Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD MEETING

Formal meeting, to which members of the public are invited to observe. Please note that questions from members of the public should be asked at the end of the meeting, and relate to one of the agenda items

10.30am – c.1pm WEDNESDAY 28TH SEPTEMBER 2016
THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
9-5	To receive apologies for absence	Chairman	Verbal
9-6	To declare interests relevant to agenda items	Chairman	Verbal
9-7	Minutes of the Part 1 meeting of 20th July 2016	Chairman	1
9-8	Minutes of the Part 1 meeting of 15th September 2016	Chairman	2
9-9	To note progress with previous actions	Chairman	3
9-10	Safety moment	Chief Nurse	Verbal
9-11	Chairman's report	Chairman	Verbal
9-12	Chief Executive's report	Chief Executive	4
9-13	Review of the Board Assurance Framework, 2016/17	Trust Secretary	5
9-14	Integrated Performance Report for August 2016	Chief Executive	
	▪ Safe / Effectiveness / Caring	Chief Nurse	
	▪ Safe / Effectiveness (incl. HSMR)	Medical Director	
	▪ Safe (infection control)	Dir. of Infect. Prevention and Control	6
	▪ Well-Led (finance)	Director of Finance	
	▪ Effectiveness / Responsiveness (incl. DTOCs)	Chief Operating Officer	
	▪ Well-Led (workforce)	Director of Workforce	
9-15	Update on the impact of the new Acute Medical Unit at Tunbridge Wells Hospital on patient flow	Chief Operating Officer	7
	Presentation from a Clinical Directorate		
9-16	Trauma and Orthopaedics Directorate	Clinical Director; Assoc. Director of Operations – Cancer and Surgery	Presentation
	Quality items		
9-17	Supplementary Quality and Patient Safety report	Chief Nurse	8
9-18	Annual Report from the Director of Infection Prevention and Control	Director of Infection Prevention and Control	9
9-19	Planned and actual ward staffing for July & Aug 2016	Chief Nurse	10
	Assurance and policy		
9-20	Update on Medical contract issues	Medical Director	Verbal
9-21	Health & Safety Annual Report, 2015/16 (incl. agreement of the 2016/17 programme)	Chief Operating Officer	11
	Reports from Board sub-committees (and the Trust Management Executive)		
9-22	Quality Committee, 01/08/16 & 14/09/16 (incl. SIs)	Committee Chairman	12
9-23	Audit and Governance Committee, 10/08/16 (incl. the Annual Audit Letter for 2015/16)	Committee Chairman	13
9-24	Finance Committee, 22/08/16 & 26/09/16	Committee Chairman	14 & 15 (to follow)
9-25	Patient Experience Committee, 06/09/16	Committee Chairman	16
9-26	Trust Management Executive, 21/09/16	Committee Chairman	17
9-27	**To consider any other business**		
9-28	**To receive any questions from members of the public**		
9-29	To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted	Chairman	Verbal

Date of next meetings:

- 19th October 2016, 10.30am, Education Centre, Tunbridge Wells Hospital
- 30th November 2016, 10.30am, Academic Centre, Maidstone Hospital
- 21st December 2016, 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 20TH JULY 2016, 12PM AT TUNBRIDGE WELLS HOSPITAL

FOR APPROVAL

Present:	Anthony Jones	Chairman of the Trust Board	(AJ)
	Avey Bhatia	Chief Nurse	(AB)
	Sylvia Denton	Non-Executive Director	(SD)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director (apart from items 7-10, 7-11 & 7-12)	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Steve Orpin	Director of Finance	(SO)
	Paul Sigston	Medical Director	(PS)
	Kevin Tallett	Non-Executive Director	(KT)
In attendance:	Richard Hayden	Director of Workforce	(RH)
	Jane Hurst	Improvement Director	(JH)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
	Christopher Pierce	Patient relative (for item 7-8)	(CP)
	Edward Pierce	Patient relative (for item 7-8)	(EP)
	Hilarie Pierce	Patient relative (for item 7-8)	(HP)
	Charlotte Smith	Patient relative (for item 7-8)	(CS)
Observing:	Claire Barnett	Assistant Trust Secretary (for item 7-8)	(CB)
	Darren Yates	Head of Communications	(DY)
	Richard Hallett	Vice-President, The Friends of Crowborough Hospital (until item 7-10)	(RHa)
	Chhaya Patankar	ST7 Paediatric Registrar	(CP)
	Conn Sugihara	Member of the public	(CSu)
	David Gazet	Reporter, Kent Messenger	(DG)

7-1 To receive apologies for absence

Apologies were received from Alex King (AK), Non-Executive Director; and Steve Tinton (ST), Non-Executive Director. AJ noted that the meeting was JH's last as Improvement Director, and thanked her for her contribution.

7-2 To declare interests relevant to agenda items

KT reported that he had completed his tenure at EDF energy, established his own company (Discidium Ltd), and been engaged (via that company) by Medway NHS Foundation Trust to deliver Programme Management Office (PMO) Services. KT added that he had signed a confidentiality agreement, to protect both Trust's commercial interests. AJ welcomed the engagement, given the relationship between the two Trusts.

7-3 Minutes of the Part 1 meeting of 29th June 2016

The minutes were agreed as a true and accurate record of the meeting, subject to the following amendment:

- Replace "Tracey Karlsson, Head of Employee Services, (TK)" with "Jeanette Barlow, Learning & Development Manager, (JB)" in the list of those "Observing"

Action: Amend the minutes of the Part 1 Trust Board meeting of 29th June 2016 (Trust Secretary, July 2016)

7-4 To note progress with previous actions

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

- **Item 9-8i ("Ensure the Trust Board receives the outcome of the planned review of Medical rotas being led by the Medical Director")**. PS noted that this would be covered under item 7-15.
- **Item 5-12ii ("Consider including details of income for 'ITU' within future 'planned and actual ward staffing' reports submitted to the Trust Board")**. SO reported that the "Planned & actual ward staffing" report now contained significantly more detail, and asked whether the requested information was therefore really necessary, as its inclusion would result in that report being more complicated. It was agreed to not include the information, and to close the action.
- **Item 6-8iii ("Consider whether the "Mean" line within the "Integrated performance report analysis" charts submitted to the Trust Board was beneficial, in terms of demonstrating the trend in performance over time").** SO noted that the update provided was self-explanatory, but highlighted that an explanation of the methodology used within the charts had been included in the performance report. AJ asked for any further comments to be given directly to SO. It was agreed that the action could be closed.

7-5 Safety moment

AB reported that following discussion between KT & KR, it was intended that a more structured approach be applied to Safety Moments. AB elaborated that a safety subject would be selected for a particular month, and weekly messages could be issued under that subject. AB added that subjects could include Infection Control, Safeguarding etc., and the Safety Team would be leading on the approach, but the Communications Team would be involved as necessary.

AJ stated he totally supported the aim of having a consistent theme. SDu concurred, but queried whether "communication" could be one of the chosen subjects, noting that item 7-8 illustrated the importance of communication in alleviating the impact of a family tragedy. SDu continued that the message could emphasise the importance of good communication. AB agreed that this could be the first subject under the new approach.

KT commended the intended programme as a change vehicle, but stated that the key to success was to use the messages to prompt a brief discussion, as this was when engagement would occur. The point was acknowledged.

7-6 Chairman's report

AJ reported that it was well known that the NHS was in state of some flux, but one of the crucial issues for the Trust Board was to maintain the focus on doing things well at the Trust, as if this was not done, patients would suffer. AJ added that the Trust had substantially improved the services offered to patients from that provided in the past, and this needed to continue.

7-7 Chief Executive's report

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

- Regardless of the financial pressures faced, the Trust needed to continually develop the services it provided to patients, and this was illustrated by the introduction of the new dichloride therapy service for men with prostate Cancer
- The Trust needed to change the way it considered the likely future demand for services, and come to terms with a potential 10% increase in activity during the winter i.e. it needed to develop contingency to deal with this while there was time to do so

AJ referred to the latter point and noted that the activity seen in previous winters was now considered to be normal. GD agreed, but highlighted that the new normal level of activity was shifting continuously, and the Trust needed to respond.

GD then continued, and highlighted that 3 new Inflammatory Bowel Disease (IBD) Nurses had been appointed. AG added that a new Lead Clinician for IBD had also been appointed.

GD then continued, and highlighted the following points:

- There had been an increase in women choosing to give birth in different locations, not simply Tunbridge Wells Hospital (TWH), which showed that informed choices were being made regarding appropriate services
- The inaugural Quality Improvement Project awards had been held, which were an important way of recognising and valuing the services provided. Trust Board Members were encouraged to read some of the accounts of the Projects.

SM then highlighted the positive work the Radiology Team had undertaken regarding Ultrasound, and reported that the DVT service was being extended into TWH, following the signing of an Any Qualified Provider (AQP) contract. The development was commended.

KT then referred to growth in activity highlighted in the report, and queried the point at which this would be considered the new norm, noting that previous analysis undertaken by Value Dynamics, on behalf of the Trust, had predicted a 17% increase in activity**.** The point was acknowledged.

7-8 A patient's experiences of the Trust's services

[N.B. This item was taken at the start of the meeting, before item 7-1]

AJ welcomed HP, CP, EP and CS to the meeting, and invited them to recount the details of their experiences in relation to the care provided to Mr Tony Pierce (TP). HP expressed her thanks for being given time to address the Board, and proceeded to highlight the following points:

- HP's husband, TP, was admitted to the ITU at TWH under the leadership of PS at the beginning of December 2015
- On 25/11/15, HP's world was turned upside down, and she knew that her life as she had known it would never be the same again. On that day, HP felt that her children also lost their mother and the journey ahead was indescribable
- The family flew to Mumbai, India, to be by TP's side. After a stressful week in India, TP was then returned to the UK and was admitted to the ITU. HP knew what was ahead but the journey to that end was terrifying as the family walked into the unknown
- Under the guidance and leadership of PS and his team the family were guided and given enough information and time to make informed decisions. The journey had started as a family, making decisions as a unit, and therefore at no time was HP prepared to make any decisions without each and every member of the family being present.
- The Medical team respected HP's wishes and facilitated them.
- HP knew when she was not with TP that he was safe and in the best possible care
- Every member of staff in the Unit acted professionally at all times. They met TP's needs and the needs of the family.
- TP died with dignity in HP's arms. HP felt very proud of her children and their partners. She also felt immense pride in herself knowing that TP would have been proud of her.
- This would not have been possible if it had not been for PS and all of his team leading the family through the days with the upmost respect, care and honesty
- HP wished to make special mention of the cleaner, who showed the family such empathy and care; and the Nurse who at the end showed such respect for TP, tidying his hair and ensuring he was comfortable.

HP continued that, as she had alluded to earlier in the meeting, she felt that her children had lost their mother on 25/11/15, and she would not be where she was now had it not been for her family, friends and the entire team at TWH. HP added that she was however pleased to say she had returned, as EP, her eldest son had announced this to all family and friends on Facebook.

HP then reiterated her thanks to all of the staff at TWH for looking after TP with such care and professionalism, and read out the contents of a letter she had sent to PS on 17/02/16. HP then passed the letter and the notes she had written to AJ. AJ stated that a copy would be provided to all Trust Board Members.

AJ thanked HP and asked whether CS, EP or CP wished to add anything. Nothing further was added. AJ then asked whether the cleaner had been identified, and thanked. PS confirmed that he had read the aforementioned letter from HP to all of the staff on the Unit.

AJ stated that the story illustrated the importance of the whole-team approach, and asked for comments or queries from Trust Board Members. KT remarked that he found the story very humbling, but very powerful, and gave thanks to HP and her children. GD stated that the story illustrated the importance of recognising and reflecting on when the Trust got things right, to enable this to be repeated across the organisation.

AJ thanked HP and her family on behalf of the whole Board.

7-9 Integrated Performance Report for May 2016

GD referred to the circulated report and highlighted that the Trust's position had been controlled, but improvement was still required. AJ then invited AG to report the latest monthly information.

Effectiveness / Responsiveness (incl. DTOCs)

AG referred to the circulated report and highlighted the following points:
- The Trust was still on course to deliver the 18-week Referral to Treatment (RTT) trajectory by July 2016
- The two main areas of focus in relation to the emergency pathway were Ambulatory pathways and Length of Stay (LOS). This was the focus of all Directorates, and would lead to the A&E 4-hour waiting time target being met by the year-end
- There was also a continued focus on matching resources to demand

AJ referred to the summary, noted that "Bed occupancy remains above 95% across the Trust", and asked what the ideal level of occupancy was. AG replied that 85% would be the ideal, but 90% provided an appropriate degree of flexibility. AJ highlighted that this level of occupancy occurred despite the additional capacity the Trust had introduced.

AG then continued, and made the following points:
- The Trust's performance was on trajectory for the 62-day Cancer waiting time target for May, but the Colorectal pathway was problematic, which was largely driven by an increase in volume of patients and some internal issues. Colorectal was the one Tumour site that was affecting wider performance, however, assurance had been obtained that the Clinical Team was focused on resolving the issues
- The Trust was performing well on the 31-day Cancer waiting time target (which related to the time between diagnosis and treatment)

SDu queried whether the issues with Breast Cancer had now been resolved. AG replied that the Breast Tumour site was now in a very strong position in relation to clearing their Patient Tracking List (PTL). SDu commended this, but expressed concern that a further issue i.e. Colorectal had now arisen. AG clarified that the Colorectal tumour site had always been identified as a risk. AG added that there were also issues with patients referred on from the Trust to other Trusts.

AG then continued, and highlighted that slow progress was being made in implementing the SAFER bundle for Wards, to aim to reduce LOS. AG added that improvements were however evident when individual Ward data was reviewed.

Safe (infection control)

SM then referred to the circulated report and highlighted the following points:
- There had still been no cases of MRSA bacteraemia for 2016/17
- The performance on MRSA screening had been the best for some time
- There had been 4 cases of Clostridium difficile in June (which was 1 case above the trajectory for the month), but the number of cases was still 1 below the trajectory for the Quarter

AJ then referred to the data on page 5 of 22 and noted that there were substantially more Clostridium difficile cases this year than the last, and asked why this was the case. SM replied that investigation had not identified a relationship between the cases seen, but awareness-raising would continue for staff in general, and for the new intake of Junior Doctors in particular. AJ asked what the audits of hand washing showed. SM answered that these showed that compliance was

very good, and the findings corresponded with audits undertaken by the Infection Control Team. AJ then asked about the prevalence of Clostridium difficile in the community. SM confirmed that no increase had been seen thus far. AJ suggested that the issue be reviewed in detail at the next Board meeting if the situation did not improve. The suggestion was acknowledged.

Safe / Effectiveness / Caring

AB then referred to the circulated report and drew attention to the following points:

- The performance in relation to patient falls was positive, and there was evidence that the actions that had been taken were having the desired effect, as a falls rate of less than 6.2 (per 1,000 Occupied Bed days) had been achieved for 2 consecutive months. The year to date (YTD) rate was also below 6.2
- Complaints response performance had improved, but the response rate for the Friends and Family Test (FFT) in Maternity had reduced due to the Department having an insufficient supply of FFT survey cards. This had however now been addressed, and the cards that had been completed gave a 99% rating, which was very good, as the usual score was 95%

KT asked why the falls position had improved. AB replied that intense focus had been important, noting that the actions taken were described in more detail in Attachment 5. AB added that repeat fallers had been a key theme and focus, whilst holding Wards to account had also helped. AB also noted that the support from the PMO in providing timely data to the Wards was also beneficial.

Safe / Effectiveness (incl. HSMR)

PS then referred to the circulated report and highlighted that the Summary Hospital-level Mortality Indicator (SHMI) of 105 related to September 2015, and was therefore a replication of the issue that had been identified via the Hospital Standardised Mortality Ratio (HSMR), which had previously been reviewed in detail.

AJ stated that he was disappointed to see a decline in performance on the Stroke-related indicators. PS replied that work was being focused on Stroke patients being admitted to a Stroke bed within 4 hours, and this had been discussed at the 'main' Quality Committee. AG added that the issue was kept constantly under review, and was closely linked to capacity at TWH.

Well-Led (finance)

SO then referred to the circulated report and reported the following points:

- The YTD deficit was just below £10.5m, which was £1.6m adverse to the YTD plan
- As the Trust was not within the Sustainability and Transformation Fund (STF) regime, it was eligible for contractual penalties relating to non-compliance with the NHS Constitutional access targets. Such penalties totalled £1.6m, & were the main contributor to the variance from Plan. However, a focus on in-house actions, including increasing elective activity, was also needed
- Pay costs were underspent against Plan for the first 3 months of 2015/16, although the level of underspend had reduced for month 3
- Medical and Scientific Therapeutic & Technical (STT) staff were now the main areas of focus in relation to Agency expenditure (after the considerable work undertaken with Nursing staff)
- CIP performance was in accordance with Plan, although the required level of performance would increase from July, as some of the schemes expected to feature later in the year were incorporated
- The cash position was as expected, and the Finance Committee had discussed the actions being taken to improve the position, on 18/07/16

Well-led (workforce)

RH then referred to the report and made the following points:

- The sickness absence rate had improved to 3.8%, which reflected the recent efforts made by efforts made by the operational management team and Human Resources
- The staff FFT response had been the highest level seen for quarterly feedback. The quarter had also received the highest grades in relation to recommending the Trust as a place to work

AJ commended the staff FFT results, and asked for an update on recruitment. RH replied that this was going well, and the focusing was now on the next wave of Nursing recruitment. RH continued that there had been some recent successes in Medical recruitment, although work was ongoing in this area. RH added that the intention was to change the approach to recruitment, by emphasising the Trust as a good place to work.

Quality Items

7-10 Supplementary Quality and Patient Safety report

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

- A revised methodology for Care Assurance audits had been introduced, now that the new Deputy Chief Nurse had started in post
- Much work had been undertaken on Protected Mealtimes, and a new Policy would be re-launched soon

AJ remarked that compliance with the Protected Mealtime arrangements tended to be satisfactory for a while, but then reduced, and asked why this was the case. AB noted that work had been undertaken regarding the use of red trays, and as a result of this review, the Policy had been refreshed. AB explained that the red trays used previously did not fit the new meal trollies that had been introduced, but work had been undertaken to resolve this. AB added that the key issue to success was the organisation of Protected Mealtimes on the Wards

AB then continued, and noted that the final report of first assessment under the new in-house Care Quality Commission (CQC) inspection process had been included, and two further assessments had been carried out since. KT commended the usefulness of the assessment report, but noted the 'amber' rating (for "Is the name of the patients consultant displayed on the patient information board (above the bedhead or on the door)?" at TWH). AB stated that it was positive that the issue had been identified during the assessment.

SD then referred back to the Protected Mealtimes issues, and asked for clarification that AB was stating that the real impasse to patients obtaining appropriate nutrition was in patients receiving help, rather than in the availability of red trays, which merely indicated that such help was required. AB clarified that the focus was on ensuring patients received the help they required, when they required it, and the Protected Mealtimes process supported this aim, by having a more systematic approach to mealtimes.

7-11 Planned & actual ward staffing for June 2016

AB referred to the circulated report and drew attention to the following points:

- The report was in the same format at usual, and demonstrated clearly that Ward staffing levels were safe
- The report needed to be changed to reflect further information regarding Care Hours Per Patient Day (CHPPD), but AB needed to consider exactly how this should be done

AJ noted that the comparative CHPPD data published so far was not very helpful. AB stated that intra-Trust data, rather than Trust-wide data would be more beneficial, but the situation would improve as the Lord Carter-led 'model hospital' data was developed. SO added that due to the summer period, the Trust was likely to continue to receive the data that had been provided thus far. AJ stated that the wide level of variation suggested wide variations in the methodology used by Trusts, and therefore cautioned against too much time being spent on comparisons. SO acknowledged the point, but noted that overall high-level comparative data was useful in identifying areas to investigate in more detail.

SO then queried whether a singular value of average CHPPD had been produced nationally, and queried whether this had been included. AJ replied that he believed this had been included in the report. AB added that the averages arising from the Lord Carter report had been included. SO stated that he understand the national data had been updated since the Lord Carter report. AB explained that data in the circulated report had been obtained from the "Unify" reporting system.

7-12 Review of clinical outcomes

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

- An update on the issues reported in the equivalent report from 2015 had been included, including the increase in mortality relating to Cerebrovascular disease
- The National Clinical Director for Stroke had notified the Trust that Maidstone Hospital (MH) had been identified as an outlier, in terms of mortality for Stroke patients. The Trust asked Dr Foster to review the data and the resulting report had been included in Attachment 7. The investigation had identified some issues relating to Clinical Coding. However, page 3 of 13 showed that Stroke mortality had reduced at both MH and TWH, which was likely to be related to the focus Stroke care had received

AJ commended the report and invited questions or comments. KT stated that there appeared to be a tendency for the Trust to become an outlier on an issue, only to have this identified externally, which prompted a response, and queried whether anything could be done to improve the Trust's responsiveness. PS acknowledged that relevant data was sometimes out of date, but stated that on reflection, assessing mortality by hospital site may have led to earlier identification of the issue.

PS then continued, and highlighted that mortality for fractured neck of femur was now below the national mean.

AJ asked for a comment on the data for "Acute and unspecified renal…" on page 13 of 13. PS replied that there appeared to be a higher mortality of patients coded with that diagnosis, but this was currently under investigation. AJ then asked for a comment on the data for "Secondary malignancies" on page 13. PS stated that the data reflected the Trust's status as a Cancer Centre. AJ finally asked about "Other gastrointestinal disorders" on the same page. PS highlighted that the Trust was not currently compliant with the recommendations from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) regarding GI bleeding.

[Post-meeting note: The Medical Director gave an update on compliance with the recommendations from the NCEPOD report "Gastrointestinal Haemorrhage: Time to Get Control?" at the 'main' Quality Committee on 06/07/16]

7-13 Safeguarding children update (ann. report to Board)

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

- A review of review of the role and functions of Local Safeguarding Children Boards (LSCBs) had been undertaken by the Government, and the report had been published in May 2016
- That review had concluded that LSCBs were not fit for purpose and a new way of undertaking Serious Case Reviews was required. The Government had responded, but a change in primary legislation was required, as the arrangements for LSCBs were very prescribed. The Trust would however be involved as necessary with any changes
- Another recommendation from the review was that Safeguarding should be included within the Department of Health's remit
- The circulated report contained details of Trust's processes

7-14 Trust Board Members' hospital visits

AJ referred to the circulated report and asked that Trust Board Members ensure they recorded the visits they made with KR, as the report probably did not accurately reflect the visits undertaken.

Assurance and Policy

7-15 Review of medical rotas/contract update

PS reported that Junior Doctors had rejected the new contract and the Government had confirmed its intention to impose this. PS added that the new contract was much more hours-based than the previous contract. PS went on to explain some of the other differences with the new contract, which included the cessation of the 'diary card' exercise, and the appointment of a "Guardian of Safe Working Hours". PS stated that the Trust was interviewing for the latter role at the end of July, and the appointed person would be required to report to the Trust Board each Quarter.

PS then continued, and reported that the first group of Junior Doctors to operate under the new contract would be Obstetric and Gynaecology Registrars, in October 2016. PS also noted that the new contract was expected to be cost neutral, although basic pay would rise, and there would be a contribution to pensions.

AJ asked for a further update to be given on Medical contract issues at the September 2016 Board meeting. This was agreed.

Action: Provide a further update to the Trust Board, in September 2016, on Medical contract issues (Medical Director, September 2016)

AJ then asked about the Consultant contract. PS replied that there had been no progress. AJ asked that PS apprise the Board as and when any developments occurred.

7-16 Estates and Facilities Annual Report 2015/16

AG referred to the circulated report and highlighted that the budget had been exceeded but practically all of the variance was due to winter pressures, in terms of managing new patient areas (for cleaning, laundry etc.), but this had now been reflected in the Directorate's 2016/17 budget.

AJ referred to comparisons with the Lord Carter productivity review, on page 8 and 9 of 12. AG noted that the Directorate had fared well on such comparisons.

AJ commended the clearly written report and the inclusion of the Lord Carter-related data.

GD referred to pages 8 and 9 of 12, and explained that all common areas of the hospitals were excluded from the calculation of "non-clinical floor space". The point was acknowledged.

AJ then asked for an update on the new Patient Transport contract. AG replied that there had been some teething problems, but the Trust had deployed its contingency, and the service was working much better, more quickly, than when the previous new contract had been introduced. SO added that the Trust was expecting a significant saving in relation to the level of support required by the Trust in relation to the new service.

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

7-17 Quality Committee, 06/07/16

SDu referred to the circulated report and highlighted that the Chief Nurse from West Kent Clinical Commissioning Group (CCG) had reported that the CCG had raised concerns at the level of Disclosure and Barring Scheme (DBS) checks undertaken at the Trust. SDu continued that it had been agreed that the latest situation should be reported to the Trust Board. RH noted that a report had been submitted to the 'Part 2' Board meeting scheduled for later that day, but highlighted that the Trust was currently at 93% compliance with such checks. RH added that data cleansing had been at the root of the reported problems, and he had informed the Chief Nurse for West Kent CCG of the improvement during the previous weekend.

SDu then added that the opportunity to learn from the Stroke care provided at The Queen Mother Hospital in Margate had been raised, and this would be reported back to the Committee in due course.

7-18 Trust Management Executive, 13/07/16

GD referred to the circulated report and invited questions or comments. None were received.

7-19 Finance Committee, 18/07/16

SDu referred to the circulated report and made the following points:

- The Committee had received a very positive presentation from the Trust's PMO, which had given great assurance

- The nature of the non-elective activity had affected the Trust's ability to undertake its planned level of elective activity and a report would be submitted to the 'Part 2' Board meeting in September 2016
- It was also agreed that a response to the recommendations from the Lord Carter-led operational productivity and performance review should be submitted to the September Board

AJ commended the report being issued in a timely manner, following the meeting on 18/07/16.

7-20 To consider any other business

There was no other business.

7-21 To receive any questions from members of the public

DG asked whether there was any risk to services provided to the A&E at MH, as a result of the ongoing Sustainability and Transformation Plan (STP) process. AJ replied that he was unable to be definitive, as the outcome of the STP was not yet known. AJ added that it would however be dishonest to suggest that there would be no possible revision of services. GD added that the STP-related discussions regarding MH had focused on the potential establishment of an elective care centre, and not on the A&E per se. GD continued and emphasised that, as had been illustrated earlier in the meeting, any intention to reduce the number of access points used by patients would need to be carefully considered.

7-22 To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted

The motion was approved.

Maidstone and Tunbridge Wells NHS
NHS Trust

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS EXTRAORDINARY TRUST BOARD MEETING (PART 1) HELD ON THURSDAY 15TH SEPTEMBER 2016, 4.30PM AT MAIDSTONE HOSPITAL

FOR APPROVAL

Present:	Anthony Jones	Chairman of the Trust Board	(AJ)
	Avey Bhatia	Chief Nurse	(AB)
	Glenn Douglas	Chief Executive	(GD)
	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:	Richard Hayden	Director of Workforce	(RH)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)

9-1 To receive apologies for absence

Apologies were received from Sylvia Denton (SD), Non-Executive Director; and Sarah Dunnett (SDu), Non-Executive Director.

9-2 To declare interests relevant to agenda items

KT reported that he had been engaged (via his own company, Discidium Ltd) by Medway NHS Foundation Trust to deliver Programme Management Office (PMO) Services.

9-3 To delegate the authority to approve the Trust's Financial Recovery Plan to the 'Part 2' Trust Board meeting scheduled for 15/09/16

The Trust Board delegated the authority to approve the Trust's Financial Recovery Plan to the 'Part 2' Trust Board meeting scheduled for later that day.

9-4 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 – September 2016

9-9 Log of outstanding actions from previous meetings — Chairman

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
9-8i (Sep 15)	Ensure the Trust Board receives the outcome of the planned review of Medical rotas being led by the Medical Director	Trust Secretary / Medical Director	September 2015 onwards (but then extended to March 2016)	It was agreed at the Board on 25/05/16 that the Medical Director would provide an update to each Trust Board, from June 2016 onwards. A further verbal update (to cover contracts) has therefore been scheduled for the September 2016 Trust Board meeting. The Board is asked to consider whether the action should continue to remain 'open' in the light of the uncertainty regarding the future of the national contract for Junior Doctors
6-8iv (June 16)	Arrange for the next meeting of the Workforce Committee to review whether the current vacancy rate had been assumed in the Trust's plans for 2016/17	Chairman of Workforce Committee / Director of Workforce	September 2016	The matter is scheduled to be considered at the next meeting of the Workforce Committee, on 29/09/16

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
6-8ii (June 16)	Arrange for the work to reduce Length of Stay to be reported to the 'main' Quality Committee in September 2016	Trust Secretary / Chief Operating Officer	September 2016	The item was discussed at the 'main' Quality Committee in September 2016
6-9 (June 16)	Submit a further report to the Trust Board in September 2016 on the impact of the new Acute Medical Unit at Tunbridge Wells Hospital on patient flow	Chief Operating Officer	September 2016	A report has been submitted to the Trust Board in September 2016

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
7-3 (July 16)	Amend the minutes of the Part 1 Trust Board meeting of 29th June 2016	Trust Secretary	July 2016	The minutes were amended
7-15 (July 16)	Provide a further update to the Trust Board, in September 2016, on Medical contract issues	Medical Director	September 2016	A verbal update report has been scheduled for the Trust Board in September 2016

Actions not yet due (and still 'open')

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - September 2016

9-12	**Chief Executive's update**	**Chief Executive**

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

1. Since our last meeting, we have been placed in to financial special measures by NHS Improvement (NHSI) to tackle our underlying financial deficit.

   We were unable to agree a control total for 2016/17 and our staffing costs have grown in the last three years above the national average. An NHSI-appointed and funded Finance Improvement Director called Simon Worthington (Bolton NHS FT Deputy CEO and Finance Director) is supporting the development of the Trust recovery plan.

   We need to ensure we balance the three areas of quality, finance and performance. Getting this balance right will deliver benefits for the Trust and its patients in the longer term.

   We have sought to closely involve our staff in the development of our financial recovery plan and have received hundreds of ideas highlighting ways in which we can make better use of our finite resources. This is hugely encouraging.

2. We have continued to focus on the delivery of high quality care throughout the summer and are working closely with our staff and partners to meet the unprecedented demand for our services.

   We have remained steadfast in our drive to improve patient care through careful and detailed monitoring of our services and patient outcomes. We identified and took all necessary measures to address a small but nevertheless increased incidence of C. difficile cases. We have also been alert to VTE's and have continued to promote key messages to our staff. This includes the launch of a new safety calendar that consolidates our organisational focus around a specific patient safety theme for the month. In September, we are focusing on improving patient communication, and have placed a great deal of emphasis on the `Hello my name is' campaign.

3. More patients with life-threatening conditions are surviving emergency bowel surgery at Tunbridge Wells Hospital which now has the ninth lowest emergency bowel surgery mortality (death) rate in England and Wales. No other hospital in the South East, outside of London, is now providing better outcomes for patients with life-threatening conditions such as bowel obstruction, perforation or a bleed and there is now only one hospital in the whole of the South of England achieving slightly better results (in Bristol).

   More than 30,000 patients have this emergency surgery each year in NHS hospitals. The Royal College of Anaesthetists recently reported that mortality rates can be as high as 20%, with the national average sitting at 11.1%. Clinicians at Tunbridge Wells Hospital have reduced mortality rates to 7.2% as part of a quality improvement project to save 1,000 more lives over two years across the South of England.

   The latest quality data from the Intensive Care National Audit & Research Centre (ICNARC) has also now been reported, and the Trust's sites were 4th and 5th best in the country for standardised mortality

4. Our hospitals have received very positive feedback following patient-led assessments (PLACE) to review how the environment supports patient's privacy and dignity, the quality of patient food, cleanliness of wards, and general building maintenance. We exceeded national average scores at MTW in all categories with nine scores over 90% and the remainder in the high 80s.

5. Maternity services have been shortlisted for a prestigious Award by the Health Service Journal (HSJ). The shortlisting in the Most Effective Adoption and Diffusion of Best Practice category is for Improving clinical outcomes and patient experience for mothers and babies having a caesarean birth.

   A multidisciplinary team (midwives, theatre staff, obstetricians and anaesthetists) collaborated to perform research and produce a short film to show what expectant mothers can do to give their baby the best possible start at a caesarean birth. This video also shows skin-to-skin contact between mother and baby, and delayed cord clamping at a caesarean birth as well as demonstrating how practices can be standardised and performed safely in the operating theatre. The developments in maternity care have received national and international interest.

   Maidstone Birth Centre recently celebrated the 2000th baby to be born at the Centre. Four-year-old Caleb Thompson was the first baby born at the Centre and came back with his parents to help us mark the milestone. The Centre really has been one of our success stories and continues to go from strength to strength with 8% of all deliveries now taking place there.

6. The Chronic Pain Unit has received a generous donation from Maidstone Hospital League of Friends in the form of two brand new vital signs monitors.

   A group of people with learning disabilities, who attend Sevenoaks Day Service, have visited Tunbridge Wells Hospital to deliver over £350 worth of toys to the children's A&E department. A number of months ago, a group from the day service came in to A&E for a tour, and to meet staff, after they attended a monthly 'Meet the Matron' session to explain that many of them found the prospect of having to come into A&E rather daunting. The tour was a great success, with a lot of positive feedback, saying that all who had attended felt much more comfortable with any potential visits in the future.

   Members of the Paediatric Diabetic Team at Maidstone Hospital, along with some of their patients, were given a cheque for £500 from the Kent Police Property Fund. The money will go to Maidstone Area Parents Support group (MAPS), set up for parents who have children with diabetes. MAPS host numerous events throughout the year which allow children with Type 1 Diabetes, and their parents, to meet others in the same position so they can share advice and experience, and offer support to each other.

   I would sincerely like to thank all of these groups for their support.

7. Congratulations to our latest internal monthly staff award winners Glen Wells (Estates), Margaret Bray (domestic), Mary Chapman (domestic), Pre-Analytics Team (Blood Sciences department), Oncology and Haematology Admin and the Acute Medical Unit Team (Maidstone)

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 – September 2016

9-13 Board Assurance Framework (BAF) 2016/17 Trust Secretary

The Board Assurance Framework (BAF) is the document through which the Trust Board identifies the principal risks to the Trust meeting its agreed objectives, and to ensure adequate controls and measures are in place to manage those risks. 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, who liaises with each "Responsible Director" to ensure that the document is updated throughout the year.

Link with the Risk Register
The BAF differs from the Risk Register in that the BAF should only contain a sub-set of risks on the Risk Register: those that pose a direct threat to the achievement of the Trust's objectives.

Review by the Trust Board
This is the first time during 2016/17 that the Board has seen the populated BAF (Board Members will recall that the objectives for 2016/17 were only agreed at the July 2016 Part 2 Board meeting).

Board members are asked to review and critique the content, by considering the following prompts:
- Are the objectives appropriately described? Should the wording of any be amended?
- Do the RAG ratings of the sufficiency of the actions taken reflect the situation as understood by the Board (and its sub-committees)?
- Do the RAG ratings of confidence that the objective will be achieved reflect the situation as understood by the Board (and its sub-committees)?
- Does any of the content require further explanation?
- Does the format of the BAF need to be amended?

The Board is reminded of the options available to it, in terms of a response, which include:
- Accepting the information as submitted;
- Requesting amendments, to objectives, risks, ratings and/or content;
- 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?
- Trust Management Executive, 21/09/16
- Finance Committee, 26/09/16 (objective 4.a only)

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

[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 2016/17

Maidstone and Tunbridge Wells NHS Trust

What is the key risk? *Main risk*

1 The Trust fails to improve key aspects of clinical care and safety

What does the Trust want to achieve? [2] *Objective*

1.a To reduce the falls rate to less than 6.2 per 1,000 occupied bed days

Relevant CQC domain/s: Safe ☒ Effective ☒ Caring ☒ Responsive ☐ Well-led ☒

What could prevent this objective being achieved? *Risks to objectives*

1. Insufficient senior leadership and commitment
2. Insufficient clarity of the performance required by each Ward, & the monitoring of such performance
3. Insufficient engagement by Wards and staff
4. The falls-related documentation not being fit for purpose

What actions have been taken in response to the above issues? *Controls*

a. A Task and Finish group for reducing falls has been established, chaired by the Chief Nurse and supported by the Director of Infection Prevention and Control and Deputy Chief Executive (1)
b. The Falls Review Panel has been strengthened with Executive Director leadership (Chief Nurse) (2)
c. Individualised thresholds have been set for each Ward, and the Falls Review Panel meets with each Ward team that exceeds their threshold as part of the wider review of practice (2)
d. The Period of Increased Incidence (PII) monitoring framework used in infection control has been revised for use in falls prevention (2)
e. The Terms of Reference for the Slips, Trips and Falls Group have been reviewed, to engage and representation from all staff groups (3)
f. A dashboard has been developed to enable falls data to be collated and viewed in one place (2)
g. The Programme Management Office (PMO) is providing support to undertake data analysis (2)
h. Nursing assessment documents for falls prevention has been reviewed (4)
i. There is a comprehensive action plan to address the areas identified as requiring improvement from the National Falls Audit (1, 2, 3, 4)

Are the actions that had been planned for this point been taken? *Gaps in control*

September 2016			November 2016			February 2017		
Yes	Partly	No	Yes	Partly	No	Yes	Partly	No
☒	☐	☐	☐	☐	☐	☐	☐	☐

If "Partly" or "No", please explain

1. N/A

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

1. The Trust Performance Dashboard (which contains the "Rate of Total Patient Falls", the "Rate of Total Patient Falls Maidstone", "Rate of Total Patient Falls TWells" the number of "Falls - SIs in month") and Integrated Performance Report graphs (which shows the "Rate of Falls" graphically)
2. Quality Accounts priorities progress reports to the Patient Experience C'ttee and Quality C'ttee
3. The 'Quality and Governance' bi-monthly report to the Trust Clinical Governance Committee, which shows the "Rate of Patient Falls per 1,000 Occupied Beddays", and the number of Falls resulting in "No Harm", "Low Harm", "Moderate Harm", and "Severe Harm") and provides a commentary on the latest position; and also includes the falls data for each Directorate at both hospital sites

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

If "No", what other data is needed?

1. N/A

Risk owner/s:	Responsible Director:	Main committee/s responsible for oversight:
Chief Nurse / Medical Director	Chief Nurse	Trust Clinical Governance Committee / Quality Committee

How confident is the Responsible Director that the objective will be achieved by the end of 2016/17? [3]

September 2016			November 2016			February 2017		
☒	☐	☐	☐	☐	☐	☐	☐	☐

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

- The rates for April, May & June of 6.85, 5.54 & 5.74 respectively. The cumulative rate for Quarter 1 is 6.04

[2] In July 2016, the Trust Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance

[3] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2016/17

Maidstone and Tunbridge Wells NHS Trust

What is the key risk? *Main risk*

2 The Trust is unable to manage (either clinically or financially) during the winter period

What does the Trust want to achieve? [4] *Objective*

2.a To achieve an average maximum Length of Stay for elective care of 3.2 days

2.b To achieve an average maximum Length of Stay for non-elective care of 6.8 days

Relevant CQC domain/s: Safe ☐ Effective ☒ Caring ☐ Responsive ☐ Well-led ☒

What could prevent this objective being achieved? *Risks to objectives*

1. Insufficient senior leadership and commitment
2. Insufficient engagement by clinical staff
3. Insufficient clarity over the performance required
4. Insufficient framework to drive patient flow
5. Poorly designed ambulatory pathways
6. Insufficient 'pull' of patients from outside of Wards
7. Insufficient incentives for good performance
8. Insufficient awareness of the action required
9. Lack of capability & capacity re complex discharges
10. Lack of optimal use of community hospitals
11. Insufficient capacity for non-elective patients
12. Insufficient change in discharge management out of the Trust (i.e. inability to deliver system-wide)

What actions have been taken in response to the above issues? *Controls*

a. The LOS programme is led by the Chief Operating Officer as Executive Sponsor, with the ADNS for Planned Care and Oncology as Project Lead (1)

b. "Perfect Discharge Week" has been rolled out across all wards, led by SAFER project team including senior presence on focused Wards (1, 2)

c. Key metrics have been set at Ward level to increase discharges before 10am, before 12pm & the flow of patients to the Discharge Lounge (3)

d. Implementation of, and monitoring of, the SAFER (*S*enior review, *A*nticipate, *F*low, *E*arlier discharges, *R*eact to delays & waits) framework (4)

e. The "Home First" pathway, introducing a "discharge to assess" model was set up on Ward 2 & AMU at Tunbridge Wells Hospital in August (5)

f. The Breakfast Club in the Discharge Lounge aims to 'pull' patients from Wards before 10am (6)

g. Introduction of an incentive scheme for Wards re the number of discharges to the Breakfast Club (7)

h. Communication plan has been set up to highlight the importance of early discharges. Badges, posters, etc. have been produced for use on the Wards (8)

i. An external company, CHS, has been engaged to support complex discharges (9)

j. Weekly conference call now fully established re the flow in community hospitals (10)

k. The HILTON model has been developed with availability increased to the Sevenoaks area (10)

l. Bed configuration plans for Tunbridge Wells Hospital (11)

m. The Trust has initiated an Emergency Pressures meeting (on 23/09) with WK CCG, KCC, Kent Comm. Health NHS FT, & Kent and Medway NHS and Social Care Partnership Trust (12)

Are the actions that had been planned for this point been taken? *Gaps in control*

September 2016			November 2016			February 2017		
Yes	Partly	No	Yes	Partly	No	Yes	Partly	No
☒	☐	☐	☐	☐	☐	☐	☐	☐

If "Partly" or "No", please explain

1. N/A

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

1. The Trust Performance Dashboard
2. Progress report to the Quality Committee and Trust Management Executive in September 2016

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

If "No", what other data is needed?

1. N/A

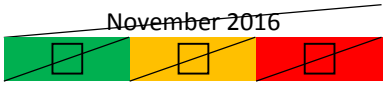
Risk owner:	Responsible Director:	Main committee/s responsible for oversight:
Chief Operating Officer	Chief Operating Officer	Trust Management Executive / Trust Board

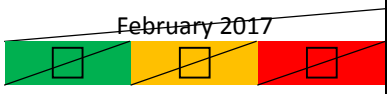
Continued overleaf

[4] In July 2016, the Trust Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance

How confident is the Responsible Director that the objective will be achieved by the end of 2016/17?[5]

September 2016 

November 2016 

February 2017 

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

- An 'Amber/Red' rating has been selected. The "Average LOS Elective" for the year to date at month 5, 2016/17 is 3.36 days, whilst the "Average LOS Non-Elective" for the year to date at month 5, 2016/17 is 7.54 days
- Ambulatory pathways were rolled out at Tun. Wells Hospital in July, led by the Directorate, but due to high escalation these have not been optimised. Pathways are in place at Maidstone but these need further embedding
- The actions taken and/or planned are the correct actions, and the "Home First" pathway is key to unlocking improvements. The pathway will be rolled out to further Wards in autumn 2016. In addition, the Clinical Director (CD) for Diagnostics & Pharmacy (DTP) will become the Trust's named clinical lead on LOS; and a Task and Finish group led by the CD for DTP will be established to drive the completion of Electronic discharge notifications (EDNs) the day before. Clinical Leads will also be appointed at Directorate level, with additional Programmed Activity (PA) support, in order to increase clinical 'buy in' and leadership. There will also be an emphasis on identifying where "Day before" actions are not fully implemented, with intensive focus on those areas by SAFER team
- The actions taken and/or planned are therefore felt to be the correct actions required, but achieving the average LOS targets listed above may not be achieved until the end of Quarter 2, 2017/18. This level of confidence is affected by the fact that there has been no reduction if non-elective demand. Confidence would therefore be boosted by additional capacity, even if this was only short-term

[5] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2016/17

Maidstone and Tunbridge Wells NHS Trust

What is the key risk? *Main risk*

3 The Trust does not have the correct level of substantive workforce for effective delivery

What does the Trust want to achieve? [6] *Objective*

3.a To reduce the vacancy rate to 8.5%

Relevant CQC domain/s: Safe ☐ Effective ☒ Caring ☐ Responsive ☐ Well-led ☒

What could prevent this objective being achieved? *Risks to objectives*

1. National shortage of certain staff groups
2. Lack of clarity/focus on the key actions required
3. A lack of clarity over the performance required by each Directorate, and the monitoring of such performance
4. Inefficiency of recruitment processes
5. Lack of urgency/commitment by recruiting managers
6. Uncertainty over the status of vacancies

What actions have been taken in response? *Controls*

a. The Trust Workforce Strategy 2015-20 and associated workplan ("Recruitment & Retention" is the first of 6 workforce priorities) (1, 2, 3)
b. Nurse Recruitment and Retention Group (Chaired by the Chief Nurse) (5)
c. Increased recruitment staffing resource (4)
d. New Ways of Working Task and Finish Group (4, 5)
e. Vacancies have been reviewed (as part of the Financial Recovery Plan) and a number of vacancies have been removed (6)

Are the actions that had been planned for this point been taken? *Gaps in control*

September 2016			November 2016			February 2017		
Yes	Partly	No	Yes	Partly	No	Yes	Partly	No
☒	☐	☐	☐	☐	☐	☐	☐	☐

If "Partly" or "No", please explain

1. N/A

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

1. The Trust Performance Dashboard (which contains the "Vacancy %")
2. Directorate performance dashboards
3. Reports to the Workforce Committee (which includes a commentary on the latest issues regarding the vacancy rate)

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

If "No", what other data is needed?

1. N/A

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Director of Workforce	Director of Workforce	Trust Management Executive / Workforce Committee / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2016/17? [7]

September 2016	November 2016	February 2017
☒	☐	☐

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

- The vacancy rate at month 5, 2016/17 is 10.3%, but the actions described above are expected to improve the rate from month 6 onwards

[6] In July 2016, the Trust Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance

[7] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2016/17

Maidstone and Tunbridge Wells NHS Trust

What is the key risk? *Main risk*

4 The Trust fails to demonstrate an ability to achieve future financial viability

What does the Trust want to achieve? [8] *Objective*

4.a To maintain operational liquidity whilst reducing working capital (from the planned level for 2016/17)

4.b To improve on the Trust's Income and Expenditure plan for 2016/17

Relevant CQC domain/s: Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well-led ☒

What could prevent this objective being achieved? *Risks to objectives*

1. A lack of senior leadership and commitment
2. Poor financial controls and/or their application
3. Lack of urgency/commitment by managers
4. Lack of capability and capacity in key areas
5. If the Financial Recovery Plan was developed without consideration of best practice elsewhere
6. If the Financial Recovery Plan is not accepted by NHS Improvement

What actions have been taken in response? *Controls*

a. The Executive have taken urgent action to mobilise the organisation since the Trust was put into Financial Special Measures (1)

b. Control targets have been set for each Directorate to reduce their cost run rate (2)

c. A number of 'Grip and Control' measures have been implemented to ensure delivery of the Plan (e.g. increased and improved communication to the wider organisation, raising the profile of Finance in the organisation (therefore increasing financial awareness, which is leading to behavioural change across the Trust) (2, 3)

d. Launch sessions have been held along with several financial recovery sessions with Directorates, and a series of Executive Challenge sessions (3)

e. A new Performance Management Framework is being implemented, to provide clarity on individual's accountability for delivery (3)

f. A review of capacity and capability across the organisation has been undertaken, to ensure the appropriate resource (Finance, PMO, Operational teams) is in place to deliver the Plan (4)

g. The Financial Recovery Plan has been informed by the Financial Improvement Programme Phase 1 report from KPMG LLP and by the guidance and advice from NHS Improvement (including that from the Finance Improvement Director) (5, 6)

Are the actions that had been planned for this point been taken? *Gaps in control*

	September 2016	November 2016	February 2017
Yes	☐	☐	☐
Partly	☒	☐	☐
No	☐	☐	☐

If "Partly" or "No", please explain

1. There is a need to finalise the implementation of the Performance Management Framework and agree the organisational structure

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

1. Financial Recovery Plan report to Quality Committee and Trust Board, September 2016
2. Monthly financial performance (including the latest position regarding liquidity)
3. Reports to the Finance Committee

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

If "No", what other data is needed?

