ensure that patients' clinical records are stored securely in ward areas.	see M14	Avey Bhatia, Chief Nurse / Paul Sigston, Medical Director	Akbar Soorma, Clinical Director				Adhere to record keeping guidelines and maintain patient confidentiality	
TW40	Emergency and Medical Services	Review the process for the management of patients presenting with febrile neutropenia to ensure they are managed in a timely and effective manner	1. Implement Rapid Aassessment Treatment (RAT) process to identify patients early within their pathway. 2. Provide education update to all relevant staff 2. Undertake audit to review impact.	Angela Gallagher, Chief Operating Officer	Akbar Soorma, Clinical Director	Cliff Evans, Consultant Nurse	1. 1/5/15 2. 1/6/15 3. 1/7/15	1. Documented new pathway 2. Education update with attendance list 3. Audit results	Febrile neutropeanic patients are identified within first 30 minutes and put on the appropriate pathway	
M21	Surgery	Review the current arrangements for the providing elective day case surgical services to ensure parity of services across the hospital campus.	1.Review current elective surgical patient pathway ensuring the involvement of both site practitioners 2. Set up a dedicated task and finish group that includes a review of facilities and admission process with patient representation 3. Ensure all relevant staff awareness of new pathway both sites	Avey Bhatia, Chief Nurse	Jonathan Appleby, Clinical Director	Siobhan Callanan, ADN Planned care Sarah Turner, General Manager	1. 1/7/15 2. 1/10/15 3. 1/10/15	1. New surgical pathway agreed and implemented. 2. Audit showing compliance 3. evidence of implementation and communication to relevant staff both sites	Parity of elective day case surgical services across the hospital campus	
TW39	Surgery	Review current nil-by-mouth guidance to ensure that it is consistent with national standards; patient information leaflets should be standardised and reflect national guidance.	1. Establish a multidisciplinary group to revise and re-issue a fasting policy that is compliant with national guidance and requirements. 2. Provide update / education of all relevant staff 3. Audit complaince with new policy	Avey Bhatia, Chief Nurse	Jonathan Appleby, Clinical Director	Siobhan Callanan, ADN Planned care	1. 1/6/15 2. 1/8/15 3. 1/12/15	1. New Fasting policy 2. update / education program with attendance list 3. Audit showing compliance with policy	Patients are provided with consistent advice and care around fasting that is reflective of national guidance	
TW47	Surgery	Review the facilities and admission process for elective surgical patients.	See M21	Avey Bhatia, Chief Nurse	Jonathan Appleby, Clinical Director					

TW46	Women's & Sexual Health	Review the current clinic provision to ensure that women who have recently miscarried or who are under review for ante-natal complications are seen in a separate area to children who are also awaiting their appointment.	1. Review current provision of clinic waiting areas to explore feasibility of providing separate area from children's clinics for women who have miscarried or are having AN complications 2. Present options at Directorate Clinical Governance and agree on plan to address	Avey Bhatia, Chief Nurse	Hilary Thomas , Interim Head of Midwifery	Hilary Thomas, interim Head of Midwifery	1. 1/5/15 2. 1/7/15	1. Report on issue and implemented changes. 2. Minutes of directorate Clinical Governance meeting 2. Reviewed on walkabout by linked executive	Women to be able to wait in an area appropriate to their individual needs	
TW51	Women's & Sexual Health	Address staffing levels and recruitment on the gynaecology ward/unit	1. Undertake Staffing levels review and present to Board 2. Agreement in place on recruitment turnover of 4% 3. Business case to enable 7 day opening of EGAU included in business planning. 4. Decision on Business Planning review 5. Recruitment as per decision from business planning review	Paul Bentley, Director of Workforce and communicati ons	Hilary Thomas , Interim Head of Midwifery	Hilary Thomas , Interim Head of Midwifery John Kennedy, Deputy Chief nurse	1. 1/6/15 2. 1/4/15 3.1/5/15 4. 1/5/15 5. Only if agreed: 1/10/15	1. Report on staffing review presented to Board 2. Business case 3. Buisness planning review and decision 4. Recruitment confirmation (if agreed)	Increased substantive staff - reduced bank and agency spend. EGAU - Improved patient care/pathways at weekends	
TW52	Women's & Sexual Health	Ensure appropriate reporting and recording of incidents on the trust system on the gynaecology ward.	1. Review current incident 'Trigger list' and update if / where required 2. Provide all gynaecology staff with update session on incident reporting and process 3. Regular review of incidents as standard agenda item at Directorate Clinical Governance meetings 4. Data review on reporting of incidents from Gynaecology	Paul Bentley, Director of Workforce and Communicat ions	Hilary Thomas, Interim Head of Midwifery	Hilary Thomas , Interim Head of Midwifery Karen Carter-Woods, Womens and Childrens Risk and Governance lead	1. 1/5/15 2. 1/8/15 3. 1/5/15 4. 1/10/15	1. Revised trigger list 2. Staff attendance lists from update sessions 3. Evidence of review of these at directorate CG meetings 4. Data reviewof incident reporting from Gynaecology	Improved awareness and reporting of risks and incidents by staff & engagement in risk meetings	
TW53	Women's & Sexual Health	Implement actions for the findings of the gynaecology ward audit undertaken in June 2014 and report provided in January 2015	1. Action Plan already in place 2. Monitoring of action plan through Directorate Clinical Governance Meetings with exceptions reported to Standards Committee	Paul Bentley, Director of Workforce and Communicat ions	Hilary Thomas, Interim Head of Midwifery	Hilary Thomas , Interim Head of Midwifery Karen Carter-Woods, Womens and Childrens Risk and Governance lead	2. 1/5/15	1. Action plan 2. Minutes of Directorate Clinical Governance meetings	Improved patient care, staff engagement and knowledge regarding the ward performance on quality issues	

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board – March 2015

3-14 Single Sex Compliance Statement **Chief Nurse**

Summary / Key points

The Department of Health requires all acute care providers to publish an annual statement of compliance with single sex accommodation.

Maidstone & Tunbridge Wells NHS Trust is compliant with the principles of single sex accommodation.

Where the mixing of sexes occurs this is due either to clinical need (such as acute stroke, coronary care) or to significant site pressures requiring use of escalation beds.

When mixed sex accommodation occurs, all patients affected are spoken to and the reasons for the mixing explained.

Any occurrence is noted at the daily site operational management meetings and plans put in place to resolve the mixed sex accommodation as soon as is practicable. The target time for resolution is 23 hrs. This allows for a patient to be cared for in a ward if admitted during the night, without having to move other patients at night.

The attached statement follows the suggest template from the Department of Health, and will be published on the Trust's website.

Which Committees have reviewed the information prior to Board submission?
None

Reason for receipt at the Board.
Information and approval

Maidstone and Tunbridge Wells NHS Trust

Declaration of compliance

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

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

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

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

March 2015

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – March 2015

3-15 Board members' hospital visits (04/12/14 to 11/03/15) Trust Secretary

"Board to Ward" visits, safety 'walkarounds' etc. are regarded as key governance tools[1] available to Board members. Such activity can aid understanding of the care and treatment provided by the Trust; and provide assurance to supplement the written and verbal information received at the Board and/or its sub-committees.

This quarterly report therefore provides details of the hospital visits undertaken by Board Members between 4th December 2014 and 11th March 2015 (the last report submitted to the Board, in December 2014, covered visits up to 3rd December).

The report includes Ward/Department visits; involvement in Care Assurance Audits; and related activity. The report does not claim to be a comprehensive record of such activity, as some Board members (notably the Chief Executive, Chief Operating Officer, Chief Nurse, Medical Director, and Director of Infection Prevention and Control), visit wards and other patient areas regularly, as part of their day-to-day responsibility for service delivery and the quality of care. It is not intended to capture all such routine visits within this report. In addition, Board members may have undertaken visits but not registered these with the Trust Management office (Board members are therefore encouraged to register all such visits).

The report is primarily for information, and to encourage Board members to continue to undertake visits. Board members are also invited to share any particular observations from their visits at the Board meeting.

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [2]
Information, and to encourage Board members to continue to undertake quality assurance activity

[1] See "The Intelligent Board 2010: Patient Experience" and "The Health NHS Board 2013"
[2] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Ward visits undertaken by Board members, 4th December 2014 to 11th March 2015

Board member	Areas registered as being visited (MH: Maidstone Hospital; TW: Tunbridge Wells Hospital)	Formal feedback provided?
Chairman	▪ A&E X2 TW ▪ Maternity TW ▪ All inpatient areas TW ▪ A&E X3 MH ▪ Oncology Centre MH ▪ Birth Centre MH ▪ All inpatient areas MH	No
Chief Executive	▪ Ward 10 TW ▪ Ward 11 TW ▪ Ward 22 TW ▪ Theatres TW ▪ Pharmacy TW ▪ SSSU TW ▪ SAU TW ▪ A&E TW ▪ Peale MH	No
Chief Nurse	▪ A&E X2 TW ▪ Cardiac Cath Lab X3 TW ▪ Delivery Suite TW ▪ Gynaecology Ward TW ▪ Hedgehog Ward TW ▪ ICU TW ▪ MAU X2 TW ▪ Neo Natal TW ▪ Post Natal TW ▪ SAU X2 TW ▪ SSSU X2 TW ▪ Theatre TW ▪ Ward 10 TW ▪ Ward 11 TW ▪ Ward 12 TW ▪ Ward 20 X2 TW ▪ Ward 21 X2 TW ▪ Ward 22 X2 TW ▪ Ward 30 X2 TW ▪ Ward 31 TW ▪ Ward 32 TW ▪ Tonbridge Cottage Hospital ▪ Foster Clark MH ▪ Whatman MH	Yes
Chief Operating Officer	▪ A&E X2 MH ▪ Chaucer MH ▪ Chronic Pain MH ▪ Cornwallis MH ▪ Foster Clark X2 MH ▪ GU Clinic MH ▪ John Day MH ▪ Jonathan Saunders MH ▪ Lord North MH ▪ Mercer Ward X2 MH ▪ Pye Oliver X2 MH ▪ UMAU X2 MH ▪ Whatman X2 MH	Yes

Board member	Areas registered as being visited (MH: Maidstone Hospital; TW: Tunbridge Wells Hospital)	Formal feedback provided?
	▪ A&E TW ▪ Cardiac Cath Lab X2 TW ▪ Endoscopy TW ▪ Haemato-Oncology Day unit TW ▪ SAU X2 TW ▪ SSSU X2 TW ▪ Ward 12 X2 TW ▪ Ward 20 X2 TW ▪ Ward 21 X2 TW ▪ Ward 22 X2 TW ▪ Ward 30 X2 TW ▪ Ward 31 TW	
Director of Finance	-	-
Director of Infection Prevention and Control	-	-
Director of Workforce and Communications	-	-
Medical Director	-	-
Non-Executive Director (KT)	-	-
Non-Executive Director (AK)	-	-
Non-Executive Director (SD)	-	-
Non-Executive Director (SDu)	▪ Ward 10 TW ▪ Ward 11 TW ▪ Pharmacy TW ▪ SSSU TW ▪ SAU TW ▪ Lord North MH ▪ Charles Dickens MH ▪ Chartwell Suite MH	No
Non-Executive Director (ST)	-	-

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – March 2015

3-16	Approval of the Budget for 2015/16	Director Of Finance

Summary / Key points

- The paper updates the Board on the development of Trust budgets for 2015/16
- The draft financial plan delivers a deficit of £13.4m (unchanged from the February paper).
- The paper includes the impact of the selected ETO (Enhanced Tariff Option) including reduced efficiency and marginal rate deductions for SCG growth and NEL threshold.
- The CIP target has been reduced in this draft by £0.7m. The CIP target is now set at £21.5m (with £14.9m of schemes identified). The general contingency has been increased by £0.8m to reflect the uncertainty that still exists over the national tariff and accompanying rules.
- The full draft TDA submission is now due on the 7th April followed by the final submission on the 14th May.
- Appendix 1 includes supporting information including a list of assumptions, income and expenditure (including a bridge between 2014/15 outturn and 2015/16 plan), CIP details, capital, cash flow, balance sheet, workforce, activity and current budgets by directorates.

Which Committees have reviewed the information prior to Board submission?
Finance Committee, 23/03/15

Reason for receipt at Trust Board
To discuss and note progress towards the draft plan submission and to note and approve the changes made since the February Board.

Agreement of the Budget 2015/16

1. Purpose

1.1 This paper summarises the key detail of the Trust's draft 2015/16 plan submission that is now due on the 7th April.

1.2 This paper highlights the key financial assumptions and the financials that will be included in the April plan submission. Much of the paper restates the information shared with the committee in February but has been updated with

- The impact of the Enhanced Tariff Option (ETO),
- Review of the SCG threshold
- Changes in A&E activity
- Adjusting the rules for CQUINs applied to the SCG (Specialist) contract.

The detail of these changes can be found in section 5.2.

1.3 The April submission is the first of two full plan returns with the final submission due to be made on the 14th May after formal Board agreement in April.

1.4 Much of the paper is a repeat of the paper presented in February. The information repeated allows the March Committee to have a document that fully explains the proposed plan in line with April submission.

2. Executive Summary

2.1 The following table represents a summarised view of the I&E schedules that are to be submitted to the TDA on the 7th April 2015.

Summary	
Income & Expenditure	**£m**
Operating Income	394.7
Operating Expenditure	(389.7)
Financing costs (Loan interest, PDC)	(20.0)
Retained Surplus/(Deficit)	**(15.0)**
Adjustments (including IFRIC 12 (PFI)	1.6
Adjusted Retained Surplus/(Deficit)	**(13.4)**

Table 1

2.2 The level of deficit is the same as presented to the committee in February. However, a number of changes have been built into the plan reflect the new tariff (£2.4m improvement) and a reduction in A&E growth (£0.2m deterioration) after further dialogue with the operational team. A further deterioration of £0.7m has resulted from reviewing the guidance over the setting of the SCG's threshold and updating the CQUINs income in the SCG contract. Given the risk around delivery of savings the CIP target has been reduced by £0.75m and finally there is a proposed increase in the general contingency of a further £0.75m.

2.3 Some further work will have to be done once the full price list and grouper is available. The committee will be advised if there is any emergent issue or financial impact once this work is complete.

2.4 The committee is asked to consider and approve that at this time the I&E position described in this paper is an accurate representation of the Trust's financial plan for 2015/16.

3. Submission timetable

3.1 The submission timetable has been described in the Planning Process paper which is an updates what was included in the Planning paper presented at the February Committee. An approximate 5 week delay has been built into the process to allow tariff changes to be built into plans and contracts.

3.2 The planning returns comprise:

- Business Plan summary
- Activity Plan
- Financial Plan
- Workforce Plan
- Planning Compliance Checklists
    - Quality and Workforce
    - Performance, Innovation and Technology
    - Finance and QIPP

4. Activity, Financial and Workforce Triangulation.

4.1 The financial and workforce projections are aligned with the activity and CIP plans to ensure consistency across the submission. This is achieved by following the same methodology involving:

- Baselines for 2015/16 set on forecast outturns, as adjusted to remove non- recurrent items and take account of the full year impact of part year events;
- Growth in activity assessed on a specialty basis for demographic data, tested and adjusted for Trust trends indicating higher projections;
- Specific adjustments made for planned service developments, cost pressures and efficiencies.

4.2 The workforce return likewise takes forecast outturn as the starting point for Whole Time Equivalent (WTE) numbers, aligned to the employee benefit costs (including temporary workforce) in the financial submission. Reductions are made for headcount affecting cost improvement schemes, and additions for Service development, and which is also being presented cost pressure related changes (e.g. 7 day services). Appendix 7 sets out the current workforce plan.

5. Financial Plan

Key Assumptions

5.1 The key assumptions for the draft full submission are set out in Appendix 1. These are referred to in the relevant sections of the commentary that follows. Those that have either been added or amended since February have been highlighted in the appendix as well as being explained in the following section.

5.2 The most significant quantifiable changes since February are:

- Impact of the Enhanced Tariff Option (ETO) – Reduction of tariff efficiency from 3.8% to 3.5% - expected impact £0.8m. This evaluation of the impact is based upon publications provided to Trusts in order for them to make their ETO/DTR choice.
- Impact of the Enhanced Tariff Option (ETO) – Marginal rate change for activity in excess of the Non Elective Threshold (was 50% now increased to 70%) – expected improvement since February £1.1m.
- Impact of the Enhanced Tariff Option (ETO) – marginal rate change for specialist activity above the 2014/15 threshold was (50% now 70%) – improvement expected £0.5m.
- Evaluation of the Specialist threshold level (adjusted 14/15 contract base) reduced by £1.6m – net impact expected will reduce income by £0.5m after growth exposed to new marginal rate charge for SCG growth.
- Reduction in A&E growth from 4.2% to 2.5% - impact will deteriorate I&E by £0.2m.

- Revision of CQUIN plan for Specialist to remove CQUIN from pass through recharges – reduces income by £0.2m.
- Increased general contingency of £0.8m.
- A reduction in the CIP target of £0.7m (CIP target now £21.5m).

5.3 There are expected to be a number of issues that will have to be considered for inclusion in the plan prior to final submission in May, these will be agreed at the April Committee (verbal updates may be available for the March Committee):

- The impact of the real outturn for 2014/15. This is not expected to be material to the bottom line but may impact on the detailed analysis that accompanies the plan to the TDA.
- Full evaluation of the ETO once the grouper, new price list and revised contracting rules are all available. The grouper has been released but the pricelist has yet to be republished.
- WTE and pay cost profiles are nearing final verification any required changes from this validation process will have to be built into the plan either for the Draft or Final Submission.
- £6.5m of PDC may have to be restated as loan finance with a resulting interest impact.
- Any unforeseen rule conflicts that result from the completion of the TDA forms.
- Complete the revaluation on the IFRS adjustment.

Summary Income and Expenditure (I&E)

5.4 The Trust is projecting a 2015/16 I&E breakeven deficit of £13.4 m which is £1.1m worse than the 2015/16 plan figure in last year's planning round of £12.3m. The improved tariff offer has offset the cost pressures previously identified including the Trust-specific CNST costs for 2015/16.

Income & Expenditure	**£m**
Revenue from Patient Care Activities	356.2
Other operating income	38.5
Total income	394.7
Employee benefits	(225.9)
Other operating costs	(163.8)
Financing costs (Loan interest, PDC)	(20.0)
Total costs	(409.7)
Retained Surplus/(Deficit)	**(15.0)**
Break even duty adjustments	
IFRIC 12 (PFI)	1.3
Donated/government grants	0.3
Total adjustments	1.6
Adjusted Retained Surplus/(Deficit)	**(13.4)**

Table 2

5.5 Appendix 2 sets out a more detailed I&E including the monthly phased profiles and a separately a bridge depicting the key changes from outturn to the planned position.

Income

5.6 Forecast outturn 2014/15 SLA income as at Month 11 has been adjusted to remove the following main non recurrent items:

- The deficit support funding of £12m

- Contractual penalties and provisions of £9.0m
- Reduction in local PFI support of £4m
- Reduction in Cancer tariff transitional support £2.9m
- Operational Resilience funding of £2.4m

5.7 Baseline SLA Activity has been projected and evaluated including demographic growth, and trend growth in A&E and non-electives. The trend data is being reviewed in the light of the Directorate business plan proposals. The detail percentage changes are set out in Appendix 1 Assumptions. Headline activity figures, as returned to the TDA, are included in Appendix 8.

5.8 High level commissioning intentions have been received but as yet no detail of QIPP or demand management schemes. At this stage no assumptions of demand management reductions have been made within the activity or financial projections.

5.9 Service developments have been assessed from:

- Clinical and business strategy work with income of £3.2m in 2015/16
- Directorate business plan proposals and cases e.g. the hyper acute stroke unit £0.2m and additional consultant A&E paediatricians £0.42m
- Directorate proposals within the efficiency/CIP programme of £2.3m (including full year effects of current year schemes)

5.10 SLA income has been priced using the original 2015/16 National Tariff adjusted for the impact of ETO and revised business rules as flagged by Monitor, see the changes in assumption section (5.2) above.

5.11 The volume forecast for specialist service activities for 2015/16 results in a gross income increase of £2.2m over the contract for 2014/15 (there is no growth over the Forecast for 2014/15). It is the growth over the contract for 2014/15 that is expected to be exposed to the new business rule for the Specialist services marginal rate of 70% (was 50%). With pricing adjustments to the contract value and this growth above the 2014/15 contract the total deduction in income due the SCG threshold and marginal rate is expected to be £1.1m. It should be noted that any further growth including pass through costs will only be funded at 70% of tariff (local or national).

5.12 In line with planning guidance the Trust has assumed that the Operational Resilience funding will need to be negotiated for 2015/16 within contract baselines. It has assumed at £2.5m at this stage to maintain the 2014/15 capacity. The Trust has provided against £0.5m of this income not being received. A cost pressure of £633k has been included to cover both the full year impact of moving to extended critical outreach services and converting them into a full 24/7 day service, in line with CQC recommendation. The funding for this will be sought from the CCGs and has been included in SLA planned income but backed out with a specific provision against the income not being agreed as part of the contract negotiations.

5.13 £4m of non-recurrent strategic change funding (1% top slice) has been included to be discussed with the CCG to support potential restructurings.

5.14 An overall provision of £9.8m is included to cover contract challenges, sanctions and commissioning risks (e.g. on demand management) together with specific provisions against the negotiable items of:

- CQC/Quality developments £1.2m (Critical Care, A&E Paeds consultants, Hyper acute stroke unit)
- Operational resilience (£0.5m of the £2.5m total)

5.15 Other operating income has been inflated by 2.1% in line with pay and general non pay costs.

5.16 HIS income, relating to charging other users, has been reduced by £2.5m in accordance with the transfer of staff to Trusts withdrawing from the shared service.

Expenditure

5.17 At this stage specific cost pressure assessments have not been released as the final Tariff guidance is delayed, only headline indications have been given in the initial draft guidance. The Trust has included its assessments of inflationary pressures, which are in line with the headline levels.

5.18 Pay costs have been inflated by 2% to cover pay award, incremental drift and employer pension cost pressures. Non pay inflation has been assumed at 2.1% for general non-pay, 3% for drugs and the PFI Unitary Charge in line with RPI projections.

5.19 CNST has been included at the recently notified level of £16.6m which represents an increase year on year of £5.9m (equating to 55%). The national tariff was uplifted to reflect an expected 35% average increase but MTW's it should be noted that this funding is exposed to Trust level case mix and in year volume changes.

5.20 Developments and additional activity has been priced at relevant marginal costs and additional pay costs and numbers included within the workforce plans.

5.21 The withdrawal of partners from the HIS consortium has been factored in with a reduction of cost of £2.5m (c. 100 WTE transferring under TUPE) and an estimate of £0.1m additional pressure to MTW following the reconfiguration of the remaining service.

5.22 The impact of the Kent Pathology Partnership, planned to commence in April 2015, has been factored into the spend plans. The draft KPP Annual Business Plan quantifies the net additional costs for set up and restructuring to the Trust for 2015/16 at c. £1.0m. The workforce transferring under TUPE have been removed from staffing costs and WTEs, but the overall expenditure plan remains the same as this cost is then charged back as a Trust to Trust non pay contract.

5.23 The capital charges have been estimated from forecast capital outturn adjusted for the impact of the capital programme in 2015/16. The current revaluation exercise is not yet complete and therefore this figure may change according to the revised useful lives and carrying values of specific property assets. At present the 2014/15 impairment has been estimated at £12m.

5.24 A provision of £4m for potential restructuring has been included and planned to be covered by CCG funding from the 1% top slice monies – this is subject to agreement as part of the contract negotiation.

5.25 The Trust has included a general contingency of 0.5% (£2.0m), with another £1.2m relating to specific cost pressure and planning risks, a new contingency against the non-delivery of recurrent CIPs and a provision against income challenges, penalties and commissioning risks of £9.8m.

Efficiency/Cost Improvement Programme

5.26 The Trust's planned efficiency and cost improvement programme requirement for 2015/16 is £22.2m, including £3.3m of full year effects. It has been developed from a combination of national benchmarking to identify high level targets and bottom up business planning, with Directorates being set a guideline 8% requirement.

5.27 The efficiency programme comprises 12 work-streams covering all areas of the organisation such as operational efficiency (e.g. improving length of stay) to resource

management (e.g. improving nursing productivity). Each work-stream has an Executive sponsor, a work-stream lead and dedicated support from the PMO.

5.28 Current progress on the programme by work-stream and Directorate is set out in Appendix 3. The Directorates have so far set out schemes amounting to £14.9m against the £21.5m target (was £21.5m before the £0.7m reduction proposed this month) with varying degrees of progress by Directorate. Work continues with Directorates to close the gap further as the March meetings continue.

5.29 Planned workforce reductions from productivity and efficiency measures have been factored into the workforce plans.

Workforce

5.30 The workforce return takes forecast outturn as the starting point for Whole Time Equivalent (WTE) numbers, aligned to the employee benefit costs (including temporary workforce) in the financial submission. Reductions are made for headcount affecting cost improvement schemes, for the transfers of staffing under TUPE for the KPP and for HIS, whilst additions are factored in for Service development, and cost pressure related changes (e.g. 7 day services).

5.31 Directorate workforce plans are being progressed and the phasing of workforce budgets will become more detailed as the Directorate plans are finalised, in particular in relation to recruitment and the use of temporary staffing.

5.32 Appendix 7 sets out the current workforce plan.

Capital

5.33 The Trust has planned a five year capital programme totalling £94m that is set out in Appendix 4. The programme includes:

- significant improvement in backlog estates (£21m)
- development of additional ward capacity at TWH (£4m)
- renewal of a main theatre block (£12m) at Maidstone Hospital;
- a replacement equipment programme of £30m including linear accelerators for the Cancer Centre;
- IM&T modernisation programme (£13m).

5.34 The primary source of capital funding is internally generated cash through deprecation and capital disposals for the sale of assets. However this does not finance all the Trust's plans and has to fund the capital loan repayments. Therefore to deliver the current plans external financing is required. Given the Trust's deficit recovery plan it is currently unable to secure external loan funding so it is planning to apply for exceptional PDC.

5.35 The feedback from the TDA on the initial plans included suggesting that the Trust needed first to plan for capital loans rather than PDC. This is the default position of the capital guidance but the Trust's deficit plan means it will fail the relevant Prudential Borrowing test that is based on its ability to finance loan debt. The Trust may need to reflect the theoretical possibility of loans in the February submission, but is discussing this further with the TDA business support team to determine if it is necessary. It should be noted that detailed supporting information such as business case documentation and LTFM extracts would need to accompany a request for additional financing.

5.36 The Trust's plans include capital PDC to support its need to increase bed capacity (£4m for a new ward at TWH in 2015/16), diagnostic capacity (£3m MRI redevelopment in 2016/17), its development of a satellite radiotherapy facility at Pembury (£8m across 2015/16 and 2016/17) and the theatre renewal at Maidstone requiring a new build (£12m across 2016/17 and 2017/18).

5.37 The asset disposals assumed for 2015/16 are £1.0m relating to the Hilcroft property neighbouring the TWH at Pembury (originally planned for disposal in the 2014/15 plan). There are alternative proposals affecting this property under consideration and also the possibility of other NHS interest in purchasing it (which would necessitate a capital neutral funds flow transfer) so this represents a risk to the capital resource. If this disposal is removed from the plans, the capital resource reduction would need to be managed by planning an equivalent reduction to in year programme spend plans.

5.38 The Directorate business plans have identified draft capital requirements but further work is required to clarify and prioritise schemes. This work will support finalisation of the programme for the final submission. By that stage the Trust will also have reviewed further its plans for linear accelerator developments at TWH. The Trust's capital resourcing is very tight so clear prioritisation will be key to maximising the use of the available resource.

Cash & Balance Sheet

5.39 Appendix 5 presents the projected cash flows for the Trust in 2015/16 in graphical form, together with an assessment of the main areas of risk to liquidity. Appendix 6 sets out the projected balance sheet positions.

5.40 The Trust anticipates ending 2014/15 with a cash balance of £0.9m, debtors of £36.8m and creditors of £34.4m. The debtor plan takes into account the nature of NHS contracting which normally results in delays of approximately 12 weeks for over performance which will increase debtors through the first half of the year, the final profile for the year will be adjusted to take account of the exact contract values as agreed with commissioners.

5.41 The impact of the 2015/16 planned deficit (pre-technical break- even adjustments) will require additional working capital financing which has been assessed at £14.9m. This has been risk assessed down to the level of £13.3m in line with the submission the Trust made last year relating to 2015/16.This has been forecast as being needed from September 2015.

5.42 The Trust is likely to be required to apply for this funding as a working capital loan rather than permanent PDC, and will be finalising this with the TDA. The timing of this funding will be subject to the ITFF process, so the Trust may firstly require temporary working capital pending the completion of the application process.

5.43 The SLA income has been assessed in line with the plan assumptions, and taking into account current discussions about making the customary advance of host CCG SLA income over a longer period than usual (6 months rather than a double payment in April). It has been risk assessed for the potential non-payment, or deferred payment of 2013/14 and 2014/15 over-performance debts. The cash flow assumes the continuing receipt of the £8m national PFI support, and the reduction to £4m of the final year of the local tapering support.

5.44 Given the risks assessed to cash flows, the Trust may also require temporary working capital during the year to manage its liquidity. The cash position will be reported proactively to the committee including in applications being made for either permanent or temporary funding.

5.45 The non-current assets assume the present forecast impairment for 2014/15 of £12m resulting from the current Trust-wide estate revaluation exercise, but this may change once the work is finalised during February/early March. No impairments have been forecast at this stage for 2015/16, and also no capital asset indexation.

Directorate Budgets

5.46 The Directorate budgets are being finalised and agreed in readiness for budget reporting from April. Appendix 9 schedules out the current budgetary control totals by Directorate. As

the plan is developed any changes identified in the planning process will be reflected in Directorate budgets or reserves where appropriate. Where the Directorate allocation of planning issues has yet to be agreed the financial impact will held in reserve. Items currently reflected in reserves that will be transferred to Directorates include the impact of ETO, CIP changes and other contracting issues such as threshold changes. Once prioritised and approved investments will be added to Directorate budgets.

6. Planning submission – next steps

6.1 The draft full planning submission is on the 7th April. This involves a fuller set of financial proformas with the other templates for activity, workforce and checklists remaining the same.

6.2 The Trust is now returning a weekly SLA contract tracker to the TDA which is used to monitor progress in contract discussions. The expectation will be that this submission includes more developed contract positions with alignment to commissioner intentions and baseline contract proposals. At this stage insufficient information has been received from the CCGs to align proposals and negotiations are at an early stage.

6.3 The SLA income needs to be reported at specific CCG level in this submission to facilitate alignment review at TDA/NHSE level. Assumptions about non recurrent income e.g. strategic change funding will need to be discussed and if possible agreed. The Trust will also be seeking to update the specialist service baseline from the plan value to a more realistic outturn level.

6.4 This submission is the first of the full plan return. The Trust makes its final planning submission on April 10th, prior to which the final return will be reviewed and agreed at the March TME, Finance Committee and Trust Board meetings. The internal business planning is expected to further inform the final submission with detailed CIP and capital plans, and capacity assessments aligned to the commissioned activity requirements. The phasing of spend and workforce budgets will also become more detailed as the Directorate plans are finalised, in particular in relation to recruitment plans and the use of temporary staffing.

7. Recommendation

7.1 The Committee are asked to review and approve the changes since February.

7.2 The Committee are also asked to:

- Note and agree the assumptions highlighted in this paper and their application to the planed values prior to the plan being submitted to the TDA as the Trust's draft plan.
- Approve the level of deficit the plan is projecting for 2015/16 prior to submission to the TDA.
- Approve the reduction of the CIP target by £0.7m to £21.5m.
- Approve the increase in the general contingency by £0.8m.
- Approve the continued development of the plan in preparation for final submission in May outlining any amendments or considerations that the committee believe should be included in that final plan submission.

	Planning Assumptions	2015/16			
	Assumption Categories			**Basis**	**Notes & Comments**
	Income inflation				
1	Tariff inflation	-0.4%		2015/16 Tariffs applied to outturn activity	Headline assumption is 0.5% (-1.6% deflator less funding for CNST - ETO impact) but Trust outturn case mix produces a lower impact
2	Non Tariff inflation	-1.6%		Headline 2015/16 National Tariff deflator	Assumed application to local priced SLA activity
3	Non NHS Clinical (RTA & other)	-2.0%			
4	Private Patients	2.1%			
5	Education & Training	1.0%			To check with DS - have a transitional arrangement agreed
6	R&D	1.0%			
7	Commercial income	2.1%			
8	Other operating income	2.1%		In line with Pay/Non pay general uplift	
	Cost inflation				
1	Employee Benefits	2.0%		Covering Pay Award, Drift and Pension cost uplift	In line with initial Tariff guidance
2	Drugs	3.0%		Inflation estimate	
3	Clinical supplies & services	2.1%		General non pay assumption	In line with initial Tariff guidance
4	CNST	55.0%		Specific notified cost	Cost increased by £5.9m to £16.6m. This includes 35% national uplift (funding in tariffs) & adjustments based on Trust claims history
5	Unitary Payment	3.1%		Per previously forecast RPI	RPI likely to be lower but PFI technical accounting will partly offset
6	Other non pay costs	2.1%		General non pay assumption	In line with initial Tariff guidance
7	Capex inflation	0.0%		No capex indexation assumed	Estimated indexation tends to be negated by impairment reviews
	Activity Growth				
1	Elective IP	0.9%		Demographics	
2	Daycase	0.9%		Demographics	
3	Total Elective	0.9%		Demographics	
4	Non Elective	1.5%		Demographics + Trend	Assessment of trend above demographic impact = 0.7%
5	Regular Attendanes	1.3%		Demographics	
6	New Outpatient Attendances	0.8%		Demographics	
7	FUP Outpatient Attendances	1.1%		Demographics	
8	Ward Attenders	0.2%		Demographics	
9	POA	0.9%		Demographics	
10	A&E	2.5%		Demographics + Trend	Growth reduced down from 4.2% after further review with operational team
11	Fractions	1.6%		Demographics	
12	Path DA	0.8%		Demographics	
13	Rad DA	0.6%		Demographics	
14	RTT	0.0%		Assumed no RTT backlog required above outturn level	
	SLA assumptions				
1	Specialist Commissionsing Growth	£0.6m		As per demographics/trend	Growth over outturn before exposure to SCG (ETO) cap - will be paid at 70%

	Planning Assumptions	2015/16			
	Assumption Categories			**Basis**	**Notes & Comments**
	Other CCG Growth	£0.9m		As per demographics/trend	
2	QIPP/Demand management	£0m		CCG proposals	No specific CCG proposals yet received
3	Deficit support funding	£0m		£12m in 2014/15 treated as non recurrent	
4	PFI local tapering support	£4.0m		Agreement with CCGs	Reduction of tapering support from £8m to £4m for 2015/16
5	PFI central support	£8.0m		Assumed recurrent £8m	No inflation assumed in the plan
6	Cancer Tariff transitional support	£2.9m		Previous agreement with SCG	Reduction of transitional support from £5.8m to £2.9m for 2015/16
7	Operational Resilience funding	£2.5m		OR funding now incorporated in baseline contracts	To be negotiated with the CCGs. Level to maintain capacity.
8	Strategic change funding	£4.0m		Bid to CCG 1% top slice fund	To be negotiated with the CCGs. To cover potential restructurings/redundancies
9	Service developments - clin strategy	£3.3m		Clinical & business strategy proposals	To be negotiated with CCGs. Some elements may be Trust to Trust arrangements.
10	CQC/Quality cost pressure	£0.6m		Directorate business case	Extended Critical care outreach 24/7 service. Funding to be negotiated with CCGs
11	A&E paediatric consultants	£0.4m		Creation of A&E paediatric service	Funding to be negotiated with CCGs.
12	Safer staffing	£0.2m		Hyper Acute Stroke unit (HASU) nursing costs	Funding to be negotiated with CCGs.
13	CQUIN	86.0%		Outturn CQUIN performance	No assumed improvement for 2015/16
14	Change of Non elective threshold	£1.3m		Change of threshold from 70:30 to 50:50	Gross benefit on outturn estimated at £1.8m, reduced to £1.3m after volume and development impacts
15	Specialist service threshold	-£0.9m		70% over 2014/15 plan value reimbursed (was 50%)	Gross income increase of £2.2m, cap reduced to £0.9m from impact of the unwinding of the cancer tariff transitional support on baseline. The impact of increasingthe % rate of payment above the contract base from 50% to 70% has increased the income by £0.5m, but a re evaluation of the level of base (to 2014/15 plan) has increased the value of income lost to the new marginal rate by £0.5m.
16	Contract income contingency	£9.8m		SLA team assessment	Provision for potential contract penalties, commissioning risks and specific negotiable developments (Critical care, HASU, A&E paeds unit, and £0.5m of Operational resilience funding)
17	Romney ward	neutral		Assumed continuation as a CCG run and funded ward	
	Other income				
1	HIS	-£2.5m		Directorate assessment	HIS income reduced by £2.5m relating to the transfer of staff to Trusts withdrawing from HIS
	Costs				
1	Volume growth	£1.4m		30% marginal cost	Assumed delivered within current capacity
2	Service Developments - clin strategy	25%-60%		Costs based on assessed marginals	
3	HIS	£2.5m		Directorate assessment	HIS costs reduced by £2.5m relating to withdrawing Trusts' takeon of staff.
4	HIS cost pressure	£0.1m		Trust assessment	Additional cost from unrecovered overheads/residual partner shares
5	KPP	£1.0m		KPP Business Plan	Net additional costs for implementation of KPP
6	Operational resilience capacity	£2.4m		Planned maintenance of 14/15 capacity (includes 7 day Pharmacy, Respiratory Consultants, HIT Therapies, Escalation	Funding to be negotiated with the CCGs. Level to maintain capacity.
7	7 day services	£0.25m		Full year effect of Phase 1 7 day therapy service	

