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 17TH DECEMBER 2014

ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment	Page
12-1	To receive apologies for absence	Chairman	Verbal	-
12-2	To declare interests relevant to agenda items	Chairman	Verbal	-
12-3	Minutes of the Part 1 meeting of 26th November 2014	Chairman	1	1-9
12-4	To note progress with previous actions	Chairman	2	10-11
12-5	Chairman's report	Chairman	Verbal	-
12-6	Chief Executive's report	Director of Workforce and Communications	3	12
12-7	Integrated Performance Report for November 2014	Director of Workforce and Communications	4	13-17
12-8	To note the Trust's Performance Recovery Trajectories (for A&E 4-hour wait, 18 week RTT wait and Cancer 62-day wait for first definitive treatment)	Chief Operating Officer	5	18-19
	Additional quality items			
12-9	A patient's experiences of the Trust's services[1]	Chief Nurse[2]	Verbal	-
12-10	Planned & actual ward staffing for November 2014	Chief Nurse	6	20-22
12-11	Board members' ward visits	Trust Secretary	7	23-25
	Planning and strategy			
12-12	The recruitment of substantive staff	Director of Workforce and Communications	8	26-32
12-13	Update on the Trust's 2015/16 planning process (including the NHS Planning Timetable, 2015/16)	Director of Finance	9	33-36
	Reports from Board sub-committees (and the Trust Management Executive)			
12-14	Audit and Governance Committee, 20/11/14 (incl. approval of revised Terms of Reference)	Committee Chair	10	37-49
12-15	Workforce Committee, 04/12/14 (to include findings from the staff Friends and Family Test)	Committee Chair	11	50-57
12-16	Patient Experience Committee, 04/12/14	Committee Chair	12	58-60
12-17	Trust Management Executive, 10/12/14	Director of Workforce and Communications	13	61
12-18	Quality & Safety Committee, 15/12/14	Committee Chair	Verbal	-
	Assurance and policy			
12-19	Approval of compliance oversight self-certification	Trust Secretary	14	62-71
12-20	Response to the Fit and Proper Persons Regulations	Trust Secretary	15	72-79
12-21	Approval of 2013/14 Ann. Report & Accounts of Maid. and Tun. Wells NHS Trust Charitable Fund	Trust Secretary	16	80
12-22	**To consider any other business**			
12-23	**To receive any questions from members of the public**			
12-24	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:

- 28th January 2015, 10.30am, Education Centre, Tunbridge Wells Hospital

Anthony Jones,
Chairman

[1] Representatives of the press and public may be excluded from the meeting during discussion of this item by reason of the confidential nature of the business to be transacted

[2] A patient's relative will also be in attendance for this item

Maidstone and Tunbridge Wells NHS
NHS Trust

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 26TH NOVEMBER 2014, 10.30 A.M. AT MAIDSTONE HOSPITAL

DRAFT, FOR APPROVAL

Present:	Anthony Jones	Chairman (Chair)	(AJ)
	Glenn Douglas	Chief Executive	(GD)
	Sylvia Denton	Non-Executive Director	(SD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Alex King	Non-Executive Director	(AK)
	Kevin Tallett	Non-Executive Director	(KT)
	Steve Tinton	Non-Executive Director	(ST)
	Avey Bhatia	Chief Nurse	(AB)
	Angela Gallagher	Chief Operating Officer	(AG)
	Steve Orpin	Director of Finance	(SO)
	Paul Sigston	Medical Director	(PS)
In attendance:	Paul Bentley	Director of Workforce and Communications	(PB)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Stephen Smith	Associate Non-Executive Director	(SS)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	Darren Yates	Head of Communications	(DY)

11-1 To receive apologies for absence

No apologies were received.

11-2 To declare any interests relevant to agenda items

There were no declarations of interest.

11-3 To agree the minutes of the Part 1 meeting of 22nd October 2014

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

11-4 To note progress with previous actions

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

- **Item 10-18: Add a further objective to the Board Assurance Framework, to reflect the Trust's intentions regarding adult emergency care**
  KR highlighted that a new objective was proposed, for approval. The objective was approved as circulated.

- **Item 10-7: Arrange for the next meeting of the Workforce Committee to focus on the recruitment of substantive staff**
  AJ proposed that the issue also be the subject of a detailed discussion at the Board, following the Workforce Committee on 04/12/14. This was agreed.
  Action: Arrange for the Trust Board to have a detailed discussion on the recruitment of substantive staff (Trust Secretary / Director of Workforce and Communications, November 2014 onwards)

11-5 Chairman's report

AJ stated that he had nothing of note to report.

11-6 Chief Executive's report

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

- A successful staff awards ceremony had been held on 21/11/14, involving celebrity guest of honour, Kim Woodburn. GD praised Mrs Woodburn's contribution, and also commended the Kent and Sussex Courier Newspaper for their support for the event, which was attended by their Editor, Roger Kasper
- GD's visit to the Chronic Pain Unit visit was prompted by the Unit raising some concerns regarding the state of the Unit's décor. GD commended the staff in the Unit, and reported that the issues underlying the concerns were being addressed.
- Additional government funding provided for winter pressure was being made available. GD commended the role of the NHS Trust Development Authority (TDA) in ensuring the Trust was allocated such funding, but cautioned that the funding to which the Trust was entitled was being made available via Clinical Commissioning Groups (CCGs), and had not yet been received by the Trust

SDu asked whether the Trust had invoiced West Kent CCG for the funds. SO confirmed that this had not been done as yet, but would be considered after the next meeting of the System Resilience Group.

AK remarked that the balance of power between acute Trusts and CCGs had changed, as evidenced from discussions held at the Health Overview and Scrutiny Committee (HOSC). AJ acknowledged the point, and invited suggestions as to how to respond to this. SDu proposed that a joint annual planning meeting with the CCG may be beneficial. GD welcomed the proposal, but stated that he was confident that the winter funding would be forthcoming in the near future. AJ proposed that a joint Board planning meeting be held with the CCG towards the end of January 2015. This was agreed. AJ agreed to write a letter to the Chairman of West Kent CCG suggesting that a meeting be held.

Action: Write to the Chairman of West Kent Clinical Commissioning Group suggesting that a joint meeting be held with the two organisation's Boards, in January 2015, to discuss (among other things) issues relating to the recent additional winter funding (Chairman, November 2014 onwards)

SDu then commented that liaison with local MPs may also be beneficial. AK supported SDu's comment. GD accepted the point, but highlighted that there was already strong liaison with stakeholders, including all the local MPs, and added that he already had future meetings with some MPs. GD also pointed out that he would be attending the Kent HOSC on 28/11/14.

GD then continued, and highlighted the following:

- The TDA had approved the renovation of wards on the Maidstone Hospital site, which was important in demonstrating the Trust's commitment to the future of that hospital
- The Trust was continuing to perform extremely well in relation to Clostridium difficile, which reflected the strong focus by both the Infection Control Team and all clinical staff
- A Deanery school visit in relation to medicine trainees took place on 21/11/14, & was a positive experience. The feedback from trainees was universally good. GD added that this was more pleasing given the fact that there had been some issues with medicine trainees in the past.

SD referred to the Chronic Pain Unit, and underlined the role that the Unit played in preventing A&E attendances. SD added that she was aware that GPs valued the Unit, which was larger than the equivalent Units at other Trusts. SD appealed for investment to be made in the Unit. PS replied that he was aware that a business case for an additional Consultant for the Unit was expected to be developed. GD concurred that this was an expanding service.

AJ then asked about the Medical Assessment Unit (MAU) at Tunbridge Wells Hospital, and stated that he had been notified of delays relating to disputes regarding office space. AG gave assurance that there were no such disputes, as appropriate space had been allocated, and therefore this was not causing any delays. GD agreed that he did not believe there was a problem, but was unsurprised that comments to that effect had been made to AJ.

11-7 Integrated Performance Report for October 2014

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

- There had been some developments in the Trust's financial position, which SO would report
- Generally speaking, under the Safety Thermometer, the Trust's care continued to be good, and above national benchmarks. However, vigilance was required regarding Pressure Ulcers, which had seen a recent increase
- The A&E 4-hour waiting time target was a challenge, and the Trust was slightly below the target for the year to date
- Cancer 62-day waiting time performance was also a challenge, and although the issues had now been addressed, the backlog of patients waiting meant that performance was not anticipated to recover until January 2015
- Delayed Transfers of Care had reduced, but remained above optimal levels. However, the recent focus of the Trust had been on the factors that were under the Trust's control

AJ reported that AK had discussed the issue of Delayed Transfers of Care with the Kent County Council (KCC) Cabinet Member for Adult Social Care and Public Health, and had highlighted that the Trust was experiencing problems. AK also offered to liaise with East Sussex County Council if required. AG reported that the main issue of concern was the need to ensure that Nursing Home and Residential Home capacity was made available to patients, to enable them to be discharged from hospital in a timely manner. GD stated that it would be beneficial if KCC Social Workers were able to assess East Sussex patients, rather than East Sussex Social Workers having to make ad-hoc visits to the Trust. AG added that a resident case manager at Tunbridge Wells Hospital would also make a huge difference. AK agreed to liaise with Councillor colleagues in Kent and East Sussex on such matters.

Action: Liaise with councillor colleagues in Kent and East Sussex County Councils to assist in identifying a resolution to the current high levels of Delayed Transfers of Care seen at the Trust (Non-Executive Director (AK), November 2014 onwards)

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

- Although Pressure Ulcers had risen to above the benchmark rate of 3, the numbers involved were small, and all appropriate actions were being taken. AB elaborated that a „back to basics' approach had been adopted, and further information was available within Attachment 5.
- The overall number of falls had increased, which had been discussed at the „main' Quality & Safety Committee in November, and it was agreed that a more detailed report would be received at the Committee in January 2015

AJ asked for details of the national average rate of falls for acute Trusts. AB replied that there was no such national benchmark for falls, but she understood from her counterparts that most other Trust's rate was circa 5 (per 1,000 occupied bed-days), and therefore the Trust's rate was higher. AJ asked whether the factors causing this relatively poor performance were known. AB speculated that the single room environment at Tunbridge Wells Hospital may be a factor. SDu asked whether the Trust deployed 'specials' nurses to patients at risk of falls. AB confirmed that the Trust did use 'specials'. KT then referred to the "Rate of Falls" graph on page 15 of 174, and queried whether the performance against benchmark was actually as poor as was being reported. AB stated that this would be explored in more detail at the 'main' Quality & Safety Committee in January 2015.

SDu then commented that she had accompanied the Tissue Viability Team on World 'Stop Pressure Ulcer Day' on 20/11/14, and lauded the awareness of the Team among clinical staff, and the understanding of the grading of pressure ulcers.

AB then drew the Board's attention to the performance on complaints response times, noting that this was related to a combination of sickness absence within the complaints team and Directorate underperformance. AB added that she was not overly concerned however.

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

- There continued to be a high level of A&E attendances and non-elective admissions, which, when combined with the aforementioned Delayed Transfers of Care, was having an adverse impact on A&E 4-hour waiting time target performance.

- A „Home for Lunch' campaign had been launched, which attempted to reduce length of stay.

AJ asked whether Consultants were engaged with the „Home for Lunch' campaign. AG replied that more and more Consultants were being engaged, along with support services. AG noted that an update would be submitted to the Trust Management Executive (TME) in December 2014.

AJ stated that he thoroughly admired the achievements of the A&E department, and noted the staff should be congratulated. The point was acknowledged.

AG continued that the 62-day cancer wait recovery plan had been included in the circulated report, but pointed out that the text in the third paragraph that stated "About 40% of patients [84] currently in the 62 Day backlog were referred from other Trusts" should have stated "About 40% of patients [44] currently in the 62 Day backlog were referred from other Trusts".

SDu referred to the comment on page 18 of 174 that ''Capacity issues have now been resolved through a combination of new appointments of consultants and outsourcing some of the work to other providers'', and asked which providers were being referred to. AG clarified that the text did not refer to formal outsourcing, but to the Trust's own Consultants providing care in an independent capacity.

AJ referred to the 62-day cancer wait recovery plan and asked for details of the patients waiting the longest. AG replied that the longest wait was for 70 days, if the patients who were exempt were excluded. GD added that a review of patients on the waiting list had been undertaken, and it had been confirmed that no patient had been clinically disadvantaged by the current performance.

SD highlighted that the issue was a significant issue nationally. GD acknowledged the point.

GD then highlighted the rise in the number of births at the Trust, which meant that there were likely to be over 5000 births by the end of the year. GD proposed the 'main' Quality & Safety Committee receive assurance that there were plans for the appropriate level of Consultant Obstetrician cover to be in place, should this number be reached. This was agreed.

Action: Arrange for the 'main' Quality & Safety Committee to receive assurance that there are plans for the appropriate level of Consultant Obstetrician cover to be in place, should the number of births at the Trust exceed 5000 p.a. (Medical Director / Chief Nurse, November 2014 onwards)

KT asked whether the Trust received income for births from mothers outside of the Trust's main catchment area. SO confirmed that a cross-charging process was in place, but the number of such births was relatively small.

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

- The Trust has received £12m of non-recurrent provider deficit funding. Such funding had also been made available to a number of other Trusts by the TDA.
- To quality for such funding, the Trust needed to be performing in accordance with its agreed financial plan for 2014/15, and also delivering its planned level efficiency savings
- The timing of the funding meant that the month 6 performance reported to the November 2014 Board meeting was asked to be changed by the TDA at the point the Trust submitted its formal financial position, which was after the Board meeting. There was therefore a difference between the position reported to the Board and that reported to the TDA
- The funding meant that the "Trust Overall RAG Rating" on the TDA Accountability Framework improved from "Red" to "Amber"
- The award meant that there was therefore a £7.4m surplus in month, and year to date, there was a favourable variance of £7.1m (i.e. a deficit of £1.3m against a planned deficit of £8.4m)
- There had been an improvement in elective activity in the month. However, non-elective activity had also increased, which was paid at marginal rate
- Escalation beds were open, which was driving the Trust's requirement for temporary staffing
- Capital expenditure was behind plan, but the forecast was still to deliver the plan by the end of the year, as some items were due to be expended in quarter 4. These included the Linear

Accelerator (LINAC) at Kent and Canterbury Hospital (K&C), which was scheduled to be commissioned in March 2015

AJ asked whether the fabric of the site at which the LINAC at K&C would be located had improved. SO replied that he had been informed that some works had been carried out.

SO continued and highlighted the following:

- In terms of cash, the assumption was that the £12m funding would negate the need to allow for additional permanent Public Dividend Capital (PDC), although some temporary borrowing may be required if the proportion of the £12m funding to be received for quarter 4 was not received in a timely manner.
- The Trust's forecast of a break-even position was dependent on the receipt of £2.475m of CCG re-investment. However, contingencies had been developed in the event of this not being received
- Control totals had been issued to Directorates

ST highlighted the non-recurrent nature of the £12m, which had been awarded to fund a deficit that was already known.

KT asked for an update on the negotiations with Specialist Commissioning. SO stated that liaison with Specialist Commissioners had improved recently, and the gap between the organisations' respective positions was now just over £3m. SO added that a proposal was awaited from Specialist Commissioning, following their commitment to provide this, and continued that if the situation was not resolved by start of the calendar year, arbitration may be required. SO also clarified that a provision for the full £3m was being held. KT confirmed his agreement with the approach being taken by SO.

AJ stressed that the £12m was non-recurrent, and acknowledged that this would not be helpful when explaining the Trust's financial position to the public.

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

- For the period covered, there was a variance between the establishment and the number of staff working, which reflected increased use of escalation beds, & increased sickness absence
- There had also been a significant rise in the level of medical and dental locum usage, which was related to the need to cover current pressures (rather than, for example, a high level of vacancies)
- The Trust was performing well with recruitment, and a report on this would be submitted to the TME and Workforce Committee in December

AB noted that she had recently returned from the Chief Nursing Officer's Summit 2014, and reported that the view among her counterparts was that additional overseas recruitment was inevitable. AB added she was aware that a number of local Trusts were intending to recruit nurses from the Philippines. AJ stated that he understood there were work permit issues for Filipino nurses. PB explained that this issue related to the need for such nurses to be registered with the Nursing and Midwifery Council (NMC) before being issued with a work permit. PB continued that the criteria for such registration was strict.

SD remarked that NMC had increased the criteria for the registration of indigenous nurses, in terms of the number of hours of nursing required. AB acknowledged the point, and noted this change was related to revalidation. AB added that this may cause problems with existing Trust nursing staff, particularly those working part time. The point was acknowledged.

AJ then asked SM to comment on performance in Infection Prevention and Control. SM duly reported the following:

- This was the Trust's longest period without a single case of Clostridium difficile, though 6 cases of avoidable infections had been reported to the TDA, following a recent request for such reporting to be made. SM stated that the TDA were now more interested in such cases, which related to a potential lapse in care, rather than in the total number of Clostridium difficile cases
- There had been no new cases of MRSA bacteraemia

- Standing Operating Procedures were now in place for Ebola, and staff had been trained in the use of Personal Protective Equipment, and handling specimens. „Walkthrough' training exercises had also been held.
- Public Health England were asking Trusts to hold patients with suspected Ebola until a negative result had been obtained, which could take up to 48 hours

AJ asked for an update on Norovirus. SM stated that there had been a flurry of cases, but nothing significant. SM added that an appropriate response was being given when cases were suspected, including cohorting patients.

Additional quality items

11-8 Clinical Quality and Patient Safety Report

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

- A Statutory Duty of Candour was being introduced, although the duty already existed as part of the contract with the CCG. The concept was not however new to the Trust and was part of the Serious Incident (SI) process, but the formalisation into statute meant that practise could now be audited, as discussions with patients had to be documented in the healthcare records, and a letter sent to patients. An audit was therefore planned in the future, and training would also be made available to staff.
- The report contained details of the Trust's performance on the national Cancer patient survey. The findings regarding privacy triangulated with other information, particularly the PLACE assessment, and it was acknowledged that a lot more attention needed to be paid to the matter, which was not just related to the physical environment.

GD reminded the Board that the Cancer survey included Cancer patients wherever they were treated in the Trust, and was not therefore just limited to treatment within the Kent Oncology Centre. AB added that the Cancer and Haematology Directorate was focused on responding to the findings, but in general, the survey was positive.

AJ commented that as a Tertiary Centre, the Trust should be performing better on the research-related survey questions. PS accepted that further work was required, but noted that efforts to increase research were being made. GD pointed out that the Trust did not generally perform well on research. AJ accepted the point, but opined that the Trust should strive to do better. GD agreed.

11-9 Response to the underlying issues involved in the 'patient story' that was heard at the Oct. 2014 Board

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

- The report incorporated AB and PS's reflections on the key aspect of the case
- It was important that the Trust had different Consultants at the weekend to those working during the week, as this was how services were able to operate. However, some of the comments made by weekend Consultants were unhelpful
- There was 7-day Outreach service in place, and there would soon be electronic trigger tools available, which would make a difference
- In May 2013, many of the junior medical staff were more junior than would ordinarily be the case, for reasons unrelated to the usual seasonal rotation
- There was 24-on call availability of Pharmacists, but it was acknowledged that the perception of this was different in the Wards
- Lessons had been learned from the handling of the complaint

SD asked why the patient was not admitted to the Royal Marsden Hospital. PS stated that he understood that the Royal Marsden were unwilling to accept the patient as an inpatient.

AJ asked PS to write to the patient's relative to inform them that the underlying issues had been subject to further reflection, and had been discussed by the Trust Board. PS agreed.

Action: Write to the patient relative that presented the 'patient story' that was heard at the October 2014 Board meeting to inform them that the underlying issues involved had been

subject to further reflection, and had been discussed by the Trust Board in November 2014 (Medical Director, November 2014 onwards)

11-10 Planned and actual ward staffing for October 2014

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

- The areas where the staffing levels were under plan included ICU, which was now a consistent trend. A review of the acuity of patients was now therefore warranted
- The under-plan staffing for Hedgehog Ward and MAU involved Clinical Support Workers (CSW). AB clarified that unless such staff could be engaged via the Bank, CSW vacancies would be filled by a Registered Nurse from the Bank, rather than by an agency CSW, as the latter was more expensive. AB also noted that Disclosure and Barring Service (DBS) checking for CSWs took a long time
- Overall performance, when compared to other Trusts was good

PS emphasised AB's latter point by relating to the staffing levels at Colchester Hospitals, and noted that an unannounced inspection by the Care Quality Commission had been prompted by a review of the staffing levels that had been reported to their Board.

AJ noted the variation in the engagement of CSWs across Wards, and asked for an explanation. AB explained that staffing was planned on a day to day basis, and sometimes shifts were intentionally staffed lower than Plan, if the patient acuity and dependence allowed for this. AB added that this would then enable Ward Managers to staff above planned levels when required.

AJ asked whether the reported rates for Ward 32 were checked, given that the 4 rates within the circulated report were at 100%. AB gave assurance that the data had been subject to validation.

AB also reported that the 35.5% "Average fill rate - care staff" for the "Intensive Treatment Unit (ITU)" should in fact be 53.5%.

11-11 Details of the extent of the cancer-related services provided by the local voluntary/third sector

PS referred to the circulated report and invited questions.

AJ asked about the role of Hospices. PS replied that in terms of the Hospices in the Weald area, there had been a drive to provide Hospice at Home care, which in turn had led to the promotion of patients being discharged home. PS added that there was very good liaison with the Hospices.

AJ then asked whether patients would always be given the option of Hospice / Hospice at Home care. AG replied that the referral was made via the CCG. PS added that he believed the system worked well, and he did not believe that Hospice capacity was a problem. AG added that patients' families often expressed a desire for Palliative Care patients to remain in hospital.

Board sub-committees

11-12 Charitable Funds Committee, 20/10/14 (incl. approval of the 2013/14 Ann. Report & Accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund)

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

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

11-13 Quality & Safety Committee, 12/11/14

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

PS noted that he was not at the meeting, but referred to the workforce challenges reported by the Children's Services Directorate, and gave assurance that work was taking place to address the issues.

11-14 Trust Management Executive, 19/11/14

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

AJ referred to recruitment of Consultants, and noted that there seemed to be difficulties. PB commented that there were some areas that had struggled to recruit, but this was not uniform. PS concurred, and added that after speaking to Medical Directors at other Trusts in Kent and Sussex, the Trust was doing relatively well, despite the national problems in workforce planning. PS elaborated that Foundation Training was being changed, to address shortages in specialties such as Psychiatry, which would adversely affect acute healthcare providers.

AJ commended creative solutions to the problems. PS accepted the point, and noted that such solutions were being encouraged, and indeed, proposed, though „traditional' solutions such as overseas recruitment were also being considered.

KT asked whether GD was able to update on progress with the Trust's clinical strategy. GD reported that an appointment had been made for a senior person to support the development of the Strategy, and the person would start in post in February. GD elaborated that the position was not a direct replacement for the previous Director of Strategy & Transformation, but would lead on some of the strategy issues. GD also noted that Jim Lusby was intending to start in March 2015, and the aforementioned new appointee would work for Mr Lusby. GD also noted that the intention was to consolidate the work undertaken thus far into a document, which would be issued in December, and form the basis of future discussions at the Board. GD added that he would also be discussing the Strategy when he attended the Kent HOSC on 28/11/14.

11-15 Audit and Governance Committee, 20/11/14

KT reported that the Committee had discussed the following points:

- The need for a Responsibility Assignment or RACI (Responsible, Accountable, Consult, Inform) matrix
- The risk management process
- Actions outstanding from Internal Audit reviews, and it was agreed that the Owners (and relevant Executive Directors) for the 3 "high" priority actions, should be invited to the February 2015 Audit and Governance Committee, to explain why the actions had not been completed (however, the invitation will be withdrawn if the actions were completed by mid-January 2015)
- A written report would be submitted to the next Board, in December

11-16 Finance Committee, 20/11/14

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

Assurance and policy

11-17 Approval of compliance oversight self-certification

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

- The compliance status was unchanged from the previous month
- Changes to the "Evidence of Trust compliance" from the previous month had been highlighted. The main point of note was the introduction of "fit and proper persons" Regulations

A discussion was then held regarding Board members being subject to DBS checking. AJ asked KR to consider the matter and make a recommendation to the Board as to whether the members of the Board should be subject to such checks. KR agreed.

Action: Make a recommendation to the Trust Board as to whether Board members should be subject to a Disclosure and Barring Service (DBS) check (Trust Secretary, November 2014 onwards)

The oversight self-certification was approved as circulated.

11-18 Ratification of Standing Fin. Instructions (ann. review)

SO referred to the circulated report and highlighted that the document had been reviewed at both the Audit and Governance Committee and Finance Committee on 20/11/14.

The Standing Financial Instructions were ratified as circulated.

11-19 Review & approval of the Board's Terms of Reference

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

ST asked why paragraph 23 and 24 had been removed. KR explained that in his view, the content of these paragraphs described the role of the Chief Executive in more detail than would be expected to appear in Terms of Reference for a Board. ST stated that he believed the paragraphs codified the respective roles of the Chief Executive and Board, and should be re-instated. This was agreed.

ST then referred to paragraph 29.6, and proposed that the TME not be a sub-committee of the Board. This was agreed.

KR pointed out that this latter decision would mean that the TME did not have a parent committee, and therefore its Terms of Reference would not require approval by the Trust Board. The point was acknowledged.