1. N/A

Risk owner:	Responsible Director:	Main committee/s responsible for oversight:
Director of Finance	Director of Finance	Finance Committee / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2016/17? [9]

	September 2016	November 2016	February 2017
	☐ ☒ ☐	☐ ☐ ☐	☐ ☐ ☐

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

- The first review meeting with NHS Improvement (NHSI) is scheduled for 21/09/16

[8] In July 2016, the Trust Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance

[9] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2016/17

Maidstone and Tunbridge Wells NHS Trust

What is the key risk? *Main risk*

5 The Trust fails to maintain and improve its reputation as a Cancer provider

What does the Trust want to achieve? [10] *Objective*

5.a To deliver the Trust's 2016/17 agreed trajectory regarding the 62-day Cancer waiting time target

Relevant CQC domain/s: Safe ☐ Effective ☒ Caring ☐ Responsive ☒ Well-led ☒

What could prevent this objective being achieved? *Risks to objectives*

1. Insufficient engagement by clinical staff outside of the Cancer and Haematology Directorate
2. Pathways may not be optimal in relation to achieving the required performance
3. Insufficient communication of the performance required outside of the Cancer and Haematology Directorate (only $^1/_3$ of the delivery is within the control of the Cancer and Haematology Directorate – the remainder is within Diagnostics, Surgery and Medicine)

What actions have been taken in response? *Controls*

a. Two Cancer Summits, and Tumour Site-specific workshops (to focus on particular specialities) have been held (1, 3)
b. The issues have been discussed in Governance meetings & the Cancer Clinical Board (1, 3)
c. There are weekly Patient tracking Lists (PTLs) for each Cancer site and for other providers (3)
d. Action/Recovery Plans are in place for each of the tumour sites (1, 3)
e. Changes are being made to pathways (2)

Are the actions that had been planned for this point been taken? *Gaps in control*

September 2016			November 2016			February 2017		
Yes	Partly	No	Yes	Partly	No	Yes	Partly	No
☐	☒	☐	☐	☐	☐	☐	☐	☐

If "Partly" or "No", please explain

1. The appointment of Clinical Nurse Specialists for the Colorectal pathway is a key enabler for that pathway. The posts have been advertised but not yet recruited to

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

1. The Trust Performance Dashboard
2. Directorate reports to the Trust Clinical Governance Committee & Trust Management Executive

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

If "No", what other data is needed?

1. N/A

Risk owner:	Responsible Director:	Main committee/s responsible for oversight:
Chief Operating Officer	Chief Operating Officer	Trust Management Executive / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2016/17? [11]

September 2016			November 2016			February 2017		
☒	☐	☐	☐	☐	☐	☐	☐	☐

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

- At month 5, 2016/17, the "Cancer 62 day wait - First Definitive" performance (overall) for the year to date is 74.2%, but for MTW patients only is 82.5%. This compares to the target performance of 85.2% & 85% respectively

[10] In July 2016, the Trust Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance

[11] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – September 2016

9-14 Integrated performance report for August 2016 — Chief Executive

The enclosed report includes:

- The 'story of the month' for August 2016
- A quality exception report
- A Workforce update
- The Trust performance dashboard
- An explanation of the Statistical Process Control charts which are featured in the "Integrated performance charts" section
- Integrated performance charts

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 21/09/16 (performance dashboard)

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

'Story of the month' for August 2016

Responsiveness

At the end of month 5 the Trust is underperforming against the constitutional standards for emergency 4 hour standard, RTT and cancer 62 day first definitive treatment.

1. Four-hour standard, non-elective activity and LOS

The Trust achieved 87.4 % against our recovery trajectory plan of 91.4% for the 4 hour standard for August. The key contributory factors are the continued increase in levels of activity, higher than planned LOS and continued increased level of patients with a delayed transfer of care. A number of projects and improvement action plans remain in place to achieve a consistent and sustainable improvement across both sites and these are focused on reducing LOS and delivering the ambulatory model for acute medicine. The level of non-elective activity continues to be higher than plan and remains above last year's level by 8.5% YTD. The non-elective length of stay is 7.6 days at the end of August against the internal phased target of 7.1. There is a clear focus on LOS improvement as the key enabler to improve capacity and flow. Bed occupancy remains above 95% across the Trust and the DTOC level has increased in August to 6.7%, (1,561 bed days).

Trust delayed transfers of care	4.1%	4.4%	4.8%	4.2%	3.6%	4.1%	3.4%	6.0%	5.5%	4.8%	6.8%	7.9%	7.1%	7.9%	6.6%	5.7%	6.0%	5.0%	5.8%	5.6%	5.5%	5.3%	6.2%	6.7%	6.7%
Row Labels	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
A : Awaiting Assessment	5	7	3	2		11	17	17	15	6	15	21	15	17	15	10	5	7	3	8	1	6	25	15	7
B : Awaiting Public Funding	7	7	6	1		1	3	2	2		1	1	4	8	7	3	1			1	1	1	8	12	25
C : Awaiting Further Non-Acute NHS Care	31	33	30	25	19	21	18	28	32	34	39	48	33	30	20	6	3	8	15	18	17	13	11	10	8
DI : Awaiting Residential Home	4		1	6	10	5	3	6	18	1	11	27	28	26	22	16	21	15	15	27	32	20	37	21	33
DII : Awaiting Nursing Home	2	20	13	16	8	17	12	30	40	21	38	90	57	52	56	40	73	53	80	73	58	67	65	67	69
E : Awaiting Care Package	8	8	13	26	15	11	18	10	7	7	20	16	27	17	32	26	43	28	36	36	28	24	39	41	41
F : Awaiting Community Adoptions	7	2	7	8	6	9	1	8	1	11	2	1		1	13	9	8	14	5	13	8	7	12	4	6
G : Patient of Family Choice	59	32	46	47	36	39	47	60	60	44	44	45	16	43	26	22	31	12	12	22	13	9	19	19	10
H : Disputes		1							2	1			1	3	1	1		1				3	1	1	
I : Housing				2		2		1	3	4	3	1		1	13	12	9	3	5	1			5	5	2
Grand Total	123	110	119	133	94	116	119	162	180	129	173	250	181	198	205	145	194	141	171	199	158	150	222	195	201

2. Cancer 2 week waits

The underperformance on cancer 2 week-wait standard is still largely due to patient choice and patient cancellation of appointments. The teams have initiated more robust processes in the booking office and with support from the CCG cancer lead we are seeing fewer patients refusing urgent appointments. If all patients accepted the first appointment dates offered to them performance would be above 95%. The work currently in place to address this is expected to show delivery of this target from September.

3. Cancer 62 day FDT

Performance is off trajectory for July but we have seen an improvement in the MTW only performance. The focus internally is on addressing all the issues that are to do with MTW processes. Clear actions have been agreed and are in place for each tumour group. A follow-up cancer summit was held in June to review actions and improvement plans that were agreed in January and much progress has been achieved,

particularly in breast and lung cancer. The cancer delivery plan is monitored on a weekly basis with the relevant managers and clinical leads. An upgrade to the electronic patient tracking system has been and is now rolled out across all MDTs.

4. RTT and elective activity.

The Trust missed the agreed RTT trajectory in august as a direct result of the reduced level of elective activity undertaken in the month and YTD. Progress is being maintained against the 18 week plan with all specialties with the bulk of the over 18 week backlog concentrated in 4 specialities, T&O, gynaecology, ENT and gastroenterology, all of which are being managed against recovery plans to achieve their targets. We are also continuing to outsource activity in T&O and neurology. The overall backlog is reducing slowly but is dependent on maintaining our elective and day case activity to the planned levels.

Quality Exception Report

Following the increase in C difficile cases that we saw in July there was only one reported case in August. This gives an YTD position of 17 against a maximum limit for the year of 27 cases.

The falls rate for the month and YTD remains below the Trust target and although a slight increase for pressure ulcers for August the YTD position still remains below the benchmark.

Maternity services are to be congratulated on the significant improvements they have made on the friends and family response rates, for the month of August a 42.3% response rate was achieved.

Workforce

As at the end of August 2016, the Trust employed 5,080.6 whole time equivalent substantive staff. The Trust will continue to focus attention on recruitment, retention and establishment reviews in order to reduce the number of vacancies in the organisation. Although the dependence upon temporary staff remains higher than planned, further work is ongoing to ensure we reduce our dependence upon expensive agency and interim workers. However the use of agency and locum staff and overtime were less than the same period last year. The use of bank staff was 410.2WTE in August 2016 which continued the upward trend in usage experienced over recent months and represented a significant improvement (+93.1 WTE) on the same period last year. Sickness absence in the month was 4.2%, representing a 0.3% deterioration on the same period last year (4.2%). However sickness absence management remains a key area of focus for the HR and operational management teams. Statutory and mandatory training compliance figure is 0.6% higher than the same period last year and despite the overall figure being rebased this year to include all subjects. Actions are in place to improve compliance further.

Appraisal levels are reported for non-medical staff for the first time after the implementation period of Q1 and compliance levels will increase next month once all received dates are added to the electronic staff record.

TRUST PERFORMANCE DASHBOARD **Position as at:** **31 August 2016**

Governance (Quality of Service): **2.0** **Amber/Red** Based on TDA 2014/15 Methodology

Finance: **TDA** **Amber**

Delivering or Exceeding Target	
Underachieving Target	
Failing Target	

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

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

	Safe	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
1-01	*Rate C-Diff (Hospital only)	15.28	4.5	9.1	15.5	6.3	3.6	11.5	11.5	
1-02	Number of cases C.Difficile (Hospital)	3	1	9	17	8	4	27	27	
1-03	Number of cases MRSA (Hospital)	0	0	1	1	0	1	0	1	
1-04	Elective MRSA Screening	98.0%	97.0%	98.0%	97.0%		-1.0%	98.0%	97.0%	
1-05	% Non-Elective MRSA Screening	97.5%	96.0%	97.5%	96.0%		1.0%	95.0%	96.0%	
1-06	**Rate of Hospital Pressure Ulcers	2.2	3.7	2.2	2.8	0.6	-0.2	*3.0*	2.9	3.0
1-07	***Rate of Total Patient Falls	6.5	5.9	6.7	6.1	-0.5	-0.1	*6.2*	6.2	
1-08	***Rate of Total Patient Falls Maidstone	5.4	4.9	5.7	5.5	-0.1			5.9	
1-09	***Rate of Total Patient Falls TWells	6.7	6.5	7.3	6.5	-0.7			7.4	
1-10	Falls - SIs in month	6	5	16	12	-4				
1-11	Number of Never Events	0	1	0	1	1	1	*0*	1	
1-12	Total No of SIs Open with MTW	24	38			14				
1-13	Number of New SIs in month	10	10	40	50	10	-			
1-14	**Serious Incidents rate	0.51	0.45	0.41	0.46	0.05	0.40	*0.0584 - 0.6978*	0.46	*0.0584 - 0.6978*
1-15	Rate of Patient Safety Incidents - harmful	1.49	0.11	1.29	0.64	-0.64	-0.59	*0 - 1.23*	0.64	*0 - 1.23*
1-16	Number of CAS Alerts Overdue	0	0			0	0	*0*		
1-17	VTE Risk Assessment	95.2%	95.1%	95.3%	95.3%	0.0%	0.3%	95.0%	95.3%	95.0%
1-18	Safety Thermometer % of Harm Free Care	96.6%	96.6%	96.9%	96.6%	-0.3%	1.6%	95.0%		93.4%
1-19	Safety Thermometer % of New Harms	2.49%	2.95%	2.33%	3.16%	0.83%	0.2%	*3.00%*	3.16%	
1-20	C-Section Rate (non-elective)	13.6%	12.6%	13.6%	13.7%	0.05%	-1.3%	*15.0%*	13.7%	

	Effectiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	Hospital-level Mortality Indicator (SHMI)******	Prev Yr: Oct 13 to Sept 14		207.7	106.0	-101.7	6.0	*Lower confidence limit to be <100*		100.0
2-02	Standardised Mortality (Relative Risk)	Prev Yr: Oct 13 to Sept 14		105.0	107.0	2.0	7.0			100.0
2-03	Crude Mortality	1.2%	0.8%	1.1%	1.2%	0.0%				
2-04	****Readmissions <30 days: Emergency	12.2%	11.2%	11.7%	11.7%	0.0%	-1.9%	*13.6%*	11.7%	14.1%
2-05	****Readmissions <30 days: All	11.3%	10.4%	10.7%	10.8%	0.1%	-3.9%	*14.7%*	10.8%	14.7%
2-06	Average LOS Elective	3.54	3.53	3.17	3.36	0.19	0.15	*3.20*	3.20	
2-07	Average LOS Non-Elective	7.41	7.62	7.33	7.54	0.21	0.70	*6.84*	7.54	
2-08	******FollowUp : New Ratio	1.27	1.56	1.27	1.60	0.33	0.08	*1.52*	1.60	
2-09	Day Case Rates	83.6%	85.4%	83.5%	84.5%	1.0%	4.5%	80.0%	84.5%	82.2%
2-10	Primary Referrals	7,771	8,275	44,191	45,435	2.8%	4.6%	104,825	109,477	
2-11	Cons to Cons Referrals	3,239	3,572	17,346	17,233	-0.7%	-2.5%	40,698	41,523	
2-12	First OP Activity	10,453	12,620	57,708	60,795	5.3%	1.9%	144,940	145,099	
2-13	Subsequent OP Activity	20,912	23,789	111,974	115,913	3.5%	0.2%	279,695	277,471	
2-14	Elective IP Activity	653	593	3,372	3,361	-0.3%	-7.3%	8,755	8,337	
2-15	Elective DC Activity	3,074	3,657	16,306	17,279	6.0%	-6.4%	44,937	41,028	
2-16	Non-Elective Activity	3,618	4,069	19,032	20,449	7.4%	5.8%	46,131	49,006	
2-17	A&E Attendances (Inc Clinics. Calendar Mth)	12,616	13,652	65,110	68,594	5.4%	-0.5%	163,967	164,376	
2-18	Oncology Fractions	5,147	5,531	27,618	29,641	7.3%	1.1%	70,642	72,617	
2-19	No of Births (Mothers Delivered)	469	514	2,479	2,490	0.4%	1.5%	5,888	5,976	
2-20	% Mothers initiating breastfeeding	81.9%	81.2%	80.8%	82.8%	2.0%	4.8%	78.0%	78.0%	
2-21	% Stillbirths Rate	0.0%	0.19%	0.32%	0.28%	*0.0%*	*-0.2%*	*0.47%*	0.28%	0.47%

	Caring	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Single Sex Accommodation Breaches	0	0	0	0	0	0	0	0	
3-02	*****Rate of New Complaints	2.14	1.43	1.69	1.32	-0.4	0.00	*1.318-3.92*	1.37	
3-03	% complaints responded to within target	82.8%	73.9%	63.3%	71.1%	7.8%	-3.9%	75.0%	73.8%	
3-04	****Staff Friends & Family (FFT) % rec care	82.2%	87.2%	83.0%	87.2%	4.2%	8.2%	79.0%	87.2%	79.2%
3-05	*****IP Friends & Family (FFT) % Positive	96.2%	96.2%	96.8%	95.8%	-1.0%	0.8%	95.0%	95.8%	95.8%
3-06	A&E Friends & Family (FFT) % Positive	89.0%	89.2%	89.0%	90.9%	1.9%	3.9%	87.0%	90.9%	85.5%
3-07	Maternity Combined FFT % Positive	96.2%	92.2%	94.6%	93.9%	-0.6%	-1.1%	95.0%	93.9%	95.6%
3-08	OP Friends & Family (FFT) % Positive	80.5%	82.6%	79.0%	82.4%	3.4%			82.4%	

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

***** New :FU Ratio is only for certain specialties -plan still being agreed so currently last year plan

***** *IP Friends and Family includes Inpatients and Day Cases* ******SHMI is within confidence limit*

	Responsiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year/Quarter to Date Prev Yr	Year/Quarter to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
4-01	******Emergency A&E 4hr Wait	91.3%	87.4%	92.1%	89.6%	-2.5%	1.4%	95.0%	91.1%	85.8%
4-02	Emergency A&E >12hr to Admission	0	0	0	0	0	0	*0*	0	
4-03	Ambulance Handover Delays >30mins	New	No data	New	No data				No data	
4-04	Ambulance Handover Delays >60mins	New	No data	New	No data				No data	
4-05	RTT Incomplete Admitted Backlog	592	1434	592	1434	842	317	916	916	
4-06	RTT Incomplete Non-Admitted Backlog	133	712	133	712	579	152	459	459	
4-07	RTT Incomplete Pathway	96.6%	91.0%	96.6%	91.0%	-5.6%	-1.0%	92%	94.1%	
4-08	RTT 52 Week Waiters	1	0	5	0	-5	0	*0*	0	
4-09	RTT Incomplete Total Backlog	725	2145	725	2145	1,420	468	1,375	1375	
4-10	% Diagnostics Tests WTimes <6wks	96.24%	99.7%	99.2%	99.7%	0.5%	0.7%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	6	2	7	2	-5	-7	9	7	
4-12	*Cancer two week wait	93.5%	91.6%	94.6%	91.6%	-2.9%	-1.4%	93.0%	92.3%	
4-13	*Cancer two week wait-Breast Symptoms	95.1%	90.8%	94.4%	90.8%	-3.5%	-2.2%	93.0%	93.0%	
4-14	*Cancer 31 day wait - First Treatment	98.6%	96.5%	97.1%	96.5%	-0.6%	0.5%	96.0%	96.0%	
4-15	*Cancer 62 day wait - First Definitive	80.8%	74.2%	75.2%	74.2%	-1.0%	-2.9%	85.2%	80.9%	
4-16	*Cancer 62 day wait - First Definitive - MTW	85.9%	82.5%	80.7%	82.5%	1.8%		85.0%		
4-17	*Cancer 104 Day wait Accountable	6.5	6.0	6.5	42.0	35.5	42.0	*0*	42.0	
4-18	*Cancer 62 Day Backlog with Diagnosis	New	80	New	80					
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	New	53	New	53					
4-20	Delayed Transfers of Care	7.1%	6.7%	6.4%	6.1%	-0.3%	2.6%	3.5%	6.1%	
4-21	% TIA with high risk treated <24hrs	63.2%	87.5%	70.5%	80.3%	9.7%	20.3%	60%	80.3%	
4-22	*******% spending 90% time on Stroke Ward	93.0%	92.6%	86.5%	92.6%	6.1%	12.6%	80%	92.6%	
4-23	*******Stroke:% to Stroke Unit <4hrs	64.4%	53.3%	64.4%	49.4%	-15.0%	-10.6%	60.0%	49.4%	
4-24	*******Stroke: % scanned <1hr of arrival	52.5%	51.7%	51.4%	54.3%	2.9%	6.3%	48.0%	54.3%	
4-25	*******Stroke:% assessed by Cons <24hrs	71.7%	56.7%	74.3%	64.1%	-10.2%	-15.9%	80.0%	64.1%	
4-26	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	*0*	0	
4-27	Patients not treated <28 days of cancellation	0	0	0	5	5	5	*0*	5	

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

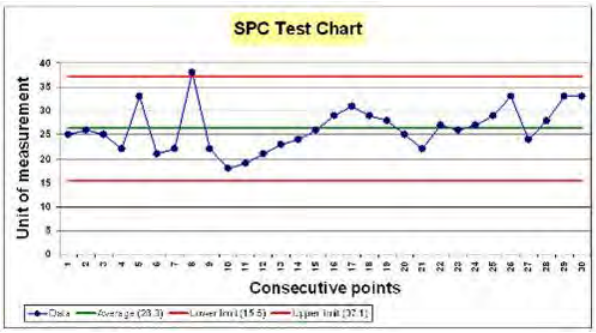
**CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory*

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

	Well-Led	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
5-01	Income	32,237	34,109	164,503	170,452	3.6%	-2.2%	418,608	418,608	
5-02	EBITDA	537	(491)	5,198	(3,195)	-161.5%	-224.6%	11,086	11,086	
5-03	Surplus (Deficit) against B/E Duty	(2,377)	(3,282)	(9,087)	(16,805)			(22,928)	(22,928)	
5-04	CIP Savings	2,314	1,250	7,890	7,349	-6.9%	-14.6%	23,076	23,076	
5-05	Cash Balance	9,783	3,964	9,783	3,964	-59.5%	189%	1,000	1,000	
5-06	Capital Expenditure	1,306	286	3,285	1,160	-64.7%	-63.8%	*15,188*	15,189	
5-07	Establishment (Budget WTE)	5,378.8	5,812.8	5,378.8	5,812.8	8.1%	0.0%	5,837.3	5,837.3	
5-08	Contracted WTE	4,972.4	5,080.6	4,972.4	5,080.6	2.2%	-4.8%	5,427.1	5,427.1	
5-09	***Contracted not worked WTE	(99.6)	(88.3)	(99.6)	(88.3)			(100.0)	(100.0)	
5-11	Bank Staff (WTE)	317.1	410.2	317.1	410.2	29.4%		155.3	155.3	
5-12	Agency & Locum Staff (WTE)	329.4	242.8	348.9	242.8	-30.4%		64.4	64.4	
5-13	Overtime (WTE)	68.0	56.8	68.0	56.8	-16.5%		5,801.7	5,801.7	
5-14	Worked Staff WTE	5,587.4	5,702.1	5,587.4	5,702.1	2.1%	-1.9%	408.6	408.6	
5-15	Vacancies WTE	406.4	599.7	406.4	599.7	47.6%		0.1	0.1	
5-16	Vacancy %	7.6%	10.3%	7.6%	10.3%	2.8%		8.5%	8.5%	
5-17	Nurse Agency Spend	(897)	(793)	(4,441)	(4,150)	-6.6%				
5-18	Medical Locum & Agency Spend	(1,168)	(1,297)	(5,220)	(6,723)	28.8%				
5-19	Temp costs & overtime as % of total pay bill		17.0%		17.0%					
5-20	Staff Turnover Rate	9.9%	10.4%		10.3%	0.4%	-0.1%	*10.5%*	10.3%	8.4%
5-21	Sickness Absence	3.9%	4.2%		4.1%			*3.3%*	4.1%	3.7%
5-22	Statutory and Mandatory Training	87.3%	87.9%		87.9%	0.6%	2.9%	85.0%	87.9%	
5-23	Appraisal Completeness	77.1%	59.0%		59.0%	-18.1%	-31.0%	90.0%	80.0%	
5-24	Overall Safe staffing fill rate	100.1%	97.5%	101.8%	100.1%	-2.7%		93.5%	100.1%	
5-25	****Staff FFT % recommended work	56.9%	64.2%	57.7%	64.2%	6.4%	2.2%	62.0%	64.2%	62.9%
5-26	***Staff Friends & Family -Number Responses	253	664	899	664	-235				
5-27	*****IP Resp Rate Recmd to Friends & Family	24.4%	30.1%	27.4%	23.8%	-3.6%	-1.2%	25.0%	23.8%	25.7%
5-28	A&E Resp Rate Recmd to Friends & Family	22.7%	15.1%	12.2%	13.9%	1.7%	-1.1%	15.0%	15.0%	12.7%
5-29	Mat Resp Rate Recmd to Friends & Family	20.7%	42.3%	15.3%	22.2%	6.9%	-2.8%	25.0%	22.2%	24.0%

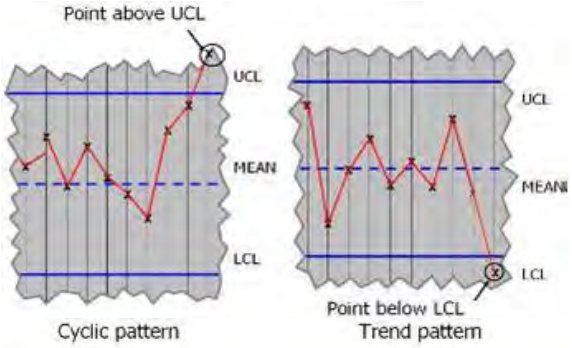
Explanation of Statistical Process Control (SPC) Charts

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

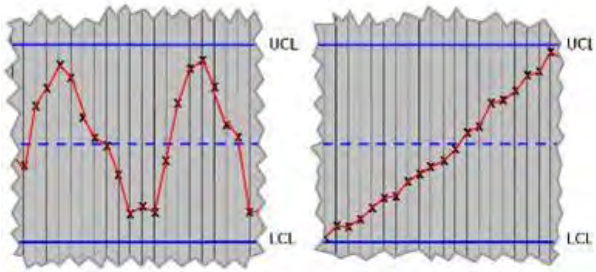


SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system.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

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

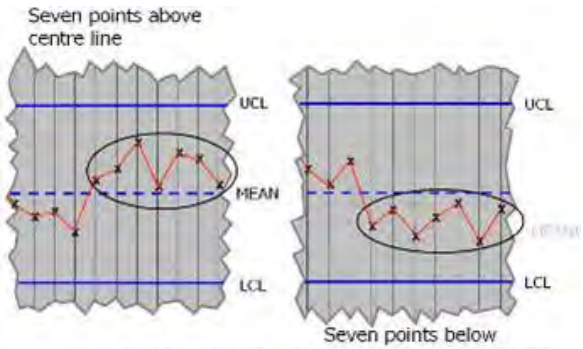


Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key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

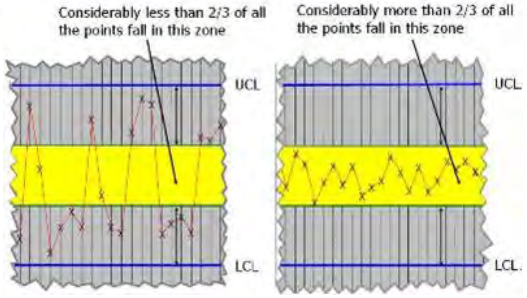


Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

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

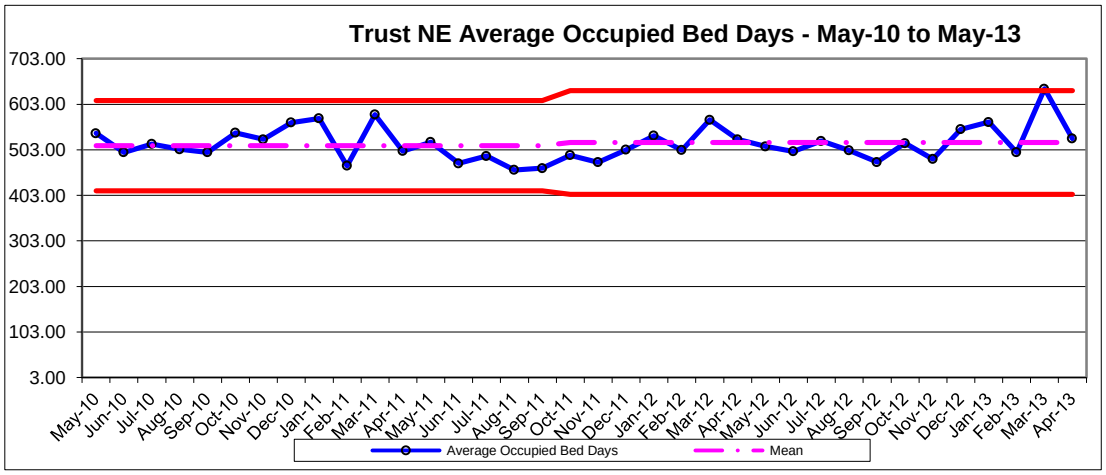


Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable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

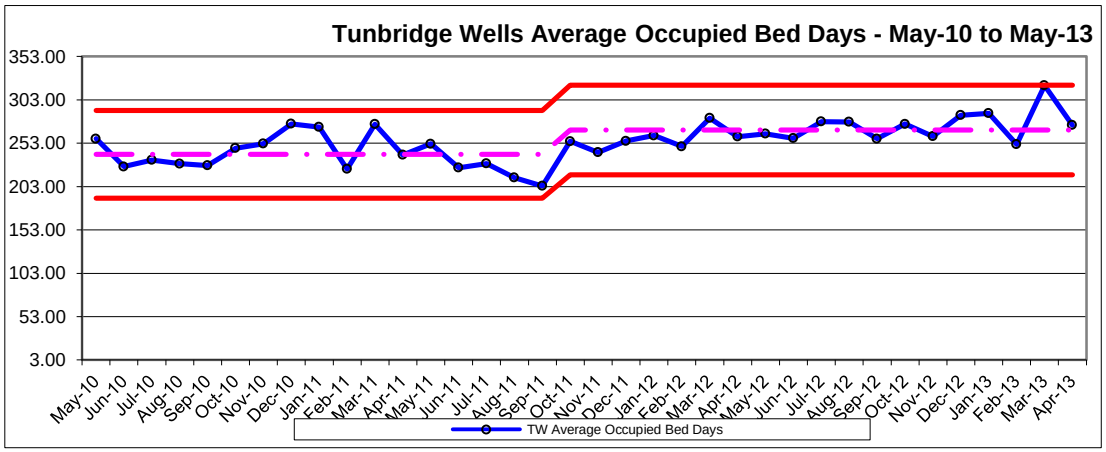


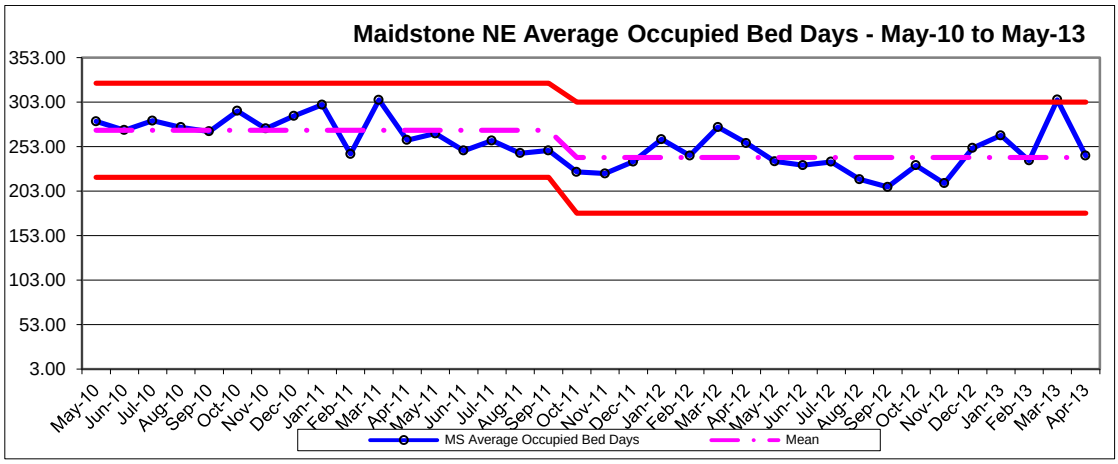
Changes to Control Lines

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



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

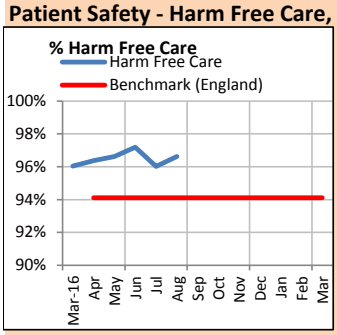


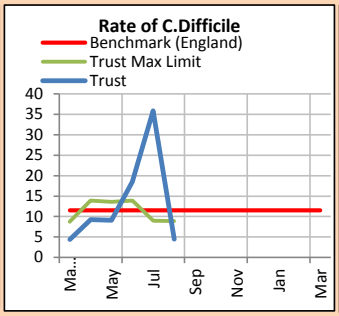


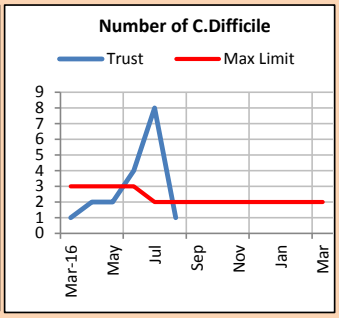
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

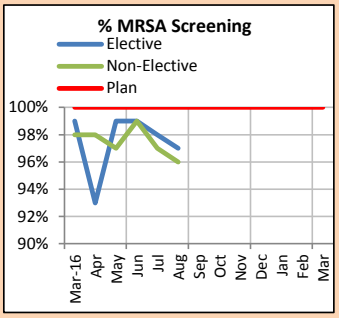
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

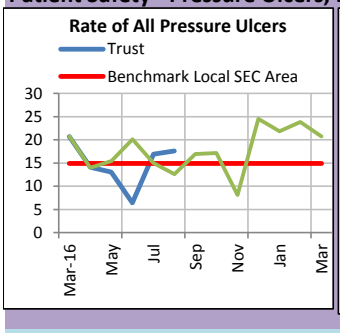


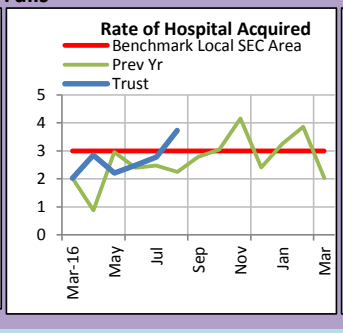


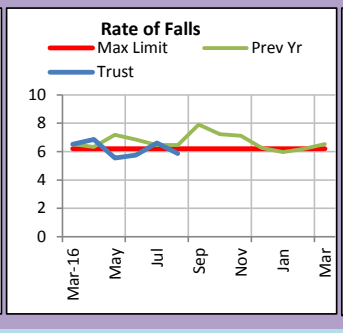


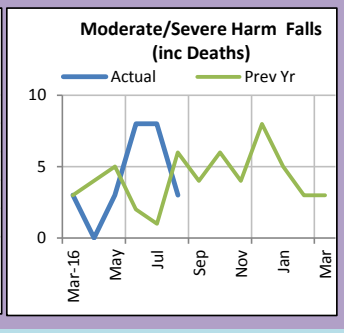


Patient Safety - Pressure Ulcers, Falls

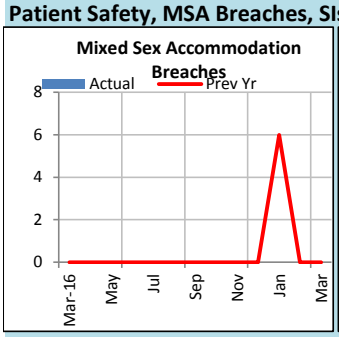


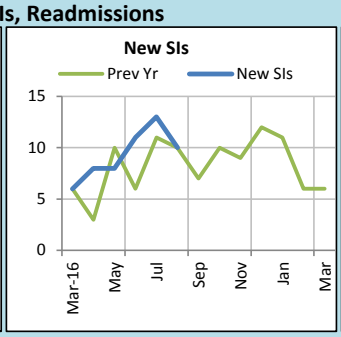


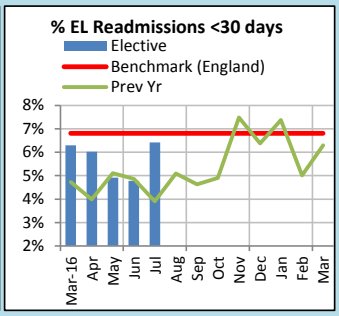


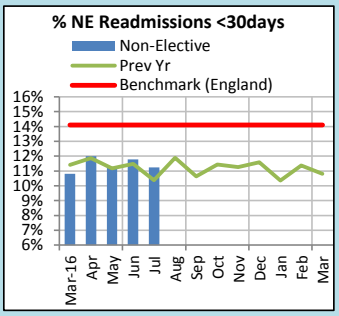


Patient Safety, MSA Breaches, SIs, Readmissions

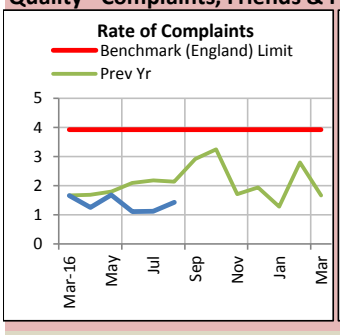


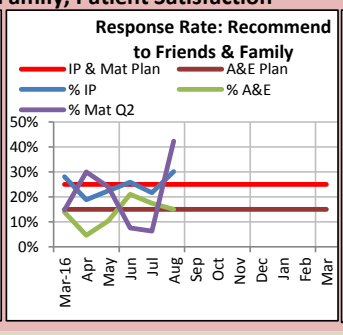


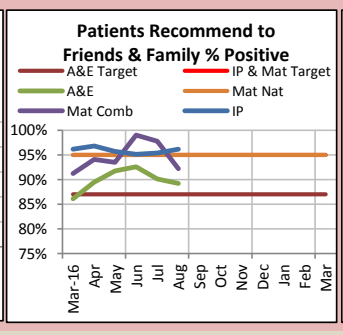


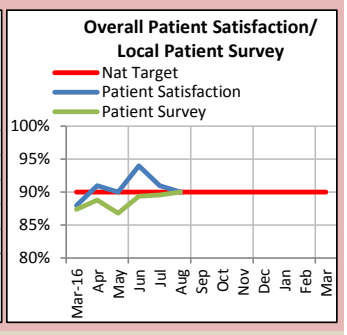


Quality - Complaints, Friends & Family, Patient Satisfaction

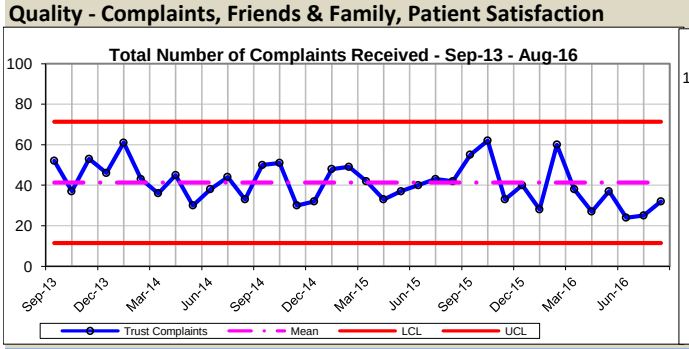


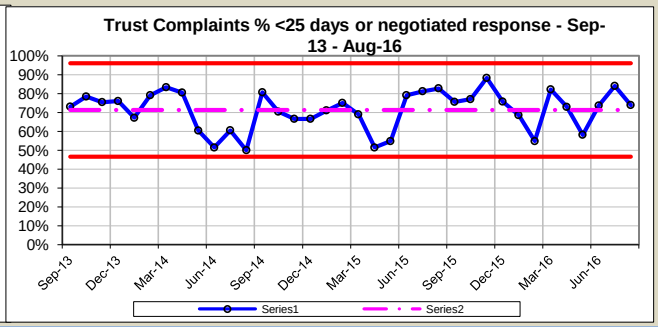




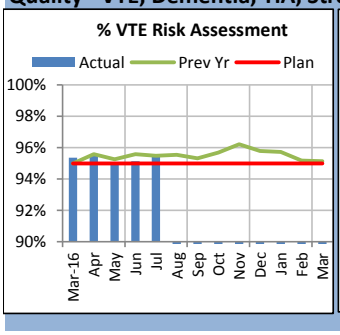


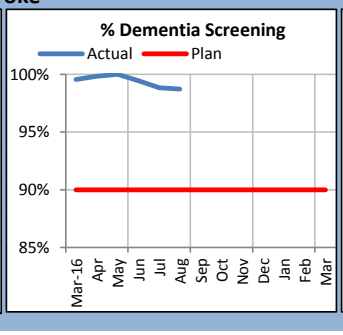
Quality - Complaints, Friends & Family, Patient Satisfaction

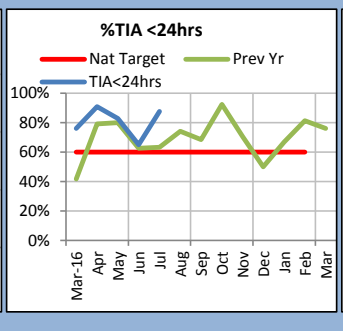


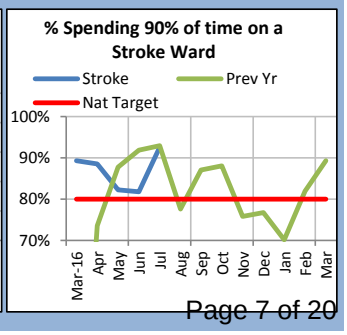


Quality - VTE, Dementia, TIA, Stroke



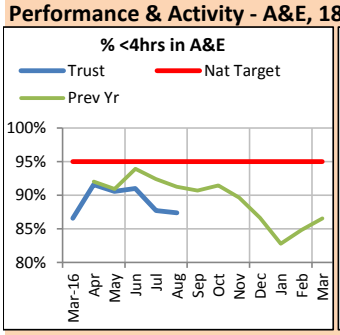


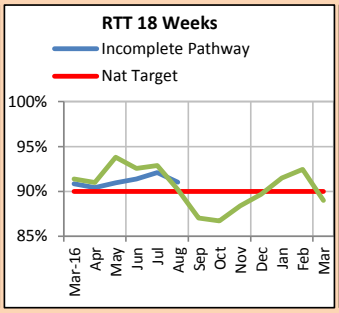


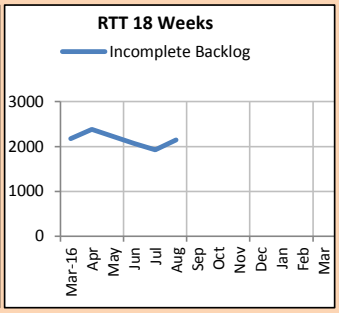


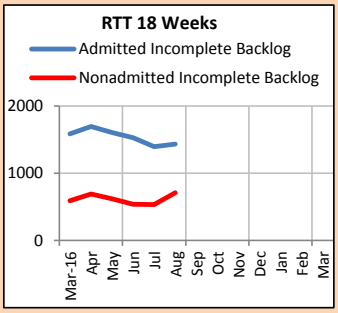
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

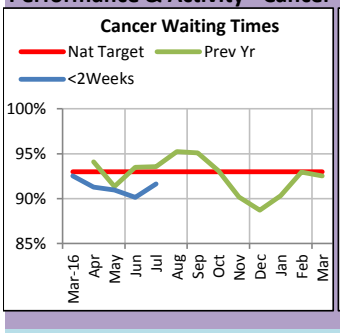


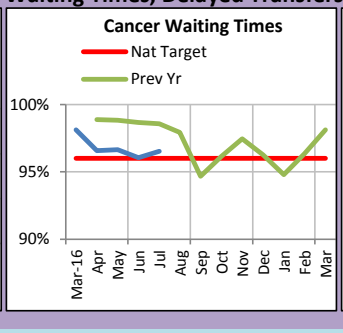


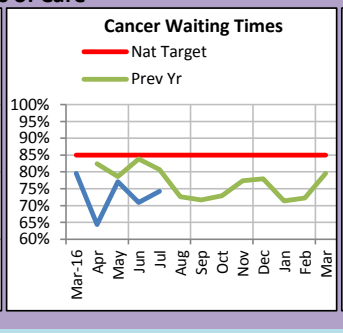


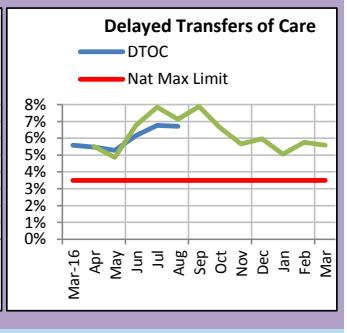


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

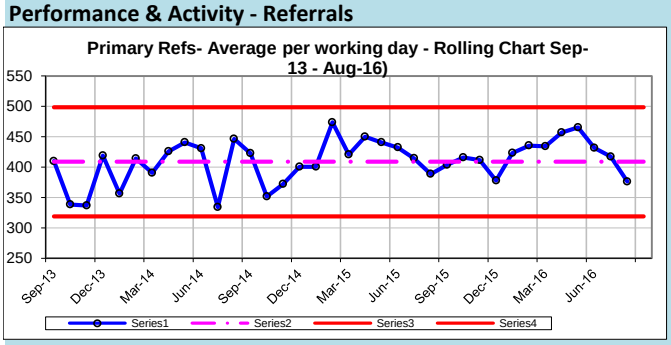


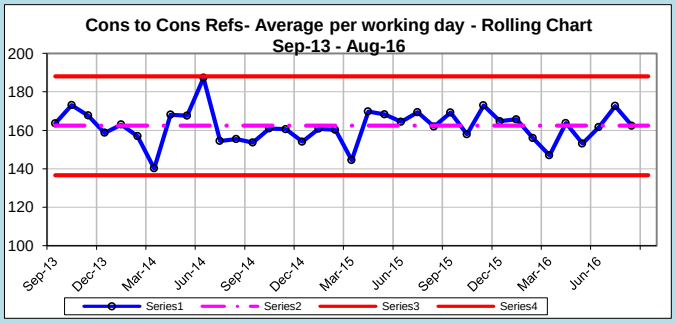




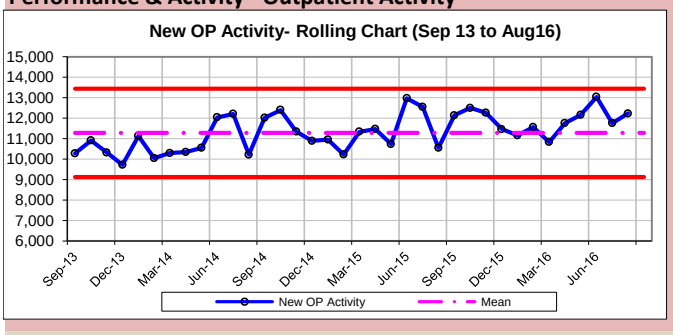


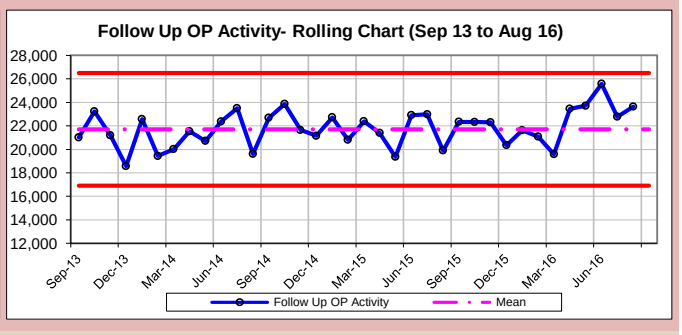
Performance & Activity - Referrals



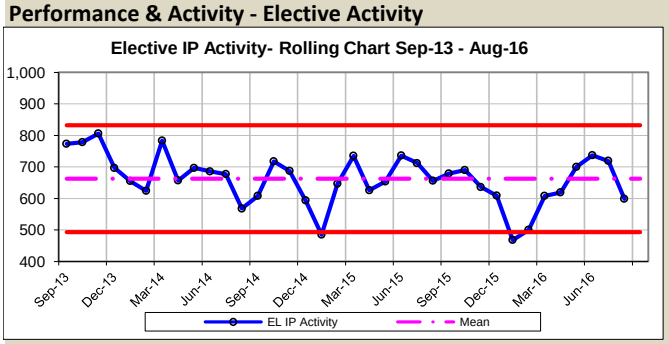


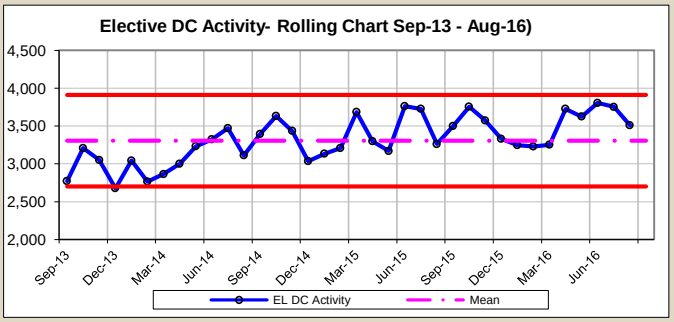
Performance & Activity - Outpatient Activity



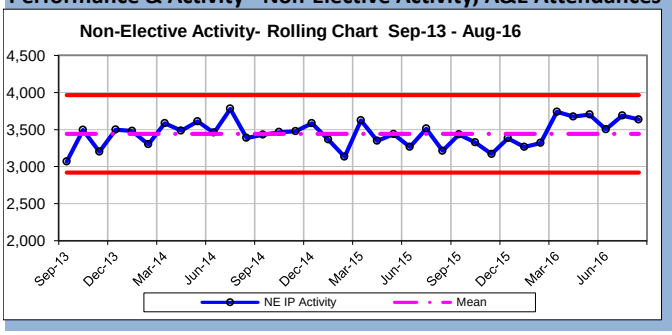


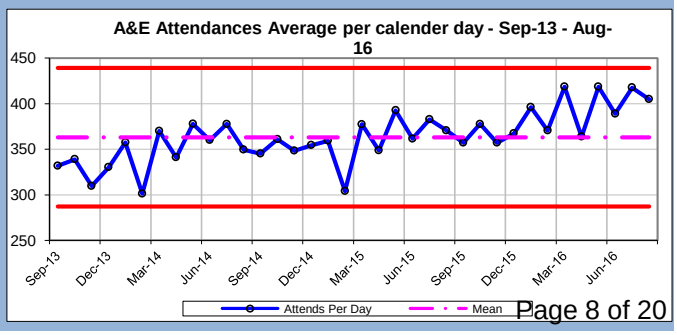
Performance & Activity - Elective Activity