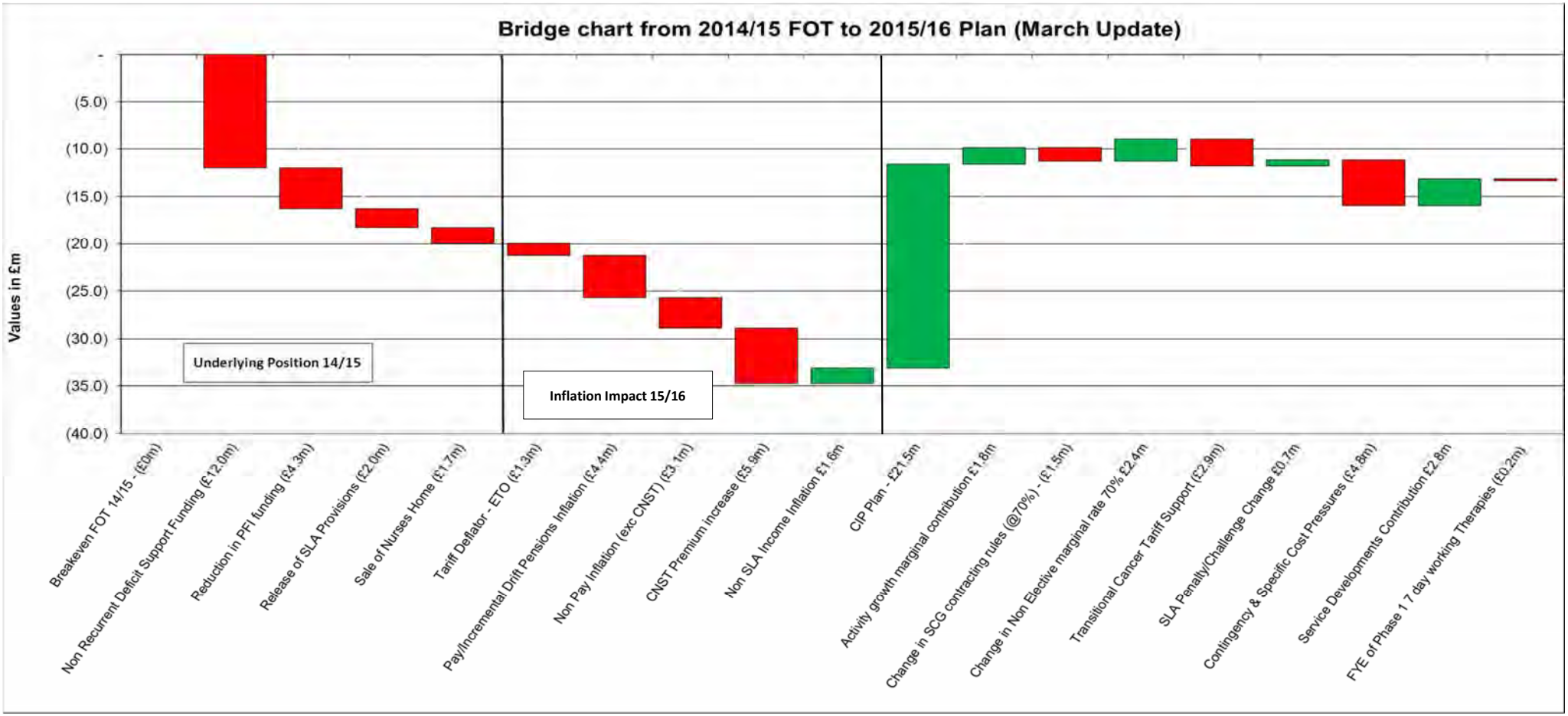
	Planning Assumptions	2015/16			
	Assumption Categories			**Basis**	**Notes & Comments**
8	CQC/Quality cost pressure	£0.6m		Directorate business case	Extended Critical care outreach 24/7 service. Assumed CCG income under negotiation.
9	A&E paediatric consultants	£0.4m		Creation of A&E paediatric service. 4 consultants.	Income to be negotiated with CCGs.
10	Safer staffing	£0.2m		Hyper Acute Stroke unit nursing costs	Income to be negotiated with the CCGs.
11	Strategic change costs	£4m		Bid to CCG 1% top slice fund	To be negotiated with the CCGs. To cover potential restructurings/redundancies
12	Non IFRIC 12 Depreciation	£14.5m		Estimate of impact of FYE of 2014/15 programme plus existing asset base rolled forward	
13	Asset Impairment	nil		No impairment assumed at this stage for 15/16	No impairment assumption, but also no indexation assumption
14	Procurement BC	£0.6m		Part year impact 2015/16 (incl £0.2m NRs)	
	Efficiencies/CIP				
1	Programme totals	£21.5m		Combination of top down targets and Dir Business plans identified to date	FYE of 14/15 = £3.3m, 15/16 schemes = £18.2m
2	Pay	£7.5m			
3	Non pay	£6.4m			
4	Income	£7.6m			
	Contingencies				
1	General contingency	£2.8m		0.5% of turnover & 40% of ETO benefit	
2	Other cost contingencies	£1.1m			To cover Business planning pressures
3	Contract income contingency	£9.8m		SLA team assessment	Provision for potential contract penalties, commissioning risks and specific negotiable developments (Critical care, HASU, A&E paeds unit, and £0.5m of Operational resilience funding)
	Cashflows				
1	Capital	£19m		Net £19m programme after asset disposals	No overall change assumed to openring and closing capital creditors. 2014/15 linacc assumed paid in April.
2	SLAs			Agreed double block in April from North Kent CCGs. WK CCG proposing to pay additional block over initial 6 months	
3	SLA overperformance (13/14, 14/15)	£10m		Forecast £5m payment in May for balance of WK CCG agreement, and £5m in June for resolution of Specialist commissioner 13/14 overperformance	

Trust Summary Income and Expenditure Plan for 2015/16

Income and Expenditure Headings	Month 1 £'000s	Month 2 £'000s	Month 3 £'000s	Month 4 £'000s	Month 5 £'000s	Month 6 £'000s	Month 7 £'000s	Month 8 £'000s	Month 9 £'000s	Month 10 £'000s	Month 11 £'000s	Month 12 £'000s	2015/16 Full Year £'000s
Income													
NHS Clinical SLA Income	25,060	24,875	26,307	27,386	25,600	26,391	26,931	25,978	26,361	26,506	26,359	31,109	**318,864**
Income From Activities	2,353	2,353	2,353	2,353	2,353	2,353	2,353	2,353	2,353	2,353	2,353	2,353	**28,238**
Sub Total NHS Clinical SLA Income	**27,413**	**27,228**	**28,660**	**29,740**	**27,953**	**28,745**	**29,284**	**28,331**	**28,714**	**28,859**	**28,713**	**33,462**	**347,101**
Non-NHS Clinical Income	701	703	703	710	710	708	711	712	713	715	715	714	**8,516**
Non-Clinical Income	3,440	3,440	3,440	3,440	3,127	3,127	3,179	3,179	3,179	3,179	3,179	3,179	**39,086**
Operating Income	**31,554**	**31,371**	**32,803**	**33,889**	**31,790**	**32,580**	**33,174**	**32,222**	**32,606**	**32,753**	**32,606**	**37,355**	**394,703**
Pay													
Medical	(5,674)	(5,664)	(5,663)	(5,638)	(5,636)	(5,644)	(5,631)	(5,628)	(5,625)	(5,618)	(5,619)	(5,621)	**(67,660)**
Nursing	(6,877)	(6,856)	(6,853)	(6,800)	(6,795)	(6,813)	(6,806)	(6,799)	(6,792)	(6,846)	(6,850)	(6,851)	**(81,938)**
Admin & Senior Manager	(2,882)	(2,867)	(2,866)	(2,829)	(2,513)	(2,525)	(2,543)	(2,538)	(2,534)	(2,524)	(2,526)	(6,528)	**(35,674)**
Scientific,Therapeutic and Technical	(2,288)	(2,288)	(2,288)	(2,288)	(2,288)	(2,288)	(2,288)	(2,288)	(2,288)	(2,288)	(2,288)	(2,288)	**(27,455)**
Support Staff	(1,094)	(1,094)	(1,094)	(1,094)	(1,094)	(1,094)	(1,094)	(1,094)	(1,094)	(1,094)	(1,094)	(1,094)	**(13,129)**
Total Pay Cost	**(18,815)**	**(18,769)**	**(18,764)**	**(18,649)**	**(18,325)**	**(18,363)**	**(18,362)**	**(18,346)**	**(18,332)**	**(18,370)**	**(18,377)**	**(22,382)**	**(225,855)**
Non Pay													
Drugs and Medical Gases	(3,072)	(3,067)	(3,067)	(3,054)	(3,053)	(3,057)	(3,055)	(3,053)	(3,052)	(3,049)	(3,049)	(3,050)	**(36,680)**
Clinical Supplies and Services	(2,807)	(2,797)	(2,800)	(2,779)	(2,772)	(2,782)	(2,772)	(2,766)	(2,764)	(2,789)	(2,790)	(2,803)	**(33,420)**
Establishment	(326)	(326)	(326)	(326)	(326)	(326)	(326)	(326)	(326)	(326)	(326)	(326)	**(3,914)**
Premises	(1,642)	(1,642)	(1,642)	(1,642)	(1,642)	(1,642)	(1,642)	(1,642)	(1,642)	(1,642)	(1,642)	(1,642)	**(19,703)**
Clinical Negligence	(1,381)	(1,381)	(1,381)	(1,381)	(1,381)	(1,381)	(1,381)	(1,381)	(1,381)	(1,381)	(1,381)	(1,381)	**(16,573)**
General Supplies and Services	(478)	(478)	(478)	(458)	(455)	(464)	(450)	(446)	(443)	(435)	(437)	(439)	**(5,461)**
Purchase of Healthcare from other Non-NHS	(275)	(273)	(273)	(267)	(267)	(269)	(266)	(265)	(264)	(263)	(263)	(264)	**(3,208)**
Services from Other Non-NHs Bodies	(1,384)	(1,384)	(1,384)	(1,384)	(1,384)	(1,384)	(1,384)	(1,384)	(1,384)	(1,384)	(1,384)	(1,384)	**(16,608)**
Other Non-Pay Costs	(881)	(869)	(868)	(838)	(835)	(845)	(837)	(833)	(829)	(821)	(823)	(825)	**(10,104)**
Total Non-Pay Costs	**(12,247)**	**(12,218)**	**(12,219)**	**(12,130)**	**(12,115)**	**(12,151)**	**(12,113)**	**(12,097)**	**(12,085)**	**(12,089)**	**(12,095)**	**(12,113)**	**(145,672)**
Operating Expenditure	**(31,062)**	**(30,987)**	**(30,983)**	**(30,779)**	**(30,440)**	**(30,514)**	**(30,476)**	**(30,443)**	**(30,418)**	**(30,459)**	**(30,472)**	**(34,496)**	**(371,527)**
Other Finance Costs													
Profit/Loss on Disposal	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	**(0)**
Depreciation	(1,514)	(1,514)	(1,514)	(1,514)	(1,514)	(1,514)	(1,514)	(1,514)	(1,514)	(1,514)	(1,514)	(1,514)	**(18,173)**
Impairment of Fixed Assets	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Interest Receivable	4	4	4	4	4	4	4	4	4	4	4	4	**44**
Interest Payable	(56)	(56)	(56)	(56)	(56)	(56)	(56)	(56)	(56)	(56)	(56)	(56)	**(673)**
Other Finance Costs	(1,169)	(1,169)	(1,169)	(1,169)	(1,169)	(1,169)	(1,169)	(1,169)	(1,169)	(1,169)	(1,169)	(1,169)	**(14,026)**
Public Dividends Payable	(443)	(443)	(443)	(443)	(443)	(443)	(443)	(443)	(443)	(443)	(443)	(443)	**(5,318)**
Total Other Finance Costs	**(3,179)**	**(3,179)**	**(3,179)**	**(3,179)**	**(3,179)**	**(3,179)**	**(3,179)**	**(3,179)**	**(3,179)**	**(3,179)**	**(3,179)**	**(3,179)**	**(38,147)**
Surplus/(Deficit)	**(2,687)**	**(2,795)**	**(1,358)**	**(68)**	**(1,829)**	**(1,113)**	**(480)**	**(1,400)**	**(991)**	**(885)**	**(1,045)**	**(320)**	**(14,970)**
Technical Adjustments	133	133	133	133	133	133	133	133	133	133	133	133	**1,600**
Surplus/(Deficit) against Breakeven Duty	**(2,553)**	**(2,661)**	**(1,225)**	**65**	**(1,696)**	**(980)**	**(347)**	**(1,266)**	**(857)**	**(752)**	**(912)**	**(186)**	**(13,370)**

Memorandum : Temporary Staffing included in Pay (excluding Internal Locums)

Stafflow	(338)	(338)	(338)	(338)	(338)	(338)	(338)	(338)	(338)	(338)	(338)	(338)	(4,056)
Bank	(775)	(775)	(775)	(775)	(775)	(775)	(775)	(775)	(775)	(775)	(775)	(775)	(9,304)
Agency	(672)	(639)	(636)	(551)	(543)	(571)	(529)	(517)	(506)	(484)	(489)	(494)	(6,631)
Total	**(1,786)**	**(1,752)**	**(1,749)**	**(1,665)**	**(1,656)**	**(1,685)**	**(1,642)**	**(1,630)**	**(1,620)**	**(1,597)**	**(1,602)**	**(1,607)**	**(19,991)**


Bridge chart from 2014/15 FOT to 2015/16 Plan (March Update)
Values in £m
-
(5.0)
(10.0)
(15.0)
(20.0)
(25.0)
(30.0)
(35.0)
(40.0)
Underlying Position 14/15
Inflation Impact 15/16
Breakeven FOT 14/15 - (£0m)
Non Recurrent Deficit Support Funding (£12.0m)
Reduction in PFI funding (£4.3m)
Release of SLA Provisions (£2.0m)
Sale of Nurses Home (£1.7m)
Tariff Deflator - ETO (£1.3m)
Pay/Incremental Drift Pensions Inflation (£4.4m)
Non Pay Inflation (exc CNST) (£3.1m)
CNST Premium increase (£5.9m)
Non SLA Income Inflation £1.6m
CIP Plan - £21.5m
Activity growth marginal contribution £1.8m
Change in SCG contracting rules (@70%) - (£1.5m)
Change in Non Elective marginal rate 70% £2.4m
Transitional Cancer Tariff Support (£2.9m)
SLA Penalty/Challenge Change £0.7m
Contingency & Specific Cost Pressures (£4.8m)
Service Developments Contribution £2.8m
FYE of Phase 1 7 day working Therapies (£0.2m)

Workstream		Surgery	T&O	Critical Care	Medicine	Oncology	DTP	W&SH	Paeds	TBC	PPU	Total Corporate	Grand Total	Workstream Opportunity as per FIMS	Workstream Variance to Opportunity
LOS	Bus Planning	100			1,256	41						0	1,397		-427
	Opportunity	*323*	*201*	*2*	*1,125*	*37*						*0*	*1,688*	***1,824***	
OP Productivity	Bus Planning	104	50		285	24		0	0			0	463		-77
	Opportunity	*129*	*149*	*30*	*178*				*13*			*0*	*499*	***540***	
Theatre Productivity	Bus Planning	250	271	5				72				0	598		-483
	Opportunity	*499*	*341*		*6*			*73*	*4*			*0*	*923*	***1,081***	
Nursing & STT Efficiency	Bus Planning	50		36	422	98	241	102	0		12	0	961		-76
	Opportunity	*203*	*77*	*32*	*377*	*47*		*186*		*25*	*12*	*0*	*959*	***1,037***	
Medical Efficiency	Bus Planning	330	40	-2	250	25	30	101	12			0	786		-835
	Opportunity											*0*	*0*	***1,621***	
Clincal Admin	Bus Planning	12		24	137	2	5	6	0			0	186		-211
	Opportunity	*23*	*13*	*35*	*179*	*50*		*41*	*28*			*0*	*369*	***397***	
Financial Management	Bus Planning	0										500	500		-1,454
	Opportunity											*0*	*1,808*	***1,954***	
Contract Mgmt	Bus Planning	1,503	166	393	490	1,076	465	593	286			0	4,972		-972
	Opportunity											*0*	*0*	***5,944***	
Procurement	Bus Planning	24	150	394	1,473	47	123	34	30		13	0	2,289		753
	Opportunity	*181*	*187*	*211*	*380*	*51*	*67*	*35*	*30*	*176*	*13*	*16*	*1,407*	***1,536***	
Drugs	Bus Planning	128	20	88	317	200		413	12			0	1,178		367
	Opportunity	*101*	*20*	*87*	*317*	*200*		*13*	*12*			*0*	*750*	***811***	
Back Office	Bus Planning	0										1,136	1,136		-3,203
	Opportunity											*0*	*0*	***4,339***	
PPU Income	Bus Planning	0									405	0	405		-11
	Opportunity											*0*	*0*	***416***	
Grand Total	**Bus Planning**	**£2,501**	**£697**	**£938**	**£4,630**	**£1,513**	**£864**	**£1,321**	**£340**	**£0**	**£430**	**£1,636**	**£14,871**	**£21,500**	**-£6,629**
Directorate 8% Target		**£2,583**	**£1,095**	**£2,592**	**£5,585**	**£1,999**	**£1,139**	**£1,733**	**£825**	**£0**	**£0**	**£3,950**	**£21,500**		
Variance to 8% Target							**-£275**	**-£411**	**-£484**	**£0**	**£430**	**-£2,314**	**-£6,629**		

Maidstone and Tunbridge Wells NHS Trust
Org Code: RWF
2015/16 Financial Monitoring - Initial Plan

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TRU 65

Efficiency Programme	Status: Fully Developed, Plans in Progress, Opportunity or Unidentified (mc 01)	Recurrent (R) or Non recurrent (NR) (mc 02)	Category: Pay (Skill Mix), Pay (WTE reduction) , Non Pay and Income (mc 03)	Risk Rating High (H), Medium (M), or Low (L) (If Unidentified must be high risk) (mc 04)	Gross Total Value 2015/16 (mc 05) £000s	15/16 Monthly Profile (in Year Savings only) Apr (mc 06) £000s	May (mc 07) £000s	Jun (mc 08) £000s	Jul (mc 09) £000s	Aug (mc 10) £000s	Sep (mc 11) £000s	Oct (mc 12) £000s	Nov (mc 13) £000s	Dec (mc 14) £000s	Jan (mc 15) £000s	Feb (mc 16) £000s	Mar (mc 17) £000s
Description of scheme																	
Savings schemes 2015/16																	
Length of Stay	Plans in Progress	R	Savings - Pay (skill mix)	M	1,824	113	124	125	152	155	146	160	164	167	174	173	171
Length of Stay			Income		0	0	0	0	0	0	0	0	0	0	0	0	0
Outpatient Productivity	Fully Developed	R	Savings - Pay (skill mix)	L	51	3	3	4	4	4	4	4	5	5	5	5	5
Outpatient Productivity	Fully Developed	R	Income	L	490	30	33	34	41	42	39	43	44	45	47	46	46
Theatre Productivity	Plans in Progress	R	Savings - Pay (skill mix)	H	540	34	37	37	45	46	43	47	48	49	52	51	51
Theatre Productivity	Plans in Progress	R	Income	H	211	13	14	14	18	18	17	19	19	19	20	20	20
Theatre Productivity	Fully Developed	R	Income	L	320	20	22	22	27	27	26	28	29	29	30	30	30
Nursing Productivity	Opportunity	R	Savings - Pay (skill mix)	H	301	6	12	12	25	27	22	29	31	32	36	35	34
Nursing Productivity	Fully Developed	R	Savings - Pay (skill mix)	L	149	9	10	10	13	13	12	13	13	14	14	14	14
Medical Productivity	Opportunity	R	Savings - Pay (skill mix)	H	1,332	77	86	87	111	114	106	118	121	124	131	129	128
Clinical Admin	Opportunity	R	Savings - Pay (skill mix)	L	250	15	16	17	21	21	20	22	23	23	24	24	24
Clinical Admin	Fully Developed	R	Savings - Pay (WTE reductions)	L	113	7	8	8	9	10	9	10	10	10	11	11	10
Financial Management	Opportunity	R	Savings Non Pay	M	1,953	121	133	134	163	166	156	171	175	179	187	185	183
Contract Management (Counting & Coding)	Plans in Progress	R	Income	H	1,528	91	101	102	128	130	122	135	138	141	148	147	145
Contract Management (Service Devp)	Plans in Progress	R	Income	M	2,072	124	138	139	173	177	165	182	187	191	201	199	196
Contract Management (Outsource Redn)	Plans in Progress	R	Savings Non Pay	L	111	6	7	7	9	10	9	10	10	10	11	11	11
Contract Management (Outsource Redn)	Fully Developed	R	Savings Non Pay	L	182	11	12	13	15	16	15	16	16	17	17	17	17
Contract Management (Local Tariff)	Plans in Progress	R	Income	H	287	18	20	20	24	24	23	25	26	26	27	27	27
Contract Management (BPT)	Plans in Progress	R	Income	L	891	52	58	59	74	76	71	79	81	83	87	86	85
Contract Management (Penalty Avoidance)	Plans in Progress	R	Income	L	13	0	0	0	1	1	1	1	1	2	2	2	2
Contract Management (Commercial Income)	Plans in Progress	R	Income	L	215	12	14	14	18	18	17	19	20	20	21	21	21
Procurement	Fully Developed	R	Savings Non Pay	L	1,181	66	75	76	99	101	93	105	108	111	117	116	114
Drugs	Fully Developed	R	Savings Non Pay	L	729	44	48	49	61	62	58	64	66	67	71	70	69
Back Office - Commercial Income	Opportunity	R	Income	L	394	22	25	25	33	34	31	35	36	37	39	39	38
Back Office - Pay	Opportunity	R	Savings - Pay (skill mix)	M	1,588	90	102	103	133	136	126	141	145	148	156	155	153
Back Office - Procurement	Opportunity	R	Savings Non Pay	L	1,134	59	69	70	95	97	89	102	105	108	115	113	112
Back Office - Procurement	Fully Developed	R	Savings Non Pay	L	149	9	10	10	13	13	12	13	13	14	14	14	14
PPU Income	Opportunity	R	Income	L	138	3	5	5	12	12	10	13	14	15	17	16	16
Total 2015/16 schemes (sc 100)					**18,146**	**1,055**	**1,182**	**1,196**	**1,517**	**1,550**	**1,442**	**1,604**	**1,648**	**1,686**	**1,774**	**1,756**	**1,736**

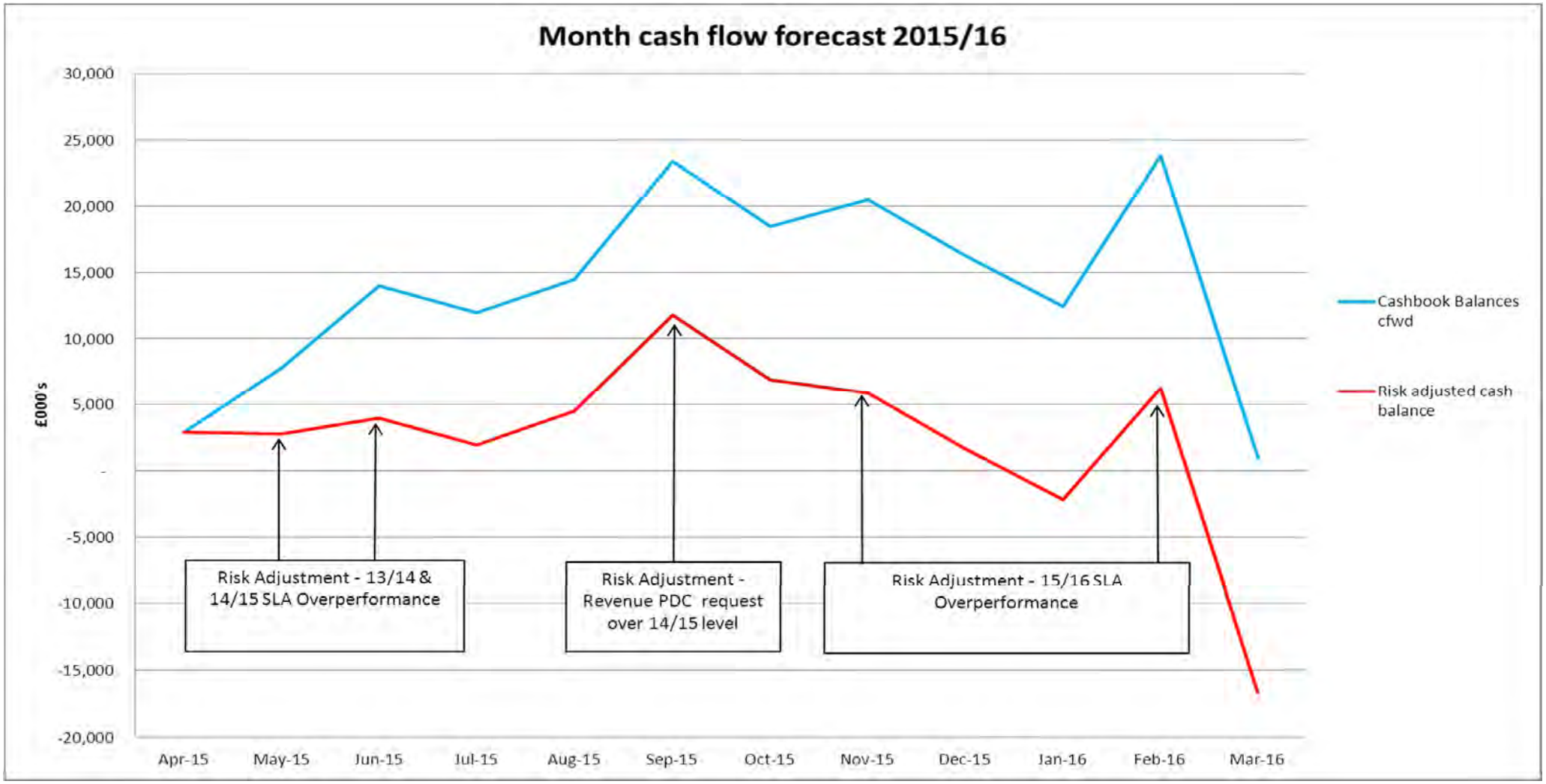
2015/16 Efficiencies Summary Information	Sub Code	Total 2015/16 Efficiency (mc 02) £000s	Fully Developed (mc 03) £000s	Plans in Progress (mc 04) £000s	Opportunity (mc 05) £000s	Unidentified (mc 06) £000s	Recurrent (mc 07) £000s	Non Recurrent (mc 08) £000s	High Risk (mc 09) £000s	Medium Risk (mc 10) £000s	Low Risk (mc 11) £000s
Total Efficiencies by Category											
Savings - Pay (Skill Mix)	130	6,035	195	2,350	3,500	0	6,044	0	2,197	3,402	445
Savings - Pay (WTE reductions)	140	113	109	0	0	0	109	0	0	0	109
Savings - Non Pay	150	5,439	2,229	117	3,094	0	5,441	0	0	1,943	3,498
Non Cashable - Pay	160	0	0	0	0	0	0	0	0	0	0
Non Cashable - WTE	170	0	0	0	0	0	0	0	0	0	0
Non Cashable - Non Pay	180	0	0	0	0	0	0	0	0	0	0
Income	190	6,559	793	5,220	540	0	6,552	0	2,029	2,068	2,456
Total Efficiency	200	**18,146**	**3,325**	**7,687**	**7,134**	**0**	**18,146**	**0**	**4,226**	**7,413**	**6,507**
Proportion of total %	210		18%	42%	39%	0%	100%		23%	41%	36%

Full Year Effect of 2014/15 Efficiency Programme in 2015/16	Status: Fully Developed, Plans in Progress, Opportunity or Unidentified (mc 01)	Recurrent (R) or Non recurrent (NR) (mc 02)	Category: Pay (Skill Mix), Pay (WTE reduction) , Non Pay and Income (mc 03)	Risk Rating High (H), Medium (M), or Low (L) (If Unidentified must be high risk) (mc 04)	Gross Total Value 2015/16 (mc 05) £000s	15/16 Monthly Profile (prior year Savings only)											
						Apr (mc 06) £000s	May (mc 07) £000s	Jun (mc 08) £000s	Jul (mc 09) £000s	Aug (mc 10) £000s	Sep (mc 11) £000s	Oct (mc 12) £000s	Nov (mc 13) £000s	Dec (mc 14) £000s	Jan (mc 15) £000s	Feb (mc 16) £000s	Mar (mc 17) £000s
Description of scheme **Full Year Effect of Savings schemes from 2014/15 in 2015/16**																	
Theatre Productivity		R	Income		12	1	1	1	1	1	1	1	1	1	1	1	1
Nursing Productivity		R	Savings - Pay (skill mix)		589	49	49	49	49	49	49	49	49	49	49	49	49
Medical Productivity		R	Savings - Pay (skill mix)		288	24	24	24	24	24	24	24	24	24	24	24	24
Clinical Admin		R	Savings - Pay (skill mix)		36	3	3	3	3	3	3	3	3	3	3	3	3
Contract Management (Counting & Coding)		R	Income		168	14	14	14	14	14	14	14	14	14	14	14	14
Contract Management (Service Devp)		R	Income		216	18	18	18	18	18	18	18	18	18	18	18	18
Contract Management (Outsource Redn)		R	Savings Non Pay		24	2	2	2	2	2	2	2	2	2	2	2	2
Contract Management (BPT)		R	Income		145	12	12	12	12	12	12	12	12	12	12	12	12
Contract Management (Penalty Avoidance)		R	Income		36	3	3	3	3	3	3	3	3	3	3	3	3
Contract Management (Commercial Income)		R	Income		48	4	4	4	4	4	4	4	4	4	4	4	4
Procurement		R	Savings Non Pay		361	30	30	30	30	30	30	30	30	30	30	30	30
Drugs		R	Savings Non Pay		84	7	7	7	7	7	7	7	7	7	7	7	7
Back Office - Commercial Income		R	Income		132	11	11	11	11	11	11	11	11	11	11	11	11
Back Office - Pay		R	Savings - Pay (skill mix)		397	33	33	33	33	33	33	33	33	33	33	33	33
Back Office - Procurement		R	Savings Non Pay		541	45	45	45	45	45	45	45	45	45	45	45	45
PPU Income		R	Income		277	23	23	23	23	23	23	23	23	23	23	23	23
Total Full Year Effect from 2014/15 (sc310)					**3,354**	**279**	**279**	**279**	**279**	**279**	**279**	**279**	**279**	**279**	**279**	**279**	**279**

Full Year Effect from 2014/15 Efficiencies Summary Information	Sub Code	Total FYE from 2014/15 Efficiency (mc 02) £000s	Fully Developed (mc 03) £000s	Plans in Progress (mc 04) £000s	Opportunity (mc 05) £000s	Unidentified (mc 06) £000s	Recurrent (mc 07) £000s	Non Recurrent (mc 08) £000s	High Risk (mc 09) £000s	Medium Risk (mc 10) £000s	Low Risk (mc 11) £000s
Total Efficiencies by Category											
Savings - Pay (Skill Mix)	320	1,310					1,310	0			
Savings - Pay (WTE reductions)	330	0					0	0			
Savings - Non Pay	340	1,010					1,010	0			
Income	350	1,034					1,034	0			
Total Efficiency	360	**3,354**					**3,354**	**0**			
Proportion of total %	370						100	0			

Capital Project	Sub Code	Sign	Type of Expenditure (mc 01)	By DH Programme (mc 02)	IFRS Expenditure Y (IFRIC 12 or 4)/N (mc 03)	Planned funding method Non-PDC, PDC, Matched, Cfwd, Loans (mc 04)	2016/17 - 2019/20					
							2015/16 Plan (mc 05) £000s	2016/17 Plan (mc 18) £000s	2017/18 Plan (mc 19) £000s	2018/19 Plan (mc 20) £000s	2019/20 Plan (mc 21) £000s	2015/16 to 2019/20 5 Year Plan (mc 22) £000s
Capital Schemes: Trust Approved Schemes (A) Identified at Plan:												
Estates Projects - Backlog maintenance	100	+	Backlog	Non central	N	Non-PDC	800	800	800	800	800	4,000
Ward refurb - Jon Saunders/John Day	110	+	Backlog	Non central	N	Non-PDC	2,947					2,947
Ward refurb - Mercer/Whatman	120	+	Backlog	Non central	N	Non-PDC		3,000				3,000
Ward refurb - Chaucer/Stroke	130	+	Backlog	Non central	N	Non-PDC			3,000			3,000
Ward refurb - Culpepper/Cornwallis	140	+	Backlog	Non central	N	Non-PDC				3,000		3,000
Ward refurb - Other Pye/Foster	150	+	Backlog	Non central	N	Non-PDC					3,000	3,000
TWH - Design variations/infrastructure	160	+	Backlog	Non central	N	Non-PDC	220	200	200	200	200	1,020
Estates Projects - other renewals	161	+	Backlog	Non central	N	Non-PDC	1,203					1,203
Kent Pathology Partnership	162	+	New Build	Non central	N	Non-PDC	624					624
Staff Accommodation - Maidstone	163	+	New Build	Non central	N	Non-PDC		2,500				2,500
Kent Pathology Partnership	164	+	IT	Non central	N	Non-PDC	269					269
ICT - Infrastructure	165	+	IT	Non central	N	Non-PDC	800	804	1,520	1,270	900	5,294
ICT - Clinical System	166	+	IT	Non central	N	Non-PDC	828	460	600	1,100	600	3,588
	167	+										0
ICT - Non-clinical systems	168	+	IT	Non central	N	Non-PDC	302	116			300	718
Core IT System Upgrade PAS	169	+	IT	Non central	N	Non-PDC	1,582	259				1,841
ICT - Inspire strategy	170	+	IT	Non central	N	Non-PDC	500	757	200			1,457
ICT - additional schemes	171	+	IT	Non central	N	Non-PDC	220					220
MRI Maidstone - incl building modification	172	+	Equipment	Exceptional PDC	N	PDC		3,000				3,000
	173	+										0
Linac replacement - Canterbury LA2	174	+	Equipment	Non central	N	Non-PDC	100					100
Linac replacement- Canterbury LA3	175	+	Equipment	Non central	N	Non-PDC		2,700				2,700
Linac replacement - Maidstone LA4	180	+	Equipment	Non central	N	Non-PDC			2,400			2,400
Linac replacement - Maidstone LA5	185	+	Equipment	Non central	N	Non-PDC				2,400		2,400
Linac replacement- Maidstone LA1	190	+	Equipment	Non central	N	Non-PDC					2,400	2,400
Trustwide equipment incl KPP	195	+	Equipment	Non central	N	Non-PDC	2,320	3,200	2,248	2,560	3,626	13,954
Inventory management cabinets/system	200	+	Equipment	Non central	N	Non-PDC	400	200				600
TWH - Lifecycle (IFRIC 12 PFI capital)	205	+	Maint - routine LF	Non central	Y: IFRIC 12	Non-PDC	326	577	525	491	500	2,419
Donated Assets	210	+	Equipment	Non central	N	Non-PDC	150	150	150	150	150	750
Contingency equipment	215	+	Equipment	Non central	N	Non-PDC	0	300	300	300	300	1,200
	220	+										0
TWH additional ward capacity	225	+	New Build	Exceptional PDC	N	PDC	4,000					4,000
Capital Schemes: Business Cases for NTDA approval												
TWH Satellite Radiotherapy Linear Accelerator - Bunkers & Equipment	280	+	New Build	Exceptional PDC	N	PDC	2,500	5,500				8,000
Maidstone Theatres	290	+	New Build	Exceptional PDC	N	PDC		6,000	6,000			12,000
Gross Capital Expenditure (Including IFRS) (Excluding Asset Transfers) (TRU55 sc290)	419						**20,091**	**30,523**	**17,943**	**12,271**	**12,776**	**93,604**
Capital Receipts - Disposals/Asset Transfers Out (a) Trust Approved Disposals/Asset Transfers Out												
Hilcroft - subject to Board Approval	431	-					(1,000)					(1,000)
Phase 2 Maidstone Nurses Home/ Trees Properties - subject to Board Approval	432	-						(3,903)				(3,903)
Total Capital Receipts - Disposals/Asset Transfers Out	452	-					**(1,000)**	**(3,903)**	**0**	**0**	**0**	**(4,903)**
Other Adjustments: Grants/Donations												
Donated Assets	470	-					(150)	(150)	(150)	(150)	(150)	(750)
Total Other Adjustments: Grants/Donations	488	-					**(150)**	**(150)**	**(150)**	**(150)**	**(150)**	**(750)**
Charge against CRL including IFRS impact (TRU 55 sc 350)	490	+/-					**18,941**	**26,470**	**17,793**	**12,121**	**12,626**	**87,951**

New Build	550	+	New Build				7,124	14,000	6,000	0	0	27,124
Maintenance routine non backlog - locally funded	560	+	Maint - routine LF				326	577	525	491	500	2,419
Backlog Maintenance	562	+	Backlog				5,170	4,000	4,000	4,000	4,000	21,170
Equipment	570	+	Equipment				2,970	9,550	5,098	5,410	6,476	29,504
Information Technology	580	+	IT				4,501	2,396	2,320	2,370	1,800	13,387
Other	590	+	Other				0	0	0	0	0	0
Gross Capital Expenditure including Asset Transfers	600	+					**20,091**	**30,523**	**17,943**	**12,271**	**12,776**	**93,604**



