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 22ND JULY 2015

THE EDUCATION CENTRE, TUNBRIDGE WELLS HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
7-1	To receive apologies for absence	Chairman	Verbal
7-2	To declare interests relevant to agenda items	Chairman	Verbal
7-3	Minutes of the Part 1 meeting of 24th June 2015	Chairman	1
7-4	To note progress with previous actions	Chairman	2
7-5	Safety moment	Chief Operating Officer	Verbal
7-6	Chairman's report	Chairman	Verbal
7-7	Chief Executive's report	Chief Executive	3
7-8	A patient's experiences of the Trust's services	Chief Nurse[1]	Verbal
7-9	Integrated Performance Report for June 2015 (incl. updates on recruitment and retention; DTOCs & HSMR)	Chief Executive	4 (& presentation)
	Quality items		
7-10	Progress with the Quality Improvement Plan	Chief Nurse	5
7-11	Clinical Quality and Patient Safety Report	Chief Nurse	6
7-12	Planned v actual ward staffing for June 2015	Chief Nurse	7
	Planning and strategy		
7-13	To discuss the winter and operational resilience plans	Chief Operating Officer	8 (& presentation)
	Reports from Board sub-committees (and the Trust Management Executive)		
7-14	Quality Cttee, 08/07/15 (incl. update on the latest Stroke care performance)	Committee Chairman	9
7-15	Charitable Funds Committee, 20/07/15	Committee Chairman	Verbal
7-16	Finance Committee, 20/07/15, to include approval of: ▪ revised Terms of Reference	Committee Chairman	10 (to follow) 11
7-17	To approve revised Terms of Ref. for the Remun. Cttee	Committee Chairman	12
	Assurance and policy		
7-18	To review the Board Assurance Framework for 2015/16	Trust Secretary	13
7-19	Health & Safety Annual Report, 2014/15 (incl. ratification of H&S Policy, & agreement of the 2015/16 programme)	Chief Operating Officer	14
7-20	Approval of compliance oversight self-certification	Trust Secretary	15
7-21	To receive the Annual Audit Letter for 2014/15	Director of Finance	16
7-22	Update on Trust Membership	Director of Workforce and Communications	17
7-23	**To consider any other business**		
7-24	**To receive any questions from members of the public**		
7-25	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:

- 30th September 2015, 10.30am, The Academic Centre, Maidstone Hospital
- 21st October 2015, 10.30am, The Education Centre, Tunbridge Wells Hospital
- 25th November 2015, 10.30am, The Academic Centre, Maidstone Hospital
- 16th December 2015, 10.30am, The Education Centre, Tunbridge Wells Hospital

Anthony Jones,
Chairman

[1] A patient and their relative will also be in attendance for this item

Maidstone and Tunbridge Wells NHS
NHS Trust

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 24TH JUNE 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)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Stephen Smith	Associate Non-Executive Director	(SS)
	Kevin Rowan	Trust Secretary	(KR)
	Kathryn Coleman	Respiratory Nurse Specialist (item 6-9 only)	(KC)
	Jennifer Graves	Respiratory Consultant (item 6-9 only)	(JG)
	Chantelle Menzies-Beer	Pulmonary Rehab Physiotherapist (item 6-9 only)	(CMB)
	Julie Moore	Community Physiotherapist (item 6-9 only)	(JM)
Observing:	Darren Yates	Head of Communications	(DY)
	Annemieke Koper	Staff Side representative	(AKo)
	Patrick Bevan	British Gas	(PBe)
	Tony Orton	British Gas	(TO)

6-1 To receive apologies for absence

No apologies were received.

6-2 To declare interests relevant to agenda items

There were no declarations of interest.

6-3 Minutes of the Part 1 meeting of 27th May 2015

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

6-4 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").** SM reported that an article had been written and would appear in the next edition of the Trust's staff magazine. It was therefore agreed the action could be 'closed'.

- **Item 5-13 ("Undertake further analysis to determine whether having 'actual' Ward staffing levels above 'planned' levels was associated with expenditure above budget").** SO reported that the analysis would be included in the information produced for month 3 onwards, and would be incorporated into the work being undertaken by AB regarding safe staffing.

6-5 Safety moment

AB reported that an incident reporting 'App' had been introduced, and demonstrated the App on an iPad device. AB added that users could access the App by a single 'click', and the number of fields required to be completed had been reduced by 50%, but further work was required to reduce the fields by a further 50%. AB noted that the App would be made available on the hand-held devices being issued across the Trust. SDu asked how many staff would have access to the App via such devices. AB replied that all members of staff on each ward (apart from A&E) would have access to a device, and therefore to the App.

KT commended the initiative.

6-6 Chairman's report

AJ highlighted that the Royal College of Nursing (RCN) had cautioned that there may be an impact on NHS organisations of new rules regarding the issue of work permits to non-EU nurses. PB clarified that the rules that had been subject to recent media coverage had been in place since 2011, and related to Tier 2 work permits. PB continued that the process of renewing such permits required the relevant person to be sponsored when their permit expired, and salary was a consideration as to whether renewal, or leave to stay, was granted. PB concluded that staff working on Tier 2 work permits were therefore unlikely to have their permits renewed, or be given leave to stay as a resident, after a 5 year period. AJ asked how many of the Trust's staff were likely to be affected. PB stated that this was unknown at present. AJ asked PB to circulate the details to Board members when this was available. PB agreed.

Action: Circulate, to Board members, the number of existing Trust staff likely to be affected by the recently reported gross annual salary threshold (£35,000) that will apply to Settlement applications by Tier 2 Visa holders from April 2016 (Director of Workforce and Communications, June 2015 onwards)

PB emphasised that the 'rule' was not new, and affected all staff on Tier 2 work permits, not just Nursing staff. PB also stated that as the Trust employed a number of overseas staff, he wished the Board to recognise the contribution such staff made, and note that the Trust would support them where feasible.

SS asked whether the Trust was asking the NHS Trust Development Authority (TDA) to lobby the Government in relation to the potential impact of the situation. PB noted that such lobbying had been undertaken via NHS Employers, but had been unsuccessful. AK suggested that some local lobbying may be beneficial, given that two local MPs were members of the Cabinet. AJ proposed that once the details were known, a letter should consider being sent to all local MPs, outlining the adverse impact of the situation. This was agreed, but AJ pointed out that the content of the letter should be steered by GD and the Executive Team.

Action: Consider sending a letter to all of the Trust's local MPs, outlining the adverse impact of the recently reported gross annual salary threshold that will apply to Settlement applications by Tier 2 Visa holders from April 2016 (Chairman of Trust Board / Chief Executive, June 2015 onwards)

6-7 Chief Executive's report

GD referred to the circulated report and highlighted the following:

- The appointment of 5 new Consultant Paediatricians was a welcome development, and the latest in the series of improvements regarding Paediatrics. The final step was to have a separate Paediatric A&E. GD commended the achievement of the recruitment, and stated that credit should be given to Hamudi Kisat, the Clinical Director for Children's Services. AJ also emphasised that the Board regarded the appointments as a significant achievement.
- Work had started on the next phase of Ward redevelopment at Maidstone Hospital (MH), with the transformation of Jonathan Saunders and John Day Wards into a new Respiratory Ward
- The Trust was a partner in the winning bid for community services in the High Weald Lewes Havens Clinical Commissioning Group (CCG). Sussex Community NHS Trust won the bid.

ST asked for an update on the Crowborough Birthing Centre. GD noted that he and the Trust's Head of Midwifery had had discussions with the Crowborough Hospital League of Friends, who wished to donate funds to improve services at Crowborough hospital. GD added that The League of Friends also wanted Maidstone and Tunbridge Wells NHS Trust (MTW) to manage the Birthing Centre, as they regarded MTW as the best provider to improve services.

GD then continued, and highlighted the following points:

- GD had met with Helen Grant MP, and noted that she was very pleased with MH at present, and in particular the service provided at the Maidstone Birthing Centre. Ms Grant had been kept informed of the new foyer development at MH by the League of Friends
- The Trust was holding a Patient Safety Conference on 03/07/15, which was an important point in the Trust's journey regarding patient safety
- GD had been involved in the embryonic development of Physicians Assistant posts, which represented an important area in the development of new ways of working. The Trust was likely to be a sponsor of a course provided by Canterbury Christ Church University

SD referred to the circulated report, noted that the Stoma Care Nurses at MH had made it through to the national finals of the Purple Iris Award, and commended the achievement. GD proposed that Board members visit the Nurses and/or invite the team to present at the Trust Board. AJ encouraged the former, but requested that an invite be sent for the latter. This was agreed.

Action: Invite the Stoma Care Nurses at Maidstone Hospital to give a presentation to a future Trust Board meeting (Trust Secretary, June 2015 onwards)

SD also proposed that the Board send its congratulations and best wishes to the team for the awards ceremony. This was agreed.

Action: Arrange for a formal letter of congratulations and best wishes to be sent from the Trust Board to the Stoma Care Nurses at Maidstone Hospital, following their achievement of being shortlisted for The Colostomy Association's Purple Iris Award (Trust Secretary, June 2015 onwards)

KT referred to the development of Physicians Assistants, and queried whether the return on investment made by the Trust would be assessed. GD replied that the arrangement would be for the Trust to offer trainees continuity of employment. PS confirmed that this was an important factor, but explained that the Trust would be likely to fund the supervision of trainees, rather than, for example, providing bursaries. PB added that there was a disparity of support in terms of the bursaries provided to different health professionals, and therefore the Trust needed to find a solution regarding Physicians Assistants that worked for the Trust. The point was acknowledged.

6-8 Integrated Performance Report for May 2015 (incl. updates on recruitment and retention; and DTOCs)

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

- Some inroads had been made into the occurrence of Delayed Transfers of Care, but Length of Stay (LOS) was still 1 day above that for the same period last year. Agency Nursing usage had increased as a result, and the solution was to ensure patients flowed in a more timely way, some of which was within the Trust's control.
- It was therefore important not to abandon hope on the issues over which the Trust had control, even though further work was also required with Social Services. Having an extra 39 beds, which would be subject of discussion under item 6-22, was insufficient of itself
- Elective activity had been high recently, which had positively affected Referral to Treatment (RTT) performance
- There had been a further 52 week breach. However, this was not a new patient, as existing breaches counted as 'new' if the breach continued for another month. The patient had nevertheless now been treated
- The Trust's performance against Cancer targets may be adversely impacted by an issue at Medway NHS Foundation Trust that was still under investigation. GD proposed that the Performance Dashboard therefore report Cancer waiting time indicator performance solely for the Trust's patients, in addition to the current indicators. This was agreed.

Action: Arrange for the Trust Performance Dashboard to report Cancer waiting time indicator performance solely for the Trust's patients (in addition to the current indicators, which included tertiary referrals) (Chief Operating Officer, July 2015)

SM then reported that there had been an MRSA bacteraemia which was still under investigation. AJ stated that despite this case, the performance on infection prevention and control in the recent past should be commended.

AB then referred to the "Safe" section of the report and highlighted the following points:

- The "Rate of Total Patient Falls" had been rated as 'Amber', but a new 'tagging' system, which had been beneficial elsewhere, was to be introduced
- Some of the benchmarks for the new indicators in the report had not been set, and discussions were continuing with the TDA regarding such benchmarks

AJ stated that he had been to a recent meeting of the Falls Group, and noted that it was well attended and the lead Consultant, Dr Milton, was very committed.

PS then referred to the "Effectiveness" section and highlighted that the Hospital Standardised Mortality Ratio (HSMR) had risen, and further investigation was underway. PS continued that the number of expected deaths had been lower than the number of actual deaths, although crude mortality had not increased. PS added that Dr Foster had also changed the deprivation levels for the Trust's catchment area, and the area was now considered to be less deprived, which affected the ratio. PS also noted that 35% of Trusts had seen their HSMR increase.

AJ asked for clarification that PS was stating that the increase in HSMR was entirely due to a change in methodology. PS confirmed that he was not stating this. GD pointed out that the other two indicators for mortality showed a different picture to HSMR, but the matter needed to be taken seriously, and suggested that a Quality Committee 'deep dive' meeting into the issue would be beneficial. AJ asked when the next 'deep dive' meeting was being held. SDu confirmed this was August, but PS noted he was unable to attend. SDu added that the Quality Committee was aware of the issue, and of PS's investigations, and stated it would be more appropriate for the Committee to consider the matter after such investigations had been completed. PS stated that this was likely to be in September. SDu also commented that the Summary Hospital-level Mortality Indicator (SHMI) was probably a more reliable indicator of mortality.

SD then noted that the Stroke indicators in the "Responsiveness" section were rated as "Red". PS commented that some of the causal issues were structural, and would be addressed as part of the plans for the future provision of Stroke services.

KT asked for a comment on the Outpatient cancellation rate. AG stated that this was a new indicator, which included cancellations made by the Trust as well as patients, and gave assurance that the cause of the 'Red' rating was cancellations by patients, not by the Trust.

AB then referred to the "Caring" section and highlighted that the key issue was the "% complaints responded to within target". AB added that complaints had been discussed at the last Quality Committee 'deep dive' meeting, and a new strategy was being put in place.

AG then referred to the "Responsiveness" section and highlighted that the cancer 104- and 62- day wait performance had been adversely affected by other referring Trusts, as the indicator methodology required the Trust to include its share of breaches arising from such referrals.

AJ queried the forecast for the A&E 4-hour waiting time target, following his comments at the Trust Board on 27/05/15. AG replied that the forecast was being revised, but further work was required, and confirmed that the forecast would be included in due course. AJ emphasised the importance of achieving the 95% target. AG acknowledged the point. JL noted that the target was in fact a quarterly, not annual, target, and therefore the dashboard should be amended to reflect this.

Action: Arrange for the Trust Performance Dashboard to be amended to reflect the fact that the A&E 4-hour waiting time target was required to be achieved on a quarterly, rather than annual, basis (Chief Operating Officer, July 2015)

AJ then queried the forecast number of breaches for the "18 week RTT - 52wk Waiters" indicator. GD clarified that the forecast reflected the number of breaches that had already occurred i.e. no further breaches were forecast.

SD asked what the timescale was for the Stroke indicators to be rated as 'Amber'. PS replied that he would cover this under item 6-15.

SO then referred to the "Well-Led" section and highlighted the following points:
- The Trust was circa £350k adverse to plan after month 2
- The most significant element of the financial position related to staffing, and in particular Medical and Nursing Agency staffing. The latter was reviewed in detail at the Finance Committee on 22/06/15, and it was noted that the focus needed to be on demand and price. It was also noted that the Trust spent more on non-framework Agencies than with framework Agencies, which was affected by Agencies removing themselves from the framework
- Achievement of the financial plan was still being forecast for the year end, but this was reliant on the aforementioned Agency situation being mitigated

PB then referred to the "Well-Led" section and highlighted the following points:
- There had been an increase in the number of vacancies, which reflected a rise in the Trust's establishment from 2014/15, as well as the transfer of some staff from the Trust, as part of the changes occurring to the Kent and Medway Health Informatics Service
- Sickness absence was stable
- Some substantive Nurses had been recruited from Italy, and the net increase in substantive Nurses and Clinical Support Workers (CSWs) was 20 WTE. In addition, no CSWs had left in the month, which was positive, given the usually transient nature of such posts. A further 85 persons had been offered and/or accepted Nurse or CSW posts (64 nurses and 20 CSWs).

AB added that another European recruitment initiative was planned for July, in Spain, and emphasised that the future focus of overseas recruitment needed to be on Europe, as non-European recruitment was fraught with difficulties.

Presentation from a Clinical Directorate

6-9 The Respiratory service

AJ welcomed KC, JG, CMB & JM to the meeting. JG gave a presentation highlighting the following:
- Chronic Obstructive Pulmonary Disease (COPD) was characterised by airflow obstruction, and unlike asthma, COPD was not fully reversible. COPD was also usually progressive, so care was aimed at management. Smoking was the main cause, and exacerbations occurred often.
- 8,700 people had COPD in West Kent, but the 'real' number was likely to be 15,300
- The drivers for change included evidence emerging from other parts of UK; the increasingly high profile of COPD within the NHS; new COPD strategy recommendations; and the drive within the Trust to reduce LOS and admissions.
- Oxygen was also a key driver, as in 2011 the cost of Oxygen was rising, and a pilot involving 100 patients was therefore agreed, to improve the service. The service was called the Home Oxygen Service – Assessment and Review (HOS-AR)
- Before HOS-AR, any doctor could prescribe; some patients were on oxygen for years without reassessment; the number of patients increased rapidly; equipment did not meet patients' needs; and the CCG were still paying for oxygen for patients who had died
- The home oxygen service resulted in significant cost savings in 2011/12 compared to 2010/11
- Pulmonary Rehabilitation (PR) was added as an ongoing service development when the previous PR contract came to an end
- The service operated from community venues across West Kent
- In 2014, 173 patients completed the assessment of the 370 patients that were offered. Patient satisfaction was high & all patients completing PR improved in at least one outcome measure
- In terms of the COPD pathway, resources became available at short notice in the summer of 2013. A pilot operated in collaboration with Kent Community Healthcare NHS Trust, from November 2013 to March 2014, and a fully commissioned service, as a combined pathway, was in operation from November 2014

- The aims of the pathway were: to provide a seamless care pathway for patients with COPD across primary and secondary care; to ensure all those who are eligible have local and equitable access to pulmonary rehabilitation programmes; and to ensure patients who required oxygen at home receive an evidenced based, high quality assessment and ongoing review of their needs
- During admission, treatment was optimised in discussion with the medical team; the pathway paperwork was started; and patients were offered PR referral, a stop smoking referral, a self-management plan, inhaler technique advice, and a follow-up once they were at home
- After admission, two Specialist Community teams supported each hospital, via Nurses, Physiotherapists and assistant respiratory practitioners. The team's role was to: support the patient post exacerbation (<2 weeks); symptom control, sputum clearance, and exercise therapy; prevent/monitor deterioration; prevent readmission; and to facilitate referral into PR
- Communication was improved via Multi-Disciplinary Team meetings (MDMs), but there was also a 'Hot clinic' for patients who would benefit from review by a clinician
- There was a high turnover of patients; as well as increasing self-management. Complex patients were taken over by community complex care nurses
- An example patient was used to illustrate the service provided, which had resulted in no admissions for the patient since July 2014
- MDMs were regarded as exciting, and much has been learned from the perspectives of other health professionals. Palliative Care input had also been hugely beneficial. An MDM was run each week, and sometimes community MDMs could be run wholly from GP practices, which improved communication between primary and secondary care
- The service was heading in the right direction in terms of the target reductions in the number of admissions and occupied bed days, as well as the target for readmissions within 30 days
- In terms of next steps, a full complement of staff was required to provide the desired service, and recruitment efforts were continuing
- The introduction of Early Supported Discharge had lagged behind, but was hoped to be in place by the winter
- As the service was commissioned by West Kent CCG, an enhanced service was not available for East Sussex patients, and there was therefore a separate Oxygen service for such patients
- In terms of future possibilities, possible additions to the pathway included a COPD admission care bundle, an Asthma pathway, a Bronchiectasis pathway, and a Plural effusions service

AJ remarked that the presentation, and the service provided, were very impressive, and suggested that efforts to promote the awareness of such services could be increased.