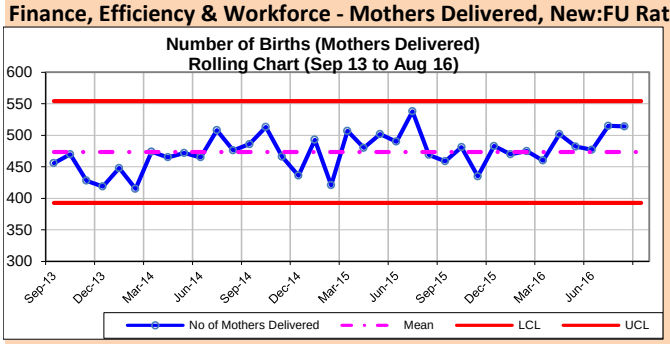
Performance & Activity - Non-Elective Activity, A&E Attendances

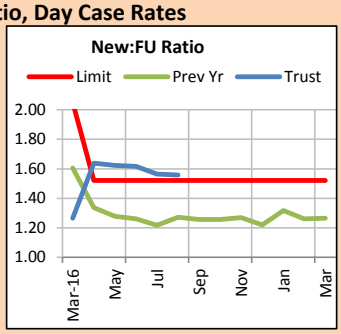


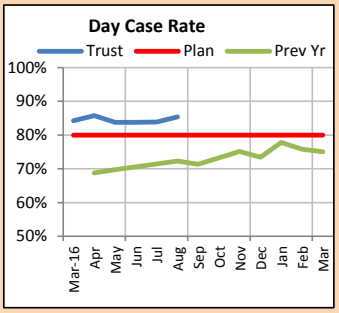


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

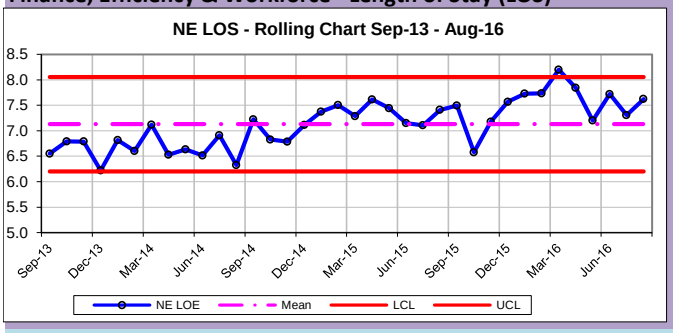
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

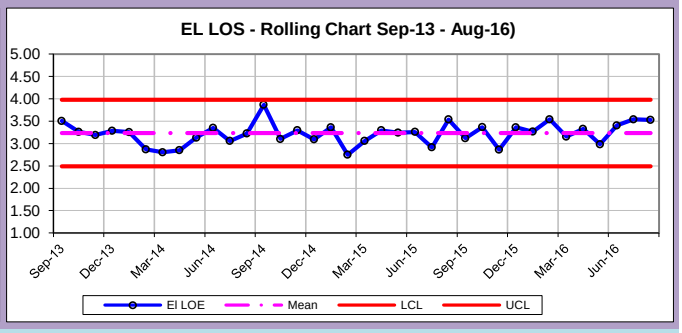




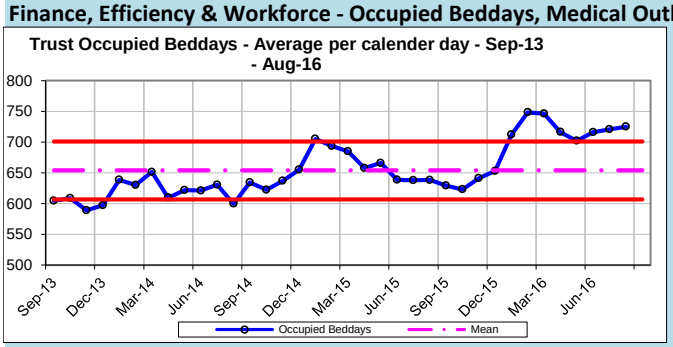


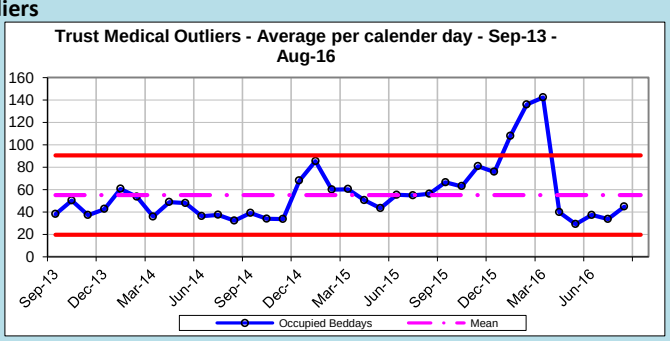
Finance, Efficiency & Workforce - Length of Stay (LOS)



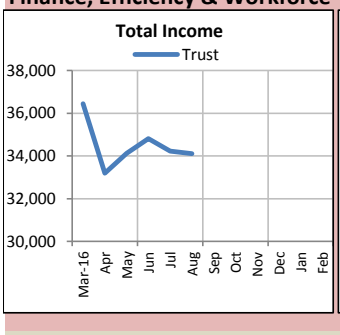


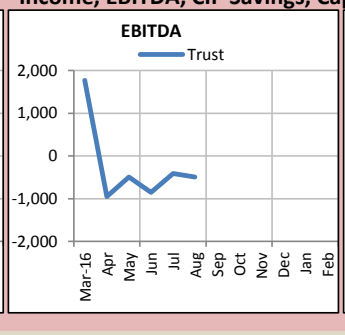
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

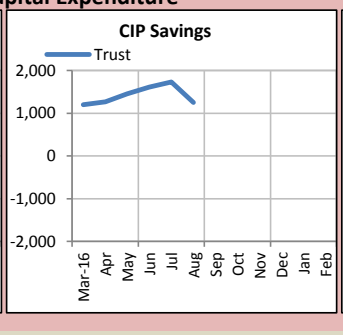


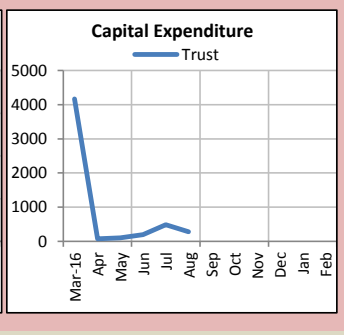


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

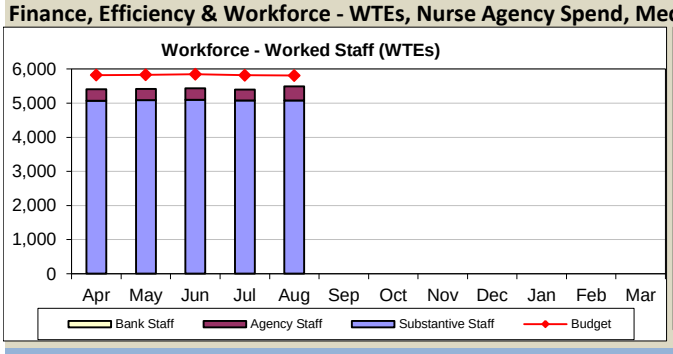


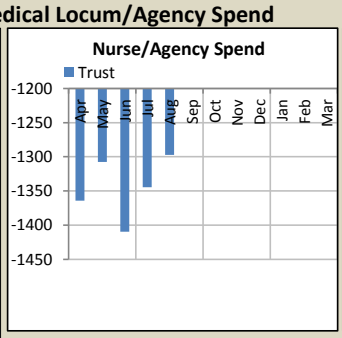


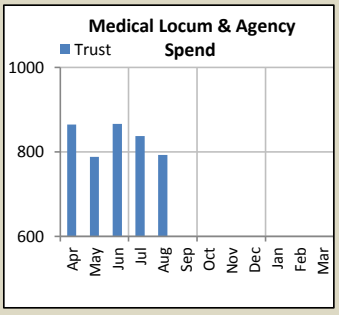




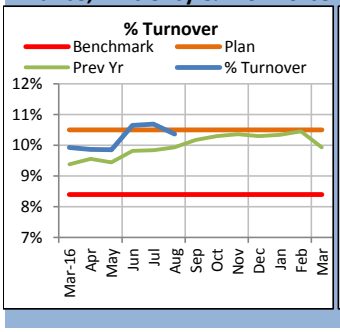
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

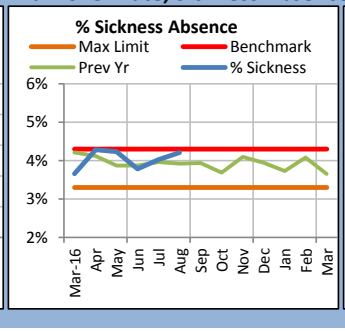


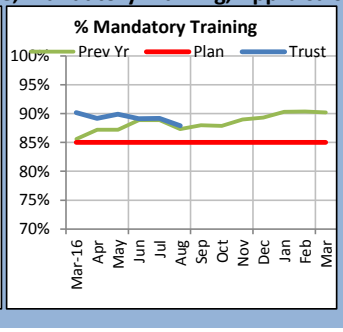




Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals







Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – September 2016

9-14	Review of latest financial performance	Director of Finance

Summary / Key points

- The Trust had an adverse variance against plan in August 2016 of £1m
- The Trust's net deficit to date (including technical adjustments) is £16.8m against a planned deficit of £11.3m, therefore £5.5m adverse to plan.
- In August the Trust operated with an EBITDA deficit of £0.5m which was £0.9m adverse to plan.
- The key drivers of the variance in the month are as follows:
    - Total income was breakeven in the month, Clinical income broke even in the month, Out Patient activity (£0.8m) favourable (9.5% above plan), Elective IP income was £0.1m adverse (£0.3m reduction between months), Non Elective income net £0.1m favourable (Non Elective activity net of Non Elective Threshold). Fines and contract penalties were £0.5m adverse in month with RTT (£0.2m adverse) and A&E fines (£0.1m adverse), Ambulance delays (£0.1m adverse). Private Patient income within Cancer Directorate was £0.2m adverse in August; we believe this is due to the increase in private oncology providers.
    - Pay was adverse to plan by £0.3m which was due to the phasing of £0.3m unidentified CIPs. The level of spend reduced between months by £0.1m which was within Medical with Nursing and STT reporting a small increase. Overspends in the month in Medical (£0.1m), Scientific and Technical Staff (£0.1m) with underspends in Nursing (£0.1m) and Admin and Clerical (£0.2m) with unidentified savings of £0.3m in the month.
    - Non Pay is overspent by £0.6m, Outsourcing of elective activity (£0.2m), £0.1m unidentified CIPS, £0.4m within Clinical Supplies and Services.
- The CIP performance in August delivered efficiencies of £1.2m which was £0.8m adverse to plan. Slippages linked to unidentified savings of £0.4m, Temporary Staffing and Contract Management (£0.1m, mainly within T&O)
- T&O Directorate is adverse to plan by £2.6m YTD, £1.9m under performance on income with £0.6m overspend linked to outsourcing elective activity.
- The Trust held £4m of cash at the end of August which is £2.6m higher than plan, this primarily relates to drawing £3m in August against the Interim Revolving Working Capital Facility (IRWCF) which was originally planned to be drawn in September. The remaining £7.1m balance will be drawn as planned in September.

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 26/09/16

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

To note the August financial position actions needed to deliver the £22.9m annual plan

[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

Trust Board Finance Pack

Month 5
2016/17

Maidstone and Tunbridge Wells NHS Trust

Trust Board Pack for August 2016

Executive Summary

Maidstone and Tunbridge Wells NHS Trust

1a. Executive Summary August 2016

Key Variances £m

	August	YTD		Headlines
Total Deficit	**(1.0)**	**(5.5)**	Adverse	The reported Trust position for August is a deficit of £3.3m which is £1m adverse to plan The main drivers were: Contract Penalties and Challenges (£0.7m), Unidentified savings (£0.4m), CIP Slippage £0.4m and overspending within outsourcing of elective activity (£0.2m), Out patient activity over performed of £0.8m in the month.
Pay	(0.3)	0.3	Favourable	Pay was £0.3m overspent in the month which includes unidentified savings of £0.3m. The level of pay spend reduced between months by £0.1m which was within Medical Staffing (£0.16m) with Support staff increasing by £50k and Nursing and STT staff groups both increasing by £25k each.
Non Elective threshold	(0.4)	(1.6)	Adverse	Non Elective activity is £0.5m over plan in August (£2.8m YTD) however part of this income has been lost due to the non elective threshold
Contract Penalties & Challenges	(0.7)	(3.0)	Adverse	18 week RTT is the main driver of the penalties (£0.2m in month, £1.1m YTD), A&E % 4 hours Arrival to Exit (£0.1m in month, £0.3m YTD)and Ambulance Handover delays (£0.1m in month, £0.2m YTD)
Out Patient Activity	0.8	0.5	Favourable	Out Patient activity was 9.5% above plan in the month with an over performance of £0.8m (14%), the level of activity in August was 6.5% higher than July and was 2.4% (1,108 cases) higher than the average of Month 1 - 4
Daycase Activity	(0.0)	(1.3)	Adverse	Daycase activity increased by £0.2m in this month (204 cases) which is the highest daycase levels over the past 12 months, however Elective IP activity in the month reduced by 129 cases and was the lowest this financial year
CIP	(0.8)	(1.3)	Adverse	CIP plan for August was £2m with a delivery of £1.2m, £0.8m adverse to plan, mainly due to unidentified savings of £0.4m and slippage within Contract Management, Temporary staffing and Theatre Utilisation

Financial Forecast

Risks:

Unidentified CIPS (£3.4m) phased from 1st July 16 equating to a reduction in budget of £0.4m per month.

Ability to deliver elective activity due to non elective activity levels

CQUINs are finalised with the Commissioners, the main CQUINs with risk are: Flu vaccinations, Health and Well being and Antibiotic prescribing

Opportunities:

Lord Carter efficiencies programme being led by the PMO team with clinicians and operational teams

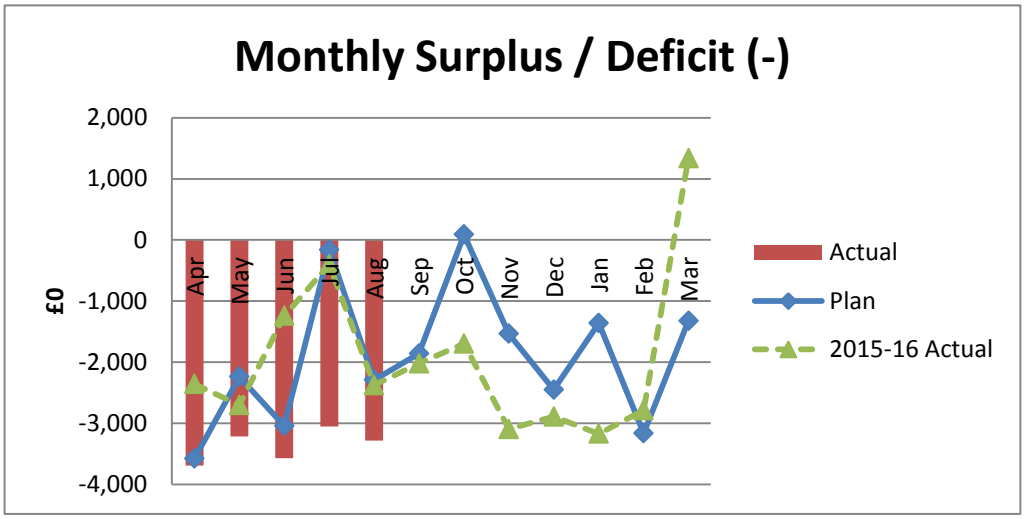
Efficiency workshop scheduled for October

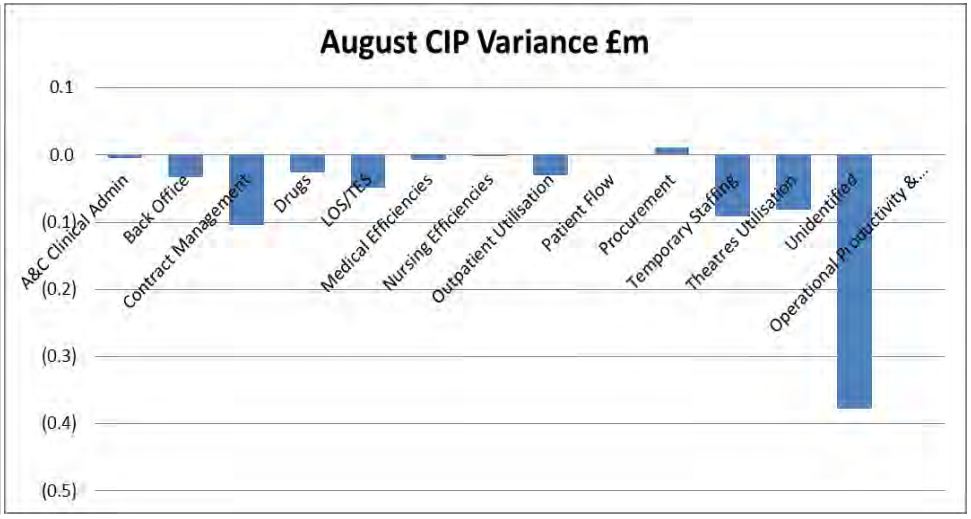
Potential CQUIN opportunity as currently the positon is based on 75% achievement

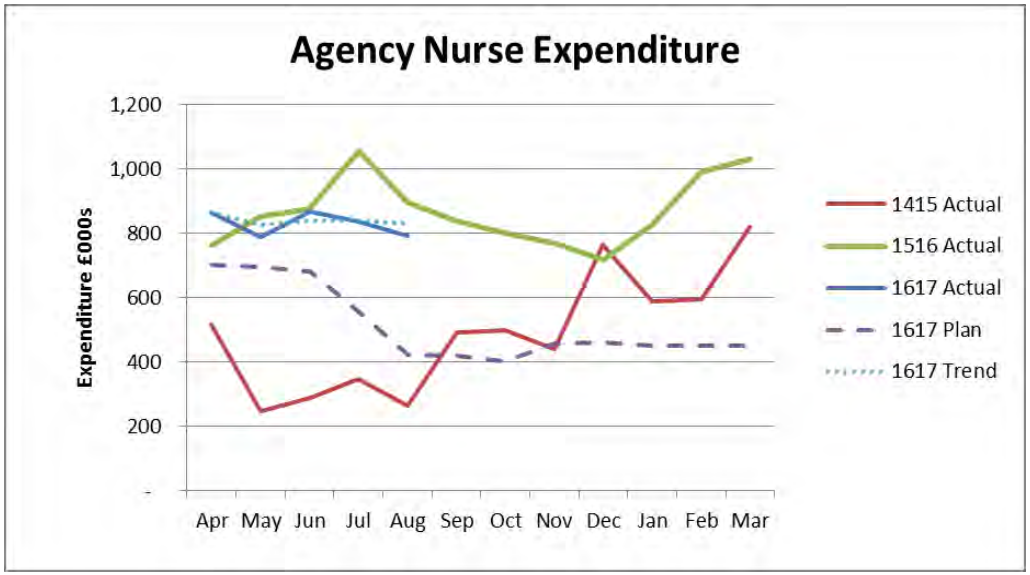
Recovery plan items identified in the last 4 weeks

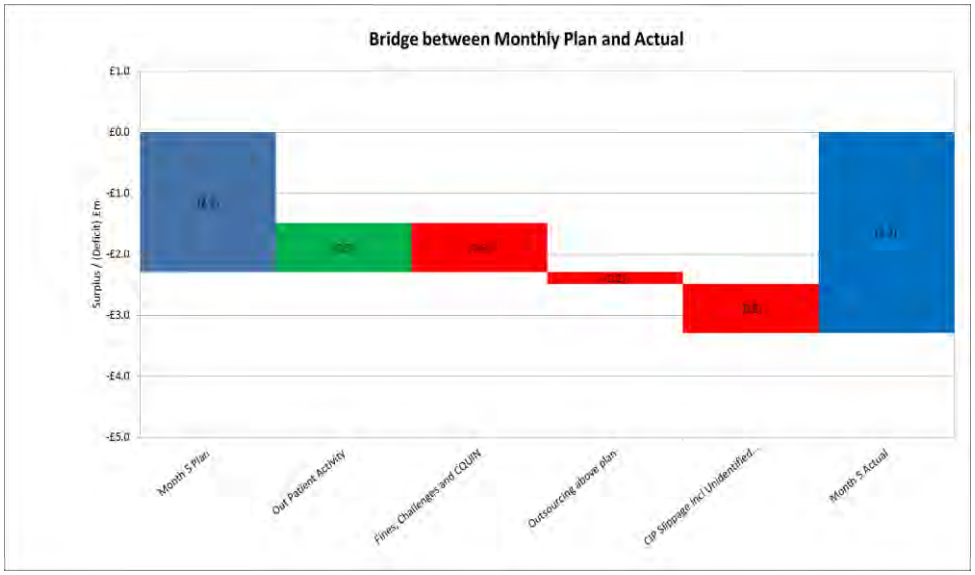
Maidstone and Tunbridge Wells NHS Trust

1b. Executive Summary KPI's August 2016









Financial Performance

Maidstone and Tunbridge Wells NHS Trust

2a. Consolidated Income & Expenditure

Income & Expenditure August 2016/17

		Current Month			Year to Date			Annual Forecast		
		Actual £m	*Plan* £m	*Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	*Forecast* £m	*Plan* £m	*Variance* £m
Revenue										
	Clinical Income	27.8	27.8	(0.0)	138.1	143.2	(5.1)	344.2	344.2	0
	High Cost Drugs	2.7	2.5	0.3	13.6	12.4	1.2	29.6	29.6	0
	Other Operating Income	3.6	3.8	(0.3)	18.8	18.7	0.1	44.9	44.9	0
	Total Revenue	34.1	34.1	(0.0)	170.5	174.3	(3.8)	418.6	418.6	0
Expenditure										
	Substantive	(17.9)	(18.5)	0.6	(89.7)	(93.0)	3.4	(223.0)	(223.0)	0
	Bank	(0.9)	(1.0)	0.1	(4.0)	(4.6)	0.6	(11.9)	(11.9)	0
	Locum	(1.1)	(0.6)	(0.5)	(5.3)	(2.8)	(2.6)	(6.6)	(6.6)	0
	Agency	(1.3)	(1.1)	(0.2)	(7.5)	(6.5)	(1.0)	(13.5)	(13.5)	0
	Pay Reserves	0.0	0.3	(0.3)	0	0.1	(0.1)	2.1	2.1	0
	Total Pay	(21.2)	(20.9)	(0.3)	(106.5)	(106.7)	0.3	(253.0)	(253.0)	0
	Drugs & Medical Gases	(4.0)	(3.9)	(0.1)	(20.5)	(19.9)	(0.7)	(47.5)	(47.5)	0
	Blood	(0.2)	(0.2)	(0.0)	(1.0)	(0.9)	(0.1)	(2.2)	(2.2)	0
	Supplies & Services - Clinical	(3.0)	(2.6)	(0.4)	(13.3)	(13.2)	(0.2)	(31.6)	(31.6)	0
	Supplies & Services - General	(0.5)	(0.5)	(0.1)	(2.3)	(2.3)	0.0	(5.5)	(5.5)	0
	Services from Other NHS Bodies	(0.6)	(0.7)	0.1	(3.3)	(3.4)	0.1	(8.1)	(8.1)	0
	Purchase of Healthcare from Non-NHS	(0.9)	(0.6)	(0.2)	(4.0)	(3.2)	(0.8)	(7.7)	(7.7)	0
	Clinical Negligence	(1.5)	(1.5)	(0.0)	(7.6)	(7.6)	(0.0)	(18.2)	(18.2)	0
	Establishment	(0.3)	(0.3)	(0.0)	(1.5)	(1.4)	(0.1)	(3.4)	(3.4)	0
	Premises	(1.7)	(1.6)	(0.0)	(9.1)	(8.3)	(0.9)	(20.0)	(20.0)	0
	Transport	(0.1)	(0.1)	0.0	(0.7)	(0.7)	(0.1)	(1.6)	(1.6)	0
	Other Non-Pay Costs	(0.2)	(0.4)	0.1	(2.0)	(1.8)	(0.2)	(4.3)	(4.3)	0
	Non-Pay Reserves	(0.4)	(0.3)	(0.1)	(1.7)	(2.3)	0.6	(4.3)	(4.3)	0
	Total Non Pay	(13.4)	(12.8)	(0.6)	(67.2)	(65.0)	(2.2)	(154.5)	(154.5)	0
	Total Expenditure	(34.6)	(33.7)	(0.9)	(173.6)	(171.7)	(1.9)	(407.5)	(407.5)	0
EBITDA	**EBITDA**	(0.5)	0.5	(0.9)	(3.2)	2.6	(5.8)	11.1	11.1	0
		(0.0)	*0.0*	*0.0*	*-1.9%*	*1.5%*	*151.0%*	*2.6%*	*2.6%*	
Other Finance Costs										
	Depreciation	(1.4)	(1.4)	(0.0)	(6.8)	(6.8)	(0.0)	(16.5)	(16.5)	0
	Interest	(0.1)	(0.1)	0.0	(0.4)	(0.4)	(0.0)	(1.3)	(1.3)	0
	Dividend	(0.3)	(0.3)	0.0	(1.3)	(1.4)	0.1	(3.4)	(3.4)	0
	PFI and Impairments	(1.1)	(1.1)	0.0	(5.6)	(5.6)	0.0	(27.0)	(27.0)	0
	Total Finance Costs	(2.8)	(2.9)	0.0	(14.2)	(14.3)	0.1	(48.2)	(48.2)	0
Net Surplus / Deficit (-)	**Net Surplus / Deficit (-)**	(3.3)	(2.4)	(0.9)	(17.3)	(11.7)	(5.7)	(37.1)	(37.1)	0
Technical Adjustments	**Technical Adjustments**	0.1	0.1	(0.1)	0.5	0.4	0.2	14.2	14.2	0
Surplus/ Deficit (-) to B/E Duty	**Surplus/ Deficit (-) to B/E Duty**	(3.3)	(2.3)	(1.0)	(16.8)	(11.3)	(5.5)	(22.9)	(22.9)	0.0

Commentary:

The Trusts deficit in August was £3.3m which was £1m adverse to plan with a YTD deficit of £16.8m (£5.5m adverse to plan).

The key drivers of the deficit in the month were: Contract penalties and challenges (£0.7m) offset by out patient activity overperforming by £0.8m, Private Patient income £0.2m adverse to plan , CIP slippage including unidentified savings (£0.8m) and outsourcing elective activity £0.2m adverse to plan.

YTD clinical income is £5.1m adverse, Elective activity £2m adverse with Non Elective over performing by £2.8m, however Non Elective threshold is higher than plan by £1.6m giving a net non elective income over performance of £1.2m. Maternity pathway slippage of £0.7m YTD is partly offset by Out Patients activity overperforming by £0.5m

Pay was adverse in the month by £0.3m which was due to £0.3m unidentified savings. Pay spend reduced in August by £0.1m which was within Medical (£0.1m) with a small increase within Nursing and STT. Medical staffing overspent by £0.15m in August (£1.1m YTD), this overspend is within the Emergency and Acute directorate (£1.1m adverse YTD), Scientific and Technical Staffing (£0.1m adverse in month, £0.4m YTD adverse) overspend within Specialty Medicine, Diagnostics and Critical Care although Critical Cares overspend is offset by vacancies within Nursing. Nursing was £0.1m favourable to plan in month £1.2m YTD, however Emergency and Acute and Cancer directorate are both overspent by £0.3m. Admin and Clerical £0.2m underspent in August (£0.7m YTD).

Excluding drugs, Non Pay was overspent in August by £0.5m, £0.1m due to unidentified savings, £0.4m relating to Clinical Supplies and Services (Diagnostic £145k, Critical Care £137k and T&O £105k) and outsourcing of elective activity £0.2m.

Expenditure Analysis

Maidstone and Tunbridge Wells NHS Trust

3a. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

		Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Change between Months
Revenue	Clinical Income	26.3	27.3	27.3	26.3	26.4	25.5	25.7	26.9	26.6	27.7	28.4	27.6	27.8	(0.2)
	High Cost Drugs	1.8	2.8	2.5	2.8	2.8	2.7	2.6	3.1	2.8	2.6	2.8	2.6	2.7	(0.1)
	Other Operating Income	4.1	4.3	4.3	4.1	4.0	4.0	4.6	6.5	3.8	3.8	3.6	4.0	3.6	0.4
	Total Revenue	**32.2**	**34.4**	**34.0**	**33.2**	**33.2**	**32.2**	**33.0**	**36.4**	**33.2**	**34.1**	**34.8**	**34.2**	**34.1**	**0.1**
Expenditure	Substantive	(17.0)	(17.1)	(17.0)	(17.5)	(17.4)	(17.3)	(17.7)	(18.1)	(17.8)	(17.9)	(18.1)	(17.9)	(17.9)	(0.0)
	Bank	(0.9)	(0.8)	(0.8)	(0.8)	(0.8)	(0.9)	(0.9)	(1.1)	(0.9)	(0.8)	(0.8)	(0.7)	(0.9)	0.1
	Locum	(0.8)	(0.8)	(0.8)	(0.6)	(0.9)	(1.0)	(0.7)	(0.6)	(1.2)	(0.9)	(1.0)	(1.1)	(1.1)	(0.0)
	Agency	(1.9)	(1.9)	(1.7)	(1.6)	(1.6)	(1.4)	(1.7)	(1.9)	(1.3)	(1.6)	(1.7)	(1.5)	(1.3)	(0.2)
	Pay Reserves	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Pay	(20.5)	(20.6)	(20.2)	(20.4)	(20.6)	(20.6)	(21.0)	(21.8)	(21.2)	(21.2)	(21.6)	(21.3)	(21.2)	(0.1)
Non-Pay	Drugs & Medical Gases	(3.1)	(4.2)	(3.7)	(4.0)	(4.1)	(4.1)	(3.9)	(4.0)	(4.3)	(4.1)	(4.4)	(3.8)	(4.0)	0.2
	Blood	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.0)
	Supplies & Services - Clinical	(2.6)	(2.8)	(2.8)	(3.0)	(2.8)	(2.5)	(2.3)	(2.3)	(2.2)	(2.7)	(2.7)	(2.7)	(3.0)	0.2
	Supplies & Services - General	(0.5)	(0.4)	(0.4)	(0.5)	(0.4)	(0.6)	(0.4)	(0.7)	(0.4)	(0.5)	(0.5)	(0.4)	(0.5)	0.1
	Services from Other NHS Bodies	(0.6)	(0.8)	(0.4)	(0.5)	(0.6)	(0.7)	(0.6)	(0.7)	(0.7)	(0.7)	(0.8)	(0.6)	(0.6)	(0.0)
	Purchase of Healthcare from Non-NHS	(0.6)	(0.6)	(0.8)	(0.6)	(0.7)	(0.3)	(0.7)	(1.1)	(0.8)	(0.7)	(0.8)	(0.9)	(0.9)	(0.0)
	Clinical Negligence	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	0
	Establishment	(0.4)	(0.3)	(0.4)	(0.4)	(0.3)	(0.3)	(0.4)	(0.4)	(0.2)	(0.3)	(0.3)	(0.4)	(0.3)	(0.1)
	Premises	(1.6)	(1.7)	(2.0)	(1.9)	(1.8)	(1.4)	(1.0)	(1.1)	(2.1)	(1.7)	(1.9)	(1.9)	(1.7)	(0.2)
	Transport	(0.1)	(0.1)	(0.2)	(0.2)	(0.1)	(0.0)	(0.1)	(0.2)	(0.1)	(0.2)	(0.2)	(0.1)	(0.1)	(0.0)
	Other Non-Pay Costs	(0.3)	(0.6)	(0.4)	(0.3)	(0.4)	(0.5)	(0.8)	(0.8)	(0.2)	(0.7)	(0.6)	(0.4)	(0.2)	(0.2)
	Non-Pay Reserves	0	0	0	0	0	0	0	0	(0.2)	(0.2)	(0.4)	(0.4)	(0.4)	0
	Total Non Pay	(11.2)	(13.1)	(12.7)	(13.0)	(12.8)	(12.0)	(11.8)	(12.9)	(12.9)	(13.4)	(14.1)	(13.3)	(13.4)	0.0
	Total Expenditure	(31.7)	(33.7)	(32.9)	(33.5)	(33.4)	(32.6)	(32.8)	(34.7)	(34.1)	(34.6)	(35.7)	(34.6)	(34.6)	(0.0)
EBITDA	EBITDA	0.5	0.7	1.1	(0.3)	(0.2)	(0.4)	0.2	1.8	(1.0)	(0.5)	(0.8)	(0.4)	(0.5)	0.1
		2%	*2%*	*3%*	*-1%*	*-1%*	*-1%*	*1%*	*5%*	*-3%*	*-1%*	*-2%*	*-1%*	*-1%*	
Other Finance Costs	Depreciation	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.4)	0.9	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(0.0)
	Interest	(0.1)	(0.0)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	Dividend	(0.3)	(0.4)	(0.4)	(0.3)	(0.2)	(0.4)	(0.4)	0.1	(0.3)	(0.3)	(0.3)	(0.2)	(0.3)	0.1
	PFI and Impairments	(1.1)	(1.1)	(1.1)	(1.1)	(1.2)	(1.1)	(1.4)	(14.2)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	0.0
		(2.9)	**(2.9)**	**(2.9)**	**(2.9)**	**(2.8)**	**(2.9)**	**(3.2)**	**(13.2)**	**(2.9)**	**(2.8)**	**(2.8)**	**(2.8)**	**(2.8)**	**0.1**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(2.3)	(2.1)	(1.8)	(3.2)	(3.1)	(3.3)	(3.0)	(11.5)	(3.8)	(3.3)	(3.7)	(3.2)	(3.3)	0.2
Technical Adjustments	Technical Adjustments	(0.0)	0.1	0.1	0.1	0.2	0.1	0.2	12.8	0.1	0.1	0.1	0.1	0.1	0.1
Surplus/ Deficit (-) to B/E Duty	Surplus/ Deficit (-) to B/E Duty	(2.4)	(2.0)	(1.7)	(3.1)	(2.9)	(3.2)	(2.8)	1.3	(3.7)	(3.2)	(3.6)	(3.1)	(3.3)	0.2

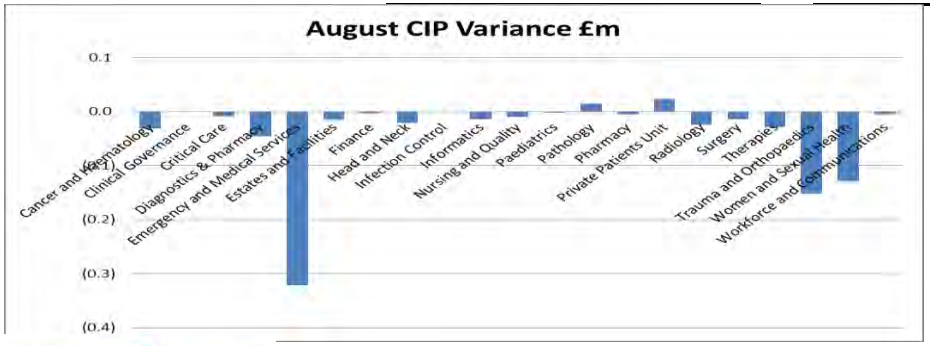
Cost Improvement Programme

Maidstone and Tunbridge Wells NHS Trust

4a. Cost Improvement Programme

Directorate Performance

	Current Month			Year to Date			Forecast					
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Fully developed*	*Plans in progress*	*Opportunity*	***Total Identified***	*Unidentified*	*Grand Total*
	£m	£m	£m	£m	£m	£m	£m	£m	£m	**£m**	£m	£m
Cancer and Haematology	0.2	0.3	(0.0)	1.3	1.3	(0.1)	2.0	0.2	0.0	**2.2**	0.3	2.5
Clinical Governance	0.0	0.0	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	(0.0)	0.0
Critical Care	0.1	0.1	(0.0)	0.5	0.7	(0.2)	1.1	0.0	0.0	**1.1**	0.2	1.3
Emergency and Medical Services	0.2	0.5	(0.3)	1.8	1.7	0.1	3.0	0.4	0.2	**3.6**	2.1	5.7
Estates and Facilities	0.1	0.1	(0.0)	0.7	0.7	(0.0)	2.0	0.1	0.0	**2.1**	0.1	2.2
Finance	0.0	0.0	(0.0)	0.2	0.2	0.0	0.4	0.0	0.0	**0.4**	0.0	0.4
Head and Neck	0.1	0.1	(0.0)	0.4	0.4	(0.0)	0.8	0.1	0.0	**0.9**	0.2	1.0
Infection Control	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	0.0	0.0
Informatics	0.0	0.0	(0.0)	0.1	0.1	(0.0)	0.3	0.0	0.0	**0.3**	0.0	0.3
Nursing and Quality	0.0	0.0	(0.0)	0.0	0.0	(0.0)	0.0	0.0	0.0	**0.0**	0.1	0.1
Paediatrics	0.0	0.0	(0.0)	0.2	0.2	0.0	0.8	0.0	0.0	**0.8**	0.1	0.9
Pathology	0.1	0.0	0.0	0.2	0.2	0.0	0.6	0.0	0.0	**0.6**	(0.1)	0.5
Pharmacy	0.0	0.0	(0.0)	0.0	0.0	(0.0)	0.0	0.0	0.0	**0.0**	0.0	0.0
Private Patients Unit	0.1	0.0	0.0	0.1	0.1	0.0	0.2	0.0	0.0	**0.2**	0.1	0.3
Radiology	0.0	0.0	(0.0)	0.1	0.2	(0.1)	0.3	0.0	0.0	**0.4**	0.2	0.5
Surgery	0.1	0.1	(0.0)	0.6	0.6	(0.0)	1.1	0.1	0.0	**1.2**	0.1	1.3
Therapies	0.0	0.0	(0.0)	0.0	0.1	(0.0)	0.1	0.0	0.0	**0.1**	0.2	0.3
Trauma and Orthopaedics	0.1	0.3	(0.2)	0.6	1.1	(0.6)	0.9	0.1	0.0	**1.0**	1.8	2.8
Women and Sexual Health	0.0	0.1	(0.1)	0.2	0.5	(0.3)	0.2	0.1	0.0	**0.3**	1.2	1.5
Workforce and Communications	0.0	0.0	(0.0)	0.1	0.1	0.0	0.1	0.1	0.0	**0.2**	(0.0)	0.2
Diagnostics & Pharmacy	0.0	0.1	(0.0)	0.1	0.3	(0.2)	0.4	0.0	0.0	**0.4**	0.6	1.0
Total	1.2	2.0	(0.8)	7.3	8.6	(1.3)	14.5	1.1	0.4	**15.9**	7.2	23.1



Women & Sexual Health: Under delivery due to unidentfied CIP; 3 focus areas identified (SLR, Foetal Medicine, EGAU) workship helped on the 18th August to brief staff and identify other opportunities. All schemes identified incorporated into the Recovery Plan.

Diagnostic, Pathology & Pharmacy: Under delivery due to unidentfied CIP, however there are a number of similar drug replacement schemes scheduled for Month 9 of £0.1m. Workshop held with the team to identify further opportunties which are now included in the Recovery Plan.

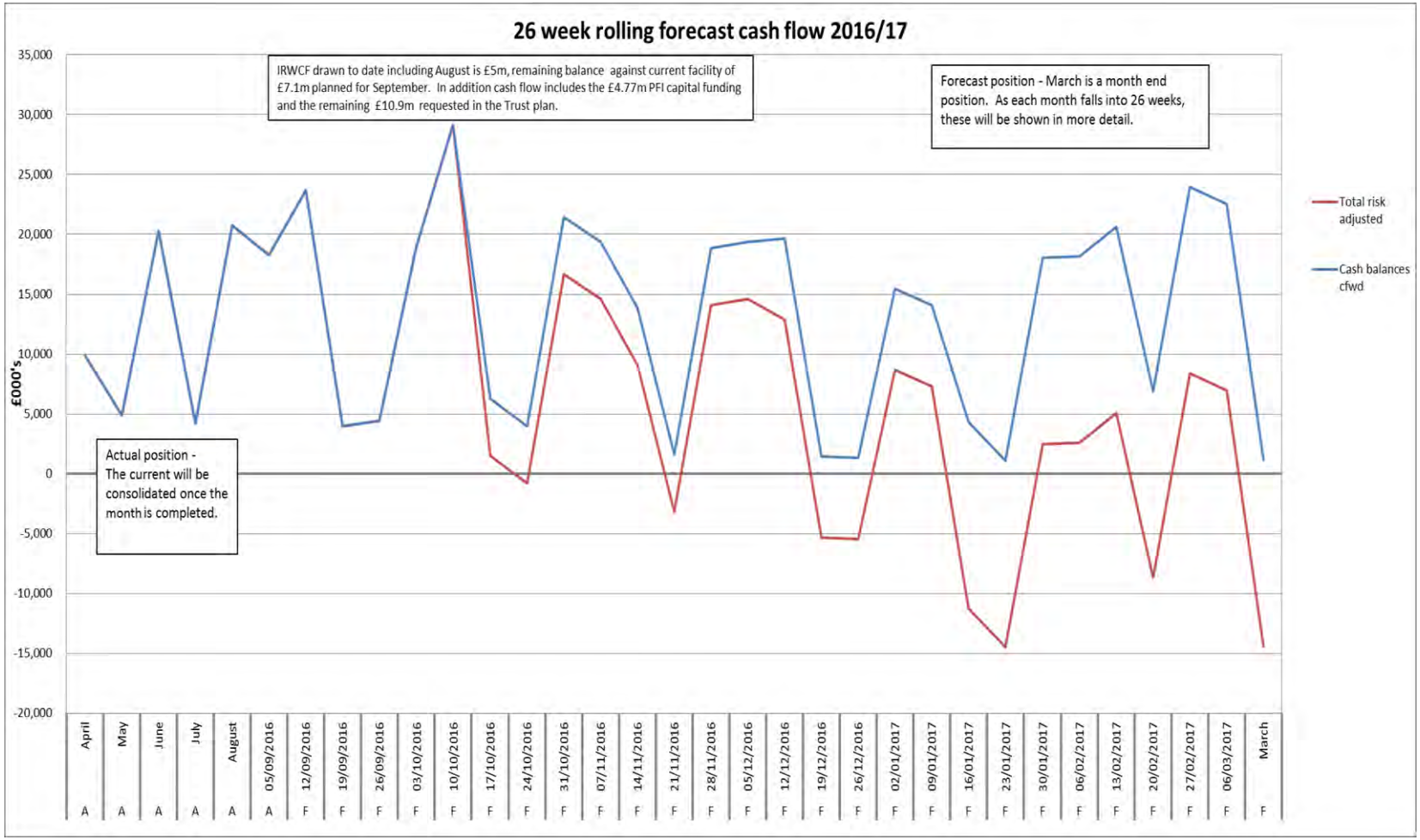
Urgent Care: Focus group underway against current medical staffing overspend. Reconcillation of Ledger, Rota and payroll completed, this has identified ideas for further investigation, to be completed by 20/09.RAG rating excercise completed against locums; resulting in a reduction in areas.

Planned Care: T&O behind plan, T&O focus group has agreed an indicative date of 8th October to ring fence beds at TWH to start to recover this loss.

Balance Sheet and Liquidity

Maidstone and Tunbridge Wells NHS Trust

5a. Liquidity
Cash Flow



Commentary

The blue line shows the Trust's cash position from the start of April, after receiving a double block from WK and Medway CCG.

In August the Trust paid £109k interest in relation to the single currency loan facility took out in March 16, the second interest instalment is due in February for £109k. The Trust will continue to pay both these instalments until the full repayment of the loan is due in February 2019.

For 2016/17 the Trust has IRWCF of £12.132m to assist the cash position. In August the Trust drew £3m and has drawn the remaining balance of £7.132m in September.

The cash forecast is driven by the I&E position with adjustments for working capital movements . The Trust needs additional external funding in line with the I&E deficit position, The red line on the graph demonstrates if external financing is unavailable and the impact on the Trust's cash position.

The Trust is currently paying all suppliers as authorised invoices become due. The teams are actively working on reducing the aged debtor balances, focusing on all debt balances over 90 days.

In September the Trust repays Public Dividend Capital of c£1m, and other loan repayments including interest of c£1.5m

Maidstone and Tunbridge Wells NHS Trust

5b. Balance Sheet

August 2016

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

	August			July	Full year	
£m's	**Reported**	**Plan**	**Variance**	**Reported**	**Plan**	**Forecast**
Property, Plant and Equipment (Fixed Assets)	345.2	346.2	(1.0)	346.2	335.5	335.5
Intangibles	2.9	1.5	1.4	2.9	1.5	1.5
PFI Lifecycle	0.0	0.0	0.0	0.0	0.0	0.0
Debtors Long Term	1.2	1.2	0.0	1.0	1.2	1.2
Total Non-Current Assets	**349.3**	**348.9**	**0.4**	**350.1**	**338.2**	**338.2**
Current Assets						
Inventory (Stock)	8.8	8.3	0.5	8.7	8.3	8.3
Receivables (Debtors) - NHS	34.5	10.6	23.9	29.9	21.1	21.1
Receivables (Debtors) - Non-NHS	12.1	7.8	4.3	14.0	10.0	10.0
Cash	4.0	1.4	2.6	6.4	1.0	1.0
Assets Held For Sale	0.0	0.0	0.0	0.0	0.0	0.0
Total Current Assets	**59.4**	**28.1**	**31.3**	**59.0**	**40.4**	**40.4**
Current Liabilities						
Payables (Creditors) - NHS	(4.6)	(5.0)	0.4	(4.7)	(5.0)	(5.0)
Payables (Creditors) - Non-NHS	(65.8)	(29.7)	(36.1)	(65.4)	(33.0)	(33.0)
Capital & Working Capital Loan	(2.2)	(2.2)	0.0	(2.2)	(2.2)	(2.2)
Temporary Borrowing	0.0	0.0	0.0	0.0	0.0	0.0
Borrowings - PFI	(4.8)	(4.8)	0.0	(4.8)	(5.0)	(5.0)
Provisions for Liabilities and Charges	(1.9)	(2.3)	0.4	(1.9)	(1.0)	(1.0)
Total Current Liabilities	**(79.3)**	**(44.0)**	**(35.3)**	**(79.0)**	**(46.2)**	**(46.2)**
Net Current Assets	(19.9)	(15.9)	(4.0)	(20.0)	(5.8)	(5.8)
Finance Lease - Non- Current	(201.1)	(201.3)	0.2	(201.5)	(198.2)	(198.2)
Capital Loan - (interest Bearing Borrowings)	(14.5)	(14.5)	0.0	(14.5)	(44.6)	(44.6)
Interim Revolving Working Capital Facility	(21.9)	(18.9)	(3.0)	(18.9)	(16.4)	(16.4)
Provisions for Liabilities and Charges	(1.3)	(1.4)	0.1	(1.3)	(0.7)	(0.7)
Total Assets Employed	**90.6**	**96.9**	**(6.3)**	**93.9**	**72.5**	**72.5**
Financed By						
Capital & Reserves						
Public dividend capital	(203.3)	(203.3)	0.0	(203.3)	(203.3)	(203.3)
Revaluation reserve	(53.8)	(53.8)	0.0	(53.8)	(53.8)	(53.8)
Retained Earnings Reserve	166.5	160.2	6.3	163.2	184.6	184.6
Total Capital & Reserves	**(90.6)**	**(96.9)**	**6.3**	**(93.9)**	**(72.5)**	**(72.5)**

Commentary:

The balance sheet remains relatively constant to plan. Key movements to August are in working capital where the cash balance is reducing from the July position as debtors and creditors are increasing. The teams are focusing on reducing the aged debtors and creditors and reviewing current processes to ensure improvement in working capital going forward.

Non-Current Assets PPE - The value of PPE continues to fall as depreciation is greater than the current capital spend, this is due to capital projects being prioritised. This is in line with plan and is not creating an unsustainable backlog of maintenance or required replacements.