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Cashbook Balances cfwd	**2,890**	**7,769**	**13,975**	**11,974**	**14,500**	**23,395**	**18,489**	**20,501**	**16,246**	**12,438**	**23,844**	**926**
risk adjusted 13/14 & 14/15 overperformance	0	5,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000
risk adjusted 15/16 overperformance								3,000	3,000	3,000	6,000	6,000
risk adjusted Revenue PDC excess request over 14/15 plan						1,600	1,600	1,600	1,600	1,600	1,600	1,600
Risk adjusted cash balance	**2,890**	**2,769**	**3,975**	**1,974**	**4,500**	**11,795**	**6,889**	**5,901**	**1,646**	**(2,162)**	**6,244**	**(16,674)**

Statement of Financial Position	Opening Balance 01/04/2015	Closing Balance 31/03/2016	Change	Assumptions
NON-CURRENT ASSETS:				
Property, Plant and Equipment	375,410	376,928	1,518	Additions less asset sales less depreciation. No indexation or impairments included in plan
Intangible Assets	1,266	666	-600	Additions less asset sales less depreciation. No indexation or impairments included in plan
Trade and Other Receivables	1,075	1,075	0	No change in balance planned, primarily RTA debtor
TOTAL Non Current Assets	**377,751**	**378,669**	**918**	
CURRENT ASSETS:				
Inventories	6,220	6,220	0	no change planned to level of inventories held
Trade and Other Receivables	36,824	36,824	0	No overall reduction in debtors reflected at plan due to uncertainties around release of 13/14 and 14/15 contract payments
Cash and Cash Equivalents	926	926	0	
Sub Total Current Assets	**43,970**	**43,970**	**0**	
Non-Current Assets Held For Sale	0	0	0	
TOTAL Current Assets	**43,970**	**43,970**	**0**	
TOTAL ASSETS	**421,721**	**422,639**	**918**	
CURRENT LIABILITIES				
Trade and Other Payables	-34,430	-37,364	-2,934	Creditor movement required to arrive at consistant cash balance taking into consideration no planned release of Debtors and £14.9m PDC as revenue cash support
Provisions	-1,667	-653	1,014	Change relates to provisions expected to be utilised in 2015/16
Borrowings	-4,774	-4,776	-2	
DH Working Capital Loan - Revenue Support	0	0	0	
DH Capital Loan	-2,174	-2,174	0	
Total Current Liabilities	**-43,045**	**-44,967**	**-1,922**	
NET CURRENT ASSETS/(LIABILITIES)	**925**	**-997**	**-1,922**	
TOTAL ASSETS LESS CURRENT LIABILITIES	**378,676**	**377,672**	**-1,004**	
NON-CURRENT LIABILITIES:				
Trade and Other Payables	0	0	0	
Provisions	-1,798	-1,336	462	Change relates to provisions expected to be utilised in 2015/16
Borrowings	-208,036	-203,258	4,778	2015/16 release of PFI creditor
DH Working Capital Loan - Revenue Support	0	0	0	
DH Capital Loan	-16,676	-14,502	2,174	2015/16 release of loan creditor
Total Non-Current Liabilities	**-226,510**	**-219,096**	**7,414**	
ASSETS LESS LIABILITIES (Total Assets Employed)	**152,166**	**158,576**	**6,410**	
TAXPAYERS EQUITY				
Public Dividend Capital	199,558	220,958	21,400	PDC drawdown per cashflow - £6.5m capital and £14.9m Revenue
Retained Earnings Reserve	-110,491	-125,481	-14,990	As per I&E
Revaluation Reserve	63,099	63,099	0	no planned change
TOTAL	**152,166**	**158,576**	**6,410**	

Workforce Plan Summary 2015/16

Pay Heading	Month 12 2014/15 WTE	Month 1 WTE	Month 2 WTE	Month 3 WTE	Month 4 WTE	Month 5 WTE	Month 6 WTE	Month 7 WTE	Month 8 WTE	Month 9 WTE	Month 10 WTE	Month 11 WTE	Month 12 WTE
Pay Costs													
Medical													
Consultants	218.05	226.05	226.45	226.09	227.05	226.15	225.71	226.56	226.19	226.17	226.32	225.99	225.99
Other Medical Grades	407.46	410.57	411.29	410.64	412.39	410.75	409.96	411.49	410.83	410.79	411.06	410.46	410.45
Medical Locums	25.02	25.02	25.07	25.03	25.13	25.03	24.99	25.08	25.04	25.04	25.05	25.02	25.02
Medical Agency	14.47	9.36	9.38	9.37	9.41	9.37	9.35	9.39	9.37	9.37	9.38	9.36	9.36
Sub Total Medical Staff	**665.00**	**671.00**	**672.19**	**671.12**	**673.98**	**671.30**	**670.01**	**672.52**	**671.43**	**671.36**	**671.81**	**670.82**	**670.82**
Nursing													
Nurses Substantive - Trained	1,421.97	1,443.55	1,443.96	1,442.53	1,443.73	1,439.97	1,438.87	1,445.43	1,445.18	1,444.82	1,457.14	1,461.06	1,461.47
Nurses Substantive - Untrained	514.08	514.08	514.66	514.15	515.55	514.21	513.60	514.26	514.28	514.26	512.61	513.99	514.03
Nurse Bank	207.10	206.61	206.85	206.64	207.20	206.66	206.42	206.68	206.69	206.68	206.02	206.58	206.59
Nurse Agency	54.57	30.49	28.32	28.10	22.56	21.90	23.67	20.90	20.10	19.50	17.84	18.29	18.69
Sub Total Nursing	**2,197.72**	**2,194.74**	**2,193.79**	**2,191.41**	**2,189.04**	**2,182.75**	**2,182.55**	**2,187.27**	**2,186.25**	**2,185.26**	**2,193.62**	**2,199.92**	**2,200.79**
Scientific, Therapeutic & Technical Staff													
STT Substantive	891.94	701.50	701.50	701.50	702.50	702.50	702.50	704.50	704.50	705.50	707.50	707.50	707.50
STT Bank	7.22	5.22	5.22	5.22	5.22	5.22	5.22	4.22	4.22	4.22	3.22	3.22	3.22
STT Agency	35.58	16.41	16.41	16.41	15.41	15.41	15.41	14.41	14.41	13.41	12.41	12.41	12.41
Sub Total STT Staff	**934.74**	**723.12**	**723.12**	**723.12**	**723.12**	**723.12**	**723.12**	**723.12**	**723.12**	**723.12**	**723.12**	**723.12**	**723.12**
Admin & Senior Managers													
A&C/Sen Man Substantive	1,066.06	1,035.84	1,035.84	1,035.84	1,035.84	935.84	942.84	956.84	963.84	963.84	963.84	963.84	963.84
A&C/Sen Man Bank	49.28	49.01	49.01	49.01	49.01	49.01	44.01	44.01	39.01	39.01	39.01	39.01	39.01
A&C/Sen Man Agency	21.82	13.82	12.93	12.93	10.71	10.48	9.37	6.26	4.04	3.60	3.15	3.37	3.37
Sub Total A&C/Sen Man Staff	**1,137.15**	**1,098.67**	**1,097.78**	**1,097.78**	**1,095.56**	**995.34**	**996.22**	**1,007.11**	**1,006.89**	**1,006.45**	**1,006.00**	**1,006.22**	**1,006.22**
Support Staff													
Support Substantive	545.05	545.05	545.05	545.05	545.05	545.05	553.75	553.75	553.75	554.65	556.85	556.85	556.85
Support Bank	9.75	9.75	9.75	9.75	9.75	9.75	7.75	7.75	7.75	6.85	6.85	6.85	6.85
Support Agency	22.37	22.37	22.37	22.37	22.37	22.37	15.67	15.67	15.67	15.67	13.47	13.47	13.47
Sub Total Support Staff	**577.17**	**577.17**	**577.17**	**577.17**	**577.17**	**577.17**	**577.17**	**577.17**	**577.17**	**577.17**	**577.17**	**577.17**	**577.17**
Total Pay WTE	**5,511.79**	**5,264.70**	**5,264.06**	**5,260.60**	**5,258.87**	**5,149.68**	**5,149.08**	**5,167.20**	**5,164.86**	**5,163.37**	**5,171.73**	**5,177.26**	**5,178.13**

Activity Plans 2015-16

RWF **Name: MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST**

	Forecast Outturn 2014/15	Plan 2015/16
Total Written Referrals - (G&A)	101,160	104,117
Elective Admissions - Ordinary Admissions (All Specialties) in Spells	8,300	8,613
of which: Elective Admissions - Ordinary Admissions (G&A) in Spells	8,297	8,610
Elective Admissions - Day Cases (G&A) in spells	40,113	41,745
Total Elective Admission (All Specialties) in spells	48,413	50,358
of which: Total Elective Admissions (G&A) in spells	48,410	50,355
Non-elective Admissions (All Specialties) in Spells	49,019	50,003
of which: Non-elective Admissions (G&A) in Spells	41,848	42,586
First Outpatient Attendances - following GP Referral (All Specialties)	84,387	87,208
of which: First Outpatient Attendances - following GP Referral (G&A)	81,430	84,273
All First Outpatient Attendances (All Specialties)	172,299	177,599
of which: All First Outpatient Attendances (G&A)	153,409	158,802
All Subsequent Outpatient Attendances (All specialties)	296,254	305,627
A&E Attendances - Total All Types	132,598	135,922

Current Directorate budgetary control totals

Current Directorate Budgetary Control Totals/Resource Limits	Income	Expenditure	Technical Impact	Resource Limit
	£m	£m	£m	£m
Clinical Directorates				
Surgery	70.3	(39.9)		**30.4**
Critical Care	10.9	(33.6)		**(22.7)**
T&O	30.0	(15.6)		**14.4**
Ermergency & Medical Services	95.4	(70.1)		**25.4**
Cancer & Haematology	57.6	(38.8)		**18.9**
Diagnostics	25.2	(33.1)		**(7.9)**
Women's & Sexual Health	31.4	(21.1)		**10.2**
Childrens	11.4	(10.7)		**0.7**
Sub Total Clinical Directorates	**332.2**	**(262.7)**		**69.4**
PPU	5.0	(4.5)		**0.5**
Sub Total Clinical Directorates inc PPU	**337.2**	**(267.2)**		**70.0**
Corporate	7.0	(75.0)		**(68.0)**
Sub Total Clinical and Corporate Directorates	**344.2**	**(342.3)**		**2.0**
Non Directorate	34.2	(49.3)		**(15.2)**
Reserves	16.3	(18.1)		**(1.8)**
Total Trust	**394.7**	**(409.7)**	**0.0**	**(15.0)**
Technical Impact			1.6	**1.6**
Breakeven Duty Position	**394.7**	**(409.7)**	**1.6**	**(13.4)**

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – March 2015

3-17 Progress Report On The Trusts 2015/16 Planning Process — Director Of Finance

Summary / Key points

- The paper updates the Trust Board on the timetable and process for planning for the financial year 2015/16
- Explains the impact of the changes to the National Tariff on the process
- Briefs the Trust Board on the content of the documents submitted to the TDA

Which Committees have reviewed the information prior to Board submission?
Finance Committee, 23/03/15

Reason for receipt at Trust Board
To discuss and note the changes to the planning process and timetable and the nature of the documents submitted.

Progress report on the Trust's 2015/16 planning process

1 Introduction

1.1 The process for providing the Trust's plan to the TDA and developing an operational budget is outlined in this paper.

2 Significant dates for planning timetable

Deadline	Date	Action
Submission of Planning Process Paper and Review of the budget for 2015/16 for 2015/16 provided to Finance Committee	23/03/2015	Finance Committee to note timetable for completing 2015/16 planning round and to confirm the assumptions and agree objectives of the plan for submission
National Contract Stocktake	27/03/2015	To check status of contracts and their closeness to signoff
Contract Signature Deadline	31/03/2015	Outstanding disputes to enter mediation process.
Submission of plan to TDA (Delayed from 27th March due to issues with National Tariff)	07/04/2015	Completion of TDA forms consistent to the plan agreed by the Finance Committee. TDA to review draft plan, results of review may be fed back to Trusts until 13th May.
Contract signoff deadline (after any mediation) – outstanding contract disputes enter arbitration	17/04/2015	Outstanding disputes enter arbitration.
Signoff from Finance Committee of the 2015/16 planning submission to the TDA.	27/04/2015	Agree final corporate plan and budget for 2015/16 prior to the Plans submission to the TDA. This meeting would also have to recognise the final contracts agreed for 2015/16 to be included in the plan.
Submit final plan to the TDA	14/05/2015	Completed TDA forms representing the final plan for 2015/16 to be submitted to the TDA.
Assurance and reconciliation of operational plans	14/05/2015 Onwards	

3 Changes in the Timetable

3.1 The timetable above represents an approximate 5 week delay compared to the original timetable, this is to allow for the plans of Trusts and Commissioners to take into account the late changes in tariff. The tariff changes were caused by the withdrawal of the original tariff proposals for 2015/16 after challenges made by providers as part of the National Tariffs consultation process. The original tariff was replaced with a choice of tariffs by providers who could choose between an "Enhanced Tariff Option" (ETO) and a "Default Tariff Rollover" (DTR). MTW chose the ETO option as it would benefit more from the 0.3% increase in prices and the improved threshold rates for Non Electives and Specialist growth compared to no deflator but the loss of funding for CQUINS.

3.2 The detailed rules associated with the ETO have only just been made available for fully understanding the detailed impact of the new tariff so cannot yet be fully reflected in the plan. Any material changes to the financial plan will be available for verbal update in the March meeting. The plan will be presented for final agreement to the April committee prior to final submission on the 14th of May.

4 Outstanding work with Directorates

4.1 The final round of planning meetings with Directorates commences on the 23rd March and will be focusing on closing the gap on CIPs and to facilitate the final budget signoff of directorate budgets.

5 Contents of submission to TDA

5.1 The planning returns comprise:

- Business Plan summary
- Activity Plan
- Financial Plan (including a Continuity of Service Risk Rating)
- Workforce Plan
- Planning Compliance Checklists
    - Quality and Workforce
    - Performance, Innovation and Technology
    - Finance and QIPP

5.2 The return is an important demonstration to the TDA that the Trust understands its business and finances and can plan accurately with confidence.

6 Conclusion

6.1 The Board is asked to note the new timetable and the content of the planning submission.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - March 2015

3-19	Full Business Case for the transformation of the procurement function	Director of Finance

Summary / Key points

In January 2015, a procurement strategic options appraisal was received by the Trust Management Executive and Finance Committee, and approval was given to develop a full investment business case including a 12 month transformation programme.

The Full Business Case (FBC) is duly enclosed. The investment in the procurement function and a number of technology projects will deliver efficiencies and support the Trust and the NHS in its challenge to reduce spend on non-pay goods and services.

The FBC will be reviewed in detail at the Finance Committee on 23/03/15, but Board approval is required, as the case is above the threshold for such approval with the Trust's Standing Financial Instructions (the case involves capital of c £800k and is over £500k of investment in additional staffing/systems). The outcome of the Finance Committee's review will be reported to the Board via the summary report from that Committee (which will be issued w/c 23/03/15).

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 23/03/15

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

Review and approval

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

Maidstone and Tunbridge Wells NHS Trust

Business Case

Procurement Transformation
FOR APPROVAL – v1.4

Issue date	March 2015
Department	Procurement
Directorate	Finance
Author	David Walach
Directorate Lead	Stuart Doyle
Executive Sponsor	Steve Orpin
ID reference	348

Approved by	Name	Signature	Date
Head of Procurement	Lesley Martin	By email	02/03/15
Finance manager	David Shelton	By email	02/03/15
Directorate Lead	Stuart Doyle	By email	02/03/15
Executive sponsor	Steve Orpin	By email	02/03/15
Supported by	**Name**	**Signature**	**Date**
Director Estates & Facilities	Jeanette Rooke	By email	02/03/15
Director of Informatics	Donna-Marie Jarrett	By email	13/03/15
HR Business Partner	Debbie Langridge	By email	02/03/15
General Manager – Critical Care	Daniel Gaughan	By email	10/03/15
Approved by	**Name**	**Minute**	**Date**
Procurement Strategy Board	Steve Orpin	4.03	02/03/15
Business Case Panel	Stuart Doyle	By email	25/02/15
Finance Committee	Steve Tinton		23/03/15
Trust Board	Anthony Jones		

Maidstone and Tunbridge Wells NHS Trust

The Business Case Summary

Strategic context

This Full Business Case (FBC) is for investment in the Procurement function and a number of technology projects that will deliver efficiencies and support the Trust and the NHS in its challenge to reduce spend on non-pay goods and services.

For the NHS, the Department of Health released in 2013 its Procurement Strategy, Better Procurement, Better Value, Better Care, which tasked all NHS organisations with reviewing their Procurement functions and mapping them against nationally adopted standards to highlight areas for improvement locally

The NHS nationally spends over £20bn on goods and services each year and the DH has tasked Trusts with reducing this by 10% over three years. At MTW, we spend £128m on goods and services. The Procurement function has helped us reduce this by £3.75m (3%) over 3 years, but it is becoming increasingly difficult to achieve results with current resources – there has been a downward trend in delivered benefit, matched with a downward trend in allocated resources. Continuing with the status quo will not deliver significant additional benefits or provide the level of service that the Trust expects.

Objectives of the investment and the problems with the status quo

The investment objectives for this programme are:

- Redesign the service so that it is fit for purpose and meets the needs of the Trust and wider NHS
- Manage compliance and alignment to central policy
- Change in focus from materials management to inventory management
- Increase procurement influence and support to all spend areas
- Improve relationships with key suppliers and internal stakeholders
- Increased use of technology and automation
- Centred focus on using partners and collaborating effectively
- Contribute directly to the strategic objectives of the Trust

The Procurement function is resourced internally currently, at a cost of £760k per annum. Some external strategic support is provided by partners and collaborative working. Resourcing levels within the current team has eroded over a number of years which has impacted on the benefits achieved from the service.

Some key points to note about the current situation and the need for change include:

- Procurement currently influences just 29% of spend on goods and services. This should be nearer 52%.
- Tapping into London's collective £6bn spend has provided access to specialist resources and delivered 38% cost reduction on one project
- Managing inventory more effectively would reduce wastage and stockholding by £550k
- Significant opportunities exist through efficient use of technology and automation

The new function will split into three core elements: Strategic, Tactical and Operational, with technology and systems underpinning the service.

The main benefits expected from the investment

The main benefits criteria for the programme are:

- Increase in cash releasing savings delivered through the cost improvement programme
- Improved competency and compliance with national procurement standards
- Increase in available skilled support for divisions
- Stronger relationships with suppliers
- Procurement decisions led by clinicians and key stakeholders
- Streamlined, automated processes, increasing available time to spend on direct patient interaction and reducing inventory levels

- Ability to identify true procedure costs and challenge profitability of service and product mix
- Reduction in duplication of procurement activity
- Access to specialist resources
- Development of local talent pool
- Stronger negotiating leverage through consolidation of purchasing power
- Stronger, more relevant procurement function that supports and is aligned with the requirements of the organisation

Financially, the benefit projection over the next three years is provided below:

High level scheme (£000)	2015 / 16	2016 / 17	2017 / 18	Total
Cost improvement	698	452	2,000	3,149
Increasing influence	390	736	1,076	2,201
Standardisation & rationalisation	310	132	160	602
Inventory & wastage	130	430	40	600
Filling the contract gap	115	406	20	541
Total	**1,642**	**2,155**	**3,296**	**7,093**

Table 4 - High level financial benefits projection

The main risks associated with the investment

The key risks considered are:

- **Financial** – Vulnerability to Trust financial position – targeted cost reduction before benefits achieved
- **Implementation** – Ability to attract talent
- **Implementation** – Time to deploy – risk that focus would be diverted and would drag
- **Implementation** – A period of transition whilst relationship and trust align
- **Strategy** – Uncertain future – organisational change and changing health economy

Available options

The shortlisted options are:

- **Option 0 – Do Nothing**: Introduce changes that do not affect structure or level of resources
- **Option 1a – Build your own**: Development of internal service to meet the requirements
- **Option 1b – Formal collaboration**: Retain and transform existing function, sharing resources and processes with a partner
- **Option 2 – Shared service**: Partner with another organisation and merge the procurement functions
- **Option 3a – Outsource (transactional only)**: Select a private sector organisation to provide the transactional procurement service on our behalf
- **Option 3b – Outsource (full business process)**: Select a private sector organisation to provide the entire procurement service on our behalf

The preferred option

The preferred option is 1b – Formal collaboration which provides the lowest risk option whilst accruing the greatest benefits. It provides a service that is fit for purpose, in line with national standards and best practice; staffed with a capable and comprehensive workforce.

The selection of the right partner is critical to the success of this option. The formal partnership is not simply about aggregating our spend and purchasing power with another organisation, but about sharing common processes and resources to simplify procurement activity, reduce the cost base and share specialist resources. The partnership, whether between two or multiple organisations, needs to be balanced and equal with no single organisation taking the lead.

A robust partner selection process has been started. There has been interest expressed in working with us under this model by four Trusts to date.

Maidstone and Tunbridge Wells NHS Trust

Funding and affordability

Capital

£000	Year 1	Year 2	Year 3	Year 4	Year 5
Total Capital	**(448.75)**	**(212.00)**	**0.00**	**0.00**	**0.00**

Costs include VAT

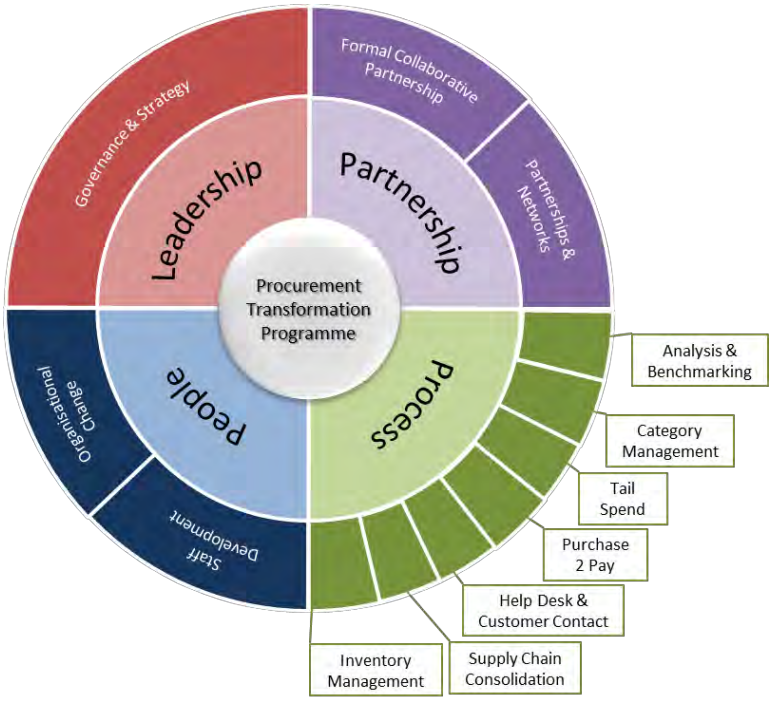
Revenue

£000	Year 1	Year 2	Year 3	Year 4	Year 5
Total benefit	**1,643.00**	**2,156.00**	**3,296.00**	**3,500.00**	**3,500.00**
Baseline costs	(744.21)	(744.21)	(744.21)	(744.21)	(744.21)
Total Investment	(640.77)	(676.52)	(674.04)	(671.56)	(669.07)
Total costs	**(1,384.98)**	**(1,420.73)**	**(1,418.25)**	**(1,415.77)**	**(1,413.28)**
Net financial benefit	**256.55**	**733.80**	**1,876.28**	**2,082.76**	**2,085.25**

Management arrangements

The management arrangements for the programme include:

- Following a standard programme and project management methodologies
- A robust programme governance structure with appropriate resources and responsibilities allocated
- The programme has been defined into 12 discrete projects across four work stream domains in line with the National Procurement Standards: Leadership, Partnership, Process and People.
- A high level programme timeline has been developed
- Arrangements for governance during and post implementation have been defined
- Arrangements for performance monitoring, benefits realisation, change management, risk management and review have been defined and agreed
- A contingency plan is in place with a change in scope outside of a 10% tolerance will trigger review by Trust Management Executive and Finance Committee



Maidstone and Tunbridge Wells NHS Trust

The Business Case

Strategic Context *The Strategic Case*

This Full Business Case (FBC) is for investment in the Procurement function and a number of technology projects that will deliver efficiencies and support the Trust and the NHS in its challenge to reduce spend on non-pay goods and services.

This FBC is the final step in an iterative process including:

- a self-assessment against national maturity standards, carried out in September 2014 and presented to the finance committee in October 2014;
- an independent review of the current situation, commissioned by the Director of Finance in November 2014, the output of which was presented to the Procurement Strategy Board on 4 December 2014;
- a Strategic Options Appraisal paper, stating the case for change, outlining each option and recommending a preferred option; presented and approved at both the Trust Management Executive and Finance committee in January 2015.

Organisational overview

In recent years, there has been a refocus from Government and the Department of Health on getting better value through the procurement of goods and services. Central Government, having gone through a substantial procurement review has now centralised the bulk of its spend through a single purchasing body to take advantage of its colossal buying power. For the NHS, the Department of Health released in 2013 its Procurement Strategy, Better Procurement, Better Value, Better Care, which tasked all NHS organisations with reviewing their Procurement functions and mapping them against nationally adopted standards to highlight areas for improvement locally. This was followed up in 2014 with the release of the DH eProcurement strategy which outlined the future state for the use of technology in the supply chain and procurement cycle.

The NHS nationally spends over £20bn on goods and services each year and the DH has tasked Trusts with reducing this by 10% over three years. At MTW, we spend £128m on goods and services as shown in Figure 1. Over the past three years the Procurement function has helped us reduce this by £3.75m (3%), and it is becoming increasingly difficult to achieve results with current resources – there has been a downward trend in delivered benefit, matched with a downward trend in allocated resources. Continuing with the status quo will not deliver significant additional benefits or provide the level of service that the Trust expects.

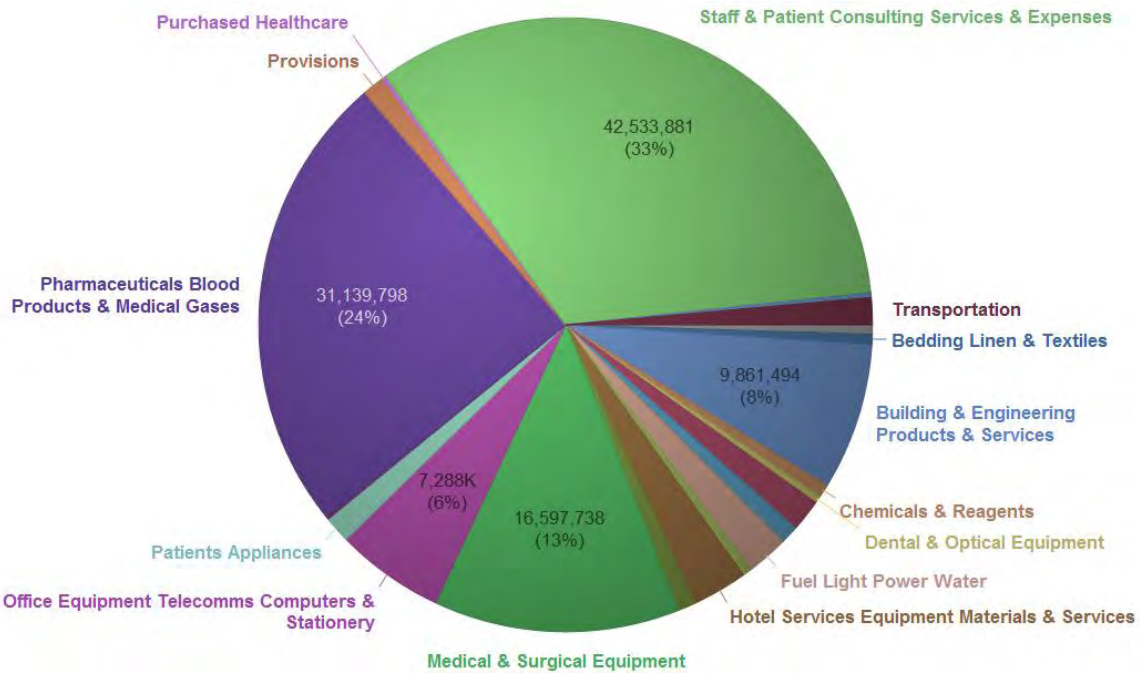


Figure 1 - Categorised breakdown of £128m spent on goods and services at MTW

Maidstone and Tunbridge Wells NHS Trust

Case for change – Business needs

The Strategic Case

The problems with the current situation and the objectives of the proposed investment

Investment objectives

The investment objectives for this project and how they align to the organisations strategic objectives (as published in the Trust strategy – "Moving Forward 2015/16 to 2019/20") are as follows:

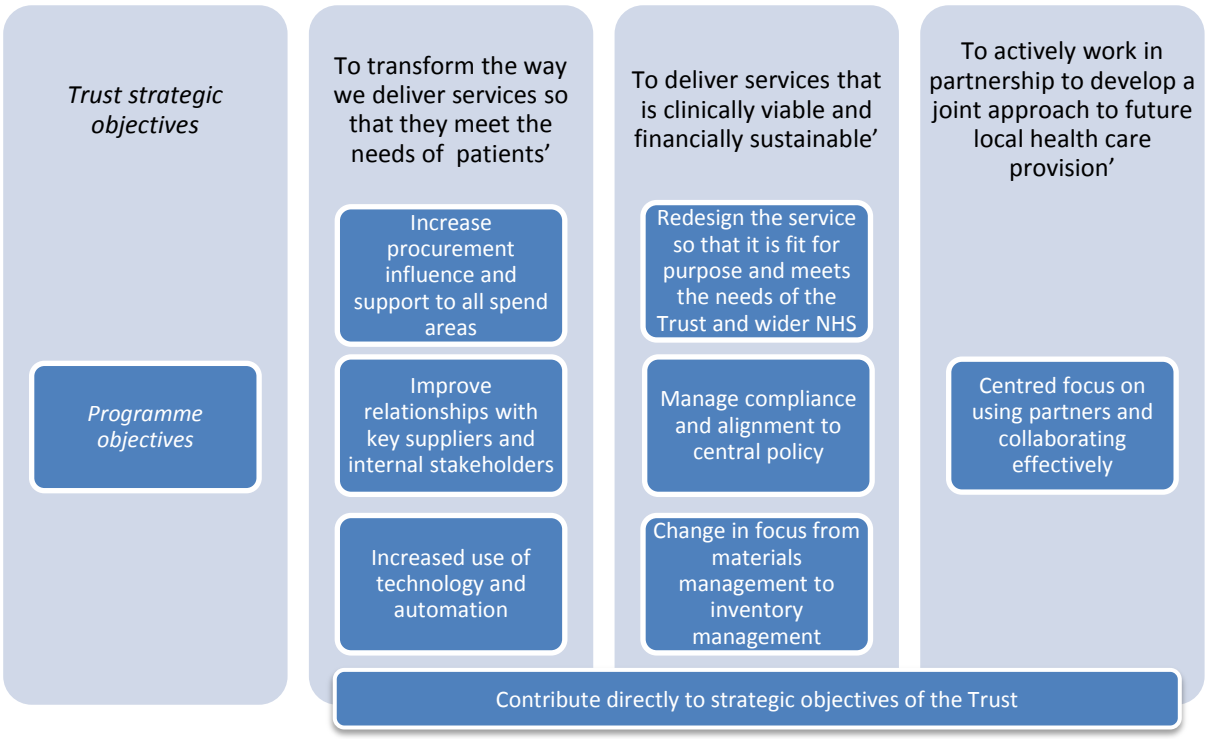


Figure 2 - Spending objectives mapped to organisational objectives

Existing arrangements

Currently, the procurement service is managed internally, supported by a purchasing system (Marrakech) which is provided by Capita. Resourcing levels within the current team has eroded over a number of years which has impacted on the benefits achieved from the service.

In 2014, the Trust signed up to the London Procurement Partnership to take advantage of the purchasing power afforded by the collective £6bn spent on goods and services by the members and to reduce duplication in the system.

The table below details the current costs for the services provided.

Existing costs (£000)	Strategic Procurement	Tactical Procurement	Operational Procurement	Enabling Systems	Total
Staffing	69.95	250.90	326.81	0.00	647.66
Systems	0.00	0.00	0.00	43.09	43.09
Partners	39.14	0.00	0.00	0.00	39.14
Others	0.00	0.00	0.00	14.32	14.32
Total	**109.09**	**250.90**	**326.81**	**57.41**	**744.21**
WTE	**1.00**	**6.80**	**12.78**	**0.00**	**20.58**

Table 1 - existing revenue costs

Maidstone and Tunbridge Wells NHS Trust

Business needs

The current procurement function influences just £37m (29%) of all spend on goods and services, with the remainder being made up of drugs, NHS service level agreements, large capital projects and agency staffing amongst other categories. It has been calculated that the Procurement function should be influencing £67m (52%) of the total spend, so significant untapped opportunity exists where procurement influence has been historically "light touch" due to the capacity, and to a certain extent the capability of the department. More information can be found in Appendix I

Procurement currently influences just 29% of spend on goods and services. This should be nearer 52%

Tapping into London's collective £6bn spend has provided access to specialist resources and delivered 38% cost reduction on one project

There has been a strong history of collaboration across Kent for some large categories of spend including Pharmaceuticals, Waste Management, IT Services, Pathology Services and Sterile Services. The Trust has also made use of nationally negotiated contracts when required. In the past 3 months, we have tapped in to further collaborative procurement arrangements by joining the London Procurement Partnership whose members collectively spend in excess of £6bn on goods and services. Collaborating and aggregating our buying power with other Trusts in London has already started to yield results such as accessing one contract for cardiac stents, which led to a 30% reduction in costs and another contract for orthopaedic implants which saw a 38% reduction before even considering changing supplier and range of products used.

The benefits from working with others does not stop there, our review showed that 40% of the money we spend is with a supply base common to 20-40 other Trusts (out of a benchmarked 54 Trusts). Working collaboratively also provides opportunities to access specialist expertise that are pooled across multiple organisations. Despite having these resources now available to us, we need to select and use our partners wisely and back them up with resources that can facilitate the collaboration and implement the contracts locally.

The key users of the procurement function tell us that they would like to have greater engagement from Procurement professionals and would like to see opportunities and support in delivery of savings more forthcoming. Clinicians want to be involved in buying decisions, but often get frustrated with blockages in the process and not being kept in the loop.

Managing inventory more effectively would reduce wastage and stockholding by £550k

The services provided by the Materials Management function (who top up regularly used consumables on wards and departments) are well received by users, but they would like to see more products under their management to free up time spent by clinical staff on administrative functions like ordering. There is also a large amount of wastage in the current process. A review of stock levels showed that, with the correct systems and processes in place, inventory currently under management could be reduced by £550k.

Inefficiencies exist within the internal supply chain, with as many as ten different departments visiting wards on a daily basis to provide goods of some description, in some cases with the same member of staff visiting two to three times in a single day. This leads to confusion for the clinical staff in knowing who to contact when they have a need.

Significant opportunities exist through efficient use of technology and automation

The systems and processes in place require significant improvement and investment. Whilst an electronic procurement system is in place, 38% of the money spent through this route is processed on paper or via manual processes and the systems in place do not interface or talk to each other causing greater inefficiencies. The DH's eProcurement strategy outlined the technological infrastructure required by each Provider organisation for an optimum Procurement and supply chain function. Out of the seven systems required, only one is in place currently with issues, two currently being implemented, with the remaining four missing.

Maidstone and Tunbridge Wells NHS Trust

Potential business scope and key service requirements

The service lines of an effective procurement function can be split into three core elements: Strategic, Tactical and Operational, with technology and systems underpinning the service. These elements are common to each strategic option.

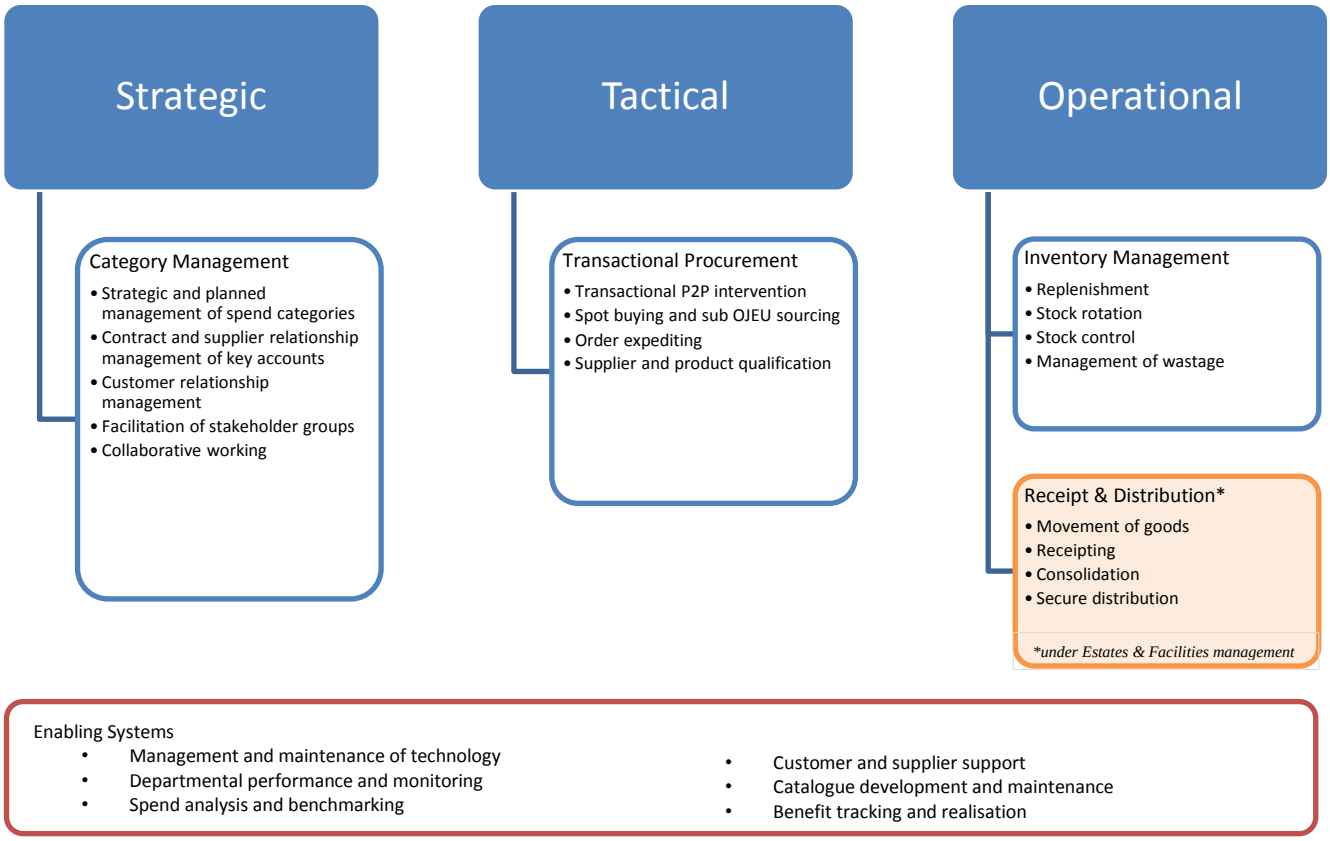


Figure 3 - Service redesign

Strategic

This new to MTW function focusses on internal stakeholder relationship management; ensuring active and positive engagement throughout the procurement cycle all the way through contract management stages.