AJ asked how many admissions involved East Sussex patients. KC replied that this was not currently known, but was being established. AG added that the issue had been raised with the CCG in East Sussex, and with West Kent, as the lead CCG, and liaison was continuing.

ST asked what was preventing the next steps being introduced immediately. JG replied that this was related to staffing. KC added that the challenge had been in finding well-trained nurses, whilst at the same time developing the pathway.

SD said that further investment may have had a positive impact on the pressure faced by A&E in the winter. AG highlighted that the CCG commissioned the service. SD suggested that the broadening of the service would be welcomed. The point was acknowledged, and it was noted that a 7-day service was provided in Hastings.

SDu stated that the team appeared to have delivered a successful change, and asked what the key lessons were for other teams needing to implement such change. JG replied that engagement with the CCG was important, as was having AG's support and influence, in terms of decision making and the acceptance of any risks. KC added that the relationship with the community team was important, but this was only possible by marketing the service to both sides, so that both wanted the same service for patients. KC stated that she would be happy to write a 'how to' guide, and JM stated that having the team to be able to bring quality care to patients' homes was the key.

KT asked for a comment on the key factors in having successful MDMs. JG stated that having an efficient coordinator was essential, and noted that this role was undertaken by Julie Banwell. JM

added that she wanted to attend the MDMs because she knew she would be able to discuss her patients and have the appropriate access to specialist expertise.

AJ thanked KC, JG, CMB and JM for their presentation, and asked that the Board's thanks and support be passed on to their colleagues.

Quality items

6-10 Progress with the Quality Improvement Plan

AB referred to the circulated report and highlighted the following:

- The Care Quality Commission (CQC) would be visiting the Trust on 29/06/15 to review the evidence relating to water quality testing
- An 'assurance inspection' would take place on 06/07/15, involving colleagues from the TDA, West Kent CCG and Healthwatch Kent. The intention was to test the compliance for each of the Compliance Actions

SO then referred to Compliance Action 16, and queried whether "Increased incident reporting through single reporting system from anesthetist and Intensivists", as listed in the "Evidence required" section had been seen, in order to warrant the "Blue" rating. AB explained that the intention had been to remove the separate incident reporting process, and channel incident reports through the 'Datix' system. AJ asked whether the staff that had reported incidents via the previous system were now using the 'Datix' system. AB agreed to clarify whether this was case.

Action: Clarify whether the staff that had previously reported incidents via the anaesthetic incident reporting system were now reporting incidents via the Trust's 'Datix' system (Chief Nurse, June 2015 onwards)

KT queried the validity of some of the ratings, and cited the 'Amber' rating in Compliance action 11, on page 44, as an example. AB replied that that rating was likely to be 'Green' for the next report.

AJ commended the report, but asked about the 'Amber' ratings for Compliance action 14, on page 47. AB confirmed that the first action had now been rated as 'Green', and the second action was likely to be rated 'Green' soon.

GD emphasised that the actions had been implemented via engagement with staff, and therefore solutions had not just been imposed.

6-11 Planned v actual ward staffing for May 2015

AB referred to the circulated report and highlighted that the only 'Red' rating was John Day ward, which was slightly below the 80% threshold. AB added that the Ward had also been 'flagged' on other indicators intermittently, and was therefore being investigated.

GD proposed that the same 'RAG' rating criteria used for Ward staffing fill rates below 100% be applied to rates above 100%. This was agreed.

Action: Apply the same 'RAG' rating criteria used for Ward staffing fill rates below 100% to rates above 100%, within future 'Planned v actual ward staffing' reports to the Trust Board (Chief Nurse, July 2015)

6-12 Review of clinical outcomes

PS referred to the circulated report and highlighted the following:

- The last Quality Committee 'deep dive' meeting had discussed clinical outcomes, and the report aimed to describe the actions taken in response to outliers on such outcomes
- Each issue included in the report had been discussed in one or more forums in the Trust
- Two of the Trust's surgeons had been identified as outliers on the National Joint Registry. On investigation, this was related to the surgeon's use of 'metal on metal' implants, which had resulted in problems with patients. PS therefore felt the matter had been resolved.
- The National Hip Fracture Database had revealed a higher than average hip fracture mortality at the Trust, and Mr Slater in the Trauma and Orthopaedics Directorate had led a review, the outcome of which was provided to the CQC. The Trust was no longer an outlier

- Vascular surgery and Carotid endarterectomy in particular was another issue, and the data on page 75 showed that no Trust was an outlier, which illustrated that national data could not always be relied on to identify outliers. Page 76 showed the Consultant level data for the South East Coast.

ST asked for assurance that an investigation occurred whenever national data identified outliers at the Trust. PS confirmed this was the case, but emphasised that national data could not always be relied upon to identify such outliers.

ST asked whether the data on page 76 identified the importance of undertaking a critical mass of procedures. PS stated that he queried whether the Trust should continue to undertake Carotid endarterectomy procedures. AJ stated that the Trust Board was unable to take a view on such matters, and would rely on clinical advice. PS stated that he would liaise with the clinical staff, and submit a proposal to a future Trust Board meeting.

Action: Submit a proposal to a future Trust Board meeting in relation to whether the Trust should continue to undertake Carotid endarterectomy procedures (Medical Director, TBC)

PB then referred to page 64 and the "Seniority of anaesthetist/surgeon", and asked what criteria had been used in the review. PS replied that he did not have this information to hand. PB asked whether this could be obtained. PS agreed to provide details of the criteria used.

Action: Provide Board members with details of the criteria used when judging the appropriateness of the seniority of Anaesthetist/Surgeon within the "reduction of fracture of neck of femur" mortality review undertaken in response to the mortality outlier alert issued to the Trust in December 2014 (Medical Director, June 2015 onwards)

PB then referred to page 67, which made reference to a letter that had been sent from the CQC, and asked for further information. PS stated that he had not included the letter in the report. GD added that the letter from the CQC just pointed out that the Trust was an outlier, but acknowledged the letter had not been seen at the Quality Committee & proposed it be received. This was agreed.

Action: Arrange for the previous mortality outlier alert letter/s issued to the Trust from the Care Quality Commission to be submitted to the 'main' Quality Committee (Medical Director / Trust Secretary, July 2015)

KT referred to the areas for improvement, and asked what was being done to improve practice, and by what timescales, PS gave assurance that all of the issues had been put in place already.

AJ asked how the Board would be notified of any identified outliers. GD answered that the aim should be to include these in the Directorates' reports to the Quality Committee, and one method of doing this was for that Committee to receive the minutes of the Directorate Clinical Governance meetings, as part of the Directorate's report. SDu stated that she had emphasised to the external Governance Adviser that the Quality Committee required assurance that such issues had been responded to appropriately. AB noted that much of the work regarding outcomes was undertaken at the Standards Committee. AJ noted that the Quality Committee did not currently see the Dr Foster outcomes data, and suggested this be reintroduced to the Quality Committee. PS agreed to submit the requested information.

Action: Arrange for outcomes data from the Dr Foster system to be submitted to the Quality Committee (Medical Director, June 2015 onwards)

KR asked whether the Board was content to receive a "Review of clinical outcomes" report once a year. It was agreed that the frequency of receipt of such reports should be covered as part of the current review of Clinical Governance being undertaken at the Trust.

Action: Ensure that the current review of Clinical Governance being undertaken at the Trust includes a recommendation regarding the frequency of future "Review of clinical outcomes" reports to the Trust Board (Medical Director / Chief Nurse, June 2015 onwards)

6-13 Board members' hospital visits

AJ referred to the circulated report and requested that Board members that had not made as many visits as others undertake further visits.

6-14 Approval of the Quality Accounts, 2014/15

AB referred to the circulated report and highlighted the following:

- The document would be published on 29/06/15
- The circulated document contained some typographical errors, but these would be corrected before publication
- The External Auditors had issued an unqualified audit conclusion
- Comments from Healthwatch Kent had been included

Questions or comments were invited. None were received. The Quality Accounts for 2014/15 were approved as circulated.

Planning and Strategy

6-15 Update on the future provision of Stroke services

PS reported that the Clinical Support Unit (CSU) for the South East had decided that pre-consultation / engagement that the Trust had undertaken needed to be undertaken again, to cover the wider region. PS stated that this was unsatisfactory, but there was little that could be done.

JL stated that there needed to be a way of expressing the Trust's indignation at the decision in a constructive manner. AJ emphasised that JL could make reference to the fact that the Board was very concerned at the decision, and of the waste of time and resources that had resulted.

PS then discussed the future of the Trust's Stroke service, and noted that plans were still underway to improve the quality of Stroke services in the short term.

SD noted that one of the first Quality & Safety Committee 'deep dive' meetings had discussed Stroke, and the need to improve had been emphasised. SD added that it would be beneficial for the Board to receive a report outlining the actions taken, and how the Trust's performance compared nationally. PS replied that the Trust generally performed at average levels, but expressed his own dissatisfaction at the timescales involved. SD stressed the need to ensure that future delays were minimised.

AJ asked what timescales were now likely to be involved, given the aforementioned situation regarding pre-consultation. GD replied that it was unlikely to be earlier than April 2016 before any changes were likely to be implemented.

SS asked where the locus of the CSU's responsibility lay. GD answered that the CSU was acting at the behest of Dartford, Gravesham and Swanley CCG, but added that West Kent CCG would have had to acquiesce to a pan Kent wide Stroke service for such a development to occur.

GD then referred to SD's suggestion regarding a report, and acknowledged that this would be beneficial. AG noted that a Directorate improvement plan was still in place, and a report was submitted to each 'main' Quality Committee. KR proposed that the July 2015 Board receive that report, as an appendix to the summary report from the 'main' Quality Committee. This was agreed.

Action: Arrange for the July 2015 Trust Board to receive the "Update on the latest Stroke care performance" report to the July 2015 'main' Quality Committee, as part of the summary report from that Committee (Chairman of Quality Committee / Trust Secretary, July 2015)

6-16 To approve the 'GS1 and PEPPOL adoption plan'

PS referred to the circulated report and highlighted that the Board was asked to approve the plan.

SO noted that he was the Board lead for Procurement, and pointed out that some actions in the plan were already underway.

PB stated that he supported the plan, but the £40,000 of "Labour cost" benefits listed on page 194 was likely to be an underestimate. The point was acknowledged.

The Board approved the adoption plan as circulated.

6-17 To approve revised Terms of Ref. for the KPP Board

GD referred to the circulated report and stated that the proposed changes reduced the number of Executives required from each Trust, but maintained the representation of each Trust.

AJ pointed out that the proposals meant that there would be 5 members of the KPP Board from East Kent Hospitals University NHS Foundation Trust (EKHUFT), but only 3 from MTW. GD confirmed he was content with this.

The Terms of Reference were approved as circulated.

The Board then delegated its authority for the 'Part 2' Board meeting being held later that day to discuss (and agree) the future direction for Pathology.

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

6-18 Workforce Committee, 01/06/15 (incl. approval of revised ToR)

AK referred to the circulated report and highlighted that the "Membership" section erroneously denoted two Chairmen for the Committee.

The report was noted, and the Terms of Reference were approved as circulated.

6-19 Patient Experience Committee, 03/06/15

SD referred to the circulated report and highlighted that the methods by which the Committee would receive information on patient experience work undertaken by Clinical Directorates had now been agreed, and the Children's Directorate would be the first to be invited to present.

AJ commended the contribution made by the two junior doctors at the meeting, and acknowledged the potential benefit of having junior doctors in attendance at other committees.

6-20 Quality Committee, 10/06/15

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

6-21 Trust Management Executive, 17/06/15

JL referred to the circulated report and invited comments or questions.

KR referred to the "Escalation policy and procedure for emergency admissions", and noted that although the Policy had been "approved" at the meeting, it had since been recognised that the consultation was incomplete, and therefore the Policy would instead be submitted for "approval" at the Clinical Operations and Delivery Group on 14/07/15.

6-22 Finance Committee, 22/06/15 (to incl. approval of the Outline Bus. Case for a new ward at Tun. Wells Hosp.)

ST referred to the circulated report (Attachment 16) & highlighted that the Finance Committee had been sympathetic to the Outline Business Case (OBC) for the new Ward at Tunbridge Wells Hospital (TWH), but could not give its full support until further information was provided. ST continued that the Committee had therefore asked that AG give a presentation to the Board in response to concerns regarding the need to strengthen the case for increased demand, & the financial implications & practicality of all options

AG then referred to Attachment 17, and gave a presentation highlighting the following:

- The case for change for the new Ward was to improve patient experience, and on the basis that TWH was unable to accommodate the totality of non-elective demand, not just in winter
- The impact of such demand was diverts from TWH to MH, an adverse impact on A&E access targets, medical outliers, reduced elective activity, increased numbers of cancelled operations, and high bed occupancy levels

- Capacity and demand analysis showed that the core funded capacity at both hospitals was less than the nationally recommended level of 85% of the predictable and consistent variation in demand for beds. There was also very little buffer before demand significantly affected operational service
- MH had a bigger gap between capacity and demand, but flexibility existed within bed capacity (in terms of empty wards and closed bays)
- Nationally, the recommended occupancy baseline was 85%, which enabled better management of peaks in demand, but the Trust's occupancy was much higher

SDu asked what assumptions had been made in the OBC regarding LOS. AG replied that continued reductions in LOS had been assumed, as these were essential as part of the Trust's required response.

AG then continued, as follows:

- All 3 Options in the OBC were required to help close the core bed requirement and offer the best solution to the Trust's capacity and flow problems in the shortest period of time
- Sustained management of demand through the available bed capacity also required improved productivity, but performance and efficiency improvement alone (i.e. without additional bed capacity) prior to winter did not close the capacity gap, and offered an operational risk
- The Trust experienced significant operational pressure last winter, which adversely affected performance against the A&E 4-hour waiting time target, particularly in terms of patients needing admission (the performance for non-admitted patients was relatively stable)
- Bed occupancy rates from May 2014 to April 2015 were consistently above baseline
- There were also high cancellation rates across all elective specialities, as a result of such specialities' beds being used for non-elective patients
- December 2014 & January 2015 also had high levels of medical outliers, & there were very high numbers of escalation beds, including the Catheter Laboratory, Theatre Recovery & Short Stay Unit. There were rarely less than 40 escalation beds in place from November 2014
- The Wells Suite (Private Patient Unit) was already used for NHS activity, but if all of the Unit's beds were used for NHS work, £1.997m of private patient income would be lost
- The benefits of increasing capacity were: improved patient flows; the ability to maintain elective activity levels; reducing the level of outsourcing of elective activity; reducing the inappropriate escalation as first line escalation; enabling the optimal use of escalation areas; enabling improved discharge and LOS management; and be a catalyst for whole-system improvement
- In terms of Therapy costs, the original costs were developed prior to a full understanding of the flow of patients, and the costs were being revised. GD added that there would be no additional activity, so the costs were likely to have been speculative on behalf of Therapy Services.

AG emphasised that the proposed initiative was not related to seeking additional demand. GD stated that he was confident that even if the wider developments resulted in reduced demand, the Trust would not be left with an unused 39 bed Ward i.e. a purchaser would be found.

ST then referred to page 256, and noted that he had interpreted Table 20 as showing that instigating Options 2 and 4 combined was more beneficial, at less capital cost, than the preferred Option 3. SO replied that the presentation from AG noted that the loss of private patient income was £1.3m worse than had been presented in the Table. ST acknowledged the point. SO also noted that Option 3 had a revenue benefit, whilst Option 2 had negative revenue implications.

AJ emphasised that Option 2 did not include full costs, as the OBC had noted these were difficult to quantify. AG agreed, and added that there was also a timing and urgency issue which led to Option 3 being preferred. ST declared that despite SO and AG's comments, he was still left with the conclusion that Options 2 and 4 combined resulted in greater benefits than Option 3 alone.

SS commented that the OBC was configured on the basis that the Trust would be always using only between 8 and 11 beds on the Wells Suite, but if this was the case, the future viability of the Wells Suite would be called into question. SS continued that another review of the Wells Suite was therefore warranted. GD agreed, and confirmed that a commitment to such a review had already been made, but pointed out that even using all of the Wells Suite beds, capacity would be insufficient. SS agreed that whatever numbers were used from the Wells Suite, there were less

than the 39 beds that would be made available under Option 3. PS noted that the elective activity undertaken by the Wells Suite during the last winter was minuscule. SO added that The Wells Suite was already exploring different ways of working

SO then referred to ST's earlier assertion that the combination of Options 2 and 4 would result in greater benefit than Option 3, and highlighted that the scoring methodology did not allow a simple addition of benefits, as ST had suggested. SO continued that ST's suggestion therefore 'broke' the scoring methodology, and Options 2 and 4 would still have a rating inferior to that of Option 3. The point was acknowledged.

AJ summarised by stating that Options 2 and 4 did not meet the Trust's current needs, and ST's point was therefore that the OBC document did not make this sufficiently clear. AJ therefore proposed that the OBC be amended to make this clearer, and the amended version then be shared with ST. ST confirmed that on this basis, he supported the OBC.

Action: Amend the Outline Business Case (OBC) for the new ward at Tunbridge Wells Hospital to emphasise the point that Options 2 and 4 did not meet the Trust's current needs, and then send the updated OBC to the Chairman of the Finance Committee (Chief Operating Officer, June 2015 onwards)

The Outline Business Case was approved on this basis.