AB also pointed out that the TME was the Trust's nominated risk management committee. GD stated that this would not make a material difference, but in practise meant that he, as Chief Executive, was responsible for risk management, and chose to use the TME as the means by which he carried out this role.

It was however agreed that the Trust Board should continue to receive a written summary report from the TME.

The Terms of Reference were approved, subject to the amendments agreed.

Action: Amend the Board's Terms of Reference to reflect the agreements made at the Trust Board meeting held on 26/11/14 (Trust Secretary, November 2014 onwards)

11-20 To consider any other business

PS reported that Dr Andy Taylor, Anaesthetist would soon be departing to assist in the efforts against Ebola in Sierra Leone, but clarified that the costs would be covered by the Department for International Development.

PS also reported that the draft findings from the recent national A&E patient survey had been issued to the Trust. AJ noted that he had already made the Non-Executive Directors aware of the findings.

11-21 To receive any questions from members of the public

There were no questions.

11-22 To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted.

The motion was approved.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – December 2014

12-4 Log of outstanding actions from previous meetings — Chairman

Actions due and still 'open'

Ref.	Action	Person responsible	Deadline	Progress [1]
11-7 (Nov 14)	Liaise with councillor colleagues in Kent and East Sussex County Councils to assist in identifying a resolution to the current high levels of Delayed Transfers of Care seen at the Trust	Non-Executive Director (AK)	November 2014 onwards	A verbal update will be provided at the Board meeting
11-7 (Nov 14)	Arrange for the 'main' Quality & Safety Committee to receive assurance that there are plans for the appropriate level of Consultant Obstetrician cover to be in place, should the number of births at the Trust exceed 5000 p.a.	Medical Director / Chief Nurse	November 2014 onwards	This has been scheduled for the 'main' Quality & Safety Committee in January 2015

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
10-7 (Oct 14)	Arrange for the next meeting of the Workforce Committee to focus on the recruitment of substantive staff	Chair of Workforce Committee / Director of Workforce and Communications	December 2014	The Workforce Committee on 4th December 2014 discussed recruitment of substantive staff
11-4 (Nov 14)	Arrange for the Trust Board to have a detailed discussion on the recruitment of substantive staff	Trust Secretary / Director of Workforce and Communications	November 2014	A discussion has been scheduled for the December 2014 Trust Board meeting
11-6 (Nov 14)	Write to the Chairman of West Kent Clinical Commissioning Group suggesting that a joint meeting be held with the two organisation's Boards, in January 2015, to discuss (among other things) issues relating to	Chairman	November 2014	A letter was sent on 28/11/14

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	the recent additional winter funding			
11-9 (Nov 14)	Write to the patient relative that presented the 'patient story' that was heard at the October 2014 Board meeting to inform them that the underlying issues involved had been subject to further reflection, and had been discussed by the Trust Board in November 2014	Medical Director	December 2014	A letter has been sent
11-17 (Nov 14)	Make a recommendation to the Trust Board as to whether Board members should be subject to a Disclosure and Barring Service (DBS) check	Trust Secretary	December 2014	A recommendation has been submitted to the December 2014 Trust Board, for consideration
11-19 (Nov 14)	Amend the Board's Terms of Reference to reflect the agreements made at the Trust Board meeting held on 26/11/14	Trust Secretary	December 2014	The Terms of Reference have been amended (to re-instate the detailed references to the role of the Chief Executive, and to remove the Trust Management Executive from being a Board sub-committee)

Actions not yet due (and still 'open')

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - December 2014

12-6 Chief Executive's update Chief Executive

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

1. In December, I visited the Orthoptic and Ophthalmic departments, Short Stay Unit at Maidstone Hospital, and went to meet the staff providing the Stroke service and was very impressed by the imaginative way they are helping Stroke sufferers.
2. I recently attended a national conference entitled "The Future of Health". Keynote speeches were given by the Secretary of State for Health, Jeremy Hunt, and Shadow Secretary of State for Health Andy Burnham. The conference focused on how we continue to create a patient-centred NHS, develop integrated health and care, and deliver sustainable higher quality care in the future. I was struck by the closeness of both main parties' policy and philosophy.
3. We are continuing to see very low levels of patients developing Clostridium difficile in hospital. November saw no hospital acquired cases. Our year to date rate of infections is below the national average (13.3 cases/100,000 bed days against a national average of 15.7). This is a major achievement.
4. We have seen significant improvements in patient experience in this year's national Accident & Emergency patient survey. Seven out of 10 patients rated their experience in our A&E departments very highly which, while not completely reflective of the positive results we have seen in specific areas, shows the majority of people we treat have a positive experience.
5. We are preparing a submission in response an invitation to tender to provide the Minor Injuries Unit at Crowborough War Memorial Hospital in East Sussex with a view to enhancing the service and strengthening urgent care in the area. We are keen to take over the running of Crowborough Birthing Unit should that become an option, expanding the quality of care and birth choices for mothers in the north of East Sussex and south of West Kent.
6. We have agreed a £1 million investment to make improvements for patients and staff. This includes ward improvements to increase winter capacity, replacement patient meal trolleys, and 100 extra car parking spaces at Maidstone. This is addition to a £400,000 ward improvement scheme that we have just completed at Maidstone Hospital.
7. Our Patient Advice and Liaison Service (PALS) held open days at both Maidstone & Tunbridge Wells hospitals to increase accessibility of the service to both patients and visitors. Patients were reassured to know they could contact PALS if they had questions or concerns. We are passing on praise and addressing the improvements patients want to see to appointment running times, parking, signage and clarity of information on some of our leaflets.
8. Congratulations to our Midwives and Kangaroo Care Project Team whose project, „The effects of Kangaroo Care for women having an elective caesarean' has been shorted for an award within the Royal College of Midwives Annual Midwifery Awards for 2015.
9. Finally, on the afternoon of 21st January 2015, the Trust will be hosting the National Institute for Health and Care Excellence (NICE), who will be holding its public Board Meeting in the Academic Centre at Maidstone Hospital. NICE holds their Board meetings every other month in a different hospital/area in the UK. Prior to the Board meeting, there will be a "Question Time" session, to enable anyone to ask questions of NICE and its procedures.

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 - December 2014

12-7	Integrated Performance Report	Director of Workforce and Communications

Summary of the Month

Due to the early scheduling of the Trust Board, this month's report does not contain the usual supplementary financial information. However, the usual performance dashboard and charts are enclosed.

Overall, the performance was similar to the previous month.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 10/12/14
- Executive Team, 16/12/14

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

Discussion and scrutiny

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

TRUST PERFORMANCE DASHBOARD — **Position as at:** **30th November 2014**

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

Responsible Committee: Quality & Safety

Delivering or Exceeding Target	
Underachieving Target	
Failing Target	

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

	Patient Safety & Quality	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
'1-01	Hospital-level Mortality Indicator (SHMI)			101.26	100.3	-0.96	0.3	*100*		100
'1-02	Standardised Mortality (Relative Risk)			91.3	102.1	10.8	2.1	*100*		100
'1-03	Crude Mortality	1.2%	1.0%	1.2%	1.1%	-0.1%				
'1-04	Safety Thermometer % of Harm Free Care	96.7%	94.6%	94.8%	96.4%		1.4%	95.0%		0.0%
'1-05	*Rate C-Diff (Hospital only)	11.4	0.0	18.4	13.3	-5.1	-7.3	*15.7*	15.4	15.7
'1-06	Number of cases C.Difficile (Hospital)	2	0	27	20	-7.0	-11.0	*35*	35	35
'1-07	Number of cases MRSA (Hospital)	0	0	2	1	-1	0	*0*	1	
'1-08	Elective MRSA Screening	98.0%	99.5%	98.0%	98.0%		0.0%	98.0%	98.0%	
'1-09	% Non-Elective MRSA Screening	95.0%	96.0%	95.0%	95.0%		0.0%	95.0%	95.0%	
'1-10	**Rate of Hospital Pressure Ulcers	3.3	2.9	2.5	2.3	-0.2	-0.7	*3.0*	2.3	3.0
'1-11	****Rate of Total Patient Falls	6.9	6.79	7.4	6.1	-1.2	-0.6	6.75	6.1	
'1-12	****Rate of Total Patient Falls Maidstone	6.3	6.35	6.6	5.4	-1.2	-1.4	6.75	5.3	
'1-13	****Rate of Total Patient Falls Tunbridge Wells	7.3	6.97	8.0	6.7	-1.3	0.0	6.75	6.7	
'1-14	Falls - SIs in month		1		25	25				
'1-15	MSA Breaches	0	0	10	5	-5	5	0	5	
'1-16	Total No of SIs Open with MTW	22	10			-12				
'1-17	Number of New SIs in month	9	2	91	74	-17	-6			
'1-18	Number of Never Events	0	0	1	2	1	2	*0*	2	
'1-19	Number of CAS Alerts Overdue	7	0			-7	0	*0*		
'1-20	*****Readmissions <30 days: Emergency	11.6%	10.8%	10.9%	11.5%	0.7%	-2.1%	*13.6%*	11.5%	14.1%
'1-21	*****Readmissions <30 days: Elective	5.9%	6.8%	5.8%	5.5%	-0.2%	-0.8%	*6.3%*	5.5%	6.8%
'1-22	***Rate of New Complaints	6.3	3.08	5.0	4.03	-1.0	-2.23	*6.26*	4.11	6.26
'1-23	% complaints responded to within target	75.5%	66.7%	57.8%	66.4%	8.6%	-8.6%	75.0%	69.3%	
'1-24	IP Resp Rate Recmd to Friends & Family	20.5%	40.1%	16.6%	44.0%	27.4%	19.0%	25%	43.5%	37.6%
'1-25	A&E Resp Rate Recmd to Friends & Family	1.9%	20.0%	2.5%	17.6%	15.2%	2.6%	15%	18.2%	19.6%
'1-26	Mat Resp Rate Recmd to Friends & Family	New	19.3%	New	19.8%	New	-0.2%	15%	19.8%	21.3%
'1-27	IP Friends & Family (FFT) Score	74	78	75	77	2	4	73	77	73
'1-28	A&E Friends & Family (FFT) Score	82	67	61	64	3	9	55	64	55
'1-29	Maternity Combined Q1 to Q4 FFT Score	New	87	New	83	New	12	71	83	71
'1-30	Five Key Questions Local Patient Survey	92.0%	93.0%			1.0%		90%	93.0%	
'1-31	VTE Risk Assessment	95.0%	95.7%	95.2%	95.5%	0.3%	0.5%	95%	95.5%	95%
'1-32	% Dementia Screening	99.3%	98.8%	99.1%	98.9%	-0.2%	8.9%	90%	98.9%	
'1-33	% TIA with high risk treated <24hrs (Oct)	73.7%	90.0%	62.9%	72.1%			60%	72.1%	
'1-34	% spending 90% time on Stroke Ward (Oct)	59.3%	88.2%	72.8%	82.7%	9.9%	2.7%	80%	80.1%	
'1-35	Stroke:% to Stroke Unit <4hrs (Sept)	New	49.0%	New	39.8%	New	New	75.0%	75.0%	
'1-36	Stroke: % scanned <1hr of arrival (Sept)	New	39.2%	New	45.3%	New	New	43.0%	43.0%	
'1-37	Stroke:% assessed by Cons <24hrs (Sept)	New	78.4%	New	74.5%	New	New	85.0%	85.0%	

Responsible Committee: Finance, Treasury & Investment

	Finance & Efficiency	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Average LOS Elective	3.2	3.7	3.3	3.3	0.0	0.0	*3.3*	3.3	3.3
3-02	Average LOS Non-Elective	6.8	6.8	6.9	6.7	-0.2	1.0	*5.7*	6.5	5.7
3-03	New:FU Ratio	1.71	1.54	1.74	1.54	-0.19	0.02	*1.52*	1.52	
3-04	Day Case Rates	79.1%	83.2%	79.3%	83.4%	4.1%	3.4%	80.0%	80.0%	82.19%

	Finance & Efficiency	Latest Month *Plan*	Latest Month Curr Yr	Year to Date *Plan*	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan	Year End Forecast	Bench Mark
3-05	Income	30,735	32,442	255,201	262,448	5.9%	2.8%	380,581	396,247	
3-06	EBITDA	1,814	2,621	14,915	22,104	68.2%	48.2%	24,718	35,270	
3-07	Surplus (Deficit) against B/E Duty	(1,258)	(251)	(9,675)	(1,584)			(12,303)	5	
3-08	CIP Savings	2,009	2,470	13,993	15,974	47.5%	14.2%	22,400	23,213	
3-09	Cash Balance	11,124	4,497	11,124	4,497	109.0%	-59.6%	926	926	
3-10	Capital Expenditure	1,231	958	10,233	3,040	-49.3%	-70.3%	*13,516*	13,396	
3-11	**Monitor Continuity of Service Risk Rating**	New	3	2	3	New	1	2	2.5	

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

Responsible Committee: Finance, Treasury & Investment

	Performance & Activity	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	**Monitor Indicative Risk Rating**	**1.0**	**2.0**	**1.0**	**2.0**	**Amber/Red**		**Green**		
2-02	Emergency A&E 4hr Wait (SITREP Wks)	96.2%	93.1%	95.7%	94.7%	-1.0%	-0.3%	95%	95.0%	94.6%
2-03	Emergency A&E >12hr to Admission	0	0	0	1	1	1	0	1	
2-04	***Ambulance Handover Delays >30mins	New	No data	New	No data	New		365	0	
2-05	***Ambulance Handover Delays >60mins	New	0	New	0	New	0	0	0	
2-06	18 week RTT - admitted patients	91.1%	95.2%	92.1%	90.6%	-1.5%	0.6%	90%	90.0%	
2-07	18 week RTT - non admitted patients	97.1%	97.5%	96.5%	96.6%	0.1%	1.6%	95%	95.0%	
2-08	18 week RTT - Incomplete Pathways	93.6%	95.7%	93.6%	95.7%	2.1%	3.7%	92%	92.0%	
2-09	18 week RTT - Specialties not achieved	2	0	24	15	-9	15	*0*	15	
2-10	18 week RTT - 52wk Waiters	0	0	0	0	0	0	*0*	0	
2-11	18 week RTT - Backlog 18wk Waiters	872	347	872	347				250	
2-12	% Diagnostics Tests WTimes <6wks	100.0%	100.00%	100.0%	99.98%	0.0%	1.0%	99.0%	99.98%	
2-13	Cancer WTimes - Indicators achieved	8	7	9	8	-1	-1	9	8	
2-14	*Cancer two week wait	97.4%	96.8%	97.4%	96.1%	-1.3%	3.1%	93%	93.0%	95.5%
2-15	*Cancer two week wait-Breast Symptoms	97.3%	96.9%	97.3%	94.8%	-2.5%	1.8%	93%	93.0%	
2-16	*Cancer 31 day wait - First Treatment	99.6%	97.7%	99.6%	98.2%	-1.4%	2.2%	96%	96.0%	98.4%
2-17	*Cancer 62 day wait - First Definitive	84.7%	79.9%	84.7%	81.8%	-2.9%	-3.2%	85%	80.0%	87.1%
2-18	Delayed Transfers of Care	3.2%	5.3%	3.3%	4.2%	0.9%	0.7%	3.5%	3.5%	
2-19	Primary Referrals	7848	7,828	62872	68,769	9.4%	10.5%	93,129	102,950	
2-20	Cons to Cons Referrals	3521	3,211	29398	27,316	-7.1%	-3.6%	42,433	41,190	
2-21	First OP Activity	11560	12,712	92349	97,385	5.5%	6.8%	135,344	145,789	
2-22	Subsequent OP Activity	22353	22,363	174579	174,117	-0.3%	4.1%	250,125	260,660	
2-23	Elective IP Activity	805	686	6110	5,286	-13.5%	-20.0%	9,584	7,913	
2-24	Elective DC Activity	2829	3,391	23061	25,514	10.6%	-2.6%	38,602	38,196	
2-25	Non-Elective Activity	3728	3,959	30676	31,792	3.6%	4.7%	*45,404*	47,558	
2-26	A&E Attendances (Calendar Mth)	9712	10,925	84111	88,641	5.4%	6.0%	*125,139*	132,598	
2-27	Oncology Fractions	5718	5,656	45038	46,863	4.1%	3.3%	67,876	70,102	
2-28	No of Births (Mothers Delivered)	428	466	3,635	3,851	5.9%	8.8%	5,310	5,777	
2-29	Midwife to Birth Ratio	New	1:28	New	1:28	New	0.00	1.28	1:28	
2-30	C-Section Rate (elective & non-elective)	23.4%	29.4%	25.6%	27.1%	1.5%	2.1%	25.0%	25.0%	
2-31	% Mothers initiating breastfeeding	83.2%	80.0%	82.0%	81.7%	-0.3%	3.7%	78.0%	81.7%	
2-32	Intra partum stillbirths Rate (%)	0.2%	0.8%	0.4%	0.2%				0.2%	

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

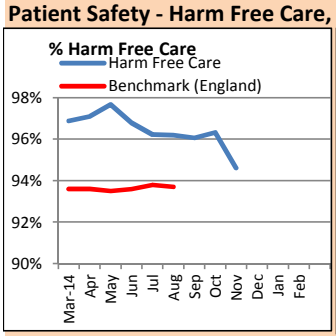
Responsible Committee: Workforce

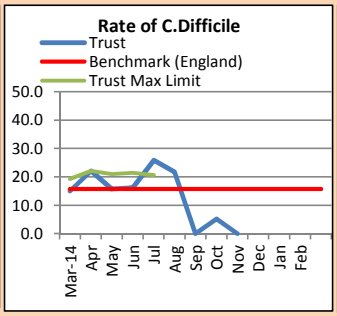
* Stroke & CWT run one mth behind, *** Ambulance Handover is unvalidated

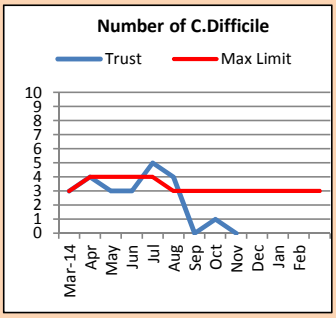
	Workforce	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ Limit	Year End Forecast	Bench Mark
4-01	Establishment (Budget WTE)	5,358.9	5,424.3	5,358.9	5,424.3	1.2%	0.0%	*5,480.3*	5,480.3	
4-02	Contracted WTE	4,950.6	4,941.7	4,950.6	4,941.7	-0.2%	-4.9%	*5,261.4*		
4-03	**Contracted not worked WTE		(106.2)		(106.2)					
4-04	Locum Staff (WTE)	21.6	18.1	21.6	18.1	-16.3%				
4-05	Bank Staff (WTE)	253.7	311.4	253.7	311.4	22.8%				
4-06	Agency Staff (WTE)	121.0	171.6	121.0	171.6	41.8%				
4-07	Overtime (WTE)	63.0	76.8	63.0	76.8	21.9%				
4-08	Worked Staff WTE	5,313.8	5,437.4	5,313.8	5,437.4	2.3%	-0.7%	*5,523.6*		
4-09	Vacancies WTE	408.3	482.5	408.3	482.5	18.2%			411.9	
4-10	Vacancy %	7.6%	8.9%	7.6%	8.9%	16.8%			7.5%	
4-11	Nurse Agency Spend	(299)	(440)	(2,771)	(3,090)	11.5%			(4,787)	
4-12	Medical Locum & Agency Spend	(730)	(775)	(5,471)	(6,269)	14.6%			(9,495)	
4-13	Staff Turnover Rate	10.8%	9.4%		9.44%	-1.4%	-1.1%	*10.5%*	9.44%	8.4%
4-14	Sickness Absence	4.2%	4.2%		3.9%	-0.1%	0.9%	*3.3%*	3.3%	3.7%
4-15	Statutory and Mandatory Training (Oct)	86.2%	84.7%		84.7%	-1.5%	-0.3%	85.0%	85.0%	
4-16	Appraisals	82.9%	75.1%	76.3%	75.1%	-7.8%	-14.9%	90.0%	90.0%	

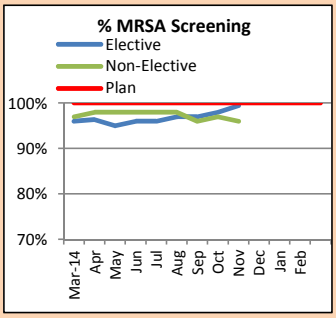
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

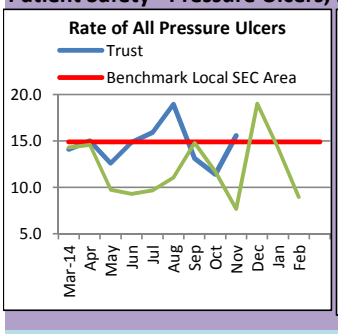


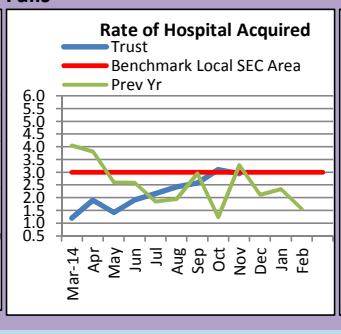


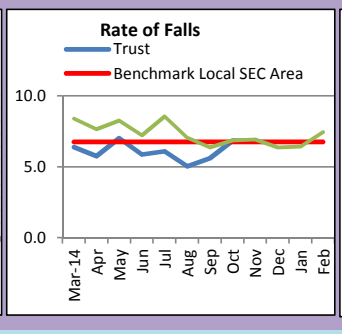


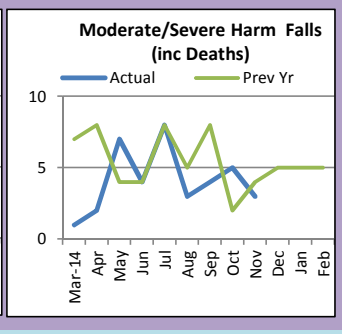


Patient Safety - Pressure Ulcers, Falls

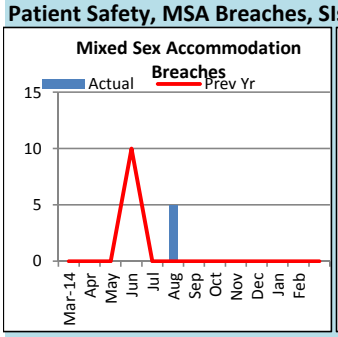


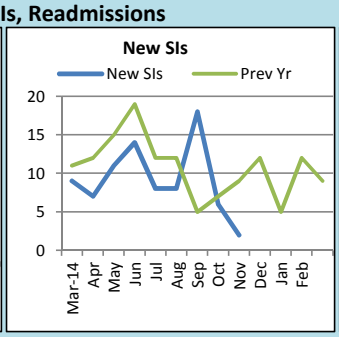


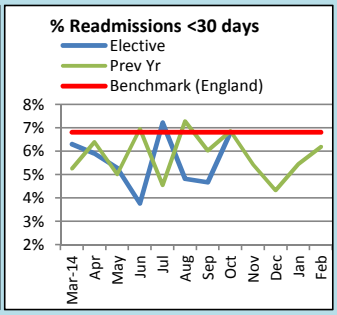


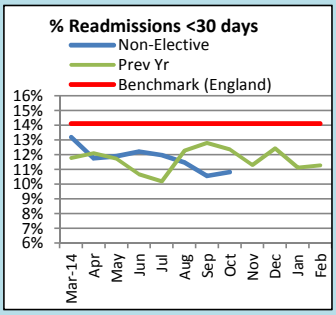


Patient Safety, MSA Breaches, SIs, Readmissions

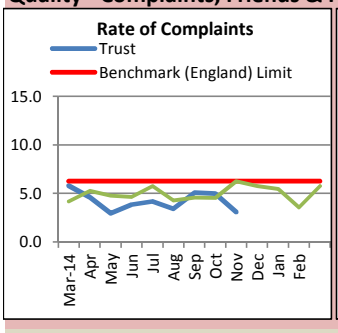


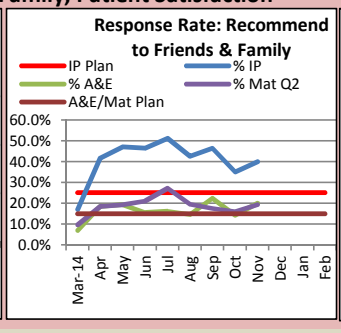


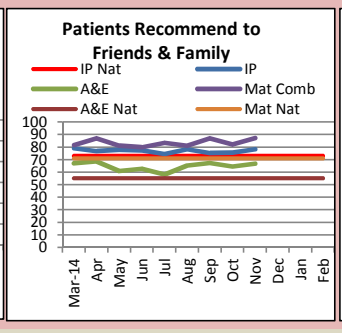


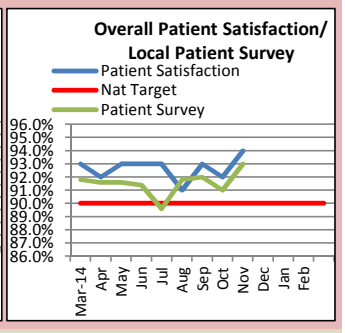


Quality - Complaints, Friends & Family, Patient Satisfaction

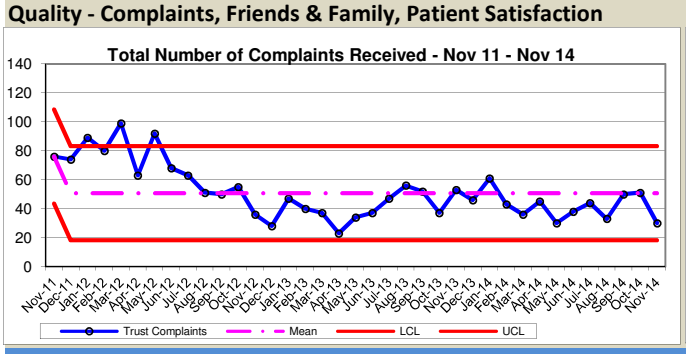


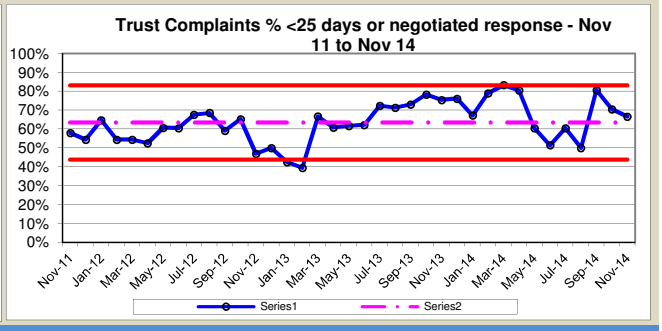




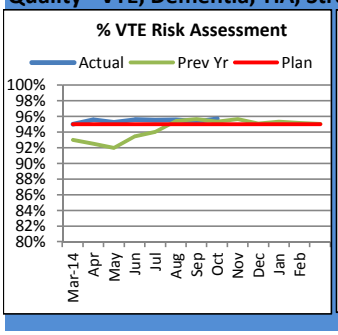


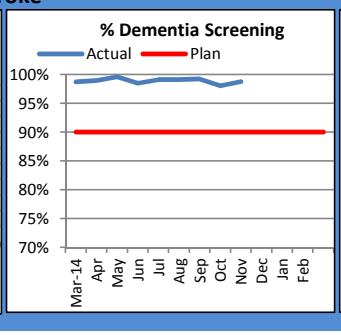
Quality - Complaints, Friends & Family, Patient Satisfaction