From the divisional manager's perspective, this will be the team that will have a close relationship with the divisions and will work closely with clinical staff to ensure the correct specifications are used for products purchased; supporting divisions with the formulation of their cost improvement schemes; and facilitating the implementation & on-going management of contracts.

The team also focuses on external supplier management through the splitting of spend into discrete portfolios of categories managed by individual members of the team. Based on project management methodology, the team takes an analytical approach to identifying opportunities and delivery of planned cost improvement schemes, governed by category boards made up of key stakeholders. Focus on value and total cost of ownership rather than exclusively price down savings initiatives. An example category analysis can be seen in Appendix II.

Tactical

The more recognisable "purchasing" function managing purchase transactions with suppliers, unplanned sourcing activity and sub-OJEU or "tail" spend not managed through the strategic category management function. The change here is moving away from manual processing of requests towards automation and efficiency, providing additional services not currently performed at the Trust e.g. order expediting and low value negotiated sourcing.

From an end users perspective, orders will be processed and fulfilled in less time, with less bureaucracy. Better pricing for commonly used products will be noticeable and proactive chasing of delayed deliveries. Divisional managers will have access to better information about their departments ordering patterns, enabling them to make decisions on areas to improve.

Operational

This function is responsible for the replenishment and distribution of goods throughout the organisation. A migration from a materials management methodology to the management of all Trust consumable and implantable inventory through robust analytical processes and techniques. This team would lead a review of the internal supply chain to maximise efficiencies and reduce duplication.

From the users perspective, all regularly used consumables in clinical areas will be managed and controlled by inventory experts with automated systems in place to reorder critical items as close to when they are used as possible. This will lead to the right product being available at the right time with little manual intervention, without feeling like the cupboards are full to bursting. There would be a significant reduction in the administrative burden associated with reordering, freeing up clinical staff to focus on direct patient contact.

Enabling Systems

This element is responsible for the systems, information, processes and performance of the Procurement Department as well as front line customer and supplier support and underpins the rest of the services.

Focus for investment

The core focus in all options is investment in enabling technology and the strengthening of capability and capacity in the strategic elements of the service. There will be limited investment in tactical and operational elements as the technology and process redesign will assist with the stretching of current resources through automation and more efficient approaches.

Development & Retention

The ability to attract and then retain qualified, experienced and capable procurement professionals has always been challenging in both the public and private sectors. There is a national shortage of good professionals that can deliver the level of benefits required in the NHS. This is compounded further with MTW's close proximity to London where professionals are tempted by higher pay and opportunities to work with large, globally renowned organisations.

There is a need to develop future procurement professionals now. A requirement is to partner with education establishments to provide work placements, apprenticeships and management trainee spaces that allow for on the job training, with rotational placements into different roles and organisations; supported with funded professional training and qualifications.

Maidstone and Tunbridge Wells NHS Trust

Case for change – Benefits

The Strategic Case

The benefits associated with the investment

This section describes the main outcomes and benefits associated with the implementation of the potential scope in relation to business needs.

Satisfying the potential scope for this investment will deliver the following high-level strategic and operational benefits. By investment objectives these are as follows:

Investment objectives	Main benefits criteria
Redesign the service so that it is fit for purpose and meets the needs of the Trust and wider NHS	Increase in cash releasing savings delivered through cost improvement programme at least three fold over a five year period
Manage compliance and alignment to central policy	Improved competency and compliance with national procurement standards – level 2 “achieving”
Increase procurement influence and support to all spend areas	Increase in cash releasing savings delivered through cost improvement programme at least three fold over a five year period
Improve relationships with key suppliers and internal stakeholders	Skilled support for divisions Stronger relationships with suppliers, leading to long term strategic relationships Procurement decisions led by clinicians and key stakeholders
Increased use of technology and automation	Streamlined, automated processes, increasing time spent on direct patient interaction and reducing inventory levels
Change in focus from materials management to inventory management	Streamlined, automated processes, increasing time spent on direct patient interaction and reducing inventory levels Ability to identify true procedure costs and challenge profitability of service and product mix
Centred on using partners and collaborating effectively	Reduction in duplication of procurement activity and access to specialist resources that would otherwise be uneconomical to employ Development of local talent pool Stronger negotiating leverage through consolidation of “purchasing power”
Contribute directly to strategic objectives of the Trust	Stronger, more relevant procurement function that supports and is aligned with the requirements of the organisation

Table 2 - Main benefit criteria

There has been a three year decline in the level of benefits achieved by the current procurement function. This is due to a combination of factors including the reduction in the resources allocated and a change in how savings are categorised. Below is the historical trend of benefits delivered.

Financial Year	Target	Achieved
2012/13	£1.4m	£1.9m
2013/14	£1.2m	£0.95m
2014/15	£1.2m	£0.9m*

Table 3 - Historical procurement CIP performance

**Projected achievement this year*

The £0.9m of savings delivered in 14/15 represents 2.4% of the £37m spend under influence. Initiatives over the past few years have addressed the same spend categories and it becomes increasingly difficult to squeeze greater value from the same processes. The new service would seek opportunities to challenge specifications and how practices are carried out as well as aggregating our buying power with other organisations via partners; we would expect to see a 6-10% (£2-3.5m) annual benefit from spend influenced.

The Trust has already started to see the benefits of this through its recent participation in the London Procurement Partnership and the TDA sponsored Demand Aggregation Project, where one project for Trauma Orthopaedics in particular netted £239k savings (38%).

The recent independent procurement review identified that there is an additional £30m not currently under direct Procurement influence that should be targeted. The developed and established service should have all this spend under control within 2-3 years, adding an additional £1-3m to the annualised benefit. An example of this is the management of Agency pricing and contract management which has historically had a light touch from procurement for capacity reasons: currently, the Trust spends £7.7m on Agency staffing. Medway Foundation Trust recently reduced their locum doctor agency pricing by 11% through an innovative negotiation.

There are significant financial benefits from managing inventory better, reducing wastage (estimated at £0.5m) and the amount of time clinical staff currently devote to the checking and replenishment of inventory. As an example, band 6 senior clinical specialists in theatres spend hours each week checking and reordering specialist stock such as Orthopaedic implants which have as much as 2,000 different items in the range. This time is diverted from direct patient interaction.

The review highlighted ten immediate high level savings opportunities, on which the new service would focus in its first year– these opportunities are valued at an annualised £3.5m.

In summary the benefit projection over the next three years is provided below.

High level scheme (£000)	2015 / 16	2016 / 17	2017 / 18	Total
Cost improvement	698	452	2,000	3,149
Increasing influence	390	736	1,076	2,201
Standardisation & rationalisation	310	132	160	602
Inventory & wastage	130	430	40	600
Filling the contract gap	115	406	20	541
Total	**1,642**	**2,155**	**3,296**	**7,093**

Table 4 - High level financial benefits projection

Benefits in years one and two are phased to take into account the period of mobilisation and transition to the new service including the recruitment of staff and implementation of technology. Cumulatively, breakeven is expected within Q3 of the first year. This projection has been based on the preferred options costs and the conservative savings targets highlighted above, with a detailed sourcing plan for years one and two embedded within divisional business plans and high level plans for years three to five.

The benefits are the result of an independent review into the procurement service and an in depth spend and opportunity analysis on a category basis. An example of this category analysis can be found in Appendix I.

Maidstone and Tunbridge Wells NHS Trust

Case for change – Risks

The Strategic Case

List and description (category and grading) of the potential risks associated with the investment

The top five risks associated with the preferred option is detailed below along with the potential mitigations. Risk scores are before mitigation is applied.

Category	Risk	Score	Potential Mitigation
Financial	Vulnerability to Trust financial position – targeted cost reduction before benefits achieved	12	Agreed period of protection from the Procurement Departments' CIP reductions until benefits fully realised
Implementation	Ability to attract talent	9	Pool of specialist resources. Strong development plan. Clearly defined job descriptions. Engage recruitment specialists to source right calibre of staff.
Implementation	Time to deploy – risk that focus would be diverted and would drag	6	Commission external project team to lead transformation programme
Implementation	A period of transition whilst relationships and trust align	6	Clear terms of reference. Partnered governance. Strong marketing
Strategy	Uncertain future -organisational change and changing health economy	6	Smaller amount of staff pooled and ensure protection within SLA agreement

Table 5 - Main risks and counter measures

Dependencies

The programme is subject to following dependencies that will be carefully monitored and managed throughout the lifespan of the scheme:

- Adequate project resources
- Available funding - £600k capital (£400 in yr1, £200 in yr2)
- Securing revenue funding aligned to requirements
- Stakeholder engagement and awareness
- Existence of willing partner
- Ability to interface / integrate systems

Constraints

The programme is subject to following constraints:

Results	Timeframes	Resources	Performance
•All procurement activity to be compliant with local SFI's and current Public Procurement Regulations	•The transformation programme must be completed within 12 months from start date and by the end of financial year 2015/16	•Benefits achieved by new service must be greater than cost of change and investment within the first year •Capital costs are phased across two financial years with no more than £400k being accrued in 2015/16.	•The solution must implement the recommendations of the department of Health Procurement Strategy and eProcurement strategy including the adoption of GS1 standards •The solution must enable the Trust to increase its compliance level to National Procurement Service to level 2 – "Achieving" across all domains

Figure 4 - constraints to the programme's success

Maidstone and Tunbridge Wells NHS Trust

The short list of options *The Economic Case*

Option 0. Do Nothing [Discounted]

Introduce changes that do not affect structure or level of resources. For example, formation of governance structure, development of performance KPIs and dashboard, rewriting and publication of Procurement strategy. Previous investment in partnership working with LPP brings a number of benefits such as access to collaborative procurements and enabling technology.

Option 1a. Build Your Own [Possible]

Development of internal service, resourced fully by MTW staff and dedicated entirely to the Trust. Significant change from the current service provided across: Structure, Systems and Process. Using partners where appropriate to aggregate demand and access specialist resources. This option has been developed with the support of an external Procurement consultant.

Trusts that have recently embarked on this approach include Medway, East Kent and Croydon.

Option 1b. Formal Collaboration [Preferred]

Hybrid between 1a and 2. Retain and transform internal service based on option 1a, with a formal collaboration arrangement, including shared governance, strategy, processes and approach.

Aggregating spend where appropriate, pooling resources for specialist talent, extending the staff professional development scheme and retaining local presence and service provision.

This option has been developed using option 1a as a basis with specialist and leadership resources being shared on a 50/50 split basis with another Trust.

The Shelford Group has recently embarked on this approach with the formation of a collaborative partnership pilot between the ten member Trusts: University Hospitals Birmingham, UCLH, Sheffield Teaching Hospitals, Oxford University Hospitals, Newcastle-Upon-Tyne Hospitals, King's College Hospital, Imperial College Healthcare, Guy's & St Thomas', Central Manchester University Hospitals, and Cambridge University Hospitals.

Option 2. Shared Service: Full Merge [Possible]

Merge service provision with a neighbouring trust to expedite the transformation process, gaining economies of scale through aggregation of spend and pooling of resources. A once-only approach to category management. This option is based on a proposal from East Kent University Hospitals NHS Foundation Trust. Whilst East Kent has been used for the development of the model, other potential partners are being explored.

Trusts that have recently embarked on this approach include the UCL Partners, made up of Whittington, Royal Free, Moorfields, North Middlesex and Great Ormond Street.

Option 3a. Outsource: Transactional Procurement [Discounted]

Development of internal service based on option 1 with the outsourcing of transactional procurement and systems management to a procurement partner. Additional benefits from access to strategic frameworks and collaborative contracts.

For this option, the Trust approached NHS Shared Business Services who offer similar services across the NHS. If this option is selected, a full procurement exercise will be carried out to select the appropriate partner.

Ashford and St Peters Hospitals NHSFT uses this model with NHS SBS.

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Option 3b. Outsource: Full BPO [Discounted]

Complete business process outsource (BPO) of strategic and transactional service lines to a procurement partner, retaining operational elements (materials management and receipt & distribution). Includes provision for local relationship managers to drive engagement and influence local stakeholders.

All resources and systems owned by partner. For this option, the Trust approached NHS Shared Business Services who offer similar services across the NHS. If this option is selected, a full procurement exercise will be carried out to select the appropriate partner.

Staffordshire and Stoke-on-Trent partnership Trust has recently implemented the Business Process Outsourcing from NHS SBS.

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The Preferred Option

The Economic Case

Option Appraisal. Why the preferred option optimises value for money (VFM)

Financial appraisal

Regardless of the option, significant investment in leadership, people, processes and systems is required to deliver the function required.

Much of this investment is in the procurement and implementation of a patient level inventory management system that will enable the Trust to understand what products are used on each patient and analyse the true cost of procedures.

The total cost of each option and investment required is outlined in the below table.

£000	0	1a	1b	2	3a	3b
Baseline (current cost)	744.21	744.21	744.21	744.21	744.21	744.21
Baseline (financial services)					230.00	230.00
Recurrent Investment						
Staffing	0.00	459.31	412.73	319.40	329.38	-122.98
Systems	0.00	95.80	94.30	57.16	332.71	312.91
Partners	0.00	13.79	13.79	13.79	280.79	534.79
Other Non-Pay	0.00	60.66	64.61	64.99	45.49	24.40
Capital charges*	0.00	91.60	91.09	91.32	90.25	86.44
Subtotal Recurrent Investment	**0.00**	**721.16**	**676.51**	**565.88**	**1,078.62**	**835.56**
Non recurrent Investment						
Project Resources	0.00	260.00	260.00	260.00	562.00	614.00
Subtotal Non-Recurrent Investment	**0.00**	**260.00**	**260.00**	**260.00**	**562.00**	**614.00**
Total Revenue Investment	**0.00**	**981.16**	**936.52**	**825.88**	**1,640.62**	**1,449.56**
Total Revenue Cost	**744.21**	**1,725.37**	**1,680.73**	**1,570.09**	**2,614.83**	**2,423.77**
Capital Investment						
Capital Systems	0.00	612.00	612.00	612.00	612.00	612.00
Capital Infrastructure	0.00	51.00	48.75	49.77	45.00	19.50
Subtotal Capital Investment	**0.00**	**663.00**	**660.75**	**661.77**	**657.00**	**640.50**

Table 6 - Costs and investment by option

**Capital charges comprise the annual depreciation over the life of the asset and the 3.5% cost of capital that NHS Trusts are required to return. Year 2 full capital charge has been used. A provision for capital costs has been included in the 2015/16 and 2016/17 capital plan through the Trust business planning process.*

Option 0 assumes that there is no change to the core procurement and finance systems in place at the Trust. Options 1a and 1b assumes an upgrade to the current Finance system and a potential change of Procurement system. Option 2 assumes the existing incumbent system is used, the tested Trust has indicated that this will require upgrade in the next 18 months. Options 3a and 3b includes costs for a change of Procurement & Finance systems to an Oracle platform and include costs for outsourcing of core financial services to a shared service.

For option 3 the baseline has been adjusted to reflect the proposed SBS pricing which does not differentiate between the current costs to deliver procurement and the current cost to deliver financial services. Financial services outsourcing is prerequisite of this option, so the baseline has been included for accuracy. There is also a cost of change element which would accrue only in year 1.

Costs also include the receipt & distribution function which is currently under the management of Estates & Facilities. The revenue investment in this area amounts to £50k.

Risk Appraisal

A full risk assessment against each option carried out, with scoring based on Trust standard risk grading matrix.

A summary of the risk score from each option is provided below. The lowest scoring option is 1b – Build your own with full collaboration.

Category	0	1a	1b	2	3a	3b
Strategy	15	8	6	6	12	12
Financial	15	12	12	0	12	12
Implementation	0	21	21	8	0	0
Operational	32	0	0	29	24	24
	62	**47**	**39**	**43**	**48**	**48**

Table 7 - Summary risk analysis

The top five scoring risks from each option are provided in Appendix II.

Benefit Appraisal

A full analysis of each option was carried out as to whether it would meet the requirements to take us to the next level of maturity against the national procurement standards, taken from the DH National Procurement Strategy. All options will provide significant benefit over the Do Nothing option (0), although some gaps could be filled within the current situation. Option (1b) delivers the maximum non-financial benefits.

The benefits matrix against the gap analysis is provided in Appendix IV.

Conclusion

The preferred option, 1b - Formal Collaboration provides the lowest risk option, whilst accruing greatest benefits. It provides a service that is fit for purpose, in line with national standards and best practice; staffed with a capable and comprehensive workforce.

It provides the Trust with a flexible, resilient service that makes best use of a scarce specialist resource pool whilst providing the opportunity for local development of talent and the retention of staff by providing clear development and progression paths and the opportunity to work across multiple organisations.

This option is preferred over options 1a and 2 because of the benefits gained by working smartly with partners and pooling specialist resources, whilst maintaining control and a close, localised relationship with the service users.

Building a large team of resources from a limited regional talent pool, as described in option 1a is considered inefficient and would take some time to build and mobilise. With option 1b, a core team is retained locally, with specialist resources pooled across multiple organisations. The effective use of partners allows for the further aggregation of buying power along with access to category experts which would otherwise be unaffordable.

A shared service across a number of Trusts (option 2) is a sound proposition as it takes advantage of a full pooling of resources. With MTW's current maturity level, focus would be diverted away from service improvements and into managing and converging competing priorities from two large organisations. Option 1b, is a step towards a more formal merger of service by having a single operating model (Figure 5), with a unified procurement strategy, common processes, systems and procedures. A single governing procurement board would oversee the allocation of resources, approving work load and measuring progress against strategy. Once both Trusts are working successfully together, at the same level of maturity and aligned priorities, the next logical step would be to gain maximum efficiencies by completing the merge process.

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Option 3a provides limited financial benefit as the same level of investment in strategic procurement and inventory management would be required. It does bring with it standardised systems and processes for the management of transactional procurement, but is the most costly option and similar benefits are achieve through options 1b and 2 through partnership.

Option 3b, full outsourcing, whilst providing the fastest mobilisation time, is more costly than the preferred option. The benefits are significant as an established service, with scalable, predefined processes forms the centre piece to the service. Access to specialist resources is available due to the economies of scale that the BPO provider has through its multiple customer base, but there is a significant risk that the level and quality of support and expertise assigned to the Trust account would diminish over time. There is also a concern that benefits in efficiencies gained over the current situation would be retained by the provider rather than released back to the Trust.

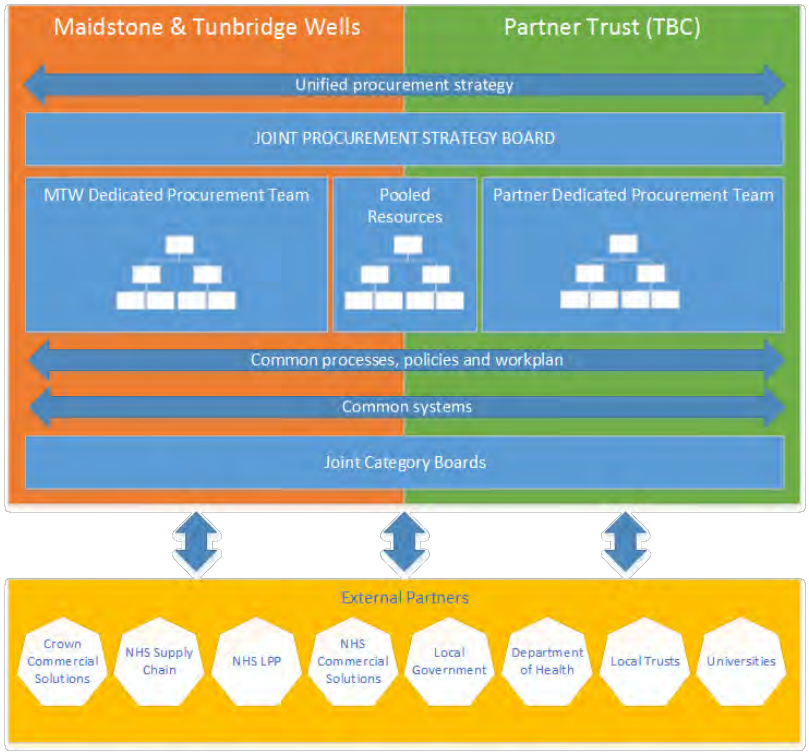

Figure 5 - Option 1b operating model

The selection of the right partner is critical to the success of this option. The formal partnership is not simply about aggregating our spend and purchasing power with another organisation, but about sharing common processes and resources to simplify procurement activity, reduce the cost base and share specialist resources. The right partner needs to be fully on board with the proposal and demonstrate a willingness to match the level of investment and support for the improvement of their internal function at the same level. The partnership, whether between two or multiple organisations, needs to be balanced and equal with no single organisation taking the lead.

Key to the partnership is the ability to share resources across all partner organisations. Whilst technology and mobile working will be utilised, a physical on site presence will be required across all partner sites. This makes distance between the partner organisations a key criteria for partner selection. Use of external partners for demand aggregation and specialist services (represented by the yellow box in Fig 5) are not geographical dependant.

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Services and / or assets required

Formal procurement partner

Selection of the correct, willing partner is critical to the success of this option. Details of the process followed for partner selection is detailed below. In the event that no willing partner is found in the immediate term, the fall-back position will be option 1a, migrating to 1b upon successful partner selection.

Partner selection process

Since the National Procurement Strategy was launched in 2013, a number of Trusts have undertaken similar investments in their Procurement function, with a number of models in existence. In order to select the correct partner, MTW needs a robust selection process which ensures that the partnership is matched against clear criteria and is built upon an equal playing field.

A selection team has been established, made up of the following individuals:

- Steve Orpin, Director of Finance
- Stuart Doyle, Deputy Director of Finance
- Lesley Martin, Head of Procurement

Figure 6 summarises the process steps for partner selection. At the time of writing, the Trust is at the "orientating meeting" step in the process with four organisations expressing interest in partnering under a similar model.

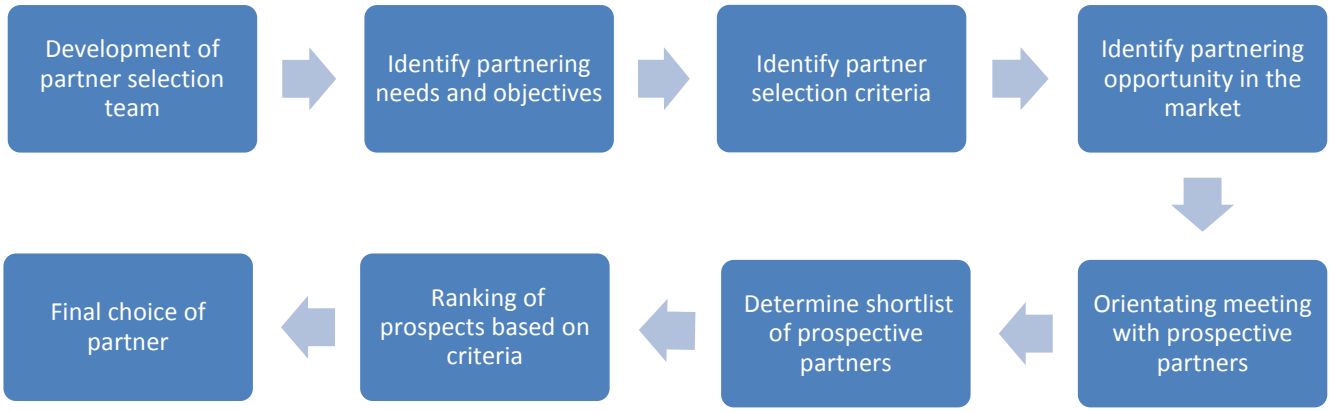

Figure 6 - Partner selection process

Short list criteria

The long list criteria were as follows:

- Organisations within geographical boundary of 40 miles radius of MTW
- Organisations of similar size and service mix
- Expression of interest (EOI)

Short list

As a result of applying these criteria, the evaluation list is provided below. The full longlist is provided in Appendix V:

Potential Partner	Within 40 miles	Similar organisation	EOI	Shortlisted
East Kent University Hospitals NHS FT	✓	✓	✓	✓
East Sussex Hospitals NHS Trust	✓	✓	✓	✓
Medway NHS FT	✓	✓	✓	✓
Dartford & Gravesham NHS Trust	✓	✓	✓	✓
University College London Hospitals NHS FT	✓	✓	✓	✓
Barking, Havering & Redbridge Hospitals NHS Trust	✓	✓	✓	✓

Table 8 - Short list of potential partners

Selection methodology

The selection criteria and associated weighting were as follows:

Criteria	Weighting %
Management capacity and commitment to success	30
Geography	10
Service / speciality mix	10
Consistent goals and strategies	30
Knowledge of partner organisation (familiarity)	20

Table 9 - Potential Partner - Shortlist criteria

Each longlisted partner was evaluated against each item of criteria and assigned a score between 1 and 5 based on the scoring matrix detailed below.

	Score
Does not meet criteria and cannot be addressed	0
Does not meet criteria for most part, but could address gaps	1
Partly meets criteria with some major addressable concerns or gaps	2
Meets criteria with minor addressable concerns or gaps	3
Meets criteria with no concerns or gaps	4
Significantly exceeds criteria and would add additional value	5

Table 10 - Potential partner - Scoring matrix

Any potential partner scoring 0 against any of the criteria will be treated as unsuitable and will be excluded from the weighted evaluation. The applied score against each criteria will be weighted based on the importance of the criteria to the selection team. The weighted scores are then summed and represented as a percentage to provide a total score for each organisation.

$$Result = \frac{\sum(Score\ x\ Weighting)}{5}$$

Equation 1- Shortlist score calculation

Potential partners must meet a minimum percentage score of 55% before they are considered for the next stage. Totalled scores over the minimum bar are then ordered and the top organisations are moved to "preferred partner" status, where further due diligence will be explored prior to final agreement.

Clearly, any potential partner will need to have undergone a similar selection process against their own criteria to ensure that the partnership is equally attractive.

Patient level inventory management system (PLIMS)

A PLIMS system forms the backbone of planned improvements in inventory management across the Trust and makes up the bulk of capital investment in this case.

The selected system will:

- Reduce the level of stock held on site by at least £500k
- Reduce clinicians time spent on ordering and replenishment activity – freeing them up to spend more time on patient focussed activity
- Improve usage data and procurement traceability data
- Manage and control inventory, improving security and tracing wastage
- Provide patient costing and implant registry information

There are a number of solutions on the market and many procurement framework agreements that are available for the Trust to access. These frameworks often require further competition between the approved solutions upon each decision to purchase.

Solutions vary between closed and secured "intelligent" cabinet systems, such as the one being trialled at the Trust for controlled drugs – relying heavily on equipment and subsequently a high capital cost; and "open" systems which provide less security and assurance, but require more investment in software and less capital investment in equipment.

Upon approval of this business case, the Trust will run a procurement process to select the correct solution. For the purposes of costing, two service providers have supplied indicative proposals for the investment. The selected proposal can be found in appendix VI. The proposal weighted towards the greater capital investment has been used in this business case.

Following a procurement exercise, the final pricing should not exceed the costs incorporated within the financial case. In the event that the cost does exceed the planned amount, no contract will be entered into without additional approval from the Trust Finance Committee and Trust Board.

Catalogue & Exchange System

These online services provide essential components for business to business automation within the NHS eProcurement strategy.

The catalogue management system will provide access to supplier managed catalogue content via international standard GS1; reducing the administrative burden on the Trust and improving the quality of data, enabling improved benchmarking of prices across organisations.

The document exchange system will provide a connector between the Trusts ordering and invoice systems and our suppliers, enabling the automated and seamless passing of electronic Purchase Orders and Invoices between businesses via an international standard PEPPOL.

Implementation of this technology will increase automation in the business process, reducing duplication and manual processing and speeding up the purchase to pay cycle, whilst minimising the risk of duplicate payments and stopping of supply due to processing errors.

A national framework has been put in place for the supply of this technology and costs are revenue based on an annual subscription model.

eSourcing System

This online toolset will provide the Trust with electronic and automated processes to support the procurement of goods and services. Replacing the manual tendering process, this tool will:

- enable the publishing of adverts to the supplier base;
- manage the tender process securely and electronically;
- significantly reduce the timelines and bureaucracy associated with the procurement process whilst ensuring we are compliant as an organisation with EU Procurement Regulations.
- improve Trust-wide visibility of contracts with external organisations

This service is provided within the membership fee of the Trusts collaborative procurement partner – the London Procurement Partnership (LPP) and will be fully implemented under the transformation programme.

Analytics & Benchmarking Service

This service forms part of the offering from the LPP and incorporates a dedicated spend analysis tool alongside a price benchmarking tool which takes multiple data sources, cleans and standardises the information before presenting back to the user in an extremely powerful and dynamic tool. This service is enhanced by a team of analysts at LPP who provide analysis and opportunities for all LPP member Trusts. Access to the tool, the development of data extracts and implementation of its use forms part of the scope of the transformation programme.

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Integrated Purchase to Pay (P2P) System

The Trust currently uses an online system called Marrakech to handle the electronic processing of purchase requisitions and orders. There are a number of inherent issues with this system including a lack of interfaces between other core business systems in the trust, resulting in manual double entry.

The Finance Directorate will be taking stock of the optimum architecture and solution for the future and a replacement or improvement of the system will be considered in the next 12 months. Within the scope of this transformation programme will development of interfaces between it, or its replacement and other business systems. The scope of the replacement could either be a move to a more integrated solution with the Trusts finance system or a replacement dedicated purchase to pay system.

Costings currently include the amount paid for the annual subscription of the core system plus a provision for the implementation of a new system.

Electronic Request for Quote System (eRFQ)

This tool will enable electronic quotations to be requested from multiple organisations quickly; opening up low spend opportunities to competition and driving better value, whilst promoting the use of "encouraged enterprises" including small, local businesses.

A limited number of tools are available on the market and are generally covered under national framework agreements. The selected system is the NHS market leader and is provided under an agreement awarded by our collaborative Procurement Partner – LPP.

Costs are based on an annual subscription model and there is no capital implication.

Help Desk and Portal System

This web based tool will provide the Procurement function with a single portal of information for staff, suppliers and partners. A help desk function will enable the logging and tracking of customer and supplier contact, ensuring issues are addressed promptly and efficiently. A team locator will enable efficient assigning of remote operational staff to support calls, significantly reducing time spent on resolving issues.

There are a small number of tools in the market place, based on an annual revenue subscription model. The final solution will be selected following a procurement exercise.

Workforce impact

There will be an overall increase of whole time equivalents (WTE) by 12 including pooled resources. A full breakdown by band is provided below. An organisational chart of the proposed structure is provided in appendix VII

	WTE			Cost (£000)		
Band	**Baseline**	**Option**	**Variance**	**Baseline**	**Option**	**Variance**
8D	0.00	0.50	0.50	0.00	44.00	44.00
8C	0.00	1.00	1.00	0.00	73.16	73.16
8B	1.00	1.50	0.50	69.95	91.45	21.50
8A	0.00	3.00	3.00	0.00	154.97	154.97
7	0.67	4.00	3.33	33.21	173.22	140.01
6	3.00	1.00	-2.00	122.10	36.12	-85.98
5	5.86	4.00	-1.86	191.60	114.95	-76.65
4	5.97	12.00	6.03	157.62	268.96	111.34
3	0.00	1.00	1.00	0.00	21.23	21.23
2	4.00	4.50	0.50	73.18	82.33	9.15
Total	**20.50**	**32.50**	**12.00**	**647.66**	**1,060.39**	**412.73**

Table 11 - Workforce impact by band

Baseline WTE and Costs are based on current budgets.

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Pooled resources will be shared on a 50/50 basis with the selected partner. Hosted employment of those shared resources will be determined during the partner selection process. Costs are based on mid-point of the band. Bandings are subject to agenda for change evaluation of each job description.

It is not anticipated that TUPE (the Transfer of Undertakings (Protection of Employment) Regulations 1981) will apply to this investment because each partner retains its own resourcing structure. New roles will be created for pooled resources, hosted by one of the partners. Staff currently employed by either partner will have an opportunity to apply for a pooled role.

There is a risk of displacement of current resources as the new structure is a significant change in job profiles from the current mix. This will be managed through the Trust's organisational change policy, supported by the HR Business Partner for Corporate.
The increase in WTE is based around:

- the strengthening of the operational team to increase the proportion of Trust inventory managed by the function and therefore the reduction of time spend by clinical staff on replenishment;
- the introduction of new Strategic procurement functions that will introduce closer working with divisions; and technical resource that will support the new systems being put in place;

Where technology is being implemented to increase automation, there is a significant reduction in staff supporting the tactical function. Out of the 12 increase in WTE, 2.5 relates to the Trusts proportion of a pooled resource as described in appendix VII
The structure for this option has been designed with support from an independent procurement consultant and has been benchmarked with a number of Trusts that have already gone through a similar investment in their Procurement function and those that are already working to the desired level of maturity including: King's College Hospital, East Kent, Medway, Guy's & St Thomas', UCLH, and Oxford University Hospitals.

Estates impact

Due to the increase in WTE and a change towards mobile working for a number of staff, there may be a requirement for a reconfiguration of facilities in use by the Procurement function across both Trust sites. Current space allocation is under review in collaboration with the Estates team which incorporates the use of hot desks.

Investment in physical inventory management cabinets will require installing of electrical and data ports where required.

Impact on other directorates

Additional investment in technology will require operational and project support from the IT directorate including networking of inventory management cabinets and hosting of related servers.

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Funding and affordability

The Financial Case

Capital costs of the preferred investment option

Capital	Year 1	Year 2	Year 3	Year 4	Year 5
Inventory Management System	(400.00)	(212.00)	0.00	0.00	0.00
IT & Telecoms	(48.75)	0.00	0.00	0.00	0.00
Total Capital	**(448.75)**	**(212.00)**	**0.00**	**0.00**	**0.00**

Notes on capital costs:

Costs include VAT

Revenue changes associated with the preferred investment option

Revenue Changes	Year 1	Year 2	Year 3	Year 4	Year 5
Total benefit	**1,643.00**	**2,156.00**	**3,296.00**	**3,500.00**	**3,500.00**
Baseline costs	(744.21)	(744.21)	(744.21)	(744.21)	(744.21)
Additional Pay	(210.48)	(412.73)	(412.73)	(412.73)	(412.73)
Additional Non Pay expenditure	(365.70)	(172.70)	(172.70)	(172.70)	(172.70)
Capital charges & depreciation	(64.59)	(91.09)	(88.61)	(86.13)	(83.64)
Total Investment	**(640.77)**	**(676.52)**	**(674.04)**	**(671.56)**	**(669.07)**
Total costs	**(1,384.98)**	**(1,420.73)**	**(1,418.25)**	**(1,415.77)**	**(1,413.28)**
Net financial benefit	**258.02**	**735.27**	**1,877.75**	**2,084.23**	**2,086.72**

Notes on revenue changes:

Year 1 costs are phased based on a recruitment plan and include project costs for implementation support and programme management. Years 2-5 show the business as usual state with depreciating assets.

How the investment will be funded:

The costs of the service will be funded through the benefits achieved by better procurement practices as detailed in the strategic case on page 10. The projected benefit over the next five years is detailed below.

£000	Year 1	Year 2	Year 3	Year 4	Year 5
Benefit	1,643.00	2,156.00	3,296.00	3,500.00	3,500.00
Cost	(1,384.98)	(1,420.73)	(1,418.25)	(1,415.77)	(1,413.28)
Net Benefit	258.02	735.27	1,877.75	2,084.23	2,086.72

Table 12 - Summary cost / benefit analysis (preferred option)

The below table details the same projection based on the do nothing option for comparison purposes.