GD emphasised that this was a calculated risk and acknowledged that further work was required on the Case. ST acknowledged that Option 2 would not be able to be implemented with the speed required by the Trust.

KR then asked how the Board wished to consider the Full Business Case (FBC), noting that the Finance Committee had agreed to review this in full. It was agreed that the FBC would not be required to be submitted to the Trust Board, and that the Finance Committee should be granted the authority to approve the FBC. It was further agreed that the Finance Committee should however notify the Board of any substantial changes from the OBC.

KR asked about the route for the aforementioned review of the Trust's Private Patient Unit. It was agreed that this review should be submitted to the Finance Committee in the first instance.

Action: Arrange for the review of the future of the Trust's Private Patient Unit to be submitted to the Finance Committee (Chief Operating Officer / Trust Secretary, June 2015 onwards)

Assurance and policy

6-23 Actions in response to the national NHS staff survey 2014

PB referred to the circulated report and highlighted that there was an error in the "Which Committees have reviewed the information prior to Board submission?" section on the front page, as the document had in fact been received at the Trust Management Executive.

Questions or comments were invited. None were received.

6-24 Reflections on the scope of clinical practice of newly appointed Consultants

PS referred to the circulated report and highlighted he was content to receive questions outside the meeting, but highlighted the peculiarity of NHS England being the authors of what doctors needed to do, despite the fact that the NHS did not employ all of the doctors in the country.

SD emphasised the importance of the agenda item, and stated it deserved sufficient time for discussion. AJ agreed, and proposed that the issue be a leading item at the next Board meeting. ST asked whether the item could be taken in the non-public (Part 2) meeting. It was agreed to add the item to the agenda of the Part 2 Board meeting in July 2015.

Action: Arrange for "Reflections on the scope of clinical practice of newly appointed Consultants" to be a leading agenda item at the Part 2 Board meeting in July 2015 (Trust Secretary, July 2015)

6-25 Approval of compliance oversight self-certification

KR referred to the circulated report and highlighted that there was no change in compliance status from that approved in May 2015.

The submission was approved as circulated.

6-26 To consider any other business

KT noted that Board members were using “BoardPad” software, and asked for a comment. KR stated that the software had been introduced initially for use by the Executive Team, but if Non-Executive Directors wished to use the software, they should make their views known to him, and he would liaise with the P.A. to the Chief Executive and Chairman, who introduced the system.

6-27 To receive any questions from members of the public

There were no questions.

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

The motion was approved.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – July 2015

7-4	Log of outstanding actions from previous meetings	Chairman

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
6-6ii (June 15)	Consider sending a letter to all of the Trust's local MPs, outlining the adverse impact of the recently reported gross annual salary threshold that will apply to Settlement applications by Tier 2 Visa holders from April 2016	Chairman of Trust Board / Chief Executive	July 2015	In the light of the clarification that the situation will affect a maximum of 11 staff (see action 6-6i below), it is considered that the proposed letter is not warranted. The Board is asked to confirm its wishes.
6-8ii (June 15)	Arrange for the Trust Performance Dashboard to be amended to reflect the fact that the A&E 4-hour waiting time target was required to be achieved on a quarterly, rather than annual, basis	Chief Operating Officer	July 2015	Discussions have been held regarding the requested amendment, but this is not yet completed
6-12i (June 15)	Submit a proposal to a future Trust Board meeting in relation to whether the Trust should continue to undertake Carotid endarterectomy procedures	Medical Director	TBC	A verbal update will be given at the July Trust Board meeting

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
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	July 2015	The requested analysis has been included in the "Planned v actual ward staffing for June 2015" submitted to the July 2015 Trust Board.
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	An updated version of the Plan has been submitted to the July Trust Board
6-6i (June 15)	Circulate, to Board members, the number of existing Trust staff likely to be affected by	Director of Workforce and Communications	July 2015	It has been established that the situation will affect a maximum of 11 staff

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	the recently reported gross annual salary threshold (£35,000) that will apply to Settlement applications by Tier 2 Visa holders from April 2016			(although this number may reduce), only 1 of which is a Registered Nurse (the other 10 are from other professions)
6-7i (June 15)	Invite the Stoma Care Nurses at Maidstone Hospital to give a presentation to a future Trust Board meeting	Trust Secretary	July 2015	The Nurses have been invited to give a presentation at the October 2015 Board. Confirmation is awaited.
6-8i (June 15)	Arrange for the Trust Performance Dashboard to report Cancer waiting time indicator performance solely for the Trust's patients (in addition to the current indicators, which included tertiary referrals)	Chief Operating Officer	July 2015	The Performance report submitted to the July 2015 Trust Board contains a separate indicator for 62-day Cancer waits ("Cancer 62 day wait - First Definitive - MTW")
6-7ii (June 15)	Arrange for a formal letter of congratulations and best wishes to be sent from the Trust Board to the Stoma Care Nurses at Maidstone Hospital, following their achievement of being shortlisted for The Colostomy Association's Purple Iris Award	Trust Secretary	July 2015	A letter was sent on 08/07/15.
6-10 (June 15)	Clarify whether the staff that had previously reported incidents via the anaesthetic incident reporting system were now reporting incidents via the Trust's 'Datix' system	Chief Nurse	July 2015	It has been established that during the 6-week trial of the anaesthetic incident reporting system, 20 incidents were reported. In the 4 months from 1st March to 30th June (i.e. after the trial ended), 11 anaesthetic-related incidents have been reported via the Datix system. 3 of these have been reported by Anaesthetists, while the remainder have been reported by other staff (including Operating Department Practitioners)
6-11 (June 15)	Apply the same 'RAG' rating criteria used for Ward staffing fill rates below 100% to rates above 100%, within future 'Planned v actual ward staffing' reports to the Trust Board	Chief Nurse	July 2015	The requested change has been incorporated into the 'Planned v actual ward staffing' report to the July 2015 Trust Board
6-12ii (June 15)	Provide Board members with	Medical Director	July 2015	An assessment of the

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	details of the criteria used when judging the appropriateness of the seniority of Anaesthetist/Surgeon within the "reduction of fracture of neck of femur" mortality review undertaken in response to the mortality outlier alert issued to the Trust in December 2014			clinical state of the patient (using the American Society of Anesthesiologists (ASA) Physical Status Classification System) and the complexity of the stated operation were used to judge the required need for different grades of clinicians. As an example, those that were extremely unwell had a Consultant in both specialties of Anaesthesia and Orthopaedics
6-12iii (June 15)	Arrange for the previous mortality outlier alert letter/s issued to the Trust from the Care Quality Commission to be submitted to the 'main' Quality Committee	Medical Director / Trust Secretary	July 2015	The Quality Committee on 03/07/15 received a report containing the outlier alert.
6-12iv (June 15)	Arrange for outcomes data from the Dr Foster system to be submitted to the Quality Committee	Medical Director	July 2015	Mortality data will be reported via the report from the Mortality Review Group (i.e. to every 'main' Quality Committee. Reports on other outcomes have been scheduled to be reported (via a "Clinical outcomes update") to the 'main' meeting every 4 four months i.e. September 2015, January 2016 and May 2016.
6-12v (June 15)	Ensure that the current review of Clinical Governance being undertaken at the Trust includes a recommendation regarding the frequency of future "Review of clinical outcomes" reports to the Trust Board	Medical Director / Chief Nurse	July 2015	The external adviser has agreed to the proposal that a formal report be submitted to the Board annually. The item has therefore been scheduled for the Trust Board in June 2016.
6-15 (June 15)	Arrange for the July 2015 Trust Board to receive the "Update on the latest Stroke care performance" report to the July 2015 'main' Quality Committee, as part of the summary report from that Committee	Chairman of Quality Committee / Trust Secretary	July 2015	The summary report from the Quality Committee on 08/07/15 contains the "Update on the latest Stroke care performance" report
6-22i (June 15)	Amend the Outline Business Case (OBC) for the new	Chief Operating Officer	July 2015	The OBC was amended, and was sent to the

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	ward at Tunbridge Wells Hospital to emphasise the point that Options 2 and 4 did not meet the Trust's current needs, and then send the updated OBC to the Chairman of the Finance Committee			Chairman of the Finance Committee on 10/07/15
6-22ii (June 15)	Arrange for the review of the future of the Trust's Private Patient Unit to be submitted to the Finance Committee	Chief Operating Officer / Trust Secretary	July 2015	The item has been scheduled for the Finance Committee in October 2015
6-24 (June 15)	Arrange for "Reflections on the scope of clinical practice of newly appointed Consultants" to be a leading agenda item at the Part 2 Board meeting in July 2015	Trust Secretary	July 2015	The item has been added to the agenda of the Part 2 Trust Board in July 2015

Actions not yet due (and still 'open')

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - July 2015

7-7	Chief Executive's update	Chief Executive

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

1. I met with our patients, their relatives, our staff, Clinical Commissioning Groups and MPs during June and July to discuss and reflect upon their experiences of our local health service. This has continued to help shape my thinking and our organisation's collective approach to providing safe, high standards of care. We helped one of our local MPs hold a public drop-in surgery at Maidstone Hospital, providing our patients and visitors with another unique opportunity to comment on their care while supporting our wish to be open and transparent. I have also emphasised to colleagues throughout our Trust the local and national importance of reducing our use of costly agency staff and getting better value for money from the goods and services we purchase. These moves will help drive up service quality now and in the future.

2. We welcomed Ben Gummer MP, Minister for Health, and Helen Whatley, MP for Faversham and Mid Kent, to Tunbridge Wells Hospital as part of their national tour of hospitals and gathering of information about health services and maternity services. The MPs were shown around our post-natal and labour ward. They spoke to colleagues about how they found working in maternity services and if they felt supported and able to raise any concerns. The Health Minster also spoke to some of our new parents and asked them about their experiences. He was impressed with the facilities, and the enthusiasm and commitment from our colleagues in wanting to provide an excellent service.

3. I officially opened the Trust's first Step up to Safety Patient Safety Conference in July. The event drew together colleagues from across the Trust and harnessed their collective abilities to make our hospitals even safer places for our patients.

4. Over 50,000 people have now heard through social media about the lifesaving skills of three of our colleagues who saved a man's life when he had a heart attack at the wheel of his car. I would like to commend the efforts of Paediatric Oncology Nurse Helen Stevens, Occupational Therapist Chloe Joseph and Medical Director Paul Sigston who were driving nearby, stopped and saved the man's life. On another occasion, Jonathan Baker from our catering department helped save a man's life as part of his volunteering work for the Urban Blue Bus in Maidstone.

   As a Trust, we collectively save many hundreds of lives every year in our hospitals. There are also thousands of people who have a better quality of life now thanks to the care we provide. We are proud to have so many lifesavers and life changers living in the community we serve.

5. We are the first hospital Trust in the South East to receive a quality mark for our Clinical Support Worker training. This hugely important area of training for our carers is described as supportive, innovative and suiting the local and national needs of our health service.

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 – July 2015

7-9	**Integrated Performance Report for June 2015** (incl. updates on recruitment and retention; DTOCs & HSMR)	**Chief Executive**

The enclosed performance dashboard for Month 3 includes updated "Well-Led" metric performance data.

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 scrutiny

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

TRUST PERFORMANCE DASHBOARD **Position as at:** **30th June 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)	16.1	5.2	18.0	5.0	- 12.9	- 10.1	*11.5*	8.9	
'1-02	Number of cases C.Difficile (Hospital)	3	1	10	3	- 7	- 6	*27*	21	
'1-03	Number of cases MRSA (Hospital)	-	1	1	1	-	1	-	1	
'1-04	Elective MRSA Screening	96.0%	100.0%	96.0%	100.0%		2.0%	98.0%	100.0%	
'1-05	% Non-Elective MRSA Screening	98.0%	98.0%	98.0%	98.0%		3.0%	95.0%	98.0%	
'1-06	**Rate of Hospital Pressure Ulcers	1.9	2.4	1.7	2.1	0.3	- 0.9	*3.0*	2.1	3.0
'1-07	***Rate of Total Patient Falls	5.9	6.8	6.2	6.6	0.4	0.4	*6.2*	6.2	
'1-08	***Rate of Total Patient Falls Maidstone	5.1	6.1	5.7	5.9	0.2			6.0	
'1-09	***Rate of Total Patient Falls TWells	6.2	7.6	6.6	7.2	0.6			7.1	
'1-10	Falls - SIs in month		-		6	6				
'1-11	Number of Never Events	1	-	2	-	- 2	-	-	-	
'1-12	Total No of SIs Open with MTW	37	24			- 13				
'1-13	Number of New SIs in month	14	6	32	19	- 13	- 11			
'1-14	**Serious Incidents rate	0.753	0.313	0.574	0.320	- 0.255	0.255	*0.065 - 1.35*	0.320	*0.065 - 1.35*
'1-15	**Medication errors causing serious harm	-	-	-	-	-	-	*0 - 0.052*	-	*0 - 0.052*
'1-16	Rate of Patient Safety Incidents - harmful	1.52	1.21	1.64	1.34	- 0.30	- 0.36	*0 - 1.698*	1.34	*0 - 1.698*
'1-17	**Patient Safety Incidents Rate	35.39	43.04	35.01	40.26	5.26		TBC	40.26	
'1-18	** Patient Safety Incidents -death/severe harm	0.54	0.52	0.57	0.54	- 0.04		TBC	0.54	
'1-19	Number of CAS Alerts Overdue	-	-			-	-	-		
'1-20	VTE Risk Assessment	95.3%	95.1%	95.6%	95.1%	-0.5%	0.1%	95.0%	95.1%	95.0%
'1-21	Safety Thermometer % of Harm Free Care	96.8%	97.2%	97.2%	96.9%	-0.3%	1.9%	95.0%		93.4%
'1-22	Safety Thermometer % of New Harms	2.75%	2.33%	6.40%	2.31%	-4.09%		*TBC*	2.31%	
'1-23	C-Section Rate (non-elective)	16.3%	13.5%	14.9%	12.9%			*TBC*	12.9%	

	Effectiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	Hospital-level Mortality Indicator (SHMI)*	Prev Yr: Oct 13 to Sept 14		103.4	103.4	- 0.0	3.4	*Lower confidence limit to be <100*		100.0
2-02	Standardised Mortality (Relative Risk)	Prev Yr: Oct 13 to Sept 14		106.9	108.0	1.1	8.0			100.0
2-03	Crude Mortality	1.1%	1.0%	1.3%	1.1%	-0.2%				
2-04	Crude Mortality Rate (non-elective)	2.4%	2.4%	2.7%	2.8%	0.07%		*TBC*	2.8%	
2-05	****Readmissions <30 days: Emergency	11.9%	10.9%	11.8%	11.5%	-0.3%	-2.1%	*13.6%*	11.5%	14.1%
2-06	****Readmissions <30 days: All	11.0%	10.2%	10.9%	10.7%	-0.2%	-4.0%	*14.7%*	10.7%	14.7%
2-07	Average LOS Elective	3.4	3.2	3.0	3.2	0.2	0.0	*3.2*	3.2	
2-08	Average LOS Non-Elective	6.5	7.2	6.6	7.4	0.8	0.9	*6.5*	6.5	
2-09	New:FU Ratio	1.46	1.42	1.54	1.47	- 0.07	- 0.05	*1.52*	1.52	
2-10	Day Case Rates	83.4%	83.0%	83.6%	83.2%	-0.4%	3.2%	80.0%	83.2%	82.2%
2-11	Primary Referrals	8,815	9,246	25,536	26,539	3.9%	5.6%	-	108,766	
2-12	Cons to Cons Referrals	3,933	3,180	10,648	9,626	-9.6%	-0.3%	39,585	39,451	
2-13	First OP Activity	12,734	12,615	35,186	33,986	-3.4%	1.4%	137,412	139,287	
2-14	Subsequent OP Activity	22,058	22,385	63,794	62,436	-2.1%	-1.9%	260,800	255,887	
2-15	Elective IP Activity	683	762	2,033	2,036	0.1%	4.5%	7,988	8,344	
2-16	Elective DC Activity	3,202	3,525	9,198	9,595	4.3%	2.0%	38,556	39,324	
2-17	Non-Elective Activity	3,897	3,707	11,870	11,457	-3.5%	-4.6%	48,289	46,080	
2-18	A&E Attendances (Calendar Mth)	11,302	11,393	35,351	34,285	-3.0%	1.5%	135,922	137,894	
2-19	Oncology Fractions	5,854	5,798	17,198	16,550	-3.8%	-7.2%	71,761	66,564	
2-20	No of Births (Mothers Delivered)	465	489	1,402	1,471	4.9%	3.1%	5,708	5,884	
2-21	% Mothers initiating breastfeeding	83.9%	78.7%	81.0%	79.5%	-1.5%	1.5%	78.0%	78.0%	
2-22	Rate of Intra partum stillbirths	-	8.0	0.7	4.0	*3.3*	- *3.3*	*7.3*	4.0	7.3

	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	-	-	-	-	-	-	-	-	
3-02	*****Rate of New Complaints	2.04	2.09	3.77	1.85	- 1.92	0.53	*1.318-3.92*	1.86	
3-03	% complaints responded to within target	51.4%	79.1%	57.8%	62.6%	4.8%	-12.4%	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	91.4%	98.3%	91.4%	96.6%	5.2%	1.6%	95.0%	95.0%	95.7%
3-06	A&E Friends & Family (FFT) % Positive	89.0%	91.3%	89.7%	89.2%	-0.5%	2.2%	87.0%	87.0%	88.3%
3-07	Maternity Combined FFT % Positive	93.1%	94.1%	91.8%	94.5%	2.8%	-0.5%	95.0%	95.0%	95.6%
3-08	OP Friends & Family (FFT) % Positive	New	77.9%	New	77.6%	New			77.6%	

