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 24TH JUNE 2015

PENTECOST / SOUTH ROOMS, THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – PART 1

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6-4	To note progress with previous actions	Chairman	2	14-15
6-5	Safety moment	Chief Nurse	Verbal	-
6-6	Chairman's report	Chairman	Verbal	-
6-7	Chief Executive's report	Chief Executive	3	16
6-8	Integrated Performance Report for May 2015 (incl. updates on recruitment and retention; and DTOCs)	Chief Executive	4	17-28
	Presentation from a Clinical Directorate			
6-9	The Respiratory service	Respiratory Clinical lead	Presentation	-
	Quality items			
6-10	Progress with the Quality Improvement Plan	Chief Nurse	5	29-55
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6-15	Update on the future provision of Stroke services	Medical Director	Verbal	-
6-16	To approve the 'GS1 and PEPPOL adoption plan'	Medical Director	10	170-202
6-17	To approve revised Terms of Ref. for the KPP Board	Chief Executive	11	203-207
	Reports from Board sub-committees (and the Trust Management Executive)			
6-18	Workforce Committee, 01/06/15 (incl. approval of revised ToR)	Committee Chairman	12	208-212
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6-20	Quality Committee, 10/06/15	Committee Chairman	14	214
6-21	Trust Management Executive, 17/06/15	Committee Chairman	15	215
6-22	Finance Committee, 22/06/15 (to incl. approval of the Outline Bus. Case for a new ward at Tun. Wells Hosp.)	Committee Chairman (Chief Operating Officer)	16 (to follow) & 17	216-315
	Assurance and policy			
6-23	Actions in response to the national NHS staff survey 2014	Director of Workforce and Communications	18	316-318
6-24	Reflections on the scope of clinical practice of newly appointed Consultants	Medical Director	19	319-324
6-25	Approval of compliance oversight self-certification	Trust Secretary	20	325-335
6-26	**To consider any other business**			
6-27	**To receive any questions from members of the public**			
6-28	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:

- 22nd July 2015, 10.30am, The Education Centre, Tunbridge Wells Hospital
- 30th September 2015, 10.30am, The Academic Centre, Maidstone Hospital

Anthony Jones,
Chairman

Maidstone and Tunbridge Wells NHS
NHS Trust

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 27TH MAY 2015, 10.30 A.M. AT MAIDSTONE HOSPITAL

FOR APPROVAL

Present:	Anthony Jones	Chairman of the Trust Board	(AJ)
	Avey Bhatia	Chief Nurse	(AB)
	Sylvia Denton	Non-Executive Director	(SD)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Alex King	Non-Executive Director	(AK)
	Steve Orpin	Director of Finance	(SO)
	Paul Sigston	Medical Director	(PS)
	Kevin Tallett	Non-Executive Director	(KT)
	Steve Tinton	Non-Executive Director	(ST)
In attendance:	Paul Bentley	Director of Workforce and Communications	(PB)
	Wendy Glazier	Head of Service, Sexual Health (for item 5-10)	(WG)
	Jim Lusby	Deputy Chief Executive	(JL)
	Lesley Navaratne	Lead Clinician for West Kent Integrated Sexual Health Services (for item 5-10)	(LN)
	Kevin Rowan	Trust Secretary	(KR)
	Stephen Smith	Associate Non-Executive Director	(SS)
Observing:	Darren Yates	Head of Communications	(DY)
	Annemieke Koper	Staff Side representative	(AKo)
	Iain McMillan	Managing Director, Kent Pathology Partnership	(IM)
	John Underwood	3M UK (until item 5-11)	(JU)

5-1 To receive apologies for absence

No apologies were received, although it was noted that Sara Mumford (SM), Director of Infection Prevention and Control, would not be in attendance.

5-2 To declare interests relevant to agenda items

There were no declarations of interest.

5-3 Minutes of the Part 1 meeting of 29th April 2015

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

5-4 To note progress with previous actions

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

- **Item 3-30 ("Arrange for an article raising awareness of the level of resource involved in the preparation of dosette boxes by pharmacy staff to be included with the Trust's staff magazine").** The update was noted. PS stated that he would ensure a message was issued to staff in some form. AJ emphasised the importance of including an article in the Staff Magazine, as this was the commitment that had been made.
- **Item 4-12 ("Ensure that details of compliance with Level 3 Safeguarding Children Training is reported to future meetings of the Trust Board, via the Summary Report from the Workforce Committee").** AJ noted he had received an email regarding his non-compliance with Adult Safeguarding training. KR explained that he had been advised that this was a technical error within the relevant IT system, which meant all persons had received such an email, not just those that were non-compliant. KR confirmed that the Trust Board had received Safeguarding Adults and Children training in April 2014.

5-5 Safety moment

PS referred to a patient safety video that Board members had been shown during a session held after the Part 2 Board meeting in April 2015, and highlighted the following points:

- Vincristine was a psychotoxic drug that had beneficial effects, but caused death when administered intrathecally
- There had been circa 30 such cases worldwide that had resulted in death
- The story in the video seen by Board members was based on the death of a boy in 2001. In response, a series of alerts had been issued from the National Patient Safety Agency, though not all of the actions had been achieved across the country
- There were a number of different issues involved, relating to chemotherapy; spinal anaesthetics; and epidural anaesthetics (which still included inherent risks)

PS then gave further details of the case of the death of 12 year-old patient from Great Ormond Street Hospital in 1997, and read some text from a blog from the patient's mother. PS also showed the needles that had been re-designed as a result of such incidents, to prevent their recurrence.

KT queried what else could be learned from such incidents, and suggested that 'Safety moments' be discussed within the other the numerous meetings held within the Trust. GD noted this would be covered later in the Board, during the summary report from the Trust Management Executive. AJ commented that the message was clear, in that errors should be designed out of systems.

5-6 Chairman's report

AJ reported that the Trust had again been in Court regarding the Corporate Manslaughter charge against it, and the case had been referred for a Case Management Hearing at the end of July 2015. AJ noted that the proceedings were sub judice, and no further comment would be made by the Trust, but emphasised that this did not indicate any lack of sympathy for the family of the patient involved in the case.

5-7 Chief Executive's report

GD referred to the circulated report and highlighted that the Ambulatory Assessment Unit (AAU) at Tunbridge Wells Hospital (TWH) had opened that week. GD encouraged Board members to visit the Unit, and stated it would allow the Trust to treat patients far more appropriately. GD also commended AG and the clinicians involved in establishing the Unit.

GD continued that the Unit would hopefully be followed by a new Ward at TWH in January 2016. AJ asked whether the Trust was 'on track' with the opening of the new Ward. GD confirmed this was the case, but emphasised that this meant the Ward would be open in January 2016. AJ asked whether the arrangement had been agreed with the Trust's PFI partners. GD replied that an agreed process was in place regarding this.

GD then continued, and highlighted the following:

- He had attended the Annual General Meeting (AGM) of The League of Friends of Tunbridge Wells Hospital, and noted it was Lady De L'Isle's last AGM as President. GD commended Lady De L'Isle's contribution to the League of Friends, and to the Hospital
- The League of Friends of the Maidstone Hospital (MH) should also be commended, and he understood that takings from their shop in the hospital front entrance had increased
- Mobile devices were being issued to staff, to record patient vital signs in real-time
- The Trust's Innovations day was held earlier in the month, and although there were some device-related innovations, the vast majority of innovations were "app"-related
- A presentation had recently been given by the Respiratory team, to showcase their achievements. GD felt that the Board would benefit from receiving the presentation. It was agreed to schedule this for a future meeting. AG noted that the team had stated they would be available to present to Trust Board meeting in June 2015.

Action: Arrange for the Respiratory Team to give a presentation to a future Trust Board meeting (Trust Secretary, May 2015 onwards)

AJ asked for details of timing for the roll-out of the aforementioned mobile devices. PS replied that it was intended to complete this within three months.

KT referred to the "app"-related innovations, and commented that he would be willing to 'conceptualise' some of the apps with the Trust's Director of Health Informatics.

SDu asked what communication had been given to the local health economy regarding the new AAU. AG replied that there had been communication, but the intention was to control referrals to the Unit far more than the Urgent Medical and Ambulatory Unit (UMAU) at MH. AG added that West Kent Clinical Commissioning Group (CCG) regarded the AAU as the first line in the efforts to control the flow of patients into the hospital differently than at present.

5-8 Integrated Performance Report for April 2015 (incl. updates on recruitment and retention; and DTOCs)

GD referred to the circulated report and highlighted that issues remained with the achievement of the A&E 4-hour waiting time target, but there was hope that the situation would improve within the next few weeks. GD continued that there were also still significant numbers of Delayed Transfers of Care (DTOCs), which had been challenging. GD emphasised that the problem was not with the A&E department, but with the flow through the hospital, and it was hoped the aforementioned AAU would reap benefit, as would a more appropriate and beneficial response from Social Services.

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

- Non-elective demand and flow was still a priority
- Overall length of stay (LOS) for non-elective activity had increased by just under 1 day over the past year
- The number of Ward outliers had impeded teams in undertaking LOS and discharge work
- Escalation was currently easing, but still existed across both sites
- Performance was reviewed on a forthrightly basis, and the focus was on internal standards within A&E and the patient flow through the hospitals

AJ noted that the dashboard indicated that the forecast for achievement of the A&E 4-hour waiting time target was 95%, and stated that he anticipated this would therefore be the position at year-end. AG confirmed this was the intention, but highlighted that the Trust was dependent on other organisations to achieve that performance, though a large proportion of the achievement was related to internal management. AJ asked for clarification that the 95% listed was indeed a forecast, and not an ambition. AG confirmed the 95% was a forecast.

AJ then referred to LOS, and noted that this was being shown as 'green' on the dashboard. AG explained that the Trust's performance was still within the parameters that had been set. AJ noted that the forecast for elective LOS was 3.3, even though last year's performance was better than this. AG clarified that the forecast was based on the current month's performance. AJ queried whether the Trust should, in effect, be planning for worse performance than 2014/15. GD emphasised that comparison across the whole year was important, rather than just comparing performance for month 1, 2015/16 with that of month 1, 2014/15.

AG then continued, and highlighted that four further 52-week wait breaches had occurred, following a retrospective review of cases back to January. AG stated that these had now therefore been reported, and more rigorous systems had been implemented. AG added that the level of training provided to the administrative staff involved in the systems had also been increased.

AJ asked about 62-day waits for Cancer, and noted that the dashboard indicated that the Trust was forecasting not to improve at year-end. AG explained that the forecast was based on month 1 performance, but the improvement trajectory included a plan to improve in Quarter 1. AJ asked AG to ensure that the forecast was updated to represent the actual year-end forecast.

Action: Ensure that the "forecast" figures within the "Performance & Activity" section of the Trust Performance Dashboard were updated to reflect the actual year-end forecast (Chief Operating Officer, May 2015 onwards)

KR then pointed out that the dashboard had contained errors in relation to the "Primary Referrals" and "Cons to Cons Referrals" indicators. KR explained that the figures in the "Year to Date - Curr Yr" column for the two indicators was incorrect, and should be the same figures that feature in the "Latest month - Curr Y" columns.

AB then referred to the circulated report and highlighted that complaints responses were still challenging, and a different approach had therefore been discussed, which involved the central complaints team drafting the response letter, based on information provided by the Directorate. AB added that the new approach would be trialled to see whether it made a difference to performance.

AJ stated that he believed the low performance was related to the priority afforded to the matter by Directorates. AB acknowledged the point, but stated that the new approach was being trialled in response to a query to the Directorates as to how performance could be improved.

KT asked whether there was anything that could be learned from Directorates that were performing well with the existing approach, and also asked whether work was being undertaken to learn from complaints, to reduce the number of complaints being made. GD acknowledged that it was disappointing that the Trust had the response rate it did, given the reduced number of new complaints. SDu noted that 'learning from complaints' was on the agenda of the next Quality & Safety Committee 'deep dive' meeting, and noted that AB would be submitting a report, but SDu would also be submitting a report of her own recent review of a number of complaints cases.

AB then continued, and highlighted that for Friends and Family Test (FFT) data, the forecast data within the dashboard would change as new benchmark data was received. AB also noted that there was to be a move away from the Net Promoter Score, and more of a focus on the percentage of positive responses, rather than just focusing on the response rate. AJ commented that the level of positive FFT responses for Outpatients would benefit from further analysis, if the score did not improve. AB acknowledged the point.

KT asked why there was a move away from the Net Promoter Score. JL replied that it had been considered to be too confusing.

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

- The month 1 financial position was slightly better than plan
- Pressure from pay costs still existed, and temporary staffing usage was still significant, albeit this was less than the peak seen in March 2015. Usage was however still higher than in April 2014
- Financial forecast information was not yet available, but would be added at month 2
- The Trust remained on course regarding cash management, although this was slightly below plan. Cash support was likely to be needed in Quarter 3, most probably in November 2015
- Capital expenditure had commenced earlier than in previous years, but SO acknowledged the need to increase this. The Capital plan included large projects, such as the new Ward at TWH, and the Ward refurbishments at MH

SDu asked whether the £1m variance against planned income was solely related to high cost drugs and devices costs. SO replied that these items were the most significant element of the variance, and added that at this point in time, he was therefore content that this would not result in a significant adverse impact on the year-end Income and Expenditure position.

SDu then asked about the volume of uncoded activity. SO noted that there was some increased elective activity, and speculated that the issue may relate to more complex activity, which took longer to code.

SDu then referred to the Transitional Support for Cancer activity, and the comment on page 19 that "The Trust will have to take appropriate steps to reduce its expenditure base accordingly", and remarked that the Trust needed to take action now. SO acknowledged that the comment in the report could have been worded differently, but confirmed that action was being taken.

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

- The staffing position would change in relation to the Kent and Medway Health Informatics Service and Kent Pathology Partnership
- Temporary staffing usage was higher than in previous years
- Forecast data would be submitted to the Workforce Committee in June, and then added to the performance dashboard
- Sickness absence had reduced
- Recruitment saw a net increase of 18 WTE nursing staff. A team from the Trust was currently in Italy, recruiting for Registered Nurses. 130 staff had been offered and had accepted posts.
- Future overseas recruitment was planned in Romania and the Philippines

AJ asked PB whether he was confident that the Trust would achieve its recruitment targets for the year. PB replied that this was likely to be very challenging. AJ remarked that the Trust was 500 staff below plan on current figures, and asked whether this was an agreed number. PB answered that some posts had been held vacant, and confirmed that not all of the 500 posts would be filled in the year. AJ asked whether PB was forecasting any major problem areas. PB stated that challenges still continued in recruiting medical staff on medical rotations, Care of the Elderly Physicians, and Registered Nurses, and these were his main areas of concern.

KT then referred to triangulation between activity, budget and workforce. PB confirmed that the establishment shown in the report was aligned with activity and budget. KT queried that there would have been some planning assumptions that had been made. SO confirmed this was the case, and added that such assumptions had been informed by Directorates' views.

5-9 Theatre scheduling – issues and potential solutions

AG referred to the circulated report and highlighted the following:

- The report had been prompted by a discussion at the Finance Committee
- A Theatre Utilisation Steering Board had been established
- A maximum of 73 hours per week would be provided per operating theatre
- A Master Schedule had been produced, and although it was initially intended to introduce a 4-week rota, this had now been delayed until the implementation of the new Patient Administration System (PAS). Until then, a 5-week rota would be in place, which was to the satisfaction of the clinical leads involved
- It was recognised that there was more work to be done in terms of increasing capacity, but this would involve 6-day working in some specialities, and also extended working to 7pm. These would continue to be explored by the Theatre Utilisation Steering Board

AJ remarked that on reading the report, he had concluded that the Trust did not have a problem with physical theatre capacity, but the problems were with bed capacity, and therefore the Trust did not need to build new theatres. AG confirmed this was the case.

AG then added that some expertise in theatre utilisation had been obtained from Meridian Productivity Ltd., with the aim of future-proofing the service.

SO referred to the outsourcing of activity, and asked whether, if activity stabilised, outsourcing would only be needed at certain points during the year, as opposed to this being a constant feature. AG confirmed this was the case.

KT then asked about the comparison between productivity rates when Consultants undertook clinical activity in the independent sector. PS replied that productivity data from the independent sector was not routinely available. KT suggested establishing a 'learning set' of Consultants who know their productivity within the private sector. PS acknowledged the suggestion, but gave assurance that Consultants were keen to increase productivity wherever possible. GD added that the aforementioned work being undertaken by Meridian would give Consultants the opportunity to identify factors that could improve their productivity. AG added that the Meridian team included three clinicians, and some ideas to increase productivity had already been proposed.

SDu referred to the statement in the report that "Lack of clinical leadership to support changes to job plans and working practises required to create more capacity within existing estate" was a "challenge", and asked for a comment. AG explained that there were some fixed points in Job

Plans that were difficult to change, and the clinical lead would often be unwilling to drive such changes. AG acknowledged that "lack" was a strong word to use in the report, and clarified that further clinical leadership should be encouraged. SDu asked whether new Consultant appointments offered the opportunity to increase flexibility. PS added that flexibility regarding 7-day working was incorporated within the Consultant contract, but the contract prevented the introduction of other forms of flexibility.

AJ stated he would be interested in establishing what other hospitals would be providing, in terms of theatre operating time, compared to the Trust's 73 hours per week. PS highlighted that the Trust would operate a maximum of 73 hours per week, and not every theatre would operate at such levels. AG noted that benchmarking information would be provided as part of the Meridian work.

Presentations from Clinical Directorate

5-10 Sexual Health

AJ welcomed LN and WG to the meeting. LN gave a presentation highlighting the following:

- The service currently saw circa 12,000 patients per year. There was a small team of 7, and circa 70% of clinics were Nurse-led.
- Kent County Council (KCC) tendered for an integrated Sexual Health service in September 2014. An 'Integrated Service' involved Sexual Health and GUM services; and HIV care and contraception. There were two tenders: one for West & North Kent, and one for East Kent
- The Trust submitted a tender in partnership with Kent Community Healthcare NHS Foundation Trust (KCHFT) to provide services in West & North Kent
- KCC awarded £4.9m contract to the Trust as Prime Provider, to commence on 01/04/15. It was originally intended for the contract to be awarded in December 2014, but this was delayed.
- The Trust's Head of Service Improvement, Steve Williams, should be thanked for his work in supporting the tender application
- In terms of the contract award, the Trust would directly manage the service in West Kent and sub-contract KCHFT to deliver services in North Kent
- The Trust would be responsible for the suitability of premises, service review, and SRI and performance reporting
- There would also be shared clinical guidelines, and clinical network development

AJ asked who would be provided with performance reporting information relating to the service. LN confirmed this would be KCC.

LN then continued, and highlighted the following:

- The Trust would receive 80% of the contract value on a block basis with 20% available on a cost-per-case basis
- The Trust was scheduled to be at 100% capacity from 01/10/15
- Opportunities for economies of scale included clinical support services such as Pathology, Pharmacy, HIV care; opportunities to provide additional sexual health services to the Kent population (including 7 prisons); and a centralised results service
- The service would be operated via a 'Hub', 'Super-spoke' & 'Spoke' model, with Maidstone being the Hub
- The service would include: extended opening hours (8am to 8pm, Monday to Friday; and weekend clinics); a single point of access (through a KCC-provided sexual health website, telephone and on line booking); Walk-in services / appointments clinics / specialist clinics; email advice (called "Just Ask"); and a professional referral service (through fax and email); sexual health screening; contraception services (nurse-led); a Consultant-led service for HIV, complex GUM and contraception; and dedicated Young Persons clinics (for those under 25)
- Outreach groups would be targeted via a "pop-up" service, whereby a bus would take the service direct to an area, and offer tests, including HIV testing.
- The overall aim was to increase Chlamydia screening, reduce teenage pregnancy, and reduce late diagnosis of HIV
- The vast majority of patients would self-refer, but fast access to appointments was important, given that Sexually Transmitted Infections (STIs) were a public health issue
- In terms of risks, the contract delivery was for an initial 2 years plus a potential further 2 years

- In addition, KCC had assumed responsibility to secure the premises from which services would operate, but not all premises had been secured. Furthermore, there were queries regarding the suitability of existing premises, and notice had been given on existing premises. This latter point had not been anticipated, but the Trust was working closely with KCC to resolve.
- In terms of IT, the service specification required IT functionality in which patients are able to book appointments on-line
- Challenges included 25 extra staff that were to be 'TUPE' transferred to the Trust but this only represented 11 WTE, as there were many part-time staff. In addition, there was a need to dual train staff in sexual health and contraception; as well as a shortfall in medical workforce - only 1 of 3 WTE Consultant posts were filled at present (by LN). There were also different Terms and Conditions for staff transferred from KCHFT
- Opportunities existed in relation to Clinical Support Services, and the Trust was to start providing Pharmacy services for STI treatments, contraception and HIV medication for North Kent, as well as pathology services for North Kent
- There would also be opportunities for Point of Care testing; clinical network development; and shared audit, research, education and training
- The future strategy included access to accurate information; temporary location of services; workforce training and development; clinical care pathways and policies; working collaboratively with KCHFT; and working with experienced providers to deliver specific service requirements (Brook for young people; and the Terence Higgins Trust for the HIV at risk group)

AJ asked what was happening with the contract for East Kent. LN confirmed that KCHFT had won the contract for East Kent. AJ then asked what the expected level of surplus would be from the contract. WG stated that the contract was worth £1.4m, and KCC had agreed to pay 80% regardless of the service delivered. WG confirmed that a healthy surplus was therefore expected.

AJ then asked for further details of how the contract was to be paid. WG explained that the Trust had to deliver a service to a specified level of activity. SO added that he understood that activity was not capped, and that additional activity would continue at the same income, but stated that going forward, the contract was likely to be on a cost-for-case basis.

PS thanked LN for her presentation, and for the leadership she had demonstrated to the service.

JL also commended the presentation, and stated that he would like to liaise with LN outside the meeting on some of the challenges highlighted, including IT-related problems. JL also asked whether primary prevention was included in the contract, and also to what extent outcomes and effectiveness were measured. LN replied that early diagnosis was a clear priority, which would have beneficial effects on outcomes, but acknowledged that in terms of Chlamydia screening, KCC were unsure of the outcomes required, so the Trust would continue to press KCC on this. WG added that the Trust was inheriting 3 Outreach Nurses, which was a new venture for the Trust.

AJ asked exactly where the Sexual Health service was located. WG explained that the service was located opposite Peale Ward at Maidstone Hospital, next to The Chronic Pain Service.

AJ thanked LN and WG for their presentation.

Quality items

5-11 Progress with the Quality Improvement Plan

AB referred to the circulated report and highlighted there was one 'red' rating, relating to overnight discharges from ICU, which were still occurring.

AJ stated that he would be keen to understand whether such discharges were occurring because of action that had not been taken by the Trust. AB replied that tracking of the situation was fundamental in ensuring that everything that could have been done to avoid overnight discharges had been done, and that the remainder of discharges were therefore for clinical reasons.

AJ asked what performance was required to enable the Care Quality Commission (CQC) to be satisfied. AB replied that the CQC would be interested in seeing the tracking system in place, but

noted that some such discharges would be expected to occur. AJ asked why the rating was therefore 'red'. GD added that the number of discharges (7) was an indication that these were occurring more routinely than should be expected, and therefore suggested that the aim should be to only have 2 to 3 such discharges.

SD referred to the statement that "…the second evening ward round takes place either in person or via telephone depending on acuity of patients", and asked what frequency such ward rounds occurred. PS replied that the arrangements described in the report were in accordance with the Intensive Care Society (ICS) Core Standards. SD asked for clarification that a judgement was therefore required by clinical staff. PS and AB confirmed this was the case.

KT commended the format of the report, but remarked that some of the ratings were not aligned with the "Action completion date". AB acknowledged the point, but pointed out that the dates were regularly reviewed. GD noted that this debate had been held at the last Board meeting, and suggested that the report could be clearer. AB acknowledged the point, but highlighted that some of the ratings involved an element of judgement.

AB then highlighted that she intended to establish a small team, in June/July, to test out whether the actions had resulted in a change in practice 'on the floor'.

PS then pointed out that in terms of 'out of hours' discharges from ICU, the Trust was the 26th worst Trust, but other local Trusts performed far worse, and added that he would circulate the link with the benchmark data on 'out of hours' discharges from ICU. AB stated that the context was helpful, but this did not negate the need for the Trust to improve.

5-12 Clinical Quality and Patient Safety Report

AB referred to the circulated report and highlighted the following:

- The Trust was a low reporter of incidents, according to data from the National Reporting and Learning System (NRLS). This message had been reiterated by the CQC, and by the Trust's staff survey findings. Improvement had occurred, but this was slow
- The reasons for this had been explored with clinical staff, and some feedback had been included in the report
- The work aligned with that being undertaken by the external Governance Adviser

KT noted the potential benefit of using mobile applications to make reporting easier. This was acknowledged.

SD asked about the timescale for introducing an improved Datix IT system. AB noted this was taking time, but confirmed that work was being undertaken with staff to introduce a new system.

AB added that the Trust could learn from the top reporting Trusts, and confirmed such learning was intended.

KT remarked that he did not believe efforts should be focused on a back-end system such as Datix, and appealed for efforts to be focused on front-end reporting. AB acknowledged the point.

5-13 Planned v actual ward staffing for April 2015

AB referred to the circulated report and highlighted the following:

- There were 2 areas with an overall RAG rating of 'Amber': John Day Ward and Ward 12
- John Day had a number of vacancies, and this was a recurring theme, but Ward 12's issues were more recent, and were related to a high level of vacancies (6), which was unusual. The Ward's FFT score (44) was also quite low, with a good response rate. Further work was therefore taking place with the Ward.
- Hedgehog and the Neonatal Unit had not been given a RAG rating, as there were some issues regarding consistency of methodology, in terms of the inclusion of trained and non-trained staff. The Wards would therefore be working to rectify the issues.

SDu asked whether it was possible to determine whether having 'actual' Ward staffing levels above 'planned' levels was associated with expenditure above budget. SO replied that budgetary

information by Ward was available, and at present, the focus was on tracking the budgetary expenditure from 2014/15 with AB's Ward staffing review, but confirmed it may be possible to undertake such analysis. GD added that it was important to recognise that such analysis needed to be flexible, as it would never be 100% accurate. It was agreed to undertake some further analysis.

Action: Undertake further analysis to determine whether having 'actual' Ward staffing levels above 'planned' levels was associated with expenditure above budget (Director of Finance, May 2015 onwards)

5-14 Findings of the national inpatient survey 2014

AB referred to the circulated report and highlighted the following:

- Overall there was little change from the previous survey
- There had been one statistically significant favourable shift, which related to patients being offered choice of food. This was pleasing as much work had been done in this area
- There were two statistically significant adverse shifts, which related to hospital specialists receiving sufficient information from the original referrer; and privacy when discussing condition or treatment
- The Trust's performance was within the mid-range when compared to other Trusts
- The report would be discussed further at the Patient Experience Committee in June, and an action plan would be produced
- The likely focus of action would be on improving the issues covered in questions 46 to 48, which related to operations and procedures

AJ commented that it was a reasonable report, but the Trust was performing around average, and that therefore there was further room for improvement. KT expressed caution that although AB's focus on certain questions was warranted, complacency should be avoided regarding the areas where the Trust was at the lower end of the average. AB acknowledged the point.

SD asked what action was intended in relation to the lack of information being given to Specialists from referrers. AB replied that further consideration was required before determining a response.

Planning and Strategy

5-15 Confirmation of Trust's planning submissions, 2015/16

SO referred to the circulated report and highlighted that the planning submissions had been made to NHS Trust Development Authority (TDA) on time but these had not yet been formally accepted by the TDA. SO continued that further queries and discussions with the TDA were therefore expected, but until the Trust was told differently, it was working with the assumptions in the submissions.

AJ asked whether the TDA had approved any Trust's plans. SO confirmed that he understood no Trust's plans had been approved by the TDA.

5-16 Discussion of the assumptions underlying the 2015/16 Winter and Operational Resilience Plan

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

- There would be further iterations of the Plan
- Winter planning was not just about increasing bed capacity
- A number of issues that arose from the last winter were being explored, as well as some of the national reports relating to the NHS as a whole, including poorer access to Mental Health services etc.
- Detailed modelling of demand and capacity had been undertaken, and this had formed the basis of the Plans
- An Ambulatory Unit at TWH had been configured, which was important in developing the Trust's resilience over the coming months
- Planning was also advanced regarding a 39-bedded inpatient facility at TWH
- Traditionally, winter was considered to start in mid-December, but this year, the start of winter would be brought forward to 01/11/15, based on the lessons from last year

- Leave plans, Theatre schedules and elective capacity had all been reviewed as part of the plans, working with Directorates. There had also been working with partners in the local healthcare economy
- Risks had also been assessed
- The 'next steps' related to the need to maximise stakeholder engagement
- Reporting would be monthly to the Trust Management Executive, and bi-monthly to Board

AJ asked whether, if the submitted plans were in place for last year, the situation would be controlled so that the 95% A&E 4-hour waiting time target and elective plans would be met. AG replied that for last year, contingent capacity would still have been required, over and above what was in the circulated plan. AG elaborated that DTOCs needed to be reduced, ideally to 2.5%, and the wider system needed to work a lot smoother. PS added that the situation would have been much better, but there would still have been escalation areas at the Trust.

AJ asked for clarification that escalation would still be required under the submitted plans, if the same circumstances occurred for the coming winter as for the last. AG confirmed this was case, but noted the plan would enable the Trust to manage better. KT stated that it would be possible to model the potential impact of circumstances similar to last winter, to enable AJ's question to be answered more definitively. The point was acknowledged, and AJ asked AG what the 'Plan B' would be. AG answered that if certain triggers were reached, escalation would occur. KT reiterated his point that modelling would enable this to be understood with more certainty. AJ stated that he would welcome such additional modelling.

SDu asked what action was planned to clear the blockages that existed in, for example, the Nursing Home sector. AG explained that although it was not explicit within the report, work was taking place with the Nursing Homes that had the top five number of conveyances, and also with the Hospice. AG added that this work was contained within the detailed plans.

GD stated that the Plan would be informed, via an iterative process, by comments from other partners, including KCHFT, and therefore some of the challenges raised by the Board would be addressed in future revisions. It was agreed to submit an updated version of the Plan to the Trust Board in July 2015.

Action: Submit an updated version of the Winter and Operational Resilience Plan to the Trust Board in July 2015 (Chief Operating Officer, July 2015)

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

5-17 Audit & Gov Cttee, 06/05/15 & 27/05/15 (to include Audit & Gov Cttee Annual Report for 2014/15)

KT referred to the circulated report and highlighted that PS had attended and addressed the Committee's concerns regarding Consultant Job Planning.

Questions were invited. None were received.

5-18 Quality & Safety Committee, 13/05/15 (to incl. approval of revised Terms of Reference)

SDu referred to the circulated report and highlighted that the Terms of Reference needed to be approved, which included a proposed change of name, to "The Quality Committee".

ST referred to Terms of Reference and stated that he understood that the principle had been agreed that not all Non-Executive Directors would be considered to be formal members of the Committee. AJ confirmed this had been agreed previously, and requested that this be reflected in the Terms of Reference.

Action: Ensure the Terms of Reference for the Quality Committee reflect the principle that only two Non-Executive Directors were to be considered as formal members (Trust Secretary, May 2015 onwards)

The Terms of Reference were approved subject to the amendment noted above.

5-19 Trust Management Executive, 20/05/15

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

- Theatre scheduling had been discussed, and the Clinical Director for Trauma & Orthopaedics confirmed their satisfaction
- The configuration of the new Ward at TWH was discussed, and it was agreed to introduce a bayed environment
- The meeting included a 'Safety moment'

AJ asked for further details of the "GS1 & PEPPOL adoption plan". PS explained that it related to bar-coding. SO added that the Board would be asked to approve an adoption plan in June 2015.

Assurance and policy

5-20 Responsible Officers Annual Report 20114/15

PS referred to the circulated report and highlighted the following:

- The appraisal system had been audited and on the whole was satisfactory
- NHS England would be visiting the Trust, to assess its processes, w/c 01/06/15
- Details of who had been appraised were contained in the report

ST asked about the 12 Consultants who had not been appraised. PS confirmed that there were acceptable reasons for all 12. AJ asked PS what action would be taken for the single Consultant who had not engaged in the appraisal process. PS replied that appropriate Trust policies would be followed, as non-engagement was not acceptable. AJ concurred with PS's latter point.

ST referred to the comment on page 139 of 277 that "The Trust governance structures are in place and allow scrutiny of clinical performance throughout the Trust" and asked for further details regarding the scope of practice of Consultant staff, in terms of competence in undertaking day-to-day procedures. PS replied that Consultants were appointed knowing their scope, and requests to undertake new interventional procedures were discussed via the Standards Committee, which reported to the Quality Committee. ST elaborated, and asked for confirmation that there was no Consultant being asked to undertake clinical work behind their level of experience. PS answered that there was no firm system that judged exactly what clinical work Consultants were undertaking, but the Consultant appraisal system was intended to affirm that Consultants were competent with the work they were being asked to undertake.

SDu stated that the source of ST's questions related to changes in the training hours now required for Consultants, which had reduced from the Consultants that had been appointed in the past. SDu added that a mentoring system may be warranted. PS confirmed that a mentoring system was in place at the Trust. ST opined that the Trust Board should direct the Medical Director to develop a system that ensured competence for individual Consultant's practice. PB commented that the Trust's aim should be to satisfy the demands of Royal Colleges etc. that Consultants were not being asked to undertake clinical duties beyond their level of competence.

AJ asked PS to consider the issues raised, and provide his thoughts at the next Board meeting. PS agreed to provide some verbal thoughts.

Action: Consider the issues raised at the Part 1 Board meeting in May 2015 relating to the scope of clinical practice of newly appointed Consultants, and provide some thoughts on the matter to the Trust Board in June 2015 (Medical Director, June 2015)

SD then referred to appraisal outputs not signed within 28 days, and asked for a comment. PS confirmed that this was not a concern to him, as the documentation was eventually provided.

AB then highlighted that Nurse Revalidation would be discussed at the Workforce Committee on 01/06/15.

The Board approved the declaration within Appendix F of the report, as circulated.

5-21 Approval of compliance oversight self-certification

KR referred to the circulated report and highlighted the following:

- The TDA had been asked whether the same statements were in place for 2015/16 as those in place for 2014/15, but a reply had not yet received, so an assumption had been made that the 2014/15 statements remained in place
- There was no change in compliance status from that approved by the Trust Board in April 2015

The submission was approved as circulated.

Annual Report and Accounts

5-22 Approval of Ann. Report, 2014/15 (incl. Gov. Statement)

KT referred to the circulated report and highlighted that it had been reviewed at the Audit and Governance Committee held earlier that day, and the Committee had agreed to recommend that the Report be approved by the Trust Board.

Questions and/or comments were invited. None were received.

The Annual Report for 2014/15 was approved as circulated.

KR then commended Sharon Chapman, Assistant Trust Secretary for her work in producing the early drafts of the Annual Report.

5-23 Approval of Annual Accounts, 2014/15

KT referred to the circulated report and highlighted the following:

- The Accounts had been reviewed at the Audit and Governance Committee held earlier that day, and the Committee had agreed to recommend that the Accounts be approved by the Board
- The key discussion at the Audit and Governance Committee related to Value for Money conclusion, and noted that “except for” conclusion had been challenged, but it had been noted that this could be removed in the future, should the Trust’s circumstances change
- The external auditors had commended the Trust’s finance team

AJ asked SO to pass on the Trust Board’s commendations to the finance team. SO agreed.

The Annual Accounts for 2014/15 were approved as circulated.

5-24 Approval of Manag. Representation Letter, 2014/15

KT referred to the circulated report and highlighted that it had been reviewed at the Audit and Governance Committee held earlier that day, and the Committee had agreed to recommend that the Letter be approved by the Trust Board, subject to a minor change to the spelling of one word.

The Management Representation Letter was approved.

5-25 To consider any other business

There was no other business.

5-26 To receive any questions from members of the public

AK noted that there had been work undertaken, and reports produced, to aim to reduce the occurrence of sharps injuries among staff, and offered to circulate the reports to Board members. AJ accepted the offer, and agreed the reports should be circulated.

Action: Circulate (to Board members) the reports that had been produced to aim to reduce the occurrence of sharps injuries among staff (Trust Secretary, May 2015 onwards)

5-27 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 – June 2015

6-4 Log of outstanding actions from previous meetings — Chairman

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
3-30 (Mar 15)	Arrange for an article raising awareness of the level of resource involved in the preparation of dosette boxes by pharmacy staff to be included with the Trust's staff magazine	Director of Infection Prevention and Control	March 2015 onwards	A verbal update will be given at the June Board meeting.
5-13 (May 15)	Undertake further analysis to determine whether having 'actual' Ward staffing levels above 'planned' levels was associated with expenditure above budget	Director of Finance	May 2015 onwards	A verbal update will be given at the June Board meeting.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
4-12 (Apr 15)	Ensure that details of compliance with Level 3 Safeguarding Children Training is reported to future meetings of the Trust Board, via the Summary Report from the Workforce Committee	Director of Workforce and Communications / Chair of Workforce Committee	June 2015	An update has been provided to the June Board as part of the summary report from the Workforce Committee
5-7 (May 15)	Arrange for the Respiratory Team to give a presentation to a future Trust Board meeting	Trust Secretary	May 2015 onwards	The Respiratory Team have been scheduled to give a presentation to the June 2015 Trust Board
5-8 (May 15)	Ensure that the "forecast" figures within the "Performance & Activity" section of the Trust Performance Dashboard were updated to reflect the actual year-end forecast	Chief Operating Officer	May 2015 onwards	The "forecast" figures within the dashboard for month 2 has been amended.
5-18 (May 15)	Ensure the Terms of Reference for the Quality Committee reflect the principle that only two	Trust Secretary	May 2015 onwards	The Terms of Reference were amended to remove "Non-Executive Directors" from the "Membership"

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	Non-Executive Directors were to be considered as formal members			section (which just leaves the "Non-Executive Director (Chair)" and "Non-Executive Director (Vice Chair)" as "Members"); and to add the following sentence to the "Attendance" section: "All other Non-Executive Directors (including the Chairman of the Trust Board) and Executive Directors (i.e. apart from listed in the "Membership") are entitled to attend any meeting of the Committee". This wording mirrors that used in the Terms of Reference of other Board sub-committees
5-20 (May 15)	Consider the issues raised at the Part 1 Board meeting in May 2015 relating to the scope of clinical practice of newly appointed Consultants, and provide some thoughts on the matter to the Trust Board in June 2015	Medical Director	June 2015	A report has been submitted to the June Trust Board
5-26 (May 15)	Circulate (to Board members) the reports that had been produced to aim to reduce the occurrence of sharps injuries among	Trust Secretary	May 2015	The information was circulated to Board members (via email) on 29/05/15

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
5-16 (May 15)	Submit an updated version of the Winter and Operational Resilience Plan to the Trust Board in July 2015	Chief Operating Officer	July 2015	The item has been added to the forward programme for July

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - June 2015

6-7	Chief Executive's update	Chief Executive

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

1. I have met with more of our staff, patients and their relatives since our last Board meeting, discussing different aspects of the care we provide and patients receive, and possible areas of learning and improvement. I have shared patient feedback from recent surveys and complaints themes with our staff to aid this process. I attended a presentation by our Respiratory Integrated Care Pathway team who are providing a new service that combines care both within the community and in our acute hospitals to better support and care for patients with chronic obstructive pulmonary disease. This is another way in which we are providing patients a seamless service and helping them better manage their conditions at home. Our doctors are also working with our top 10 nursing homes with the highest level of referrals and looking at ways of supporting the care their residents receive, reducing possible hospital admissions.

2. We are piloting a new culture change programme for our staff, focusing on the importance of ensuring our patients have a positive experience. We are also using this as an opportunity to help our staff define our future direction and how we achieve our future vision together.

3. We have appointed five new consultant paediatricians as part of our commitment to further enhance unplanned children's care in West Kent. The new consultants start in the autumn, providing a dedicated consultant paediatric presence in Tunbridge Wells Hospital A&E department seven days a week. This is a defining improvement in paediatric care within Kent.

4. Work has started on the next phase of our ward redevelopment programme at Maidstone Hospital. Jonathan Saunders and John Day wards at Maidstone are being transformed into a new respiratory ward at a cost of £3 million. This development continues to modernise the hospital's aging wards. It has been a huge team effort across the whole range of our staff to achieve this, and I am very grateful for the leadership shown by matrons and ward managers to ensure all wards and departments ran smoothly while associated moves took place.

5. Our stoma care nurses at Maidstone Hospital have made it through to the national finals of the Purple Iris Award, which celebrates the best stoma care departments across the country. They are already rated among the top five teams in the country by making the award shortlist and we wish them well for the grand final in July.

6. The Maidstone Birth Centre continues to go from strength to strength, celebrating another milestone with the arrival of its 1500th baby. Leon Guntrip was born on 1st June weighing 6lb 10oz. Leon's mother Hannah praised our Birth Centre staff, who she said were amazing.

7. I would like to thank the Kent and Sussex Hospital Fund Darts League for their generous donation of £10,000. This latest donation from the League, which has now raised £100,000 for the Trust, has been used to buy 32 new barrier nursing trolleys.

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 – June 2015

6-8	**Integrated Performance Report for May 2015** (incorporating an update on recruitment and retention)	**Chief Executive**

The enclosed report includes, as usual, the Trust performance dashboard; integrated performance charts; and financial performance overview. The latter will be discussed and accompanied by a presentation at the Finance Committee 22/06/15 that will focus on significant income and pay variances.

Further details on recent recruitment and retention will be provided verbally at the meeting.

Which Committees have reviewed the information prior to Board submission?

- Executive Team, 16/06/15
- Trust Management Executive, 17/06/15

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

Discussion and scrutiny

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

TRUST PERFORMANCE DASHBOARD **Position as at:** **31st May 2015**

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

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

	Delivering or Exceeding Target	
	Underachieving Target	
	Failing Target	

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

***** Stroke SNAP Inidicators & CWT run one mth behind,*

	Safe	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
'1-01	*Rate C-Diff (Hospital only)	15.7	4.8	18.9	5.0	-13.9	-9.9	*11.5*	9.7	
'1-02	Number of cases C.Difficile (Hospital)	3	1	7	2	-5.0	-4.0	*27*	23	
'1-03	Number of cases MRSA (Hospital)	1	0	1	0	-1	0	*0*	0	
'1-04	Elective MRSA Screening	95.0%	98.0%	95.0%	98.0%		0.0%	98.0%	98.0%	
'1-05	% Non-Elective MRSA Screening	98.0%	97.0%	98.0%	97.0%		2.0%	95.0%	97.0%	
'1-06	**Rate of Hospital Pressure Ulcers	1.4	3.0	1.7	1.9	0.3	-1.1	*3.0*	1.9	3.0
'1-07	***Rate of Total Patient Falls	7.0	6.8	6.4	6.5	0.1	0.3	*6.20*	6.2	
'1-08	***Rate of Total Patient Falls Maidstone	5.5	5.8	6.0	5.8	-0.2			6.1	
'1-09	***Rate of Total Patient Falls TWells	8.2	7.4	6.7	6.8	0.1			6.2	
'1-10	Falls - SIs in month		5		6	6				
'1-11	Number of Never Events	0	0	2	0	-2	0	*0*	0	
'1-12	Total No of SIs Open with MTW	27	20			-7				
'1-13	Number of New SIs in month	11	10	18	13	-5	-7			
'1-14	**Serious Incidents rate	0.577	0.484	0.485	0.323	-0.16	0.3	*0.065 - 1.35*	0.323	*0.065 - 1.35*
'1-15	**Medication errors causing serious harm	0.00	0.00	0.00	0.00	0.00	0.0	*0 - 0.052*	0.00	*0 - 0.052*
'1-16	Rate of Patient Safety Incidents - harmful	1.94	1.22	1.70	1.40	-0.30	-0.3	*0 - 1.698*	1.40	*0 - 1.698*
'1-17	**Patient Safety Incidents Rate	35.07	39.64	34.81	38.90	4.09		TBC	38.90	
'1-18	** Patient Safety Incidents -death/severe harm	0.68	0.48	0.59	0.55	-0.05		TBC	0.55	
'1-19	Number of CAS Alerts Overdue	1	1			0	1	*0*		
'1-20	VTE Risk Assessment	95.6%	95.1%	95.6%	95.1%	-0.5%	0.1%	95%	95.1%	95%
'1-21	Safety Thermometer % of Harm Free Care	97.7%	97.0%	97.4%	96.8%	-0.6%	1.8%	95.0%		93.4%
'1-22	Safety Thermometer % of New Harms	1.40%	2.18%	3.65%	2.30%	-1.3%		*TBC*	2.30%	
'1-23	C-Section Rate (non-elective)	14.4%	10.2%	14.2%	12.6%			*TBC*	12.6%	

	Responsiveness	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	Emergency A&E 4hr Wait (SITREP Wks)	95.2%	89.7%	95.8%	89.9%	-5.8%	-5.1%	95%		91.9%
4-02	Emergency A&E >12hr to Admission	0	0	2	0	-2	0	*0*	0	
4-03	Ambulance Handover Delays >30mins	New	No data	New	No data				No data	
4-04	Ambulance Handover Delays >60mins	New	No data	New	No data				No data	
4-05	18 week RTT - admitted patients	87.1%	93.8%	89.2%	92.4%	3.2%	2.4%	90%	92.4%	
4-06	18 week RTT - non admitted patients	96.3%	98.5%	96.4%	98.3%	1.9%	3.3%	95%	98.3%	
4-07	18 week RTT - Incomplete Pathways	95.3%	97.3%	95.3%	97.3%	2.0%	5.3%	92%	97.3%	
4-08	18 week RTT - Specialties not achieved	3	4	4	9	5	9	*0*	9	
4-09	18 week RTT - 52wk Waiters	0	1	0	6	6	6	*0*	6	
4-10	18 week RTT - Backlog 18wk Waiters	605	514	605	514				514	
4-11	% Diagnostics Tests WTimes <6wks	99.9%	99.93%	99.9%	99.93%	0.0%	0.9%	99.0%	99.93%	
4-12	Cancer WTimes - Indicators achieved	8	7	9	7	-2	-2	9	9	
4-13	*Cancer two week wait	94.9%	94.0%	94.9%	94.0%	-0.9%	1.0%	93%	94.0%	
4-14	*Cancer two week wait-Breast Symptoms	89.0%	96.5%	89.0%	96.5%	7.5%	3.5%	93%	96.5%	
4-15	*Cancer 31 day wait - First Treatment	99.5%	98.9%	99.5%	98.9%	-0.6%	2.9%	96%	98.9%	
4-16	*Cancer 62 day wait - First Definitive	89.1%	83.4%	89.1%	83.4%	-5.7%	-1.6%	85%	85.0%	
4-17	*Cancer 104 Day wait Accountable	New	5.5	New	5.5	New	5.5	*0.0*	5.5	
4-18	Delayed Transfers of Care	3.6%	4.8%	3.4%	5.2%	1.8%	1.7%	3.5%	3.5%	
4-19	% TIA with high risk treated <24hrs	60.0%	80.0%	67.9%	79.5%	11.7%	19.5%	60%	60.0%	
4-20	% spending 90% time on Stroke Ward	72.2%	89.5%	76.0%	79.1%	3.1%	-0.9%	80%	80.0%	
4-21	***** Stroke:% to Stroke Unit <4hrs (Apr)	29.8%	37.9%	29.8%	37.9%	8.1%	-17.1%	55.0%	55.0%	
4-22	***** Stroke: % scanned <1hr of arrival (Apr)	51.1%	41.4%	51.1%	41.4%	-9.7%	-1.6%	43.0%	43.0%	
4-23	***** Stroke:% assessed by Cons <24hrs (Apr)	74.5%	69.0%	74.5%	69.0%	-5.5%	-16.0%	85.0%	85.0%	
4-24	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	*0*	0	
4-25	Patients not treated <28 days of cancellation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*0.0%*	0.0%	
4-26	Outpatient Cancellation Rate -Hosp & Patient	31.3%	30.3%	31.3%	30.0%	-1.4%		TBC	30.0%	

*** Serious Incidents, Patient Safety Incidents and Medication Errors Rate is per 1,000 Occupied Beddays* *SHMI is within confidence*

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

	Effectiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	Hospital-level Mortality Indicator (SHMI)*	Prev Yr: July 13 to June 14		101.5	103.4	1.9	3.4	*Lower confidence*		100
2-02	Standardised Mortality (Relative Risk)	Prev Yr: July 13 to June 14		102.4	110.1	7.7	10.1	*limit to be <100*		100
2-03	Crude Mortality	1.1%	1.1%	1.3%	1.2%	-0.2%				
2-04	Crude Mortality Rate (non-elective)	2.7%	2.0%	2.9%	2.7%	-0.13%		*TBC*	2.7%	
2-05	****Readmissions <30 days: Emergency	12.0%	11.5%	12.0%	11.5%	-0.4%	-2.1%	*13.6%*	11.5%	14.1%
2-06	****Readmissions <30 days: All	10.9%	10.6%	10.9%	10.6%	-0.4%	-4.1%	*14.7%*	10.6%	14.7%
2-07	Average LOS Elective	3.1	3.2	3.0	3.3	0.3	0.0	*3.2*	3.2	
2-08	Average LOS Non-Elective	6.6	7.4	6.6	7.5	0.9	1.1	*6.5*	6.5	
2-09	New:FU Ratio	1.53	1.45	1.58	1.49	-0.09	-0.03	*1.52*	1.52	
2-10	Day Case Rates	83.4%	82.6%	83.6%	83.3%	-0.3%	3.3%	80.0%	83.3%	82.19%
2-11	Primary Referrals	8,604	8,208	16,887	17,233	2.0%	6.2%	104,066	110,468	
2-12	Cons to Cons Referrals	3,352	2,844	6,715	6,150	-8.4%	-0.4%	39,585	39,423	
2-13	First OP Activity	11343	9,727	22281	21,371	-4.1%	-6.8%	146,918	146,918	
2-14	Subsequent OP Activity	19923	19,089	40487	40,051	-1.1%	-2.8%	264,118	264,118	
2-15	Elective IP Activity	696	652	1357	1,274	-6.1%	2.2%	7,988	7,988	
2-16	Elective DC Activity	3131	2,965	6034	6,070	0.6%	0.9%	38,556	38,556	
2-17	Non-Elective Activity	4064	3,932	8022	7,750	-3.4%	-3.7%	*48,289*	48,289	
2-18	A&E Attendances (Calendar Mth)	11376	11,950	22068	22,892	3.7%	1.1%	*135,922*	135,922	
2-19	Oncology Fractions	5685	5,261	11440	10,752	-6.0%	-4.0%	71,761	71,761	
2-20	No of Births (Mothers Delivered)	472	502	937	982	4.8%	3.2%	5,708	5,892	
2-21	% Mothers initiating breastfeeding	81.1%	78.5%	79.5%	78.8%	-0.7%	0.8%	78.0%	78.0%	
2-22	Rate of Intra partum stillbirths	0.0	0.0	1.1	2.0	*0.9*	*-5.3*	*7.3*	2.0	7.3

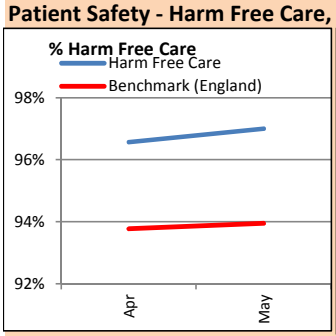
	Well-Led	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
5-01	Income	31,576	32,241	63,353	62,986	3.3%	-0.6%			
5-02	EBITDA	615	142	1,308	633	-50.4%	-51.6%			
5-03	Surplus (Deficit) against B/E Duty	(2,348)	2,700	(4,709)	(5,057)					
5-04	CIP Savings	No Data	No data	3,394	3,045	45.8%	-10.3%			
5-05	Cash Balance	19,199	16,816	19,199	16,816	10.3%	-12.4%			
5-06	Capital Expenditure	846	647	1,444	879	111.3%	-39.1%			
5-07	Establishment (Budget WTE)	5,392.2	5,552.6	5,392.2	5,552.6	3.0%	0.0%			
5-08	Contracted WTE	4,930.4	4,868.4	4,930.4	4,868.4	-1.3%	-5.7%			
5-09	***Contracted not worked WTE		(98.5)		(98.5)					
5-10	Locum Staff (WTE)	12.4	17.8	12.4	17.8	43.2%				
5-11	Bank Staff (WTE)	270.2	271.7	270.2	271.7	0.6%				
5-12	Agency Staff (WTE)	104.2	266.3	104.2	266.3	155.5%				
5-13	Overtime (WTE)	69.7	72.5	69.7	72.5	4.0%				
5-14	Worked Staff WTE	5,301.8	5,424.2	5,301.8	5,424.2	2.3%	-2.7%			
5-15	Vacancies WTE	461.8	684.2	461.8	684.2	48.2%				
5-16	Vacancy %	8.6%	12.3%	8.6%	12.3%	43.3%				
5-17	Nurse Agency Spend	(246)	(851)	(761)	(1,614)	112.1%				
5-18	Medical Locum & Agency Spend	(901)	(1,005)	(1,426)	(1,931)	35.4%				
5-19	Temp costs & overtime as % of total pay bill									
5-20	Staff Turnover Rate	9.7%	9.4%		9.5%	-0.2%	-1.1%	*10.5%*	9.5%	8.4%
5-21	Sickness Absence	3.6%	3.9%		4.0%	0.2%	0.6%	*3.3%*	3.3%	3.7%
5-22	Statutory and Mandatory Training	86.3%	87.2%		87.2%	0.9%	2.2%	85.0%	85.0%	
5-23	Appraisals	Not reported unitl Quarter 1								
5-24	Overall Safe staffing fill rate	100.1%	103.3%	100.1%	103.4%	3.2%		TBC	103.4%	
5-25	****Staff FFT % recommended work	New	58.0%	New	58.0%		0.0%	58.0%	58.0%	61.7%
5-26	***Staff Resp Rate Recmd to Friends & Family	New	TBC	New	TBC				TBC	
5-27	Resp Rate Recmd to Friends & Family	45.7%	26.7%	43.7%	27.3%	-16.4%	-2.7%	30.0%	30.0%	26.3%
5-28	A&E Resp Rate Recmd to Friends & Family	19.3%	9.3%	18.9%	8.0%	-10.8%	-12.0%	20.0%	20.0%	14.8%
5-29	Mat Resp Rate Recmd to Friends & Family	19.3%	12.4%	18.9%	15.2%	-3.7%	0.2%	15.0%	15.0%	23.6%

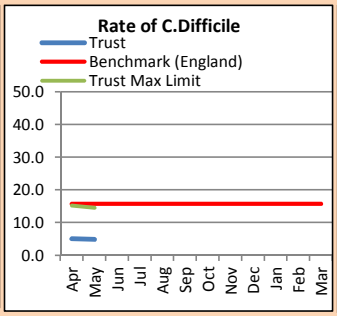
	Caring	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Single Sex Accommodation Breaches	0	0	0	0	0	0	0	0	
3-02	*****Rate of New Complaints	1.6	1.79	3.8	1.74	-2.0	0.42	*1.318-3.92*	1.78	
3-03	% complaints responded to within target	60.5%	54.8%	57.8%	53.2%	-4.6%	-21.8%	75.0%	75.0%	
3-04	****Staff Friends & Family (FFT) % rec care	New	84.3%	New	84.3%	New	9.3%	75.0%	75.0%	77.2%
3-05	IP Friends & Family (FFT) % Positive	93%	94.3%	91%	95.6%	4%	1%	95.0%	95.0%	95.5%
3-06	A&E Friends & Family (FFT) % Positive	88%	87.5%	90%	88.2%	-2%	1%	87.0%	87.0%	87.5%
3-07	Maternity Combined FFT % Positive	92%	95.2%	91%	94.7%	4%	0%	95.0%	95.0%	95.7%
3-08	OP Friends & Family (FFT) % Positive	New	77.7%	New	77.4%	New			77.4%	
3-09	Five Key Questions Local Patient Survey	91.6%	91.6%			0.0%		90%	90.0%	

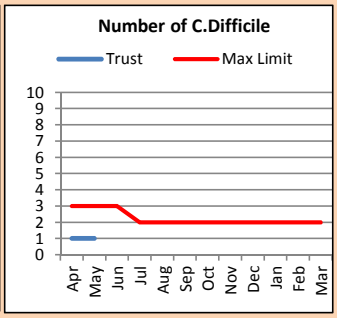
* Rate of C.Difficile per 100,000 Bed days, ** Rate of Pressure Sores per 1,000 admissions (excl Day Case), *** Rate of Falls per 1,000 Occupied Beddays, **** Readmissions run one month behind, ***** Rate of Complaints per 1,000 occupied beddays.

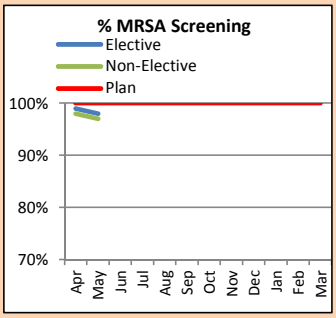
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

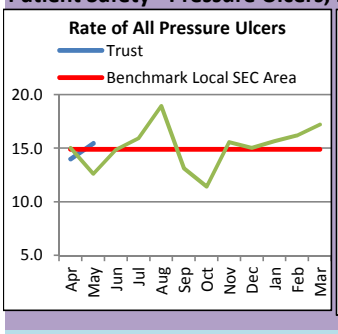


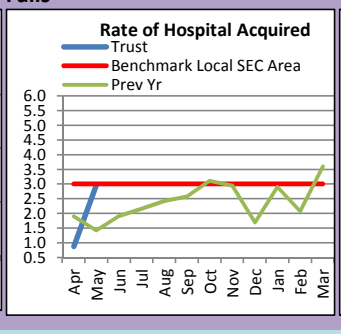


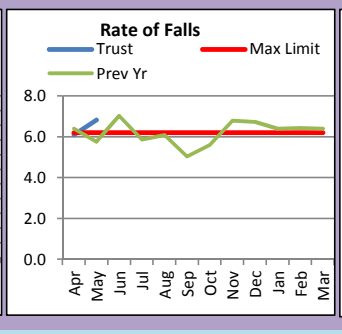


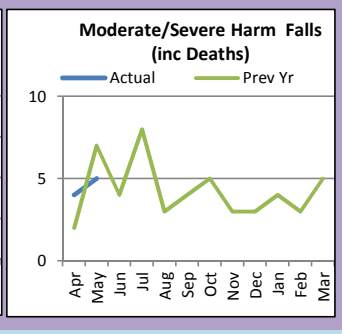


Patient Safety - Pressure Ulcers, Falls

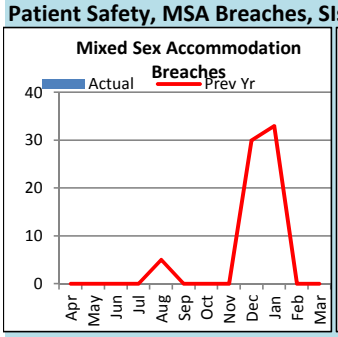


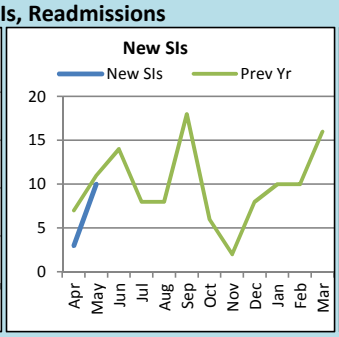


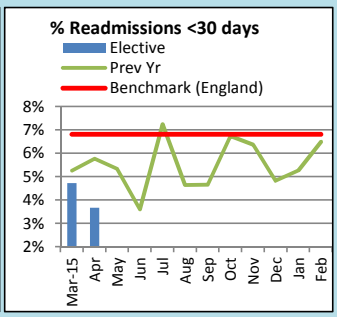


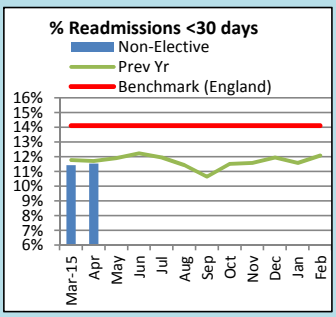


Patient Safety, MSA Breaches, SIs, Readmissions

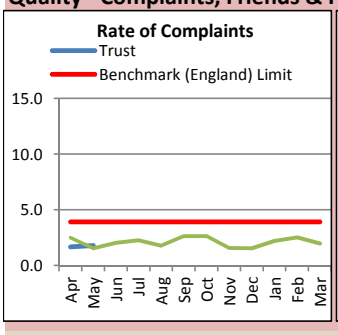


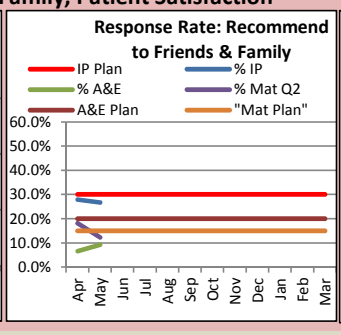


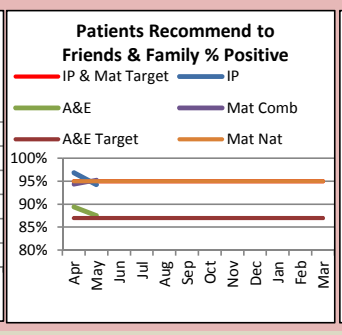


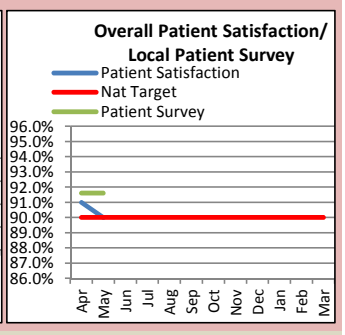


Quality - Complaints, Friends & Family, Patient Satisfaction

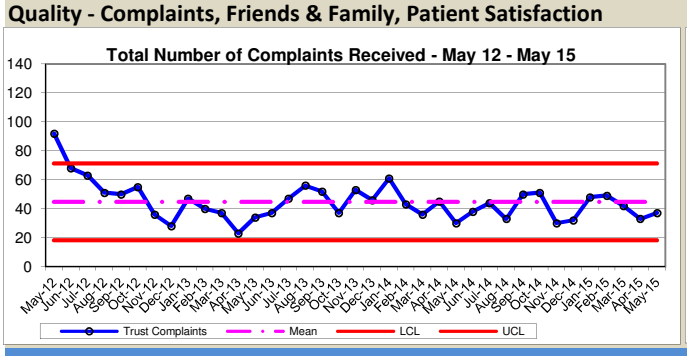


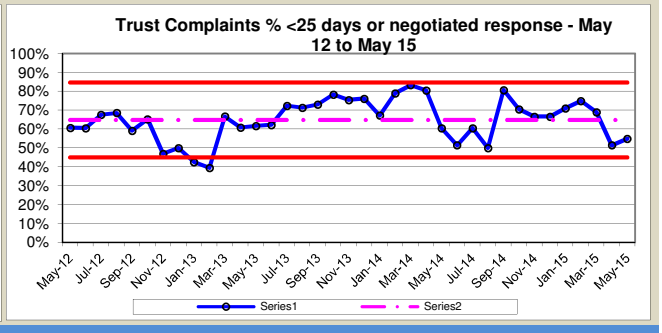




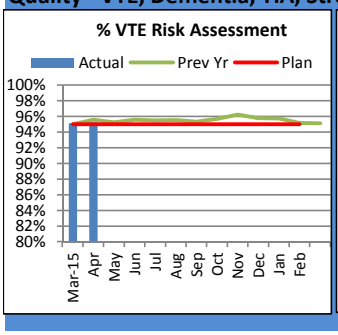


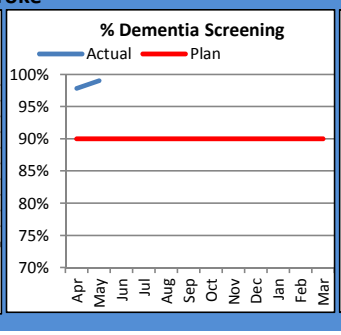
Quality - Complaints, Friends & Family, Patient Satisfaction

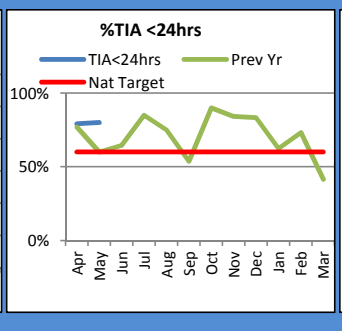


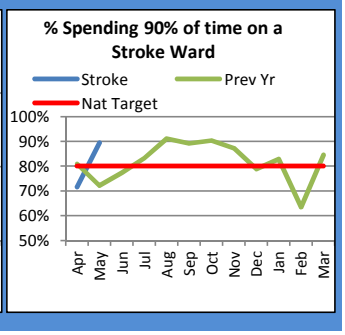


Quality - VTE, Dementia, TIA, Stroke



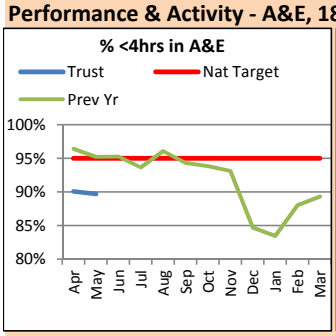


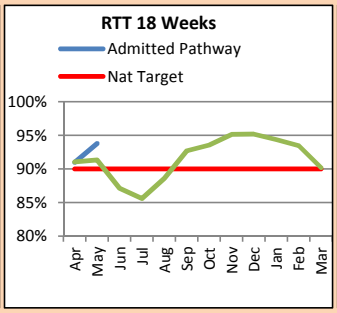


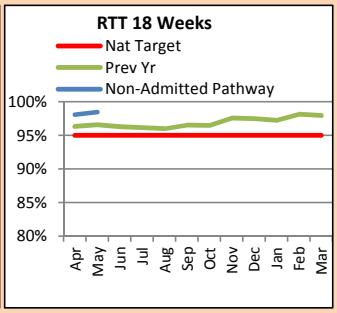


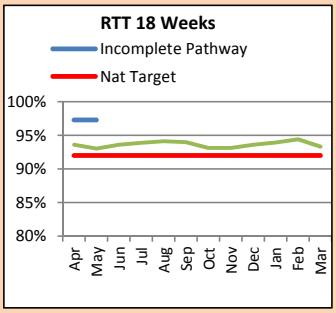
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

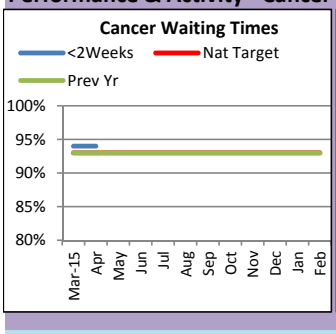


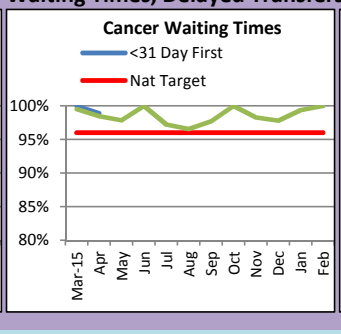


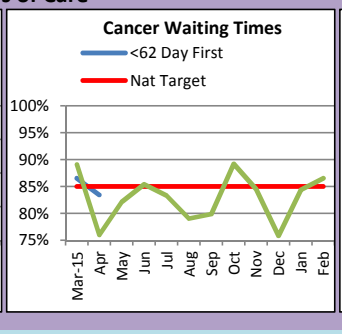


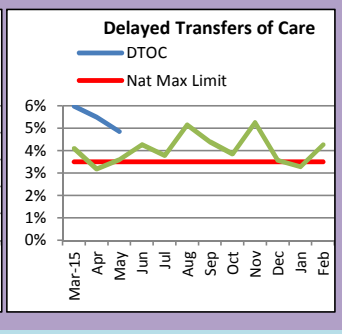


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

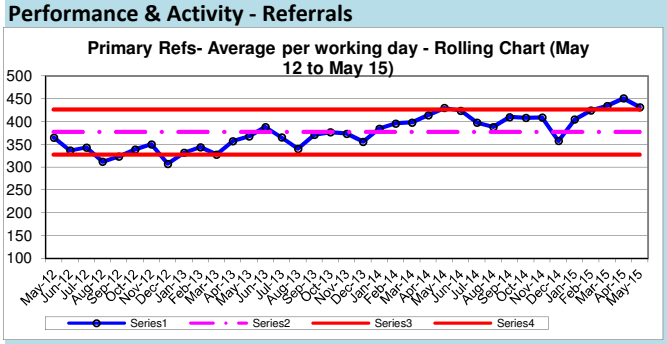


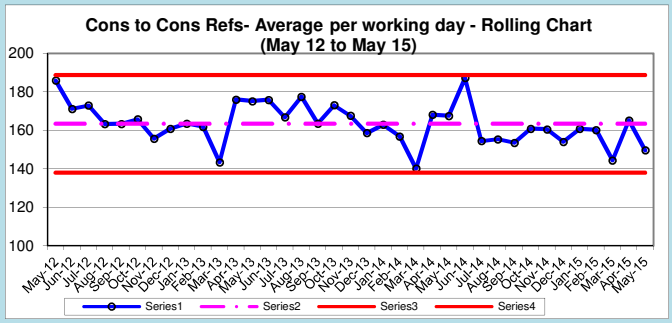




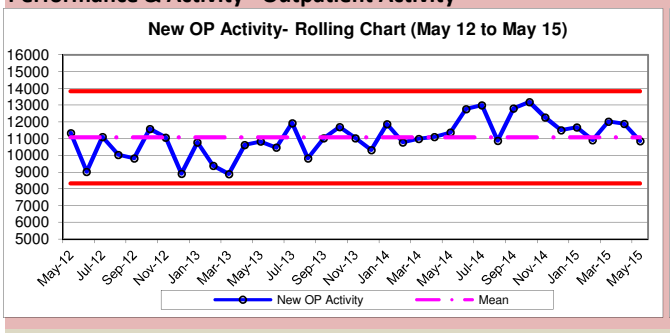


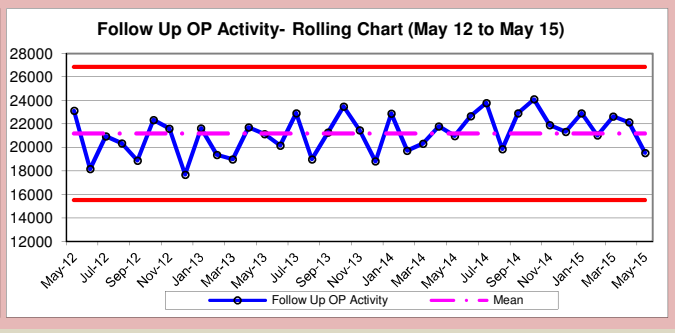
Performance & Activity - Referrals



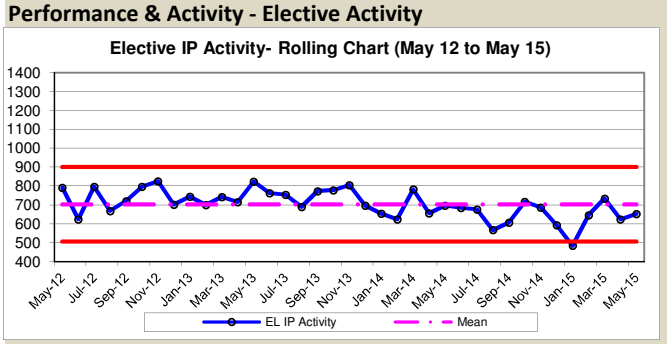


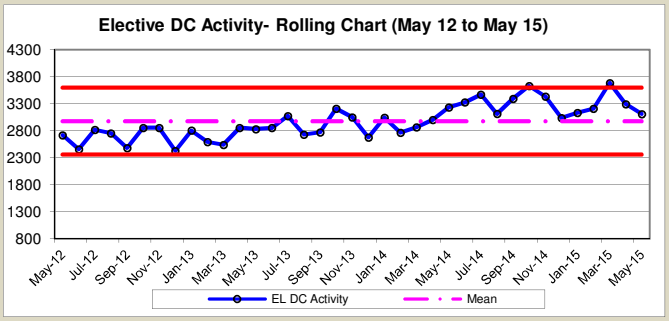
Performance & Activity - Outpatient Activity



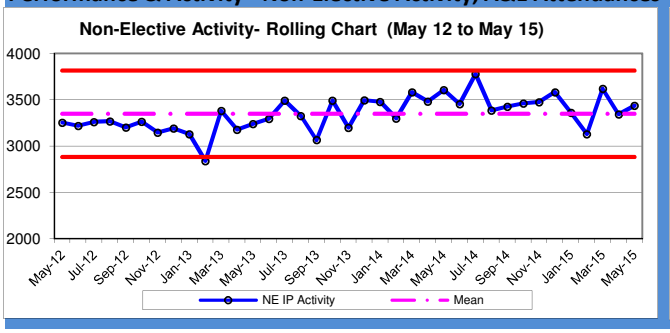


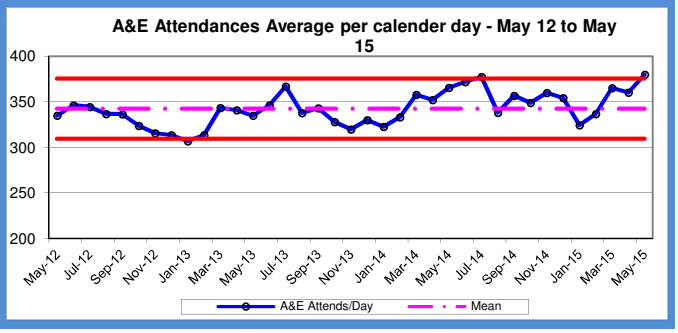
Performance & Activity - Elective Activity





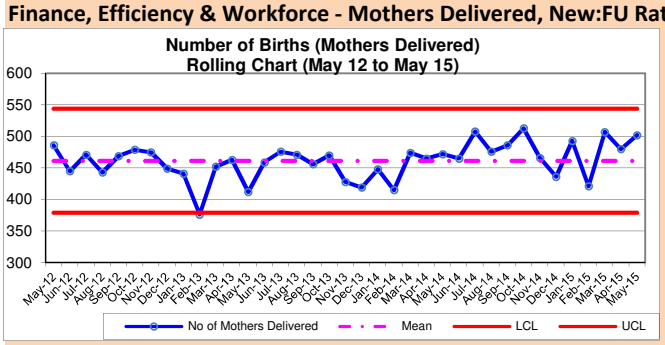
Performance & Activity - Non-Elective Activity, A&E Attendances

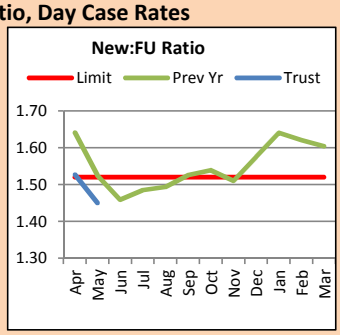


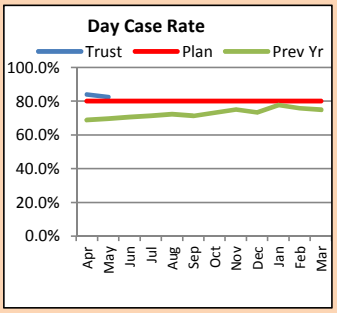


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

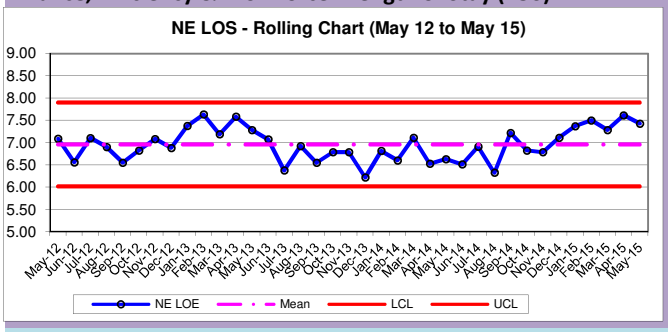
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

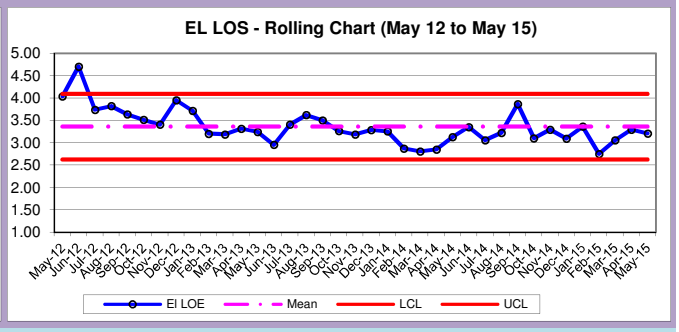




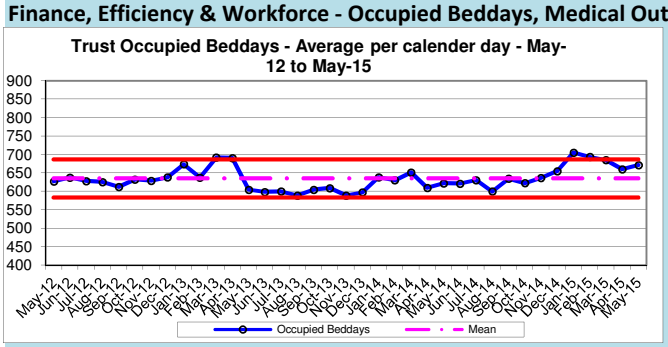


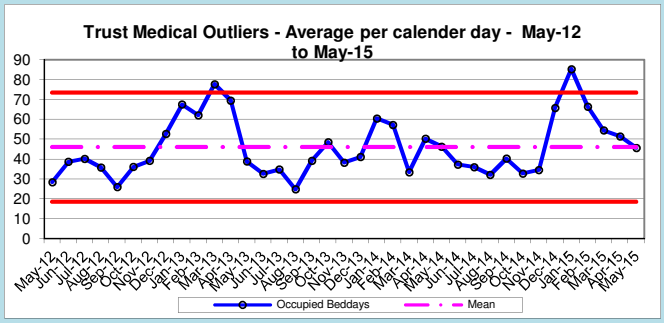
Finance, Efficiency & Workforce - Length of Stay (LOS)



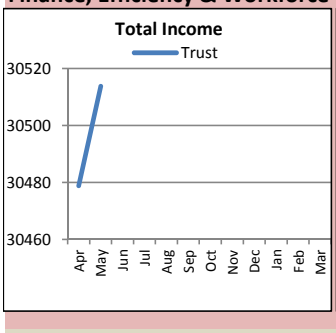


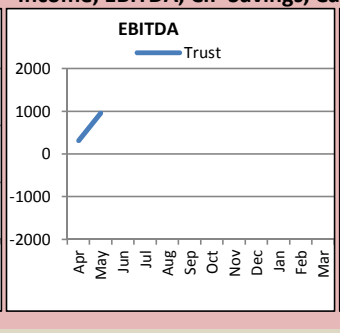
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

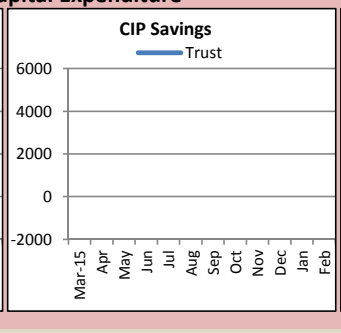


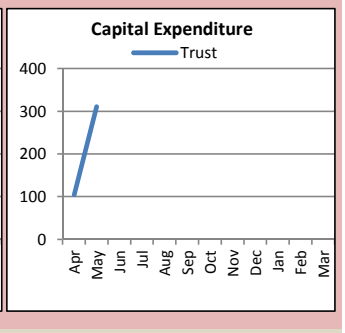


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

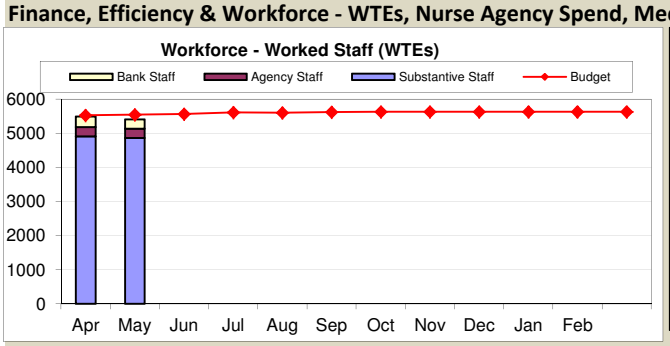


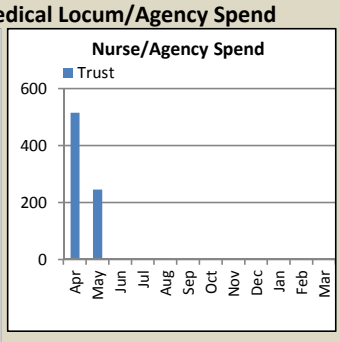


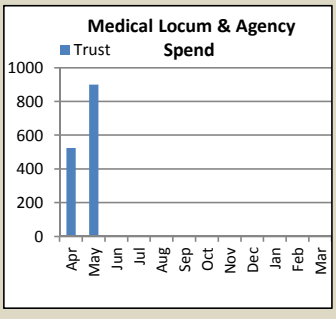




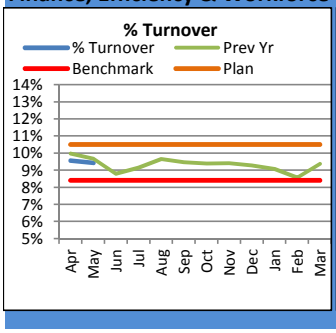
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

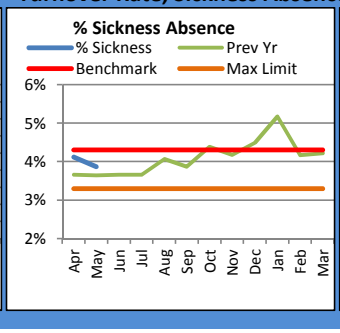


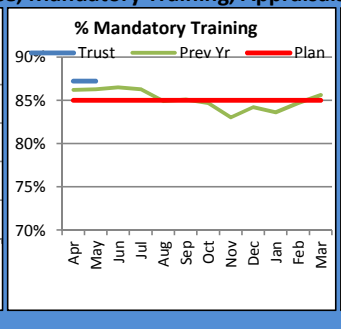


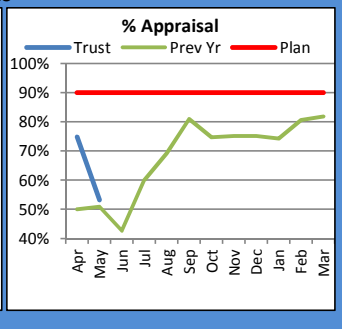


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









M2 Financial Performance overview

1. Overview of the Financial Position at M2 2015/16

1.1. This written summary provides an overview of the financial position at M2 of 2015/16. It should be read alongside the finance pack, which has also been circulated to Board members.