Current Assets Inventory has remained consistent as the reported June position, with pharmacy stock at £4.1m, cardiology stocks £1.3m, materials management £1m and all other stock including theatres of £2.4m. Inventory reduction is a cash management and potential CIP being discussed. NHS Receivables have increased since July and remain significantly higher than the plan value. An additional interim resource has been brought in on the recommendation from KMPG to assist with the reduction of debtors, working closely with the CCGs and other NHS organisations. Due to the financial situation of many neighbouring NHS organisations regular communication is continuing and "like for like" arrangements are being actioned. Of the £34.5m balance, £20m relates to invoiced debt with £10.8m aged over 90 days. £1.3m 15/16 over performance has been agreed with NHS England and this will be received in September, discussions with the remaining CCG's on the £2.2m balance for over performance is ongoing.
Trade receivables is also above plan (by £4.2m), included within this balance is trade invoiced debt of £1.3m and private patient invoiced debt of £1.1m.

Current Liabilities Trade payables has increased since July and remains significantly above plan. At present the Trust has a policy to pay approved invoices within 30 days but there are £7.9m of unapproved invoices, and £4.9m approved invoices at month end. £30m of accruals, including TAX, NI, Superannuation and PDC. Also included with trade payables is £27.6m of deferred income primarily relating to the advance received from WK and Medway CCG's in April of c£18 million.

Capital Programme

Maidstone and Tunbridge Wells NHS Trust

6a. Capital Programme

Capital Projects/Schemes

	Year to Date			Annual Forecast	Committed
	Actual	*Plan*	*Variance*	*Plan*	
	£000	£000	£000	£000	£000
Estates	32	900	868	9,384	358
ICT	1,090	1,481	391	2,671	1,262
Equipment	37	825	788	2,581	576
PFI Lifecycle (IFRIC 12)	0	0	0	552	552
Donated Assets	54	200	146	800	314
Total	**1,214**	**3,406**	**2,192**	**15,988**	**3,061**
Less donated assets	-54	-200	-146	-800	-314
Contingency Against Non-Disposal	0	0	0	0	0
Adjusted Total	**1,160**	**3,206**	**2,046**	**15,188**	**2,747**

Commentary:

The total resource for the 2016/17 capital programme is £15.988m, including PFI lifecycle and donated assets, which has been approved by the Trust Board and prioritised by the relevant lead Directors.

The Estates projects include significant investment for Backlog Maintenance of £2m, the majority of which relates to deferred 2015/16 schemes, and a new electrical substation at Maidstone Hospital at a cost of c£2.6m. The OBC for the TWH Linac Bunkers has been approved by the Trust Board and has a capital value of c£7.3m phased over 2 years (£4m in 16/17), the case is due for submission to NHSI once specialist commissioner support is obtained.

The equipment prioritisation process has been completed and is due for review at the TME in September. The Procurement Inventory project is underway and being implemented in early 2016/17.

There is a contingency allocation of £200k within the equipment schemes to allow for any emeregency purchases within the year e.g. x-ray tube replacement.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – September 2016

9-15	The impact of the new Acute Medical Unit at Tunbridge Wells Hospital on patient flow	Chief Operating Officer

At the Trust Board meeting in June 2016, it was agreed that a further report should be submitted to the Trust Board, in September 2016, on the impact of the new Acute Medical Unit at Tunbridge Wells Hospital on patient flow.

The requested report is enclosed.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Review and discussion

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

Update report: 'The impact of the new Acute Medical Unit at Tunbridge Wells Hospital on patient flow'

1. Introduction

Due to considerable operational pressures upon capacity and disruption to the flow of patients through the hospital it was agreed in the spring of 2015 that there was an organisational need to increase capacity for inpatient beds and assessment facilities at Tunbridge Wells Hospital to support the on-going growth in demand and activity. The assessment at the time showed a shortfall of 40 core medical beds which increased to 61 during the winter period.

Following business case approval, a capital programme was launched and the new ward was opened in mid-March 2016 as an Acute Medical Unit with 16 assessment / ambulatory trolleys and 22 short stay medical beds.

The new ward has not yet been able to function to it's full service model due to the continued pressure from non-elective activity in medicine and reliance upon the area for medical escalation. .

The following issues remain our key operational bottlenecks:

- 4-hours ED access standard
- High volume of medical outliers
- Bed occupancy levels over 90%
- Reduction in elective activity at TWH
- Detrimental financial impact relating to income from activity.
- High rate of operations cancelled or postponed due to lack of capacity.

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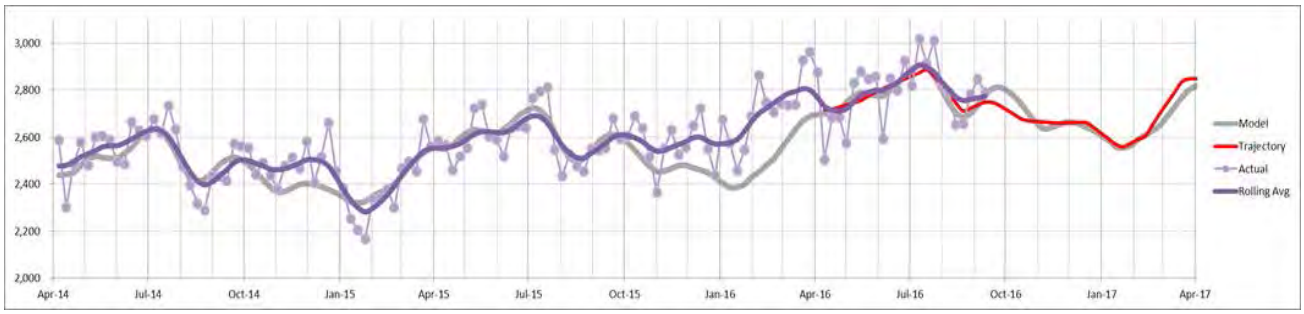
2. Emergency Demand

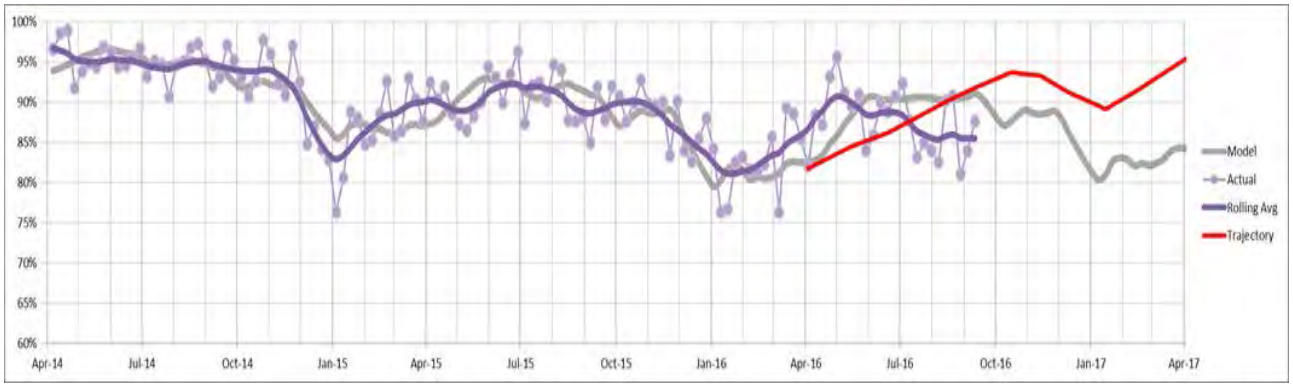
The uplift in attendances seen over the winter period of 2015-16 is now the reality in terms of and increased level of non-elective demand. The year to date (YTD) attendance is 7.6% higher than the equivalent period last year, compared to the normal annual growth of around 2%.

We modelled our demand on last year's pattern and YTD, the attendance is within half a percent of that predicted by the model. This is strong evidence that attendances are behaving 'normally' (meaning they are conforming to the seasonal patterns observed over the last 12 years), and that the increase in attendance observed last winter was a step-up in demand rather than a temporary anomaly.

Attendance (Type 1 only)



Performance Scores (Type 1 only)



The recovery from the usual winter dip in performance was more rapid than usual this year, reaching levels in the low 90% in late May, early June – a month or so earlier than the seasonal model predicts. The new ward supported this early recovery and ensured elective activity performed against plan. Unfortunately ED performance slipped from there instead of sustaining, and has averaged 86.9% over the summer (June/Jul/Aug).

3. <u>Outline of improvements in Q1 & 2 of 2016-17</u>

The continued increase in emergency activity over the first 6 months of the year has resulted in the escalation of the ambulatory cubicles on the new ward. As a result we have not been able to implement the ambulaotory model of care for medical referrals to the extent that is needed or was planned. In collaboration with the National Ambulatory Programme we have relooked at how we can use the a space on the ambulatory unit differently to enable more assessment and throughput of patients. The revised approach will be in place from October 2016.

<u>Conclusion</u>

We continue to have key issues to address regarding the non-elective pathway including the increase in demand and the slower than needed pace on LOS. We will continue to review what is possible in terms of increasing elective activity through the winter months.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – September 2016

9-17 Supplementary Quality and Patient Safety report — Chief Nurse

Summary / Key points

This report provides information on actions being taken to improve the Trust's position in regard to falls prevention, PLACE, Friends & Family response rates, Care Assurance Audits and Protected Meal-times.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Quality Report – September 2016

The purpose of this report is to bring to the attention of the board any specific quality or patient safety issues that are either not covered within the integrated monthly performance report but require board oversight or are covered but require greater detail.

This report is intentionally brief, highlighting only those quality indicators / areas of work which require further explanation or acknowledgement. The Board is asked to note the content of this report and make any recommendations as necessary.

Falls prevention:

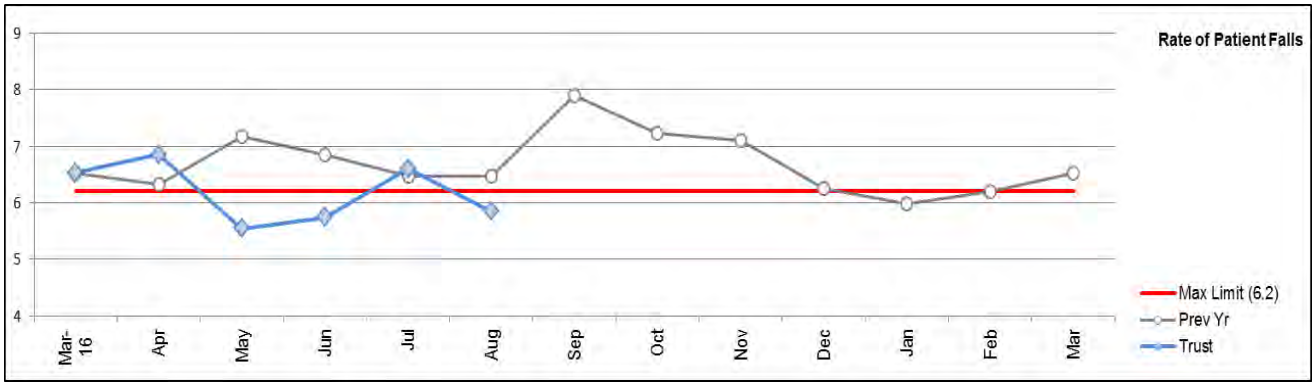
The falls rate threshold for 2016/17 has been set at 6.2 per 1,000 occupied bed days. The rate for the month of August was at 5.85 per 1000 occupied bed days and year to date the rate is at 6.1.

The Falls Task and Finish group continue to meet regularly to monitor the position closely by ward during the month, to support as required and understand the reasons behind any increases in falls numbers.

The agreed actions below for 2016/17 are all in progress:

- Task and Finish group for reducing falls chaired by the chief nurse
- Reviewed terms of reference for Slips, Trips and Falls group
- Revised the Period of increase Incidence (PII) monitoring framework for falls
- New agreed threshold for falls number on each ward/unit
- Review nursing assessment documents for falls prevention
- Review Policy and procedure for management of falls.
- Screen saver – falls prevention message
- Developed dashboard to enable fall's data to be collated and viewed in one place
- Regular meetings with Ward Managers and Matrons to discuss and understand any challenges or support required for individual wards with higher than threshold numbers.

Comparison of Patient Falls 2014/2015 to 2015/2016



Patient-led Assessments of the Care Environment (PLACE)

PLACE assessments apply to all hospitals delivering NHS-funded care, including day treatment centres and hospices. This process puts patient views at the centre of the assessment, and uses information gleaned directly from patient assessors to report how well a hospital is performing in the areas assessed – privacy and dignity, cleanliness, food and general building maintenance.

The assessments are undertaken annually and are reported publicly to help drive improvements in the care environment. Most importantly, patients and their representatives make up at least 50 per cent of the assessment team, which gives them the opportunity to drive developments in the health services they receive locally.

In 2016, the assessments highlighted for the first time how well the premises from healthcare providers are equipped to meet the needs of people with disabilities. This covered a limited range of aspects with strong environmental or buildings associated components.

Improvements made since 2015
Following the assessment carried out in 2015 we have invested in several identified concerns and this progress is reflected in this year's results.

- Completion of Maidstone main entrance refurbishment
- Redevelopment of Maidstone, John Day Ward
- Refurbishment of Maidstone Outpatients
- Redecoration of A&E at TWH.
- New patient chairs in main outpatients and in Ophthalmology outpatients.
- New mealtime aids.
- Patient ward furniture.
- Redecoration of the bereavement room
- Refurbishment of patient showers in Lord North.
- Waste recycling containers.
- Development of TWH, Medical Assessment Unit.

Results for 2016
This year's assessments were undertaken as follows;

- Inspections were undertaken over three days on each site during May 2016.
- On each day there were two teams; each led by a patient representative with a senior nursing representative plus infection prevention matron and a GM or AGM from Facilities.
- At Maidstone and TWH we assessed 10 wards, 5 departments, Emergency Department, main reception and all public toilets and communal areas plus the external areas.
- Food tasting and meal and beverage service was undertaken on 3 wards on each site.

In summary the results achieved for 2016 are **all** above the national average, for further details please see Appendix attached.

Friends and Family (FFT)

A project group has been established with the external company 'I want Great Care' (IWGC) who are supporting the Trust with the collection and reporting of our FFT data. The group includes representation from Nursing and Midwifery staff and a patient Representative.

The purpose of the group is to support the launch of the new contract with the company and to raise the profile of the importance and value of patient feedback within the Trust. The group will monitor progress against actions set out in the Trusts' Quality account this year as follows:

- Friends & Family results to be clearly and consistently displayed within departments including actions and improvements as a result of qualitative feedback
- 85% of areas will display their FFT positive response rates and their actions to support improvements by March 2017
- By March 2017 the Trust will achieve 25% response rates in FFT in all adult inpatient and Maternity Services and 15% response rate for Accident and Emergency services

The group is also going to work with the communications team to agree a range of new material to promote the importance of FFT to both staff and patients.

With the new contract now in place the results over the past two months reflect continued efforts made by all staff in ensuring that patients are being provided with the opportunity to provide feedback to the Trust using the FFT cards.

The inpatient results for the last two months (including day case and children) were 21.73% in July with a significant increase to 30.01% in August. The percentage of positive comments was 95.4 % in July with a slight increase in August positive responses to 96.2% which is encouraging.

For A&E (including children) the response rates decreased slightly from recent months to 17.52% in July with a further decrease to 15.1% in August. The percentage of positive comments was 90.2% in July with a slight decrease in August to 89.2%.

The maternity response rate for July continued to be low with a further reduction to 6.35%, however following a concerted effort by the leadership team in maternity services the results for August increased to 42.3% which is a significant achievement by the whole team.

The above results indicate some overall improvements in response rates. There has however been some inconsistency in the results in some areas which highlights the importance of continued staff engagement with data collection. There is a need to firmly embed this process into everyday activity which will be reviewed as part of the project group.

Care assurance Audits.

Some of our patient representatives met with the Deputy Chief Nurse and colleagues from estates in late July to review the range of patient experience audits that are completed with their support and importantly to obtain their views and suggestions around any potential changes to the range of audits that are carried out. Patient representatives have to date supported the Trust in a number of ways which has included the Care Assurance audits which until recently had been conducted on a monthly basis and also support with the regular Monthly PLACE audits (Patient-led Assessments of the Care Environment). Support has also been available with a number of other areas in response to requests from the Trust.

The discussion provided an opportunity to reflect on the history and experience of our Patient Representatives in their support to the Trust to date and for them to share their ideas and suggestions as to how we can continue to build on the invaluable support offered to the Trust.

One of the outcomes of that meeting was agreement that the Care Assurance Programme would be **discontinued in its current format and would be integrated into the Trust CQC Audit Programme,** which would mean that ideally each audit team will comprise of one patient representative.

The care assurance audits have provided opportunities for patient representatives to talk with patients about different aspects of their experience as a patient in our care, which we would maintain in the new agreed approach.

We are currently reviewing the template that Patient representatives would complete to support these audits, it is possible that we will use some of the questions used previously in the Care assurance programme.

We are keen to ensure that we continue to engage our patient representatives with patient experience audits as they provide valuable and objective feedback to the Trust, which helps us to focus on and identify areas for improvement.

Protected mealtimes

The Adult Patient Mealtime Policy and Procedure (Including Protected Mealtime and Mealtime Support) has been launched in September following a range of presentations and discussions with multi professional staff in the preceding weeks aimed at raising awareness of the forthcoming launch.

As part of the launch all wards have been issued with new signage which has been displayed on the outside of wards across the Trust. The launch was also supported with Trust wide information shared on the weekly Chief Executive update sent out to all staff. A copy of the new approved policy is available on the Trust Q pulse.

The Meal Time Standard sets out the principles of a protected meal time, allowing patients to be free of unnecessary interruption during these essential times of the day. The key message to staff has been focussed around ensuring that meal times are a time when all non-essential attention is placed on enabling patients to enjoy their food.

Patient Safety Calendar

During the month of September we are currently championing the topic of Communication which has been highlighted as an issue identified in both our patient complaints and serious incidents. It was also recognised as being essential in underpinning all further patient safety topics that are planned for the rest of the 2016/7.

1-9 Sept: Launch of 'Hello my name is…' we will ask all of our staff to pay extra attention to how they start a conversation with patients, visitors and colleagues.
We will also take the opportunity to introduce one of our executives or department leads to the staff at MTW and they will give us their views on communication, with a new face regularly published for that month. This will be uploaded onto the trust intranet as both their photographs with the hello my name is logo.
Our Chief Nurse will also instigate a discussion on the staff forum to generate good ideas and examples of things that we have done to improve communication at MTW.

12-16 Sept: 'How can I help you?' during this stage we will concentrate on more active listening and the use of interpreting services.

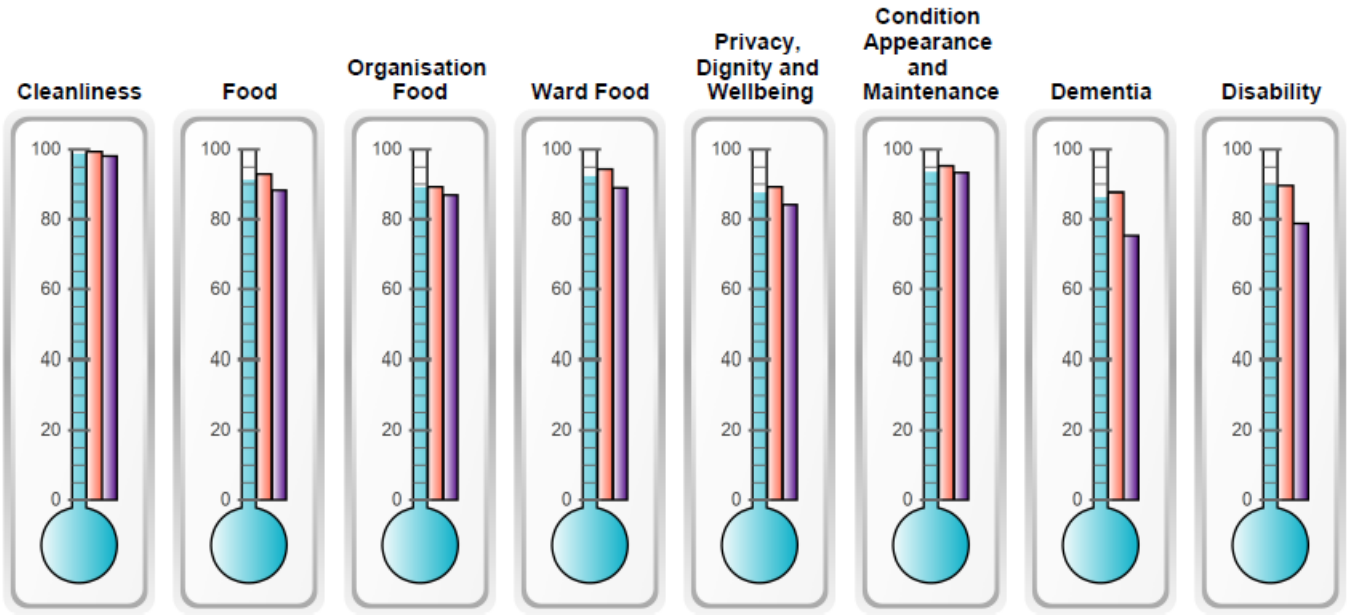
19-23 Sept: Confirmation and explanation, checking our patients understanding. knowing that we got it right or wrong. Learning from complaints-what we have done to put things right, you said, we did analogy's.

26-30 Sept: 'Do you have any questions?' Who to contact if our patients have any follow-up questions. Ensuring our contact phone numbers are manned, etiquette for answering the phone.

PLACE RESULTS FOR 2016

APPENDIX

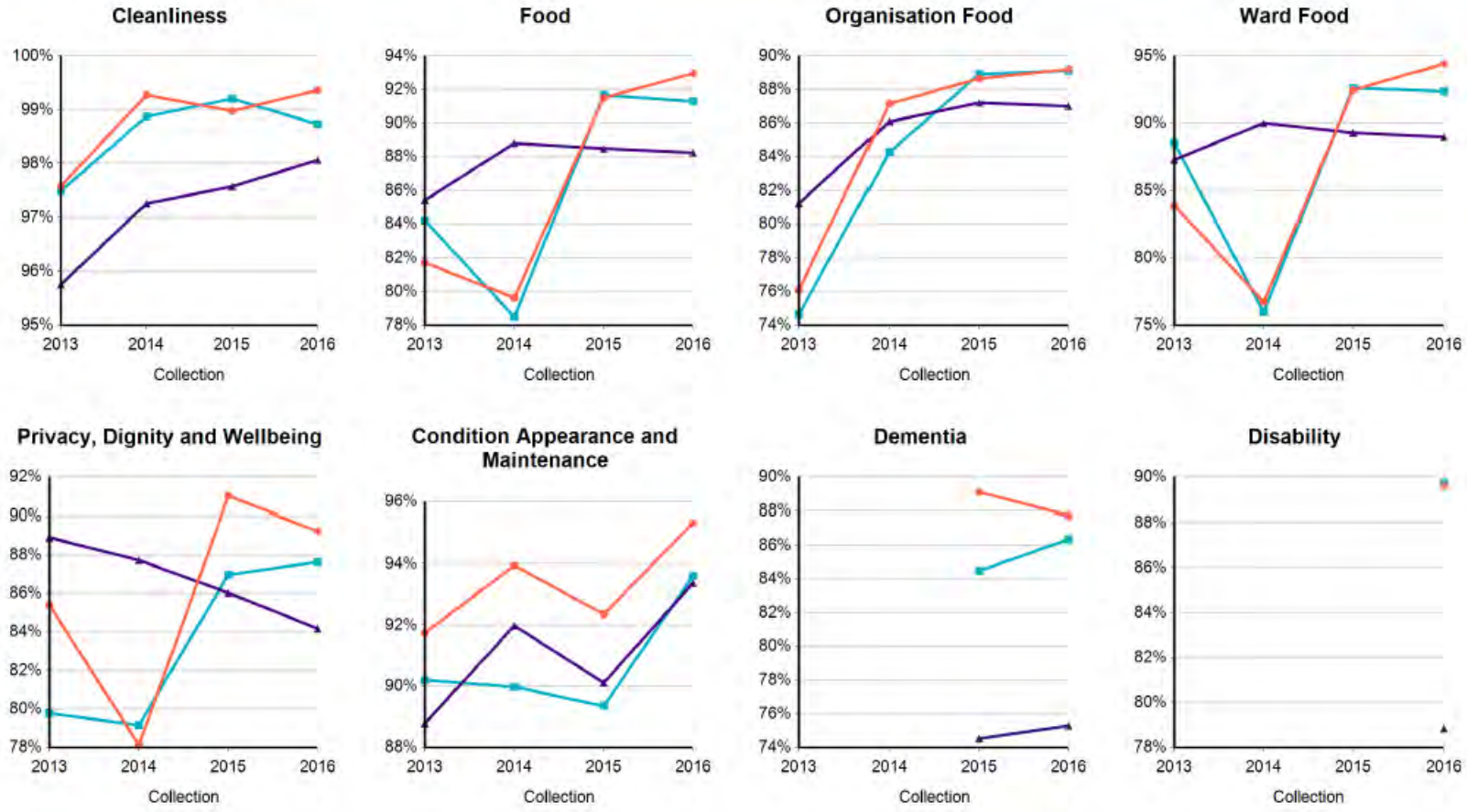
MAIDSTONE GENERAL HOSPITAL- Collection: 2016



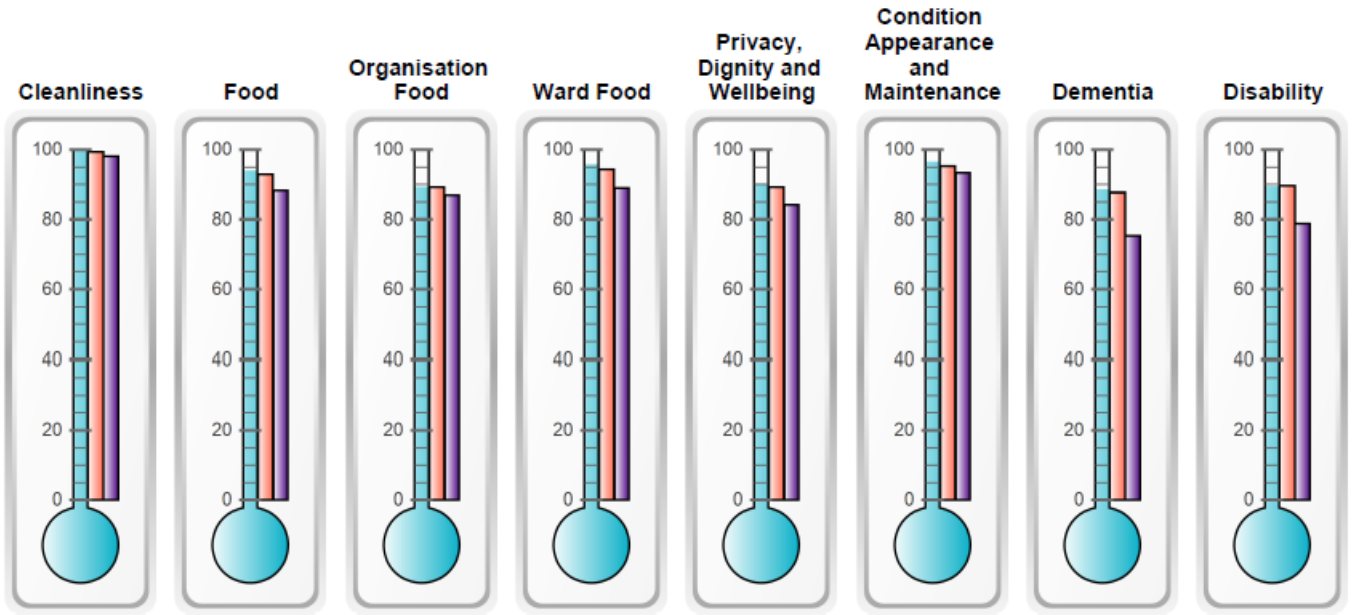
	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	3333.0000	318.5039	102.1090	216.3949	326.0000	1391.0000	815.9117	459.6680
Available Score (Actual)	3376.0000	348.8737	114.5880	234.2857	372.0000	1486.0000	944.8571	512.3697
Site Score	98.73%	91.29%	89.11%	92.36%	87.63%	93.61%	86.35%	89.71%
Organisation Average	99.36%	92.96%	89.21%	94.40%	89.21%	95.32%	87.70%	89.59%
National Average	98.06%	88.24%	87.01%	88.96%	84.16%	93.37%	75.28%	78.84%

MAIDSTONE GENERAL HOSPITAL

Site Scores Organisation Average National Average



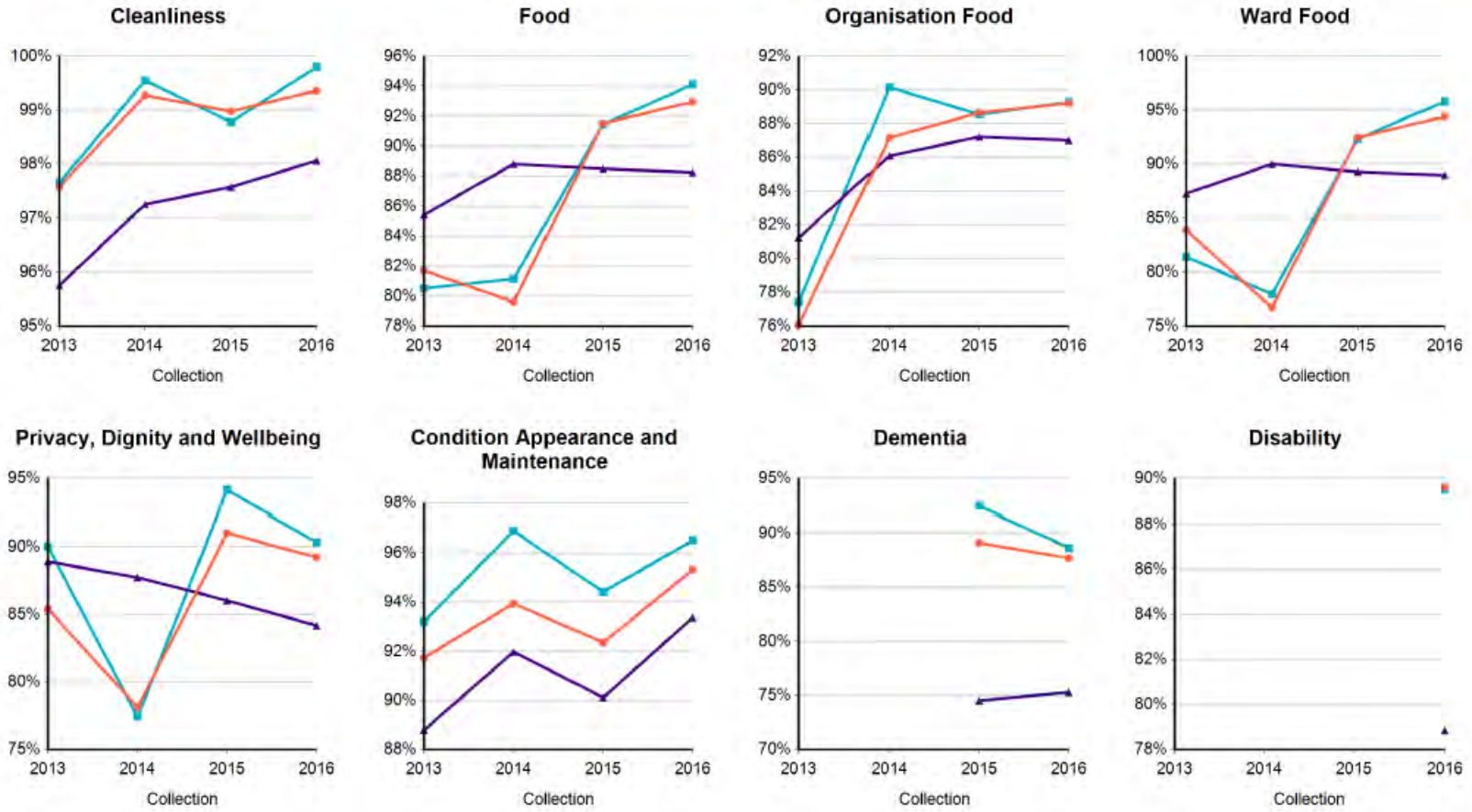
THE TUNBRIDGE WELLS HOSPITAL- Collection: 2016



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	3487.0000	414.5081	102.2981	312.2100	298.0000	1438.0000	778.9117	483.6680
Available Score (Actual)	3494.0000	440.4703	114.5880	325.8823	330.0000	1490.0000	878.8571	540.3697
Site Score	99.80%	94.11%	89.27%	95.80%	90.30%	96.51%	88.63%	89.51%
Organisation Average	99.36%	92.96%	89.21%	94.40%	89.21%	95.32%	87.70%	89.59%
National Average	98.06%	88.24%	87.01%	88.96%	84.16%	93.37%	75.28%	78.84%

THE TUNBRIDGE WELLS HOSPITAL

Site Scores Organisation Average National Average



Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – September 2016

9-18	Annual Report from the Director of Infection Prevention and Control	Director of Infection Prevention and Control

The enclosed report provides a summary of infection prevention and control activity in the Trust between April 2015 and March 2016.

The Director of Infection Prevention and Control is required to produce an Annual Report and release it publicly as outlined in 'Winning Ways: Working Together to Reduce HCAI in England' 2003.

This year has seen further improvement in the Trust's *C. difficile* performance, building on previous successes over the last ten years, extending that improvement to other healthcare associated infections (HCAI) and taking the Trust into the top quartile of performance, benchmarked against other Trusts in England.

Infection control policy and practice have been re-examined in order to achieve consistent progress in reducing Healthcare Associated Infection (HCAI). As a Trust we have a zero tolerance approach to healthcare associated infection and aim to have no avoidable infections.

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

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

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

Director of Infection Prevention and Control – Annual Report to the Board 2015/16

1. Executive Summary

This report outlines the activities of the Trust relating to infection prevention and control for the financial year 2015/16 including key achievements. It describes the Trust arrangements to allow early identification of patients with infections and measures taken to reduce the spread of infections to others.

Prevention and control of healthcare associated infections (HCAIs) is a key priority for Maidstone and Tunbridge Wells NHS Trust which has an infection prevention and control strategy and programme of activities which includes national initiatives for the reduction of infection rates.

The Infection Prevention Team (IPT) advises and co-ordinates activities to prevent and control infection; however it is the responsibility of all staff in the organisation to comply with Trust policies and implement guidelines in their local area. The IPT also works closely with other stakeholders in relation to strategies for prevention of infection including Commissioning CCGs, Public Health England and Regional Specialist Laboratories.

This year has seen further improvement in the Trust's *C. difficile* performance, building on previous successes over the last ten years, extending that improvement to other healthcare associated infections (HCAI) and taking the Trust into the top quartile of performance, benchmarked against other Trusts in England.

Infection control policy and practice have been re-examined in order to achieve consistent progress in reducing HCAI. As a Trust we have a zero tolerance approach to healthcare associated infection and aim to have no avoidable infections.

By the end of the year the Trust had maintained very low levels of MRSA and achieved an in-year 36%, and cumulative two-year 55%, reduction in *C. difficile* infections.

Maidstone and Tunbridge Wells NHS Trust maintains compliance with CQC Outcome 8 Regulation 12 "Cleanliness and Infection Control" and the Health & Social Care Act 2008.

2. Our year in numbers

3. Successes

The Infection Prevention team (IPT) has had success in 2015/16, building on previous year's improvements, ensuring sustained reductions in healthcare associated infections (HCAIs) and achieving the planned reductions.

Notably, the Trust position with respect to *C. difficile* improved with a further 36% reduction in cases in year taking MTW into the top 15 acute Trusts in England with respect to *C. difficile* performance, completely reversing the position seen in 2006.

The Trust position with respect to MRSA bacteraemia was maintained with just one Trust-attributable case seen for the year. The number of bacteraemia cases has been reduced by 98% since 2004 and has remained at one case for the year for the last two years.

The IPT led the work on the catheter-associated urinary tract infection (CA-UTI) CQUIN, achieving a reduction in hospital acquired CA-UTI of 29% against as CQUIN target of 10%. Partly as a consequence of the work done to reduce CA-UTI, the incidence of hospital acquired *E. coli* bacteraemia also fell by 44%

Root cause analysis (RCA) is carried out for all *C. difficile* infections, MRSA bacteraemias, Methicillin sensitive *Staphylococcus aureus* (MSSA) and *E. coli* bacteraemias. The IPT has been supporting the CCGs in their RCA processes for community acquired infections.

Monitoring of infection prevention practice and performance throughout the Trust supported by triangulation audits is reported by the directorates to the Infection Prevention and Control committee (IPCC). This method of monitoring and reporting has been identified as best practice by the NHS Improvement and shared with other organisations

The infection prevention Link Nurse programme remains very active and meets on a monthly basis. An annual conference is held with invited speakers.

The IPT actively participates in national surveillance schemes, submitting epidemiological data on all *C. difficile* cases, MRSA, MSSA and *E. coli* bacteraemia patients and selected surgical site infections to Public Health England (PHE).

Two new members of the infection prevention team were appointed this year and we said good bye to an infection control nurse and to our long serving surgical site surveillance nurse who retired in December.

4. Structure

The Chief Nurse is the executive lead for Quality within the Trust.

Dr Sara Mumford (consultant microbiologist) is the Director of Infection Prevention and Control (DIPC), attends the Trust Board and leads the Infection Prevention and Control strategy for the Trust, reporting to the Chief Executive Officer.

The Trust Infection Prevention and Control Committee (IPCC) is chaired by the Chief Nurse or the DIPC and meets bi-monthly. The committee has wide representation from throughout the Trust and has external representation from West Kent CCG and Public Health England. The directorates report to the IPCC on all aspects of infection prevention and antimicrobial stewardship.

The DIPC presents a monthly report to the Trust Management Executive.

4.1. Infection Prevention and Control Team

During the year there were staff changes within the infection prevention team.

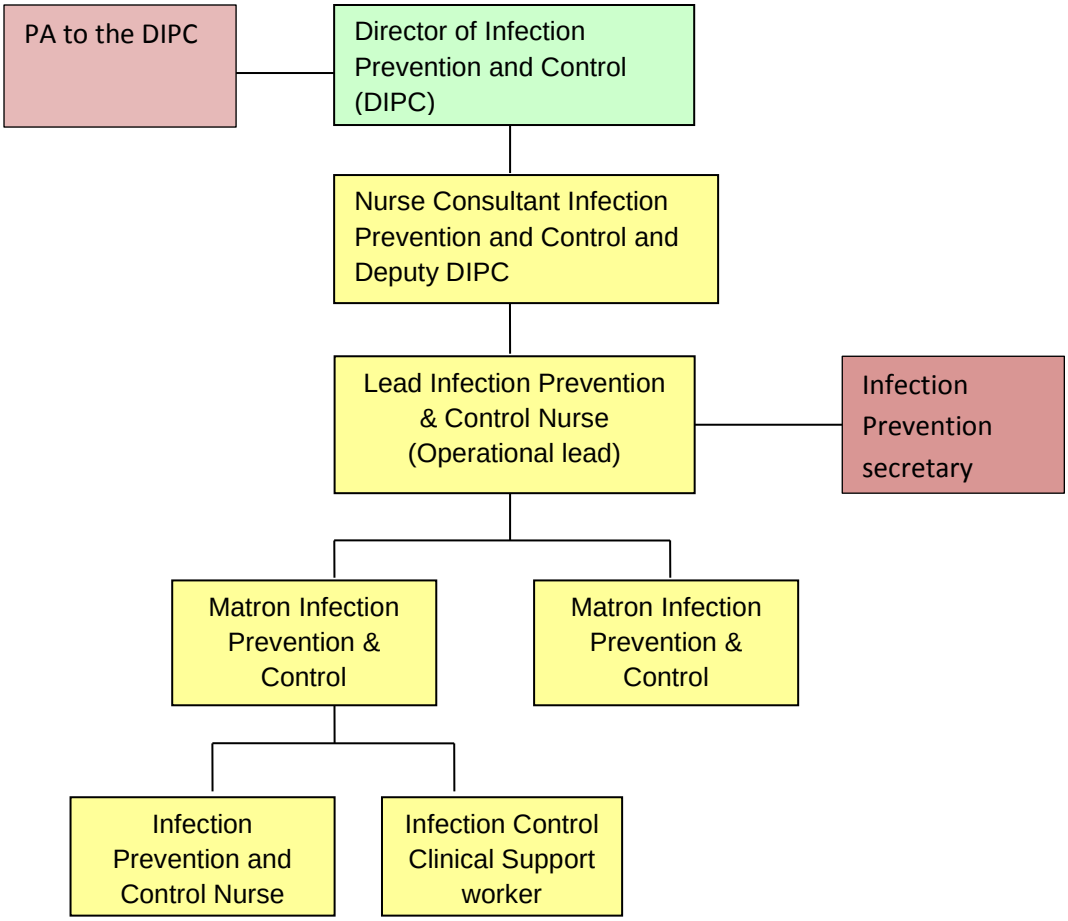
Following the retirement of Helen Gregson, the surgical site surveillance nurse, Pam Howe, infection control lead nurse, took on this additional role pending the recruitment of Helen's replacement.

Sheenagh Gallagher, infection prevention nurse left the Trust to return to Norfolk and Claire Bolden joined the team as a Band 6 infection prevention nurse. Claire had been working on the Acute Stroke Unit at Maidstone as a staff nurse and has been a popular addition to the team.

Karen Fogg joined the team as a Clinical Support Worker. She has proved invaluable in enhancing the communication with ward based CSWs and also taking on the data collection work for both the surgical site surveillance and some of the routine infection control audits.

A joint post is being developed with Trauma and Orthopaedics to fulfil the surgical site surveillance role.

Fig 1: Structure of the Infection Prevention Team



4.2 Infection Prevention and Control Committee

The Infection Prevention and Control committee (IPCC) meets bi-monthly and during this year has reported to the Quality and Safety Committee.

With the restructuring of governance arrangements within the Trust the IPCC will report to the Trust Clinical Governance committee and upwards to Quality Committee and the Trust Board from April 2016. The committee Terms of Reference were reviewed and revised to reflect the new structure in February 2016.

The directorates report into the IPCC on all aspects of infection prevention and antibiotic stewardship.

The objectives of the IPCC include:

- To advise and support the Infection Prevention and Control Team.
- To provide assurance to the Trust Clinical Governance Committee with respect to infection prevention and control structure, processes and outcomes and compliance with CQC outcome 8 and the 'Hygiene Code' (The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance).
- To inform the Trust Clinical Governance Committee in a timely manner of any serious problems or hazards relating to infection control.
- To receive reports from the Infection Prevention and Control Team.
- To monitor Healthcare Associated Infection against key performance indicators including receiving reports on compliance data from Directorate representatives.
- To discuss and approve Infection Prevention and Control policies.
- To review the annual infection control programme and audit programme.
- To ensure the implementation of national guidance, and action plans arising from Patient Safety alerts relating to Infection control
- To monitor progress against CQUIN targets related to infection control

The Infection Prevention and Control Committee has no formal sub-committees. However, the Committee receives reports specifically on infection control issues from:

- Directorate Representatives (CD or Matron) from each Directorate.
- The Antimicrobial Pharmacist
- The vascular access specialist practitioner
- Occupational Health Manager
- Director of Estates & Facilities (or deputy)
- Clinical Audit
- The Risk and Compliance Manager
- Learning & Development
- C. difficile review panel
- Others as issues arise

5. Care Quality Commission

The Health Act 2008, now superseded by the Health and Social Care Act 2013, contains a Code of Practice usually referred to as the Hygiene Code. The 2008 Act requires acute Trusts to comply with the Code and outlines penalties for non-compliance. CQC Outcome 8 is based on the requirements of the Hygiene Code

MTW continues to comply with the Hygiene Code and CQC outcome 8 and to collate evidence to support compliance.

6. Healthcare Associated Infection

6.1. HCAI action plan

A new HCAI action plan was developed in April 2015 and implemented throughout the year. The plan was monitored through the IPCC and reported to the Trust Clinical Governance committee. The 2014/15 plan was completed with outstanding actions signposted to the new action plan.

Key actions include:

- Audit of compliance with IV to oral antibiotic switch
- Development of e-learning package for antibiotic training for doctors
- Development of the outpatient antimicrobial therapy (OPAT) service
- Improved recording of antibiotic history of new admissions
- Improving information on antimicrobials for patients
- Introduction of admission lounge risk assessment for HCAI
- Audit compliance with screening for Carbapenem resistant enterobacteriaceae
- Ensure compliance with NICE quality standards for Surgical Site infections
- Ensure compliance with NICE quality standard for Infection Prevention and Control
- Achieve CA-UTI CQUIN
- Trust wide prevalence survey for HCAI
- Introduce ‘focus on’ programme across link nurse network
- Trial of UV-C light decontamination
- Development of IC handbooks for temporary and student staff.

The action plan was also shared at the Trust Management Executive and agreed by the Clinical Directors.

Any outstanding actions at the end of the year were signposted into the 2016/17 action plan.

6.2. *Clostridium difficile*

Reducing *Clostridium difficile* infections was one of the key objectives for the Trust throughout 2015/16.

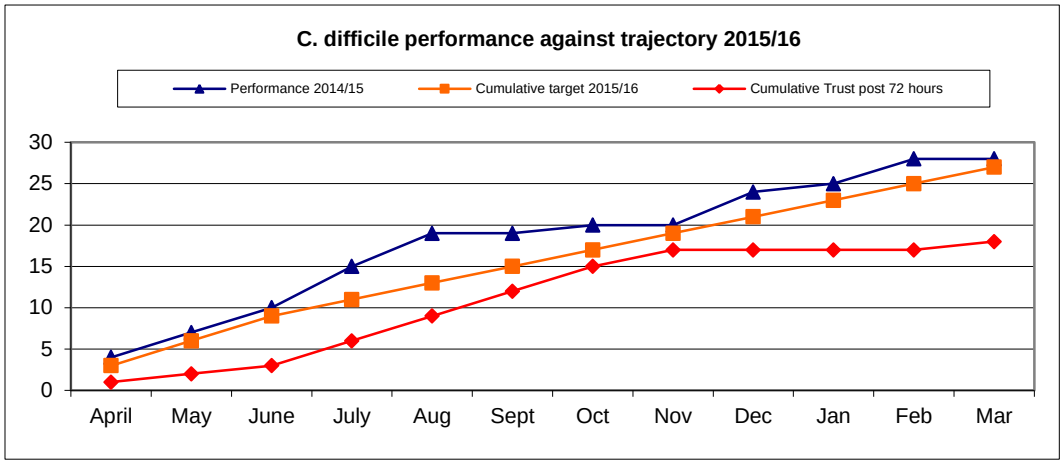
6.2.1. Rates of Infection

The Trust achieved a 36% reduction in *C. difficile* infection this year. The out-turn of 18 cases achieved the objective of 27 cases and improved upon the out-turn for the previous

year. The rate of infection for the year was 7.4/100 000 bed days compared with a national benchmark of 14.96/100 000 bed days.

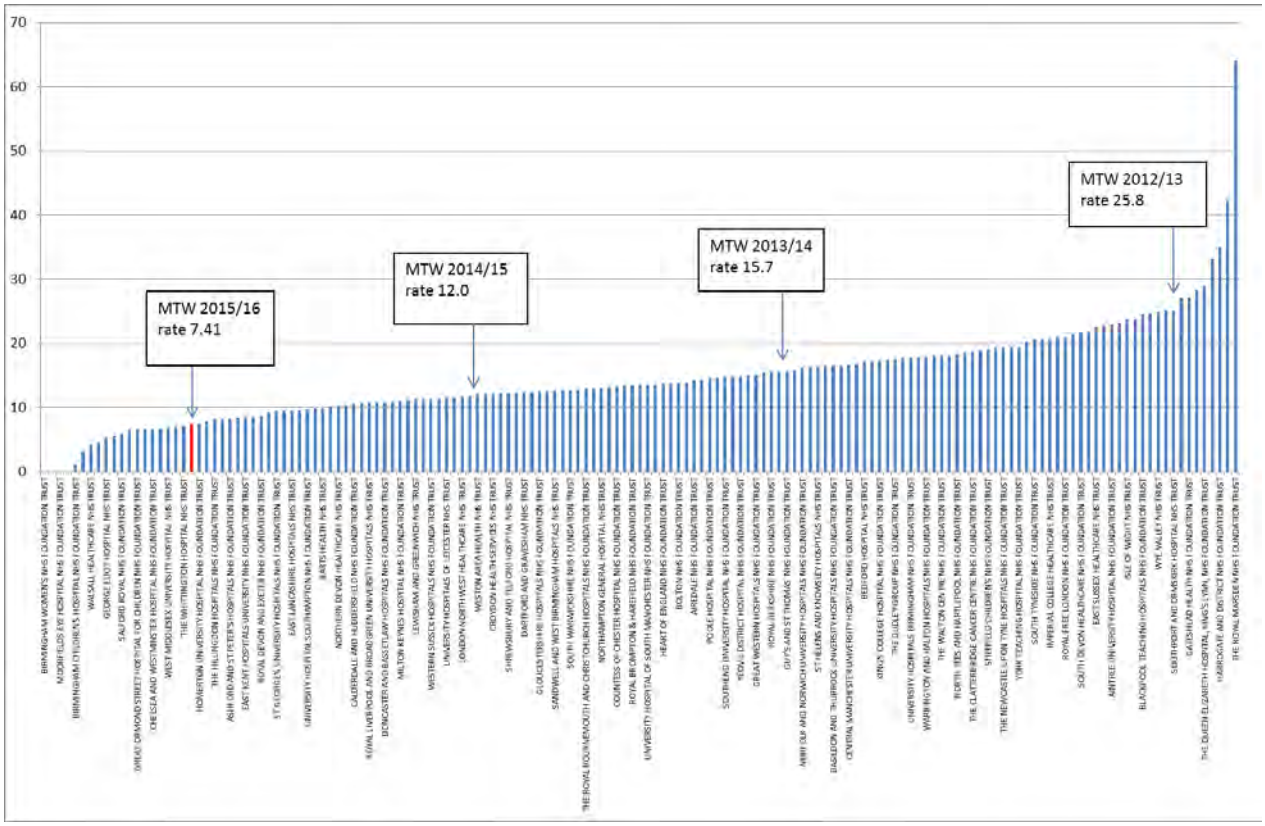
The NHS England objective limit was designed to bring the Trust up to the best performing quartile for the previous year.