	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)	95.3%	93.2%	95.6%	90.9%	-4.7%	-4.1%	95.0%		93.2%
4-02	Emergency A&E >12hr to Admission	-	-	2	-	- 2	-	-	-	
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	85.6%	92.6%	88.0%	92.5%	4.5%	2.5%	90%	92.5%	
4-06	18 week RTT - non admitted patients	96.1%	98.6%	96.3%	98.4%	2.1%	3.4%	95%	98.4%	
4-07	18 week RTT - Incomplete Pathways	95.7%	96.9%	95.7%	96.9%	1.2%	4.9%	92%	96.9%	
4-08	18 week RTT - Specialties not achieved	4	2	8	11	3	11	-	11	
4-09	18 week RTT - 52wk Waiters	-	-	-	6	6	6	-	6	
4-10	18 week RTT - Backlog 18wk Waiters	425	564	425	564				564	
4-11	% Diagnostics Tests WTimes <6wks	100.0%	99.99%	100.0%	99.99%	0.0%	1.0%	99.0%	99.0%	
4-12	Cancer WTimes - Indicators achieved	6	7	7	7	-	- 2	9	9	
4-13	*Cancer two week wait	96.0%	91.1%	95.4%	92.6%	-2.8%	-0.4%	93.0%	93.0%	
4-14	*Cancer two week wait-Breast Symptoms	96.2%	95.1%	92.3%	95.9%	3.6%	2.9%	93.0%	95.9%	
4-15	*Cancer 31 day wait - First Treatment	98.5%	98.8%	99.0%	98.8%	-0.1%	2.8%	96.0%	98.8%	
4-16	*Cancer 62 day wait - First Definitive	76.0%	79.0%	82.4%	81.2%	-1.1%	-3.8%	85.0%	85.0%	
4-17	Cancer 62 day wait - First Definitive - MTW	77.8%	84.6%	85.0%	86.2%	1.2%		85.0%		
4-18	*Cancer 104 Day wait Accountable	New	4.0	New	9.5	New	9.5	-	9.5	
4-19	Delayed Transfers of Care	4.3%	6.8%	3.7%	5.7%	2.0%	2.2%	3.5%	3.5%	
4-20	% TIA with high risk treated <24hrs	64.7%	62.5%	66.7%	72.4%	5.7%	12.4%	60%	60.0%	
4-21	% spending 90% time on Stroke Ward	77.4%	91.7%	76.5%	82.9%	6.4%	2.9%	80%	80.0%	
4-22	***** Stroke:% to Stroke Unit <4hrs (May)	40.0%	53.3%	32.3%	45.2%	12.9%	-9.8%	55.0%	55.0%	
4-23	***** Stroke: % scanned <1hr of arrival (May)	47.3%	44.4%	44.6%	43.3%	-1.3%	0.3%	43.0%	43.0%	
4-24	***** Stroke:% assessed by Cons <24hrs (May)	85.5%	75.6%	71.7%	74.0%	2.3%	-11.0%	85.0%	85.0%	
4-25	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	*0*	0	
4-26	Patients not treated <28 days of cancellation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*0.0%*	0.0%	
	Outpatient Cancellation Rate -Hosp & Patient	31.2%	30.6%	31.3%	30.1%	-1.2%		TBC	30.1%	

*** 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*

	Well-Led	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From	YTD Variance From	Year End Plan/	Year End Forecast	Bench Mark
5-01	Income	33,087	34,118	96,347	97,103	5.1%	0.8%			
5-02	EBITDA	1,748	1,599	3,052	2,232	-11.3%	-26.9%			
5-03	Surplus (Deficit) against B/E Duty	(1,306)	1,296	6,015	6,353					
5-04	CIP Savings	1,652	1,661	5,066	4,717	37.6%	-6.9%			
5-05	Cash Balance	18,198	14,250	18,198	14,250	-0.8%	-21.7%			
5-06	Capital Expenditure	1,066	445	2,510	1,324	100.3%	-47.3%			
5-07	Establishment (Budget WTE)	5,392.2	5,487.5	5,392.2	5,487.5	1.8%	0.0%			
5-08	Contracted WTE	4,930.4	4,962.4	4,930.4	4,962.4	0.6%	-4.6%			
5-09	***Contracted not worked WTE		0.0		0.0					
5-10	Locum Staff (WTE)	12.4	22.9	12.4	22.9	84.8%				
5-11	Bank Staff (WTE)	270.2	300.5	270.2	300.5	11.2%				
5-12	Agency Staff (WTE)	104.2	241.1	104.2	241.1	131.3%				
5-13	Overtime (WTE)	69.7	0.0	69.7	0.0	-100.0%				
5-14	Worked Staff WTE	5,301.8	5,512.6	5,301.8	5,512.6	4.0%	0.5%			
5-15	Vacancies WTE	461.8	525.1	461.8	525.1	13.7%				
5-16	Vacancy %	8.6%	9.6%	8.6%	9.6%	11.3%				
5-17	Nurse Agency Spend	(246)	(874)	(246)	(2,488)	911.4%				
5-18	Medical Locum & Agency Spend	(901)	(1,051)	(901)	(2,982)	231.0%				
5-19	Temp costs & overtime as % of total pay bill									
5-20	Staff Turnover Rate	8.8%	9.8%		9.6%	1.0%	-0.7%	*10.5%*	9.6%	8.4%
5-21	Sickness Absence	3.7%	3.9%		4.0%	0.2%	0.6%	*3.3%*	3.3%	3.7%
5-22	Statutory and Mandatory Training	86.5%	88.9%		88.9%	2.4%	3.9%	85.0%	85.0%	
5-23	Overall Safe staffing fill rate	100.4%	101.3%	100.2%	102.7%	0.9%		TBC	102.7%	
5-24	****Staff FFT % recommended work	New	58.0%	New	58.0%		0.0%	58.0%	58.0%	61.7%
5-25	***Staff Resp Rate Recmd to Friends & Family	New	TBC	New	TBC				TBC	
5-26	Resp Rate Recmd to Friends & Family	New	30.1%	44.1%	28.3%	-15.8%	-1.7%	30.0%	30.0%	26.8%
5-27	A&E Resp Rate Recmd to Friends & Family	New	7.9%	New	8.0%				20.0%	14.1%
5-28	Mat Resp Rate Recmd to Friends & Family	21.1%	15.5%	19.6%	15.3%	-4.3%	0.3%	15.0%	15.0%	23.2%

* 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.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – July 2015

7-9	**Integrated Performance Report for June 2015** (incl. updates on recruitment and retention; DTOCs & HSMR)	**Chief Executive**

The enclosed report includes:

- The 'story of the month' for June 2015, which includes the latest position on Delayed Transfers of Care (DTOCs)
- The Trust performance dashboard
- Integrated performance charts; and
- Financial performance overview. This was discussed, and accompanied by a presentation, at the Finance Committee on 20/07/15.

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

In addition, a brief presentation will be provided (by the Medical Director) on the recent increase in Hospital Standardised Mortality Ratio (HSMR).

Which Committees have reviewed the information prior to Board submission?

- Executive Team, 14/07/15
- Finance Committee, 20/07/15 (financial performance only)

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

Discussion and scrutiny

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

‘Story of the month’ for June 2015

A&E attendances and non-elective admissions returned to normal levels in June but delayed transfers of care increased significantly to 6.8% with over half of the on-going high numbers solely related to Social Services input from Kent County Council. There is also an issue with patients awaiting care in community hospitals as their beds are also occupied by significant numbers of patients awaiting Social Services input.

	26/04/2015	03/05/2015	10/05/2015	17/05/2015	24/05/2015	31/05/2015	07/06/2015	14/06/2015	21/06/2015	28/06/2015	05/07/2015	12/07/2015
Delayed by Health	52.8%	47.2%	34.0%	28.3%	45.3%	37.7%	34.0%	54.7%	41.5%	43.4%	49.1%	52.8%
Delayed by Social Services	22.6%	15.1%	11.3%	22.6%	13.2%	37.7%	34.0%	37.7%	37.7%	37.7%	41.5%	45.3%
Delayed by both parties	3.8%	1.9%	1.9%	3.8%	7.5%	1.9%	5.7%	0.0%	0.0%	0.0%	1.9%	1.9%

Despite the increased delayed transfers of care the average non-elective length of stay (LOS) decreased to 7.2, but this reflects the fact that the long stay patients were still in hospital at the end of the month and so excluded from the average LoS figures. As a result the average occupancy for the month decreased to 647 patients a night from 670 patients a night in May.

The Referral to Treatment (RTT) performance in June remained stable with an increase in elective and day case activity. Despite the improved levels of elective activity during June the Trusts 18 week backlog increased to 564 which reflects earlier pressures from non-elective demand and increased referrals. This should reduce as restrictions on elective activity decrease and the application of the revised RTT rules.

The performance on Cancer targets in May (reported a month in arrears) shows a continued underperformance on the 62 day target and an in-month drop in the cancer 2 week-wait target. There were 4.0 breaches of the 104 day target all due to late referrals from other providers. The 62 day position for patients managed entirely by MTW is much better at 84.6% for May and at 86% for the year to date.

There was a single MRSA bacteraemia case in June, but Clostridium difficile cases remained low at just 1. The rate of readmissions reduced slightly.

The number of falls reduced in June but the drop in occupied bed days means that the rate of falls increased. Whilst the numbers of falls resulting in harm remain low this is an area that the Trust is focusing on, particularly for the wards and Tunbridge Wells Hospital.

Complaints received by the Trust remain steady and we have made some good progress in increasing our response rate.

The month saw an increase in the substantive workforce of the nursing and midwifery group, and a sizeable reduction in the demand for temporary nursing shifts (7272 in May) to 6152 in June. However this month also showed a reduction in the number of those shifts filled by bank as opposed to agency. The revised process for temporary staff control discussed at the Board in May is beginning to be implemented and further work is being undertaken.

Other workforce metrics show stability with the level of sickness absence, and levels of statutory and mandatory being maintained. Appraisal levels will not be reported until the first month of quarter 2. An update on recruitment and retention will be given at the July Board meeting.

TRUST PERFORMANCE DASHBOARD **Position as at:** **30th June 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)	16.1	5.2	18.0	5.0	- 12.9	- 10.1	*11.5*	8.9	
'1-02	Number of cases C.Difficile (Hospital)	3	1	10	3	- 7	- 6	*27*	21	
'1-03	Number of cases MRSA (Hospital)	-	1	1	1	-	1	-	1	
'1-04	Elective MRSA Screening	96.0%	100.0%	96.0%	100.0%		2.0%	98.0%	100.0%	
'1-05	% Non-Elective MRSA Screening	98.0%	98.0%	98.0%	98.0%		3.0%	95.0%	98.0%	
'1-06	**Rate of Hospital Pressure Ulcers	1.9	2.4	1.7	2.1	0.3	- 0.9	*3.0*	2.1	3.0
'1-07	***Rate of Total Patient Falls	5.9	6.8	6.2	6.6	0.4	0.4	*6.2*	6.2	
'1-08	***Rate of Total Patient Falls Maidstone	5.1	6.1	5.7	5.9	0.2			6.0	
'1-09	***Rate of Total Patient Falls TWells	6.2	7.6	6.6	7.2	0.6			7.1	
'1-10	Falls - SIs in month		-		6	6				
'1-11	Number of Never Events	1	-	2	-	- 2	-	-	-	
'1-12	Total No of SIs Open with MTW	37	24			- 13				
'1-13	Number of New SIs in month	14	6	32	19	- 13	- 11			
'1-14	**Serious Incidents rate	0.753	0.313	0.574	0.320	- 0.255	0.255	*0.065 - 1.35*	0.320	*0.065 - 1.35*
'1-15	**Medication errors causing serious harm	-	-	-	-	-	-	*0 - 0.052*	-	*0 - 0.052*
'1-16	Rate of Patient Safety Incidents - harmful	1.52	1.21	1.64	1.34	- 0.30	- 0.36	*0 - 1.698*	1.34	*0 - 1.698*
'1-17	**Patient Safety Incidents Rate	35.39	43.04	35.01	40.26	5.26		TBC	40.26	
'1-18	** Patient Safety Incidents -death/severe harm	0.54	0.52	0.57	0.54	- 0.04		TBC	0.54	
'1-19	Number of CAS Alerts Overdue	-	-			-	-	-		
'1-20	VTE Risk Assessment	95.3%	95.1%	95.6%	95.1%	-0.5%	0.1%	95.0%	95.1%	95.0%
'1-21	Safety Thermometer % of Harm Free Care	96.8%	97.2%	97.2%	96.9%	-0.3%	1.9%	95.0%		93.4%
'1-22	Safety Thermometer % of New Harms	2.75%	2.33%	6.40%	2.31%	-4.09%		*TBC*	2.31%	
'1-23	C-Section Rate (non-elective)	16.3%	13.5%	14.9%	12.9%			*TBC*	12.9%	

	Effectiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	Hospital-level Mortality Indicator (SHMI)*	Prev Yr: Oct 13 to Sept 14		103.4	103.4	- 0.0	3.4	*Lower confidence limit to be <100*		100.0
2-02	Standardised Mortality (Relative Risk)	Prev Yr: Oct 13 to Sept 14		106.9	108.0	1.1	8.0			100.0
2-03	Crude Mortality	1.1%	1.0%	1.3%	1.1%	-0.2%				
2-04	Crude Mortality Rate (non-elective)	2.4%	2.4%	2.7%	2.8%	0.07%		*TBC*	2.8%	
2-05	****Readmissions <30 days: Emergency	11.9%	10.9%	11.8%	11.5%	-0.3%	-2.1%	*13.6%*	11.5%	14.1%
2-06	****Readmissions <30 days: All	11.0%	10.2%	10.9%	10.7%	-0.2%	-4.0%	*14.7%*	10.7%	14.7%
2-07	Average LOS Elective	3.4	3.2	3.0	3.2	0.2	0.0	*3.2*	3.2	
2-08	Average LOS Non-Elective	6.5	1.0	6.6	7.4	0.8	0.9	*6.5*	6.5	
2-09	New:FU Ratio	1.46	1.42	1.54	1.47	- 0.07	- 0.05	*1.52*	1.52	
2-10	Day Case Rates	83.4%	83.0%	83.6%	83.2%	-0.4%	3.2%	80.0%	83.2%	82.2%
2-11	Primary Referrals	8,815	9,246	25,536	26,539	3.9%	5.6%	-	108,766	
2-12	Cons to Cons Referrals	3,933	3,180	10,648	9,626	-9.6%	-0.3%	39,585	39,451	
2-13	First OP Activity	12,734	12,615	35,186	33,986	-3.4%	1.4%	137,412	139,287	
2-14	Subsequent OP Activity	22,058	22,385	63,794	62,436	-2.1%	-1.9%	260,800	255,887	
2-15	Elective IP Activity	683	762	2,033	2,036	0.1%	4.5%	7,988	8,344	
2-16	Elective DC Activity	3,202	3,525	9,198	9,595	4.3%	2.0%	38,556	39,324	
2-17	Non-Elective Activity	3,897	3,707	11,870	11,457	-3.5%	-4.6%	48,289	46,080	
2-18	A&E Attendances (Calendar Mth)	11,302	11,393	35,351	34,285	-3.0%	1.5%	135,922	137,894	
2-19	Oncology Fractions	5,854	5,798	17,198	16,550	-3.8%	-7.2%	71,761	66,564	
2-20	No of Births (Mothers Delivered)	465	489	1,402	1,471	4.9%	3.1%	5,708	5,884	
2-21	% Mothers initiating breastfeeding	83.9%	78.7%	81.0%	79.5%	-1.5%	1.5%	78.0%	78.0%	
2-22	Rate of Intra partum stillbirths	-	8.0	0.7	4.0	*3.3*	- *3.3*	*7.3*	4.0	7.3

	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	-	-	-	-	-	-	-	-	
3-02	*****Rate of New Complaints	2.04	2.09	3.77	1.85	- 1.92	0.53	*1.318-3.92*	1.86	
3-03	% complaints responded to within target	51.4%	79.1%	57.8%	62.6%	4.8%	-12.4%	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	91.4%	98.3%	91.4%	96.6%	5.2%	1.6%	95.0%	95.0%	95.7%
3-06	A&E Friends & Family (FFT) % Positive	89.0%	91.3%	89.7%	89.2%	-0.5%	2.2%	87.0%	87.0%	88.3%
3-07	Maternity Combined FFT % Positive	93.1%	94.1%	91.8%	94.5%	2.8%	-0.5%	95.0%	95.0%	95.6%
3-08	OP Friends & Family (FFT) % Positive	New	77.9%	New	77.6%	New			77.6%	

	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)	95.3%	93.2%	95.6%	90.9%	-4.7%	-4.1%	95.0%		93.2%
4-02	Emergency A&E >12hr to Admission	-	-	2	-	- 2	-	-	-	
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	85.6%	92.6%	88.0%	92.5%	4.5%	2.5%	90%	92.5%	
4-06	18 week RTT - non admitted patients	96.1%	98.6%	96.3%	98.4%	2.1%	3.4%	95%	98.4%	
4-07	18 week RTT - Incomplete Pathways	95.7%	96.9%	95.7%	96.9%	1.2%	4.9%	92%	96.9%	
4-08	18 week RTT - Specialties not achieved	4	2	8	11	3	11	-	11	
4-09	18 week RTT - 52wk Waiters	-	-	-	6	6	6	-	6	
4-10	18 week RTT - Backlog 18wk Waiters	425	564	425	564				564	
4-11	% Diagnostics Tests WTimes <6wks	100.0%	99.9%	100.0%	99.9%	-0.1%	0.9%	99.0%	99.0%	
4-12	Cancer WTimes - Indicators achieved	6	7	7	7	-	- 2	9	9	
4-13	*Cancer two week wait	96.0%	91.1%	95.4%	92.6%	-2.8%	-0.4%	93.0%	92.6%	
4-14	*Cancer two week wait-Breast Symptoms	96.2%	95.1%	92.3%	95.9%	3.6%	2.9%	93.0%	95.9%	
4-15	*Cancer 31 day wait - First Treatment	98.5%	98.8%	99.0%	98.8%	-0.1%	2.8%	96.0%	98.8%	
4-16	*Cancer 62 day wait - First Definitive	76.0%	79.0%	82.4%	81.2%	-1.1%	-3.8%	85.0%	85.0%	
4-17	Cancer 62 day wait - First Definitive - MTW	77.8%	84.6%	85.0%	86.2%	1.2%		85.0%		
4-18	*Cancer 104 Day wait Accountable	New	4.0	New	9.5	New	9.5	-	9.5	
4-19	Delayed Transfers of Care	4.3%	6.8%	3.7%	5.7%	2.0%	2.2%	3.5%	3.5%	
4-20	% TIA with high risk treated <24hrs	64.7%	62.5%	66.7%	72.4%	5.7%	12.4%	60%	60.0%	
4-21	% spending 90% time on Stroke Ward	77.4%	91.7%	76.5%	82.9%	6.4%	2.9%	80%	80.0%	
4-22	***** Stroke:% to Stroke Unit <4hrs (May)	40.0%	53.3%	32.3%	45.2%	12.9%	-9.8%	55.0%	55.0%	
4-23	***** Stroke: % scanned <1hr of arrival (May)	47.3%	44.4%	44.6%	43.3%	-1.3%	0.3%	43.0%	43.0%	
4-24	***** Stroke:% assessed by Cons <24hrs (May)	85.5%	75.6%	71.7%	74.0%	2.3%	-11.0%	85.0%	85.0%	
4-25	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	*0*	0	
4-26	Patients not treated <28 days of cancellation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*0.0%*	0.0%	
	Outpatient Cancellation Rate -Hosp & Patient	31.2%	30.6%	31.3%	30.1%	-1.2%		TBC	30.1%	