1.2. Under the TDA Accountability Framework the Trust is flagged as Red due to its reported financial position at month 2. The Finance pack shows for month 2 an adverse variance of -£0.4m against a deficit plan of a -£2.3m resulting in a year to date deficit of -£5.1m against a planned deficit of -£4.7m, an adverse year to date variance of -£0.3m. These figures include the full utilisation of reserves available for the first two months of 2015/16. Any financing to support the Trust's liquidity has yet to be agreed.

1.3. Total income for the year to date is £63.0m against a budget of £63.4m. Income for the month is £32.2m which was £0.7m better than the £31.6m plan for the month.

1.4. The income headlines are outlined below:

- Income CIPs of £0.8m were delivered against an income CIP expectation of £1.1m. This £0.3m shortfall is a significant element of the overall income variance.
- With the CIP shortfall and underperformances on outpatients the delivery of NHS Clinical Income is £0.5m adverse to plan year to date.
- All applicable contractual deductions and penalties have been applied and a provision has been made for challenges.
- The new GUM contract is generating a £0.3m favourable variance within Non NHS Clinical Income.
- Commercial income is £0.2m behind plan at the end of month 2, which is the most significant driver in the overall non patient income adverse variance of £0.2m to date.

1.5. A combination of a higher than planned level of activity and a number of discharged patients with significant lengths of stay has generated the £0.2m over performance in non-elective income by the end of May. Also by the end of May A&E activity is broadly on plan and the non-elective threshold despite the higher activity in May and in effect the increase in case mix has remained on plan, there are still negotiations underway with commissioners to try and ensure that the level of Threshold reflects an appropriate level of activity given the changes in service since the Thresholds was set in 2008/09.

1.6. Elective inpatient and day case activity is ahead of plan by £0.1m at the end of May. This was a result of a 0.7% increase in activity (+£50k) and a 3.1% (+£86k) impact from a richer case mix.

1.7. An 86% achievement rate for CQUINs has been assumed in the income position.

1.8. Transitional support of £0.6m for Cancer received from NHS England to reduce the impact of the cancer tariff in 2015-16 has been included in the position.

1.9. The levels of escalation beds increased in May (average per day 50.3) over April (average per day 43.5). May also saw highs on the 5th of 68 beds in escalation.

1.10. Operating costs are £0.4m adverse against a plan of £62.0m. Pay deteriorated against plan by £0.8m in May generating a year to date adverse variance of £1.1m. Non pay costs were also adverse by £0.4m but remained favourable at the end of May by £0.8m.

1.11. At the end of May vacancies have resulted in a £0.8m underspend against the budget for established posts. More than half of this year to date variance was generated by vacancies in Scientific and Technical grades (+£0.5m). Bank and Medical Locum staff was also favourable to plan by £0.1m. Agency Nursing (-£1.0m) and Medical agency (-£0.6m) are significantly overspent to plan. Information recorded on Roster-pro suggests Nursing Agency hours have dropped since March but costs remain at high levels.

1.12. Non pay overspent by £0.4m in May and is now £0.8m underspent year to date. Significant overspends for the year to date are:

- Drugs and medical gases £0.3m adverse (in part offset in the position by the over performance in HCD income to date of £0.1m)
- Clinical Supplies is £0.3m adverse to plan

1.13. Significant underspends in non-pay include:

- Purchase of healthcare from non NHS bodies £0.3m favourable.
- Other non-pay costs including reserves and contingencies £0.8m.

1.14. EBITDA is a £0.6m surplus and is now adverse to plan by -£0.6m.

1.15. The financing costs including those related to the PFI and deprecation totalled £5.8m, which is now underspent against the in year plan by £0.3m (£0.1m underspent in month) due to the revaluation of assets and the holding of capital funds to support the potential ward development.

1.16. The I&E forecast to the end of the financial year shows the Trust delivering its planned deficit of £14.1m. This will require the delivery of the CIP programme and the control of costs such as agency spend.

1.17. Cash balances of £16.8m were held at the end of May. The Trust still has the benefit of the advance of one month’s contract payment from CCGs along with its normal April payment. The Trust has been informed that the funds for NHD support (£2.1m) that was expected in May will now be received in September so the cash flow forecast has been amended accordingly.

1.18. The contracting process requires each month’s activity has to be reconciled with commissioner. The reconciliation process for Aprils income will start late June after the freeze date for data submission to SUS.

1.19. Total debtors are £26.8m. This is after a £1.5m reduction in May which was influenced by the receipt of £3.5m from NHS England for PFI support. £5.6m of the debt is aged over 90 days with WKCCG owing £4.2m, NHS England £2.9m, EK Hospitals FT £2.5m and Medway FT £1.4m. 90 day invoiced debt for private patients billed through Compucare is currently £0.2m (£1.5m in total for all invoiced debt) with other non NHS invoiced debt over 90 days old totals £0.3m (£0.6m in total).

1.20. Total creditors are £44.2m. Against the 95% target for payments made within 30 days the Trust achieved 84.4% in May for Trade creditors (77.7% in March 2015) and 78.3% in May for NHS creditors (56.3% in March 2015).

1.21. Capital expenditure to month 2 was £0.9m against the profiled plan £1.4m. To support the £4m proposed ward development at Tunbridge Wells the Trust has capped its submitted a capital plan to the TDA of £20m to £16m. This cap is in place until the Trust obtains support for the £4m of funds requested in the Trust's resource limit. The Trust has also requested support for the £2.5m radiotherapy development at the Tunbridge Wells hospital.

2. CIP Delivery

2.1. The month 2 position shows a CIP delivery of £3m against a target of £3.4m.

2.2. Medical Efficiency (-£0.1m), Length of Stay (-£0.2m), Back Office Functions (-£0.3m) and procurement and Drugs who are both adverse to plan (-£0.1m) are offset by overachievement in Financial Management (+£0.1m) and Non Recurrent savings (+£0.5m). Against the CIP target of £21.5m the latest review of plans has identified a shortfall of £3.5m for which the Trust is identifying new schemes to meet.

3. Conclusion

3.1. In order for the Trust to achieve its financial targets it will need to deliver its full CIP programme and ensure it reduces its reliance on Agency staff especially for nurses.

3.2. The Trust Board are requested to note this report and any actions arising from the presentation made to the Finance Committee.

Key Performance Indicators as at Month 2

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

Maidstone and Tunbridge Wells NHS Trust

Key Metrics (A) Accountability Framework	Current Month Metrics: Plan (mc 01) £000s	Actual / Forecast (mc 02) £000s	Variance (mc 03) £000s	RAG Rating (mc 04)
NHS Financial Performance				
1a) Forecast Outturn, Compared to Plan	(14,126)	(14,126)	0	RED
1b) Year to Date, Actual compared to Plan	(4,709)	(5,057)	(349)	GREEN
Financial Efficiency				
2a) Actual Efficiency recurring/non-recurring compared to plan - Year to date actual compared to plan				AMBER
- Total Efficiencies for Year to Date compared to Plan	3,394	3,045	(349)	
- Recurrent Efficiencies for Year to Date compared to Plan	3,394	3,045	(349)	
2b) Actual Efficiency recurring/non-recurring compared to plan - Forecast compared to plan				GREEN
- Total Efficiencies for Forecast Outturn compared to Plan	18,146	18,146	0	
- Recurrent Efficiencies for Forecast Outturn compared to Plan	18,146	18,146	0	
Underlying Revenue Position				
3) Forecast Underlying surplus / (deficit) compared to Plan	(3,353)	(3,353)	0	GREEN
Cash and Capital				
4) Forecast Year End Charge to Capital Resource Limit	18,963	18,963	0	GREEN
5) Permanent PDC accessed for liquidity purposes		0		GREEN

Trust Overall RAG Rating				
				RED

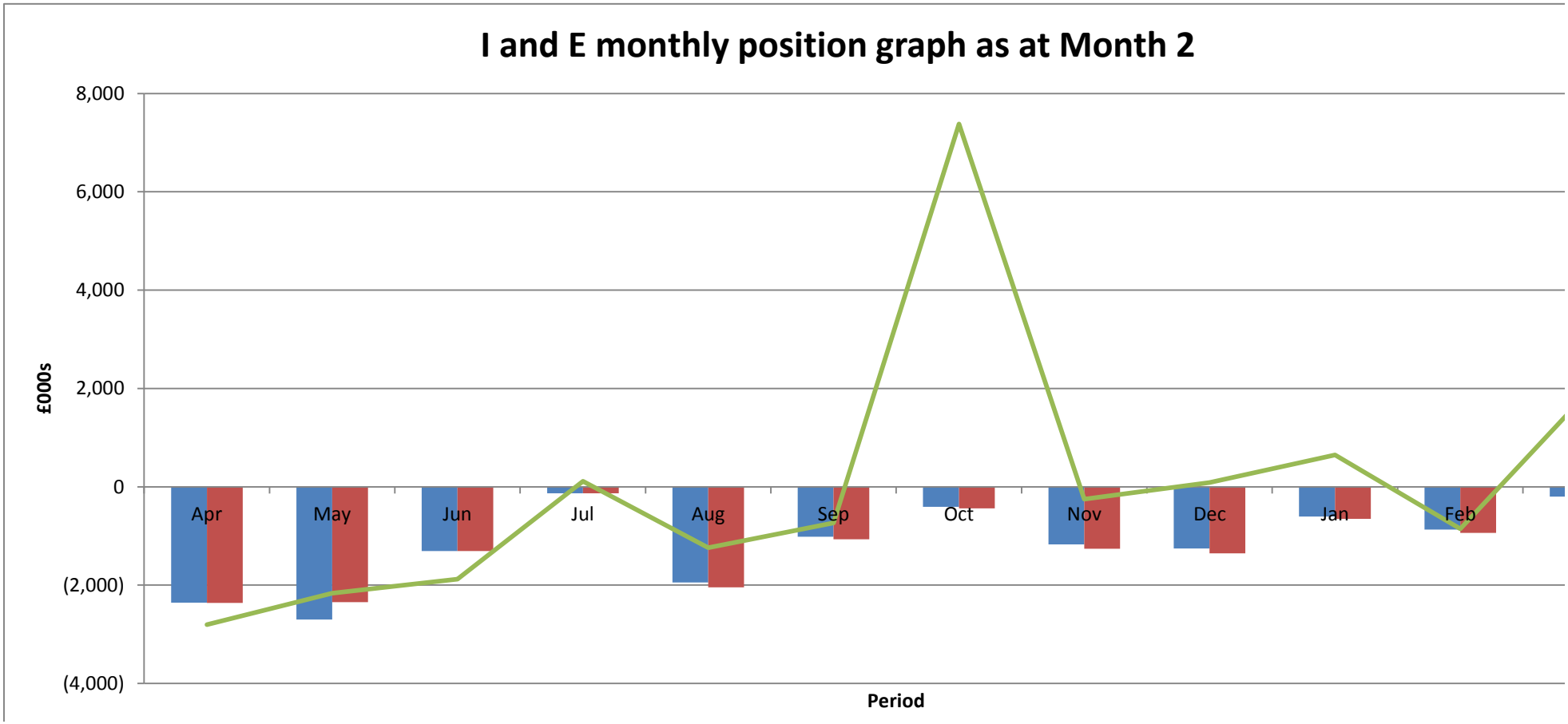
(B) Continuity of Service Risk Ratings				
Year to Date Rating	1.50	1.50	0.00	RED
Fotecast Outturn Rating	1.50	1.50	0.00	RED

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

I&E Monthly Position Graph as at Month 2 2015/16

Maidstone and Tunbridge Wells NHS Trust

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual/FOT 15/16	(2,357)	(2,700)	(1,306)	(134)	(1,949)	(1,017)	(410)	(1,170)	(1,257)	(607)	(872)	(199)
Plan 15/16	(2,361)	(2,348)	(1,306)	(133)	(2,048)	(1,068)	(441)	(1,261)	(1,354)	(653)	(940)	(213)
Actual 14/15	(2,805)	(2,163)	(1,882)	111	(1,242)	(734)	7,380	(251)	84	646	(856)	1,867

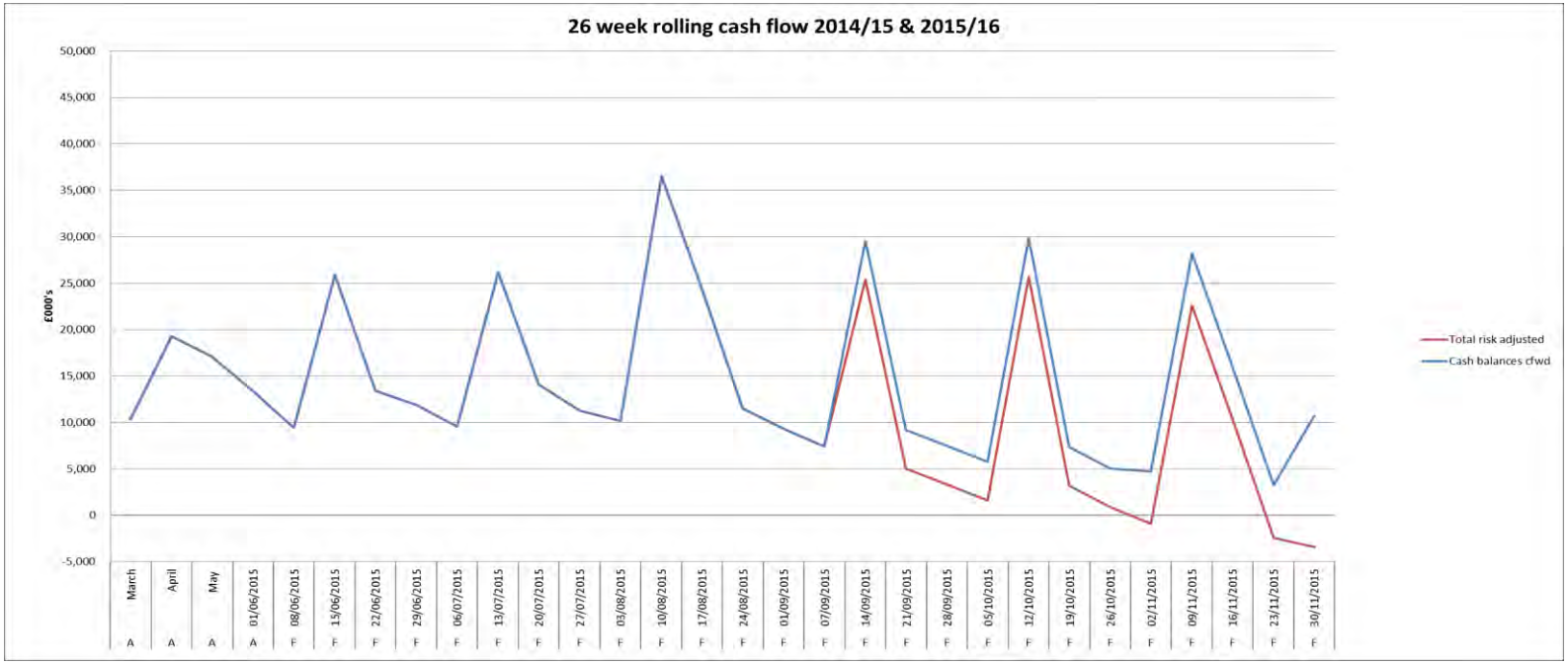


CIP Summaryh: as at Month 2

CIP Implementation tracking dashboard						Maidstone and Tunbridge Wells NHS Trust					
Workstream View		Year To Date (M2)			Target	Workstream Indicators of Progress					
Updated on 12th June 15	Executive	Plan £'000	Actual £'000	Variance £'000	Across Trust Workstreams £'000	Highest delivery Risk Log score	Highest QIA score	Milestones Met	Milestones Over Due	Financial Delivery	Plan Delivery
WORKSTREAMS BY ACROSS DIRECTORATES											
Medical Efficiency	Paul Sigston	263	122	(141)	1,621	12	4	35	17	R	G
Nursing & STT Efficiency	Avey Bhatia	228	271	43	1,037	16	4	5	15	G	R
A&C Clinical Admin	Angela Gallagher	56	14	(42)	397	tbc	tbc	5	12	R	A
LOS	Angela Gallagher	247	10	(237)	1,824	16	12	49	1	G	A
Theatre Productivity	Angela Gallagher	140	17	(123)	1,081	12	6	5	1	G	G
Outpatient Productivity	Steve Orpin	69	71	2	540	12	6	15	0	G	G
Procurement	Steve Orpin	255	158	(97)	1,536	12	tbc	tbc	tbc	G	A
Contract Management	Steve Orpin	961	958	(3)	5,944	12	12	35	26	A	A
PPU	Steve Orpin	92	84	(8)	416	15	12	3	0	G	G
Back Office Functions	Paul Bentley	689	437	(252)	4,339	tbc	tbc	27	0	A	A
Financial management	Steve Orpin	254	400	146	1,954	tbc	tbc	tbc	tbc	R	R
Drugs	Angela Gallagher	140	48	(92)	811	tbc	tbc	tbc	tbc	G	R
Non-Recurrent Savings to be validated			456	456							

Maidstone and Tunbridge Wells NHS Trust

26 Week graphical presentation of cash balances up to w/c 30th November 2015, actuals at 5th June 2015



	A	A	A	A	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Week commencing	March	April	May	01/06/2015	08/06/2015	15/06/2015	22/06/2015	29/06/2015	06/07/2015	13/07/2015	20/07/2015	27/07/2015	03/08/2015	10/08/2015	17/08/2015	24/08/2015	01/09/2015	07/09/2015	14/09/2015
Cash balances cfwd	**10,334**	**19,276**	**17,038**	**13,337**	**9,427**	**25,852**	**13,421**	**11,873**	**9,550**	**26,162**	**14,051**	**11,253**	**10,180**	**36,528**	**24,312**	**11,526**	**9,291**	**7,395**	**29,548**
Debtors carry forward into 15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15/16 o/performance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
External Financing - Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
External Financing - capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Asset Sales	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NHD Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,146
Total risk adjusted	**10334**	**19276**	**17038**	**13337**	**9427**	**25852**	**13421**	**11873**	**9550**	**26162**	**14051**	**11253**	**10180**	**36528**	**24312**	**11526**	**9291**	**7395**	**25402**

	F	F	F	F	F	F	F	F	F	F	F
Week commencing	42,268	42,275	42,282	42,289	42,296	42,303	42,310	42,317	42,324	42,331	42,338
Cash balances cfwd	9,162	7,439	5,766	29,850	7,319	5,033	4,720	28,188	15,972	3,226	10,733
Debtors carry forward in 15/1	0	0	0	0	0	0	0	0	0	0	0
15/16 o/performance	0	0	0	0	0	0	0	0	0	0	0
External Financing - Revenue	0	0	0	0	0	0	1,500	1,500	1,500	1,500	10,000
External Financing - capital	0	0	0	0	0	0	0	0	0	0	0
Asset Sales	0	0	0	0	0	0	0	0	0	0	0
NHD Support	4,146	4,146	4,146	4,146	4,146	4,146	4,146	4,146	4,146	4,146	4,146
Total risk adjusted	**5,016**	**3,293**	**1,620**	**25,704**	**3,173**	**887**	**-926**	**22,542**	**10,326**	**-2,420**	**-3,413**

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board - June 2015

6-10 CQC Quality Improvement Plan, Monthly Assurance Report Chief Nurse

Summary / Key points

Please see monthly update on the progress to date with the Quality Improvement Plan which was reviewed by the Trust Management Executive on 17/06/15. This contains progress update on the Enforcement notice, Compliance actions and also an update from 'Should do' actions that were scheduled to be completed this month or those that are due shortly.

Overall progress is good, with evidence of actions being addressed and changes implemented.

See first page for summary update on progress to date with RAGB rating

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 17/06/15

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

CQC Quality Improvement Plan

Assurance Report JUNE 2015

This report is produced to provide staff, patients, stakeholders, the CQC and the board with an assurance against the Quality Improvement Plan developed and agreed in response the CQC inspection report that was published in February 2015. This is a monthly report (commenced April 2015 onwards), following which the main Quality Improvement Plan will be updated. The report will be submitted to the Trust Management Executive, the Trust Board, TDA and the CQC and will be shared with local commissioning groups. A summary will be published on the MTW intranet and MTW website.

The first section presents the progress of the Enforcement notice and Compliance actions. The second section provides information about the progress on the 'Should do' actions to date.

Overview of progress to date

Enforcement action – Water testing Maidstone Hospital

The enforcement notice relating to annual water sampling for legionella was responded to immediately with actions undertaken to address the issue and ensure governance is now place to prevent the risk of re-occurrence. The CQC will be visiting Maidstone hospital on 30th June to review evidence submitted in practice.

Compliance action – CDU Tunbridge Wells

The CDU is now used as a single sex environment 24/7 with some provision of capacity on the MAU. Impact is being closely monitored.

Compliance actions – Paediatrics

The agreement and implementation of a suitable Trust-wide paediatric early warning system is well underway and expected to be completed in June.

Joint meetings between the paediatric and surgical directorates have led to the development of a draft Standard Operating Procedure for children on a surgical pathway, with good progress to date.

Compliance actions – Critical care

Continued progress has been made in addressing the compliance actions against Critical Care, with a fully compliant intensivist rota expected October 2015, following additional recruitment. Work is continuing on the Standard Operating Procedures for admitting and discharging critically ill patients on ITU. Pressures continue in relation to patient flow which impedes some timely transfers and a longer term strategy has been put into place to address in patient capacity at Tunbridge Wells Hospital.

Critical Care outreach service has been recruited into and the consultation for a 24/7 day service is underway.

Compliance action – Contracted security staff training and knowledge

Good progress has been made with a joint partnership agreement now in place with contractors regarding the provision of training. Security staff training has been fully reviewed and training is nearly compliant for the mandatory requirements, and on schedule for completion within timeframe.

Compliance Action – Process for incident reporting

Work continues on this compliance action with a staff information leaflet developed and being distributed. The patient safety pages on the intranet are being developed as an alternative source of information for staff. The review of the current system for incident reporting has been completed and a proposal for improvements written with involvement of staff continuing in improving and developing the current system.

Status of plan

Rating below relate to the progress of the enforcement/compliance action as a whole based on the date of **overall completion**. Some of the original actions, once completed have resulted in other actions being required which is simply an evolution of the situation for example compliance action 2, action 3b.

There is an element of judgement on the RAGB rating, based on the update and evidence provided and discussions.

The table below provides a summary of any issues arising.

KEY to progress rating (RAGB rating)

	Blue	Fully Assured
	Amber	Not running to time and / or more assurance required
	Green	Running to time, in progress / not running to time but sufficient assurance of progress
	Red	Not assured / actions not delivering required outcome

	Operational lead	Progress rating	Issues / Comments
Enforcement Notice – Water testing	Jeanette Rooke, Director of Estate & Facilities		Action completed and evidence submitted to CQC for review. Awaiting CQC visit on 30th June.
CA 1 - Paediatric Early Warning Scoring (PEWS) system	Jackie Tyler, Matron Children Services		Identified need to have single trust PEWS system in place (both inpatient and emergency department). Good progress being made.
CA 2 – ICU weekend cover	Daniel Gaughan General Manager, Critical Care		Continued good progress with expected full compliance by October 2015. Risks assessed and mitigation in place in the meantime.
CA 3 – ICU consultant within 30mins	Daniel Gaughan General Manager, Critical Care		

	Operational lead	Progress rating	Issues / Comments
CA 4 – ICU delayed admissions	Jacqui Slingsby Matron, Critical Care Directorate		Slight delay due to multi department / specialist involvement in development and consultation of new operational policy. Ongoing progress.
CA 5 – ICU delayed discharges	Jacqui Slingsby Matron, Critical Care Directorate		
CA 6 – ICU overnight discharges	Jacqui Slingsby Matron, Critical Care Directorate		Occasional patients continue to be discharged overnight from ITU (none routine) thus not meeting core standards. Increased demand at TWH in May. Continued concerns relating to patient flow but plan in place to create additional capacity at TWH.
CA 7 – Critical Care Outreach 24/7 service provision	Siobhan Callanan Associate Director of Nursing		None raised
CA 8 – ICU washing facilities	Jacqui Slingsby Matron, Critical Care Directorate		All actions completed
CA 9 – Cultural/linguistic needs	Richard Hayden Deputy Director of Workforce		None raised
CA 10 – CDU Privacy and dignity	Lynn Gray Associate Director of Nursing		None raised
CA 11 – Medical records	Wilson Bolsover Deputy Medical Director		Audit still outstanding
CA 12 – Security staff	John Sinclair Head of Quality, Safety, Fire and Security		Good progress, joint partnership arrangements now in place. Training nearly fully compliant.
CA 13 – Incident reporting	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		None raised
CA 14 – Joint management of children with surgery	Hamudi Kisat / Johnathan Appleby Clinical Directors		Delay in formalising Standard Operating Procedure but in progress
CA 15 – Children's Clinical governance	Karen Woods Risk and Governance Manager, Children and Women's Services		None raised
CA 16 – Incident reporting + lessons learnt	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		Completed compliance action
CA 17 – Corporate clinical governance	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		None raised
CA 18 – Topical anaesthetics	Jackie Tyler, Matron Children Services		None raised

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Enforcement Notice

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

Report submitted with all actions completed. Request for Enforcement notice to be lifted submitted with supporting evidence. RAGB = BLUE

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Compliance action 1				CA1
Issue: *The PEWS system had not been validated and was not supported by a robust escalation protocol that was fit for purpose and was not standardised across the children's' directorate*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead:** *Jackie Tyler, Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. PEWS chart reviewed in line with tertiary referral centres (Nottingham) or PEWS from National Institute for Innovation (used in other Trusts)	The Nottingham model identified is not validated for use in Paediatric Emergency Department (ED). No national validated PEWs charts for all areas. Following joint meeting Brighton Paediatric PEWs system has been identified as suitable for use across all paediatric areas & paediatric ED Information, audit data and draft documentation collated and received from Brighton NHS Trust. Ward manager visiting Brighton this week to meet with development team. Meeting arranged with ED to agree Trust PEWS documentation	1. Validated PEWS in place. 2. Revised escalation protocol in place 3. Staff competent and consistent in using PEWS and escalation. 4. 3 monthly audit of compliance 5. Evidence of communication via meetings	31/6/15	
2. Escalation protocol reviewed alongside the PEWS chart review	To be reviewed at the meeting due to the issue now raised above			
3. Once agreed, PEWS chart and escalation protocol implemented across Children's services directorate via teaching sessions, ward level meetings, A&E and Childrens services Clinical Governance meeting	Not commenced until PEWS charts agreed and standardised across all relevant departments			
PHASE 2 Electronic solution (Nervecentre) for PEWS and escalation implemented (brought forward within existing IT plan). NB excludes paediatric A&E		6. Compliance audit from Nervecenter	31/12/15	
Action Plan running to time: Yes				
Evidence submitted to support update (list):				
Assurance statement :				
In progress				
Areas of concern for escalation:				
Lack of standardisation of PEWs assessment paperwork between ED and Paediatrics				

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Compliance action 2				CA2
Issue: *Contrary to the core standards of the Intensive Care Society: There was a lack of cover by consultants specialising in intensive care medicine at weekends; for example, one consultant covered more than 15 patients on two sites.*				
Lead: *Greg Lawton , Clinical Director*		**Operational Lead:** *Daniel Gaughan, GM*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Morning week-end ward rounds on both units implemented	Implemented January 2015	1. Anaesthetic electronic rota showing allocation of intensivists at weekends to site allocation 2. Business plan including risk assessment, mitigations and staffing analysis against core standards 3. TME Meeting minutes where business case considered and decision made 4. Audit of patients medical notes documenting weekend Consultant reviews	1/2/15	
2a. Second ward round at weekend is taking place at both units. Risk assessment undertaken with mitigations in place as required 2b. Second ward round at weekend in person	2a. Risk assessment completed with mitigation in place. 2b. Agreement to implement a 1-8 compliant rota, implementation planned September 2015		2a. 31/3/15 2b. 1/10/15	
3a. The rota for the intensivists reviewed in line with the requirements of the ICS core standards 3b. Rota fully meeting the ICS requirements	3a. Review completed 3b. Agreement to implement a 1-8 compliant rota, implementation planned September 2015		3a. 31/3/15 3b. 1/10/15	
4. Business case for additional intensivists developed and considered	Currently with Investment Assessment Group (IAG) for assessment. Plan to get executive sign off and Trust Management Executive agreement in June. Re advertising in June for the agreed 2 WTE from a previous business case.		17/6/15	
5. Mitigation in place for non-compliance	Mitigation is in place as part of CQC intensivist risk assessment		30/6/15	
6. Recruitment achieved	Re-advertising in June		1/4/16	
Action Plan running to time: YES				
Evidence submitted to support update (list): Intensivist rota, Risk Assessment				
Assurance statement :				
Significant progress with agreement to change in intensivist rota				
Areas of concern for escalation:				
Availability of suitable candidates for consultant intensivist positions.				

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Compliance action 3				CA3
Issue: *Contrary to the core standards of the Intensive Care Society: The consultant was not always available within 30 minutes. There was only one ward round per day when there should be two to comply with core standards.*				
Lead: *Greg Lawton , Clinical Director*		**Operational Lead:** *Daniel Gaughan, GM*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Travel times & distance for each consultant being reviewed to assess compliance with 30 minutes availability for each individual consultant.	This action has been completed	1. Report from Clinical Director outlining each Consultant's travel distance and confirmation of each Consultants ability to respond within 30 minutes. 2. Any delays in responding to be reported as incidents (DATIX) 3. Audit of patients medical notes documenting weekend Consultant reviews	31/5/15	
2. Risk assessment to be undertaken where travel times exceed 30mins	This has been completed to support mitigation until new rota commences in September 2015.		31/5/15	
3. Ward round compliance actions in CA2	Please refer to summary update in CA2		3a. 31/3/15 3b. 1/10/15	
Action Plan running to time: **YES**				
Evidence submitted to support update (list): Risk assessment				
Assurance statement :				
Fully compliant rota expected September 2015				
Areas of concern for escalation:				
Appointment of consultant intensivists.				

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Compliance action 4				CA4
Issue: *Contrary to the core standards of the Intensive Care Society: Admissions were delayed for more than four hours once the decision was made to admit a patient to ICU*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Jacqui Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Consider option of ring-fencing ITU bed for admission	Discussion and agreement at Trust Management Executive: the ring-fencing of ITU bed will be implemented where possible	1. Minutes of TME meeting where ring-fencing option discussed 2. SOP for ITU admissions, transfers and discharges. SOP for managing critically ill patient when ITU is full 3. Site report documentation 4. Monthly performance data 5. DATIX IR1 completed for each patient who has a delayed admission to ITU due to inability to move wardable patients. Investigation into each occurrence with clear lessons learnt and changes implemented	20/5/15	
2. Standard Operating Procedure developed relating to ITU admissions	Operational Policy which incorporates admission policy reviewed and comments made. Consultation continues at ICU and directorate meetings. Expected ratification in August 2015		31/5/15 New date: 31/8/15	
3. Review SOP for managing critically ill patients requiring ITU, when ITU capacity is full (for e.g. in recovery)	Task and finish group of all stakeholders working on pathways for patients in escalation areas formulated and draft pathway disseminated for comment. This work has been re-visited and updated.		30/4/15	
4. ITU referrals & those patients requiring ITU will be identified and discussed at each site meeting and priorities escalated as appropriate.	Attendance at each site meeting by Shift leader/matron in place. Associate Director responsible for the site ensures ITU capacity and demand is discussed at each site meeting and plans put in place with clinical teams to transfer out as appropriate. ITU referrals are consultant to consultant and raised to both the Clinical site team and Matron/Shift leader in ICU. Clinical priorities identified by the Consultant intensivist		1/4/15 Assurance will be tested on 6th July (Review)	
5. When no prospect of ITU capacity available on either site then arrangements for transfer to another unit will be made.	Consider escalation feasibility before any transfer. Critical care capacity within Trust reviewed before transfer outside of organisation. National Emergency bed service already in place.		1/1/15	
Action Plan running to time: ~~**Yes**~~ **/ No**				
Evidence submitted to support update (list): Recovery flow chart, Guidelines for the Management and Delivery of Critical Care in the Emergency Recovery Unit at TWH, Operational policy *ICU*				
Assurance statement :				
Areas of concern for escalation:				

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Compliance action 5				CA5
Issue: *Contrary to the core standards of the Intensive Care Society: Discharges from the ICU were delayed for up to a week. Of all discharges, 82% were delayed for more than 4 hours*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Jacqui Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Standard Operating Procedure to be developed relating to ITU discharges	Operational Policy which incorporates admission policy reviewed and comments made. Consultation continues at ICU and directorate meetings. Expected ratification August 2015 at Standards Committee	1. SOP for ITU admissions, transfers and discharges. 2. Site report documentation. 3. Monthly performance data 4. DATIX incident report completed for each patient who has a delayed discharge from ITU Investigation into each occurrence with clear lessons learnt and changes implemented	31/5/15 New Date: 31/8/15	
2. Transfers out of ITU to be followed up on a named patient basis at each site meeting	In place at site meetings		1/4/15	
3. To link in with Trust wide work around patient flow and delayed discharges improvement plan developed in line with D16 CQUIN and in collaboration with Chief Operating Officer and Clinical Site Management team	Monthly delayed discharge performance data captured on performance dashboard and within monthly unit reports. Performance against milestones reported at monthly CQUIN board. Incident forms completed for each delay, clinical site team identified as handlers.		30/5/15	
Action Plan running to time: **No**				
Evidence submitted to support update (list): Operational policy ICU, ICU dashboard, delayed discharges summary data				
Assurance statement :				
Areas of concern for escalation:				

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Compliance action 6				CA6
Issue: *Contrary to the core standards of the Intensive Care Society: Overnight discharges take place from the ICU.*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Jacqui Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. All ward fit patients to be identified to the site team at the earliest opportunity but by 1500 at the latest each day.	All patients deemed ward fit or likely to be fit are named at site meetings and entered on capacity handover form to the site team, together with any special requirements i.e. Side room needed, specialist ward etc. Displayed in site team on communications board	1. Incident (DATIX) report to be raised on all post 2000hrs transfers. Review and identification of where lessons can be learnt and improvements made	1/3/15	
2. Transfer plans to be agreed and completed by 2000 hrs at the latest. No patients to be routinely transferred from ITU after 2000.	Core standards state: *'Discharge from Critical Care should occur between 07:00hrs and 21:59hrs' (2.12)* During May 5 patients at TWH and 3 at Maidstone were transferred to wards between 22:00 and 07:00, which is 1 more than in April. Incident reports raised. Theme is in relation to demand this month with 60 more bed days utilised. Patients though deemed fit prior to these times were not able to be moved to a ward due to bed capacity issues.		1/3/15	
Action Plan running to time: **Yes / No**				
Evidence submitted to support update (list): ICU dashboard data, out of hours discharges. Site reports				
Assurance statement :				
Areas of concern for escalation:				
Demand at TWH increased since April by 53 level 3 bed days in May. Concern in relation to patient flow continues, which impedes patients having timely transfers. Long term strategy for inpatient capacity at TWH in planning phase				

Compliance action 7				CA7
Issue: *The outreach service does not comply with current guidelines (National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2011))*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Siobhan Callanan, ADN planned care*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Business Case approved	Approved	1. Rota showing 24 hour / 7day cover 2. Review of service and performance data via Directorate Clinical Governance meetings	27/1/15	
2. Recruitment to posts	All Band 7 posts fully recruited to		1/9/15	
3. Implementation of a 24 hour 7 day out-reach service which will be fully integrated with critical care service	Consultation commenced on 1st June 2015 Staff meeting held with Q&A sheet to inform all staff Further 1.1 and group meetings – dates agreed Draft rota to be drawn up		1/10/15	
Action Plan running to time: YES				
Evidence submitted to support update (list): Copy of consultation letter Copy of Q&A sheet for staff				
Assurance statement :				
All staff have been fully briefed and are engaged in the process.				
Areas of concern for escalation:				
None at present				

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Compliance action 8				CA8
Issue: *Improvements are needed in relation to the environment in the Intensive Care Unit with regards to toilet/shower facilities for patients.*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Jacqui Slingsby, Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Conversion of an existing toilet to a patient toilet & bathroom facility at Tunbridge Wells Hospital	Bathroom facilities for patients have always been in place at TWH and contains a toilet within the shower room. The staff toilet which is co-located to the existing facility has been re-assigned and designated as a patient toilet, with appropriate signage	1. Photo of Toilet / shower facilities appropriate for patient use 2. Confirmation at Executive / Non Executive walkabout	1/4/15	
2. Provision of appropriate patient washing facilities within Critical Care at Maidstone Hospital	Shower room available and two designated patient toilets, one which has disabled access; all in use. Awaiting new shower chair delivery, existing shower chair in place		1/4/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list):				
Assurance statement :				
Photographs: Submitted with April update All areas commissioned. Executive walk round at Maidstone – Avey Bhatia & Steve Tinton 13/4/15 at Tunbridge Wells – Paul Sigston 14/4/15				
Areas of concern for escalation:				

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Compliance action 9 CA9

Issue: *The provider did not ensure that care and treatment was provided to service users with due regard to their cultural and linguistic background and any disability they may have*

Lead: *Richard Hayden, Deputy Director Human Resources*	**Operational Lead:** *Richard Hayden, Deputy Director Human Resources & John Kennedy, Deputy Chief Nurse*

Actions	Monthly summary update on progress	Evidence required	Action completion date	Rating
1. Appoint a dedicated lead for Equality and Diversity for Trust	Interim E&D Lead appointed April 2015 Business Care for substantive post holder to be agreed by 30 June Chief Nurse appointed as Board Lead May 2015	1. Substantive E&D Lead Appointed 2. Training records against E&D awareness programme 3. New E&D Strategy 4. Detailed action plan for improvements 5. Evaluation of changes to service and feedback from staff (staff survey), patients, Healthwatch and community groups (with actions developed and monitored as required)	1/9/15	
2. Develop an E&D awareness programme for all staff	April – 2015 – E&D training 89% compliant against 85% target Benchmarking and intelligence from partner Trust to inform awareness programme and roll out plan		1/10/15	
3. Review and develop new E&D strategy for organisation, in collaboration with MTW staff and partner organisations	Draft Workforce strategy approved June 2015. E&D priorities included & supported by implementation plan for approval by 30 June 2015		1/9/15	
4. Ensure current process for accessing translation services is communicated to all staff	Staff communication circulated on 30th January 2015		1/2/15	
5. Identify an existing NHS centre of excellence and buddy with them to ensure best practice and learning implemented in a timely fashion	Partnership arrangements under discussion with Southern Health, Portsmouth NHS FT and Leicestershire Partnership Trust.		1/6/15	
6. Conduct a comprehensive review of all existing Trust practices in relation to E&D requirements - for example information, translation, clinical practices, food, facilities	Under assessment with intention to commission external support by 31 July Priority Plan to be finalised linked to Equality Delivery System (EDS2) grading plan		1/4/16	
7. Develop links with local support groups and communities to engage them in the improvement plan for the Trust with assistance from Healthwatch	Under assessment with patient and Carers Groups. Healthwatch will also act as final approver for EDS2		1/10/15	
8. Ensure appropriate organisational governance with assurance to Trust Board in relation to Equality and Diversity	Briefing on E&D plans, EDS2 and Leadership and Governance plan will be submitted to Executive team by 30 June		1/9/15	

Action Plan running to time: Yes

Evidence submitted to support update (list):

Assurance statement :

Areas of concern for escalation:

Compliance action 10				CA10
Issue: *Dignity and privacy of patients was not being met in the Clinical Decisions Unit (CDU)*				
Lead: *Akbar Soorma, Clinical Director*		**Operational Lead:** *Lynn Gray, ADN emergency*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Options appraisal for addressing existing dignity and privacy issues in CDU (2 main options are Option 1: changing function of CDU or Option 2: provision of toilet facilities)	CDU has become single sexed (female) from 8th June with 2 rooms on MAU being used if required for men. Standard Operating Procedure (SOP) circulated	1. Options appraisal paper 2. Changes to CDU environment reviewed by link executives and reported at Standards Committee 3. Site report documentation	1/5/15	
2. Agree preferred option and implement	Preferred option at present is for a single sex CDU		Option 1: 1/4/16 Option 2: 1/10/15	
3. Each patient to be tracked and discussed at each site meeting to ensure timeframes met and plan for discharge / transfer in place	CDU capacity and demand is discussed at each site meeting. Site report will reflect any variance from SOP over the last 24 hours.		1/4/15	
4. To link in with Trust wide work around patient flow and action TW30	Review of pathways to support the A&E flow has occurred as a result of Ambulatory Assessment Unit opening in May.		30/5/15	
Action Plan running to time:				
Evidence submitted to support update (list):				
Assurance statement :				
Areas of concern for escalation:				
Monitoring impact of single sex CDU				

Compliance action 11 CA11

Issue: *The provider did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.*

Lead: *Paul Sigston, Medical Director*

Operational Lead: *Wilson Bolsover, Deputy Medical Director*

Actions	Monthly summary update on progress	Evidence required	Action completion date	Rating
1. Reinforce requirements of Health Care Record keeping amongst multidisciplinary staff, including timely recording of actions undertaken by: 1a. Record Keeping champion for department who will be a source of information and support for record keeping standards 1b. Investigate the possibility of providing a name stamp for staff 1c. Staff involvement in record keeping audit	a) Currently under discussion with clinical directors b) This has been considered and will considered if the audit shows this may be of benefit c) Audit will need to include the availability and completeness of the case records. Under discussion with audit team.	1. Minutes of Directorate Clinical Governance meetings 2. Staff audit pilot 3. Record keeping champion program and list 4. Report on name stamps for staff and recommendations 5. Induction programme for new doctors 6. Report from task and finish group on records	1a. 1/6/15 1b. 1/6/15 1c. 1/6/15	
2. Review induction programme for new Doctors to ensure adequate training provided.	a) Induction for trainees includes legibility of notes (15.4.15) b) Clinical Tutors asked to add in requirement to avoid loose papers (7.5.15) c) College tutors to be prompted about induction for non-training grades once (b) completed.		1/5/15	
3. Multidisciplinary Task and Finish group (sub-group of health records committee) to review current notes with fresh eyes and consider where improvements can be made	a) Discussed at CD Board (6.5.15). No perceived need to change the case note records ahead of implementation of electronic records.		1/6/15	
4. Record keeping audit to be included in case reviews at Directorate CG Meetings	Not commenced as yet		1/9/15	

Action Plan running to time: Yes

Evidence submitted to support update (list):

Assurance statement :

Work has commenced and is in progress

Areas of concern for escalation:

None

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Compliance action 12				CA12
Issue: *Contracted security staff did not have appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs.*				
Lead: *Jeanette Rooke, Director of Estates and Facilities*		**Operational Lead**: *John Sinclair, Head of Quality, Safety, Fire & Security*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Provide documentation outlining the joint partnership with our contractor in regards to the provision of training.	Completed and closed. Documentation of joint partnership arrangements agreed.	1. Agreed documentation on joint partnership arrangements 2. Induction Attendance / compliance report on all existing security staff to Security Group 3. TNA document 4. Report on training compliance to Security Group 5. Certificates of training 6. Certificates of training	18/5/15	
2. All contractors to attend the Trust approved and agreed Induction Training and attend the Trust mandatory training	All Security Staff have completed the mandatory Trust training courses apart from two new starters who are currently going through registration processes.		1/4/15 New date: 1/7/15	
3. Contractors to be included on the Training Needs Analysis document outlining all requirements, frequency and levels	Training needs for contractors are outlined in the documentation of joint partnership arrangements (as per 1.) rather than the trust wide TNA due to the specific nature of this group. The analysis of the training needs is included in this documentation		1/5/15	
4. Review compliance with all training requirements against existing security team	Security Contractor have 100% compliance rate in accordance with BSIA and ACS		1/5/15	
5. The Security Manager to provide training logs for the SMART Risk Assessment Training undertaken through one to one sessions with all security officers.	Security Manager has completed SMART Risk Assessment Training with 95% of the personnel deployed to both sites. The remaining employees will receive said training by the scheduled action completion date. SMART- Safeguarding Managing Risk Tool. Used to assess high risk patients-Two officers to complete-this is due to shift patterns		1/4/15 New date: 1/7/15	
6. All current security staff to be booked onto and attend Mental Health Awareness Training and dementia awareness training	All contracted Security Staff have been booked on Mental Health Awareness Training and Dementia Awareness Training courses provided by the Trust. All staff will have completed all above training by August 2015. Course feedback reviews will be undertaken to ascertain whether further higher level of training is required to provide the necessary support to meet the appropriate needs.		1/8/15	
Action Plan running to time:	**Yes**			
Evidence submitted to support update (list):				
Assurance statement :				
Areas of concern for escalation:				

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Compliance action 13				*CA13*
Issue: *The process for incident reporting did not ensure that staff were aware of and acted in accordance with the trust quality and risk policy.*				
Lead: *Avey Bhatia, Chief Nurse*		***Operational Lead:*** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	***Monthly summary update on progress***	***Evidence required***	***Action completion date***	***Rating***
1. Staff leaflet on Trust Quality and Risk Policy, including incident reporting process to be produced in collaboration with staff and distributed to existing staff and new starters at induction	Leaflet completed Distribution underway	1. Leaflet + audit of distribution and staff engagement through survey 2. fully implemented intranet and web page 3. Datix Staff survey + reporting figures / by profession 4. Education presentation + staff survey 5. Newsletter every month	1/5/15 Distribution will take 2-3months but is underway	
2. Governance page to be developed on the intranet and MTW website with clear signposting to Incident Reporting section	Allocated lead for this work. Intranet work nearly completed. Bolder reporting incident button already changed on intranet front page		Intranet 1/6/15 Website 1/10/15	
3. Incident reporting process currently under review, with full collaboration with clinical staff, to improve reporting process and investigate possibility of hosting reporting portal on mobile media	Datix upgrade completed. Datix review group established. Ongoing work on streamlining reporting process. Discussions well underway with IT and DATIX about reporting portal on mobile media.		1/6/15 New date for completion of all actions: 1/8/15	
4. Education / update program on Governance, Quality and Patient Safety including incident reporting and learning lessons from incidents to be rolled out to all medical and nursing staff over next year	Identified within team and included in Governance team strategy, this work will be supported by internal recruitment to patient safety manager secondment		1/9/15	
5. Continue to publish articles on Governance Gazette Newsletter relating to incident reporting and learning lessons. Encourage staff to write their own articles for publication.	Monthly articles in Governance Gazette		monthly	
Action Plan running to time: ***Yes***				
Evidence submitted to support update (list):				
Assurance statement :				
This action plan is well underway with good progress. Some unexpected delays in Datix upgrade but now resolved				
Areas of concern for escalation:				
Patient safety team is awaiting recruitment of a 6month secondment Patient Safety Manager who will help implement some of these required changes. Recruitment expected June 2015				

Compliance action 14				CA14
Issue: *The clinical governance strategy within children's services did not ensure engagement and involvement with the surgical directorate*				
Lead: *Hamudi Kisat, Clinical Director & Johnathan Appleby, Clinical Director*		**Operational Lead:** *Hamudi Kisat, Clinical Director & Johnathan Appleby, Clinical Director*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Meeting between senior clinicians and managers Children's services directorate and Surgical directorates to establish clear roles and responsibilities of the care of children on the paediatric ward	Paediatric Clinical Director to attend surgical clinical governance meeting to discuss Standard Operating Policy- Lead for paediatrics -Dr Kisat	1. Minutes of joint meeting 2. Standard Operating Procedure 3. Audit of practice 4. MTW Clinical Governance Strategy 5. Agenda, Minutes and attendance records from CG meetings	1/5/15	
2. Standard Operating Procedure for care of children on surgical pathway on paediatric wards	In draft format – awaiting review at Surgical Clinical Governance Meeting		1/6/15	
3. Implementation of the SOP into routine daily practice			1/8/15	
4. Trust to develop a consistent approach to Clinical Governance through MTW Clinical Governance Strategy developed in collaboration with internal and external stakeholders	Trust Clinical Governance review in progress		1/9/15	
Action Plan running to time: Yes				
Evidence submitted to support update (list):				
Assurance statement :				
Currently running to schedule – slight delay on formalising draft SOP due to meeting date				
Areas of concern for escalation:				
None				

Compliance action 15				CA15
Issue: *The children's directorate risk register did not ensure that risks are recorded and resolved in a timely manner.*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead:** *Karen Carter-Woods, Risk and Governance Manager*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. A full review of the directorate risks	Completed	1. Risk register shows children's section managed in a timely manner 2. Minutes of Directorate meeting / Clinical Governance meeting 3. Meeting agendas	1/5/15	
2. An update session for all senior nursing and medical staff on the purpose and process of the risk register	Update session carried out on the nurse update day 23rd April & at Clinical Governance meeting May 14th. Updates for junior staff will be continuing over next month		16/6/15	
3. Ensure review of risk register is standing agenda item at Directorate meetings / Clinical Governance meetings	Already standing agenda item at Directorate meetings Now standing agenda item at Paediatric Clinical Governance meeting		16/6/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): Directorate R&G report **(**March). New risk register				
Assurance statement :				
Raising awareness of staff involvement in paediatric risks ongoing within the directorate				
Areas of concern for escalation:				
Nil				

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Compliance action 16				CA16
Issue: *There were two incident reporting systems, the trust electronic recording system and another developed by consultant anesthetists and intensivists one for their own use. The trust could not have an overview of all incidents and potentially there was no robust mechanism for the escalation of serious incidents. Therefore opportunities were lost to enable appropriate action to be taken and learn lessons.*				
Lead: *Avey Bhatia, Chief Nurse*		**Operational Lead:** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Anaesthetic incident reporting pilot discontinued. Those involved in running this system, and other clinical staff fully engaged with the review on the DATIX system to improve reporting process	Confirmation e-mail from the lead for the anaesthetic pilot that this is discontinued. Meeting regarding Datix improvements due May	1. Written Confirmation from coordinator of system 2. Leaflet audit of distribution and staff survey 3. Newsletter article 4. Increased incident reporting through single reporting system from anesthetist and intensivists	1/2/15	
2. Staff leaflet to include reminder about rationale for single reporting system	Leaflet completed		1/5/15	
3. Reminders in Governance Gazette and via intranet and website about the SINGLE reporting system in the Trust.	In May's edition of the Governance Gazette		1/5/15	
4. Assc. Dir. Quality, Governance and Patient Safety to attend Anaesthetic CG meeting for discussion and update on reporting system	Attended Anaesthetic Clinical Governance meeting 14th May and updated attendees on reporting system		1/5/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): e-mail confirmation + Governance Gazette + Leaflet + CG meeting minutes				
Assurance statement :				
This compliance action has been completed				
Areas of concern for escalation:				
None				

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Compliance action 17				CA17
Issue: *There was a lack of engagement and cohesive approach to clinical governance. Mortality and morbidity reviews were not robust, not all deaths were discussed and there was no available documentation to support discussions.*				
Lead: *Paul Sigston, Medical Director*		**Operational Lead:** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Full review and collaborative process involving all stakeholders for developing and implementing a cohesive and comprehensive clinical governance system from ward to board	Draft CG strategy commenced. External consultant started Governance review in April 2015 and is reviewing current governance arrangements and will produce options /recommendations for improvements	1. CG strategy including clear CG process from ward to board 2. M&M review documentation of full review process and evidence of clear discussions and shared learning 3. Update outline and attendance	1/9/15	
2. Development of a MTW Clinical Governance Strategy	Will continue alongside review process above		1/7/15 New date: 1/10/15	
3. Mortality and morbidity review process to be reviewed in collaboration with stakeholders and developed with exploration of further use of technology and clinical governance processes to improve rigor, transparency and effectiveness	MTW mortality review process has been reviewed and strengthened with work continuing at Trust and directorate level. Quality 'Deep Dive' into current process. Mortality Review workshop hosted by Dr. Foster being attended by MD and CN to learn other Trusts approaches NTDA to assess and provide supportive feedback in July.		1/8/15	
4. Update for staff involved at directorate and Trust level on their role in the mortality & morbidity review process	Will follow on from action taken above.		1/10/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): External consultant update on governance review at executive meeting. Minutes of Trust Mortality Review Group meeting				
Assurance statement :				
This action plan is running to time at present				
Areas of concern for escalation:				
None at present				

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Compliance action 18				CA18
Issue: *The arrangement for the management and administration of topical anaesthetics was ineffective.*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead:** *Jackie Tyler, Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Standard Operating Procedure for the administration of topical anaesthetics for children to be developed and implemented	SOP completed and implemented	1. SOP for children's services. 2. Audit of prescription charts. 3. Training records of staff undertaking PGD training	1/5/15	
2. Topical anaesthetics for children prescribed in all areas of the Trust	Audit of compliance being undertaken		1/6/15	
3. A number of key staff to undertake PGD training to facilitate appropriate timeliness of prescribing.	Training ongoing for Paediatric staff- all band 6 nurses rostered onto trust PGD study days Ward manager now compliant and able to assess staff competency		1/7/15	
Action Plan running to time: Yes				
Evidence submitted to support update (list):				
Assurance statement :				
This action plan is currently running to time				
Areas of concern for escalation:				

Should do actions

The following provides an update on 'should do' actions that are either due now or within the next 4 weeks.

REF	Service or Directorate	Issue Identified	Action/s	Exec Lead	Lead	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	***Summary Update***
TW43	Corporate	Ensure that all staff introduce themselves and wear name badges at appropriate times.	3. Inclusion in customer care training: 'hello my name is…' 4. Joint working with Healthwatch to provide feedback from enter and view visits	Paul Bentley, Director of Workforce and communications	Richard Hayden, Deputy Director of Workforce	Richard Hayden, Deputy Director of Workforce	3. 1/6/15 4. 1/6/15	1.Communication to staff and managers 2. Spot check. Feedback reports from Healthwatch visits and assurance reports to Workforce Committee (actions where required)	All staff wearing name badges at all times and introduce themselves	***No further update***
TW49	Corporate	Have clarity about the definition of what constitutes an Serious Incident Requiring Investigation (SIRI) or Never Event in relation to the retained swabs.	3. Governance page to be developed on the intranet and MTW website with clear signposting to what constitutes and SI and Never event including in relation to retained swabs 4. Education / update program on Governance, Quality and Patient Safety including incident reporting and learning lessons from incidents to be rolled out to targeted medical and nursing staff over next year. This will include a section on what constitutes an Serious Incident or Never Event in relation to the retained swabs.	Avey Bhatia, Chief Nurse	Avey Bhatia, Chief Nurse	Jenny Davidson, Assc Director Gov, Quality and Pt Safety	3. Intranet 1/6/15 Website 1/10/15 4. 1/6/15	1. Staff leaflet and SI policy 2. Intranet & Website 3. Education / update program and attendance 4. Newsletter article	Staff can articulate about the definition of what constitutes an Serious Incident (SI) or Never Event. In areas where swabs are used this will include in relation to the retained swabs	***Intranet: still in progress but work is underway to develop these pages.*** ***A staff leaflet on patient safety incidents has been developed and is being distributed.*** ***Education program will commence when the new Patient Safety manager is in post (expected July)***

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REF	Service or Directorate	Issue Identified	Action/s	Exec Lead	Lead	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	***Summary Update***
M1	Diagnostics Therapies and Pharmacy	Arrange for the safe storage of medicines so that unauthorised access is restricted.	2. The annual Medicines Safety Audits will continue to be done with specific ward and departmental action plans which are continually monitored throughout the year	Paul Sigston, Medical Director	Sara Mumford, Clinical Director	Jim Reside, Chief Pharmacist John Kennedy, Deputy Chief Nurse	1. 1/6/15	Annual Medicines Safety Audit	Compliance with safe storage of medicines so that unauthorised access is restricted.	***2. The Annual Meds Safety Audit is scheduled to be completed in June 2015.***
M13	Diagnostics Therapies and Pharmacy	Develop systems to ensure that medicines are stored at temperatures that are in line with manufacturers' recommendations.	5. *Monitoring Temp of rooms where medicines are stored* Development of joint EME and Pharmacy Business Case with options to monitor room temperatures	Paul Sigston, Medical Director	Sara Mumford, Clinical Director	Jim Reside, Chief Pharmacist John Kennedy, Deputy Chief Nurse	5. 1/6/15	1. Purchase order confirmation from procurement 2. Replacement programme confirmation from Directorate lead 3. Data from daily fridge monitoring and escalation to EME / pharmacy 4. Business Case 5. Minutes of TME where buisness case considered	Systems in place to ensure that medicines are stored at temperatures that are in line with manufacturers' recommendations .	***5. A business case to look at options for ward/room temperature monitoring is currently being completed by Michael Chalklin with assistance for Helen Burn.***

REF	Service or Directorate	Issue Identified	Action/s	Exec Lead	Lead	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	***Summary Update***
M16	Emergency and Medical Services	Review the ways in which staff working in medical care services can access current clinical guidance to ensure it is easily accessible for them to refer to.	1. All actions in conjunction with actions identified in M4. In addition: 3. All current clinical guidance will be available online via departmental intranet page	Avey Bhatia Chief Nurse / Paul Sigston, Medical Director	Akbar Soorma, Clinical Director	Donna Jarret, Director of Informatics Jenny Davidson Assc Dir, Gov, Quality, Patient Safety	1. 1/6/15 3. 1/6/15	1. Report on review of current clinical guidance 2. Update on departments pages of intranet	Medical staff aware of where to find clinical guidelines	***Communications team has commenced the work to develop departmental pages in the intranet.*** ***Search function of the Qpulse document system is in process of being improved.*** ***Major review of the current document management systems is underway***
TW31	Emergency and Medical Services	Review the systems in place in the ED for developing, implementing and reviewing plans on quality, risk and improvement.	1. Review of Governance structures within ED to ensure appropriate capacity to undertake quality improvement work. This work will be undertaken alongside the Trust wide improvements in the Clinical Governance framework 2. Clarify roles and responsibilities with regards to the Governance agenda, document and communicate to all staff. 3. Review strategy of communicating to staff regarding care delivered in ED, what is done well and what needs improving. 4. Agree how all staff can become engaged with this	Angela Gallagher, Chief Operating Officer	Akbar Soorma, Clinical Director	Claire Hughes, Matron A&E Christy Lowe, Lead Cons for Clinical Governance	1. 1/6/15 2. 1/6/15 3. 1/6/15 4. 1/6/15	1. Documented Clinical Governance structure that will allow for the development, implementation and review of plans on quality, risk and improvement and improved staff engagement. 2. Clinical Governance framework consistent with MTW clinical Governance strategy	Improved patient care, staff engagement and knowledge regarding the ED performance on quality issues	***1. Our CG structure does allow for quality, risk and improvement (audits, service reviews, quality indicators, complaints and SIs etc).*** ***From January 2015 there is wider staff representation (nursing), and they are engaging well.*** ***2. Roles and responsibilities are clear. Communication of agenda and minutes, they are circulated to all staff.*** ***3. Strategy of communicating to staff re: care. This is***

REF	Service or Directorate	Issue Identified	Action/s	Exec Lead	Lead	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	***Summary Update***
			and produce a plan to implement							***done through CG meeting and minutes. 4. Staff engagement - ENP and majors nurses study days held on same days as CG and they attend in the afternoon. The nurses are starting to present topics, and all items discussed at CG are relevant to all in the ED.***
TW51	Women's & Sexual Health	Address staffing levels and recruitment on the gynaecology ward/unit	1. Undertake Staffing levels review and present to Board	Paul Bentley, Director of Workforce and communications	Hilary Thomas , Interim Head of Midwifery	Hilary Thomas , Interim Head of Midwifery John Kennedy, Deputy Chief nurse	1. 1/6/15	1. Report on staffing review presented to Board 2. Business case 3. Buisness planning review and decision 4. Recruitment confirmation (if agreed)	Increased substantive staff - reduced bank and agency spend. EGAU - Improved patient care/pathways at weekends	***1. Staffing report presented to Trust board on 29th April 2015 2. Business cases written 3. outcome of business planning awaited 4. Recruitment on-going***

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Trust Board – June 2015

6-11 Safe Staffing: Planned V Actual - May 2015 **Chief Nurse**

Summary / Key points

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

The report also includes some nurse sensitive indicators to support the professional judgement of safe delivery of care. Nurse sensitive indicators are those indicators that may be adversely impacted on if staffing levels are insufficient for the acuity and dependency of the ward. These indicators are supported by the Department of Health (2010) and latterly by the NICE review of ward staffing published in July 2014.

The fill rate percentage is the actual hours used compared to the hours set in the budgeted establishment. That is, the budgeted establishment sets out the numbers of Registered Nurses and Clinical Support Workers based on an average acuity and dependency (or planned case mix for elective units). When units are faced with increased acuity and/or dependency, in escalation or undergo a service change that is not currently reflected in the budget, this is represented by an 'overfill'.

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

Other areas, most notable UMAU and SAU where trolley bays have been converted to beds to provide 24 hour care to meet increased urgent care demand – ie escalation.

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

Fill rates below less than 90% represent a potential risk, however in some cases this is a managed risk. This may be due to decreased activity or dependency. Maidstone ICU would be an example where they are below the planned rate of 100%. However staff were redeployed to TWH ICU where acuity was higher than planned.

The RAG rating for the fill rate is rated as:
Green: Greater than 90%
Amber Less than 90%
Red Less than 80%

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

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

- The ward maintained a nurse to patient ratio of 1:5 – 1:7
- Acuity and dependency within expected tolerances
- Workforce issues such as significant vacancy

- Quality & safety data
- Overall staffing levels
- Risks posed to patients as a result of the above

The **overall** RAG status gives an indication of the safety levels of the ward, compared to professional judgement as set out in the Staffing Escalation Policy. The arrow indicates improvement or deterioration when compared to the previous month. The thresholds for the overall rating are set bout below:

RAG	Details
	Minor or No impact: Staffing levels are as expected and the ward is considered to be safely staffed taking into consideration workloads, patient acuity and skill mix. RN to patient ratio of 1:7 or better Skill mix within recommended guidance Routine sickness/absence not impacting on safe care delivery Clinical Care given as planned including clinical observations, food and hydration needs met, and drug rounds on time. OR Staffing numbers not as expected but reasonable given current workload and patient acuity.
	Moderate Impact: Staffing levels are not as expected and minor adjustments are made to bring staffing to a reasonable level. OR Staffing numbers are as expected, but given workloads, acuity and skill mix additional staff may be required. Requires redeployment of staff from other wards RN to Patient ratio >1:8 Elements of clinical care not being delivered as planned
	Significant Impact: Staffing levels are inadequate to manage current demand in terms of workloads, patient acuity and skill mix. Key clinical interventions such as intravenous therapy, clinical observations or nutrition and hydration needs not being met. Systemic staffing issues impacting on delivery of care. Use of non-ward based nurses to support services RN to Patient ratio >1:9 Need to instigate Business Continuity

Reason for receipt at the Board.
Assurance

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

May, 2015		Day		Night		Nurse Sensitive Indicators					
Hospital Site name	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	FFT Response Rate	FFT Score	Falls	PU - ward acquired	Overall RAG Status	Comments
MAIDSTONE	Acute Stroke	98.4%	103.2%	100.0%	109.1%	37%	90.9%	11	0		Falls increased slightly. FFT returns improved
MAIDSTONE	Romney	101.1%	100.0%	95.2%	112.9%			1	0		
MAIDSTONE	Cornwallis	89.8%	106.5%	112.9%	N/A	34%	100.0%	1	1		Considered reduction in RNs during the day. Ward moves taking place in month with subsequent change in staff ratios during the month. FFT response rate improved
MAIDSTONE	Coronary Care Unit (CCU)	80.6%	N/A	98.4%	N/A	100%	100.0%	0	0		Minimal impact on care as CCU is co-located on Culpepper and cross cover between staff is
MAIDSTONE	Culpepper	98.4%	95.2%	98.4%	100.0%	47%	94.1%	0	0		
MAIDSTONE	Foster Clark	103.2%	137.6%	110.5%	117.7%	34%	80.0%	5	0		
MAIDSTONE	Intensive Treatment Unit (ITU)	91.5%	N/A	91.9%	N/A	20%	100.0%	0	0		
MAIDSTONE	John Day	79.4%	110.8%	97.8%	132.3%	17%	88.9%	8	1	↓	Decreased fill for RNs had some impact on patient care. Higher reliance for CSWs as high numbers of confused patients. Matron curretnly reviewing staffing and ward working paterns
MAIDSTONE	Jonathon Saunders	97.6%	101.6%	100.0%	187.1%	38%	100.0%	4	1		Additional support at night to cover Norovirus outbreak over 13 nights.
MAIDSTONE	Lord North	94.8%	90.3%	98.9%	100.0%	45%	92.3%	2	0		
MAIDSTONE	Mercer	100.0%	100.0%	97.8%	103.2%	14%	100.0%	5	0		
MAIDSTONE	Pye Oliver	87.9%	171.0%	116.1%	174.2%	42%	97.9%	4	1	↓	additional CSW reuqired for increased dependency throughout the month. RN redeployed to other wards on 2 occaisions. Additional CSW staff on to cover ward move at end of month
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	93.8%	94.7%	125.8%	177.4%	13%	95.3%	3	0		Additional staff required to cover night escalation on 14 occaisions.
TWH	Acute Stroke	95.7%	103.2%	97.8%	109.7%	86%	94.7%	2	0		
TWH	Coronary Care Unit (CCU)	97.8%	90.3%	98.9%	N/A	88%	91.4%		0		
TWH	Gynaecology	91.7%	100.0%	100.0%	100.0%	31%	97.9%		0		
TWH	Intensive Treatment Unit (ITU)	110.1%	96.8%	110.1%	N/A				0		
TWH	Medical Assessment Unit	96.3%	137.6%	87.1%	143.5%	14%	100.0%	15	2	↓	Over established on CSWs in preparation for opening AAU. Risk of lower RN at night accepted on this basis.
TWH	SAU	106.5%	129.0%	148.4%	164.5%	0%	0.0%		0		Escalated at night all month.
TWH	Ward 32	100.0%	100.0%	100.0%	100.0%	12%	96.0%	1	0		
TWH	Ward 10	90.8%	109.7%	87.1%	140.3%	9%	100.0%	1	0	↑	2 pts requiring specials over 8 nights, plus one patient with mental health problems requiring special over night on a further 8 nights. RN reduction risk accepted on this basis.
TWH	Ward 11	95.4%	130.1%	94.4%	148.4%	49%	100.0%	1	2		
TWH	Ward 12	96.7%	121.5%	82.1%	143.5%	35%	92.3%	13	0	↑	Some impact on patient care at night. Adverse shift in RN to CSW ratio. Improvement since last month when RN night fill rate was 75.6%
TWH	Ward 20	97.7%	87.1%	109.2%	150.0%	67%	81.3%	17	2		
TWH	Ward 21	96.6%	103.2%	89.7%	113.6%	49%	100.0%	3	1		Minor impact on patient care at night.
TWH	Ward 22	100.8%	104.3%	97.8%	98.9%	160%	95.8%	9	2		
TWH	Ward 30	95.7%	122.4%	80.6%	125.8%	3%	100.0%	6	0		Wards 30 and 31 frequently cross-cover. Whilst Ward 30 was low at night, support from 31 minimised imapact on patient care
TWH	Ward 31	111.3%	98.1%	96.8%	122.6%	57%	96.0%	6	1		
TCH	Stroke Rehab	92.3%	95.2%	100.0%	100.0%	67%	75.0%	6	0		
TWH	Ante-Natal	110.1%	96.8%	100.0%	100.0%				0		Midwife fill rate at night on Delivery Suite improved from last month. Maternity unit to be viewed in totality as midwives move with women. 1:1 care in established labour was maintained at all times.
TWH	Delivery Suite	93.9%	90.3%	90.0%	90.3%				0	↑	
TWH	Post-Natal	98.6%	87.1%	100.0%	95.2%	12.4%	94.7%		0		
TWH	Gynae Triage	98.4%	100.0%	96.8%	100.0%				0		
TWH	Hedgehog	102.2%	102.0%	104.3%	87.1%	0%	0.0%		0		low unresigstered fill rate had minimal impact on care as slightly over on RNs.
MAIDSTONE	Birth Centre	100.0%	100.0%	100.0%	100.0%				0		
TWH	Neonatal Unit	100.0%	80.6%	96.8%	96.8%				0		Minimal impact on care during the day. Focus given to ensuring adquate cover for night.
MAIDSTONE	MSSU	105.7%	82.8%	91.4%	N/A	0%	0.0%		0		
MAIDSTONE	Chaucer	98.3%	179.8%	111.0%	186.0%	74%	98.2%	3	0		Additional CSW requirement to cover specials; combination of patients in bays and a side room reducing ability to cohort.
TWH	SSSU	103.3%	106.7%	N/A	N/A	0%	0.0%	0	0		

Movement in overall RAG rating

↑ indicates an postive move compared to previous month

↓ indicates a negative move compared to previous month

no arrow indicates no change compared to previous month

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Trust Board Meeting - June 2015

6-12	**Report on the process for reviewing outliers of clinical outcomes**	**Medical Director**

In September 2014, the Quality & Safety Committee 'deep dive' meeting reviewed "clinical outcomes", and agreed that a report should be submitted to the Trust Board in June 2015 (and annually thereafter) outlining the process for reviewing clinical outcomes, and notifying the Board of any outliers of concern (and the Trust's response).

It is essential that Trust processes have oversight of the outcomes of our clinical care on patients. However, there are many differing aspects of "outcomes" with varying credibility of measurement. This report describes some of those outcome measures, describes our scrutiny and will provide detail of some outliers and the actions taken.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Discussion 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

The Trust processes for reviewing clinical outcomes and notifying the Board of outliers

Introduction

It is essential that Trust processes have oversight of the outcomes of our clinical care on patients. However, there are many differing aspects of “outcomes” with varying credibility of measurement. This report describes some of those outcome measures, describes our scrutiny and will provide detail of some outliers and the actions taken.

Examples of outcomes that are measured

- Patient satisfaction with care
  - Patient survey
  - Friends and Family
  - Complaints
- Patient rated measures of outcomes
  - PROMS
- Readmissions
- Reoperations
  - National Joint Registry
- Infections rates
  - SSI (Surgical site infections)
  - C Difficile etc.
- Length of Stay
- Mortality
  - Multiple databases
    - Dr Foster
    - ICNARC (Intensive Care National Audit & Research Centre)
    - Cancer Outcomes
- Audit of processes of care
  - EQ (Enhancing Quality)
  - SSNAP (Sentinel Stroke National Audit Programme)

Trust review of data

Several of the outcomes outlined above are reviewed at Trust Board or its subcommittees and I will not comment on those processes further.

External scrutiny is provided by a variety of organisations that alerts the Chief Executive and Medical Director to any clinical outliers. This would include National Joint Registry, National Hip Fracture Database and Dr Foster. In addition, the CQC have an overview of these databases and are also alerted to any outlier status.

The Directorate systems and the Standards Committee review all of the outcomes mentioned above.

Examples of Outliers and measures taken.

National Joint Registry
Two of the surgeons employed within the Trust had higher than expected revision rates for primary hip replacements. This was communicated to the Trust in November 2014, though the Trust was aware of this likelihood over a year earlier. The reasons for this and the actions taken will be discussed at the Board.

National hip Fracture Database
In December 2014, the Trust received notification from the Dr Foster unit at Imperial informing us of a higher than expected mortality related to patients admitted with a fractured neck of femur. The directorate had been aware of this issue from internal scrutiny of our mortality and the Chief Nurse and The Medical Director facilitated a multidisciplinary meeting to formulate plans to improve the pathway and care of such patients. An audit of all of the deaths for a 12 month period were analysed and conclusions drawn.

Appendix 1 describes the action.

Cerebrovascular Disease
Patients with Cerebrovascular disease have demonstrated a higher than expected mortality within the Trust. Work is being done to improve our stroke care. Analysis of our data shows that our admitted patients with cerebrovascular disease have a raised age compared to the national average.

Vascular surgery
As can be seen on the attachment, the Trust continues to provide some Carotid endarterectomy operations to patients. We are not an outlier - Appendix 2 demonstrates the variability in outcomes nationally and shows the figures for the South East Coast region.

Appendix 1: Actions taken in response to higher than expected mortality related to patients admitted with a fractured neck of femur

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

REDUCTION OF NECK OF FRACTURE OF NECK OF FEMUR MORTALITY REVIEW

REPORT OUTLINE

Response to the Care Quality Commission, following notification of a mortality outlier alert for "reduction of fracture of neck of femur" dated 16/02/15.

Action taken:

Review of all 30 day mortality amongst patients with procedure codes O17.1, W19.1, W24.1 between September 2013 and September 2014 (n=15)

Method:

A list was obtained of patients who died within 30 days with procedure codes O17.1, W19.1, W24.1 between September 2013 and September 2014 from Dr Foster. Data submitted to the National Hip fracture database (NHFD) was reviewed for the period September 2013 to August 2014 to identify the total numbers of procedures performed (Annex 2) and Best Practice Tariff (BPT) attainment.