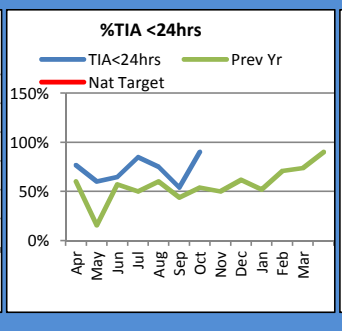


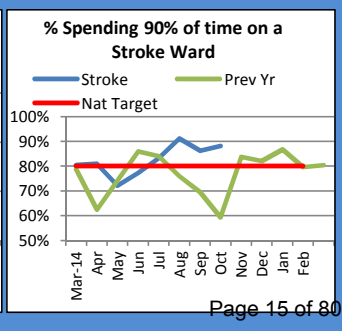


Quality - VTE, Dementia, TIA, Stroke



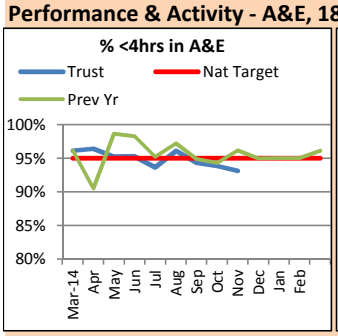


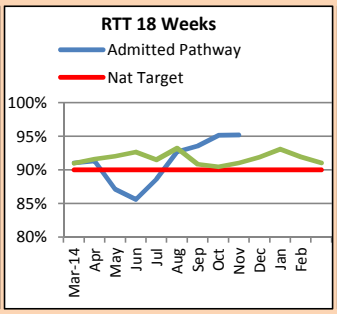


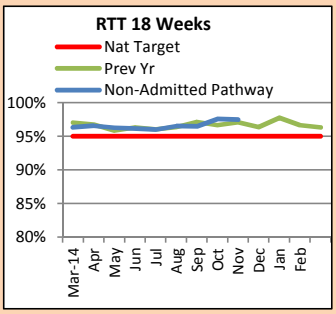


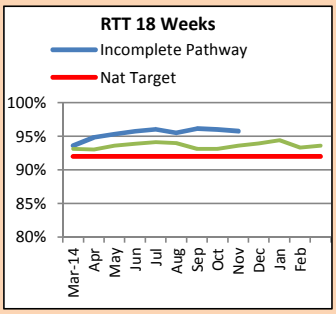
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

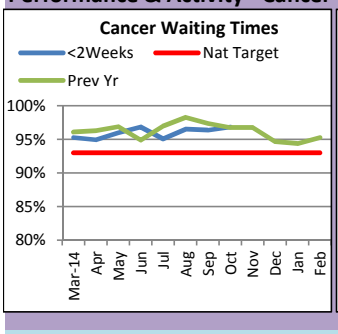


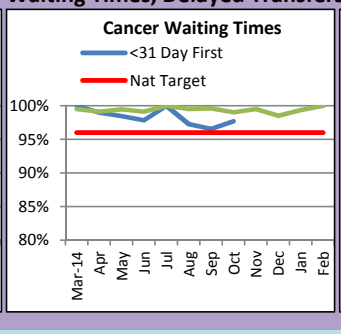


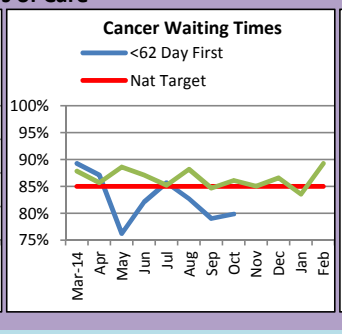


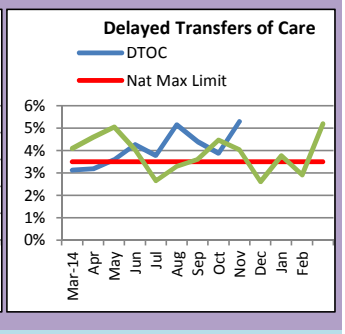


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

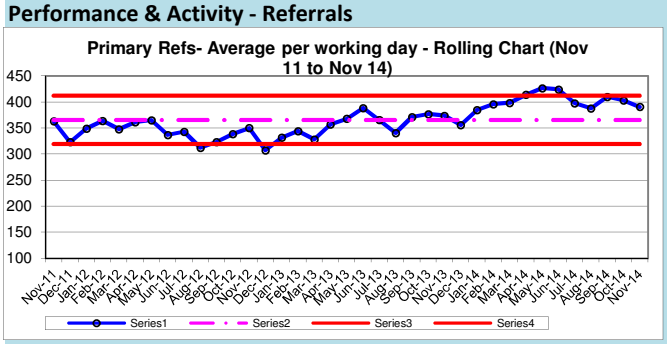


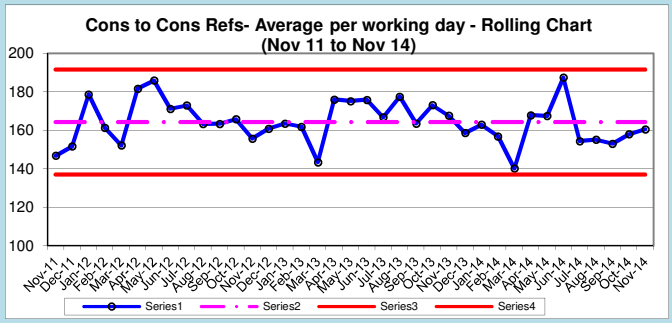




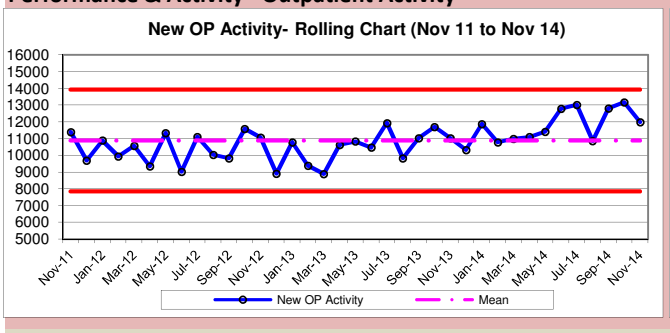


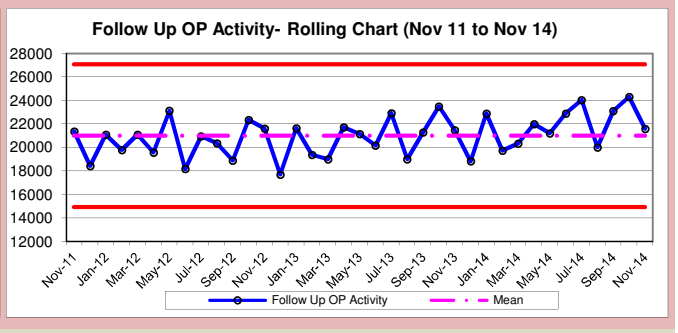
Performance & Activity - Referrals



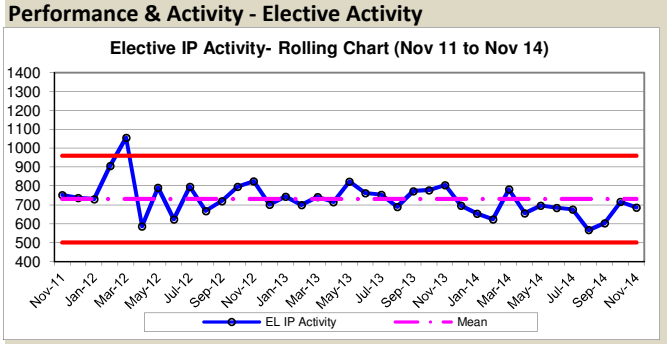


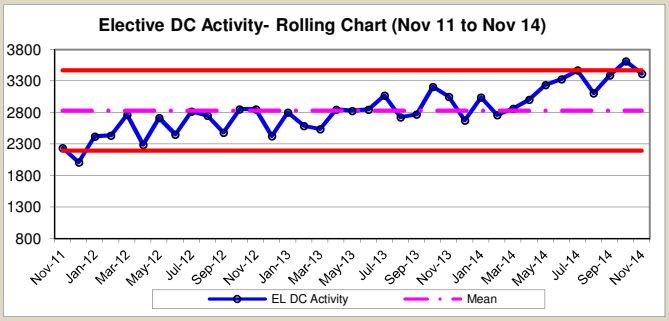
Performance & Activity - Outpatient Activity



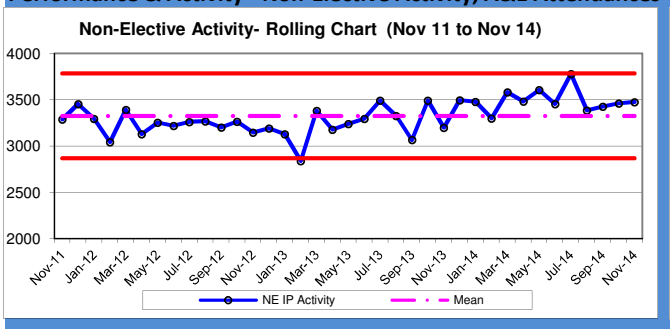


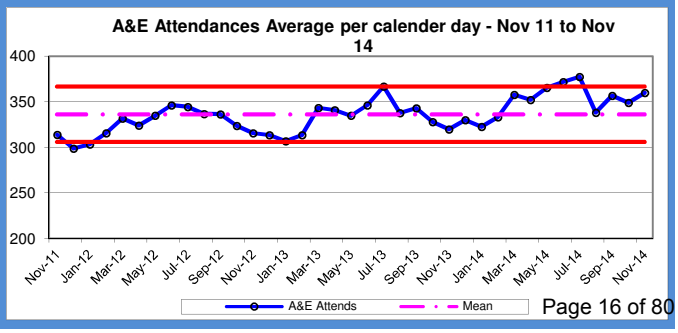
Performance & Activity - Elective Activity





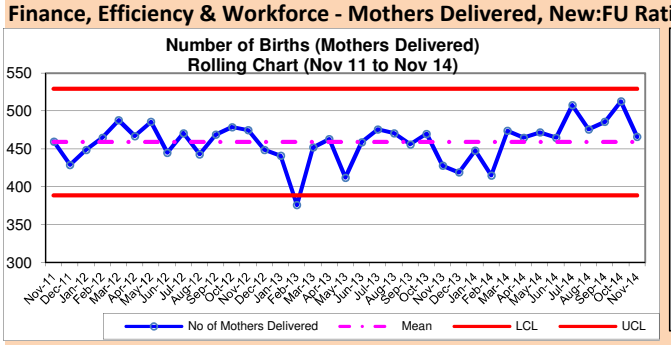
Performance & Activity - Non-Elective Activity, A&E Attendances

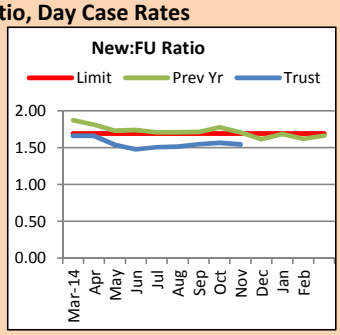


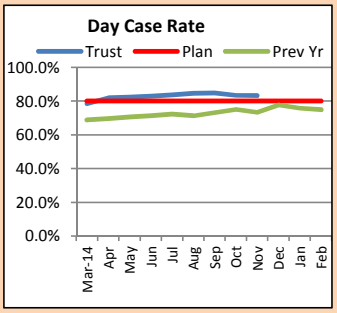


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

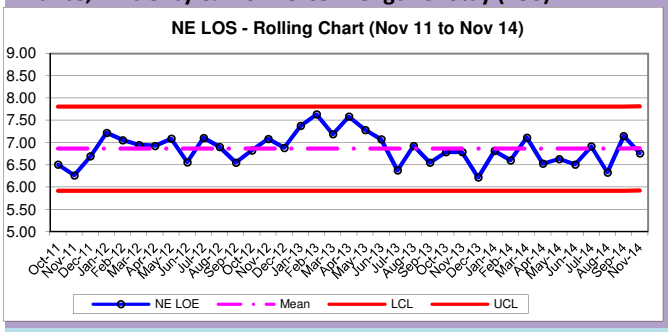
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

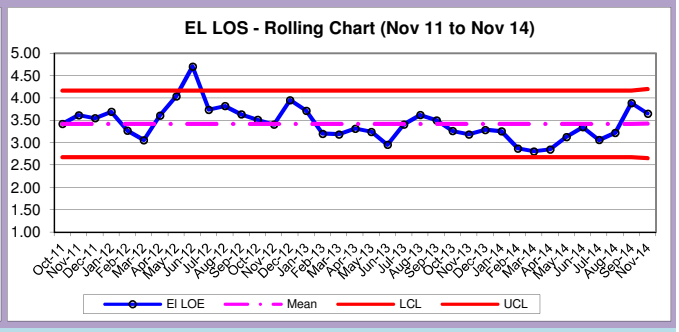




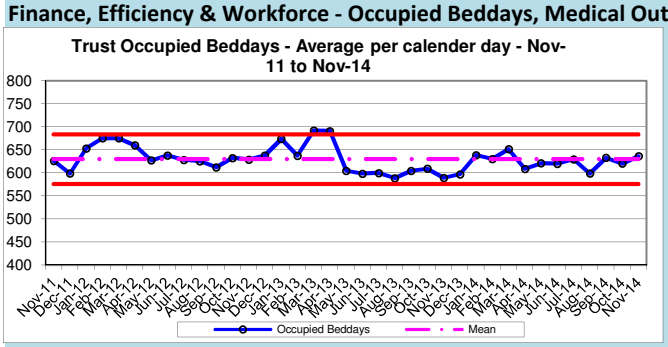


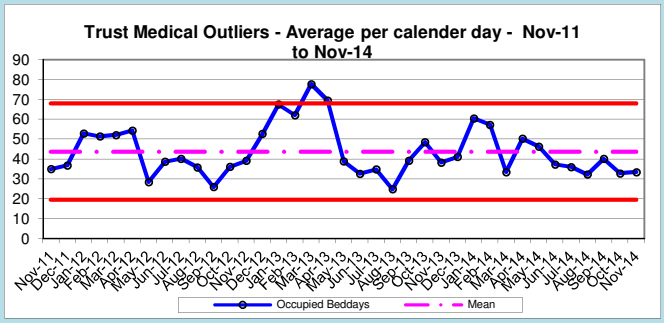
Finance, Efficiency & Workforce - Length of Stay (LOS)



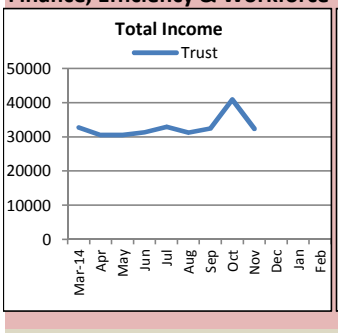


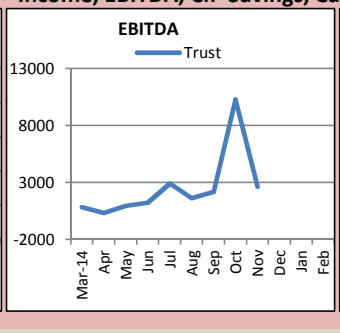
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

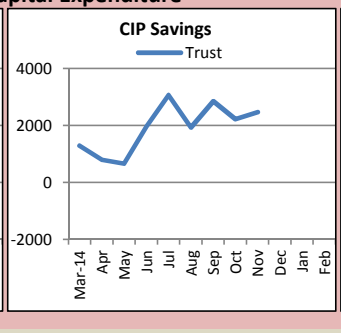


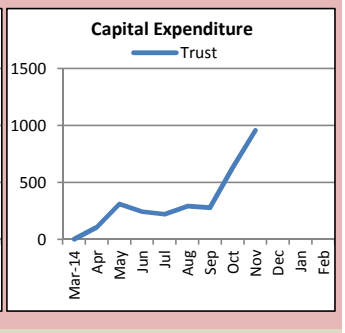


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

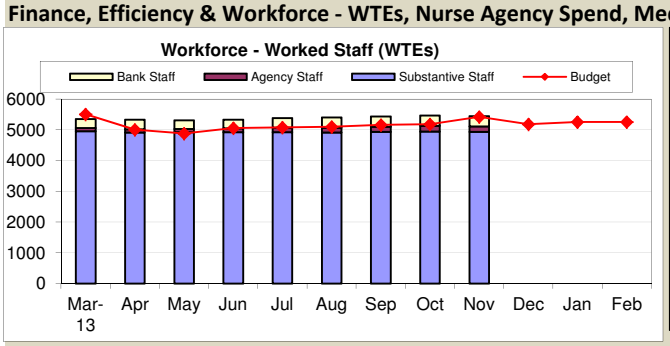


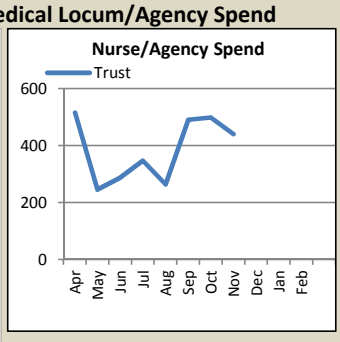


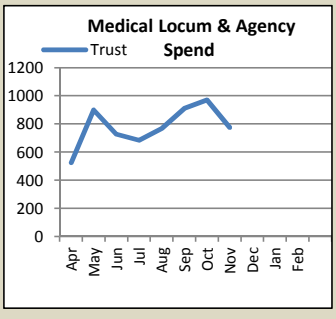




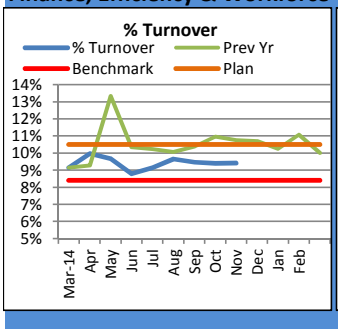
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

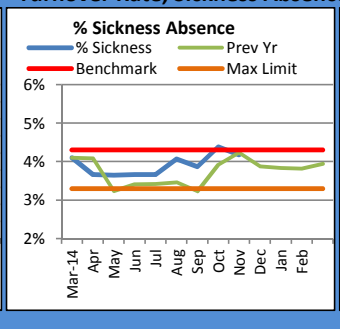


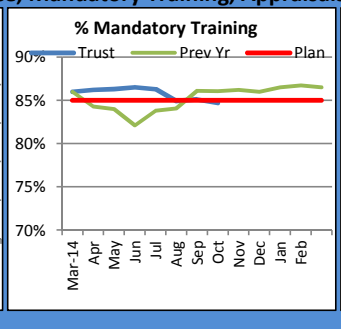


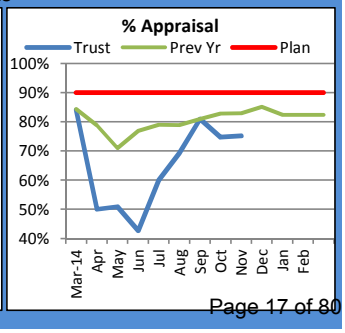


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Trust Board Meeting - December 2014

12-8 Performance recovery trajectories — Chief Operating Officer

Summary / Key points

The Trust's Performance Recovery Trajectories for Planned and Unscheduled Care are enclosed.

The trajectories have been submitted to the NHS Trust Development Authority (TDA), and will be used to monitor the Trust's performance through to the end of 2014/15.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 10/12/14

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

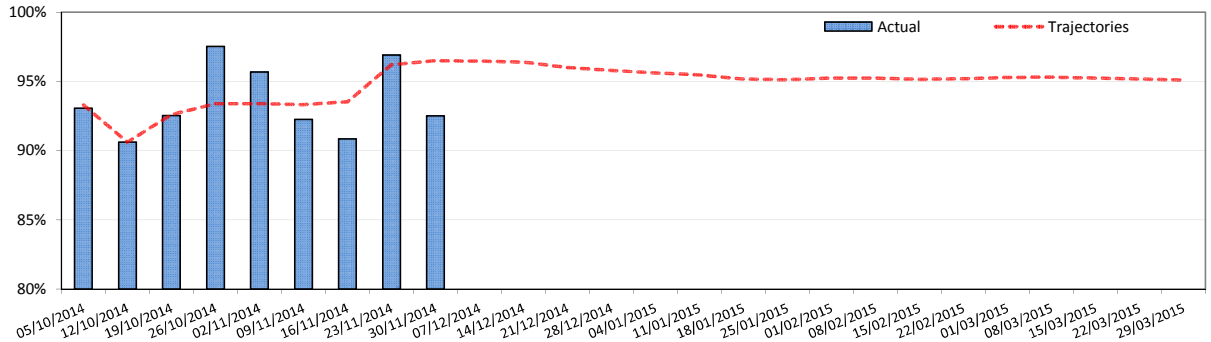
Planned and Unscheduled Care

Performance against submitted trajectories

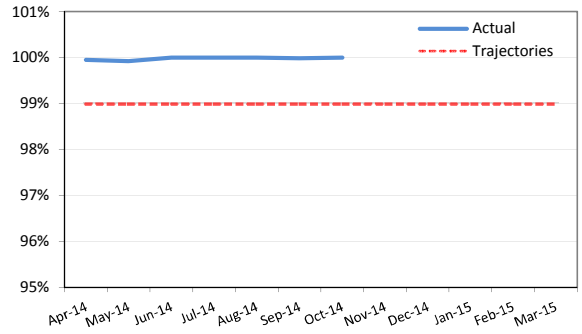
Maidstone and Tunbridge Wells NHS Trust

Trust YTD = 94.7%

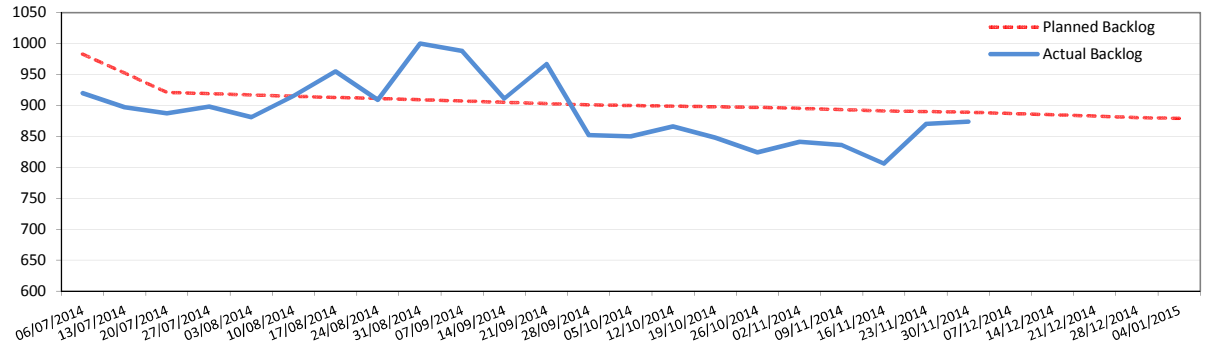
A&E Winter Projections



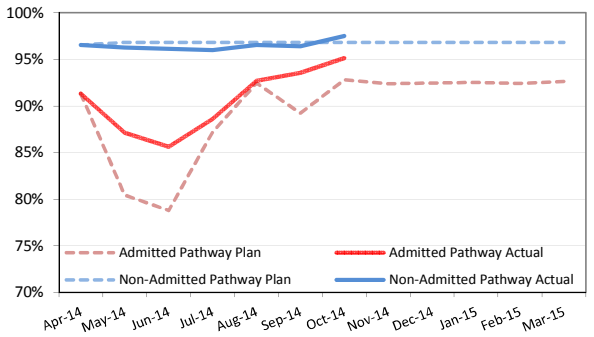
Diagnostic Waiting Times



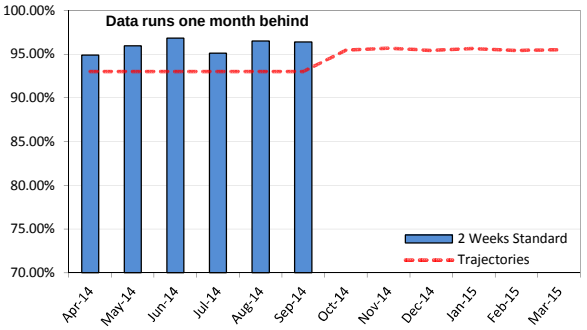
RTT Backlog



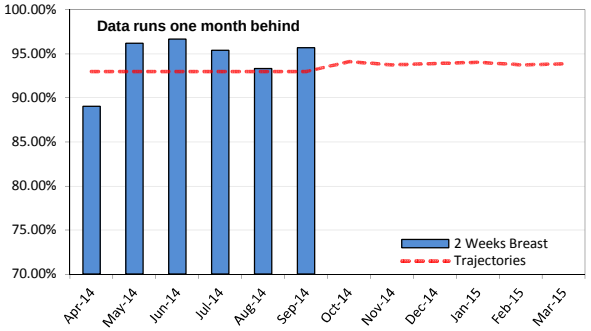
Referral to Treatment



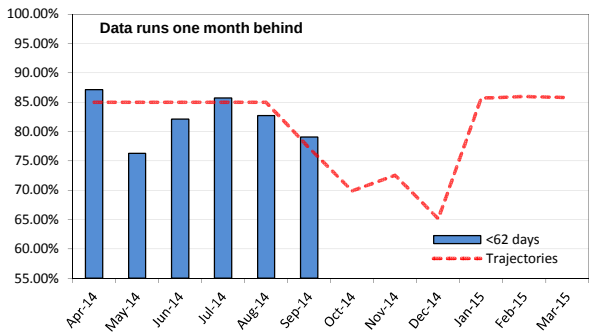
Cancer Waiting Times - % < 2 Weeks Standard



Cancer Waiting Times - % < 2 Weeks Breast



Cancer Waiting Times - 62 Days standard



Trust Board Meeting - December 2014

12-10 Safe Staffing: Planned V Actual – November 2014 Chief Nurse

Summary / Key points

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

This report provides an exception report to the Board based on the premise that any variance from plan that is less than 80% or greater than 110% requires further commentary.