Fig 2: *C. difficile* performance against trajectory



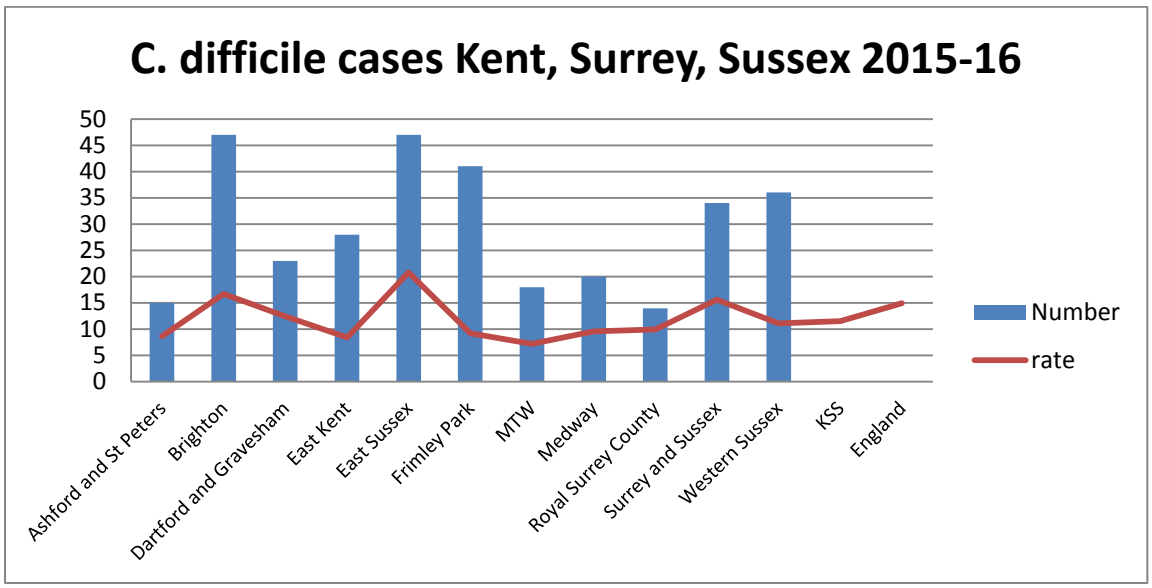
Performance remained below the Trust trajectory for the whole year with a three month period from December - February when there were no cases. Maidstone hospital had a 5 month period with no cases.The improvement in performance in *C. difficile* has placed MTW in the upper quartile for infection rates for the first time and in the top 15 of acute Trusts in England.

Fig 3. Trust apportioned *C. difficile* rates for England. 2015/6



MTW also performed well compared with our neighbouring Trusts in Kent, Surrey and Sussex as shown in Fig 4.

Fig 4. *C. difficile* cases in Kent, Surrey and Sussex



The cumulative rate of *C. difficile* infections for Kent, Surrey and Sussex was 11.54/100 000 bed days and the England rate for acute Trusts was 14.96/100 000 bed days, a significant rise from the previous year.

The year on year improvement by MTW following the 2006 outbreak has now been sustained over a period of ten years with reduction of over 96% in cases overall.

Fig 5: New cases of *C. difficile* from April 2005 to March 2016

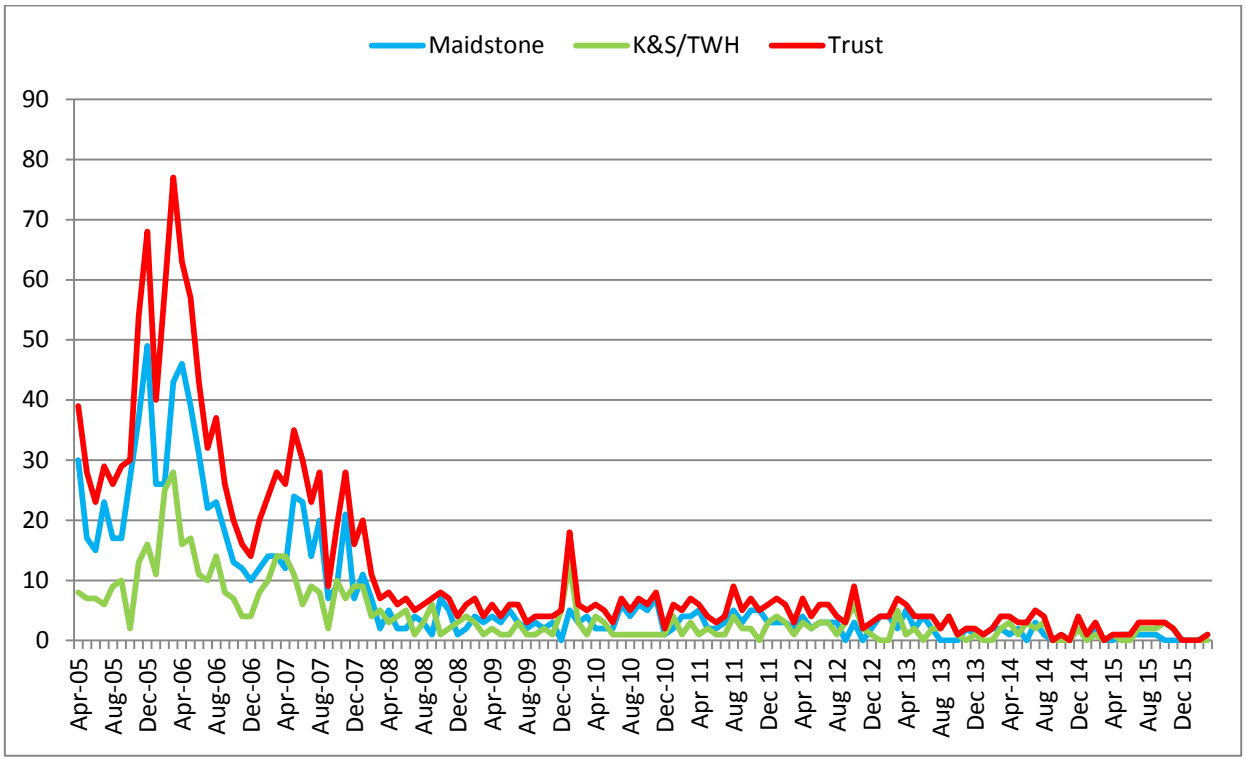
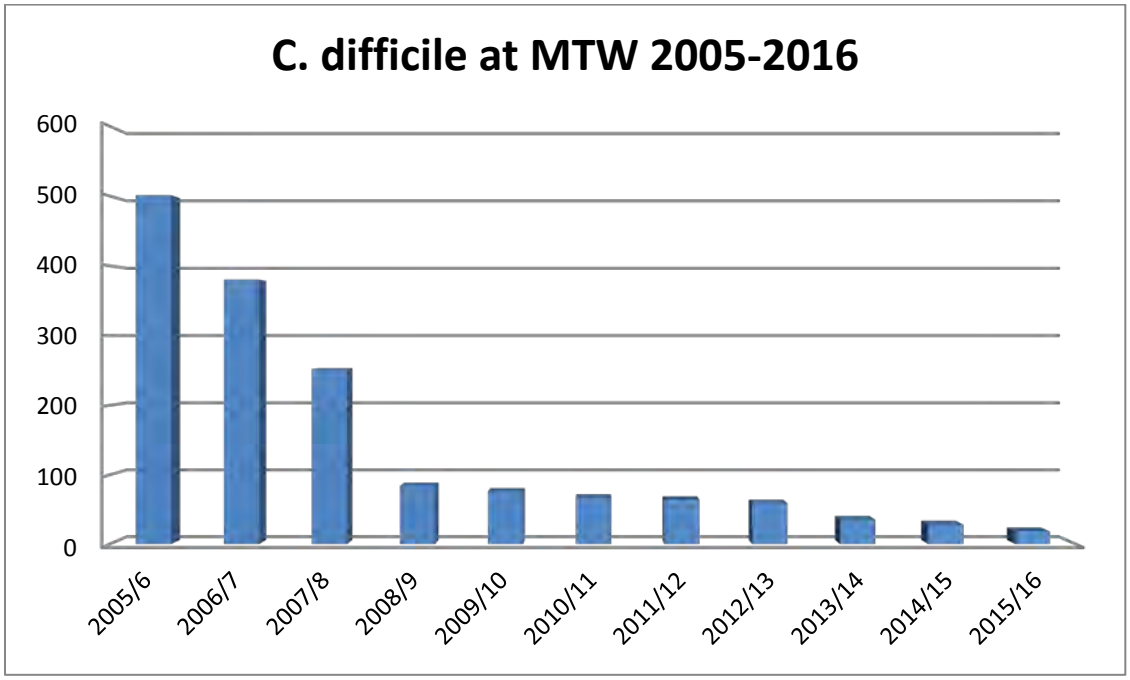


Fig 6: *C. difficile* cases by year



The Trust objective for 2016/17 was released by NHS England in February 2016. Many Trusts had difficulty in achieving the 2015/16 objective so these were carried over into 2016/17. The objective for MTW for 2016/17 is 27 cases – nine cases above the 2015/16 out-turn.

6.2.2. Laboratory diagnosis

During 2015/16, the microbiology laboratory processed 7839 samples for *C. difficile* on 4710 patients. Of these 1816 were GP patients, the others being inpatients in acute or community settings, MTW A&E or outpatient attenders.

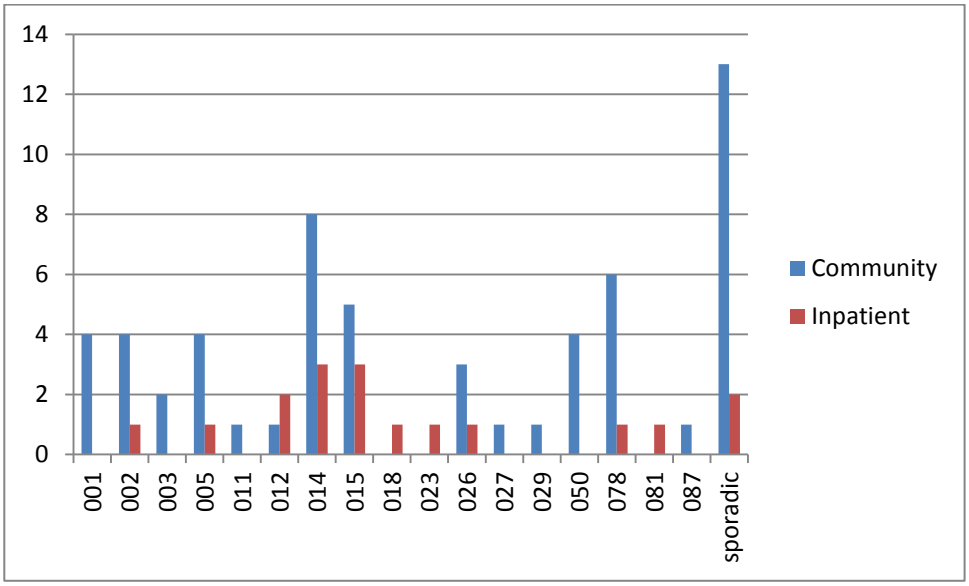
166 patients were newly identified as carriers of toxigenic *C. difficile* (89 in 2014/15), 114 inpatients and 52 community patients.

Eighty patients were diagnosed with acute *C. difficile* infection. 18 cases were attributable to the acute Trust and 62 to the community. Of the community acquired infections, 38 were diagnosed on samples sent in by their GPs and 24 were diagnosed during the first 72 hours of their hospital admission. Fourteen of the community cases had had recent hospital admission at MTW.

All cases are sent to the reference laboratory for ribotyping to detect any possible links between cases. Where there is suspicion of a link a request is made to the Regional Microbiologist for multi-variant loci analysis (MVLA - a type of genetic finger-printing) to confirm or rule out an association between cases. This was requested on one pair of cases at MTW this year but no link was found.

There are no discernable trends in the ribotypes of *C. difficile* either in the acute or primary care setting. Typing of hospital cases tends to reflect those types prevalent in the community. The 027 strain which caused the outbreak in 2005/6 has decreased in prevalence to back ground levels. The monitoring of ribotypes will continue in order to detect any trends and give an early warning of any new epidemic strains emerging.

Fig 7: Ribotyping of all C. difficile cases 15/16



A treatment algorithm is in place to enable identified carriers to be treated to avoid progression on to acute infection.

6.2.3. Isolation

The standard within the Trust for isolation of patients with potentially infectious diarrhoea is two hours.

All *C. difficile* patients are isolated on diagnosis if not already in a side room. In addition, those identified as carriers are isolated whilst they are symptomatic and for at least 48 hours after they become asymptomatic.

The *C. difficile* cohort areas on Mercer ward and TW10 are no longer designated due to the low numbers of patients with acute infection. Active management of side room provision continues.

The Infection Prevention team produce isolation lists on a daily basis to support the bed managers and ensure the best use of the side rooms available at Maidstone Hospital and to alert staff of infection control issues at Tunbridge Wells Hospital. Information includes advice on which patients may be de-isolated if necessary and prioritises lower risk patients who would benefit from isolation. The list also alerts site practitioners to community issues such as outbreaks of norovirus in local nursing homes and community hospitals and any wider outbreaks which may result in patients attending A&E.

6.2.4. Case review

All cases of *C. difficile* infection (CDI), both community acquired and in-patient, are assessed by root cause analysis investigation. The IPT works collaboratively with the CCG infection control teams to investigate community and pre-72 hour cases. Root cause analysis multidisciplinary meetings are held for all hospital-attributable (post-72 hours) cases and any GP or pre-72 hour cases with recent hospital admission. This enables any lessons associated with cases arising in the community to be learned and ensures that the impact of inpatient treatment on patients is understood.

Following the multidisciplinary meeting the case goes to the *C. difficile* panel where the RCA is examined by the DIPC and Chief Nurse. There is an expectation that the ward manager and consultant for the case will attend as a minimum.

The panel considered all 18 hospital-attributable cases and a further 14 GP and pre-72 hour cases where the patient had recent MTW admission.

The *C. difficile* panel assesses the root cause of the infection and also whether or not any lapses of care have been identified. This allows infections to be identified as avoidable or unavoidable.

The root causes for the hospital-attributable cases for 2015/16 are summarised below:

Table 1: Outcomes of RCA for hospital-attributable cases April 2015- March 2016

Organism	Unavoidable (appropriate antibiotics)	Inappropriate antibiotics	Delayed diagnosis of community acquired infection	Cross infection
C. difficile	12	5	1	0

There were no instances of cross infection during the year.

Most (12/18) cases were judged to be due to appropriately prescribed antibiotics. It is likely that these patients were carriers of the organism and the use of antibiotics damaged the balance of their normal bacterial flora and allowed the *C. difficile* to grow and produce toxin.

Antibiotics were considered inappropriate if they were prescribed outside the Trust guidance without agreement from a consultant microbiologist, continued for too long, or prescribed for the wrong indication.

Lapses of care are defined and standardised by a Kent and Medway-wide agreement.

Lapses of care are graded as follows:

0 – No sub-optimal care

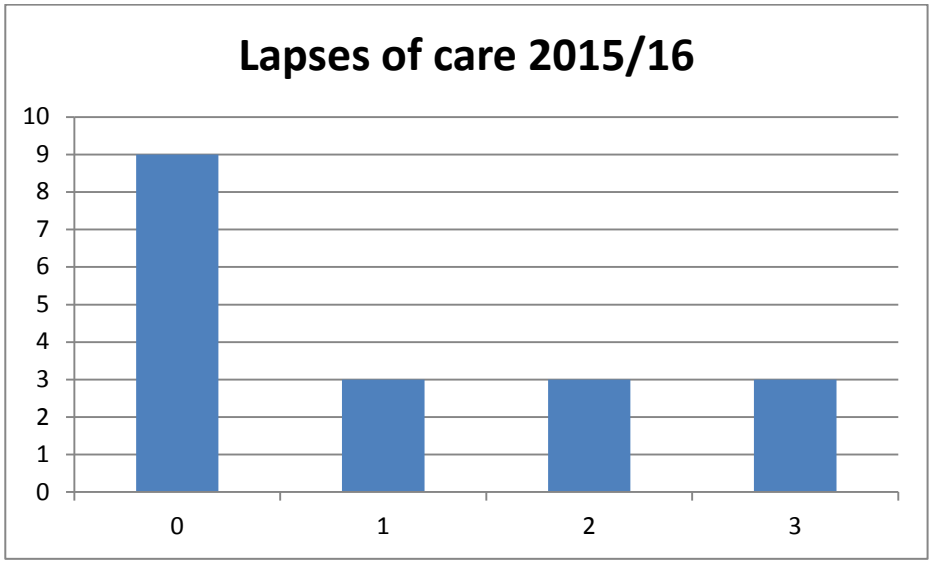
1- Lapse of care but different management would not have made a difference to the outcome

2- Lapse of care, different management might have made a difference to the outcome

3- Lapse of care, different management would reasonably have been expected to have made a difference to the outcome

The grading of lapses of care means that a finding of a lapse of care does not necessarily indicate that the case was avoidable.

Fig 8: Lapses of care for hospital-attributable *C. difficile* 2015/16



Identified lapses of care included
- Delays in collection of specimen
- Inappropriate antibiotic prescribing
- Delay in isolation

Potential lapses of care which were not seen in any RCA included
- Poor hand hygiene
- Cross infection
- Cleaning standards which fell consistently below the required standard

The distribution of cases by directorate is shown in the table below:

Table 2: Balanced scorecard for C. *difficile* by directorate

	Acute and Specialist medicine	Surgery	Trauma and Orthopaedics	W & SH	Total
April 15			1		1
May 15	1				1
June 15		1			1
July 15	2				2
August 15	2		1		3
September 15	3		1		4
October 15	1			2	3
November 15	1		1		2
December 15					0
January 16					0
February 16					0
March 16	1				1
Total	11	1	4	2	**18**

Eleven patients (4 community acquired and 7 hospital acquired) died during the same admission to hospital as their *C. difficile* diagnosis; however *C. difficile* infection was not the cause of death in any of the cases. The infection was mentioned in Part 2 of the death certificate in five patients.

6.2.5. Periods of Increased Incidence

The concept of Periods of Increased Incidence was introduced in the 2009 HPA/DH guidance '*Clostridium difficile* – How to deal with the problem'.

The guidance recommends that a PII should be declared when two cases occur in the same clinical area within a 28 day period. At MTW a PII is declared for the ward area whenever a new case of *C. difficile* is diagnosed. This increased response to a single case has been implemented to identify and resolve any issues on the ward or associated with antibiotic prescribing in a timely way, mitigating the risk of a second case occurring.

In response to the PII declaration, several actions have to be taken:

- Weekly audits of antibiotic use by the antimicrobial pharmacist
- Weekly audit of the ward using the *C. difficile* High Impact Intervention audit tool until a score of >90% is achieved for three consecutive weeks and there have been no more cases during that time
- When a PII is stepped down the ward is subject to random spot checks over the next month to ensure that improvement is sustained
- Increased cleaning with throughout the ward with all single rooms HPV fogged on discharge
- Daily review by the infection control team
- Additional training by the IPT where required

If a second case occurs in the same ward area the PII is escalated to an incident and an investigation commences. If ribotyping leads to suspicion of cross infection or there is a third case, the incident is escalated to an outbreak and the outbreak policy is followed. A Serious Incident is also declared at this point.

Additional actions taken when an incident is declared include
- Multidisciplinary investigation meeting held
- Intensive infection prevention team support

During 2015/16, sixteen PIIs were declared for *C. difficile*, six at Maidstone and ten at TWH. Two wards had two PIIs during the year and one ward had three. The PIIs lasted an average of six weeks with the longest period being 12 weeks. Where a ward does not show improvement during the first three weeks, there is an escalation process involving the ward manager, matron and infection prevention team to address the issues.

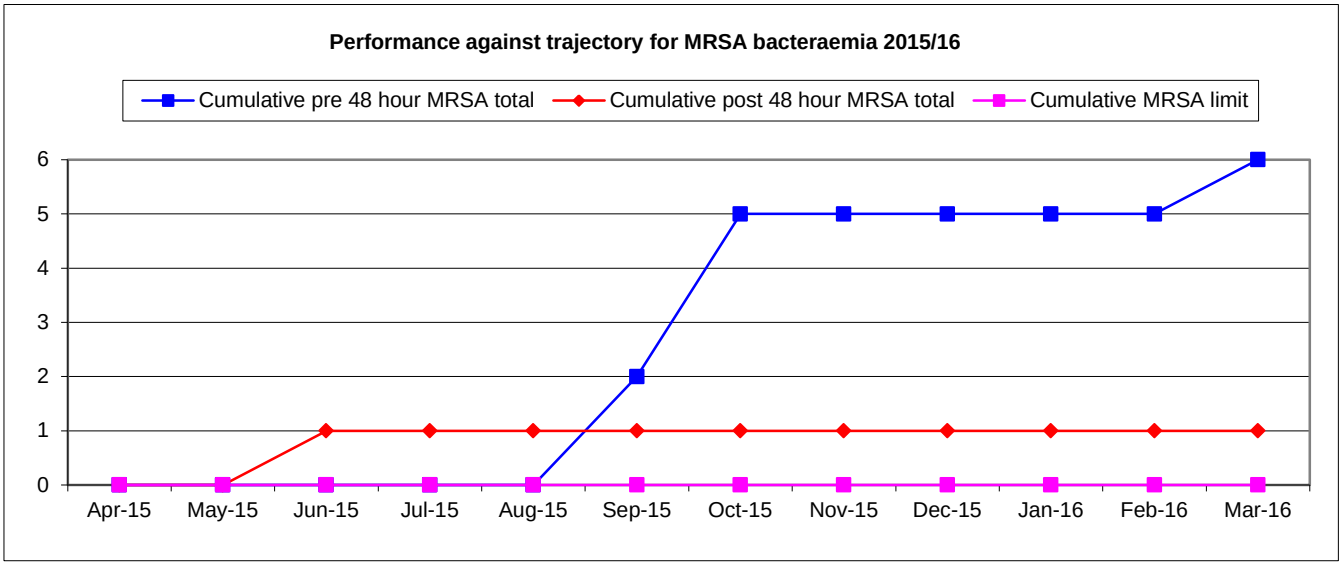
Two incidents were declared for wards where two cases occurred within 28 days. The PII was extended pending further investigation. No links were found between the cases; on one ward the cases were of different ribotypes and on the second ward the cases were of the same ribotype but any link was ruled out by MVLA (genetic finger-printing)

6.3. Methicillin resistant *Staphylococcus aureus* (MRSA)

6.3.1. Cases

Previous improvement in the incidence of MRSA bacteraemia has been maintained with just one hospital-attributable case seen for the year. There was no objective limit set by NHS England but there was an expectation of maintaining previous performance.

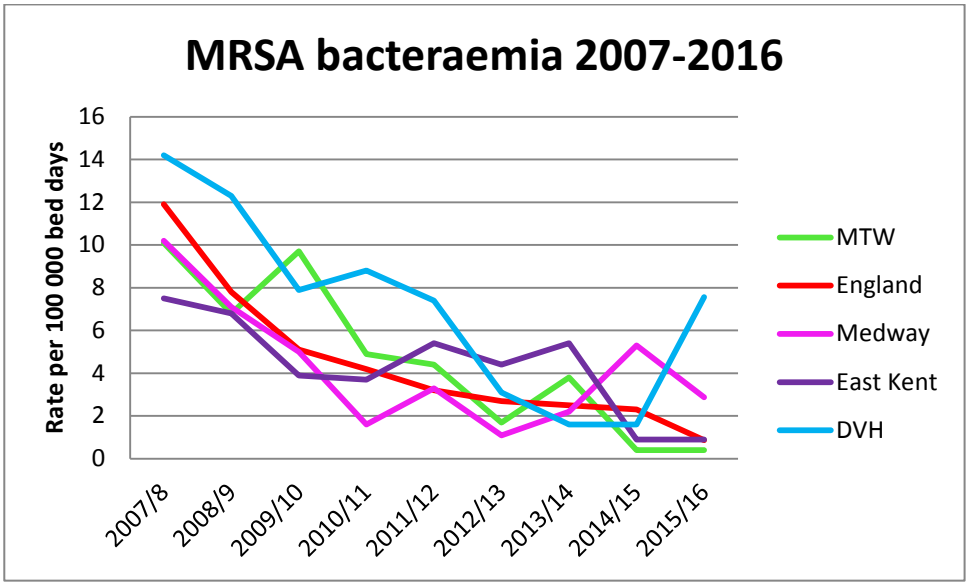
Fig 9: Performance 2015/16 – Trust and community cases



The rate of Trust apportioned MRSA bacteraemia for 2015/16 was 0.40/100 000 occupied bed days. To put this in context, the national (England) rate was 0.87/100 000.

Hospital-attributable cases (post 48 hours) are those arising on or after the third day of admission where day 1 is the day of admission.

Fig 10: MTW rate benchmarked against local trusts and the National trend



Key strategies in the reduction of post 48 hour MRSA bacteraemia are:

- Dedicated vascular access specialist practitioner to provide training and competencies for junior doctors and registered nursing staff
- MRSA screening for all non-elective admissions and eligible elective admissions.
- screening all patients prior to elective caesarean sections and other obstetric patients at 36 weeks or on admission (This has been found to be a risk factor at MTW in previous MRSA bacteraemia cases.)
- Antibiotic prophylaxis for known carriers having high risk invasive procedures (RCA has identified this as a risk factor at MTW).

6.3.2. Root Cause Analysis

All cases of MRSA bacteraemia have root cause analysis completed. This is a multidisciplinary team approach and where appropriate includes colleagues from the CCG and community health Trust. A serious incident is declared for all cases of Trust-attributable cases of MRSA bacteraemia. For pre 48 hour cases, the IPT and the relevant clinical team take part in the RCA led by the CCG. There were six community acquired MRSA bacteraemia cases diagnosed at MTW this year

The process also requires a submission to the Public Health England post infection review (PIR) process which apportions responsibility for cases to the acute Trust, the CCG or a third party. The third party can be another acute Trust, a community or mental health Trust or private healthcare facility or even the patient themselves. Where there is disagreement, the Director of Public Health (DPH) is asked to adjudicate.

The findings at RCA for the single trust apportioned case were as follows:

Case 1: The patient was admitted through A&E suffering from retention of urine. Catheterised in A&E and required repositioning of catheter the following day. On day 3 of admission became more unwell. Blood cultures were taken. Admission screen was reported as positive after blood culture had been taken. Blood culture positive the following day and treated with appropriate antibiotics for MRSA. The root cause was identified as a probable contaminated culture

6.3.3. Screening

It has been Trust policy to screen all elective admissions (except for certain excluded groups) to comply with Department of Health policy. The policy has been fully implemented since March 2009.

New guidance was published by the Department of Health in June 2014 (Implementation of modified admission MRSA screening guidance for NHS (2014). The guidance outlines a more focussed, cost-effective approach to MRSA screening.

Following the publication of the guidance the screening at MTW was reviewed and revised. The revised policy was implemented in November 2014. As a consequence of this there has been no change in the incidence of MRSA bacteraemia within the Trust and further revision has not been required

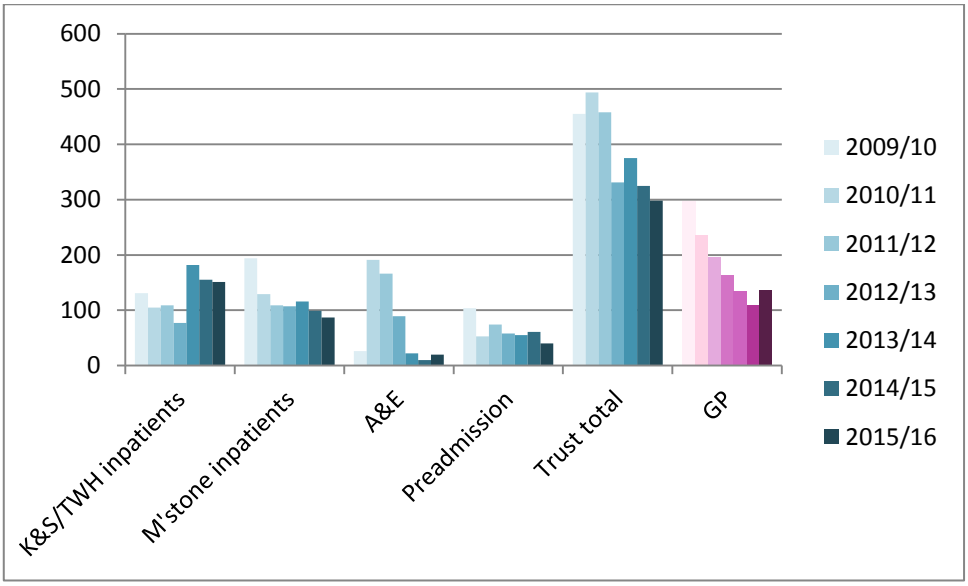
New patients who are colonised are usually identified within 24 hours of admission. Advances in laboratory testing enable a positive result to be available 18 hours after the specimen arrives in the laboratory. Colonised patients are also identified as a result of

clinical samples. Patients who remain in hospital for more than a week are rescreened on a weekly basis.

In turn, this allows effective decolonisation of the patient to be started in a timely manner, reducing the risk of infection and spread to other patients.

Patients who are known to be colonised are commenced on the decolonisation protocol on admission.

Fig 11: New MRSA colonisations 2009-2016



A total of 87 823 screens (217 394 swabs) were carried out during 2015/16. 434 patients were identified as new carriers. The current new positive rate of screening swabs is 0.5%.

6.3.4. Periods of Increased Incidence

Whenever two or more new (post 48 hour) acquisitions of MRSA colonisation are identified by screening on the same ward, a Period of Increased Incidence (PII) is declared for the ward where the acquisitions occurred. A single case of MRSA bacteraemia will also trigger a PII.

When the PII is declared the following actions are taken:

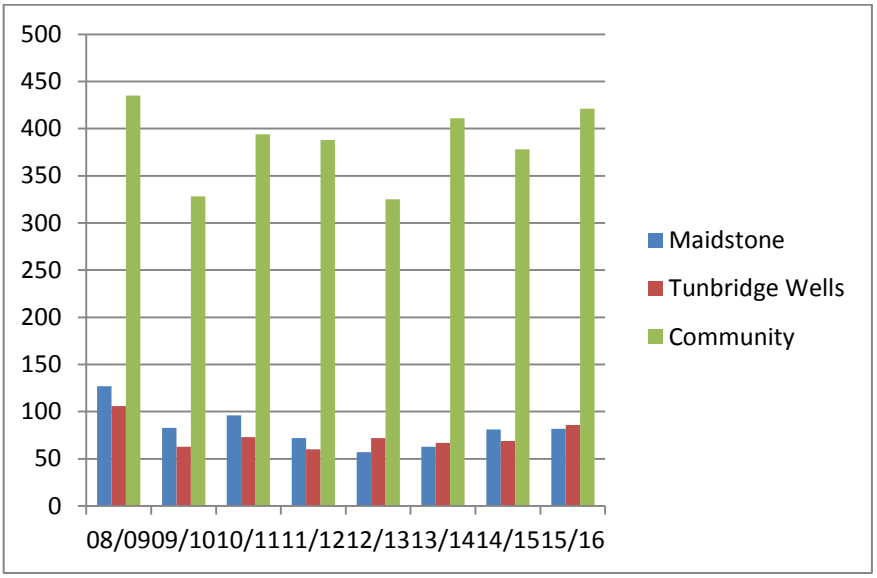
- Weekly audits of compliance with the *Control and Management of Methicillin Resistant Staphylococcus aureus (MRSA) including Screening and De-colonisation policy*
- Weekly audits of antibiotic prescribing
- The antibiograms of the MRSA isolates are examined for similarity. If the isolates are indistinguishable by antibiogram, they are sent to the reference laboratory for further typing and genetic finger printing.
- Where cross infection is proven:
    - A Serious Incident is declared
    - A full outbreak investigation is undertaken
    - Ward staff may be screened to ensure that no staff are colonised

6.4. Extended spectrum *Beta*-lactamase producing organisms (ESBLs)

Prospective ESBL organism surveillance has been on-going in the Trust since 2007. ESBL organisms are often associated with the elderly and particularly in those with urinary catheters although they may be seen in any site. They may be difficult to treat clinically as they have multiple resistances to antibiotics.

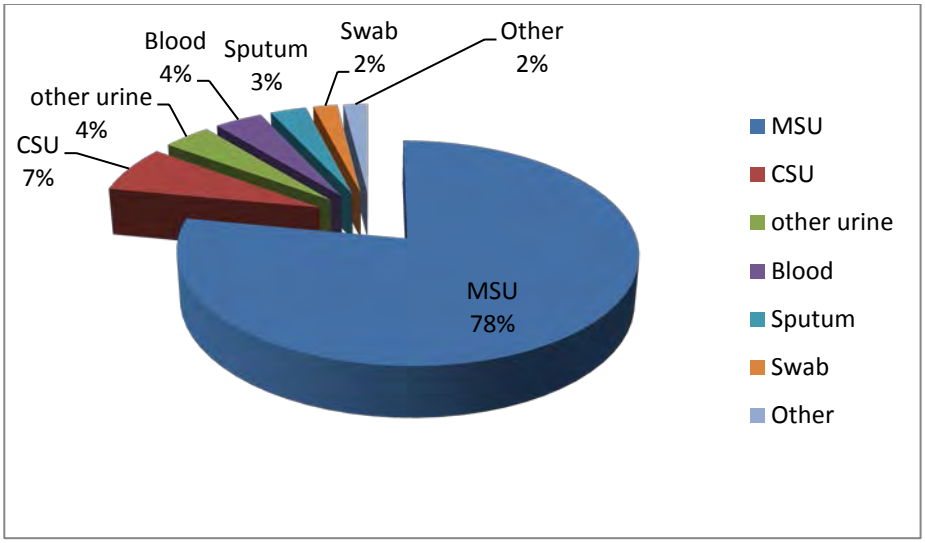
Retrospective data shows that ESBL organisms were seen at Kent and Sussex and Pembury Hospitals earlier than at Maidstone where they didn't appear consistently until October 2005.

Fig 12: New ESBL isolates 2008-2016



There is no seasonal variation or trend in the number of cases seen. New isolates are reported as in-patients if the sample is taken from a patient in hospital. There is no differentiation between those acquired in hospital or the community. There has been no significant change in the number of new hospital cases

Fig 13: New ESBL isolates by specimen site 2015-16



The percentage of cases arising in mid-stream urine specimens has remained the same this year with a small decrease in the number associated with urinary catheters. Overall there has been an increase in the proportion of isolates from other sites; however the actual numbers have decreased. Although long term catheters are a recognised risk factor of acquiring an ESBL organism, non-catheterised patients account for the vast majority of patients with ESBL organisms. This is likely to be due to the treatment of recurrent urinary tract infection with broad spectrum antibiotics, selecting out resistant strains which then colonise the individual's gastrointestinal tract and form a reservoir of infection.

6.5. Non-MRSA screening

Over the last two years, selective screening for Glycopeptide resistant enterococcus, Methicillin sensitive *Staphylococcus aureus* and Carbapenem resistant enterobacteriaceae has been introduced at MTW.

6.5.1. Glycopeptide resistant Enterococci (GRE)

Haematology patients are often immunosuppressed and GRE is a recognised opportunistic pathogen in this group of patients. The incidence of infection has always been low at MTW although it is known that other Trusts in the region have endemic GRE and patients can acquire long-term carriage of this organism. GRE poses a particular risk for immune-compromised patients.

A screening programme amongst haematology patients was put in place in March 2014 with all haematology patients screened on admission and discharge. The carriage rate amongst this cohort of patients has remained constant at around 20%. Identification of carriers enables antibiotic regimens to be tailored to individual patients depending on their carrier status.

114 carriers of GRE were newly identified from April 2015 - March 2016. 76 were screened on Lord North as part of the routine admission and discharge screening protocol. Others were screened as outlying haematology patients.

Five patients developed GRE bacteraemia; prior knowledge of their carrier status enabled the correct antibiotics to be given at an early stage in their treatment.

6.5.2. Methicillin Sensitive *Staphylococcus aureus* (MSSA)

MSSA has been known to be a major cause of orthopaedic surgical site infection and prosthesis infection for many years. One third of the normal population have nasal colonisation with *Staphylococcus aureus.* A screening programme for pre-operative total hip and knee patients was introduced in November 2014.

For 2015/16, the first full year of screening, 1208 patients were screened at pre-admission clinics. 219 (18%) were found to be positive and treated pre-operatively with nasal antibiotic cream to reduce their risk of post-op infection.

6.5.3. Carbapenem resistant/ Carbapenemase producing Enterobacteriaceae (CRE/CPE)

All Trusts have been required to have a screening programme for Carbapenem resistant organisms in place following a Patient Safety Alert in 2014.

The alert required the Trust to assess the local situation with respect to CRE/CPE and determine if immediate action was necessary to reduce the risk of an outbreak. In addition the IPCC was to develop an action plan to implement the Acute Trust CPE toolkit which includes an element of education for Trust staff.

CPE and CRE are organisms found in the gut which are resistant to virtually every antibiotic and represent a major cross infection risk. Some organisms have the ability to transfer their resistance genes from one organism to another and even across species.

The Trust policy requires screening on a risk based approach – focussing on screening patients transferred in from healthcare abroad and patients who are transferred from (or have recently been in patients in) other UK hospitals and tertiary referral centres, including haematology patients and neonates.

Patients requiring screening are identified on or before admission and are screened by three rectal swabs on different days. Whilst awaiting the outcome of the screening swabs patients are isolated with enhanced barrier nursing precautions including the use of long-sleeved gowns. Neonates are screened by three faecal swabs, the third being at least 48 hours after transfer from another unit

In 2015/16, 1965 CRE/CPE screening swabs were processed; 765 of these were from neonates with 671 being taken as part of an outbreak investigation on the Neonatal unit (see section 10).

Four adult patients were identified as carriers of CRE. All of these patients were transfers in from other healthcare facilities. All necessary precautions were implemented according to the policy and there were no episodes of cross infection.

6.6. Routine surveillance and Alert organisms

Alert organisms are those which indicate potential severe disease or, when seen in high numbers, suggest that there may be an outbreak either in the community or hospital. They often present infection control risks as they are highly infectious.
These organisms are routinely reported both to the Infection Prevention team and Public Health England as part of the national surveillance scheme

6.6.1. Blood cultures

A total of 1046 patients had positive blood cultures during 2015/16, an increase of 91 (9%) on the previous year. This may be partly due to the increased activity in non-elective admissions but is also likely to reflect the perceived increase in acuity of patients admitted.

A total of 14155 blood cultures were taken from patients, with 1300 sets positive, an overall rate of 9.2%.

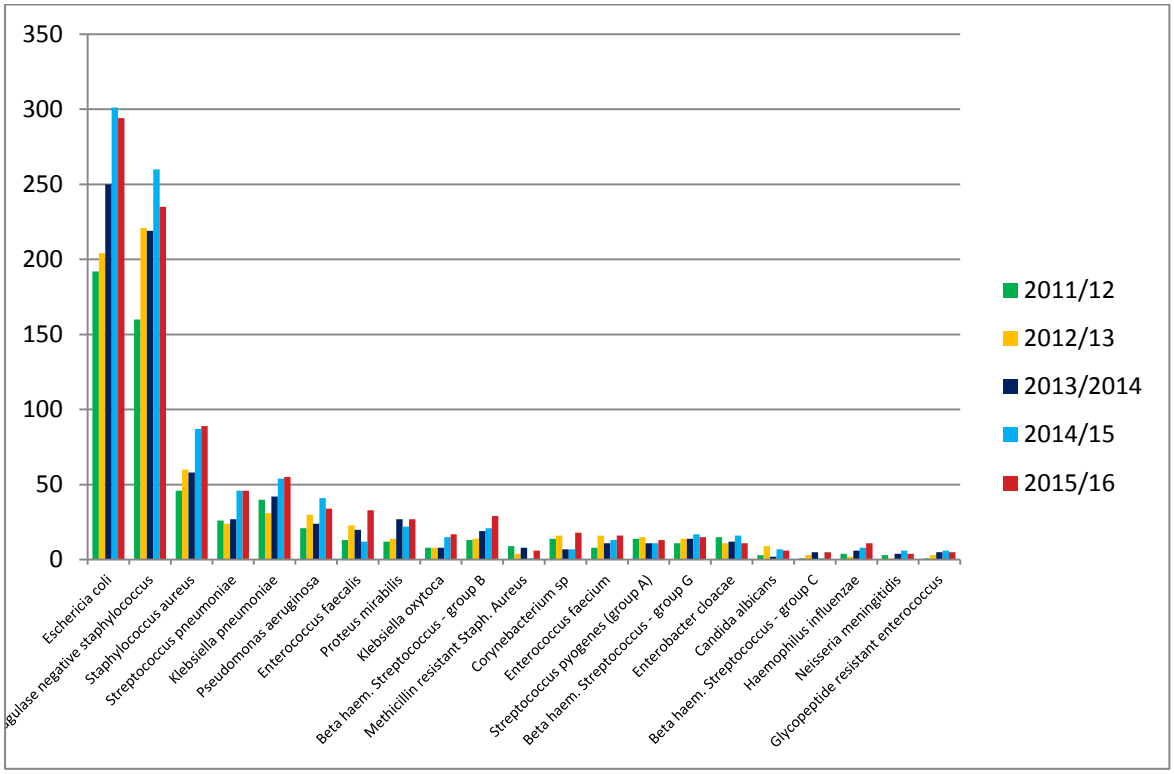
The commonest isolate was *E. coli* which is often associated with urinary tract infection. Hospital acquired cases of *E. coli* bacteraemia decreased by 44% over the year, partly due to the successful work done to reduce catheter associated urinary tract infection.

Some isolates are seen in small numbers but are highly significant for their ability to cause serious infection. These include *Neisseria meningitidis* (a cause of meningitis), *Staphylococcus aureus*, beta haemolytic streptococci and *Streptococcus pneumoniae*.

Glycopeptide-resistant enterococci are a particular risk to immuno-compromised patients and the number of isolates is increasing slowly year on year.

Coagulase negative staphylococci may cause infection but are more likely to represent contamination of the blood culture at the time of taking the specimen. If all isolates were contaminants this would represent a contamination rate of 1.6%, less than the previous year.

Fig 14: Commonest significant isolates from blood cultures 2011-2016



6.6.2. Methicillin sensitive *Staphylococcus aureus*

Since January 2010, MSSA bacteraemia has been part of the mandatory surveillance for HCAI. Epidemiological information is now collected on these cases. There is no objective limit for MSSA and there is currently no NHS England plan to impose one in the future. The first full year of MTW mandatory data collection showed a decrease in both community and hospital acquired MSSA bacteraemia, with the second, third and fourth years showing an increase in cases overall with a small decrease in hospital acquired cases.

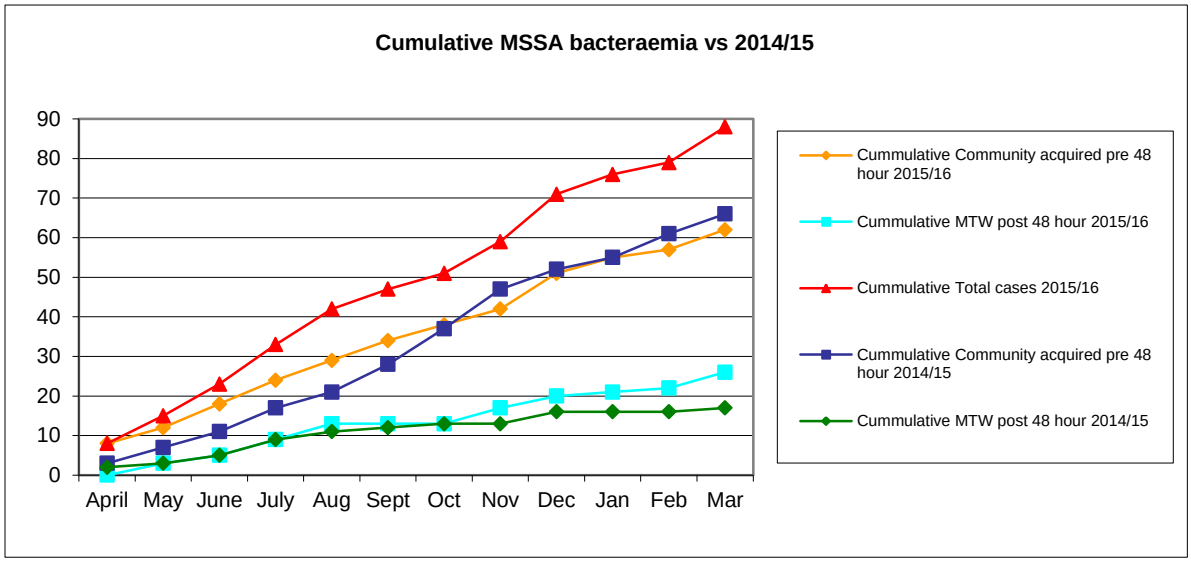
In 2015/16 the trend was reversed with an overall increase in cases, but notably with an increase in hospital acquired cases of just over 50% (26 cases vs 17 cases in 2014/15).

88 patients were diagnosed with methicillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia in 2015/16.

70% of the positive cultures were taken in A&E or an admissions unit indicating that the infections arose in the community. Any isolate from a blood culture taken within 48 hours of admission is classified as community acquired.

Root cause analysis was completed on all 26 cases of hospital attributable MSSA bacteraemia and the outcomes reported to the IPCC and to directorate governance meetings. In view of the increase in the number of cases, all hospital attributable MSSA RCAs will be reviewed at the C. difficile panel during 2016/17 to provide additional scrutiny and to ensure that the learning is embedded.

Fig 15: Cumulative MSSA bacteraemia cases 2015/16 compared with 2014/15



6.6.3. Invasive Group A streptococci (iGAS)

Invasive GAS (iGAS) infections are uncommon but very serious when they do occur. iGAS causes a range of diseases including necrotizing fasciitis, septic arthritis, meningitis, pneumonia, puerperal sepsis (associated with childbirth), wound infections as well as non-focal bacteraemia.

Case fatality rates are high at approximately 15-20% within one week of diagnosis although in the national outbreak in 2009 the case fatality rate has been reported as up to 23%. Invasive GAS infections have a seasonal pattern, with highest incidence from December to April. When a national increase in invasive GAS infection over and above the expected trend is seen, enhanced national surveillance is carried out and microbiology laboratories are required to contribute to the surveillance data. Whilst other forms of GAS infection saw an increased incidence in 2015/16 with many cases of throat infection and scarlet fever seen, there was no discernible increase in the number of iGAS infections seen at MTW.

6.6.4. Norovirus

The incidence of norovirus was comparatively low compared with previous years. The following table is a summary of wards affected by norovirus. All the ward areas coped well. There was no ward to ward spread seen.