A mortality review form was devised to collect data to reflect clinical information and criteria for assessing good clinical practice (Annex 1). Data collection included demographics, management and treatment, pre-morbid condition, day of admission and surgery,

Based on the notes review of each patient a judgment was made on the standard of care.

15 notes were available for review. The review team consisted of the following:

P Sigston Medical director.
Role: Coordinate review and report; final sign off of report.

G Slater Clinical director of trauma and orthopaedics.
Role: Coordination of the review; review of the results; compilation of report.

F Young, TARN/NHFD Coordinator.
Role: Acquisition of records, distribution of NHFD data.

Results:

All fifteen sets of notes were available for review.

One patient (M0136183) was erroneously identified as suffering from a fractured neck of femur. The patient in question had suffered a distal femoral peri-prosthetic fracture above a knee replacement. This patient was not included in any further analysis.

One patient's notes did not contain any information about their admission with a fractured neck of femur. It was assumed this episode was in a temporary set of notes that could not be found despite an extensive search. Information on this patient could be found on the trust's electronic discharge notification, iSoft, and PACs system however a full review of the care delivered could not be carried out.
Fourteen patients were identified as having died following the procedures:
O17.1 Remanipulation of intracapsular fracture of neck of femur and fixation using nail or screw
W19.1 Primary open reduction of fracture of neck of femur and open fixation using pin and plate

W24.1 Closed reduction of intracapsular fracture of the neck of femur and fixation using nail or screw

Data submitted to the NHFD for the trust show that between September 2013 and August 2014 a total of 252 cannulated screws, DHS and IM nails were performed. Dr Foster data has identified fourteen patients died giving a 30 day mortality of 5.5%

Review of the notes indicated:

Place of admission:
As requested in your correspondence reference A5858/LF point two:
All surgery was carried out at Tunbridge Wells Hospital (TWH).
Thirteen patients were admitted directly to TWH, one patient fell whilst an in-patient at Maidstone hospital and was transferred to TWH for surgery

Admitted from:
As requested in your correspondence reference A5858/LF point three: “It would be helpful for us if, for the cases you review, you could provide us with the names of any care homes or nursing homes these patients were admitted from.”
For one patient the data was not available. Nine patients where admitted from their own home.
One patient was an in-patient when they fell and sustained their fracture.
The remaining three were admitted from:

The Groves Residential Home
6 Bower Mount Rd
Maidstone ME16 8AU

The Chestnuts EMI care home
18-20 London Rd
Tonbridge TN10 3DA

Heather View Nursing Home
Beacon Rd
Crowborough TN6 1AS

The two patients from the latter two residences both suffered severe dementia. The first patient lived 24 days and the second 14 days postoperatively. It was therefore felt all the admissions were appropriate.

Admitting consultant
The patients were evenly distributed amongst the consultants within the department each consultant having one death under their care.

Day of admission
The distribution of day of admission was as follows:

Monday	2
Tuesday	3
Wednesday	1
Thursday	2
Friday	1
Saturday	0
Sunday	5

No information on the distribution of day of admission for fractured NOF patients who survived was available for this review.

Time to surgery & BPT
Of the fourteen patients; one patient underwent surgery on the day of admission, eleven the day after admission, and two patients underwent surgery two days after admission. Twelve patients had their surgery within 36 hours of admission.

Eleven patients fulfilled the criteria for BPT.
Three patients did not achieve BPT:
Two had surgery more than 36 hours after admission, one of whom was a lady on renal dialysis who was not medically fit for surgery earlier.
One patient did not have a postoperative abbreviated mental test score (AMTS) recorded.
All patients were reviewed by the orthogeriatric team. In this small sample 79% achieved BPT compared to a national average of 64%

ASA grade
The ASA physical status classification system is a system for assessing the fitness of cases before surgery. These are:
1 Healthy person.
2 Mild systemic disease.
3 Severe systemic disease.
4 Severe systemic disease that is a constant threat to life.
5 A moribund person who is not expected to survive without the operation.

ASA grade distribution was as follows:
ASA 1: 0
ASA 2: 4 patients
ASA 3: 5 patients
ASA 4: 3 patients
ASA 5: 0
Unrecorded 1
Unavailable 1

Seniority of anaesthetist/surgeon

The seniority of surgeon and anaesthetist was judged appropriate for each case. Of the thirteen cases for which information was available, eight cases had a consultant surgeon directly involved. Of the twelve cases for which information was available six had a consultant anaesthetist directly involved. All patients with an ASA score of four had both a consultant surgeon and anaesthetist directly involved.

Procedure

2 patients received intramedullary devices (PFNa Synthes)
12 Patients underwent Dynamic Hip Screw fixation
All procedures were judged appropriate for the type of fracture sustained.

DNAR (Do Not Attempt Cardiopulmonary Resuscitation) order

Four patients were known to have community DNAR order in place on admission.
Eight other patient's had DNAR orders in place at the time of their death;

DATE OF DEATH	DNAR
19/12/13	19/12/13
08/12/13	18/09/13 COMMUNITY
21/10/13	NO
24/02/14	13/02/14 COMMUNITY
02/01/14	01/01/14

DATE OF DEATH	DNAR
31/07/14	COMMUNITY
26/09/13	17/09/13
29/04/14	28/04/14
18/04/14	20/03/14 COMMUNITY
01/07/14	08/06/14
21/09/13	03/09/13
20/02/14	20/02/14
03/05/14	UNKNOWN
30/04/14	29/04/14 COMMUNITY

Cause of death
Cause of death was recorded as follows:

CAUSE OF DEATH AS RECORDED ON DEATH CERTIFICATE				
1a	1b	1c	2	PM
HAEMORRHAGE	ISCHAEMIC COLITIS AND DUODENITIS		NOF & COPD	YES
BRONCHOPNEUMONIA			NOF	NO
END STAGE RENAL DISEASE	HYPERTENSION INTERSTITIAL NEPHRITIS		PERIPHERAL VASCULAR DISEASE	Unk
END STAGE ALZHEIMERS			WALDENSTROM'S MACROGLOBULINAEMIA	NO
MYOCARDIAL INFARCTION				NO
BRONCHOPNEUMONIA			NOF, advanced dementia	NO
ASPIRATION PNEUMONIA	PARKINSON'S DISEASE		NOF	NO
ACUTE KIDNEY FAILURE	CCF		NOF	NO
DIVERTICULITIS			NOF	NO
METASTATIC OESOPHAGEAL CA				NO
BRONCHOPNEUMONIA	CVA		NOF	NO
MYOCARDIAL INFARCTION			NOF	NO
CHEST INFECTION			NOF, CCF, ALZHEIMERS	NO
SEPSIS	PNEUMONIA	LUNG CANCER	NOF	NO

6 patients died of chest infections
2 patients died of myocardial infarctions
2 patients died from intra-abdominal complications
2 patients had a pre-injury diagnosis of terminal cancer from which they succumbed.
1 patient admitted was on renal dialysis and died of end stage renal disease in the Kent and Canterbury renal unit.
1 patient developed acute kidney failure.
One post-mortem examination was known to be carried out.

Standard of care:

A conclusion of standard of care could be made on thirteen patients as follows:

- No substandard care: Eight patients received a good standard of care.
- Room for improvement: Five patients

Of these five patients, for one patient the “room for improvement” grading was based on organisational rather than clinical care as the notes were very disorganised and difficult to navigate. It was felt this did not affect outcome.

The remaining four patients in which there was room for improvement in clinical care were assessed as follows:

- Some substandard of care would not have affected outcome: 2 patients
- Some substandard care might have affected outcome: 2 patients
- Substandard care, would reasonably have been expected to affect outcome: None

The two patients where care may have affected patients were as follows:

1) 93 year old female died of: 1a: Acute renal failure. 1b: CCF. 2: NOF.
   Past medical history of breast cancer and pacemaker fitted.
   Due to lack of bed availability spent 18 hours in A&E before transfer to a ward.
   Did meet criteria for BPT.
   Underwent surgery on Saturday, no written entry in notes on first post-operative day (Sunday) although routine bloods were checked. Admitted with a creatinine of 121, rising creatinine not acted upon until Monday.

2) 75 year old female died of 1a: Aspiration pneumonia. 1b: Parkinson’s disease. 2: NOF
   Past medical history of severe Parkinson’s disease.
   The patient was put ‘nil by mouth’ due to poor swallow and therefore did not receive treatment for Parkinson’s disease. 24 to 36 hour delay in passing a nasogastric tube.
   Due to severity of Parkinson’s disease this patient was not graded “Substandard care, would reasonably have been expected to affect outcome”.

Conclusion

We found evidence of good practice,

Good practice was demonstrated in:

- Use of a NOF proforma booklet to record admission notes.
- Involvement of orthogeriatric team in the care of all patients.
- High attainment of the criteria for best practice tariff.
- Use of an electronic trauma board collating data to a database.
- Consultant led handover twice a day at 08:00 and 20:00 seven days a week.
- Consultant run trauma lists seven days a week.

Areas identified for improvement were as follows:

1) Recording of blood results in the patient’s notes.
2) Ensuring patients undergoing surgery on Friday and Saturday have written entries in the notes on the first postoperative day.
3) Concern about the management of patients with Parkinson’s disease.
4) Concern about the management of patients undergoing renal dialysis.

The orthopaedic directorate will raise point one in the directorate governance meeting to raise awareness amongst junior staff.

The orthopaedic directorate has set up an audit of those patients undergoing surgery on Friday and Saturday to assess the frequency with which these patients have written entries in their notes on the first postoperative day.

The care of patients with significant Parkinson’s disease undergoing emergency surgery remains challenging. Withholding oral treatment whilst the patient is nil by mouth risks a significant deterioration in cognitive function. We will recommend the early involvement of a consultant

specialising in the management of Parkinson's disease. The use of early Nasogastric tubes and/or transdermal patches (Rotigotine) needs to be explored and care pathways developed.

Patients on renal dialysis who sustain a fracture of the neck of femur are poorly served in the region. The renal unit at the Kent and Canterbury does not have on site emergency trauma care. Likewise the renal dialysis unit at Guy's is served by a trauma unit based at St. Thomas'. The directorate has been in touch with the renal units at these hospitals to develop care pathways. As a result at present patients are treated at TWH and offered haemofiltration in the intensive care unit before transfer to a renal unit as soon as the patient's conditions permits.

Further comments:

With regards to point 4 in your correspondence reference A5858/LF "any actions the trust has taken to improve outcomes":

1) The directorate now funds a second registrar on call during trauma list hours on the weekend (08:00 to 17:30). This allows one registrar to be available for the operating list while a second covers the A&E department and wards.
2) The directorate discusses the live graphs available from the NHFD (Annex 3,4,5) in its monthly governance meetings thereby detecting any deterioration in performance at an early opportunity.
3) The trust has introduced a mortality review program whereby all deaths are reviewed by a consultant not involved in the initial care of the deceased. Reports are forwarded to a trust mortality review board.

With regards to point 5 in your correspondence reference A5858/LF "please could you let us know details of any improvement activity for this service…in response to this alert":

A neck fracture neck of femur group has been set up and met twice. This group comprises of; the medical director, chief nurse, clinical director for trauma and orthopaedics, orthopaedic clinical lead for neck of femur fractures (consultant orthopaedic surgeon), consultant orthogeriatrician, consultant anaesthetist, and consultant in Emergency medicine.

The second meeting of this group was also attended by trauma coordinators, paramedics, radiographers, physiotherapists, occupational therapists, ward nurses and a patient who had been treated with a fractured neck of femur.

As a result of these meetings:

An audit has been started looking at the delay between patient presentation in A&E, the xray request being made, the xray being done, and its findings being acted upon. As a consequence of initial results a trust cordless phone has been ordered for the on call orthopaedic registrar to allow radiographers to contact them directly when they identify a fractured neck of femur.

One of the consultant anaesthetists has started performing local anaesthetic nerve blocks in A&E on patients presenting with a fractured neck of femur. The aim is to improve analgesia and reduce the use of opioids. The outcome of these blocks is being audited prior to wider introduction.

The directorate has identified a patient warming system to be used preoperatively. This blanket is currently being assessed by the trust's safety committee prior to introduction.

Furthermore we confirm this report will be discussed at the directorate business meeting and directorate governance meeting. It will also be submitted to the trust Quality and Safety committee.

Annex 1

Mortality Review Form

Patient Name:		NHS Number:
Age:	M/F:	Date Of Birth: ☐☐/☐☐/☐☐

GENERAL DETAILS	
Name of Consultant Reviewer:	
Date of death:	Time of death:
Date of last medical review:	Time of last medical review:
Consultant & specialty at time of death:	
Cardiac arrest Y / N	
Operation or invasive procedure during admission: ☐ Yes ☐No ☐Unknown	
ITU episode (s) during admission: ☐ Yes ☐No ☐Unknown	
Where did the patient die (Please state ward or unit)	

Patient Factors		
Cause of Death 1a 1b 1c	**Comorbidity** Cardiac Respiratory Diabetes Renal Gastro Hepatic/Obst jaundice	Malignancy Chemo (within 30 days) Morbid obesity (>30) Neuro Psychiatric Dementia

DIAGNOSIS	
DATE OF INJURY	DAY OF INJURY
DATE OF ADMISSION	DAY OF ADMISSION
DATE OF PROCEDURE	DAY OF PROCEDURE
DATE OF DEATH	DAY OF DEATH
SITE OF ADMISSION	
DATE DISCHARGE FROM T&O	
DISCHARGE DESTINATION	
CARE HOME DISCHARGED TO:	

Initial Assessment	
Date of admission	Time

Time from arrival to 1st clinical review:	Hours Minutes
Time from arrival to 1st consultant review:	Hours Minutes
Within 24 hrs was patient commenced on 'End of Life' pathway?	☐ Yes ☐No ☐Unknown
Admitted to ICU (including via operating theatre) from ED?	☐ Yes ☐No ☐Unknown

In the First 24 hours	
Was there evidence of a clear management plan?	☐ Yes ☐No ☐Unknown
Was the initial management plan appropriate?	☐ Yes ☐No ☐Unknown
Was the plan followed appropriately?	☐ Yes ☐No ☐Unknown

Ongoing Clinical Care	
Did the medical staff write in the notes every weekday?	☐ Yes ☐No ☐Unknown
Were there any periods when a patient was not reviewed by a consultant for >72hrs?	☐ Yes ☐No ☐Unknown
Was fluid balance managed appropriately?	☐ Yes ☐No ☐Unknown
Were there significant errors in medication?	☐ Yes ☐No ☐Unknown
Was there appropriate specialty involvement?	☐ Yes ☐No ☐Unknown

Ongoing Clinical Care	
PAR > 3 at any time	Positive Blood Culture?
Any patient fall?	Urine Infection
Pressure ulcer post admission?	MRSA colonisation
DVT / PE post admission?	

End of Admission	
Was a decision made to limit treatment?	☐ Yes ☐No ☐Unknown
Was a resuscitation decision documented in the notes? ☐ Yes ☐No ☐Unknown Date decision made: ☐☐/☐☐/☐☐	
How long before death did a consultant see the patient?	☐ < 4 hours ☐ 4- 12 hours ☐ 12 – 24 hours ☐ 24 – 72 hours ☐ > 72 hours ☐ Unknown

Investigation Results	
Transfusion	☐ Yes ☐No ☐Unknown
Electrolyte abnormality (Na <120 or>150; K<2.5 >6.5)	☐ Yes ☐No ☐Unknown
Acute kidney injury (urea or creatinine 2x> baseline)	☐ Yes ☐No ☐Unknown
Abrupt drop in Hb (>25%)	☐ Yes ☐No ☐Unknown
Hypoglycaemia (<3mmol/l)	☐ Yes ☐No ☐Unknown

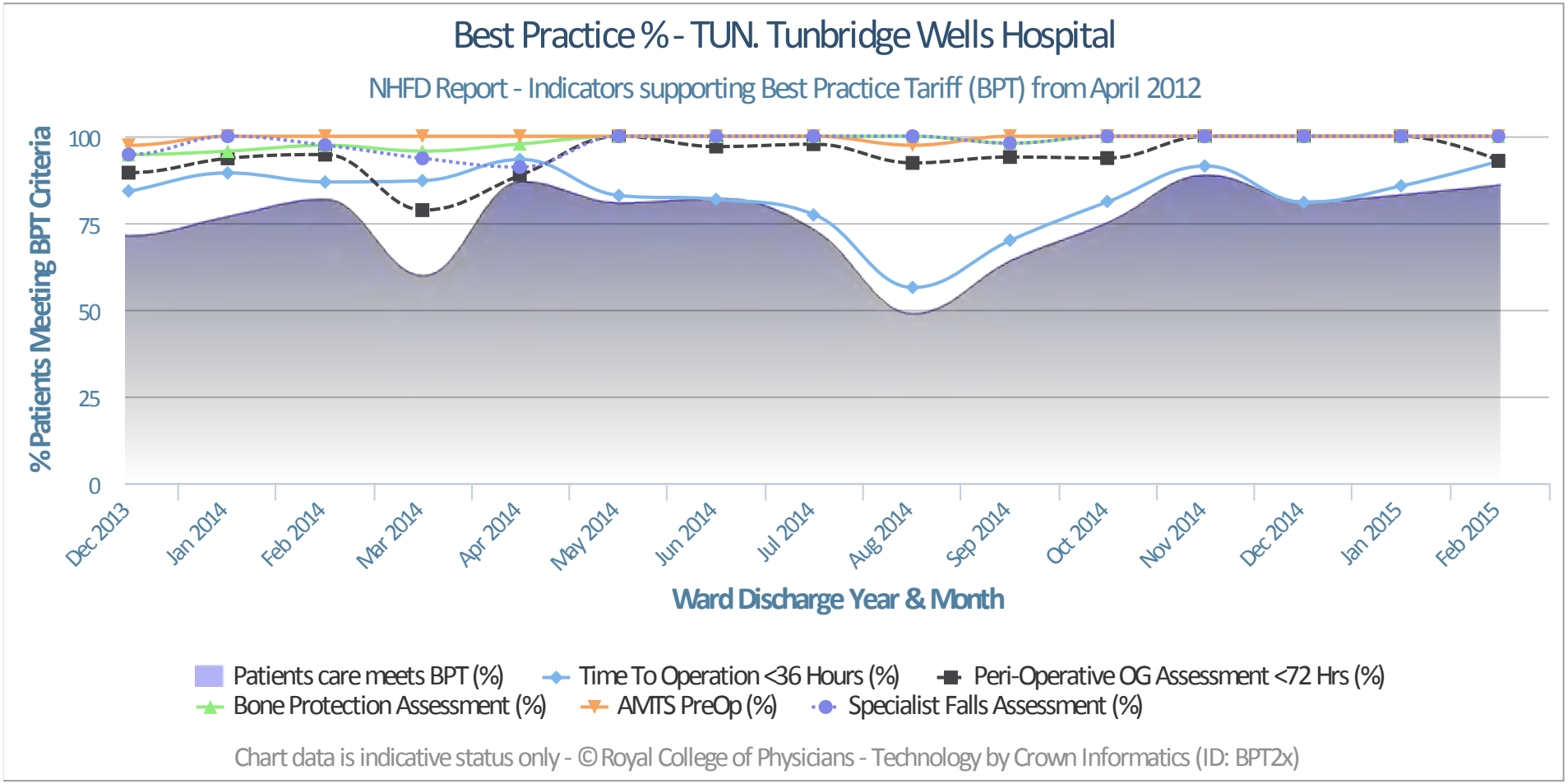
Surgical Care and Invasive procedures			
Main operation/ Invasive Procedure:			
ASA grade: ☐ **1** ☐ **2** ☐**3** ☐ **4** ☐**5** ☐ **Unknown** ☐ **N/A**			
Grade of anaesthetist appropriate for case?	☐ Yes	☐No	☐Unknown ☐ N/A
Anaesthetic delays / complications?	☐ Yes	☐No	☐Unknown ☐ N/A
Appropriate procedure performed?	☐ Yes	☐No	☐Unknown ☐ N/A
Grade of surgeon appropriate for case?	☐ Yes	☐No	☐Unknown ☐ N/A
Surgical delays / complications?	☐ Yes	☐No	☐Unknown ☐ N/A
Admitted to ITU / HDU post op?	☐ Yes	☐No	☐Unknown ☐ N/A
Was ITU/HDU indicated?	☐ Yes	☐No	☐Unknown ☐ N/A
Was the timing of the procedure appropriate?	☐ Yes	☐No	☐Unknown ☐ N/A
Any significant postoperative complication?	☐ Yes	☐No	☐Unknown ☐ N/A
Was there an unplanned Return to theatre or procedure room?	☐ Yes	☐No	☐Unknown ☐ N/A
Any additional operations / invasive procedures:			

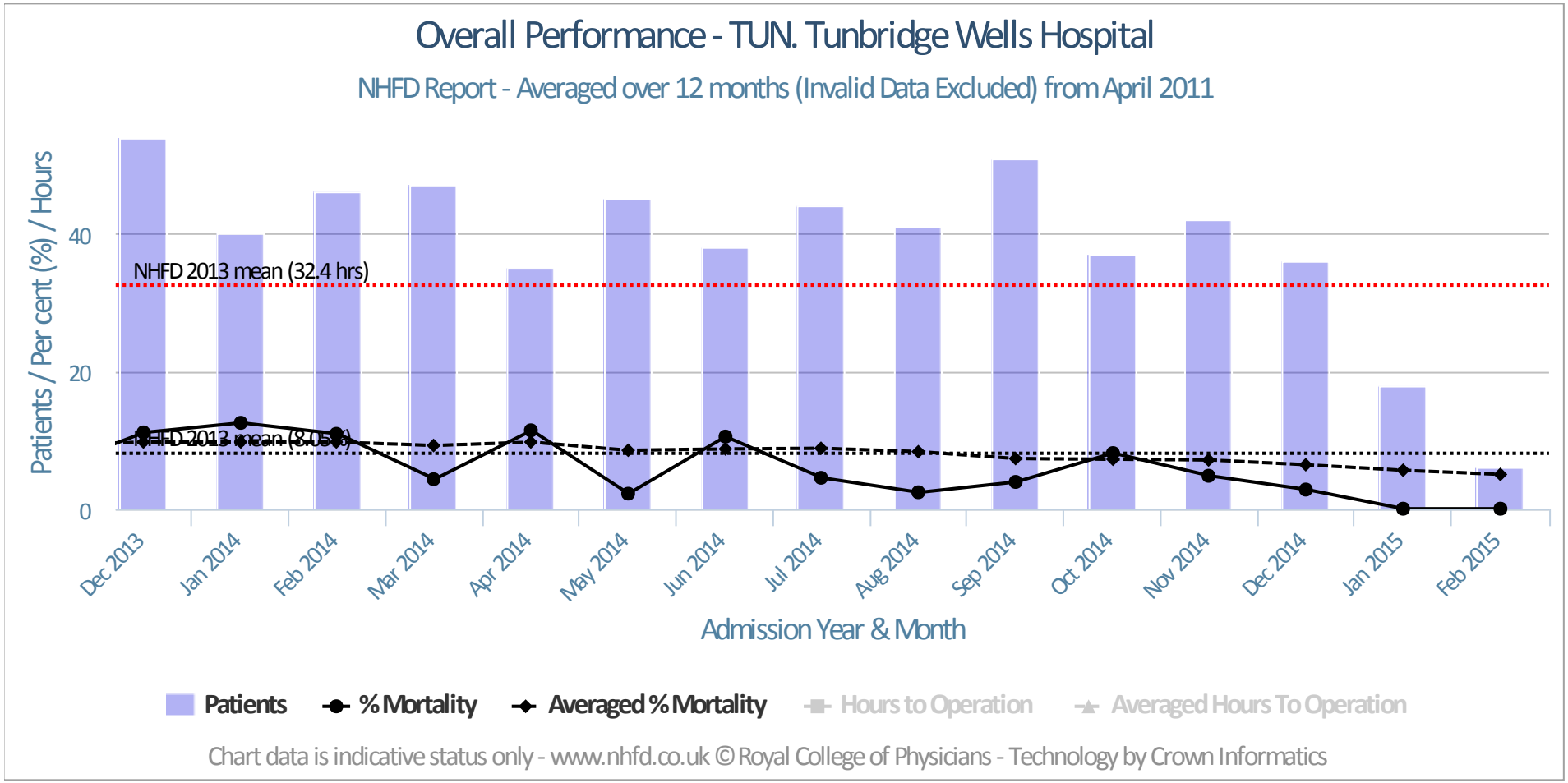
NCEPOD CLASSIFICATION OF CARE			
☐	**A**	**Good Practice**	A standard that you accept for yourself, your trainees and your institution
☐	**B**	**Room for Improvement**	Aspects of **clinical** care that could have been better
☐	**C**	**Room for Improvement**	Aspects of **organisational** care that could have been better
☐	**D**	**Room for Improvement**	Aspects of both **clinical and organisational** care that could have been better
☐	**E**	**Less than Satisfactory**	Several aspects of **clinical and/or organisational** care that were well below satisfactory

FORM COMPLETED & REVIEWED BY:					
Name & grade		Signed		Date	
Consultant		Signed		Date	
Governance Lead		Signed		Date	

Annex 2

Date	Total NOFs	In hospital mortality	30 day mortality	DHS	Cannulated screw	IM nail long	IM nail short	Arthroplasty cemented	Arthroplasty - bipolar cemented	THR	No op
Aug-13	34	3	3	17	0	1	0	15	0	1	0
Sep-13	47	7	7	22	0	2	0	22	1	0	0
Oct-13	33	2	3	14	0	2	0	14	0	3	0
Nov-13	35	2	2	20	0	0	0	10	2	3	0
Dec-13	55	7	7	24	1	3	1	21	1	3	1
Jan-14	40	5	5	12	0	3	1	19	1	4	0
Feb-14	46	6	5	14	0	4	0	23	1	4	0
Mar-14	47	1	2	10	0	7	0	26	0	4	0
Apr-14	36	4	4	12	1	2	1	17	0	3	0
May-14	45	2	1	13	0	2	0	25	1	4	0
Jun-14	38	4	4	14	1	3	1	19	0	0	0
Jul-14	44	3	2	13	0	8	1	21	0	1	0
Aug-14	41	1	1	15	0	4	0	22	0	0	0
					0						
Total	**541**	**47**	**46**	**203**	**3**	**41**	**5**	**254**	**7**	**30**	**1**


Best Practice % - TUN. Tunbridge Wells Hospital
NHFD Report - Indicators supporting Best Practice Tariff (BPT) from April 2012
% Patients Meeting BPT Criteria
100
75
50
25
0
Dec 2013
Jan 2014
Feb 2014
Mar 2014
Apr 2014
May 2014
Jun 2014
Jul 2014
Aug 2014
Sep 2014
Oct 2014
Nov 2014
Dec 2014
Jan 2015
Feb 2015
Ward Discharge Year & Month
Patients care meets BPT (%)
Time To Operation <36 Hours (%)
Peri-Operative OG Assessment <72 Hrs (%)
Bone Protection Assessment (%)
AMTS PreOp (%)
Specialist Falls Assessment (%)
Chart data is indicative status only - © Royal College of Physicians - Technology by Crown Informatics (ID: BPT2x)


Overall Performance - TUN. Tunbridge Wells Hospital
NHFD Report - Averaged over 12 months (Invalid Data Excluded) from April 2011
Patients / Per cent (%) / Hours
40
20
0
NHFD 2013 mean (32.4 hrs)
NHFD 2013 mean (8.05%)
Dec 2013
Jan 2014
Feb 2014
Mar 2014
Apr 2014
May 2014
Jun 2014
Jul 2014
Aug 2014
Sep 2014
Oct 2014
Nov 2014
Dec 2014
Jan 2015
Feb 2015
Admission Year & Month
Patients
% Mortality
Averaged % Mortality
Hours to Operation
Averaged Hours To Operation
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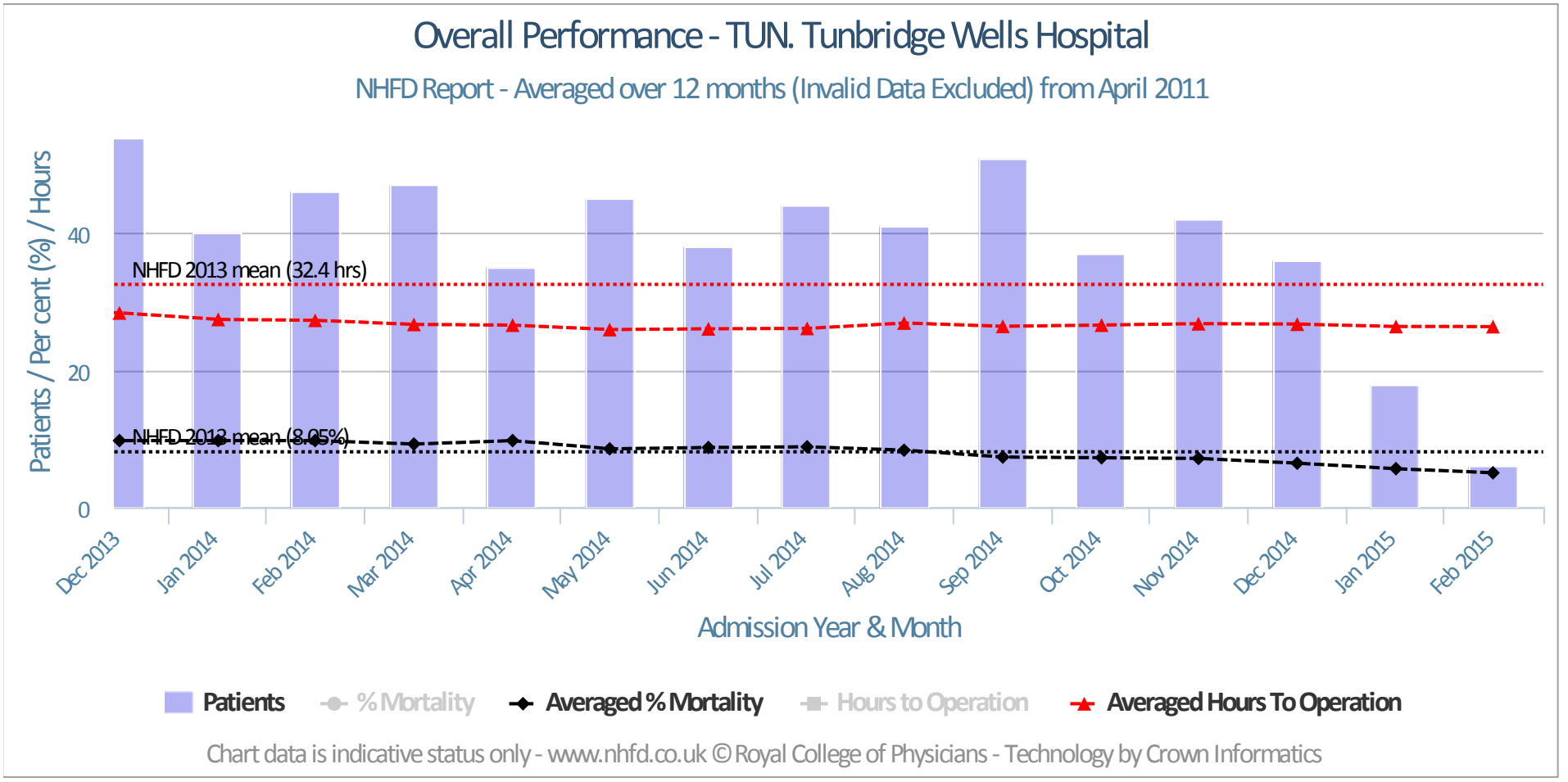
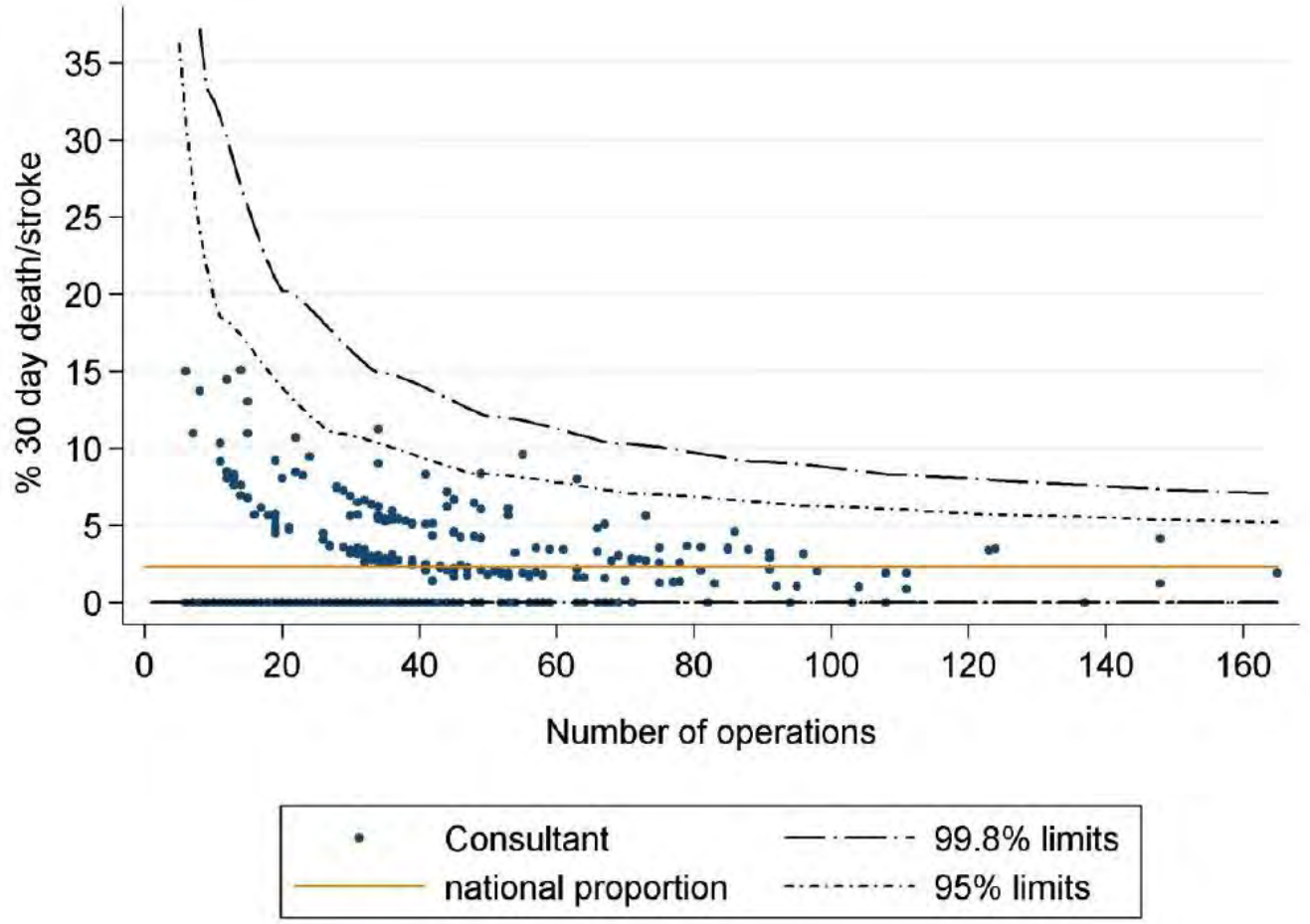

Overall Performance - TUN. Tunbridge Wells Hospital
NHFD Report - Averaged over 12 months (Invalid Data Excluded) from April 2011
Patients / Per cent (%) / Hours
40
20
0
NHFD 2013 mean (32.4 hrs)
NHFD 2013 mean (8.05%)
Dec 2013
Jan 2014
Feb 2014
Mar 2014
Apr 2014
May 2014
Jun 2014
Jul 2014
Aug 2014
Sep 2014
Oct 2014
Nov 2014
Dec 2014
Jan 2015
Feb 2015
Admission Year & Month
Patients
% Mortality
Averaged % Mortality
Hours to Operation
Averaged Hours To Operation
Chart data is indicative status only - www.nhfd.co.uk © Royal College of Physicians - Technology by Crown Informatics

Appendix 2: Variability in Carotid endarterectomy outcomes (nationally and for the South East Coast region)

Figure 2: Funnel plot of risk-adjusted rate of stroke/death within 30 days of a carotid endarterectomy, with surgeon figures shown in comparison to the national average rate of 2.4%



South East Coast

Trust	Name	GMC	CEAs	Total CEAs with outcomes	% Stroke and/or Death	Status	Median (IQR)
Ashford and St Peter's Hospitals NHS Foundation Trust			132	117	1.7%		11(5, 37)
	Mr Tahir Ali	4511423	40	39	0.0%	▲	
	Mr Neil Browning	3148569	58	53	1.9%	▲	
	Mr Marcus Cleanthis	4424004	13	13	7.7%	▲	
	Mr Kieran Dawson	2809861	23	14	0.0%	▲	
Brighton and Sussex University Hospitals NHS Trust			120	120	1.7%		9(7, 14)
	Mr Michael Brooks	2719236	25	25	0.0%	▲	
	Mr Matthew Button	4192648	18	18	0.0%	▲	
	Mr Mario Caruana	5194168	27	27	0.0%	▲	
	Mr Karim El Sakka	6072934	34	34	5.9%	▲	
	Mr Peter Laws	3316050	13	13	0.0%	▲	
	Mr Mahmoud Salman	5201046	26	26	0.0%	▲	
	Mr Syed Yusuf	3600238	*	*	*	▲	
Dartford and Gravesham NHS Trust			17	17	0.0%		25(13, 29)
	Mr Andrew McIrvine	1745490	29	29	0.0%	▲	
East Kent Hospitals University NHS Foundation Trust			209	208	2.4%		6(4, 9)
	Mr Robert Insall	2623478	70	70	1.4%	▲	
	Mr Thomas Rix	4258649	30	30	3.3%	▲	
	Mr Jawaharlal Senaratne	5188769	109	108	1.9%	▲	
East Sussex Healthcare NHS Trust			23	19	10.5%		27(24, 44)
	Mr George Evans	2310376	19	15	13.3%	▲	
	Mr Andrew Sandison	3189991	*	*	*	▲	
Frimley Park Hospital NHS Foundation Trust			200	199	2.5%		9(5, 20)
	Mr Patrick Chong	4047425	53	53	1.9%	▲	
	Mr David Gerrard	3353062	59	59	3.4%	▲	
	Mr Peter Leopold	2511579	39	39	5.1%	▲	
	Mr Magdy Moawad	4668576	18	17	0.0%	▲	
	Mr Peter Rutter	2268943	*	*	*	▲	
	Ms Sabine Sonnenberg	3703966	30	30	0.0%	▲	
	Mr Richard Wilson	4524203	19	19	0.0%	▲	
Maidstone and Tunbridge Wells NHS Trust			32	32	6.3%		24(14,189)
	Mr Mark Tyrrell	3156571	71	68	2.9%	▲	
Medway NHS Foundation Trust			91	91	3.3%		13(7, 30)
	Mr Samuel Andrews	3263664	*	*	*	▲	
	Miss Ginny Bowbrick	3407686	53	53	5.7%	▲	
	Mr Waleed Edrees	4483579	35	35	0.0%	▲	
Surrey and Sussex Healthcare NHS Trust			88	87	1.1%		11(7, 14)
	Mr Nicholas Hopkins	1599761	65	64	0.0%	▲	
	Mr Tom Loosemore	2650517	47	47	2.1%	▲	

Trust	Name	GMC	CEAs	Total CEAs with outcomes	% Stroke and/or Death	Status	Median (IQR)
Western Sussex Hospitals NHS Trust			83	81	3.7%		16(12, 24)
	Mr David Allen	2424538	*	*	*	▲	
	Mr David Beattie	3483523	46	44	6.8%	▲	
	Mr Mario Caruana	5194168	27	27	0.0%	▲	
	Mr Hany Hafez	4157834	10	10	0.0%	▲	
	Mr Peter Laws	3316050	13	13	0.0%	▲	
	Mr Mahmoud Salman	5201046	26	26	0.0%	▲	

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – June 2015

6-13 Board members' hospital visits (12/03/15 to 10/06/15) Trust Secretary

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

This quarterly report therefore provides details of the hospital visits undertaken by Board Members between 12th March and 10th June 2015 (the last report submitted to the Board, in March 2015, covered visits up to 11th March).

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, 12th March 2015 to 10th June 2015

Board member	Areas registered as being visited (MH: Maidstone Hospital; TW: Tunbridge Wells Hospital)	Formal feedback provided?
Chairman	▪ Cornwallis Ward MH ▪ Peale Ward MH ▪ Pye Oliver MH ▪ Romney Community MH ▪ UMAU MH ▪ Ambulatory Assessment Unit TW	Yes
Chief Executive	▪ Admissions Lounge MH ▪ Cornwallis MH ▪ Peale MH ▪ Pye Oliver MH	Yes
Chief Nurse	▪ Chartwell MH ▪ Cornwallis Ward MH ▪ Foster Clark MH ▪ Histopathology MH ▪ ICU/HDU MH ▪ Oncology out patients MH ▪ Peale Ward MH ▪ UMAU MH ▪ Delivery Suite TW ▪ Ward 21 TW ▪ Tonbridge Cottage Hospital	Yes
Chief Operating Officer	▪ A&E MH ▪ Cornwallis MH ▪ Foster Clark MH X2 ▪ John Day MH ▪ Jonathan Saunders MH ▪ Mercer Ward MH ▪ Peale MH X2 ▪ Pye Oliver MH ▪ Romney Community MH ▪ Whatman MH ▪ Gynaecology TW ▪ Neo Natal TW ▪ Post Natal TW	Yes
Deputy Chief Executive	▪ Pathology MH ▪ Microbiology MH ▪ Tonbridge Cottage Hospital	-
Director of Finance	▪ Cardiac Cath Lab MH ▪ CCU MH ▪ Charles Dickens MH ▪ Lord North MH ▪ Cardiac Cath Lab TW	Yes
Director of Infection Prevention and Control	-	-
Director of Workforce and Communications	▪ Romney Community MH ▪ W&C Out Patients TWH ▪ GU Clinic TW	Yes
Medical Director	▪ Ward 30 TW ▪ Ward 31 TW ▪ Ward 32 TW	Yes
Non-Executive Director (KT)	-	-
Non-Executive Director (AK)	-	-
Non-Executive Director (SD)	-	-

Board member	Areas registered as being visited (MH: Maidstone Hospital; TW: Tunbridge Wells Hospital)	Formal feedback provided?
Non-Executive Director (SDu)	▪ Admission Lounge MH ▪ Cornwallis MH ▪ Pye Oliver MH	Yes
Non-Executive Director (ST)	▪ Chartwell MH ▪ Histopathology MH ▪ ICU/HDU MH ▪ Oncology Out patients MH	Yes

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - June 2015

6-14 Quality Accounts for 2014/15 — Chief Nurse

The Trust is required by the Health Act 2009 to produce Quality Accounts of services provided by the organisation. The accompanying Regulations state that the Quality Accounts must be published by 30th June.

The final draft Quality Accounts for 2014/15 are therefore enclosed, for review and approval.

An earlier draft was submitted to the Quality & Safety Committee on 13th May 2015, and a draft was circulated to all Board members by email, for comment, on 19th May 2015.

The Quality Accounts are required to be externally audited, and the auditors have provided an unqualified conclusion, which is contained with the Accounts, at the end of the document. It should be noted that the scope of the external audit is referred to as "limited assurance", and therefore in this context the term "limited assurance" is not a negative term (which is the case when the term is used in the context of Internal Audit reviews).

Which Committees have reviewed the information prior to Board submission?

- Quality & Safety Committee, 13/05/15 (earlier draft)

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

Review and approval

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

Maidstone and Tunbridge Wells NHS Trust

Quality Accounts

2014/15

Quality Accounts

Introduction

Providing safe, high quality health services and a good overall experience for our patients, staff and the public is at the centre of everything we do at Maidstone and Tunbridge Wells NHS Trust (MTW).

The Health Act 2009 requires all NHS healthcare providers in England to provide an annual report to reflect on standards of care and set priorities for improvement. These are called Quality Accounts.

Our Quality Accounts for 2014/15 highlight the progress we have made against key priorities for the year to improve services for our patients and presents those areas that we will be focusing on as priorities for 2015/16.

We believe patients have a fundamental right to receive the very best care. This should be provided to them in the most appropriate setting, by teams of highly skilled and expert healthcare professionals who care passionately about the care they provide. We believe we have continued to make strong progress at MTW in providing patients the highest standards of care.

There are a number of national targets set each year by the Department of Health and locally, against which we monitor the quality of the services we provide. Through these Quality Accounts we aim to provide you with information on how effective our services are, how they are measured and where we aim to make improvements.

Index

Part One
Chief Executive's Statement

Welcome to our Quality Accounts (QA) for Maidstone and Tunbridge Wells NHS Trust. As well as being a retrospective review of the standards of care we provided our patients during 2014/15, the QA is also a forward-looking document that sets out our objectives to further improve our patient experience over the coming year.

This is our sixth annual care review. We once again welcome this important opportunity to work closely with our patients and many partner organisations in an open and transparent way to further improve patient care.

The information contained within our QA is drawn from actual patient experience, collated throughout the year in a range of ways including daily patient experience surveys and reviews of patient care against key national standards. I would like to thank our patients for sharing their experiences with us and helping inform our on-going journey of improvement.

Earlier this year we became one of only a handful of hospital Trusts throughout the country to be chosen by two leading cancer charities to help improve the experience of people diagnosed with secondary breast cancer. The first and most important step towards achieving an ever-improving service for patients locally and nationally is to listen to their experience. Our patients are at the centre of everything we do and we continue to listen closely to them.

Towards the end of 2014 and early 2015 it became clear locally and nationally that the NHS faced unprecedented demand for unplanned, emergency services. As a consequence we saw many more patients requiring prolonged unplanned (emergency) stays in hospital. A high number of these patients had complex discharge requirements and needed external support to leave hospital. We are continuing to work with our partners in the local health economy to address our changing patient needs now and in the future.

Unfortunately, despite the best efforts of our clinical teams who have worked tirelessly throughout the year, it was not always possible to meet all of our waiting time standards for all of our patients. This was mainly, and most evidently the case, as demands for unplanned emergency care grew during the winter months. As a consequence, the Trust assessed, treated, admitted (to hospital) or discharged (home) 92% of patients in A&E within four hours during the year against the national standard of 95%. We did, however, meet the national standard for ensuring 95% or more of patients are assessed within 15 minutes of arrival in A&E.

Despite the incredible demands on our service, and to the credit of our clinical teams, we have consistently achieved good outcomes and kept our patients safe throughout the year. This is reflected in many areas but perhaps none more so than in our ever falling levels of hospital acquired cases of the Clostridium difficile infection. This is a reflection of excellent clinical practice.

As well as the feedback mentioned above, to identify our key priorities for this year we have also analysed trends in our complaints, worked collaboratively with our many stakeholders and taken account of national reports.

We were disappointed to be rated `Requires Improvement' following our Care Quality Commission review in October 2014. However, we have used this review proactively to support further improvements. It was pleasing to note that our staff were universally found to be caring.

As a result of our overall review of patient care and safety at Maidstone and Tunbridge Wells NHS Trust throughout the year, our priorities for 2015/16 are:

Patient Safety

- To improve the system of incident reporting and learning lessons from incidents, complaints and claims.
- To improve the patient safety culture within the organisation to ensure the organisations and all staff are responsive to learning
- Improve patient flow through the Trust
- To improve the quality of stroke care

Patient Experience

- To meet the needs of our patients with due regard to their cultural and linguistic backgrounds
    - Review and improve linguistic translation services
- Implement Friends and Family Test for Outpatient Services and improve learning and action taken in response to Friends and Family feedback
- The ensure meaningful patient and public involvement in all services improvements

Clinical Effectiveness and Governance

- Ensure clinical governance frameworks and processes throughout the Trust and at speciality level are effective
- Review and improve the effectiveness of Morbidity and Mortality meetings and reviews
- To ensure that systems and processes as well as support for our staff is in place to discharge our responsibility to be honest, open and truthful in all dealings with patients and the public.

We will continue to support our highly skilled staff to help achieve the improvements we have set ourselves, as part of our on-going commitment to provide safe, high quality care. We will closely monitor the clinical priorities in our Quality Accounts throughout the coming year and make our progress publicly available.

The information contained within this report represents an accurate reflection of our organisation's performance in 2014/15 and has been agreed by the MTW Trust Board.
Thank you for taking the time to read our Quality Accounts. If you have any comments or suggestions for our Trust, you can contact us in the following ways:

Write to us at: The Patient Experience Committee, Care of Room 128, Service Centre, Maidstone Hospital, Hermitage Lane, Kent, ME16 9QQ.
Follow us on Twitter: www.twitter.com/mtwnhs
Join us on Facebook: www.facebook.com/mymtwhealthcare
Become a member of our Trust: www.mtw.nhs.uk/mymtw

Glenn Douglas
Chief Executive

Part Two
Quality improvement initiatives

In this part of the report, we tell you about the areas for improvement in the next year in relation to the quality of our services and how we will intend to assess progress throughout the year. We call these our quality priorities and they fall into three areas: patient safety, patient experience and improvements in clinical effectiveness by focussing improvements in our governance structures.

The quality improvement priorities are only ever a small sample of the quality improvement work undertaken across the Trust in any one year. The initiatives selected in previous years will almost always continue into subsequent years, although the focus may change accordingly to need. By selecting new initiatives each year it ensures that a wide breath of areas are covered and prioritised each year.

We have chosen ten quality priorities in 2015/16 which represent the views of our stakeholders, but are also in line with the Trust's overarching strategy for quality improvement. The priorities are aligned to the Quality Improvement Plan developed following the recent Chief Inspector of Hospitals Care quality Commission inspection and our Safety Improvement Plan. We have also considered internally generated data such as complaints, patient safety incidents and important national reports such as the Morecambe Bay Investigation[1] and the Keogh Mortality Review[2] and the Berwick review[3] into patient safety.

Quality Improvement Priorities 2015/16

Patient Safety

- To improve the system of incident reporting and learning lessons from incidents, complaints and claims.
- To improve the patient safety culture within the organisation to ensure the organisations and all staff are responsive to learning
- Improve patient flow through the Trust
- To improve the quality of stroke care

Patient Experience

- To meet the needs of our patients with due rega ic backgrounds
    - Review and improve linguistic translation services
- Implement Friends and Family Test for Outpatient Services and improve learning and action taken in response to Friends and Family feedback
- The ensure meaningful patient and public involvement in all services improvements

[1] Kirkup B. 2015. The Report of the Morecombe Bay Investigation. Morecombe Bay Investigation. The Stationary office.
[2] Keogh B. 2013. Review into the quality of care and Treatment provided by 14 hospital trusts in England: overview report. NHS England
[3] Berwick D. 2013. A promise to learn – a commitment to act. Improving the safety of Patients in England. National Advisory Group on the safety of Patients in England. Crown Copyright

Clinical Effectiveness and Governance

- Ensure clinical governance frameworks and processes throughout the Trust and at speciality level are effective
- Review and improve the effectiveness of Morbidity and Mortality meetings and reviews
- To ensure that systems and processes as well as support for our staff is in place to discharge our responsibility to be honest, open and truthful in all dealings with patients and the public.

We will monitor our progress against these subjects through our directorate and trust level governance structures. This report and assurance of our progress against it will be presented at the Trust Management Executive Committee (TME), Quality and Safety Committee (sub-board to Trust board) and the Patient Experience Committee.

In addition we will provide an update on progress to our health care commissioners on a bi-monthly basis.

During 2014/15 we focussed on the following:

Patient Safety

- Reducing the number of avoidable harms with a focus on:
  - Hospital acquired infections, in particular MRSA, C Difficile,
  - Falls
  - Hospital acquired pressure ulcers
- Review and enhance the emergency care provision for children in our Accident & Emergency Department

Clinical Effectiveness

- To provide an integrated approach to care with our community colleagues with a specific focus on:
  - Dementia
  - Discharge Planning
- Enhance Stroke Care pathway

Patient Experience

- To improve our ward environments, with particular focus on day rooms and communal areas between wards at Tunbridge Wells Hospital.
- To improve management and actions in response to complaints to ensure each is used as an opportunity from which we can learn
- To improve the quality of written information, particularly in relation to patient information leaflets and letters to General Practitioners.
- Friends and Family Test

In part 3 we reflect on the progress that we have made against these areas and provide a summary update

Patient Safety

Ensuring we keep patient safety as a top priority in the organisation, with a focus on the following:

- To improve the system of incident reporting and learning lessons from incidents, complaints and claims.
- To improve the patient safety culture within the organisation to ensure the organisations and all staff are responsive to learning
- Improve patient flow through the Trust
- To improve the quality of stroke care

To improve the system of incident reporting and learning lessons from incidents, complaints and claims

Developing and improving care and as a result of lessons learnt from incidents, complaints and claims is at the heart of good governance. Whilst the organisation has had a system for incident reporting for many years this is an area where improvement is required, as identified from a recent internal staff survey and in the Care Quality Commission (CQC) report published in February 2015. Similarly the organisation has a system for sharing lessons learnt from incidents, complaints and claims and it is recognised that this could also be improved both in terms of organisational wide learning and in evidencing that this learning ensures sustained improvements in delivering safe patient care.

Aim/goal

To make the process of reporting incidents quicker, easier and more accessible for all staff
To engage all staff groups to report incidents
To improve the current system of sharing the learning from incidents, complaints and claims

Description of Issue and rationale for prioritising

The organisation is committed to improve the reporting of incidents and the learning from them, together with the learning from complaints and claims in order to make sustained improvements to the services and care we deliver. There is a system in place for reporting but it is recognised that this needs improvement and work has commenced on this following a staff survey undertaken in November 2014.

Identified areas for improvement and progress during 2014/15

The following actions have been undertaken in 2014-15

- The establishment of a „Governance Gazette‘ newsletter sent to all staff areas that shares lessons learnt from incidents, complaints and claims
- The upgrade of the incident reporting system (DATIX) to improve usability
- The establishment of a multidisciplinary DATIX review group to review and suggest further improvements to the reporting system and thus it‘s usage by staff and feedback to staff who report incidents.

Initiatives for further action for 2015/16

- Incident reporting process to be developed to be easier, quicker and more accessible for all staff
- To develop a programme of staff engagement events identifying and engaging staff groups who currently are low reporters of incidents
- To publish a summary of learning from every serious incident in our Governance newsletter
- To implement a methodology for triangulating lessons from incidents, complaints and claims more effectively in order to identify overarching themes and organisational learning.
- To review the current communication pathways for lessons learnt from incidents, complaints and claims and, with the informatics and communication teams consider and implement more effective ways to get messages of learning to staff and the public.

Executive lead: Avey Bhatia, Chief Nurse
Board Sponsor: Avey Bhatia, Chief Nurse
Implementation lead: Jenny Davidson, Assc Director Quality, Governance & Patient Safety
Monitoring: Clinical Governance Committee

To improve the patient safety culture within the organisation to ensure the organisations and all staff are responsive to learning

Developing a culture of patient safety is a central tenant of quality care. Real, meaningful and sustained changes and improvements can only occur within a culture of collaboration, trust, support and openness. This ‗just' culture enhances learning in a way that a ‗blame' culture cannot and it is the aspiration of this trust to make significant improvements through the organisation. The Berwick report highlighted with clarity that the NHS must become a *‗system devoted to continual learning and improvement'* and that *‗fear is toxic to both safety and improvement'*. In this way a culture that abandons blame as a tool and that *‗culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime'* (p8,9,10)

Aim/goal

To engage all staff in developing a ‗just' culture that is understood, practiced and owned by everyone

Description of Issue and rationale for prioritising

A considerable amount of work has already been undertaken to start to understand, benchmark and improve the culture around patient safety and engaging staff in learning and embedding change. We have good evidence that local level improvements do occur as a result of lessons learnt from incidents, complaints and claims, but this has been more of a challenge at organisational level, which was identified in the recent CQC report

Identified areas for improvement and progress during 2014/15

The following actions have been undertaken in 2014-15

- The establishment of a ‗Governance Gazette' newsletter sent to all staff areas that shares lessons learnt from incidents, complaints and claims
- Organisational Staff Survey on patient safety culture undertaken in November 2014
- Establishment of a multidisciplinary Patient Safety Think Tank group that considers and discusses patient safety culture and systems issues and offers possible solutions.
- Establishment of an accredited Patient Safety education programme for staff

Initiatives for further action for 2015/16

- To implement an engagement campaign called ‗Step up to Safety' with the aim of raising awareness and engaging staff sign up to a ‗just' culture
- To host a patient safety culture focussed conference for MTW staff
- To engage staff is making a patient safety film that is then used to educate staff on the importance of ‗just' culture and accountability.

Executive lead: Avey Bhatia, Chief Nurse
Board Sponsor: Avey Bhatia, Chief Nurse
Implementation lead: Jenny Davidson, Jenny Davidson, Asso Director Quality, Governance & Patient Safety and members of the Patient Safety Think Tank
Monitoring: Trust Management Executive and Quality and Safety Committee

To improve patient flow through the Trust

Patients should be treated in the right place, by the right staff at the right time. This has been incredibly challenging for the organisation especially during the last six months. Ensuring effective and efficient flow through the hospital Is essential for delivering safe timely care in the right environment.

Aim/goal

To have effective flow throughout the hospital, that enables patients to be cared for in the right environment by the right staff at the right time.

Description of Issue and rationale for prioritising

The last six months have been incredibly challenging for the organisation. There have been extreme difficulties with managing patient flow through the hospital and discharging patients out of hospital due to lack of capacity both in hospital and in the community. This has resulted in the organisation having to use several escalation areas, increased usage of temporary staff and the organisation being unable to deliver the Accident and Emergency 4 hour standard. This has also put our staff under incredible pressure but their commitment and tenacity has ensured that patients have been managed safely.

Identified areas for improvement and progress during 2014/15

Despite these challenges remaining the issues could have been more challenging had various initiatives not been in place. The Trust and commissioners have worked closely together to develop pathways to ensure that some patients can be assessed quickly and put appropriate arrangements in place to prevent patients from being admitted. One of the very successful initiatives is Therapy Assisted Discharge Service (TADS).

Initiatives for further action for 2015/16

The Trust is fully committed to continuing its intense work on reducing length of stay and working with our commissioners and social services to reduce delayed transfers of care. The initiatives developed over the previous years will also continue.

- 50% reduction in delayed transfers of care from MTW in the next 12 months
- Review of wards at MTW to improve efficiency and flow through ward location and co-adjacencies
- Creation of additional capacity at the Tunbridge Wells Hospital (30 -39 nine bed unit)

Executive lead: Angela Gallagher, Chief Operating Officer
Board Sponsor: Angela Gallagher, Chief Operating Officer
Implementation lead: Lynn Gray, Associate Director Nursing, Emergency and Medical Services
Monitoring: Trust Management Executive

To improve the quality of Stroke care

Stroke care and services have been under national and local review for some time and this has been a focus for quality improvements for the last 18months. It is intended that this work continues to be a high priority in the organisation.

Aim/goal

The Trust intends to continue work on the improvements the stroke service by ensuring access to a stroke bed within 4hrs of attendance to Emergency Department, ensuring a CT (computerised tomography) scan within an hour of arrival at the hospital and the provision of a 7 day Transient Ischaemic Attack (TIA) service. These will have significant impact on the safety of patients requiring stroke care.

Description of Issue and rationale for prioritising

There is a national review of hyper-acute stroke service. MTW stroke service has fallen below the expectations of the Trust evidence by both the Maidstone and Tunbridge Wells site achieving level E on the national SSNAP data (national benchmarking). Over the last 18months significant work has been undertaken and improvements have been made, however the Trust continues to strive for further improvements to ensure excellence of care. In preparation for the national review being undertaken the Trust has engaged in an active engagement with local stakeholders. It is expected that the national review will give further clarity now that the period of purdah has concluded.

Identified areas for improvement and progress during 2014/15

The following actions have been undertaken in 2014-15

- Trust has set up a Stroke Improvement Board, chaired by the medical director
- A stroke Clinical Nurse Specialist has been employed
- Stroke plan has been developed with stakeholders, under the programme board, along with a review of current service s and options for future service provision
- Tangible improvements seen in the Sentinel Stroke National Audit Programme (SSNAP) data (Maidstone site stroke services now re-assessed as C, Tunbridge Wells site stroke services now reassessed as D)

Initiatives for further action for 2015/16

- To further improve the stroke service the Trust will
    - Ensure that patients are admitted to stoke bed within 4 hours of arrival, with a measure of MTW achieving a position in the upper quartile of SSNAP national data set.
    - Ensure that a CT scan is performed in under an hour of arrival, with a measure of MTW achieving a position in the upper quartile of SSNAP national data set.
    - Provision of a high risk TIA service 7 days /week (daytime)

Executive lead: Paul Sigston, Medical Director
Board Sponsor: Paul Sigston, Medical Director
Implementation lead: Lynn Gray, Associate Director Nursing, Emergency and Medical Services
Monitoring: Quality Committee

Patient Experience

Ensuring we continue to review and improve the patients experience, meeting their individual needs, responding to feedback and enabling collaborative approach to service development with a focus on the following:

- To meet the needs of our patients with due regard to their cultural and linguistic backgrounds
    - Review and improve linguistic translation services
- Implement Friends and Family Test for Outpatient Services and improve learning and action taken in response to Friends and Family feedback in all areas
- To ensure meaningful patient and public involvement in all services improvements

Meeting the needs of our clients with due regard to their cultural and linguistic backgrounds

The NHS has clear values and principles about equality and fairness as set out under the NHS constitution[4] and laws under the Equality Act 2010. This means all people have the right to be treated fairly and without discrimination and all patients should be treated as an individual and with respect and dignity.

Aim/goal

To meet the needs of all clients with due regard for their cultural and linguistic background.
To ensure our services meet these needs effectively by undertaking a review of the linguistic translation services and improving the service

Description of Issue and rationale for prioritising

The organisation recognises that meeting an individual's linguistic needs is an important part of the service provided. A linguistic translation service should be efficient, easy to access and available to all staff and service users at any time, but we currently are not able to fully meet this standard. There is no Equality and Diversity lead currently in post to lead and direct the trust in developing a clear strategy and provide focus and expertise in this area, this is recognised and is being addressed.

Identified areas for improvement and progress during 2014/15

As a new priority area for the organisation for 2015-16 the focus thus far has been on improving the translation services for our patients.

Initiatives for further action for 2015/16

- Recruitment of an Equality and Diversity lead for the Trust
- Implement the tender process for linguistic translation and adopt an efficient system that meets patients and service needs
- Implement a staff flag project, where staff who speak other languages wear a flag of this country on their name badge
- Development of an Equality and Diversity awareness programme for all staff
- Development of a MTW Equality and Diversity strategy

Executive lead: Paul Bentley, Director of Workforce and Communications
Board Sponsor: Paul Bentley, Director of Workforce and Communications
Implementation lead: Richard Hayden, Deputy Director of Workforce and John Kennedy. Deputy Chief Nurse
Monitoring: Workforce Committee and Patient Experience Committee

[4] The NHS Constitution. The NHS belongs to all of us. March 2013

Fully implement Friends and Family Test for Outpatient Services and improve learning and action taken in response to Friends and Family test

The Friends and Family test from NHS England was introduced in 2013 as an opportunity for patients to provide feedback on services. Initially implemented in Emergency Department, inpatients and maternity services it has provided the trust with an opportunity to receive information from service users that can guide the development and improvement to services and care.

Aim/goal

The aim is to expand the friends and family test to service users at all MTW outpatient departments and use this information to improve learning and implement improvements.

Description of Issue and rationale for prioritising

The Friends and Family test is an opportunity for services to reflect on their care, celebrate positive feedback and consider how and where to improve. It also provides the trust with a way of benchmark the quality of its services both internally and with other trusts to provide assurance and focus for developments.

Viewed as a valuable feedback tool the trust is keen to roll this test out to service users in outpatients services, where currently only internal quality surveys are undertaken.

Identified areas for improvement and progress during 2014/15

- Friends and family test has been implemented in outpatients
- Return rates have been much improved over 2014-15, with a concerted effort from all front line staff in these areas
- There has been improved analysis of the results in all clinical areas however more work is required.
- Whilst significantly improving the response rates the satisfaction net promoter score has remained above the national average.

Initiatives for further action for 2015/16

- Include outpatient services in overall Friends and Family report
- Establish a robust feedback loop where learning and improvements can be identified and changes implemented
- Triangulate results with themes from incidents and complaints, identify areas of good practice and where development should be focussed
- Ensure results, learning and changes are publically displayed in outpatient areas and kept up to date

Executive lead: Avey Bhatia, Chief Nurse
Board Sponsor: Sylvia Denton, Non-Executive Director and Chair of Patient Experience Committee
Implementation lead: John Kennedy, Deputy Chief Nurse
Monitoring: Patient Experience Committee

The ensure meaningful patient and public involvement in all service improvements

The Trust has a number of ways of involving patients and the public in service improvement including local and national surveys, the friends and family test, the patient experience committee and service user groups such as the Maternity Services Liaison Committee (MSLC). We do, however recognise that more can be done to make this engagement more meaningful and consistent throughout the organisation.

Aim/goal

The aim is to undertake a review of current patient and public involvement processes, identify effective practice, identify areas for improvement and implement a cohesive approach and strategy.

Description of Issue and rationale for prioritising

There are a considerable number of diverse ways patients and the public get involved in providing feedback and contributing to shaping service developments, however it is not consistently seen throughout the organisation. We feel patient and the public provide invaluable contribution to service development so prioritise a review to identify where we can improve and develop in this area.

Identified areas for improvement and progress during 2014/15

During 2014-15 we worked hard to increase our response rates to the Friends and Family Test with good success across all areas. We revised our Care Assurance Programme and implemented the Quality Road Map. We have undertaken pre consultant public engagement for reviewing stroke services and involved patients in other service improvement like the fractured neck of femur pathway. We have also commenced a review of the Patient Experience Committee.

Initiatives for further action for 2015/16

- Review of all patient and public involvement activities in the Trust including all local and national patient experience surveys to identify good practice and areas for development.
- Include service user representation at meetings where service improvement is on the agenda.
- Conclude review of Patient Experience Committee.
- Focus on Children Services feedback.

Executive lead: Avey Bhatia, Chief Nurse
Board Sponsor: Sylvia Denton, Non-Executive Director and Chair of Patient Experience Committee
Implementation lead: John Kennedy, Deputy Chief Nurse
Monitoring: Patient Experience Committee

Clinical Effectiveness and Governance

Ensuring we have transparent, effective and consistent clinical governance frameworks, processes and culture within the organisation, with a focus on the following:

- Ensure clinical governance frameworks and processes throughout the Trust and at speciality level are effective.
- To ensure that systems and processes as well as support for our staff is in place to discharge our responsibility to be honest, open and truthful in all dealings with patients and the public.
- Review and improve the effectiveness of Morbidity and Mortality meetings and reviews

Ensure clinical governance frameworks and processes throughout the Trust and at speciality level are effective

Effective clinical governance is central to the achieving the safe and high quality care we strive to give. Understanding what good governance is, reviewing our current clinical governance frameworks, processes and culture, and identifying where changes can be made and then implementing a clear framework is a key priority for the coming year.

Aim/goal

To undertake an organisational review of ward to board clinical governance framework, processes and culture in order to identify effective practice and areas of improvement. To implement changes where required and measure improvements.

Description of Issue and rationale for prioritising

Good clinical governance is a central part of safe and effective care. The recent CQC report and other internal reviews suggest there are inconsistencies around clinical governance within the organisation and improvements are required. There are some examples of excellent clinical governance but the overall framework needs strengthening to support a more consistent approach.

Identified areas for improvement and progress during 2014/15

The following actions have been undertaken in 2014-15

- The establishment of an Patient Safety Think Tank, a multidisciplinary group set up to consider the current position and future aspirations for patient safety within MTW
- An internal review of directorate clinical governance processes to establish current position of meetings and processes in place
- A patient safety culture survey was undertaken in November 2014 which provided sufficient intelligence to inform and develop the patient safety and culture priorities
- The implementation of a MTW _Governance Gazette' newsletter which shares governance related information with staff in the organisation.

Initiatives for further action for 2015/16

- An external supported review of organisational clinical governance to identify good governance and culture, identify areas for improvement and implement new governance framework within the organisation.
- Establishment of a consistent organisational governance framework that supports effective directorate level clinical governance.
- Establishment of a system of intelligent monitoring that will enable more effective measurement of quality and safety.

Executive lead: Avey Bhatia, Chief Nurse
Board Sponsor Avey Bhatia, Chief Nurse:
Implementation lead: Jenny Davidson, Assc Director Quality, Governance & Patient Safety
Monitoring: Quality Committee

Review and improve the effectiveness of Morbidity and Mortality meetings and reviews

In July 2013 Sir Bruce Keogh published his Review into the quality of care and treatment provided by 14 hospital trusts in England. This review provided an opportunity for learning and reflection for all trusts to consider a more rigorous and meaningful approach to mortality reviews.

Aim/goal

The aim is to further develop our existing mortality review process and demonstrate how this process can lead to care and service improvements through openness and shared learning

Description of Issue and rationale for prioritising

The current mortality review process is still in its infancy and requires development and progression to make it more effective. The CQC report published in January 2015 highlighted the need for further work in this area. An effective mortality review process will provide better opportunities for identifying good practice and where things could be improved. Further, triangulating this data with other quality measures such as Dr Foster data, complaints, patient safety incidents and claims will mean moving to a more proactive risk management approach.

Identified areas for improvement and progress during 2014/15

The following actions have been undertaken in 2014-15

- The establishment of a Mortality review process and Trust Mortality Review Group
- Monthly meetings of the Trust Mortality Review Group to review mortality forms submitted from the directorates
- Establishment of Mortality review discussion at some clinical governance meetings at directorate level

Initiatives for further action for 2015/16

- Review of current governance process against new CQC Well – led Domain
- In collaboration with directorate leads and external partners agree an improved mortality review process that is documented as a standard operating procedure
- Review membership of the Trust Mortality Review Group to ensure representation within and external to the organisation
- With data analysts and informatics department, consider ways of automating the Mortality Review process that would make for a more timely and efficient process
- With data analysts, consider and implement a triangulation system to ensure the data is being used more effectively in proactive risk management
- Publication of summary reports on the intranet to demonstrate transparency and ensure shared learning across the organisation

Executive lead: Paul Sigston, Medical Director
Board Sponsor: Paul Sigston, Medical Director
Implementation lead: Jenny Davidson, Assc Director Quality, Governance & Patient Safety
Monitoring: Quality Committee and Trust Board

To ensure that systems and processes as well as, support for our staff is in place to discharge our responsibility to be honest, open and truthful in all dealings with patients and the public.

From October 2014 all NHS providers have been required to comply with statutory Duty of Candour that was one of the recommendations form the Francis report[5]. This means that all health and social care providers in England now have a legal duty to be open and honest with patients and families about their care and treatment, including any mistakes that may have caused avoidable harm. We are keen that this essence of honesty, openness and truthfulness is adopted as routine for all dealings with patients and the public.

Aim/goal

The aim is to ensure all systems and processes follow the requirements and the essence of the statutory duty of candour.
To implement a support system for staff to discharge their responsibilities to be honest, open and truthful in al dealings with patients and public

Description of Issue and rationale for prioritising

Whilst there has been some considerable work on implementing the statutory requirements of Duty of Candour and processes are in place, this work is ongoing. The current process needs refinement to ensure that we not only meet all the requirements to their full extent but also that we can evidence that we are doing so to provide assurance. Cultural change and staff confidence to support this is an area for priority and focus over the coming year.

Identified areas for improvement and progress during 2014/15

The following actions have been undertaken in 2014-15

- The establishment of a Duty of Candour process to meet the requirements
- Staff training programme implemented
- Inclusion in induction programme for all new staff
- Commencement of evidence log for assurance

Initiatives for further action for 2015/16

- To update the ‗Being Open' Policy to include the Duty of Candour requirements
- To further extend the training programme in place for all staff
- To further develop resources to assist and support staff when undertaking duty of candour in the clinical setting
- Along with the ‗Cultural change' programme and ‗Step up to Safety' campaign, implement a strategy to further embed the ‗Honest and open' culture
- Develop a more robust support process for patients, relatives / carers and staff who have been affected by an incident that causes harm
- To implement an internal assurance process to provide continuous evidence of meeting the statutory requirements

Executive lead: Paul Sigston, Medical Director
Board Sponsor: Paul Sigston, Medical Director
Implementation lead: Jenny Davidson, Assc Director Quality, Governance & Patient Safety
Monitoring: Quality Committee and Trust Board

[5] Robert Francis QC. 2013. The Mid-Staffordshire NHS Foundation Trust Public Enquiry

In this following section we report on statement relating to the quality of the NHS services provided as stipulated in the regulations

The content is common to all providers so that the accounts can be comparable between organisations and provides assurance that Maidstone and Tunbridge Wells Board has reviewed and engaged in national initiatives which link strongly to quality improvement

Statements relating to the quality of NHS services provided as required within the regulations

The Trust is registered by the Care Quality Commission to provide the following services:

Maternity and midwifery services (at both hospital sites)
Family planning services (at both hospital sites)
Surgical procedures (at both hospital sites)
Diagnostic and screening procedures (at both hospital sites)
Treatment of disease, disorder or injury (at both hospital sites)
Termination of pregnancies (at Tunbridge Wells Hospital only)

No conditions were applied to the registration.

During 2014/15 the Trust provided and/or subcontracted the full range of services for which it is registered (during 2014/2015 the Trust provided and/or sub-contracted 101 NHS services). All the data available on the quality of care in these NHS services has been formally reviewed (with commissioners).

The income generated by the NHS services reviewed in 2014/2015 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2014/2015.

Reviewing standards

To ensure that we are providing services to the required standards the Trust supported a number of reviews of its services during 2014/15, undertaken by external organisations such as:

- Care Quality Commission – 1 inspection (October 2014)
- Healthwatch - Enter and view visit (August 2014)
- Ofstead and the Care Quality Commission safeguarding children inspection (April 14).
- Kent, Surrey & Sussex Local Supervising Authority (statutory supervision of midwives) – inspection September 2014).
- South East London Kent & Medway Trauma Network - Review of Trauma Services (September 2014)
- Care Quality Commission IR(MER) – General inspection (October 2014)
- Counter Terrorism Security Advisers (CTSAs) – Inspection (September 2014)
- Clinical Pathology accreditation (CPA) - Microbiology (July 2014)
- Human Tissue authority – Tunbridge Wells hospital mortuary (January 2015)
- Kent police – Counter Terrorism Crime and Security Act - Inspection (September 201ISO accreditation 9001:2008 E.M.E. Services (April 2014)
- Pharmacy - Aseptic Units - Regional Quality Assurance – 2 visits (2014)
- Annual Cancer Review (July 2014)
- Patient Led Assessments of the Care Environment (PLACE) – (March and May 2014)

Internally we have the following ongoing reviews to assess the quality of service provision:

- Care assurance audits
- Internal PLACE reviews
- Infection Control including hand hygiene audits
- Trust Board member ~~-w~~walkabouts”

The outcomes of these are included within our triangulation process to review clinical areas and identify anywhere additional support and actions are required to maintain standards. Reports are scrutinised within identified committees within our governance structure and where necessary action plans are developed and monitored.

Clinical Audit

This section of the Quality Account provides information about the Trust's participation in clinical audit. Identified aspects of care are evaluated against specific criteria to ascertain compliance and quality. Where indicated, changes are implemented and further monitoring is used to confirm improvement in healthcare delivery. Participation in national clinical audits, national confidential enquires and local clinical audit is mandated and provides an opportunity to stimulate quality improvement within individual organisations and across the NHS as a whole.

During 2014/15, MTW participated in 100% of relevant confidential enquiries and 100% of all relevant national clinical audits. During the same period, MTW staff successfully completed 162 clinical audits (local and national) to action plan stage from 462 audits on the programme to be undertaken. The remaining audits are at various stages of completeness and will be continued through to completion.