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

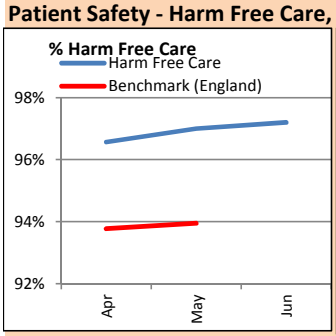
**** Contracted not worked includes Maternity /Long Term Sick* ***** Staff FFT is Quarterly therefore data is latest Quarter*

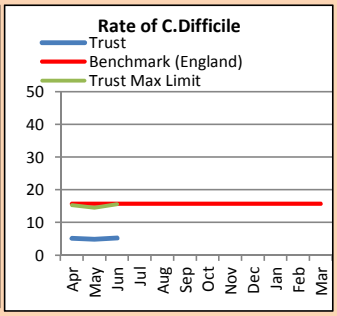
	Well-Led	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From	YTD Variance From	Year End Plan/	Year End Forecast	Bench Mark
5-01	Income	31,576	32,241	63,353	62,986	3.3%	-0.6%	-	-	
5-02	EBITDA	615	142	1,308	633	-50.4%	-51.6%	-	-	
5-03	Surplus (Deficit) against B/E Duty	(2,348)	2,700	(4,709)	(5,057)			-	-	
5-04	CIP Savings	0	0	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%			0.0%	
5-17	Nurse Agency Spend	(246)	(851)	(761)	(1,614)	112.1%			0	
5-18	Medical Locum & Agency Spend	(901)	(1,005)	(1,426)	(1,931)	35.4%			0	
5-19	Temp costs & overtime as % of total pay bill									
5-20	Staff Turnover Rate	8.8%	9.8%		9.6%	1.0%	-0.7%	*10.5%*	9.6%	8.4%
5-21	Sickness Absence	3.7%	3.9%		4.0%	0.2%	0.6%	*3.3%*	3.3%	3.7%
5-22	Statutory and Mandatory Training	86.5%	0.0%		0.0%	-86.5%	-85.0%	85.0%	85.0%	
5-23	Overall Safe staffing fill rate	100.4%	101.3%	100.2%	102.7%	0.9%		TBC	102.7%	
5-24	****Staff FFT % recommended work	New	58.0%	New	58.0%		0.0%	58.0%	58.0%	61.7%
5-25	***Staff Resp Rate Recmd to Friends & Family	New	TBC	New	TBC				TBC	
5-26	Resp Rate Recmd to Friends & Family	45.0%	30.1%	44.1%	28.3%	-15.8%	-1.7%	30.0%	30.0%	26.8%
5-27	A&E Resp Rate Recmd to Friends & Family	New	7.9%	New	8.0%				20.0%	14.1%
5-28	Mat Resp Rate Recmd to Friends & Family	21.1%	15.5%	19.6%	15.3%	-4.3%	0.3%	15.0%	15.0%	23.2%

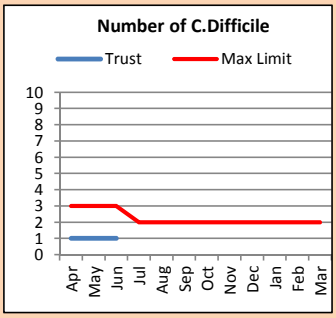
* Rate of C.Difficile per 100,000 Bed days, ** Rate of Pressure Sores per 1,000 admissions (excl Day Case), *** Rate of Falls per 1,000 Occupied Beddays, **** Readmissions run one month behind, ***** Rate of Complaints per 1,000 occupied beddays.

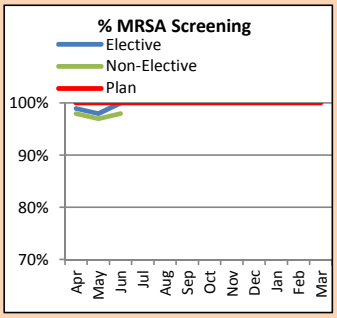
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

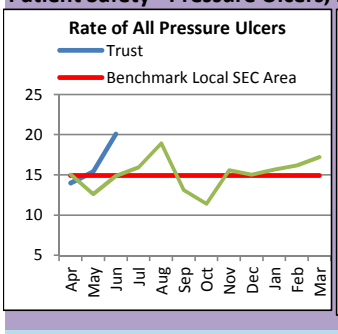


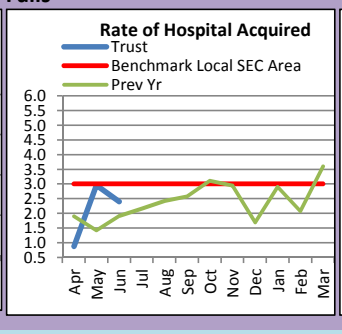


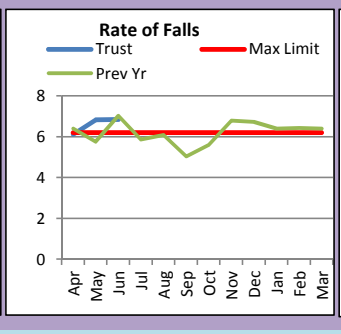


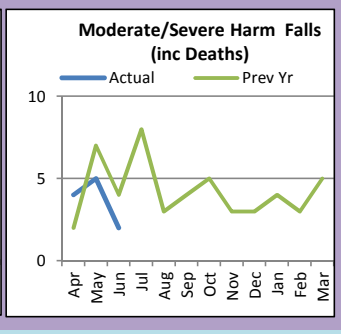


Patient Safety - Pressure Ulcers, Falls

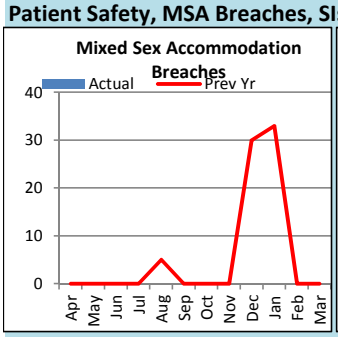


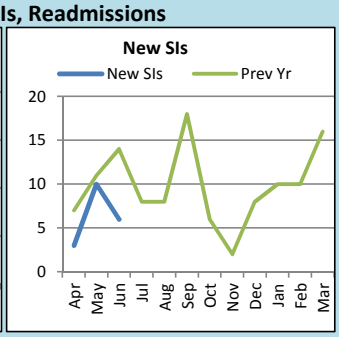


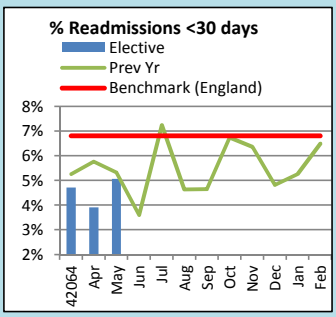


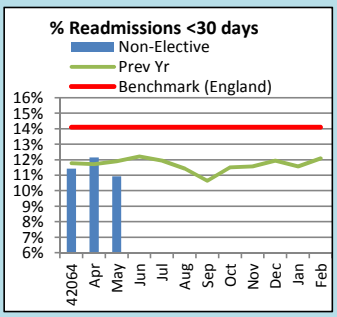


Patient Safety, MSA Breaches, SIs, Readmissions

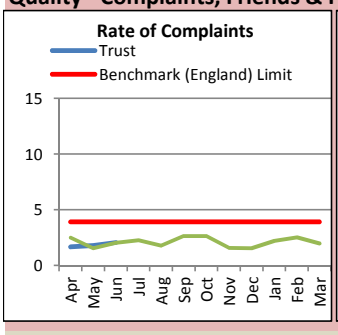


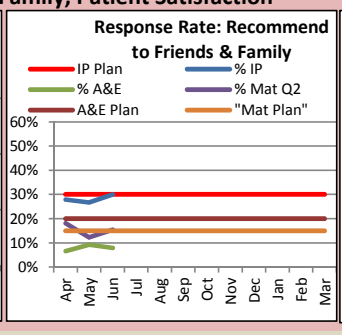


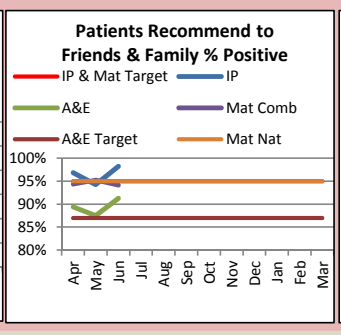


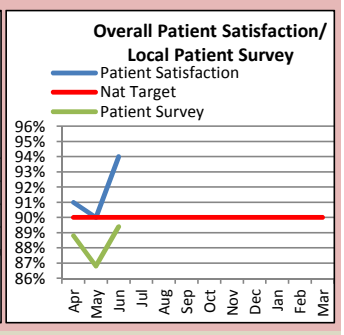


Quality - Complaints, Friends & Family, Patient Satisfaction

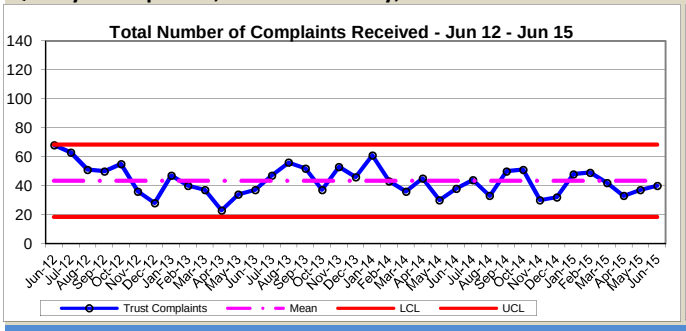


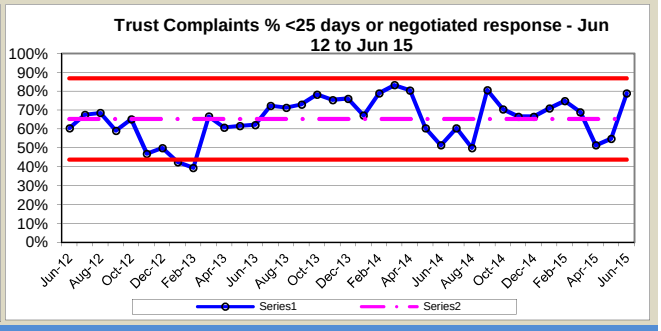




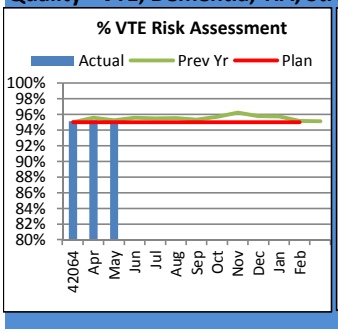


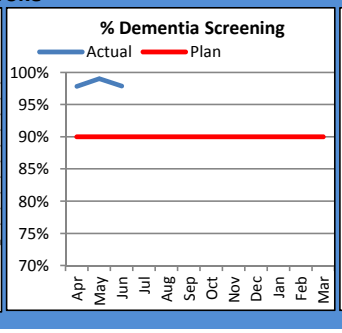
Quality - Complaints, Friends & Family, Patient Satisfaction

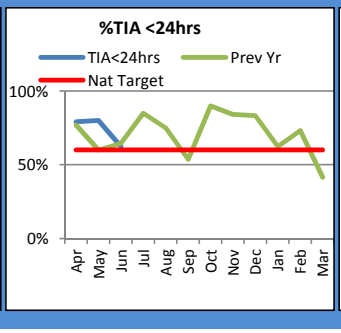


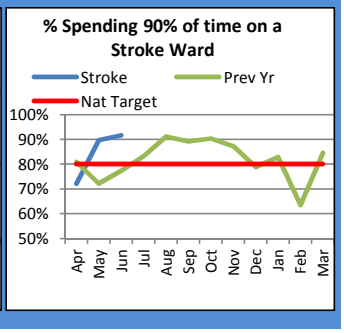


Quality - VTE, Dementia, TIA, Stroke



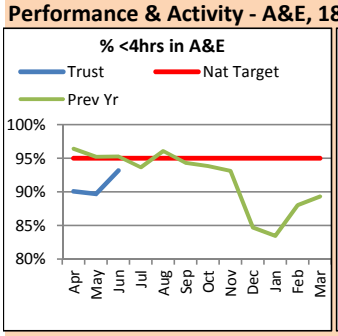


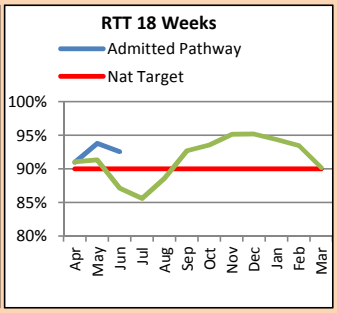


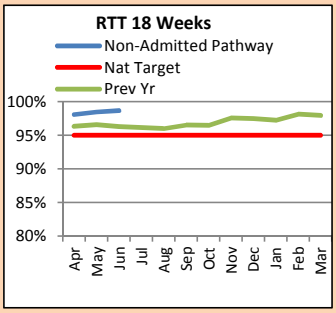


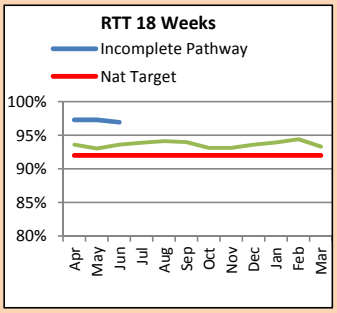
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

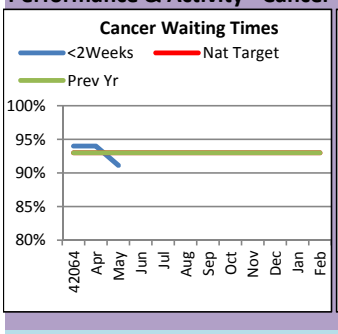


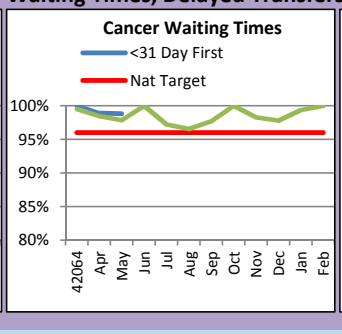


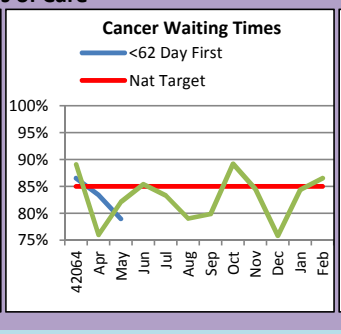


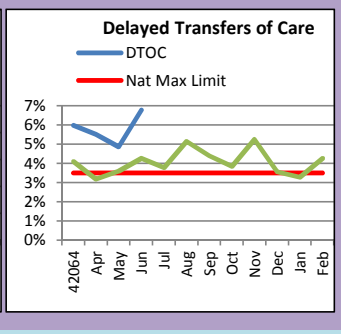


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

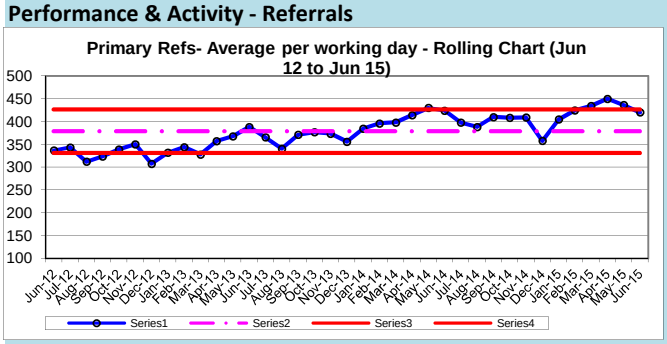


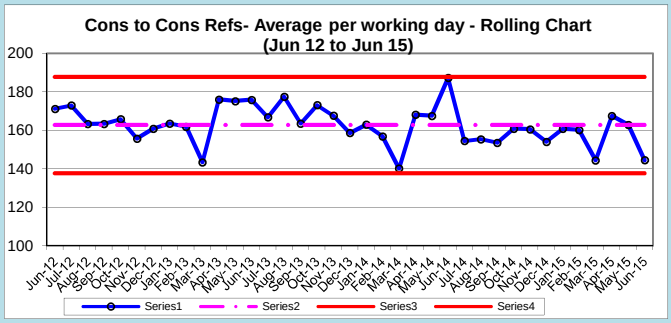




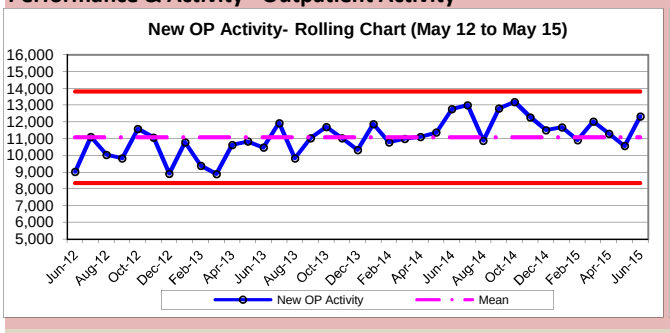


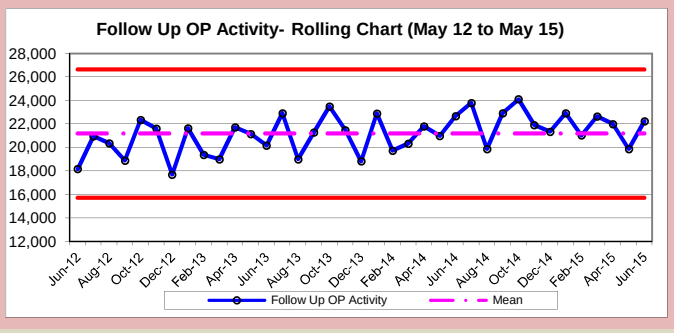
Performance & Activity - Referrals



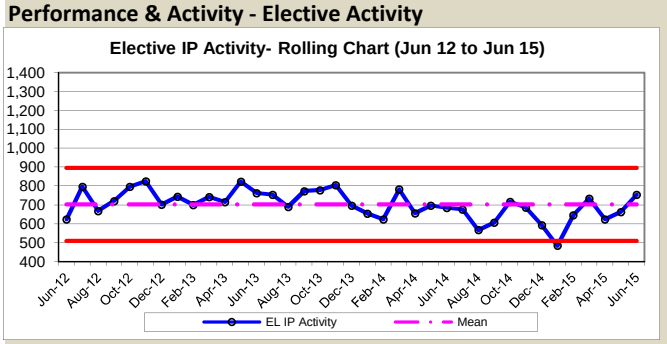


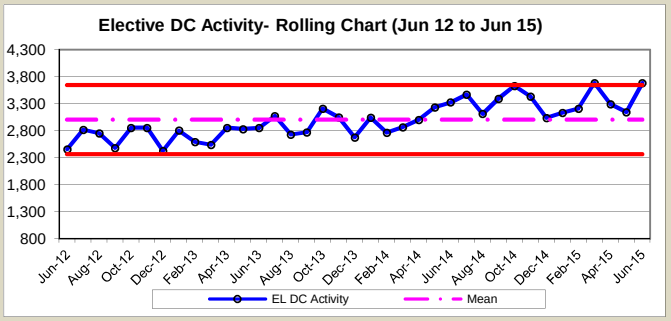
Performance & Activity - Outpatient Activity