Areas that fell below the planned numbers did so in a planned reactive manner.

ICU – Maidstone site: 70% fill rate for un-registered staff. This had no impact on direct patient care, as overall dependency for the Maidstone Unit during the month was below anticipated demand.

Where possible, and appropriate, staff were re-deployed to Tunbridge Wells ICU where acuity and dependency was higher.

ICU – Tunbridge Wells site: fill rate for un-registered staff was 53% for the night shift. This was acceptable and had minimal impact on direct patient care. RN fill rate was above plan by 4%. Whilst the unit was fully occupied many of the cases were routine post-operative care, requiring Level 2 care.

Hedgehog: Clinical Support Worker fill rate was 53% for day shift and 83% for night shift. The overall Registered Nurse (Child) fill was above plan at 122% and 111% for days and nights respectively. Key issues for decrease in fill rates relate to the need to escalate Woodland, which results in an overall dilution of support workers. The focus is kept on ensuring RN (Child) shifts are covered.

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

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

UMAU – increased requirement met for staff at night.

Surgical Short Stay/Day Unit (SDU) – TWH: This unit was used for escalation, primarily overnight.

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

Jonathan Saunders: increased requirement for clinical support workers, particularly at night for increased dependency. There was 16 nights where additional staff were required. All these patients are ‘named’ and had a matron level review of need.

John Day required additional Clinical Support Workers at night to manage a number of patients with increased dependency. These patients had significant confusional states, as well as geographical layout and location increasing risk for absconding as one bay has an emergency exist directly from the bay. This bay is not directly visible from the rest of the ward. This additional requirement was put in place following a matron level review of need.

Pye Oliver: Increased requirement for dependency with a significant number of medical patients requiring high levels of support with personal care. This additional requirement was subject to matron level review.

Mercer: increased dependency and risk of falls particularly at night. High number of patients with combined risk of falls and confusional state. High level of need for the delivery of personal hygiene needs during the night. Review of falls incidence data indicates that when falls occur on this ward, they tend to happen late in the evening or early in the morning. The staffing review indicated a need for an increase clinical support worker staff at night to meet mobility and toileting assistance needs. This is currently being addressed via the ward's business planning process.

Ward 20: required additional clinical support worker support at night due to a high number of confused/delirious patients prone to wandering. During the course of the month there were 28 days when there were 16 patients with cognitive impairment at high risk of falls and wandering. There were 7 additional patients for the 1st 6 nights of the month at increased risk of falls.

ASU – Tunbridge Wells site: increased dependency, 9 nights required additional Clinical Support Workers to special a patient with cognitive impairment. This requirement was subject to matron level review.

Ward 12: increased dependency; Clinical Support Workers required to special confused or high risk falls patients on 8 occasions overnight.

Ward 31 – the skill mix was altered here to reflect the current acuity and dependency of the patients on the ward. There were a number of days during the month where the skill mix was altered at night to ensure sufficient numbers of staff on duty. There were 7 occasions where a RN bank shift was not filled, and was covered by an experienced clinical support worker.

The enclosed Appendix gives the beakdown by ward.

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

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Assurance

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

Planned v Actual for November 2014

Hospital Site name	Ward name	Main 2 Specialties on each ward		Day		Night	
		Specialty 1	Specialty 2	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)
Maidstone District General Hospital - RWF03	Acute Stroke	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	99.2%	105.8%	100.0%	126.7%
Maidstone District General Hospital - RWF03	Romney	314 - REHABILITATION	300 - GENERAL MEDICINE	97.8%	97.8%	100.0%	95.0%
Maidstone District General Hospital - RWF03	Cornwallis	100 - GENERAL SURGERY	101 - UROLOGY	100.0%	110.0%	97.8%	100.0%
Maidstone District General Hospital - RWF03	Coronary Care Unit (CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	95.6%		100.0%	
Maidstone District General Hospital - RWF03	Culpepper	320 - CARDIOLOGY	300 - GENERAL MEDICINE	100.0%	100.0%	100.0%	100.0%
Maidstone District General Hospital - RWF03	Foster Clark	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	99.3%	116.7%	99.2%	105.0%
Maidstone District General Hospital - RWF03	Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		93.3%	70.0%	92.1%	
Maidstone District General Hospital - RWF03	John Day	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	88.0%	128.9%	97.8%	116.7%
Maidstone District General Hospital - RWF03	Jonathan Saunders	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	100.8%	126.7%	100.0%	160.0%
Maidstone District General Hospital - RWF03	Lord North	370 - MEDICAL ONCOLOGY	800 - CLINICAL ONCOLOGY	99.3%	100.0%	101.1%	100.0%
Maidstone District General Hospital - RWF03	Mercer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	93.5%	107.5%	93.5%	200.0%
Maidstone District General Hospital - RWF03	Pye Oliver	100 - GENERAL SURGERY	101 - UROLOGY	91.7%	146.7%	93.3%	116.7%
Maidstone District General Hospital - RWF03	Urgent Medical Ambulatory Unit (UMAU)	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	104.1%	97.3%	133.3%	200.0%
The Tunbridge Wells Hospital - RWFTW	Acute Stroke	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	98.9%	100.0%	100.0%	123.3%
The Tunbridge Wells Hospital - RWFTW	Coronary Care Unit (CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	100.0%	96.7%	98.9%	
The Tunbridge Wells Hospital - RWFTW	Gynaecology	502 - GYNAECOLOGY		101.7%	97.6%	103.3%	100.0%
The Tunbridge Wells Hospital - RWFTW	Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		101.7%	100.0%	104.2%	53.3%
The Tunbridge Wells Hospital - RWFTW	Medical Assessment Unit	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	101.0%	113.3%	100.6%	105.0%
The Tunbridge Wells Hospital - RWFTW	SDU	100 - GENERAL SURGERY	101 - UROLOGY	105.6%	113.3%	141.7%	143.3%
The Tunbridge Wells Hospital - RWFTW	Ward 32	110 - TRAUMA & ORTHOPAEDICS	100 - GENERAL SURGERY	98.3%	100.0%	103.3%	103.3%
The Tunbridge Wells Hospital - RWFTW	Ward 10	100 - GENERAL SURGERY		99.0%	100.8%	87.5%	100.0%
The Tunbridge Wells Hospital - RWFTW	Ward 11	100 - GENERAL SURGERY		101.9%	104.4%	97.5%	106.7%
The Tunbridge Wells Hospital - RWFTW	Ward 12	320 - CARDIOLOGY	301 - GASTROENTEROLOGY	91.0%	102.2%	89.1%	118.3%
The Tunbridge Wells Hospital - RWFTW	Ward 20	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	95.9%	115.8%	98.3%	170.0%
The Tunbridge Wells Hospital - RWFTW	Ward 21	340 - RESPIRATORY MEDICINE	302 - ENDOCRINOLOGY	111.0%	104.4%	108.7%	110.0%
The Tunbridge Wells Hospital - RWFTW	Ward 22	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	99.2%	112.9%	101.1%	109.7%
The Tunbridge Wells Hospital - RWFTW	Ward 30	110 - TRAUMA & ORTHOPAEDICS		88.0%	119.1%	92.5%	101.7%
The Tunbridge Wells Hospital - RWFTW	Ward 31	110 - TRAUMA & ORTHOPAEDICS		107.2%	77.3%	83.3%	108.9%
Tonbridge Cottage Hospital - RWF10	Stroke Rehab	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	97.1%	103.3%	100.0%	100.0%
The Tunbridge Wells Hospital - RWFTW	ante-natal	501 - OBSTETRICS		100.0%	93.3%	98.3%	90.0%
The Tunbridge Wells Hospital - RWFTW	delivery suite	501 - OBSTETRICS		97.8%	106.7%	94.1%	108.3%
The Tunbridge Wells Hospital - RWFTW	post-natal	501 - OBSTETRICS		103.6%	111.0%	100.0%	100.0%
The Tunbridge Wells Hospital - RWFTW	Gynae Triage	502 - GYNAECOLOGY		100.0%	96.7%	98.3%	100.0%
The Tunbridge Wells Hospital - RWFTW	Hedgehog	420 - PAEDIATRICS		122.2%	53.8%	111.7%	83.3%
Maidstone District General Hospital - RWF03	Birth Centre	501 - OBSTETRICS		100.0%	100.0%	100.0%	100.0%
The Tunbridge Wells Hospital - RWFTW	Neonatal Unit	420 - PAEDIATRICS		105.0%	83.3%	93.3%	110.0%
Maidstone District General Hospital - RWF03	MSSU	100 - GENERAL SURGERY		104.2%	110.0%	103.1%	

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – December 2014

12-11 Board members' ward visits (11/09/14 to 03/12/14) Trust Secretary

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

This quarterly report therefore provides details of the visits undertaken by Board Members between 11th September and 3rd December 2014 (the last report submitted to the Board, in September 2014, covered visits up to 10th September).

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

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

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [2]

Information, and to encourage Board members to continue to undertake quality assurance activity

[1] See "The Intelligent Board 2010: Patient Experience" and "The Health NHS Board 2013"

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

Ward visits undertaken by Board members, 11th September to 3rd December 2014

Board member	Areas registered as being visited (MH: Maidstone Hospital; TW: Tunbridge Wells Hospital)	Formal feedback provided?
Chairman	1. Ward 32 – Wells Suite, TW 2. ITU, MH 3. Kent Oncology Centre, MH 4. A&E, MH 5. A&E, TW 6. Main Reception, MH 7. Main Reception, TW 8. Theatres, TW 9. Chronic Pain Unit, MH 10. Short Stay Surgery Unit, MH 11. Pye Oliver, MH 12. Chartwell Suite, MH 13. Admissions Lounge, MH	No
Chief Executive	1. A&E, MH 2. Short Stay Surgery Unit, MH 3. Theatres, MH 4. Ophthalmic Theatres, MH 5. Ward 30, TW 6. Ward 31, TW 7. Chronic Pain Unit, MH 8. Orthoptics, MH 9. All wards at night, MH 10. All wards at night, TW	Yes
Chief Nurse	1. Tonbridge Cottage Hospital 2. ITU, MH 3. ITU, TW 4. Ward 32 - Wells Suite, TW 5. CCU, TW 6. A&E, TW 7. A&E, MH 8. Maternity, TW 9. Paeds, TW 10. Orthoptics/Optometry, MH 11. Ward 10, TW 12. Ward 11, TW 13. Ward 12, TW 14. Ward 20, TW 15. Ward 21, TW 16. Ward 22, TW 17. Ward 30, TW 18. Ward 31, TW	Yes
Chief Operating Officer	1. Gynaecology, TW 2. Midwifery department, TW	No
Director of Finance	-	-
Director of Infection Prevention and Control	-	-
Director of Workforce and Communications	1. A&E, MH	No
Medical Director	1. Chaucer, MH 2. ICU/HDU, MH 3. Short Stay Surgery Unit, MH 4. Theatres, MH	Yes

Board member	Areas registered as being visited (MH: Maidstone Hospital; TW: Tunbridge Wells Hospital)	Formal feedback provided?
	5. ICU/HDU, TW 6. Biochemistry, MH 7. Ophthalmic Theatres, MH 8. Haematology, MH	
Non-Executive Director (KT)	1. Short Stay Surgery Unit, MH 2. Theatres, MH 3. Biochemistry, MH 4. Ophthalmic Theatres, MH 5. Haematology, MH	No
Non-Executive Director (AK)	-	-
Non-Executive Director (SD)	-	-
Non-Executive Director (SDu)	1. Chaucer (x2), MH 2. Cornwallis (x2), MH 3. Eye Unit, MH 4. Pye Oliver (x2), MH 5. CCU, MH 6. Charles Dickens, MH 7. Culpepper Ward, MH 8. Foster Clark, MH 9. John Day, MH 10. Jon Saunders, MH 11. Mercer, MH 12. Dietetics, Therapies, MH 13. UMAU, MH 14. Whatman Ward, MH 15. Ward 11, TW 16. Ward 12, TW 17. Tissue Viability Nurse, MH	Yes
Non-Executive Director (ST)	-	-

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - December 2014

12-12	The recruitment of substantive staff	Director of Workforce and Communications

Summary / Key points

At the November 2014 Board, it was agreed to arrange for the Trust Board to have a detailed discussion on the recruitment of substantive staff.

The enclosed report (and accompanying presentation) was received at the Workforce Committee and Trust Management Executive in December, and is submitted to the Trust Board for completeness.

To supplement the enclosed, a brief presentation on options will be given at the Board meeting.

Which Committees have reviewed the information prior to Board submission?

- Workforce Committee, 04/12/14
- Trust Management Executive, 10/12/14

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

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

1.0 Introduction

1.1 The purpose of the paper is to outline options available to the Trust to reduce the dependence upon temporary staff by increasing effective recruitment and retention.

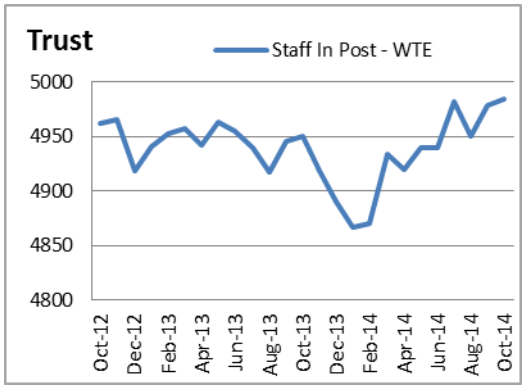
1.2 The paper focuses on the nursing and midwifery staff group for illustrative purposes, and because this is the largest group within the workforce and because this group has shown the greatest increase in establishment in recent times.

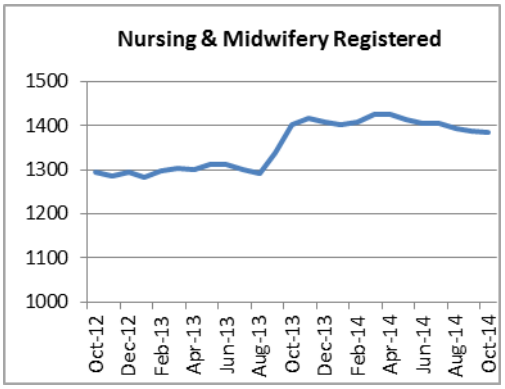
2.0 Present Position

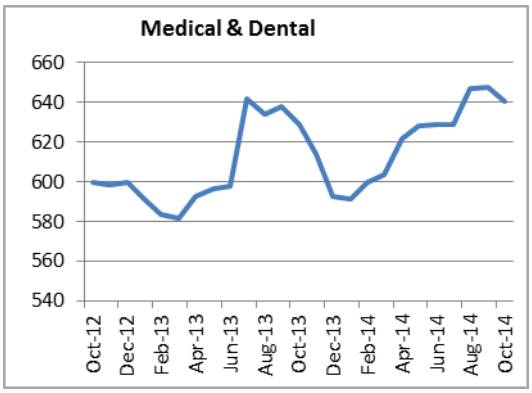
2.1 Understanding the size and shape of the current workforce is integral to understanding the recruitment situation.

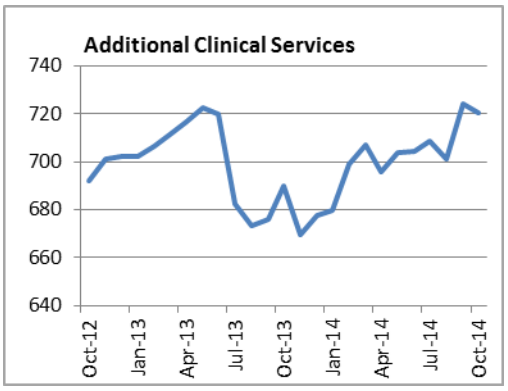
2.2 As at October 2014, excluding the temporary workforce, we employed 4,952.1 whole time equivalents (WTE). Including the temporary workforce we employed 5,453 WTE.

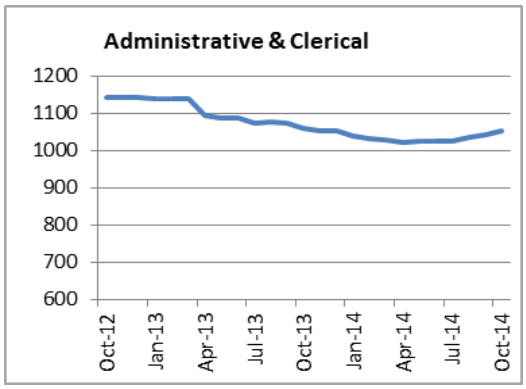
Staff in Post

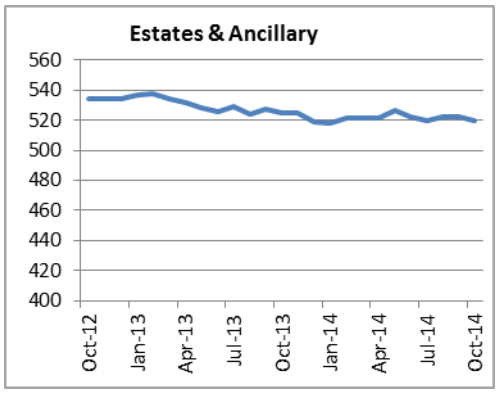


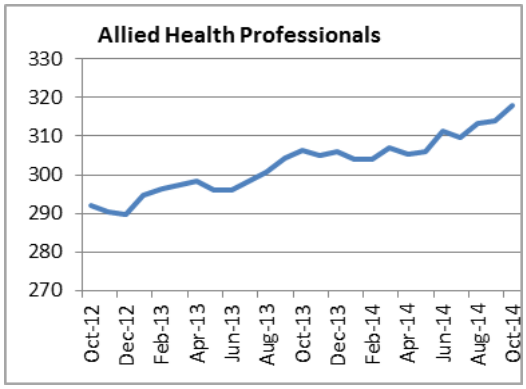


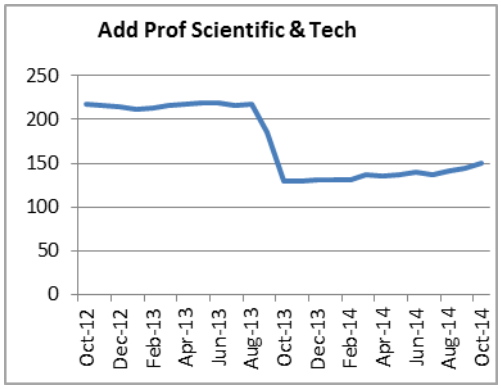


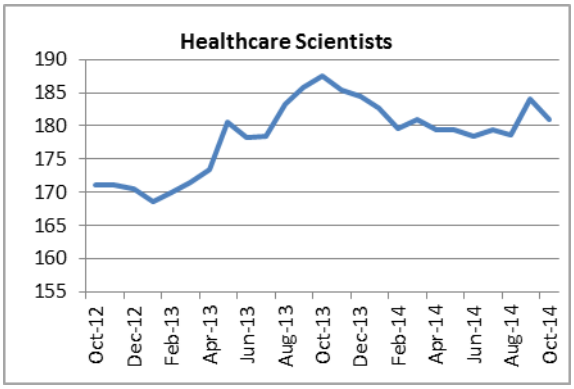












Vacancies

2.3 Currently the Trust has 469 vacant posts:

Staff Group	Establishment	Vacancy
Admin & Clerical / Senior Management	1,168	121
Medical	659	23
Nursing and Midwifery (registered and non-registered)	2104	195
Scientific, technical and therapeutic	932	64
Estates and Facilities Support staff	558	66
Total	**5,421**	**469**

2.4 41 of these are being held as non-recurrent CIPs purely in the back-office and this figure is likely to be considerably greater with decisions locally to hold posts as vacant and not actively recruit, following discussion at Execs these posts will be removed from the establishment permanently. This is consistent with the workforce plan which seeks to reduce the number of staff in admin and clerical, estates and facilities in order to protect front-line staff.

2.5 The recruitment and retention challenge is heightened through the dual impact of an increase in establishment (for example an increase of 61wte in establishment for registered nurses and midwifes between November 2013 and October 2014) and a reduction of staff in post (for example a 34wte decrease in registered nurse and midwifes for the same period).

3.0 Proposed Options

A) Reduce turnover

3.1 The national average turnover benchmark for registered nurses and midwifes is 12%. Currently MTW is running at 8%. However, a further 2 % reduction in turnover for registered nurses and midwifes (currently 8% to 6%) will reduce the need to recruit by 28wte.

3.2 Options to retain more include:

a. Introducing loyalty bonus payments/retention premium, so that on the anniversary of taking up a role as in the designated grades the member of staff receives a one off bonus of 5% of their annual basic salary, for a band 5 this would be circa £1,200. Therefore for Band 5 nurses and midwives this would equate to an annual cost of circa £1.4m. This does not represent the right return on investment or necessarily improve stability as a member of staff could receive the payment and then leave, I therefore do not recommend this but wanted to 'air' this with the committee for discussion.

b. Introducing a guaranteed set of benefits for those staff who stay for a set period. For example education and training investment, gym membership, holiday club, opportunity for a guaranteed sabbatical or greater work/life balance opportunities.

Loyalty would be rewarded which should enable turnover to be reduced. Furthermore some of the above initiatives may also impact on health and wellbeing, reduce absence rates and align to one of Simon Steven's objectives. More detailed analysis would need to be undertaken. However delivering corporate gym membership is likely to cost between £100-130k if true corporate membership is negotiated and purchased.

3.3 The development of online exit questionnaires and induction questionnaires for new starters will enable greater and timelier analysis for the drivers of turnover and areas where expectations are not met by staff group and geographical area. These will be available from January 2015 although an online temporary exit questionnaire is currently in operation.

B) Improve recruitment

3.4 Analysis shows that in order to eradicate the current nursing and midwifery vacancy levels (registered and non-registered) and take account of turnover the trust would need to recruit approximately 300wte. To deliver this level of recruitment, even with greater use of social media and recruitment campaigns, the national shortage of registered nurses being experienced across the UK necessitates greater creativity and tenacity than has hitherto been exercised. Whilst our vacancy rate is not an outlier in the market, the quality and cost of temporary staff to the organisation means that the requirement to recruit substantively is compelling.

a. Pay a signing on bonus for new recruits i.e. a traditional golden handshake. Therefore payment of £1200 per new recruit for the above 300wte nursing and midwifery would equate to a cost of £360k (300 new starters multiplied by £1200). If the payment was able to reduce our vacancy level by 25%, which in turn reduced our dependence upon temporary staff by 25%, achieving a saving of circa £150k per month and £1.8m full year. The inherent risk is that existing staff are aggrieved, leave and return thereby incurring greater cost to the organisation, and secondly that the reduction in vacant posts does not lead to a reduction in the usage of temporary staff.