The national clinical audits and national confidential enquiries that Maidstone and Tunbridge Wells NHS Trust participated in during 2014/15 are shown in Table 1 as follows-

National Clinical Audits for inclusion in Quality Accounts 2014 – 2015	***Participation*** Y, N or NA	***No of cases submitted***	***% cases submitted***	***Comments***
Recruited patients during 2014-15 (Any period during 01/04/2014 to 31/03/2015)				
Peri and Neonatal				
Neonatal Intensive and Special Care (NNAP)	Y	694	100%	
Maternal, Newborn and infant clinical outcome review. (MBRRACE-UK)	Y	20	100%	Stillbirths 17 Neonatal Deaths 3
Children				
Paediatric Inflammatory Bowel Disease. (Round 4) (IBD Programme)	Y	5	100%	6+ patients to be included within the report
Epilepsy 12 (Childhood Epilepsy)	Y	22	100%	
Paediatric Diabetes (NPDA)	Y	1230	100%	
Paediatric Intensive Care (PICANet)	NA			MTW does not provide this service
Acute Care				
National Cardiac Arrest Audit (NCAA)	Y	223	100%	
Adult Critical Care Case Mix Programme (ICNARC) (Round 2) (CMP)	Y	968	100%	
Emergency Laparotomy Audit (NELA)	Y	125	100%	Data collection still open and data being submitted.
Adult Community Acquired Pneumonia	Y	Part 1 60/60 Part 2 26 (all patients that met the criteria)	100% 100%	Data collection still open and data being submitted.
Pleural Procedures	Y	15/17	88%	Unable to obtain notes
Fitting child (care in emergency departments)	Y	50/50	100%	
Mental health (care in emergency departments)	Y	100/100	100%	
Long Term Conditions				
National (Adult) Diabetes Audit (NDA)	Y	3783	100%	
Inflammatory Bowel Disease (IBD) Programme - Biologic Therapy only	Y	80	100%	Data collection still open and data being submitted
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Y	119	100%	
Rheumatoid and early inflammatory arthritis	Y	12	100%	
National Audit of Intermediate Care	NA			Audit not applicable to the trust.
Chronic Kidney Disease in Primary Care	NA			MTW does not

National Clinical Audits for inclusion in Quality Accounts 2014 – 2015	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
				provide this service
Renal Replacement Therapy (Renal Registry)	NA			MTW does not provide this service
Elective Procedures				
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein	Y	Hip: 161 Knee: 195 Groin: 44 Varicose: N/A		
Coronary angioplasty/ National audit of PCI	Y	229	100%	
Older People				
Older people (care in emergency departments)	Y	158/200	79%	Mix up with junior doctor re no's required per site
Sentinel Stroke National Audit Programme (SSNAP)	Y	1. Organisational Audit 2. Clinical Audit – 567	100%	1. Organisational data submitted. 2. data collection still open and data being submitted
Cardiovascular disease				
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Y	TWH: 201 Maidstone: 251		Data collection still open and data being submitted.
Heart failure	Y	301	100%	Data collection still open and data being submitted.
Cardiac Rhythm Management (CRM)	Y	407	100%	
Adult Cardiac surgery	NA			MTW does not provide this service
Congenital heart disease (Paediatric cardiac surgery)	NA			MTW does not provide this service
Pulmonary Hypertension	NA			MTW is not a Specialist PH centre.
National Vascular Registry	NA			MTW does not provide this service.
Cancer				
Lung Cancer (NLCA)	Yes	240	100%	Data collection still open and data being submitted
Bowel Cancer (NBOCAP)	Yes	274	100%	Data collection still open and data being submitted
Head & Neck Cancer (DAHNO)	Yes	31	100%	Data collection still open and data being submitted
National Prostate Cancer Audit	Yes	360	100%	Data collection still open and data being submitted
Oesophago-gastric cancer (NAOCG)	Yes	88	100%	Data collection still open and data being submitted
Trauma				
Falls and Fragility Fractures Audit Programme (FFFAP) pilot	1. NA 2. NA 3. Y	1. Falls 2. Fracture Liaison Service Database 3. National Hip Fracture Database = 420		1. No data collection this period. 2. MTW does not provide this service. This is a community service.

National Clinical Audits for inclusion in Quality Accounts 2014 – 2015	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
Severe Trauma (Trauma Audit & Research Network) TARN	Y	320	100%	
National Joint Registry (NJR)	Y	983	100%	
Psychological conditions				
Prescribing Observatory for Mental Health (POMH)	NA			MTW does not provide this service
Suicide and homicide in mental health (NCISH)	NA			MTW does not provide this service
Blood transfusion				
(National Comparative Audit of Blood Transfusion Programme) National comparative audit of blood transfusion of patient information and consent 2014	Y	15	100%	
National Confidential Enquiries				
Sepsis	Y	6/6	100%	Data collection still open and data being submitted.
Gastrointestinal Haemorrhage	Y	7/8	88%	Case notes unavailable

43 national audits were published in 2014/15 with actions taken to address areas of non or partial compliance. A number of improvements have been made in line with national recommendations, including-

1. National review of asthma deaths.

All people with asthma are now being provided with written guidance in the form of a personal asthma action plan (PAAP) that details their own triggers and current treatment plan. This will ensure people at high risk of severe asthma attack are aware of factors that exacerbate or trigger asthma so that measures can be taken to reduce their impact.

2. **National audit of Dementia Care in General Hospitals 2nd Round.**

‗This is me' document now available and used on all patients admitted with or diagnosed with Dementia. This will ensure that person centred care is practiced throughout the Trust. Maidstone and Tunbridge Wells Trust now signed up to Dementia Action Alliance as dementia friendly.

3. **British Thoracic Society Bronchiectasis 2012.**

New bronchiectasis dedicated clinic running at Tunbridge Wells Hospital to assist with sputum culture and sensitivities and enable patients to be reviewed by a chest physician.

4. **National adult Diabetes Inpatient Audit 2013.**

A new universal Diabetes Foot care Assessment form to be completed for all known and newly diagnosed diabetic inpatients. This will ensure ongoing monitoring of feet and early identification of potential foot problems. Hypo boxes are now available on all wards to ensure hypoglycaemic episodes are treated promptly.

5. **Paediatric Inflammatory Bowel Disease (IBD) Round 4.**

A new IBD database is being developed within the trust to capture all IBD clinical data. This will ensure better recording of the key clinical areas that need monitoring in the IBD patient.

6. **Epilepsy 12 (Childhood Epilepsy).**

   A business case has been submitted for an Epilepsy Specialist nurse to be employed within the trust. This will enable an increased clinic capacity.

7. **BTS National Paediatric Asthma Audit.**

   Clinic staff are being trained to check Inhaler techniques for asthma patients before discharge. Patient Information Leaflets and written asthma plans are being produced to improve information given to patients and recording clinical documentation.

8. **National Paediatric Diabetes Audit (NPDA).**

   The installed the Twinkle database system, which enables participation in future NPDA audits and full completion of the required clinical patient data.

9. BTS National Paediatric Pneumonia.

   A more judicious allocation of IV antibiotic therapy for community acquired pneumonia was implemented following a review of antibiotic routes used for the administration of antibiotic therapy to bring it in line with recommendations.

Please see Appendix A for full details of progress against each of the reported national audit results 2014/15.

A number of service improvements have been made as a result of the **120** local clinical audits completed to action plan stage, across all directorates, in 2014/2015. Trust staff identified local areas of concern/interest, reviewed their practice and made recommendations for change. Staff actively use clinical audit as a quality improvement process to improve patient care and outcomes through the systematic review of the care they provide against explicit criteria. Improvements include:

Actions taken following local audits	Trust Actions
Tissue Viability	Additional staff training sessions together with continual monitoring systems (via DATIX) and investment in pressure relieving boots and other pressure relieving systems and equipment has continued the trend of reducing the incidence of hospital acquired damage to (2.0%) this is significantly below the national average.
Physiotherapy	A joint venture between the Accident and Emergency (A&E) and physiotherapy departments, saw the beginning of an innovative service where physiotherapists would be based within the Accident and Emergency departments at Maidstone and Tunbridge Wells Hospitals. 96% of patients were seen by the physiotherapy practitioners within 1 hour of presentation in the Accident and Emergency department.
Medicine (Falls / Stroke)	After the first audit a falls pro-forma was introduced to aid assessment of older people admitted with falls. Following the second audit ~~-m~~edication review" stickers were introduced to go on drug charts alerting healthcare professionals to patients at high-risk. A Falls Co-ordinator has also been employed to improve the management of patients at risk of falls.
Radiotherapy	In order to ensure timely radiotherapy treatment for cancer patients, teams were informed of the need to adjust the ~~-r~~eady to start date" when the planning process is delayed due to clinically accepted reasons. Breast specialist radiographers now liaise with the physiotherapy team with regards to adequate recovery for Seromas which can be built into the breast pathway. Patient pathway has been revised by breast specialist and physiotherapist. Operational standards have now been met.
Medicine	EGC labelling across wards has significantly improved following the introduction of laminated cards attached to each ECG machine. This has reduced the potential for incorrect prescribing of medications,
Surgery	The initial audit led to the implementation of electronic prescribing. The re-audit has shown that there were no prescribing errors.
Midwifery	A re-audit of maternity documentation has shown a marked improvement with the documentation at the Birth Centre with fully compliance now achieved. This is important as good documentation impacts on achieving a smooth handover of care, if a woman requires transfer to Tunbridge Wells hospital in an emergency, ensuring that potential risks and problems are communicated appropriately.
Sexual Health	Changes in staff training, updated local treatment guidelines and clear Pelvic Inflammatory Disease (PID) clinical management pathways have resulted in improvements in clinical care for this group of patients treated in the GUM clinic. All aspects of the clinical management pathway are now being

Actions taken following local audits	Trust Actions
	met thus improving patient treatment.
Critical Care	A patient survey into the current epidural service has shown a high level of patient satisfaction with the information provided and the pain relief achieved.
Trauma & Orthopaedics	An audit looking at the recording of operations on booking forms for the ~~-r~~emoval of metalwork" has led to improvements in surgeons planning, in advance, the equipment necessary for theatre. This means less wasted time in theatre looking for equipment mid procedure, quicker operations and less anaesthetic. This is safer for patients and prevents operative complications.
Orthoptics	A patient satisfaction survey carried out on all hospital clinic sites where this service is provided has shown an overall satisfaction level of 99.5%. Improvements implemented as a result of patients comments from the previous survey include: more signage relating to availability of refreshments in the waiting areas; a white board purchased to keep patients informed of any delays to clinic waiting times; improvements and additional equipment was purchased for the children's play areas and a television was installed in the waiting area.

NICE Guidelines

Every year the National Institute for Health and Care Excellence (NICE) develops guidelines for the NHS to review and implement to enhance practice and the care of patients. As at the end of 2014/15 there have been **979** NICE guidance documents disseminated to the specialty leads throughout the Trust. Of those, **883** (**90.2%**) have been evaluated. **343** (**38.8%**) of the evaluated guidance are relevant to the Trust. The breakdown is shown in the table below.

Guidance Type	Published	Evaluated	Relevant
Clinical Guidelines (NICE CG's)	**193**	**171**	**106**
Interventional procedures (NICE IPG's)	**450**	**406**	**77**
Technology appraisals (NICE TA's)	**336**	**306**	**160**
Totals	**979**	**883**	**343**

Please see Appendix C for full details of trust compliance with guidance that has been audited and completed during 2014/15.

Research

Participation in clinical research

Commitment to research as a driver for improving the quality of care and patient experience

MTW Research team

During 2014/15, Maidstone and Tunbridge Wells NHS Trust made significant strides in delivering key local and national strategic initiatives to benefit patients.

1. Increasing the number of research participants year on year

During 2014/15 Maidstone and Tunbridge Wells NHS Trust recruited over 2,000 patients and volunteers to research trials at MTW- a rise of 33% on the previous year. Patients and volunteers were recruited to a wide range of studies, including drug studies, interventional and observational projects. Maidstone and Tunbridge Wells NHS Trust met the recruitment target of 1,100 for 2014/15 as set by the Kent Surrey and Sussex Clinical Research Network.

2. Increased research funding

In the summer of 2014, Maidstone and Tunbridge Wells NHS Trust secured a significant research grant to support surgical surgery at the Trust of over £300,000. This funding is to support a project looking at the impact of isometric exercise both pre and post abdominal surgery on patient recovery. The study is due to start in early 2015. A number of consultants were all successful in being awarded smaller grants to support research which have been used to buy key medical equipment and research staff.

3. Widen the expertise of the Research and Development Team

Increased funding has enabled the Trust to employ key specialists to the Research and Development Department including a microbiologist, a Research Associate and a Clinical Support

Worker. These posts have widened the scope of projects that MTW can participate in, especially microbiological, respiratory and community-based studies. The Research Department also welcomed several new nurses to the department to support oncology, respiratory, ophthalmic and surgical research.

4. Increase the diversity of research projects

There are presently 308 studies open at Maidstone and Tunbridge Wells NHS Trust, inclusive of randomised clinical trials, observational studies, MTW investigator led and student projects. Increasing participation in clinical research demonstrates Maidstone and Tunbridge Wells NHS Trusts commitment to improving the quality of care on offer and to making a contribution to wider health improvement. Research staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

5. Appointed England's first dedicated Patient Research Ambassador

Frances Mossie, Patient Research Ambassador

Early in 2014, Maidstone and Tunbridge Wells NHS Trust appointed England's first dedicated Patient Research Ambassador (PRA). The voluntary role is designed to provide a strong link between Trust research staff and research patients and volunteers. Over the past 12 months, the PRA has worked tirelessly to provide information, support and reassurance to many research participants and has significantly contributed to the delivery of the Trust's Patient and Public Involvement in Research strategy.

6. Develop research expertise in support services

Over 300 clinical staff participated in research approved by a research ethics committee during 2014/15. Maidstone and Tunbridge Wells NHS Trust has focused on encouraging non-medical staff to lead innovative research locally and nationally to increase the diversity of research conducted. Clinical staff, with the role of either Principle or Chief Investigator, now includes senior nursing staff, therapeutic and service support staff. The aim for the forthcoming year is to widen the opportunities for support service staff further, particularly within pharmacy and microbiology.

7. Increase awareness of the importance of research.

With the support of the PRA, Maidstone and Tunbridge Wells NHS Trust has focused on ensuring the public, both locally and nationally, is provided with information relating to research. Over the past 12 months, the Research and Development Department has opened a Facebook page, joined Twitter and invested in producing educational resources to aid understanding. Educational

blogs and videos, featuring members of the Research and Development Department, are available for the public to view on the National Institute for Health Research website.

In May 2015, the Research Department will share with a wide audience the improvements made in delivering the Research Patient and Public Involvement Strategy at the National R&D Forum in Manchester. MTW research staff will run a workshop to highlight the importance and the benefits of including the public in developing and delivering research.

Since 2008/9, over 250 research papers have been published either solely by research staff at Maidstone and Tunbridge Wells NHS Trust or through collaboration working with staff from other institutions, spanning a wide range of journals, both in the UK and across the world

8. Strengthen research governance

During the summer of 2014, the Kent Oncology Centre Clinical Trials Unit (KOC-CTU) at Maidstone Hospital came under the line management of the central Research and Development Department and became fully embedded into the central governance processes. This move has allowed for greater support of staff within the CTU and supported the development of one central research facility. This central facility is more efficient and effective for staff as well as patients.

The oncology centre continues to expand its portfolio of cancer trials ensuring that all cancer patients have an opportunity to participate in the open trials at MTW. New appointments were made to the department to increase haematology related research and expand opportunities to recruit patients at Tunbridge Wells hospital.

Goals agreed with commissioners

Use of the CQUIN payment framework
This section describes how the Commissioning for Quality and Innovation (CQUIN) payment framework is used locally. The CQUIN framework aims to support a shift within the NHS to ensure that quality is the organising principle for all NHS services. It provides a means by which payments made to providers of NHS services depends on the achievements of locally agreed quality and innovation goals.

In 2014/15 2.5% of the contract value was dependent on achieving the CQUIN targets in line with the CQUIN payment framework.

Further details of the agreed goals for 2014/15 and for the following 12 month period are available electronically at www.mtw.nhs.uk

Within the commissioning payment framework for 2014/15 quality improvement and innovation goals were set as indicated in the table below.

	Target	*Achieved (local data)	RAG Rating
National CQUINS			
Friends & Family Test - Implement Staff FFT Test from 1st April 2014	**Implement**	Implemented	Green
Friends & Family Test - Phased Expansion of Staff FFT - Jan 15	**Implement**	Implemented	Green
Friends & Family Test - Early Implementation National Timetable for Outpatients - April 2015	**Implement**	Implemented	Green
Friends & Family Test - % response rate for Inpatients Q4	**30%**	**30.7%**	Green
Friends & Family Test - % response rate for A&E	**20%**	***17.6%**	Amber
Friends & Family Test – % response rate for Inpatients in March only	**40%**	***29.6%**	Amber
Safety Thermometer: Falls Rate per 1,000 Occupied Beddays	**6.75**	**6.16**	Green
Safety Thermometer - VTE - SI Related	**3**	**4**	Amber
Dementia Screening - % patient of patients screened	**90%**	**98.9%**	Green
Dementia Risk Assessment - % of those screened who had a risk assessment completed <72hrs after admission	**90%**	**99.3%**	Green
Dementia – referral for specialist diagnosis	**90%**	**100%**	Green
Named Lead clinician for Dementia and Training	**Yes**	**Yes**	Green
Ensuring Carers feel supported - monthly audit	**Yes**	**Yes**	Green

	Target	*Achieved (local data)	RAG Rating
Local CQUINS	**Target**	**Achieved**	
Reducing Incidence of AKI - Implementation of Education Programme	**Yes**	**Yes**	Green
Reducing Incidence of AKI - Compliance to all 4 numerators	**68%**	***74.6%**	Green
15% reduction in the number of AKI 3 patients identified compared to 2013/14 baseline	**497**	***416**	Green
Improve the use of Cardiac rehabilitation service - For 90% of eligible patients the programme is offered - within the agreed timescales	**90%**	***100%**	Green
Improve use of the cardiac rehabilitation service- Increase Uptake of cardiac rehabilitation service for all eligible patients to 65%.	**65%**	***39%**	Red
Improve use of the cardiac rehabilitation service - 88.5% completion rate for all eligible patients commencing cardiac rehabilitation.	**88.5%**	***92%**	Green
Implementation of the Interface Formulary - % of items prescribed from the Formulary Q3, 90% for Q4	**90%**	**90%**	Green
Ophthalmology - Repatriation of stable condition glaucoma patients	**500**	**606**	Green
Reporting of Medication-related safety incidents	**450**	**476**	Green
Emergency Paediatric Pathways - Number of paediatric patients attending A&E that are reviewed by a paediatric nurse (Q4)	**Implement pathways**	**Completed**	Green
Falls Screening in hospital settings for >75yrs if appropriate (Q4)	**90%**	**93.4%**	Green
Rate of Surgical site infections per 10,000 specified orthopaedic operations (April 14 to March 15)	**75**	***99.3**	Red
Patient Experience Survey - Nov, Dec and Jan - Improvement from 2013/14 for Inpatients, Outpatients and A&E for each question by Site.	**Data not yet available**	**Data not yet available**	

* *Figures shown are the latest available data – this is because some of the data will not be available until after publication of performance.*

Commentary

In this section we highlight some of the CQUIN improvements and developments in 2014/15, including what we achieved and what challenged us.

Friends and family test: This CQUIN focussed on extending the friends and family tests FFT to all staff in the trust. All MTW staff now has the opportunity to feedback their views on their organisation at least once per year. This is in line with the trust strategy of engaging staff to promote a cultural change where staff have confidence to speak up, and where the views of staff are heard and are acted upon. This will help us deliver a reputation for positive patient experience which the trust believes will lead to greater productivity, more investment and long-term sustainability. Cultural change workshops are scheduled thought out the year to support this cultural change.

Safety Thermometer: This CQUIN focussed on reduction in the rate of falls, Reduction of SI related and hospital acquired venous thromboembolisms (VTE). The reduction in number of patients falling in hospital was a huge success; the trust reduced the rate of falls by 10% when compared to last year.
The Trust delivered its target of ensuring that at least 95% of patients were given a VTE risk assessment in 2014-15. The Trust managed to maintain the number of VTE related SIs at four (same as in 13/14) but failed to achieve the reduction by one that was required to deliver the CQUIN. Despite extensive work by clinical teams, the number of hospital acquired VTEs increased in the last year. Reporting of VTE assessment has improved across the trust as a result of greater staff awareness which is important for continued improvement. This will continue to be an area of focus for the trust.

Dementia: This CQUIN focussed on finding, assessing, investigate and referring patients with dementia. The Trust delivered an excellent dementia training programme and that coupled with the excellent clinical leadership and engagement enabled the Trust to exceed the requirements of this CQUIN. This is a significant achievement as it means that more patients with dementia were identified early and supported to help them manage their condition and have a more positive experience with health and social care services. This CQUIN will be further embedded in the next year and this will require continued investment which the Trust is committed to.

Acute kidney injury (AKI): This CQUIN focussed on improving prevention, detection and management of acute kidney injury (AKI) for all hospital in-patients. The Trust made a tremendous success of this CQUIN. As a result of the concerted work by clinical teams, the Trust has significantly improved clinical outcomes and reduced the length of time that patients stayed in hospital. These improvements will ultimately contribute to the reduction in the number of AKI related deaths in our hospitals. This Trust will continue to embed this CQUIN in 2015/16 to further improve outcomes and patient experience for patients with AKI by working more closely with GPs to ensure patients are managed appropriately after their discharge from hospital- this will help further reduce deaths from AKI related complications.

Cardiac rehabilitation: The aim of this CQUIN was to increase the number of eligible patients taking up and completing cardiac rehabilitation programmes. The trust met the CQUIN target for two of the three measures agreed with the CCG, more than 90% of eligible patients were offered the programme within the agreed timescales and more than 88.5% of those who started the programme completed it. However, the Trust failed to increase uptake of the programme to the agreed 65% because of delays in recruitment of extra staff required to deliver the programme. The Trust and the CCG have worked closely to resolve this issue and progress has been made to recruit the extra staff required to deliver the improvement.

Transforming Outpatients Project: This aim of this project is to enable better clinical management and to improve patient experience by allowing GPs to seek and receive specialist advice without having to refer patients to hospital for an outpatient appointment. The Trust successfully rolled out this initiative to three specialities Orthopaedics, Pain, and Rheumatology ahead of schedule. Feedback from Patients, GPs, and Consultants has been positive and the Trust and the CCG have now formed an Executive led Joint Project Board to expand this innovative project to other areas. There is patient representation on the Joint project Board and this has been invaluable in ensuring that the project remains patient centred.

Ophthalmology – repatriation of stable condition glaucoma patients: The aim of this CQUIN was to enable patients with stable glaucoma that do not need to be treated in a hospital to receive care in the community near where the live. This transfer to the community only happens when the consultants looking after each patient is fully satisfied that the clinical care appropriate for the

patient can be provided safely in the community. This CQUIN will serve patients having to travel to hospital unnecessarily and ensure we make best use of the most appropriate services to treat patients. The Trust discharged over five hundred patients for care in the community in the last year and in so doing met the agreed CQUIN target.

Medication safety incidents reporting: The aim of this CQUIN was to improve the reporting of medication related safety incidents. It's widely acknowledged that within the NHS some fatal, serious incidents and never events involving medication errors may not be reported to the National Reporting and Learning System (NLRS) and therefore a learning opportunity is lost. As a result of the excellent clinical leadership and vigilance of our clinical teams, the Trust exceeded the requirements of this CQUIN. Although the number of incidents reported has gone up the Trust encourages staff to continue reporting these incidents as this will allow everyone to see and act where there is a problem.

Emergency paediatric pathways: The aim of this CQUIN was to ensure the Trust has laid the foundation for ensuring that paediatrics patients receive high levels of care tailored for their needs and clinical requirements. The Trust completed all the required preparatory work including developing paediatric pathways for emergency patients, recruiting paediatric nurses and making physical environment changes required to support the paediatric pathways.

Reducing rate of surgical site infections (SSIs): The aim of the CQUIN was to reduce the number of patients with wound infection following hip prosthesis, knee prosthesis and repair of neck of femur surgery. The Trust failed to deliver this improvement and this will remain an area of focus in the next year. A focus group led by the Clinical Director for Trauma and Orthopaedics has been formed to draw up and implement an action plan to reduce surgical site infections sustainably. The key areas of action identified so far include ringing fencing more T&O beds, supporting pre-operative warming of patients and a review of wound disinfectant regimes. It is recognised that the Trust may have a higher rate of SSIs because of the profile of the Fractured Neck of Femur (NOF) patients admitted to the Trust. Nevertheless the trust policy is that every SSI is subject to a root cause analysis to ensure learning.

Statements from the CQC

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

A team of 41 CQC inspectors visited Maidstone Hospital, Tunbridge Wells Hospital and Stroke Rehabilitation services provided at Tonbridge Cottage Hospital. The Quality Summit took place on 29 January 2015 and the final reports were published on 3 February 2015. The Trust has been assessed overall as _Requires Improvement' and was given 29 good ratings; 43 require improvement ratings and 6 inadequate ratings. There is one enforcement action and 18 compliance actions: _must dos' within the report. There are 49 _should do' actions which relate to the key issues within directorates and trust wide.

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

A comprehensive Quality Improvement Plan (QIP) has been developed following extensive discussions with our staff and stakeholders and was submitted to the CQC in March 2015. This plan will now be implemented and overall progress will be monitored monthly at the Trust Management Executive with the Trust Board receiving monthly reports. Progress updates will be published on the MTW website and internally on the intranet.

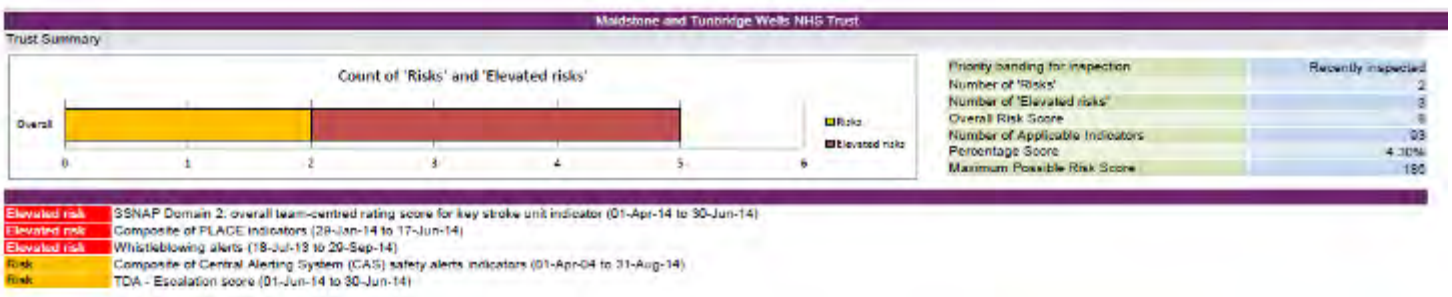
Intelligent Monitoring:

The CQC developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals in 2013. These indicators relate to the five key questions asked of all services. The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements. Judgements will always be based on the result of an inspection, which will take into account Intelligent Monitoring analysis alongside local information from the public, the trust and other organisations.

Trusts are given a risk rating between 1 and 6, with Band 1 being the highest priority rating (or greatest risk) and 6 being the lowest priority (or lowest risk).

The rating is revised approximately every quarter.

The last report was published in December 2014 and the profile is given below. A banding was not given as the Trust had been recently inspected. However a risk score of 8 should correspond to a banding of 4.



The next report will be released in draft form in April 2015 for the Trust to comment. The final report will be published in May 2015.

Full reports can be accessed via the CQC website www.cqc.org.uk

Improving data quality at MTW

Maidstone and Tunbridge Wells NHS Trust is committed to providing a service of the highest quality. To achieve this, data that clinical, operational and strategic decisions are based on need to be of the highest quality. Specifically, MTW needs to ensure its data quality so that it can:

- Provide effective and efficient services to its patients, staff and partners.
- Produce accurate and comprehensive management information on which timely, informed decisions are made to inform the future of the Trust.
- Monitor and review its activities and performance
- Produce accurate data to ensure appropriate reimbursement and account for performance as required
- Meet the standards set out for Information Governance and the requirements of the Information Commissioner

During 2014-15 the Trust successfully completed the completeness and validity checks set out as part of the Information Governance Toolkit. This is confirmed by the results from the NHS Information Centre's Secondary Uses Services data quality reports. The Trust has not been subject to an Audit Commission Payment By Results audit in 2014-15.
The Trust has a Data Quality Steering Group that takes action on data quality issues. Areas identified for improvement during 2015-16 are:-

- Continue to expand the use of the NHS Number within in the Trust as the primary identifier and ensure the small drop in completeness does not recur in 2015-16
- Improve data quality in key areas required to implement the new Patient Administration System
- Continue an on-going program of data quality workshops for staff based on targeted areas for improvement.

NHS Number and General Medical Practice Code Validity
Maidstone and Tunbridge Wells NHS Trust submitted records during 2014-15 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient_s valid NHS number was:
  98.7% for admitted patient care;
  98.6% for outpatient care; and
  95.0% for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:
  99.9% for admitted patient care;
  99.9% for outpatient care; and
  99.7% for accident and emergency care.

Information Governance Toolkit attainment levels
The Trust achieved a 74% satisfactory (Green in the toolkit grading scheme) score against the Information Governance Toolkit Version 12, and achieved 10 of the 45 requirements at level 3. The remaining requirements were achieved at level 2 as required by the Operating Framework for England for 2011/12.

The Trust has a robust Information Governance Management Framework that has been in place throughout the year and significant improvements continue to be made in many areas. An action plan has been developed to address the areas of weakness identified and progress against the action plan is monitored by the Information Governance Committee which is chaired by the Trust Data Protection Officer. The Trust Board is kept fully appraised of Information Governance issues affecting the organisation.

The Trust has an action plan in progress to continue to improve its compliance with the IG standards.

Clinical Coding

Maidstone and Tunbridge Wells NHS Trust employ a team of appropriately qualified staff to code clinical data. This coding it independently audited to ensure that the coding reflects the patient's diagnosis and treatment. Audit results for 2014-15 were as follows:-

Primary Diagnosis	92.5%
Secondary Diagnosis	98.8%
Primary Procedure	99.2%
Secondary Procedure	97.6%

Errors may occur when a clinical coder translates the written information provided by a clinician regarding a patient's diagnosis and treatment into standard codes. These codes are nationally and internationally recognised and are used by healthcare professionals and researchers to check on the outcomes of a patient's diagnosis and treatment and compare it to other patients and organisations in other parts of the country and abroad.

The lower performance in relation to the primary diagnosis was essentially down to a systems constraint which impacted upon the recording of 5 character ICD 10 codes. This in turn equates to a non-coder error.

Part Three

Update on improvement initiatives 2014/15

This section will provide a summary update on the initiatives we prioritised last year:

Patient Safety - *Reducing the number of avoidable harms with a focus on*

Hospital acquired infections, in particular MRSA, C Difficile

Aim/Goal

To reduce our C. difficile cases to less than 40 for the year and to sustain or decrease our low rate of MRSA bacteraemia, maintaining our zero tolerance of avoidable infection.

Planned Actions for 2014/15	Summary Update
Reduction in C. difficile cases to less than 40	The Trust had 28 cases of C. difficile (35 previous year). This is a 20% reduction from last year's out turn. The rate of infection was 12 per 100 000 bed days (the national benchmark is 15.7 per 100 000 bed days).
Continued focus on robust antibiotic stewardship	Extension of the educational programme for the safe and appropriate use of antibiotics Implementation of the national acute Trust carbapenemase-producing Enterobacteriaceae (CPE) toolkit
Rigorous monitoring of deep cleaning programme	The deep cleaning programme is monitored through the Infection Prevention and Control Committee. Progress against the plan is via a written report presented to the February, June and October Committees. Estates present a general report at this time which includes compliance against the routine cleaning standards
Sustain relationships and joint working with community colleagues to ensure good progress is maintained for appropriate antibiotic prescribing and management	Agreement across the health economy of methodology for assessment of any lapses of for all C. difficile cases. Working across the health economy to have a whole system approach to the reduction of C. difficile. Review of the MRSA screening programme to support local needs

Falls

Aim/goal

We aimed to reduce the rate of falls in the year from 7.2 per 1,000 occupied bed days to 6.75 per 1,000 occupied bed days

Planned actions for 2014/15	Summary update
Overall rate of falls decreasing	Rate of 6.2 per 1,000 occupied bed days at March 2015
Review of Bed Rails assessment	Bed rails assessment review has been ongoing over the last 12 months with an audit planned for April 2015
Review and implementation of revised checking process for selection and condition of alarm mats	Implementation of staff training on use of Falls Sensor alarm (including appropriate checking of sensor pads) with Competency tool developed for staff
Consideration of a ‗eview sticker' to demonstrate medications review has been undertaken	Implemented ‗eview sticker' to demonstrate medications review has been undertaken
Review of Serious Incident investigation and closure process	Review undertaken of Serious Incident investigation and closure process relating to falls, with improvements made

Hospital acquired pressure ulcers

Aim

Our priority for the coming year is to sustain the reduction in the number of hospital acquired pressure ulcers in line with the current national agenda of zero tolerance to pressure damage as set out by the National Patient Safety Agency. We are aiming to reduce the incidence of category 2 pressure ulcers by 15% and to achieve zero incidence of hospital acquired category 3 and 4 pressure ulcers.

Planned actions for 2014/15	Summary update
Sustain the reduction in the number of hospital acquired pressure ulcers in line with the current national agenda	2014/2015 has seen a sustained reduction of facility acquired pressure damage (FAPD) of category 3 and 4 - during 2014 there were no category 3 FAPD compared to 8 in 2013/14 ; 1 category 4 FAPD which when investigated was found to be unavoidable. The February 2015 prevalence audit has confirmed that MTW is continuing to maintain the reduction in pressure FAPD
Enhance and strengthen the work between the Tissue Viability team, the Safeguarding Matron and the Lead Nurse for Dementia Care to develop and implement strategies to manage challenging behaviours in relation to concordance with care, ensuring frontline staff have the skills required to adequately prevent tissue damage in patients with cognitive impairment.	The plan for 2015/16 is to review all patients with facility acquired pressure damage with the lead nurses for dementia care and falls prevention – the rationale for this is to develop internal strategies which should ultimately assist front line staff in delivering quality care to those patient with challenging behaviours – to be arranged.

Planned actions for 2014/15	Summary update
Review the efficacy of the current mattress systems (non-dynamic) to ensure they remain the product of choice	Mattress audits will be undertaken in 2015 dates to be agreed. A mattress audit in 2014 was undertaken at Maidstone however TWH was not achieved due to a shortage of replacement covers and mattresses. To overcome the risk of a mattress not being fit for purpose there is a policy and procedure for the decontamination and maintenance of mattresses in place The current standard hospital bed mattress stock is 5years old and will require replacement to ensure it remains effective in reducing the risk of pressure damage and infection prevention requirements. During 2015 evaluations will be undertaken to review alternative systems available on the market; this process will include EME, Procurement, and Infection Prevention team, Moving and Handling and Tissue Viability – with the ultimate aim to have a preferred mattress for the trust. The business case for the replacement mattress will re reviewed and resubmitted to the finance director
Review the role of the link nurse and the way in which frontline staff gain and maintain pressure damage prevention skills	The link nurse role is reviewed at each link nurse meeting held twice yearly. Competencies have been agreed and reviewed for nurses‘s and Care Support Workers. Education is provided by the tissue viability team - 6 sessions for 2015 have been planned for Pressure Ulcer Prevention and Category Recognition, on the learning and development website. although these sessions have not previously been formally evaluated by the attendees verbal feed back has been positive, written evaluations will completed for each session for 2015 to ensure a robust and effective teaching experience is achieved The Tissue Viability Nurse‘s do maintain a regular visible presence on the wards and are available for help and advice as required.

Review and enhance the emergency care provision for children in our Accident & Emergency Department

Aim

All persons under the age of 18 years should receive care from Registered Nurses who are specifically trained in the care of sick children.

Planned actions for 2014/15	Summary update
Undertake a full acuity and dependency review for the Accident & Emergency Department (using RCN Emergency forum ‗Baseline Emergency Staffing Tool' (BEST), and triangulate with the Hurst Model and Professional Judgement Model for setting safe staffing levels. Consider linking to the modified Paediatric Acuity and Nursing Dependency Assessment (PANDA) tool being trailed within Paediatrics)*.	An acuity and dependency review has been undertaken for the Emergency Department at Tunbridge Wells Hospital in June 2014. In response to this we are reviewing our nursing establishments in order to ensure safe staffing in line with the draft NICE guidelines published in February 2015 It is our intention by the end of June 2015 to carry out further acuity and dependency review using the PANDA tool to ensure that paediatric staffing is safe and appropriate
Build on the full review of staffing, in line with the National Quality Board recommendations (work already undertaken in 2013/14)	We have now recruited 8 Registered Children's Nurse's to work across both sites and ensure implementation of the paediatric pathway through the Emergency Department's (ED) The team of RSCN's will be line managed by an ED band 7 with dual qualification. They will also work closely with the RCN on the paediatric ward and will report to the Paediatric Matron
Strengthen communication and supervision links between the A&E Department and Children's Services directorate	In addition to the close supervision there is a monthly paediatric/ED Liaison meeting that is Matron led and involves both Directorates. It is also attended by the Clinical Directors for both Directorates
Review pathways for sick children, ensure they remain appropriate and are consistently followed.	The paediatric pathway has been reviewed through the paediatric/ED liaison meeting and has been agreed at Directorate board for both Directorates

Clinical Effectiveness - *To provide an integrated approach to care with our community colleagues with a specific focus on*

Dementia

Aim/goal

To identify those patients with dementia with a view to ensuring that an effective care plan is in place to enable them to receive the best care possible throughout their pathway between the acute and community sectors

Planned actions for 2014/15	Summary update
Continue with work commenced last year with the Association for Alzheimer's and Dementia Support Services (ADSS) for the implementation of the dementia buddy scheme.	Work continues with ADSS and the Dementia Buddy Scheme, which is now running on both hospital sites. A dementia buddy coordinator is employed through ADSS and leads on the recruitment and training of volunteers. We currently have 53 volunteers in total, with 36 on Maidstone site and 17 on Tunbridge Wells Site. There are currently 2 wards covered at Maidstone and 1 at Tunbridge Wells with a view to expand as more volunteers are recruited. A day room area has been developed between 2 wards at Maidstone Hospital for the buddies to utilise, and they have run lunch clubs, activity sessions and painting sessions. Parameters for the dementia buddies have been developed with regards to Nutrition and Moving and Handling to assist them in the work they are undertaking. The buddies are also completing evaluation forms of the service provided and this will be presented at the Dementia Strategy Steering Group
Work closely with the Patient Environment Steering Group to ensure best practice guidance for dementia friendly environments are considered and implemented in all future refurbishment and estate development	Estates and facilities department have been provided with the Kings Fund documentation on Enhancing the Environment for dementia patients in order to assist them in their planning and implementation of refurbishment and estate development
Establish a reporting mechanism for the results of the carers' survey to ensure that feedback is disseminated across the Trust and findings are understood and implemented locally	Results of the „Carers survey' are reported to the Dementia Strategy Group meeting twice a year, and where required actions identified. The results are also disseminated to the ward managers; matrons and dementia champions for further dissemination.

Discharge Planning

Aim/goal
Ensure all patients have their discharge from hospital planned to ensure there is a seamless transfer home with appropriate support in place and communication with all relevant parties, with particular focus on enhanced electronic discharge notification ensuring all agencies receive electronic notification, as appropriate

Planned actions for 2014/15	Summary update
Development of detailed action plans in partnership with project leads from each organisation aimed at improving the efficiency and effectiveness of services at a whole system level	Twice weekly conference call with the Clinical Commissioning Group (CCG), Kent Community Health Foundation Trust (KCHT), and Kent County Council (KCC) is in place to discuss and monitor any delays in discharging patients from the acute sector. Evidence – diarized conference calls
Test new ideas for service integration, for example, Telehealth for patients with respiratory and Chronic Obstructive Pulmonary Disease conditions as part of reducing the presentation of patients with these conditions at A&E	Visits have been made to service providers to start scoping the viability of telemedicine within respiratory medicine. On agenda for next Respiratory Meeting to agree how to proceed
Development and implementation of Enhanced Electronic Discharge Notification (EEDN) allowing full multi-disciplinary notification of discharge, including community and social care teams	Currently in development stages, IT infrastructure allows for the extension to our current EDN. Electronic Patient Records team are looking at progressing this project over the coming year
Review work plans to enable 7 day working across disciplines and specialities	Business Case completed by Emergency & Medical Services Directorate to implement 7 day services in a number of areas

Enhance Stroke Care pathway

Aim:
To ensure 80% of patients with a diagnosis of stroke receive 90% of their care on a dedicated stoke ward
Update: We have achieved this target for 2014/15.

Planned actions for 2014/15	Summary update
Stroke Steering Group initiated	Stroke Steering Group implemented at a Corporate level with KCHT and CCG input. Minutes available
Action Plan developed	Local Stroke implementation groups have been set up on each site and chaired by the Stroke Clinical Nurse Specialist's. Minutes of meetings available
Ring fenced bed on each acute stroke ward	Implemented and included on daily Site Report. Also discussed at each of the four daily Site Meetings
Escalation criteria to be monitored	If Ring Fenced bed is not available due to capacity issues, a key priority from the Site Meeting will be to ensure one is available within the next 4 hours. Cross site working is improving and suitable Stroke patients do now access a stroke bed on the other site in order to ensure they receive appropriate stroke care.

Patient Experience

To improve our ward environments, with particular focus on day rooms and communal areas between wards at Tunbridge Wells Hospital

Aim

Following the publication of the Francis report, which put heavy emphasis on patients having access to communal areas, and feedback from Patient-led Assessment of the Care Environment (PLACE), we have decided to focus on both day rooms across the Trust, and the inter-ward spaces at Tunbridge Wells Hospital.

Planned actions for 2014/15	Summary update
Patient Environment Steering Group (PESG) to ensure ward day rooms are prioritised for investment from PLACE funds	Included as part of refurbishment plans for Maidstone Hospital site. Key focus for Maidstone Hospital in 2014 was the revision of way-finding and colour coding signage and hospital zones. Some investment has been made in furniture on both sites, and particular attention has been paid to maximising 'end of ward' space on the wards at Tunbridge Wells by creating small seating areas by the main window
PESG to liaise closely with members from the Dementia Steering Group to ensure any initiatives supplement and support the work of the Dementia Steering Group	The links between the PESG and the Dementia Steering Group remain strong with clear understanding of the role both groups play in enhancing the environment for both patients living with Dementia and the wider population
Set of principles for common areas to be agreed to ensure that they are inviting spaces for all	Key principles in place guided by infection control and hospital design regulations These considerations are kept in mind at all PESG meetings where ward refurbishments are discussed. Colour coding and patient engagement are the key factors, along with the principle of providing a communal space, where possible, in all ward refurbishment

To improve management and actions in response to complaints to ensure each is used as an opportunity from which we can learn

Aim

Our aim this year is to build on the work over the last year to ensure that all complaints are seen as an opportunity to learn from and that we embed the learning. We aim to ensure complainants receive timely responses which have been fully investigated and address all issues raised.

We aim to ensure that our Trust Board are fully appraised of the numbers of complaints per month, the emerging themes and trends, and are sufficiently sighted on these to enable full cross organisational understanding and improvement

Planned actions for 2014/15	Summary update
Implementation of further training re investigation of issues and drafting of complaint responses including using complaints and PALS scenarios in the	Complaints training open to all staff and focusing on the investigation of complaints and drafting complaint responses was delivered by the central

Planned actions for 2014/15	Summary update
development of a new Trust-wide customer services/Organisational Development programme	complaints team up until June 2014. Due to capacity issues within the central team, we were unable to offer training August 2014 to March 2015. One of the team objectives moving into 2015-16 is to review and relaunch the training programme. We are trying to work towards delivering a full day's training, allowing delegates to 'investigate' and 'respond' to a case study. Complaints and PALS case studies have been used in designing a new Trustwide customer services training programme; the pilot is scheduled to take place on 29 May 2015.
Continue with the development of more efficient statistical reporting so that actions can be targeted on recurring themes and areas of high incidence in a more timely way	An amalgamated PALS/complaints report has been developed which combines the data captured to highlight recurring themes. This is submitted to the Clinical Governance Committee for discussion and review
Report publically the number of complaints received, the number of upheld and actions taken	Annual complaints report provides all this information. Number of complaints received is included in Trust's annual report.
Strengthen the links between patient experience/stories and the Board, by offering more patients the opportunity to tell their story, in person, to the board.	During 2014/15, the Trust Board agreed to hold meetings in public every month (previously this was every 2 months). A 'patient story' is normally heard at every other meeting, and in 2014/15, stories were relayed in person at the Board meetings in May, October and December 2014, and February 2015. Such stories provide invaluable first hand experience of being a patient of the Trust, and are supplemented by visits of Board members to hospital areas (which are reported to the Board each quarter)
To continue to develop and enhance our practice of early engagement with patients and families	In terms of PALS, we launched our Open Day programme in September 2014 to raise awareness of the service and make it easy to capture feedback from patients A programme of PALS ward rounds was launched in March 2015 to gather feedback from inpatients.

To improve the quality of written information, particularly in relation to patient information leaflets and letters to General Practitioners.

Aim:

To enhance the quality of the information that we provide to patients and carers to ensure that it is clear, informative, timely and in a suitable format.

Planned actions for 2014/15	Summary update
Health Records Manager and Communications Department to improve the quality, readability and consistency of patient letters.	Extensive work has been carried out on the letters sent to patients to simplify the content. A standardised format is used by clinical secretaries and information is printed on the reverse
Patient Information and Leaflet Group to consider an alternative approach to highlight information leaflets by subject matter, e.g. colour coded stripe	The Patient Information and Leaflet Group reviewed the 'Department of Health' guidance on leaflets. The Trust guidance was amended to allow more than 2 colours within leaflets that are printed within the Trust (core leaflets printed externally will still follow the 2 colour rule). This allows Directorates to adopt local colour stripes to highlight information by subject matter.
In addition to essential patient and visitor information, the trust will also improve the information provided about changes we are making in relation to feedback from the public via surveys and complaints	We publish the result of the friends and family test in ward areas for staff, patients and visitors to see. These are updated monthly

Friends and Family Test

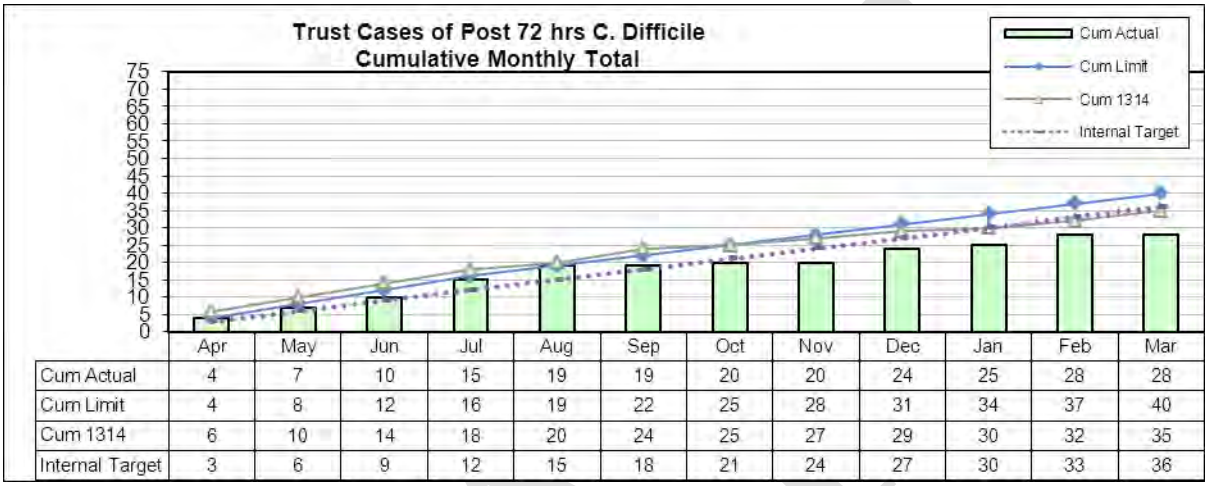
Aim: to significantly improve our response rate for the Friends & Family Test (FFT), whilst maintaining our overall net promoter score:

Planned actions for 2014/15	Summary update
Improved internal awareness	FFT now used routinely as part of the Directorate reports to Quality & Safety Committee FFT returns for A&E noted at Site Operational meetings Use of FFT in the development of service improvements, business planning and staffing reviews
Weekly reporting of returns to departments	Weekly return estimates collated and circulated to wards
Consideration of alternative means of feedback (e.g. increased use of IT, mobile technologies)	Consideration has been given to the use of IT and mobile technologies and is included in the Trust's IT Strategy. The implementation of NerveCentre will be considered for FFT feedback once the initial clinical care modules have been fully established. Use of text and voice activated technology is being set up for outpatients, with the service undergoing testing in March 2015 and fully live by April 2015.
Implementation of FFT for all outpatients	Initial feedback has been via paper survey and on-line survey monkey. The latter has not proved

Planned actions for 2014/15	Summary update
	popular. A text/telephone service similar to the Out Patient Department reminder service is being implemented for OPD from April 2015.
Implementation of FFT for staff	This is in place as part of the national staff survey, and via a twice yearly local staff surveys. Overall the response from staff has been excellent

Review of Quality Performance

Infection Control – C.Difficile Cases – The Trust exceeded this standard with 28 cases against a maximum of 40 cases for the year. The number of CDifficile cases throughout 2014-15 was 7 fewer than the number reported for 2013-14 – 20% reduction

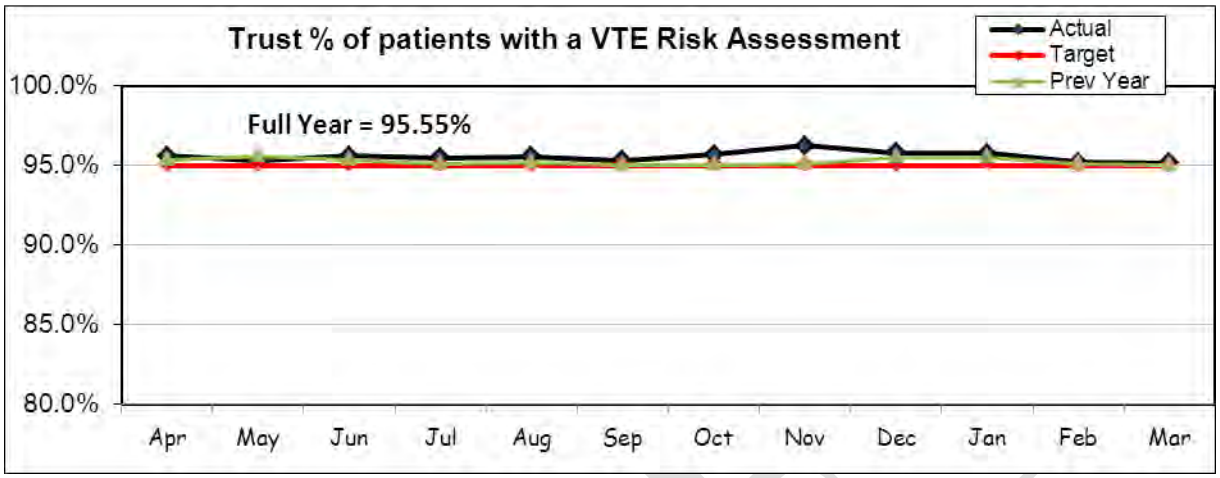


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cum Actual	4	7	10	15	19	19	20	20	24	25	28	28
Cum Limit	4	8	12	16	19	22	25	28	31	34	37	40
Cum 1314	6	10	14	18	20	24	25	27	29	30	32	35
Internal Target	3	6	9	12	15	18	21	24	27	30	33	36

Infection Control – MRSA Cases – The Trust achieved the standard, with 1 case of unavoidable post 48 hr MRSA bacteraemia through the year against a Trust standard of zero avoidable.

Prevention of blood clots or venous thromboembolism (VTE)

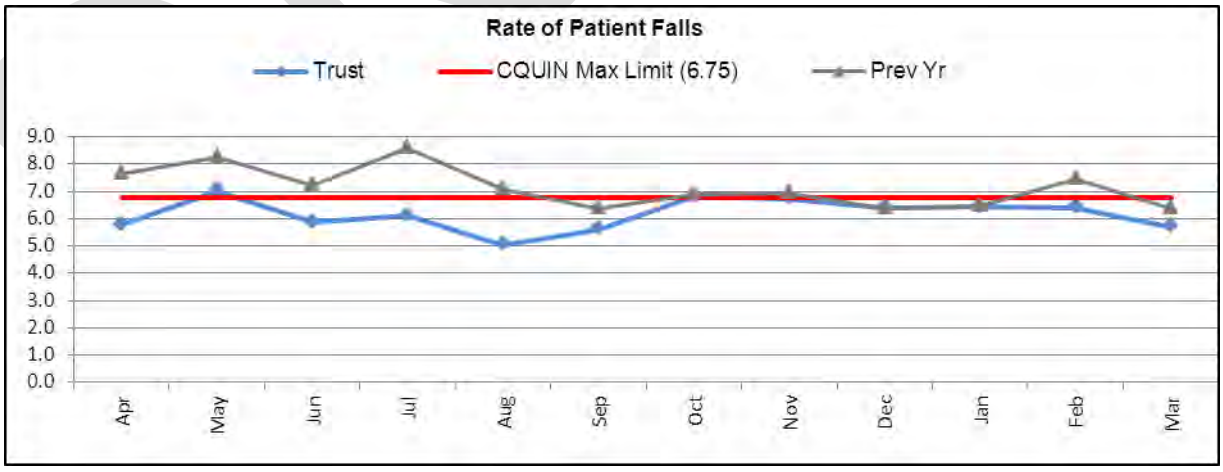
% Patients VTE Risk Assessment – The Trust ensured that 95% of patients were given a VTE Risk Assessment in 2014-15.



Reducing the number of patient falls

See key priorities for 2014/15 and update summary in section 2

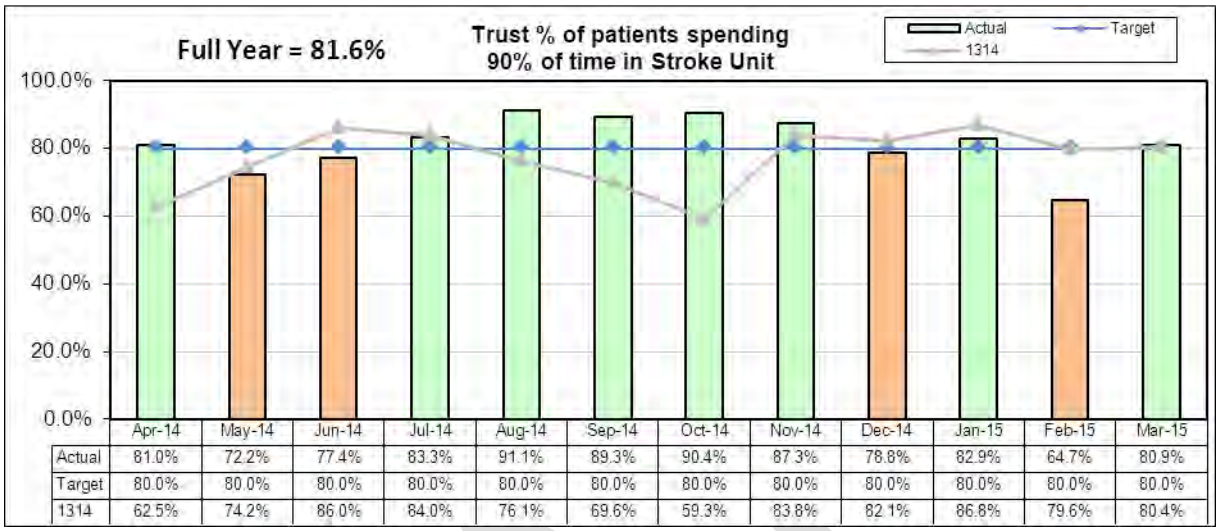
Rate of Falls – The Trusts' rate of Falls per 1,000 Occupied Beddays is below the local quality improvement target (CQUIN) of 6.75 at 6.16 for the year (7.1 for the previous year). The number of Falls reported in 2014-15 is a 9.8% reduction (-156) from the previous year.



CLINICAL EFFECTIVENESS
Continue our focus on improving care for patients who have had a stroke

See key priorities for 2014/15 and update summary in section 2

80% of patients spending 90% of time on in Stroke Unit - The Trust achieved this standard of 80% of stroke patients to spend 90% of their time on a dedicated stroke ward in 2014-15.



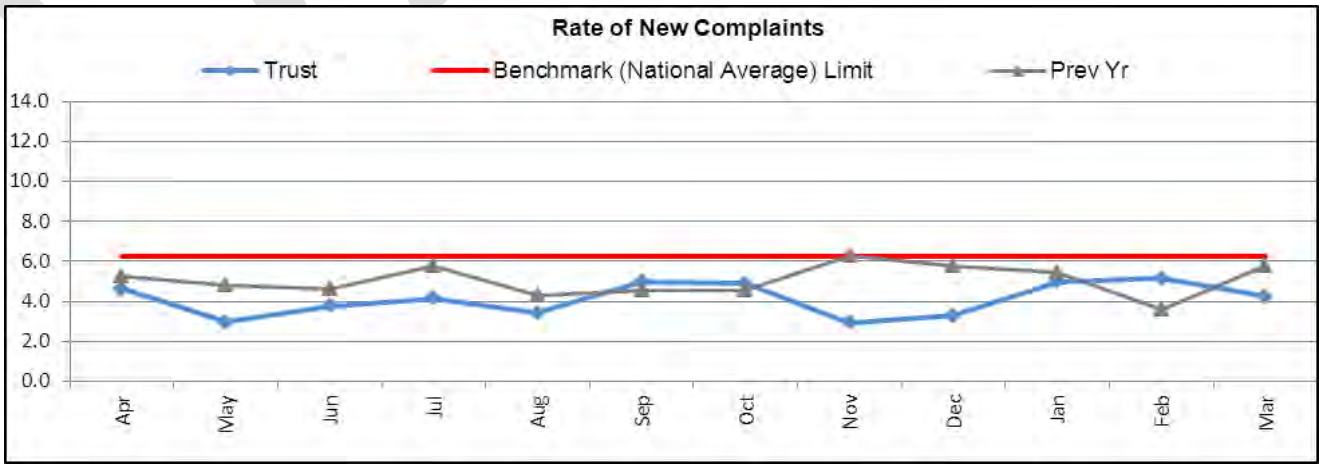
	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Actual	81.0%	72.2%	77.4%	83.3%	91.1%	89.3%	90.4%	87.3%	78.8%	82.9%	64.7%	80.9%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
1314	62.5%	74.2%	86.0%	84.0%	76.1%	69.6%	59.3%	83.8%	82.1%	86.8%	79.6%	80.4%

PATIENT EXPERIENCE

See key priorities for 2014/15 and update summary in section 2

Complaints management

Rate of New Complaints- The Trusts' rate of New Complaints per 1,000 episodes is below the national benchmark of 6.26 at 4.11 for the year (5.07 for the previous year). The number of new complaints received in 2014-15 is a 14% reduction (-79) from the previous year.



Patient Surveys

During 2014 the Trust undertook three National Surveys run by PICKERS Europe and the CQC. They were the following:

- Children's Inpatient and Day Case Survey
- Emergency Department Survey
- Inpatient Survey

The Emergency Department survey runs bi-annually and was previously run in 2012. The Children's Inpatient and Day Case Survey was an additional survey that was added to the CQC survey programme.

As stated in last year's account the Trust aimed to improve the experience of patients across the organisation through focusing on key areas that were highlighted. Below are the questions that were focused on and this year's results are compared with those of the previous year where possible.

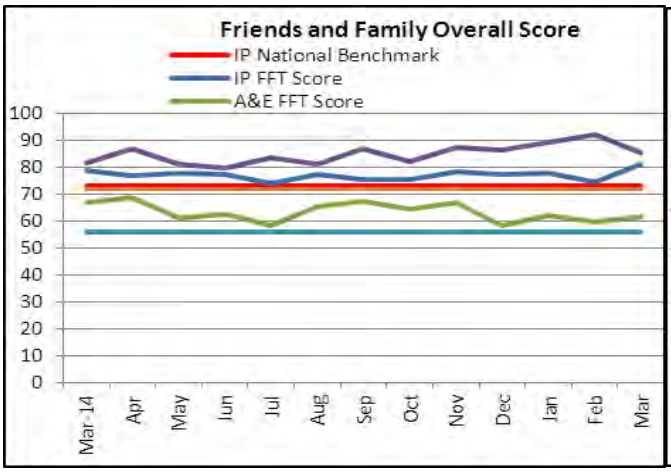
National Inpatient Survey 2014

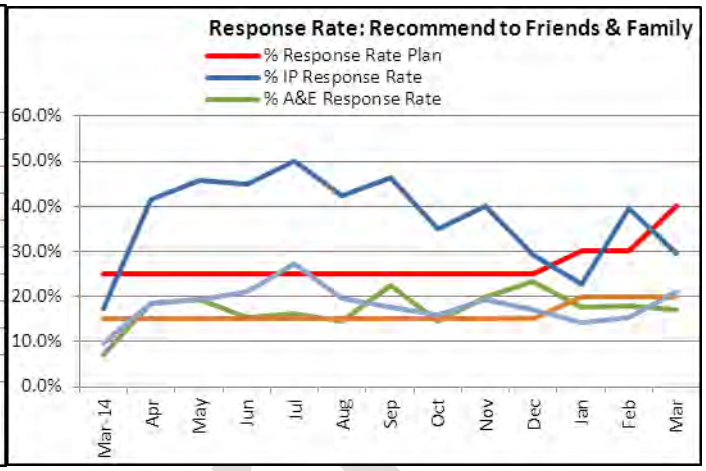
Focus questions from National Inpatient Survey		National Inpatient Survey	
		2013	2014
1	Were you involved as much as you wanted to be in decisions about your care and treatment?	91.2%	87.5
2	Did you find someone on the hospital staff to talk to about your worries and fears?	45.5%	47.3
3	Were you given enough privacy when discussing your condition or treatment	97.4%	95.6
4	Did a member of staff tell you about medication side-effects to watch for when you went home?	43.7%	42.0
5	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	73.6%	71.4

We continue to survey our inpatients using electronic questionnaires and these are reported monthly to the trust board.

The Trust has met the original overall response rates for the year of 25% for Inpatient, 15% for A&E and 15% for Maternity Friends and Family (FFT) however, it is expected that the Trust will not meet the higher target of 30% for Quarter 4 and 40% for March for inpatients and 20% for Quarter 4 for A&E. The Trust is performing consistently on the overall net promoter score, being consistently above the national benchmark for all three areas indicating that patients would recommend the Trust to their Friends and Family.

MTW Friends and Family scoring





Learning from Serious Incidents / Never Events

To ensure there is a system of learning from incidents and never events we have robust reporting, investigation and learning process in place. We report all serious incidents centrally to a national system and identify trends and themes to help to reduce risks going forward.

All serious incidents and never events undergo a root cause analysis and an action plan developed to share learning and prevent a similar situation from occurring. All serious incidents and never events are reported to an executive led review panel.

Further to this the Trust established a multidisciplinary Patient Safety Think Tank in August 2014 to review and consider the patient safety culture and processes within MTW. A roadmap has been commenced and developments to improve the systems, education and culture are underway. The ‗Step up to Safety' campaign is due to be launched this summer along with a patient safety focussed conference to be hosted in July.

Actions and learning from serious incidents are key to improvements and ensuring patient are safe and provided with high quality care. In 2014/15 learning and actions included:

- Improvements to the recruitment to nurse bank and the induction process for all staff
- An awareness drive to remind staff about the chaperone policy that protects patients and staff
- A review of medical locum packs (with information and signposting to assist and guide locum doctors in their work) ensure they are read, understood and used
- The implementation of a new trauma booklet including a documented handover section
- Strengthening of the fast-track procedure, including additional safeguards for identifying flagged reports
- A system implemented for urgent referrals between radiographers and clinical staff
- A new CT/head guideline produced with a new system of CT scanning for identified higher risk patients
- Head and Neck injury guidelines included at induction for all new medical staff to A&E and in the rolling teaching programme
- Dementia guidelines included at induction for new staff and teaching programmes for existing staff
- Change current procedure of storage of thiopentone. The emergency supply is now be kept in a red sealed drug tray with thiopentone labels placed over the injection port lid of the thiopentone ampoule
- System administrators reminded of the requirement to only use patient level and person identifiable data when appropriate and to always consider pseudonymisation and anonymisation of data

Never Events

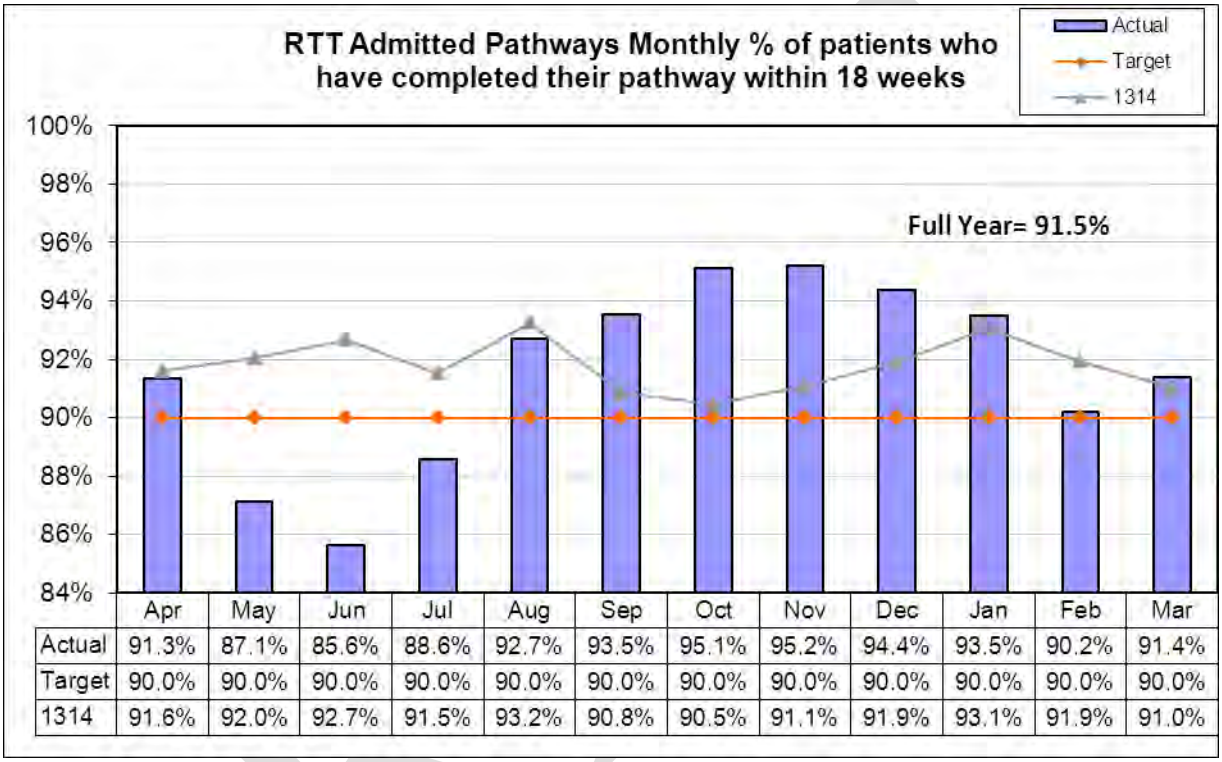
There were 2 Never events during 2014/15. Full root cause analysis was carried out during the detailed investigation and a number of recommendations were implemented to ensure the risk of reoccurrence is minimised.

The first Never event was the wrong insertion of chest drain and subsequent actions include the use of an annotation marker in the primary x-ray image, rather than post-processing electronic annotation markers being used, a chest drain check list implemented in practice and an awareness and education programme for all A&E medical and radiology staff.

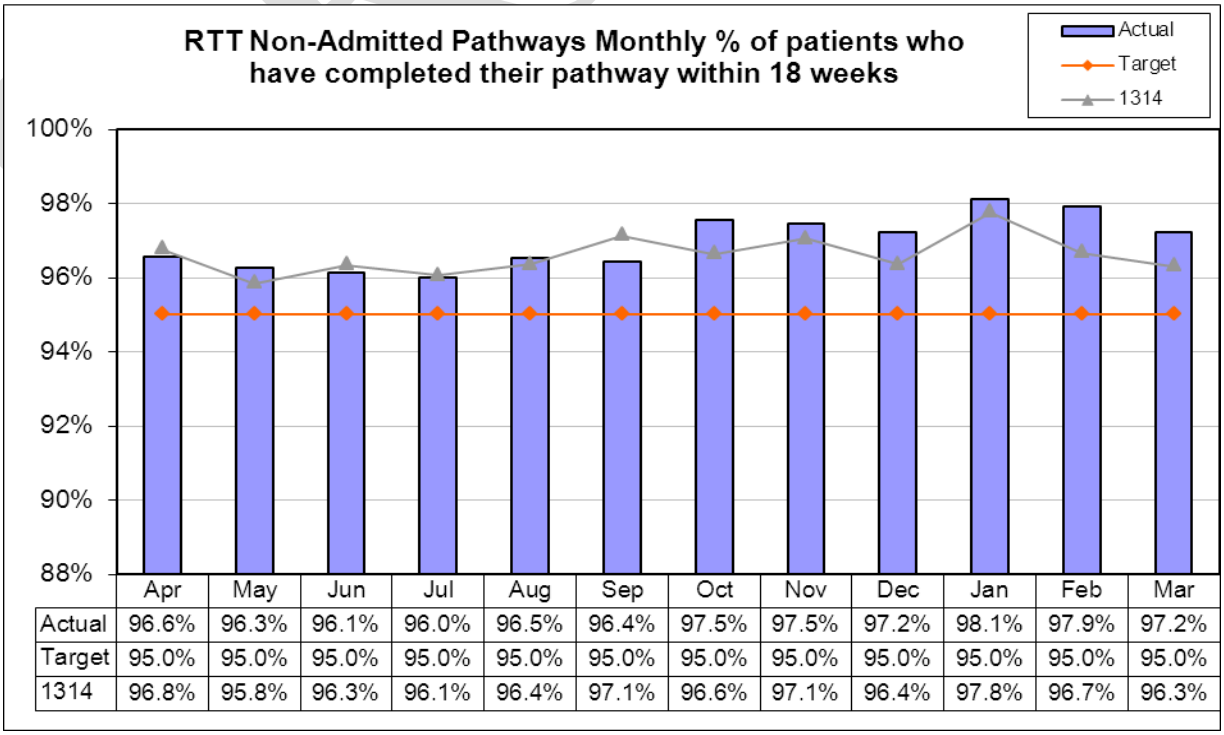
The second Never event was a wrong Prosthesis/Implant. Subsequent actions include the revision of WHO surgical checklists to include a check that correct prosthesis is implanted.

Other Quality Monitoring and Improvement Measures

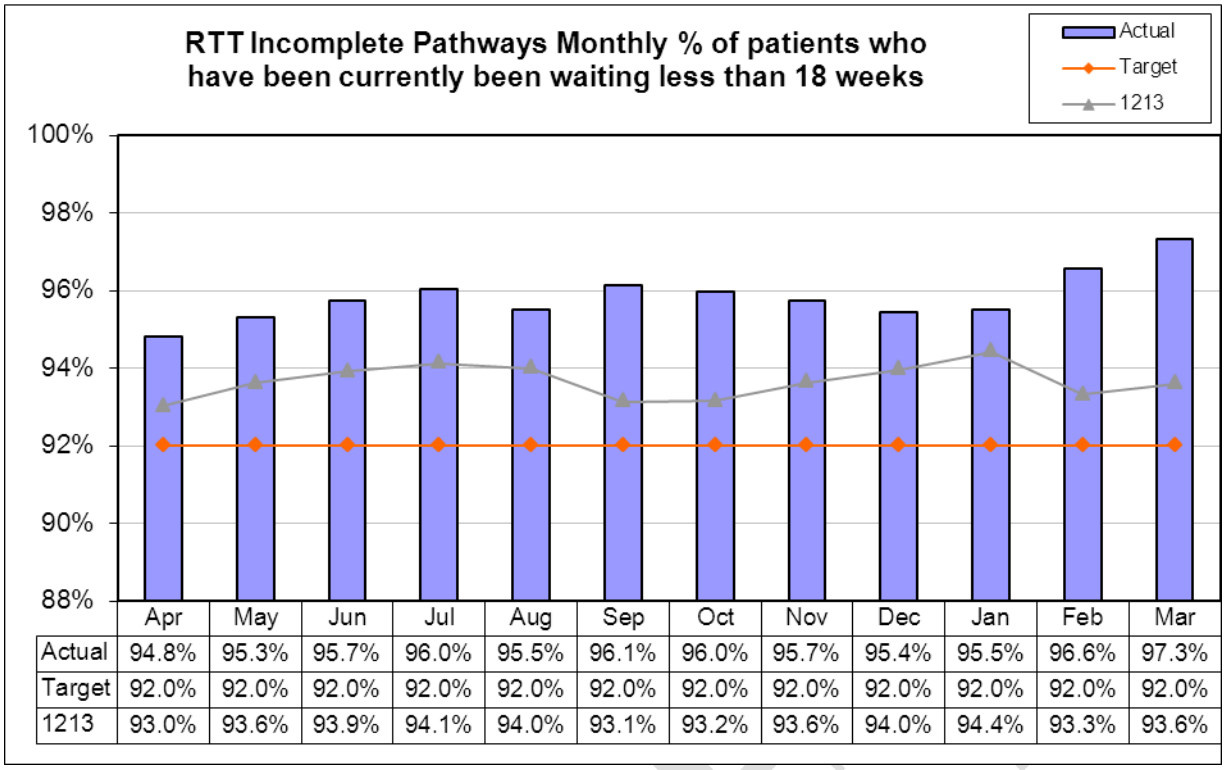
18 weeks standard – The Trust achieved this standard at an aggregate Trust level, ensuring at least 90% of admitted patients were treated in hospital following GP referral in 18 weeks. The Trust also ensured that at least 95% of non-admitted patients were seen within the same period and that at least 92% of patients on an Incomplete Pathway had been waiting less than 18 weeks.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	91.3%	87.1%	85.6%	88.6%	92.7%	93.5%	95.1%	95.2%	94.4%	93.5%	90.2%	91.4%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
1314	91.6%	92.0%	92.7%	91.5%	93.2%	90.8%	90.5%	91.1%	91.9%	93.1%	91.9%	91.0%

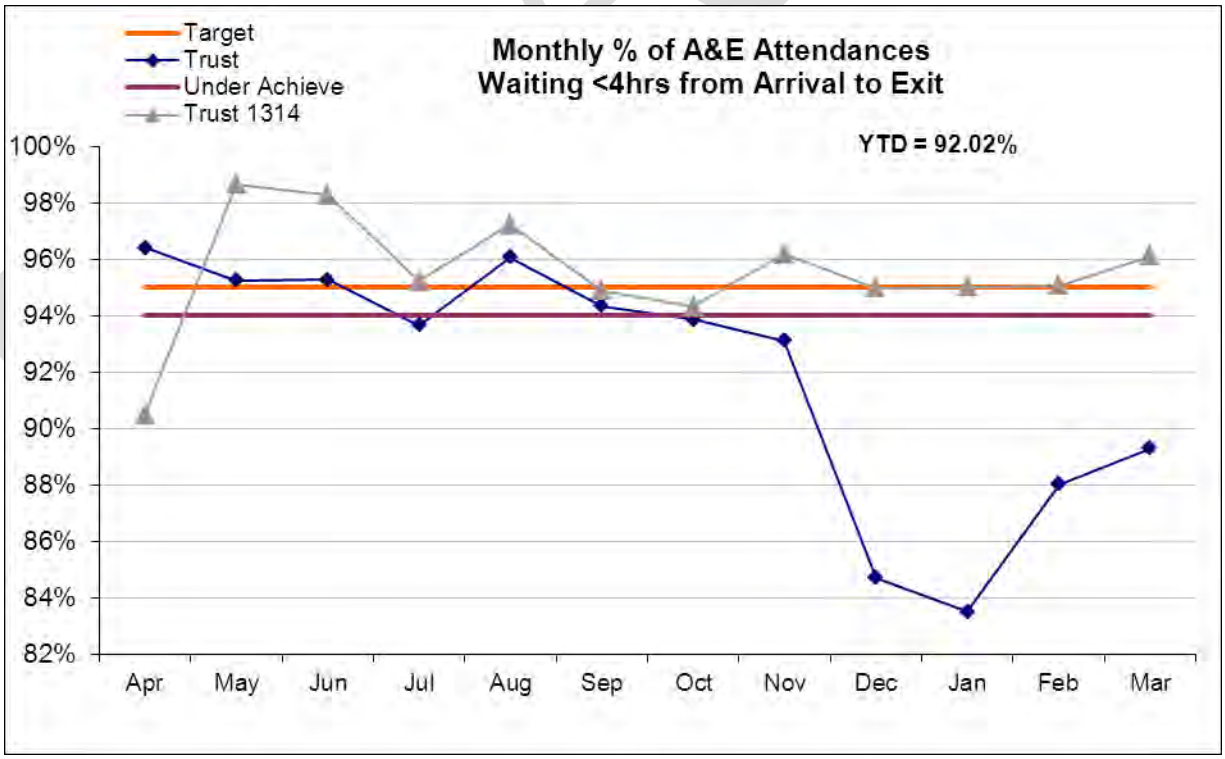


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	96.6%	96.3%	96.1%	96.0%	96.5%	96.4%	97.5%	97.5%	97.2%	98.1%	97.9%	97.2%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
1314	96.8%	95.8%	96.3%	96.1%	96.4%	97.1%	96.6%	97.1%	96.4%	97.8%	96.7%	96.3%

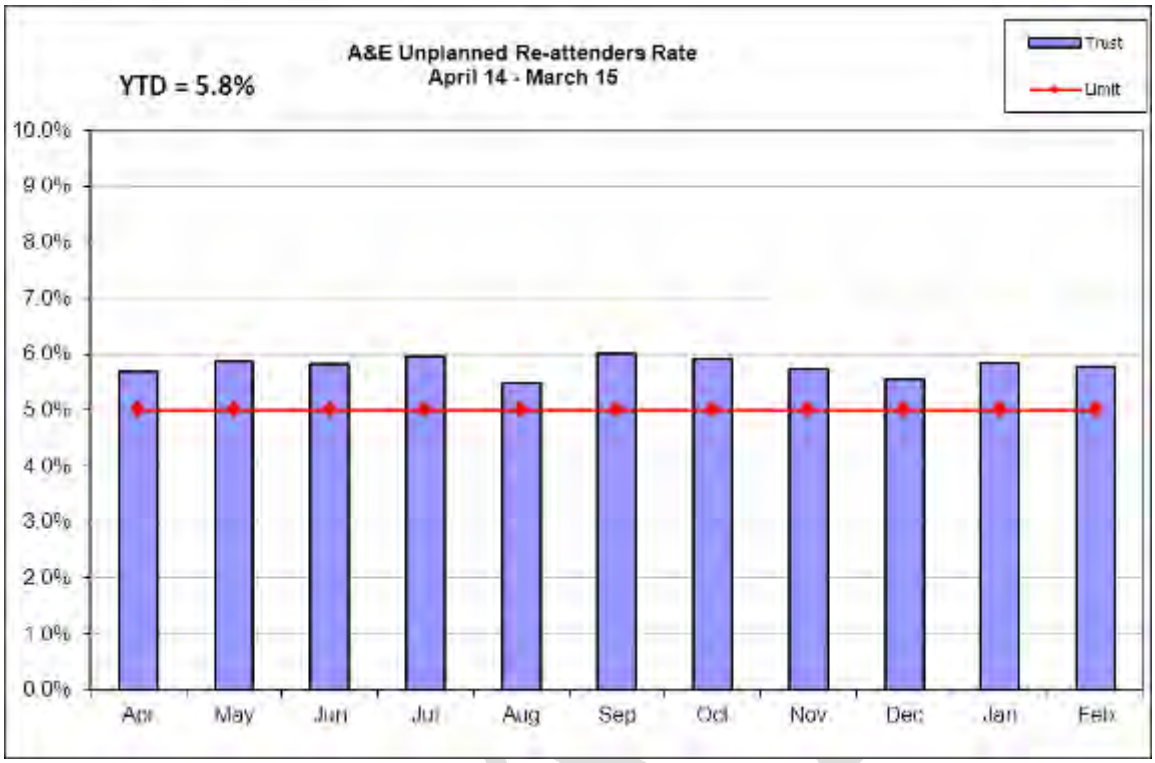


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	94.8%	95.3%	95.7%	96.0%	95.5%	96.1%	96.0%	95.7%	95.4%	95.5%	96.6%	97.3%
Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
1213	93.0%	93.6%	93.9%	94.1%	94.0%	93.1%	93.2%	93.6%	94.0%	94.4%	93.3%	93.6%

Emergency 4 hour access – The Trust did not achieve this standard of 95% of patients being seen, treated, admitted or discharged within 4 hours of arrival in its A&E departments in 2014-15 at 92.02%.