Table 3: Summary of Norovirus incidents

Month	Ward	Patients affected	Staff affected	Bed days lost	Closure	Days closed
December 15	Chaucer	7	1	None	1 bay	6
March 16	Chaucer	16	6	20	Whole ward	8
March 16	Pye Oliver	7	0	11	Whole ward	4
March 16	Mercer	11	1	17	Whole ward	8
March 16	Edith Cavell	3	0	10	Whole ward	5
March 16	Chaucer	16	5	23	Whole ward	12

Experience from previous years coupled with rapid diagnosis using PCR technology has enabled the Infection Prevention team to work closely with the operations team to minimise disruption caused by Norovirus.

Relatives are asked not to visit when there is Norovirus infection within the Trust.

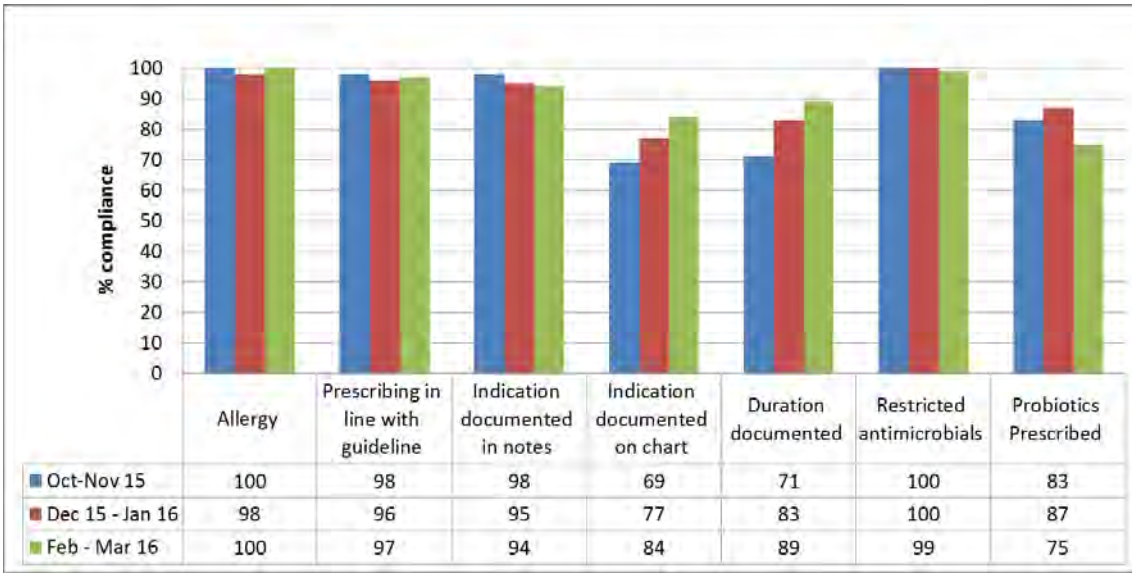
7. Antimicrobial Stewardship

The Antimicrobial Stewardship Group (ASG) has been active in the Trust for several years. The group includes the consultant microbiologists and antibiotic pharmacists and meets monthly to discuss the ongoing review of antimicrobial guidelines, antimicrobial usage, the introduction of new antibiotics and changes in guidelines to reflect national policy or local requests from clinicians. The group works closely with the WKCCG antimicrobial pharmacist who attends the monthly meetings. The group reports to the Drugs and Therapeutics committee.

As sections of the antibiotic guideline are reviewed, consultant colleagues from other specialties are invited to the ASG to discuss particular issues and review antibiotic changes.

Audits of antibiotic use are reviewed by the Antimicrobial Stewardship Group and by the Infection Prevention and Control Committee (IPCC). Information on the audit outcome is reported to clinicians through the Clinical Directors and clinical governance. Consultants and ward managers also receive the ward based antibiotic audits.

Fig 16: Antibiotic prescribing audit to March 2016



	Allergy	Prescribing in line with guideline	Indication documented in notes	Indication documented on chart	Duration documented	Restricted antimicrobials	Probiotics Prescribed
Oct-Nov 15	100	98	98	69	71	100	83
Dec 15 - Jan 16	98	96	95	77	83	100	87
Feb - Mar 16	100	97	94	84	89	99	75

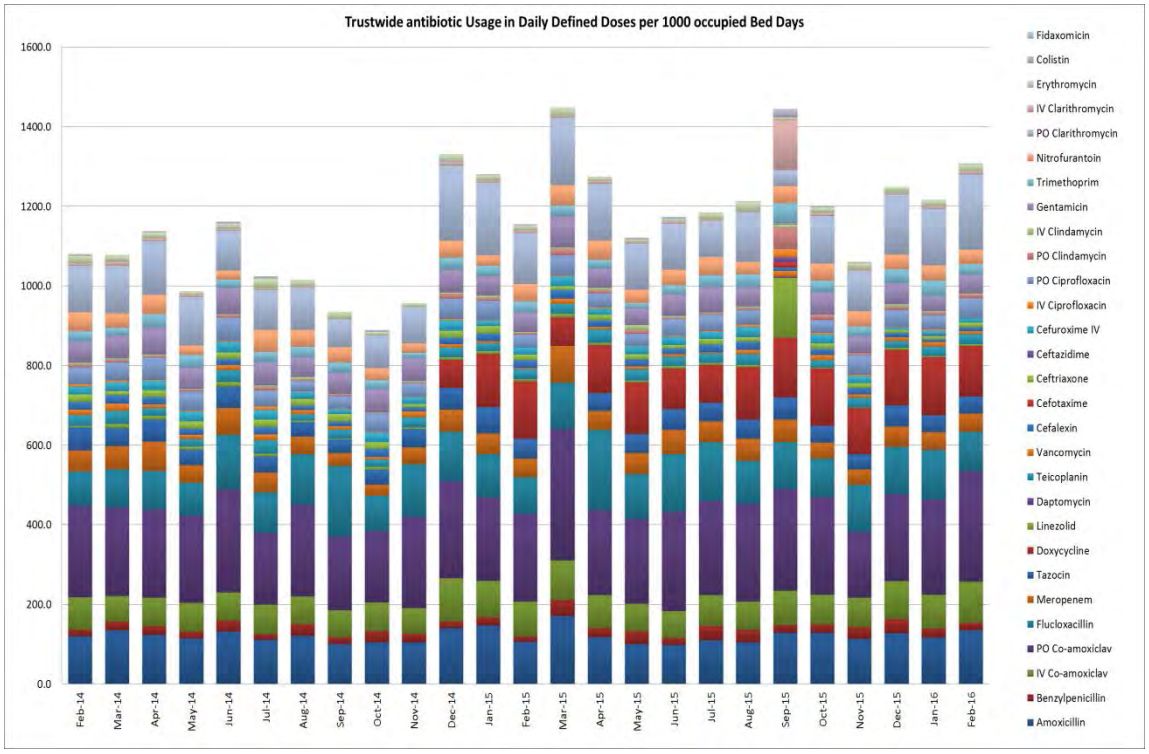
Compliance with all standards has improved over the last few years and remains high.

Whole Trust audits against the antibiotic prescribing policy are completed bimonthly and the surgical prophylaxis guidelines audit is carried out twice a year. In addition, wards in a Period of Increased Incidence for *C. difficile* or MRSA are audited against the policy weekly. Wards invariably achieve 100% compliance when under this close scrutiny.

7.1. Antimicrobial usage

Antibiotic usage is monitored on a monthly basis and discussed by the ASG. In December 2014, Doxycycline was added to the number of antibiotics included in the routine surveillance causing a sharp spike in the consumption data shown below.

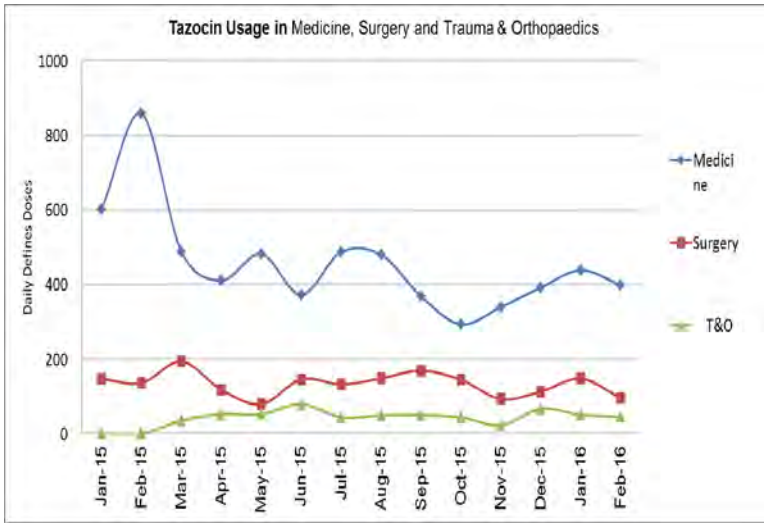
Fig 17: Trust wide antibiotic consumption in DDDs per 1000 occupied bed days

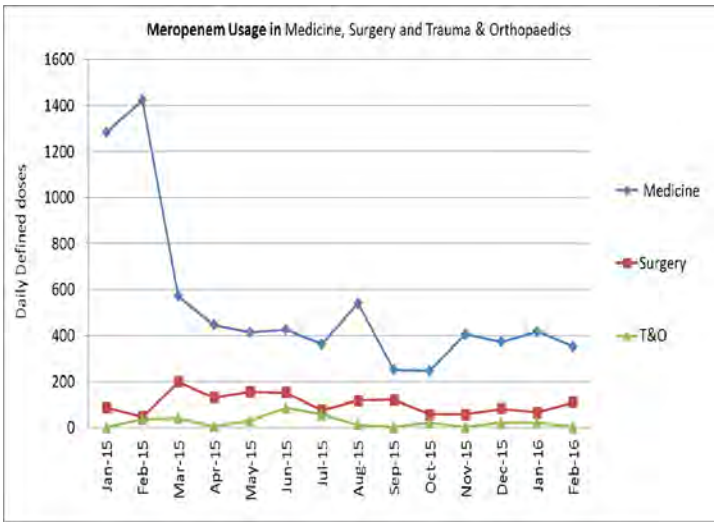


Efforts continued throughout the year to control the usage of second line antibiotics and this was largely successful with an overall reduction in Piperacillin-tazobactam (Tazocin) and Meropenem use compared with previous years.

Awareness and accessibility of the Trust antimicrobial guidance was improved by the development of a smart phone app enabling immediate access to the guideline and updates.

Fig 18: Restricted antimicrobial usage to March 2016





7.2. Antimicrobial Training and Education

Two of the consultant microbiologists, Dr Sluga and Dr Mumford give teaching sessions on infection control and antibiotic usage to junior doctors of all grades as part of the Trust induction and post graduate training programme.

The pharmacists receive training in antibiotic stewardship from the antibiotic pharmacists as part of their governance programme.

In addition, Dr Sluga and Dr Mumford regularly attend clinical directorate clinical governance sessions and give updates on various topics within antimicrobial prescribing.

An e-learning package is being developed to supplement the training given to junior doctors, to be used by consultant medical staff and pharmacists. A different version of the e-learning is also under development for nursing staff.

8. Saving Lives

The Saving Lives programme is embedded in the organisation and compliance with the High Impact Interventions is audited on the wards and monitored through a web based system providing evidence for the nursing and midwifery Key Performance Indicators.

The high impact interventions which are audited monthly are:

- Peripheral line insertion and continuing care
- Central line insertion and continuing care
- Urinary catheter insertion and continuing care

Audit results are reported to the IPCC as part of the triangulation audits reports from the directorates.

9. Surveillance

Orthopaedic surgical site infection (SSI) has been included in the mandatory healthcare associated infection surveillance system from April 2004. All NHS Trusts or facilities undertaking orthopaedic surgery must do surveillance in one or more of the orthopaedic categories - total hip replacement, hip hemi-arthroplasty, knee replacement and open reduction of long bone fracture. In any financial year, surveillance must be continued for a minimum of three consecutive months, commencing at the start of a calendar quarter. The surveillance scheme is coordinated by the Healthcare-associated Infection and Antimicrobial Resistance (HCAI & AMR) Department of the Communicable Disease Surveillance Centre (CDSC) at the Public Health England (PHE) in Colindale.

The PHE web based data capture system also collates data from a number of other categories of surgery which Trusts can complete on a voluntary basis. Due to the vacancy of the surgical site surveillance nurse the activity in this area has had to be restricted to the mandatory orthopaedic surveillance only since December 2015.

9.1. Orthopaedic Surgical Site Surveillance

All cases of surgical wound infection in the surveillance programme are subject to root cause analysis. Patients are asked to fill in a questionnaire six weeks after discharge detailing any problems with their surgical wound. This system has the advantage of detecting minor wound infections treated by the GP in the community.

Following the reconfiguration of services in 2012 the infection rates increased and the directorate has struggled to reduce the rates back to baseline. Full root cause analysis has been carried out, a task and finish group is in place and an action plan has been implemented. Changes have been made to reflect NICE guidance on surgical site infection.

Key Actions:

Pre Operative:

- MSSA screening
- Clean towels and bedding to be used at home for the night prior to surgery
- Pre warming of patient to maintain normothermia
- Pre-operative chlorhexidine wash cloths

Peri-operative

- Chlorhexidine skin preparation
- Remove unnecessary equipment from theatre and ensure trolley is under laminar flow
- Strict enforcement of theatre protocols
- Antibiotic prophylaxis given at correct time
- Patient temperature monitoring – exceptions acted upon
- Patient blood glucose monitoring – exceptions acted upon

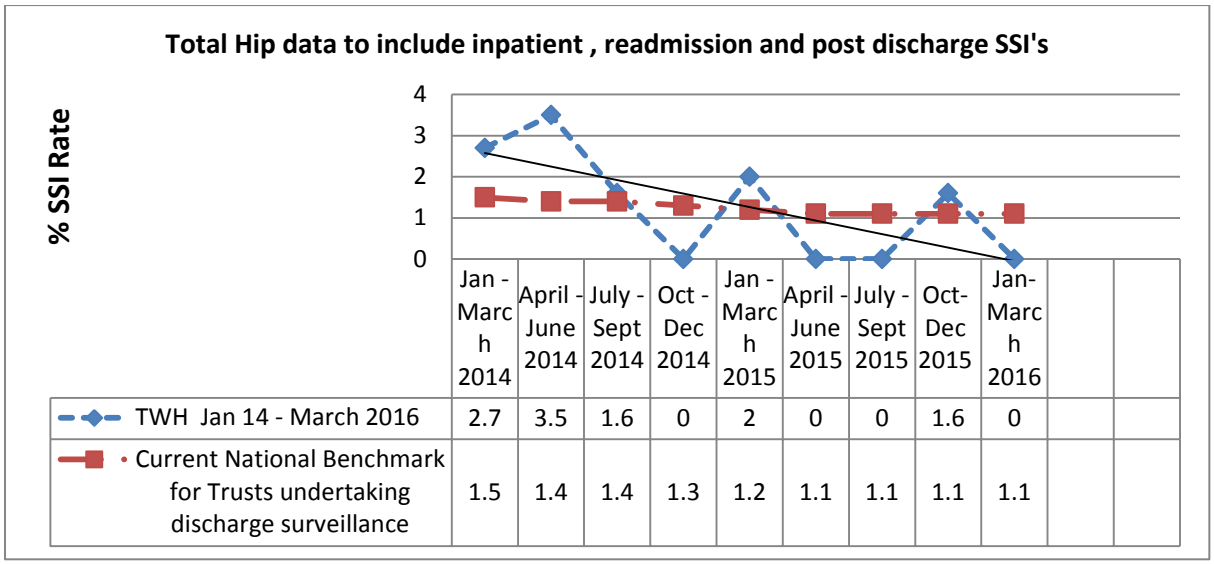
Post operative

- Patient warmed post op
- Blood glucose monitoring
- Consistent management of oozing wounds
- Ward policy for managing surgical dressings.

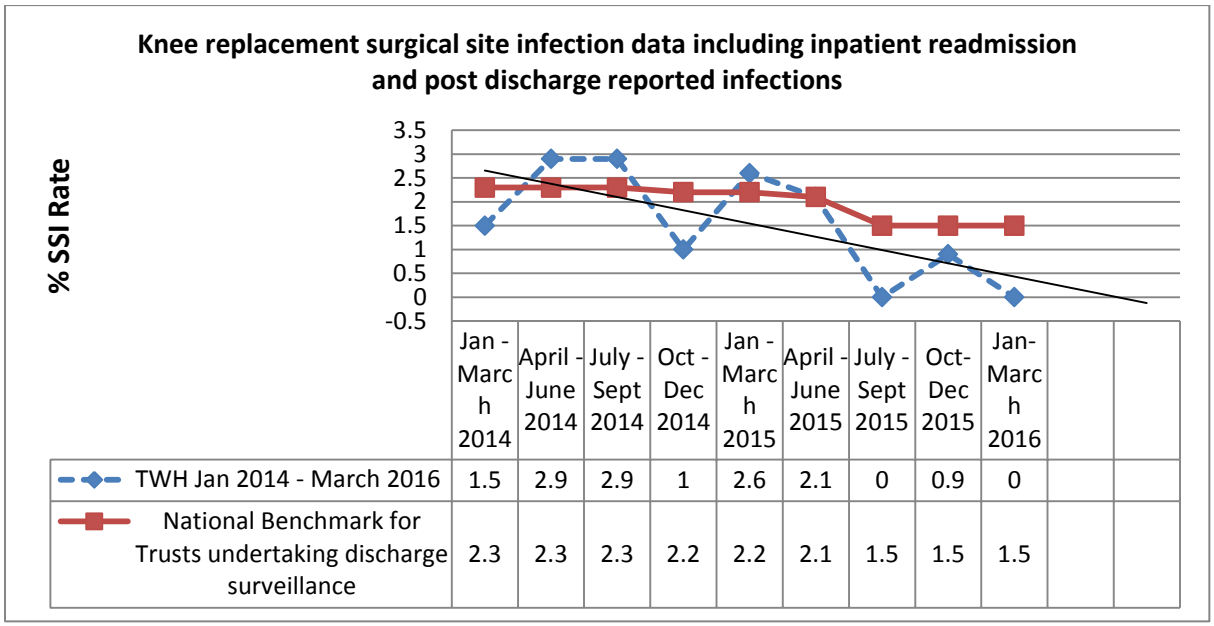
Infection rates are decreasing compared with the national benchmarks for elective hips and knees. Numbers of infection are low, so a single infection can move the Trust from below the national benchmark rate to above it.

Only one elective hip SSSI and three elective knee SSSIs have been seen for the year

Fig 19: SSSI rates for elective hips and knees



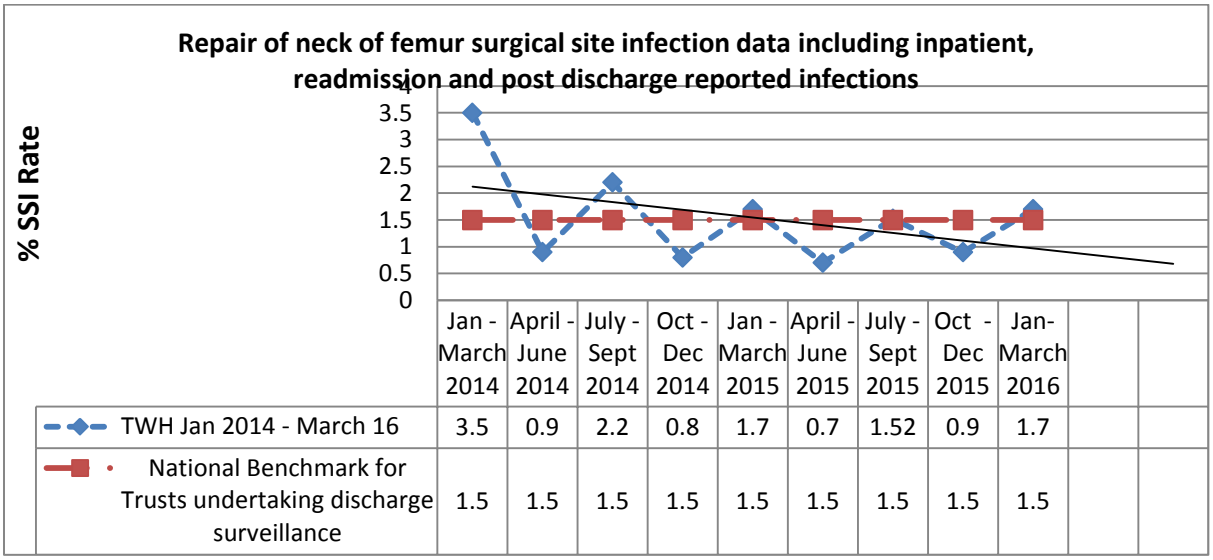
	Jan - March 2014	April - June 2014	July - Sept 2014	Oct - Dec 2014	Jan - March 2015	April - June 2015	July - Sept 2015	Oct-Dec 2015	Jan-March 2016
TWH Jan 14 - March 2016	2.7	3.5	1.6	0	2	0	0	1.6	0
Current National Benchmark for Trusts undertaking discharge surveillance	1.5	1.4	1.4	1.3	1.2	1.1	1.1	1.1	1.1



	Jan - March 2014	April - June 2014	July - Sept 2014	Oct - Dec 2014	Jan - March 2015	April - June 2015	July - Sept 2015	Oct-Dec 2015	Jan-March 2016
TWH Jan 2014 - March 2016	1.5	2.9	2.9	1	2.6	2.1	0	0.9	0
National Benchmark for Trusts undertaking discharge surveillance	2.3	2.3	2.3	2.2	2.2	2.1	1.5	1.5	1.5

There has been very slight improvement in the rate of SSSI for fractured neck of femur surgery with six cases of infection seen for the year and an infection rate on or below the national benchmark.

Fig 20: Infection rates for fractured neck of femur



9.2. Breast Surgical site surveillance

Collection of surveillance data for Breast surgery has been undertaken since January 2014. This was continued until December 2015 in order to gain a clearer statistical picture of our surgical site infection (SSI) rates.

Breast surveillance is a voluntary Public Health England module and is only undertaken by a small number of Trusts within England. The number of operations at TWH is low and cannot be assessed statistically in isolation. Our breast surgeons work on both sites so it is reasonable to combine the data from both sites to assess against the national benchmark.

Table 4: Surgical site Infection data for breast surgery.

Whole Trust Data	April – June 2014	July - Sept 2014	Oct - Dec 2014	Jan - March 2015	Oct – Dec 2015
Number of procedures	203	176	170	201	196
Number of SSI's – Readmissions (there were no inpatient SSI's)	2	1	2	2	2
% Rate of SSI-Inpatients and Readmissions	1%	0.57%	1.18%	1.00%	1.00%
National % Rate of SSI-Inpatients and Readmissions	0.70%	0.70%	0.70%	0.60%	1.1%
Number of post discharge SSI's confirmed in Clinic	4	5	4	2	1
Number of post discharge SSI's patient report only	0	2	3	3	1
Total Number of SSI's reported	6	8	9	7	4
% Rate of Total SSI's reported	2.96%	4.55%	5.29%	3.48%	2%

Where infection has occurred, root cause analysis has been undertaken. Trend analysis suggests the following risk factors for infection.

- Antibiotic prophylaxis given too late (i.e not within 30 minutes prior to knife-to-skin)
- BMI >26
- Pre-existing diabetes
- Dressing removed within 48 hours

10. Incidents, Outbreaks and Serious Infections

For the period April 2015 to March 2016, the following events were investigated as infection control incidents:

- Norovirus – five wards at Maidstone Hospital affected by Norovirus. (see section 6.6.4)
- Chaucer – Two cases of *C. difficile* within a 21 day period – No cross infection.
- TW31 – Two cases of *C. difficile* within a 20 day period – No cross infection
- Neonatal Unit – Single case of cross infection of carbapenem resistant *Klebsiella pneumoniae.* Both the index case and the secondary case were colonised only and remained well until discharge from hospital. All infection prevention measures were put into place. Several outbreak meetings held. Serious Incident declared

Action plans were developed for all incidents and the IPT provided additional support for ward areas and staff

11. Training and education

The infection control team undertakes both formal and informal teaching as part of its training and education role. The formal sessions take place in lecture/class rooms organised in advance. These take the form of induction/welcome days, mandatory updates, link network and student training. Informal training is undertaken in the workplace on an ad hoc basis as the need arises.

With the recruitment of overseas nurses increasing the IPT have been supporting the new staff with ward based training to ensure that they are competent in the infection prevention processes at MTW.

The team continues to provide Statutory and Mandatory training. These sessions are the Trust Welcome day for new starters and the clinical and non-clinical mandatory training.

An on-line package is available for staff to use to fulfil the requirement for annual training. It is recommended that staff attend face to face training one year and access online training the next.

The team also participates in the induction training for junior doctors with the DIPC leading the infection control training. The consultant microbiologists provide training in antibiotic prescribing during induction training. In addition, training on infectious diseases and the use of antibiotics is provided as part of the post graduate educational programme.

Link nurse meetings are held monthly on alternate sites. The programme is replicated on each site to enable more staff to attend. Each meeting has an educational element followed by a round table session leading to discussion about issues raised. In addition a Link nurse study day is held annually with invited speakers and this is also open to MTW staff who are not Link nurses and healthcare staff from other organisations.

The nurse consultant led a 'Focus on…' initiative to raise awareness of different infection prevention issues throughout the year. Subjects included catheter care, hand hygiene and diarrhoea.

The clinical support workers induction trainers have themselves been trained to use an infection control package which enables consistent infection control advice to be cascaded to all staff.

Other bespoke practical training sessions have been developed to provide targeted training to facilities staff including porters and domestics who may not have English as a first language.

An Infection Control handbook for temporary staff has also been developed to ensure that bank and agency staff receive consistent messages on infection control issues. A separate package has been developed for student nurses.

We have also had educational visits from Greenwich University students and the DIPC teaches on an infection control module for MSc students at the London School of Hygiene and Tropical Medicine.

12. Audit

The infection control team have worked closely with the audit department to develop a comprehensive audit programme which monitors all aspects of infection control including compliance with infection control policies within the Trust.

Eleven stand-alone audits were carried out plus monthly elective MRSA screening audits. A further three audits are only carried out following the event to which they relate e.g. outbreak, ward closure etc.

In addition to these audits the IPT undertakes bi-monthly triangulation audits which are compared with the monthly ward audits and reported as a performance report to the IPCC.

The triangulation audits are conducted on:

- Bare below the elbows
- Hand hygiene
- Commode cleanliness
- MRSA decolonisation
- MRSA care pathway compliance
- MRSA non-elective screening

As part of the PII process additional audits are completed on

- Ward laundry management
- Decontamination of reusable devices

Audits are reported to the IPCC

12.1. CA-UTI CQUIN

The Trust and WKCCG agreed a local CQUIN for reduction of catheter associated- urinary tract infection including the implementation of the HOUDINI tool for assessing patients with urinary catheters. The target was a 10% reduction in CA-UTI by Q4 with a baseline in Q1 of 7% of patients with indwelling urinary catheters developing an infection during their admission. A standard definition of CA-UTI was agreed. Regular audits were completed to collect the required data throughout the year. In Q4 the CA-UTI rate was 5% (a reduction of 29% overall) with 98% compliance with the HOUDINI tool achieving the full value of the CQUIN.

13. Innovation and research

The IPT has a strong track record in innovation to solve problems associated with infection prevention and control. This year we had the opportunity to be involved in the development of a new system for UVC light decontamination.

13.1. LUCID

The LUCID study was a European surveillance study of *C. difficile* led by a team at Leeds Institute of Biomedical & Clinical Sciences. MTW contributed annual and monthly testing data on C. difficile.

13.2. UVC

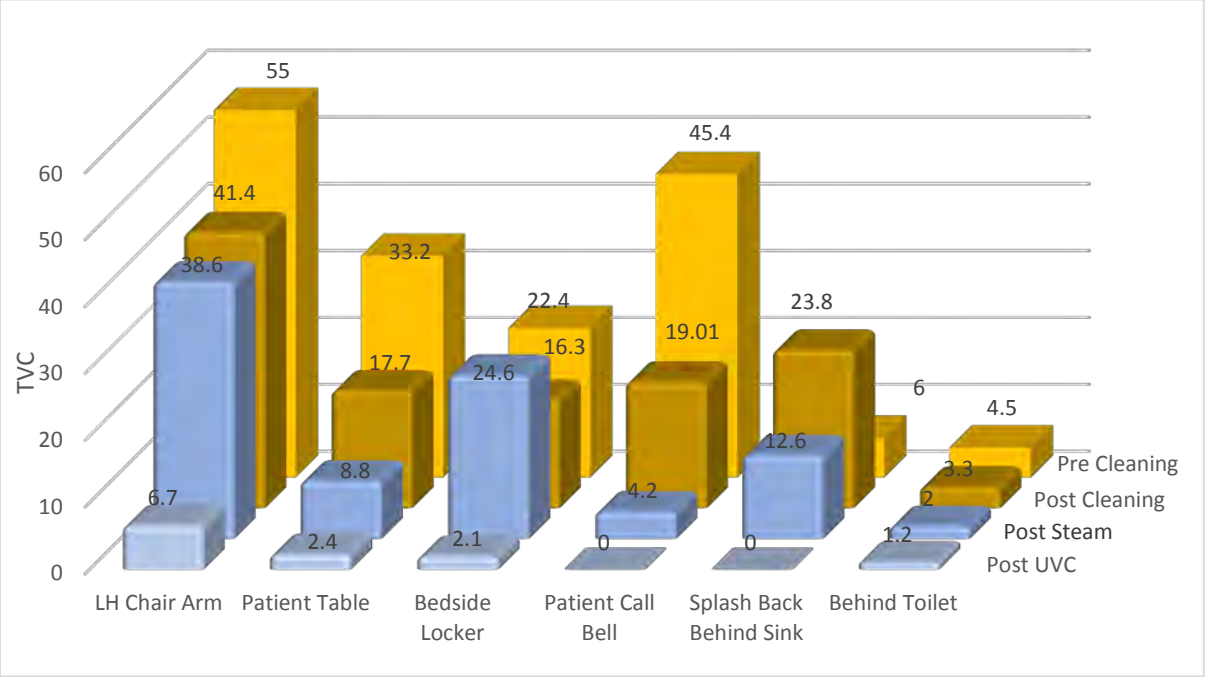
MTW has been working with Hygiene Solutions, a medical technology company, to further develop their UVC light decontamination system. The system was successfully trialled at MTW and showed a decrease in environmental decontamination compared with our current cleaning methods of Difficil- S and steam cleaning, although not as reliable as HPV fogging in the removal of *C. difficile* spores.

We were looking at the system to determine whether or not there was a place for it to replace some but not all of the current HPV cleans, especially at TWH where the time taken to clean rooms post discharge slows the patient flow.

The test used to assess this was the Total Viable count (TVC) which is the number of live organisms left after a cleaning process. The UVC process took an average of 18 minutes per room after the standard manual cleaning processes had been completed. Results are shown in Fig 21.

In addition the system records which rooms have been cleaned through a bar coding method.

Fig 21: Average TVC after each process



The results were impressive and would represent a significant time saving if the system were implemented at MTW.

We continue to work with the company and explore other opportunities to develop innovative systems.

14. Challenges for 2015/16

The main challenges for infection prevention and control in the year ahead are:

- Sustaining the previous gains in the rate of *C. difficile* and meeting the objective
- Ensuring compliance with NICE guidance for antimicrobial stewardship
- Ensuring continued compliance with the updated Code of Practice on the prevention and control of infections and related guidance (Hygiene Code) (July 2015)
- Controlling and monitoring the development of antibiotic resistance
- Additional proactive infection control training for new ward staff with face to face support
- Working with local CCGs and NHSI to assist in peer review of other Trusts infection control
- Control use of broad spectrum antibiotics
- Support the CQUINs for antimicrobial reduction
- Introduction of UVC light decontamination across the Trust.
- The DIPC has been invited to speak at the Federation of Infection Societies annual conference in November 2016 on MTW's ten year journey of recovery from the *C. difficile* outbreak

15. Recommendation

The Board is asked to note the contents of this report.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – September 2016

9-19 Safe staffing: Planned v Actual – July and August 2016 Chief Nurse

The enclosed report shows the planned v actual nursing staffing as uploaded to UNIFY for the months of July and August 2016. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

Care Hours Per Patient Day
CHPPD is calculated by adding the hours of available registered nurses to the hours of available healthcare support workers during each 24 hour period and dividing the total by every 24 hours of in-patient admissions, or approximating 24 patient hours by counts of patients at midnight. NHS England have recommended the latter for the purposes of the UNIFY upload and subsequent publication.

The Carter report indicated a range for CHPPD between 6.3 and 15.48. The median was 9.13.
Overall CHPPD for Maidstone Hospital for July was 7.8 and for August 7.9, compared to 8.0 for June.

For Tunbridge Wells Hospital the overall CHPPD was 10.3 for July and 9.8 for August, compared to 8.5 for June.

A review of data currently available in Trust's published board reports would suggest many organisations are still debating this internally.

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

This is evident in a number of areas where there has been an unplanned increase in dependency. A number of wards have required additional staff, particularly at night, to manage patients with altered cognitive states, increased clinical dependency or with other mental health issues.

Wards in this category during July were Wards 10, 20 and 31.

Wards in this category during August were Wards 10 and 20. Whatman Ward also had 3 nights for enhanced care needs which ameliorated the shortfall in RN cover over night.
Maidstone Stroke unit had a requirement for enhanced care in a bay for 6 nights.

All enhanced care needs are supported by an appropriate risk assessment, reviewed and approved by the Matron.

Maidstone Stroke Unit had a higher fill rate in their CSW cohort during July due to a number of EU nurses awaiting PIN but who are actively contributing to patient care. They have been reflected in the CSW numbers as they cannot legally function fully as a Registered Nurse.

Escalation areas account for the remainder of the over-fill.

For July these areas were Maidstone AMU (UMAU), TWH AMU, and SAU. These areas remained escalated during August, with additional support required to the SSSU to enable staff to support Theatre recovery to maintain elective day surgery activity.

A number of areas had a reduced fill rate, most notably CCU at Maidstone. This unit is co-located

with Culpepper Ward, and as such staff move between the two areas as required. Cross-cover support within directorates is also evident with Wards 30 and 31, where staff move between wards according to patient acuity and staff skill mix. This reviewed several times a day by the Directorate Matron.

Maternity manage staffing as a 'floor' with support staff moving between areas as required. Midwifery needs are assessed regularly by the Labour Ward Coordinator with midwives following women from delivery through to post-natal. During August, the maternity service had a shortfall in support workers, however all women in established labour received 1:1 care from a Registered Midwife.

Neonatal Unit support workers show a significant under-fill. The numbers of support works on any given shift are small. There was some unscheduled absence which was not backfilled, as the skill mix was adequate to ensure both babies and parents were provided with the support needed. The Paediatric directorate were aware and staff were available elsewhere in the directorate if required.

A number of wards have had a shift in the RN:CSW ratio. In all cases this was a considered approach based on RN skill mix, acuity of patients and availability of support from other sources such as Site Practitioners and Clinical Nurse Specialists. A number of wards are able to safely alter their RN:CSW ratios for some periods, more often at night.

Wards in this category during July were Wards 12, 21,31, Peale, and Whatman.
Wards in this category during August were Wards 12, 21, Peale and Whatman.

Accident & Emergency (A&E) Departments overall fill rates are good against planned staffing levels. Maidstone A&E had a reduced fill rate for support workers overnight however this was acceptable given the acuity of presenting patients.

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

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

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

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

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

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

The **overall** RAG status gives an indication of the safety levels of the ward, compared to professional judgement as set out in the Staffing Escalation Policy. The arrow indicates improvement or deterioration when compared to the previous month. The thresholds for the overall rating are set out below:
The key underlying reasons for amber overall ratings are vacancy resulting in an adverse shift of the RN to CSW ratios and high levels of acuity and dependency.

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 observations, 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?

- N/A

Reason for submission to 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

July'16		Day		Night		Overall Care Hours per pt day	Nurse Sensitive Indicators						Financial review			
Hospital Site name	Ward name	Average fill rate registered nurses/midwives	Average fill rate care staff (%)	Average fill rate registered nurses/midwives	Average fill rate care staff (%)		FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Overall RAG Status	Comments	Budget £	Actual £	Variance £ (overspend)	
MAIDSTONE	Acute Stroke	95.5%	119.4%	99.2%	100.0%	7.2	17.3%	100.0%	4	0		CSW includes a number of Overseas RNs awaiting NMC PIN.	121,494	129,636	-8,142	
MAIDSTONE	Foster Clark	106.4%	96.8%	100.0%	104.8%	6.2	0.0%	0.0%	3	1			101,090	159,403	-58,313	
MAIDSTONE	Cornwallis	94.4%	106.5%	98.9%	116.7%	7.0	60.5%	95.5%	0	0		CSW fill rate reflect 3 shifts where a CSW was utilised instead of temporary RN cover.	81,243	83,124	-1,881	
MAIDSTONE	Coronary Care Unit (CCU)	67.7%	N/A	100.0%	N/A	8.6	106.3%	100.0%	0	0		Cross cover from Culpepper; staffing flexed shift by shift according to needs.	101,669	98,898	2,771	
MAIDSTONE	Culpepper	103.2%	96.8%	100.0%	100.0%	7.5	59.0%	95.7%	0	0						
MAIDSTONE	John Day	98.6%	98.4%	98.9%	108.1%	7.4	33.3%	94.4%	8	2			154,821	149,562	5,259	
MAIDSTONE	Intensive Treatment Unit (ITU)	95.2%	100.0%	91.1%	N/A	29.4	100.0%	100.0%	0	0			166,867	167,139	-272	
MAIDSTONE	Pye Oliver	92.3%	95.2%	98.4%	98.4%	6.1	19.7%	80.0%	5	2			115,880	114,949	931	
MAIDSTONE	Chaucer	113.6%	97.6%	98.1%	100.0%	6.8	6.6%	100.0%	4	0			140,993	162,376	-21,383	
MAIDSTONE	Lord North	98.1%	67.7%	96.8%	100.0%	7.1	102.4%	100.0%	1	0		Sickness & vacancy, risk assessed - not coverd to ensure cover at night.	88,632	109,644	-21,012	
MAIDSTONE	Mercer	104.8%	96.0%	100.0%	100.0%	6.3	9.8%	83.3%	4	0			98,103	104,143	-6,040	
MAIDSTONE	Edith Cavell (MOU)	100.0%	100.0%	100.0%	97.2%	8.1	0.0%	0.0%	5	0			62,243	48,742	13,501	
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	88.6%	95.6%	121.5%	200.0%	11.1	8.0%	90.9%	1	0		Escalated at night. Considered risk for day fill rate to ensure cover at night.	118,587	141,334	-22,747	
TWH	Stroke (W22)	88.2%	96.1%	96.1%	103.2%	10.1	94.7%	94.4%	5	0		Vacancy: support provided by directorate and CNS	176,547	145,729	30,818	
TWH	Coronary Care Unit (CCU)	97.8%	122.6%	96.8%	N/A	10.7	96.6%	100.0%	0	0		CSW fill rate reflects 7 shifts, where a CSW was a used to support a good RN skill mix to provide personal care; this was a considered approach.	59,970	55,987	3,983	
TWH	Gynaecology	95.7%	92.5%	100.0%	100.0%	9.7	27.7%	95.3%	0	0			64,169	67,860	-3,691	
TWH	Intensive Treatment Unit (ITU)	100.8%	100.0%	100.8%	N/A	26.0	0.0%	0.0%	0	0			179,174	176,468	2,706	
TWH	Medical Assessment Unit	98.6%	94.4%	134.2%	100.0%	9.7	31.0%	96.6%	11	0		Ambulatory bays escalated at night	166,175	199,424	-33,249	
TWH	SAU	106.5%	91.9%	115.1%	112.9%	9.0	0.0%	0.0%	0	0		Escalted over night	87,704	95,373	-7,669	
TWH	Ward 32	88.7%	80.6%	96.8%	87.1%	6.6	0.0%	0.0%	2	1		Part of Wells Suite, cross cover as required.	119,957	132,817	-12,860	
TWH	Ward 10	91.2%	125.0%	97.6%	196.8%	7.9	9.2%	100.0%	2	0		Enhanced care requirements through-out the month.	122,010	138,254	-16,244	
TWH	Ward 11	98.2%	100.0%	94.4%	119.4%	6.6	21.2%	100.0%	4	0			123,537	121,502	2,035	
TWH	Ward 12	86.5%	105.4%	91.1%	87.8%	6.5	22.5%	100.0%	13	2		Shift in RN fill rate during the day, a considered risk to ensure safe cover at night.	118,380	138,816	-20,436	
TWH	Ward 20	98.9%	102.4%	99.2%	119.4%	7.1	23.5%	50.0%	12	1		Cohort nursing for high falls risk and wandering.	126,167	127,767	-1,600	
TWH	Ward 21	104.8%	86.0%	90.3%	122.6%	6.4	29.2%	90.5%	7	1		5 nights where RN was downgraded to CSW as a consiered/accepted risk. 4 nights where staff were redeployed to other areas.	129,541	131,933	-2,392	
TWH	Ward 2	81.3%	89.5%	97.6%	110.8%	6.0	0.0%	0.0%	25	0		Vacancy factor and reduced fill rate from Bank. Support provided by matron and directorate team	102,243	130,777	-28,534	
TWH	Ward 30	86.5%	80.9%	94.4%	100.0%	6.2	7.1%	87.5%	1	1		Support provided from within directorate, staff moved between 30 & 31 as per daily assessment	119,529	159,594	-40,065	
TWH	Ward 31	94.6%	98.6%	96.0%	112.9%	7.2	53.3%	87.5%	9	3		CSW fill rate reflects need for observation overnight, ensuring sufficient number of staff on shift to maintain this.	122,797	147,245	-24,448	
Crowborough	Birth Centre	100.0%	90.3%	100.0%	96.8%				0	0			86,690	71,709	14,981	
TWH	Ante-Natal	98.4%	103.2%	98.4%	103.2%		6.4%	97.8%	0	0			626,776	646,785	-20,009	
TWH	Delivery Suite	97.5%	93.5%	99.6%	91.9%				0	0						
TWH	Post-Natal	96.8%	100.0%	98.4%	100.0%				0	0						
TWH	Gynae Triage	96.8%	100.0%	98.4%	100.0%				0	0			12,406	13,310	-904	
TWH	Hedgehog	104.3%	70.9%	96.2%	94.9%	10.5	18.8%	94.5%	0	0		Nursery Nurse/CSW fill rate an accepted risk to ensure cover at night.	211,290	200,313	10,977	
TWH	Birth Centre	98.4%	90.3%	100.0%	96.8%				0	0			62,136	61,769	367	
TWH	Neonatal Unit	107.5%	58.1%	103.8%	83.9%	14.1			0	0		CSW fill rate an accepted risk.	165,068	162,318	2,750	
MAIDSTONE	MSSU	123.3%	87.2%	0.0%	N/A	11.4	0.0%	0.0%	0	0		RN: CSW shift accepted to ensure sufficient staff to provide care.	43,160	46,122	-2,962	
TWH	Peal	91.2%	126.5%	95.7%	N/A	7.6	12.0%	77.8%	1	0		RN: CSW ratio considered risk based on acuity	87,094	76,997	10,097	
TWH	SSSU	101.6%	104.8%	N/A	N/A		0.0%	0.0%	0	0			23,262	17,388	5,874	
MAIDSTONE	Whatman	100.8%	96.0%	83.1%	154.8%	5.6	0.0%	0.0%	9	0		Vacancy, considered risk with support from site team. Reviewed daily. High CSW fill rate to ensure total number of staff on ward was sufficient to ensure observation and care delivery.	0	107,833	-107,833	budget sitting within romney this month
MAIDSTONE	A&E	96.4	87.1	98.6	83.9		16.7%	87.6%	6	0			197,495	222,116	-24,621	
TWH	A&E	104.1%	96.8%	106.1%	90.3%		18.3%	92.6%	2	0			294,412	281,667	12,745	
												Total Established Wards	4,979,311	5,346,822	(367,511)	
												Additional Capacity beds	41,453	91,494	-50,041	
												Other associated nursing costs	2,972,575	2,300,714	671,861	
												Total	7,993,339	7,739,030	254,309	

RAG Key

Underfill

Over fill

August '16		Day		Night		Overall Care Hours per pt day	Nurse Sensitive Indicators						Financial review		
Hospital Site name	Ward name	Average fill rate registered nurses/midwives	Average fill rate care staff (%)	Average fill rate registered nurses/midwives	Average fill rate care staff (%)		FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Overall RAG Status	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	99.4%	95.2%	96.0%	125.0%	7.1	54.3%	92.0%	3	0		6 nights of enhanced care need in bay. Reviewed by Matron.	121,494	126,766	-5,272
MAIDSTONE	Foster Clark	95.1%	94.4%	100.0%	100.0%	5.8	0.0%	0.0%	8	4			101,090	104,287	-3,197
MAIDSTONE	Cornwallis	99.2%	98.4%	98.9%	87.1%	6.9	75.9%	95.0%	0	0		4 CSW shifts unfilled as an accept risk.	81,246	79,641	1,605
MAIDSTONE	Coronary Care Unit (CCU)	67.7%	N/A	100.0%	N/A	8.4	146.2%	100.0%	0	0		Cross-covered by Culpepper. CCU is collocated on Culpepper.	101,669	109,493	-7,824
MAIDSTONE	Culpepper	104.8%	135.5%	100.0%	96.8%	8.1	79.4%	96.3%	0	0		Increased CSW to enable responsive cover to CCU as required.			
MAIDSTONE	John Day	95.7%	96.8%	100.6%	109.7%	7.2	7.7%	100.0%	6	2			154,822	135,749	19,073
MAIDSTONE	Intensive Treatment Unit (ITU)	94.8%	100.0%	93.5%	N/A	31.3	100.0%	100.0%	1	1			169,797	154,158	15,639
MAIDSTONE	Pye Oliver	90.3%	94.4%	100.0%	95.2%	6.2	30.8%	100.0%	7	3			115,879	121,489	-5,610
MAIDSTONE	Chaucer	95.5%	101.6%	98.7%	105.4%	6.4	80.0%	100.0%	2	0			140,997	138,222	2,775
MAIDSTONE	Lord North	98.7%	85.5%	97.8%	103.2%	7.3	85.0%	97.1%	2	0		9 CSW shifts down over the month. Due to sickness, accepted risk with priority given to cover at night.	88,632	104,398	-15,766
MAIDSTONE	Mercer	110.5%	83.9%	98.9%	101.6%	6.3	29.5%	100.0%	2	0		10 CSW shifts down over the month. Accepted risk, as RN fill rate good.	98,102	97,436	666
MAIDSTONE	Edith Cavell (MOU)	101.4%	97.4%	100.0%	84.0%	8.1	0.0%	0.0%	1	0		Decreased CSW fill rate an accepted risk.	62,243	65,506	-3,263
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	86.5%	98.3%	120.4%	196.8%	12.6	0.2%	0.0%	2	0		Twilight shifts not covered, on 10 occasions, unable to provided dedicated RN cover to the Treatment suite on 5 occasions - covered by cross-cover from ward staff. Ambulatory bays escalated at night.	93,365	135,179	-41,814
TWH	Stroke/W22	89.8%	91.0%	99.4%	100.0%	9.7	37.5%	100.0%	8	0		Low RN fill rate during the day, supported by Matron and CNS as appropriate.	176,550	162,767	13,783
TWH	Coronary Care Unit (CCU)	93.5%	74.2%	94.6%	N/A	10.2	35.9%	92.9%	0	0		CSW fill rate an accepted risk.	59,971	65,009	-5,038
TWH	Gynaecology	92.4%	97.6%	100.0%	100.0%	9.1	69.1%	97.3%	0	0			64,170	67,934	-3,764
TWH	Intensive Treatment Unit (ITU)	99.2%	100.0%	97.2%	87.1%	28.3	50.0%	100.0%	0	0		CSW fill rate an accepted risk. RN staffing provided appropriate levels for acuity. RN shift coordinator supervisory.	179,174	181,047	-1,873
TWH	Medical Assessment Unit	96.4%	99.2%	132.9%	105.4%	8.6	50.6%	96.1%	12	2		Ambulatory bays escalated overnight.	166,180	209,213	-43,033
TWH	SAU	105.6%	83.9%	123.7%	130.6%	8.1	0.0%	0.0%	0	0		Escalated over night. CSW fill rate accepted risk as unit working with SSSU staff.	87,701	107,187	-19,486
TWH	Ward 32	88.7%	80.6%	96.8%	87.1%	9.3	33.6%	95.7%	0	0		Fill rate reflects NHS funded bed base. Overall cross-cover from PPU team, as increased numbers of NHS patients.	119,958	125,062	-5,104
TWH	Ward 10	94.0%	107.3%	92.7%	156.5%	7.3	0.0%	0.0%	0	1		Enhanced care needs for most of the month. Patients requiring close observation x 2 for 15 nights. Increased to 3 patients for 3 nights, then down to 1 patient for 7nights. Regularly reviewed by Matron	122,012	119,256	2,756
TWH	Ward 11	98.6%	98.9%	96.0%	108.1%	6.7	37.2%	100.0%	4	0			123,538	123,383	155
TWH	Ward 12	87.6%	97.8%	99.2%	98.4%	6.6	14.5%	87.5%	0	1		3 episodes of short term sickness, and 4 shifts unable to fill from Bank. Accepted risk not to go agency.	118,381	127,578	-9,197
TWH	Ward 20	97.8%	98.4%	98.4%	124.7%	7.1	27.8%	100.0%	13	0		Cohort nursing for cognitively impaired group of patients. Need support from security for 1 patient on 9 nights	126,168	148,985	-22,817
TWH	Ward 21	96.5%	90.3%	84.5%	125.8%	6.4	22.4%	92.3%	5	0		RN:CSW ratio an accepted risk. 4 occasions when RN redeployed to another ward, and 7 occasions of no available bank or agency (framework).	129,539	145,859	-16,320
TWH	Ward 2	84.5%	83.1%	97.6%	101.1%	5.9	0.0%	0.0%	9	1		18 RN shifts unfilled for early shift in month. Accepted risk with support from Matron	102,243	124,630	-22,387
TWH	Ward 30	81.8%	102.7%	94.4%	96.8%	6.5	33.0%	97.1%	3	2		17 shifts unfilled (due to vacancy). Support provided mid-shift from other surgical wards.	123,434	130,626	-7,192
TWH	Ward 31	95.2%	86.2%	98.4%	97.8%	6.7	25.0%	92.3%	3	0		CSW fill rate an accepted risk based on acuity.	122,797	141,041	-18,244
Crowborough	Birth Centre	100.0%	100.0%	100.0%	100.0%				0	0			86,691	73,863	12,828
TWH	Ante-Natal	95.2%	67.7%	80.6%	83.9%		42.3%	92.2%	1	0		Ante-natal ward an accept risk for midwifery cover at night, as midwives follow women to delivery suite. 1:1 care provided for all women in established labour. CSW fill rate had some minor impact on care.	617,972	643,668	-25,696
TWH	Delivery Suite	98.6%	79.0%	100.7%	91.9%				1	0					
TWH	Post-Natal	100.0%	86.0%	97.6%	80.6%				0	0					
TWH	Gynae Triage	101.6%	93.5%	100.0%	96.8%				0	0			12,408	11,866	542
TWH	Hedgehog	96.8%	67.7%	107.7%	87.1%	10.3	28.9%	95.6%	0	1		CSW reflects nursery nurse fill rate. Priority given to ensuring cover at night.	215,708	189,723	25,985
TWH	Birth Centre	93.5%	96.8%	96.8%	100.0%				0	0			62,136	71,142	-9,006
TWH	Neonatal Unit	96.3%	87.1%	104.8%	71.0%	12.8			0	0		CSW fill rate an accepted risk	165,069	160,114	4,955
MAIDSTONE	MSSU	110.0%	97.9%	90.9%	N/A	17.4	0.0%	0.0%	0	0			43,160	50,409	-7,249
MAIDSTONE	Peal	82.2%	148.4%	100.0%	N/A	8.1	30.9%	100.0%	3	0		RN gaps downgraded to CSW to maintain overall nursing presence. Skill mix an accepted risk.	82,061	70,907	11,154
TWH	SSSU	115.2%	50.0%	N/A	N/A	8.7	0.0%	0.0%	0	0		Increased RN fill rate reflects escalation and supporting day surgery activity through theatre recovery.	23,261	26,204	-2,943
MAIDSTONE	Whatman	104.0%	83.9%	86.3%	141.9%	5.4	0.0%	0.0%	6	0		CSW fill rate at night reflects enhanced care for 3 nights, and using CSW to cover shortfall in RNs over the last week of the month; this was an accepted risk to maintain overall nursing presence.	0	107,575	-107,575
MAIDSTONE	A&E	97.6%	91.9%	100.0%	87.1%		11.0%	88.5%	2	0		Decreased CSW at night an accepted risk.	222,715	197,933	24,782
TWH	A&E	99.7%	93.5%	103.9%	98.4%		19.2%	89.6%	2	0			294,415	305,290	-10,875
												Total Established Wards	**4,976,748**	**5,260,594**	**(283,846)**
												Additional Capacity beds	41,452	79,182	-37,730
												Other associated nursing costs	2,845,029	2,425,165	419,864
												Total	7,863,229	7,764,942	98,287

budget sitting within romney (c£73k)

RAG Key

Under fill

Over fill

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – September 2016

9-21	**Health & Safety Annual Report, 2015/16 (including agreement of the 2016/17 programme)**	**Chief Operating Officer**

The Health and Safety Executive (HSE) advised that the Board should lead on health and safety and set the agenda. This performance report allows the Board to:

- Discuss and agree the Trust's health and safety objectives
- Agree the work programme for 2016/17
- Formerly delegate the management to the Health and Safety Committee.