£000	Year 1	Year 2	Year 3	Year 4	Year 5
Benefit	900.00	900.00	900.00	900.00	900.00
Cost	(744.21)	(744.21)	(744.21)	(744.21)	(744.21)
Net Benefit	155.79	155.79	155.79	155.79	155.79

Table 13 - Summary cost / benefit analysis (do nothing)

The above information is presented cumulatively in graphical form below:

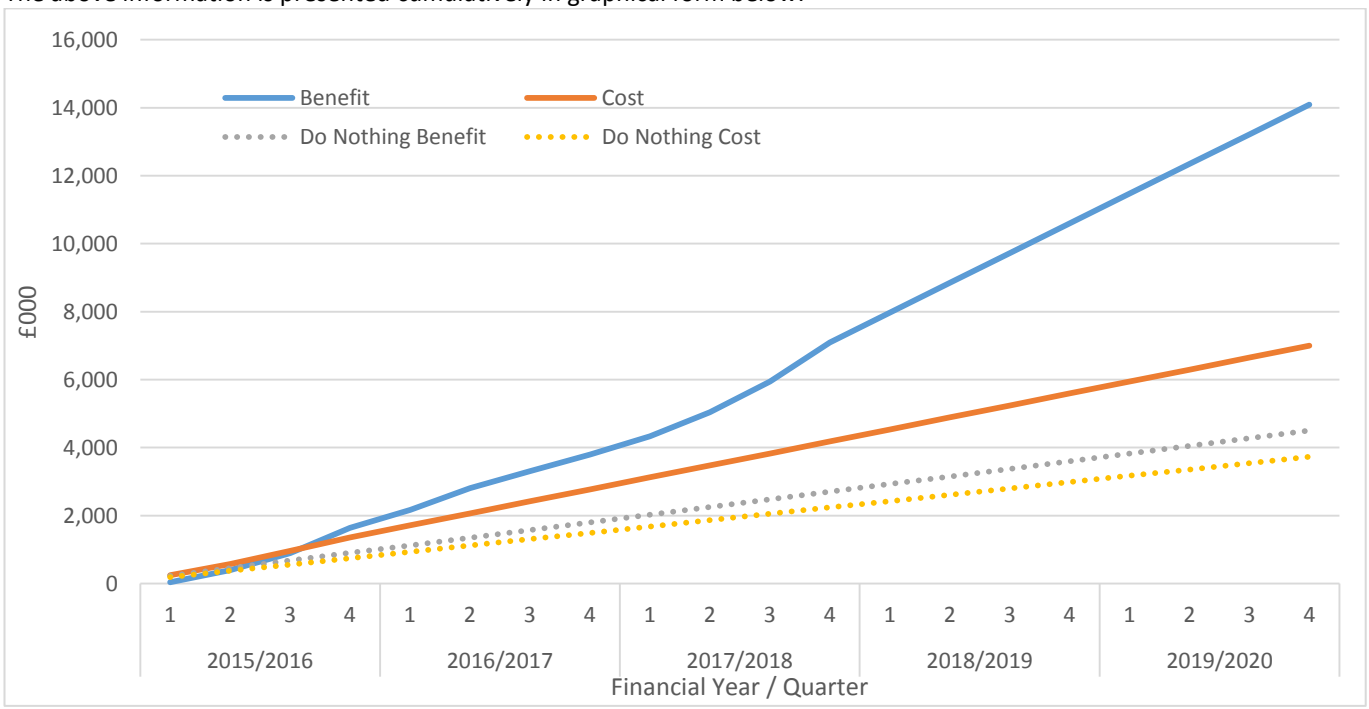

Figure 7 - Cumulative cost / benefit projection

A detailed breakdown of costs for all options can be found in Appendix VIII.

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Procurement Route

The Commercial Case

The procurement and implementation of all technology will follow Trust SFI's and will be led by the Health Informatics team, supported by the Procurement function to ensure robust and objective evaluation criteria is applied to the procurement process; ensuring the most economically advantageous solution is selected and implemented. For each solution and service described in the Economic Case, the following procurement route will apply.

Patient level inventory management system (PLIMS)

This solution will be procured via a further competition tender exercise under a framework agreement, awarded in compliance with the Public Procurement Regulations. The procurement process will be led by the Procurement and Health Informatics teams in line with Trust SFI's. It is anticipated that the selection process will take three months from project initiation.

Catalogue & Exchange System

This solution will be purchased compliantly under a national framework agreement awarded by Northumbria Healthcare NHS Foundation Trust on behalf of the Department of Health.

Electronic Request for Quote System (eRFQ)

This solution will be purchased compliantly under a framework agreement awarded by NHS London Procurement Partnership.

Help Desk and Portal System

This solution will be purchased through competitive tender under the Trust's SFI's

Commercial arrangement with partner

Once a formal partner has been selected, there will be a requirement to have a formal partnership agreement or SLA between the partnering organisations.

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Management Arrangements — *The Management Case*

Project management arrangements

The programme will follow Managing Successful Programmes methodology, with individual defined projects managed in accordance with PRINCE 2 methodology supported by Lean Six Sigma approaches and tools for process improvement and efficiency projects. A full quality impact assessment can be found in Appendix IX.

Programme reporting structure

The reporting organisation and the reporting structure for the programme are as follows:

A Procurement Strategy board (steering board) will meet monthly to oversee strategic direction and high level progress against plan. This board will also be responsible for the resolution of issues that cannot otherwise be resolved at a lower level. This board will report quarterly into the Trust Finance Committee and ultimately the Trust Board. Following implementation, this board will oversee the performance of the procurement activity and agree future direction and work plans.

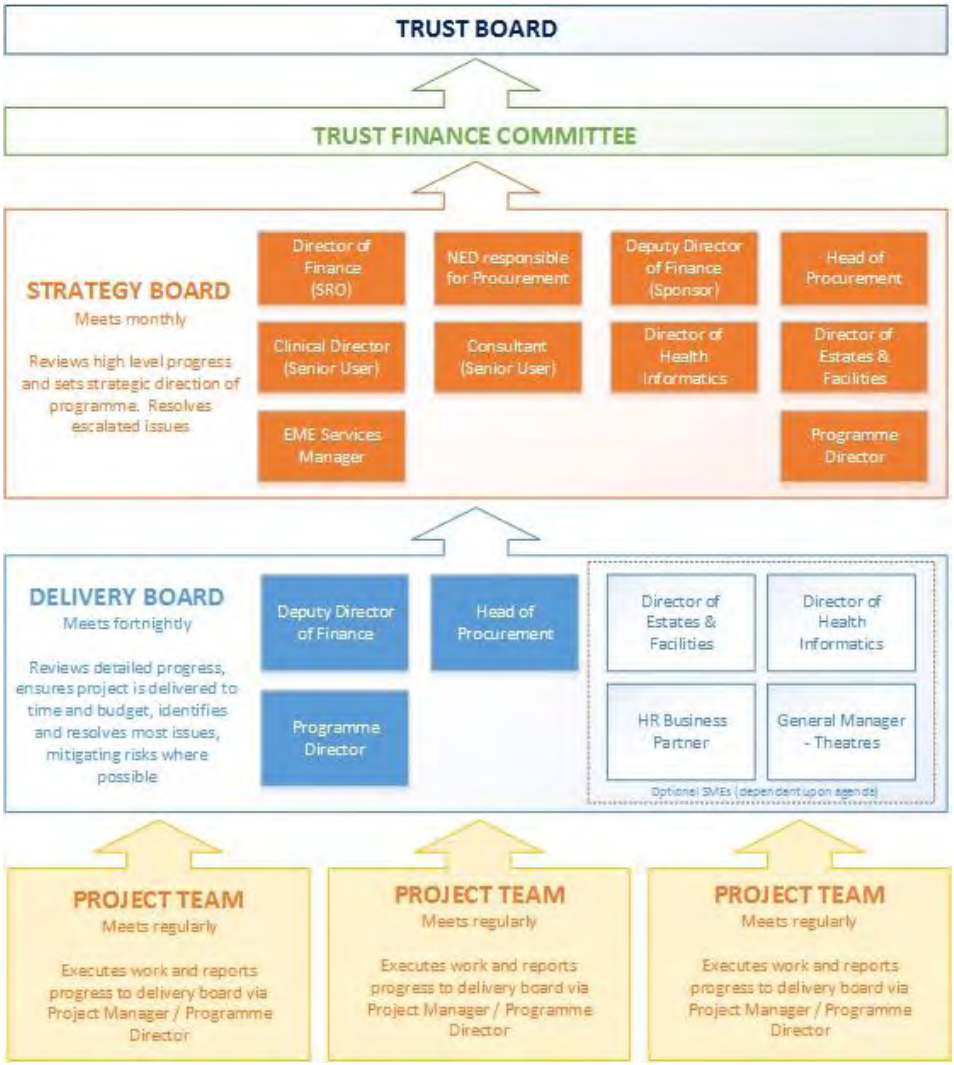

Figure 8 - Programme governance structure

A programme delivery board will meet fortnightly to review detailed progress and to resolve any issues. Key stakeholders will form part of the membership of this board to provide expert knowledge and support.

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Individual project teams will meet on a regular basis as the project requires to execute work packages and update the project and programme managers as to progress. The output of these groups will be reported to the programme delivery board at key milestones and decision gateways.

Programme roles and responsibilities

Role	Responsibilities	Assigned Resource
Senior Responsible Owner / Executive	• Owns vision, direction, integration, results • Leads change • Selects projects • Sets goals and performance expectations • Eliminate barriers • Overall accountability for programme	Director of Finance
Sponsor	• Identifies and scopes projects • Acts as unblocker – obtains project resources • Drives change • Owns change control	Deputy Director of Finance
Programme Assurance	• Ensures benefits are realised • Challenges performance	NED responsible for Procurement Finance Committee Trust Board
Programme Director / Project Managers	• Determines and applies project strategy • Lead and direct teams to execute project • Ensures delivery of project against plan	External Consultants
Process Owner	• Owns business process • Ensures changes are sustained	Head of Procurement
Senior User	• Represents those that will use the service • Specification of benefits	Clinical Director – Trauma & Orthopaedics Consultant Cardiologist
Subject Matter Expert / Supplier	• Support definition of processes • Advise on technical aspects	HR Business Partner Director of Health Informatics Director of Estates & Facilities General Manager – Theatres Chief Pharmacist EME Services Manager

Table 14 - Programme roles and responsibilities

Programme & Project Definition

The programme is made up of 12 discrete projects, defined across the four domains within the National Procurement Standards: Leadership, Partnership, Process and People.

A definition of each project including description, key deliverables, measures for success and timescale is provided as Appendix X.

Maidstone and Tunbridge Wells NHS Trust

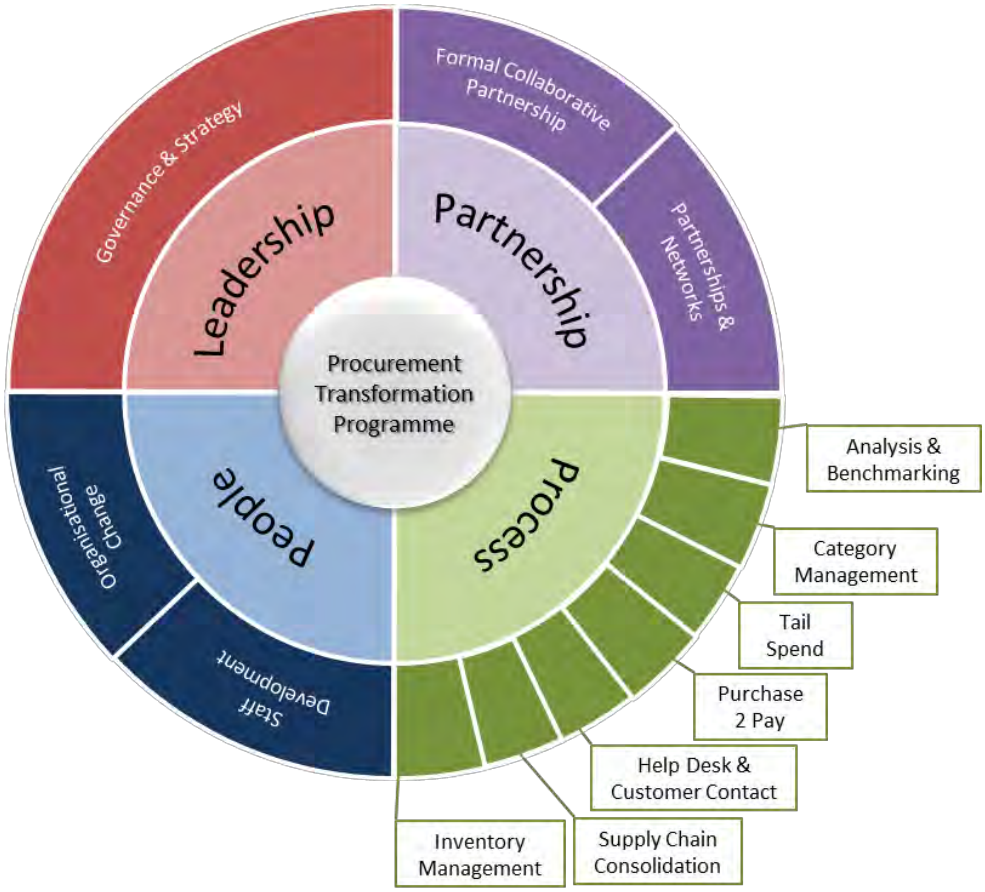


Figure 9 - Programme Definition Wheel

Timetable

The high level project plan is detailed below

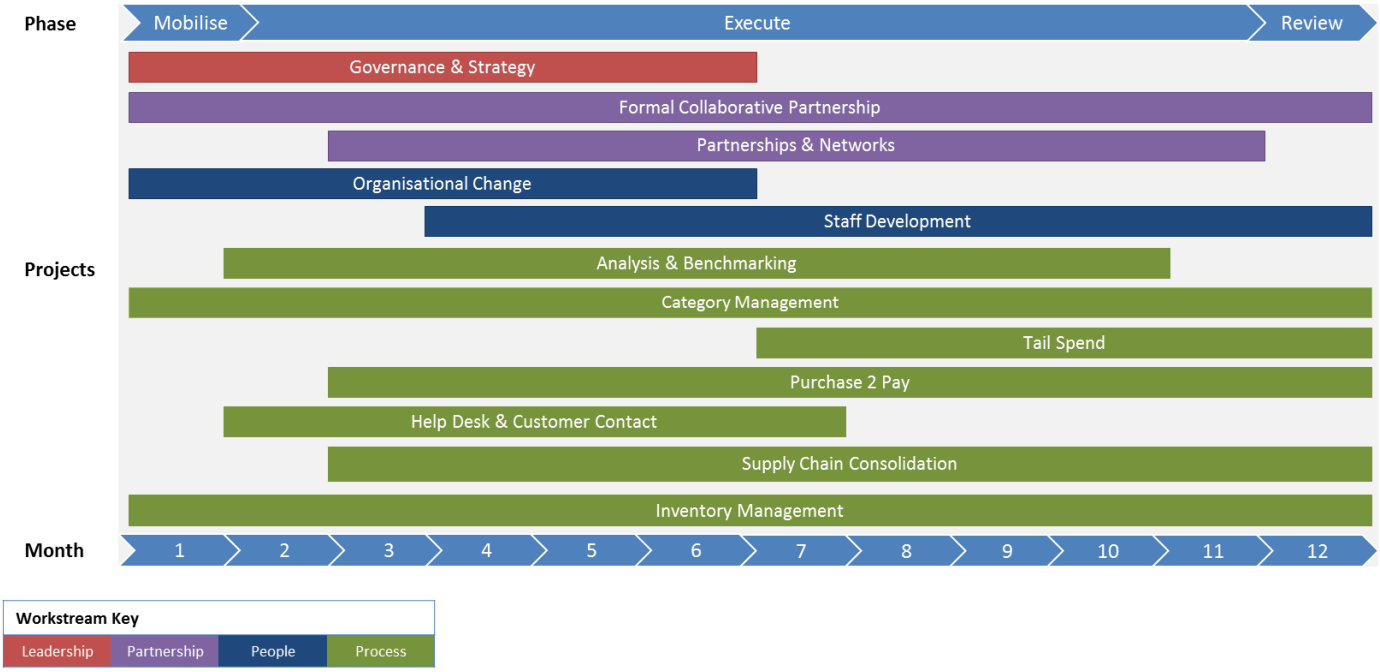


Figure 10 – High level programme timeline

Maidstone and Tunbridge Wells NHS Trust

Business assurance and benefits realisation arrangements

Governance

Under the proposed operating model, the new Procurement service would have a single Procurement Board overseeing the strategy and performance of the partnered function, with 50:50 senior membership from both member Trusts including Executive and Non-Executive Directors responsible for Procurement.

Resources would be allocated based on this board's approval with VETO options on either side for collaborative projects, allowing each partner's resources to work on their own projects where appropriate.

Performance reports would be fed into each partnering Trust's governance structure. For MTW, this would likely take the form of quarterly performance updates to the Finance Committee with a six monthly report to the Trust Board.

Specialist category boards would be established across partners with expert representation from clinical and non-clinical users, ensuring that all decisions are focussed on the service users and the best needs of the patient.

Performance monitoring

The Department of Health has published a standard set of KPI's which form a nationally recognised procurement performance dashboard. This dashboard measures procurement functions against three core domains: "Doing it well", "doing it efficiently" and "doing it right". To support the comparison, the model provides a set of metrics that each organisation measures themselves against: core metrics, strategic metrics and tactical metrics, an example dashboard can be found in appendix XI.

This dashboard will be monitored by the Procurement Board and Trust Finance Committee. It will also feature in a six monthly Trust board update and will include benchmarks against other Trusts' performance. Additionally, category analysis and highlight reports (similar to the one provided in appendix II) will be monitored along with the financial benefits achieved against the procurement category plan.

Arrangements for benefits realisation

Each project will have its own benefits realisation model which will report into an overarching benefit tracking report.

Additionally, the cash releasing benefits will form part of the organisations cost improvement programme (CIP) and will be monitored and verified in line with Trust policy.

Where benefits are likely not to meet expectation, mitigation and alternative arrangements will be commissioned by the Programme Strategy Board.

Change Management

Projects with an organisational change element will follow the Trust's organisational change policy and will be supported by the HR business partner for corporate areas.

Change control for the project will be managed through a formal PRINCE2 process which will be owned by the programme sponsor.

A communications plan will be developed as part of the programme initiation phase which will incorporate a full stakeholder mapping and ensure that all relevant stakeholders are kept informed of changes to the service and progress against the programme.

Staff effected by change projects will be encouraged to be fully involved and in some cases lead the implementation. This will ensure a sense of ownership when the project moves into post implementation and business as usual phases.

Consideration will be given to lessons learnt from previous collaborative projects to reduce the risk of failure and to ensure that common mistakes are not repeated. All partners will be fully informed throughout the process and will be actively involved in decisions.

Maidstone and Tunbridge Wells NHS Trust

Risk management and contingency arrangements

Arrangements for risk management

Risks will be managed through a central programme risk register in line with organisational policy and will be reviewed, depending upon their scoring by the appropriate board:

Risks scoring	Managed by
10 or less (Blue & Green)	Project Team / Programme Manager
Between 11 and 15 (Amber)	Programme Delivery Board
Between 16 and 19 (Red)	Programme Strategy Board
Between 20 and 25 (Red)	Trust Board

Table 15 - Risk management escalation

The programme sponsor is responsible for risk logging and monitoring.

Contingency plans

In the event that this project fails, a fall back to option 1a will be implemented to guarantee the continued delivery of the required services and outputs. Every effort will be made to bring the programme back on track and any change in scope and cost outside of 10% will return to the TME and Finance Committee for further discussion.

Arrangements for post project evaluation

The arrangements for post implementation review (PIR) and project evaluation review (PER) have been established in accordance with best practice and are as follows:

Post implementation review (PIR)

This review ascertains whether the anticipated benefits have been delivered. The review is timed to take place April 2016.

Programme evaluation review (PER)

This review appraises how well the project was managed and whether or not it delivered to expectations. It is timed to take place in April 2016

Maidstone and Tunbridge Wells NHS Trust

Version history

Version	Issue date	Brief Summary of Change	Owner's Name
0.7	11/02/2015	Draft for discussion	David Walach
0.8 – 0.11	13/02/2015	Minor changes to formatting and financials	David Walach / Stuart Doyle
0.12	16/02/2015	Minor changes following Strategy Board review	Procurement Strategy Board
0.13	20/02/2015	Updating of missing information and addition of executive summary	David Walach
1.0	20/02/2015	For review by business case panel and supporting managers	David Walach
1.1 – 1.3	09/03/2015	Updates from reviewers incorporated	David Walach
1.4	11/03/2015	Baseline financials recalculated in line with outturn projections	David Walach / David Shelton
2.0	13/03/2015	Final version	Steve Orpin

Pre- submission checklist

Item	Complete
Completed fully signed business case template	Yes
Revenue breakdown completed	Yes
Capital breakdown completed	Yes
Quality impact assessment completed	Yes
Appendices attached	Yes

Maidstone and Tunbridge Wells NHS Trust

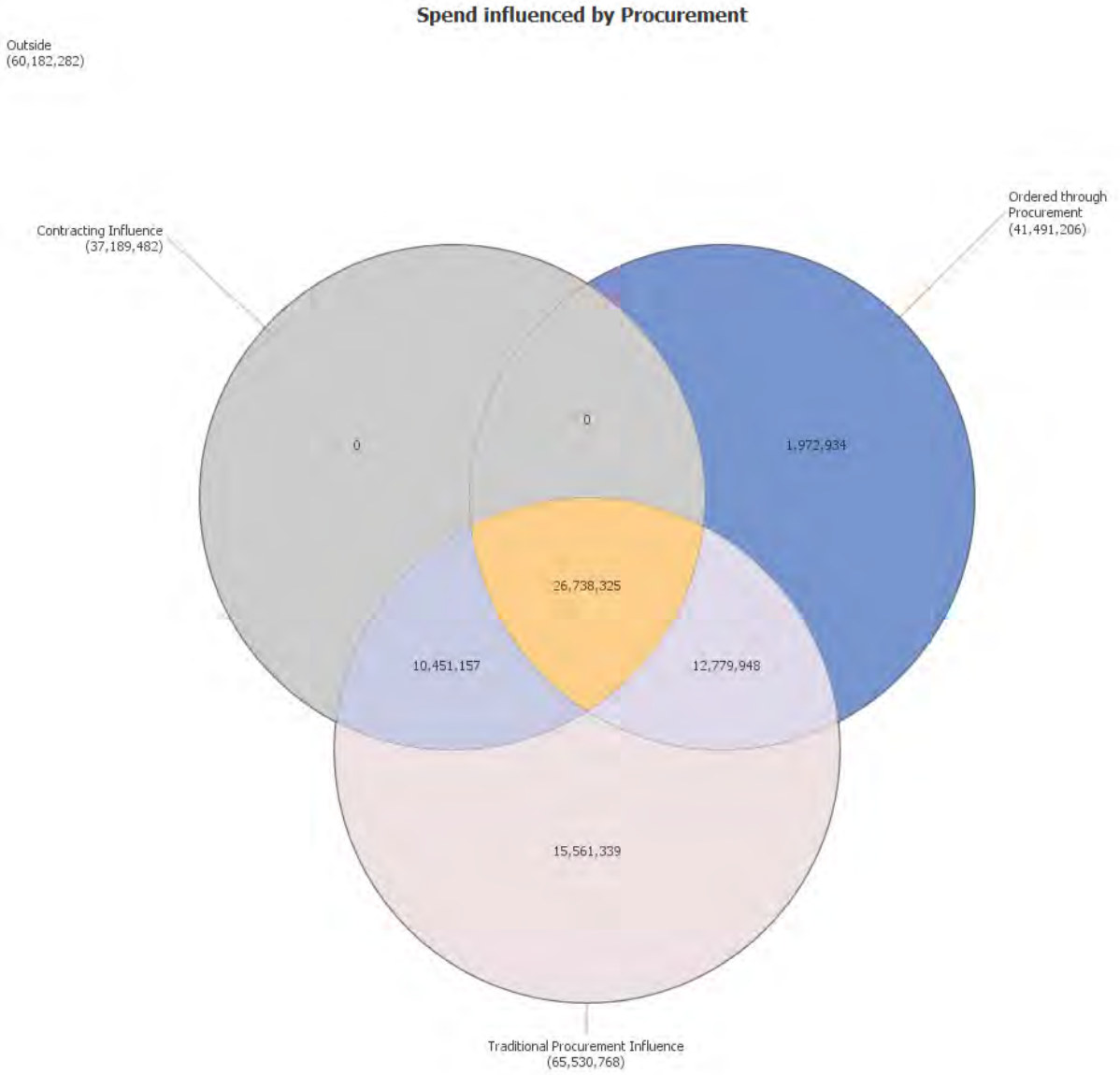
Contents of appendices

Ref	Description	Case
I	Level of current procurement influence	Strategic
II	Example category analysis	Strategic
III	Top 5 scoring risks for each option	Economic
IV	Benefits matrix against standards gap analysis	Economic
V	Partnership selection longlist	Economic
VI	Inventory Management proposal - Avantec	Economic
VII	Organisational chart of proposed structure	Economic
VIII	Detailed cost breakdown	Financial
IX	Quality Impact Assessment	Management
X	Project definitions	Management
XI	Department of Health Procurement dashboard example	Management

APPENDIX I

Level of current procurement influence

The Strategic Case



The above Venn diagram is an analysis of the £128m that MTW spends on Goods and Services annually, mapped against four criteria:

1. **Spend under formal contract** – the proportion of spend that is under a formal contract, competitively tendered by the Procurement function, or accessed via a national or other collaborative contractual agreement. This category is represented by the top left circle
2. **Ordered through procurement** – the proportion of spend that is ordered via the central procurement systems (Marrakech, Bank System, NHS Supply Chain, Shires). This category is represented by the top right circle
3. **Traditional procurement influence** – the proportion of spend that would traditionally be under a centralised procurement functions influence, represented by experience from other Trusts of similar size with a maturity level of 2 or 3 against the National Procurement Standards. This category is represented by the bottom circle
4. **Outside** – the proportion of spend outside any of the three above categories. This includes Pharmaceuticals (managed by Pharmacy), Large scale construction contracts (managed by Estates & Facilities) and NHS to NHS SLA's (Managed by Finance)

The intersections within the Venn diagram show the amount of spend that overlaps. The level of spend under contract that would be expected to be influenced by Procurement is £37.2m (29% of the total). The spend expected to be under contract either traditionally or as it is currently purchased through Procurement's systems is £30.3m (24% of the total). The bulk of the gap includes Agency Staffing (£7.7m), Legal Fees (£2.4m), Management Consultancy (£5.3m) and Medical & Surgical (£3.9m)

APPENDIX II

Example category analysis

The Strategic Case

Category Spend – **Medical & Surgical**

Total spend	£16,597,738
Opportunity	£773,000

Tail indicator:
No of suppliers vs % of spend

80%	90%	95%	Balance	Total
26	58	95	336	431

Observations

- Recent membership to LPP has identified quick wins by migrating contracts for Trauma Orthopaedics and ICD's and Pacemakers without changing supplier. Further work on rationalisation of these ranges would yield further benefit
- The Trust is actively engaged in the TDA's DAP project which should produce significant return
- The product standardisation and rationalisation group has not met for some time despite attempts to restart it. There is a significant opportunity from rationalising ranges, standardising across sites and reducing the use of "premium priced" consumables
- There is limited clinical engagement to drive change amongst peers

Top 10 suppliers

NHS Supply Chain	£4,959,335
St Jude Medical	£1,185,592
Medtronic	£858,480
Johnson & Johnson	£818,681
Stryker	£663,775
Depuy Synthes	£582,908
Covidien Commercial	£549,252
Vygon	£466,454
T.J. Smith & Nephew	£359,283
Olympus Keymed	£345,562

Spend breakdown

Benchmarks	MTW	Benchmark	% saving
PM2160 Pacemaker Endurity DR System	£1,225	£925	25%
FSB976 Administration set for Infusomat Space Pump	£1.70	£1.30	24%
7655405CE Groshong NXT Clearvue PICC Introducer	£122	£90	26%

Opportunities	Targeted spend	Saving	Time to implement
1. Reintroduce product standardisation group	£6,454k	£322k	0-6 months
2. Management for spend with no formal contract	£4,064k	£406k	3-9 months
3. Negotiate cessation or reduction of loaned equipment cost	£2,254k	£45k	0-3 months

APPENDIX II

Top five scoring risks for each option

The Economic Case

Top 5 risk analysis from each option

Risk scores are before mitigation is applied.

Option 0 – Do Nothing

Category	Risk	Score	Potential Mitigation
Financial	Difficult to maintain current benefit level	15	Focus efforts on schemes delivering greatest financial benefit
Strategy	Unable to meet demands of improvement from the centre (DH, Government)	15	Implement changes within current resources
Operational	Difficulty to recruit at current structure	12	Use recruitment agencies, develop internal staff
Operational	Inefficient and labour intensive processes, poor data	12	Reduce value added activity
Operational	Unable to support clinical divisions and meet requirements	8	Improve communication

Option 1a – Fully resourced

Category	Risk	Score	Potential Mitigation
Financial	Vulnerability to Trust financial position – targeted cost reduction before benefits achieved	12	Agreed period of protection from CIP reductions until benefits fully realised
Implementation	Staff focussed on operational pressures rather than the transformation programme	9	Commission external project team to lead transformation programme
Operational	Sustained leadership and development roadmap	9	Clear, defined and published strategy and programme plan
Implementation	Recruitment at the right capability	9	Clearly defined job descriptions. Engage recruitment specialists to source right calibre of staff
Strategy	Perception of inefficient and duplicative approach	8	Strong partnership working. Objective business case.

Option 1b – Formal collaboration

Category	Risk	Score	Potential Mitigation
Financial	Vulnerability to Trust financial position – targeted cost reduction before benefits achieved	12	Agreed period of protection from CIP reductions until benefits fully realised
Implementation	Ability to attract talent	9	Pool of specialist resources. Strong development plan. Clearly defined job descriptions. Engage recruitment specialists to source right calibre of staff.
Implementation	Time to deploy – risk that focus would be diverted and would drag	6	Commission external project team to lead transformation programme
Implementation	A period of transition whilst relationships and trust align	6	Clear terms of reference. Partnered governance. Strong marketing
Strategy	Uncertain future -organisational change and changing health economy	6	Smaller amount of staff pooled and ensure protection within SLA agreement

Option 2 – Shared Service – Full Merge

Category	Risk	Score	Potential Mitigation
Operational	Resources spread could impact on relationships and face to face contact	12	Ensure adequate resources and encourage use of video conferencing
Operational	Locked into inflexible contract	9	Ensure robust SLA with clear performance indicators
Operational	Increased bureaucracy, resulting in slow decisions and risk to benefit realisation	8	Shared priorities and governance. 50/50 relationship. VETO option
Implementation	Different systems results in challenging interface requirements	8	Commission specialist project team and fund interfacing requirements
Strategy	Limited influence over future and direction	6	Strong leadership driving the governance board

Option 3a – Outsource transactional procurement

Category	Risk	Score	Potential Mitigation
Operational	Locked into predefined, inflexible contract	12	Ensure robust contract with clear performance indicators, ensuring flexibility
Financial	Fixed cost of contract, difficult to achieve CIP and drive efficiencies	12	Ensure robust contract with clear performance indicators
Operational	Rigid and defined processes, reducing flexibility	8	Design and agree processes and working practices, identify solutions for inefficient processes
Operational	Slow and costly to change with common needs being a requirement	8	Contingency fund for change requests, strong leadership and contract management
Operational	Ill-informed contract management, poor historical track record	8	Strong contract with clear performance indicators and good contract manager

Option 3b – Outsource full BPO

Category	Risk	Score	Potential Mitigation
Strategy	Locked into predefined, inflexible contract	12	Ensure robust contract with clear performance indicators, ensuring flexibility
Financial	Fixed cost of contract, difficult to achieve CIP and drive efficiencies	12	Ensure robust contract with clear performance indicators
Operational	Rigid and defined processes, reducing flexibility	8	Design and agree processes and working practices, identify solutions for inefficient processes
Operational	Slow and costly to change with common needs being a requirement	8	Contingency fund for change requests, strong leadership and contract management
Operational	Ill-informed contract management, poor historical track record	8	Strong contract with clear performance indicators and good contract manager

APPENDIX IV

Benefits matrix against standards gap analysis

The Economic Case

Filling the gaps in the Procurement Standards

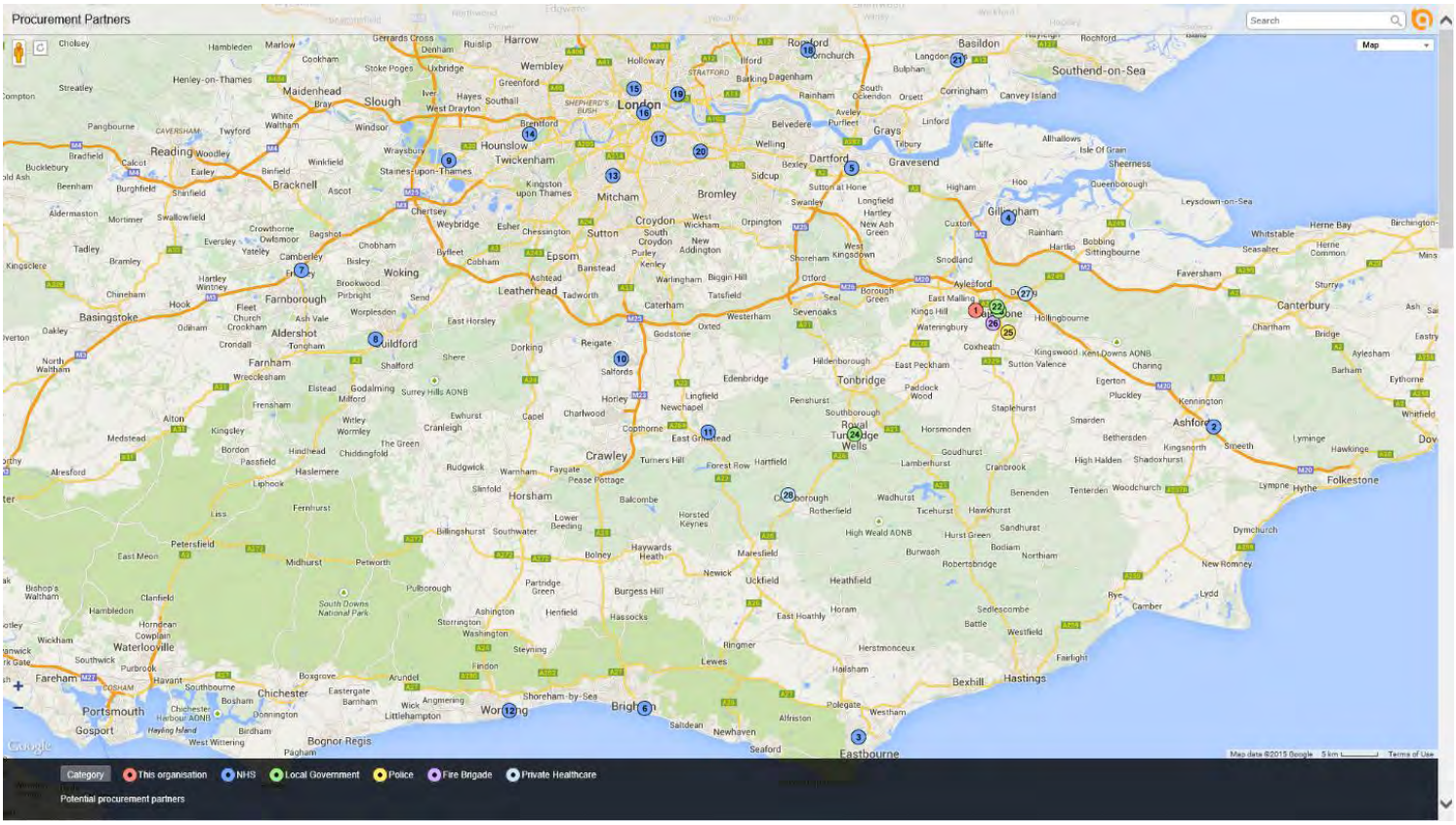
Domain	Requirement	Do Nothing	Build Your Own		Shared Service	Outsource	
		0	1a	1b	2	3a	3b
Leadership	Developed and published strategy	✓	✓	✓	✓	✓	✓
	Co-developed strategy with board leads	✓	✓	✓	✓	✓	✓
	Procurement KPIs and objectives reviewed by board	✓	✓	✓	✓	✓	✓
	Key category and progress reports reviewed regularly by board	✗	✓	✓	✓	✓	✓
	Advertising of opportunities at all levels of spend	✗	✓	✓	✓	✗	✗
	Regular benchmarking of prices with other organisations	✓	✓	✓	✓	✓	✓
Partnership	Contribute to national networks	✗	✓	✓	✓	✓	✓
	Pooling of resources	✗	✗	✓	✓	✓	✓
	Structured working with procurement partners including commitment	✓	✓	✓	✗	✓	✓
	Structured supplier appraisal with key suppliers	✗	✓	✓	✓	✓	✓
	Contract management implemented across all contracts	✗	✓	✓	✓	✓	✓
	Joint supplier meetings / seminars with structured objectives	✗	✓	✓	✓	✓	✓
	Procurement documents streamlined	✗	✓	✓	✓	✓	✓
	Use of once only tools e.g. SID4GOV	✗	✓	✓	✓	✓	✓
	Routine capturing of monitoring data from “encouraged enterprises”	✗	✓	✓	✓	✓	✓
People	Procurement focussed training for all users	✗	✓	✓	✗	✓	✗
	Procurement staff able to engage with senior stake holders	✗	✓	✓	✓	✓	✓
	3 year plan of procurement activity matches to skills and resources	✓	✓	✓	✓	✓	✓
	Stakeholder user groups In place	✗	✓	✓	✓	✓	✓
	Defined programme and processes for internal stakeholder management	✗	✓	✓	✓	✓	✓
	Initiatives to measure performance of engagement	✗	✓	✓	✓	✓	✓
Process	Action plan for adoption of GS1	✗	✓	✓	✓	✓	✓
	eProcurement action plan being executed	✗	✓	✓	✓	✓	✓
	eProcurement system transacting significant spend based on GS1 standards	✗	✓	✓	✗	✗	✗
	Significant use of exchange services	✗	✓	✓	✗	✓	✓
	Category management and processes in place	✗	✓	✓	✓	✓	✓
	Programme and project management in place	✗	✓	✓	✓	✓	✓

Domain	Requirement	Do Nothing	Build Your Own		Shared Service	Outsource	
	Specifications and decisions made by clinical category groups	✗	✓	✓	✗	✓	✓
	Sustainable development incorporated into Procurements	✗	✓	✓	✓	✓	✓
	Off contract spend identified and plans in place to address	✗	✓	✓	✓	✓	✓
	Detailed non pay data captured by category and analysed using a BI tool	✗	✓	✓	✓	✓	✓
	Systems to ensure internal prices are consistent and variances addressed	✗	✓	✓	✓	✓	✓
	Expenditure data mapped to activity for demand planning	✗	✓	✓	✓	✓	✓
	Systems enable active management of inventory	✗	✓	✓	✗	✗	✗
	Quantified wastage and stock write-offs	✗	✓	✓	✗	✗	✗
Independent review recommendations	Defined service based on Strategic, Transactional and Operational	✗	✓	✓	✓	✓	✓
	Management of Receipt & Distribution and Materials Management functions	✗	✓	✓	✓	✓	✗
	Select and implement Patient Level Inventory and Costing System	✗	✓	✓	✗	✗	✗
	Extend materials management service to all regularly used consumables	✗	✓	✓	✓	✓	✗
	Consider supply chain consolidation	✗	✓	✓	✓	✓	✗
	Development of robust category plans based on spend data, market intelligence and output from contract management system	✗	✓	✓	✓	✓	✓
	Development framework for procurement professionals to train and progress through the organisation	✗	✓	✓	✓	✗	✗

APPENDIX V

Partner longlist

The Economic Case



	Potential Partner	Within 40 miles	Similar organisation	EOI	Shortlisted
2	East Kent University Hospitals NHS FT	✓	✓	✓	✓
3	East Sussex Hospitals NHS Trust	✓	✓	✓	✓
4	Medway NHS FT	✓	✓	✓	✓
5	Dartford & Gravesham NHS Trust	✓	✓	✓	✓
6	Brighton & Sussex University Hospitals NHS Trust	×	✓	×	×
7	Frimley Health NHS Trust	×	✓	×	×
8	Royal Surrey County Hospital NHS Trust	×	✓	×	×
9	Ashford & St Peters NHS Trust	×	✓	×	×
10	Surrey & Sussex Healthcare NHS Trust	✓	✓	×	×
11	Queen Victoria Hospital NHS Trust	✓	×	×	×
12	Western Sussex Hospitals NHS Foundation Trust	×	✓	×	×
13	St Georges Healthcare NHS Trust	✓	✓	×	×
14	West Middlesex NHS Trust	✓	✓	×	×
15	University College London Hospitals NHS FT	✓	✓	✓	✓
16	Guy's & St Thomas' NHS FT	✓	✓	×	×
17	King's college Hospital NHS FT	✓	✓	×	×
18	Barking, Havering & Redbridge NHS Trust	✓	✓	✓	✓
19	Barts Health NHS Trust	✓	✓	×	×
20	Lewisham Healthcare NHS Trust	✓	✓	×	×
21	Basildon & Thurrock UH NHS FT	✓	✓	×	×
22	Kent County Council	✓	×	×	×
23	Maidstone Borough Council	✓	×	×	×
24	Tunbridge Wells Borough Council	✓	×	×	×
25	Kent Police	✓	×	×	×
26	Kent Fire Brigade	✓	×	×	×
27	Horder Centre	✓	×	×	×
28	Kent Institute of Medicine & Surgery (KIMS)	✓	×	×	×
29	Croydon Health NHS Trust	✓	✓	×	×

APPENDIX VI

Inventory Management Proposal

Avantec

The Economic Case

Avantec®
Omnicell Systems

Driving down hospital costs
Driving up service to patients

Maidstone and Tunbridge Wells Foundation Trust

Inventory Management Systems Proposal

12th January 2015

- **Total Control of Supplies**
- **Powerful data and patient costing**
- **Advanced Medicines Management**
- **Systems design and consulting**

Contents

Doc Ref: MTW IMS Proposal SB120115v1

Prepared by Steven Bateson

1. Avantec Solutions

Introduction

Omnicell systems are used in over 3000 hospitals around the world and in 75 NHS hospitals. Avantec are the exclusive suppliers of Omnicell systems to NHS hospitals. We offer a range of intelligent systems for managing medicines and supplies around the hospital.