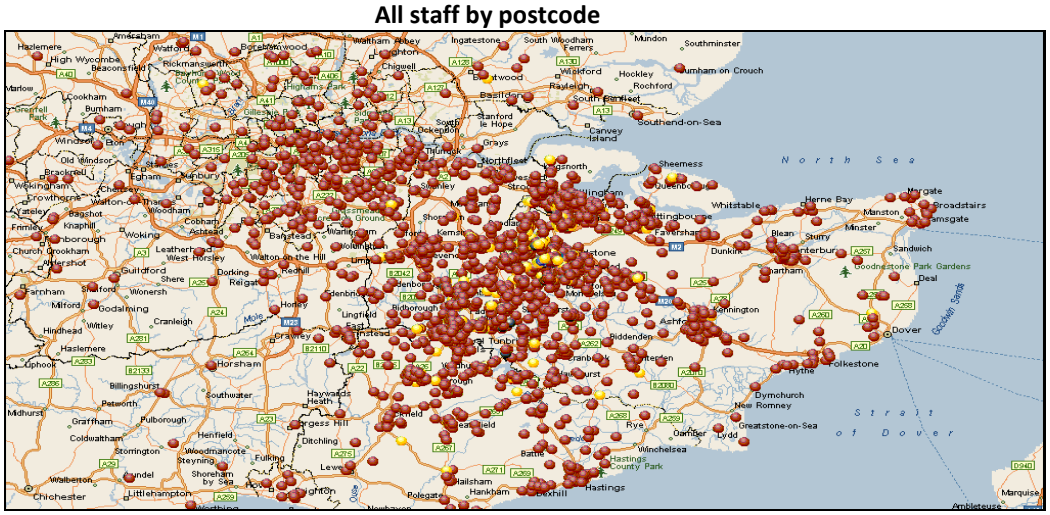
b. Speed up recruitment. Time from vacancy through interview to member of registered staff commencing in post varies enormously from 9 weeks to 35 weeks with the average running at 18.5 weeks. If we could standardise to 16 weeks this would reduce the dependence on temporary staff.

c. Increasing availability of residential accommodation for new recruits. At present there is very limited residential accommodation available for staff. Anecdotal evidence has suggested that offering this either subsidised or not may help to attract and retain staff. Having available, subsidised and nice residential

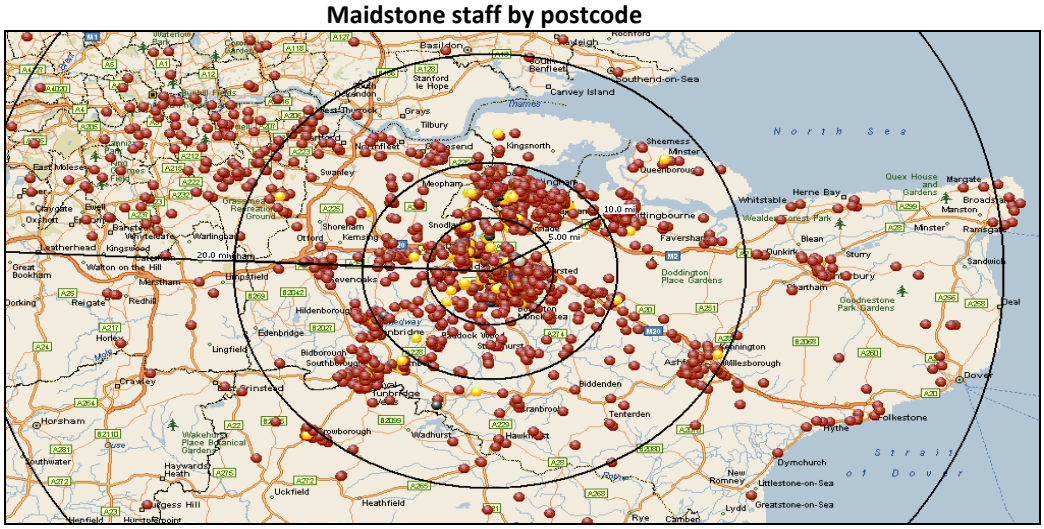
accommodation is key in attracting staff from wider geographical areas and especially overseas campaigns.

d. Local target recruitment. Our data suggests that 40% of our staff live within 5 miles of our hospitals.

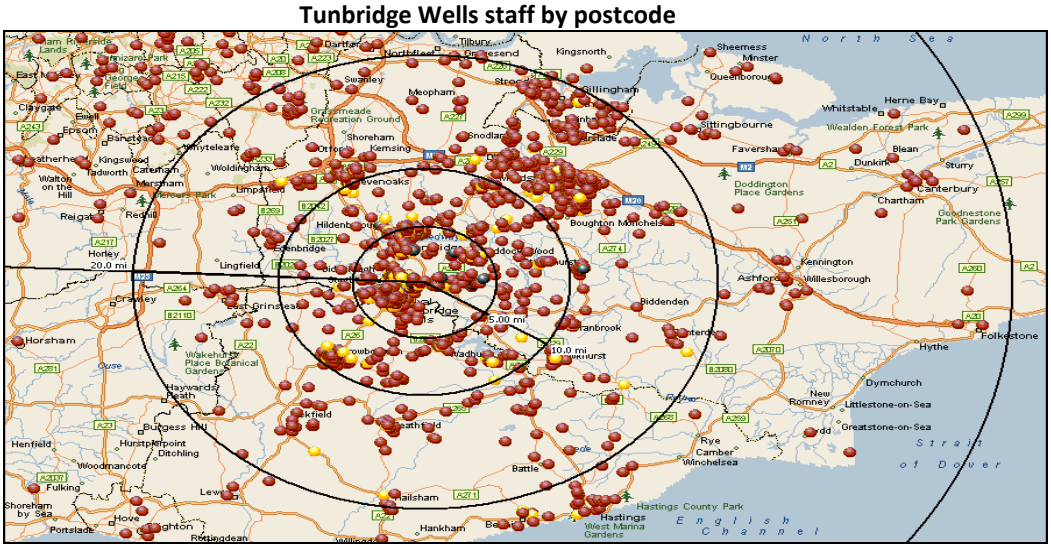
All staff by postcode



Maidstone staff by postcode



Tunbridge Wells staff by postcode



We have had recent success with a local job fair for nursing staff and plan to run similar initiatives throughout next year to attract staff and capitalise naturally on our current neighbour's situation.

We can buy the NMC register as a marketing tool and send a personal note to each registered nurse with a postcode within 20 miles distance of the hospitals. This personal approach and an invitation to the hospital to meet key personnel may appeal to people at various stages of their career.

e. Provision of iPads to our students and bursary of £1,000. We are seeking to encourage more students to train with us and develop our reputation locally as the place that supports students. The bursary would only have to be paid back if the individual did not pursue a career with us once qualified. We would guarantee substantive employment with all students who are provided a bursary by the Trust.

f. Guaranteed employment to anyone who is a student with us. We provide multiple placements for students each year. We should guarantee them a job when they complete their studies subject to successful registration with the NMC. This may be an area where we pay the MTW golden hello.

g. Scheduled nurse interviews. It is proposed that authority to appoint be given to a matron on a weekly rotational basis and that each Tuesday and Thursday the trust run drop in interviews where subject to reference and health clearance the person would complete their application, be interviewed and leave the Trust knowing if they had been offered a job or not, this recruitment would be undertaken following a national campaign for registered nurses and a local campaign for Clinical Support Workers.

C) Increase uptake of bank shifts

a. Pay bank shifts undertaken by substantive staff at their grade and pay point. Analysis shows that for a given month more staff would receive an increase and the overall amount paid by the Trust would actually reduce. A consideration would need to be given to whether we implemented a hybrid approach and offered mid-point as routine but for staff whose substantive point is above midpoint their actual pay point. This would increase the overall cost but initial analysis suggest the increase is marginal

b. Increase hourly rate to create a fringe/regional weighting to combat the 'inner and outer' Agenda for Change weighting. Analysis shows that London Trusts are paying more favourably and therefore in order to attract more local temporary workers to sign up to our bank, and even consider a substantive career with the Trust, we should consider such a radical rethink.

c. Introduce a loyalty bonus payment for bank staff, so that on the anniversary of completing X number of shifts within a window the member of staff receives a one off bonus of £500 and for substantive staff potentially more, subject to debate in the committee this will be modelled and the case for implementation produced.

D) Reduce Sickness

a. Decrease the demand for temporary staffing by reducing the sickness absence rate. At present sickness absence rates for registered nurse and midwives is 4.7% which costs £190k per month, based on like for like back fill, this would and does increase if the backfill is provided by more expensive agency staff. A 1% reduction in this level to 3.7%, near the 2011/12 levels would achieve a saving of circa £50k per month. However the benchmark average sickness absence for England and Wales is currently 6%.

3.5 The above have been discussed with the executive team and following the debate with the workforce committee the full working up of the benefits and cost of each proposal it is proposed that the ideas be tested with a demographically representative sample of our workforce through the use of focus groups. This will have the benefit of testing what we feel may work with the people who would be affected, as well as managing the message that the Trust is looking creatively at the area of recruitment and temporary staffing.

4.0 Recruitment Plan

4.1 The recruitment plan for the Trust aims to go beyond the normal day to day 'business as usual' recruitment to a more structured and proactive recruitment strategy which is more aggressive in order to reduce the number of vacancies. It should be noted that we will incur additional expenses through adverting and the dedicated staff responsible for recruitment albeit this will be offset by the reduction in use of expensive temporary staffing. It is common knowledge that the market is very competitive at present for certain staff groups and professions, in particular registered nurses.

4.2 A 12 month recruitment plan by staff group has been developed for the year ahead which will continually be revised and reviewed, and performance managed against.

4.3 The summary plan for nursing and midwifery, which has been shaped and developed in conjunction with the Deputy Chief Nurse, provides a monthly target of at least 30 nurses in order to reduce the vacancy rate and effectively consume turnover, this would deliver a gross recruitment of 360 nursing staff for the year, which if successful would eradicate all vacancies and enable turnover of 8%, assuming no increase to the establishment.

4.4 The plan lists and schedules the additional initiatives that will be undertaken in the year in order to provide us with a constant pipeline of nurses coming through the system through a number of different routes, rather than rely on one source. This also has the benefit of ensuring the Trust has a good presence in the health economy and that the 'brand' remains in the minds of potential candidates and applicants throughout the year rather than just one specific campaign, which has been the traditional approach.

4.5 The Trust will attend relevant Job fairs and Recruitment Fairs. The events will vary from specific events for specific staff group's e.g. cardiac nurses or Trust wide.

4.6 Overseas campaigns are also being scheduled for next year, with a greater geographical reach than Europe. The most appropriate countries are being identified and work permit and professional registration issues being addressed.

4.7 The Trust will run regular assessment centres to enable potential candidates, responding to continuous generic adverts for areas such as nursing, can respond and attend assessment testing and be appointed if successful on the day.

4.8 The Trust is committed to hosting recruitment Open Days for Nursing and/or other hard to recruit areas. These will be advertised ahead of the events both in local and national press as well as various social media platforms. Events will include the opportunity to for potential applicants to visit wards and departments on the day as well as undergo assessment to speed up recruitment. The recent Open day has resulted in 19 conditional employment offers being made.

5.0 Conclusion

5.1 The need to reduce dependence upon temporary staffing through the measures identified above is an integrated package, albeit that not all the measures need to be enacted.

5.2 The discussion at TME will inform the debate on this issues concluding with the Board in December.

Paul Bentley, Director of Workforce and Communications
December 2014

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - December 2014

12-13 Business planning **Director of Finance**

Summary / Key points

The enclosed report provides an update on the progress of the business planning process and includes the key milestones.

The directorates are in the process of developing their Business Plans for 2015/16, which explicitly include the need for them to triangulate workforce, finance and activity/capacity and demand.

Review support meetings have been held between each Directorate and the members of the Business Planning Group.

Executive challenge meetings have been scheduled between 10 and 22 December to ensure that plans are on track.

It is anticipated that an initial headline plan submission will be required for the NHS Trust Development Authority (TDA) on 13 January 2015, followed by the draft Business Plan for 2015/16 on 27 February and the final submission on 10 April.

In the light of the headline plan submission being required before the January 2015 Board meeting (and Finance Committee), the Board is asked to delegate the authority to finalise and approve the submission to the Chief Executive.

Which Committees have reviewed the information prior to Board submission?

- N/A (though the Finance Committee has received regular updates on the process at recent meetings)

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

1. Information and assurance; and
2. To authorise the Chief Executive to finalise and approve the initial headline plan submission for 2015/16 (which is required to be submitted to the NHS TDA by 13th January)

[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

Business Planning – 2015/16 and 2016/17

Introduction

A paper was submitted to the August Finance Committee that outlined the purpose, governance arrangements and an overview of the process with a high level timetable.

Current status

The Business Planning Group (BPG) has issued the guidance and the template that is to be completed by all clinical directorates and corporate departments.

The Directorates have also received relevant guidance and template to enable them to develop their capacity/demand plan, workforce plan, revenue (resource limit) plan (including the CIP target for 15/16 of 8%) and their capital plan. As part of the planning process we are triangulating workforce, finance and activity / capacity and demand.

The Directorates have been actively supported by a clearly defined structure of functional expertise that is specifically for their use in the construction of the plan. This is further enhanced by the BPG providing corporate consistency and direction during the development of their 2015/16 plans.

Support/review progress meetings have been held between each Directorate and the BPG regarding the draft Business Plan for 2015/16.

Next steps

Review meetings between each Directorate and the Executive team have been planned for the period between 10 and 22 December to ensure that plans are on track.

The NHS Planning timetable for 2015/16 has been issued (see Appendix 1). The key dates were already built into the key milestones as shown below, bar number 10 which is new. An early understanding of the specific requirements of the TDA are being sought to enable relevant planning, particularly regarding the expectations for 2016/17.

Key milestones

	What	Who	When
1	Status report to Finance Committee	S Orpin Finance Committee	Mid December
2	Executive challenge session	Directorate team Executive team	December (before Christmas)
3	Review of 'Initial headline plan' submission (for 15/16) ahead of submitting to TDA	Trust Board TME	Early January
4	'Initial headline plan' submission to TDA (for 15/16)	S Orpin	13 January (tbc)
5	Status report to Finance Committee	S Orpin Finance Committee	Mid-January
6	Status report to TME	Clinical Directors TME	Mid-January
7	Further iterations of Business plans (for 15/16 and 16/17)	Directorates Support depts	January to mid February
8	Status report to Finance Committee	S Orpin Finance Committee	Mid February
9	Executive challenge session	Directorate team	Mid-late February

	What	Who	When
		Executive team	
10	Draft full Business plan (for 15/16) submission to TDA*	S Orpin	27 February (tbc)
11	Review of draft Business Plan (for 15/16 and 16/17)	Trust Board	End February
13	Status report to Finance Committee	S Orpin	Mid-March
14	Final Business Plans reviewed	TME	Mid-March
15	Final Business Plans signed off	Directorate team Executive team	Mid-End March
16	Final Business Plans approved	Trust Board TME	By 31 March
17	Final submission to TDA (for 15/16)	S Orpin	10 April (tbc)

The Finance Committee are asked to consider, and thereby recommend to the Trust Board, how the Board have the opportunity to review the 'Initial headline plan' submission to be made to the TDA on 13 January 2015, and whether to recommend that the Board take the same opportunity ahead of the subsequent draft full Business Plan (for 15/16) to be made on 27 February.

Risks

The Business Planning Group have identified the following risks

- Ability to achieve the required 8% CIP target, particularly for Directorates who have very little income
- Impact on demand as a result of demand management intentions from West Kent Clinical Commissioning Group (CCG)
- Ability to fund capital requirements for replacement equipment

Mike Court

Interim Assistant Director of Strategy 9 December 2014

Appendix 1 - NHS Planning Timetable for 2015/16

By 1 Nov 2014	NHS England and CCG Commissioning Intentions provided to Trusts
By 23 Dec 2014	Publication of Final 2015/16 Planning Guidance, including provisional tariff assumptions, to be followed by: ▪ Standard Contract for 15/16 ▪ Revised Contract Dispute Resolution procedure
Jan 2015	Publication of revised National Tariff1
Jan – 11 Mar 2015	Contract negotiations – including voluntary mediation
13 Jan 2015	Submission of initial headline plan data (CCGs, NHS England, NHS Trusts)
From 29 Jan 2015	Weekly contract tracker to be submitted each Thursday (CCGs, NHS England, NHS Trusts)
13 Feb 2015	Checkpoint for progress with planning measures and trajectories (CCGs, NHS England)
20 February	National Contract stocktake – to check the status of contracts
27 Feb 2015	Submission of full draft plans (CCGs, NHS England, NHS Trusts)
27 Feb – 30 Mar 2015	Assurance of draft plans (CCGs, NHS England, NHS Trusts)
6 Mar 2015	Checkpoint for progress with planning measures and trajectories (CCGs, NHS England)
11 Mar 2015	Contracts signed post-mediation (CCGs, NHS England, NHS Trusts and Foundation Trusts)
12 Mar – 23 Mar 2015	Contract arbitration (CCGs, NHS England, NHS Trusts)
By 25 Mar 2015	Arbitration outcomes notified to commissioners and providers (CCGs, NHS England, NHS Trusts)
By 31 Mar 2015	Plans approved by Boards of CCGs, NHS Trusts and Foundation Trusts
10 Apr 2015	Submission of full final plans (CCGs, NHS England, NHS Trusts and Foundation Trusts)
From 10 Apr 2015	Assurance and reconciliation of operational plans

Trust Board Meeting - December 2014

12-14	**Summary report from Audit and Governance Committee, 20/11/14**	**Committee Chair (Non-Executive Director)**

The Audit and Governance Committee met on 20th November 2014.

1. **The key matters considered at the meeting were as follows:**
   - The need for a Responsibility Assignment or RACI (Responsible, Accountable, Consult, Inform) matrix was discussed
   - The Terms of Reference were reviewed and agreed, subject to subsequent comparison with the example Terms of Reference with the recently-updated NHS Audit Committee Handbook (2014 version). This comparison has now been undertaken and several additions have been made as a result (within paras 7.5, 7.7, 7.10, 7.15, 7.16 and 7.19). The most significant of these additional proposals relates to the Committee's role in reviewing "…the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties…". A „track changes' version, showing the proposed changes, as well as a „clean' version (with the changes accepted), is enclosed, for approval.
   - Updates on progress with the plans for Internal Audit, External Audit and Counter Fraud were received
   - A verbal summary of the latest financial issues was given by the Director of Finance
   - The latest losses & compensations, and single tender waivers data were received
   - The Board Assurance Framework and Risk Register for 2014/15 were reviewed
   - The revised Standing Financial Instructions were approved (subject to any changes made by the Finance Committee)

2. **The Committee received details of the following Internal Audit reviews:**
   - N/A (no reports had been issued since the last Committee meeting in September 2014)

3. **The Committee was also notified of the following "high" priority outstanding actions from Internal Audit reviews:**
   - Non Patient Income Flows (MTW131409). Car Parking Income – "Regular reconciliations should be undertaken between the figures provided by the Zerox system and the actual values banked, to ensure that all income is accounted for". Although it was confirmed that reconciliation is taking place, the procedure needs to be formally documented, in a Policy.
   - Clinical Activity Recording (MTW131410). Recharging of High Cost Drugs - "Management should review the need for additional resource to assist with the calculation of HCD recharges, in the absence of the one individual with the relevant knowledge and responsibility. Written procedural guidance should be developed for the process for recharging HCDs".
   - Outpatient Clinic Maintenance (MTW131413). Performance Management – "The range of performance reports used should be reviewed, and reporting incorporated on key areas such as cancelled clinics and waiting times to drive improvements in these areas. Analysis of the reasons for shortnotice clinic cancellations needs to be made, and action take to address the main root causes. Management should review the cashing-up process across all clinics and consider options for a more reliable and efficient method for capturing clinic outcomes."

4. **The Committee agreed that:**
   - The Owners (and relevant Executive Directors) for the 3 "high" priority actions outstanding from Internal Audit reviews (see above), should be invited to the February 2015 Audit and Governance Committee, to explain why the actions have not been completed (however, the invitation will be withdrawn if the actions were completed by mid-January 2015)
   - The Director of Finance would pursue the development of a high-level RACI matrix, via the Executive team

- A future Audit and Governance Committee meeting should consider the methods by which it should fulfil its Terms of Reference, particularly the duty to "…review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives"
- The Director of Workforce and Communications should be asked to undertake an investigation into counter fraud case 14/15.0016
- A separate meeting should be held to discuss the Risk Register and BAF processes, and the reporting of risks to the Board and its sub-committees
- The Director of Estates and Facilities should be invited to attend the Audit and Governance Committee in February 2015, to discuss the management of the Directorate's risks
- The method of the next committee self-assessment should involve each Committee member completing a survey, with the focus on eliciting a subjective assessment; whilst the Trust Secretary should complete an evaluation focusing on the factual / process-related aspects of the Committee's functioning
- Audit and Governance Committee meetings should be extended to 3 hours, if practicable

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

- The revised Terms of Reference need to be approved by the Board

Which Committees have reviewed the information prior to Board submission?

- N/A

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

1. Information and assurance; and
2. To approve the revised Terms of Reference for the Audit and Governance 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

AUDIT AND GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1. Constitution / Purpose

1.1 The Audit and Governance Committee has been established by the Trust Board as a non-executive committee of the Board. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

1.2 The Committee supports the Board by critically reviewing the governance and assurance processes on which the Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control (including the Board Assurance Framework); oversight of the Internal and External Audit, and Counter Fraud functions.

1.3 The Committee also undertakes detail review of the Trust's Annual Report and Accounts.

2. Authority

2.1 The Committee is authorised by the Trust Board to investigate any activity within its Tterms of Rreference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. –The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3. Membership

3.1 The Committee shall be appointed by the Trust Board from amongst the Non-Executive Directors of the Trust , –(other than the Chairman of the Trust Board), and shall consist of not less than three members. –A Non-Executive Director Chair of the Committee will be appointed by the Trust Board, together with a Deputy. If a Non-Executive Director member is unable to attend a meeting they will be responsible for finding a replacement to ensure quoracy for the meeting.

3.2 Other ~~staff members~~individuals may be co-opted to attend to address issues of specific concern at the discretion of the committee Chair.

4. Quor~~acy~~um

4.1 The committee shall be quorate when two Non-Executive members are present (including either the committee Chair or deputy Chair)~~, which could include the appointed committee chair~~.

5. Attendance

5.1. The following will routinely attend meetings of the Committee (but will not be members):

- Director of Finance
- ~~Director of Corporate Affairs~~
- Deputy Director of Finance (Financial Governance)
- ~~Head of Quality & Governance~~
- Head of Internal Audit ~~Manager~~and/or other appropriate representatives
- External Audit Engagement Lead ~~Manager~~and/or other appropriate representatives

- Local Counter Fraud Specialist
- Trust Secretary

5.2 ~~Full members~~ Members (listed above) are expected to attend all ~~will attend 60% of~~ meetings of the Committee

5.3 The Chief Executive and other Executive Directors will be invited to attend when the Committee is discussing areas of risk or assurance that are the responsibility of that Ddirector and it is felt that their attendance is necessary to fully understand or address the issues

5.4 The Chief Executive will be invited to attend, at least annually, to discuss ~~with the Audit Committee~~ the process for assurance that supports the Annual Governance Statement ~~on Internal Control~~; and the agreement of the Internal Audit annual plan.

5.5 The Committee will meet privately with the Eexternal and Iinternal Aauditors regularly, not less than once per year.

5.6 The Trust Secretary ~~Director of Corporate Affairs~~ will provide appropriate support to the Chairman and committee members and will be responsible for ensuring that minutes of the meeting are taken.

6. Frequency of meetings

6.1 Meetings shall be held not less than four times a year. The Chair of the Committee will have the discretion to agree additional meetings in order to adequately meet the objectives of the Committee. ~~Any Board Director may make a formal request to the Chair of the Committee for an additional meeting.~~

6.2 The External Auditor or Head of Internal Audit may request an additional meeting if they consider that one is necessary. Any member of the Trust Board ~~Director~~ may put a request in writing to the Chair of the Committee for an additional meeting, stating the reasons for the request. The decision whether or not to arrange such a meeting will be at the sole discretion of the Chair of the Committee.

7 Duties

7.1 The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

7.2 The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

7.3 In particular, the Committee will review the adequacy of:

7.3.1 All risk and control related disclosure statements (in particular the Annual Governance Statement ~~on Internal Control and declarations of compliance with the Essential Standards for Quality and Safety~~), together with any accompanying Head of Internal Aaudit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board

7.3.2 The underlying assurance process that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

7.3.3 The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification.

7.3.4 The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Protect.

7.4 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. ~~-~~It will also seek reports and assurances from D~~d~~irectors and managers, as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

7.4 ~~7.5~~ This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

~~7.4~~7.5 As part of its integrated approach, the Committee will have effective relationships with other key committees, so that it understands processes and linkages. However, these other committees must not usurp the Audit and Governance Committee's role.