This annual report provides:

- A review of the Trust's Health and Safety performance for 2015/16
- Assessment against objectives and Key Performance Indicators (KPIs) set in the previous year
- Discussion of the key health and safety issues identified within the year
- Discussion document for the Board to determine the objectives and KPIs for 2016/17
- Identifies the strategy and action plan for the next year and going forward

Which Committees have reviewed the information prior to Board submission?

- Health & Safety Committee, 01/08/16
- Trust Management Executive 21/09/16

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

- To review the Annual Report
- To agree the programme for 2016/17
- To delegate the management of the programme to the Health and 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

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Health and Safety – Annual Board Report and Programme for 2016

Requested/ Required by: Trust Board and the Trust Management Executive

- Health and Safety at Work etc Act 1974.
- Management of Health and Safety at Work Regulations 1999.
- Workplace health and Safety Standards 2013

Main author: Risk and Compliance Manager (Jeff Harris)
Contact Details: ext. 24581 jharris2@nhs.net

Other contributors: Health and Safety Advisor,
Occupation Health Manager,
Moving and Handling Coordinator,
Local Security Management Specialist,
Radiation Protection Adviser,
Falls Prevention Practitioner,
Estates Health and Safety Advisor,
Vascular Access Specialist Practitioner

Document lead: **Chief Operating Officer**
(Board lead for Health and safety)

Directorate: Quality and Governance

Health and Safety – Annual Board Report and Programme for 2016

Requirement for document:	This annual report and programme is: • A review of the Trust's health and safety statistics and performance for 2015/16. • Assessment against objectives and KPI's set in the previous year. • Discussion of the key health and safety issues identified within the year. • Discussion document for the Board to determine the objectives and KPI's for 2016/17. • Identifies the strategy and action plan for the next year and going forward.
Cross references:	This report is in response to key health and safety legislation enacted under the Health and Safety at Work etc Act 1974. This report is supported by the Trust's key policies and procedures: • Maidstone and Tunbridge Wells NHS Trust Health and Safety Policy. • MTW Risk Management Policy and Strategy.

Version Control:		
Issue:	**Description of changes:**	**Date:**
12	First annual Board report	May 2012
14	Second annual Board Report	May 2013
15	Third annual Board Report	May 2014
16	Fourth annual Board Report	May 2015
17	Fifth annual Board Report	July 2016

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Executive Summary

Introduction

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Staff, contractor and visitor injury statistics make up about 20% of the total injuries, which is dominated by patients. There are many programmes and initiatives for patient safety so this report concentrates on staff safety only.

Highlights

- Good progress has been made and the majority of the intended programme was completed.
- There was a conscious effort to improve reporting this year and there was a 9% increase compared to last year.
- The number of staff injuries increased by 4% and the number of RIDDOR reportable injuries decreased by 15%. Reporting has increased with more near misses reported. However the reduction in serious injuries suggests improving safety standards.
- Falls account for about 18% of all staff injuries. The number of staff falls increased this year. The data for the last 4 years is showing an average of about 64 per year which is within the normal range based on the number of employees. Soft evidence suggests that increase may be attributable to improved reporting.
- Injuries from violence accounts for about 22% of all staff injuries. The data shows a significant increase of 67% this year. This is significantly larger than in previous years and not yet understood.
- Moving and handling account for 15% of staff injuries. Last year there was a significant 48% drop in moving and handling injuries and this could not be explained. This year there has been an increase of 51% and numbers are similar to previous years. There was likely under reporting in 2013/14 as it is not believed or demonstrated that there has been a fall in safety standards this year.
- Injuries from medical sharps reported on Datix fell by 10% to 99 this year. However, 161 staff referred to occupational health following an injury. This indicates 38% under reporting which is an anomaly discussed at the H&S committee and assigned for action to Occupational Health.
- The eye splash group was established and undertook a series of actions including an awareness campaign. This year there were 14 eye splash incidents (reduction of 26%).
- Collisions, Traps or Struck are incidents that occur when staff move around the workplace. In 2014/15 there were 77 injuries. This year this has reduced by 32% to 52 injuries. These are now 13% of staff injuries (down from 20%).
- In 2014/15 there were 6 burns/scalds to staff. This year there was a significant increase to 12. Two were RIDDOR reportable. These resulted from the handling of food and drinks.
- Occupational ill health is identified and reported by the Occupational health department. Only 1 incident of occupational ill health was reported on Datix and this was work related stress. Datix is not used by staff to report occupational ill health.

Health and Safety Executive

Health is not considered a high risk industry so the HSE will not undertake proactive inspections or visits. However, they will undertake reactive visits based on intelligence. There have been no HSE visits, investigations or enforcement notices this year.

1. Introduction

The Health and Safety Executive (HSE) advised the Board in 2012 that they should lead on health and safety and set the agenda. This performance report is to allow the Board to discuss health and safety and lead the strategy moving forward.

Health and Safety legislation requires the Trust Board to control the health and safety risks to their employees and "others" not in their employment. "Others" refers to contractors, volunteers, visitors etc. The term extends to include patients and it is patients who generally suffer most harm in a clinical environment. There are numerous standards, requirements and bodies whose key role is to protect the safety of patients. Hence, this report and strategy will focus on the safety of staff. However, protecting staff is a key element of patient safety.

For several years the Trust has been recording staff injury statistics. These have included contractors and visitors. These only make up about 20% of the total injuries which is dominated by patients. These have been divided into groups based on severity:

- Deaths to employees, contractors and visitors (deaths at work).
- Incidents and Injuries reportable to the HSE under the "Reporting of Injuries, Diseases and dangerous Occurrences' Regulations 2013" (RIDDOR).
- All staff and visitor injuries.

The injuries have been divided into 7 types based on the categories used by the HSE in their national statistics. About 97% of the total injuries fit into these categories. This allows for bench marking against all industry and the health sector:

- Falls (staff and visitor slips, trips and falls)
- Medical Sharps (needle stick injuries)
- Violence and abuse (includes physical assault and trauma).
- Struck by or collision with an object
- Moving and handling
- Contact with machinery and hot surface (includes hot liquids)
- Contact with a hazardous substance (includes biological agents)

Reporting rates are important as a fall in injuries could be a result of improving standards or reducing reporting. The reporting rates were also measured.

The Trust has an Occupational Health Service that undertakes health surveillance on staff to identify or prevent occupational diseases if they arise from employees work. They maintain records of referral of staff for workplace illness.

2. Review of Objectives and Programme set for 2015/16

In July 2015 the Trust Board agreed a programme for 2015/16:

Action	Leads	Progress and Comments
Health and Safety Management		
Ensure that all Clinical and high risk departments have completed their annual review of H&S Audits.	Trust H&S advisor	All clinical and high risk departments have completed audits.
Embed the program of audits of the documents uploaded to the H&S audit software.		As of 1st April 80% of departments were fully compliant. 19% were partially compliant and only 1% were non-compliant. 11% of departments were late with their annual audit. Need to embed

Action	Leads	Progress and Comments
		the programme to improve on these figures.

Action	Leads	Progress and Comments
Falls (Falls Prevention Practitioner)		
Continue with awareness and training to further reduce staff falls.	Falls Prevention Practitioner	Staff falls have increased and further awareness campaign is required.
A detailed analysis of last year's staff and visitor's falls will be undertaken. This will look at root causes.	Risk Manager	The analysis was completed. A report with recommendations was presented to the falls group and H&S Committee.
Violence and abuse		
Provide physical restraint training for security staff, porters and front line nursing.	Head of Safety and Security	In progress for security staff. This needs further review by new LSMS.
For each staff group to achieve the required target for Violence and abuse training (CRT training).	LSMS	Have improved training compliance but needs further improvement. Departure of LSMS halted the programme but this has now restarted.
Provide a secure room for patients sectioned under section 136 of the mental health Act in A&E on both sites	Head of Safety and Security	No progress – LSMS needs to review requirement.
Support Kent police as a member of the steering group for the development of a joint protocol for handling mental health patients.	LSMS	Trust engaged with Kent police.
Moving and Handling		
Complete the 2 year review of all patient handling generic risk assessments and safe systems of work	M&H Co-ordinator	This is an ongoing element. However, less than 50% have been reviewed, it is expected that a greater proportion will have been completed by the end of April 2017
Need to continue the inclusion of spinal handling in generic risk assessments and continue the training programme.		Spinal Handling training dates are planned and delegates booked until the end of 2016. A request will be made for further training room booking for 2017
Develop the in house database to adequately record training and competency evidence		Learning and Development Manager has advised that the additional module has been purchased to facilitate improved storage of all training records. However, the system is not yet live and is carried over as an ongoing objective.
Need to address the lack of patient canvasses resulting in an inability to follow safe practise.		A canvas replacement programme is in place with all areas at Maidstone Hospital having a provision of canvases.
		It is expected that the wards at TWH will have a provision by April 2017
Sharps		
The sharps task and finish group will share the detailed findings of the injury study with all clinical staff through: • Posters. • Banners. • Laminated cards.	Risk Manager	Special edition of the Governance Gazette. Posters and banners were displayed. Alerts sent out and included in M&S training. There was a reduction in sharps injuries this year. – need to continue to change staff attitude and culture with respect to sharps.
Will share the detailed findings of the injury study through presentations to clinical groups.		Presented to all clinical groups. Presented to the HRMG (risk networking group for the south east).
Complete the trials on blood gas syringes across the trust and standardise on one design	Vascular Access Specialist	Trial undertaken successfully in both A&E departments. Results presented to A&E clinical governance. Approval for introduction gained

Action	Leads	Progress and Comments
	Practitioner	from the Medical Sharps Task and Finish Group and the Medical Devices Group. Decision cascaded via KPI. Trust wide training and implementation program undertaken. Ongoing training programme in place.

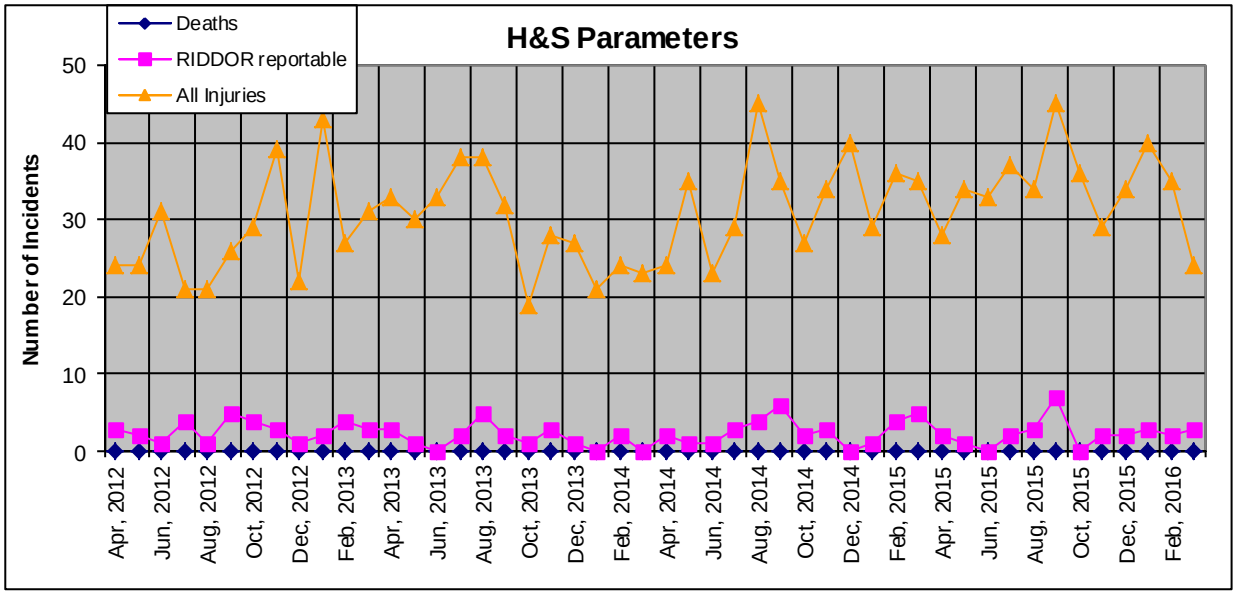
Continue to review new safety devices in the market place across the Trust.	Vascular Access Specialist Practitioner	New subcutaneous safety butterfly needles were trialled for subcutaneous infusions. Approval for introduction gained from the Medical Sharps Task and Finish Group and the Medical Devices Group. Trust wide training is taking place. A new safety CT/MRI compatible cannula is currently being trialled in both Radiology Departments across both Trust sites. New safer safety needles were introduced Trust wide. A Trust wide training programme was undertaken.
Review safety sharps training to assess if refresher training is required and how this can be delivered.	Vascular Access Specialist Practitioner	Safety sharp training is integral in trust induction programmes for clinical and non- clinical staff. It is also integral in the Blood Culture, IV Therapy, Venepuncture, Cannulation and CVAD study days. The opportunity to provide Trust wide medical sharps training has been implemented at the introduction or change of any medical sharp device into the Trust
Eye Splashes (Risk Lead for Critical Care)		
The task and finish will: • Investigate various forms of eye protection. • Formulate a staff awareness campaign • Consider the possibility of eye protection zones or compulsory use for some procedures in: o Theatres. o Maternity.	Risk Lead for Critical Care	The group developed and completed an action plan which included an awareness campaign. The number of eye splashes reduced by nearly 50% with none reportable to the HSE.
Occupational Health		
Increase awareness of the need to report work place stress and other ill health events on Datix via a safety alert.	Risk Manager.	This was not completed and only one case of occupational stress was reported on Datix in 2015/16.
Increase awareness of the need to report work place stress and other ill health events on Datix via H&S training.	Health and Safety Advisor	It was intended to reinforce the need for Datix reporting of ill health, needle stick injury and eye splashes through Datix . The time for training only allowed staff injuries to be covered, ill health was not reinforced.
Encourage staff and there managers to report work related stress and other ill health events through Datix.	Occupational Health Manager.	Staff referred to Occupational Health were advised to report ill health, needle stick injury and eye splashes through Datix. However, this has been unsuccessful in increasing reporting.

3. Statistics for 2015/16

The datix incident database was interrogated on the 9th April 2016 for all non-patient injuries.

Injuries

The data for 2015/16 has been compared with the data from previous 2 years.

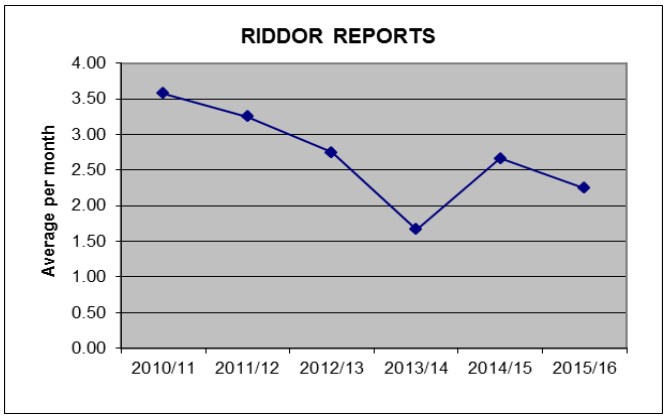


The Trust submitted 27 RIDDOR reports in the year at an average of 2.25 per month. This is a significant decrease from 2.67 the previous year. The dip in 2013/14 was not fully explained and could be a result of underreporting. A conscious effort has been made to increase reporting over the last two years.

Only 70% or RIDDOR reports were submitted on time. It was over 85% for the previous two years. Need to educate Managers to recognise and report RIDDOR's quickly.

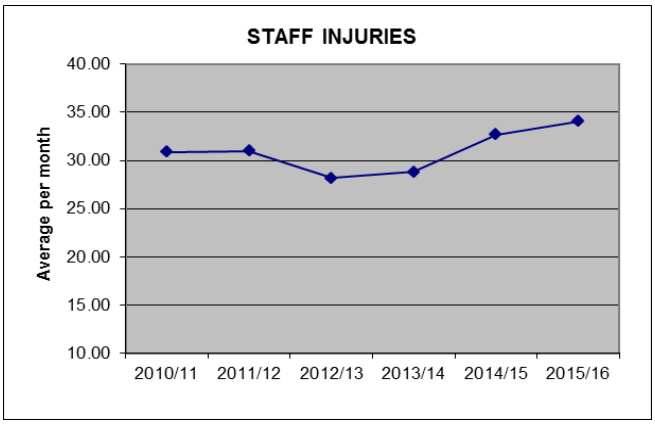
There was a significant reduction in 7 day injuries (25 to 16). However, there was an increase in specified injuries (6 to10). 70% of the specified injuries were broken bones from falls (50% were elderly visitors). 2 were injured children (trapped fingers) therefore only 2 were staff falls.

Dangerous occurrences were unchanged (1 per year).



There was 409 staff injuries (an average of 34.1 injuries per month). This compares with an average of 32.7 for the previous year. This is an increase of 4%. This could be a result of increased reporting.

There have been no Deaths.

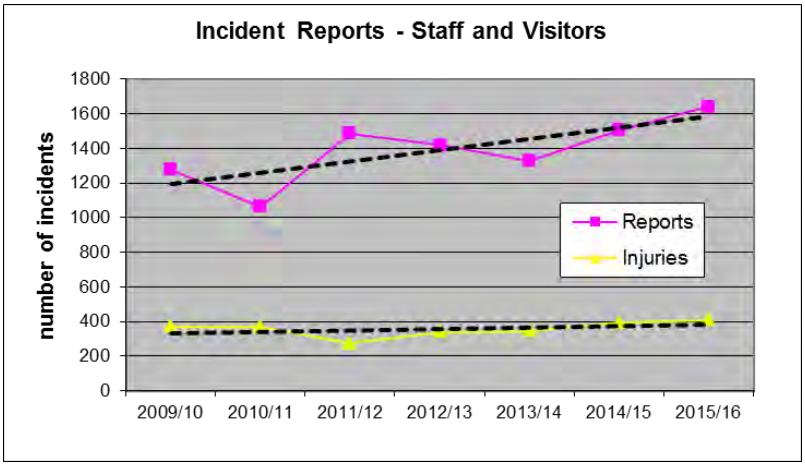


Reporting

There were 1641 non-patient incidents reported in 2015/16. This is a 9% increase on the previous year. A conscious effort was made to increase reporting this year.

The total number of injuries has remained steady while incident reporting shown an upward trend.

	Reports	Injuries
2009/10	1277	371
2010/11	1062	372
2011/12	1485	272
2012/13	1419	338
2013/14	1328	286
2014/15	1505	392
2015/16	1641	409

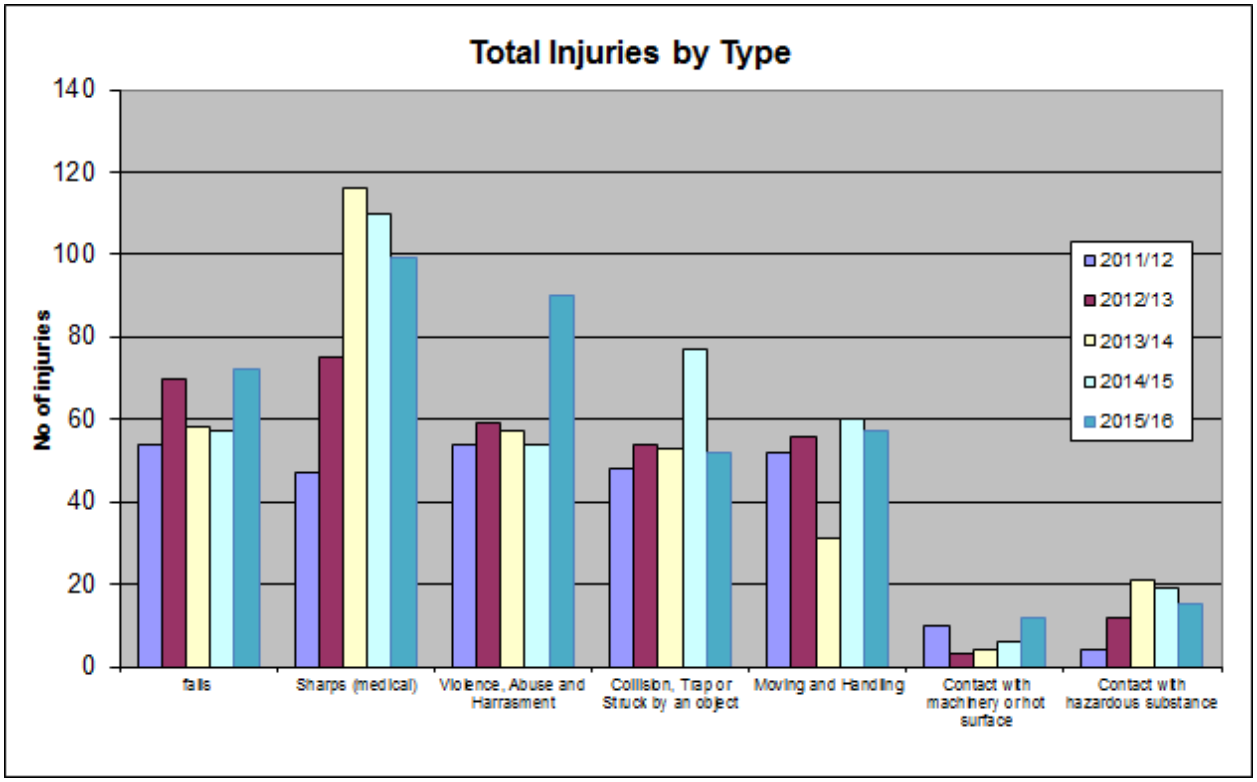


Categories of Incidents resulting in injury

The seven largest categories make up 97% of all staff injuries.

Three have increased and four have shown a decrease.

	2014/15	2015/16		Change	
Falls	57	72	18%	26%	
Sharps (medical)	110	99	24%	-10%	
Violence, Abuse and Harrasment	54	90	22%	67%	
Collision, Trap or Struck by an object	77	52	13%	-32%	
Moving and Handling	60	57	14%	-5%	
Contact with machinery or hot surface	6	12	3%	100%	
Contact with hazardous substance	19	15	4%	-21%	
Cuts non-medical sharps	8	9	2%	13%	
Others	1	3	1%		
	392	409	100%		



Occupational Ill Health

Occupational ill health is identified and reported by the Occupational health department. Only 1 incident of occupational ill health was reported on Datix. The cases have reduced over recent years.

ILL HEALTH	2011/12	2012/13	2013/14	2014/15	2015/16
Skin and dermatitis	3	3	1	0	0
Work related stress	1	0	0	0	1
Occupational respiratory disease	0	0	0	0	0
Enviromental causes of ill health	5	1	0	1	0
Total Occupational Ill Health	**9**	**4**	**1**	**1**	**1**
Others (not occupational)	2	5	2	2	6

The planned awareness campaign was not completed. However, this alone will not significantly increase reporting. Staff do not understand the difference between Occupational and normal ill health. A detailed options analysis is required to identify a process that will meet the Trust requirements. Once agreed an action plan can be developed to implement the new procedure.

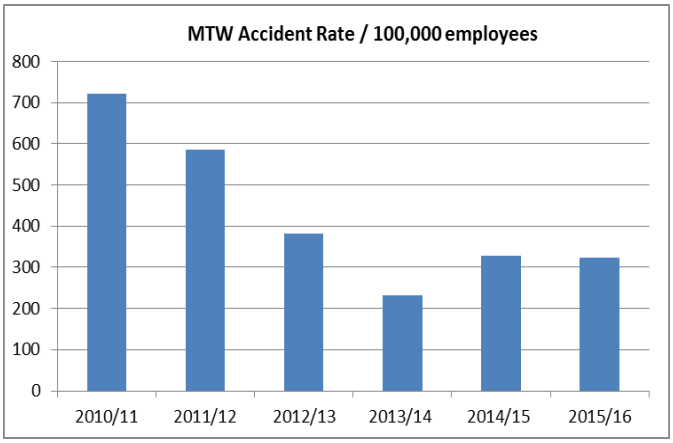
Benchmarking

Accident Rates

The HSE uses accident rates to compare organisations. The most useful are workplace deaths and the number of RIDDOR reportable injuries per 100,000 employees. The HSE publish data for the health sector and for all industries. Data is based on total employee numbers rather than whole time equivalents.

All industries (2014/15)	Death	0.46	per 100,000 employees
Health sector (2014/15)		0.5	
MTW (2015/16)		0	
All industries (2014/15)	All RIDDOR injuries	293	
Health sector (2014/15)		327	per 100,000 employees
MTW (2010/11)	All RIDDOR injuries	**721**	per 100,000 employees
MTW (2011/12)		**585**	
MTW (2012/13)		**383**	
MTW (2013/14)		**232**	
MTW (2014/15)		**329**	
MTW (2015/16)		**324**	

The health sector is more hazardous and complex than most work environments. The CCG has set risk levels; rates of <600 are rated as green, 600 to 660 as amber and >660 as red. **Hence MTW is rated as green.**



Further comparison data was obtained from other local Trusts. The Healthcare Risk Management Group (HMRG) has members from many Trust's in the South East. Our rate compares well with other acute Trusts (their data is for last year).

Type of Trust	Total RIDDOR's	Employees	Injury Rate (per 100,000 staff)	
MTW	27	8340*	**324**	2015/16
Health sector (HSE national data)			**327**	2014/15
Acute and Community Trust 1	14	3328	**421**	2014/15
Acute and Community Trust 2	52	8570	**607**	2014/15
Mental Health Trust 1	59	4580	**1288**	2014/15
Hospices & Community Service	3	566	**530**	2014/15
Private Healthcare Hospital 1	2	403	**496**	2014/15
Private Healthcare Hospital 2	3	650	**461**	2014/15
Private Healthcare Hospital 3	14	1700	**823**	2014/15
HMRG Average			**661**	**2014/15**

Our injury rate compares well against the national rate for health care organisations and other local Trust's. Benchmarking was only possible against organisations willing to share their data.

*** Note:** "This number includes the total headcount of all staff employed (all those for who we would have to report incidents and RIDDORs), and includes all bank staff used and all staff from hosted organisations."

4. Key Health and Safety Areas

6.1 Falls

Falls account for about 18% of all staff injuries. The number of staff falls this year has increased significantly by 26% to 72. A study was carried out during the year on 14 months of staff falls:

- Slips on wet floors – 14% (from cleaning)
- Slips on wet and contaminated floors – 24% (spillage, flooding, weather etc)
- Largest cause was no cause – 23% (staff could not account for why they fell – clumsiness etc)
- All other causes were all less than 10%

Actions have been built in to the programme for next year.

All staff must be vigilant and apply common sense controls such as:

- Moving goods at less busy times.
- High vigilance and immediate action when there are spillages
- Not moving excessive loads (only one trolley at once).
- All staff looking where they are going and not at a phone.

There are several recommended actions resulting from the study:

- Continue to increase staff awareness of the factors that increase the risk of falls.
- Review the training and competences of domestic staff.
- Complete the review and replacement of the Maidstone kitchen floor.
- Continue to discourage the use of unauthorised paths.
- Design work areas to minimise tripping hazards.
- Continue to improve the Maidstone Estate.

6.2 Violence and Abuse

Injuries from violence accounts for about 22% of all staff injuries. The data shows a significant increase of 67% this year. This is significantly larger than in previous years

Physical assaults have not significantly increased but minor injury has. This is not thought to be an increase in violence to staff but either, increased reporting or a reduction in staff tolerance to abuse.

The LSMS left the Trust during the year. The new LSMS is in post and will investigate this trend further.

6.3 Moving and Handling

Moving and handling accounts for 14% of staff injuries. Last year there was a small 5% decrease in injuries. Numbers are similar to previous years

6.3.1 Generic Risk Assessment Review

A proportion of these have been reviewed this year, it is expected that all will be reviewed by the end of March 2017 and will form a rolling ongoing review programme.

6.3.2 Falls Handling

The combined falls and moving and handling training courses (Falls Handling) are continuing to run through 2016. The courses are very well evaluated with many staff indicating that the session is a learning experience as well as an update.

Managers have requested local falls handling training sessions that have been well supported. This has included all therapeutic radiographers at Maidstone and Kent and Canterbury hospitals.

The Hover-Jack and scoop equipment that was introduced over a year ago have been used in practice. This is evidence that staff are assessing the fallen person more carefully and reducing the risk of displaced fracture and/or exacerbated of pain and injury on all sites, including MTW services at Kent and Canterbury Hospital.

6.3.3 Spinal Handling

Spinal handling training continues as an optional update for areas where staff are likely to care for a patient with suspected or actual spinal injury. This course is also very well evaluated by staff.

6.3.4 Patient Canvas

Patient canvases have been significantly lacking over the past few years. This has resulted in staff being unable to follow the identified safe system of work for lateral transfers. The canvas replacement programme has increased the provision at Maidstone and will be addressing the need at TWH during 2016/17.

6.3.5 Miami J Collar

During 2015 specific Miami J collar training sessions were set up to deliver collar training to ward staff and therapeutic radiographers. It had been identified that patients requiring a cervical collar are treated in oncology and admitted to medical and paediatric wards.

Collar training is part of a new dedicated paediatric handling programme commencing June 2016.

It is hoped that when the new elements of the AT-Learning data base are fully operational, training and competency records can be uploaded and reports generated to fully identify staff training, competency assessment and outstanding training needs.

6.3.6 Hoist Sling Sizing

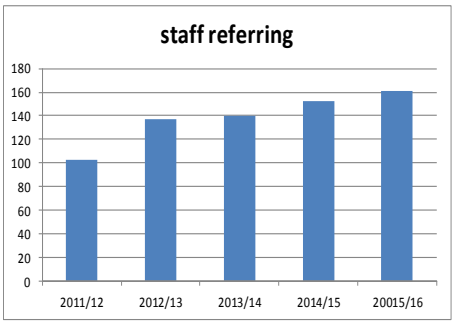
The Falls and Spinal Handling training sessions, together with evaluation of external training providers, has identified inadequate sling sizing training has been delivered to Trust staff. This can result in the wrong size sling being selected and a risk of patient fall.

Sling sizing training has been delivered to the external trainers and added to the Falls Handling training. In addition, an internal safety notice has been distributed, ad-hoc training sessions and drop-in training sessions have been delivered to address this risk.

6.4 Sharps

Injuries from medical sharps fell to 24% of all staff injuries (from 28%) but is still the largest cause of injury to staff. The number of reported injuries fell by 10% to 99 this year.

Occupational Health reported that 161 staff had been referred following needle stick injury. However, only 99 incidents were reported on Datix. This indicates 38% under reporting. The programme last year had actions to encourage staff to report incidents through Datix. These have been unsuccessful so a different approach is needed. The occupational health data shows an increase in injuries year on year.



Last year there were no RIDDOR reportable sharps injuries. This year there was one because a blood borne virus was confirmed for the patient (the staff member was not infected). The HSE interviewed the Trust health and safety advisor but was happy with the Trust investigation and did not visit.

The main cause of injury is staff not respecting sharps and self-injuring through lack of concentration. The sharps group will continue to promote sharps safety and change the embedded culture.

The Vascular Access Specialist Practitioner has continued to train all new medical staff, through induction programmes, for Blood Cultures and where appropriate in Venepuncture and Cannulation. Sharps injuries and best practice in handling medical sharps is discussed. Practical skills stations facilitate competency assessment and serve to highlight poor practice.

Nursing staff attending study days on Intravenous Therapy, Venepuncture and Cannulation and Central Venous Access Devices also receive training on sharps injuries and best practice in handling medical sharps. Staff are provided with a selection of supervised clinical skills stations with high staff to student ratios, to practise their technique in a safe and supported environment.

Every opportunity to engage company representatives in the Trust wide training of staff in the correct handling and disposal of medical sharps has been undertaken, especially coinciding with either the introduction of a new medical sharp or the change of an existing medical sharp device. Company- led Trust wide training is viewed as an essential element when considering new devices for trial and potential introduction to the Trust.

6.5 Eye Splash Injury

In 2014/15 there were 19 eye splash incidents in the Trust and one of these was reportable to the HSE as a blood borne virus infection was possible. The eye splash group was established and undertook a series of actions including an awareness campaign.

This year there were 14 eye splash incidents (reduction of 26%). The incidents predominantly occur in delivery suite (36%) and ITU (21%).

None were reportable. However, blood testing was undertaken in at least 9 of the incidents because the patient's status was unknown. This was 9 near misses so we must not be complacent. Need to continue the awareness campaign with posters etc.

6.6 Collisions, Traps or Struck by and Object

These incidents occur when staff move around the workplace. It can be indicative of cramped conditions, bad housekeeping and rushing around. In 2014/15 there were 77 injuries. This year this has reduced by 32% to 52 injuries. These are now 13% of staff injuries (down from 20%).

6.7 Machinery, Hot Surfaces and Fluids

In 2014/15 there were 6 burns/scalds to staff. This year there was a significant increase to 12. Two were RIDDOR reportable as 7 day injuries. 7 were in Wards and Clinics involving food and kettles. Need to increase staff awareness of the hazards of kitchens.

6.8 Occupational Ill Health

Occupational ill health is identified and reported by the Occupational health department. Only 1 incident of occupational ill health was reported on Datix and this was work related stress. Datix is not used by staff to report occupational ill health.

Risk and Occupational Health staff will meet to identify if there is significant underreporting. Staff do not understand the difference between Occupational and normal ill health.

Last year's programme required Risk and Occupational Health staff to encourage employees referring with ill health issues to report the issues on Datix. This has been unsuccessful. A new approach may be required.

A detailed options analysis is required to identify a process that will meet the Trust requirements. Once agreed an action plan can be developed to implement the new procedure.

7. Health and Safety Executive Inspections and Investigations in 2015/16

7.1 Trust Inspection

Health is not considered a high risk industry so the HSE will not undertake proactive inspections or visits. However, they will undertake reactive visits based on intelligence. These include:

- RIDDOR incidents. If the report is late it is a technical breech so they can charge under FFI.
- Reports from other agencies such as CQC, MHRA, Environment Agency etc.
- Whistle blowing.

The new powers given to the CQC means that it will become the primary enforcing agency for some incidents.

7.2 Investigation Visits

The HSE has not visited the Trust this year to undertake investigations following RIDDOR reportable incidents. However, they have requested further information following the late reporting of RIDDOR incidents.

7.3 HSE Priorities, Projects and Targets

In March 2016 the Head of Operations for the HSE presented the HSE's Priorities, Projects and Targets for 2016/17. This focused on the new HSE initiative "Helping Britain Work Well":

- Acting Together – Health and safety should not be a responsibility assigned to a particular individual or part of an organisation, but an integral part of everyone's role. There needs to be much broader ownership of the issues
- Tackling Ill Health - Work-related ill health is a major problem, with conditions ranging from cancer and other long-latency diseases, to stress and musculoskeletal disorders. Greater awareness of the harm, costs and preventability of work-related ill health should drive action to improve health outcomes.
- Managing Risk Well - Successful organisations understand that sensible and proportionate risk management is integral to delivering their business. This approach enables innovation and protects an organisation's most vital asset, its people. Positive outcomes can include reduced sickness absence, lower costs and a good reputation. Health and safety professionals have an important role to play helping businesses to get it right in an efficient and effective way to improve standards.
- Keeping Pace with Change – Need to anticipate and tackle the new health and safety challenges that come with social, economic and technological change. The ability to horizon scan, when combined with the deep knowledge and expertise, means anticipating new health and safety challenges. Need to develop high-quality capability, anticipating the workplace challenges of tomorrow.

It is not clear how the HSE will promote and enforce these aims. Less strategically the HSE will still actively promote safer sharps, sufficient qualified advisors and RIDDOR investigations. Fees for intervention will be actively sought.

8. Health and Safety Legislation

There have been no significant changes to Health and Safety legislation this year.

Fees for FFI have increased to £129 per hour. Invoices must be paid within 30 days.

The NHS staff council and the Health and safety Executive published guidance in July 2015 entitled “Health and Safety Competences for NHS Managers”. It describes the competencies various staff groups should have for managing Health and safety. This guidance is not legally enforceable but will be seen as “reasonable” by the HSE and hence we could face enforcement action under H&S legislation if it is not followed. This is being reviewed by the Health and Safety Committee.

9. Summary and Conclusions

Good progress has been made and the majority of the 2015/16 programme was completed.

There was a conscious effort to increase reporting this year and there was a 9% increase. This also resulted in a 4% increase in reported staff injuries and a 16% reduction in RIDDOR injuries. There was a significant decrease in 7 day injuries (25 to 16). There was an increase in specified injuries (6 to10). However, most of these were elderly visitors. The reduction in the more serious RIDDOR injuries combined with an increase in total injuries suggests increased reporting.

Falls

Falls account for about 18% of all staff injuries. The number of staff falls has increased this year. The data for the last 4 years is showing an average of about 64 per year. This is not high for 9,700 employees and achieving a significant reduction is unlikely.

Violence and abuse

Injuries from violence accounts for about 22% of all staff injuries. The data shows a significant increase of 67% this year. This increase is not fully understood.

The new Trust LSMS is now in post and will investigate this trend further.

Moving and Handling

Moving and handling accounts for 14% of staff injuries. Last year there was a small 5% decrease in injuries. Numbers are similar to previous years.

The specialist update training sessions have proved to be focused and well received by staff. Many have indicated that these sessions have been good learning experiences and preferred to a general update.

Sharps

The number of sharps injuries reported on Datix fell by 10% to 99 this year. This is a modest reduction considering the extensive education and awareness campaign undertaken by the sharps group. Sharps are still the largest cause of injury to staff.

However, Occupational Health reported that 161 staff had been referred following needle stick injury. This indicates 38% under reporting. The programme last year had actions to encourage staff to report incidents through Datix. These have been unsuccessful so a different approach is needed. The occupational health data shows an increase in injuries year on year.

The main cause of injury is staff not respecting sharps and self-injuring through lack of concentration. There sharps group will continue to promote sharps safety and change the embedded culture.

Eye Splashes

In 2014/15 there were 19 eye splash incidents in the Trust and one of these was reportable to the HSE as a blood borne virus infection was possible. The eye splash group was established and undertook a series of actions including an awareness campaign.

This year there was a 26% reduction in eye splash incidents and none were reportable to the HSE. However, blood testing was undertaken in at least 9 of the incidents because the patient's status was unknown.

Occupational Ill Health

There are two significant issues with incident reporting by staff referred to Occupational health Department:

- Occupational inn health events are not being recorded on Datix and there is a possibility that we are failing to report to the HSE.
- Staff are referring to Occupation Health following needle stick injuries but failing to report on Datix.

These indicate under reporting and a failure to investigate incidents and trends. A strategy and process to significantly increase reporting is required.

The Health and Safety Executive

In March 2016 the HSE presented the new HSE initiative "Helping Britain Work Well". It is very strategic and it is not clear how the HSE will promote and enforce these aims.

Health is not considered a high risk injury so the HSE will not undertake proactive inspections or visits. However, they will undertake reactive visits based on intelligence. There have been no HSE visits or investigations this year. There have been no significant changes to Health and Safety legislation this year.

The NHS staff council and the Health and safety Executive published guidance in July 2015 entitled describing the competencies various staff groups should have for managing Health and safety. This guidance is not legally enforceable but will be seen as "reasonable" by the HSE and hence we could face enforcement action under H&S legislation if it is not followed.

10. Objectives for 2016/17

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPIs
Health and Safety Management (Health and Safety Advisor)					
Embed the program of audits of the documents uploaded to the H&S audit software.	Will work with Department Managers and Directorate Risk leads to improve compliance and complete the annual audit program.	H&S advisor	Risk Manager	Progress will be monitored by lead and reported to the H&S committee.	Need: 90% of Departments fully compliant (green). 0% of Departments non-compliant (red). 95% of audits to be current.
Through training and manager awareness increase the number of RIDDOR incidents reported on time.	Increase reporting rate to 85% by October and achieve 85% for the year.	H&S advisor	Risk Manager	Progress will be monitored by lead and reported to the H&S committee.	Aim for 90% of RIDDOR's to be reported on time.
Need to increase staff awareness of the risks posed by hot, food and drinks and kitchen equipment.	Throughout the year	H&S advisor	Risk Manager	Progress will be monitored by lead and reported to the H&S committee.	Decrease the number of staff burns and scalds next year
Falls (Falls Prevention Practitioner)					
Continue with awareness and training to further reduce staff falls.	(The focus of the falls team is on reducing Patient falls)	Falls Prevention Practitioner	Trust H&S Advisers	Continue with regular refresher training. All falls will be investigated	Continue with awareness and training to further reduce staff falls.
Radiation Protection (Radiation Protection Advisor)					
Control of Electromagnetic Fields at Work Regulations 2016	Throughout the year	Radiation Protection Adviser / EME and Technical Services Manager	Risk Manager	Progress will be monitored by leads and reported to the H&S committee.	Medical Equipment has been appropriately risk assessed and an action plan is in place
Audit programme: Staff compliance with personal radiation dosimeter policies and procedures	Throughout the year	Radiation Protection Adviser	Risk Manager	Progress will be monitored by lead and reported to the H&S committee.	90% of staff issued with personal dosimeters are wearing them correctly

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI
Violence and abuse (Local Security Management Specialist - LSMS)					
Review physical restraint and CRT training for all Trust staff groups.	Complete a training needs assessment by December 2016	LSMS	Learning and Development.	Progress will be reported to the H&S committee as part of Trust Officer's reports.	Training included in the 2016/17 training programme
Investigate trends in violence and abuse reporting to determine the reason for the increase in reported injuries.	By December 2016	LSMS	Risk Manager	Progress will be reported to the H&S committee as part of Trust Officer's reports.	Identify reasons for trends.
Consider the provision of a secure room for patients sectioned under section 136 of the mental health Act in A&E on both sites	Devise a plan during 2016 and if required include in Estates plan for 2016/17.	Head of Safety and Security and A&E Matrons	LSMS	Progress will be reported to the H&S committee as part of Trust Officer's reports.	Decision on if a room is required.
Support Kent police to develop a Kent wide protocol for the management of missing and mental health patients.	Throughout the year	LSMS	Head of Safety and Security	Progress will be reported to the H&S committee as part of Trust Officer's reports.	Develop of a joint protocol for handling missing and mental health patients.
Moving and Handling (Moving and Handling Coordinator)					
Complete the 2 year review of all patient handling generic risk assessments and safe systems of work	By 31-3-2017.	Sue Tizzard M&H Co-ordinator		ST to include on H&S committee report.	After the first year 30% of assessments have been reviewed. It is expected that the remainder will be completed by 31.03.17 and will be a continuous ongoing update programme.
Need to continue the inclusion of spinal handling in generic risk assessments and continue the training programme.	By 31-3-2017.	Sue Tizzard M&H Co-ordinator	Spinal Pathway Group	To be completed as part of the 2 year review cycle. Spinal Group will review progress ST to include on H&S committee report.	Continue to deliver the monthly training sessions. L&D's completion of the additional module for AT-Learning will facilitate better identification of training needs.