Our automated inventory management systems for supplies include closed cabinet systems and open scanning systems for live inventory tracking and patient costing, as well as top-up systems for lower cost consumables. All these systems feed into one central Omnicell server which is integrated with your hospital systems.

Cabinets

Open Systems

Top-up and patient costing systems

This range of systems is designed to meet the needs of every department, every store room and every product range, providing an integrated system within the Trust that operates across multi-sites and interfaces with existing Trust systems in order to streamline operational efficiency.

Benefits

- Stock reduction & demand planning
- Consumption reduction
- Staff time savings
- Patient costing
- Comprehensive data to drive further savings

Cabinet Systems

The cabinets are available in 1,2,3 and half-cell sizes. They are modular and completely reconfigurable. System options include fingerprint ID, catheter racks, suture racks and supply drawers. We also have RFID cabinets for use with RFID tagged high cost supplies. Both our open systems and cabinet systems offer real-time inventory tracking with patient costing.

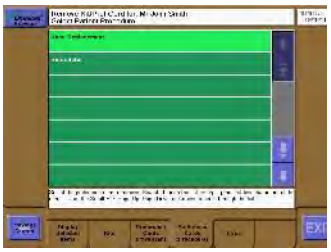
Open Systems

OpenCT and casePick – touch screen PC with wireless scanner & PDA

OpenCT is the Omnicell open system solution being used in departments across the NHS. Transactions can be recorded by scanning with a wireless scanner or interactively through the touch screen. casePick adds our wireless PDA functionality to OpenCT, allowing multiple users to issue items at the same time. This is ideal for large central stores and case picking. Both our open systems and cabinet systems offer real-time inventory tracking with patient costing.

System Features

The open and closed systems have many features and options including lot/serial number and expiry tracking and picking and case preference cards.



Open or Closed?

Choosing the right blend of open and closed systems is a very important decision that goes far beyond the upfront cost of each system.

Often open systems struggle to achieve a suitable level of compliance, requiring – often costly and time consuming – workarounds such as locked or manned stores, relocating everything to a central store or even CCTV, whilst some areas are left completely uncontrolled. Cabinet systems act as your storeroom, store man and inventory management system all in one and can be placed in as many locations as you need, giving secure access to all authorised staff 24/7.

When considering the true cost and value of open v closed systems you should not only consider the initial system and implementation costs (as well as ongoing license and maintenance costs), but also the ongoing costs of additional store rooms, additional stores/mm staff, reduced stock and spend savings, other shelving/storage you need to buy and also any operational and clinical impact of having stock located to suit the system and not where it is required clinically.

The optimal inventory management solution comes from a mix of open and closed solutions that deliver the best long term value and operational efficiency and improves patient care. Only Omnicell offers the full range of flexible solutions with open, closed and top-up systems.

Patient Costing Systems

***patCost* – handheld or web-browser terminal with scanner (colour touch screen)**

The Avantec 'patCost' application allocates costs to a patient's account as and when chargeable items are used in the patient's treatment. This can be used as a stand-alone product or in conjunction with other Omnicell systems where it is not possible to issue to a patient in the store.

Transactions be recorded from any device with a web browser as well as our dedicated app on the Avantec PDA. patCost also records batch/serial and expiry information via a barcode scanner.

Top-up Systems

rePlenish

The 'rePlenish' system is a PDA barcode scanner used for top-up in high volume low cost stock areas, e.g. wards and bulk low cost items. The user simply scans the room location and item's product or shelf barcode to order. rePlenish works in 3 modes – KanBan, 'quantity on hand' and 'quantity to order' giving hospitals full control over the process and providing the flexibility to be used across different departments. RePlenish combines with a web based application to then manage and process orders.

RFID Kanban

Our RFID Kanban top-up systems utilise either a RDIF panel or mailbox with supplies in bins configured for Kanban (i.e. stock split between 2 bins). When a Kanban bin is empty the user simply puts the RFID tag into the mailbox or panel. This triggers the replenishment order. With the panel, the system also confirms the restock when the restocker moves the tag from the panel back to the bin. RFID Kanban system eliminates the need for top-up counts saving more staff time.

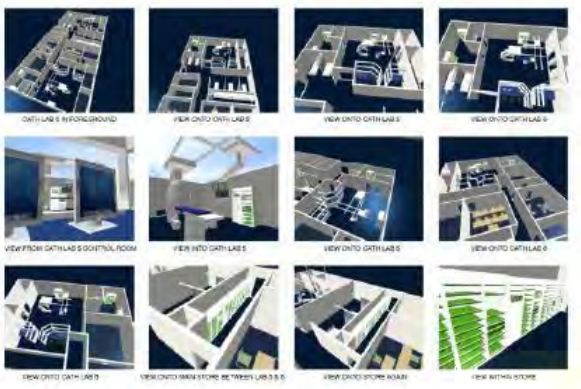
GS1

Omnicell is a GS1 Solution Associate. Omnicell systems can manage GTINs and GLNs as well as scan all types of GS1 barcodes including expiry date and lot and serial numbers. This supports the NHS Procurement Development Programme and E-procurement strategy which are driving the adoption of GS1 coding standards across the NHS.

System Design and Implementation

System Design

The comprehensive range of open, closed and top-up systems combine to offer great flexibility for almost any clinical or store area whilst supporting many different operational and clinical workflows.



The systems can be used in variety of ways, for example in a store room model, possibly incorporating dedicated case picking, whilst it is also possible to have systems right at the point of use in theatres, labs, prep rooms and anaesthetic rooms to track real-time usage, and any combination thereof.

The system design for any hospital and department is based on many factors but ultimately is about delivering best value i.e. delivering the maximum benefits and savings for the least cost. Different systems will deliver different levels of benefits and have different costs. The right

blend of systems will ensure savings from stock reduction, consumption reduction and staff time are maximised, whilst delivering accurate patient costing and other management data.
From brochure

Implementation

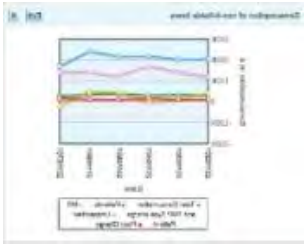
We don't just sell you a system. Our experienced sales and project teams work closely with you to design lean processes combined with the right blend of systems in the right locations to ensure the system is easy to use yet effective so you achieve the most from your system and maximise your return on investment.

You will be assigned a dedicated Project Manager for the duration of your project and our project teams have experience of installing nearly 1000 systems in 75 UK hospitals – from a single system to hospital-wide implementations - which brings with it unrivalled knowledge of almost every type of hospital department and the specific requirements and challenges of each. We use recognised project methodologies and software such as Prince 2 and Microsoft Project.

Management Information System

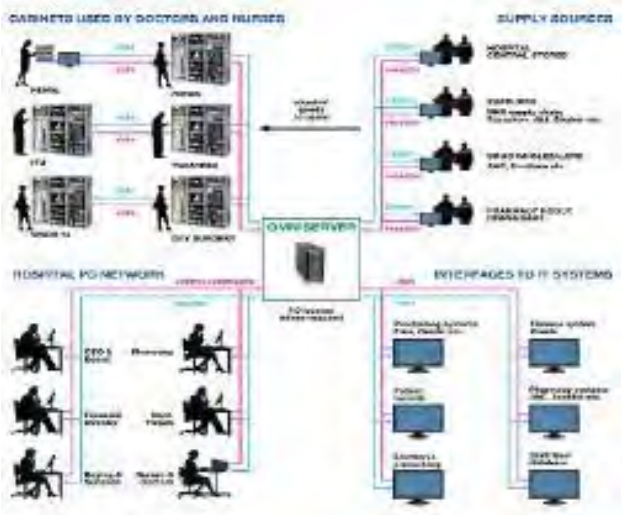
Reporting

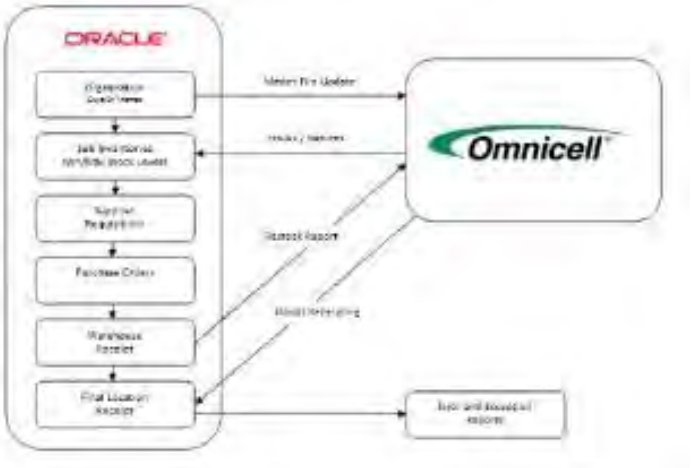
Omnicell uses an SQL database and has a comprehensive range of reporting options. This includes over 100 standards reports, a custom report writer and our optimisation and KPI suite, InSight.



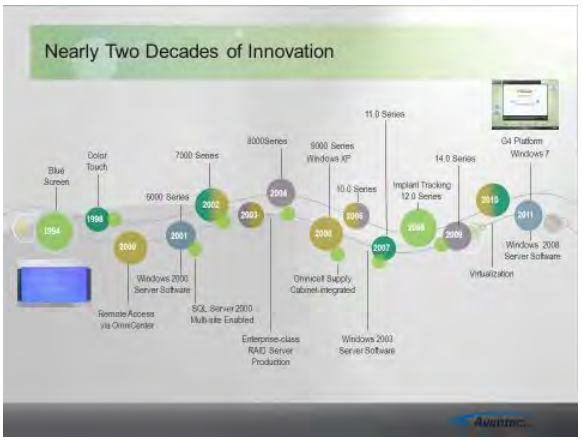
Integration

The Omnicell solution provides one fully integrated database that is fed by all open and closed data capture systems within the hospital. Omnicell is designed to integrate with your existing hospital systems. We typically interface with your purchasing and finance system, patient administration systems, theatre management systems, patient costing system and data warehouse.





Innovation



The Omnicell product has been developed and refined over the last 22 years to become one of the world's leading healthcare IMS systems. Omnicell is currently running the 18th iteration of the management software and the hardware is continually being developed to keep abreast of the latest security and technologies.

Avantec have development complimentary systems for use within the NHS. We are now in the unique position of being able to offer a complete product portfolio of both open and closed systems (hand scanners, open systems, secure cabinets, RFID systems and software solutions) that can manage the full complement of medicines and supplies within the Hospital/Trust environment.

Quality

We take quality seriously and aim for the highest standards in both hardware and software as well as implementation and ongoing service and support. Our own solutions have been developed to high quality standards over 20 years and we use the highest quality third party products from suppliers such as Apple, Microsoft and Motorola. These are some of the reasons why over 3000 Hospitals, including 75 NHS Trusts have chosen Avantec and Omnicell:

- Over 20 years' experience
- Market leader - in over 75 NHS Trusts
- Project teams experienced in many NHS installations
- Full range of systems – open, closed, top-up
- UK-wide 24/7/365 support
- Existing, live interfaces with most NHS systems inc SBS, Oracle, ABS, Integra, Cerner

- UK product development
- Turnkey implementation – one price, no ongoing license costs
- Your long term partner

2. Your inventory system solution

Avantec's fully integrated Omnicell IMS solution offers a range of closed, open and top-up systems which combine to deliver a bespoke solution to fully support each department's needs within the hospital.

Based on the information given in the 'site data', we have proposed some solutions for each of the departments within each phase. However, there are many permutations of system design using the right blend of open, closed and top-up systems. Furthermore, each of these solutions needs to be fully considered, taking into account available store rooms and physical space, operational and process review, clinical requirements, materials management resource and processes, clinical resource and processes and pros and cons of each system type e.g. compliance levels, storage capacity, system costs and system benefits.

We have for the purpose of this submission, offered a mixed solution that provides Omnicell cabinets for holding and managing high value items, whilst lower value and bulk items are to be managed with a top-up system. Patient costing has been included using the patCostWeb system in each theatre to track item and kit usage.

Other variations, including the use of RFID systems can also be included following further discussions.

We would urge the Trust to discuss the pricing options with us before concluding their evaluation.

Client objectives

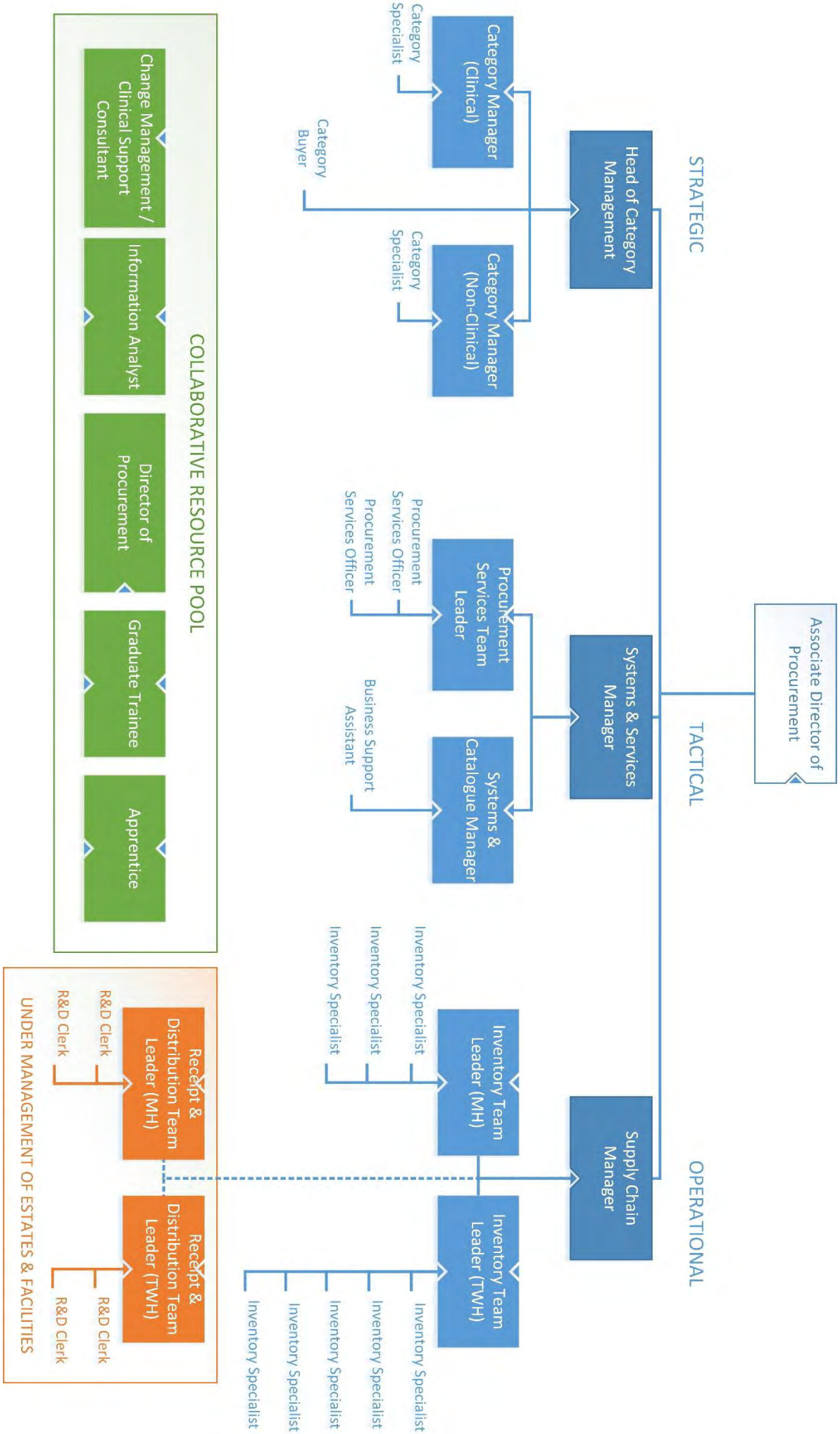
The installation of a materials management system will be required to address the following objectives:

1. Reduce the level of stock, by £500k
2. Free up theatre staff time
3. Improve the usage data usage and procurement traceability data
4. Manage inventory and control more timely
5. Improve the security of stock
6. Provide patient costing and tracking of lot numbers 7. Gain control and manage all inventory in one place.

APPENDIX VII

Organisational chart of proposed structure

The Economic Case


STRATEGIC
TACTICAL
OPERATIONAL
Associate Director of Procurement
Head of Category Management
Systems & Services Manager
Supply Chain Manager
Category Manager (Clinical)
Category Manager (Non-Clinical)
Category Specialist
Category Specialist
Category Buyer
Procurement Services Team Leader
Systems & Catalogue Manager
Procurement Services Officer
Procurement Services Officer
Business Support Assistant
Inventory Team Leader (MH)
Inventory Team Leader (TWH)
Inventory Specialist
Inventory Specialist
Inventory Specialist
Inventory Specialist
Inventory Specialist
Inventory Specialist
Inventory Specialist
Receipt & Distribution Team Leader (MH)
Receipt & Distribution Team Leader (TWH)
R&D Clerk
R&D Clerk
R&D Clerk
R&D Clerk
UNDER MANAGEMENT OF ESTATES & FACILITIES
COLLABORATIVE RESOURCE POOL
Change Management / Clinical Support Consultant
Information Analyst
Director of Procurement
Graduate Trainee
Apprentice

APPENDIX VIII

Detailed cost breakdown

The Financial Case

Detailed Revenue Financials

£000	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Comments
Pay Expenditure							
Band 8D	0.00	(11.00)	(44.00)	(44.00)	(44.00)	(44.00)	0.5 WTE - 1 role shared partner
Band 8C	0.00	(36.58)	(73.16)	(73.16)	(73.16)	(73.16)	1 WTE
Band 8B	(69.95)	(83.83)	(91.45)	(91.45)	(91.45)	(91.45)	1.5 WTE - 1 role shared with partner
Band 8A	0.00	(90.40)	(154.97)	(154.97)	(154.97)	(154.97)	3 WTE
Band 7	(33.21)	(151.57)	(173.22)	(173.22)	(173.22)	(173.22)	4 WTE
Band 6	(122.10)	(22.57)	(36.12)	(36.12)	(36.12)	(36.12)	1 WTE - 2 roles shared with partner
Band 5	(191.60)	(114.95)	(114.95)	(114.95)	(114.95)	(114.95)	4 WTE
Band 4	(157.62)	(245.96)	(268.96)	(268.96)	(268.96)	(268.96)	12 WTE
Band 3	0.00	(21.23)	(21.23)	(21.23)	(21.23)	(21.23)	1 WTE
Band 2	(73.18)	(80.05)	(82.33)	(82.33)	(82.33)	(82.33)	4.5 WTE - 1 role shared with partner
Sub Total Pay	(647.66)	(858.14)	(1,060.39)	(1,060.39)	(1,060.39)	(1,060.39)	
Non-Pay Expenditure							
Systems							
Purchase To Pay System	(43.09)	(43.09)	(43.09)	(43.09)	(43.09)	(43.09)	Assumed new service at same or lower cost
Catalogue & Exchange System	0.00	(19.80)	(19.80)	(19.80)	(19.80)	(19.80)	Assumed GHX system
eSourcing System	0.00	0.00	0.00	0.00	0.00	0.00	Assumed LPP ProContract System
eRFQ System	0.00	(7.50)	(7.50)	(7.50)	(7.50)	(7.50)	Assumed Multiquote System
Analytics & Benchmarking Service	0.00	0.00	0.00	0.00	0.00	0.00	Assumed LPP PI System
Patient Level Inventory Management System	0.00	0.00	(49.00)	(49.00)	(49.00)	(49.00)	Assumed Avantec System
Portal (Help Desk) System	0.00	0.00	(18.00)	(18.00)	(18.00)	(18.00)	Assumed Noesis Cloud System
Partners							
Dartford & Gravesham NHS Trust	13.79	0.00	0.00	0.00	0.00	0.00	Removal of shared HOP resource
NHS Commercial Solutions (Pharmacy)	(14.93)	(14.93)	(14.93)	(14.93)	(14.93)	(14.93)	
NHS London Procurement Partnership	(38.00)	(38.00)	(38.00)	(38.00)	(38.00)	(38.00)	Annual increase in fees unknown
Other Expenses							
Overhead (IT Support)	(1.50)	(2.93)	(2.93)	(2.93)	(2.93)	(2.93)	Assumed £90 per WTE based on current cost
IT Equipment / Telephones	(1.20)	(13.68)	(13.68)	(13.68)	(13.68)	(13.68)	Mobile rental and call cost based on £16 per month per person
Training & Development	(6.92)	(48.75)	(48.75)	(48.75)	(48.75)	(48.75)	Assumed £1,500 per WTE
Travel & Subsistence	(1.00)	(7.82)	(7.82)	(7.82)	(7.82)	(7.82)	Based on average £711 (Radiotherapy) joint working with EK. Subject to change based on selected partner
Stationery	(2.80)	(4.45)	(4.45)	(4.45)	(4.45)	(4.45)	Based on average spend per WTE in baseline (£137)
Uniforms	(0.40)	(0.80)	(0.80)	(0.80)	(0.80)	(0.80)	Based on average spend per operational WTE in baseline (£50)
Document Storage	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	(0.50)	
Project costs	0.00	(260.00)	0.00	0.00	0.00	0.00	Assumed Waltec Solutions project support
Sub Total Non-Pay	(96.55)	(462.25)	(269.25)	(269.25)	(269.25)	(269.25)	
Capital Charges							
Depreciation	0.00	(49.75)	(70.95)	(70.95)	(70.95)	(70.95)	Computer equipment deprecating over 5 years. Inventory management phased across 2 years, depreciating over 10 years
PDC Charge	0.00	(14.84)	(20.14)	(17.66)	(15.18)	(12.69)	3.5% charge of capital assets
Sub Total Capital Charges	0.00	(64.59)	(91.09)	(88.61)	(86.13)	(83.64)	
Total Expenditure	(744.21)	(1,384.98)	(1,420.73)	(1,418.25)	(1,415.77)	(1,413.28)	
Benefits - CIP							
Cost Improvement	900.00	698.00	452.00	2,000.00	3,150.00	3,150.00	
Increasing influence	0.00	390.00	736.00	1,076.00	0.00	0.00	
Standardisation & rationalisation	0.00	310.00	132.00	160.00	300.00	300.00	
Inventory & wastage	0.00	130.00	430.00	40.00	50.00	50.00	
Filling the contract gap	0.00	115.00	406.00	20.00	0.00	0.00	
Total Benefits - CIP	900.00	1,643.00	2,156.00	3,296.00	3,500.00	3,500.00	
Net Benefit (Cost)	155.79	258.02	735.27	1,877.75	2,084.23	2,086.72	

Detailed Capital Financials

Capital Purchase	Value	Life	Salvage Value
Inventory Management System - Phase 1	(400.00)	10	0.00
Inventory Management System - Phase 2	(212.00)	10	0.00
Mobile Computer Equipment	(48.75)	5	0.00

£000	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10
Inventory Management - Phase 1										
Depreciation	(40.00)	(40.00)	(40.00)	(40.00)	(40.00)	(40.00)	(40.00)	(40.00)	(40.00)	(40.00)
Opening Value	(400.00)	(360.00)	(320.00)	(280.00)	(240.00)	(200.00)	(160.00)	(120.00)	(80.00)	(40.00)
Closing Value	(360.00)	(320.00)	(280.00)	(240.00)	(200.00)	(160.00)	(120.00)	(80.00)	(40.00)	0.00
Capital Charge	(13.30)	(11.90)	(10.50)	(9.10)	(7.70)	(6.30)	(4.90)	(3.50)	(2.10)	(0.70)
Inventory Management - Phase 2										
Depreciation	0.00	(21.20)	(21.20)	(21.20)	(21.20)	(21.20)	(21.20)	(21.20)	(21.20)	(21.20)
Opening Value	0.00	(212.00)	(190.80)	(169.60)	(148.40)	(127.20)	(106.00)	(84.80)	(63.60)	(42.40)
Closing Value	0.00	(190.80)	(169.60)	(148.40)	(127.20)	(106.00)	(84.80)	(63.60)	(42.40)	(21.20)
Capital Charge	0.00	(7.05)	(6.31)	(5.57)	(4.82)	(4.08)	(3.34)	(2.60)	(1.86)	(1.11)
Mobile Computer Equipment										
Depreciation	(9.75)	(9.75)	(9.75)	(9.75)	(9.75)	0.00	0.00	0.00	0.00	0.00
Opening Value	(48.75)	(39.00)	(29.25)	(19.50)	(9.75)	0.00	0.00	0.00	0.00	0.00
Closing Value	(39.00)	(29.25)	(19.50)	(9.75)	0.00	0.00	0.00	0.00	0.00	0.00
Capital Charge	(1.54)	(1.19)	(0.85)	(0.51)	(0.17)	0.00	0.00	0.00	0.00	0.00
Totals										
Depreciation	(49.75)	(70.95)	(70.95)	(70.95)	(70.95)	(61.20)	(61.20)	(61.20)	(61.20)	(61.20)
Capital Charge	(14.84)	(20.14)	(17.66)	(15.18)	(12.69)	(10.38)	(8.24)	(6.10)	(3.96)	(1.81)
Grand Total	**(64.59)**	**(91.09)**	**(88.61)**	**(86.13)**	**(83.64)**	**(71.58)**	**(69.44)**	**(67.30)**	**(65.16)**	**(63.01)**

APPENDIX IX

Quality Impact Assessment

The Management Case

Quality Impact Assessment	*The Management Case*
Clinical Effectiveness	
Have clinicians been involved in the service redesign? If yes, list who.	
Guy Slater, Clinical Director for Trauma & Orthopaedics and Scott Takeda, Consultant Cardiologist have both agreed to be clinical leads on the Procurement Strategy Board	
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)	
Yes, Department of Health Procurement Strategy, Better Procurement, Better Value, Better Care	
Are relevant Clinical Outcome Measures already being monitored by the Directorate? If yes, list. If no, specify additional outcome measures where appropriate.	
N/A	
Are there any risks to clinical effectiveness? If yes, list	
Yes, there is a risk that inefficient inventory management practices could result in products being unavailable to treat patients	
Have the risks been mitigated?	
Yes, one of the projects in the programme addresses inventory management	
Have the risks been added to the departmental risk register and a review date set?	
Yes – risks have been logged in the programme register and will be managed as detailed in the management case	
Are there any benefits to clinical effectiveness? If yes, list	
Streamlined, automated processes, increasing available time to spend on direct patient interaction	
Patient Safety	
Has the impact of the change been considered in relation to:	
Infection Prevention and Control?	Y - Reduced inventory levels in clinical areas (gathering dust, which acts as locus for infection)
Safeguarding vulnerable adults/ children?	N/A
Current quality indicators?	N/A
Quality Account priorities?	N/A
CQUINS?	N/A
Are there any risks to patient safety? If yes, list	
Yes, there is a risk that inefficient inventory management practices could result in products being unavailable to treat patients	
Have the risks been mitigated?	
Yes, one of the projects in the programme addresses inventory management	
Have the risks been added to the departmental risk register and a review date set?	
Yes – risks have been logged in the programme register and will be managed as detailed in the management case	
Patient experience	
Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not.	
Yes	
Has the impact of the change been considered in relation to: • Promoting self-care for people with long-term conditions? • Tackling health inequalities?	
N/A	
Does the redesign lead to improvements in the care pathway? If yes, identify	

Reduces risk of stock being unavailable. Correct products and services used that meet the need of the service
Are there any risks to the patient experience? If yes, list
None
Have the risks been mitigated?
N/A
Have the risks been added to the departmental risk register and a review date set?
N/A
Are there any benefits to the patient experience? If yes, list
Less clutter in corridors/ with inventory monitored less chance of cancelled procedures
Equality & Diversity
Has the impact of redesign been subject to an Equality Impact Assessment?
Yes
Are any of the 9 protected characteristics likely to be negatively impacted? (If so, please attach the Equality Impact Assessment)
No
Has any negative impact been added to the departmental risk register and a review date set?
No
Service
What is the overall impact on service quality? – please tick one box

Improves quality	✓	Maintains quality		Reduces quality	

APPENDIX X

Project definitions

The Management Case

Workstream	Leadership
Project	**Governance and Strategy**
Description	Implement a robust, stakeholder led governance structure for procurement, encapsulating a clear Procurement strategy for the organisation which is well communicated to staff and suppliers.
Owner	Associate Director of Procurement

Deliverables / Products	• Programme / strategy branding
	• Procurement Strategy Board
	• Category Boards
	• Defined performance measures and dashboards
	• Regular information reporting to finance committee (quarterly) and board (annually)
	• Accreditation and recognition of success (awards)
	• Published procurement strategy including:
	  ○ How we support customers
	  ○ How we engage markets
	  ○ Sustainable development (environmental, social, economic, encouraged enterprises)
	  ○ eProcurement strategy
	  ○ How we measure ourselves
	  ○ Service and cost improvement schemes

Measures for success	• Level of awareness of programme • Defined performance measures aligned to National, Trust and Directorate priorities • Clinicians driving procurement decisions • Clear direction for customers, suppliers & staff
Duration	6 months

Workstream	Partnership
Project	**Formal Collaborative Partnership**
Description	There is significant duplication between NHS organisations competing for scarce resources, with non-standardised processes. The Trust is seeking a formal collaborative partner to pool specialist resources and follow common systems & processes under a unified Procurement strategy
Owner	Deputy Director of Finance / Associate Director of Procurement
Deliverables / Products	• Collaborative partner • Pooled resources • Standard and common processes • Unified Procurement Strategy • Single governance structure
Measures for success	• All deliverables met
Duration	12 months

Workstream	Partnership
Project	**Partnerships and Networks**
Description	The NHS has colossal purchasing power, spending £20bn each year on goods and services. MTW spends £128m each year and purchases the same, or similar items to other Trusts. We are seeking to develop stronger networks and partnerships with similar organisations to reduce duplication and maximise on economies of scale
Owner	Associate Director of Procurement
Deliverables / Products	• Strong relationships with key procurement partners: • CCS, NHS Supply Chain, LPP, Local Government, Local Trusts • Contribution to national networks
Measures for success	• 50% of spend routed via collaborative agreements • Improvement in benchmarked pricing against peers
Duration	9 months

Workstream	People
Project	**Organisational Change**
Description	There are significant gaps in the level of staffing resources in the Procurement structure, with the wrong roles, focussed in the wrong places. A new structure has been designed which builds a team with the right skill and knowledge mix to deliver the Trusts requirements. This project will implement the new structure.
Owner	Associate Director of Procurement
Deliverables / Products	• Organisational Structure • Approved job descriptions and person specifications • Staff consultation • Recruitment
Measures for success	• Reduction in gaps in service delivery • Alignment of staffing to requirements • Ability to recruit into structure • Level of satisfaction from staff
Duration	6 months

Workstream	People
Project	**Staff Development**
Description	There is a national shortage of qualified and capable procurement professionals backed with a history of organisations poaching from the same diminishing pool of resources. This project will seek to develop the capability of the internal resources and establish schemes to introduce and develop a new breed of Procurement professional
Owner	Associate Director of Procurement
Deliverables / Products	• Partnership with further education establishment • Apprentice • Management Trainee • Internal training scheme • Continuous professional development scheme / funded training • Individual PDP's for all staff • Procurement awareness training for all Trust employees • Procurement training for all employees with buying responsibilities
Measures for success	• % cover of PDP for staff • Level of retention and progress on training scheme (including recruitment) • % staff qualified or working towards
Duration	9 months

Workstream	Process
Project	**Supply Chain Consolidation**
Description	Supply of goods is fragmented in the organisation with as many as 10 departments visiting a ward each day to replenish stock. This leads to confusion and inefficient, duplicated processes. This project seeks to streamline the internal supply chain and consolidate deliveries
Owner	Supply Chain Manager
Deliverables / Products	• Consolidation of orders to wards (Supply Chain and external suppliers) • Structured and communicated delivery schedule for each clinical area • Internal ordering / picking from other departments (pharmacy fluids, blood consumables etc)
Measures for success	• Reduced clinical time spent on order related activities • Reduction in visits to clinical areas
Duration	10 months

Workstream	Process
Project	**Inventory Management**
Description	The Materials Management function at the Trust manage only a subset of the regularly used consumables the Trust orders. The rest is maintained and reordered by clinical staff. Stock levels are based on knowledge and there is little standardisation between processes. This project will standardise inventory management across the Trust, implement automation based on robust calculated inventory levels. All regularly used items will be managed in a single system built upon GS1 standards
Owner	Supply Chain Manager
Deliverables / Products	• Inventory Management System • Extended inventory control (high cost items) • Calculation of wastage • Standardised replenishment and cycle count process • Reviewed and optimised stock levels • Automated reordering • GS1 enabled product and location identification • Linking of product usage to activity • Activity and trend driven demand planning
Measures for success	• Reduced stock holding • Reduced emergency deliveries • Reduced cancellations due to product outages • Reduced time spent on ordering related activities • Reduction in wastage • % of products covered by GS1 standards
Duration	12 months

Workstream	Process
Project	**Help desk and customer contact**
Description	Information on service "exceptions" is limited. Customer and supplier contact is not measured and customers often complain that issues are not addressed quickly enough. There are inefficiencies in how stock-outs are handled which diverts inventory specialists from managing their stock effectively. This project seeks to standardise customer contact, providing tools and resources to effectively manage and record exceptions, ensuring enquiries are dealt with as soon as possible and by the right member of staff.
Owner	Systems & Services Manager
Deliverables / Products	• Help desk and portal system • Calls to department logged, categorised and triaged • Inventory exceptions assigned to nearest specialist • Monitoring of issue resolution timescales • Standardised process for handling of customer and supplier enquiries • Management of suppliers on site - Supplier Accreditation • Knowledge base / FAQ to reduce common issues • Regular surveys to test customer satisfaction • Team location tool based on GS1 standards
Measures for success	• Reduction in calls into department • 80% of calls resolved within 24 hours • Reduction in stock outs resulting in patient cancellation • Year on year improvement in average customer satisfaction score
Duration	6 months