Internal Audit

7.6 The Committee shall ensure that there is an effective I~~i~~nternal A~~a~~udit function established by management that meets mandatory ~~NHS~~ Public Sector Internal A~~a~~udit Standards and provides appropriate independent assurance to the ~~audit~~ Committee, Chief Executive and Trust Board. ~~-~~This will be achieved by:

7.6.1 Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

7.6.2 Review and approval of the Internal Audit ~~strategy~~Charter, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework

7.6.3 Consideration of the major findings of Internal Audit work (and management's response), and ensure co-ordination between the I~~i~~nternal and E~~e~~xternal auditors to optimise audit resources

7.6.4 Ensuring that the Internal Audit Function is adequately resourced and has appropriate standing within the organisation

7.6.5 Carrying out an a~~A~~nnual review of the effectiveness of I~~i~~nternal A~~a~~udit

External Audit

7.7 The Committee shall review the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management's responses to their work.~~-~~ This will be achieved by:

- Consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit
- Discussion and agreement with the External Auditor, before the audit commences of the nature and scope of the audit as set out in the annual plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy
- Discussion with the External Auditors of their ~~local~~ evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review all External Audit reports, including the report to those charged with governance, agreement of the A~~a~~nnual A~~a~~udit L~~l~~etter (before submission to the Trust Board) and any work carried outside the annual audit plan, together with the appropriateness of management responses.
- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non audit service

Other Assurance Functions

7.8 The ~~Audit~~ Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

7.9 These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

~~7.10 In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality and Safety Committee which is the Trust's integrated governance committee responsible for ensuring the effectiveness of risk management structures, systems and processes~~.

~~7.11 In reviewing the work of the Quality and Safety Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that can be gained from the clinical audit function.~~

Counter Fraud

7.10 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud that meet NHS Protect's standards and shall review the outcomes of counter fraud work.

Management

7.11 The Committee shall request and review reports and positive assurances from D~~d~~irectors and managers on the overall arrangements for governance, risk management and internal control.

7.12 They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Annual Report and Financial Reporting

7.13 The ~~Audit~~ Committee shall monitor the integrity of the financial statements of the Trust and the formal announcements relating to the Trust's financial performance.

7.14 The Committee should ensure that the systems for financial reporting to the Trust~~—~~ Board, including those of budgetary control, are subject to review as to ~~–~~completeness and accuracy of the information provided to the Board.

7.15 The Committee shall review the Annual Report and Financial Statements before submission to the Trust Board, focusing particularly on:

- the wording in the Annual Governance Statement ~~on Internal Control~~ and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies and practices
- unadjusted mis-statements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- the letter of Management R~~r~~epresentation
- explanations for significant variances
- qualitative aspects of financial reporting

Whistleblowing

7.16 The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

Parent committee and r~~R~~eporting procedure

~~7.16~~7.17 The committee is a sub-committee of the Trust Board.

7.177.18 The minutes of ~~Audit~~ Committee meetings shall be formally recorded by the Trust Secretary~~ and submitted to the Board~~. The Chair of the Committee shall also provide a brief written report to the Trust Board, summarising the issues covered at the meeting and drawing to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

7.19 The Committee will report to the Board annually (via a written Annual Report) on its work in support of the Annual Governance Statement~~ on Internal Control~~, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and embeddedness of risk management in the organisation, and the integration of governance arrangements~~ and the appropriateness of the self-assessment against the Essential Standards for Quality and Safety~~.The Annual Report should also describe how the Committee has fulfilled its Terms of Reference, and give details of any significant issues that the Committee considered in relation to the financial statements, and how these were addressed.

7.20 The Committee shall undertake an annual self assessment to ensure the objectives of the Terms of Reference are being met.

Sub-committees and reporting procedure

7.21 The committee has no sub-committees.

8. Administrative a~~A~~rrangements

8.1 The Committee shall be supported administratively by the~~, Director of Corporate Affairs~~ Trust Secretary, whose duties in this respect will include:

- Maintenance ~~Agreement with the Chairman~~ of an ~~Annual Work~~forward p~~P~~rogramme of work, setting out the dates of planned meetings and key agenda items.
- Agreement of agenda for next meeting with Chair~~man and attendees~~, allowing adequate notice for reports ~~papers~~ to be prepared~~ by directors / managers~~ which adequately support the relevant agenda item.
- Collation and distribution of agenda and reports~~papers at least~~ one week before the date of the meeting~~.~~
- Ensuring the minutes are taken and that a record is kept of matters arising and issues to be carried forward.
- ~~Maintaining a database of all governance and assurance reviews of the Trust, both internal and external, including Royal College reports, QA reviews, DoH etc.~~
- Advising the Committee on all pertinent areas.

9. Emergency powers and urgent decisions

9.1 The powers and authority which the Trust Board has delegated to the Audit and Governance Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least two Non-Executive Director members. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Audit and Governance Committee, for formal ratification.

10. Review of Terms of Reference and Monitoring Compliance

10.1 These ~~t~~Terms of R~~r~~eference will be agreed by the Audit and Governance Committee and approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

~~The Governance team will provide quarterly reports to the Committee. The report will include Assurance that:~~

- ~~Duties are being followed.~~
- ~~Reports from the committee have been made to the Board.~~
- ~~The Committee has the required membership.~~
- ~~Members have achieved the required frequency of attendance.~~
- ~~The committee has been quorate.~~
- ~~The meetings have been sufficiently frequent.~~
- ~~The terms of reference meet NHSLA Risk Management Standard 2.1.3.~~

Terms of Rreference agreed by Audit and Governance Committee: April 2013
Terms of Rreference approved by the Board: May 2013
~~Terms of reference to be reviewed: April 2014~~
Terms of Reference agreed by the Audit and Governance Committee, November 2014
Terms of Reference approved by the Trust Board, December 2014

AUDIT AND GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1. Constitution / Purpose

1.1 The Audit and Governance Committee has been established by the Trust Board as a non-executive committee of the Board. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

1.2 The Committee supports the Board by critically reviewing the governance and assurance processes on which the Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control (including the Board Assurance Framework); oversight of the Internal and External Audit, and Counter Fraud functions.

1.3 The Committee also undertakes detail review of the Trust's Annual Report and Accounts.

2. Authority

2.1 The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3. Membership

3.1 The Committee shall be appointed by the Trust Board from amongst the Non-Executive Directors of the Trust (other than the Chairman of the Trust Board), and shall consist of not less than three members. A Non-Executive Director Chair of the Committee will be appointed by the Trust Board, together with a Deputy. If a Non-Executive Director member is unable to attend a meeting they will be responsible for finding a replacement to ensure quoracy for the meeting.

3.2 Other individuals may be co-opted to attend to address issues of specific concern at the discretion of the committee Chair.

4. Quorum

4.1 The committee shall be quorate when two Non-Executive members are present (including either the committee Chair or deputy Chair).

5. Attendance

5.1. The following will routinely attend meetings of the Committee (but will not be members):

- Director of Finance
- Deputy Director of Finance (Financial Governance)
- Head of Internal Audit and/or other appropriate representatives
- External Audit Engagement Lead and/or other appropriate representatives
- Local Counter Fraud Specialist
- Trust Secretary

5.2 Members (listed above) are expected to attend all meetings of the Committee

5.3 The Chief Executive and other Executive Directors will be invited to attend when the Committee is discussing areas of risk or assurance that are the responsibility of that Director and it is felt that their attendance is necessary to fully understand or address the issues

5.4 The Chief Executive will be invited to attend, at least annually, to discuss the process for assurance that supports the Annual Governance Statement; and the agreement of the Internal Audit annual plan.

5.5 The Committee will meet privately with the External and Internal Auditors regularly, not less than once per year.

5.6 The Trust Secretary will provide appropriate support to the Chairman and committee members and will be responsible for ensuring that minutes of the meeting are taken.

6. Frequency of meetings

6.1 Meetings shall be held not less than four times a year. The Chair of the Committee will have the discretion to agree additional meetings in order to adequately meet the objectives of the Committee.

6.2 The External Auditor or Head of Internal Audit may request an additional meeting if they consider that one is necessary. Any member of the Trust Board may put a request in writing to the Chair of the Committee for an additional meeting, stating the reasons for the request. The decision whether or not to arrange such a meeting will be at the sole discretion of the Chair of the Committee.

7 Duties

7.1 The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

7.2 The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

7.3 In particular, the Committee will review the adequacy of:

- 7.3.1 All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- 7.3.2 The underlying assurance process that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- 7.3.3 The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification.
- 7.3.4 The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Protect.

7.4 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from Directors and managers, as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

7.5 This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

7.6 As part of its integrated approach, the Committee will have effective relationships with other key committees, so that it understands processes and linkages. However, these other committees must not usurp the Audit and Governance Committee's role.

Internal Audit

7.7 The Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Trust Board. This will be achieved by:

7.6.1 Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

7.6.2 Review and approval of the Internal Audit Charter, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework

7.6.3 Consideration of the major findings of Internal Audit work (and management's response), and ensure co-ordination between the Internal and External auditors to optimise audit resources

7.6.4 Ensuring that the Internal Audit Function is adequately resourced and has appropriate standing within the organisation

7.6.5 Carrying out an annual review of the effectiveness of Internal Audit

External Audit

7.8 The Committee shall review the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit
- Discussion and agreement with the External Auditor, before the audit commences of the nature and scope of the audit as set out in the annual plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy
- Discussion with the External Auditors of their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review all External Audit reports, including the report to those charged with governance, agreement of the Annual Audit Letter (before submission to the Trust Board) and any work carried outside the annual audit plan, together with the appropriateness of management responses.
- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non audit service

Other Assurance Functions

7.9 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. 7.9 These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

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Counter Fraud

7.10 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud that meet NHS Protect's standards and shall review the outcomes of counter fraud work.

Management

7.11 The Committee shall request and review reports and positive assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

7.12 They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Annual Report and Financial Reporting

7.13 The Committee shall monitor the integrity of the financial statements of the Trust and the formal announcements relating to the Trust's financial performance.

7.14 The Committee should ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

7.15 The Committee shall review the Annual Report and Financial Statements before submission to the Trust Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies and practices
- unadjusted mis-statements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- the letter of Management Representation
- explanations for significant variances
- qualitative aspects of financial reporting

Whistleblowing

7.16 The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

8. Parent committee and reporting procedure

8.1 The committee is a sub-committee of the Trust Board.

8.2 The minutes of Committee meetings shall be formally recorded by the Trust Secretary. The Chair of the Committee shall also provide a brief written report to the Trust Board, summarising the issues covered at the meeting and drawing to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

8.3 The Committee will report to the Board annually (via a written Annual Report) on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and embeddedness of risk management in the organisation, and the integration of governance arrangements.The Annual Report should also describe how the Committee has fulfilled its Terms of Reference, and give details of any significant issues that the Committee considered in relation to the financial statements, and how these were addressed.

8.4 The Committee shall undertake an annual self assessment to ensure the objectives of the Terms of Reference are being met.

9. Sub-committees and reporting procedure

9.1 The committee has no sub-committees.

10. Administrative arrangements

10.1 The Committee shall be supported administratively by the Trust Secretary, whose duties in this respect will include:

- Maintenance of a forward programme of work, setting out the dates of planned meetings and key agenda items.
- Agreement of agenda for next meeting with Chair, allowing adequate notice for reports to be prepared which adequately support the relevant agenda item.
- Collation and distribution of agenda and reports one week before the date of the meeting
- Ensuring the minutes are taken and that a record is kept of matters arising and issues to be carried forward.
- Advising the Committee on all pertinent areas.

11. Emergency powers and urgent decisions

11.1 The powers and authority which the Trust Board has delegated to the Audit and Governance Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least two Non-Executive Director members. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Audit and Governance Committee, for formal ratification.

12. Review of Terms of Reference and Monitoring Compliance

12.1 These Terms of Reference will be agreed by the Audit and Governance Committee and approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

Terms of Reference agreed by Audit and Governance Committee: April 2013
Terms of Reference approved by the Board: May 2013
Terms of Reference agreed by the Audit and Governance Committee, November 2014
Terms of Reference approved by the Trust Board, December 2014

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - December 2014

12-15	Summary report from the Workforce Committee, 04/12/14	Committee Chair (Non-Executive Director)

Summary / Key points

The following report provides information on the Workforce Committee held on 4 December 2014. The primary focus of the meeting was the recruitment and retention of substantive staff.

Recruitment and retention of substantive staff

Paul Bentley gave a presentation demonstrating the extent of the challenge and the proposed actions to address the recruitment issues. He outlined options for the Trust to consider, such as different reward initiatives which are innovative and different from the traditional approaches the Trust has relied upon in the past. Given the size of the challenge faced, this approach is believed to be appropriate.

The report concentrated on nursing and midwifery given this is the largest area of challenge. The recruitment challenge is approximately 400 Whole Time Equivalent (WTE), of which the Nursing and Midwifery workforce represents half.

Graphs were used to illustrate the number of WTE staff in post per staff group as at October 2014. Employed registered nursing and midwifery staff numbers have increased in the last year. Consultant numbers have also increased by 55% in the last 10 years. There is a commitment to reducing back office staff.

The Director of Workforce and Communications gave a breakdown of the current 469 vacant posts, 41 of which are being held as non-recurrent CIPs in the back office and this figure is likely to be higher if those posts are removed permanently from the establishment. This is consistent with the workforce plan to reduce staff in non-patient facing areas whilst increasing front line staff.

The proposed options are to reduce turnover, improve recruitment, increase uptake of bank shifts and reduce sickness, and the Committee discussed the proposals to achieve these. In addition, the Trust intends to have a more structured and proactive recruitment strategy particularly with nursing posts.

Medical Engagement

The Medical Director and Director of Workforce and Communications commissioned a piece of work from the University of Warwick to examine the current levels of engagement within the medical workforce, and the committee received a report and the results of the survey. The results demonstrated that the Trust is not an outlier, and that there are variations in engagement between specialties. For example, emergency medicine, ophthalmology, cancer and haematology, children's services are in the higher ranges of relative medical engagement, in contrast to general and colorectal surgery and women's health which are in the lower ranges. The trainee and staff grades demonstrate the lowest levels of relative medical engagement albeit with a relatively small sample size. The Consultants, who comprised the majority of respondents broadly reflect the Trust's overall results. The response rate was 204 out of a possible 650. The results will be discussed further at the Trust Management Executive (TME) and Clinical Directors meeting, and action plans developed accordingly

Friends and Family Test

The Committee received a report about the results of the second staff Friends and Family Test and the changes that have been made to how the scores are presented by the Department of Health. The survey enquires about the likelihood of staff recommending the Trust as a place to receive treatment and as a place to work. The second survey also included supplementary questions in an attempt to identify reasons behind the replies. For example, policies, procedures and communication was the main reason given why staff were unlikely to recommend the Trust as a

place to work. Whilst the results demonstrate the need for focused work to drive improvements, it should be noted that some changes have already been implemented and the wider staff engagement strategy outlines the approach for the future. The report received by the Committee is enclosed (in Appendix 1), for additional information.

Medical Education Update

The Director of Medical Education (DME) summarised his report, highlighting the following:

- Trainees report a high level of satisfaction with the medical education programmes across the Trust.
- Excellent feedback was received from the School of Medicine Core Medical Training visit on 21 November 2014.
- The Trust has successfully applied for funding from Health Education Kent, Surrey and Sussex (HEKSS) for a multiprofessional project using the WHO patient safety modules. The aim is to infuse the Trust with a culture of safety in clinical practice.
- The DME is in the process of setting up a multiprofessional mentoring programme to support new consultants, senior nursing staff and senior managers during their first year. This will commence in January 2015.
- The DME described the role and training of Physicians Associates, the Trust hopes to have some in post.
- HEKSS and London South have merged into a single Local Education Training Board called HE London and the South East.

2015/16 Back Office CIP Proposals

The Committee received a report outlining the proposed transformational back office cost improvement schemes for next year. The aim is for 8% savings this year and next year. There are 5 priority schemes to achieve the target:

1. Corporate information / portal
2. Temporary staffing usage
3. Market testing – the Trust is working with East Sussex and BSUH to identify services to review.
4. Integrated education
5. Residential accommodation for staff

Schemes 1, 2, 4 and 5 were discussed under other agenda items at the meeting.

Workforce Dashboard

The Committee received the workforce dashboard for information. The establishment has been updated in line with the revised plan presented to the Workforce Committee and Finance Committee in June 2014 and is consistent with the figures reported elsewhere. Activity is at appropriate levels.

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

Appendix 1: Staff Friends & Family Test report received at the Workforce Committee, 04/12/14

Maidstone and Tunbridge Wells NHS
NHS Trust

WORKFORCE COMMITTEE – 4 DECEMBER 2014

08/12/14	**FRIENDS AND FAMILY TEST (Q1)**	**RICHARD HAYDEN** **ASSOCIATE DIRECTOR OF WORKFORCE**

Summary / Key points

The enclosed report provides information on the results from our second Staff Friends and Family Test (FFT) and also changes that have been made to how the scores are presented by the Department of Health.

National benchmark data is now available for England and Wales for Quarter 1 and 2.

The results clearly demonstrate the need for further focused work to drive improvements and in particular within the workforce response. The Trust staff survey action plan is also attached.

Which Committees have reviewed the information prior to Board submission?

- None

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [2]

- Information
- 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

1.0 INTRODUCTION

1.1 The purpose of the paper is:

- To outline the key results from the Friends and Family Test for the Trust.

2.0 BACKGROUND

2.1 NHS England published revised plans on 28/2/2014 for the NHS Staff Friends and Family Test (FFT). The revised guidance sets out minimum requirements for the operation of the Staff FFT:

> "A proportion of staff should have the opportunity to respond to Staff FFT in each of the three quarters, with all staff having the opportunity once per year, as a minimum requirement. Organisations may provide all staff with the opportunity to respond each quarter if they so wish."

2.2 The FFT forms part of the Trust CQUIN, albeit the results have been excluded.

2.3 The Trust has commissioned a private provider to run the online surveys "Impressions" which will be accessible to all staff, initially via the intranet and then through other means (i.e. hand held devices).

2.4 The first survey for the Trust took place in June 2014 for a three week period. The second survey took place for a three week between during August and September 2014.

2.5 The Q3 results will be calculated from the annual staff survey which has now commenced in the organisation. 850 staff have been randomly selected by an external provider to complete the survey.

3.0 NATIONAL COMPARISON

3.1 These comparison figures are intended as an indication only. Trusts may have used different collection methods and targeted different staff groups, however I think it helpful to compare the Trust position with local acute Trusts.

3.2

Organisation	% likely to recommend treatment		% unlikely to recommend treatment		% likely to recommend work		% unlikely to recommend work	
	Q1	Q2	Q1	Q2	Q1	Q2	Q1	Q2
National Average	**75**	**77**	**8**	**8**	**61**	**61**	**19**	**19**
MTW	77	77	5	5	47	51	26	21
East Sussex Hospitals Trust	65	65	15	15	39	36	41	43
Brighton and Sussex University Hospitals	68	70	10	9	57	50	20	25
Medway NHS Foundation Trust	62	59	13	15	48	42	23	30
East Kent Hospitals University NHS Foundation Trust	78	70	6	9	55	45	22	31

Results published by NHS England

3.3 The national average response rate was 14.3% (163,686 responses from 1.1m workforce headcount) in Q1 and 12.4% in Q2 (141,450 responses from 1.1m workforce headcount).

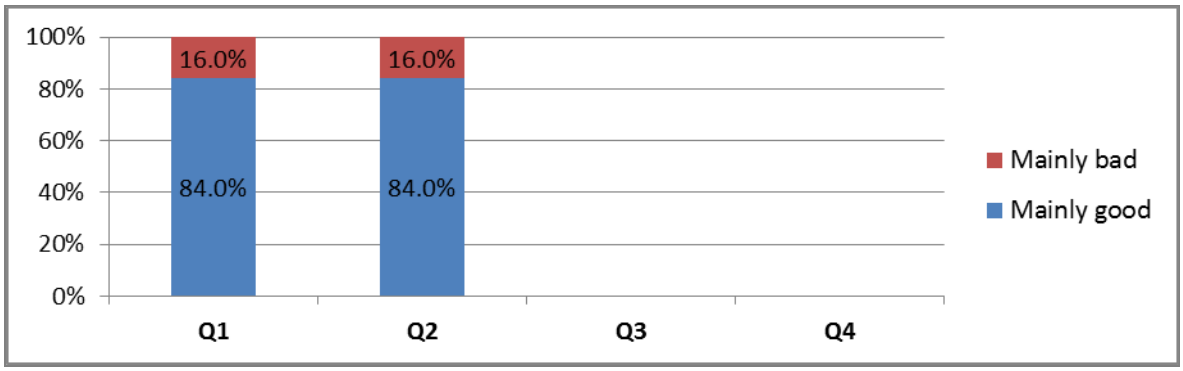
3.4 The Trust response rate for Q1 was 10.5% and 7.7% for Q2.

4.0 TRUST Q2 2014 RESULTS

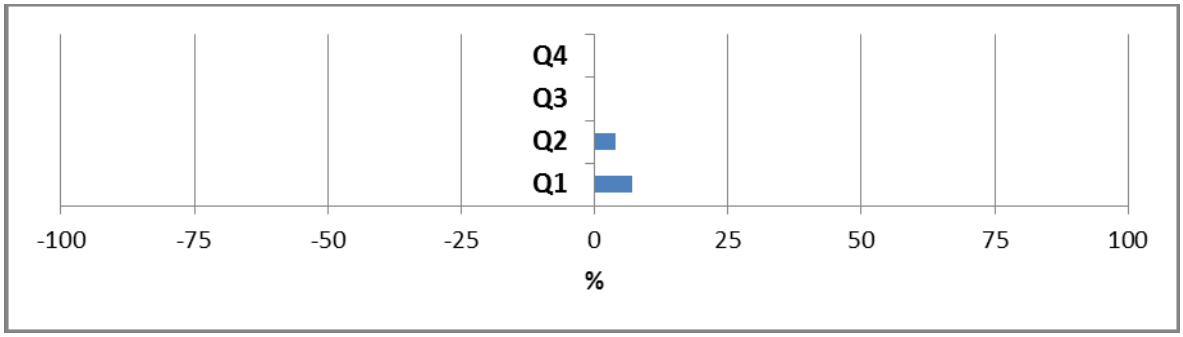
4.1 434 staff completed the Q2 online survey, representing a disappointing 7.7%.

4.2 This is a reduction on the first survey (592) but it is important to note that the survey took take place during the summer holidays.

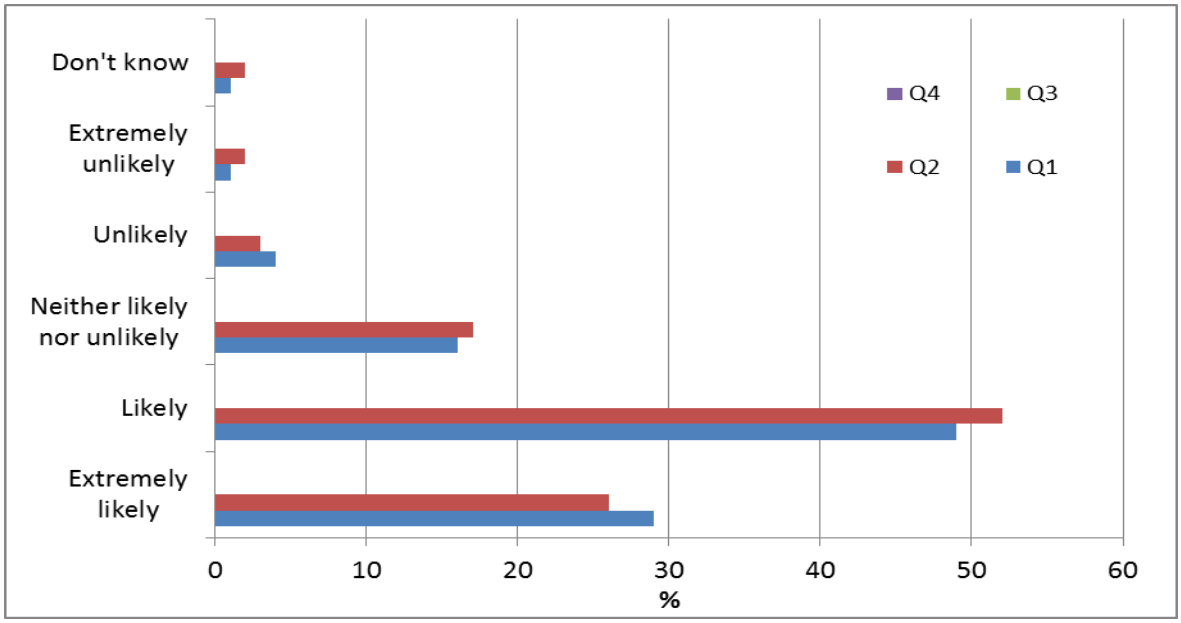
4.3 Staff Morale: Thinking about your overall experience of working at our Trust, is your impression…?