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPIs
Develop the in house database to adequately record training and competency evidence	By 31-3-2016.	M&H Co-ordinator	Head of Safety and Security	ST to include on H&S committee report.	Adequate database in place providing evidence.
Need to address the lack of patient canvasses resulting in an inability to follow safe practise.	By 31-3-2016.	M&H Co-ordinator	Head of Safety and Security	ST to include on H&S committee report.	Have sufficient canvasses across the Trust.
Sharps (Sharps Task and Finish Group)					
The sharps task and finish group will continue to use all means to change staff attitude and the embedded medical sharps culture.	Throughout the year	Risk Manager	Sharps task and finish group.	Sharps group will report to medical device and H&S committees.	Decrease sharp injuries again this year.
Analyse the injury data for 2015/16 and compare with previous data set. Highlight learning.	By August 2016.	Risk Manager	Sharps task and finish group.		
Continue to review new safety devices in the market place across the Trust.	Complete in 2016/17	Vascular Access Specialist Practitioner	Procurement	Sharps group will report to medical device and H&S committees.	Compliance with the H&S (Sharp Instruments in Healthcare) Regulations 2013.
Review safety sharps training to assess if refresher training is required and how this can be delivered.	Complete in 2016/17	Vascular Access Specialist Practitioner	Sharps task and finish group.	Sharps group will report to the H&S committee.	Reduce injuries as a result of lack of training
Complete an options appraisal for increasing the reporting of sharps injuries by staff referring to occupational health.	Complete by October 2016 H&S Committee meeting.	Occupational Health Manager	Risk Manager	Report to H&S committee through the occupational health report	Ensure all referred staff report through Datix.
Develop an action plan to increase reporting	Complete by December 2016 H&S Committee meeting.	Occupational Health Manager	Risk Manager	Report to H&S committee through the occupational health report	Ensure all referred staff report through Datix.

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPIs
Eye Splashes (Risk Lead for Critical Care)					
The task and finish will continue with the awareness campaign through posters etc.	This is an ongoing project throughout the year.	Risk Lead for Critical Care	Risk Manager	Progress will be reported to the H&S committee.	Increased awareness will increase the wearing of eye protection and reduce injury.
Occupational Health (Occupational Health Manager)					
Increase awareness of the need to report work place stress and other ill health events on Datix via a safety alert.	Complete throughout 2016/17	Risk Manager.	Occupational Health Manager.	Reported to H&S Committee via Occupational health report.	Comparison of numbers referred to numbers reported.
Increase awareness of the need to report work place stress and other ill health events on Datix via H&S training.	Complete throughout 2016/17	Health and Safety Advisor	Training and Development	Reported to H&S Committee via Occupational health report.	Comparison of numbers referred to numbers reported.
Encourage staff and there managers to report work related stress and other ill health events through Datix.	Complete throughout 2016/17	Occupational Health Manager.	Occupational Health Department	Reported to H&S Committee via Occupational health report.	Comparison of numbers referred to numbers reported.
Complete an options appraisal for increasing the reporting of work related stress and other ill health events through Datix.	Complete by October 2016 H&S Committee meeting.	Occupational Health Manager	Risk Manager	Report to H&S committee through the occupational health report	Ensure all referred staff report through Datix.
Develop an action plan to increase occupational Ill health reporting	Complete by December 2016 H&S Committee meeting.	Occupational Health Manager	Risk Manager	Report to H&S committee through the occupational health report	Ensure all referred staff report through Datix.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - September 2016

9-22	Summary report from Quality Committee, 01/08/16 and 14/09/16	Committee Chair (Non-Executive Director)

The Quality Committee has met twice since the last Trust Board meeting, on 1st August (a 'deep dive' meeting) and 14th September (a 'main' meeting).

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

- A review of the actions agreed from previous meetings
- The Consultant in Palliative Medicine/Lead Nurse for Palliative Care & Associated Services attended for a "Review of End of Life Care", and gave a presentation which highlighted the following issues:
  - "End of Life Care" was defined differently by different organisations. "Palliative Care" was the active holistic care of patients with advanced progressive illness
  - A number of relevant national documents had been issued, including 'More Care Less Pathway' (an Independent review of the Liverpool Care Pathway (ICP), otherwise known as the 'Neuberger Report')
  - There were 529,655 deaths in England and Wales in 2015, and 1,521 deaths at the Trust in 2015/16. 78% of the people that died in England between 2004 & 2008 had at least 1 admission to hospital in their last year of life. The most preferred place of death for healthy individuals was their "Own home", but most individuals (at 2010) actually died in hospital. However, as individuals approached death, the location of death became less critical (compared to other factors such as access to pain relief, access to professional support etc.) and this explained why dying patients were usually cared for in locations other than their home. A 2014 study showed that 28.8% percent of patients were dead 12 months after spending at least 1 night in hospital
  - The Trust's Specialist Palliative Care Team (SPCT) included a Lead Nurse for Palliative Care (0.8 WTE); A Clinical Nurse Specialist (CNS) (5.5 WTE); and 0.4 WTE of an End of Life Care CNS. In addition there was a Medic (1 WTE); a Clinical Ethicist; a Chaplain; a Macmillan Information Officer; Oncology Counsellors (1 WTE); and the Patient Affairs Office. The Team was also supported by the Integrated Discharge Team, Site-specific CNSs and the Acute Oncology Team (Nurses, AHPs and Doctors)
  - Palliative Care Team activity data showed that the median number of patients seen per Unit was 1134 (compared to the equivalent national figure of 582); whilst the median proportion of a diagnosis other than Cancer was 29.5% (compared to 23% nationally)
  - The LCP aimed to bring a Hospice-based approach to hospital care, but following some concerns, the LCP was withdrawn following a recommendation from the Neuberger Report. As the LCP had been used extensively across the country, the withdrawal created a vacuum, and therefore a number of different alternative approaches emerged
  - The Care Quality Commission (CQC) inspection reports rated End of Life Care as "Requires Improvement" for Maidstone and Tunbridge Wells Hospitals, although "Caring" and "Well-led" received a "Good" rating for both sites
  - The Trust scored below national median scores on The Royal College of Physicians' National Care of the Dying Audit of Hospitals (NCDAH) for many Clinical measures. However, the prescribing of anticipatory medications in the Trust was in accordance with national averages, which would appear inconsistent with the report findings of a low rate of documentation of the recognition of dying. In addition, the mean number of deaths submitted by each Trust nationally was 77, but the Trust's data was only taken from 44 cases
  - The Trust's NCDAH Action Plan involved a re-audit the clinical elements of the national audit; a qualitative review of End of Life Care; detailed observation of deaths on 2 Wards; undertaking a bereavement survey; developing practical support for relatives/next of kin of dying patients, and promoting dignity; and revising and updating the Individualised Care Plan for the dying (ICP), which had replaced the LCP

- It was noted that the Trust had a number of challenges in relation to many of the factors, particularly in relation to "Care during the final admission" (such as meeting patients' wishes regarding their preferred place of death); and "Care after death" (such as the timely provision of death certificates to relatives)
- The Committee discussed whether the completion of the ICP should be mandatory. The obstacles to taking such a step were aired, but it was agreed that commitment should be made to have all appropriate patients on an ICP by 01/08/17

2. In addition to the agreements referred to above, the Committee agreed that:

- The Consultant in Palliative Medicine/Lead Nurse for Palliative Care & Associated Services should: consider the development of a mobile device 'App', to supplement the End of Life resources available to staff on the Trust Intranet; and formalise the commitment that all appropriate patients should have an ICP by 01/08/17
- A follow-up review of End of Life Care should be provisionally scheduled for the Quality Committee 'deep dive' meeting in August 2017
- A "Review of Mortality" should be provisionally scheduled for the Quality Committee 'deep dive' meeting in December 2016
- The Chief Nurse should submit a briefing to the 'deep dive' meeting in October 2016 on the latest position regarding the Trust's compliance with the CQC's 5 domains

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

- The Committee was generally assured by the action taken by the SPCT, and the presentation demonstrated that the Trust had appropriate processes in place. However, the need to be able to provide evidence, in the form of completed ICPs, was emphasised, to enable claims that the Trust managed its End of Life Care patients in an appropriate way to be fully supported
- It was agreed that commitment should be made to have all appropriate patients on an ICP by 01/08/17

4. The key matters considered at the meeting on 14th September were as follows:

- A review of the actions agreed from previous meetings
- The draft Financial Recovery Plan was presented by the Director of Finance[1]. The resulting discussion included a query as to the impact of the Plan on patients. Assurance was given that all schemes had been subject to a Quality Impact Assessment, led by the Medical Director and Chief Nurse.
- The latest Stroke care performance, including the future of Stroke services in the region
- The clinical outcomes of patients treated for a gastrointestinal (GI) bleed at the Trust were reviewed (this was a specific request from the previous 'main' meeting). The Medical Director gave assurance that GI bleed patients were being treated safely at the Trust
- The Trust Clinical Governance Committee meetings held on 08/07/16 and 10/08/16. The points raised included:
  - The increase in Clostridium difficile cases for July (beyond the trajectory)
  - The pressures in achieving elective activity at Tunbridge Wells Hospital due to capacity issues for emergency flow
  - A Sepsis audit had identified continued issues with poor compliance, but the Sepsis Committee had been invigorated with an Anaesthetic Consultant Lead
  - A number of Serious Incidents (SIs) were discussed in detail, and the occurrence of a further Never Event was reported (which was still under investigation)
- The Head of Communications attended to give a report on the role of Communications in Trust-wide learning
- The Associate Director of Quality Governance gave an update on the implementation of Quality Accounts priorities for 2016/17, and it was agreed that updates would be submitted every 4 months i.e. every other 'main' meeting
- Recent findings from relevant Internal Audit reviews were noted, as were the unapproved minutes of the Quality Committee 'deep dive' meeting held on 01/08/16

[1] The Finance Committee proposed, at its meeting on 22/08/16, that part of the agenda of the Quality Committee meeting should be devoted to reviewing the draft Financial Recovery Plan. Members of the Finance Committee were therefore invited to attend the meeting for this item

- The Chief Operating Officer reported on the work being undertaken to reduce Length of Stay, and was asked to submit a further report on such work to the Committee in November

5. In addition to the agreements referred to above, the Committee agreed that:

- The Trust Secretary should liaise with the Director of Finance to arrange for a 'lessons learned' exercise to be undertaken, at an appropriate future point, in relation to the Trust being placed into Financial Special Measures, and for the outcome of the exercise to be reported to an appropriate Committee
- The Trust Secretary should arrange for a brief informal meeting to be held for Trust Board Members, before the formal Trust Board meeting on 15/09/16, to discuss the Financial Recovery Plan
- The Medical Director should liaise with colleagues and consider whether an arrangement should be explored, with Medical Directors at other Trusts, to enable paediatric skeletal survey reports to be obtained in a timelier manner than at present (the Committee had heard that changes had been made in response to a previous SI so that children could not be discharged until a full skeletal survey report had been received, and this had resulted in some delays in discharge, as such reports had to be sourced from a Paediatric Radiologist, who worked outside of the area)

6. The issues that need to be drawn to the attention of the Board are as follows:

- The Committee's review of the draft Financial Recovery Plan (see above for details)

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 assurance

[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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – September 2016

9-23	**Summary report from Audit and Governance Committee, 10/08/16 (incl. the Annual Audit Letter for 2015/16)**	**Committee Chair (Non-Executive Director)**

The Audit and Governance Committee met on 10th August 2016. Immediately after the 'main' meeting, the Committee reconvened as the "Auditor Panel" (to advise on the selection, appointment and removal of External Auditors from 2017/18). A summary report from the "Auditor Panel" has been submitted to the Part 2 Trust Board meeting, due to commercial confidentiality.

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

- Anupdate on progress with the Internal Audit plan for 2016/17 (incl. progress with actions from previous Internal Audit reviews was reported. The list of recent Internal Audit reviews are shown below (in section 2).
- The status of outstanding recommendations from previous Kent and Medway Health Informatics Service (KHMIS) Internal Audit reviews was noted, including the fact that the original 59 outstanding recommendations had been consolidated into 26 open recommendations
- A Counter Fraud update was reviewed, and it was noted that the Trust had an overall Green rating on the annual review against the standards set by NHS Protect in relation to anti-fraud, bribery and corruption work. Actions relating to the two standards rated as Amber have been included in the 2016/17 work plan
- A 'Progress and emerging issues report (including the External Audit Letter for 2015/16)' was received from External Audit. No matters of significance were reported. The Annual Audit Letter is enclosed in Appendix 1. Following the meeting, the Trust received notification by email (25/08/16) from Grant Thornton of an error in the Letter (page 11), in that the fee was quoted as £75,079 but should have read £75,069. The amended letter was therefore circulated to Audit and Governance C'ttee members by email on 30/08/16.
- The Director of Finance provided a verbal summary of the latest financial issues
- The latest losses & compensations data was reviewed, which showed a similar value as for the first quarter in 2015/16 for a reduced number of cases
- The latest single tender waivers data was reviewed, which showed an increase in volumes of waivers raised compared to the previous financial year, but a reduction in value
- A report detailing gifts, hospitality and sponsorship declared in the period 29/04/16 to 28/07/16 was considered. The Committee discussed the treatment of payments received for advisory services delivered outside of the Trust and agreed that such arrangements should (continue to) be declared in advance and recorded on the appropriate register of interests, but the Trust's current Policy regarding the declaration of individual payments received in respect of these relationships / services did not need to be declared should remain
- A report on the Reference Costs Assurance Programme was considered and it was noted that, although a final report was still awaited (from the auditors, PwC), the Trust had been found to be materially compliant with the relevant guidance.
- An "Overview of partnerships" was reviewed and it was agreed that the Trust's relationship with its PFI partner (Kent and East Sussex Weald Hospital Ltd) should be added to the list of key partnerships
- The findings from the Committee's self-assessment / compliance with Terms of Reference exercise were considered, and the Trust Secretary's recommendation that an annual evaluation of the Internal Audit Service should be undertaken, was approved
- The Committee's forward programme was noted and the Chair invited the Committee to consider how it might in the future add value through quality assurance, e.g. the evaluation and success of Quality 'Deep Dives'.

2. The Committee received details of the following Internal Audit reviews:

- "Additional Consultant Payments" (which received a "Limited Assurance" conclusion)
- "Consultant Job Plans" (which received a "Limited Assurance" conclusion)
- "Cash Collection Processes" (which received a "Limited Assurance" conclusion)
- "Data Quality of Key Performance Indicators" (which received a "Reasonable Assurance" conclusion)
- "Achievement of Best Practice Tariffs" (which received a "Reasonable Assurance" conclusion)
- "Cost Improvement Plans" (which received a "Reasonable Assurance" conclusion)
- "Review of Retrospective Never Events" (which received a "Reasonable Assurance" conclusion)

3. The Committee was also notified of the following "Urgent" priority outstanding actions from Internal Audit reviews:

- Consultant Job Plans (1 outstanding action)
- Additional Consultant Payments (1 outstanding action)
- Local Registration Authority Management Reviews (1 outstanding action)

4. The Committee agreed that (in addition to any actions noted above):

- The Medical Director should present a report on the issue of Consultant Job Plans at the next Workforce Committee
- The Director of Finance should incorporate, within the Financial Recovery Plan reports to the Finance Committee, the measures taken by the Trust to mitigate the risk of future qualification of the Trust's accounts / Value for Money conclusion by External Audit
- The viability of extending the Trust's Patient Property Policy and Procedure to cover loss of hearing aids; glasses and dentures should be explored
- The Director of Finance should report to the next meeting on the number and value of rejected Waivers for the period (30/04/16 to 30/06/16), along with further analysis of Waivers requested by the Procurement; Estates and Pharmacy departments
- The Trust Secretary should circulate the most recent independent evaluation of TIAA, once received from the Head of Internal Audit

5. The issues that need to be drawn to the attention of the Board are as follows:

- The Annual Audit Letter is the final mandatory report issued from External Auditors in relation to the Annual Accounts. Under the Trust's 'Reservation of Powers and Scheme of Delegation', the Board is obliged to receive the Annual Audit Letter, which is enclosed

Which Committees have reviewed the information prior to Board submission?

- N/A

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

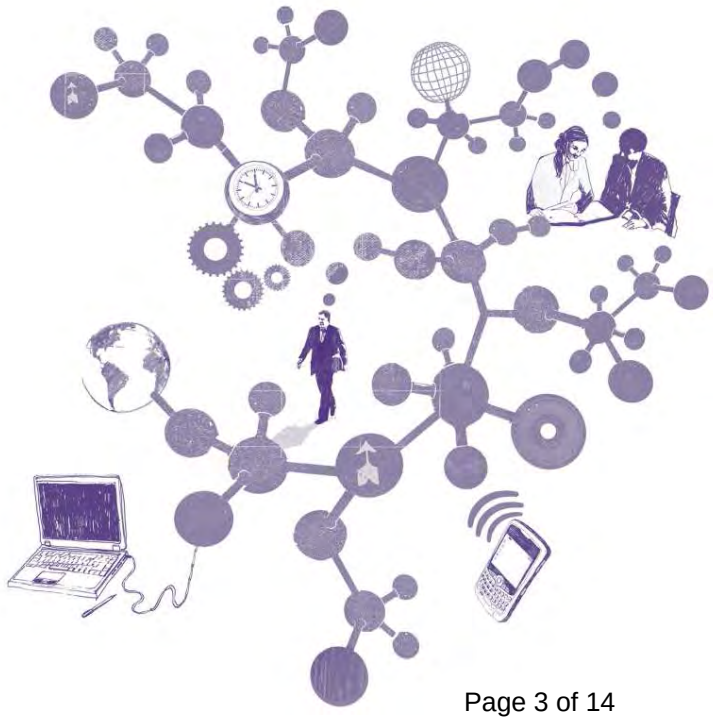
- Information and assurance
- To receive the Annual Audit Letter for 2015/16

[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 Annual Audit Letter for Maidstone and Tunbridge Wells NHS Trust

Year ended 31 March 2016

July 2016



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Contents

Executive summary

Purpose of this letter

Our Annual Audit Letter (Letter) summarises the key findings arising from the work we have carried out at Maidstone and Tunbridge Wells NHS Trust (the Trust) for the year ended 31 March 2016.

This Letter is intended to provide a commentary on the results of our work to the Trust and its external stakeholders, and to highlight issues we wish to draw to the attention of the public. In preparing this letter, we have followed the National Audit Office (NAO)'s Code of Audit Practice and Auditor Guidance Note (AGN) 07 – 'Auditor Reporting'.

We reported the detailed findings from our audit work to the Trust's Audit Committee as those charged with governance in our Audit Findings Report on 25 May 2016.

Our responsibilities

We have carried out our audit in accordance with the NAO's Code of Audit Practice, which reflects the requirements of the Local Audit and Accountability Act 2014 (the Act). Our key responsibilities are to:

- give an opinion on the Trust's financial statements (section two)
- assess the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (the value for money conclusion) (section three).

In our audit of the Trust's financial statements, we comply with International Standards on Auditing (UK and Ireland) (ISAs) and other guidance issued by the NAO.

Our work

Financial statements opinion

We gave an unqualified opinion on the Trust's financial statements on 27 May 2016.

Value for money conclusion

We were satisfied that the Trust put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources except for 'sustainable resource deployment'. This is on the basis that the Trust delivered a £23.4m deficit in 2015/16 and is forecasting a deficit of £22.9m in 2016/17. We therefore qualified our value for money conclusion in our report on the financial statements on 27 May 2016.

Consolidation template

We also reported on the consistency of the consolidation schedules submitted to the Department of Health with the audited financial statements. We concluded that these were consistent.

Use of statutory powers

We referred a matter to the Secretary of State, as required by section 30 of the Act, on 18 May 2016 because the Trust has not recovered the cumulative deficit from 2013/14 within the required three years, as set out in the Department of Health's "Guidance on breakeven duty and provisions."

Certificate

We certify we have completed the audit of the accounts of Maidstone and Tunbridge Wells NHS Trust in accordance with the requirements of the Code of Audit Practice.

Quality Accounts

We completed a review of the Trust's Quality Account and issued our report on 30 June. We concluded the Quality Account and the indicators we reviewed were prepared in line with the Regulations and guidance.

We would like to record our appreciation for the assistance and co-operation provided to us during our audit by the Trust's staff.

Grant Thornton UK LLP
July 2016

Audit of the accounts

Our audit approach

Materiality

In our audit of the Trust's financial statements, we use the concept of materiality to determine the nature, timing and extent of our work, and in evaluating the results of our work. We define materiality as the size of the misstatement in the financial statements that would lead a reasonably knowledgeable person to change or influence their economic decisions.

We determined materiality for our audit of the Trust's accounts to be £6,982,000, which is 1.75% of the Trust's gross revenue expenditure. We used this benchmark as in our view, users of the Trust's financial statements are most interested in where it has spent the income it made in the year.

We also identified cash and cash equivalents as an area to set a lower level of specific materiality at £500,000. Although the balance of cash and cash equivalents is not large in value, all transactions made by the Trust affect the balance and it is therefore considered to be material by nature.

We set a lower threshold of £250,000, above which we reported errors to the Audit Committee in our Audit Findings Report.

The scope of our audit

Our audit involves obtaining enough evidence about the amounts and disclosures in the financial statements to give reasonable assurance they are free from material misstatement, whether caused by fraud or error.

This includes assessing whether:

- the Trust's accounting policies are appropriate, have been consistently applied and adequately disclosed;
- significant accounting estimates made by management are reasonable; and
- the overall presentation of the financial statements gives a true and fair view.

We also read the annual report to check it is consistent with our understanding of the Trust and with the accounts on which we give our opinion.

We carry out our audit in line with ISAs (UK and Ireland) and the NAO Code of Audit Practice. We believe the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Our audit approach was based on a thorough understanding of the Trust's business and is risk based.

We identified key risks and set out overleaf the work we performed in response to these risks and the results of this work.

Audit of the accounts

These are the risks which had the greatest impact on our overall strategy and where we focused more of our work.

Risks identified in our audit plan	How we responded to the risk
Financial position and going concern The Trust had to manage its cash flow carefully for the last quarter of 2015/16, requiring a £16.9m cash injection from the Department of Health and restrictions on creditor payments.	As part of our audit work we: • Reviewed the Trust's assessment of the appropriateness to account on a going concern basis; • Reviewed the Trust's disclosure in the statement of accounts to ensure sufficient disclosure; • Reviewed the Trust's cash flow forecasts and correspondence with the TDA regarding future support. **We did not identify any issues impacting on our unqualified opinion on the accounts.**
Occurrence of healthcare income The Trust receives 82% of its revenue from Clinical Commissioning Groups and NHS England to provide healthcare services. The Trust invoices its commissioners throughout the year and accrues for activity in the final quarter of the year. Invoices for this activity are not agreed until after the accounts are produced for audit. There is a risk that income from healthcare may be overstated.	As part of our audit work we : • Evaluated the Trust's policy for accounting for income for appropriateness and consistency with last year; Gained an understanding of the Trust's system for accounting for healthcare income and the controls in place; • Tested a sample of income to supporting documents and receipt of cash • Checked the consistency of income recorded by the Trust against expenditure recorded by the commissioners. • Checked year end accruals for activity against supporting working papers **We did not identify any issues impacting on our unqualified opinion on the accounts.**
Valuation of property plant and equipment The Trust's property, plant and equipment, including the main hospital site, represent 88% of the Trust's total assets. Their value is estimated by property valuation experts.	As part of our audit work we have: • Considered the independence and experience of the Trust's valuer; • Reviewed the scope of the valuer's work and the resultant report from the valuer to understand key assumptions; • Discussed with management the key assumptions about the basis of valuation, including asset lives, to ensure these were appropriate; • Checked that the valuation had been correctly reflected in the Trust's asset register. **We did not identify any issues impacting on our unqualified opinion on the accounts.**

Audit of the accounts

Audit opinion

We gave an unqualified opinion on the Trust's financial statements on 27 May 2016, in advance of the national deadline.

The Trust made the accounts available for audit in line with the national timetable for submission, and provided a good set of working papers to support them. The finance team responded promptly and efficiently to our queries during the course of the audit.

Issues arising from the audit of the accounts

We reported the key issues from our audit to the Trusts Audit Committee on 25 May 2016.

Annual Governance Statement and Annual Report

We are also required to review the Trust's Annual Governance Statement and Annual Report. We are satisfied that these meet the requirements of the DH Group Manual for Accounts and are consistent with the audited financial statements.

Other statutory duties

We are required to refer certain matters to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 where applicable. On 18 May 2016, we reported to the Secretary of State that the Trust would breach its statutory breakeven duty, that is, to achieve a balanced financial position over a three year period.

Value for Money conclusion

Background

We carried out our review in accordance with the NAO Code of Audit Practice, following the guidance issued by the NAO in November 2015 which specified the criterion for auditors to evaluate:

In all significant respects, the audited body takes properly informed decisions and deploys resources to achieve planned and sustainable outcomes for taxpayers and local people.

Key findings

We performed a risk assessment to identify the key risks where we concentrated our work. The key risks we identified and the work we performed are set out in the table.

Overall VfM conclusion

We are satisfied that, in all significant respects, except for the matter we identified below, the Trust had proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2016.

Our review highlighted the following issues which gave rise to a qualified 'except for' VFM conclusion:

- the Trust delivered £23.4m deficit in 2015/16; and
- the Trust is forecasting a deficit of £22.9m in 2016/17.

Risk identified	Work carried out	Findings and conclusions
Financial outturn The Trust made a deficit in 2015/16 of £23.4 million, compared to a budgeted deficit outturn of £14.1 million.	We reviewed the Trust's arrangements for putting together and agreeing its budget, including identification of savings plans; and its arrangements for monitoring and managing delivery of its budget and savings plans for 2015/16, including the impact on service delivery.	The Trust reported a year end deficit of £23.4m, compared to an initial budgeted outturn of £14.1m. It delivered Cost Improvement Savings of £20.8m, compared to a target of £21.5m. The ongoing worsening position has been discussed regularly with the Board and TDA. The assumptions used in the budget setting, particularly for staffing costs, bed utilisation and volume of elective work were not realised. The key drivers for overspend were: • overreliance on agency covering key vacancies • although non-elective activity levels are in line with 2014/15, the demand on beds has increased due to delayed transfer cases and higher complexity cases • as a result of increased non elective through A&E, elective work cancelled resulting in reduced income levels Although the Trust has a good understanding of its financial position, based on the significant increase in the year end deficit, we concluded there were weaknesses in the Trust's arrangements to plan finances effectively to ensure sustainable resource deployment.

Value for Money

Table 2: Value for money risks continued

Risk identified	Work carried out	Findings and conclusions
Financial sustainability The Trust has a challenging 2016/17 cost improvement savings target of £23 million.	We reviewed the Trust's arrangements for updating, agreeing and monitoring its sustainability and operational plans, and for communicating key findings to those charged with governance and the Finance Committee.	The Trust is predicting a £22.9m deficit in 2016/17, based on achieving cost improvement savings of £23m. There is a clear focus on working with directorates to identify savings, using both Carter data and improved Service Line Reporting to help identify areas of focus. As at March 2016, £4m of the savings target is not supported with identified programmes. Whilst good progress has been made to clearly identify savings, given the size of unidentified savings at the start of the year, we concluded there were weaknesses in the Trust's arrangements for planning finances effectively to support its strategic priorities.
CQC inspection An inspection by the Care Quality Commission in February 2015 rated the Trust as requiring improvement overall, with particular areas of weakness being: - The Trust was assessed as not being 'well-led'	We reviewed how the Trust is implementing and monitoring delivery of the action plan agreed to address the findings of the CQC inspection.	The Trust has made good progress in addressing its improvement plan. The enforcement notice, served in February 215, has been lifted. Our review does not give us reason to qualify the vfm conclusion in the areas of applying the principles of good governance and to deploy workforce to deliver its priorities effectively. However, the Trust cannot take full assurance until the CQC return to re-inspect.

Quality Accounts

The Quality Account

The Quality Account is an annual report to the public from NHS trusts about the quality of services they deliver. It allows trust boards and staff to show their commitment to continuous improvement of service quality, and to explain progress to the public.

Scope of work

We carry out an independent assurance engagement on the Trust's Quality Account, following Department of Health (DH) guidance. We give an opinion as to whether we have found anything from our work which leads us to believe that:

- the Quality Account is not prepared in line with the DH criteria;
- the Quality Account is not consistent with other documents specified in the DH guidance; and
- the two indicators in the Quality Account where we carry out detailed work are not compiled in line with the DH regulations and meet expected dimensions of data quality.

Key messages

- We confirmed that the Quality Account had been prepared in line with the requirements of the Regulations;
- We confirmed that the Quality Account was consistent with the sources specified in the Guidance;
- We confirmed that the commentary on indicators in the Quality Account was consistent with the reported outcomes;
- Our testing of two indicators included in the Quality Account found that these were reasonably stated in accordance with the Regulations and six dimensions of data quality . (Accuracy, Validity, Reliability, Timeliness, Relevance and Completeness)

Quality Account Indicator testing

We tested the following indicators:

- Percentage of patients risk assessed for venous thromboembolism (VTE)
- Rate of clostridium difficile infections.

We reviewed the process used to collect data for the indicators. We checked that the indicators presented in the Quality Report reconciled to the underlying data. We then tested a sample of cases to check the accuracy, completeness, timeliness, validity, relevance and reliability of the data, and whether the calculation is in accordance with the definition.

Based on the results of our procedures, nothing came to our attention that caused us to believe that the indicators we tested were not reasonably stated in all material respects.

Conclusion

As a result of this we issued an unqualified limited assurance report on your Quality Account.

Appendix A: Reports issued and fees

We confirm below our final fees charged for the audit and confirm there were no fees for the provision of non audit services.

Fees

	Planned £	2015/16 Actual fees £	2014/15 fees £
Statutory audit	75,069	75,069	100,092
Charitable fund	4,500	tbc*	2,500
Total fees	**79,569**	**tbc***	**102,592**

* The charitable fund requires a full audit in 2015/16, compared to an independent examination in 201415. This is scheduled for September 2016. We will confirm the actual fee on completion of this work.

Fees for other services

Service	Fees £
Assurance on your quality report	10,000

Reports issued

Report	Date issued
Audit Plan	February 2016
Audit Findings Report	May 2016
Annual Audit Letter	July 2016

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – September 2016

9-24	Summary report from Finance Committee, 22/08/16	Committee Chairman (Non-Executive Director)

The Finance Committee met on 22nd August 2016.

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

- The terms of and implications for the Trust as a result of being placed in Financial Special Measures by NHS Improvement (NHSI), and the future actions and changes required to address this, were the main focus of the meeting. As part of this, the Committee heard that:
  - Confirmation of the terms of Financial Special Measures from NHSI had focussed on the Trust's failure to agree a control total and decision to forecast a deficit (of £22.9m), as well as its excessive rate of pay growth over the past two / three years.
  - The Trust was now required to demonstrate the necessary actions to achieve a control total deficit of £4.7m, excluding STF funding, against a forecast deficit of £22.9m.
  - The Trust would receive support in constructing the required Financial Recovery Plan over the next 4 weeks / 1 month from Simon Worthington, who had been appointed Financial Improvement Director, and David Hoppe, member of the NHSI Improvement Team.
  - Two launch events were being held on 23/08/16 to brief staff regarding Financial Special Measures, and outlining the actions required to deliver a Financial Recovery Plan.
- The key drivers of adverse performance against plan were identified as i) the imposition of fines arising from failure to agree a control total, not been recognised in the original plan, and ii) the longer term issues arising from elective / non-elective activity mix (including Length of Stay and iii) failure to deliver CIPs. All of these issues were discussed within the context of what could be done to improve performance for the remainder of the year
- The Committee heard observations of the Trust from Jane Hurst, former Improvement Director, focussing on: the existing good base from which to build; lack of urgency and pace and the need to develop detailed action plans; the need to focus on implementation of KPMG recommendations and apply resources to grip and control initiatives and lack of awareness of and accountability for the need to improve financial performance;
- The Committee emphasised the need for prioritisation, pace, and clinical engagement with financial planning, as well as considering the importance of how best to nuance and communicate the required changes to retain commitment amongst all staff.
- The governance arrangements required to support change were discussed, including the need to ensure appropriate scrutiny of the Financial Recovery Plan by the Finance and Quality Committees and Trust Board prior to submission to NHSI
- Performance for Month 4 was noted and, in particular, the status of Elective Day case income being below plan by £0.6m in month and £1.9m year to date was discussed within the context of looking forward.
- An "Update on the Corporate Back Office Savings Work-stream" was reported to be largely on plan. The existence of wider Sustainability and Transformation Plan (STP) initiatives in this field was recognised.
- The "Service Line Reporting (SLR) – quarterly update" was reviewed.
- A presentation was given on the "Lord Carter Efficiency Review Update and Next Steps", including a demonstration of the portal containing the Trust's comparative performance There was also discussion about staffing levels and the committee supported the urgent review of levels against benchmarks. The committee encouraged adoption of Lord Carter initiatives as soon as possible.
- A report on the "The Financial Implications of the Kent and Medway Sustainability and Transformation Plan (STP)" was reviewed
- The outcome of the review of the future of the Private Patient Unit was discussed
- The monthly report on breaches of the external cap on the Agency staff pay rate was reviewed, and a report on the use of the Trust Seal was noted.

2. In addition to the agreements referred to above, the Committee agreed that:

- The Director of Finance would consider how to increase granularity within Cost Improvement Plan reporting on performance against target and progress against other objectives
- The Deputy Chief Executive would update the report, 'Outcome of the review of the future of the Private Patient Unit', to include a more complete evaluation of Option 3 (Exit PPU) and consideration of a requirement for all treatment to be pre-approved (removal of provision for debts) with a view to consideration of final recommendations by the Trust Management Executive (21/09/16) and Finance Committee (26/09/16)
- The Director of Finance would ensure that the challenges arising from the application of the Marginal Rate Threshold were appropriately articulated and evidenced for consideration at the Board to Board with West Kent CCG on 30/08/16
- The Deputy Director of Finance (Financial Performance) would provide a report to the Committee in October 2016 with details of analysis to date of (internal and external data) on Care Hours Per Patient Per Day (CHPPD)
- The Director of Finance would provide, as an adjunct to the Financial Recovery Plan, a scenario analysis of the ultimate outcome of continuation of current trends re elective / non elective activity levels, including consideration of appropriate metrics and triangulation

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

- It was agreed that progress against the Plan was to be scheduled to be reviewed and monitored on a monthly basis at Finance Committee and Trust Board meetings, and for relevant matters arising from the Plan to be reviewed at Quality Committee meetings
- It was agreed that the Trust's response to Financial Special Measures / Recovery Plan in advance of the first review meeting with NHSI should be considered at a joint Finance / Quality Committee meeting on 14/09/16, and approved at an additional Trust Board meeting on 15/09/16

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – September 2016

9-24	Summary report from Finance Committee, 26/09/16	Committee Chairman (Non-Executive Director)

The Finance Committee met on 26th September 2016.

1. **The key matters considered at the meeting were as follows:**
   - The "Safety Moment" highlighted the launch of the "Patient safety calendar", and the theme for September (communication) was noted. It was also noted that specific action focused on encouraging staff to introduce themselves, by adopting the "#hellomynameis" campaign.
   - An update on Financial Special Measures (FSM) & the Financial Recovery Plan was given, following the review meeting with NHS Improvement (NHSI) on 21/09/16. It was noted that a further review meeting would take place in mid-November, so the Trust would remain in FSM until at least that point. The discussion at the meeting focused primarily on the monitoring of the delivery of the Recovery Plan, and assurance was given regarding the governance arrangements that had been established
   - The month 5 financial performance for 2016/17 was reviewed, and there was specific discussion about CIP performance and the trend in the use of Agency staff
   - The Head of Costing & SLR, Head of PMO, and Director of Operations, Planned Care, attended to present the outcome of the Service Line Reporting (SLR)-related 'deep dive' in Ophthalmology. The presentation described the comparisons with other Trusts, and the opportunities identified to improve the financial contribution that Ophthalmology made to the Trust. The Committee commended the work, and noted that further 'deep dive' reviews were planned in other areas, but agreed that updates on these would be reported as part of the routine monitoring of performance against Plan (and in the quarterly SLR update reports)
   - The process and timeline for the Trust's 2017/18 & 2018/19 planning submissions was reported, which included the fact that the Final Plan submission to NHSI was due on 23/12/16. It was also noted that the deadline for the draft submission in November did not fit with the timing of the November Finance C'ittee, so an additional meeting may be required.
   - It was noted that the review of the future of the Private Patient Unit would be considered at the Trust Board on 21/09/16 (Part 2), as part of the review of bed configuration
   - The Committee was apprised of the latest situation regarding interim working capital financing arrangements, and although this was not anticipated to be required until November (if at all), it was noted that a Board resolution, preceded by review of the Finance Committee, would be required in the event of the Trust needing to access such financing
   - An update was given on the Business Case for additional Radiotherapy Linear Accelerator bunker capacity at Tun. Wells Hospital (for which the Outline Bus. Case had been approved by the Board in April 2016), and it was confirmed that the Case was unlikely to proceed in 2016/17, as NHS England had requested 6 key actions before the Case could progress
   - The financial aspects of the Board Assurance Framework were reviewed, and it was agreed that the wording of the key risk and objectives was still correct, even in the light of the Trust being placed in FSM. The 'amber' rating of the Director of Finance's confidence that the objectives would be achieved by the end of 2016/17 was also supported by the Committee
   - The Committee considered, and supported, a proposed approach to the 2016/17 estate revaluation (it was noted this would have ordinarily been considered at the Audit and Governance Committee, but the timings involved did not allow for this)
   - The latest breaches of the external cap on the Agency staff pay rate were reported
2. **In addition the agreements referred to above, the Committee agreed that:**
   - The Director of Finance and Trust Secretary should liaise, to consider whether it was feasible for an existing Board sub-committee meeting to be used to review the Trust's draft Planning submissions for 2017/18 and 2018/19, prior to submission to NHSI, on 21/11/16 (and thereby negate the need for an extraordinary Finance C'ttee meeting in November)
3. **The issues that need to be drawn to the attention of the Board are as follows:**
   - The Committee had been assured the governance arrangements for monitoring the

implementation of the Financial Recovery Plan, but was rightly keen to see the impact of that implementation on the Trust's financial position for the remainder of 2016/17

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - September 2016

9-25	Summary report from Patient Experience Committee, 06/09/16	Committee Chair (Non-Executive Director)

The Patient Experience Committee (PEC) met on 6th September 2016.

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

- An update on the CIP workstream on cancelled and missed patient appointments
- Evaluation on the Trust's new translation service, implemented on 1st June 2016
- The latest performance of the Trust's Stroke services
- In accordance with the agreement at the Patient Experience Committee in March 2016, a presentation was given by the End of Life Care Team, which resulted in the Committee endorsing a pilot for the SWAN initiative (with the purpose of providing excellent end of life care for all) within the Trust
- An update on Complaints and PALS contacts for the period April to June 2016
- An update from Healthwatch, which confirmed that Enter and View visits had been scheduled for Outpatients at both Trust sites on 28 and 29/09/16
- Progress on the Quality Accounts priorities for 2016/17.
- An update on Patient Led Assessments of the Care Environment (PLACE) Annual Report / Review of PLACE Action Plan was given (See Section 3)
- Notification of recent/planned service changes, including details of the road closures affecting access to Tunbridge Wells Hospital until January 2017
- An update on work from the West Kent Clinical Commissioning Group
- An update on Communications activity, including overviews of positive, negative and neutral news coverage for the Trust
- The response to the NHS Inpatient Survey 2015 (including proposed response to the issues raised by the survey questions: "Did a member of staff tell you about medication side effects to watch for when you went home?" and "Were you told how to take your medication in a way you could understand?). The formation of a Medications Working Group which would focus on improving practice in this area, was reported
- The findings from and response to the Cancer Patient Experience Survey 2015. The Clinical Audit Action Plan agreed in response to the survey was noted, along with key changes implemented since the previous Audit
- Findings from the local patient survey (and Friends and Family Test), noting that Overall satisfaction had remained stable at 91% for the last two months of the current year, and that agreement had been reached to review the methodology and format of the survey to simplify it, align it to the National Inpatient Survey and improve accessibility
- An update from the Patient Information and Leaflets Group (PILG)
- A report from the Quality Committee meetings on 13/06/16, 06/07/16, and 01/08/16
- Reflections from a Junior Doctor. The meeting was attended by a Junior (Core Training 2, Leadership) Doctor representative who asked about the provision of dementia clocks for patients in each bay / area, and explained that patient transfers were sometimes a source of concern for her peers, and could lead to disorientated patients and disruption in continuity of care. The Committee asked the Junior Doctor to provide further detail of any transfers that were perceived as unnecessary so that the Chief Nurse could respond and provide reasons as necessary
- A report on Care Assurance Audit Feedback (and future plans for the Audit Programme), which highlighted the recent agreement for the integration of the Care Assurance Programme into the Trust's CQC audit schedule.

2. The Committee agreed that:

- The Trust Secretary should share contact details PEC contact details with the Communications team to enable direct notification of significant Trust-related news in advance of publication
- The Deputy Chief Nurse should clarify several points with the supplier of the proposed new

vanity unit for patient bathrooms before trialling it with a wheelchair user and continue to explore the provision of a suitable mirror in bathrooms
- The Head of Staff Engagement and Equality should report to the next meeting on the implementation of the Trust translation service, including: updates on the issues raised to date; assessment of the feasibility of using "Facetime" in the provision of translation services and quantified details of clinician resistance to use of telephone translation
- The Trust Secretary should arrange for the End of Life Care team to provide an update to the PEC on the outcome of the pilot of the SWAN initiative within the Trust
- The PEC's Healthwatch Kent representative should clarify the nature of concerns reported as having been raised by the WKCCG about the new GP triage system
- The Deputy Chief Nurse should submit a report on the issues arising from the NHS Inpatient Survey 2015, not addressed in the latest report submitted to the PEC
- The Trust Secretary should schedule for the PEC to receive a report on the Medications Working Group at each meeting
- The Deputy Chief Nurse should arrange for an update report on the National Cancer Patient Experience Survey 2015 to be submitted to the next PEC meeting
- The Deputy Chief Nurse should establish the availability of detailed call-bell data for Maidstone Hospital and provide a report to the PEC
- The Trust Secretary should ensure that the Junior Doctor who attended the meeting should provide the Chief Nurse with a list of examples of potentially inappropriate patient transfers
- The Chief Nurse should review the information provided by the Junior Doctor and provide the reasons for the transfers
- The Deputy Chief Nurse should establish the status of availability of 'dementia clocks' for Maidstone Hospital
- A letter should be sent from the Chair of the PEC to The League of Friends for the Maidstone Hospital and The League of Friends of Tunbridge Wells Hospital, noting the appreciation of their support, as expressed by the Junior Doctor who attended the meeting
- The Trust Secretary to liaise with the Deputy Chief Nurse (CO'B) about a potential member for the informal Patient Experience Group
- "Care Assurance Audit Feedback" be replaced with a standing agenda item of "Patient Experience Group Feedback" for the PEC from December 2016 onwards
- The Deputy Chief Nurse should consider, as part of the intended review of the Local Inpatient Survey, ensuring that questions reflect the exact wording of correlating questions in the NHS National Inpatient Survey
- The Trust Secretary should schedule a review of Dementia Strategy for 2017-20 at a future PEC meeting

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

The Committee considered a proposed new design of name badge for Trust staff, which was intended to be more visible, clearer and to conform to best practice in typographical terms. The Committee agreed that the Chief Nurse should implement a cost-neutral, phased introduction of the new design name badge, subject to securing Executive and Trust Board approval. The issue is due for consideration by the Executive team during w/c 26/09/16.

The Committee also agreed to highlight the positive nature of the Patient-led Assessment of the Care Environment ('PLACE') findings to the Trust Board, particularly the significant improvement that had been recognised in the "Condition, Appearance and Maintenance" category, following the major investment in Maidstone Hospital in 2015, and the fact that the results achieved by the Trust for 2016 were above the national average across the board.

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

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

Information and assurance and to note the information under Section 3

[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 – September 2016

9-26	**Summary of the Trust Management Executive (TME) meeting, 21/09**	**Deputy Chief Executive**

The TME has met once since the last Board meeting. The key items covered were as follows:

- In the **safety moment**, the launch of the "Patient safety calendar" was highlighted, and it was noted that the theme for September was communication, as poor communication was the underlying theme to most complaints/PALs contacts. It was noted that specific action focused on encouraging staff to introduce themselves, by adopting the "#hellomynameis" campaign.
- The key issues highlighted via the **reports from the Clinical Directors (CD)** were as follows:
  - Staffing concerns were again highlighted by a number of CDs, but new Consultant appointments were reported in a number of specialties
  - The Women's and Sexual Health Directorate was at particular risk in relation to the planned industrial action by Junior Doctors, as their new intake of such Doctors occurred in October. Contingencies were however being explored
  - The CD for Cancer and Haematology reported that progress was being made in relation to the external Service Level Agreements (SLAs) with local Trusts
  - The CD for Critical Care reported that delayed admissions to ICU had improved within the last 2 months, and also gave an update on the concerns raised by Consultant Intensivists that had been discussed at the June 2016 TME meeting
  - The CD for Diagnostics and Pharmacy reported that work was continuing to address the backlog that occurred as a result of the recent failure of the Radiology Information System (RIS) (which rendered the System unavailable for 10 days)
  - The CD for Surgery reported that proposed changes to the Middle Grade rota (to enable Specialist Trainees to be included) had been accepted by Health Education England Kent, Surrey and Sussex (HEKSS) (subject to minor amendments)
  - The CD for Head & Neck reported that problems with server capacity in Ophthalmology posed the risk of curtailment of medical retinal services, but a solution had been identified by the IT Department, and this was being implemented
  - The CD for Trauma and Orthopaedics reported the occurrence of a new Never Event, which involved a wrong sided implant being inserted into a patient's knee
- The **performance for month 5**, 2015/16 was noted, as was the latest position regarding **infection prevention and control**
- The Chief Operating Officer reported on the **outcome of the review of Trauma surgery**, although it was noted that further work was still required in relation to specialist trauma. Following a discussion, it was agreed to ensure that the Group undertaking the review took into account the optimal level of efficiency when assessing the capacity requirements (and not just accept the inefficiencies in the current process)
- The Chief Operating Officer also reported on the **work being undertaken to reduce Length of Stay** (the same report had been given at the 'main' Quality Committee on 14/09/16)
- The report of the recent meetings of the **Trust Clinical Governance Committee** (a formal sub-committee of TME) was noted
- The Director of Finance gave an update on the meeting that had been held with NHS Improvement (NHSI) earlier that day regarding **Financial Special Measures**, and highlighted the key aspects of the **Financial Recovery Plan**
- An update on the **Kent and Medway Sustainability and Transformation Plan** (STP) was given, as part of the review of the **draft Trust Strategy** ("Time to Change…"), for which the Head of Strategy attended. The TME confirmed its support for recommending that the Trust Board approve the Strategy
- The Chief Operating Officer reported the outcome of the current **review of bed configuration/capacity**, which incorporated the outcome of the review of the future of the Private Patient Unit. The proposals were discussed in detail and were, in general, supported, subject to a number of caveats (which related to cost, and the further work required in relation to the

proposals regarding the Catheter Laboratory and Surgical Assessment Unit)

- The Chief Operating Officer also reported on the development of the **Winter and Operational Resilience Plan**, and it was noted that the final Plan would be submitted to the November TME. The TME supported the recommendation to proceed with commissioning of the Maidstone Orthopaedic Unit (MOU), to enable elective Orthopaedic activity to again be undertaken at that site
- The process and timescales involved in **business planning for 2017/18 & 2018/19** were discussed, which included notification that the Final Plan submission to NHSI was due on 23/12/16
- The delay to the planned **implementation of the SAcP (replacement PAS+)** (which was scheduled for 01/10 & 02/10/16) was reported, & the 3 key reasons for the delay were described
- A report was received on the **work being undertaken regarding Medical productivity** (the same report would be submitted to the Finance Committee in October)
- The **Business Cases** that had been approved since the last TME meeting were noted, and several Business Cases were approved (all of which related to capital equipment schemes)
- Two **replacement Consultant posts were approved** (for a Consultant Oncologist and a Consultant Intensivist)
- A review of **risks that were currently rated as 'red'** was undertaken, and the rating of the one of the risks was accepted as being open to challenge
- The **Board Assurance Framework for 2016/17** was received, and an update on the **Internal Audit plan for 2015/16** (including outstanding actions) was noted
- Updates were received on the work of the TME's main **sub-committees** (MTW Programme Committee, Informatics Steering Group, Clinical Operations and Delivery Committee, Health & Safety Committee, Policy Ratification Committee and Information Governance Committee). The report from the Health & Safety Committee included the Annual Report for 2015/16 and programme for 2016/17)
- A report on the process for undertaking **Disclosure and Barring Scheme (DBS) checks** (which was requested following an issue raised at a previous TME meeting) was received
- Under Any Other Business, the Trust Secretary highlighted that NHS England had issued a consultation on **proposals regarding the management of conflicts of interest**, & encouraged TME members to view and respond to the consultation if they had views on the issues

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