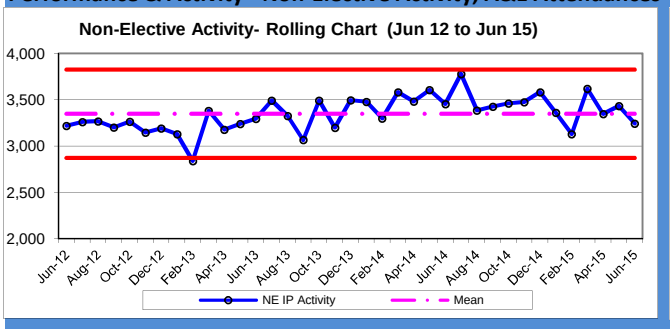


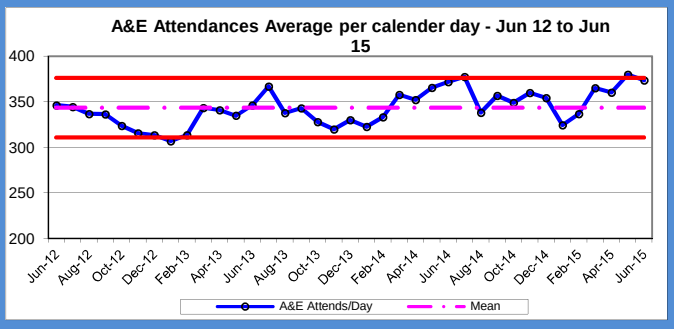
Performance & Activity - Elective Activity





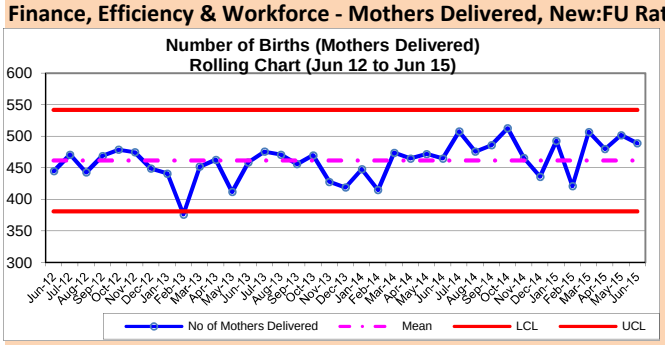
Performance & Activity - Non-Elective Activity, A&E Attendances

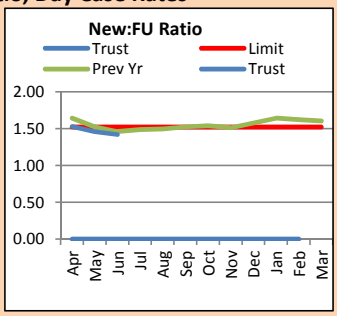


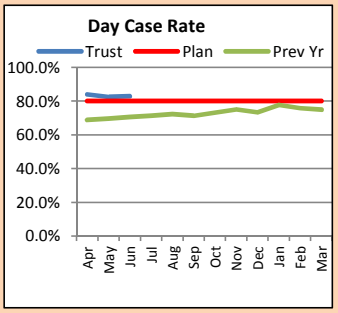


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

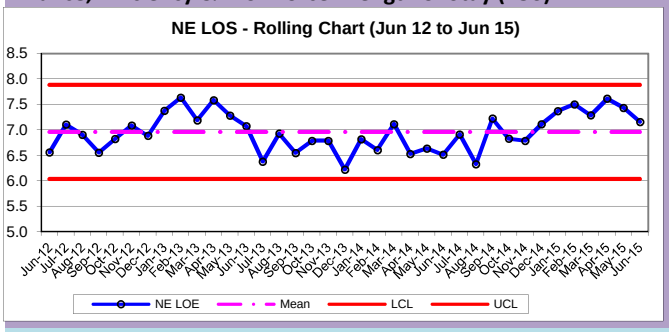
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

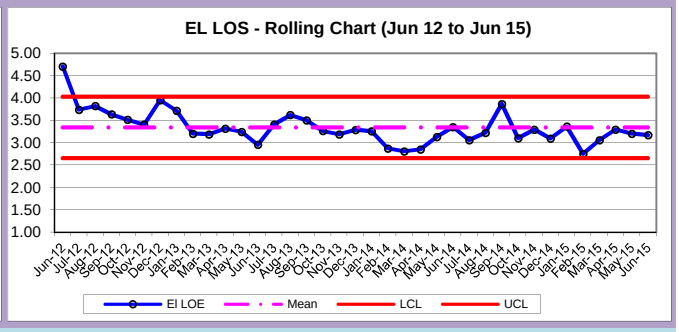




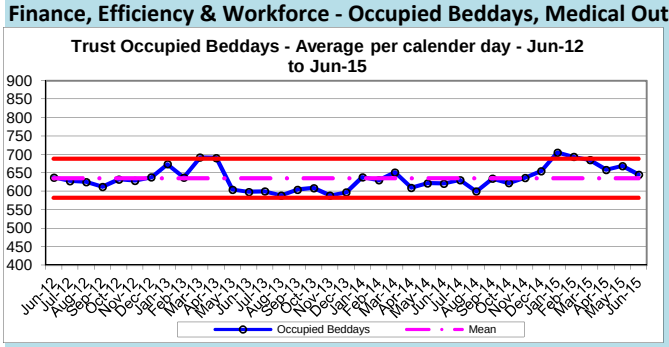


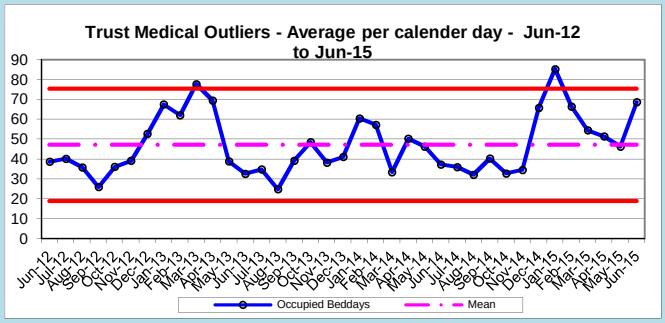
Finance, Efficiency & Workforce - Length of Stay (LOS)



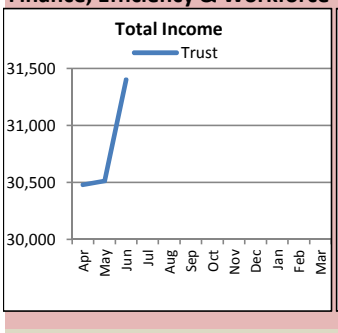


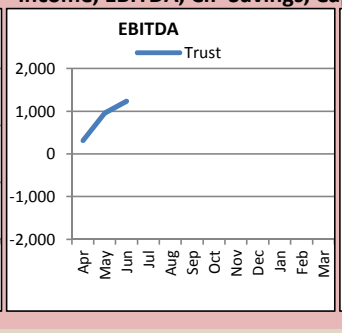
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

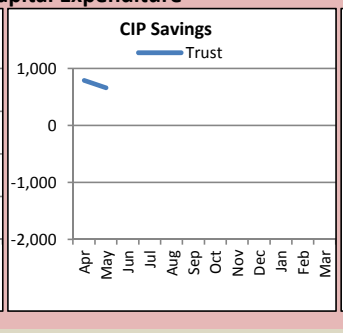


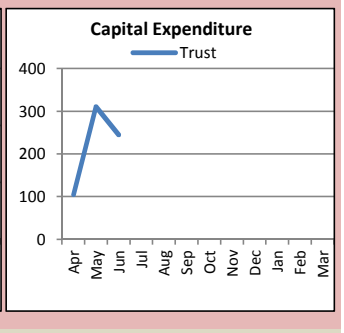


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

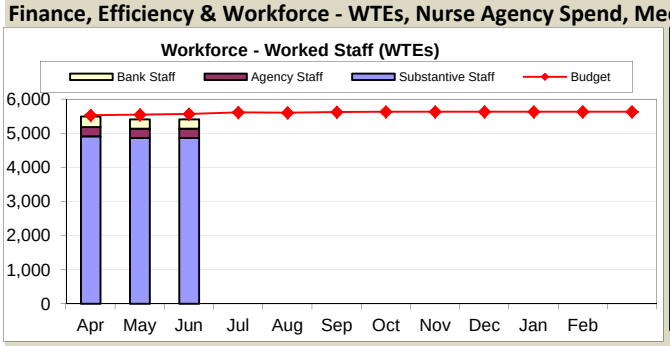


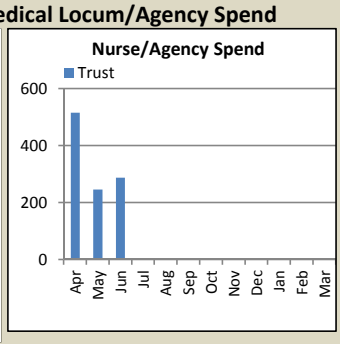


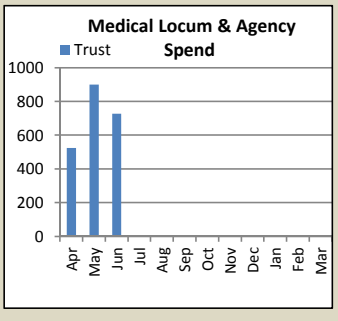




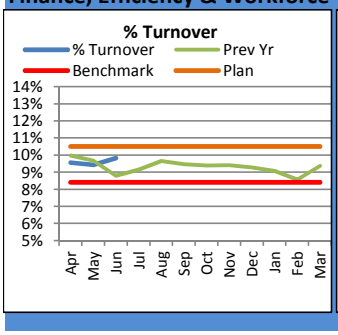
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

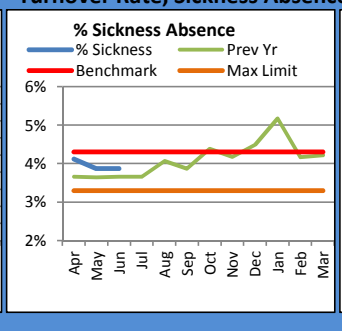


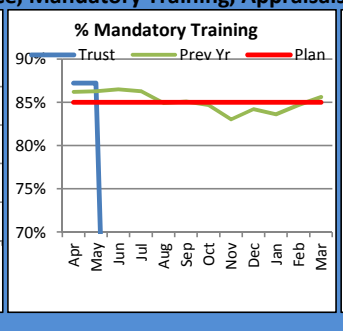


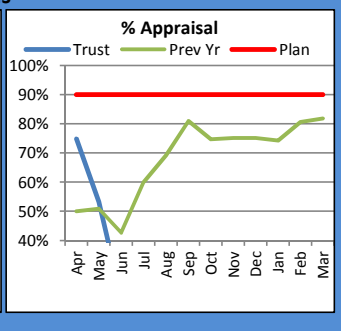


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









M3 Financial Performance overview

1. Overview of the Financial Position at M3 2015/16

1.1. This written summary provides an overview of the financial position at M3 of 2015/16. It should be read alongside the detailed 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 3. The Finance pack shows for month 3 the Trust met its deficit plan of a £1.3m resulting in a year to date deficit of £6.3m against a planned deficit of £6.0m, an adverse year to date variance of £0.3m. These figures include the full utilisation of reserves available for the first three 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 £97.1m against a budget of £96.3m. Income for the month is £34.1m which was £1.0m better than the £33.1m plan for the month.

1.4. The income headlines are outlined below:

- Clinical Income is £1.2m favourable 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 contributing to a favourable variance of £0.5m within Non NHS Clinical Income.
- A recoding of a provision carried over from 2014/15 worth £0.3m was the main driver behind the adverse to plan movement in month of £0.5m for non-patient services. This £0.3m charge was coded to "Supplies and Services –Clinical" in previous months.

1.5. Increased levels of Elective activity (inpatient and day case) including a higher utilisation of independent sector capacity accounts for £0.2m of the year to date favourable clinical income variance (£0.3m favourable variance in June)

1.6. Readmissions, A&E waits and RTT performance in June contributed to the favourable variance to date of £0.9m (£0.5m in June).

1.7. Non Elective activity was below plan in June which also improved the Trust's position against the Non Elective Threshold. The combined position driven by non-elective activity is therefore broadly on plan year to date and slightly better than plan in month.

1.8. A less acute case mix compensated by a 1% increase in activity has resulted in A&E income matching planned levels for both the month and year to date.

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

1.10. Transitional support of £0.9m for Cancer received from NHS England to reduce the impact of the cancer tariff in 2015-16 has been included in the position.

1.11. The levels of escalation beds reduced slightly in June (average per day 49.7) over April (average per day 50.3). In June the level of escalated beds ranged from 38 (8th June) to 58 (1st June).

1.12. Operating costs are £1.6m adverse against a plan of £93.3m. Pay deteriorated against plan by £0.7m in June generating a year to date adverse variance of £1.8m. Non pay costs were also adverse by £0.5m but remained favourable at the end of June by £0.2m.

1.13. At the end of June due to vacancies in Scientific posts (£0.7m) and nursing (£0.4m) total vacancies to date have resulted in a £1.4m underspend against the budget. At the end of June Bank and Medical Locum staff costs remain favourable to plan by £0.1m. Agency Nursing (-£1.6m) and Medical agency (-£0.8m) are significantly overspent to plan. Information recorded on Roster-pro suggests Nursing Agency hours have stayed at the levels seen in May which are lower than the hours recorded in March. The use of “off framework” agencies that charge higher hourly rates are keeping costs high. Procurement are working with framework agencies to secure the best rates and making sure booking processes utilise these compliant framework agencies. If this work succeeds it could reduce nurse agency costs by 10 to 15% per month. There is also an increase in the use of agency staff to cover shifts that receive enhanced rates of pay (nights, weekends and Bank holidays).

1.14. In the TDA plan the workforce in June measured in whole Time Equivalents (WTEs) was expected to be made up of 4,791 of substantive staff and 697 bank and agency 5,488 WTE in total. The actual make-up of the workforce in June was 4,662 of substantive staff and 565 of bank and agency 5,227 in total. This leaves a gap of 261 (4.8%). The vacancy % on the dashboard assumes that agency and Medical Bank WTE’s are covering vacant posts which equates to a further 264 WTE’s (4.8%) which is adds to the 9.6% vacancy rate quoted in the performance dashboard. In May the like for like vacancy % was 12.3%.

1.15. Non pay overspent by £0.5m in June and is now £0.2m 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 £0.5m adverse to plan
- Purchase of Healthcare from non NHS is adverse to plan by £0.3m.

1.16. Significant underspends in non-pay include:

- Purchase of healthcare from other NHS bodies £0.5m favourable.
- Other non-pay costs including reserves and contingencies £1.1m.

1.17. EBITDA is a £2.2m surplus and is now adverse to plan by -£0.8m.

1.18. The financing costs including those related to the PFI and deprecation totalled £8.8m, which is now underspent against the in year plan by £0.5m (£0.2m underspent in month) as it was in May this is due to the revaluation of assets and the holding of capital funds to support the potential ward development.

1.19. The performance in June still suggests the Trust will deliver it's I&E planned deficit of £14.1m. Significant risk still exists around the delivery of the CIP programme and the control of costs such as agency spend.

1.20. Cash balances of £14.3m were held at the end of June (£16.8m 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 cash forecast still assumes the funds for NHD support (£2.1m) will be received in September.

1.21. The contracting process requires each month's activity has to be reconciled with commissioner. Commissioners have requested a delay in the reconciliation process for April after experiencing problems with their data warehouse.

1.22. Total debtors are £24.8m which is £2.0m lower than the reported May figure. Debt over 90 days has reduced by £0.8m to £4.6m at the end of June. Debtors in excess of a £1m are;

- WKCCG £4.4m,
- NHS England £3.1m,
- EK Hospitals FT £1.9m
- and Medway FT £1.6m.

90 day invoiced debt for private patients billed through Compucare is currently £0.4m (£1.4m in total for all invoiced debt) with other non NHS invoiced debt over 90 days old totalling £0.3m (£1.8m in total).

1.23. Total creditors are £40.3m. Against the 95% target for payments made within 30 days the Trust achieved 83.5% in June for Trade creditors (77.7% in March 2015) and 82.6% in June for NHS creditors (56.3% in March 2015).