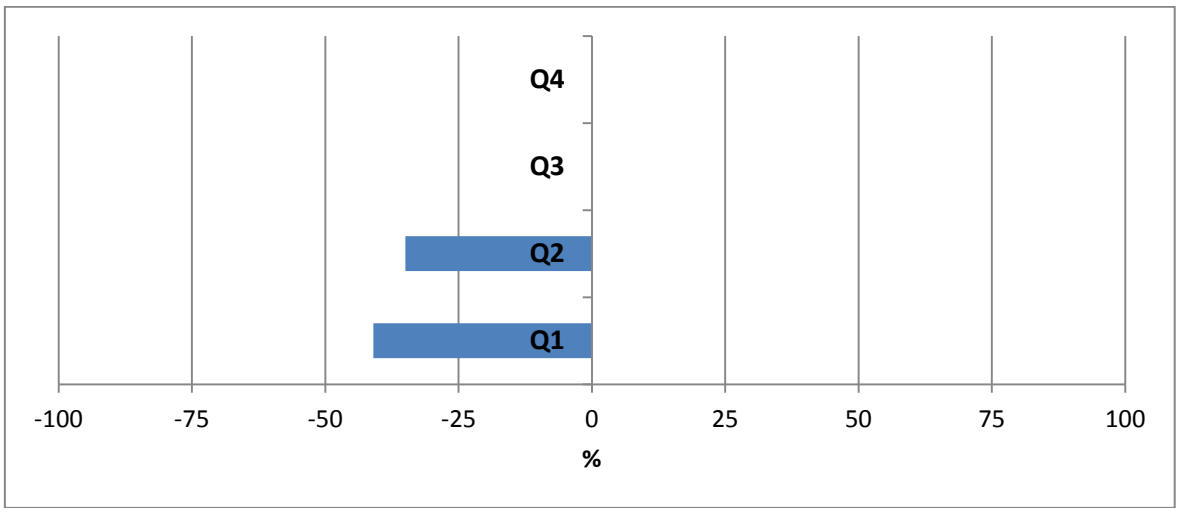
4.4 Service: How likely are you to recommend the Trust to friends and family if they needed care or treatment?



4.5 The above score is made up of the following responses to the question:

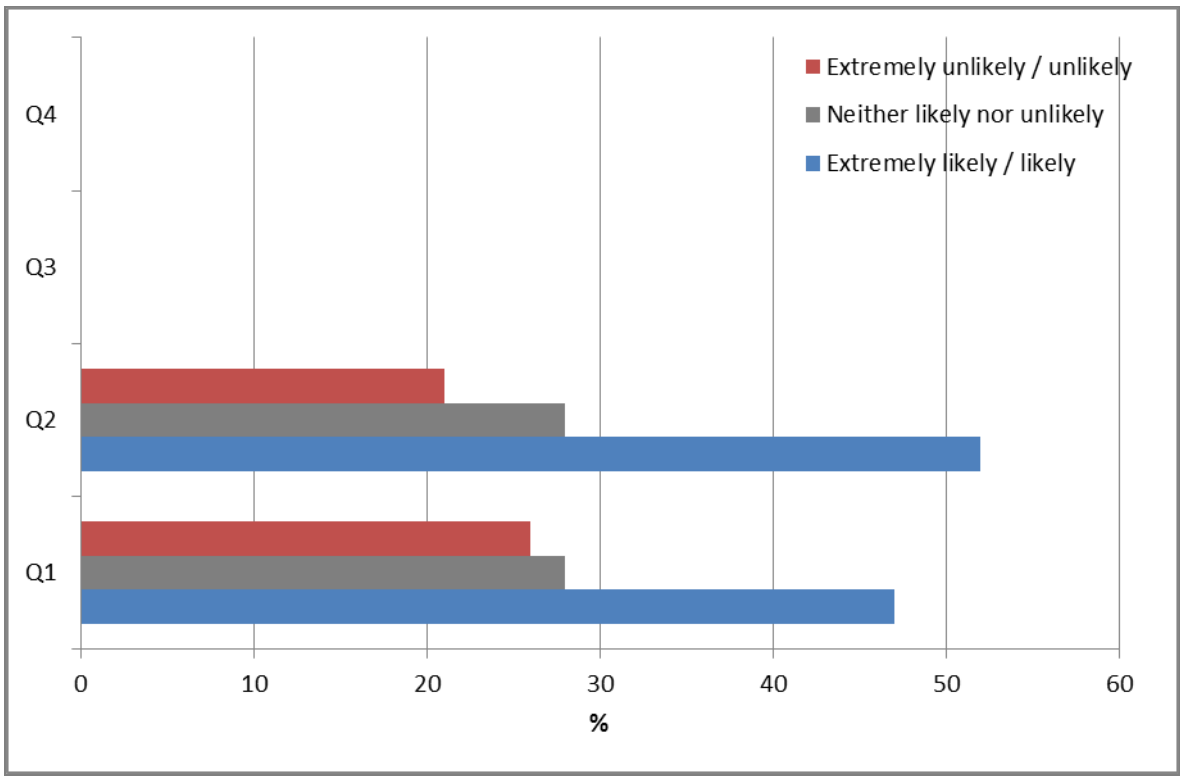


4.6 Workplace: How likely are you to recommend the Trust to friends and family as a place to work?"



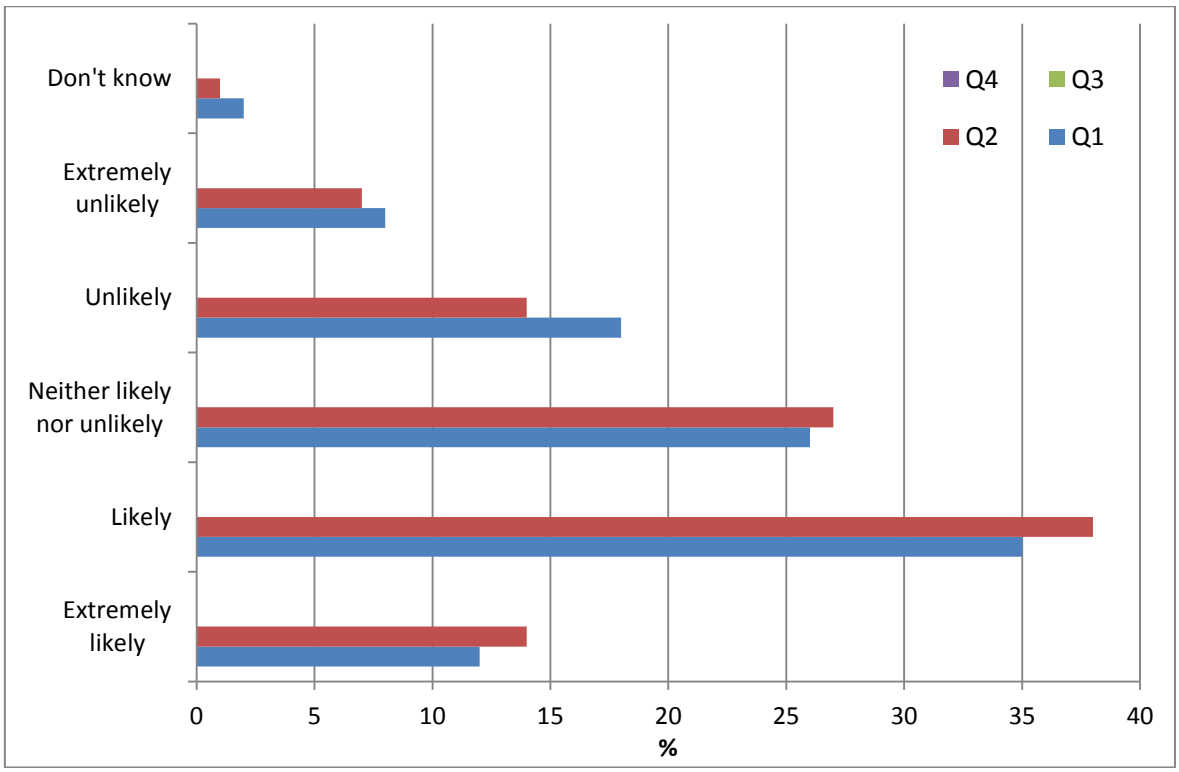
4.7 The above chart represents the previous calculation to produce the workplace FFT score which was changed after the first collation of national results.

4.8 The results from the new calculation are illustrated below for both Q1 and Q2:

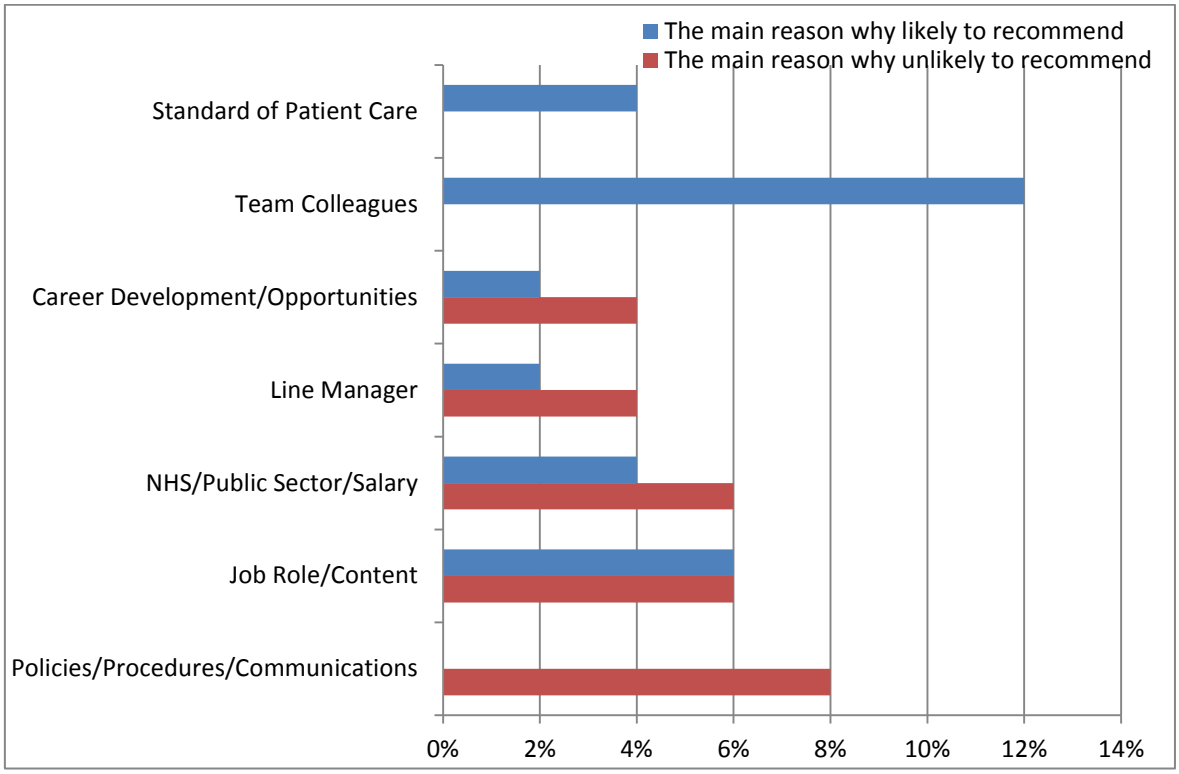


4.9 The chart shows an improvement on the Q1 position with a greater positive response to recommending the Trust to friends and family as a place to work, it is important to note that the neighbouring Trusts have not seen the same improvement.

4.10 The above score is made up of the following responses to the question:



4.11 In order to understand the above responses in more detail, two subsequent questions were asked to ascertain what the main reasons were for either recommending or not recommending the organisation as a place to work.



5.0 CONCLUSION

5.1 Whilst the results clearly demonstrate the need for focused work to drive improvements, it is important to note that some changes have already been implemented and the wider staff engagement strategy outlines the approach for future developments.

5.2 The National Staff Survey replaces the FFT in Quarter 3, however, the key focus in this period is to:

i. Drive improvements in the FFT return rate by deploying hand held devices for certain staff groups

ii. Develop the intranet in order to publish trust results, progress with actions and also national bench mark data

iii. Publish the results on different forums, including social media, to drive engagement and demonstrate to staff the value of the feedback

iv. Run a set of staff focus groups on both sites to assist with the formation of plans to drive improvements

5.3 The additional questions asked for the Quarter 2 survey in relation to the workforce response provides greater understanding and areas for focus. However the low return rate means that these supplementary questions will remain for future surveys to continue to develop the picture.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – December 2014

12-16	Summary report from the Patient Experience Committee, 04/12/14	Committee Chair (Non-Executive Director)

Media Coverage:
The committee were updated on the recent media coverage relating to a complaint on the care a patient had received at Tunbridge Wells Hospital (TWH). An independent investigation had found no evidence to support the allegations of neglect. However there are key recommendations for the Trust relating to effective communication and escalation out of hours and support for families and staff.

Patient Experience Dashboard: The following points were highlighted to the Committee:
- The NHS Trust Development Authority (TDA) produce the dashboard quarterly covering 9 key areas
- The report provides a comparison against other Trusts
- There has been an 11% reduction in complaints and improvements have been made with the Friends and Family Test
- In the PLACE inspections there were two areas of concern, privacy and dignity and cleanliness. The privacy and dignity issues primarily related to patients in outpatients.

A question was raised whether patients in gowns also wear dressing gowns. It was confirmed that patients walking through general areas are not exposed, and this is the subject of on-going review. A question was raised regarding the cost involved in providing dressing gowns which would add to achieving patient's dignity. Patient pathways are under review to ensure that patients in gowns are not expected to sit or walk through public areas.

Complaints Report, Key Themes: The report highlighted:
- The main themes were patient falls and delayed treatment. Communication related complaints had seen a slight reduction on the last two quarters.
- A large number of complaints related to theatres although it was explained that this covers other areas such as the Chronic Pain Unit. The Chairman requested that the categorising of these complaints be looked at to include only theatres, it was confirmed this would be included in the report to the June meeting.
- PALS have seen a slight drop compared to last year and the recurrent themes were highlighted. It was noted that PALS have increased their office hours and profile by holding events to increase their visibility and next year weekly ward visits will be implemented to raise their profile and how to raise concerns.
- The complaints data is to be published on the Trust website to increase awareness.
- Response times have been struggling to achieve compliance. Upheld complaints and the learning from them
- The Trust receives a number of compliments and the Trust must make an effort to collect these and it requires wards and services to provide the numbers to give a better understanding of the balance of service.

Patient Experience Annual Report: The following was highlighted:
- The report covers the period January 2013 to March 2014.
- An annual staffing review has taken place and there was a subsequent follow through by NICE to set safe staffing levels and the Trust is predominantly compliant.
- There is a problem with recruiting staff and the reliance on temporary staff impacts patient care and experience.
- The Chairman noted the very good data on pressure ulcers and this was a key measure for nursing care, congratulating the wards on the substantial improvement over the last few years and urged them to keep it up. It was concluded that members need to get further information on benchmarking and comparisons and requested this be brought to the next meeting.

End of Life Care: A presentation was given to the Committee highlighting the following:

- 3 national reports have been published including the response to withdrawal of the Liverpool Care Pathway (LCP)
- The recent Care Quality Commission (CQC) inspection had focused on End of Life Care and the CQC had interviewed members of the team and the findings were awaited.
- A Clinical Audit was undertaken looking at medical records for 51 deaths. The results highlighting where the Trust was above and below average. It was noted that the Trust had improved and was now compliant in a number of areas.
- Single rooms are an asset in end of life care
- Education e-learning packages are to be revised in light of the new Best practice guidance.
- The Independent review of the LCP report identified 44 recommendations and it was agreed to not use LCP.

The Best Practice Guidance has key.5 principles It was noted that Version 2 of the guidance is being piloted on 8 wards. The results would be reported to the End of Life Care Group in March. Following approval it would be widely implemented and a framework developed.

Healthwatch Update: Healthwatch is a consumer voice in Kent and Medway, consisting of a team of volunteers and 4 team members for Medway. Healthwatch ensure services consult with the public and raise concerns and they commission other organisations to undertake reports including child and mental health services and nursing homes. For Maidstone and Tunbridge Wells NHS Trust, Healthwatch co-facilitated the CQC listening events and provided feedback.

Healthwatch work with organisations to ensure they feedback themselves, although they do use Twitter and have public forums and listening events.

Local Patient Survey including. Friends and Family: The report highlighted the following:

- The report included patient feedback relating to responding to call bells noting that the Trust was performing consistently at 90-92% satisfaction.
- Wireless call bells had been tested and the Trust would consider a roll out approach across the wards. It was confirmed that the results would be bought back to the next meeting including details regarding the time taken when activating and deactivating the call bells.
- Friends and family response rate for September and October was on a slight downward trend and there would be renewed focus to address the issue.

National A&E Survey: The report highlighted the following:

- The results became known to the Trust last week and an action plan was to be produced
- The A&E departments were on a journey of improvement and had improved on all but 2 questions in the survey
- The survey was last conducted in 2012 and the Trust had made concerted efforts to improve in many areas.
- Overall the survey shows significant improvements
- The survey showed the Trusts overall satisfaction rate (final question) was in the worst performing Trusts and was not representative of all the other questions.

National Cancer Survey: The report highlighted the following:

- The report highlighted the Trusts achievement in the top 20% and bottom 20% of Trusts
- A detailed action plan had been produced where the Trust met the national average or less and where the department felt improvements could be made.
- The survey gave patients the opportunity to leave free text comments and these were complimentary although comments were also received regarding patients needing more help with financial support. In response to this the Trust is setting up an advice clinic and the McMillan Information centre is being relocated to the Outpatient department to become more accessible.
- Over 90% of patients thought their care overall was good.

Patient Information and Leaflets Group: The Group have approved 66 new leaflets and 3 external leaflets have also been accepted for use by the Trust. Discussion took place regarding how readability is tested and it was confirmed the leaflets are sent to patient representatives to check and ensure they can be understood. Any changes are fedback and the leaflet updated.

A formal meeting of the group would be held annually and a report would be provided to the next meeting.

Patient Led Assessment of the Care Environment (PLACE) Report: The report highlighted the following:

- The inspection was undertaken over seven days looking at four key result areas
- The food and hydration assessment criteria has changed so cannot be benchmarked against previous years
- The Trust scored lower than the national average for food and hydration although this related to food preparation and service rather than the quality of food. It was noted that the Trust will be taking over food provision at Tonbridge Cottage Hospital.
- Privacy and Dignity showed a low score in outpatient areas.
- Next year's inspection would include a fifth element covering Dementia and there would be a long list of questions to cover.

Any Other Business:

It was reported that a patient admitted following a Stroke had received excellent care at the Hospital and at Tonbridge Cottage Hospital, adding that the patient had received physiotherapy within their home following discharge. The Chairman reported he had attended a Therapies Clinical Governance session and seen the work being undertaken by outreach clinics.

An item is to be added to future agendas to allow participates of the PLACE inspections to report what they had found on the wards.

It was reported that a member of TWH League of Friends had held a coffee morning and had raised £4,000 for the TWH League of Friends. They were thanked for their contribution.

It was noted that a discussion would take place regarding how the Committee could meet the demands of the agenda including the possibility of bimonthly meetings.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

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 - December 2014

12-17	Summary of the Trust Management Executive (TME) meeting, 10/12/14	Director of Workforce and Communications

This report provides information on the TME meeting held on the 10th December 2014. The key points from the meeting were as follows:

- An in-depth discussion was held on the Trust's **recruitment and retention challenges** and the options available to address these. A number of useful ideas were proposed, which will be considered as part of the larger suite of actions needed
- The latest **performance, for month 8**, 2014/15 was reported
- Details of the Trust's efforts to reduce **length of stay** were received, as were the **Performance Recovery Trajectories** for A&E 4-hour wait, 18 week RTT wait and Cancer 62-day wait (the latter of which is also being received at the Board in December)
- An update on **infection prevention and control was received**, which included further details of the preparedness regarding Ebola and Carbapenem resistant Enterobacteriaceae (CRE)
- The **Directorate reports** identified the following issues:
  - Efforts to introduce improvements within the Surgical Directorate were continuing, and there was evidence of such efforts having benefit
  - Trauma and Orthopaedics continued to aim to address the identified issues regarding hip fracture mortality, Surgical Site Infection & Patient Reported Outcome Measures (PROMS)
  - Recent capacity issues within Maternity seem to be abating, based on a review of the level of predicted bookings to the end of 2014/15
  - The backlog in Radiology reporting was now under control, and the reporting backlog that arose following the implementation of the new Radiology Information System (RIS) was scheduled to be addressed by the first week of January 2015
  - Actions were continuing to ensure that the Kent Pathology Partnership (KPP) came into operation on 1st April 2015.
  - Concerns remained regarding the Linear Accelerator (LINAC) replacement program, and in particular the replacement of "LA #2" at Kent and Canterbury Hospital
  - A favoured site for the Tunbridge Wells Hospital Radiotherapy satellite had now been identified, and provisional plans have been drawn up
  - Clinical activity within Children's services had been high, and a business case to enable the Woodlands Unit to be available for escalation on a „24/7' basis was being prepared
  - A Critical Care doctor would soon be travelling to Sierra Leone to assist in the efforts against the Ebola outbreak
  - A&E 4-hour waiting time target performance remained challenging, but Tunbridge Wells Hospital had recently achieved all the required standards under the weekly monitoring indicators system for the first time
  - The GP out of hours service operated by "Integrated Care 24 Ltd" (IC24) would be moving its base to Tunbridge Wells Hospital in January 2015
- The output/recommendations from the **Patient Safety Think Tank** (to date) were reported
- The **recently-approved business cases** were noted
- Updates were received on the work of the **TME's sub-committees** (Capital Prioritisation Group; Clinical Operations & Delivery Group; Information Governance Committee and the Policy Ratification Committee)

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
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 – December 2014

12-19 Oversight Self-Certification, Month 8, 2014/15 Trust Secretary

The enclosed schedule sets out the proposed oversight self-certification submission for month 8, based on performance as at 30th November 2014. This submission must be sent to the NHS Trust Development Authority (TDA) by the end of December (i.e. by 31st).