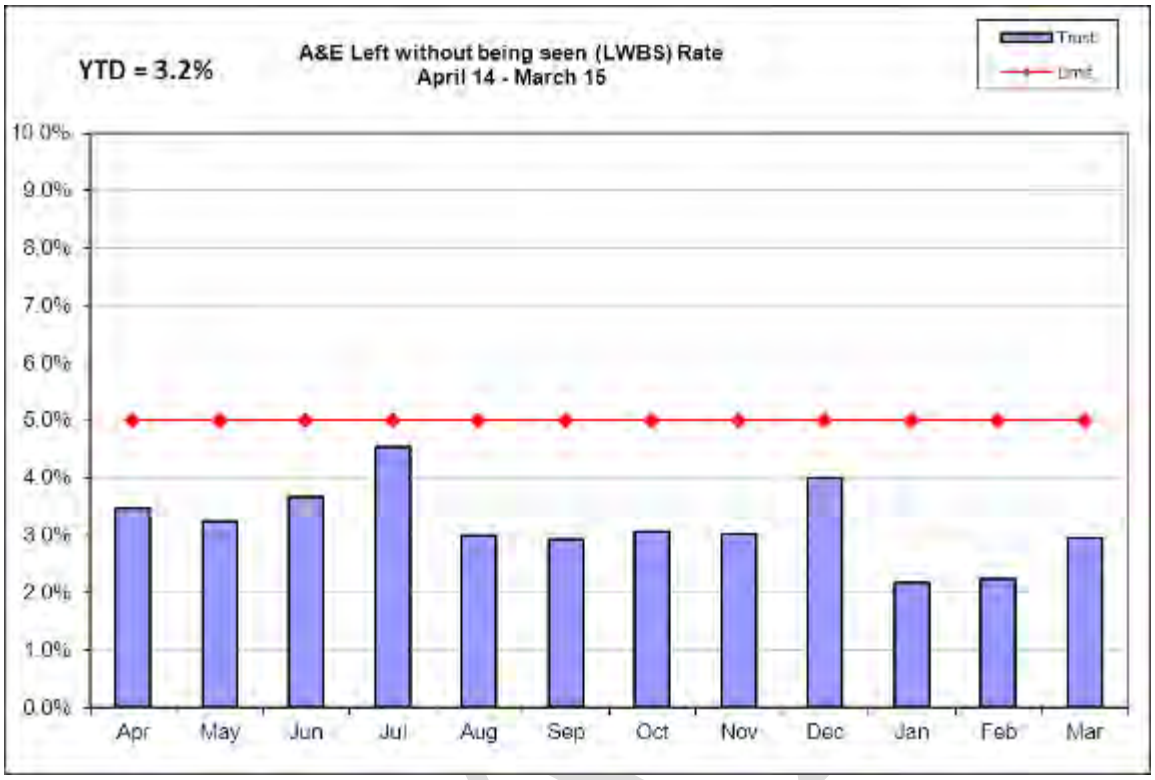


A&E Unplanned Re-attendance Rate – The Trust did not achieve this standard of less than 5% unplanned re-attendance rate at 5.8%, however, this is a 1.9% improvement on last year

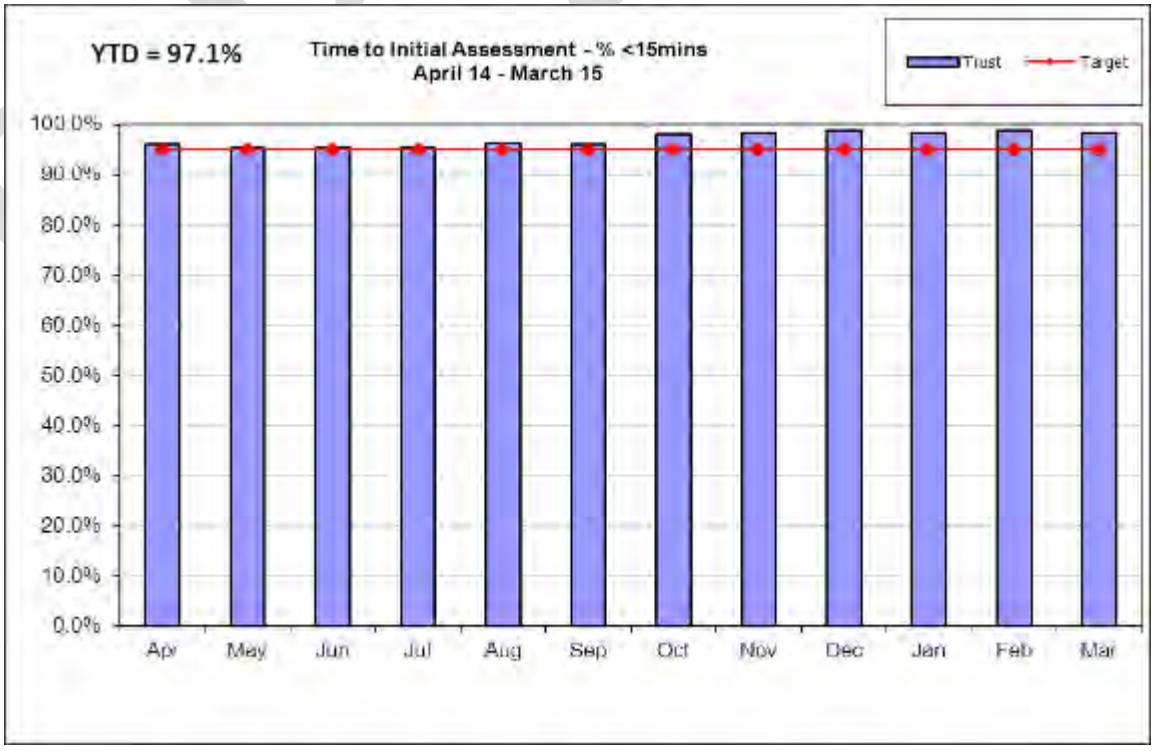


The trust has in place a System-wide Winter Plan, now extended to end April 2015 with focus on effective and timely discharge of medically fit for discharge patients and clear & rapid escalation of delays involving other agencies. The trust also has a number of initiatives in partnership with community colleagues for non-elective admission avoidance following trauma, stroke and repiratory conditions. There is a fully operational Urgent Medical Amublatory Unit at Maidstone with a similar service planned for Tunbridge Wells Hospital to enable follow up review of patients initially seen and discharged from the Accident & Emergency Department.

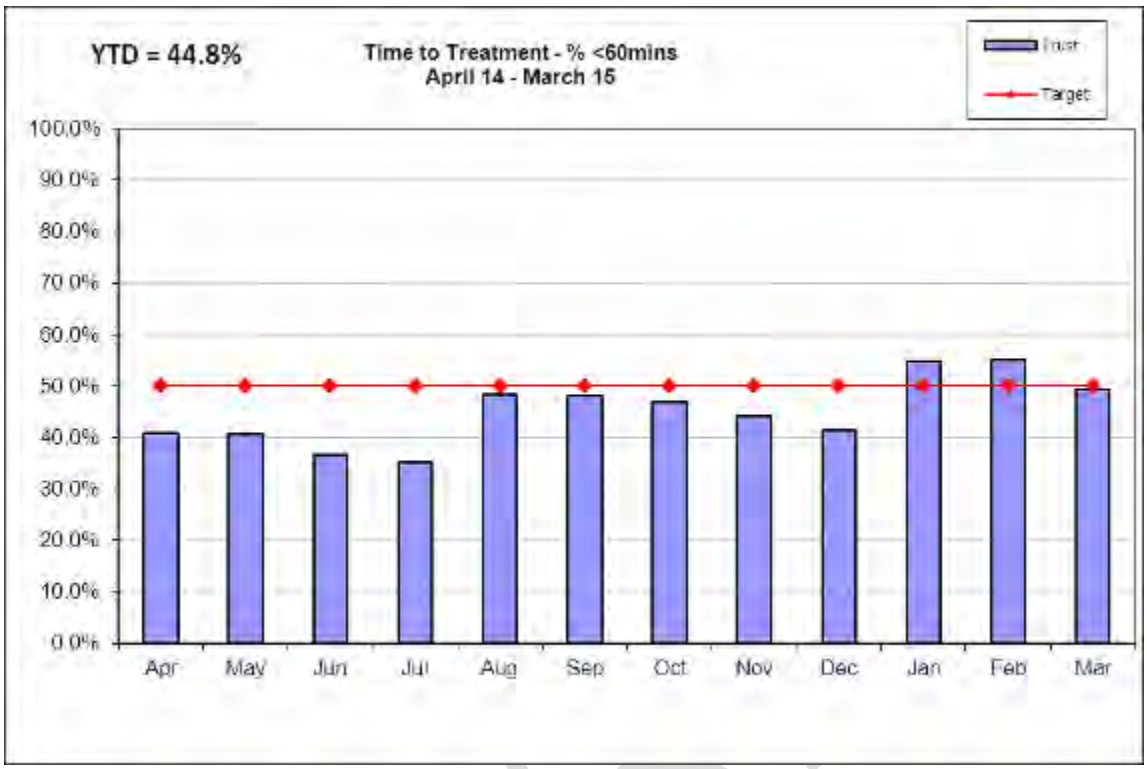
A&E Left without being Seen Rate – The Trust achieved this standard, of less than 5% of patients leaving its A&E Departments without being seen at 3.2%.



A&E Time to Initial Assessment <15 minutes – The Trust achieved this standard of 95% of patients arriving in its A&E Departments being assessed within 15 minutes of arrival at 97.1%.

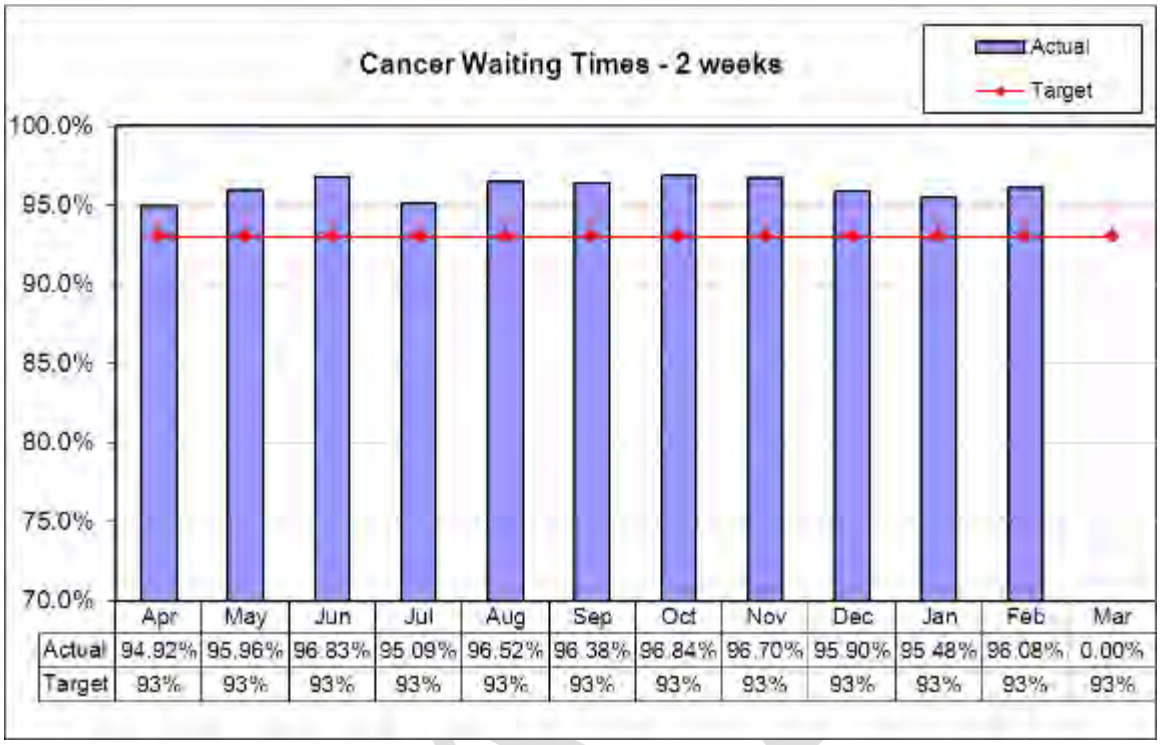


A&E Time to Treatment <60 minutes – The Trust did not achieve this standard of 50% of patients arriving in its Emergency Departments being treated within 60 minutes of arrival at 44.8%. This is a 6.5% improvement on last year.



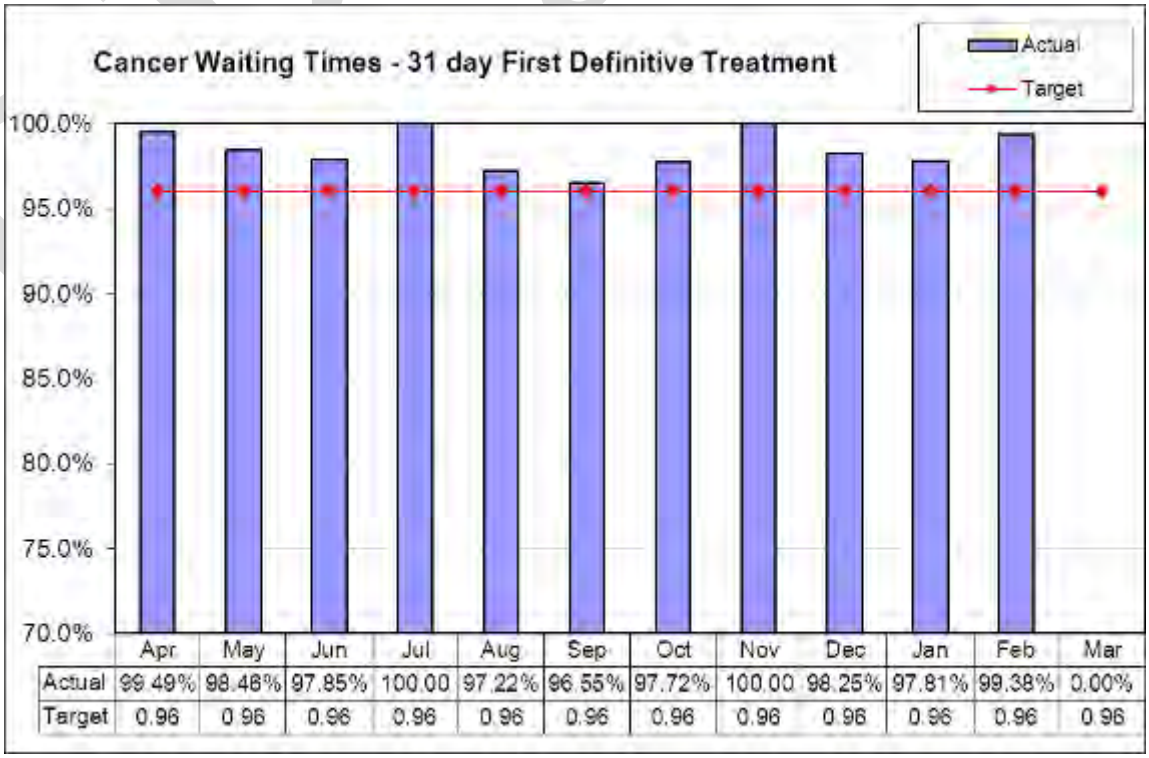
A rapid assessment and treatment model has been implemented to improve the flow of patients through the A&E department and development is underway of frail elderly pathways for emergency presentations

Cancer Waiting Time Targets - 2 weeks from referral – The Trust has achieved this standard ensuring that 93% of patients with suspected cancer were seen within two weeks.



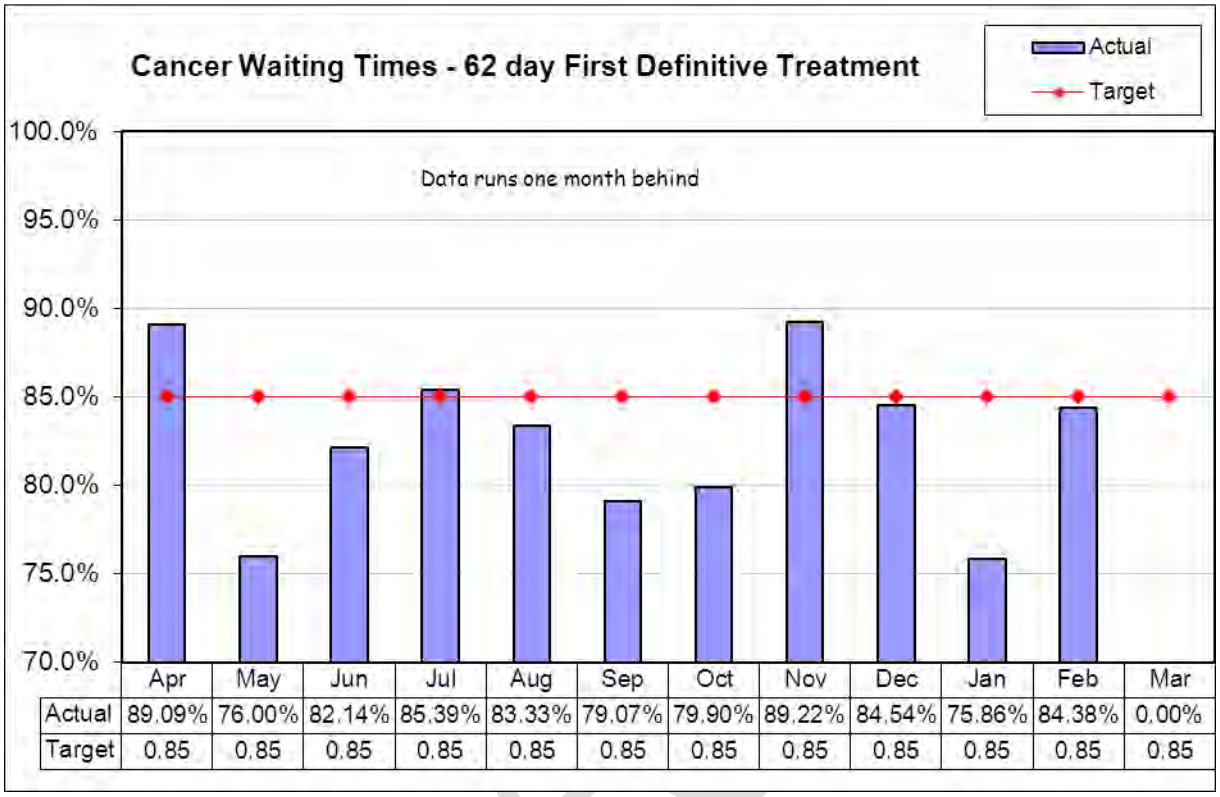
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	94.92%	95.96%	96.83%	95.09%	96.52%	96.38%	96.84%	96.70%	95.90%	95.48%	96.08%	0.00%
Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

Cancer Waiting Time Targets – 31 Day First Definitive Treatment – The Trust has achieved this standard ensuring that 96% of patients who needed to start their treatment within 31 days did so.



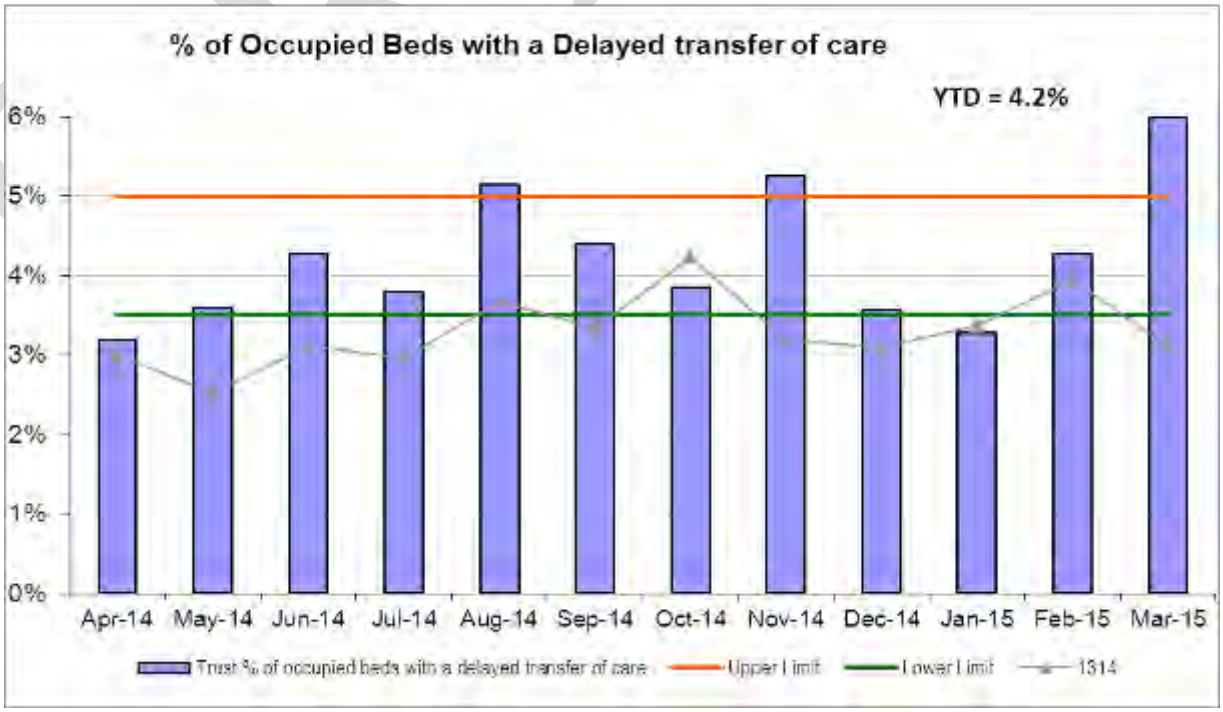
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	99.49%	98.46%	97.85%	100.00	97.22%	96.55%	97.72%	100.00	98.25%	97.81%	99.38%	0.00%
Target	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96

Cancer Waiting Time Targets – 62 day First Definitive Treatment – The Trust did not achieve this standard of 85% of patients who needed to start their first definitive treatment within 62 days did so (expected 82%).

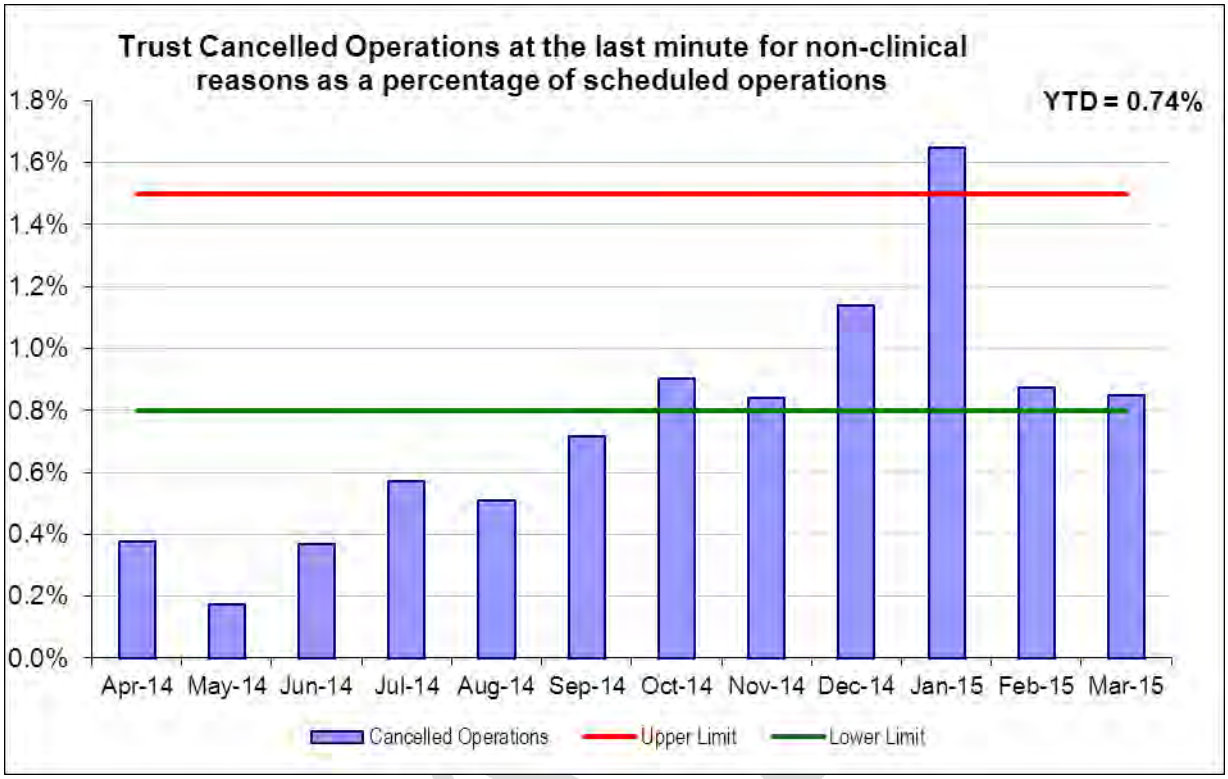


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	89.09%	76.00%	82.14%	85.39%	83.33%	79.07%	79.90%	89.22%	84.54%	75.86%	84.38%	0.00%
Target	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85

Delayed transfers of care – The Trust did not achieve this standard of Delayed transfers of care remaining below the national limit of 3.5% for the year at 4.2%.



Cancelled operations – The Trust achieved the cancelled operations national standard of 0.8% for the sixth year running.



National Indicators

There are a variety of national indicators highlighted within the Outcomes Framework that each Trust is required to report on.

Maidstone and Tunbridge Wells NHS Trust considers that this data is as described for the following reasons:-

The Trust has achieved level 2 for the Information Governance Toolkit. As part of this process audits of clinical coding and non-clinical coding have been undertaken as well as completing the "completeness and validity checks".

In addition three key indicators are selected and audited each year as part of the Board's assurance processes. This is over and above the indicators audited as part of the audit of these quality accounts.

The NHS Outcomes framework has 5 domains:

1. Preventing people from dying prematurely
2. Enhancing the quality of life for people with long-term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm

Domain	Prescribed data requirements **The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to —**	2013/2014 local and national data	2014/2015 local and national data	2012/2013 National average
1 & 2	(a) the value and banding of the summary hospital-level mortality indicator (~~–~~SHMI") for the trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. *The palliative care indicator is a contextual indicator.	100.30 Jul 12 – Jun 13 *(Better)*	101.50 Jul 13 – Jun 14 (Worse)	National average is 100
3				
	i) groin hernia surgery	0.082	0.084	0.085
	ii) varicose vein surgery	N/A	N/A	0.225
	iii) hip replacement surgery	0.433	0.440	0.438
	iv) knee replacement surgery	0.280	0.304	0.318
	during the reporting period *(See below for explanation of reporting data)*	(Apr 11 to Mar 12)	(Apr 12 to Mar 13)	(Apr 12 to Mar 13)
3	the percentage of patients aged— i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.***1**	**Trust** 13.1% **Elective** 5.8% **Non-Elective** 11.3%	**Trust** 10.9% **Elective** 5.5% **Non-Elective** 11.6%	(Q1 13/14 position) **Elective:** 6.81% **Non-Elective** 14.10%
4	the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	69	77	77

Domain	Prescribed data requirements **The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to —**	2013/2014 local and national data	2014/2015 local and national data	2012/2013 National average
5	the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	95.2%**2**	95.5%	96.0% (Jan 2015)
5	the rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	15.7 ***3**	12.0	15.5
5	The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, The number and percentage of such patient safety incidents that resulted in severe harm or death. *(See below for explanation of reporting data)*	5743 2.0%	6173 1.6%	

*1 Local and national data is based on 30 day re-admission.
*2 Q4 not yet published so taken from local data.
*3 Figure based on local data as national data not published at time of report. National denominator figure derived from HES data, local denominator derived from KH03 return.
*4 Local % based on incident occurrence date during 2012/13. National % based on incident closure date during 2012/13.

Explanation re PROMS:
A patient reported outcome measure (PROM) looks at the impact of a procedure on a patient's lifestyle. This is separate to any surveys which look at the experience a patient has during their stay in hospital – highlighted above. This may be positive or negative. Depending on the type of surgery the patient is asked about specific activities before and six months after the procedure. The results are analysed to provide a numerical value indicating whether or not there has been an improvement.

From the four surgical procedures for which PROMs data is captured, the findings were:

Groin Hernia – 44 returns of which 25 reported an improvement on lifestyle following the operation[6].
Hip Replacement – 161 returns of which 142 reported an improvement in lifestyle[1].
Knee Replacement – 195 returns of which 150 reported an improvement in lifestyle[1].
Varicose Vein – insufficient number of questionnaires returned to be able to quantify the data[1].

The clinical director for T&O has begun to drill into the patient identifiable data to ascertain where improvements can be made.

Explanation re incidents
The proportion of patient safety incidents which resulted in severe harm or death for 2014/15 was 1.6% (2.0% 2013/14). This is calculated by dividing the number of serious and catastrophic incidents reported by Maidstone and Tunbridge Wells NHS by the total number of patient safety incidents 6173 (5743 for 2013/14)

[6] EQ-5D Index HSCIC April 2012 to March 2013, provisional data (published 08 May 2014) returned records = modelled records.

How performance compares with the national average for this indicator where the data is available and meaningful:
The latest report from the National Reporting and Learning System (NRLS), which was published in March 2015 and covers the period of 01/04/14 to 30/09/14, provided a reporting rate of 22.9 compared to 6.04 the same time last year. The rate of incidents reported is per 1,000 bed days. This places the Trust within the lowest 25% of reporters

Improving performance
Maidstone and Tunbridge Wells NHS Trust is taking the following actions to improve performance, and so the quality of its services. Monitoring and actions to further improve include the following:

Mortality data
We continue to review mortality data bi-monthly at the Trust's Standards Committee which is chaired by the medical director. A trust-wide morality review group meets monthly to review mortality by speciality.

C difficile
We have a rolling programme of audits to ensure three key indicators are reviewed every year in relation to C difficile, 18 week referral to treatment and A&E four-hour waits.

Serious Incidents
With respect to serious incidents involving severe harm and death; we continue to monitor all such incidents via an executive-led panel. This reviewed the root causes of incidents to ensure that actions can be put in place to mitigate the risk of recurrence of similar events. The learning is disseminated across the Trust through directorate and corporate governance committees.

Scrutiny
Along with the key priorities for the year these indicators are scrutinised by the relevant governance committees and the Quality & Safety Committee.

Additional areas of significant improvement during 2014/15

Enhanced Recovery and Enhancing Quality: The Trust is exceeding all targets in Enhanced Recovery for Elective Colorectal, Gynaecology and Orthopaedic pathways. Colorectal surgery improvements include giving specific information to patients regarding the operation and administering Carbohydrate drinks preoperatively. Gynaecology improvements include ensuring the correct/timely antibiotics are given and clear discharge instructions are provided. Orthopaedic improvements include information related to the operation and managing to mobilise within 24 hours of their operation.
A new pathway in Caesarean Section is commencing exploratory work.

The Enhancing Quality pathways of Community Acquired Pneumonia and Heart Failure are matching their improvement targets – Community Acquired Pneumonia (as a new pathway) is currently base lining results from this year to set a target for improvements next year. Heart Failure results show improvement over the last year and matches the improvement target set. More patients are receiving, among other care measures, the right information about their condition and how to manage it at home post discharge. New pathways of Acute Kidney Injury and Chronic Obstructive Pulmonary Disease have commenced data submission with another pathway in Atrial Fibrillation planned.

The Trust achieved their targets for the Kent, Surrey and Sussex (KSS) Quality Award for 2013-14.

Maidstone and Tunbridge Wells Trust has been recognised by Kent, Surrey and Sussex (KSS) Academic Health Science Network (AHSN) for its performances across **ALL** pathways involving EQ and ERP for the period 2012-2014 with the **Award as 'Most Consistent Top Performing Acute Provider' (against all Acute Trusts in KSS)**

Safety Thermometer – The Safety Thermometer is a national reporting system that requires trusts to undertake a point prevalence audit of all inpatients at ‗apoint in time' each month. This is normally done on the third Wednesday of each month.

The Safety Thermometer reviews four key harms that are deemed to be indicators of a safe organisation. These harms are pressure ulcers, falls with harm, catheter associated urinary tract infection and new VTE.

The national benchmark is 92% harm free care. The Trust has been consistently achieving in excess of this throughout the year. The Trust included Safety Thermometer in its annual audit programme to validate the process of the data collection and validation. The audit provided the Trust with significant assurance that processes for data collection and validation were appropriate and accurate.

The Trust has seen a sustained improvement in hospital acquired pressure ulcer prevention. Safety Thermometer data puts us well above average nationally (need to check year end position on national safety thermometer).

The Trust has worked with Salford Hospital, as well as publishing in national nursing journals, to share the learning around pressure ulcer prevention.

The Trust has taken part in a national pressure ulcer reporting research project to both contribute to the wider learning, and to gain further assurance that our reporting systems are effective and accurate.

The Trust is also part of the Patient Safety Collaborative under the direction of the Academic Health Science Network and NHS England to ensure that our good practice is shared, and to ensure we can learn further from our colleagues.

Infection Prevention and Control: The Trust had 28 cases of C. difficile (35 previous year). This is a 20% reduction from last year‘s out turn. The rate of infection was 12 per 100 000 bed days (the national benchmark is 15.7 per 100 000 bed days). As a result of the innovative work done to reduce C. difficile within the Trust, the Infection Prevention and Control team were runners up, and highest performing acute Trust, in the Infection Prevention Society‘s Team of the Year awards in 2014

Part 4
Appendices A, B and C

Appendix A

43 National reports were published in 2014/15 with action to be taken in 2014/15.

National Annual reports published March 2014 - April 2015	Report Received	
Peri and Neonatal		
Neonatal Intensive and Special Care (NNAP) 2013	Yes	Report received October 2014. Documented consultation with parents/carers needs to be improved within medical notes, so that the information gets transferred onto Badger.net for data submission for NNAP.
Children		
National Paediatric Asthma Audit 2013	Yes	Report received April 2014. Asthma awareness training sessions have been implemented; these are attended by all clinical staff working within paediatrics. Patient information leaflets and written asthma plans have been developed and are now in use.
National Childhood Epilepsy 12	Yes	Report received December 2014. With specialty for assessment and action plan.
MBRRACE-UK Maternal infant and prenatal programme.	Yes	Report received December 2014. With specialty for assessment and action plan.
National Pregnancy in Diabetes Audit 2013	Yes	Report received August 2014. Patient training on the management of pregnancy with type 2 diabetes to be updated.
UK IBD Paediatric Audit	Yes	Report received August 2014. With specialty for assessment and action plan.
Acute Medicine		
CEM Severe Sepsis and Septic Shock in A&E	Yes	Report received August 2014. New Staff training includes- the need to give and document oxygen administration, prompt IV fluid administration, taking and recording of vital signs, the need to take blood cultures before the patient leaves A&E, monitoring of urine output and prompt administration of antibiotics.
CEM Asthma in children in A&E	Yes	Report received January 2015 and with specialty for action plan development.
CEM Paracetamol overdose in adults in A&E	Yes	Report received January 2015 and with specialty for action plan development.
BTS Pleural Procedures 2014	Yes	Report received October 2014 and with specialty for action plan development.
Acute Care		
NAP 5 Awareness under Anaesthesia National Audit	Yes	Report received September 2014. Assessment shows that the trust is fully compliant with recommendations made in the national report. All theatres are equipped with peripheral nerve stimulators to monitor neuromuscular blockade. Monitoring for the depth of anaesthesia is undertaken to ensure that awareness does not occur. There is a policy for the management of any reported cases of awareness under anaesthesia. (No cases were reported from the trust during this period). Information leaflets are given to patients as part of the consenting process.
National Cardiac Arrest Audit	Yes	Quarterly reports are received and reviewed within the specialty.

National Annual reports published March 2014 - April 2015	Report Received	
		Survival rates at Maidstone & Tunbridge Wells were shown to be considerably above the predicted levels. Mandatory training sessions will continue to be held.
National Breast Screening Pathology	Yes	Report received October 2014. With specialty for action plan development
National Care of the Dying (NCDAH) Round 4	Yes	Report received May 2014. End of life care steering group chaired by the Chief Nurse. Best practice guidance written and in use included prescribing guidance of medications for the five key symptoms at end of life.
Long Term Conditions		
National Adult Diabetes Audit 2013	Yes	Report received January 2015 and with specialty for action plan development.
Falls and Fragility Fractures audit	Yes	Report received September 2014. Post-falls assessment checklist developed to assist doctors in patient care post falls. Ad-hoc and formal training for clinical staff on reduction of inpatient falls.
National Review of Asthma Deaths	Yes	Report received April 2014. All patients with asthma attending A&E need to be referred to the Respiratory Nurse Specialists and advised to see their GP. All people with asthma should be provided with a personal asthma action plan that details their own triggers and current treatment.
National BSR Gout Audit 2013	Yes	Report received April 2014. Increase use of ultrasound to determine crystal deposits in joints.
National UK IBD Biologics 2013	Yes	Report received August 2014. Ensure sites participate in either the biologics audit or the PANTS research project. New IBD database being set up to allow for monitoring of follow-up and disease activity.
National UK IBD 2012/13 Round 4	Yes	Report received June 2014 and with specialty for action plan development.
National Chronic Obstructive Pulmonary Disease (COPD)	Yes	Report received February 2015. Development of the Early Supported Discharge Service as per CCG commissioning. Business case planning to improve spirometry services for 2015/16.
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Report received December 2014 and with specialty for action plan development.
National Adult Diabetes Inpatient Audit (NaDIA)	Yes	Report received June 2014. Diabetes foot assessment form has been implemented and in use for any patients attending with diabetes. Expanding clinical education sessions to include other clinical areas that do not specialise in diabetic care so that everyone has a general understanding of the management of the adult diabetic patient.
Elective Procedures		
Adult Critical Care Case Mix Programme (ICNARC)		Reports received June 2014. With specialty for assessment and reporting
National Emergency Laparotomy Audit (NELA) Organisational Report	Yes	Report received and reviewed July 2014. There is full image linking facility with the local vascular, cardiothoracic and neurosurgical units. There are protocols for transfer that are agreed by the CCG and are associated with SLA contracts. Our regional trauma unit is at King's. Patients admitted under the surgical teams care remain under their care at all times until formally accepted by another team and this is documented in the notes and via a ~~-w~~hite card" system. The on-call teams are encouraged to use predictor of mortality and morbidity both pre and post operatively for all emergency patients. This is not universally used at

National Annual reports published March 2014 - April 2015	Report Received	
		present and will require further education and reinforcement. All emergency activity of any age is audited regularly and the results discussed at the monthly surgical clinical governance meetings
Cardiovascular Disease		
National Coronary Angioplasty 2012	Yes	Report received July 2014. Operators reminded to complete Tomcat data fields for ‗risk factors', creatinine levels and ‗discharge date/status'.
MINAP 2013/14	Yes	Report received January 2014 and with specialty for action plan development.
Cardiac Arrhythmia 2013 (CRM)	Yes	Report received January 2015 and with specialty for action plan development.
Heart Failure Audit 2013-14	Yes	National report still not available on website.
Elective Surgery (PROMS)	Yes	Reports received. With specialty for assessment.
Cancer		
Bowel Cancer (National Bowel Cancer audit Programme)(NBOCAP) 2013	Yes	Report received March 2015 and with speciality for action plan development
Head & Neck Cancer (DAHNO) (8th report)	Yes	Report received July 2014. Plan to improve data entry as detailed in Maidstone & Tunbridge Wells Hospital Head and Neck Multi Disciplinary Team (MDT) 2014 work plan
Lung Cancer (National Lung Cancer Audit) 2013	Yes	Report received March 2015 and with speciality for action plan development
Oesophago-gastric cancer (NOGCA) 2013	Yes	Report received December 2014 and with speciality for action plan development
Trauma		
Severe Trauma (Trauma Audit & Research Network) TARN 2014	Yes	Following a successful pilot the Trauma Assisted Discharge Service (TADS) has been expanded to include all trauma patients. This allows patients to return to their own home as opposed to temporary accommodation or community hospitals with the on-going therapy support required for up to 4 weeks. Trauma Physiotherapists now fit all standard TLSO braces and stock is kept on the ward allowing patients to be fitted and treated on the day. An Ortho-plastic service has been set up at TWH with joint operating with Consultants. Template for poly-trauma Electronic Discharge Notification to be developed to identify all injuries on discharge summary.
National Joint Registry: Hip and knee replacements 2014	Yes	Report received September 2014. With specialty for action plan development.
Hip Fracture (National Hip Fracture Database) (NHFD) 2014	Yes	Report received September 2014. Trust-wide action plan produced from the Hip Fracture Working Group. Fast track bloods and diagnostics to enable fast track through Emergency Department to Ward. New patient information leaflets produced. Pressure damage and mortality reviews undertaken to ensure they remain within or below the NHFD national %.
Heavy Menstrual Bleeding Audit	Yes	National report received August 2014. With specialty for action plan development
Sexual Health		
BASH/BHIVA 2013. Survey of partner	Yes	Report received May 2014 with specialty for action plan

National Annual reports published March 2014 - April 2015	Report Received	
notification for HIV patients		development
National audit of management of anogenital herpes	Yes	Report received December 2014. Patients offered treatment at presentation of clinical symptoms began within the last five days. Counselling and support to be offered to patients with suspected clinical herpes. Delivery plan in place.
Patient Surveys		
National Accident and Emergency Department Survey 2014	Yes	Report published November 2014. Report received and disseminated. With specialties for action plan development
Confidential Enquiries		
Tracheostomy Study	Yes	Report published 13 June 2014. 25 Recommendations- Theatres/CCU, ENT and care on the general wards. A Task and Finish Group has been set up to share and standardise all policies and documentation used in the care of these patients. A programme of training sessions on the care of tracheostomies has been set up. When patients are transferred into the trust the tracheostomy tubes will be changed to trust standard sizes as soon as possible upon their arrival. Bedside capnography planned to be made available across the trust and training programmes set up. A WHO type document specific to the insertion of tracheostomy has been developed for the use on ITU. A tracheostomy ~~-p~~assport" has been developed for use with each patient to record all data – to be used when patients are transferred between levels of care.
Lower Limb Amputation	Yes	Report published November 2014. The topic covered by this report is not relevant to the trust as this group of patients are treated in a dedicated vascular unit. The trust submitted organisational data. The report was reviewed and assessed - only one recommendation was relevant. If any of these patients are admitted to the trust via A&E they would be assessed and then transferred to a vascular unit for treatment by a dedicated team within the timeframe specified

Appendix B

Updated actions on reports received during March 2013 to April 2014. These have previously been reviewed and action plans developed. These action plans have been reviewed and this report shows which actions have been completed and implemented.

National Annual reports published March 2013 - April 2014	Report Received	Improvements
Peri and Neonatal		
Neonatal Intensive and Special Care (NNAP) 2012	Yes	All babies with a gestational age of <32 weeks or 1501g at birth undergoing 1st retinopathy or prematurity (ROP) results have improved since the use of stickers and the new database.
Children		
National Paediatric Asthma Audit 2012	Yes	Patient Information leaflets and written asthma plans have been developed and are now in use.
National Patient level Insulin pump audit	Yes	Discussion regarding more consultant hours dedicated to diabetes. A business case is being produced regarding cGMS to be purchased as per the standard.
Paediatric Pneumonia 2012	Yes	A more judicious allocation of IV antibiotic therapy in CAP with a senior review on ward rounds to aim for oral therapy.
Child Health (CHR-UK)	Yes	Clinic letters have been made more comprehensive. A business case for a specialist Epilepsy Nurse has been written.
A&E Medicine		
CEM Feverish Children in A&E	Yes	Report received April 2013. Paediatric A&E card redesigned to ensure recording of blood pressure and GCS (Glasgow Comma Score). New information leaflet being designed to give parents advice about what to do after their feverish child is discharged from A&E.
CEM Renal Colic in A&E	Yes	Report received April 2013. A&E staff ensure pain scores are recorded regularly and reassessed after analgesia is given.
CEM #NOF in A&E	Yes	Report received April 2013. Development of nursing role to include hip x-ray requests when clinical findings indicate an x-ray is necessary. A&E staff to ensure pain scores are recorded regularly and reassessed after analgesia is given.
Seizure Management (NASH2) 2013	Yes	Report received January 2014. Referral form updated to ensure key information available to neurology team. Additional training for medical staff to ensure GCS and temperature recorded and that patients receive a senior review prior to discharge.
CEM Consultant Sign-Off in Emergency Departments	Yes	Report received June 2013. All A&E staff to ensure patients attending A&E are seen / discussed with a senior doctor prior to their discharge.
National Potential Donor Audit Round 2	Yes	Report received August 2013. To improve rates of organ donation staff education of organ donation with e-learning made compulsory learning for trust new doctors. E-learning package available on website. Supporting ongoing medical and nursing staff organ donation education.
Adult community acquired pneumonia	Yes	National comparative data received July 2013. Education of clinicians to ensure x-ray requests for suspected Community Acquired Pneumonia are clearly marked as urgent. CURB65 scores to be reviewed for

National Annual reports published March 2013 - April 2014	Report Received	Improvements
		each patient to ensure treatment with appropriate antibiotics. Educate junior doctors that patients with high predicted mortality need to be referred to a senior clinician to ensure timely and appropriate referral to Critical care.
Emergency use of Oxygen	Yes	Report received December 2013. Junior doctors to ensure that oxygen therapy is recorded on the prescription chart and target range is set.
Non-invasive ventilation – adults 2013	Yes	National comparative data received July 2013. Educate SeCAMB and A&E to ensure no more than 28% oxygen given prior to first ABG. New NIV proforma produced and in use with prompts to ensure ABG's taken at regular intervals, a treatment / escalation plan is in place.
Long Term Conditions		
National Adult Diabetes Audit 2012	Yes	Report received April 2013. New clinic proforma being designed to ensure better recording of the 8 care processes (monitoring of HbA1c level, blood pressure, cholesterol, serum creatinine, urine albumin, foot surveillance, BMI and smoking status).
National Dementia Round 2	Yes	Report received June 2013. Training programme with competencies now available for all clinical and non-clinical staff working with patients with dementia. Trust now signed up to Dementia Action Alliance as dementia friendly. All staff now receives basic awareness of dementia training on induction days.
Adult Diabetes Inpatient Audit (NADIA) 2012	Yes	Report received October 2013 and with specialty for action plan development.
National Parkinson's Disease 2012/13	Yes	Report received October 2013. New PD nurse appointed to allow for additional clinics so patients can be reviewed at 6-12 month intervals. New consultation checklist produced to endure there is documented evidence of information regarding driving, occupational hazards, end-of-life care issues given to patients.
National BSR Gout Audit 2013	Yes	Report due January 2014 not received until April 2014. Increase use of ultrasound to determine crystal deposits in joints.
Elective Procedures		
Adult Critical Care Case Mix Programme (ICNARC) (Round 2)		Report received June 2013 with specialty for action plan development.
Cardiovascular Disease		
National Cardiac Interventions (eg angioplasty)	Yes	Report received August 2013. To improve data completeness, operators are reminded to complete risk factors, creatinine levels and discharge status on TOMCAT system.
National UK IBD Biologics 2012	Yes	Report received August 2013. Appointment of a new Consultant Gastroenterologist with an interest in IBD to be able to increase clinic capacity for review of patients at 3 and 12 months after starting biologic agent. Consultant now in place.
National Cardiac Rehabilitation Audit	Yes	Report received September 2013. Wording in patient induction updated to encourage attendance at health education sessions.
MINAP 2012/13	Yes	Report received October 2013. Educate junior staff on the importance of secondary medication and the need to check against the list of 5

National Annual reports published March 2013 - April 2014	Report Received	Improvements
		secondary prevention therapies.
Cardiac Arrhythmia 2012	Yes	Report received October 2013 and with specialty for action plan development.
Heart Failure Audit	Yes	Report received December 2013. Continue education of clinical staff to ensure details of contraindications to ACE / ARB and beta blockers are documented.
Cancer		
Bowel Cancer (National Bowel Cancer audit Programme)(NBOCAP) 2013	Yes	Report received July 2013 and with specialty for action plan development.
Head & Neck Cancer (DAHNO) (8th report)	Yes	Report received July 2013 and with speciality for action plan development. To improve data entry as detailed in Maidstone & Tunbridge Wells Hospital Multi Disciplinary Team 2013 work plan
Lung Cancer (National Lung Cancer Audit) 2013	Yes	Report received January 2014. High level of compliance. Low Median Survival to be reviewed more formally. Develop the Lung Cancer pathway to increase the proportion of patients receiving CT scan prior to Bronchoscopy.
Oesophago-gastric cancer (NOGCA) 2013	Yes	Report received June 2013. Data retained by Upper GI Clinical Nurse Specialist to be analysed. The functioning of the Multi Disciplinary Meetings to be closely monitored. Assurance of the formal basis of the referral service to University College Hospital (UCL) by directorate business team. Decision about the repatriation of the operative stage of the patient pathway will require a) plan for introducing this level of monitoring of individual surgeon's performance, b) require a strategy for the monitoring of impacts of minimally invasive techniques at the level of the individual operator
Trauma		
Severe Trauma (Trauma Audit & Research Network) TARN 2013	Yes	Report received April 2013. With specialty for action plan development
National Joint Registry: Hip and knee replacements 2013	Yes	Report received September 2013. With specialty for action plan development.
Hip Fracture (National Hip Fracture Database) (NHFD) 2013	Yes	Report received September 2013 Trust-wide action plan produced from the Hip Fracture Working Group. Protocol written for fast track beds for #NOF patients on trauma wards.
Heavy Menstrual Bleeding Audit	Yes	National report received August 2014. With specialty for action plan development
Sexual Health		
BHIVA 2012 – People with HIV not in care and survey of clinic policy and practice regarding retention in care.	Yes	Report received May 2013. Report reviewed but no actions required as data considered old and irrelevant at the time of specialty review.
BASH/BHIVA 2013. Survey of partner notification for HIV patients	Yes	Report received May 2014 with Specialty for Action plan development
Patient Surveys		
National Cancer Experience Survey 2012-13	Yes	Report published August 2013 Report received and disseminated. Currently sitting with directorates for action plan development.
National Inpatient Survey	Yes	Report published April 2013 Report received and disseminated. Currently sitting with directorates for action plan development.

National Annual reports published March 2013 - April 2014	Report Received	Improvements
National Maternity Survey 2013	Yes	Report published December 2013. Report received and disseminated. Currently sitting with directorates for action plan development.
National Chemotherapy Patient Experience Survey 2012	Yes	Report published February 2014. Report received and disseminated. Currently sitting with directorates for action plan development.
Confidential Enquiries		
Subarachnoid Haemorrhage (SAH)	Yes	Received November 2013 and reviewed in August 2014. These patients are assessed on admission and discussed with King's College Hospital; they are then transferred to a tertiary centre for specialist treatment. King's endeavour to admit patients with SAH within 24 hours of referral and treat within 14 hours. Clinical audits are in progress to review the process of examination, assessment and documentation. Two protocols for the care of SAH have been received from King's College Hospital with a view to standardising the trust protocol for this.

Appendix C

Summary of local audits undertaken during 2015/15 against NICE Guidelines

Audits of NICE Guidelines are an ongoing process of implementing change and measuring improvement until full compliance is achieved. The following table shows compliance against NICE Guidelines from local trust audits and the actions put in place to achieve full compliance. Where partial or non compliance is found, changes will be implemented and a re-audit will be undertaken.

Compliance has been assessed as: Fully compliant if all standards have been met. Partially compliant when >50% of the standards have been met. Non compliance is where less than 50% of the standards have been met.

NICE guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
Falls admissions re-audit Round 3 NICE CG's 21 and 161	Not compliant	A falls proforma has been introduced to aid assessment of older people admitted with falls. "Medication review" stickers were introduced to go on drug charts alerting healthcare professionals to patients at high-risk. A Falls Co-ordinator has also been employed to improve the management of patients at risk of falls. The falls pro-forma has now been integrated into the fractured neck of femur pro-forma and key elements are in the medical pro-forma.
NICE CG24 Network Audit of Small Cell Lung Cancer Patients including Patient Pathways and Outcomes	Partially compliant	Since the initial audit significant changes have been made to both the diagnostic pathways and organisation of the MDTs. There is also more capacity in terms of oncologists and chemotherapy to start treatment promptly. The unit is also now giving concurrent chemo radiotherapy in limited stage patients.
NICE CG 179 Management of Pressure Ulcers	Compliant	Patients are being risk assessed on admission and regularly reviewed during their hospital stay. All at risk patients are nursed on appropriate pressure relieving systems. This forms part of a bi-annual audit programme into the management of pressure damage.
Rehabilitation after Critical Illness NICE CG83	Not compliant	A risk assessment and trigger tool is being developed for use by therapy services at point of discharge from critical care. A patient information leaflet is being updated detailing information about their critical care stay, their illness, the treatments they have undergone, and the short- and long-term physical and non-physical problems they may experience An ITU Follow up service is now in place This NICE guidance is currently undergoing revision based on evidence that suggests some of the proposed standards do not result in better patient or economic outcomes
NICE CG84 - Re-audit of the management of children with Diarrhoea & vomiting	Partially compliant	Improvements have been demonstrated; however there is still a need to practice naso-gastric tube insertion for vomiting children not able to keep fluids down which can avoid unnecessary IV fluid management and less trauma to children. Staff training is in place.
NICE GC67 – Lipid Modification	Compliant	No problems identified in relation to Maidstone and Tunbridge Wells Outpatient clinics in respect of lipid management.
NICE CG 137 The use of EEG in the diagnosis of Epilepsy in Children	Partially compliant	EEGs were done in a timely manner. Some EEG's were felt to be unnecessary, this did not pose any risk to the patients but may lead to further unnecessary expensive investigations being carried out.
NICE CG48 - Secondary prevention in primary and secondary care for patients following a myocardial infarction - re-audit	Partially compliant	The main area of non-compliance identified was with the routine prescription of beta-blockade following 'enzyme-driven' MI's where patients have sustained minimal myocardial damage. This is a clinically controversial area and whilst recommended as part of NICE guidance the evidence base is very weak and this practice is not supported by a substantial body of cardiologists.
NICE TA071 & 152	Non compliant	The reason for non-compliance with the recommendations needs to

NICE guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
Use of Coronary Stents at TWH - reaudit		be fully documented in the patient summary without this it is difficult to ascertain if there are genuine reasons for any clinical non-compliance.
NICE TA94 - Cardiovascular disease - statins	Compliant	100% compliance with standard ensuring patients with Cardiovascular Disease are prescribed statin therapy.
NICE TA187 - Crohn's Disease - infliximab @ TWH re-audit	Partially compliant	A new Consultant Gastroenterologist has been appointed. A business case for a new Irritable Bowel Disease Clinical Nurse Specialist has been submitted to assist with the workload to re-assess patients at least every 12 months. Fully compliant with remaining clinical guidelines.
NICE CG144 - Suspected DVT management and appropriate use of doppler ultrasound - diagnosis only	Not compliant	The audit shows 100% sensitivity in identifying DVT's using the single Wells Score. Trust is currently requesting considerably more scans than required. A new Doppler Ultra Sound request form is being developed which includes prompts to correctly calculate the Two-level Wells Score to reduce the number of unnecessary scans.
NICE TA195 - Treatment of rheumatoid arthritis after the failure of a TNF inhibitor (Abatacept only. Criterion 4, 6 and 7)	Compliant	100% were treated in accordance with the NICE guideline regarding the duration of treatment with abatacept, frequency of follow-up in clinics and patient response to abatacept.
NICE CG79 - Management of patients with newly diagnosed rheumatoid arthritis re-audit	Partially compliant	GP training sessions have been carried out on the importance of early referral to the Early Arthritis Clinic so patients seek help earlier. An early arthritis pathway is being developed to formalise the treatment of these patients.
NICE CG174 - Intravenous Fluid therapy in Adults in hospital	Not compliant	A teaching sessions on IV fluid management as they relate to the NICE Guidelines is being developed. Trust guidelines on fluid management are being updated in line with the NICE guidance
NICE CG 92 - Compliance with low molecular weight heparin for VTE prophylaxis in patients with lower-leg immobilization.	Not compliant	Patients with lower limb plasters are not always being prescribed with Low Molecular Weight Heparin (LWMH) when discharged from A&E. Clinicians to use the Trust Lower Limb Mobilisation Pathway and NICE Guideline to identify at risk patients requiring LWMH upon discharge.
NICE CG156 Re-audit of Fertility (Hycosy): Assessment and treatment for people with fertility problems	Compliant	Progressive improvements were demonstrated. A new referral pathway has been introduced to speed up the investigation phase. This has lead to improvements in the time patients are seen in clinics and clinics are being more effectively run.
NICE CG37 - Audit of the management of routine postnatal care of women and their babies	Partially compliant	The maternity service has appropriate procedures for handover of care and there is a structured programme for supporting breastfeeding. The Postnatal Care Record document is being reviewed and amended to prompt and encourage the documentation of care planning and discussions with the mother, including those relating to advice about signs and symptoms and contact details
NICE CG 55 - Documentation of Intra-partum care given to women at Maidstone Birth Centre. Re-audit	Compliant	Following additional training sessions on documentation, this audit demonstrates a significant improvement in documentation at the Birth Centre with all standards now being met.
NICE CG 55 - Re-audit of the management of severe (>2 litres) postpartum haemorrhage	Partially compliant	A skills training programme has been developed and is in progress as part of ongoing Patient Safety Measure programme. Full compliance with recording of measures undertaken including surgical measures.
NICE TAG 156 - Routine antenatal anti-D prophylaxis for women who are rhesus D negative audit	Compliant	All patients received information leaflets and received Anti-D appropriately.
NICE CG 107 -Antenatal care, delivery & outcome for women with a raised	Partially compliant	Local protocol now updated to state that patients with a BMI greater than 30 should have their scan booked towards the end of the 19-20+6 week window for optimal views, using the highest quality

NICE guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
BMI		machines, optimising settings for obese patients.
NICE IPG 144 - An audit of the use of Cell Saver in Obstetrics	Partially compliant	Use of cell saver was shown to be appropriately used, clinically safe and cost effective.
NICE CG064 - Prophylaxis against infective endocarditis	Partially compliant	Stickers to be put on patients notes to detail written and verbal information given to patient. Clinical outcomes were in line with this NICE Guideline.

Part 5
Stakeholder feedback

1. West Kent Clinical Commissioning Group
2. Health Overview and scrutiny Committee – Kent County Council
3. Healthwatch Kent
4. Independent Auditors' Limited Assurance Report
5. Statement of directors' responsibilities

West Kent Clinical Commissioning Group comments on the 2014/15 Quality Account for Maidstone and Tunbridge Wells NHS Trust

NHS West Kent CCG have continued to support MTW in their quality improvements. I consider we have a strong, open and honest relationship that enables us to challenge appropriately with a shared aim to improve patient care.

The past year has seen some really good work on ‗Duty of Candour' by the Trust, a statutory requirement in response to the Francis Inquiry. This demonstrates the Trust's keenness to support staff to be honest, open and truthful in all dealings with patients and public. Good work has also been seen in the clinical governance agenda, the publication of the Governance Gazette for staff shows MTW's ambition to have a consistent approach towards clinical governance and sharing of good practice.

The result of the CQC inspection of October 2014 was disappointing as they were assessed overall as ‗Requires Improvement'. The Trust held a Quality Summit in January 2015, which the CCG attended. MTW have responded to the report with a robust quality improvement plan which they have been keen to share with the CCG who will, alongside the CQC, have oversight of its completion.

Patient flow has been a significant challenge to MTW over the past 6 months, requiring the use of escalation areas and increased use of temporary staff. The CCG will continue to support MTW and their work with partner agencies to make improvements to the delivery of timely and safe care. The CCG is also keen to support MTW in their improvements to their stroke services.

West Kent CCG Quality Team have been invited to support MTW in their quality assurance by undertaking quality visits to a variety of wards and departments, which we look forward to undertaking in the year ahead. Equally we will continue to attend the MTW quality and safety meetings, and work closely with the Chief Nurse and Quality/Governance Team demonstrating our commitment to work with our partners to support the delivery of safe and effective care.

Alison Brett

Acting Chief Nurse
West Kent Clinical Commissioning Group

12th June 2015

Health Overview and Scrutiny Committee – Kent County Council comments on the 2014/15 Quality Account for Maidstone and Tunbridge Wells NHS Trust

Draft Quality Accounts were submitted to the Kent Overview and Scrutiny Committee, Kent County Council. The Chairman, Robert Brookbank, was unable to provide comment but requested that the committee receives a final version.

Healthwatch Kent comments on the 2014/15 Quality Account for Maidstone and Tunbridge Wells NHS Trust

As the independent champion for the views of patients and social care users in Kent we have read your Quality Accounts with great interest.

Our role is to help patients and the public to get the best out of their local health and social care services and the Quality Account report is a key tool for enabling the public to understand how their services are being improved. With this in mind, we enlisted members of the public and Healthwatch Kent staff and volunteers to read, digest and comment on your Quality Account to ensure we have a full and balanced commentary which represents the view of the public.

On reading the Account, our initial feedback is that the account is still very lengthy and we would advise that an additional summary document be published separately to make the information more accessible to the public reading it. However, the consistent layout and headings makes it easy to follow and the use of bullet points breaks up the information into manageable amounts which can be digested.

The report references the use of the Friends and Family Test (FFT) to gather patient experience. It is certainly encouraging to know that the Trust is making efforts to hear what the public are saying. However, we are keen to understand the other ways in which the Trust has engaged with the public and involved them in their decision making. We would also welcome further detail on how seldom heard groups are being engaged with and their experiences heard. It is acknowledged that the Trust has highlighted the need for an Equality Lead to oversee a translation service which will help communication with patients.

Furthermore in next year's edition we would like to see how listening to what patients and the public have said has influenced or affected the —Initiatives for further action" and —Areas For Improvement". We think that evidence of how the public and patient voice has impacted on future planning would be well received.

Healthwatch Kent would like to take this opportunity to say that Maidstone & Tunbridge NHS Trust have been very open with Healthwatch Kent and we have worked together on a number of projects this year including talking to patients about their experiences of stroke services. We would like to see the Trust do more engagement with the public and listen to their views of how services could be improved.

In summary, we would like to see more detail about how you involve patients and the public from all seldom heard communities in decisions about the provision, development and quality of the services you provide. We hope to continue and develop our relationship with the Trust to ensure we can support you with this.

Healthwatch Kent May 2015

Independent Auditors' Limited Assurance Report comments on the 2014/15 Quality Account for Maidstone and Tunbridge Wells NHS Trust

Independent Auditor's Limited Assurance Report to the Directors of Maidstone and Tunbridge Wells NHS Trust on the Annual Quality Account

We are required to perform an independent assurance engagement in respect of Maidstone and Tunbridge Wells NHS Trust's Quality Account for the year ended 31 March 2015 (~~t~~he Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 (~~t~~he Regulations").

Scope and subject matter
The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following indicators:

- Percentage of patients risk assessed for venous thromboembolism (VTE); and
- Rate of clostridium difficile infections.

We refer to these two indicators collectively as —~~t~~he indicators".

Respective responsibilities of directors and auditors
The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by DH in March 2015 (–the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2014 to June 2015;
- papers relating to quality reported to the Board over the period April 2014 to June 2015;
- feedback from the Commissioners dated 12 June 2015;
- feedback from Local Healthwatch dated May 2015;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated June 2015**;**
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey 2014;
- the latest national staff survey 2014;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2015;
- the annual governance statement dated May 2015;
- the Care Quality Commission's Intelligent Monitoring Report dated July 2014; and
- the results of the Payment by Results coding review dated January 2015.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the —documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Maidstone and Tunbridge Wells NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Maidstone and Tunbridge Wells NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed
We conducted this limited assurance engagement under the terms of the guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Maidstone and Tunbridge Wells NHS Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and

- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

[insert firm's signature]

Grant Thornton UK LLP
Fleming Way
Manor Royal
Crawley
RH10 9GT

19 June 2015

Statement of directors' responsibilities in respect of the Quality Account

To be confirmed on receipt of auditor report

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Accounts presents a balanced picture of the trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- The Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Chief Executive

Date:

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board - June 2015

6-16 GS1 and PEPPOL adoption plan **Medical Director**

Introduction

GS1 is a global, not-for profit, organisation that has defined standards and corresponding barcodes to enable clear and unique identification of People, Places and Items. PEPPOL (Pan European Public Procurement OnLine) is the culmination of a multi-year project co-funded by the European Commission and 11 member states. It provides a set of messaging standards that enable business documents (such as purchase orders and invoices) to be electronically exchanged without manual intervention between buying and selling organisations.

The NHS eProcurement Strategy was published by the Department of Health in May 2014 and compliance with the strategy by NHS Trusts was mandated as a requirement of the 2014/15 NHS Standard Contract. Under this requirement, acute trusts are required to put in place a board-approved GS1 and PEPPOL adoption plan (originally before the end of March 2015, but now extended to the end of June 2015).

The enclosed Strategic Outline Case (SOC) sets out the strategic context along with activities and high-level plans required by the Trust to deliver the initial recommendations of the NHS eProcurement Strategy relating to the consistent adoption of GS1 and PEPPOL standards. Having agreed the strategic context and the proposed approach, further detailed business cases will be prepared covering the specific actions and investments required based on further detailed assessments.

Our GS1 Vision

To improve patient safety and outcomes, drive efficiency and reduce risk by interfacing with the Trust's clinical systems to provide visibility of the full patient pathway through GS1 standardisation.

By connecting patient, product, event, location, medical record and equipment through a global standard we will connect information in a way that is not currently possible. We will create a new ability to identify improvements for our Patients, our Trust and our Suppliers, integrating information and enabling our clinically-led organisation.

From the moment a patient requires healthcare through to discharge, the Trust will, at the touch of a button, be able to see their complete pathway: where they have been, who treated them, what products were used and/or implanted, which equipment they used, the drugs they took, where they were located, their movements around the hospital and their interaction with clinical staff.

In the event of a problem, the Trust will be able to identify the patients affected in minutes and commence any remedial action. In addition, the Trust will be able to identify any counterfeit drugs and stop them entering our pharmacy.

Approval

This report seeks agreement to the Strategic Outline Case (SOC) for onward consideration and approval by Trust Board and submission to DH by end June which is to include a bid for funding.

The Adoption Plan/SOC has already been reviewed by the Informatics Steering Group, and Trust Management Executive, and support was provided.

Which Committees have reviewed the information prior to Board submission?

- Informatics Steering Group, 11/06/15
- Trust Management Executive , 17/06/15

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

Maidstone and Tunbridge Wells NHS Trust

Strategic Outline Case

Strategic outline plan for the adoption of GS1 and PEPPOL standards
FOR APPROVAL v2.0

Issue date	June 2015
Department	Health Informatics
Directorate	Health Informatics
Author	David Walach
Directorate Lead	Donna-Marie Jarrett
Executive Sponsor	Steve Orpin
ID reference	

Approved by	Name	Signature	Date
GS1 Lead / Director of Health Informatics	Donna Marie-Jarrett		
Finance manager	Stuart Doyle		
Clinical Lead	Paul Sigston		
Executive sponsor	Steve Orpin		
Supported by	**Name**	**Signature**	**Date**
Director Estates & Facilities	Jeanette Rooke		
HR Lead	Richard Hayden		
Approved by	**Name**	**Minute**	**Date**
Informatics Steering Group	Jim Lusby		
Trust Management Executive	Glen Douglas		
Trust Board	Anthony Jones		

Maidstone and Tunbridge Wells NHS Trust

Strategic Outline Case - Summary

Strategic context

This document sets out the strategic context along with activities and high-level plans required by the trust to deliver the initial recommendations of the NHS eProcurement Strategy (May 2014) relating to the consistent adoption of GS1 and PEPPOL standards. Having agreed the strategic context and the proposed approach further detailed business cases will be prepared covering the specific actions and investments required based on further detailed assessments.

GS1 is a global, not-for profit, organisation that has defined standards and corresponding barcodes to enable clear and unique identification of:

- People – such as Patients and Staff
- Places – such as Sites, Departments, Rooms, Suppliers
- Items – such as Products, Documents, Assets

GS1 standards are widely adopted globally in the retail and pharmaceutical industries where barcodes with unique product identifiers are mandated on all consumer products and commonly used at point of sale to speed up the "checkout" process.

PEPPOL (Pan European Public Procurement OnLine) is the culmination of a multi-year project co-funded by the European Commission and 11 member states. It provides a set of messaging standards that enable business documents (such as purchase orders and invoices) to be electronically exchanged without manual intervention between buying and selling organisations.

GS1 standards can be applied to a variety of use cases across the trust to support both patient safety and procurement; ranging from patient identification and product safety recall, through to medical records management and procurement. The PEPPOL standard currently supports the procurement use cases

Objectives of the investment and the problems with the status quo

Our GS1 Vision

To improve patient safety and outcomes, drive efficiency and reduce risk by interfacing with the Trusts clinical systems to provide visibility of the full patient pathway through GS1 standardisation.

By connecting patient, product, event, location, medical record and equipment through a global standard we will connect information in a way that is not currently possible. We will create a new ability to identify improvements for our Patients, our Trust and our Suppliers, integrating information and enabling our clinically-led organisation.

From the moment a patient requires healthcare through to discharge, we will, at the touch of a button, be able to see their complete pathway. Where they have been, who treated them, what products were used, which products were implanted, which equipment they used, the drugs they took, where they were located, their movements around the hospital and their interaction with clinical staff.

In the event of a problem, we'll be able to identify the patients affected in minutes and commence any remedial action. We'll be able to identify counterfeit drugs and stop them entering our pharmacy.

The main risks associated with the investment

The key risks considered are:

- **Financial** – Availability of required funding
- **Financial** – Benefits stated may not be achieved within a reasonable time period
- **Implementation** – Systems and services being put in place centrally by DH could be delayed
- **Implementation** – Internal resources unable to be released

Maidstone and Tunbridge Wells NHS Trust

Available options

The shortlisted options are:

- **Option a – Do Nothing**: Introduce changes that do not affect structure or level of resources
- **Option b – Distribute responsibilities**: Responsibility for adoption of standards is distributed to individual departments and directorates
- **Option c – Central co-ordination**: Establish a centrally coordinated programme of activities to oversee the adoption of standards consistently across all aspects of the trust

The preferred option

The preferred approach is to coordinate activities relating to the adoption of GS1 and PEPPOL standards through a single programme operating across all relevant departments (option c). The trust nominated GS1 lead would head up the programme reporting progress to the board. Individual elements of activity would be subject to specific business cases / justifications.

Funding and affordability

Based on the high-level current state assessment, and guidance received to date from DH, the overall programme is expected to deliver the trust a gross benefit of £5.53m against a revenue cost of £2.14m, generating a net benefit of £3.39m by the end of FY 2020/21, with breakeven being achieved in 2017/18. Capital funding of £1.5m over a three year period will be required to deliver the programme.

Some of the costs included in the projection, £1.24m (revenue) and £0.6m (capital) are already covered and committed to through other approved programmes and business cases, as such the related benefits also overlap, so both have been included in this high level document for completeness. The net projected additional investment by FY2020/21 would be £0.9m (revenue) and £0.9m (capital).

It should be noted that these figures are derived from a high level analysis based on an excel tool mandated by DH and that further detailed work will be required prior to commencing the next phase of the programme which we anticipate will change the values

Capital

£000	2015/1	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Funding allocated	(400)	(212)	0	0	0	0	0
Requires funding	0	(440)	(447)	0	0	0	0
Total Capital	**(400)**	**(662)**	**(447)**	**0**	**0**	**0**	**0**

Revenue

£000	2015/16	2016/17	2017/1	2018/19	2019/20	2020/21	2021/22
Total benefit	**0**	**338**	**751**	**1,069**	**1,124**	**1,124**	**1,124**
Allocated funds	(131)	(175)	(190)	(188)	(186)	(184)	(181)
Investment Required	(30)	(80)	(159)	(175)	(171)	(167)	(121)
Total costs	**(161)**	**(255)**	**(349)**	**(363)**	**(357)**	**(351)**	**(302)**
Net financial benefit	**(161)**	**83**	**401**	**706**	**767**	**773**	**822**

As part of the adoption of the global GS1 and PEPPOL standards across NHS the Department of Health (DH) has agreed to provide direct support up to six acute NHS trusts in England to act as demonstrator sites. The aim of these sites will be to demonstrate the true costs, challenges and resultant opportunities and benefits that arise from adopting the core enablers and primary use cases for GS1 and PEPPOL standards.

Demonstrator site trusts will be expected to adopt the three core enablers and the three primary use cases across all relevant areas of their organisation

Maidstone and Tunbridge Wells NHS Trust

Future Scope

The activities described herein relate to the initial adoption of GS1 and PEPPOL standards which are considered as the base level that all acute trusts should achieve. Having achieved that there are a number of secondary use cases that can then be considered building on the standards adopted.

Approval of funds

The Board is asked to approve expenditure of £30k to develop the case for investment further, obtaining more detailed information for a full business case to be presented to the board.

Management arrangements

The management arrangements for the programme include:

- Following a standard programme and project management methodologies
- A robust programme governance structure with appropriate resources and responsibilities allocated
- A high level programme timeline
- Arrangements for governance during and post implementation have been defined
- Arrangements for performance monitoring, benefits realisation, change management, risk management and review have been defined and agreed

Maidstone and Tunbridge Wells NHS Trust

The Strategic Outline Case

Strategic Context *The Strategic Case*

The NHS in England is going through a period of unprecedented challenge with an aging population, increasingly complex care requirements and growing levels of litigation.

National Context

The use of GS1 standards for the clear and consistent definitions including location, product and patient, has been stated within numerous policies and publications across NHS for some years. These include Coding for Success (DH 2007), ISB1077: AIDC for patient identification (2012) and most recently the NHS eProcurement Strategy (2014) and the Personalised health and care 2020: a framework for action (2014).

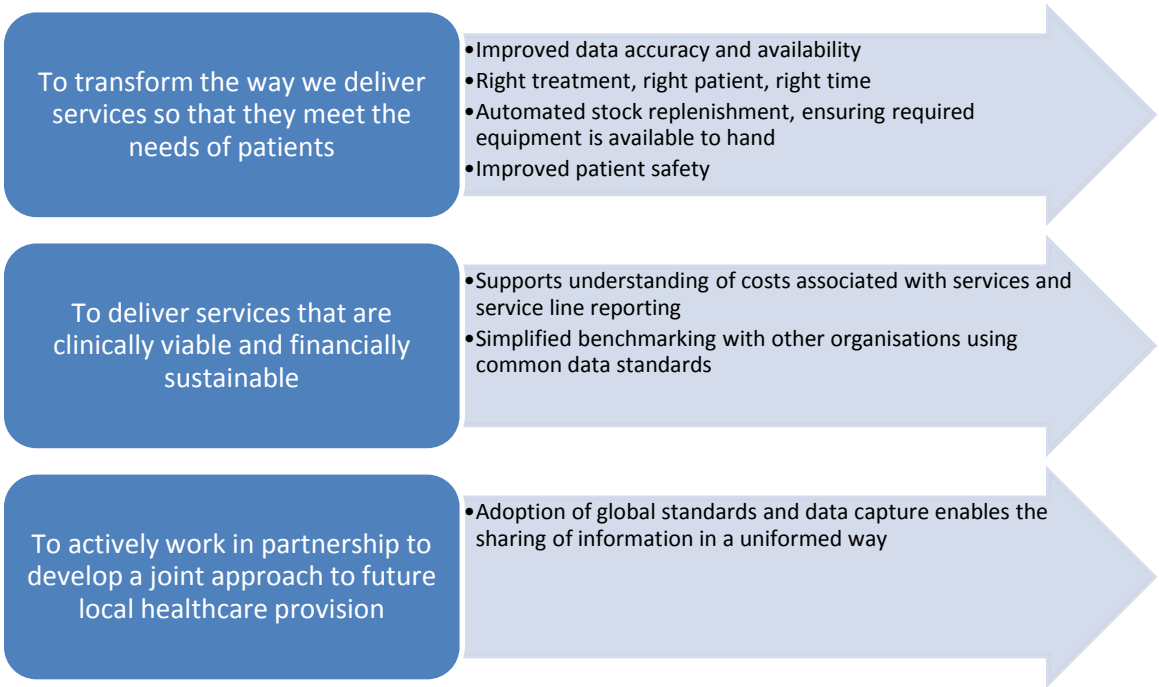
Compliance with GS1 standards and with the recommendations of the eProcurement strategy is now part of the NHS Standard Contract, with commissioners expecting acute trusts to comply.