1.24. Capital expenditure to month 3 was £1.3m against the profiled plan £2.6m. Capital spend has been slowed to support the £4m proposed ward development at Tunbridge Wells; the Trust will aim to underspend its submitted capital plan to the TDA of £20m to £16m. This management of capital spend will remain in place until the Trust obtains support for the £4m of funds requested in its 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 3 position shows a CIP delivery of £4.7m against the target that was included in the TDA plan of £5.1m.

2.2. The schemes identified are forecast to deliver £19.6m by year end this is a £1.6m improvement over the forecast reported at month 2 but still leaves £1.9m of schemes that the Trust is working to identify.

2.3. Against the revised year to date total CIP expectation of £5.1m shortfalls in Medical Efficiency (-£0.3m), Length of Stay (-£0.4m) and procurement (-£0.2m) are offset by overachievement in Contract Management (+£0.6m), Nursing and Scientific staff efficiencies (+£0.2m) and back office functions (+£0.1m).

3. Conclusion

3.1. June was a productive month with income exceeding plan and excluding the cost of nurse and medical agency at a marginal cost.

3.2. The risks identified in May remain and 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 within nursing. The benefits from actions to reduce the rates paid to agencies are yet to be seen and the challenge to reduce the hours that agency nurses cover still needs to be addressed.

3.3. The Trust Board is requested to note this report and any actions from the presentation made to the Finance Committee.

Key Performance Indicators as at Month 3 2015/16

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

Maidstone and Tunbridge Wells NHS Trust

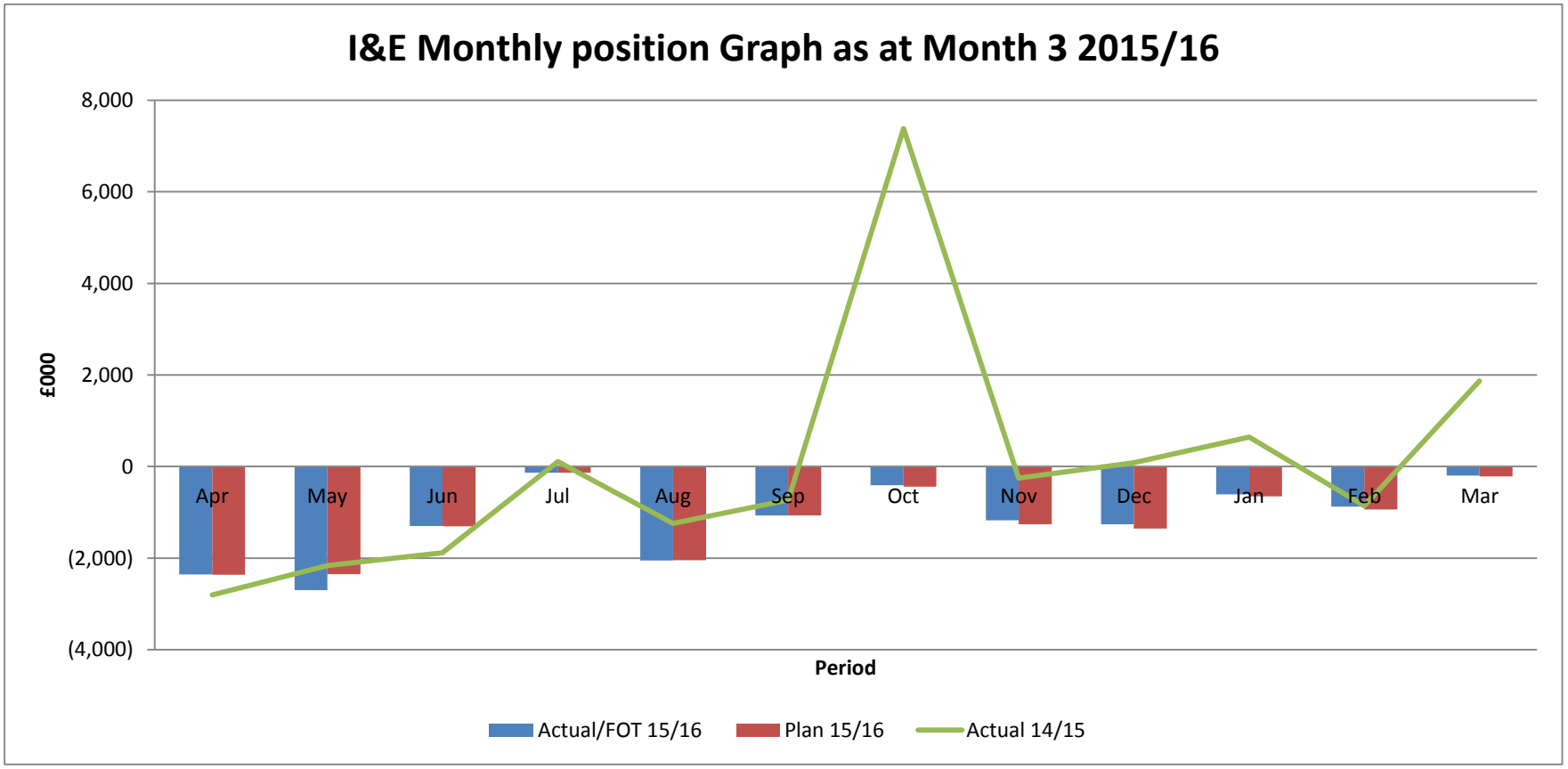
Key Metrics	Current Month Metrics			
(A) Accountability Framework	**Plan** (mc 01) **£000s**	**Actual / Forecast** (mc 02) **£000s**	**Variance** (mc 03) **£000s**	**RAG Rating** (mc 04)
NHS Financial Performance				
1a) Forecast Outturn, Compared to Plan	(14,126)	(14,126)	0	RED
1b) Year to Date, Actual compared to Plan	(6,015)	(6,353)	(339)	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	5,056	4,717	(339)	
- Recurrent Efficiencies for Year to Date compared to Plan	5,056	4,717	(339)	
2b) Actual Efficiency recurring/non-recurring compared to plan - Forecast compared to plan				GREEN
- Total Efficiencies for Forecast Outturn compared to Plan	21,496	21,496	0	
- Recurrent Efficiencies for Forecast Outturn compared to Plan	21,496	21,496	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	20,013	20,013	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

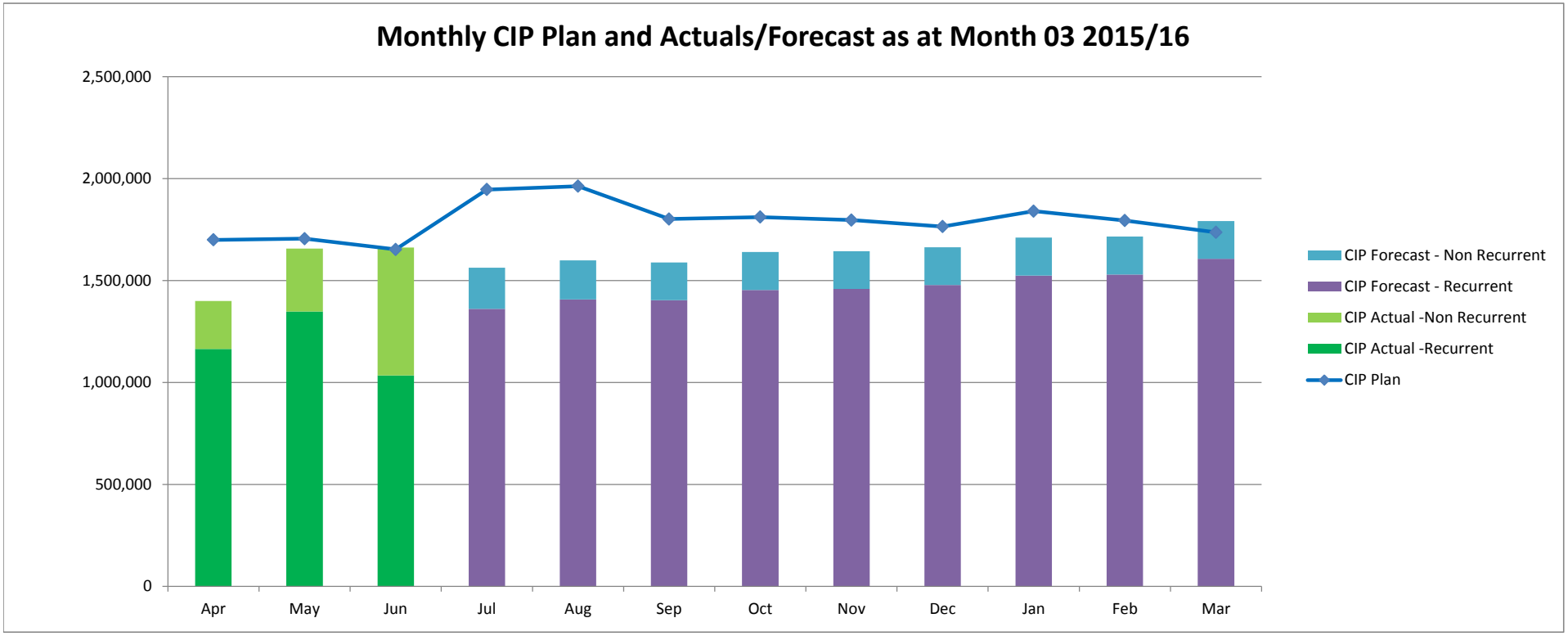
Maidstone and Tunbridge Wells NHS Trust

I&E monthly position graph as at Month 3 2015/16

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual/FOT 15/16	(2,357)	(2,700)	(1,296)	(134)	(2,049)	(1,068)	(411)	(1,173)	(1,260)	(608)	(874)	(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



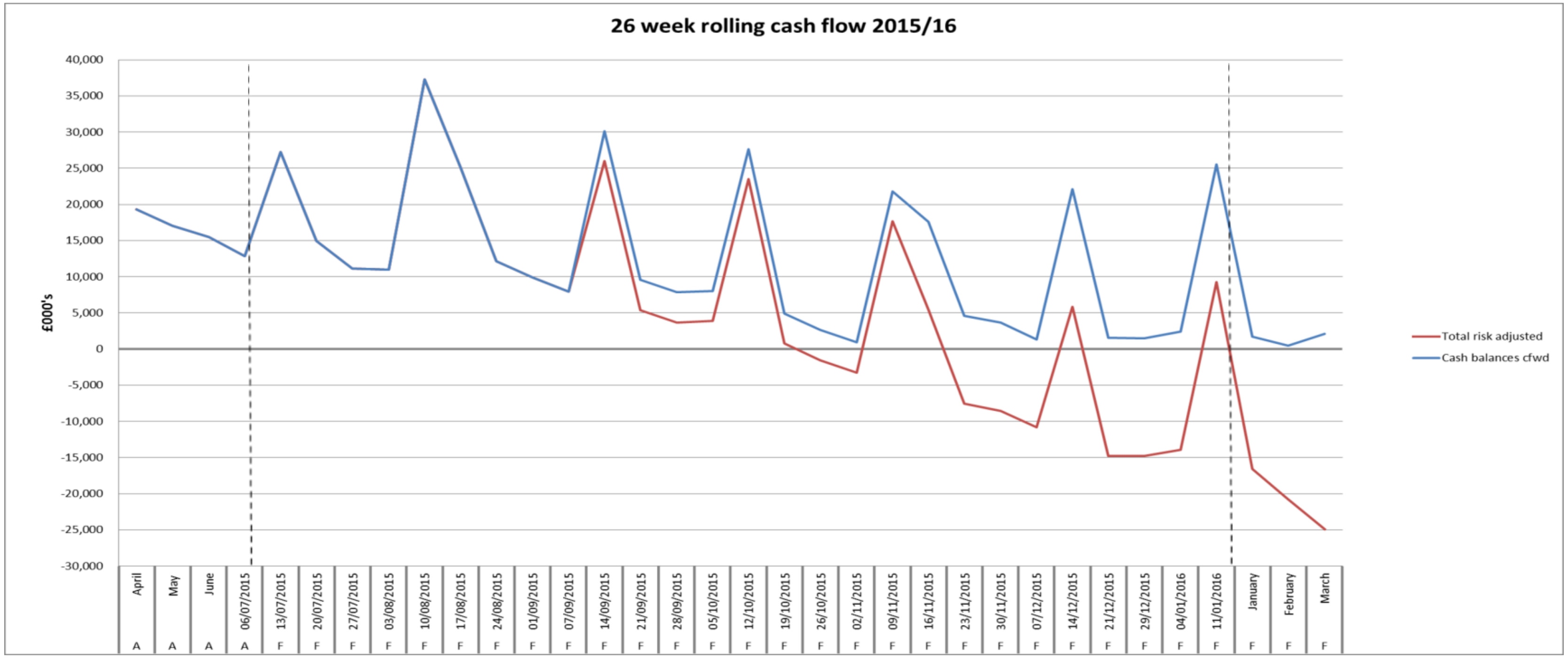
Maidstone and Tunbridge Wells NHS Trust



Recurrent v Non Recurrent	YTD	FOT
	£000	£000
Recurrent	3,546	16,768
Non Recurrent	1,171	2,861
Total	**4,717**	**19,629**

Maidstone and Tunbridge Wells NHS Trust

26 Week graphical presentation of forecast cash balances up to w/c 11th January 2015, actuals at 10th July 2015



	A	A	A	A	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Week commencing	April	May	June	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	21/09/2015	28/09/2015	05/10/2015	12/10/2015
Cash balances cfwd	**19,276**	**17,038**	**15,453**	**13,041**	**26,878**	**14,767**	**10,947**	**10,809**	**37,145**	**24,929**	**12,143**	**9,908**	**7,938**	**30,163**	**9,777**	**8,054**	**8,281**	**27,873**
Debtors carry forward into 15/16	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
External Financing - Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
External Financing - capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Asset Sales	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	4,146	4,146	4,146	4,146	4,146
Total risk adjusted	**19,276**	**17,038**	**15,453**	**13,041**	**26,878**	**14,767**	**10,947**	**10,809**	**37,145**	**24,929**	**12,143**	**9,908**	**7,938**	**26,017**	**5,631**	**3,908**	**4,135**	**23,727**

	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Week commencing	19/10/2015	########	02/11/2015	09/11/2015	16/11/2015	23/11/2015	30/11/2015	07/12/2015	14/12/2015	21/12/2015	29/12/2015	04/01/2016	11/01/2016	January	February	March
Cash balances cfwd	**5,343**	**3,057**	**1,328**	**22,204**	**17,988**	**5,242**	**4,249**	**1,926**	**22,719**	**2,359**	**2,304**	**3,211**	**26,373**	**2,710**	**1,676**	**2,125**
Debtors carry forward in 15/16	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	2,000	4,000
External Financing - Revenue	0	0	0	0	8,000	8,000	8,000	8,000	8,000	8,000	8,000	8,000	8,000	10,000	10,000	13,800
External Financing - capital	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	900	900
NHD Support	4,146	4,146	4,146	4,146	4,146	4,146	4,146	4,146	8,292	8,292	8,292	8,292	8,292	8,292	8,292	8,292
Total risk adjusted	**1,197**	**- 1,089**	**- 2,818**	**18,058**	**5,842**	**- 6,904**	**- 7,897**	**- 10,220**	**6,427**	**- 13,933**	**- 13,988**	**- 13,081**	**10,081**	**- 15,582**	**- 19,516**	**- 24,867**

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - July 2015

7-10 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. This contains progress update on the Enforcement notice, Compliance actions and also and update from 'Should do' actions that were scheduled to be completed this month.

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?

- N/A

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

Assurance

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

CQC Quality Improvement Plan

Assurance Report JULY 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 presents progress of the 'should do' actions due this month.

On 6th July a group of stakeholders including Clinical Commissioning Group representatives, Healthwatch representatives and MTW representatives undertook an assurance review to 'test' progress in practice. This assurance review was hugely successful and provided a good level of assurance. The highlighted the need for greater communication and bedding of actions with front line clinical staff in terms of standards and expectations.

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 visited Maidstone hospital on 30th June to review evidence submitted in practice and the report is awaited.

Compliance actions – Paediatrics

The agreement and implementation of a suitable Trust-wide paediatric early warning system (PEWS) has been agreed and new charts are being printed. The prescription of topical anaesthetics for children has been tested in practice with evidence of good compliance both in A&E and inpatient wards. Training for PGD is well underway.

The Clinical Director for Paediatrics attended Surgical Clinical Governance meeting to discuss the new Standard Operating Procedure and other key documents related to the management of children form the Royal College of Surgeons.

Compliance actions – Critical care

Continued progress has been made in addressing the compliance actions against Critical Care, with a fully compliant intensivist rota expected September 2015, recruitment to Consultant posts continues There are continued pressures in meeting capacity demands but improvements seen in practice and incidents are monitored closely to ensure lessons can be learnt. Attendance at site meetings highlights issues and ensures follow up on a named patient basis.

Compliance Action – Process for incident reporting

Work continues on this compliance action with the new patient safety information leaflet for staff in the process of being distributed. There has been good progress with improving incident reporting process, with a more streamlined reporting form and the development of a DATIX app being added to the i-pads in the clinical areas, making reporting considerably faster and more accessible.

Compliance Action – Clinical Decision Unit (CDU)

CDU is now single sex, with good staff awareness of the standards expected.