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

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

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

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

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

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

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

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

General conditions

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

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

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

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

Condition	Evidence of Trust compliance / Commentary	Latest assessment
▪ Criteria are transparent ▪ Criteria are published		

Pricing conditions

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

Competition conditions

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

Integrated care conditions

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

Oversight Self Certification – Board Statements

Statement	Evidence of Trust compliance	Latest assessment
For clinical quality, that: 1. the Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	▪ The Trust's integrated performance dashboard is reviewed monthly and includes the TDA's "routine quality & governance indicators" ▪ A "Clinical Quality & Patient Safety Report" report is submitted to the Trust Board ▪ The Quality & Safety Committee, and its sub-committees, provides a focus on quality issues arising from Directorates. A summary of each Quality & Safety Committee meeting is reported to the Board ▪ The Patient Experience Committee provides a patient perspective and input ▪ The Chief Nurse, a Board member, is accountable for quality ▪ There are dedicated complaints and Serious Incidents (SI) management functions ▪ Ongoing conduct of Family and Friends Test is reported through the Trust performance dashboard ▪ Patient stories are heard at Trust Board meetings ▪ SI report summaries are circulated to all Board members ▪ Board member visits to wards and departments enable triangulation of quality and other performance indicators. Pairings of NED and Executive Board members, to further promote such visits, have now been issued. Board members also participate in the conduct of Care Assurance Audits ▪ Systems investment (e.g. Q-Pulse, Symbiotix, Dr Foster) supports effective quality information/data management ▪ Quality Accounts have been developed in liaison with stakeholders ▪ Quality Impact Assessments conducted on all CIP initiatives ▪ Priority of patient care reflected in Trust values & embedded in staff appraisal The independent assessment of the Trust's Quality Governance Framework has largely endorsed the Trust's self-assessment and gave a validated score of 3.5; an action plan has been drafted to achieve further improvements. Further improvements include: - strengthening the processes through which learning is shared and embedded has been recognised, and - developing further benchmarks to support the assurance & target setting process The latest CQC Intelligent Monitoring data ~~assessment updated in July 2014 rated the Trust as "3" (with 6 being the highest/best score). The next Intelligent Monitoring data will~~ was published by the CQC in December 2014. The Trust was not issued with a "Priority banding for inspection" because the Trust was "Recently Inspected".	Compliant

Statement	Evidence of Trust compliance	Latest assessment
	However, the overall risk score was 8 which approximately equates to a Band 4.	
For clinical quality, that: 2. the board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements	The Trust has full registration with the CQC. The Trust is registered to deliver the following regulated activities: (i) treatment of disease, disorder and injury; (ii) surgical procedures; (iii) diagnostic screening procedures; (iv) maternity and midwifery services; (v) termination of pregnancy; (vi) family planning. An ~~recent~~ application was ~~had been~~ made to the CQC to amend the Trust's registration to reflect the fact that all of these activities occur at both of the Trust's hospital sites (apart from (v) termination of pregnancy, which is only undertaken at Tunbridge Wells Hospital). This application ~~is being considered by the CQC at present~~ has now been approved, which means that the "Family Planning" regulated activity can be carried out at Maidstone Hospital. The Trust's relevant pages on the CQC website have been updated to reflect the CQC's decision. A CQC inspection of Tunbridge Wells Hospital reported in January 2014 concluded „moderate concerns' about the Management of Medicines and Staffing outcomes. Actions are underway to address the areas of concern identified by the inspection, and the latest position was reported to the Trust Management Executive on 17th September. A Care Quality Commission inspection of Maidstone Hospital was undertaken in February 2014. Actions are underway to address the areas of concern identified by the inspection, and the latest position was reported to the Trust Management Executive on 17th September. The outcome of the inspection by the CQC's Chief Inspector of Hospitals in October 2014 is awaited.	Compliant
For clinical quality, that: 3. the board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	The Medical Director is the responsible officer for medical practitioner revalidation. The Trust Board in May 2014 received the 2013/14 Annual Report from the Responsible Officer, and approved a „statement of compliance' confirming that the Trust, as a designated body, was in compliance with the regulations governing appraisal and revalidation.	Compliant
For finance, that: 4. the board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time	Trust response: The Trust reported a deficit for 2013/14 and the financial situation is under ongoing review with the TDA. The Trust was recently awarded £12m by the TDA for 2014/15. ~~However, t~~The Trust continues to operate as a going concern.	Compliant

Statement	Evidence of Trust compliance	Latest assessment
For governance, that 5. the board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times	The NTDA accountability framework aims to ensure that Trusts have a real focus on the quality of care provided. Under this framework, quality focus is achieved through: (i) Planning – the Trust conducts an annual process of service and budget planning and the Board reviews and agrees the IBP (ii) Oversight – the Trust participates fully in the oversight model (self-certification, review meetings) (iii) Escalation – The Trust welcomes support from the TDA and will cooperate fully with escalation decisions. The Trust, has fully engaged with a risk summit of performance issues (c.diff, surgical trainees, A&E) (iv) Development – the Trust will embrace the development model as appropriate. The Trust has committed to development programmes for (i) Board members; (ii) Executive team, (iii) Clinical Directors and (iv) General Managers/Matrons. (v) Approvals – the Trust is fully engaged in the FT application process and is awaiting dialogue with the TDA on the timetable towards authorisation. Trust values and priorities mirror the TDA's underpinning principles: ▪ local accountability – e.g. liaison with CCGs, Patient Experience Committee, patient satisfaction monitoring, whistleblowing & complaints management ▪ openness and transparency – e.g. embedded in Trust value on respect; duty of candour in Board Code of Conduct; open approach to Public Board meetings (which now take place each month) and both external &, internal communications channels; a growing membership ▪ making better care easy to achieve – the Trust's stated priority, above all things, is the provision of high quality & safe care to patients (Patient First). ▪ (d) an integrated approach to business – the Trust has adopted an integrated governance approach including an integrated performance dashboard.	Compliant
For governance, that: 6. all current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.	See 5 above. In addition: ▪ The Trust monitors performance each month in accordance with the TDA Quality and Governance indicators. A Board Assurance Framework and Board level risk register, supported by an overall Risk management Policy, are established and scrutinised by accountable Executive Directors, and reported ▪ Risks receive ongoing scrutiny and assurance ▪ Mitigating actions have agreed dates for delivery ▪ An annual Internal Audit plan is agreed and focuses on areas of key risk ▪ A professional Trust Secretary is employed ▪ A dedicated Risk Manager is employed ▪ The Trust fully participates in the TDA Oversight process	Compliant

Statement	Evidence of Trust compliance	Latest assessment
	▪ The independent assessment of the BGAF & QGF was conducted in July 2013 and the positive results reported to the Trust Board in September 2013; a follow up review conducted in December 2103 re-affirmed the assessment.	
For governance, that: 7. the board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance	See 6 above. In addition: All risks are RAG rated according to severity and likelihood; mitigating actions are monitored and reported. Key risks to the Trust's agreed objectives are reported via the Board Assurance Framework. The Trust Management Executive (EDs and CDs) is the designated risk management committee of the Trust and reports to the Trust Board.	Compliant
For governance, that: 8. the necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	The Board and its sub-committees are involved in the development of the Trust's annual plans, including specific aspects as required (financial, winter pressures, infection control, health and safety etc.). Key risks to the Trust's agreed objectives are reported via the Board Assurance Framework. The Audit and Governance Committee, like all Board committees, provides a report to the Board following each meeting which is presented by the Committee Chair (a NED). The Board is fully engaged to the development of the IBP and the Clinical Strategy that underpins it.	Compliant
For governance, that: 9. an Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	The Annual Governance Statement 2013/14 was agreed by the Trust Board in May 2014.	Compliant
For governance, that: 10. the Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward	Quality and governance indicators are monitored by the Board each month through the integrated performance dashboard. The Board is committed to achieving all targets and has set the vision of being in the best 20% of acute trusts nationally. The Trust is currently performing against the requirements of the NTDA oversight model.	Compliant

Statement	Evidence of Trust compliance	Latest assessment
For governance, that: 11. the trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit	The Trust has achieved IG toolkit level 2 for 2013/14	Compliant
For governance, that: 12. the board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.	A Trust Board Code of Conduct is in place which confirms the requirement to comply with the Nolan principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership. A register of interests is maintained and Board members are invited to declare any interests relevant to the agenda at the beginning of each Board meeting, and each Board sub-committee. A new Non-Executive Director commenced in September 2014, which means that all formal Board positions are now filled substantively.	Compliant
For governance, that: 13. the board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	▪ The composition and operation of the Board has been debated in Board development activity and a paper produced to enable the further review of Board composition when vacancies occur. ▪ A launch session for the Board development programme for 2014 took place in December 2013, facilitated by Hay Group; this will synchronise with separate Executive Director, Clinical Director, General Manager/Matron development programmes. ▪ The Remuneration Committee reviews the performance of Executive Directors. ▪ The TDA has conducted a review of the Trust Board. ▪ The Trust continues to adhere to the Oversight process.	Compliant
For governance, that: 14. the board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan	▪ All Executive Director (and Clinical Director) positions are filled. ▪ The objectives of Executive Directors cascade from the Trust's corporate objectives which are agreed by the Trust Board. The Trust Board agreed the Trust's objectives for 2014/15 in September 2014, and agreed that these objectives should also apply for the 2015/16 year (subject to minor amendments regarding specific targets)	Compliant

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - December 2014

12-20 Response to the Fit and Proper Persons Regulations Trust Secretary

Summary / Key points

At the Trust Board in November 2014, a discussion was held as to whether Board members should be subject to Disclosure and Barring Service (DBS) checking, in the light of the introduction of the "Fit and Proper Persons" Regulations (FPPR). The Trust Secretary was asked to consider the matter and make a recommendation to the Board regarding DBS checks. The enclosed report provides such a recommendation, as part of a proposed overall response to the FPPR.

Since the November Trust Board meeting, guidance and advice on the FPPR has been issued by NHS Providers (formerly the Foundation Trust Network), the NHS Confederation, NHS Employers, the Care Quality Commission (CQC) and NHS Trust Development Authority (TDA - which specifically relates to NHS Trust Chair and Non-Executive Director appointments). This guidance and advice has been reviewed, and informs the recommendations in this report.

In summary, the recommendation is to introduce an additional process for Board members, involving:
1. Self-declaration;
2. DBS check;
3. Due diligence checks;
4. Annual appraisal confirmation; and
5. Contract of employment

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
To agree the Trust's response to the newly-introduced "Fit and Proper Persons" Regulations

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

Introduction

- The "Fit and Proper Persons" Regulations (FPPR) for Directors of health service bodies are now in effect, and such bodies are required to ensure they have appropriate processes in place to ensure they comply with the requirements.
- This report proposes a response, which is presented for discussion and approval

Background

- The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry recommended that a statutory „fit and proper persons' requirement be imposed on health service bodies (in relation to their Directors[2])
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were duly enacted and the relevant aspects came into force on 27/11/14. The Regulations introduced the new requirement that Directors of health service bodies be "fit and proper persons"
- The FPPR apply to all Directors and "equivalents", which includes Executive Directors of NHS Trusts (as well as Foundation Trusts & Special Health Authorities[3]). The CQC guidance makes it clear that the FPPR will apply regardless of a Director's voting rights on a Board, and will apply to permanent, interim & associate[4] positions (providing they are members of the Board)
- In the case of NHS bodies, the Chairman of the Trust Board has responsibility to ensure that the FPPR are adhered to, in general terms. However, for Chairman and Non-Executive Directors of NHS Trusts, the duty to ensure compliance with the FPPR falls to TDA, as the appointing authority.
- The CCQ will assess a provider's processes for ensuring compliance with the FPPR, under their „well-led' domain. Specifically, the CQC will confirm that the provider has undertaken appropriate checks and is satisfied that, on appointment and subsequently, all new and existing Directors are "of good character" and are not "unfit" (see below), which may involve (at inspection) checking personnel files and records about appraisal rates for Directors. The CQC will also require the Chair of the NHS provider to declare that appropriate checks have been undertaken in reaching a judgement that all Directors are deemed to be fit and none meet any of the unfit criteria. The CQC will report on the FPPR under the „well-led' section in their inspection reports, and as part of this, will consider whether the FPPR have been breached. If this is concluded, the CQC will be able to take enforcement action. The CQC will not have the authority to remove individual Directors from their posts, though in effect, they can insist that NHS bodies do this, via their enforcement action, & via liaison with the TDA and Monitor.
- The FPPR state that Directors cannot be "unfit". The criteria for being "unfit" are absolute i.e. if any of the criteria apply, the individual should not hold a post as a Director. The criteria are that the individual cannot…
  - be an undischarged bankrupt;
  - have sequestration awarded in respect of their estate;
  - be the subject of a bankruptcy restrictions order;
  - be a person to whom a moratorium period under a debt relief order applies;
  - have made a composition or arrangement with, or granted a trust deed for, creditors;
  - be included in the children's barred list or the adults' barred list; and
  - be prohibited, by or under any enactment, from holding their office or position, or from carrying on any regulated activities[5].

[2] A statutory requirement for providers to ensure that their "workers" were "of good character" (inter alia) has been in place since 2010

[3] The Regulations do not therefore apply to Clinical Commissioning Groups

[4] The Regulations will not therefore apply to those staff who have "Associate Director" in their job title but who are not members of the Board

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

- Directors also need to be able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work for which they are employed. This requirement is not absolute, and involves an element of judgement.
- Directors also need to have the qualifications, competence, skills and experience which are necessary for the work to be performed by them. Again, this requirement is not absolute, and involves an element of judgement. Although the FPPR make no differentiation between „qualifications', „competence', „skills', and „experience', the CQC guidance makes it clear that providers may consider appointing an individual to a role based on their „qualifications', „skills' and „experience' with the expectation that they will develop specific „competence' to undertake the role within a specified timeframe.
- In addition Directors need to be "of good character". This requirement is also not absolute. However, in determining whether a Director is "of good character", the FPPR state that consideration should be given as to whether:
  - the person has been convicted in the UK of any offence; or
  - the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals
- Finally, Directors should not have "been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity…". This applies to any previous misconduct or incompetence in a previous role for a service provider, even if the individual was working in a more junior capacity at that time (or working outside England). Again, judgement is required, though the CQC guidance provides definitions of "Serious misconduct or mismanagement", "Responsible for, contributed to or facilitated", and "Privy to", to assist such judgements.
- The FPPR make no reference to convictions, bankruptcies or similar matters that have been „spent'. However, the CQC's guidance states that they will have regard to such considerations.
- The FPPR also make no distinction between the severity an "offence", & therefore a providers' considerations should not automatically exclude "minor" offences, including motoring offences

Assessment

- An additional process will need to be established, as the Trust's existing practices are insufficient to demonstrate compliance with the FPPR. For example, systematic checks are not made, nor central records kept, in relation to whether any Directors:
  - meet the criteria for being "unfit";
  - have been convicted in the UK of any offence;
  - have been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals etc.

Recommendations

a. In addition to the existing processes for appointing Board members (which incorporates certain pre-employment checks), the Trust should introduce a specific process for its Board members, to be coordinated by the Trust Secretary (in liaison with the Human Resources department), and to involve the following 5 steps (which are illustrated in Appendix 1):

   1. Each Director should be asked to sign a declaration covering the specific aspects of the FPPR (verbatim). The proposed declaration is enclosed at Appendix 2.

      It is recommended that the declaration forms part of the application process for new Executive Directors (the application process for new Non-Executive Directors is operated by the TDA), and that this be then re-affirmed on appointment (for all Directors), and annually thereafter (again, for all Directors). The latter two stages mirror the current Directors' declaration of interests process, and would be scheduled to be undertaken at the same time.

      If an individual is unable to sign the declaration, the reasons should be discussed with the Chairman of the Trust Board (the Trust Secretary will also be available for an initial discussion). For Executive Directors, the discussion should involve the Chief Executive. This discussion may result in the declaration being amended to reflect the specific circumstances of that individual. For example, they may have been convicted in the UK of a minor offence, which would prevent them from the signing the declaration, but which, in the

judgement of the Chairman, would not mean that they were not of “good character”. In this case, the declaration form would be amended to enable the individual to sign it, and a record would be kept (by the Trust Secretary) of the reasons why the declaration form was amended.

2. An “Enhanced with list checks” Disclosure and Barring Service (DBS) check should be undertaken for each Director. The “standard” DBS check covers spent and unspent convictions, cautions, reprimands and final warnings. The “Enhanced with list checks” check also includes a check of the DBS barred lists, which is one of the FPPR criteria for being “unfit” (as listed above).

   As DBS checks are by their nature retrospective, it is also recommended that the Trust applies the “DBS update” process to all Board members. This enables (for an annual fee, which is proposed to be paid by the Trust) employers to be notified of any changes to an individual’s DBS status proactively i.e. without the need to undertake a new check.

   If the DBS check identifies any convictions that have not been declared (see step 1 above), the Chairman will discuss the findings of the check with the individual (and the Chief Executive, for an Executive Director), and instigate appropriate action.

   The steps involved in the DBS process are contained in Appendix 3. The TDA will be amending their recruitment processes to ensure that all new Non-Executive Director appointees have a DBS check as part of their pre-employment checks. However, the Trust will be required to actually undertake the check on behalf of the TDA. The TDA have not yet confirmed which level of DBS check they will be requiring, but it is proposed that regardless of the TDA’s requirements, the Trust undertake the “Enhanced with list checks”, for the reasons stated above.

3. The Trust Secretary should undertake „due diligence’ checks for each Director, to support the declarations in step 1 i.e. to determine whether the individual:
   - is an undischarged bankrupt
   - has had sequestration awarded (which has not been discharged) in respect of their estate
   - is the subject of a bankruptcy restrictions order, or an interim bankruptcy restrictions order, or an order to like effect made in Scotland or Northern Ireland
   - is a person to whom a moratorium period under a debt relief order applies (under Part VIIA (debt relief orders) of the Insolvency Act 1986(b))
   - has made a composition or arrangement with, or granted a trust deed for, creditors (and not been discharged in respect of it)
   - Is not prohibited, by or under any enactment, from holding their office or position, or from carrying on any regulated activities
   - has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals
   - has been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity

   Such „due diligence’ checking should also incorporate any specific qualification requirements for Executive roles (e.g. that the Director of Workforce and Communications be a member of the Chartered Institute of Personnel and Development), and will include (but not be limited to) publicly available registers, such as:
   - the Individual Insolvency Register (IIR)
   - the Companies House database of disqualified directors (under the Company Directors Disqualification Act 1986)
   - the Insolvency Service’s register of Directors they got disqualified
   - the List of Registered Medical Practitioners
   - Nursing and Midwifery Council (NMC) register
   - Other professional registers
   - Publicly available investigation reports of failings within health and social care provision

Such checks will be undertaken on appointment, & annually thereafter. Ad-hoc checks will also be undertaken if any information is received that warrants such checks being made.

If these checks identify any issues of concern in relation to the FPPR, the Trust Secretary will raise these concerns with the Chairman of the Trust Board, who will in turn discuss the concerns with the individual, and instigate appropriate action.

4. The annual appraisal process for all Board members should incorporate a formal review and confirmation that the individual:
   - continues to have the qualifications, competence, skills and experience which are necessary for the work to be performed by them; and
   - continues to be able by reason of their health (after reasonable adjustments are made) of properly performing tasks which are intrinsic to the work for which they are employed

   These aspects should be part of the formal documentation for such appraisals.

   Obviously, this step is not intended to prevent any changes in an individual's circumstances being reviewed and responded to at the time such changes occur (i.e. relevant action should not be deferred until an individual's annual appraisal).

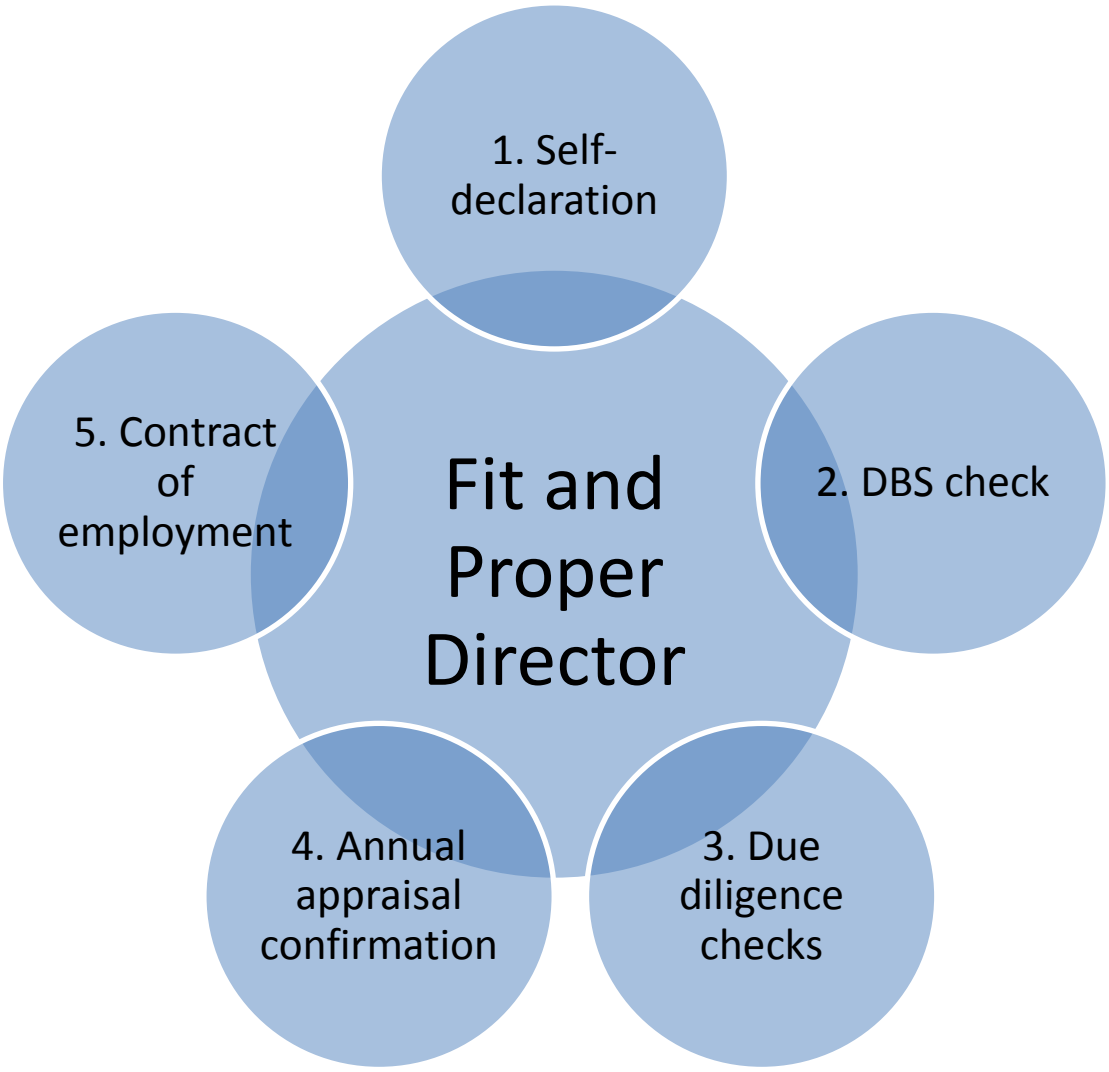
5. The contracts of employment for those marked with a * in the list in point b. below (and the standard contract for any new Executive Director appointments) should be reviewed, and if necessary amended, to take into account the fact that an individual cannot continue within the role should they meet any of the criteria for being "unfit" (as listed earlier).

The above 5 steps will be applied routinely. However, if an allegation is made that a specific Board member is in breach of the FPPR, the Trust Secretary will oversee an investigation into the circumstances of the allegation, and ensure the findings of the investigation are provided to the Chairman of the Trust Board, for consideration.

b. The process described in steps 1-5 should be applied to all those individuals who constitute the "Board", using the definition with the recently-ratified Standing Financial Instructions i.e. "Any person that is expected to be present at, and participate in, meetings of the Trust Board, as a matter of routine…". Currently, this would therefore include the following individuals:
   - Chairman of the Trust Board
   - Non-Executive Directors (5)
   - Chief Executive*
   - Chief Nurse*
   - Chief Operating Officer*
   - Director of Finance*
   - Director of Infection Prevention and Control*
   - Director of Workforce and Communications*
   - Medical Director*
   - Associate Non-Executive Director

c. The process described in steps 1-5 should be applied to all existing post-holders, as well as to new appointments (including any new appointments meeting the definition in point b). Although, legally speaking, the FPPR do not apply retrospectively, the CQC guidance makes it clear that providers are expected to apply the new requirements to their existing Directors.

Appendix 1: Diagrammatic representation of proposed process



Appendix 2: Proposed 'Fit and proper person' declaration for Directors

In accordance with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which the requirement that Directors (or equivalent) of health service bodies be "fit and proper persons", I hereby declare that…

(a) I have the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which I am employed

(b) I am able by reason of my health (after reasonable adjustments are made) of properly performing tasks which are intrinsic to the office or position for which I am appointed, or to the work for which I am employed

(c) I have not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity[6] or providing a service elsewhere which, if provided in England, would be a regulated activity

(d) I am not "unfit". In this regard…
- … I am not an undischarged bankrupt
- … I have not had sequestration awarded (which has not been discharged) in respect of my estate
- … I am not the subject of a bankruptcy restrictions order, or an interim bankruptcy restrictions order, or an order to like effect made in Scotland or Northern Ireland
- … I am not a person to whom a moratorium period under a debt relief order applies (under Part VIIA (debt relief orders) of the Insolvency Act 1986(b)).
- … I have not made a composition or arrangement with, or granted a trust deed for, creditors (and not been discharged in respect of it)
- … I am not included in the children's barred list or the adults' barred list, maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
- … I am not prohibited, by or under any enactment, from holding my office or position, or from carrying on any regulated activities[6]

(e) I am of "good character". In this regard…
- … I have not been convicted in the UK of any offence, or been convicted elsewhere of any offence which, if committed in any part of the UK, would constitute an offence
- … I have not been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

Signed:

Name Date:
Job title

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

Appendix 3: Steps involved in undertaking a Disclosure and Barring Service (DBS) check

1. The employer obtains an application form from the Disclosure and Barring Service (DBS)

2. The employer gives the applicant the form to fill in and return to them along with (original) documents proving their identity

3. The employer sends the completed application form to DBS

4. The DBS sends a certificate to the applicant. The employer has to ask the applicant to see the certificate

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - December 2014

12-21	**Annual Report & Accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund**	**Trust Secretary**

The Annual Report and Accounts of the Maidstone and Tunbridge Wells NHS Trust Charitable Fund were submitted to the Trust Board on 26/11/14, having duly been reviewed at the Charitable Funds Committee on 20/10/14. The Board gave its approval, based on the recommendation of the Charitable Funds Committee.

However, it has since been discovered that the version of the Annual Report and Accounts that was submitted to the Board on 26/11/14 did not contain the small number of changes that the Charitable Funds Committee was informed would be made before the document was submitted to the Trust Board. These changes are as follows:

1. Page 9: Cash investment changed from £613k to £615k (to reflect the revised balance from Santander)
2. Page 10: The "Resources Expended 2010/11 to 2013/14" graph has been replaced with a version with re-ordered columns (though the detail with the graph remains unchanged)
3. Page 11: Details of the £59k purchase of the Endobronchial ultrasound (EBUS) have been added
4. Page 12: The "Incoming Resources 2010/11 to 2013/14" graph has been replaced with a version with re-ordered columns (though the detail with the graph remains unchanged)
5. Page 19: The "Balance Sheet as at 31 March 2014" has been amended to reflect the additional £2k Santander balance (see point 1. above) and the creditor to reflect the sharing of this across the funds
6. Page 26: Note 6 reflects the additional £2k Santander balance (see 1. above)
7. Page 26: Note 7 reflects requirement to share this balance across the funds (see 5. above)

In addition to the above, during the final checks made with the External Auditors, it was agreed to change the text in Note 1.4, by deleting the text "in conjunction with the auditors" (so the text now reads: "Where there is a legal restriction or a binding agreement with a donor, on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. There are a number of funds currently classified as restricted where there is no evidence to support this classification. The Trust is continuing its work~~, in conjunction with the auditors~~ to correct this classification where appropriate". This change has been made as the new text more accurately reflects the situation (i.e. the Trust is not addressing this issue in conjunction with the auditors).

None of these changes represent a material difference to the Annual Report and Accounts that the Board approved on 26/11/14. However, the situation has been discussed with the Chair of the Charitable Funds Committee and Chairman of the Trust Board. And it has been agreed that, for completeness, the Board should be asked to approve these changes. The Management Representation Letter (which was also approved by the Board on 26/11/14) has not been affected.

The final version of the 2013/14 Annual Report and Accounts has not been re-submitted to the Board meeting, but is available on request from the Trust Secretary, should Board members wish to see the complete document.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Approval

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