Regulation is expected shortly from EU relating to Unique Device Identification (a mechanism to accurately identify different types of medical device through distribution and use with a patient) and Falsified Medicines. Both will rely on trusts having appropriate mechanisms in place to accurately read and record information contained within bar coded labels, and in the case of UDI, automated linking of product information with patient records.

Another key driver is EU regulations relating to the increased use of electronic procurement and invoicing (EU directive 2014/55/EU) which stipulates that, by the end of 2018 all public organisations must be capable of receiving electronic invoices from suppliers.

Local context

Locally, MTW has set out its key strategic objectives (as published in the Trust Strategy – "Moving Forward 2015/16 to 2019/20") as below which has been linked to the key benefits of the adoption of the core enablers and primary use cases:



Maidstone and Tunbridge Wells NHS Trust

Case for change – Business needs *The Strategic Case*

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

Some good work has been carried out to date towards using standards and technology to automate certain processes:

- Patient wristbands have been printed with compliant GS1 barcodes since 2012
- Pharmacy has automated dispensing through the use of robots that can use GS1 barcodes printed on medicines – its worth noting that not all suppliers packaging is GS1 compliant
- Estates & Facilities has implemented a trust wide location identification system using barcodes assigned to each physical location which can be amended to use GS1 standards
- The Procurement transformation programme, agreed by the board in April 2015, outlines a case for the implementation of trust wide technology that will utilise these standards and deliver one of the core enablers and the first primary use cases – much of the high level funding identified in this document has been agreed via the procurement business case
- Pharmacy on the Maidstone site has embarked on a pilot of a medicines inventory management system which is GS1 compliant and provides greater security, verification and promotes patient safety – a key element in the Trusts CQC action plan
- Procurement has incorporated the requirement for suppliers to adopt GS1 and PEPPOL standards into standard terms and conditions of contract

Scope

Whilst the opportunities relating to the adoption of GS1 and PEPPOL standards set out in the DH eProcurement strategy are significant, the scope of the initial adoption covered by the proposed programme is limited to the core enablers and primary use cases. Throughout this document activity described relates to the following six main areas.

Core enablers:

- **Location coding** – to simplify trade and internal processes using consistent location numbers across the trust based on the GS1 Global Location Number (GLN).
- **Catalogue Management** – to ensure consistent product master data and pricing is used across the trust and the NHS as a whole based on the GS1 Global Trade Item Number (GTIN).
- **Patient Identity** – to be able to positively identify a patient through automated, point of care reading of an in-patient's wrist band in line with ISB1077 and using the GS1 Global Service Relationship Number (GSRN).

Primary Use Cases:

- **Inventory Management** – to have the relevant stock at appropriate levels available at point of use and to be able to electronically trace products and medicines to a discrete location or patient.
- **Purchase-to-Pay** – all purchase orders, advanced shipping notes and invoices to be exchanged between trusts and suppliers via a PEPPOL compliant access point.
- **Product recall** – to be able to trace products and medicines to a discrete location or patient using electronic means to allow safe and efficient recall.

Current state assessment

Illustrated in Appendix 1 is an assessment of each of the core enablers and primary use cases in respect to each of the main trust departments with indication of the level of adoption. This assessment has then been used to inform both the cost benefit assessment and the programme plan in respect to the level of activity required. The assessment also highlights, in the notes, major factors or requirements needed to effect adoption across all relevant departments such as system developments or hardware needed.

Maidstone and Tunbridge Wells NHS Trust

National and local infrastructure

The DH's eProcurement strategy detailed the infrastructure that is required to be put in place in order for the requirements of the strategy to be met. This included elements that needed to be funded and implemented locally, and elements that will be centrally provided by the DH. The diagram below illustrates the requirement. The National Infrastructure is planned to be in place by July 2016, with full compliance by all Trusts and Suppliers by 2021.

Maidstone and Tunbridge Wells NHS Trust

The short list of options	*The Economic Case*
Option a. Do Nothing – continue as current	
Advantages	**Disadvantages**
• Existing cost base maintained • No changes to current working practices	• Not compliant with NHS Standard Contract • Difficulty of automatically tracking products to patients • Risk to service delivery where key products are not available at the time of use • No change to existing cost base • Not compliant with UDI, FMD or EU electronic invoicing regulations
Option b. Responsibility for adoption of the standards is distributed to individual departments and directorates	
Advantages	**Disadvantages**
• Leads to compliance with NHS Standard contract • Compliance with EU regulations on UDI, FMD and electronic invoicing	• Potential for different approaches to be adopted across the trust leading to greater overall cost • Risk of duplication of effort both internally and from technology providers • Competing priorities, overlap and disjoin between activities • Lack of focus for (stretched) internal resources
Option c. Establish a centrally coordinated programme of activities to oversee the adoption of standards consistently across all aspects of the trust. [PREFERRED]	
Advantages	**Disadvantages**
• Leads to compliance with NHS Standard contract and with EU regulations on UDI, FMD and electronic invoicing • Consistent approach across all aspects of the trust • Coordination of system developments and updates to minimise overall cost to trust	• Level of overall investment required to effect changes • Commitment required from individual lead to coordinate activities

The benefits attributable to the adoption of the GS1 and PEPPOL standards as described by the core enablers and primary use cases and delivered through a coordinated programme of actions are illustrated in Appendix 3. Using the cost / benefit tool provided by the DH, the overall benefit projection for the programme is estimated at £5.5m. These take account of the initial current state assessment and are based on guidance from DH informed by national and international research. More detailed assessments of the benefits will be outlined in a full business case.

Maidstone and Tunbridge Wells NHS Trust

Funding and affordability — *The Financial Case*

The indicative costs identified in the options appraisal, informed by the existing level of adoption shown in the current state assessment and from guidance provided by Department of Health programme team is shown in the table in Appendix 4. Investment required can be broadly broken down into 3 main elements

- **Project and change management services** – resourcing required to undertake project management activities and to manage changes required to effect and embed the GS1 and PEPPOL standards
- **New technology or systems** – where, through detailed assessment, it is evident that additional hardware including bar code scanners and specialist printers, is required to embed the processes. Similarly, it may be necessary to replace existing systems in order to gain necessary functionality.
- **Systems developments** – updates may be required to systems already used across the trust in order to effect the adoption of the standards. Similarly, certain interfaces and integrations may be required to enable automated transfer of data between systems.

Certain elements of the projected costs and benefits are already incorporated within existing business cases and programmes of work. This overarching strategic outline case seeks to highlight the overall investment required to implement the Trust wide solution

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The overall revenue cost projection for the programme is £2.1m of which £1.2m has been funded by other programmes, leaving a projected additional investment of £0.9m covering the period to end FY 2020/21. The Department of Health cost and benefit model used for the financial assessment can be found in Appendix 3 and 4. There would be a total capital requirement of £1.5m over three financial years, of which £0.6m has already been approved and allocated in previous business cases. Capital expenditure relates to acquisition and implementation of systems and hardware. Further assessment will be undertaken with individual elements of activity in order to confirm that position.

Capital costs

Capital Project	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**
Funded through other business cases and programmes							
Inventory Management (phases 1 & 2)	(400)	(212)	0	0	0	0	0
Funding required							
Inventory Management (phases 3 & 4)	0	(200)	(380)	0	0	0	0
ERP & Pharma Systems Readiness & Integration	0	(90)	0	0	0	0	0
Purchase of barcode scanners	0	(50)	0	0	0	0	0
Programme Management and Execution	0	(100)	(67)	0	0	0	0
Total Investment	**0**	**(440)**	**(447)**	**0**	**0**	**0**	**0**
Total Capital	**(400)**	**(652)**	**(447)**	**0**	**0**	**0**	**0**

Notes on capital costs: Costs include VAT

Maidstone and Tunbridge Wells NHS Trust

Revenue costs							
Revenue Changes	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**
Total benefit	**0**	**338.10**	**750.80**	**1,069.10**	**1,124.00**	**1,124.00**	**1,124.00**
Costs funded through other business cases	(131.30)	(175.15)	(190.01)	(187.87)	(185.72)	(183.58)	(181.44)
Additional funding required	(30.00)	(80.44)	(159.45)	(174.75)	(170.88)	(167.02)	(120.51)
Total costs	**(161.30)**	**(255.19)**	**(349.46)**	**(362.62)**	**(356.60)**	**(350.60)**	**(301.95)**
Net financial benefit	**(161.30)**	**82.91**	**401.34**	**706.49**	**767.40**	**773.40**	**822.05**

Costs inclusive of VAT

Detailed financial breakdowns can be found in Appendix 5.

Procurement Route — *The Commercial Case*

Specific commercial proposals relating to the delivery of individual projects will be detailed within relevant businesses cases. Broadly, the key requirements for delivering adoption of the GS1 and PEPPOL standards across the trust comprise three elements:

- **Project and change management services** – consideration should be given to the availability of in-house resources to deliver. Where this is not available or practical then use should be made of existing contracts or frameworks of supply through the trust's own procurement function, the London Procurement Partnership or Crown Commercial Services.
- **New technology or systems** – use will be made of existing frameworks of supply.
- **Systems developments** – where it is necessary to effect updates to existing systems operated by the trust it is expected that these will be covered through the existing contracts of supply and maintenance. Should that not be the case, for example where new technology or systems are required to be purchased then use should be made of existing frameworks of supply. In respect to the adoption of a PEPPOL compliant access point provider a central framework of supply is being put in place that the trust will be able to call off against.

Maidstone and Tunbridge Wells NHS Trust

Management Arrangements *The Management Case*

Including benefits realisation plan, project plan and risk management

Responsibility for the overall programme of activities within the trust will rest with the trust's nominated GS1 lead. The programme will be managed through the Trust's informatics steering group and the corporate system programme board reporting into the Trusts Management Executive.

A programme manager will manage the coordination of the individual projects of work across departments and directorates. In line with that centralised management approach nominated leads will be assigned from IT, Finance, Procurement, Pharmacy, Estates & Facilities and HR to ensure coordination of activities and approaches.

The programme will be structured around the following key milestones:

1) Assessment of current status (illustrated with Appendix 1)
2) Establishment of central programme group including confirmation of governance arrangements
3) Business case development for individual projects as required
4) Adoption activities
5) Benefits realisation review

Benefits Realisation Plan

The benefits outlined in the Economic Case cover a range of aspects including cash releasing, financial non-cash releasing and quality improvements.

Quality improvements include such things as:

- Increased data accuracy and reliability enabling improved analytics and decision making;
- Patient safety and experience improvements through "right patient, right product, right treatment"; and
- Increased automated data transfer between systems and organisations reducing potential errors and time delays.

Overall programme plan

A high level programme plan is illustrated in Appendix 2 giving indication of the major elements, the projected duration based on the initial opportunity assessment and a proposed delivery schedule. This latter element is given to represent the phasing of activities recognising that each of the key strands can be undertaken in parallel and recognising that adoption of the elements across all (relevant) departments will take some time to conclude.

Risk management

A high level risk log for the programme is illustrated in Appendix 6 based on the trust's standard approach to risk management. It will be the responsibility of the trust's nominated GS1 lead and governance boards to ensure that, throughout the duration of the programme, appropriate regular reviews are undertaken of the programme risk register and that significant or strategic risks are raised to the trust's board in accordance with the trust's standard risk management approach.

Maidstone and Tunbridge Wells NHS Trust

Defining the programme		
Individual	**Function/Role/Department**	**Area of activity**
Medical Director	Executive Sponsor	Link to executive, overall leadership of operational use cases
Director of Health Informatics	GS1 Lead	Overall programme leadership, IT and Informatics lead, Patient identification core enabler
Director of Finance	SRO	Link to Procurement Transformation Programme, Link to executive
Head of Procurement	Procurement lead and use case process owner	Catalogue Management core enabler, Inventory Management and P2P use cases, Supplier engagement and contracts
Head of Pharmacy	Pharmacy lead and use case process owner	Catalogue Management core enabler, Medicines Management and P2P use cases
Head of Medical Devices	Medical Equipment lead and use case owner	Medical Equipment use case
Director of Estates & Facilities	Estates & Facilities lead and use case owner	Location numbering core enabler
Head of Financial Services	Finance lead	Inventory Management and P2P use case

Maidstone and Tunbridge Wells NHS Trust

Version history

Version	Issue date	Brief Summary of Change	Owner's Name
0.1 - 0.4	04/06/2015	Draft for discussion	David Walach
0.5	05/06/2015	Draft for review by Informatics Corporate Systems Group	David Walach / Donna-Marie Jarrett
0.6 - 0.7	09/06/2015	Changes to financials and format to Trust standard	David Walach / Donna-Marie Jarrett
1.0	09/02/2015	For approval by HI Steering Group	David Walach
1.0	20/02/2015	For review by business case panel and supporting managers	David Walach
1.1 – 1.3	09/03/2015	Updates from reviewers incorporated	David Walach
1.4	11/03/2015	Baseline financials recalculated in line with outturn projections	David Walach / David Shelton
2.0	13/03/2015	Final version	Steve Orpin

Pre- submission checklist

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

Maidstone and Tunbridge Wells NHS Trust

Contents of appendices

Ref	Description	Case
1	Current state assessment	Strategic
2	Programme plan / high level milestone plan	Management
3	Key high level costs and benefits tables	Economic / Financial
4	Summary cost benefit and timetable	Financial
5	Detailed financials	Financial

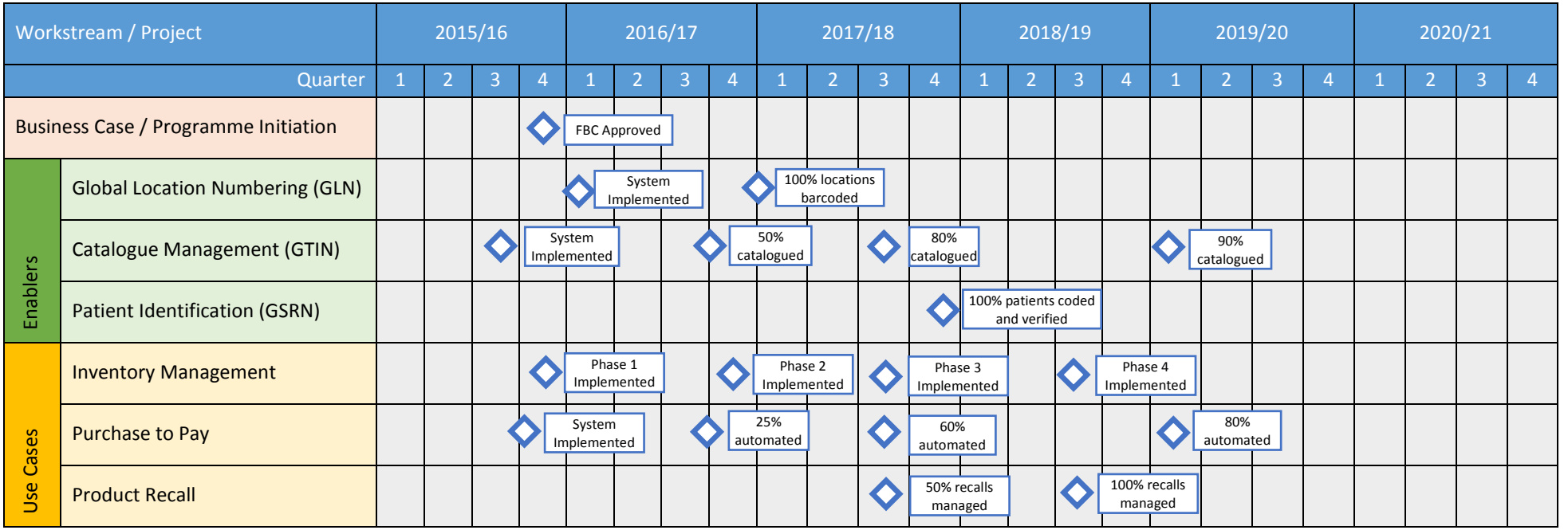
Appendix 1 – Current State Assessment

Initial high level assessment of the existing deployment and adoption of the GS1 and PEPPOL standards across the trust is illustrated in the table below with corresponding notes. This has been used as a guide to the population of the programme plan and the costs benefits summaries.

	Departments involved in adoption														Notes
	Catering	Clinics	Community	EBME	Estates	Finance	IT	Medical records	Pathology	Pharmacy	Procurement	Sterile services	Theatres	Wards	
Core enablers															
1 Location numbering	A	R	R	A	A	R	R	R	R	R	R	R	R	R	Location numbers have been allocated, but not using GS1 standards. Different systems in use by various departments.
2 Catalogue management	R	R	R	R	R	R	R	R	R	A	R	R	R	R	Requirement for suppliers to adopt GS1 standards within contracts. Catalogues currently managed manually. No GTINS collected or used in the Trust currently. A large number of pharmacy / high cost medical products have GTIN (bar) codes as provided by the suppliers, but with limited use. Plans in place to purchase catalogue management solution in 2015.
3 Patient identification	R	R	R	X	X	R	A	R	R	R	R	R	R	R	Compliant patient identifier barcode on patient wristband. Not currently used. Limited scanners available or systems configured.
Primary use cases															
1 Inventory management	R	R	X	X	R	R	R	X	X	R	R	X	R	R	Basic inventory management principles employed across the Trust – not currently GS1 compliant. Plans in place to purchase GS1 compliant inventory management system in 2015. Full deployment by 2017
2 Purchase-to-pay processing	R	R	X	X	R	R	R	X	X	R	R	X	X	X	Plans in place to purchase PEPPOL access point in 2015 and integrate with Trust systems. Full deployment by 2017. Suppliers enabled by 2021
3 Product recall	R	R	R	R	R	X	X	X	R	R	R	R	R	R	Current process is manual with recal alerts being distributed to departments over targeted emails and an assumption that the departments resolve any that affect their patients. Plans in place to purchase GS1 compliant inventory management system in 2015, used to capture link between implantable devices and patients. Partially implemented within Pharmacy for prescribed drugs. Plans in place for stock drugs and theatres through ePrescribing and Inventory management

Key: **Green** – full adoption, **Amber** – partial adoption, **Red** – minimal or no adoption, **Blue** – not considered relevant

Appendix 2 – Programme Plan / high level milestone plan



Element	Duration	Proposed delivery schedule	Notes
GS1 Lead/Sponsor nominated		October 2014	Complete – Donna-Marie Jarrett
Senior programme manager nominated		May 2015	Clinical lead, executive sponsor selected. Funding requested for Programme Manager
Opportunity assessment (Phase 0)	2 months	May - June 2015	Completion of Strategic Outline Plan, Costs / Benefits Tool, High level GS1 deployment assessment, Risk Assessment, High level engagement with key personnel
Full Business Case	3 months	July – October 2015	For elements not already covered by other cases
Location numbering			
Detailed assessment	2 months	July - September 2015	Trust already has room numbering and barcoding in place. Changes required to make the solution GS1 compliant

Element	Duration	Proposed delivery schedule	Notes
Procurement	3 months	September – December 2015	Procurement of systems and service provider to update codes
Implementation	12 months	April 2016 - March 2017	
Governance / Review	13 months	April 2016 – March 2017	
Closure		April 2017	
Catalogue management			
Detailed assessment	3 months	July 2015 – September 2015	
Procurement	2 months	September 2015 – November 2015	Procurement of GS1 accredited catalogue solution
Implementation	24 months	November 2015 – October 2017	
Governance / Review	26 months	September 2015 – October 2017	
Closure		November 2017	
Patient identification			
Detailed assessment	3 months	July 2015 - October 2015	Already in place. Detailed assessment will highlight any amendments or enabling work to be completed for use cases
Implementation	24 months	April 2016 – March 2018	
Governance / Review	25 months	April 2016 – April 2018	
Closure		May 2018	
Inventory Management			
Detailed assessment	2 months	July 2015 – September 2015	Supplies covered by Procurement Transformation Business Case
Procurement	3 months	August 2015 - November 2015	Pharmacy and Supplies
Implementation	36 months	November 2015 – October 2018	Pharmacy and Supplies. Four phases: Phase 1 (supplies) – TWH 2015, Phase 2 (supplies) – MGH 2016, Phase 3 (pharma) – MGH 2016, Phase 4 (pharma) – TWH 2017
Governance / Review	37 months	November 2015 - November 2018	
Closure		December 2018	

Element	Duration	Proposed delivery schedule	Notes
Purchase-to-pay processing			Covered by Procurement transformation Business Case – P2P solution including PEPPOL exchange
Detailed assessment	3 months	July 2015 – October 2015	
Procurement	2 months	October 2015 – December 2015	Purchase of PEPPOL enabled exchange provider
Implementation	24 months	December 2015 - November 2017	
Governance / Review	25 months	November 2017	
Closure		December 2017	
Product recall			
Detailed assessment	3 months	July 2015 – October 2015	Covered by Procurement Transformation Business Case – Inventory Management solution
Implementation	36 months	November 2015 – October 2018	
Governance / Review	37 Months	November 2015 – November 2018	
Closure		December 2018	

Appendix 3 – Key high level costs and benefits tables

Costs – Key Enablers

		Enabler	Context	Narrative	Indicative Implementation / Change Cost	Indicative Annual Revenue Cost	Trust Estimated Implementation / Change Cost	Trust Estimated Annual Revenue Cost	Notes / Assumptions
Costs: Core Enablers	1	**Current catalogue solution/s**	**Key driver in Implementing GTIN from PIM**						
		1.1	Number of 'catalogue solutions' to be integrated to the PIM	Each of your catalogue solutions will need to be integrated to the PIM to receive GS1 GTIN's as they become available	£5,000	£1,000	£0	£0	Assumed that this is the same as 1.3. Catalogue system for supplies and one for pharmacy. Pharmacy solution assumed as in place already
		1.2	If none in trust, selection and ongoing running costs of 'catalogue management' solutions	Your trust will need a catalogue solution	£35,000	£10,000	£25,000	£10,000	Assumed purchase of GHX Nexus solution including implementation costs. This cost is already budgeted in Procurement Transformation
		1.3	Integration to PIM / catalogue solution		£10,000	£2,000	£10,000	£2,000	Assumed integration costs for Pharmacy catalogue to PIM. GHX costs covered by Procurement
	2	**Trust internal systems and integration**	**Key driver in implementing GTIN feeds to data warehouse - price intelligence**						
		2.1	ERP GS1 readiness and capability	Each of your internal transactional systems will need to receive GS1 GTIN & attribute information from either your catalogue of directly from the PIM	£50,000	£5,000	£30,000	£5,000	Assumed systems change for Finance System. Ongoing licence cost
		2.2	ERP integration to PIM / catalogue solution		£10,000	£2,000	£10,000	£2,000	Interface costs from GHX Nexus to Integra. Cost covered by Finance Systems Upgrade
		2.3	Inventory management solution GS1 readiness and capability		£50,000	£5,000	£0	£0	Assume purchase of GS1 Ready Inventory Management solution
		2.4	Inventory management integration to PIM / catalogue solution		£10,000	£2,000	£10,000	£2,000	Assumed £5k interface cost plus professional services. Covered by Procurement transformation programme

	Enabler	Context	Narrative	Indicative Implementation / Change Cost	Indicative Annual Revenue Cost	Trust Estimated Implementation / Change Cost	Trust Estimated Annual Revenue Cost	Notes / Assumptions
	2.5	Top up solution GS1 readiness and capability		£50,000	£5,000	£0	£0	Assumed top up solution replaced by inventory management solution
	2.6	Top up solution integration to PIM / catalogue solution		£10,000	£2,000	£0	£0	Assumed top up solution replaced by inventory management solution
	2.7	Pharma solution GS1 readiness and capability		£50,000	£5,000	£30,000	£5,000	Assumed cost of interface, systems change and professional services
	2.8	Pharma solution integration to PIM / catalogue solution		£10,000	£2,000	£10,000	£2,000	Assumed cost of interface and professional services
3	**Patient identification**	**All patients have GSRN (GS1 prefix & NHS number)**						
	3.1	Upgrade PAS to include GSRN for patient and care giver		£50,000	£5,000	£0	£0	Already in place
	3.2	Purchase wrist band printers (@ £500 each)		£5,000	£500	£0	£0	Already in place
	3.3	Purchase wrist band scanners (@ £200 each)		£100,000	£10,000	£50,000	£5,000	Scanners not yet in place. PAS system can handle barcode scans. Estimated 250 scanners
	3.4	Update SOP's and training		£50,000	£5,000	£0	£0	Already in place
	3.5	Ongoing purchase of wrist bands		£2,000	£2,000	£0	£0	Already in place
4	**Location coding**	**Key driver in implementing GS1 standards**						
	4.1	Programme to implement GLN usage across trust	All locations within a trust will need to be allocated a GLN & registered on the national NHS GLN registry	£100,000	Not applicable	£30,000		Reduced cost based on updating current location numbering system with GS1 codes and issuing to other systems

		Enabler	Context	Narrative	Indicative Implementation / Change Cost	Indicative Annual Revenue Cost	Trust Estimated Implementation / Change Cost	Trust Estimated Annual Revenue Cost	Notes / Assumptions
	5	**Detailed analysis and business case**	Production of detailed future state architecture, costs, benefits and full business case		£100,000	Not applicable	£30,000		Assumed business case and programme management by same team
	6	**Programme execution**	Programme, change and process management teams	The likely timescale to implement the above will be in the range of 12- 24 months	£400,000	Not applicable	£120,000		Assumed business case and programme management by same team. Appoint Band 8a for 2 years

Costs – Primary Use Cases

		Use Case	Context	Narrative	Indicative Implementation / Change Cost	Indicative Annual Revenue Cost	Trust Actual Implementation / Change Cost	Trust Actual Annual Revenue Cost	Notes / Assumptions
Primary Use Cases	7	**Trust wide inventory management**	**Key driver in traceability and inventory / supply chain optimisation**						
		7.1	Current Inventory management provider costs and timelines to become GS1 compliant		£25,000	£5,000	£0	£0	Assumed purchase of GS1 ready inventory management solution
		7.2	If none in trusts selection and ongoing running costs of 'inventory management' solutions		£100,000	£20,000	£1,200,000	£90,000	Assumed cost of Omnicell for Supplies and Pharmacy high cost areas + open systems and patient costing. £612k (50%) is already committed through the Procurement Transformation Programme
		7.3	Integration to PIM / Catalogue solution		£10,000	£2,000	£0	£0	Duplicate of 2.4
		'Top up' solution	**Key driver in traceability and inventory / supply chain optimisation**						
		7.4	Current 'top up' solution provider costs and timelines to become GS1 compliant		£25,000	Not applicable	£0		
		7.5	If none in trusts selection and ongoing running costs of 'inventory management' solutions		£50,000	£10,000	£0	£0	Assumed top up solution replaced by inventory management solution
		7.6	Integration to PIM / Catalogue solution		£10,000	£2,000	£0	£0	Assumed top up solution replaced by inventory management solution
		7.7	**Programme execution, change and process management teams**	Circa £1 million based on a 600 bed trust. Timescale to complete = 12-24 months	£1,000,000	£100,000	£60,000	£43,000	Assumed 2 years of programme management and implementation support, direct. Continuing support.
	8	**Purchase 2 pay**	**Key driver in the cost of implementing PEPPOL**						

Use Case	Context	Narrative	Indicative Implementation / Change Cost	Indicative Annual Revenue Cost	Trust Actual Implementation / Change Cost	Trust Actual Annual Revenue Cost	Notes / Assumptions
8.1	Number of current 'exchange providers'	Current exchange providers will need to become PEPPOL access points. Should a trust have more than one access point implementation cost and running costs will be higher	£25,000	Not applicable	£0		
8.2	In-house developed exchange	Your trust becomes an accredited PEPPOL access point provider in its own right	£100,000	£20,000	£0	£0	No exchange currently in use
		OR					
		Your trust selects a 'separate AP' and decommissions its internal exchange	£25,000	£15,000	£0	£0	No exchange currently in use
8.3	Commercial arrangements with 'accredited AP provider'	New commercial arrangement will need to ensure a PEPPOL accredited AP is used	£25,000	£15,000	£10,000	£5,000	Assumed GHX Exchange as accredited Access Point. Costs covered by Procurement Transformation Programme

Benefits

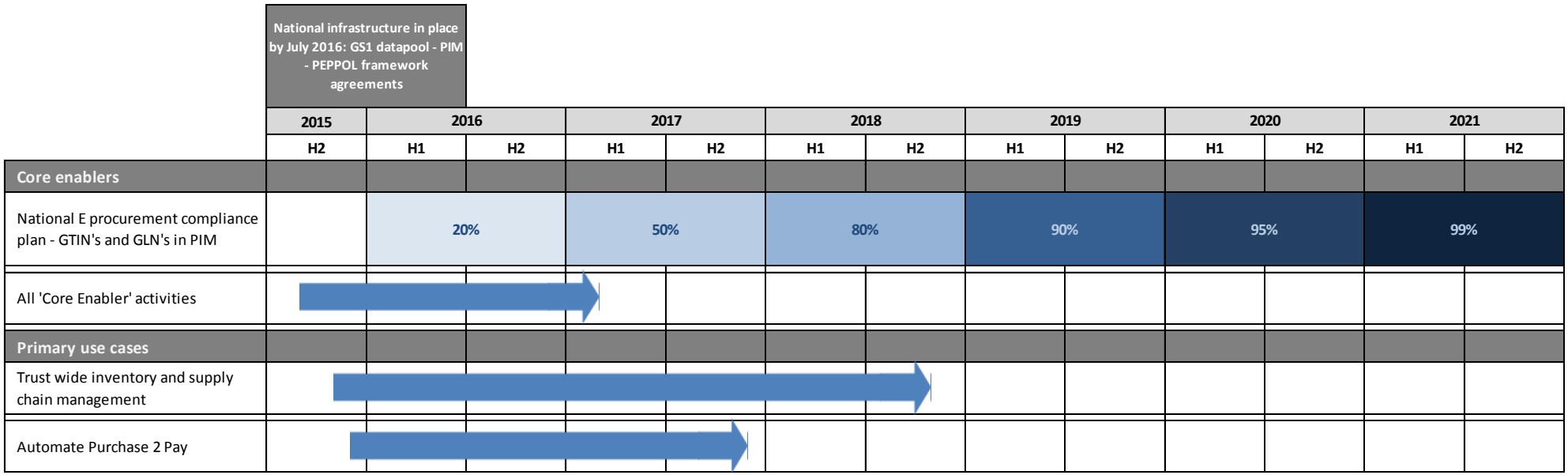
		Benefit	Context	Narrative	Effect	Independent Estimates	Trust Estimate	Benefit	Annual / One Off	Notes
Benefits: Core Enablers	1	**Reduce Adverse Drug Events**	Medication error rate in inpatient admissions used as baseline	Number of medication errors reported in trust annually	Determines baseline for reduction	2,000	2,000			This full benefit will only occur when medicines use cases have been implemented in addition to the core enablers and primary use cases
			ADE cost	Each ADE costs the trust circa £3,000-5,000 (McKinsey's Strength in Unity)		£3,000	£3,000			
			Range of reduction in ADEs (total)	McKinsey's Strength in Unity estimate 30-50% reduction		30%	20%	£1,200,000	Annual	
			Range of reduction based on completing the core enablers	DH estimate of 25% of the total reduction will result from completing the core enablers		25%	10%	**£120,000**	Annual	
	2	**Reduce trust data management cost**	Data management headcount	McKinsey estimate 10 FTE's working to collect / correct data within all systems		10	4			These benefits will occur when core use case has been implemented
			Labour cost	Hospital staff all in labour cost		£60,000	£40,000			
			Activity reduction post program	20-30% labour cost reduction		20%	10%	**£16,000**	Annual	
Benefits: Primary Use Cases	3	**Trust wide Inventory and top up management**	Inventory levels held taken from annual accounts	Inventory held	Determines baseline for one off saving	Not applicable	£5,636,000			
			Trust turnover relevant to inventory held (medical, non medical and pharmacy)	Trust turnover	To calculate weeks cover figure	Not applicable	£49,890,000			
			Gives a simple ration of inventory held against spend expressed as weeks cover	Weeks cover	For information		27.97			

		Benefit	Context	Narrative	Effect	Independent Estimates	Trust Estimate	Benefit	Annual / One Off	Notes
			Inventory held reduction	McKinsey estimate 30% reduction in stock cover when Inventory management is implemented. This accounts for all stock (expensed / consigned etc)	Determines baseline for one off saving	30%	20%	**£1,127,000**	One off	
			Reduction in obsolescence	McKinsey estimate 20% of inventory held as a value is lost through wastage and obsolescence annually		20%	20%			
				McKinsey estimate that full inventory and top up implementation will reduce this by 50%-57%		50%	40%	**£451,000**	Annual	
	4	**Reduce recall processing cost**	Number of recalls effected by the trust	Mckinsey's estimate 1000 per annum	Determines baseline for reduction	1,000	200			These benefits will only occur when core use case + full trust inventory management have been implemented
			Labour cost	Hospital staff all in labour cost: £60,000		£60,000	£40,000			
			In-trust recall activity	4-20 hours required to check stock for typical recall		4	4			
			Activity reduction	60-80% reduction in activity		60%	60%	**£11,000**	Annual	
	5	**Automate purchase 2 pay processes**	Paper invoice reduction	Number of non electronic invoices issued annually	Determines baseline for cost saving	15,000	10,000			These benefits will occur when core use case has been implemented
				Number of non electronic invoices received annually	Determines baseline for cost saving	10,000	93,766			
				Cost to send paper invoice (European Association of Corporate Treasurers)		£11.00	£11.00			
				Cost to receive paper invoice (European Association of Corporate Treasurers)		£14.00	£14.00			

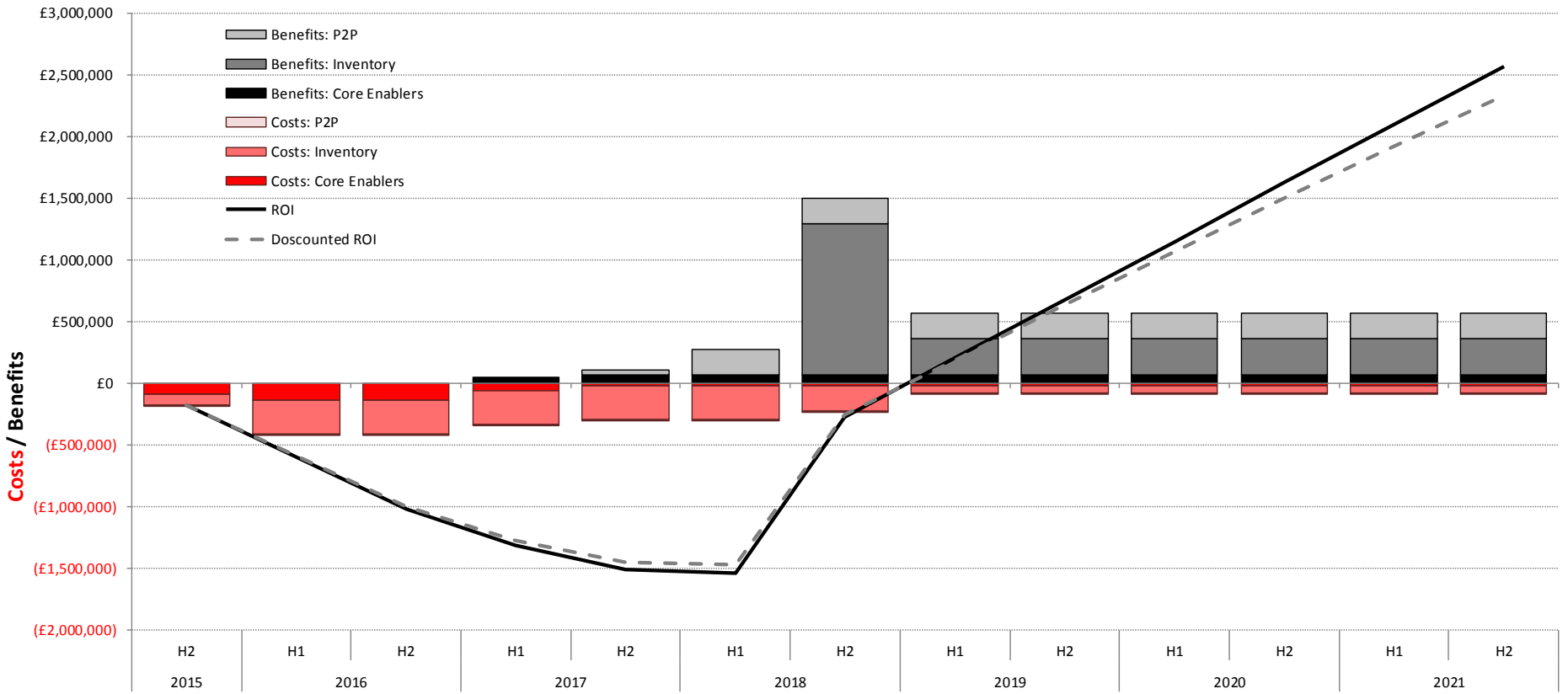
		Benefit	Context	Narrative	Effect	Independent Estimates	Trust Estimate	Benefit	Annual / One Off	Notes
			e-invoice cost reduction	Paper invoices cost 74% to 89% more to process than electronic invoices (Gartner study)		74%	40%	**£406,000**	Annual	
	6	**Reduce ADE's**	ADE reduction as a result of this use case being implemented	DH estimate of 25% of the total reduction will result from completing the primary use cases		25%	10%	**£120,000**	Annual	These benefits will only occur when core enablers + primary use cases have been fully implemented

Appendix 4 – Summary cost benefit and timetable

Taken from DH cost / benefit model



Benefit:Cost analysis	2015	2016		2017		2018		2019		2020		2021		
	H2	H1	H2	H1	H2	H1	H2	H1	H2	H1	H2	H1	H2	Total
Costs	£184,556	£418,833	£418,833	£339,944	£300,083	£298,000	£228,000	£88,000	£88,000	£88,000	£88,000	£88,000	£88,000	**£2,716,250**
Benefits	£0	£0	£0	£45,333	£101,833	£271,000	£1,495,000	£562,000	£562,000	£562,000	£562,000	£562,000	£562,000	**£5,285,167**
Cashflow	-£184,556	-£418,833	-£418,833	-£294,611	-£198,250	-£27,000	£1,267,000	£474,000	£474,000	£474,000	£474,000	£474,000	£474,000	**£2,568,917**
Cumulative cash flow (ROI)	**-£184,556**	**-£603,389**	**-£1,022,222**	**-£1,316,833**	**-£1,515,083**	**-£1,542,083**	**-£275,083**	**£198,917**	**£672,917**	**£1,146,917**	**£1,620,917**	**£2,094,917**	**£2,568,917**	



All 'Core Enabler' activities

Trust wide inventory and supply chain management

Automate Purchase 2 Pay

Appendix 5 – Detailed Financials

Detailed Capital Financials

Capital Purchase	Value	Life	Salvage Value	Funded?	Year Spent
Inventory Management System - Phase 1	(400.00)	10	0.00	Y	2015/16
Inventory Management System - Phase 2	(212.00)	10	0.00	Y	2016/17
Inventory Management System - Phase 3	(200.00)	10	0.00	N	2016/17
Inventory Management System - Phase 4	(380.00)	10	0.00	N	2017/18
ERP & Pharma Systems Readiness & Integration Project	(90.00)	10	0.00	N	2016/17
Barcode scanners	(50.00)	5	0.00	N	2016/17
Programme management and execution year 1	(100.00)	5	0.00	N	2016/17
Programme management and execution year 2	(67.00)	5	0.00	N	2017/18

£000	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Inventory Management - Phase 1 (Supplies TWH)	Funded										
Depreciation	(40.00)	(40.00)	(40.00)	(40.00)	(40.00)	(40.00)	(40.00)	(40.00)	(40.00)	(40.00)	0.00
Opening Value	(400.00)	(360.00)	(320.00)	(280.00)	(240.00)	(200.00)	(160.00)	(120.00)	(80.00)	(40.00)	0.00
Closing Value	(360.00)	(320.00)	(280.00)	(240.00)	(200.00)	(160.00)	(120.00)	(80.00)	(40.00)	0.00	0.00
Capital Charge	(13.30)	(11.90)	(10.50)	(9.10)	(7.70)	(6.30)	(4.90)	(3.50)	(2.10)	(0.70)	0.00
Inventory Management - Phase 2 (Supplies MGH)	Funded										
Depreciation	0.00	(21.20)	(21.20)	(21.20)	(21.20)	(21.20)	(21.20)	(21.20)	(21.20)	(21.20)	(21.20)
Opening Value	0.00	(212.00)	(190.80)	(169.60)	(148.40)	(127.20)	(106.00)	(84.80)	(63.60)	(42.40)	(21.20)
Closing Value	0.00	(190.80)	(169.60)	(148.40)	(127.20)	(106.00)	(84.80)	(63.60)	(42.40)	(21.20)	0.00
Capital Charge	0.00	(7.05)	(6.31)	(5.57)	(4.82)	(4.08)	(3.34)	(2.60)	(1.86)	(1.11)	(0.37)
Inventory Management System - Phase 3 (Pharma MGH)	Requires funding										
Depreciation	0.00	(20.00)	(20.00)	(20.00)	(20.00)	(20.00)	(20.00)	(20.00)	(20.00)	(20.00)	(20.00)
Opening Value	0.00	(200.00)	(180.00)	(160.00)	(140.00)	(120.00)	(100.00)	(80.00)	(60.00)	(40.00)	(20.00)
Closing Value	0.00	(180.00)	(160.00)	(140.00)	(120.00)	(100.00)	(80.00)	(60.00)	(40.00)	(20.00)	0.00
Capital Charge	0.00	(6.65)	(5.95)	(5.25)	(4.55)	(3.85)	(3.15)	(2.45)	(1.75)	(1.05)	(0.35)
Inventory Management System - Phase 4 (Pharma TWH)	Requires funding										
Depreciation	0.00	0.00	(38.00)	(38.00)	(38.00)	(38.00)	(38.00)	(38.00)	(38.00)	(38.00)	(38.00)
Opening Value	0.00	0.00	(380.00)	(342.00)	(304.00)	(266.00)	(228.00)	(190.00)	(152.00)	(114.00)	(76.00)
Closing Value	0.00	0.00	(342.00)	(304.00)	(266.00)	(228.00)	(190.00)	(152.00)	(114.00)	(76.00)	(38.00)
Capital Charge	0.00	0.00	(12.64)	(11.31)	(9.98)	(8.65)	(7.32)	(5.99)	(4.66)	(3.33)	(2.00)
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**	**2025/26**

ERP & Pharma Systems Readiness & Integration Project	**Requires funding**										
Depreciation	0.00	0.00	0.00	(9.00)	(9.00)	(9.00)	(9.00)	(9.00)	(9.00)	(9.00)	(9.00)
Opening Value	0.00	(90.00)	(90.00)	(90.00)	(81.00)	(72.00)	(63.00)	(54.00)	(45.00)	(36.00)	(27.00)
Closing Value	0.00	(90.00)	(90.00)	(81.00)	(72.00)	(63.00)	(54.00)	(45.00)	(36.00)	(27.00)	(18.00)
Capital Charge	0.00	(3.15)	(3.15)	(2.99)	(2.68)	(2.36)	(2.05)	(1.73)	(1.42)	(1.10)	(0.79)
Barcode scanners	**Requires funding**										
Depreciation	0.00	(10.00)	(10.00)	(10.00)	(10.00)	(10.00)	0.00	0.00	0.00	0.00	0.00
Opening Value	0.00	(50.00)	(40.00)	(30.00)	(20.00)	(10.00)	0.00	0.00	0.00	0.00	0.00
Closing Value	0.00	(40.00)	(30.00)	(20.00)	(10.00)	0.00	0.00	0.00	0.00	0.00	0.00
Capital Charge	0.00	(1.58)	(1.23)	(0.88)	(0.53)	(0.18)	0.00	0.00	0.00	0.00	0.00
Programme management and execution year 1	**Requires funding**										
Depreciation	0.00	(20.00)	(20.00)	(20.00)	(20.00)	(20.00)	0.00	0.00	0.00	0.00	0.00
Opening Value	0.00	(100.00)	(80.00)	(60.00)	(40.00)	(20.00)	0.00	0.00	0.00	0.00	0.00
Closing Value	0.00	(80.00)	(60.00)	(40.00)	(20.00)	0.00	0.00	0.00	0.00	0.00	0.00
Capital Charge	0.00	(3.15)	(2.45)	(1.75)	(1.05)	(0.35)	0.00	0.00	0.00	0.00	0.00
Programme management and execution year 2	**Requires funding**										
Depreciation	0.00	(13.40)	(13.40)	(13.40)	(13.40)	(13.40)	0.00	0.00	0.00	0.00	0.00
Opening Value	0.00	(67.00)	(53.60)	(40.20)	(26.80)	(13.40)	0.00	0.00	0.00	0.00	0.00
Closing Value	0.00	(53.60)	(40.20)	(26.80)	(13.40)	0.00	0.00	0.00	0.00	0.00	0.00
Capital Charge	0.00	(2.11)	(1.64)	(1.17)	(0.70)	(0.23)	0.00	0.00	0.00	0.00	0.00
Sub totals - already funded	**Funded**										
Capital required	(400.00)	(212.00)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Depreciation	(40.00)	(61.20)	(61.20)	(61.20)	(61.20)	(61.20)	(61.20)	(61.20)	(61.20)	(61.20)	(21.20)
Capital Charge	(13.30)	(18.95)	(16.81)	(14.67)	(12.52)	(10.38)	(8.24)	(6.10)	(3.96)	(1.81)	(0.37)
Sub totals - additional funding	**Requires funding**										
Capital cost	0.00	(440.00)	(447.00)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Depreciation	0.00	(63.40)	(101.40)	(110.40)	(110.40)	(110.40)	(67.00)	(67.00)	(67.00)	(67.00)	(67.00)
Capital Charge	0.00	(16.64)	(27.05)	(23.35)	(19.48)	(15.62)	(12.51)	(10.17)	(7.82)	(5.48)	(3.13)
Grand Total	**(53.30)**	**(80.15)**	**(78.01)**	**(75.87)**	**(73.72)**	**(71.58)**	**(69.44)**	**(67.30)**	**(65.16)**	**(63.01)**	**(21.57)**

Detailed Revenue Financials

£000	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	Comments / Assumptions
Funded through other business cases								
Inventory Management Maintenance	0.00	(32.00)	(49.00)	(49.00)	(49.00)	(49.00)	(49.00)	
Inventory Systems Manager (B7)	(43.00)	(43.00)	(43.00)	(43.00)	(43.00)	(43.00)	(43.00)	
Catalogue Management System	(25.00)	(15.00)	(15.00)	(15.00)	(15.00)	(15.00)	(15.00)	
PEPPOL Accredited Exchange System	(10.00)	(5.00)	(5.00)	(5.00)	(5.00)	(5.00)	(5.00)	
Capital Charge	(13.30)	(18.95)	(16.81)	(14.67)	(12.52)	(10.38)	(8.24)	
Capital Depreciation	(40.00)	(61.20)	(61.20)	(61.20)	(61.20)	(61.20)	(61.20)	
Sub Total - Already Funded	**(131.30)**	**(175.15)**	**(190.01)**	**(187.87)**	**(185.72)**	**(183.58)**	**(181.44)**	
Additional funding required								
Detailed business case	(30.00)	0.00	0.00	0.00	0.00	0.00	0.00	
Inventory Management Maintenance	0.00	0.00	(31.00)	(41.00)	(41.00)	(41.00)	(41.00)	
Capital Charge	0.00	(16.64)	(27.05)	(23.35)	(19.48)	(15.62)	(12.51)	
Capital Depreciation	0.00	(63.40)	(101.40)	(110.40)	(110.40)	(110.40)	(67.00)	
Sub Total - Additional funding required	**(30.00)**	**(80.04)**	**(159.45)**	**(174.75)**	**(170.88)**	**(167.02)**	**(120.51)**	
Total cost of programme	**(161.30)**	**(255.19)**	**(349.46)**	**(362.62)**	**(356.60)**	**(350.60)**	**(301.95)**	
Benefits								
Reduction of Adverse Drug Incidents	0.00	0.00	0.00	120.00	240.00	240.00	240.00	Based on Pharma Inventory Management solution implemented
Reduce data management cost	0.00	0.00	0.00	0.00	16.00	16.00	16.00	Reduction once all use cases implemented
Inventory reduction	0.00	338.10	450.80	338.10	0.00	0.00	0.00	Total benefits phased across years based on implementation and capital plan
Inventory waste reduction	0.00	0.00	200.00	400.00	451.00	451.00	451.00	Benefits increase as system is rolled out
Reduce recall processing costs	0.00	0.00	0.00	11.00	11.00	11.00	11.00	Following inventory management implementation
Invoice processing cost reduction	0.00	0.00	100.00	200.00	406.00	406.00	406.00	
Total Benefits	**0.00**	**338.10**	**750.80**	**1,069.10**	**1,124.00**	**1,124.00**	**1,124.00**	
Net Benefits	**(161.30)**	**82.91**	**401.34**	**706.49**	**767.40**	**773.40**	**822.05**	

Appendix 6 – Risk mitigation

Risk	Owner	Likelihood	Impact	Score	Possible Mitigation
There is a risk that the level of funding made available to the programme is not sufficient to enable full adoption of the standards.	DJ	Possible	Major	12	Programme management to monitor costs against adoption Ongoing review of costs and activities to identify further opportunities to capitalise costs. Just under half of the cost has already been funded through other programmes
There is a risk that the proposed timetable of activities is not achieved.	DJ	Possible	Moderate	9	Programme management to monitor delivery of actions against plan
There is a risk that internal resources and/or support is not made available as required.	DJ	Possible	Moderate	9	Ongoing engagement by the trust's nominated GS1 lead with the board and departmental heads to raise the profile of the work and garner the necessary support
There is a risk that sufficient levels of buy-in and agreement are not achieved from key staff including clinical.	DJ	Possible	Major	12	Ensure appropriate engagement with key relevant staff groups including clinical throughout each stage of the programme
There is a risk that external suppliers do not make the necessary changes or adhere with the overall timetable set out by Department of Health.	DJ	Likely	Minor	8	Working with trust procurement functions ensure that adoption of the requisite standards and operational practices are built into contracts of supply and that future sourcing decisions take account of the requirements.
There is a risk that the benefits stated are not achieved within a reasonable time period.	DJ	Possible	Major	12	Engagement of Finance within programme team to support identification and monitoring of benefits
There is a risk that the systems and services being managed centrally by Department of Health are delayed.	DJ	Likely	Moderate	12	Engagement with the Department of Health project team to monitor progress of delivery projects.
There is a risk that the data currently available within the trust is of a lower than expected quality leading to additional effort required to re-work.	DJ	Possible	Moderate	9	Ongoing review of relevant data sources across the trust to identify potential issues and development of local action plans to cleanse data where needed.
There is a risk that the current systems used across the trust are unable to handle the required data elements or of handling the proposed interfaces leading to the need to develop or replace key systems.	DJ	Possible	Moderate	9	Detailed assessment of current operating systems against future requirements need to be undertaken for individual key elements of activity

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - June 2015

6-17 Revised Terms of Reference for the KPP Board — Chief Executive

The Terms of Reference for the Kent Pathology Partnership (KPP) Board form part of the Collaboration Agreement for KPP, which was approved by the Trust Board in September 2014.

The Collaboration Agreement states that "The Terms of Reference of the KPP Board set out in Schedule 2 (Terms of Reference of the Kent Pathology Partnership Board) may only be changed from time to time with the written agreement of the Members".

On 10th April 2015, the KPP Board considered whether changes should be made to the Terms of Reference, and agreed that the "Composition and membership" section should be amended. The proposed amendments were made to simplify the structure, whilst still ensuring representation from both Trusts.

In addition, a „housekeeping' change is proposed to section 7, which corrects a cross-referencing error within the original Terms of Reference.

The proposed revised Terms of Reference, with changes „tracked', are enclosed, for approval.

The Board at East Kent Hospitals University NHS Foundation Trust will be asked to approve the changes at its meeting on 26th June 2015.

On a related matter, the Part 2 Board meeting will discuss (and be asked to agree) the future direction for Pathology. The Trust Board is therefore asked to delegate its authority for the Part 2 meeting to undertake this function[1].

Which Committees have reviewed the information prior to Board submission?
- KPP Board, 10/04/15

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [2]
1. Approval of the revised Terms of Reference
2. To delegate authority for the Part 2 Board meeting to discuss (and agree) the future direction for Pathology

[1] The Trust's Standing Orders state that "When the Board is not meeting as the Trust in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Trust in public session"

[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

SCHEDULE 2: TERMS OF REFERENCE OF THE KENT PATHOLOGY PARTNERSHIP ("KPP") BOARD

The definitions set out in the Collaboration Agreement dated {●} 2014 shall apply in these Terms of Reference.

1 GENERAL

KPP is legally hosted by East Kent Hospitals University NHS Foundation Trust ("EKHUFT"). The legal hosting principles are set out at Schedule 3 to the Collaboration Agreement.

KPP is jointly owned by its Members (East Kent Hospitals University NHS Foundation Trust and Maidstone and Tunbridge Wells NHS Trust).

The Members shall have strategic control of KPP via the Annual Business Plan which shall be approved by the Member Boards in accordance with the Collaboration Agreement. The functions and ambitions for KPP are set out in the Annual Business Plan and the KPP Board shall act within the remit of the Annual Business Plan at all times.

Oversight of the day to day operational management of KPP is delegated to the KPP Board by the Members in accordance with these Terms of Reference.

The day to day operational management shall be carried out by the KPP Management Team.

2 COMPOSITION AND MEMBERSHIP

The membership of the KPP Board shall comprise of the persons listed below. This will be increased with any increase in the number of Members on a per Member basis.

1. The Chief Executive of Maidstone and Tunbridge Wells NHS Trust (MTW) (Chair)
2. The Chief Executive of EKHUFT (Deputy Chair)
~~3. The Director Finance of MTW~~
~~4.~~3. The Director of Finance of EKHUFT
~~5.~~4. The Chief Operating Officer of MTW
~~6. The Chief Operating Officer (or equivalent) of EKHUFT~~
~~7. The Medical Director of MTW~~
~~8.~~5. The Medical Director of EKHUFT
~~9.~~6. A Non-Executive Director of MTW
7. A Non-Executive Director of EKHUFT
~~10.~~8. The Director of Human Resources of EKHUFT

Attendees:

- The KPP Managing Director
- The KPP Clinical Director

The KPP Board may permit or require the attendance of officers of KPP to attend meetings of the Board. Said officers will be formally recorded as ‘attendees’ at the meetings and shall not have voting rights.

The KPP Board shall be authorised to co-opt other individuals to the KPP Board, and shall ensure that it has either through its membership or co-option sufficient expertise to enable it to deal with its agenda. Such persons will be formally recorded as ‘attendees’ and shall not have voting rights.

Any of the members listed above may appoint an alternate person to act on their behalf and has the authority to:

- Exercise that member's powers; and
- Carry out that member's responsibilities in relation to the taking of decisions in the absence of the member listed above.

Any attendance of an alternate member must be agreed by the KPP Board.

Chair

The Chair shall be appointed by the Members' and where there are only two Members' the Chair shall be the Chief Executive of the Member that is not the Legal Host Member.

3 VOTING AND DECISIONS

Subject to Clause 5.4 of the Collaboration Agreement, a decision is taken at KPP Board meetings by a unanimous vote of the members present, and each member has one vote. Alternates appointed in line with Paragraph 2 above will also have a vote.

At the discretion of the Chair, all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise

Quorum

The quorum for the KPP Board shall be four of the members listed above, with at least one from each Member, including either the Chair or Deputy Chair.

Decisions

Subject to Clause 5.4 of the Collaboration Agreement, all decisions of the KPP Board will be taken as agreed provided the decision is unanimously agreed and the meeting is quorate.

All decisions of the KPP Board shall be automatically binding on KPP once passed in accordance with this protocol subject to:

- the decision not conflicting with the authority outlined in these Terms of Reference or the Annual Business Plan approved by the Members' Boards; and

- the provision at Clause 5.4 of the Collaboration Agreement.

The Members have the ultimate authority to control KPP. Any requirements of the Members shall be imposed on the KPP Board by an amendment to the Annual Business Plan and/or these Terms of Reference, to which the KPP Board is bound to comply.

4 ACCOUNTABILITY & RESPONSIBILITY

The KPP Board will be accountable to the Board of Directors of each of the Members.

The KPP Managing Director will be accountable to the KPP Board.

The KPP Board will be responsible for:

- constituting KPP and implementing the governance framework;

- designing the configuration and infrastructure of the Services;

- implementing the strategic direction of KPP in accordance with the Annual Business Plan;

- agreeing the annual programme of objectives; an operational plan; and performance milestones and measures in the Annual Business Plan;
- setting and monitoring the annual budget in the Annual Business Plan;
- negotiating and approving the Service Level Agreements between KPP and the Members or other NHS bodies or Customers;
- ensuring that KPP accounts are subject to satisfactory audit as part of each Member's reporting and accounting process;
- managing performance and quality standards of the Services, taking remedial action where necessary, including recommending disciplinary action in relation to Staff;
- consider and recommend changes to membership or management of KPP
- approving equipment purchases in line with the Scheme of Delegation
- seeking to resolve any disputes arising between Members in connection with the Services;
- ensuring that KPP's governance and quality assurance arrangements are adhered to and subject to regular review;
- ensuring that all material risks are identified, managed and mitigated
- establishing any sub-committees it deems necessary to discharge the above responsibilities, and agreeing Terms of Reference and membership of any such sub-committees.

5 INTERESTS OF BOARD MEMBERS

No member of the KPP Board shall be interested (otherwise than as a representative of a KPP Member) in any contract entered into by KPP.

Members of the KPP Board, observers and officers attending the KPP Board shall comply with the National Health Service Guidance on Business Ethics, to the extent that the same may properly be applied to the circumstances of the KPP Board.

All members of the KPP Board shall declare any interests in any matter coming before the KPP Board and the Chair shall consider whether such interest requires the member to withdraw from the meeting for that item of business.

6 MEETINGS AND PROCEEDINGS OF THE BOARD

Frequency of Meetings

KPP Board meetings shall be generally held on a monthly basis. Extraordinary meetings may be called at any time by the Chair upon not less than three (3) clear Business Days' notice being given to the other members of the KPP Board of the matters to be discussed.

Agenda and papers shall be issued five (5) Business Days ahead of the meeting. The KPP Managing Director shall be responsible for sending the meeting invitations and co-ordinating location and agendas.

The KPP Board may from time to time make and alter rules for the conduct of their business, the summoning and conduct of their meetings including adjournments, and the custody of

documents. No rule may be made which is inconsistent with the Collaboration Agreement or the Annual Business Plan. No rule may be made which would conflict with the legislation, regulations or Standing Orders governing any of the Members.

The KPP Board shall keep minutes of the proceedings at meetings of the KPP Board and ensure minutes are kept of the meetings of any sub-committee. Minutes of the KPP Board shall be approved by the KPP Board at its next meeting. Duplicate copies of the approved minutes shall be submitted to each of the Members.

Notices of the meeting shall be given not less than five (5) days in advance and where possible seven (7) days in advance of the meeting, together with the agenda and agenda papers. Notice shall be sent in writing to the address notified by each Board member.

Emergency powers

In cases of emergency the KPP Board Chair may take urgent action to decide any matter within the remit of the KPP Board, subject to consultation with at least one other member of the KPP Board from a Member other than that of the KPP Chair. Any such emergency action shall be reported to the next KPP Board meeting.

Responsibility for Communicating Decisions

The responsibility for communicating recommendations and decisions shall be undertaken by the KPP Board Chair. Members of the KPP Board shall be tasked with and specifically responsible for ensuring key messages are cascaded within their organisations.

7 REVIEW

These Terms of Reference should be subject to review by the KPP Board on an annual basis, or following any significant changes in circumstances of KPP or its Members.

Any proposed amendments to the Terms of Reference which are agreed by the KPP Board shall be referred to the Members for their approval in accordance with Clause ~~4.3~~ 4.2 of the Collaboration Agreement.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board - June 2015

6-18	Summary report from the Workforce Committee, 01/06/15	Committee Chairman (Non-Executive Director)

The Workforce Committee met on 1st June and covered the following issues:

Workforce Strategy: The Committee received a presentation on the workforce strategy. The strategy document outlines the approach for the next 5 years, and there are 6 interlinked elements. Committee members discussed the document:

- Equality and diversity has been included because of its importance and because it was flagged by the CQC that the Trust does well in some elements, but not so well in others, e.g. disability, in the case of promotional pathways for some protected characteristic groups.
- The recruitment and retention section needs a greater emphasis e.g. Physicians Assistants, skill mixing, alternative solutions, career progression.
- There needs to be more emphasis on valuing the workforce.
- The messages in the Trust Cultural Change Workshops are consistent with the issues raised in the Committee's discussion.

The strategy was supported, and it will be consulted upon extensively and then recommended for approval by the Trust Board. If approved an action plan will be prepared.

Nursing and Midwifery Revalidation: The Committee received a presentation on nursing and midwifery revalidation, and the Committee's attention was drawn to the following:

- This is for registered nurses only. The Chief Nurse hoped it would have been brought in for CSWs first and this may take place in due course.
- Revalidation has not been undertaken previously by the NMC.
- Currently registered nurses are expected to maintain evidence of their practice, and declare compliance on the register every 3 years.
- Registered nurses pay a retainer fee every year to remain on the register.
- Revalidation will be linked to appraisal.
- The medical model will not be followed.
- The NMC Code has been revised and is more current especially in terms of use of social media by nursing staff.
- This is not a mechanism to discipline staff or raise issues for the first time.
- Confirmation that revalidation requirements have been met must be carried out by another NMC registrant, for a Chief Nurse the registrant would be another Chief Nurse.
- MTW has been working closely with Guys and St Thomas who have advised the Trust to link this to the existing appraisal process.
- The Revalidation Board will be established.
- The responsibility lies with the individual registered nurse to revalidate otherwise they cannot practice.
- The Chief Nurse has written to nurses encouraging them to start using the NMC Code as part of their appraisal.

Recruitment and Retention Plan: The Committee received a presentation on the registered nurse recruitment plan, and the Committee's attention was drawn to the following:

- The focus is on registered nurses. There is no issue with recruitment of CSWs following recent assurances about supply.
- The data in the presentation has been cross checked at the Recruitment and Retention Group.
- The new ward will need additional nursing staff.
- There are nurses currently in the recruitment pipeline which will impact the vacancy data
- Following recent overseas recruitment, 13 further whole time equivalent staff were appointed.
- The careers section of the website has been updated and personalised.
- Facebook and Twitter are being used to raise the profile of the Trust.
- There are 300 bank only staff, there are plans to offer incentives to covert to permanent roles.
- The impact of overseas recruitment on agency spend is being quantified.

- Work is underway to understanding why nurses remain in the Trust.
- The Chief Nurse reported that CNS posts in the Trust are being reviewed in terms of value added to the organisation.
- The Trust has partnerships and contacts with schools and in the local community to promote career opportunities in the Trust.

Medical Appraisal and Revalidation: The committee received the annual report on medical appraisal and revalidation. A panel from NHS England attended the Trust on 2 June 2015 to carry out a revalidation verification visit.

Medical Education Update: The report provided information on medical education and training programmes, in particular:

- Trust wide multi-professional projects are up and running with very good initial feedback.
- Currently working through requirements following the Ophthalmology School visit.
- Mentoring programme first phase has taken place.

Workforce Risk Register: The 3 principal risks relating to the workforce are:

1. Recruitment and retention
2. Temporary staffing
3. Culture including employee engagement.

The Committee agreed the 3 key risks and discussed the RAG rating of each risk. The report provided assurance on the current controls and key actions to mitigate the risks.

Workforce Performance Dashboard: The categories in the dashboard have been adjusted to include the NTDA accountability framework. The dashboard reflects the performance for the first month of 2015/16, and the dashboard will be fully populated with the forecast for the year end in time for the September Workforce Committee. There will be adjustments during the course of the year to take account of KPP and HIS changes.

Workforce Return to TDA: The committee received the detailed workforce return submitted to the NTDA and confirmed that they were assured.

Terms of Reference: The Committee agreed revised Terms of Reference, which are enclosed for the Board's approval.

Level 3 Safeguarding Children Training: The Committee received an update on compliance with Level 3 Safeguarding Children Training. Current compliance is 69.4% against the target of 85%. The Chief Nurse has mapped out capacity to deliver the target and 84% should be achieved by September 2015. The Chief Nurse and Director of Workforce and Communications have written to individual staff members and this will be followed up with the CDs.

Payroll provider tender: The payroll service was awarded to McKesson after a tendering process last year. The payroll service provided by McKesson has been much improved. The committee was informed that SBS has recently purchased McKesson.

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 Workforce Committee

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

Maidstone and Tunbridge Wells NHS
NHS Trust

MAIDSTONE & TUNBRIDGE WELLS NHS TRUST

Workforce Committee

Terms of reference

1 Purpose

The Workforce Committee is constituted at the request of the Trust Board to provide assurance to the Board in the areas of workforce development, planning, performance and employee engagement.

The Committee will work to assure the Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that is supporting business success.

2 Membership

Non-executive Chairman
Non-executive Director (Chair)
Non-executive Director
Chief Operating Officer
Director of Workforce and Communications

Other Non-Executive Directors and Executive Directors may attend by open invitation.

The Director of Medical Education and the Associate Director of Workforce will attend by invitation of the Chair.

3 Quorum

The Committee shall be quorate when two Executive Directors and two Non-executive Directors are in attendance.

4 Attendance

Other staff, including members of the Human Resources Directorate, may attend to address specific agenda items.

5 Frequency of meeting

The Committee will meet quarterly. The Chair can call a meeting at any time if issues arise.

6 Duties

To provide assurance to the Board on:

- workforce planning and development, including alignment with business planning and development;

- equality and diversity in the workforce;
- employee relations trends, e.g. discipline, grievance, bullying/harassment, sickness absence, disputes;
- occupational health and wellbeing in the workforce
- external developments, best practice and industry trends in employment practice;
- staff recruitment, retention and satisfaction;
- employee engagement
- terms and conditions of employment, including reward;
- organisation development, organisational change management and leadership development in the Trust;
- training and development activity in the Trust including prioritisation;

To convene task & finish groups to undertake specific work identified by itself or the Trust Board.

To review and advise upon any other significant matters relating to the performance and development of the workforce.

7 Parent committees and reporting procedure

The Committee Chairman will report activities to the Trust Board following each meeting or as required.

8 Sub-committees and reporting procedure

LAB (Local Academic Board).

9 Administration

The Committee will be serviced by administrative support from the Trust Management Secretariat.

10 Review of terms of reference and monitoring compliance

Terms of reference agreed by Workforce Committee: 1 June 2015
Terms of reference approved by Trust Board: 24 June 2015
Terms of reference to be reviewed: June 2016

Maidstone and Tunbridge Wells NHS
NHS Trust

Management Committee Structure

TRUST BOARD

- **Audit and Governance Committee** (Bi-monthly) Chaired by NED
- **Remuneration Committee** Chaired by Chairman
- **Charitable Funds Committee** Chaired by NED
- **Quality and Safety Committee** (Bimonthly) Chaired by NED
- **Trust Management Executive** (monthly) Chaired by CEO
- **Patient Experience Committee** Chaired by NED
- **Workforce Committee** Chaired by NED
- **Finance, Treasury and Investment Committee** Chaired by NED

Audit and Governance committee oversees the activities of all the Committees

THICK ARROWS INDICATE INFORMATION FLOWS

Board Committees

Sub-Committees

Revised February 2014

Quality and Safety Committee

- Health & Safety Committee (bimonthly) Chief Operating Officer
  - Waste Group
  - Security Group
  - Resilience Committee
  - Medical Devices Committee
  - Patient Environmental Steering Group
  - Falls Committee
  - HIS Management Group
  - Occupational Health Group
  - KESWHL monthly Liaison Meeting for TW Hospital
  - Local & specialist H&S committees
  - Medical Gas Committee
  - Water Hygiene Steering Group
  - Asbestos Management Group
- Standards Committee (bimonthly) Medical Director
  - Nutritional Steering
  - Resuscitation
  - Sepsis Group
  - Transfusion
  - Ethics Committee
  - Research & Clinical Audit Committee
  - Interventional Procedures
  - Supervisors of Midwives
  - Medicines Management
  - Nursing, Midwifery & AHP Steering Group
  - Critical Care Delivery
  - Drugs & Therapeutics
  - Organ Donation
  - Dementia Steering Group
  - Blood Transfusion committee
- Infection Prevention & Control Committee (bimonthly) chaired by chief Nurse
- Safeguarding Children (Bi monthly) Chaired by Chief Nurse
- Safeguarding Adults (Bi monthly) Chaired by Deputy Chief Nurse
- Clinical Governance Committee (bimonthly) Chaired by Chief Nurse

Trust Management Executive

- Maidstone Programme Board
- TWH Programme Board

Directorates Meet regularly and feed in to the Trust Specialist committee meetings

- Performance Meeting
- OPERATIONAL DIRECTORATES
  - **Trauma & Orthopaedics**
  - **Critical Care**
  - **Cancer & Haematology**
  - **Diagnostics Therapies & Pharmacy**
  - **Operations Management**
    - Planned Care
    - Outpatients
    - Medical Records
    - Private patients
  - **Acute & Emergency Medicine**
  - **Speciality & Elderly Medicine**
  - **General Surgery, Urology, Head & Neck and Gynae-oncology**
  - **Women's & Sexual Health**
  - **Children's Services**

Finance, Treasury and Investment Committee

- IM&T Strategy Group (monthly) Chaired by ICT Director

Workforce Committee

- **Information Governance Committee (bimonthly)** Chaired by Chief Nurse
  - Health Records committee
  - Data Quality Steering Group
  - ICT Asset Administrators Group

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Trust Board meeting – June 2015

6-19	**Summary report from the Patient Experience Committee meeting, 03/06/15**	**Committee Chairman (Non-Executive Director)**

A Patient Experience Committee meeting was held on 3rd June, and covered the following issues:

- The **revised Terms of Reference** that were approved by the Board in April 2015 were noted
- The Deputy Chief Nurse provided initial feedback from the **2015 PLACE inspections**. It was noted that responses to the assessment are in the process of being collated and submitted to NHS England, and the national results are expected to be issued in August 2015.
- The **future use of call bell data** were discussed, and it was noted that data on call bell responses would continue to be included in the 'local surveys' report to the Committee
- The latest **Complaints and PALS contacts data** was reviewed; and an update on the latest activity of **Healthwatch Kent** was given by the Healthwatch representative
- The **draft Patient Experience priorities for 2015/16**, which form part of the Quality Accounts for 2014/15, were reviewed
- The Head of Communications gave a **Communications and Membership update**
- The Committee received **notification of planned service changes**, which included an update on the implementation of Chemotherapy E-Prescribing; the New Ambulatory Assessment Unit at Tun. Wells Hospital; & the plans to introduce a new Ward at that Hospital
- The latest findings from the **local patient survey (incl. Friends and Family)** were reviewed, as were the findings from the national **NHS Inpatient Survey 2014**
- The Committee received an update on the activity of its sole sub-committee, the **Patient Information and Leaflets Group** (PILG)
- Summary reports from the recent meetings of the **Quality and Safety Committee** were received. Committee members welcomed the level of detail within the reports
- Two **Junior Doctors** attended, and provided their patient experience-related observations
- The latest position regarding **Care Assurance Audits** was noted. It was acknowledged that these had not taken place since March, as a result of the need to undertake the PLACE assessments, but Audits would now be scheduled for the future.

A number of actions were agreed at the meeting, including the following:

- A complaints teaching session should be arranged for junior doctors; and the Trust's complaints leaflet should be reviewed to ensure it explicitly states that complaints documentation will not be filed within a patient's Healthcare Records
- The comments made at the Patient Experience Committee should be reflected within the specification for the Trust's new translation service
- Reports should be submitted to the Committee in September 2015 relating to: the time taken to answer telephone calls to the Trust; the number of Mixed Sex Accommodation breaches at the Trust; and the research into the workforce implications and impact on patient and staff experiences of the all single room hospital accommodation at Tunbridge Wells Hospital
- Junior doctors should be invited to be involved in the development / finalisation of patient information leaflets; and
- The methods by which the Patient Experience Committee receives information on the patient experience work undertaken by Clinical Directorates should be reconsidered

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

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Trust Board meeting – June 2015

6-20	Summary report from the Quality Committee meeting, 10/06/15	Committee Chairman (Non-Executive Director)

A Quality Committee 'deep dive' meeting was held on 10th June and covered the following issues:

"Learning outcomes from upheld complaints"

- The Chief Nurse and Complaints & PALS Manager presented a report aiming to provide assurance on the Trust's current processes around learning outcomes from complaints, and the work being done to make the processes more robust.
- Case studies were included, to illustrate the process.
- It was recognised that more work was required to improve the robustness of the processes, particularly in relation to the consistency of responses from Directorates. The process of ensuring Directorates completed an action plan was also noted to be very labour intensive
- The Chairman of the Quality Committee also presented a report she had prepared following her review of a selection of 9 randomly selected complaints. All of the complaints reviewed were noted to be well written, and use an appropriate tone. The Chairman's concerns related to delays in issuing responses, in the inconsistency between Directorates, and the limited assurance around learning within each Directorate and across the Trust. It was noted that further work was needed in this area.

"Review of the Mortality Review Group"

- The Medical Director provided details of the Mortality Review Group (MRG). Details of the current process for reviewing all deaths at the Trust were shown, and anonymised examples of completed "Mortality Review Forms" were presented, along with minutes of recent meetings of the MRG
- It was noted that the process only included in-hospital deaths, and the vast majority of deaths occurred within Medicine. The Committee discussed whether all deaths should continue to be reviewed, and it was agreed that an initial review be undertaken for all deaths, but a more detailed review only be undertaken for a selection of deaths, and this decision should be ratified by the Board.
- It was also agreed that the wider Dr Foster information relating to mortality should be discussed at MRG.
- In terms of reporting of mortality information to the Trust Board, it was noted that the MRG was now a formal sub-committee of the Quality Committee, and the MRG would therefore report its findings to the 'main' Quality Committee, which would provide a report to the Board every 2 months. A decision could then be made as to whether any further information needed to be provided to the Board.

Future meetings

- It was agreed that the 'deep dive' meeting, on 10th August would focus on "Review of Discharge arrangements" and "Review of Multidisciplinary Team (MDT) meetings". In addition, the external Governance Adviser's report should be discussed at that meeting
- It was agreed that 'deep dive' meeting in October should focus on Review of plans for 7-day working" and "Review of Pharmacy"

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

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Trust Board meeting – June 2015

6-21 Summary of the TME meeting, 17/06/15 **Deputy Chief Executive**

The Trust Management Executive (TME) met on 17/06, and the key points covered were as follows:

- The Chief Nurse gave a **safety message** relating to the need to ensure Risk Registers were kept updated, and regularly discussed at Directorate meetings
- The **Directorate reports** highlighted the following issues:
  - The Emergency Services Recovery action plan was reviewed
  - Work is continuing to try and introduce Radiology email reporting, and discussions were being held with the Kent and Medway Health Informatics Service (HIS)
  - A Haematology peer review had been held, and overall had been positive, though some areas for improvement had been identified
  - Five new Paediatric Consultants had been appointed, and would start in the autumn. However, the current shortage of Paediatric Registrars was continuing to pose challenges
  - The new Head of Midwifery was undertaking a review of the Midwifery structure to ensure the mix of staff and location was appropriate
  - The transfer of management of Pye Oliver Ward from Surgery to Medicine was noted
  - Consultant staffing within Anaesthetics was demanding focused attention by the Directorate
- The latest **performance, for month 2**, 2015/16 was reported (including the latest position regarding infection prevention and control). The A&E 4-hour waiting time target was noted to be challenging, but the positive performance in relation to Clostridium difficile was commended.
- The Chief Nurse provided the latest update on progress in implementing **the Quality Improvement Plan** developed in response to the findings from the CQC's inspection
- The latest position regarding **Length of Stay and Delayed Transfers of Care** was reported
- An update on the **Kent Pathology Partnership** (KPP) was given, and it was noted that KPP remains paused at present, until the Trust Boards determine the future direction for Pathology
- An update on the development of the **clinical strategy**, and the importance of Directorate staff engaging in the meetings being scheduled by the Head of Strategy was highlighted
- The full **winter and operational resilience plans** were discussed, and the Escalation policy and procedure for emergency admissions was 'approved'
- An update on the **future options for Stroke services** was given, but it was noted that the key issue was the outcome of the Kent and Medway review of Stroke Service
- The latest **CIP delivery plan** tracking dashboard was reviewed
- The Director of Workforce and Communications submitted the **draft Workforce Strategy**, 2015-20, for comment. The need to ensure alignment with the Clinical Strategy was acknowledged.
- The **Informatics Delivery Plan**, which included an update on the implementation of the SAcP was reviewed and approved. The Committee also reviewed the "**GS1 & PEPPOL adoption plan**", which was presented in the form of a Strategic Outline Case (SOC). The TME supported the SOC, which has been submitted to the June 2015 Trust Board, for approval.
- The recently-approved **business cases** were noted, and the business cases regarding Intensive Care Medical staffing and a Paediatric Epilepsy Specialist Nurse were approved.
- The **Outline Business Case for a new ward at Tunbridge Wells Hospital** was reviewed, and supported. The same case has been submitted to the June 2015 Trust Board, for approval.
- A request to appoint a 'replacement' **Sexual Health Consultant** was approved (the post is linked to the newly-awarded sexual health contract that the Board heard about at its meeting in May)
- An update on the **Internal Audit reviews** within the 2015/16 plan was provided, and updates were received on the work of the **TME's sub-committees** (Capital meetings; Sustainability Development & Environment Committee; Clinical Operations and Delivery Group; Policy Ratification Committee and Health Informatics Group)

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

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

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

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Trust Board Meeting - June 2015

6-22	**Review of the Outline Business Case for a new ward at Tunbridge Wells hospital**	**Chief Operating Officer**

The Outline Business Case (OBC) for the new ward development at Tunbridge Wells Hospital is enclosed. The Trust Board is asked to approve the OBC.