Workstream	Process
Project	**Tail Spend**
Description	The Trust spends £128m with 2,791 suppliers. 80% of this spend is with the top 130 suppliers, leaving 2,491 (95%) suppliers to manage as "tail spend". Its rare that this spend is opened up to formal competition due to the size of the task for limited return. This project will implement new approaches to managing this proportion of spend, based on technology that will enable competition between suppliers and the opening of opportunities to the marketplace
Owner	Systems & Services Manager
Deliverables / Products	• eRFQ system • Opening all spend to competition • Advertising of opportunities at all levels of spend • Short term pricing agreements for regularly used consumables outside of formal contract • Opportunities to encouraged enterprises measured
Measures for success	• £50k savings per annum • 10% of opportunities offered to encouraged enterprises • 80% of regularly used consumables covered under contract or pricing agreement
Duration	6 months

Workstream	Process
Project	**Purchase to Pay (P2P)**
Description	The purchase to pay process at the Trust is fragmented, with multiple paper based processes in use to purchase different products or services. There is little integration between the customer, supplier and back office systems leading to inefficiencies and errors. Invoices are often sent around the organisation for approval despite having been approved at order stage. This project seeks to introduce a standardised, automated process, supported by technology and international standards
Owner	Systems & Services Manager
Deliverables / Products	• New P2P System • Standardised processes • Catalogue management system • Exchange system • Removal of paper processes • 80% catalogue coverage (contract only) • Interfaces / integration with Finance system • Online training resources • Buyer intervention only for non-contracted products • Receipt time accounting • Electronic invoicing • Stop / significantly reduce call-off orders • Stop / significantly reduce standing orders • Standardised self service reports available to end users and managers • GS1 standards adopted for location and product identification • Order expediting process
Measures for success	• Faster acquisition times average reduction to 6 days • Improved data - 80% data available at line level detail. 80% of products used captured • Reduction in invoice mismatches / approvals • Invoices captured at line level • 15% of invoices processed electronically without human intervention • 80% of orders bypassing Procurement team • 90% orders delivered on time in full
Duration	10 months

Workstream	Process
Project	**Category Management**
Description	Category management is a process which relies on cross functional teamwork to generate procurement outcomes that fully satisfy agreed business needs. This project will implement new processes, approaches and systems which will support clinicians and directorates directly in their purchasing decisions and deliver significant increase in benefits returned from Procurement activity currently.
Owner	Head of Category Management
Deliverables / Products	• Market engagement - regular supplier engagement days; meet the buyer events; suppliers engaged before procurement exercises; partnership working • Lean sourcing methodology - standardised processes • Project management methodology - documents, templates, processes • Customer relationship management - stakeholder groups, category boards, regular contact, embedded into divisional governance • Contract management system • eRFX system • Use of eAuctions • 3-5 year sourcing plan • Advertising of opportunities at all levels of spend • Monitoring of opportunities to encouraged enterprises • Once only processes - supplier qualification • Proactive contract management and reviews • Supplier Management
Measures for success	• £1.6m savings in first year • Opportunities advertised at all levels of spend • Improved satisfaction from service users
Duration	12 months

Workstream	Process
Project	**Analysis and Benchmarking**
Description	Data and information is key to the success of every organisation. If you can't measure it, you can't manage it. This project will implement supporting tools and processes that will enable the Trust to deliver on its cost improvement programmes and support the service development and performance measurement of the Procurement function as a whole
Owner	Systems & Services Manager
Deliverables / Products	• Analysis & Benchmarking System • Consolidated data source • Price variation analysis • Benefit realisation models • Performance measures • Analysis based sourcing planning • Service improvement data collection and analysis • Monitoring of encouraged enterprises and sustainability • Category intelligence tool • Customer and supplier satisfaction
Measures for success	• Standard performance measures reported to strategy board, finance committee and board • Data driven opportunity analysis and planning • Robust, evidence based benefits realisation for 80% of delivered sourcing projects • Improvement in customer satisfaction from baseline
Duration	9 months

APPENDIX XI

Department of Health Procurement Dashboard Example

The Management Case

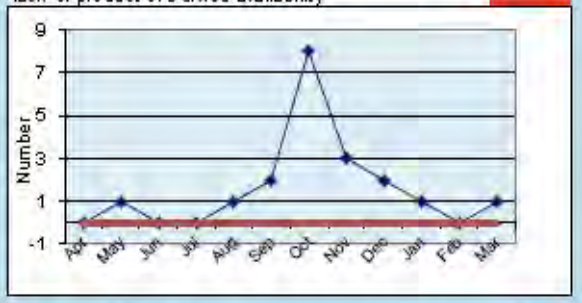
NHS Procurement Dashboard | Trust name here | Report Date / Period

Doing it Well

C1 - Impact on Patient Care

RAG: R

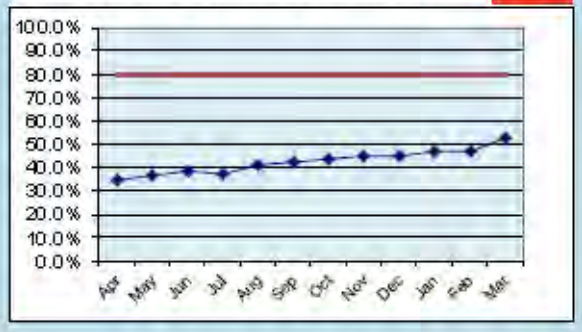
Number of instances where patient outcome, experience or safety has been adversely affected by a lack of product or service availability



C2 - Spend Control

RAG: R

Percentage of non pay expenditure captured electronically through purchase to pay systems



Commentary

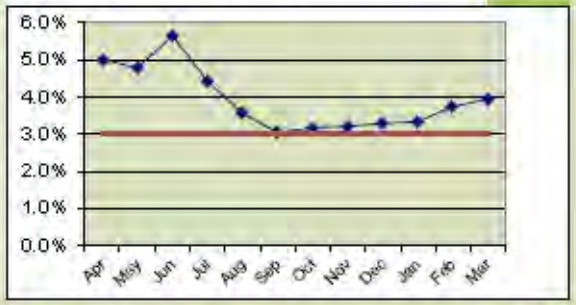
Enter notes to assist interpretation of dashboard

Doing it Efficiently

C3 - Cost Improvement

RAG: G

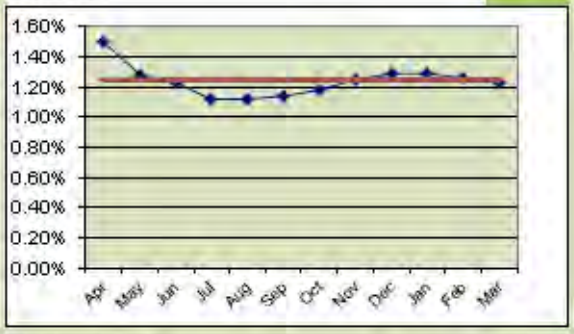
Value of contribution to cost improvement as a percentage of non pay expenditure



C4 - Cost to Procure

RAG: G

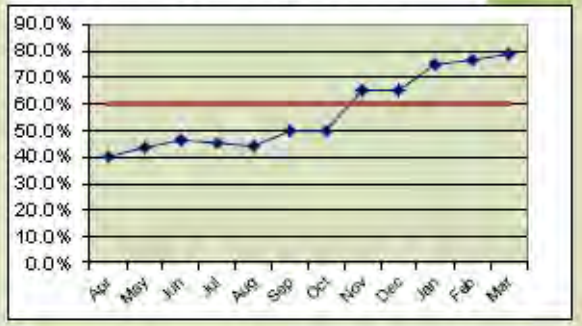
Cost to procure as a percentage of non pay expenditure



C5 - Collaboration

RAG: G

Percentage of non pay expenditure through national and/or collaborative purchasing arrangements



Doing it Right

C6 - Standards of Procurement

RAG: A

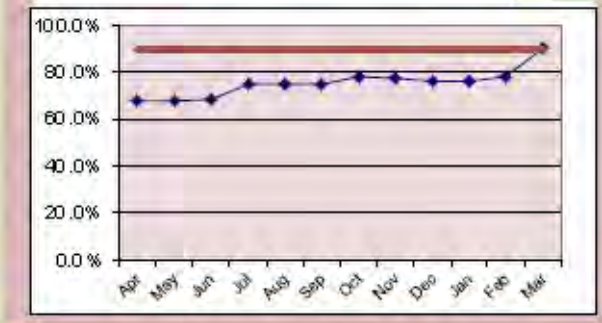
Progress against the NHS Standards of Procurement

Enter notes on NHS Standards of Procurement

C7 - Staff Qualification

RAG: G

Percentage of recognised procurement staff with an appropriate formal procurement qualification(s)



Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – March 2015

3-20	Summary report from the Quality & Safety Committee meeting, 02/03/15 & 11/03/15	Committee Chair (Non-Executive Director)

The Quality & Safety Committee met on 2nd March and 11th March 2015.

The meeting on 2nd March was a 'deep dive' meeting (that had deferred from 12th February), and covered the following issues:

- **Update on the progress in implementing the new emergency paediatric pathway:** The Chief Nurse provided an updated report, including the latest timeline being monitored by the Emergency Paediatric Pathway Working Group
- **The cancer pathway (with a focus on 62-day waiting time performance):**
  - The Deputy Chief Operating Officer was in attendance. It was noted that the Trust's performance had been adversely affected by wider national issues (such as the impact of new treatments, and the complexity of the Cancer pathway); as well as local issues (such as the referrals from Cancer Units, and difficulties with the internal diagnostics pathway). However, the 62-day target for Quarter 3 of 2014/15 had been delivered.
  - It was also noted that the 2-week and 31-day targets had been delivered, but the 62-day waiting time target had not delivered in Quarters 1 and 2. The Committee heard that this below-standard performance was in part due to a 12% increase in clinical demand, when compared to the previous year, but other factors included the receipt of late referrals from other hospitals (of the 187 patients that had breached the 62-day deadline, 85 were referrals from other hospitals. Of these 85, 85% were referred after 42 days, which left little time for the Trust to undertake treatment and remain within target). It was noted that even if patients were referred to the Trust after 42 days, the Trust still incurred part of the breach (if such a breach occurred).
  - A question was raised whether any analysis had been undertaken to determine whether perceived inefficiencies in the Trust's performance had affected referrers' behaviour, and resulted in a change in the flows of referred patients. It was agreed to undertake an analysis of Cancer referrals, to determine if there has been change in flows of referred patients (including whether there has been a shift of referrals to London Cancer Providers)
- It was also agreed that **the focus of the next „deep dive' meeting, on 13th April**, will be 1) the Quality Improvement Plan (QIP) developed in response to the Care Quality Commission (CQC) inspection report; and 2) 'Surgery review' (this item was originally scheduled for the March meeting but had to be deferred).
- Finally, it was agreed that **"Learning outcomes from upheld complaints"** should be scheduled for the Quality & Safety Committee 'deep dive' meeting in June 2015

The meeting on 13th March 2015 was a 'main' meeting, and covered the following issues:

- An update on the **latest position regarding „Out of Hours Treat and Transfer'** was provided, and assurance was given that the 7 patients aged over 80 who were transferred between hospitals 'out of hours' were transferred for clinical reasons.
- The latest **Stroke care performance** was reported, and it was noted that the latest Sentinel Stroke National Audit Programme (SSNAP) data showed that Maidstone Hospital's rating had moved from a 'D' to a 'C'
- All the **Directorates** presented their reports. The key issue raised were as follows:
  - The report from **Diagnostics, Therapies & Pharmacy** highlighted some 'red' rated risks, and it was agreed that the Medical Director would submit a report to the next 'main' Quality & Safety Committee on a) the delay in the implementation of the "Intelligent fridges"; and b) the problems with the provision of external internet access for the Pharmacy robot at Tunbridge Wells Hospital.

- **Emergency & Medical Services** highlighted the need to reduce the number of 'open' incidents, and it was agreed to submit a report to the next 'main' Quality & Safety Committee in May 2015 on the recent audit of 'open' incidents.
- **Surgery** highlighted that an increased incidence of Endophthalmitis cases over recent months, following cataract surgery, was being investigated, to identify causative factors.
- **Trauma & Orthopaedics** reported comparative performance on Surgical Site Infections (SSIs), and acknowledged that further work was required regarding SSIs. Performance on the National Hip Fracture Database over the past 3 years was also reported, which showed a marked improvement.
- **Women's & Sexual Health** reported that the previous risk relating to the Ultrasound machine at Sevenoaks hospital was in the process of being resolved.
- **Cancer & Haematology** highlighted that the implementation of e-prescribing was 4 weeks behind schedule, but the aim was still to 'go live' on 6th April 2015
- **Trauma & Orthopaedics** highlighted that their review of mortality was continuing, and the reduction of surgical site infections remained a priority.
- **Children's Services** reported that Inpatient capacity was insufficient, and had resulted in some recent problems
- **Critical Care**'s report was also received

- The latest draft **Quality Improvement Plan** (which has been developed in response to the CQC inspection was reviewed
- A written report was received on the latest media coverage / **reputational risk** issues
- The minutes of the **Quality & Safety Committee ‚deep dive'** held on 02/03/15 were received
- The latest **Quality & Governance** report highlighted that mixed sex breaches were high for December due to high levels hospital activity and use of escalation wards; and contained detailed of recommendations arising from recent Coroner's inquests
- The latest **Serious Incidents** were considered, and an update from the **Patient Safety Think Tank** was received
- The recent findings from relevant **Internal Audit reviews** were received
- An update on the **visits from external agencies** was received
- The findings from the recent **Complaints Survey Feedback** were received. Although there only 7 respondents, the survey did indicate the areas requiring improvement, including the need to keep complainants informed of progress with the investigation and response
- A **gap analysis against the complaints handling guidance** published by the Parliamentary and Health Service Ombudsman in November 2014 was received, and it was noted that of the 5 key stages, the Trust was compliant on 1, partially compliant on 2, and 'red' on 2
- 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 - March 2015

3-21	Summary report from Workforce Committee, 05/03/15	Committee Chair (Non-Executive Director)

This report provides a summary of the papers received and discussed at the Workforce Committee on 5 March 2015.

Emerging Workforce Challenges

The 3 priorities are:

1. Recruitment and retention. Indicative numbers from the business planning process for 2015/16 demonstrate that the Trust will need to recruit approximately 950 WTE staff. Recruitment at this level will require innovative approaches. There is a drive to reduce the use of temporary staff to fill vacancies. Staff turnover has reduced by 1% in the last year.
2. Meaningful employee engagement needs to be underpinned by cultural change.
3. Equality and diversity. Shortfalls have been identified for both patient care and employment. The aim is to increase employment and promotion opportunities for under-represented and protected characteristic groups, and to establish active groups for these employees.

NHS Staff Survey 2014

A presentation was given on the results of the survey and set them in the context of the national & local picture. The overall results are good, but there are some areas the Trust needs to focus on:

- Address equality and diversity issues from the point of view of staff and patients.
- Meaningful engagement.
- Shift prevailing leadership style.
- Shift emphasis to more strategic leadership rather than day to day leadership.
- There is no formula for cultural change, the Trust needs to take some risks on innovations to make a difference.

Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile

The second report was published in February 2015. There are 6 areas the Trust needs to focus on:

- The Trust does not have a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors, but does need to develop one.
- The Trust values the role of volunteers, but they must be managed and supervised and arrangements need to be formalised.
- The Trust has DBS in place for all substantive staff and volunteers, however, as this is based on a moment in time, it can provide a false assurance. It was noted that Savile did not have a criminal record.
- The Trust needs a policy for the use of social media to ensure that inappropriate access does not take place on Trust premises.
- Staff such as contractors, PFI partners and agency staff must meet the same standards as Trust employees.
- The whole scope of Trust recruitment processes should be reviewed to ensure consistency and robustness across all departments and functions.

Medical Education Update

The report provided information on medical education and training programmes in the Trust, in particular:

- The current round of faculties is underway, at this stage it's difficult to gauge current trainee satisfaction.
- The core medical training visit took place on 21/11/14 and the report has been received. Feedback was generally very good, with a few mandatory actions required which can be achieved
- IMACS has been incorporated into the education department.
- Projects involving patient safety and simulation are underway.
- Working relations with the medical workforce team are much improved.

Wider Community Relations: Shaping our workforce for tomorrow

The report provided an update on recent work to strengthen and develop partnerships with local education providers, and highlighted the following developments:

- Active participation in the submission of a bid for a new secondary school in Maidstone with Valley Invicta Academies Trust. The involvement of the Trust will help shape the curriculum around health and promote careers in the health sector.
- The opportunity for non-executive director positions on the Valley Invicta Academies Trust Board
- The development of apprenticeships for the Clinical Admin Units.
- Each HRBP, as part of their appraisal, has an objective to establish links with local schools to promote career opportunities in the Trust.
- The HRBP team has also been involved in a career fair for unemployed people in Tunbridge Wells
- The HRBP team is involved in the West Kent Employment Initiative with KCC for disadvantaged young people, which involves the Trust providing back office administrative roles and classroom facilities for a group of young people for a defined period, and supporting successful candidates applying for substantive administrative roles in the Trust.
- Further work will take place on the Trust's approach to work experience.

Workforce Risk Register

The 4 principal risks relating to the workforce are:

1. Recruitment
2. Temporary staffing
3. Employee engagement
4. Achieving culture of excellence in the organisation – consistently top performing.

The Committee agreed the 4 key risks and discussed the RAG rating system used to monitor the planned actions to mitigate the risks.

Workforce Dashboard

The report was received and noted. The Committee would welcome input on the medical appraisal cycle, similar to the report received in previous years from Dr G Russell.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Trust Board meeting – March 2015

3-22	Summary report from the Patient Experience Committee, 05/03/15	Committee Chair (Non-Executive Director)

Patient Experience Annual Report – Benchmarking Data
The report circulated was an addendum to the Patient Experience Annual Report containing national benchmarking data for staffing levels, Friends and Family test, Safety Thermometer, Pressure Ulcers, Falls and Dementia.

End of Life Care
A Kent wide survey into bereavement is being coordinated by Public Health, looking at the support bereaved relatives receive. The survey is in the planning phase & timeframes is being developed.

The pilot of the Best Practice Guidelines, which had replaced the Liverpool Care Pathway guidance, had been undertaken on 8 wards within the Trust and valuable feedback received. The team were finalising the End of Life document which would then be implemented across the Trust.

Update on CQC Inspection October 2014
The Trust had developed a Quality Improvement Plan (QIP) in response to the CQC Inspection report and a working draft would be submitted to the CQC by 16th March. The CQC will revisit the Trust in 4-6 months to check progress against the actions.

Complaints Themes
80 compliments were received between October and December 2014. They are being investigated to ensure learning is recognised & shared across Directorates & at Clinical Governance meetings.

PALs have been holding Open Days for 6 months collecting feedback from patients and visitors in reception areas, A&E and Outpatients, and will be launching weekly ward visit days.

In November 2014 the Parliamentary Health Service Ombudsman (PHSO) produced new guidance on complaint handling and a gap analysis has been undertaken to identify how well the Trust is achieving against the standards and to identify learning. The Trust was offered the opportunity to partner with NHS Benchmarking, to conduct a patient satisfaction survey, which was launched in November 2014 and the analysis was included. The report covers a 6 month period from July to December although the Trust only received 7 responses. Concerns raised included the time taken to respond and communication whilst the investigation is on-going

Healthwatch Update:
Membership is improving and there is now a local team in every area in Kent, although the areas covered are large. Healthwatch are encouraging NHS and Social Care providers to interact together. It was confirmed the Trust has a good relationship and engagement with Healthwatch.

National A&E Survey:
The circulated report highlighted that there had been improvements in all but one area and the Trust had scored the national average or better. The positive results and improvements were noted and commended.

National Cancer Survey:
The circulated report highlighted the action plan was being progressed. A financial advice service for patients was being implemented with the McMillan Information Centre in April.

Patient Led Assessment of the Care Environment (PLACE) Report:
The report highlighted the action plan is monitored throughout the year and good progress has been made. It was noted that the results in certain areas were not good, including privacy and dignity given the facilities available at Tunbridge Wells Hospital (TWH) and that substantial improvement is required for the next inspection.

It was concluded that the plan is reviewed at the Patient Environment Steering Group (PESG) and the dates for the next inspections would be available shortly.

Care Assurance Inspections Feedback
The circulated report highlighted the Care Assurance and PLACE audits are to be combined to involve the environment and utilise the time spent talking with patients.

Feedback following the Care Assurance Audit held the previous day was reported, noting it covered Cardiac Cath Lab and SSSU at TWH, both areas are used for escalation patients which impact on patient experience. Discussion took place regarding the logistics and difficulty involved in turning an area into an inpatient area. It was highlighted it was pleasing to hear the standard of care remained good under difficult circumstances and showed the quality of staff in that area.

Call Bells (time to respond)
The circulated report highlighted there were 69,000 nurse activations. The mean response time was less than 2 minutes.

Junior Doctor experience
Discussion took place regarding accommodation and the availability of on call rooms for doctors. The Junior Doctor present noted that the Trust has a good teaching set up and the Education Centres, Library and Dr Mess at TWH offer an amazing facility.

Review of Patient Experience Committee
A report was circulated outlining the principles underlying a number of proposed changes being considered to the form and function of the Committee. The circulated report is enclosed at Appendix A. Comments were invited on the principles. Some comments were received at the meeting, and additional comments were asked to be provided to the Trust Secretary by 19th March. The comments received (both at the meeting and since) are as follows:

- There has been general support for the intention to reduce the number of Trust staff attending the meetings. Although some concern has been expressed that the absence of Directorate staff may mean that questions were not able to be addressed at the meeting, and would therefore result in delayed responses, such circumstances are considered to be unlikely, as there will still be sufficient staff at the meeting to provide a response. The intention is also that Directorates attend by invitation, and it is likely that at least one Directorate would attend for each meeting, to discuss a particular subject, as chosen by the Committee.
- Some concern was raised at any intention to remove the "Junior Doctor Experience" agenda item. It was confirmed that if there is a rationale to keep an agenda item then it would remain.
- The need to use existing reports for discussion (for example, for complaints), rather than create specific reports for the sole purpose of the Committee, has been emphasised. It has been known that the intention would be to (where possible), use reports that already exist, rather than create new ones. For example, the Quality & Safety Committee and Patient Experience Committee meetings are likely to be in different months, but it should be possible to use the complaints report that has already been to Quality & Safety Committee at the Patient Experience Committee.
- One respondent commented that some of the proposed agenda items are repetitive (i.e. Patient Surveys, Local Patient Surveys and Friends & Family Surveys) and could be combined.
- A suggestion has been made that relevant items from the CCG/Social Services should be heard at Committee, as an occasional agenda item.
- An alternative suggestion to having meetings every 2 months is to lengthen the current time of the existing 3-monthly meetings, to three hours, in recognition of the fact that many of the external members have to travel considerable distances to attend.

Board members are invited to provide their own views, to inform the proposals (which will ultimately lead to revised Terms of Reference for the Committee).

Which Committees have reviewed the information prior to Board submission?

- N/A

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

1. Information and assurance; and
2. To comment on the proposals to change the form and function of the Patient Experience Committee

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

Appendix A: Review of the Patient Experience Committee

PATIENT EXPERIENCE COMMITTEE - MARCH 2015

1-12 REVIEW OF PATIENT EXPERIENCE COMMITTEE TRUST SECRETARY

It is good practise to review the form and function of Committees regularly, to ensure they are performing their required role efficiently and effectively. In this regard, the functioning of the Patient Experience Committee has been reviewed, and a number of changes are being considered. Before such changes are formally proposed (& ultimately agreed by the Trust Board), the principles underlying such changes are submitted for discussion and agreement, as follows:

- The Committee should remain a formal sub-committee of the Trust Board
- The number of Trust staff currently attending the meeting is considered to have an adverse effect on the quality of discussion and critique by non-Trust members. The option of only having staff that are speaking to an agenda item being at the meeting should be considered (this would not apply to any members of the Trust Board). However, the Trust's (2) Patient Experience Matrons should attend as a matter of routine, and be expected to contribute.
- A review of other staff expected to attend routinely should be undertaken, as should a review of the external members
- The link with the Quality & Safety Committee should be made more formal i.e. the Patient Experience Committee should be commissioned to review certain topics by the Quality & Safety Committee, and provide a report, and vice versa
- The Committee should also receive a summary report outlining the work undertaken by the Quality & Safety Committee, for information/assurance (and to help prevent any unnecessary duplication of work). The summary report submitted from the Quality & Safety Committee to the Trust Board should be used for the purpose. Similarly, a summary report of the Patient Experience Committee should be submitted to the Quality & Safety Committee.
- The standing items that the Committee covers should include:
  - Findings from the national NHS patient surveys (along with a response)
  - Friends and Family Test findings (and response, if required)
  - Findings from local patient surveys
  - Findings from relevant Healthwatch Kent 'Enter & View' visits (with a response, if relevant)
  - Comments from NHS Choices/'My NHS', and Social Media (Facebook, Twitter etc.)
  - Complaints information
  - PALS contacts information
  - Progress against the "Patient Experience" priorities in the Trust's Quality Accounts
- The relevance of all other existing regular agenda items should be reviewed, and if not considered to be relevant, should be dropped.
- The Committee should consider requesting Directorates to present the work they are undertaking regarding Patient Experience to the Committee, so that the Committee has a broader understanding of the local work taking place with patient/care representatives. This would be expected to include the work of committees such as the Maternity Services Liaison Committee and other such forums
- Verbal reports should be the exception, and most agenda items should be via by a written report, to enable committee members to undertake preparation in advance of the meeting
- Committee members should take more of an active role in setting the agenda items. The option of the Committee agreeing 'items for detailed scrutiny at future meetings' should be considered (i.e. as a formal part of each agenda)
- The frequency of the meeting should be increased, to every 2 months
- External members of the Committee should be offered the opportunity to give, rather than just receive, reports. For example, there could be items such as "Feedback from those involved in Care Assurance Audits", "Update from Healthwatch Kent" etc.
- External members of the Committee should be encouraged to adopt more of a 'critical friend' role i.e. to challenge, critique and push for improvement

Reason for receipt at the Patient Experience Committee (decision, discussion, information, assurance etc.)
Discussion and agreement

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – March 2015

3-23	**Summary of the Trust Management Executive (TME) meeting, 18/03/15**	**Chief Executive**

This report provides information on the TME meeting held on the 18th March 2015. The meeting was not a 'usual' TME, and was actually a joint meeting with the Trust Board, which focused on the plans for 2015/16.

Presentations on such plans were given for the all Clinical Directorates (apart from Women's and Sexual Health), and for Estates and Facilities Management and Health Informatics.

Each presentation covered the following themes:

- Vision and key objectives;
- Key business cases that were planned to be developed in 2015/16;
- Key issues relating to demand and capacity;
- Key issues relating to workforce;
- key issues relating to finance; and
- Key risks

Copies of the presentations have been circulated to all Board members.

All of those present found the meeting useful, although it was acknowledged that further work was required in relation to the prioritisation of business cases. It was also acknowledged that further liaison needed to take place with commissioners, to ensure that the Directorates' plans match commissioners' intentions.

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 - March 2015

3-24	**Senior Information Risk Owner update (including approval of the Information Governance Toolkit submission for 2014/15)**	**Chief Nurse (Senior Information Risk Owner / SIRO)**

The Board are advised that as Senior Information Risk Owner (SIRO), I have received and been satisfied with assurance reports in relation to Information Governance from the Information Asset Owners of the Clinical Directorates as well as from the Heads of Corporate functions.

Information Governance Management Framework (IGMF)
The Information Governance Committee reviewed the IGMF on 4 March 2015. The Caldicott Guardian and Data Protection Officer were happy to approve the framework as meeting the needs of the organisation for the coming year.

IG Toolkit v12

- The Trust is required to make its year end submission to the Information Governance (IG) Toolkit by 31st March 2015. During the year evidence rolled over from prior years has been reviewed to ensure it meets the requirements of the 2014/15 Toolkit and additional evidence has been posted where possible to support the Trust position.
- At July 2014 the Trust target was to maintain a minimum Level 2 position against all 45 requirements and if possible to achieve a number of requirements at Level 3. The Board are advised that the Trust is achieving the minimum Level 2 score against each of the 45 requirement of the Toolkit. A number of the requirements will be met at level 3.
- Internal Audit (TIAA) have undertaken an independent review of evidence pertaining to 15 of the 45 Toolkit requirements and the Trust has received a 'significant assurance' audit report. A copy is available to Board members on request (from the Trust Secretary).
- The Board is asked to support a recommendation for year- end submission of not less than 71% (satisfactory). This is a reduction of 11% on the 2013/14 submission, as fewer requirements achieved a level 3 scoring due to lack of formal processes and documentation for monitoring and auditing of requirement compliance. A detailed breakdown of the Toolkit requirements and proposed submission details by attainment level is enclosed, at Appendix A.

Information Governance Partnership Board (IGPB)
The Trust has played an active role during the year on the Kent and Medway Information Governance Partnership Board. The IGPB is accountable to the Joint Kent Chief Executive's Group consisting of representatives from 17 organisations, of which 14 are Local Authorities. The board is responsible for maintaining the Kent and Medway Information Sharing Agreement.

Incident Reporting
During 2014/15, the Trust had one notifiable Information Governance-related 'Serious Incident Requiring Investigation'. The details of the incident were as follows:

- Data relating to children attending A&E was sent to two colleagues at the Clinical Commissioning Group (CCG), via NHS mail, as part of the CQUIN monitoring progress (the data used had originally been generated for another purpose).
- The CQUIN evidence was in the form of a Word document that contained other embedded documents, and one of these embedded documents was an Excel spreadsheet containing a graph showing performance. This file also contained the data used to generate the graph. The two CCG colleagues were not entitled to see this patient level data.
- A number of lessons have emerged following the Root Cause Analysis and an action plan has been developed to strengthen the Trust's safeguards to try to prevent a recurrence being possible.
- The incident was declared to the Information Commissioner's Office and Department of Health (via the IG Toolkit), in December 2014.

Information Risks

The Board are advised that one new ICT risks has been added to the Trust risk register, pertaining to the potential for the Trust, as host on behalf of the Kent consortium, to receive claims for loss of data/service in relation to the GE PACS/RIS solution. The Board are assured that an agreement that provides for reimbursement from the supplier for losing the RIS solution has been put in place to address this risk.

Which Committees have reviewed the information prior to Board submission?

- Information Governance Committee, 04/03/15
- Trust Management Executive (circulated to members via email in the absence of a TME meeting in March 2015)

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

Review, and to approve the proposed year-end submission

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

Appendix A: IG Toolkit version 12 (2014-2015) assessment: Requirements List

Req No	Description	Status	Attainment Level
Information Governance Management			
12-101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	Reviewed And Up dated	Level 3
12-105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	Reviewed And Up dated	Level 2
12-110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	Reviewed And Up dated	Level 3
12-111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	Reviewed And Up dated	Level 2
12-112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	Reviewed And Up dated	Level 2
Confidentiality and Data Protection Assurance			
12-200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	Reviewed And Up dated	Level 3
12-201	Staff are provided with clear guidance on keeping personal information secure, on respecting the confidentiality of service users, and on the duty to share information for care purposes	Reviewed And Up dated	Level 2
12-202	Personal information is shared for care but is only used in ways that do not directly contribute to the delivery of care services where there is a lawful basis to do so and objections to the disclosure of confidential personal information are appropriately respected	Reviewed	Level 2
12-203	Individuals are informed about the proposed uses of their personal information	Reviewed And Up dated	Level 2
12-205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	Reviewed And Up dated	Level 2
12-206	There are appropriate confidentiality audit procedures to monitor access to confidential personal information	Reviewed And Up dated	Level 2
12-207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	Reviewed	Level 2
12-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	Reviewed And Up dated	Level 2
12-210	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	Reviewed	Level 2
Information Security Assurance			
12-300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	Reviewed And Up dated	Level 3
12-301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	Reviewed And Up dated	Level 2

Req No	Description	Status	Attainment Level
12-302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	Reviewed And Up dated	Level 2
12-303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	Reviewed And Up dated	Level 2
12-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	Reviewed And Up dated	Level 2
12-305	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	Reviewed	Level 2
12-307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	Reviewed And Up dated	Level 2
12-308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	Reviewed	Level 2
12-309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	Reviewed And Up dated	Level 2
12-310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	Reviewed And Up dated	Level 2
12-311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	Reviewed	Level 2
12-313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	Reviewed	Level 2
12-314	Policy and procedures ensure that mobile computing and teleworking are secure	Reviewed And Up dated	Level 2
12-323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	Reviewed	Level 2
12-324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	Reviewed And Up dated	Level 2
Clinical Information Assurance			
12-400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	Reviewed And Up dated	Level 2
12-401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	Reviewed	Level 2
12-402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	Reviewed And Up dated	Level 2
12-404	A multi-professional audit of clinical records across all specialties has been undertaken	Reviewed And Up dated	Level 3
12-406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	Reviewed And Up dated	Level 2

Req No	Description	Status	Attainment Level
Secondary Use Assurance			
12-501	National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as standards develop	Reviewed And Up dated	Level 2
12-502	External data quality reports are used for monitoring and improving data quality	Reviewed And Up dated	Level 2
12-504	Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained	Reviewed And Up dated	Level 2
12-505	An audit of clinical coding, based on national standards, has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last 12 months	Reviewed And Up dated	Level 2
12-506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	Reviewed And Up dated	Level 2
12-507	The Completeness and Validity check for data has been completed and passed	Reviewed And Up dated	Level 2
12-508	Clinical/care staff are involved in validating information derived from the recording of clinical/care activity	Reviewed And Up dated	Level 2
12-510	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national clinical coding standards	Reviewed And Up dated	Level 2
Corporate Information Assurance			
12-601	Documented and implemented procedures are in place for the effective management of corporate records	Reviewed	Level 2
12-603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	Reviewed And Up dated	Level 3
12-604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	Reviewed	Level 2

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - March 2015

3-26 Estates and Facilities Annual Report to Board — Chief Operating Officer

Summary / Key points

This report seeks to update the board with a broad perspective of the Estates, Capital and Facilities Management (FM) functions for the financial year 2014/15.

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

Introduction

This is the second Estates and Facilities Management (EFM) annual report to update the board with a broad perspective of the Estates, Capital and Facilities Management (FM) function and includes a review of the key developments and improvements achieved in the financial year 2014/15 and to look ahead to the planned areas of focus for the financial year 2015/16.

2 Financial Overview

2.1 Financial Position – Revenue

2.1.1 The Directorate has a balanced business plan for 2014/15, with a proposed cost improvement programme (CIP) of 8% equating to £2.4m. The savings are being monitored on a fortnightly basis to ensure these are delivered and any risks which materialise during the year will be managed and mitigated accordingly.

2.1.2 The Directorate completed 2013/14, achieving a cost improvement programme (CIP) of almost 12% equating to £3m and year end revenue position of £16k adverse, against an annual budget of £25.8m excluding the PFI unitary payment.

2.1.3 The budget for 2014/15 was set as;

Service		**Annual Budget £**
Estates	Income	-47,000
	Pay	1,310,000
	Non Pay	10,981,000
	Reserves	-1,232,000
	Sub total	11,012,000
Facilities	Income	-5,434,000
	Pay	13,585,000
	Non Pay	5,322,000
	Reserves	-563,000
	Sub total	12,910,000
E&F Directorate	**Total**	**23,922,000**
PFI Unitary Payment	**Total**	**22,624,604**
Estates Capital	**Total**	**4,200,000**
		£ 50,746,604

2.1.4 Estates and Facilities Financial Position 2014/15 as at month 9 the financial position was;

Service	Annual Budget £	Corporate CIP Target Set £	Actual CIP Year End Forecast* £	Year End Forecast £	Year End Forecast
Estates	11,011,987			11,480,000	(4%)
Facilities	12,909,887			14,838,000	(15%)
Total	23,921,874	2,469,989	1,803,973	26,318,000	(10%)
		10%	7.5%		(7%)

2.1.5 **Estates Services**

The Estates Services budget has a forecast 4% overspend for this financial year. The overspend is attributable to a couple of key issues; Training and Site resilience work.

2.1.5.1 **Training**

The Estates training budget has been reduced in previous years to a minimal amount which did not meet the costs of statutory and regulatory training. This training is essential to ensure that the Trust is compliant with Statutory Legislation and Health Technical Memorandums. The annual budget required is being reviewed and incorporated into business planning for future years, however, significant catch up was required within the financial year which attributed to the overspend.

2.1.5.2 **Site Resilience Work**

During the year existing plant and equipment has failed which necessitated a review of the site resilience and contingency planning. Additional stand-alone generators have been secured to support the one main High Voltage Generator. This is essential to ensure continued operation of the site in the event of a mains power failure.

2.1.6 **Facilities Services**

The Facilities Services budget overall is forecasting 15% overspend for this financial year. The overspend is attributable to; Winter pressures (7%), Patient Transport (16%) and Postage (26%).

2.1.6.2 **Winter Pressures**

The current higher than predicted demand on services has necessitated an increase on both pay and non-pay resource. An additional 130 meals per day are currently being provided at Tunbridge Wells Hospital. These costs are being identified to Finance on a monthly basis.

2.1.6.3 **Patient Transport**

Private resource is used for inter-site patient transfers and used to mitigate the poor performance of the Kent and Medway Non-Emergency Patient Transport Service which was awarded to NSL by West Kent CCG. This contract has 18 months left and work has commenced on the new specification and tendering process.

2.1.6.4 **Postage**

A continued significant demand on external post has been seen through the year resulting in the 26% adverse movement. New cost saving measures have been identified and are being implemented.

2.2 Financial Position – Capital

2.2.1 The Estates Capital for the year was £4.2m. The programme consists of works on the backlog maintenance programme (defined by the completion of risk assessments) new development and redevelopment projects and projects to ensure compliance with statutory and legislative requirements.