Although a Full Business Case (FBC) will be produced, in accordance with accepted standards, the OBC represents the key milestone in the development, as if the Board approves the OBC, the Trust will then proceed to enter into binding contracts with suppliers.

The OBC was reviewed at the Trust Management Executive on 17/06/15, and is scheduled to be reviewed at the Finance Committee on 22/06/15. The Case was supported, subject to some further consideration of the costs involved for Therapies, as listed in Appendix B. A verbal report of the outcome of the Finance Committee's review will be provided at the Trust Board meeting.

In addition to reviewing the OBC, the Board is also asked to consider how it wishes to consider the FBC. The options are:

1. Review of the FBC in full
2. Receipt of the summary details of the FBC (including final costings)
3. Notification of the final costings within the FBC by exception i.e. if, in the judgement of the Director of Finance, they differ significantly from the estimated costs within the OBC

The NHS Trust Development Authority will review the FBC, as part of the Trust's request for funding.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 17/06/15
- Finance Committee, 22/06/15

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

Review and approval

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

Maidstone and Tunbridge Wells NHS Trust

MTW New inpatient capacity

OUTLINE BUSINESS CASE

OBC V1.9

Maidstone and Tunbridge Wells NHS Trust

Business Case

MTW Outline Business Case - new inpatient capacity

Issue date	8th June 2015
Department	Corporate
Directorate	Emergency & Medical
Author	N. Baber
Clinical lead	A Soorma
Executive Sponsor	A. Gallagher
ID reference	353

Approved by	Name	Signature	Date
General Manager/ADO	M Dalziel/ L Grey		
Finance manager	J Coffey		
Clinical Director	A Soorma		
Executive sponsor	A Gallagher		
Supported by	**Name**	**Signature**	**Date**
Director Estates & Facilities	J Rooke		
Director of Informatics	D Jarrett		
Associate Director of Workforce	R Hayden		
Approved by	**Name**	**Minute**	**Date**
Directorate Board			
Investment Appraisal Group			
Trust Management Executive			
Finance Committee			
Trust Board			

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1. The Executive Summary

1.1. Introduction

1.1.1.The purpose of this Strategic Outline Business Case (OBC)

The purpose of this OBC is to determine the preferred way forward for services at the Maidstone Hospital and the Tunbridge Wells Hospital in the light of considerable operational pressures upon capacity and significant disruption of the flow of patients through hospital.

The capital cost of the preferred way forward is £4.475M
Revenue total after capital charges is a positive contribution of £170k.
Total cost £4.305M

1.1.2. Structure and content of the document

The Outline Business Case has been prepared using the agreed standards and format from HM Treasury for Business Cases, as set out in the HM Treasury Green Book. The approved format is the Five Case Model, which comprises the following key components:

The strategic case - this sets out the case for change, together with the supporting investment objectives for the scheme

The economic case - this demonstrates that the organisation has selected the most economically advantageous offer, which best meets the existing and future needs of the service and optimises value for money (VFM)

The commercial case - this sets out the content of the proposed deal

The financial case - confirming funding arrangements, affordability and the effect on the balance sheet of the organisation

The management case - detailing the plans for the successful delivery of the scheme to cost, time and quality.

1.2. The Strategic Case

This OBC directly supports the core strategic objectives of the Trust, in particular the aspirations for:

- Transforming the way we deliver services so that they meet the needs of patients
- Delivering services that are clinically viable and financially sustainable

The OBC is aligned with the national and local strategic context including:

- NHS Outcomes Framework (Department of Health, 2012)
- CQC Fundamentals Standards of Care (Care Quality Commission, 2014)
- Recommendations around the management of inpatient capacity from The NHS Urgent and Emergency Intensive Support Team.
- Kent Joint Health and Wellbeing Strategy – Outcomes for Kent 2014-17
- MTW Emergency and Medical Services Directorate Business Plan March 2015
- MTW CQC Improvement Plan 2015
- WKCCG Strategic Commissioning Plan 2014-19

The investment objectives are:

- Objective 1. To improve the quality of patient experience, patient outcomes and patient safety at our hospitals by matching inpatient bed capacity, as soon as possible in 2015-16 operating year as closely as possible to the recommended 85 percentile of variation in patient's demand for overnight stay on both of MTW main sites both during normal operation period and during winter peak demand period.

- Objective 2. To improve the patient flow through the hospital so more patients receive the right care, in the right location at the right place... first time

A robust case for change has been developed around the objectives of the case. Demand and capacity assessment shows there are significant gaps in inpatient capacity at the Trust in normal operating periods, exacerbated during the winter pressure period and increasing over the next 5 years. This case examines options to achieve the objectives, in the context of joint local health economy strategies.

1.3. The Economic Case

Options of geographical scope, the scale of change, estate solution and delivery options at TWH and Maidstone were considered at long list stage and refined to a short list that have been fully appraised at OBC stage.
The short list options are:

Table 1 showing the shortlist options

Option	Description
1	Do nothing/minimum
2	Service productivity and efficiencies and improvements in community provision
3	Internal conversion to provide new capacity and provide alternative accommodation for displaced administrative services. a) Bays b) Single rooms
4	Change use of the Wells (private patient) Suite
5	A new build at TWH for step down patients

1.4. The Financial Case

This scheme is a key priority for the Trust. The Trust has chosen to run at risk using its internally generated capital money in the first place to support the new ward development and in order to secure its delivery in a very short timeline.

Hard and soft FM costs that the Trust will own:

- Capital charges on £4m ward build at TWH assuming 60 years for depreciation/rate of return calculations.
- Rates
- Energy and Utility
- Domestics
- Portering/Catering

PFI operator costs using appropriately scaled UP variation costs are due to come through for the AAU conversion at TWH

The UP recurrent impacts will include:

- Service costs
- Insurance costs Capital life cycling (could be memorandum)

1.5. The Commercial Case

The project may be delivered with the support of Scape.
Scape is a public sector owned built environment specialist that offers a full suite of national frameworks and innovative design solutions. Scape Group brings together delivery teams in order to enable the development of performance managed and rapidly deployed procurement solutions.
The trust has experience of using Scape successfully with the Maidstone Urgent Medical Ambulatory and Assessment ward project. Solutions are designed to encourage reducing costs and increasing quality.

1.6. The Management Case

The technical leadership and project management will be provided internally by MTW NHS Trust.
The project will include formation of a clinical reference group to work on optimal clinical use and design of model of care.
A significant milestone to achieve will be the successful decant of services currently occupying the estate outlined for the development
The current timescale indicates a target date for completing clinical commissioning, late February 2016

1.7. Recommendation

This OBC has revisited the SOC assumptions and findings, established the preferred option and put in place the arrangements for the procurement of the scheme.

The MTW board and other approving authorities are asked to decide whether the project should move on to the procurement phase.

Maidstone and Tunbridge Wells NHS Trust

2. Strategic Case

2.1. National strategic context

MTW serves a population of approximately 550,000 in West Kent and East Sussex. MTW serves as a regional centre for the whole of Kent and Medway for many oncological services, including complex cancer resection surgery. The Tunbridge Wells Hospital at Pembury is a designated regional trauma centre.

Nationally, the emergency care system is under pressure. This winter, the NHS in England posted its worst A&E performance in a decade and at least 15 hospitals declared critical incidents as demand surged. This led to cancelled operations and asking people to come to A&E only in an extreme emergency.

Nationally, hospitals have been getting busier over the past five years, with increased numbers of emergency (non-elective) admissions and elective admissions. Population change is one factor driving increased NHS activity, but between 2009/10 and 2013/14 hospital activity increased at a faster rate than the population grew. Other factors such as the increasing numbers of older people, changes in the way that services are provided and changes in clinical practice have also combined to increase hospital activity.

This OBC has been prepared in the context of national documents and strategies including:

Table 2 showing national strategic publications relevant the case

National Publication	Context for case
NHS Outcomes Framework (Department of Health, 2012)	Treating and caring for people in a safe environment and protecting them from avoidable harm Ensuring that people have a positive experience of care
CQC Fundamentals Standards of Care (Care Quality Commission, 2014)	Service users must be treated with dignity and respect. Care and treatment must be provided in a safe way. Systems and processes must be established to ensure compliance with the fundamental standards.

2.2. Local strategic context

Regionally, hospitals have been getting busier. The local population is increasing and the age profile of that population is aging. There are also a number of unhealthy lifestyle factors that are contributing to an underlying increase in health care demand. These include obesity, smoking prevalence and low levels of exercise.

This OBC has been prepared in the context of local documents and strategies including:

Table 3 showing local strategic publications relevant the case

Local Publication	Context for case
Kent Joint Health and Wellbeing Strategy – Outcomes for Kent 2014-17	Transform services to improve outcomes, patient experience and value for money
The Kent and Medway Joint Strategic Needs Assessment (JSNA) –live document	The over 65 population in Kent has been rising by 4% p.a. The over 80 population in Kent is forecast to rise by 21% in next 6 years Projected increase in cardiovascular disease, respiratory disease, diabetes, stroke, some cancers, osteoarthritis…
MTW Integrated Business Plan 2014	MTW developing as a major emergency centre, a trauma centre, a cancer centre and specialist surgery centre.
MTW Emergency and Medical Services Directorate Business Plan March 2015	Surges in demand on the emergency pathway specifically in Q3/Q4 2014-15 Swale activity / pathway changes impacting on demand To establish correct bed base aligned to demand and acuity, and shape our inpatient service delivery to contain ourselves within that bed base through LOS programmes and integrated working with partners at transfers of care. To consistently and robustly meet our targets (emergency 4 hour access, MRSA Bacteraemia, C difficile, Diagnostic waiting times, Stroke, TIA, RTT) and work efficiently to mitigate DTOC's, mixed sex breaches, ambulance fines, and also reduce mortality rates, complaints and

Local Publication	Context for case
	serious incidents.
MTW CQC Improvement Plan 2015	Ensure that the directorate of specialty and elderly medicine reviews its capacity in medical care services to ensure capacity is sufficient to meet demand
WKCCG Strategic Commissioning Plan 2014-19	Senior input earlier in the patient journey resulting in safe rapid discharge and improved overall quality of care. Matching specialist medical capacity to patient demand

For MTW upward pressure on demand has been compounded by some issues at Medway Foundation Trust (MFT). MFT has experienced some difficulty meeting the emergency care needs of its population. East Sussex Healthcare Trust has reconfigured some of its emergency services which has changed some dynamics of regional emergency demand.

The MTW Quality Improvement Plan in response to the recent Care Quality Commission (CQC) inspection (2014) included a requirement that the directorate of specialty and elderly medicine reviews its capacity in medical care services to ensure capacity is sufficient to meet demand. This case is informed by that assessment.

MTW NHS Trust has strategic objectives developed in the light of the national and regional NHS context. These are:

- To transform the way we deliver services so that they meet the needs of patients
- To deliver services that are clinically viable and financially sustainable

MTW has a 5 year estates improvement plan that includes a considerable investment in service and environmental improvements. This includes a £3 million redevelopment of John Day and Jonathan Saunders Wards in June 2015, creating 31-bedded respiratory ward with 4-bedded bays and single rooms for inpatients that will greatly enhance their privacy and dignity.

The Trust has taken the opportunity to undertake a number of other service moves to improve services and mitigate risk to bed stock. These include:

Maidstone and Tunbridge Wells NHS Trust

2.3. Maidstone hospital reconfigurations

Table 4 showing Maidstone hospital reconfiguration

Area	Dates of Move	
Doctors' Mess	Achieved	Moved from Travers Unit into old endoscopy suite
Admissions Lounge	18th & 19th April	Currently located on Whitehead. It moves back to original location with improved privacy and dignity flows for patients in line with CQC guidelines.
Gynaecology Services on Peale	30th April & 1st May	Moves to Whitehead with the development of an additional colposcopy suite
Cornwallis Ward (19 beds)	23rd & 24th May	Female surgery moves to Peale Ward (13 beds)
Pye Oliver Ward (22 surgical beds)	29th & 30th May	Male surgery moves to Cornwallis (19 beds) Reduction in surgical bed base will eliminate potential for medical outliers.
Chaucer Ward	28th & 29th May	Relocate to the old orthopaedic unit (an upgraded 12 bedded area to develop a frail elderly unit, renamed the Edith Cavell Unit).
Link Corridor	Work starts 13th April	New walkway to link Edith Cavell Unit to UMAU, as no access via Jonathan Saunders.
Jonathan Saunders (23 beds)	3rd & 4th June	Ortho-geriatric rehabilitation services and medicine will decant to Chaucer Ward (33 beds).
John Day (26 beds)	4th & 5th June	Gastroenterology will decant to Pye Oliver (28 beds)
New John Day	Work starts 8th June	Build completes 30th October. Commissioning during November 2015.
Foster Clark Ward (28 beds)	27th November	Respiratory team move to new John Day (31 beds)

2.4. Objectives of the proposed investment

The investment objectives for this project, developed during the SOC and reconfirmed during the OBC, are as follows:

Objective 1
To improve the quality of patient experience, patient outcomes and patient safety at our hospitals by matching inpatient bed capacity, as soon as possible in 2015-16 operating year as closely as possible to the recommended 85 percentile of variation in patient's demand for overnight stay on both of MTW main sites both during normal operation period and during winter peak demand period.

Objective 2
To improve the patient flow through the hospital so more patients receive the right care, in the right location at the right place... first time

These objectives link directly with the trust objectives to

- To transform the way we deliver services so that they meet the needs of patients
- To deliver services that are clinically viable and financially sustainable

2.5. The current situation

Unscheduled care pathways in hospital are driven only by the flow of patients who arrive at the hospital door. Whilst there may be opportunities for commissioners to modify the way the general public and the primary and community care services access the hospital, once they arrive, the patients' needs have to be met promptly, safely and efficiently.

In the case of people who present to the Emergency Department, NHS service standards require very rapid completion of assessment and delivery of definitive treatment within four hours of arrival. Just how prompt, safe and resilient these unscheduled care services will be for patients is profoundly affected by the clinical efficiency and effectiveness of downstream care by the hospital, by length of stay, by discharge planning and by the efficiency of partnerships for onward health and community support, particularly for the 20% or so of frailer patients whose needs on leaving hospital will remain complex.

It is widely recognised that the hour by hour, day by day flow of unscheduled patients into various specialties requires careful planning and availability of resources to be able to escalate resources appropriately if demand rises or bottlenecks appear.

Bottlenecks cause overcrowding; overcrowded hospitals are dangerous places for patients and stressful places for staff. By taking effective steps to improve flow and reduce length of stay,

overcrowding can be reduced or eliminated. Money will be saved. Harm events will be reduced. Staff will find their work more rewarding.[1]

2.6. Demand and capacity

Optimum occupancy rates for hospital beds are context dependent and vary between organisations but, the National Audit Office has suggested that hospitals with average bed occupancy levels above 85 per cent can expect to have regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections.

Analytical work within the Trust shows that, using the criteria recommended by the NHS Urgent and Emergency Care Intensive Support Team, there are significant inpatient capacity gaps at the Trust. (For full details and assumptions see appendix D)

In 2014/15 the core funded capacity at both hospital sites was less than the recommended level of 85% of the predictable and consistent variation in demand for beds. This meant the hospitals, according NHS Urgent and Emergency Care Intensive Support Team criteria, were overcrowded. To reiterate, overcrowded hospitals are dangerous places for patients and stressful places for staff.

The trust's capacity and demand evaluation identifies a need to secure additional beds, as part of our core bed stock and during periods of escalation, particularly at TWH.
It was recognised, by the project team, that any additional beds alone would only offer a short term solution unless they act as a catalyst to ensure that the 'right patients arrive and are admitted to the right ward, first time', thereby supporting the whole patient flow through the system. Additional beds alone are not the long term solution. For further detail on demand and capacity, see appendix D.

2.6.1. Normal operating months

Table 5 showing capacity gap in normal operating months

Site	Current 'funded' bed stock	Demand for beds *at recommended 85th percentile of variation*	Gap
Maidstone	248	285	37
TWH	305	345	40
Trust	553	630	77

[1] The NHS Urgent and Emergency Intensive Support Team 2010

2.6.2. Winter pressure period. During the winter pressure period, demand for beds increases. This increase in demand is illustrated by the table below:

Table 6 showing capacity gap in the winter pressure period

Site	Current 'funded' bed stock	Demand for beds *at recommended 85th percentile of variation*	Gap
Maidstone	248	316	68
TWH	305	366	61
Trust	553	682	129

2.6.3.Escalation areas

As part of the Trust's planning for winter pressures, a number of escalation areas have been identified where patients can be accommodated overnight during peaks of demand. The clinical operations group have assessed the areas used in 2014/15. Some are suitable for continued use as patient escalation accommodation. Some areas are not suitable and they should only be used in an emergency because, if used, they will severely disrupt patient flow or they are not compatible with safe, high quality patient care.

The Wells (Private) Suite beds, reserved for private use, have also been classified as not suitable for pre-planned escalation, although the use of these will be subject to assessment in the short list options.

The following table outlines the escalation areas that have been used and which are suitable for pre-planned escalation use.

Table 7 showing escalation areas and which are suitable for pre-planned use

Maidstone escalation areas	Suitable for pre-planned escalation	Beds
Chaucer	Yes	12
UMAA	Yes	8
Whatman	Yes	28
Cardiac Catheter Laboratory	No	6
Short Stay Surgical unit	No	14
Total pre-planned escalation available at Maidstone		48
Tunbridge Wells escalation areas	Suitable for pre-planned escalation	Beds
The Wells Suite	No	13
Cardiac Catheter Laboratory	No	13
Short Stay Surgery Unit	No	15
Operating theatre recovery	No	12

Ward 11	No	1
Total pre-planned escalation available at TWH		0

2.6.4. Current demand and capacity summary

The table above shows Maidstone has suitable escalation available, if put into operation, to cover current normal operating periods and all but 20 of the 68 current winter pressure period capacity gaps.

The Tunbridge Wells hospital has no suitable escalation areas to cover the current normal operating period 40 bed gap or the 61 bed winter pressures capacity gap.

2.6.5. Delayed transfers of care

Part of the assessment of service need, carried out during the OBC, was an assessment of the typical number of patients, and the number of beds they occupy in MTW hospitals who have been delayed in their transfer of care out from the hospital. A reduction of these through improved systems in the community and in the Trust may solve some of the demand and capacity imbalance. The following table summarises the volume of delayed transfers of care in 2014/15 and the beds being used by patients with delayed transfers of care.

Table 8 showing extent of delayed transfers of care at the Trust

Category of delay	Maidstone	Tunbridge Wells	Total bed days lost in the year
Awaiting assessment	218	94	313
Awaiting public funding	21	107	128
Awaiting further non-acute NHS care	584	956	1540
Awaiting residential home	129	107	236
Awaiting nursing home	392	455	847
Awaiting care package	198	394	592
Awaiting community adoptions	107	181	288
Patient of family choice	821	1744	2565
Disputes	6	0	6
Housing	45	26	71
Total bed days lost	2522	4064	6586
Total beds used by patients while their transfer is delayed	8	12	20

In summary, approaching 4% of acute inpatient beds in the Trust are occupied by patients who should have been transferred out of the hospital.
The winter period always brings particular challenges and each of the NHS and Social Care organisations in Kent share the collective responsibility to work in the interests of the patient and to focus their clinical and management time and energy on ensuring high quality, joined up care.
The number of patients who are 'medically stable,' but waiting for safe and appropriate transfer home or to another place of care is closely monitored and every effort is being made to reduce any delays.
Arrangements for leaving hospital are co-ordinated by an Integrated Discharge Team, which includes nurses and social workers. Their role is to work with individual patients, who may have complex needs, to ensure they receive on-going care in the most appropriate place..

2.6.6. Future demand and capacity needs
Future reductions in demand or increases in capacity are options for decreasing capacity gaps

The following table summarises some of the potential change in the next 3-5 years and their potential effect on current percentage capacity shortfall.

Table 9 showing potential demand and capacity changes

Potential changes in demand and capacity	Scale of change	TWH peak period capacity gap	Maidstone peak period capacity gap
Current winter capacity shortfall. (After using appropriate escalation) *Based upon current Trust data using recommended benchmark*	-	17%	6%
Ward refurbishment and improvements to patient environment reducing capacity at Maidstone *Based upon current Trust estates plans*	+2%	-	8%
Increases in geographical catchment, East Sussex, North Kent and Trauma centre related at TWH *Estimated increase based upon current catchment*	+5%	22%	13%
Increases in demographic and lifestyle related demand 2015-20 *A prudent Trust estimate based upon ONS demographic growth and recognised pressures due to aging population and lifestyle factors*	+8%	30%	21%
Moving demand to community settings, productivity and efficiency savings as per Kent Joint Health and Wellbeing Strategy (JHWBS) *A fifteen percentage point reduction in hospital demand is forecast in the Kent JHWBS. A further 5% has been added to this, by the Trust planning team, in order to plan for an optimistic level of hospital demand reduction*	-20%	10%	1%

After the scenario of potential changes outlined above, including a 20% reduction in demand due to moving demand to community settings, efficiency and productivity, the Tunbridge Wells Hospital is left with a 10% gap to having the capacity to deliver projected demand.
This equates to a remaining capacity gap at the Tunbridge Wells Hospital of 37 beds.

2.7. Case for change – Business needs and problems with the current situation

As the demand for beds regularly exceeds normal funded level, various areas of the hospital are escalated into use as accommodation for patients for their overnight stay. This has led to patients being accommodated in areas that are inappropriate for use as a ward environment. In the previous months this has included patients staying in operating theatre recovery rooms overnight, staying in area of the emergency department after their emergency treatment has finished, and emergency patients staying in elective wards and longer stay patients staying in short stay assessment areas.
This leads to poor patient experience, escalation areas may lack required adjacency. Handovers between teams increase, patients under the care of specialist teams may be dispersed throughout the hospital.
Ambulatory and assessment units are disrupted and elective pathways blocked.
This system is disruptive to smooth and efficient patient flow through the hospital. A hospital system operating above recommended capacity may have negative effects on patient outcomes and patient safety.

The project team have compiled the following list of problems the trust is experiencing with the current situation.

- Patients being housed at peak times in areas of the hospital not compatible with high quality care. For example: A&E, theatre recovery unit
- Cancelled elective operations
- Difficulties meeting 4 hour wait performance in A&E YTD 92.3%[2]
- Risk to 12 hour wait in A&E, (2 patients breached in year)
- The trust operates at an escalated Red bed state (approximately 40% of days) and black bed state (occasionally)
- Outliers (patients in beds not allocated to patients with their particular needs)
- Frequent ambulance service diverts from TWH to Maidstone hospital. This occurs an estimated 70% of days in recent months
- Ambulances delayed in their handover of patients at the hospital front door
- Patients transferred between hospital sites for non-clinical reasons
- Cancelled Cardiac catheter laboratory procedures
- ICU discharge delays as sited in CQC report
- Stroke patients delayed in reaching stroke unit as per stroke standards. Four hour standard MTW performance: 39% of patients have been reaching stroke ward within 4 hours
- Safari ward rounds
- Admission and assessment units unable to function as process designed

[2] Figures taken where available from Trust dashboard Feb 2015

- Delayed treatment leading to LOS higher than necessary for patients
- Poor fit of capacity to demand leading to inappropriate use of staff, staff 'burnout' , loss of experienced staff, difficulty recruiting.

2.8. Case for change -Benefits associated with the investment

The project team have compiled the following list of intended benefits expected from the planned investment. These benefits are based upon successful achievement of objectives through the planned investment and through successful reduction in hospital demand. The reduction in hospital demand will be require collaboration in the local health community to achieve the 15% reduction in demand for hospital beds set out in the Kent Joint Health and Wellbeing Strategy.

- Red bed state declared half as frequently in the year following investment compared to the year preceding investment
- No Black bed states declared in the year following investment
- Ambulance service diverts reduced by half.
- No outliers in elective orthopaedic wards at TWH in the year following investment bringing about an increase in elective income
- No outliers in surgical elective wards at Maidstone in the year following investment bringing about an increase in elective income
- Achievement of the 4 hour A&E waiting time standard in the year following investment eliminating any associated fines
- No 12 hour wait breaches A&E waiting time standard
- No patients transferred between hospital sites for non-clinical reasons in the year following investment, therefore reducing wasted bed days (i.e. reducing LOS) associated with transferring patients between wards.
- A reduction in cancelled elective operations on the day before surgery
- A target reduction of cancelled elective operations, for non-clinical reasons, of 70% in the year following investment from the year preceding investment therefore bringing in extra elective revenue.
- Intensive Care Society compliance regarding ICU discharge delays
- Stroke patients reach stroke unit as per stroke standards. Four hour standard MTW performance meets standard and brings in extra tariff income from best practice tariff
- No patients being housed in the year following investment, at peak times in areas of the hospital not compatible with high quality care. Specifically: Operating theatre recovery unit. This will improve quality of care, increase patient satisfaction and reduce complaints
- Admission and assessment units function as process designed realising benefits (early senior assessment and treatment leading to LOS reduction, reduction of unnecessary admission) associated and described by those projects

2.9. Case for change –Risks

The project team have compiled the following list of business and service risks surrounding the planned investment, together with their counter measures. These include risks associated with taking action and risks associated with taking no action. At a later stage in the business case process the team completed a risk assessment specifically tailored to the short list of options, this is included in the economic case.

Table 10 showing the project's service risks

Main risk	Counter measure
Risk that MTW is unable to meet the emergency needs of its catchment population during pressure points in 2015/16. This has in 2014/15 led some trusts to declare a major incident	Prompt appraisal and approval of project. Work with partners to reduce effect
Risk that MTW reputation undermined with patients and public by its inability to fulfil its service requirements	Prompt appraisal and approval of project. Work with partners to reduce effect
Risk of loss of elective service and income to other NHS and private providers	Prompt appraisal and approval of project. Work with partners to reduce effect
Reduction in demand on hospital emergency care system making the extra capacity unnecessary	Incorporate flexibility into design so patients with different needs can be accommodated if required
Increasing capacity itself leading to increasing 'demand'	Work with commissioners on efficient pathway design and signposting. Incorporate flexibility into design so patients with different needs can be accommodated if required
Providing a facility that does not have required adjacency	Design team includes representatives across wide spectrum e.g. clinical , operational, estates etc.
Risk of delay to project and/or disruption of (adjacent or displaced) services during build and implementation	Consideration in long list option critical success factors
Risk of delay to project as existing services will require alternative location in a site with limited estate options	Decant options and costing to be included as part of the case
The risk that the availability of funding leads to delays and reductions in scope as a result of reduced monies.	Trust finance team consider contingencies
Staff not recruited	HR and clinical teams plan early

Main risk	Counter measure
Costs vary from projections	Project control. Draw upon the trust's considerable experience of reconfiguration and hospital build projects

2.10. Constraints

- Planning permissions. Local authority planning permission would be required for any significant build outside of the current hospital building. There may be difficulties obtaining such permission as the hospital has occupied the footprint limit allowed in the previous local authority planning permissions. For options inside the building planning permission is unlikely to be required, as long as there is no significant change to the outside of the hospital building.

- PFI contracts. There is a need to work though the legal requirements of any change in use of parts of the PFI building from administrative use to clinical use. The Trust Estates department are assured this will not be a significant constraint.

2.11. Dependencies

- Prompt approval by MTW Board and successful assurance of the internal decision making and governance processes that underpin that approval to the TDA.
- Sufficient capital resource being made available. Trust will be seeking a capital investment loan but will initially be deploying Trust capital resource.
- A consistent model of care ambulatory, elective and emergency is desirable and so both sites of the trust are interdependent.
- Ward refurbishment programme
- Commissioner/ local health economy programmes
- Moving clinical services into administrative area would depend on successful relocation of administrative staff

3. The Economic Case

3.1. The long list of options

A key component of developing a Business Case is the option appraisal exercise. It is only by comparing the alternatives that the real merits of any particular course of action are exposed. In order to achieve this, the TDA and HM Treasury recommend beginning with identifying a 'long list' of options, containing all the initial ideas about possible solutions. It is recommended that this should include not only the conventional solutions, but also any more innovative suggestions, however unlikely they may at first appear. Imaginative thinking is encouraged through brain storming and the range of options considered should be as wide as possible.

This exercise of generating the long list was undertaken by the Project Team in March 2015 as part of the development of the SOC, they have been revisited through the development of the OBC and are summarised below and recorded in an appendix.

The long list of options was developed and categorised under the headings of Scope, Technical Solutions, Service Delivery, Implementation and Funding. A summary of inclusions, exclusions and possible options are detailed in the table below:

Table 11 showing the long list options

Long list options		Finding
	Options of geographical scope	
	No change	Carry forward
	Tunbridge Wells only	Discount
	Maidstone only	Discount
	MTW wide	Preferred
	MTW plus satellite unit	Carry forward
	Options of scale of change	
	Sustain and improve quality and productivity of core services	Carry forward
	Rebalance service moves and changes of use of estate	Preferred
	Significant investment new services	Discount
	Options of service solution	
	Service productivity and efficiencies and improvements in community provision	Carry forward
	New (external to the hospital) build	Carry forward
	Internal conversion to provide more capacity (bays)	Preferred
	Internal conversion to provide more capacity (single rooms)	Carry forward

Long list options		Finding
	Change use of Wells (private) Suite to become NHS only	Carry forward
	Move Orthopaedics service from TWH to Maidstone	Discount
	No build. Move 'other service' from TWH to Maidstone	Discount
	Delivery options at TWH	
	Service improvement and efficiencies only	Carry forward
	Step down unit	Carry forward
	Mixed medical unit	Carry forward
	Medical assessment unit	Carry forward
	Other TBC	Carry forward
	Delivery options at Maidstone	
	Service improvement and efficiencies only	Carry forward
	Reconfiguration of Peale as a surgical ward	Preferred
	New build at Maidstone	Discount

3.2. The short list of options

The next stage in the process was for the long-listed options to be reduced to a more manageable 'short list' of options for in-depth appraisal and evaluation. The HM Treasury's 5 Case Model calls for a do nothing / minimum option to be short-listed and appraised even where it is not considered to be a realistic option. Its function is to provide a benchmark so that the value of the alternative 'do something' options may be judged by reference to current service provision.

Five short list options were refined by the project group from the long list.
The short list options are:

Table 12 showing the shortlist options

Option	Description
1	Do nothing/minimum
2	Service productivity and efficiencies and improvements in community provision
3	Internal conversion to provide new capacity and provide alternative accommodation for displaced administrative services. c) Bays d) Single rooms
4	Change use of the Wells (private patient) Suite
5	A new build at TWH for step down patients

3.3. Option appraisal

The various short list options for delivery of this project have been appraised to ensure value for money (VFM), in accordance with the tools and techniques devised by HM Treasury for the use by public sector organisations.

This section describes the options, describes the strengths weaknesses, opportunities and threats presented by each option.

Option 1
Do nothing/minimum

Description
With this option, extra escalation staffing nursing and support service costs will continue as per 2014/15.
In addition there will be an additional cost of to nurse patients more safely 'in corridors'. This may be calculated on 1 band 5 nurse per shift on each trust site. Covering 2 12h shifts. It is expected this will be required at Maidstone for 20 days and TWH for 40 days
Loss of elective income will continue as per 2014/15 as shown in the indicative costs in the SOC
There will be a loss of best practice tariff for stroke.
There will be continued fines for delays experienced by the ambulance service. These fines amount to £250 for each 30 minute delay and £1000 for each 60 minute delay.
There may be a financial penalty for failing to achieve the A&E 95% target.

SWOT
Strengths of this option: *The strength* of this option is the initial low capital cost

Weaknesses of this option: *The weakness* of this option does not address the objectives

Opportunities presented by this option: *The opportunities* provided by this option were not possible to define.

Threats presented by this option:
Are significant, with the top three business risks identified in the project not addressed.
These include:

- Risk that MTW is unable to meet the emergency needs of its catchment population. This has in 2014 led some trusts to declare a major incident
- Risk that MTW reputation undermined with patients and public by its inability to fulfil its business requirements
- Risk of loss of elective service and income to other NHS and private providers

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Table 13 showing option 1 summary information for economic case appraisal

	Option 1
	Do nothing
Capital	
Estate and facilities (Inc. professional services)	
IT (Inc. professional services)	
Subtotal	£0
Risk	
Decant Estates and Facilities	
Decant IT	
Equipment	
Subtotal	£0
Revenue	
Income	
Operational exenditure	-£2,473,797
IT (Inc. professional services)	
Decant Estates and Facilities	
Decant IT	
Subtotal	-£2,473,797
Capital Charges	
Revenue Total	-£2,473,797
Total cost	-£2,473,797
Non-financial Benefits score	Score 55. Least benefit of the 5 options
Non-financial benefits rank	5
Risk score	Score 125. Joint highest risk of the 5 options
Risk rank	5

Option 2

Service productivity and efficiencies and improvements in community provision

Description

At the front door to radically improve management of demand this would require 3 new consultant physicians. (One emergency medical and two care of the elderly or similar) These senior medical physicians would be supported by medical teams and 5 band 7 nurses, 3 band 7 prescribing pharmacists and 1.5WTE administrative support.

This option would involve the setting up of a **'bridging team'** between acute and community. They would facilitate earlier discharge and accompany the patient home. This would include a lead nurse Band 7 and an estimated 14 WTE band 6 nurses. There would need to be 1.5 WTE of administrative support in the form of case managers. It is prudent to allow for additional 1 WTE qualified occupational therapist support and 1 WTE physiotherapists support.

Each medical ward will require an additional band 5 nurse (6 in total) Each second surgical ward will require an additional band 5 nurse (3 in total)

There will be extra costs in the community to provide step down facilities and other support facilities for the front door team and the bridging team to call upon, these costs are difficult to quantify.

As recommended by HM Treasury the team considered costs of some risks.
Despite the spends outlined above, the team considered there would be a residual cost of risk of 50% p.a. of not avoiding the extra spend on escalation nursing as per 2014/15 and a residual cost of risk of 50% loss of elective income as per 2014/15

SWOT

Strengths of this option: *The strength* of this option is that it aligns with NHS strategic direction
Weaknesses of this option: *The weakness* of this option is that it may be asking too much of efficiency productivity and changes to community provision and that it does not address the defined immediate acute needs. There is also an element that the secondary care facility will incur all the costs but receive little income.
Opportunities presented by this option: *The opportunities* provided by this option. If an investments to be made an investment in this option may present an opportunity to the local health economy
Threats presented by this option: *The threats /risks.* The risk that efficiency and productivity alone will not be enough to meet the objectives and there being undefined costs in the community

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Table 14 showing option 2 summary information for economic case appraisal

	Option 2
	Service productivity and efficiencies and improvements in community provision
Capital	
Estate and facilities (Inc. professional services)	
IT (Inc. professional services)	
Subtotal	£0
Risk	
Decant Estates and Facilities	
Decant IT	
Equipment	
Subtotal	£0
Revenue	
Income	£998,859
Operational exenditure	-£1,541,803
IT (Inc. professional services)	
Decant Estates and Facilities	
Decant IT	
Subtotal	-£542,945
Capital Charges	
Revenue Total	-£542,945
Total cost	**-£542,945**
Non-financial Benefits score	230 (third best of 5 options)
Non-financial benefits rank	3
Risk score	103 (third best of 5 options)
Risk rank	3

As previously stated there will be additional resource requirements in the community to provide step down facilities and other support facilities for the front door team and the bridging team to call upon. As these resources have been difficult to quantify no cost has been allocated.

Option 3

Internal conversion to provide new capacity and provide alternative accommodation for displaced administrative services. Preferred option

Description

This option involves the internal conversion of an administrative area in the TWH to provide more capacity.

This may be 4 bed bays or a single room design as decided by a clinical reference group. The operational use will be decided via a clinical reference group. From a bed modelling/shortfall bays would seem to offer the preferred solution as this will maximise safely the number of additional beds that nursing can support.

This option will avoid the escalation nursing costs incurred during 2014/15 and allow the Trust to gain significant amounts of elective income lost during 2014/15.

As recommended by HM Treasury the team considered costs of some risks.
Despite the spends outlined above, the team considered there would be a residual cost of risk of 10% per annum of not avoiding the extra spend on escalation nursing as per 2014/15 and a residual cost of risk of 10% loss of elective income as per 2014/15

SWOT

Strengths of this option: *The strength* of this option is the control and flexibility it gives to MTW to immediately respond to operational challenges and recent failures to deliver required level of service. The chance to address current imbalance in capacity relatively quickly
Following the SOC, further analytical assessment of a 39 bedded medical ward was undertaken. It was found that: assuming a new ward at TWH was a medical ward, and with an average patient medical Length of stay (LOS) of 7.8 the 39 beds would accommodate 150 patients a month, averaging a 5 bed turnover per day.39 beds would fill the shortfall in core bed stock at Tunbridge Wells but a 20 bed escalation/winter shortfall will remain.

Weaknesses of this option: *The weakness* of this option include that potentially it could be seen as going against NHS strategy, however the intention is provide appropriate facilities for the emergency demand currently being seen not to increase emergency provision. By doing this the Trust can provide elective care to the population rather than lose that to other providers.

Opportunities presented by this option: *The opportunities* provided by this option are flexibility to provide for different patient pathways, to increase flow of patients. Enabling assessment units to function as designed. Enabling elective pathways to function more efficiently.
Threats presented by this option:
The threats /risks. Provision of displace administrative functions may be expensive and complex.

Table 15 showing option 3 summary information for economic case appraisal

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	Option 3
	Internal conversion to provide new capacity and provide alternative accommodation for displaced administrative services. Preferred option
Capital	
Estate and facilities (Inc. professional services)	-£3,570,000
IT (Inc. professional services)	-£139,134
Subtotal	-£3,709,134
Risk	
Decant Estates and Facilities	-£274,014
Decant IT	-£192,220
Equipment	-£300,000
Subtotal	-£4,475,368
Revenue	
Income	£1,997,717
Operational exenditure	-£1,376,002
IT (Inc. professional services)	-£16,859
Decant Estates and Facilities	-£39,800
Decant IT	-£105,374
Subtotal	£459,682
Capital Charges	-£289,607
Revenue Total	£170,075
Total cost	-£4,305,292
Non-financial Benefits score	Score: 415. Highest benefit score of the 5
Non-financial benefits rank	1
Risk score	Score: 66. Second least risk score of the 5
Risk rank	2

Option 4

Change use of the Wells Suite

Description

The Wells Suite is a 30 bedded private suite at the TWH. However it is currently occupied by NHS patients particularly at peak periods of demand in the winter. The team considered this unit would only provide for 13 beds in period of low demand and 7 extra NHS beds at periods of peak demand were its use to be formally changed to NHS only.

Changing the use to NHS would increase clinical staffing costs that would be partially offset by reduction in some administrative staff.

As recommended by HM Treasury the team considered costs of some risks.
Despite the spends outlined above, the team considered there would be a residual cost of risk of 90% per annum of not avoiding 66% of the extra spend on escalation nursing as per 2014/15 and a residual 90% risk of loss of 66% elective income as per 2014/15

SWOT

Strengths of this option: *The strength* of this option is the control and flexibility it gives to MTW to immediately respond to operational challenges and recent failures to deliver required level of service. The chance to address some of the current imbalance in capacity relatively quickly

Weaknesses of this option: *The weaknesses* of this option include a loss of income – to be defined. The capacity this option may make available at 13 beds is approximately one third of the current gap at TWH and one fifth of the gap during winter pressures.

Opportunities presented by this option: *The opportunities* provided by this option are some flexibility to provide for different patient pathways, to increase flow of patients. Enabling some improvement in assessment units to function as designed. Enabling some elective pathways to function more efficiently.

Threats presented by this option: *The threats /risks* A potential loss of income

Table 16 showing option 4 summary information for economic case appraisal

	Option 4
	Change use of the Wells Suite
Capital	
Estate and facilities (Inc. professional services)	
IT (Inc. professional services)	
Subtotal	£0
Risk	
Decant Estates and Facilities	
Decant IT	
Equipment	
Subtotal	£0
Revenue	
Income	-£689,801
Operational exenditure	£78,729
IT (Inc. professional services)	
Decant Estates and Facilities	
Decant IT	
Subtotal	-£611,072
Capital Charges	
Revenue Total	-£611,072
Total cost	-£611,072
Non-financial Benefits score	Score: 280 Second highest benefit score of
Non-financial benefits rank	2
Risk score	Score: 63 least risk score of the 5 options
Risk rank	1

Option 5

A new build at TWH for step down patients

Description

The team considered this option would comprise a nurse led 20 bed step down unit that would be staffed by nurses in a similar fashion to the old step down stroke facility at the Kent and Sussex Hospital in Tunbridge wells. It would care primarily for the medically fit.

The unit would require 5 to 6 junior medical staff in order that the unit was covered by a junior clinician 24 hours a day. A senior clinician would need to be present at least once a day and therefore 5 PA consultant time would be required.

As recommended by HM Treasury the team considered costs of some risks.
Despite the spends outlined above, the team considered there would be a residual cost of risk of 90% per annum of not avoiding 50% of the extra spend on escalation nursing as per 2014/15 and a residual 90% risk of loss of 50% elective income as per 2014/15

SWOT

Strengths of this option: *The strength* of this option is the control and flexibility it gives to MTW to immediately respond to operational challenges and recent failures to deliver required level of service.

Weaknesses of this option: *The weaknesses* of this option include potentially less flexibility in that a build offsite would potentially only be suitable for medically fit, step down patients requiring rehabilitation. An acute hospital increasing provision for the medically fit may not be a good fit with national strategy.

Opportunities presented by this option:
The opportunities provided by this option include the opportunity to replicate a successful model of stroke rehabilitation the Trust provided at the Kent and Sussex Hospital.

Threats presented by this option:
The threats /risks Planning permission may be difficult to achieve, space is limited and earmarked for some other projects at the Trust. The Trust may see providing more rehabilitation/ step down capacity on an acute site as contrary to the desired strategic direction of travel. Recent trends in the acuity of patient mix at the hospital is for less medically fit, younger patients and more frail elderly patients with multiple and clinically complex problems. A step down unit is not the right environment for many of these patients Were the unit sited on the car parks at TWH this would impact on patient, visitor and staff access to the hospital and so this threat will need to be managed if this option were chosen. .

Table 17 showing option 5 summary information for economic case appraisal

	Option 5
	Step down at TWH
Capital	
Estate and facilities (Inc. professional services)	-£1,800,000
IT (Inc. professional services)	-£257,474
Subtotal	-£2,057,474
Risk	
Decant Estates and Facilities	
Decant IT	
Equipment	
Subtotal	-£2,057,474
Revenue	
Income	£1,024,470
Operational exenditure	-£1,168,508
IT (Inc. professional services)	
Decant Estates and Facilities	
Decant IT	-£136,353
Subtotal	-£280,391
Capital Charges	-£181,555
Revenue Total	-£461,946
Total cost	-£2,519,420
Non-financial Benefits score	Score 195. Second least benefit of 5 options
Non-financial benefits rank	4
Risk score	Score 125. Joint most risk of 5 options
Risk rank	5

3.4. Non-financial benefit and risk appraisal - scoring and ranking

In line with HM treasury Green Book recommendations each option has been weighted and scored for benefits and the likelihood and impact of risks associated with each option scored and recorded. The following two tables summarise the results.

Table 18 Benefits (non-financial) score (weight each criteria to make a total of 100) Score each option on each criteria (1-5)

Option		Option 1		Option 2		Option 3		Option 4		Option 5	
Potential benefit	**Weight**	Score	Weight * score	Score	Weight * score	Score	Weight * score	Score	Weight * score	Score	Weight * score
Supports meeting required demand	**25**	0	**0**	2	**50**	5	**125**	1	**25**	2	**50**
Flexible solution in terms of patient type	**10**	0	**0**	2	**20**	5	**50**	3	**30**	2	**20**
Minimal disruption to services	**5**	1	**5**	3	**15**	4	**20**	5	**25**	3	**15**
Achievable in timescale	**10**	5	**50**	0	**0**	3	**15**	5	**50**	0	**0**
Support better flow through hospital	**15**	0	**0**	2	**30**	4	**60**	2	**30**	2	**30**
Supports NHS strategy of meeting patient's needs in best location	**5**	0	**0**	5	**25**	3	**15**	2	**10**	0	**0**
Sustainable	**10**	0	**0**	3	**30**	5	**50**	5	**50**	4	**40**
Improves quality of experience/ outcomes/ safety	**20**	0	**0**	3	**60**	4	**80**	3	**60**	2	**40**
Total score	**100**		**55**		**230**		**415**		**280**		**195**
Rank 1 = most benefit			**5**		**3**		**1**		**2**		**4**

Table 19 A risk score and rank for each option

Risks: Non-financial scoring Give 1-5 likelihood and impact rating for each option on each criteria

Risk	Option 1			Option 2			Option 3			Option 4			Option 5		
	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score	Likelihood	Impact	Risk score
Unable to meet emergency needs of our population	5	4	**20**	4	4	**16**	2	2	**4**	4	4	**16**	3	4	**12**
MTW reputation undermined	5	4	**20**	4	3	**12**	1	1	**1**	4	3	**12**	2	1	**2**
Loss of elective service	5	5	**25**	4	3	**12**	2	3	**6**	5	4	**20**	4	3	**12**
Trust 'exposed' if demand drops further than expected	1	1	**1**	1	1	**1**	2	2	**4**	1	2	**2**	2	3	**6**
Capacity used for patients who should not be in hospital	1	1	**1**	1	1	**1**	1	1	**1**	1	1	**1**	4	4	**16**
Inadequate adjacency	1	1	**1**	1	1	**1**	1	1	**1**	1	1	**1**	4	3	**12**
Delay for unforeseen reasons	1	1	**1**	4	4	**16**	3	4	**12**	1	1	**1**	5	4	**20**
Lack of funding	5	4	**20**	4	4	**16**	4	4	**16**	1	2	**2**	5	4	**20**
Shortfall in required staff	4	4	**16**	4	4	**16**	4	3	**12**	2	2	**4**	4	4	**16**
Lack of commissioner support	5	4	**20**	4	3	**12**	3	3	**9**	2	2	**4**	3	3	**9**
Total score			**125**			**103**			**66**			**63**			**125**
Rank 1 = least risk			**5**			**3**			**2**			**1**			**5**

Maidstone and Tunbridge Wells NHS Trust

Table 20 summarising the information required for the OBC short list option appraisal

	Option 1	Option 2	Option 3	Option 4	Option 5
	Do nothing	*Efficiency/ Prod. Comm.*	*New ward*	*Wells*	*Step down at TWH*
Capital					
Estate and facilities (Inc. professional services)			-£3,570,000		-£1,800,000
IT (Inc. professional services)			-£139,134		-£257,474
Subtotal	£0	£0	-£3,709,134	£0	-£2,057,474
Risk					
Decant Estates and Facilities			-£274,014		
Decant IT			-£192,220		
Equipment			-£300,000		
Subtotal	**£0**	**£0**	**-£4,475,368**	**£0**	**-£2,057,474**
Revenue					
Income		£998,859	£1,997,717	-£689,801	£1,024,470
Operational expenditure	-£2,473,797	-£1,541,803	-£1,376,002	£78,729	-£1,168,508
IT (Inc. professional services)			-£16,859		
Decant Estates and Facilities			-£39,800		
Decant IT			-£105,374		-£136,353
Subtotal	**-£2,473,797**	**-£542,945**	**£459,682**	**-£611,072**	**-£280,391**
Capital Charges			-£289,607		-£181,555
Revenue Total	-£2,473,797	-£542,945	£170,075	-£611,072	-£461,946
Total cost	**-£2,473,797**	**-£542,945**	**-£4,305,292**	**-£611,072**	**-£2,519,420**
Non-financial Benefits score	55	230	415	280	195
Non-financial benefits rank	**5**	**3**	**1**	**2**	**4**
Risk score	125	103	66	63	125
Risk rank	**5**	**3**	**2**	**1**	**5**

3.5. The preferred option

As shown in table 20 the new ward at TWH option scored the highest of the short list options in terms of non -financial benefits. It was assessed by the senior operational team to have the potential for: 8 times as much benefit as the 'do nothing' option, twice the benefit of the 'step down' and 'efficiency productivity alone' options and one and a half times the benefit of the 'Wells Suite conversion' option.

In terms of risk associated with each option, the 'New Ward 'option and the 'Wells Suite conversion' both resulted in similar levels of risk. Both were assessed by the senior operational team to be solutions with approximately half the risk score of the other three options.

The new ward option was just over twice the cost of the do nothing option but gave eight times the benefit and was assessed to have half the risk score.

The second and third highest benefit scoring options of 'Wells suite conversion' and 'efficiency and productivity only' , because of the difficulty meeting capacity requirements, were associated with significant financial risk of continuing to lose elective income and incurring additional nursing costs. The full costing of this risk was not included in the financial section of the economic appraisal, however, it was recorded in the narrative of each option and the project team considered these options carried too high a risk to be taken forward as preferred options.

On this basis, option 3, the new ward conversion at TWH, was chosen as the preferred option.

3.6. The quality and risk appraisal.

This section outlines the Trust's approach to ensuring quality and safety of the service in terms of building environment, requirements around infection control, privacy, dignity, disability and equality. Additional detail around the environmental sustainability of the proposed unit is also included. As the provider of the service MTW has a responsibility to review the quality aspects of the business case. Options were assessed for benefits and for risks. A Quality Impact Assessment that assesses the key areas affected by the investment has been collated. The key quality dimensions that were assessed are Clinical Effectiveness, Safety and Patient Experience

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3.6.1. Quality Impact assessment.

Quality Impact Assessment	
Clinical Effectiveness	
Have clinicians been involved in the service redesign? If yes, list who.	
Yes. Dr A Soorma and senior clinical director colleagues	
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)	
Yes. The NHS Urgent and Emergency Intensive Support Team.	
Are relevant Clinical Outcome Measures already being monitored by the Directorate? If yes, list. If no, specify additional outcome measures where appropriate.	
Yes. Full set of outcome measures as required by the TDA and reported on Trust Performance Dashboard including: Mortality rates, infection rates, falls, incidents, VTE rates, re admissions and length of stay.	
Are there any risks to clinical effectiveness? If yes, list	
Risks relating to project delay, decant and staffing are described and mitigation recorded in project risk register.	
Have the risks been mitigated?	
Yes	
Have the risks been added to the departmental risk register and a review date set?	
They will be added to the departmental risk register and a review date set within 1 month of business case being approved.	
Are there any benefits to clinical effectiveness? If yes, list	
Providing clinical care in an environment designed for the purpose, clinical effectiveness will be supported and enhanced by 'getting the right patient in the right bed 1st time'.	
Patient Safety	
Has the impact of the change been considered in relation to:	
Infection Prevention and Control?	Y
Safeguarding vulnerable adults/ children?	Y
Current quality indicators?	Y
Quality Account priorities?	Y
CQUINS?	Y
Are there any risks to patient safety? If yes, list	
No	
Have the risks been mitigated?	

N/A
Have the risks been added to the departmental risk register and a review date set?
N/A
Are there any benefits to patient safety? If yes, list
Providing clinical care in an environment designed for the purpose with appropriate clinical adjacency. Separation of elective and emergency flow Reduction of time patients spend unnecessarily delayed in a hospital environment Providing a mix of bays and rooms to meet the needs of patients for whom a single room is not always the best or safest option.
Patient experience
Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not.
Yes
Has the impact of the change been considered in relation to: • Promoting self-care for people with long-term conditions? • Tackling health inequalities?
Yes
Does the redesign lead to improvements in the care pathway? If yes, identify
Providing clinical care in an environment designed for the purpose with appropriate clinical adjacency. Separation of elective and emergency flow Reduction of time patients spend in a hospital environment Reduction in transfers between clinical teams or a reduction of ward rounds across several wards by the same team/s
Are there any risks to the patient experience? If yes, list
No
Have the risks been mitigated?
N/A
Have the risks been added to the departmental risk register and a review date set?
N/A
Are there any benefits to the patient experience? If yes, list
Yes Providing clinical care in an environment designed for the purpose with appropriate clinical adjacency. Separation of elective and emergency flow Reduction of time patients spend in a hospital environment Reduction in transfers between clinical teams or a reduction of ward rounds across several wards by the

same team/s Many patients find being accommodated in a ward bay, less isolating and a more positive experience than being in single rooms. The flexibility of both bays and single rooms is a key quality impact.

Service					
What is the overall impact on service quality? – please tick one box					
Improves quality	✓	Maintains quality		Reduces quality	
Clinical lead comments					
The clinical lead, represented through the Investment Appraisal Group, supported the preferred option.					

3.7. Building standards

Building Regulations, Legislation and specifically the Health Building Notes (HBN) and Health Technical Memoranda (HTM) are to be used as a basis for the functional design plans, and to define the type and number of rooms within the agreed schedules of accommodation.

The Trust will appoint Project Management support as well as Technical Advisors and Quantity Surveyors and Architects to develop and oversee the design solution in accordance with Legislation and best practice. In addition the Trust currently employs its own capital project team which includes, Fire Officer, Quantity Surveyor, Project Management and Security Specialist, to ensure the requirements are adhered to.

3.8. Infection control

The prevention and control of infection is a priority for MTW, and it is important that infection control requirements are designed in at the planning stages of any healthcare facilities, including new builds, refurbishments or change-of-use projects.

The MTW Infection Control Team will be involved in planning and design stages for the new in patient ward. The Team will continue to be involved throughout the construction process and to the final stage of the project (handover to clinical use).

The design plans have been drawn up in consideration of the HBN 00-09: 'Infection control in the built environment'. As part of the project the building contractors will work together with the Infection Control Team on a number of infection control aspects including, but not limited to:

Ensuring functional layout of rooms prevent cross-contamination with organisms that can lead to potential infections in patients;

Ensuring finishes to floors, walls, ceilings, doors, windows, and any other fixtures and fittings are compliant with HBN and HTM standards and existing design;

Ensuring that any ventilation and air transfers systems are safe and limit the risk of carrying infections around the building.

Access to the construction area will be via a dedicated external route, away from internal corridors and public access.

3.9. Business continuity during construction

The construction project requires refurbishment of existing buildings (Administration area) which is not used for clinical activity. There will be no need to transfer any clinical activity from the preferred location. However, building contractors will need to ensure that appropriate access to and from the construction site remains clear throughout the build project to limit the impact on other services provided from the TWH site. Temporary service diversions and hoardings will be used to maintain a safe environment for patients visiting and working at TWH during the construction process. Building contractors will also be required to comply with the arrangements for parking on the TWH site during the build.

3.10. Consultation and engagement

3.10.1.Clinical engagement

The original need for additional bed stock at TWH was recognised by the Director after last winter's capacity difficulties. This was then quantified in the capacity and demand work which was shared and understood by the clinical management team and particular within medicine. The numbers of beds and layout of the ward has been widely discussed within the directorates in order to ascertain the views of the clinical teams and which specialty could best utilise the new bed capacity. Wider engagement took place within Surgical and T&O team when it was recognised that there could be opportunity for swapping ward specialties around. The outcome of these discussions demonstrated that it was not a simple process. The principle of maximising the bed numbers to reflect the capacity shortfall was understood along with the need to offer flexibility with the available space resulting in the 39 bedded 4 bed bay configuration. This was then supported by the TME in May.

The debate then continued within the clinical teams around the numbers of single side rooms required as this related to the future specialty use. The clinical representatives took part in a risk assessment and review of the options. The outcome of all the discussion resulted in the recommendation that the capacity is needed for medical elderly frail patients, but the need for greater side rooms along with the opportunity for a larger MAU, resulted in the following: MAU

will be on level minus -1 I (in the new ward) and the new medical elderly unit will be where MAU was on level 0.

3.10.2.health economy stakeholders

At the FBC development stage MTW will continue to engage with a wider group of service users, including patients, their families and friends, and carers, to develop functional designs for the proposed facilities.

Support for the investment will be sought from a number of key stakeholders and organisations, including: Kent and Medway Area Team from NHS England, West Kent CCG, High Weald Lewes and Havens CCG, Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG and Kent Ambulance NHS Trust.

A number of meetings and presentations will be held with commissioners during the development of the FBC. This will be facilitated through appropriate work-streams during the project implementation stage.

3.11. Activity and service level agreement (SLA) implications.

These are described in the financial case although a key principle is that the health community will not be purchasing additional emergency activity. Rather emergency activity will be accommodated within high quality facilities and therefore the Trust will be able to operate its elective facilities in an efficient manner. The reduction in disruption to the flow of patients will allow the Trust to increase elective activity that has been, in recent months outsourced by Trust and commissioners to other providers.

3.12. Workforce planning

The workforce model for the unit will comprise medical, nursing, support service and administrative staff groups. Workforce planning will follow the usual Trust process of review and challenge.

The model adopted will be based on the recommendations set out in national documents and reflects the standard staffing adopted for wards across the UK.

The ratio of registered nurses to patients will need to be in the 1:5 – 1:8 range depending on specialty.

The changes to current staffing associated with the preferred option is summarised below:

Table 21 summarising workforce changes related to preferred option

	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Other
Consultants							1.5
Junior Medical							8.4
Nursing			10.75		1		
Admin			1				
Other	2.5		1.4		0.35		0.6
Total	2.5	0	13.15	0	1.35	0	10.5

Table 22 Table summarising the total nursing staff new ward complement

	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Other
Nursing	2.87		40.91	4	2		18.42

3.13. Estates

3.13.1. The preferred option is to provide a total of 39 beds through the development of 9no. four bed ward bays and 3no. single rooms, two of which will be designed to accommodate bariatric patients, a facility not currently provided for. The space has been designed in accordance with HBN and HTM with the acknowledgement at this stage that there is one derogation that en-suite facilities to the four bed bays will not be provided. However, the full ratio of toilet and shower facilities to beds will be provided. This provides the optimal use of space within the given footprint.

3.13.2. The design and finish of the new facility will comply with legislation and the standards achieved throughout the rest of the hospital site, in order to achieve the same, if not better, energy and environmental performance.

3.13.3. The works will take place within a self-contained unit and will not impact on the day to day operation of the Hospital activity. Through project planning and communication with stakeholders any works that may cause noise will be agreed and monitored and works ceased and re-programmed, if unacceptable.

3.13.4. Contractor will be designated a secure compound area in the hospital grounds away from any clinical activity, which will be returned to present condition on completion of the project. All contractors will be required to attend the Trust and Project Co local Induction and Site Contractors training course before being permitted to work on site

A site plan of the area is provided below

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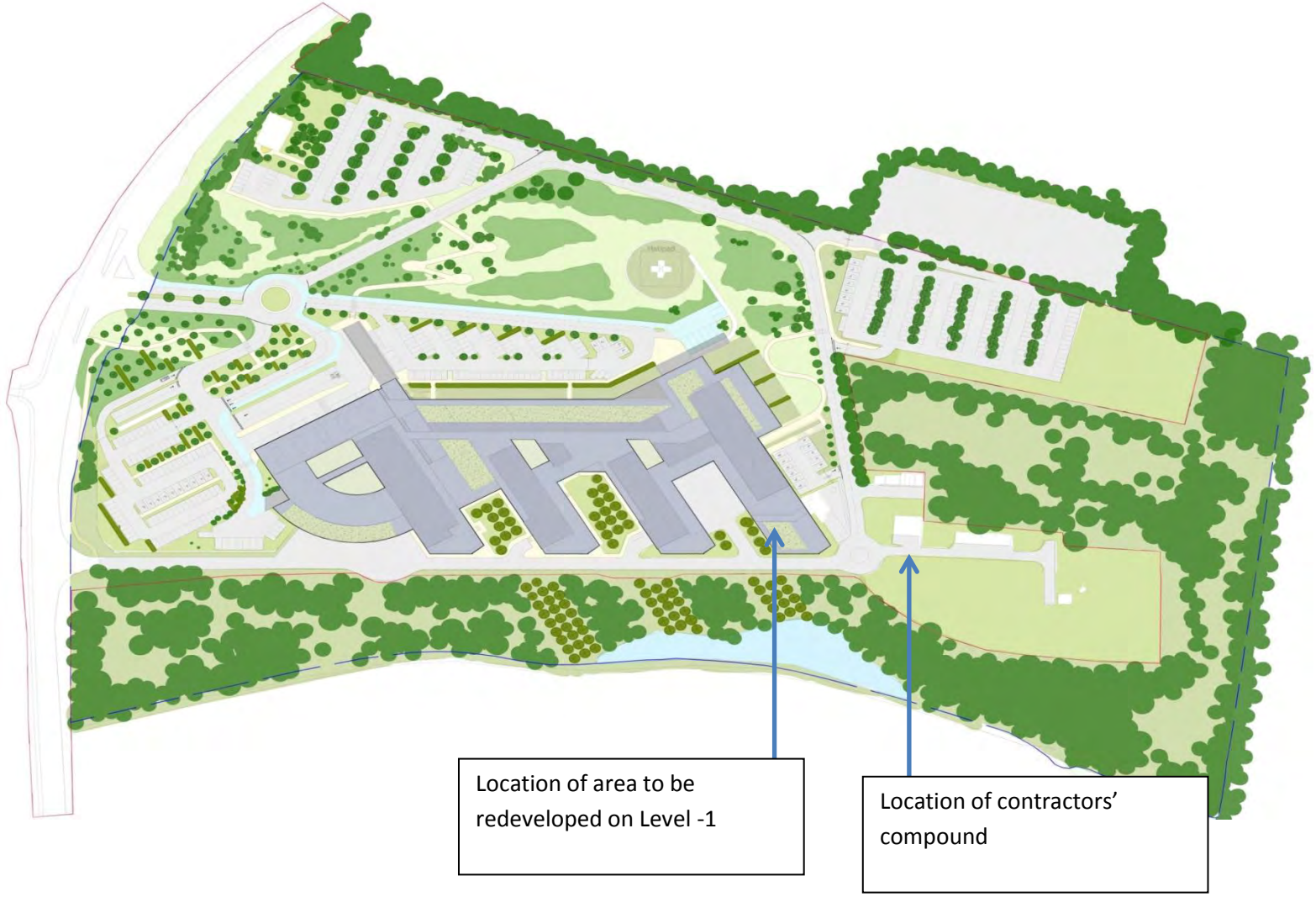
Development Control Plan



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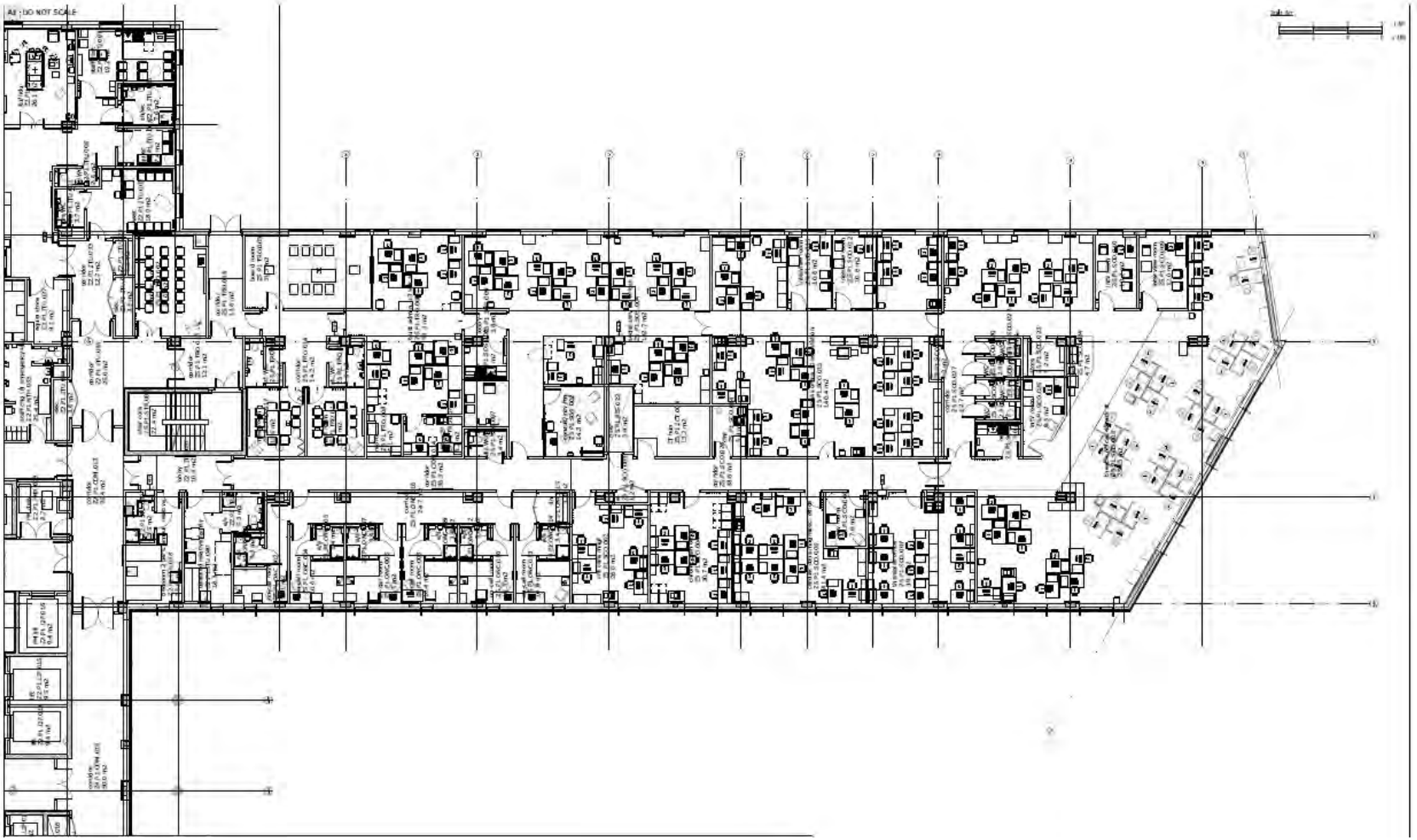
The area to be redeveloped currently consists primarily of office accommodation, see drawing below.



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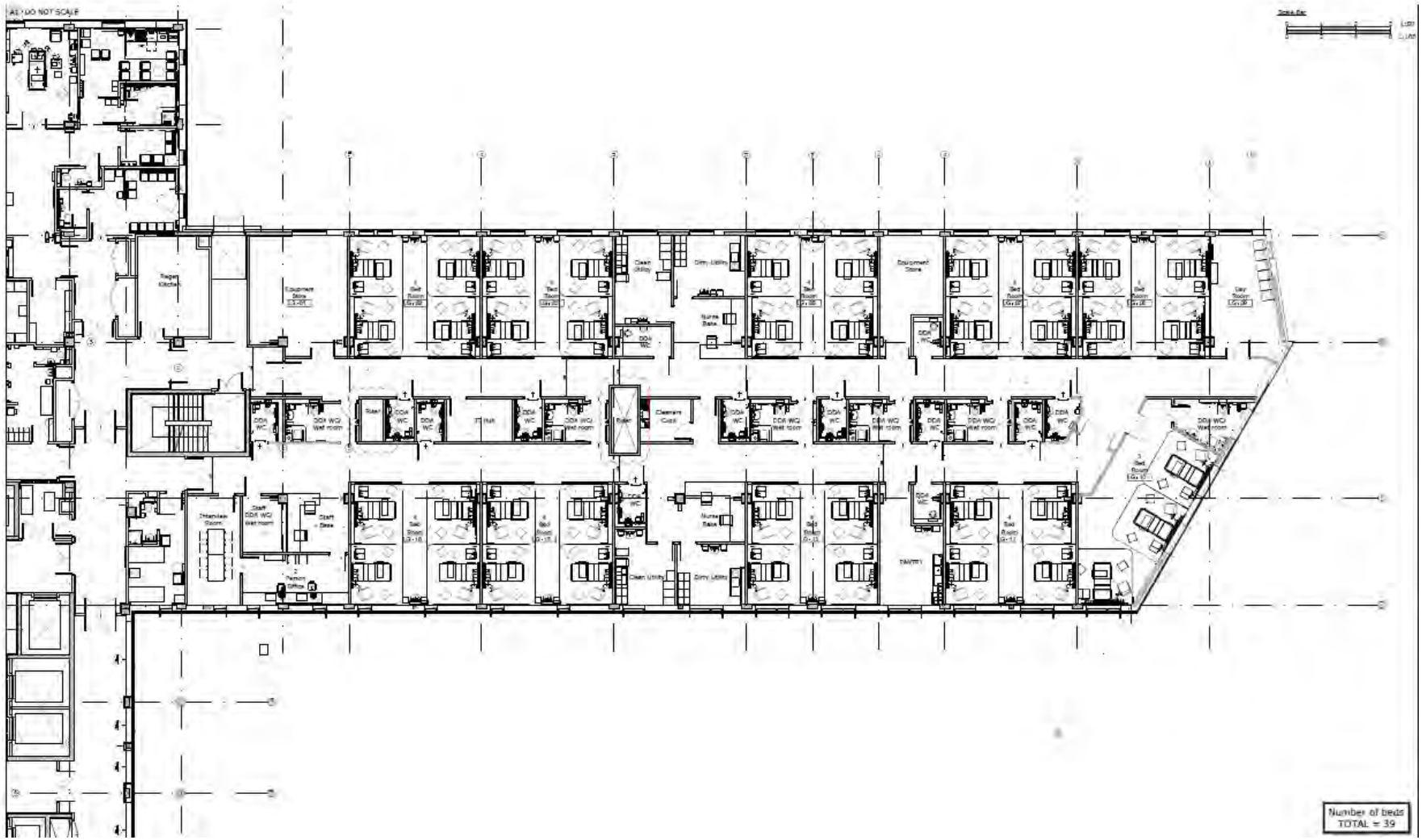
The proposed new design.



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3.14. The proposed design will include the following

Current preferred way forward subject to full clinical engagement and support

- 9no. four bed bays
- 3no. single rooms with en-suite
- Day room
- Toilet and Shower facilities for patients
- Toilet facilities for staff
- Dirty Utilities
- Clean Utilities
- Day Room
- Central Staff Base with Pneumatic Tube
- Nurse Base
- Sisters Office
- Therapy Room
- Equipment Store
- Cleaners Cupboard
- Linen Store
- ICT Hub
- Regeneration Kitchen
- Ward Pantry

3.15. The outline estates cost schedule

Table 23 summarising some detail in estates costs

	Estates and Facilities £
i) Ward area	3,570,000
ii) Equipment	300,000
iii) Decant Costings (New Ward)	
Ward area	274,014
Seminar Rooms - TWH	0
Seminar Rooms - Maidstone	0
	274,014
Total Capital	**4,144,014**

Revenue

	Estates and Facilities £
i) Ward area	
ii) Equipment	
iii) Decant Costings (New Ward)	
Ward area	39,800
Seminar Rooms - TWH	0
Seminar Rooms - Maidstone	0
Total Revenue	**39,800**

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3.16. Outline Information technology cost schedule

Table 24 summarising some detail in IT costs

		Qty	Unit Cost	Capital	Revenue
Building Works					
	Create Hub Room	0	0	0	0
	Air Conditioning	1	4,000	4,000	750
	Room UPS	0	0	0	0
Sub total				4,000	750
Connectivity					
	Radio/Wireless	0	0	0	0
	Laser	0	0	0	0
	Structure Cabling - 6 port bed	316	220	0	0
Sub total				0	0
Infrastructure					
Core	Patch Panels	10	75	750	0
	Racking	1	1,000	1,000	0
	Switches	7	6,000	42,000	6,174
	Cables Cat6	400	20	8,000	0
	Stacking	7	250	1,750	0
	Uplinks	0	500	0	0
	Access Points & Wireless	1	4,500	4,500	0
	UPS & PDU	1	1,500	1,500	0
Phones	Phones 7945	6	278	1,668	0
	Phones 7921	4	160	641	0
	Phones 7925	10	370	3,700	0
	Phone multicharger	2	232	465	0
	ATA190	2	116	233	0
	Red phone	1	180	180	89
PC/Printers	PC	9	951	8,559	1,260
	MFP	2	794	0	1,589
	Wrist Band Printer	2	441	882	0
Omnicell	Build	1	700	700	0
	Server License	1	411	411	0
	CCN - KMHIS	1	1,800	0	1,800
Nursing Obs	Ipad + cases	30	197	5,910	0
	Airwatch	1	2,070	0	2,070

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		Qty	Unit Cost	Capital	Revenue
	NerveCentre	15	759	11,385	0
Patient Entertainment System	TV	36	240		0
	Brackets	36	18		0
	Exterity	36	223		0
	Remotes	36	14		0
	Consultancy	2	500		0
	Headphone cabling	36	50		0
	Headphone	2628	1		3,127
Sub total				94,234	16,109

Professional Services					
	Project Manager	50	400	20,000	0
	Senior Consultant	0	0	0	0
	Server Engineer	12	400	4,800	0
	Network Engineer	20	400	8,000	0
	PES Engineer	6	375	2,250	0
	Telephony Engineer	6	375	2,250	0
	Desktop Engineers	9	400	3,600	0
Sub total				40,900	0
Grand Total	**Grand Total**			**139,134**	**16,859**

3.16.1.Assumptions used in the calculation of IT costs for the OBC:

In relation to decant of existing services: E&F has estimated the potential for between 200-400 individual office moves; therefore worst case assumed. Potentially, more than 50% of office moves may require new network points. A one in seven ratio for printers and relocation and reassignment to new groups of users has been used.

In relation to IT for the new ward, it has been assumed that there will be 6-ports to a bed.

Maidstone and Tunbridge Wells NHS Trust

4. The Financial Case

4.1. Source of organisational funding

This scheme is a key Trust priority. The Trust has chosen to run at risk using its internally generated capital money in the first place to support the new ward development and in order to secure it delivery in a very short timeline. Whilst this takes place an appropriate case is being prepared for external consideration for a capital investment loan.

4.2. Costs and affordability

4.2.1. Assumptions

The following assumptions have been made in calculating the costs associated with developing a 30 or 39 bedded ward at TWH:

- Potential benefits from de-escalation of TWH escalation areas and protection of elective activity has been prorated based on the % of winter bed shortfall that will be met i.e. 39 additional beds / 61 current winter bed shortfall = 64% of pressure to be met via increase in beds.
- Escalation Saving on Temporary nursing staff has been calculated by reviewing the hours requested on roster pro for 'escalation' for Short stay ward TWH, Theatres at TWH and Cardiac Catheter Laboratory at TWH. It is estimated that £444k of extra nursing costs has been incurred during 2014-15 relating for escalation in these areas; the potential savings included within the business case has then been prorated based on the % of bed shortfall that will be met with the new ward.
- Protection of elective activity due to bed pressures. The average day case and in patient income per working day at TWH (Orthopaedics, Surgery, Urology, ENT Cardiology and Obstetrics and Gynaecology specialties) has reduced by 14% between September and March compared to April and August, average income. If the same level of income per working day was maintained between Sept and March the income would have been £2m higher. The savings for 'protection of elective activity' included in the business case assumes the reduction is due to bed pressures and as a result a % of the income will be maintained if a new ward is built.
- Nursing – The costs for the 30 bedded ward has been based on Ward 10's staffing numbers. An initial assessment of a shift pattern for the 39 bedded ward has been provided by the Associate Directors of Nursing for Planned Care and for Emergency Care
- Medical Staffing – 15 PAs of consultant medical cover has been included (as advised by Associate Director of Operations for Emergency service). An assessment on the potential extra junior doctor support has been included, this assumes the 30 bedded ward would require 2 doctors in the day and 1 at night with the 39 bedded ward requiring 3 during day and 1 at night.

- Cleaning – Assumes extra 7.5 hours cleaning required per day (Mon to Fri) and extra 12.5 hours Sat and Sunday above current cleaning numbers.
- Depreciation and PDC based upon a £4m capital cost and 60 year depreciation period
- PFI Operator costs (Unitary payment (UP)) Information unavailable for costing
- Therapies – Staffing number and costs have been provided by the therapies manager
- Rates, Energy and Utilities – Estimated increase based on service line reporting calculations which estimate that a clinical area costs £45 more per square meter than non-clinical area

4.2.2. Costs for the 39 bed unit

Table 25 summarising costing of preferred option

	Preferred option
Internal conversion to provide new capacity and provide alternative accommodation for displaced administrative services. Preferred option	
Capital	
Estate and facilities (Inc. professional services)	-£3,570,000
IT (Inc. professional services)	-£139,134
Subtotal	-£3,709,134
Risk	
Decant Estates and Facilities	-£274,014
Decant IT	-£192,220
Equipment	-£300,000
Subtotal	-£4,475,368
Revenue	
Income	£1,997,717
Operational exenditure	-£1,376,002
IT (Inc. professional services)	-£16,859
Decant Estates and Facilities	-£39,800
Decant IT	-£105,374
Subtotal	£459,682
Capital Charges	-£289,607
Revenue Total	£170,075
Total cost	-£4,305,292

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Table 26 summarising operational expenditure of preferred option

Memorandum breakdown of operational Expenditure					
	Do nothing	*Efficiency/ Prod. Comm.*	*New ward*	*Wells TBC*	*Step down at TWH*
Additional Medical Staff		-£330,000	-£702,165		-£444,403
Additional Nursing Staff/Cost	-£476,080	-£1,088,035	-£404,250	-£305,955	-£672,464
Additional Clin Support staff		-£86,610	-£56,197		
Additional Overhead Staff		-£37,158	-£80,690	£410,094	
Additional Non Pay			-£132,700	-£25,410	-£432,941
Other	-£1,997,717				
Operational expenditure total	**-£2,473,797**	**-£1,541,803**	**-£1,376,002**	**£78,729**	**-£1,168,508**

Maidstone and Tunbridge Wells NHS Trust

5. The Commercial Case

5.1. Procurement Route

The project may be delivered with the support of Scape.

Scape is a public sector owned built environment specialist that offers a full suite of national frameworks and innovative design solutions. Scape Group brings together delivery teams in order to enable the development of performance managed and rapidly deployed procurement solutions.