2.3 Financial Position – Income

2.3.1 The Directorate income to date is under performing by £15k against the £5.5m target. The adverse movement is predominately due to loss of staff residential accommodation income at Tunbridge Wells with the reduction of rent as a goodwill gesture to the FY1s following their relocation from Burslem House at the old Kent and Sussex Hospital.

3 Workforce Overview

3.1 Recruitment

3.1.1 The average headcount for the Directorate is; 548.92 Whole Time Equivalents (WTE) a reduction of 20WTE from the previous year.

3.1.2 The turnover rate in Estates is 19% and 12% in FM. The high turnover in Estates has been due to the retirement of long service members of staff.

3.2 Bank, Agency and Overtime

3.2.1 The overtime spend remains steady at 7.7% of the annual pay bill. 3% has been spent on Agency usage and 1.3% on Bank staff. The remaining 88% of the annual pay is on contracted employees.

3.3 Sickness Absence

3.3.1 The Directorates sickness rate is 2.34% in Estates and 5.16% in FM against the Trust target of 3.3%.

3.4 Training and Development

3.4.1 Workshop training was provided for 40 supervisors and junior managers on Customer Engagement and Managing Staff Performance.

3.4.2 In FM staff continue to progress through the NVQ system.

3.4.3 In Estates a significant training programme has been completed to ensure that the Trust meets its duty to be compliant with Statutory Legislation and Health Technical Memorandums.

The training included;

- Water Hygiene Responsible Person
- Legionella Awareness Training
- Asbestos Management Responsible Person
- Mechanical and Pressure Systems Authorised Person
- Confined Spaces
- Managing Capital Projects
- HTM Awareness
- Electrical Infrastructure, Low Voltage and High Voltage Authorised Persons
- Estates and Facilities Management
- Decontamination

3.5 Awards and Recognition 2014

- **Chairman's Award**, Winner: Jonathan Baker, Catering Assistant.
- **Respect Award**, Winner – Team: Ward 12
- **Delivery Award**, Winner – Individual: Krysztof Malinowski
- **Excellence Award**, Runner up – Team: FM Zone Managers and Supervisors.

4 Estate Strategy and Capital Development Projects

4.1 Refreshing the Estate

4.1.1 The Estate development team are working collaboratively with colleagues to develop a joint approach to estate strategy planning.

4.1.2 The Estate Strategy previously agreed by the Trust Board plans until 2017. The new Trust Five Year Strategy will be reviewed during 2015 and the Estate Strategy revised to incorporate the strategic direction and plan to indicate the sequencing of investments required over the next 3-5 years.

4.2 Capital Projects

4.2.1 Projects Approved

Instruction to proceed with the Capital programme was given in August 2014 and through the concentrated period of seven months the Capital Project team have delivered the following projects within the £4.2m allocation;

- Clinical Admin Unit office reconfigurations
- Maidstone Main Entrance Refurbishment
- Improvements to the old Maidstone MOU
- Waste cupboard compliance commenced
- Main Kitchen Dishwasher replacement
- Service Yard statutory requirements
- Signage
- KPP Phase 1
- KPP Phase 2 commenced

- Maidstone Staff Car Park commenced
- Doctors Mess
- Admissions Lounge
- Ambulatory Assessment Unit at TWH commenced
- 32 High Street, Residential Accommodation completed
- New PET-CT facility commenced
- Backlog maintenance programme

4.2.2 **Project Progress**

An Asset Management Portfolio Summary, which provides an update on all capital schemes for the reporting period 1 March 2014 to 31 March 2015 is enclosed (Appendix 1). The summary shows a "RAG rating" for each scheme, based on the programme, budget and scope. Schemes which are progressing to budget and plan are rated green. Any schemes which are over budget or which are not progressing to plan are shown as red. Projects are indicated as amber, if programme delays are anticipated or the budget is likely to be exceeded.

4.2.3 **Estate Profile**

The following properties have been agreed for release and/or sold within 2014;

Property	Status	Value
Nurses Home and Oakapple House, Maidstone	Sold	£2,175,000
Magnolia House	Sold	£620,000
Hillcroft	Marketing to commence in Spring 2015	

5 Directorate Activity and Operational Performance

During 2014/15 operational progress included:

5.1 Estates and Facilities Governance

The governance structure within the Directorate was reviewed within the year to manage and monitor the Directorates statutory regulation responsibilities, with specific focus on those specialist and technical areas not covered previously by a Committee or sub-committee.

5.2 Maidstone 6 Facet Survey

The Director of EFM has commissioned an independent 6 Facet Survey. The Survey forms the 'core' estates information required by NHS EstateCODE. Historically this has always been regarded as the minimum data set of information necessary on which to base intelligent decisions about the future of an estate. It provides good base information for an Estates Strategy and can assist property transfer and is consistent with the updated NHS Premises Assurance Model – PAM.

The six areas of the survey are;

Facet 1 – Physical Condition Survey (Fabric & Mechanical & Electrical)
Facet 2 – Statutory Compliance Audit (including Fire)
Facet 3 – Space Utilisation Audit
Facet 4 – Functional Suitability Review
Facet 5 – Quality Audit
Facet 6 – Environmental Management Audit

This will provide a comprehensive understanding of the physical estate and a refresh of the works required. The information will be used to review the Risk Register and Estate Strategy.

5.3 Sustainability

5.3.1 StepJockey signs are now in place by the Stairs in both the Maidstone and Tunbridge Wells Hospitals. StepJockey aims to encourage healthier behaviour by labelling it for calorie burn. These new signs use the QR Codes and behavioural economics encourage people to make a habit of using the stairs instead of lifts and elevators.

5.3.2 On behalf of the Trust we have entered our efforts on Recycling for a Public Sustainability Award.

5.4 Laundry

The Trust laundry at Parkwood has recently installed state of the art system for the monitoring of wash cycles; washing products used; temperature control etc and is the first in the UK to introduce this system, which will provide auditable data in regards to operational costs, usage and infection control compliance.

5.5 Security

Following the CQC Inspection during October 2014 it was identified that 30% of the security officers had received training in dealing with vulnerable patients with a range of physical and mental ill health needs, a reduction from 70%. An action plan has commenced to ensure that all staff are fully trained and competent. This will be completed by August 2015.

5.6 Non Emergency Patient Transport Services (NEPTS)

The West Kent Clinical Commissioning Group (CCG) made the decision to move to one provider, to ensure a comprehensive and efficient service for patients across Kent and Medway. The NEPTS contract was awarded to NSL Care Services in January 2013 and went live throughout Kent and Medway on 1 July 2013.
This contract is due to expire on 30 June 2016 and works have commenced to re-tender this contract.

The Trust continues to invest in the service to ensure safe and effective mitigation of the risks currently experienced in delayed patient journeys.

5.7 Compliance with Standards and Regulations

5.7.1 Risk Register

The directorate is continuing to proactively manage its risk register with open risks reviewed by the Trust Risk Manager and Director of EFM monthly. Where necessary red and amber items are escalated to the Trust risk register and Board Assurance Framework. During the year 13 risks have been removed from the Risk Register as actions have been completed. Remaining risks have been reviewed and score adjusted as the backlog maintenance programme is delivered (see Appendix 2).

There remains 11 entries on the Trust Risk Register; one is RAG rated as High (Red), six as Medium (Amber) and four as Low (Green). Of these, six have a defined date for completion of the necessary works required to remove the risk. The remaining five risks will be reviewed on the completion of the 6 facet survey that has now commenced.

Our Condition Survey will provide an assessment of physical property conditions. The survey should identify any deficiencies, and maintenance issues including, but not limited to structural, mechanical, electrical, plumbing, fire protection, site layout, site utilities, storm water management, soil erosion and life safety systems.

The Statutory Compliance element, Facet 2, recognises the extent to which the facilities comply with the statutory regulations.

This identifies whether staff and visitors (including people with disabilities) are able to operate within our buildings without detriment to their well-being and confirms that our building environment does not compromise the quality of service that staff are able to provide.

Of these five risks, four relate to the building infrastructure and building condition, which are RAG rated as Amber to Green. These risks are being managed through a programme of reduction (mitigate), retention (accept and budget) and avoidance (eliminate, withdraw). The Backlog Maintenance programme and the Planned Preventative Maintenance programme are reducing and monitoring the risk. Contingency plans are in place should there be a system failure to reduce/avoid any effect on service delivery.

The reports produced by the survey will include calculated costs for remedial works which can be broken down into specific departments/blocks of the site. The Facet survey report will be valuable in our decision making process to facilitate an informed decision making process, with respect to renovation and/or maintenance of our property and buildings within our Estate.

5.7.2 Water Management

Following the CQC Chief Inspectors visit week commencing 13 October 2014 senior Trust management became aware that the annual water sampling for legionella was six months overdue at Maidstone Hospital and an Enforcement Notice was issued. Pseudomonas tests and records were found to be compliant. Tunbridge Wells Hospital is compliant for all areas in water hygiene management in accordance with statutory regulations. A comprehensive Action Plan was immediately implemented, all works have been completed and all water sampling results returned clear.

A full report with supporting evidence has been submitted to the CQC and the Trust is currently waiting notification that the Enforcement Notice has been lifted.

5.8 Tunbridge Wells Hospital – PFI

The Tunbridge Wells Hospital PFI Project Agreement continues to perform well and there is an excellent working relationship between all parties. The site has full statutory and good contractual compliance.

5.9 Patient-Led Assessments of the Care Environment (PLACE) Programme

The new style PLACE programme which replaced PEAT was introduced in April 2013 and involved collaboration between hospital staff and patient assessors. There is a formal annual inspection undertaken during April/May which the Trust are given 6 weeks notification to arrange and undertake. The multi-disciplinary team continue to undertake similar inspections on a monthly basis. The results of the audits and progress are monitored at the Patient Environment Steering Group (PESG), reported to the Estates and Facilities Governance and Advisory Group, Infection Prevention and Control Committee and Trust Board.

The performance outcomes were published nationally on 20 September 2014 and the Trust scores against the averages are shown below;

PLACE 2014	Cleanliness	Food and Hydration	Privacy, Dignity and Wellbeing	Condition appearance and maintenance
National Ave	97.25%	88.79%	87.73%	91.76%
MTW	99.27%	79.61%	78.12%	93.94%

The action plan has been agreed and is monitored through the Patient Environment Steering Group.

6 Estates and Facilities Management Key Objectives for 2015/16

The Directorate Business Plan for 2015/16 identifies the following key objectives;

6.1 The Directorate is working towards applying for the RoSPA Occupational Health & Safety Awards. The RoSPA Awards are internationally recognised and have fast become the most sought after accolade by organisations from every sector. This Award will prove the ongoing commitment to raising health and safety standards and to be a part of the longest running and most highly respected occupational safety awards programme.

6.2 Review of substantive staffing levels and develop plan to implement an increase where appropriate to support clinical activity.

6.3 Develop and maintain highly trained and skilled workforce providing a career framework focused on competencies and skills for all staff.

6.4 Procure a Computer Aided Facility Management System (CAFM) within EME.

6.5 Complete the annual capital renewal program within each budget cycle and effectively spend funding received to reduce deferred maintenance.

6.6 Develop and implement programs to reduce energy consumption.

6.7 Agree new Staff Residential Accommodation Strategy and develop and implement action plan.

6.8 Formal system of control to ensure robust Development Control Plan (DCP) to support clinical services.

Jeanette Rooke
Director, Estates and Facilities Management
7 March 2015

Appendix 1

Scheme	Description	Status
Electronic Door Holds OV129		**Project Complete**
Mortuary Works	Building works and installation of fridge as part of the repatriation of the Post Mortem service to TWH	**Works commenced**
Ambulatory Assessment Unit at TWH - Build only	Works required to provide 10 trolley spaces for Ambulatory Assessment Unit (AAU)	**Works commenced**
Staff Accommodation at Twells		**Completed**
KPP – Estates	Kent Pathology Partnership	**Works commenced**
Clinical Admin Moves	To complete office moves/refurbishment for HR, Recruitment, Diabetes etc	**Completed**
TWH Linac Development	Fees required to progress works to begin in 15/16	**Works ongoing**
MH Main Entrance Refurbishment	Enabling works associated with the reconfiguration of the front entrance to reprovide L of F facility	**Works commenced**
Car Park Extension Maidstone	To create up to an additional 101 car parking spaces at MH	**Works commenced**
Patient meal trolleys - Maidstone	To replace patient meal trolleys that are currently over 20 years old and to meet leagal requirements relating to food safety	**Completed**
MOU Improvements	works and equipment required to the existing redundant Maidstone Orthopaedic Unit (MOU) to bring it to a standard that can be considered safe and satisfactory and which will allow the 12 beds to form a part of the Trust bed capacity planning.	**Completed**
Waste Cupboards to main corridors	Statutory requirement to segregate waste streams as identified in Trust risk register (red risk)	**Works commenced**
Admissions Lounge	to expand and develop the old Admission lounge on the first floor of Travers unit. This involves the relocation of the junior Dr's Mess and the Rheumatology office.	**Works commenced**
Service Yard – Maidstone		**Works commenced**
Dishwasher replacement and installation – Maidstone		**Completed**
Electric bed movers - trust wide		**Completed**
Fire Alarms	balance from 13/14	**Completed**
Discharge Lounge (13/14)	Credit note received in M1	**Completed**
Re Routing Utility Services	VAT adjustment from 13/14	**Completed**
Fire Alarm Replacment	VAT adjustment from 13/14	**Completed**
Final Connections & Commissioning	VAT adjustment from 13/14	**Completed**

Scheme	Description	Status
Breast Care Door Entry	VAT adjustment from 13/14	**Completed**
Ward Works - Deep Cleaning Programme	To replacement flooring in Stroke Unit and to carry out fixed wire testing + balance of invoices from 13/14	**Completed**
Fixed Wire Testing (13/14)	balance from 13/14	**Completed**
General Flooring upgrade	A&E flooring and desk replacement	**Completed**
Improvements to BMS system (13/14)	balance from 13/14	**Completed**
Replacement Signage (13/14)	VAT recovery on invoices paid in M12 13/14	**Completed**
Oil Distribution and Controls	VAT to be recovered in M2 for invoice paid in M12 13/14	**Completed**
Block B - Whatman/Mercer	Addresses Whatmans environment raised by the nursing and Infection Control teams, work includes repairs to damaged flooring and increasing the size of the current dirty utility area.	**Completed**
Cornwallis/Culpepper corridor	Part flooring, decoration, fire alarms, general works	**Completed**
John Saunders/John Day	Works to be confirmed	**Completed**
Pye Oliver /Foster Clark	Part flooring, decoration, fire alarms, general works	**Work Started**
Chaucer	Part flooring, decoration, fire alarms, general works	**Completed**
Theatres	Part flooring, decoration, fire alarms, general works	**Completed**
X Ray	Fire alarms	**Completed**
Whitehead Ward	Part flooring, decoration, fire alarms, general works	**Completed**
Charles Dickens	Fire alarms	**Quote/Tender Stage**
Works to Electrical Infrastructure	Enabling works for emergency generator connection, replacement distribution board HDU etc	**Completed**
Block Q Plate Heat Exchangers	Ongoing replacement programme of calorifiers	**Completed**
Block D&A Fire Damper Replacement	Ongoing replacement programme of fire dampers	**Completed**
Flooring replacement general	Ongoing replacement programme of flooring	**Quote/Tender Stage**
Cold Water Storage (Block S)	Replacement of non compliant water storage vessel	**Completed**
Replacement of oil distribution pipework	Replacement of oil distribution pipework	**Work Started**
Boiler House Controls	Replacement of obsolete equipment	**Completed**
Charles Dickens (Hot Water Flow)	To improve the hot water flow due to circulation issues	**Quote/Tender Stage**
VRV Chiller Replacement Oncology		**Completed**
Smoking Shelter	To create an additional smoking shelter at the rear of MH	**Completed**
Fire Precautionary Works		**Completed**

Scheme	Description	Status
L1 Fire Alarms – General		**Completed**
Works to Block H		**Completed**
Works to Block F		**Completed**
John Day Development	Merger of 2 wards to develop a 31 bedded area for a 24 hour acute respiratory service	**Order Placed**
Link corridor between UMAU & MOU	This is an enabler to the John Day Development project	**Works commenced**

Appendix 2

As at 16 March 2015

Title	Description	RAG	Completion
Upgrade Fire Alarm System to L1 Standard	Kent Fire and Rescue Service have advised that the Hospital Fire Safety Standards do not meet the current requirements. A programme of work is agreed with them to meet these standards. This replaces Register entry ID 1214.	LOW	31 March 2015
Localised area (Waste Storage) capacity	The existing Waste Cupboards situated at various locations around the site will not provide sufficient space to allow segregation of waste streams in accordance with the Department of Health latest publication on the safe management of Healthcare Waste & Care Quality Commission requirements.	LOW	June 2015
Condition of Residential Accommodation Maidstone	The services infrastructure to the residential complex is in need of replacement/upgrading to ensure reliable and continued safe operation. (Services currently over 35 years old).	LOW	Action Plan: Backlog Maintenance 6 Facet Survey
Defective Fire Dampers	A proportion of Fire dampers are inoperable and require replacement. Like for like replacement is not possible.	LOW	31 March 2015
Whole Site infrastructure Maidstone	Condition Appraisals have rated elements of the Engineering infrastructure as condition D in accordance with Estate code i.e. Operationally unsound and in imminent danger of breakdown Replaces entry ID: 1812 and ID 1825	MOD	Action Plan: Backlog Maintenance 6 Facet Survey
Security issues Maidstone Hospital	Work is required to support the existing Security provision Replaces and updates ID 1716	MOD	31 March 2016
Defective Hose Connectors	Defective hose connectors could fail and lead to water at 65DegC leaking through the ceiling tiles onto persons below - Potential STF hazard.	MOD	December 2015
Workplace Pedestrian and Traffic Risk Assessments - Compliance with Workplace Health and Safety Standards	Annual assessment of Pedestrian and Vehicle movements around the Hospital sites to ensure adequate management and control systems are in place. That controls reflect site changes and flows, Traffic and Pedestrian. See summary of Risk Assessments for both sites.	MOD	31 March 2015
Long term actions required to address condition of clinical estate areas maidstone Hospital	Undertaking of significant improvement to the building fabric to permit delivery of clinic services in appropriate modern and compliant environments in accordance with current standards.	MOD	Action Plan: Backlog Maintenance 6 Facet Survey
Condition of the hospital blocks at	Condition appraisals in 2011 have rated elements of blocks in accordance with Estates code as operationally	MOD	Action Plan: Backlog

Title	Description	RAG	Completion
Maidstone Hospital	unsound and in imminent danger of breakdown. This replaces earlier risks from 2011 on.		Maintenance 6 Facet Survey
Reliability and Potential of total failure of Batch Tunnel Washer (BTW) at the Trust Laundry Heronden Road	The BTW is over 30 years old of obsolete design and spare parts are often made to order. It is the primary washing machine used for the Bulk of MTW non- infected linen. The incidence of breakdown is increasing risking economic continuity of clean linen supply.	HIGH	Action Plan: Replacement through Lease retention money

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - March 2015

3-27 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 January 2015. The content has now been updated, to reflect:
- The latest performance and risk information, and
- Executive Directors' updated ratings of controls and year-end forecast

New text is shown in red, whilst deleted text is shown as ~~strikethrough~~. A summary page highlights the latest 'RAG' ratings.

Board members are asked 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, 23/03/15 (objective 2.7 only)

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Review and discussion (refer to prompts above)

[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	A↓
1.5 Increase the level of clinical services that are available 7 days a week	A	A=
1.6 Deliver the highest quality TIA and Stroke service	A	A↑
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	G↑
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	G	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: 2	Number of 'Amber' forecast ratings: 10	Number of 'Green' forecast ratings: 10
Number of 'Red' control ratings: 1	Number of 'Amber' control ratings: 11	Number of 'Green' control ratings: 10

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 (i.e. Will the objective be met at year-end?)
										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), which is now at full establishment (with the appointment of a new Infection Control Lead Nurse) 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) o. The Surveillance team is intended to be strengthened, to focus on increasing the support to front-line staff	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 ~~December 2014~~ February 2015): Clostridium difficile = ~~23~~ 29 cases; rate (per 100,000 bed days) = ~~13.5~~ 13.7. The rate for the full 2013/14 year was 15.7 (based on 35 cases) b. Year to date (to end of ~~December 2014~~ February 2015): MRSA bacteraemia = 1 case; rate (per 100,000 bed days) = ~~0.6~~ 0.5. The rate for the full 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**	**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 4. The Trust declared full compliance with the NHS England Patient Safety Alert ("Rising trends and outbreaks in carbapenemase") in June 2014 **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 e. Phase 2 of the actions is being progressed	~~None~~ An audit of the robustness of the process is intended for 2015/16 (but this gap is not regarded as significant enough to affect the RAG rating of the controls)	None	Sara Mumford	Infection Prevention and Control Committee	**N/A - Objectives agreed at Trust Board, 24/09/14**	**A**	**G**	**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 = 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)~~ has been approved	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 an update was provided on 05/03/15) 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) c. The advert for the 4 new hybrid Consultant posts will be issued soon	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**	**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 (i.e. Will the objective be met at year-end?)
										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 (~~December 2014 February 2015~~), the FFT response rate is ~~42.6%~~ 40.6% (inpatients); 18.2% (A&E); and ~~19.6%~~ 18.7% (Maternity) b. Year to Date (~~December 2014 February 2015~~), the FFT score is 77 (inpatients); ~~64~~ 63 (A&E); and ~~83~~ 84 (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)~~ None	Avey Bhatia	Quality & Safety Committee	**N/A - Objectives agreed at Trust Board, 24/09/14**	G	G	G	A↓
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 c. Approval of business case for additional Pharmacy staff to allow for 7-day opening on a shift system (i.e. Saturday 9-4; Sunday 10-4) d. Temporary Sunday opening of each main pharmacy site, between 11am and 2pm (until recruitment of additional staff from above business case has been completed)	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 c. The Internal Audit 'Consultant Job Plans Follow Up' review resulted in a limited assurance conclusion, due to concerns regarding the relevant Policy; the coordination of the process; and access to Consultant's Job Plans. The Audit and Governance Cttee has expressed its concerns, and the Medical Director will be attending the May 2015 Cttee, to provide a response. d. There are now timely Critical Care ward rounds on both hospital sites 7 days per week e. The recruitment process of the new additional Pharmacy staff has commenced. it is hoped to have these staff in post in time to start full 7-day opening from June/July	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	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 4. Potential delay as a result of NHS England's review of Stroke in Kent and Medway **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 (~~October~~ December 2014) performance: % TIA with high risk treated <24hrs = ~~72.1%~~ 75.2% b. Year to date (~~November 2014 January 2015~~) performance: % spending 90% time on Stroke Ward = ~~83.5%~~ 83.3%; % to Stroke Unit <4hrs = ~~41.6%~~ 39%; % scanned <1hr of arrival = ~~43.8%~~ 43.4%; % assessed by Cons <24hrs = ~~73.6%~~ 73.7% 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 scheduled to receive an options paper in May 2015 (though this may be subject to delay as a result of NHS England's review of Stroke in Kent and Medway) e. The latest overall SSNAP grade~~s~~ (covering Oct - Dec 2014) ~~is "D" at both hospitals~~ are "C" at Maidstone Hospital; and "D" at Tunbridge Wells Hospital (A is highest & E lowest) f. The latest SSNAP "Organisational Audit" score~~s~~ are "D" (for Maidstone) and "C" (for Tunbridge Wells) (The SSNAP organisational audit is only completed every 2 years)	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	A	A↑

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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 (i.e. Will the objective be met at year-end?) 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																
1.7	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) 2. Risk of Specialist Staffing not being in place to deliver Chemotherapy E-prescribing **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 c. Recruitment efforts to ensure that all Specialist Staff required to deliver Chemotherapy E-prescribing are in place	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. The FBC for Chemotherapy eprescribing has been approved by the NHS Trust Development Authority 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~~ on 6th April 2015 (this date has been selected to avoid the Easter holiday period) d. Al Specialist Staff required to deliver Chemotherapy E-prescribing are in place e. A Plan to have the Trust's derogation removed has been submitted to NHS England, who have agreed that the derogation will be lifted if the Plan is delivered	None	None	Angela Gallagher	Trust Management Executive	**N/A - Objectives agreed at Trust Board, 24/09/14**	**G**	**G**	**G**	**G=**
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~~ the new financial year b. Implementation of new online induction (from January 2015) ~~c. Middle manager development programme (launched in autumn 2014)~~ c. Integrated suite of leadership development programmes (Board to Ward) commencing March 2015	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 (~~December 2014 February 2015~~), the FFT response rate is ~~42.6%~~ 40.6% (inpatients); 18.2% (A&E); and ~~19.6%~~ 18.7% (Maternity) b. Year to Date (~~December 2014 February 2015~~), the FFT score is 77 (inpatients); ~~64~~ 63 (A&E); and ~~83~~ 84 (Maternity) c. Annual NHS staff survey 2014 showed an increase in staff engagement, motivation and satisfaction and recommending the Trust as a place to work and receive treatment. Above national average	1. Staff champions are intended to be introduced 2. Development of MTW Cultural Barometer - Board to Ward 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**	**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 4. Lack of ward capacity (inpatient beds) (mainly at Tunbridge Wells Hospital (TWH)) **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. The person will fulfil the role until the end of March 2015 f. A Crisis Intervention Group has been established. This is a multi-disciplinary forum chaired by the Assoc. Director of Operations for Emergency Services g. The Capacity and Demand Group, which informs the decision-making of The MTW Programme Board (which is considering options for increasing ward (inpatient bed) capacity) h. Oversight by the Trust Management Executive i. A system-wide review of non-elective patient flow will be undertaken by the Emergency Care Intensive Support Team (ECIST) in Quarter 1 of 2015/15	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~~ February 2015): ~~6.8~~ 6.9 days b. A&E 4-hour wait performance is 93.7% for the year to date (~~December 2014~~ February 2015) c. There have~~s~~ been ~~1 (one)~~ 2 (two) 12-hour A&E wait breach~~es~~ for the year to date (February 2015) d. Non-Elective Activity for the year to date (~~December 2014~~ February 2015) is ~~4.7%~~ 3.9% above plan	1. Engagement / ownership among clinical teams is variable 2. Options to increase inpatient bed capacity at TWH will not be confirmed until Quarter 1 of 2015/16	None	Angela Gallagher	Trust Management Executive	**N/A - Objective only agreed at Trust Board, 26/11/14**	**A**	**A**	**A=**

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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 (i.e. Will the objective be met at year-end?
										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)~~ a. The Quality Improvement Plan (QIP), which was submitted to the CQC on 16/03/15 a. Monitoring and oversight of progress with the ~~QIP action plans~~, via ~~Quality & Safety Committee and~~ the Trust Management Executive and Trust Board b. Engagement with Directorates	1. CQC ~~compliance~~ inspection~~s~~ (October 2014) 2. Internal Audit review of Trust's in-house process ("CQC Process Review - MTW131421") 3. Progress reports on ~~action plan~~ Quality Improvement Plan implementation to Quality and Safety Committee, Trust Management Executive and Trust Board 4. Monthly progress reports to the CCG and NHS TDA **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")~~ a. The CQC's inspection at the Trust in October 2014 concluded a "Requires Improvement" rating for the Trust as a whole, and its two main hospital sites (Maidstone and TW) b. 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)~~ 1. The Quality Improvement Plan has been finalised, but has not yet been implemented in full	None	Avey Bhatia	Trust Board / Quality & Safety Committee	**N/A - Objectives agreed at Trust Board, 24/09/14**	**A**	**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:** 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 and 11/03/15), Trust Management Executive (10/12/14) and Trust Board (17/12/14 and 25/03/15) 3. Findings from the Safety Climate survey (Oct / Nov 2014) **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~~ b. A 'Roadmap' has been developed, to focus efforts in Reporting and Learning; Education and Support; and Human Factors, Leadership and Collaboration	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**	**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 (~~December 2014~~ February 2015), the vacancy rate is ~~8.7%~~ 9.3%) b. There has been an increase in the use of temporary staff. Temporary staff usage for the year to date (~~December 2014~~ February 2015) is ~~293~~ 279 WTE (bank) , ~~206~~ 212 WTE (agency) and ~~39~~ 20 (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**	**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 = 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 (~~December 2014~~ February 2015), temporary staff usage is ~~293~~ 279 WTE (bank) ~~206~~ 212 WTE (agency), and ~~39~~ 20 (locum)	1. Need for greater use of intelligence from ~~'Roster Pro' system for nursing staff~~ staffing systems 2. Need to ~~increase scrutiny of requests~~ enforce control mechanisms	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**	**R=**

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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 (i.e. Will the objective be met at year-end?
										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 R**elevant 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, which now contain additional triangulation 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 report~~s~~ to Trust Board (~~December 2014~~ February 2015) 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.~~ none of the Wards have an overall RAG status of red (the RAG rating gives an indication of the safety levels of the ward, compared to professional judgement, as set out in the Staffing Escalation Policy) b. The latest 6-monthly report~~s~~ 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**	**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 R**elevant 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 g. A Crisis Intervention Group has been established, to assist with patient flow. This is a multi-disciplinary forum chaired by the Assoc. Director of Operations for Emergency Services h. A system-wide review of non-elective patient flow will be undertaken by the Emergency Care Intensive Support Team (ECIST) in Quarter 1 of 2015/15	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 (~~December 2014~~ February 2015), 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~~ Individuals have been recruited to key posts (i.e. A&E Consultant, Care of the Elderly Consultant, General Managers, Matrons), but these have not yet started in post 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**	**A**	**R=**

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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 (i.e. Will the objective be met at year-end?
										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																
2.7	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 f. Agreement has been reached with West Kent CCG for 2013/14 and 2014/15 (based on month 8's activity forecast)	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 (eviewed by the Trust Board in October 2014) **Formal external assessments:** External audit of accounts **Included in integrated performance report?** Yes	a. Year to date (~~December 2014~~ February 2015), the Trust has a deficit of ~~£1.5m~~ £1.7m against a planned deficit of ~~£10.3m~~ £12.6m. This incorporates ~~9/12~~ 11/12 of the £12m non recurrent deficit support funding received from the TDA b. Year to date (~~December 2014~~ February 2015) CIP delivery is ~~£17.5m~~ £21.7m against a target of ~~£16.0m~~ £20.3m 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~~	None	Steve Orpin	Finance Committee / Trust Board	**N/A - Objectives agreed at Trust Board, 24/09/14**	**A**	**A**	**A**	**G↑**
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 4. Increase in volume and acuity of patients over the winter period **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 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. The person will fulfil the role until the end of March 2015 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 (~~December 2014~~ February 2015), average LOS is 3.2 (elective) and ~~6.8~~ 6.9 (non-elective) days	1. There are currently some vacancies in key posts (i.e. A&E Consultant, Care of the Elderly Consultant, General Managers, Matrons)	None	Angela Gallagher	Trust Management Executive	**N/A - Objectives agreed at Trust Board, 24/09/14**	**A**	**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 3. Workforce-related risks (staff relocation issues) **Relevant Risk Register entries:** N/A	a. KPP Project Board established and meeting regularly, informed by the output of specific workstreams (including Workforce, which is meeting fortnightly) b. KPP Project Manager in post c. Substantive KPP Managing Director ~~in post~~ now appointed d. Legal advice ~~sought~~ provided with regards to competition-related risks e. Oversight by KPP Board, which is chaired by the MTW Chief Executive (and which met for the first time, in shadow form, on 13/03/15) f. Weekly liaison with EKHUFT to address workforce risks	1. Agenda, minutes and reports to KPP Project Board 2. Update reports on progress with KPP to Trust Board (the latest of which is scheduled for March 2015) **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~~ is scheduled 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 d. The Shadow KPP Board met on 13/03/15 to discuss the intended implementation of KPP on 01/04/15. An update on KPP will be provided at the March 2015 Board e. The KPP Annual Business Plan for 2015/16 is scheduled to be submitted to the April 2015 Board, for approval	None	None	Angela Gallagher	Trust Board	**N/A - Objectives agreed at Trust Board, 24/09/14**	**G**	**G**	**G**	**G=**

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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 (i.e. Will the objective be met at year-end?)
										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 i. The new Head of Strategy has started in post j. The Deputy Chief Executive starts in post at the end of April 2015 k. The TME held an 'away' seminar on 18/03/15 which discussed the issues that prevent the Clinical Directors leading on Strategy; and how such issues should be addressed	1. Strategy update reports to the Trust Management Executive and Trust Board (the latest draft Strategy ~~will be~~ was discussed at the January 2015 meetings) 2. Agenda, minutes and reports to CSTG 3. Engagement log 4. Agenda, minutes and reports to TME **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	None	Glenn Douglas	Trust Board	**N/A - Objectives agreed at Trust Board, 24/09/14**	**A**	**A**	**G**	**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 e. Review of risk management within Estates by the Audit and Governance Committee, 12/02/15	1. Internal estates update reports (e.g. to Trust Management Executive in September 2014) 2. Estates and Facilities Annual Report to Trust Board (the latest report will be received at the Board in March 2015) **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~~ was 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)~~, but it has been recommended that they become a member of the Clinical Strategy Transformation Group	None	Angela Gallagher	Trust Board	**N/A - Objectives agreed at Trust Board, 24/09/14**	**A**	**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~~ held on 27/01/15) j. The TME held an 'away' seminar on 18/03/15 which discussed the issues that prevent the Clinical Directors leading on Strategy; and how such issues should be addressed	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	Glenn Douglas	Trust Board	**N/A - Objectives agreed at Trust Board, 24/09/14**	**G**	**G**	**G**	**G=**

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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 (i.e. Will the objective be met at year-end?)
										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. 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 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 c. Good working relationships have been developed and maintained with the current provider of the UGI services (Guy's and St Thomas' NHS Foundation Trust)	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. 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~~ A long-term strategy for the UGI service has not yet been determined by NHS England, but this has not been significant enough to affect the RAG ratings in the BAF	None	Paul Sigston	Trust Board	**N/A - Objectives agreed at Trust Board, 24/09/14**	**G**	**G**	**G**	**G=**

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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

This tests whether (or not) the controls are sufficient to enable the objective to be achieved.

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 – March 2015

3-28	Oversight Self-Certification, Month 11, 2014/15	Trust Secretary

The enclosed schedule sets out the proposed oversight self-certification submission for month 11, based on performance as at 28th February. This submission must be sent to the NHS Trust Development Authority (TDA) by the end of March (i.e. by 31st).

As Board members are aware, each month the Trust Board is required to 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 the 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. 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 2017.

Significant additions from the previous report and submission, which was agreed at the Board meeting in February 2015, are highlighted, whilst deletions are shown as ~~struckthrough~~.

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); and
- 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 – Compliant?
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. The Regulations introduced 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 enables a judgement 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 is 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 ask the	Yes

[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 – Compliant?
	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". A proposed approach to the new Regulations was approved at the December 2014 Trust Board, and implementation has commenced.	
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.**	No Compliant by 31/03/2017
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: '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.	Yes
G8 – Patient eligibility and selection criteria (for services and accepting referrals) ▪ Criteria are transparent ▪ Criteria are published	The Referral and Treatment Criteria (RATC) which apply from 1st April 2014 are published on the West Kent CCG website ("Kent and Medway clinical commissioning groups' (CCGs') [sic] schedule of policy statements for health care interventions, and referral and treatment criteria").	Yes

Pricing conditions

Condition	Evidence of Trust compliance	Latest assessment – Compliant?
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).	No Compliant by 31/03/2017
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**	No Compliant by 31/03/2017
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**	No Compliant by 31/03/2017
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.	Yes
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.	Yes

Competition conditions

Condition	Evidence of Trust compliance	Latest assessment – Compliant?
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.	Yes
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.	Yes

Integrated care conditions

Condition	Evidence of Trust compliance	Latest assessment – Compliant?
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.	Yes

Oversight Self Certification – Board Statements

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
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	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	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 final report of the Trust's inspection by the Care Quality Commission in October 2014 was published in February 2015, and confirms that Trust's overall rating as 'Requires Improvement'. ~~An action plan is in development, and this will be discussed further at the February 2015 Board meetings.~~ A Quality Improvement Plan has been developed in response, and was discussed at the February 2015 Trust Board.	
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 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 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.	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	The final report of the Trust's inspection by the Care Quality Commission in October 2014 was published in February 2015, and confirms that Trust's overall rating as 'Requires Improvement'. ~~An action plan is in development, and this will be discussed further at the February 2015 Board meetings.~~ A Quality Improvement Plan has been developed in response, and was discussed at the February 2015 Trust Board.	
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.	Yes
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, and the 2014/15 financial accounts are being prepared on this basis.	Yes
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.	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	(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 ▪ 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.	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
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.	Yes
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.	Yes
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. The guidance for the 2014/15 Governance Statement has now been issued, and is being reviewed by the Trust Secretary. The Statement will be prepared by the required deadlines.	Yes
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. Although the Trust is now unable to meet the required performance (95%) in terms of the A&E 4 hour waiting time target for the 2014/15 year, the Board confirmed (in February 2015) that a compliance status of "Yes" was appropriate for the statement, on	Yes (?)

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	the basis that the Trust's plans were sufficient to deliver the 4-hour A&E waiting time target, even though the target would not actually be met. ~~that it In the light of this, the Board is asked to consider whether it wishes to continue to declare compliance with statement 10, or whether the Trust's compliance status should be changed to 'No'.~~ ~~If the Board does agree to declare 'No', a "target date for completion" would need to be provided (in such circumstances, 01/04/15 is proposed, as this is the earliest date at which the target becomes achievable again).~~	
For governance, that: 11. the trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit	The Trust has achieved IG toolkit level 2 for 2013/14, and the proposed year-end submission for 2014/15 maintains Level 2 achievement against all Requirements	Compliant
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.	Compliant

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	▪ 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 implementation has commenced.	
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