The trust has experience of using Scape successfully with the Maidstone Urgent Medical Ambulatory and Assessment ward project. Solutions are designed to encourage reducing costs and increasing quality.

Scape's strategy to achieve the most economically advantageous tenders is to collate significant volumes of works (usually a four year programme) and procure them on both cost and quality. This enables Scape to select the best single supplier to deliver a service that is competitively priced and of the highest calibre.

Scape select a single source partner with the very best skillsets and a strong local delivery focus for each framework. Each partner then has the facility to tender each element of the commission through their supply chain, so the optimum local delivery team is selected for your project. For nearly a decade, Scape have developed and managed highly successful frameworks; this has encouraged continually reducing costs, ever increasing quality and has shaped an environment of collaboration and innovation; all of which directly supports your need to deliver more for less.

Previous customers have noted the following benefits of using the Scape framework;

- **Time savings** - Minimum 200 days are saved compared to traditional procurement. 100% of projects have been delivered on time and on budget since 2006.
- **Cost savings** - A current average of 14p for every £1 spent is saved across all projects through procurement, supply chain and early risk reduction savings.
- **Robust validated costs** - Your cost plan will be market tested 65% at feasibility, 85% at planning and 100% at contract to ensure robustness. 100% of the final price is market tested and independently verified as a current market price and value for money.
- **Demonstrable performance** - Performance is monitored and captured by Scape on your behalf at all stages of the project. Audited KPIs are reported direct to you via MiProject, a live performance and PM portal.
- **National delivery, local growth** - Procured nationally, the framework secures huge economies of scale. Delivered locally, it also drives social and economic benefits for communities throughout the UK.
- **Low contractor fees** - Low contractor fees, set at 1.75%, along with low management costs ensure your project benefits from being part of over.

There are number different Frameworks; Minor Works, Major Works, Project Management, Quantity Surveying, Facilities Management, Asset Management, Surveying and Design Service, Civil Engineering and Infrastructure. The Trust has commenced early discussions for this option utilising Scape process with the following registered supplier;

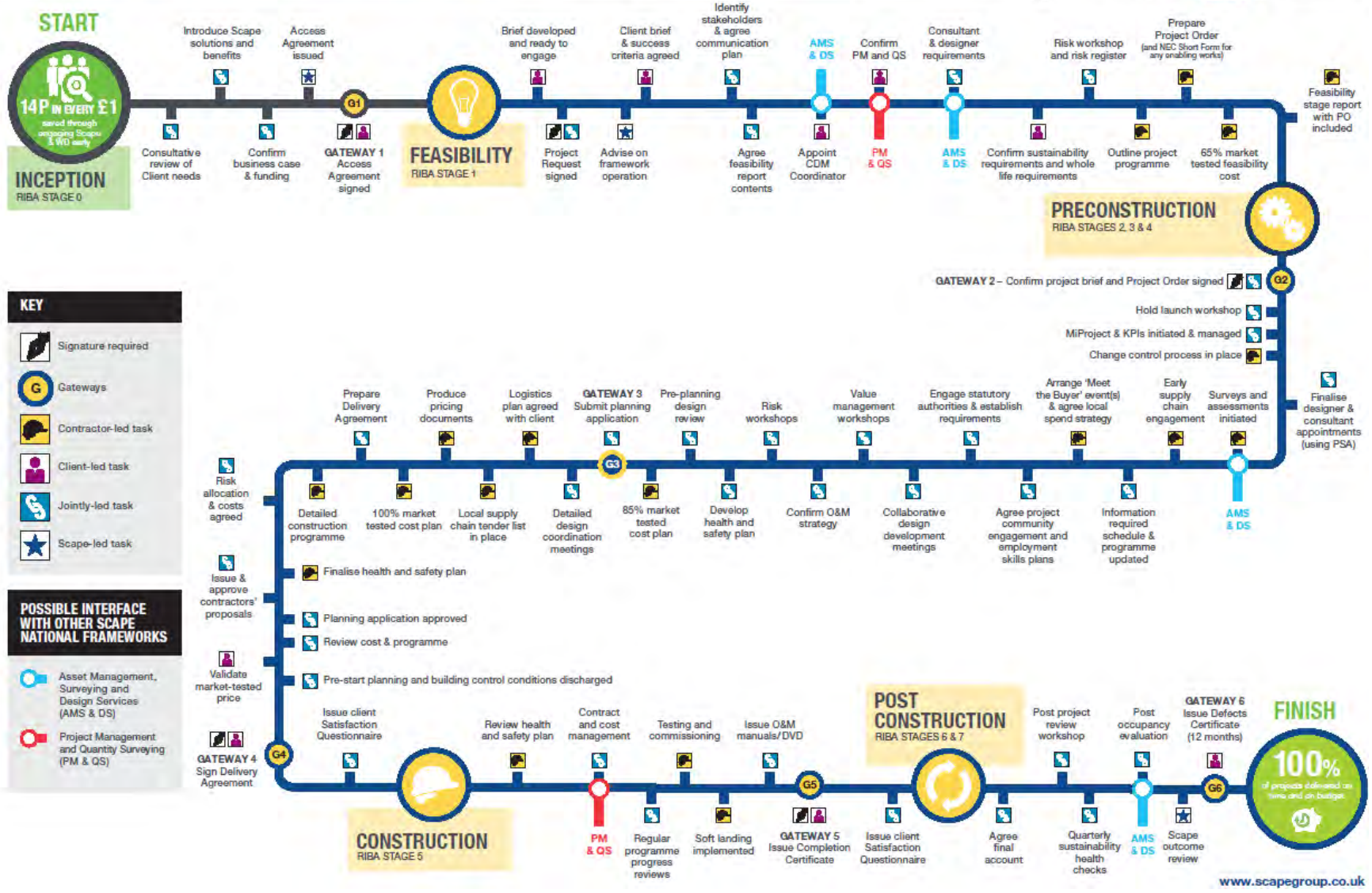
Framework	**Supplier**
Major Works (projects over £2m)	Willmott Dixon Interiors
Quantity Surveying and Project Management	Faithful & Gould

The major works framework process is shown below.

Maidstone and Tunbridge Wells NHS Trust

THE MAJOR WORKS FRAMEWORK PROJECTS £2 MILLION AND ABOVE...

Scape Procure



This is a traditional design and build project, however, the Trust has already commissioned work to prepare the 1:250 drawings that are included within this document.

These drawings have been shared with Wilmott Dixon who have confirmed their high level project timetable as;

Element	Timescale
Prepare Project Programme, Costs, Brief	End of May 2015
Project Workshop Meeting	2 June 2015
Sign Delivery Agreement	End of June 2015
Commence works on site	1 August 2015
Complete works on site	End of December 2015
Trust Commission works	January 2016

These works proposed are within Tunbridge Wells Hospital which was provided under a Private Finance Initiative (PFI). Therefore, formal agreement will be required with the Project Co and the Lenders. The formal route to agreement would normally require approximately eight weeks, however, a draft document has been developed based on previous project and this has been issued to Project Co for their early consideration and identification of associated costs.

It is regarded by Project Co as a straight forward proposal and therefore should not present any risk to agreement or delay to the project.

The Trust will be required to take out Building Insurance as per any building works being undertaken.

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6. Management Arrangements

6.1. Programme Structure

TME

MTW Programme steering group

TWH New ward steering group

Deliverables: To evaluate, direct and where applicable, agree recommendations from the project groups re.

- Operational model / design solution
- HR process & staffing
- Communication & stakeholder engagement
- Legal & Risk management
- Business case & Financial control

Clinical reference group (operations group)

Deliverables:

- Service model & pathways
- Ward design
- Operational policies
- HR and staff Recruitment plan– clinical , nursing, therapy , pharmacy soft FM,
- Fully Equipped unit
- Operational risk management
- Associated other ward specialty relocation

Construction project group

Deliverables:

- Design and build
- IT solution
- Patient entertainment
- Fixed equipment

Decant project group

- Deliverables
- Identified Space options, both sites
- Staff relocation plan
- Identify small works and IT / telephone requirements.
- Empty ward by agreed construction commence date.

6.2. Project management arrangements

The technical leadership and project management will be provided internally by MTW NHS Trust.
The project will include formation of a clinical reference group to work on optimal clinical use and design of model of care

6.3. The governance arrangements

The governance arrangements are covered by the MTW Board.

The main aims are to:

- Ensure the decision making can be integrated with MTW normal management processes as much as possible
- Clinical leadership and project management support can be targeted effectively and efficient
- Best practice is applied in terms of project management and governance

6.4. Outline project plan and timetable

Key phases of project:

1. Commercial
    - Justification of need based on demand and capacity and operational resilience
    - Assessment of options, considering the strategic fit and required Investment – how much £ to resolve the current problems in terms of both capital and revenue consequences.
    - Business case development/ formal agreement with 'Project co' (the company that run the PFI at TWH) and securing health economy support
2. Design and configuration based on operational use. To including decant solutions.
3. Decant and construction.
4. Implementation – move and migration

More detail on these key phases is shown in the project plan attached below.

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6.5. Indicative time scale

ID	Task Name	Duration	Start	Finish
1	**TWH Escalation Ward**	**5 days**	**Mon 23/02/15**	**Fri 27/02/15**
2	Project Initiation Document	5 days	Mon 23/02/15	Fri 27/02/15
3	**Governance and Funding**	**133 days**	**Mon 23/02/15**	**Wed 26/08/15**
4	**Business Case for Preparatory Works**	**63 days**	**Mon 23/02/15**	**Wed 20/05/15**
5	Estates Lead	1 day	Mon 23/02/15	Mon 23/02/15
6	Appoint Specialists (Architects; QS)	1 day	Mon 23/02/15	Mon 23/02/15
7	Develop Business Case	20 days	Mon 06/04/15	Fri 01/05/15
8	Investment Appraisal Group	1 day	Mon 04/05/15	Mon 04/05/15
9	MTW Programme Board	1 day	Thu 07/05/15	Thu 07/05/15
10	TME	1 day	Wed 20/05/15	Wed 20/05/15
11	**Assign Project Team Members**	**1 day**	**Wed 20/05/15**	**Wed 20/05/15**
18	SOC	10 days	Fri 08/05/15	Thu 21/05/15
19	**Outline Business Case**	**128 days**	**Mon 23/02/15**	**Wed 19/08/15**
20	Develop	50 days	Mon 23/02/15	Fri 01/05/15
21	Investment Appraisal Group	1 day	Mon 04/05/15	Mon 04/05/15
22	TME	1 day	Wed 20/05/15	Wed 20/05/15
23	Finance Committee	1 day	Fri 22/05/15	Fri 22/05/15
24	Trust Board	1 day	Wed 27/05/15	Wed 27/05/15
25	TDA	40 days	Thu 28/05/15	Wed 22/07/15
26	Capital Investment Loan (CIL) Application	20 days	Thu 23/07/15	Wed 19/08/15
27	Full Business Case Agreed With TDA	5 days	Thu 20/08/15	Wed 26/08/15
28	**Design**	**83 days**	**Mon 23/02/15**	**Wed 17/06/15**
29	1:250	53 days	Mon 23/02/15	Wed 06/05/15
30	1:50	20 days	Thu 07/05/15	Wed 03/06/15
31	Room Data Sheets	10 days	Thu 04/06/15	Wed 17/06/15
32	Equipment	10 days	Thu 04/06/15	Wed 17/06/15
33	ICT	10 days	Thu 04/06/15	Wed 17/06/15
34	**Relocations**	**51 days**	**Thu 21/05/15**	**Thu 30/07/15**
35	Appoint Specialist	1 day	Thu 21/05/15	Thu 21/05/15
36	Option Review	10 days	Fri 22/05/15	Thu 04/06/15
37	Establish Project Group	1 day	Fri 22/05/15	Fri 22/05/15
38	Legal Lease Agreement	20 days	Fri 05/06/15	Thu 02/07/15
39	Commission	10 days	Fri 03/07/15	Thu 16/07/15
40	Relocation	10 days	Fri 17/07/15	Thu 30/07/15
41	**Procurement (Build)**	**66 days**	**Thu 07/05/15**	**Thu 06/08/15**
42	OJEU	15 days	Thu 07/05/15	Wed 27/05/15
43	PQQ Appraisal	5 days	Thu 28/05/15	Wed 03/06/15
44	Tenders	20 days	Thu 04/06/15	Wed 01/07/15
45	Evaluation	10 days	Thu 02/07/15	Wed 15/07/15
46	Contract Award & Standstill	10 days	Thu 23/07/15	Wed 05/08/15
47	Contract Award Notice to OJEU	1 day	Thu 06/08/15	Thu 06/08/15
48	**Procurement (ICT & Equipment)**	**1 day**	**Fri 07/08/15**	**Fri 07/08/15**
49	Purchase Orders	1 day	Fri 07/08/15	Fri 07/08/15
50	**Legal and Contract**	**45 days**	**Thu 11/06/15**	**Wed 12/08/15**
51	PFI Project Agreement - Supplementry Schedule	40 days	Thu 11/06/15	Wed 05/08/15
52	Building Insurance	5 days	Thu 06/08/15	Wed 12/08/15
53	**Construction**	**125 days**	**Thu 06/08/15**	**Wed 27/01/16**
54	Build	120 days	Thu 06/08/15	Wed 20/01/16
55	Commissioning Tests and Certificates	5 days	Thu 21/01/16	Wed 27/01/16
56	**Commission**	**15 days**	**Thu 28/01/16**	**Wed 17/02/16**
57	**Non Clinical**	**5 days**	**Thu 28/01/16**	**Wed 03/02/16**
58	Facilities	5 days	Thu 28/01/16	Wed 03/02/16
59	ICT	5 days	Thu 28/01/16	Wed 03/02/16
60	Materials Management	1 day	Thu 28/01/16	Thu 28/01/16
61	Equipment	1 day	Thu 28/01/16	Thu 28/01/16
62	Clinical Clean	5 days	Thu 04/02/16	Wed 10/02/16
63	Clinical	5 days	Thu 11/02/16	Wed 17/02/16

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6.6. Training arrangements

On-going training and development is crucial to the continued delivery of modern and high quality professional services. The Trust is committed to creating a learning organisation where staff are recognised as an important resource and learning is valued.

The training arrangements will be developed as part of the work of the Clinical Reference Group for the OBC

6.7. Business assurance and benefits realisation arrangements

The benefits identified within this Strategic Outline Case (SOC) and set out below will be monitored throughout the development of the scheme, via project evaluation reviews (PER) and post implementation reviews (PIR), to maximise the opportunities for them to be realised.

• Supports Strategy – National / Regional / Local, including flexibility and future proofing

• Secures value for money

• The scheme is developed to have sufficient flexibility and future proofing to meet capacity requirements and efficiency targets

• Further improves patient and public experience through the quality of the built environment

• Patient experience is enhanced through improvement against current outcomes and performance

• Measured improvement in recruitment and retention of staff

• The facility encourages improvements in staff overall performance, morale and job satisfaction

6.8. Risk Management and Contingency plans

The project uses a standard MTW risk matrix scoring to develop a project risk register. During the Outline Business Case process a project risk register has been developed with the Project Team.

ID NO.	RISK DESCRIPTION	RISK SCORE	RAG RATING	MITIGATING ACTIONS	RESIDUAL RISK SCORE	RESIDUAL RAG RATING
1	**Business case time line risk:** Risk to being able to develop a comprehensive OBC Business case by June for approval from all relevant committees, in order to secure approval in sufficient time to allow 6 month construction and hit January 2016 goal date	4x4 likely x Sig	Red	SOC completed. OBC underway - Dedicated member of staff to write B case with working group to be set up with senior management input from finance and strategy	3x4 Possible x Sig	Amber
2	**Timeline slippage** - there is a very tight time line relating to the distance between each key milestone decision and delivery point. There is no contingency time built into the time line and therefore any delay in any aspect of the programme plan will have a direct impact of the subsequent milestone dates and ultimately delay to go live	4x4 likely x Sig	Red	Time line to be widely shared and commitment to key milestone sought from SRO and each project lead as to the production of the necessary documents and decisions needed to be made	3x4 Possible x Sig	Amber

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ID NO.	RISK DESCRIPTION	RISK SCORE	RAG RATING	MITIGATING ACTIONS	RESIDUAL RISK SCORE	RESIDUAL RAG RATING
3	**Staffing** : risk to being able recruiting sufficient staff including Medical, nursing and AHP, soft FM to cover the new ward	4x4 likely x Sig	Red	Identify numbers required of medical /nursing/AHP and begin recruitment campaign flowing B case agreement concerning revenue costs. A staged opening of the ward may need to be planned for depending on the success of the recruitment - this also need to be considered within the design of the ward e.g. ability to run with half the beds only open.	3x4 Possible x Sig	Red
4	**Decant of staff -** there are 149 staff needing to be moved from the area in which the new ward will be located. There is a risk that similar alternative location will not be found on site.	4x4 Likely x Sig	Red	Identify options for location and develop a set of alternative operational polices which will support the reduction of fixed desks eg increases number of HOT desk. Determine who has to be on site or could work near to site and who could relocate back to Maidstone. Identify feasibility and impact of lease or purchase of office block as a short term solution of any shortfall .	4x4 Likely x Sig	Red

ID NO.	RISK DESCRIPTION	RISK SCORE	RAG RATING	MITIGATING ACTIONS	RESIDUAL RISK SCORE	RESIDUAL RAG RATING
5	**Risk to Patient & staff experience** during ward development: Potential risk of noise disturbance to the ward above and education black below the area being developed	3x3 possible x moderate	Amber	Ensure that there is excellent communication to all key stakeholders and patients/relatives; Key staff groups to know when key noises phases of the development are likely take place .	3x2 possible x low	Green
6	**Operational Risk**: of securing new operational pathways and models of care within a new ward design .	3x3 possible Moderate	Amber	Early clinical stakeholder involvement in developing and confirming which patient group and specialty is to use the new ward capacity, along with defining the care pathways in line with best practice will help align the design to the operational needs of the service	3x3 possible Moderate	Amber
7	**Equipment Risk**: a. that IT, telephones infrastructure and capacity will not meet the staff decant and new ward layout plans and b. All ward equipment will not be ordered and delivered ready for go live.	3x4 possible x significant	Amber	a. Ensure that staff location plans are discussed with IT department to determine feasibility re technical infrastructure requirements b. Ensure that all equipment is identified in a timely way so that order can be place considering their lead in and delivery times once the B case has been agreed and revenue budget released	3x4 possible x Significant	Amber

6.9. Arrangements for post project evaluation

Post Project Evaluation (PPE) will be undertaken to improve future project briefing, project management, and implementation for future projects.

It will also be used to measure the performance of the completed facility against the benefits identified within this Business Case.

During the course of the project, MTW NHS Trust may implement a performance measurement based on a series of Key Performance Indicators (KPIs).

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OBC Version history

Version	Issue date	Brief Summary of Change	Owner's Name
1.0	Internal to project team	Initial working drafts in development	N Baber
1.1	Internal to project team	Following benefits and risk workshop	N Baber
1.2	Internal to project team	Estates detail included	N Baber
1.3	To IAG	Strategy first edit. Preparation for financials	N Baber
1.4 to 1.8	Internal to project team	Estates and IT updates. Financial assessments	S Jones
1.9	To Executive team and TME	Finalise OBC workforce and financials	A Gallagher

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Appendix A

Identifying options *The Economic Case*

Critical Success Factors

The following critical success factors that each option is accessed against have been agreed by the project group. The group included associate directors of operations, senior nurses programme manager

- Adjacency to required clinical and support facilities
- Quality – patient safety
- Quality – patient experience
- Quality – patient outcomes
- Positive impact on efficiency and financial performance
- Flexibility in use
- Patient accessibility
- Sustainable
- Supports development objectives
- Achievable within timescale
- Minimal disruption to other clinical service
- Proven design

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Long list options

Options concerning the geographical scope of the investment (*where are we looking at?)*

Option	Option 1a	Option 1b	Option 1c	Option 1d	Option 1e
Description	*Continue with current arrangement*	*Tunbridge Wells*	*Maidstone only*	*MTW wide*	*MTW wide plus satellite*
Meets objective					
Match inpatient bed capacity to patient demand and improve flow	*x*	*1/2*	*1/2*	✓	✓
Satisfies critical success factors					
Adjacency	✓	*?*	*?*	✓	✓
Patient safety	-	*?*	*?*	✓	*?*
Patient experience	*x*	*?*	*?*	✓	✓
Patient outcomes	*x*	*?*	*?*	✓	✓
Positive impact on	*x*	*?*	*?*	✓	✓
Flexibility in use	*x*	*?*	*?*	✓	✓
Patient accessibility	*x*	*?*	*?*	✓	✓
Sustainable	*x*	*?*	*?*	✓	✓
Supports development	*x*	*?*	*?*	✓	*?*
Achievable within	*x*	*?*	*?*	✓	*?*
Minimal disruption to	*x*	*?*	*?*	✓	✓
Proven design	*x*	*?*	*?*	✓	*?*
Summary	*Carry forward*	*Discount*	*Discount*	*Preferred*	*Carry forward*

The project group discounted any investment that did not take into account both sites of the trust. However, the operational team are part way through implementing a reconfiguration of services at the Maidstone site. This includes increasing capacity in a number of areas on the site. As this programme is on -going the group decided the focus of investment in this case should be on the Tunbridge Wells Hospital site.

Options concerning the long term v short term scope of the investment

Option	Option 2a	Option 2b	Option 2c
Description	*Sustain and improve quality and productivity of core services*	*Rebalance service through moves and changes of use of estate*	*Significant investment to support strategy e.g. new services in community/ new elective care hospital etc.*
Meets objective			
Match inpatient bed capacity to patient demand and improve flow	✓	✓	*?*
Satisfies critical success factors			
Adjacency	✓	✓	*?*
Patient safety	✓	✓	*?*
Patient experience	✓	✓	*?*
Patient outcomes	✓	✓	*?*
Positive impact on	✓	✓	*?*
Flexibility in use	✓	✓	*?*
Patient accessibility	✓	✓	*?*
Sustainable	✓	✓	*?*
Supports development	✓	✓	*?*
Achievable within	✓	*?*	*?*
Minimal disruption to	✓	*?*	*?*
Proven design	✓	*?*	*?*
Summary	*Carry forward*	*Preferred*	*Discount*

The project group considered the scope of this project in terms of balance between long term strategic change and short term operational goals. The group considered the investment would focus on improving quality and productivity of core services but also build on emerging opportunities and be flexible to respond to future needs. It was not thought appropriate that his project consider new ways of delivering services in a long term context requiring major investment such as that for moving hospitals / units or major community changes.

It was considered that emerging opportunities were being taken and this investment should be seen as part of these. The recent opportunities taken include

1. Formation of surgical assessment unit
2. Conversion of administration space into a patient assessment ambulatory unit
3. An outpatient procedure room into an ophthalmic theatre
4. A clinical examination are into an inpatient bedded area

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Options concerning the service solution

Option	Option 3a	Option 3b	Option 3c i	Option 3c ii	Option 3d	Option 3e	Option 3f
Description	*Service productivity and efficiencies only*	*New (external to the hospital) build*	*Internal conversion to provide more capacity-Change management block to a ward with 4 bed bays*	*Internal conversion to provide more capacity- Change management block to a ward with single rooms*	*Change use of Wells Suite to become NHS only*	*No build. Move Orthopaedics service from TWH to Maidstone*	*No build. Move ' other service' from TWH to Maidstone*
Meets objective							
Match IP capacity to patient demand & improve flow	*?*	✓	✓	✓	*?*	*x*	*x*
Satisfies critical success factors							
Adjacency	-	?	✓	✓	✓	*x*	*x*
Patient safety	-	✓	✓	✓	✓	*?*	*?*
Patient experience	-	✓	✓	✓	✓	*?*	*?*
Patient outcomes	*x*	✓	✓	✓	✓	*x*	*x*
Positive impact on efficiency and financial performance	*?*	?	✓	✓	*?*	*x*	*x*
Flexibility in use	-	?	✓	*?*	*?*	*x*	*x*
Patient accessibility	x	?	✓	✓	✓	*x*	*x*
Sustainable	?	✓	✓	✓	✓	*x*	*x*
Supports development	?	✓	✓	✓	✓	*x*	*x*
Achievable within timescale	?	*?*	*?*	*?*	*?*	*x x*	*x x*
Minimal disruption to other	x	✓	✓	✓	*?*	*x*	*x*
Proven design	✓	✓	✓	✓	✓	*x*	*x*
Summary	*Carry forward*	*Carry forward*	*Preferred*	*Carry forward*	*Carry forward*	*Discount*	*Discount*

The group considered moving orthopaedics back to Maidstone was not a viable option in the timescale as it would require going back on a reconfiguration just bedded in, it may require consultation and would not support trauma unit service provision.

The internal conversion option would require the provision of alternative accommodation for displaced administrative services

Change use of Wells Suite to become NHS only would not displace so many administrative services but would, in all likelihood, provide for less clinical capacity and would require alternative arrangements for the private service

The group considered new build option and all single rooms to be potentially less flexible and potentially constrained in the number of beds those options could provide. The operational group strongly favoured a design incorporating bays and single rooms to maximise flexibility of use and capacity potential. The new build option was considered a feasible contingency option. Potentially this could be a temporary step down facility.

The new build was carried forward although it was thought a new build may be more difficult to achieve in the timescale due in part to planning permission requirements

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Long list options continued

Options concerning the operational use of the facility at TWH

The project group considered that options including new 'step down areas' may have a risk of increasing handovers within hospital and not facilitating improved flow out of the hospital. However, a number of patients in the hospital at any time are deemed medically ready for discharge. A step down facility therefore could not be discounted at this stage and the group felt flexibility in use was an important consideration to take forward. The project board are arranging for consultation with senior clinical and management staff to gauge the best way to use the space. The team have engaged a clinical champion to take forward the development and operational policy of the ward

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Long list options continued

Options concerning the delivery solution of the investment at Maidstone

Option	Option 1d	Option 2d	Option 3d
Description	*Service improvement and efficiencies only*	Reconfiguration of Peale as a surgical ward	*New build at Maidstone*
Meets objective			
Match inpatient bed capacity to patient demand and improve flow	*x*	*?*	*?*
Satisfies critical success factors			
Adjacency	✓	✓	*?*
Patient safety	-	✓	*?*
Patient experience	-	✓	✓
Patient outcomes	-	✓	✓
Positive impact on efficiency and financial	-	✓	*x*
Flexibility in use	*x*	*?*	*x*
Patient accessibility	✓	*?*	✓
Sustainable	✓	✓	✓
Supports development	✓	✓	✓
Achievable within	-	✓	*x*
Minimal disruption to	-	✓	✓
Proven design	-	✓	*?*
Summary	*Carry forward*	*Preferred*	*Discount*

The trust is part way through implementing a reconfiguration of services at the Maidstone site. This includes increasing capacity in a number of areas on the site and at this time a new build on the site was not considered a realistic opt

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Long list options continued

Options concerning the implementation

Option	Option 1e	Option 3e	Option 4e	
Description	*No change*	*Big bang*		
Meets objective				
Match inpatient bed capacity to patient demand and improve flow	*?*	✓		
Satisfies critical success factors				
Adjacency	-	-		
Patient safety	-	-		
Patient experience	-	-		
Patient outcomes	-	-		
Positive impact on	-	-		
Flexibility in use	-	-		
Patient accessibility	-	?		
Sustainable	-	-		
Supports development	-	?		
Achievable within	-			
Minimal disruption to	-			
Proven design	-			
Summary	*Carry forward*	*Preferred*		

In general it was considered any best value option ought to be progressed as soon as practical

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Long list options continued

Options concerning the funding

Funding Option	Option 1f	Option 2f	Option 3f	Option 4f
Description	*TBC*	*TBC*		
Meets objective				
Match inpatient bed capacity to patient demand and improve flow				
Satisfies critical success factors				
Adjacency				
Patient safety				
Patient experience				
Patient outcomes				
Positive impact on				
Flexibility in use				
Patient accessibility				
Sustainable				
Supports development				
Achievable within				
Minimal disruption to				
Proven design				
Summary				

Summary matrix of long list options

Geographic scope options	*Continue with current arrangement*	*Tunbridge Wells only*	*Maidstone only*	*MTW wide*	*MTW wide plus satellite*		
	Carry forward	*Discount*	*Discount*	*Preferred*	*Carry forward*		
Long / short term scope options	*Sustain and improve quality and productivity of core services*	*Rebalance service moves and changes of use of estate*	*Significant investment new services*				
	Carry forward	*Preferred*	*Discount*				
Service solution options	*Service productivity and efficiencies & improvements in community only*	*New build external*	*Internal conversion to provide more capacity-Change management block to a ward with 4 bed bays*	*Internal conversion to provide more capacity- Change management block to a ward with single rooms*	*Change use of Wells Suite to become NHS only*	*No build. Move Orthopaedics service from TWH to Maidstone*	*No build. Move ' other service' from TWH to Maidstone*
	Carry forward	*Carry forward*	*Preferred*	*Carry forward*	*Carry forward*	*Discount*	*Discount*
Options concerning the operational use of the facility at TWH	*Service improvement and efficiencies only*	*Step down unit*	*Mixed medical unit*	*Medical assessment unit*	*Other TBC*		
	Carry forward	*Carry forward*	*Carry forward*	*Carry forward*	*Carry forward*		
Delivery options at Maidstone	*Service improvement and efficiencies only*	Reconfiguration of Peale as a surgical ward	*New build at Maidstone*				
	Carry forward	*Preferred*	*Discount*				
Implementation options	*Phased 18 months*	*Big bang*					
	Discount	*Preferred*					

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Short list options

Option 1

Do nothing/minimum

This option does not address the objective

Option 2

Service productivity and efficiencies and improvements in community provision

Scope	MTW wide solution
Service solution	Service productivity and efficiencies & improvements in community only
Operational use	TBC via clinical reference group
Delivery at Maidstone reconfiguration programme	The reconfiguration of Peale as a surgical ward as part of on-going
Implementation	As soon as practical
Funding	TBC

Option 3

Internal conversion to provide new capacity and provide alternative accommodation for displaced administrative services

Scope	MTW wide solution
Service solution	Internal conversion to provide more capacity. a) TWH Trust management block with 4 bed bays or b) a single room design
Operational use	TBC via clinical reference group
Delivery at Maidstone	The reconfiguration of Peale as a surgical ward as part of on-going reconfiguration programme
Implementation	As soon as practical
Funding	TBC

Option 4

Change use of the Wells Suite

Scope	MTW wide solution
Service solution	Change use of Wells Suite to become NHS only
Operational use	TBC via clinical reference group
Delivery at Maidstone reconfiguration programme	The reconfiguration of Peale as a surgical ward as part of on-going
Implementation	As soon as practical
Funding	TBC

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Option 5

A new build at TWH for step down patients

Scope	MTW wide solution
Service solution	A new potentially temporary and / or mobile unit at TWH
Operational use:	TBC
Delivery at Maidstone: reconfiguration programme	The reconfiguration of Peale as a surgical ward as part of on-going
Implementation	As soon as practical
Funding	TBC

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Appendix B

Detail – Funding and affordability Option 3

39 Bedded Ward		
	£ per Annum (- = Pressure)	Comment
Nursing	-1,860,481	Information from S Callanan and L Gray
Support Staff	-89,118	Assume same as 30 bedded ward
Medical	-702,165	*15 PA Consultant requirement for 7 days service (ADO Emergency Service), estimated 3 doctors during day and 1 at night paid on MN37/04 payscale*
Therapies (OT, Physio, S&LT)	-273,433	*Information from Amanda Allen*
Pharmacy	-18,800	*Information from Jim Reside- Band 6 required plus band 2 however band 6 agency has been used in winter pressure so assume band 6 cost is included in 1415 spend so only band 2 has been added*
Ward Non Pay Costs	0	Assume no increase in overall activity numbers therefore no costs have been included
Depreciation and Capital Charges (PDC 3.5%)	-298,545	Assumes 60 year depreciation on a capital investment of £4m
Increase in energy and utilities	-63,810	Assumes clinical area costs £45 per sq metre more than non clinical areas (infromation from Service Line reporting). Assumes 1418 sq mt as per ward 10
PFI Operator Costs (Unitry Payment)		Information unavailable
NR IT decant	-274,321	Per IT 21-05
Escalation Saving - Temporary Nursing Staff	283,802	Assumption no escalation on SSSU, Cardiac Cath Lab and Theatres will stop, calculation is based on roster pro nursing hours for the reason code 'escalation'. Saving based on 64% reduction in escalation (extra ward will meet 49% of the bed shortfall)
Protection of Elective Activity due to Bed Pressures	1,277,229	Assume 64% of income will be protected (i.e. Month 1-5 average income per working day to be maintained but for only 64% of the time)
Total	**-2,019,643**	

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Assessment of lost elective income resulting from bed pressure – 2014-15

Summary Daycase and In Patient Income per Month

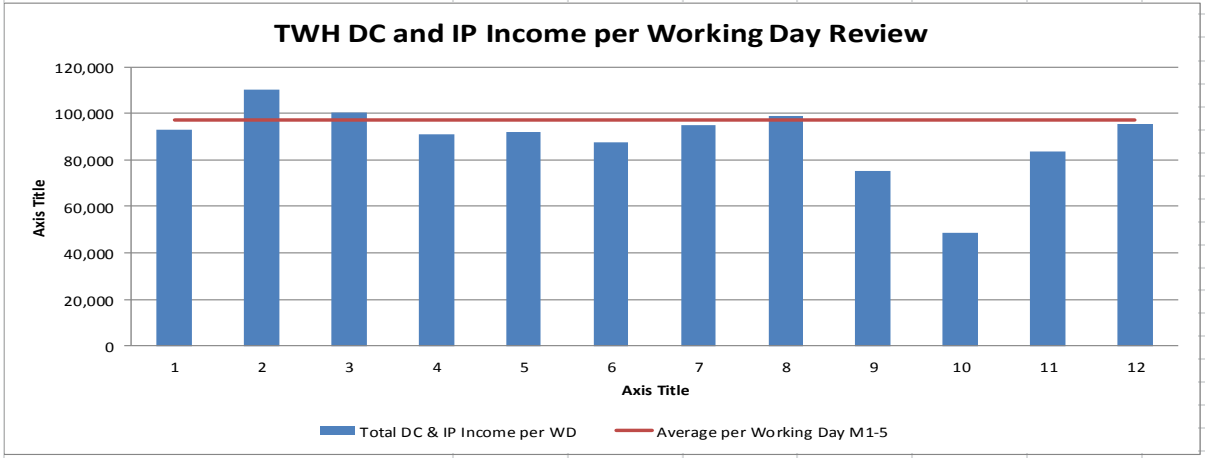
	Month												
Specialty	1	2	3	4	5	6	7	8	9	10	11	12	Grand Total
Obs and Gynae	241,204	276,321	288,560	267,494	252,172	250,631	289,789	266,302	174,607	130,456	205,518	255,066	2,898,120
Cardiology	95,296	133,465	133,977	124,113	78,912	97,192	124,114	123,405	39,021	17,148	14,610	104,831	1,086,084
Surgery	244,457	284,938	258,999	274,999	309,910	297,678	308,641	351,943	274,230	252,930	302,729	370,724	3,532,178
Urology	18,655	19,275	17,184	33,541	22,832	15,001	29,512	15,402	16,396	18,785	11,903	20,277	238,763
ENT	227,990	194,810	229,057	257,611	205,540	208,229	228,857	214,404	164,571	136,574	234,484	203,840	2,505,967
T&O	1,033,617	1,293,069	1,178,565	1,134,099	965,301	1,059,599	1,203,310	1,008,615	906,616	469,843	900,448	1,148,461	12,301,543
Total	**1,861,219**	**2,201,878**	**2,106,342**	**2,091,857**	**1,834,667**	**1,928,330**	**2,184,223**	**1,980,071**	**1,575,441**	**1,025,736**	**1,669,692**	**2,103,199**	**22,562,655**

Working Days	20	20	21	23	20	22	23	20	21	21	20	22	253

Average Income per Working Day

	Month												
	1	2	3	4	5	6	7	8	9	10	11	12	Total
Total DC & IP Income per WD	93,061	110,094	100,302	90,950	91,733	87,651	94,966	99,004	75,021	48,845	83,485	95,600	
Average per Working Day M1-5	97,077	97,077	97,077	97,077	97,077	97,077	97,077	97,077	97,077	97,077	97,077	97,077	
Total Income if Working day M1-5 was maintained						2,135,684	2,232,761	1,941,531	2,038,608	2,038,608	1,941,531	2,135,684	
Estimated Maximum Income Protection						**207,354**	**48,538**	**-38,540**	**463,167**	**1,012,872**	**271,839**	**32,485**	**1,997,717**

Per Working day average			
M1-5	M6-12	Variance	%
97,077	83,669	13,407	14%



Maidstone and Tunbridge Wells NHS Trust

Assessment of Temporary Nursing costs associated with Escalation Costs – 2014-15

Roster pro Information for Escalation reason

Depart	(All)
CC1	(All)
Band	(All)
indicative site	(Multiple Items)

Hours as per Roster pro

Sum of bHoursWorked				Finperiod														
Summary Reason	CC5desc	Bank or Agency	Trained Un Trained	1	2	3	4	5	6	7	8	9	10	11	12	Grand Total	Estimated Hourly rate	Estimated Cost per Annum
Escalation	CATHETER LABORATORY (TWH)	A	Untrained		12						7	463	290	217	224	1,212	22	26,752
			Trained	32	73	8	48	12	31	77	25	981	988	1,083	626	3,981	35	139,325
		A Total		**32**	**85**	**8**	**48**	**12**	**31**	**77**	**32**	**1,444**	**1,277**	**1,300**	**850**	**5,192**		
		B	Untrained		8							246	446	822	223	1,743	11	19,245
			Trained									98	331	292	174	894	18	15,637
		B Total			**8**							**344**	**776**	**1,113**	**397**	**2,637**		
	CATHETER LABORATORY (TWH) Total			**32**	**92**	**8**	**48**	**12**	**31**	**77**	**32**	**1,787**	**2,053**	**2,413**	**1,246**	**7,829**		**200,959**
	DAY SURGERY WARD (14A) PEM	A	Untrained		11		50	51	46	44	68	130	81	57	93	631	22	13,934
			Trained	22	194	135	246	79	332	351	433	633	387	491	328	3,628	35	126,967
		A Total		**22**	**205**	**135**	**296**	**130**	**378**	**395**	**501**	**763**	**468**	**548**	**421**	**4,259**		
		B	Untrained	83	78	90	224	140	313	275	174	34	435	343	265	2,451	11	27,056
			Trained	167	174	154	260	168	231	261	313	511	760	561	573	4,133	18	72,321
		B Total		**250**	**252**	**244**	**484**	**308**	**543**	**536**	**487**	**545**	**1,195**	**904**	**838**	**6,583**		
	DAY SURGERY WARD (14A) PEM Total			**271**	**457**	**379**	**779**	**438**	**921**	**930**	**988**	**1,308**	**1,663**	**1,451**	**1,259**	**10,842**		**240,278**
	SHORT STAY SURGICAL UNIT TWH	A	Untrained												6	6	22	132
			Trained										46		6	52	35	1,803
		A Total											**46**		**12**	**58**		
		B	Untrained										12			12	11	132
			Trained										22		12	34	18	591
		B Total											**34**		**12**	**46**		
	SHORT STAY SURGICAL UNIT TWH Total												**79**		**24**	**103**		**2,658**
	THEATRE STAFFING (TWH)	A	Trained												40	40	35	1,400
		A Total													**40**	**40**		
	THEATRE STAFFING (TWH) Total														**40**	**40**		0
Grand Total				**303**	**549**	**386**	**827**	**450**	**951**	**1,007**	**1,019**	**3,095**	**3,795**	**3,864**	**2,569**	**18,813**		**443,895**

Maidstone and Tunbridge Wells NHS Trust

Appendix C

Statements of support from stakeholders

Maidstone and Tunbridge Wells NHS Trust

Appendix D

IT costs to relocate existing staff from administrative area

Option 1: Relocate within TWH				150 staff within TWH	
		Qty	Unit Cost	Capital	Revenue
Building Works					
	Create Hub Room	0	0	0	0
	Air Conditioning	0	0	0	0
	Room UPS	0	0	0	0
	Sub total			0	0
Connectivity					
				0	0
	Structure Cabling	300	220	66,000	114,738
	Sub total			66,000	114,738
Infrastructure + Systems					
	HR Scanning System		50,000	50,000	10,000
	Patch Panels	36	75	2,700	0
	Racking	18	1,000	18,000	0
	Switches	18	6,000	108,000	13,230
	Cables Cat6	300	25	7,500	0
	Stacking	18	250	4,500	0
	UPS & PDU	18	1,500	27,000	0
	Danwood Printers (additonal)	10	794	0	7,944
	Sub total			217,700	23,230
Professional Services					
	Project Manager	30	400	12,000	0
	Senior Consultant	7	700	4,900	0
	Server Engineer	5	400	2,000	0
	Network Engineer	22	400	8,800	0
	PES Engineer	0	0	0	0
	Telephony Engineer	35	375	13,125	0
	Desktop Engineers	35	350	12,250	0
	Danwood Printers (engineer)	15	450	6,750	0
	Sub total			59,825	0
	Grand Total			**343,525**	**137,968**

Maidstone and Tunbridge Wells NHS Trust

IT Costs for a new ward within TWH

Internal New Ward		Qty	Unit Cost	Capital	Revenue
Building Works					
	Create Hub Room	0	0	0	0
	Air Conditioning	1	4,000	4,000	750
	Room UPS	0	0	0	0
	Sub total			4,000	750
Connectivity					
	Radio/Wireless	0	0	0	0
	Laser	0	0	0	0
	Structure Cabling -6 port bed	316	220	69,520	120,857
	Sub total			69,520	120,857
Infrastructure					
Core	Patch Panels	10	75	750	0
	Racking	2	1,000	2,000	0
	Switches	9	6,000	54,000	7,938
	Cables Cat6	400	20	8,000	0
	Stacking	9	250	2,250	0
	Uplinks	0	500	0	0
	Access Points & Wireless	1	4,500	4,500	0
	UPS & PDU	1	1,500	1,500	0
Phones	Phones 7945	6	278	1,668	0
	Phones 7921	4	160	641	0
	Phones 7925	10	370	3,700	0
	Phone multicharger	2	232	465	0
	ATA190	2	116	233	0
	Red phone	1	180	180	89
PC/Printers	PC	9	951	8,559	1,260
	MFP	2	794	0	1,589
	Wrist Band Printer	2	441	882	0
Omnicell	Build	1	700	700	0
	Server License	1	411	411	0
	CCN - KMHIS	1	1,800	0	1,800
Nursing Obs	Ipad + cases	30	197	5,910	0
	Airwatch	1	2,070	0	2,070
	NerveCentre	15	759	11,385	0
Patient Entertainment System	TV	36	240	8,640	0
	Brackets	36	18	648	0
	Exterity	36	223	8,028	0
	Remotes	36	14	504	0
	Sub total			125,554	14,746
Professional Services					
	Project Manager	50	400	20,000	0
	Senior Consultant	0	0	0	0
	Server Engineer	12	400	4,800	0
	Network Engineer	20	400	8,000	0
	PES Engineer	6	375	2,250	0
	Telephony Engineer	6	375	2,250	0
	Desktop Engineers	9	400	3,600	0
	Sub total			40,900	0
	Grand Total			**239,974**	**136,353**

Maidstone and Tunbridge Wells NHS Trust

IT Costs for a new modular ward outside TWH building

Modular New Ward		Qty	Unit Cost	Capital	Revenue
Building Works					
	Ducting Works	0	0	0	0
	Create Hub Room	0	0	0	0
	Air Conditioning	1	4,000	4,000	750
	Room UPS	0	0	0	0
	Sub total			4,000	750
Connectivity					
	Fibre run to MER1 & MER2	1	17,500	17,500	0
	Laser	0	0	0	0
	Structure Cabling -6 port bed	316	220	69,520	120,857
	Sub total			87,020	120,857
Infrastructure					
Core	Patch Panels	10	75	750	0
	Racking	2	1,000	2,000	0
	Switches	9	6,000	54,000	7,938
	Cables Cat6	400	20	8,000	0
	Stacking	9	250	2,250	0
	Uplinks	0	500	0	0
	Access Points & Wireless	1	4,500	4,500	0
	UPS & PDU	1	1,500	1,500	0
Phones	Phones 7945	6	278	1,668	0
	Phones 7921	4	160	641	0
	Phones 7925	10	370	3,700	0
	Phone multicharger	2	232	465	0
	ATA190	2	116	233	0
	Red phone	1	180	180	89
PC/Printers	PC	9	951	8,559	1,260
	MFP	2	794	0	1,589
	Wrist Band Printer	2	441	882	0
Omnicell	Build	1	700	700	0
	Server License	1	411	411	0
	CCN - KMHIS	1	1,800	0	1,800
Nursing Obs	Ipad + cases	30	197	5,910	0
	Airwatch	1	2,070	0	2,070
	NerveCentre	15	759	11,385	0
Patient Entertainment System	TV	36	240	8,640	0
	Brackets	36	18	648	0
	Exterity	36	223	8,028	0
	Remotes	36	14	504	0
	Sub total			125,554	14,746
Professional Services					
	Project Manager	50	400	20,000	0
	Senior Consultant	0	0	0	0
	Server Engineer	12	400	4,800	0
	Network Engineer	20	400	8,000	0
	PES Engineer	6	375	2,250	0
	Telephony Engineer	6	375	2,250	0
	Desktop Engineers	9	400	3,600	0
	Sub total			40,900	0
	Grand Total			**257,474**	**136,353**

Appendix E Bed modelling data

Assessment of Bed Requirements

1. Assumptions

a. 2014/15 activity and case mix used as basis to form requirement.
b. Length of Stay assumed constant at 2014/15 level.
c. No growth built in to initial assessment, although potential impact quantified
d. John Saunders/John Day impact outside scope (assumed neutral impact).*NB*
e. Assumes Romney Ward continues under Primary Care.

Maidstone and Tunbridge Wells NHS Trust

2. Requirements

a. Core beds

85th percentile of the variation in beds occupied overnight between April and November 2014 for both Elective and Non elective activity.
Additional beds added to increase elective beds up to 95th percentile of variation.
Additional beds added to account for average number of patients requiring bed in A&E overnight.

b. Winter escalation beds

Beds required during winter months on top of core requirement.
Difference between Core beds required and 95th percentile of the variation in beds occupied overnight between December and February.

	Tunbridge Wells			Maidstone		
Directorate	**Core Requirement**	**Winter Requirement**	**Winter Esc**	**Core Requirement**	**Winter Requirement**	**Winter Esc**
Surgery	75	76	1	48	51	3
Trauma & Orthopaedics	74	75	1	2	2	0
Women's & Sexual Health	10	11	1	1	1	0
Cancer & Haematology	2	2	0	18	18	0
E&M Services	184	203	19	217	245	28
Grand Total	**345**	**366**	**21**	**285**	**316**	**31**

Maidstone and Tunbridge Wells NHS Trust

3. Funded and Escalation Bed stock

	Tunbridge Wells			Maidstone		
Directorate	**Funded**	**Total (Inc Esc)**	**Esc**	**Funded**	**Total (Inc Esc)**	**Esc**
Surgery	67			47	47	
Trauma & Orthopaedics	68					
Women's & Sexual Health	10					
Cancer & Haematology				18	18	
E&M Services	160			183	231	48
Grand Total	**305**	**0**	**0**	**248**	**296**	**48**

Critical escalation beds that have adverse effects on patient flows have been excluded from the above.
Ward detail available in summary analysis paper.

4. Tunbridge Wells

Analysis shows circa 40 bed shortfall in requirement throughout the year (Core bed stock).
As no further escalation beds are currently identified, the shortfall in beds increases during winter to a maximum escalated requirement of 61 beds.
Beds used to relieve passed pressures are as follows. These beds have not been used to close the gap as present as they are not considered as 'pre-planned' escalation:

Critical Esc WardName	Total
THE WELLS SUITE	13
CARDIAC CATHETER LAB	13
SHORT STAY SURGERY UNIT	15
RECOVERY - TWH	12
WARD 11	1
Grand Total	**54**

Maidstone and Tunbridge Wells NHS Trust

5. Maidstone

Analysis shows a circa 37 bed shortfall in core requirement but only a 20 bed shortfall in maximum beds required during winter. The proportion of core/escalation beds are misaligned.
Converting 37 escalation beds to funded beds would meet core requirement throughout the year.
This would leave 11 escalation beds available out of a maximum requirement of 31 during winter.
Maidstone would have a 20 bed escalation shortfall based on assumptions documented above.
Beds used to relieve passed pressures are as follows. These beds have not been used to close the gap as present as they are not considered as 'pre-planned' escalation:

Critical Esc WardName	Total
CARDIAC CATHETER LAB MAIDSTONE	6
SHORT STAY SURGICAL UNIT	14
Grand Total	**20**

Note
Effect of ward reconfiguration at Maidstone
John Day/ John Saunders -18 (49-31)
MOU +12
This represents a 6 bed reduction overall, thought to be offset by Surgery using SSU to escalate into an overnight unit

Maidstone and Tunbridge Wells NHS Trust

Summary - Assessment of Bed Requirement - Version 6

Requirement for core beds has been based on the recommended 85th percentile of the variation in demand April - November.
An assessment of the additional beds required for Winter pressures has been calculated using the 95th percentile of the variation in demand during December - February.
Requirement is based on 2014/15 levels of activity and length of stay performance.
Adult General and Acute Beds modelled (excludes children and maternity beds)

Tunbridge Wells Hospital Summary

	Core Beds												Winter Beds	
Directorate	Funded Bedstock	Requirement for 85% of days	Elective Beds Requirement	Non Elective Bed Requirement	iance	Additions - Elective at 95%	Additions - A&E at Midnight	Requirement after adjustments	Elective Beds Requirement	Non Elective Bed Requirement	Variance	2% Growth	Requirement 95% of Days	Additional
Surgery	67	73	6	67	6	2		75	8	67	8	1.5	76	1
Trauma & Orthopaedics	68	71	19	52	3	3		74	22	52	6	1.5	75	1
Women's & Sexual Health	10	10	5	5	0			10	5	5	0	0.2	11	1
Cancer & Haematology	0	2	2	0	2			2	2	0	2	0.0	2	0
E&M Services	160	178	5	173	18		6	184	5	179	24	3.7	203	19
Grand Total	**305**	**334**	**37**	**297**	**29**	**5**	**6**	**345**	**42**	**303**	**40**	**7**	**366**	**21**

Tunbridge Wells Bedstock

Directorate	WardName	Values Core	Escalation	Critical Esc	Total
Surgery	SHORT STAY SURGERY UNIT	0	0	15	15
	SURGICAL ASSESSMENT UNIT	8	0		8
	WARD 10	30	0		30
	WARD 11	29	0	1	30
Surgery Total		**67**	**0**	**16**	**83**
Trauma & Orthopaedics	WARD 30	30	0		30
	WARD 31	30	0		30
	WARD 32	8	0		8
Trauma & Orthopaedics Total		**68**	**0**		**68**
Women's & Sexual Health	GYNAECOLOGY INPATIENTS	10	0		10
Women's & Sexual Health Total		**10**	**0**		**10**
E&M Services	ACUTE STROKE UNIT	10	0		10
	CARDIAC CATHETER LAB	0	0	13	13
	CORONARY CARE UNIT	8	0		8
	MEDICAL ASSESSMENT UNIT	30	0		30
	WARD 12	30	0		30
	WARD 20	30	0		30
	WARD 21	30	0		30
	WARD 22	22	0		22
E&M Services Total		**160**	**0**	**13**	**173**
Undesignated	RECOVERY - TWH	0	0	12	12
	THE WELLS SUITE	0	0	13	13
Undesignated Total		**0**	**0**	**25**	**25**
Grand Total		**305**	**0**	**54**	**359**

Maidstone Bedstock

Directorate	WardName	Values Core	Escalated	Critical Esc	Total
Surgery	CORNWALLIS WARD	19	0		19
	PYE OLIVER WARD	28	0		28
	SHORT STAY SURGICAL UNIT		0	14	14
Surgery Total		**47**	**0**	**14**	**61**
Cancer & Hae	LORD NORTH WARD	18	0		18
Cancer & Haematology Total		**18**	**0**		**18**
E&M Service	CARDIAC CATHETER LAB MAIDSTON	0	0	6	6
	CHAUCER	21	12		33
	CULPEPPER WARD	13	0		13
	FOSTER CLARKE WARD	28	0		28
	JOHN DAY WARD	26	0		26
	JONATHAN SAUNDERS WARD	23	0		23
	MAIDSTONE CORONARY CARE UNIT	6	0		6
	MERCER WARD	26	0		26
	STROKE UNIT	26	0		26
	URGENT MEDICAL & AMBULATORY	14	8		22
	WHATMAN WARD	0	28		28
E&M Services Total		**183**	**48**	**6**	**237**
Grand Total		**248**	**48**	**20**	**316**

Maidstone Hospital Summary

	Core Beds												Winter Beds	
Directorate	Funded Bedstock	Requirement for 85% of days	Elective Beds Requirement	Non Elective Bed Requirement	iance	Additions - Elective at 95%	Additions - A&E at Midnight	Requirement after adjustments	Elective Beds Requirement	Non Elective Bed Requirement	Variance	2% Growth	Requirement 95% of Days	Additional
Surgery	47	43	29	14	-4	5		48	34	14	1	1.0	51	3
Trauma & Orthopaedics	0	1	1	1	1	1		2	1	1	2	0.0	2	0
Women's & Sexual Health	0	1	1	0	1			1	1	0	1	0.0	1	0
Cancer & Haematology	18	18	5	13	0			18	5	13	0	0.4	18	0
E&M Services	183	215	5	210	32		2	217	5	212	34	4.3	245	28
Grand Total	**248**	**278**	**41**	**237**	**30**	**5**	**2**	**285**	**46**	**239**	**37**	**6**	**316**	**31**

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - June 2015

6-23	Staff Survey Action Plan 2014	Director Of Workforce & Communications

Summary / Key points

Three key Trust priority areas have been identified as a result of the findings from the 2014 Staff Survey:

1) Improving employee health and well-being
2) Addressing shortfalls in equality and diversity
3) To move the culture of the organisation to one of greater inclusivity in order to greater engage staff in decisions that will affect them.

These three key themes form part of the Trust Workforce Strategy for the next five years. The Strategy and detailed implementation plans have been shared with the TME and Board.

Which Committees have reviewed the information prior to Board submission?

- None

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

Discussion and decision

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

1.0 INTRODUCTION

1.1 The purpose of the paper is:

- To outline the Trust 2014 staff survey outcome priorities and key actions
- To provide an update of directorate progress with the development of local plans
- To outline the timetable and plan for monitoring performance against the Trust overarching plan and directorate plans.

2.0 BACKGROUND

2.1 The Trust took part in the 12th annual National NHS Staff Survey between September and December 2014.

2.2 The results were previously shared and discussed by the Board. The results are an improved set of results year on year against a national benchmark and an improving position in a largely 'falling market' locally.

2.3 The results have been shared Trust-wide and directorate management teams have had the opportunity to discuss the survey as it relates to their area and have been tasked with the development of plans to address local issues.

2.4 The delivery of local priorities is important because it ensures ownership and a more localised and bespoke approach to issues raised.

3.0 TRUST PRIORITIES

3.1 Three key priority areas have been identified as a result of the findings from the 2014 Staff Survey.

1) Improving employee health and well-being

Nationally employee wellbeing has been identified as priority. Locally 1/3 of our staff report a work related stress incident in the last 12 months and sickness absence levels have increased in the last 12 months. Therefore we will:

a) Remodel the Occupational Health provision
b) Develop a Health and Wellbeing Board in partnership with East Sussex and other local providers
c) Review the Managing Attendance Policy and Procedure
d) Promote employee fitness
e) Improved education and training for managers

2) Addressing shortfalls in equality and diversity

Nationally there was a fall in the levels of confidence in organisations providing equal opportunities and an increase in those reporting discrimination. Locally whilst almost all protected characteristic groups are strong advocates of the Trust, employees from these groups experience higher levels of discrimination when applying for promotions and experience higher levels of aggression and violence from patients. Therefore we will:

a) Appoint a lead for Equality and Diversity
b) Re-establish workforce groups for staff with protected characteristics, as defined by the legislation, commencing with the BME group

c) Improve patient translation services
d) Raise awareness for all staff
e) Appoint a Board lead for Equality and Diversity

3) To move the culture of the organisation to one of greater inclusivity in order to greater engage staff in decisions that will affect them.

Whilst MTW staff are more engaged than the national average and those working in organisations locally, in order to be a high performing organisation and in the top 20% of Trusts nationally we need to increase the levels of meaningful engagement and drive a culture of continuous improvement. Therefore we will:

a) Deploy employee champions throughout organisation
b) Improve the use of social media and tools to promote two way meaningful communication
c) Run employee focus groups exploring key issues for our workforce
d) Greater visibility of senior leadership team

3.2 These three key themes form part of the Trust Workforce Strategy for the next five years. The Strategy and detailed implementation plans will be shared with the TME and Board by August 2015.

4.0 DIRECTORATE ACTION PLANS

4.1 Whilst all directorate's are yet to submit their action plans the themes which are emerging, albeit with a local emphasis are:

a) Improving engagement
b) Finding effective mechanisms to raise concerns about patient care
c) Reducing sickness levels
d) Reducing discrimination

4.2 These are consistent with the Trust wide action plan, albeit as applied to the local situation.

5.0 MONITORING PROGRESS

5.1 Progress against directorate action plans will be addressed during the quarterly performance meetings, held with each directorate. Directorate management teams will be expected to bring an updated action plan to the performance meeting, identify success and where it exists any shortcomings.

5.2 Progress against the overarching Trust Action Plan will be monitored through the Trust Management Executive and assurance provided to the Workforce Committee (September 2015 onwards) for onward transmission to the Board.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - June 2015

6-24	Reflections On The Scope Of Clinical Practice Of Newly Appointed Consultants	Medical Director

Summary / key points

The enclosed report provides information on scope of practice of newly appointed consultants. I will discuss in detail the issues that arise, the processes that are in place and the limitations that are recognised.

I also attach a recent NHS England paper that informs the debate.

Which Committees have reviewed the information prior to Board submission?

- None

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

Introduction

Having had a brief discussion at a previous Board meeting, I am delighted to discuss this topic with this paper. Competence and scope of clinical practice is a complex issue and one that is very much in the public and media domain at present.

For many decades, Doctors have been seen to “control” their own practice, deciding themselves what level of competence or training is required for each aspect of their practice.

Several aspects of medical regulation have been invoked in order to safeguard patient safety, including the Specialist Register, the Responsible Officer regulations and fitness to practice investigations.

Appointment of consultants will be discussed and the problems that may arise, particularly with European regulations.

Appointment of Consultants

An AAC (appointments advisory committee) is required by statute in order to appoint a consultant. It is essential in an NHS trust, to have a Royal College representative, whose primary role is to assess the suitability of a candidate to a particular role: in particular, this individual assures the panel of the competence of the individual to perform the consultant role in a particular specialty or subspecialty. Generally, the competence is assured by noting that the individual has a CCT (certificate of completion of training), or is within 6 months of its award.

Training

Specialist training takes place over many years (6-8), and I will describe a few aspects.

Trainees enter specialist training following competitive interview after their foundation years: there are variable ratios of applicants to vacancies, which remarkably show a world wide consistency. Within the UK, there are a number of specialties that do not achieve maximum “fill” rates which causes a problem with future recruitment.

Assessment in the form of ARCP or RITA occur every year within a Deanery training scheme, with interim reviews every 6 months. During these “assessments”, trainees will present their portfolios, which will include:-

- Competencies (DOPS, WBA, ACEX, ALMAT, CBD)
- Log book
- CPD
- Self declaration
- Multi source feedback

The Deanery panel will award a marking system to the trainee.
1 – good progress, through to 4 which indicates the trainee should leave the training scheme. The award of 6, however, does declare the completion of training and the imminent award of CCT.

The award of CCT allows the Doctor to apply to be entered on the Specialist Register.

Specialist Register

It is only in the past 15 years that Doctors in the UK were required to be on a Specialist Register for their field of practice (including GP) for appointment to certain positions. However, the law does not prevent any doctor from practicing in any field independently. This is aspect of regulation has gained recent media coverage with the Aesthetic issues.

At present there are three routes to entry to the Specialist Register

- Completion of Deanery approved Training as detailed above
- CESR – certificate of equivalence of specialist recognition
- Recognition of Specialist Training within the EEC.

Maintenance of competence of skills of consultants

I attach a document from NHS England, which describes some of the issues that are of concern with to ensuring that Doctors at all levels are competent in their practice.

Most consultants will be employed at a point in time to undertake a specific role, however, the required role will alter with time, and the introduction of novel techniques eg Laparoscopic surgery.

25 years ago, almost no general surgeons removed gall bladders with a laparoscope and yet today, no patient would be subjected to an open operation without very good reason.

In this trust, we will not allow a new technique to be introduced without appropriate governance (via New Interventional Procedures etc). Examples of where this has been used are:-

- Bubble technology for lymph node excision in breast cancer
- Radiofrequency Ablation of liver and lung metastases of tumours
- Laparoscopic Prostatectomy

However, most advances in medicine are small incremental steps rather than wholesale change in practice, such that each step is a reasonable improvement in care rather than a radical overhaul.

National Clinical Outcomes

The NHS has published a number of sets of outcome data for different operations or interventions, however, it is difficult to “draw a line” as to what practice is acceptable, particularly when one considers case mix. There are very few instances of clinicians being outside of the expected range.

This has limited the usefulness of such national initiatives.

Summary

It is essential that we appoint the most appropriate consultants to positions within the trust. We should consider not only the present requirements, but also the ability of the clinician to adapt to the changing environment. The underlying principle that the Doctor has an underlying duty of care to ensure that s/he is competent to perform a task is still the basis of Good Medical Practice.

SRO Interim Statement: Continuing Professional Development for Doctors – requirements for the revalidation process

The 3-year programme to implement the Medical Profession (Responsible Officer) Regulations (2010) and 2013 amendments, throughout the UK, began in December 2012. The implementation plan scheduled 20% of doctors to undergo the process of revalidation in 13/14, 40% the following year, with the remaining 40% completing their revalidation in 15/16. Throughout the implementation, the Professional Standards Team at NHS England and Regional Revalidation Support Teams leading the programme, with collaborating bodies the General Medical Council, NHS Employers and Medical Royal Colleges, have collaborated closely, sharing experience and emerging practice.

Based on this accumulated experience, the Senior Responsible Owner of the implementation programme, Dr Mike Bewick, Deputy Medical Director, NHS England, has asked the Professional Standards Team to revisit the guidance on the information to support a doctor's annual appraisal, for doctors, appraisers and responsible officers. The project plan and governance arrangements for this work are currently under development, with a view to delivering the guidance by March 2016. In the meantime, a number of interim statements are being produced to provide guidance for doctors, appraisers and responsible officers to follow, in order to guide practical implementation and ensure best practice and consistency of approach across all designated bodies.

The paragraphs below provide an interim statement on: **Volume and Content of Continuing Professional Development (CPD) for Appraisal**

1. Employers and those contracting doctors' services have a responsibility to ensure that their workforce is up to date and practising to appropriate standards
2. The General Medical Council, as the regulator, has a set of standards that they expect every doctor to meet. It expects employing organisations to support doctors in meeting those standards
3. The General Medical Council also has a legal duty to promote high standards of medical education. This includes continuing professional development (CPD) of doctors, following completion of undergraduate education and postgraduate training.
4. Responsibility for identifying and undertaking the elements of a doctor's CPD lies with the individual doctor and should reflect the context in which they work. Doctors are responsible for their own personal learning. Needs and issues are also reviewed in the appraisal process, with the help of the doctor's appraiser. The appraiser will make a judgement as to whether the learning needs have been met appropriately and will advise the doctor's responsible officer.

Volume, content, style (be it externally provided or self-directed) or indeed timing of CPD is not specified, in either the GMC or in any other guidance. Nor is it recommended that any blanket approach to all doctors be used in terms of their personal development. The volume, content, type of delivery and timing of CPD activity must be individually tailored to the specific needs and interest of each individual doctor and his or her practice. As noted in the GMC's guidance, CPD should focus on outcomes or outputs rather than on inputs and a time-served approach.

5. Every doctor working with his or her appraiser, is expected to:
    - identify their needs for CPD across their full scope of work;
    - plan how they will address those needs, agreeing a personal development plan (PDP);
    - undertake learning activities that are relevant to their practice and will support their professional development;
    - make use of both formal and informal on-the-job learning opportunities;
    - demonstrate that they have done so to their appraiser.

6. In formulating any recommendation on the doctor's fitness to practise, the responsible officer will triangulate information received on the doctor's performance from a range of sources, including a summary of the annual appraisals conducted over the revalidation period (in practice, usually every 5 years). Other sources of information may include CQC data, other organisations where the doctor works and other governance streams. The responsible officer also has responsibility for ensuring the quality assurance of the appraisal system throughout the designated body.

7. Doctors determine what supporting information is submitted to their appraisal, in accordance with GMC Guidelines. The appraiser will assess this information to determine whether it meets the minimum data set required by the GMC, whether the information is appropriate and proportionate to the doctor's scope of work and whether it demonstrates that the doctor has actively engaged in the revalidation process.

8. The responsible officer should not specify blanket requirements for nature or quantity of CPD, for groups of doctors, unless these have been either:
    (i) specified as mandatory requirements by the designated body and therefore form part of the contract of employment, or
    (ii) agreed between the doctor and the responsible officer as part of the process of addressing a concern about the doctor's practice or
    (iii) required by a Medical Royal College or Faculty, of which the doctor is a member or a trainee

9. There is no specified format for undertaking CPD. How a doctor meets their learning needs will depend on preferred ways of learning, objectives of the learning and the opportunities available. It is the doctor's responsibility to undertake sufficient appropriate CPD to remain up to date and fit to practise in their work and to be able to demonstrate this at their appraisals.

10. Most medical royal colleges and faculties have developed CPD schemes or guidance to support those doctors who are medical college members or trainees in maintaining and developing their professional standards in their specialty. The colleges and faculties require doctors participating in these schemes to obtain a specified number of CPD credits over a specified period of time. Doctors may find these specialty-specific guidelines helpful in developing their personal development plans with their appraisers. The medical Royal College and Faculties guidelines are not applicable to doctors who are not college members or trainees, nor are they a substitute for a personal development plan of outputs-based learning tailored to the individual doctor's needs. Many doctors in England are members of medical Royal Colleges and Faculties and will wish to adhere to the relevant guidance. However, there is no requirement that doctors are members, unless specified by the employer, for a specific post. Where doctors are not members of a Royal College or Faculty, or the role that they are employed to undertake does not specify membership of the relevant Royal College or Faculty, there is no requirement for doctors to undertake specific number of hours of CPD each year, or to acquire a particular number of CPD credits as specified by the Royal Colleges and Faculties.

11. Where an appraiser is unable to judge that a doctor's presented CPD activity is appropriate (for example, it does not address the previous year's PDP or does not reflect the full scope of activity), he or she should seek advice from the responsible officer before proceeding with the appraisal meeting. Where a responsible officer and doctor cannot agree that the doctor's presented supporting information (including CPD) is sufficient, and any gaps cannot be addressed before a revalidation recommendation is due, the responsible officer should seek advice from colleagues in the responsible officer network or the GMC Employer Liaison Advisor in the first instance.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – June 2015

6-25 Oversight Self-Certification, Month 2, 2015/16 — Trust Secretary

The enclosed schedule sets out the proposed oversight self-certification submission for month 2, 2015/16, based on performance as at 31st May. This submission must be sent to the NHS Trust Development Authority (TDA) by the end of June (i.e. by 30th).

The TDA have now confirmed that the monthly self-certification requirements for 2015/16 are the same as for 2014/15.

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

The Trust is not required to provide supporting evidence (as listed in the "Evidence of Trust compliance" columns), and is just required to respond to each statement with "Yes" (i.e. compliant), "No" (i.e. not compliant) or "Risk" (i.e. at risk of non-compliance). If "No" or "Risk" 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 "Latest assessment – Compliant?" column.

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 had been agreed previously at the Board, the Trust will continue to declare non-compliance with such items, and the date by which the Trust will become compliant is proposed as 31/03/2017.

The evidence has been refreshed and updated from that reviewed at the Board in May 2015. Additions are highlighted, whilst deletions are shown as ~~struckthrough~~.

No change in compliant status is proposed from that agreed by the Board in May 2015.

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:
1. Review the evidence presented to support the self-assessment (and amend if required); and
2. Approve the self-assessment for the forthcoming submission to the TDA

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

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

General conditions

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

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

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

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
	provider to check the fitness of existing Directors and provide the same assurance to them, where concerns about such Director come to the CQC's attention. Although the Regulations will not, strictly speaking, be applied retrospectively, the Trust will likely need to ensure current Board members meet the Regulations' requirements for being "fit and proper". A proposed approach to the new Regulations was approved at the December 2014 Trust Board, and implementation has commenced (DBS checks are currently being processed for all Board members, and step 3 of the agreed process ('due diligence checks') is in progress).	
G5 – Having regard to Monitor guidance – guidance exists or is being developed on: ▪ Monitors enforcement ▪ Monitors collection of cost information ▪ Choice and competition ▪ Commissioners rules ▪ Integrated Care ▪ Risk Assessment ▪ Commissioner requested services ▪ Operation of the risk pool	Monitor guidance is at varying degrees of progress through the consultation process. Trust response: **As an aspirant Foundation Trust, the guidance has not yet been fully reviewed and embedded. However the Trust will receive a summary of Monitor guidance requirements so that it can ensure compliance at a time appropriate to its foundation trust application trajectory.**	No Compliant by 31/03/2017
G7 – Registration with the Care Quality Commission	The Trust has full registration with the CQC. The Trust is registered to deliver the following regulated activities at both main hospital sites: 'Treatment of disease, disorder or injury'; 'Surgical procedures'; 'Diagnostic and screening procedures'; 'Maternity and midwifery services' and 'Family planning'. In addition, the Trust is registered to undertake 'Termination of pregnancies' at Tunbridge Wells Hospital.	Yes
G8 – Patient eligibility and selection criteria (for services and accepting referrals) ▪ Criteria are transparent ▪ Criteria are published	The Referral and Treatment Criteria (RATC) which apply from 1st April 2015 are published on the West Kent CCG website ("Kent and Medway clinical commissioning groups' (CCGs') schedule of policy statements for health care interventions, and referral and treatment criteria").	Yes

Pricing conditions

Condition	Evidence of Trust compliance	Latest assessment – Compliant?
P1 – Recording of Information (about costs) to support the Monitor pricing function by the prompt submission of information	Trust response: **As an aspirant Foundation Trust, the requirement has not yet been fully reviewed and embedded. However the Trust will receive a summary of the Monitor pricing condition so that it can ensure compliance at a time appropriate to its foundation trust application trajectory** An action plan is required to ensure readiness to comply with all Monitor Pricing conditions at the required time (the Director of Finance will be responsible for leading on this).	No Compliant by 31/03/2017
P2 – **Provision of information** to Monitor about the cost of service provision	Trust response: **As an aspirant Foundation Trust, the requirement has not yet been fully reviewed and embedded. However the Trust will receive a summary of the Monitor information condition so that it can ensure compliance at a time appropriate to its foundation trust application trajectory**	No Compliant by 31/03/2017
P3 – Assurance report on submissions to Monitor. To ensure that information is of high quality, Monitor may require Trusts to submit an assurance report	Trust response: **As an aspirant Foundation Trust, the requirement has not yet been fully reviewed and embedded. However the Trust will receive a summary of the Monitor assurance reporting condition so that it can ensure compliance at a time appropriate to its foundation trust application trajectory**	No Compliant by 31/03/2017
P4 – Compliance with the national tariff (or to agree local prices in line with rules contained in the National tariff)	The Trust is compliant with the national tariff and where local tariffs are applied, are subject to negotiation and agreement with the CCG/Commissioners.	Yes
P5 – Constructive engagement concerning local tariff modifications The aim is to encourage local agreement between commissioners and providers where it is uneconomical to provide a service at national tariff; thereby minimising Monitors need to set a modified tariff.	The Trust is compliant with the national tariff and where local tariffs are applied, are subject to negotiation and agreement with the CCG/Commissioners.	Yes

Competition conditions

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

Integrated care conditions

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

Oversight Self Certification – Board Statements

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

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	achieve further improvements. Further improvements include: - strengthening the processes through which learning is shared and embedded has been recognised, and - developing further benchmarks to support the assurance & target setting process The final report of the Trust's inspection by the Care Quality Commission in October 2014 was published in February 2015, and confirms that Trust's overall rating as 'Requires Improvement'. A Quality Improvement Plan has been developed in response, and has been submitted to the CQC. It is monitored via monthly reports to the Trust Management Executive and Trust Board.	
For clinical quality, that: 2. the board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements	The Trust has full registration with the CQC. The Trust is registered to deliver the following regulated activities at both main hospital sites: 'Treatment of disease, disorder or injury'; 'Surgical procedures'; 'Diagnostic and screening procedures'; 'Maternity and midwifery services'; and 'Family planning'. In addition, the Trust is registered to undertake 'Termination of pregnancies' at Tunbridge Wells Hospital. The final report of the Trust's inspection by the Care Quality Commission in October 2014 was published in February 2015, and confirms that Trust's overall rating as 'Requires Improvement'. A Quality Improvement Plan has been developed in response, and has been submitted to the CQC. It is monitored via monthly reports to the Trust Management Executive and Trust Board.	Yes
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.~~ The May 2015 Trust Board ~~is scheduled to~~ received the 2014/15 Annual Report from the Responsible Officer, and approved a 'statement of compliance' confirming that the Trust, as a designated body, was in compliance with the regulations governing appraisal and revalidation.	Yes
For finance, that:	~~The Trust reported a deficit for 2013/14 and the financial situation~~	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
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	~~is under ongoing review with the TDA. The Trust was recently awarded £12m of non-recurrent funding by the TDA for 2014/15.~~ The Trust continues to operate as a going concern, and the 2014/15 financial accounts ~~have been~~ were prepared on this basis. The External "Audit Findings" report for 2014/15 stated~~s~~ that "We have reviewed the Directors' assessment and are satisfied with managements assessment that the going concern basis is appropriate for the 2014/15 financial statements". The Trust achieved a small surplus in 2014/15, and the Trust Board ~~will be asked to~~ approved the 2014/15 Accounts in May 2015.	
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 Plan ~~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 (iv) Development – the Trust will embrace the development model as appropriate (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 take place each month) and both external &, internal communications channels; a growing membership	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	▪ making better care easy to achieve – the Trust's stated priority, above all things, is the provision of high quality & safe care to patients (Patient First). ▪ an integrated approach to business – the Trust has adopted an integrated governance approach including an integrated performance dashboard.	
For governance, that: 6. all current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.	See 5 above. In addition: ▪ The Trust monitors performance each month in accordance with the TDA Quality and Governance indicators. A Board Assurance Framework and risk register, supported by an overall Risk Management Policy, are established and scrutinised by various Committees ▪ Risks receive regular scrutiny and assurance ▪ Mitigating actions have agreed dates for delivery ▪ An annual Internal Audit plan is agreed and focuses on areas of key risk ▪ A professional Trust Secretary is employed ▪ A dedicated Risk Manager is employed ▪ The Trust fully participates in the TDA Oversight process ▪ The Trust is currently being evaluated against the Well-Led Framework via an external Governance Adviser ▪ ~~The independent assessment of the BGAF & QGF was conducted in July 2013 and the positive results reported to the Trust Board in September 2013; a follow up review conducted in December 2103 re-affirmed the assessment.~~	Yes
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 (BAF). The BAF for 2015/16 is currently being developed, via Board-level discussion of key risks.	Yes
For governance, that: 8. the necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating	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	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	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 with the development of the IBP and the Clinical Strategy that underpins it.	
For governance, that: 9. an Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	~~The Annual Governance Statement 2013/14 was agreed by the Trust Board in May 2014. The 2014/15 draft Statement was submitted to the NHS TDA (and the Trust's auditors) by the required deadline of 23rd April 2015, and the Trust Board in May 2015 will be asked to approve the final version.~~ The Annual Governance Statement 2014/15 was approved by the Trust Board in May 2015.	Yes
For governance, that: 10. the Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward	~~Quality and governance indicators are monitored by the Board each month through the integrated performance dashboard. The Board is committed to achieving all targets and has set the vision of being in the best 20% of acute trusts nationally.~~ ~~Although the Trust did not meet the required performance (95%) in terms of the A&E 4 hour waiting time target for the 2014/15 year, the Board confirmed (in February 2015) that a compliance status of "Yes" was appropriate for the statement, on the basis that the Trust's plans were sufficient to deliver the 4-hour A&E waiting time target, even though the target would not actually be met.~~ The Trust Board monitors compliance with existing targets, and actions to address any issues, at each meeting, via the integrated performance report.	Yes
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 2014/15 against all Requirements. The submission was approved by the Trust Board in March 2015	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,	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	Compliant

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
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.	leadership. A register of Directors' 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. The Register of Directors' Interests was refreshed in March/April 2015, and features within the Annual Report for 2014/15, which the Trust Board ~~will be asked to~~ approved in May 2015. ~~A new Non-Executive Director commenced in September 2014, which means that~~ All formal Board positions are ~~now~~ filled substantively.	
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.	~~▪ 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 in 2013/14. ▪ The Trust continues to adhere to the Oversight process ▪ A proposed approach to the new 'fit and proper persons' Regulations was approved at the December 2014 Trust Board, and implementation has commenced (DBS checks are currently being processed for all Board members, and step 3 of the agreed process ('due diligence checks') is in progress).	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 Board is currently discussing the key risks and ~~agreed the Trust's~~ objectives for ~~2014/15~~ 2015/16. ~~in September 2014, and agreed that these objectives should also apply for the 2015/16 year (subject to minor amendments regarding specific targets)~~	Compliant