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		Awaiting report form the CQC following on site review on 30th June 2015
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, however PEWS charts still not in place (currently in printing)
CA 2 – ICU weekend cover	Daniel Gaughan General Manager, Critical Care		Continued good progress with expected full compliance by September 2015. Risks assessed and mitigation in place in the meantime.
CA 3 – ICU consultant within 30mins	Daniel Gaughan General Manager, Critical Care		
CA 4 – ICU delayed admissions	Jacqui Slingsby Matron, Critical Care Directorate		This has been longer than anticipated due to multi department / specialist involvement in development and consultation of new operational policy (due to be ratified August 2015)
CA 5 – ICU delayed	Jacqui Slingsby Matron, Critical		

	Operational lead	Progress rating	Issues / Comments
discharges	Care Directorate		
CA 6 – ICU overnight discharges	Jacqui Slingsby Matron, Critical Care Directorate		There were 0 at Maidstone and 4 at TWH in June. This is an improvement from May (3 at Maidstone, 5 at TWH). Plan in place to create additional capacity at TWH. Amber less than 5. Green less than 3.
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		All actions completed
CA 11 – Medical records	Wilson Bolsover Deputy Medical Director		Audit still outstanding, but plan in place
CA 12 – Security staff	John Sinclair Head of Quality, Safety, Fire and Security		All actions completed
CA 13 – Incident reporting	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		Leaflet distribution continues
CA 14 – Joint management of children with surgery	Hamudi Kisat / Johnathan Appleby Clinical Directors		None raised
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
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

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)	Visit to Brighton completed by Ward Manager and Paediatric ED sister to look at PEWs in action in different areas Meeting with ED matron, nurse consultant took place on 16th June with draft paperwork Amendments and changes agreed PEWS charts agreed at Directorate meeting on 26th June 2015 Documentation sent to printers for modifications on 2nd July	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	30/6/15	
2. Escalation protocol reviewed alongside the PEWS chart review	Escalation protocol on back of PEWs charts.			
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	To train staff and pilot new PEWs charts through July for implementation 1st August			
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: **NO -** Delay due to change of PEWs charts- required as need to be used in ED, ambulatory and inpatient areas. Previous charts not suitable for ED.				
Evidence submitted to support update (list): Draft PEWS charts, awaiting minutes from Paediatric Directorate Meeting				
Assurance statement :				
The new PEWs charts will be utilised across all areas for children aged 0-16years				
Areas of concern for escalation:				
None				

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 and monitored on electronic rota	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	3a. Rota has been reviewed and agreement reached to meet ICS requirements. 3b. Decision made to implement a 1-8 compliant rota, implementation - 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	Reviewed, this will be implemented in September 2015.		3a. 31/3/15 3b. 1/10/15	
4. Business case for additional intensivists developed and considered	Agreed at TME June 2015		17/6/15	
5. Mitigation in place for non-compliance	Mitigation part of CQC intensivist risk assessment		30/6/15	
6. Recruitment achieved	Re-advertising in July		1/4/16	
Action Plan: running to time				
Evidence submitted to support update (list): Intensivist rota, Risk assessment				
Assurance statement :				
Business case agreed at June TME recruitment process on going				
Areas of concern for escalation:				
Inability to recruit suitably qualified intensivists. This will require close monitoring and action plan if recruitment process is not successful				
Assurance review feedback (visit 6th July):				
Mainly assured that progress made as described above. Ward round evidence seen and staff aware of intentions of the 1:8 complaint rota to start in September.				

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 has now been assessed by the Clinical Director	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 New complaint 1-8 rota to be implemented in September 2015	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 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 implementation September 2015				
Areas of concern for escalation:				
Potential risk of inability to recruit suitable intensivists				
Assurance review feedback (visit 6th July):				
Mainly assured that progress made as described above. 2 consultants are more than 30minutes from site, however this will be resolved with the new 1:8 rota to be implemented in September. Assurance of change within department from staff interviewed.				

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	Discussed at Trust Management Executive June 15 This has not happened consistently due to ICU bed demand; consideration is given on a daily basis at the site meetings where critical care capacity is available across the trust going into the night.	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.	20/5/15	
2. Standard Operating Procedure developed relating to ITU admissions	Operational Policy which incorporates admission policy reviewed and comments made. Agreed at Directorate level, out for wider trust consultation. Expected ratification in August 2015		29/6/15 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)	The SOP is part of the new operational policy which has now been distributed for comment and will be tabled at the next standards committee (August) for ratification.		31/8/ 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	
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: NO, date revised				
Evidence submitted to support update (list): ICU Standard operational policy in draft form for consultation.				
Assurance statement :				
Areas of concern for escalation:				

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 complete at directorate level. Policy out for wider consultation with all critical care users. 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.	29/6/15 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. Trust operational plan in place to open an additional ward at TWH by Jan 2016 with the aim to ease patient flow across the trust.		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:				
Data for first quarter of D16 CQUIN will illustrate non compliance with requirement to discharge all patients identified as ward fit within 24 hours				

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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 June no patients were transferred out of hours Maidstone and 4 at Tunbridge Wells. This is an improvement from May (3 at Maidstone, 5 at Tunbridge Wells) Incident reports raised. Patients though deemed fit prior to these times were not able to be moved to a ward due to bed capacity issues. Trust operational plan in place to open an additional ward at TWH by Jan 2016 with the aim to ease patient flow across the trust.		29/6/15
Action Plan running to time: **No**			
Evidence submitted to support update (list): ICU dashboard data, out of hours discharges. Site reports			
Assurance statement :			
Areas of concern for escalation:			
Continuing issues with patient flow across the trust impacting on ICU patient discharges and admissions.			

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 Nearly all 1:1 meetings completed Draft rota still under consultation		1/10/15	
Action Plan running to time:				
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				

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.		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 Reviewed and seen on 6th July internal review – fully compliant				
Areas of concern for escalation:				

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 being finalised and will be submitted for July 2015 IAG 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 WF strategy approved June 2015. E&D priorities included & supported by implementation plan for approval by September 2015 Workforce Committee BME Forum met 22 June 2015		1/9/15	
4. Ensure current process for accessing translation services is communicated to all staff	Staff Communication circulated January 2015 – plan to recirculate July 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	Working in partnership 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 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 Meeting to be arranged with Healthwatch July 2015		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:				
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 became single sexed (female) from 8th June with 2 rooms on MAU being used if required for men. SOP circulated. This has been maintained to date.	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	Long term plan has been discussed within the Directorate and two options are being scoped (AAU and MAU) to find an alternative area for CDU capacity from January 2016 once the new ward opens. Both options provide DSSA compliance.		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 continues to be discussed at each site meeting. Site report reflect s any variance from SOP over the last 24 hours (none have occurred to date).		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 AAU opening in May.		30/5/15	
Action Plan running to time: YES				
Evidence submitted to support update (list):				
Assurance statement :				
CDU single sex (all female). All staff aware of standard operating procedure and mandatory single sex CDU status.				
Areas of concern for escalation:				

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 re-considered if the audit shows this may be of benefit c) Audit will need to include the availability and completeness of the case records. Agreement with Audit team to undertake this audit over coming 6 weeks	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 new date 1/9/15	
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 new date 1/10/15	

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

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	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	Completed – evidence in the security SLA minutes		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	Completed and closed		1/5/15	
4. Review compliance with all training requirements against existing security team	Completed. Security contractor has 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.	Completed – evidence in the security SLA minutes		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 security staff booked on sessions		1/8/15	
Action Plan running to time:				
Evidence submitted to support update (list):				
Assurance statement :				
Completed and fully assured				
Areas of concern for escalation:				
Request for all our security officers to be put on the L&D mandatory training system.				

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 continues following external printing of leaflet	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 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. Reporting page streamlined and quicker. DATIX app now being loaded on the new Ipad's to be used in clinical practice		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 new patient safety manager secondment due to commence in September 15.		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 Manager due to commence post September 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	Dr Kisat attended the surgical directorate in the clinical governance meeting on 16th June and presented 2 papers 1) Standard for Surgery in paediatrics 2013 2) Commissioning guideline for emergency appendicectomy RCS 2015	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	Local guideline reviewed at Paediatric Directorate meeting 26th June 2015 – awaiting comments also circulated by email to Fazal Hassan and allied surgical speciality.		1/6/15	
3. Implementation of the SOP into routine daily practice	Patients admitted to Inpatient Ward now shared care between Paediatrics and Speciality Teams		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	External report expected end of July 2015		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	On-going review and updating at Directorate meetings	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	Staff updates on-going: new 'Risk Update' publication distributed		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):				
Assurance statement :				
On-going commitment continues within Directorate				
Areas of concern for escalation:				
None				

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. Assc. Director Quality Governance and Patient Safety attended Anaesthetic Clinical Governance meeting in May 2015 to discuss the Trust Incident reporting system in place and take questions.	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, but distribution continues		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				

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 (7/7/15) Discussion underway with IT/ health informatics at MTW to implement IT based system NTDA to assess and provide supportive feedback in August		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				

Maidstone and Tunbridge Wells NHS
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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	Completed	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	Assessed in July 2015. Drug charts reviewed and topical anaesthetics prescribed. Evidence of good staff awareness.		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 until end of year to enable compliance Ward manager now compliant and able to assess staff competency Training continues		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:				
None				

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	Lead	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	Summary Update
M12	Diagnostics Therapies and Pharmacy	Ensure that systems are in place to ensure that the system of digital locks used to secure medicines storage keys can be accessed only by authorised people.	3. Audit of digital locks to the medicines security audit	Sara Mumford, Clinical Director	Jim Reside, Chief Pharmacist John Kennedy, Deputy Chief Nurse	3. 1/7/15	1. Trust Medicines Policy updated 2. Audit of digital lock compliance with Medicines Policy added to medicines security audit criteria and checklist	1. Medicines Policy in place 2. Regular audit of security of medicines to include key pad access	1. Medicines Policy in place 2. Regular audit of security of medicines to include key pad access - new audit tool devised to include questions about digital locks on wards (copy attached). Trust wide audit being carried out in June/July with completion by early August 2015. Action plan to address deficiencies to follow from results.

REF	Service or Directorate	Issue Identified	Action/s	Lead	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	Summary Update
TW35	Emergency and Medical Services	Develop systems to ensure the competence of medical staff is assessed for key procedures.	1. Identify a list of key procedures for all medical staff 2. Review SI's and complaints to identify any particular procedures that have caused harm to patients to support prioritisation of this work	Akbar Soorma, Clinical Director	Akbar Soorma, Clinical Director	1. 1/7/15 2. 1/7/15	1. List of key procedures produced 2. Copies of signed competency documents 3. Agreement between CD and Specialist medicine department lead on standardisation approach 4. Document outlining agreed standards and process for the assessment of competency for identified key procedures for all medical staff	No patient safety incidents caused by a lack of operator skill or knowledge Systems in place to ensure the competence of medical staff is assessed for key procedures.	Relevant medical staff undergo competency training for a variety of medical clinical procedures. Training sessions are signed off for competency in individual skills. Non-training grades have specific sessions which are directed at skill and knowledge development. Particular issues or developments are highlighted at clinical governance sessions.

REF	Service or Directorate	Issue Identified	Action/s	Lead	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	Summary Update
M&TW2	Emergency and Medical Services	Make sure that medical staff complete training in safeguarding children at the level appropriate to their grade and job role (TW Specific for A&E)	2. Ensure all staff booked or have attended required training	Akbar Soorma, Clinical Director	Jo Howe, Lead Nurse for Children's Safeguarding	2. 1/7/15	1. Report on review of medical staff training (TNA) 2. Documentation to support attendance at training 3.Medical staff able to describe key elements of Child Protection	Appropriate actions taken to protect vulnerable children All staff appropriately trained in safeguarding of children	Appropriate level of training for medical staff is in place. Attendance levels are monitored and feedback at Quality and Safety meetings.
TW27	Emergency and Medical Services	Ensure the protocol for monitoring patients at risk is embedded and used effectively to make sure patients are escalated in a timely manner if their condition deteriorates.	4. Undertake monthly audits to monitor compliance. 5. Implementation of on-going Education programs for all relevant staff groups to ensure regular updates on PAR scoring.	Akbar Soorma, Clinical Director	Lynn Gray, ADN Emergency Care	4. 1/7/15 5. 1/7/15	1. Audit showing compliance with observations recorded and escalated appropriately as needed 2. Education attendance lists 3. Communication with staff 4. New CAS card 5. outline of new education programme	Deteriorating patients identified, escalated and treated without delay	Monthly audits in place at both sites. Statistics clearly displayed in both departments to highlight current improvements. Educational campaign in place. Individuals identified as not meeting the standard expected which is clearly identified within their appraisals will have the issue discussed with them and support put in place

REF	Service or Directorate	Issue Identified	Action/s	Lead	Operational leadership	Date to be completed	Evidence Required	Outcome/success criteria	Summary Update
TW40	Emergency and Medical Services	Review the process for the management of patients presenting with febrile neutropenia to ensure they are managed in a timely and effective manner	3. Undertake audit to review impact.	Akbar Soorma, Clinical Director	Cliff Evans, Consultant Nurse	3. 1/7/15	1. Documented new pathway 2. Education update with attendance list 3. Audit results	Febrile neutropenic patients are identified within first 30 minutes and put on the appropriate pathway	Regular monthly audits in place. Required improvements / learning discussed with those involved. This standard features in the appraisal documents of all nursing staff. Education campaign in place and real life case studies highlighted to all staff.
TW46	Women's & Sexual Health	Review the current clinic provision to ensure that women who have recently miscarried or who are under review for ante-natal complications are seen in a separate area to children who are also awaiting their appointment.	2. Present options at Directorate Clinical Governance and agree on plan to address	Hilary Thomas , Interim Head of Midwifery	Hilary Thomas, interim Head of Midwifery	2. 1/7/15	1. Report on issue and implemented changes. 2. Minutes of directorate Clinical Governance meeting 2. Reviewed on walkabout by linked executive	Women to be able to wait in an area appropriate to their individual needs	Area designated and furniture in place. Quote being obtained for additional screen to display patient names linked to Kiosk so that patients can be called from this area.etc

Maidstone and Tunbridge Wells NHS
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Trust Board Meeting - July 2015

7-11 Clinical Quality and Patient Safety Report — Chief Nurse

This exception report provides the Board with an update on the following 3 issues:

- Complaints – acknowledging the improved response times for June 2015
- Falls – whilst achieving a significant reduction over the last 2 years the first quarter this year has seen an increase
- Reporting and management of incidents – further information on improvements made.

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

Quality Report

July 2015

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

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

Complaints

For the year 2014-15, the Trust reported 485 formal complaints. This is a significant reduction on the year before and is the third consecutive year the Trust has reduced its number of formal complaints by over 10% as compared to the year before. We consistently receive lower than the national mean in terms of numbers of complaints whilst over the same period raising awareness on 'how to make a complaint'..

Achieving our performance target of 75% in responding to complaints has been challenging. During 2014-15, we only attained this in September (80.6%) and February (75%). Results from the complaints satisfaction survey have indicated that complainants feel it is taking too long to respond to complaints.

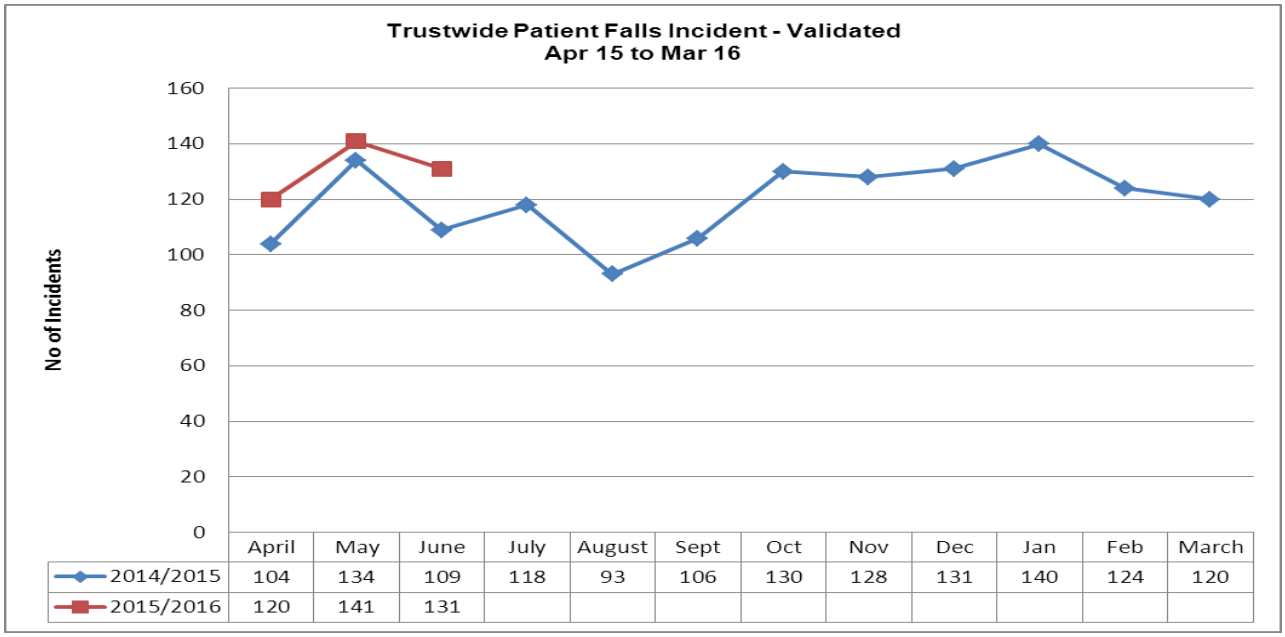
In light of this, increased efforts have been made to focus on achieving response times, with the launch of a 6-month pilot programme in three directorates (Trauma & Orthopaedics, Surgery and Critical Care), whereby there has been greater involvement from the central complaints team in the investigating complaints and formulation of complaint responses. The aim of this pilot is to improve compliance with response times, but also provide a more bespoke service to the complainant, thereby enhancing their satisfaction from the process. In June 2015, we reported an improvement performance of 79.1% (May was 54.8%), which we endeavour to maintain and further improve in the coming months.

Patient Falls

Over the last 3 months there has been a rise in falls in comparison to the previous year. On review of sites, this rise has been most significant at Tunbridge Wells Hospital. The majority of falls relate to slips, trips or falls on level ground. It is noted that the Emergency and Medical Services Directorate had a notable increase in falls over this period, with Trauma and Orthopaedic Directorate having a slight increase in the number of falls. The main themes arising are: falls occurring overnight, patients with confusion, patients who independently mobilise. There have also been a small number of patients who had repeated falls whilst in hospital.

All falls are reviewed in detail at the falls panel and the ongoing action plan is monitored. A new system of tagging is being implemented in Maidstone. This means there is a nurse always in the bay and hands-over to a colleague when leaving.

Figure 1: Comparison of Patient Falls 2014/2015 to 2015/2016



	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
2014/2015	104	134	109	118	93	106	130	128	131	140	124	120
2015/2016	120	141	131									

The patient safety team are working with the falls team to review national initiatives that are underway to reduce falls to see what else we need to do. The programme of work is being further reviewed and will be explored further within the relevant forums i.e. directorate clinical governance and Trust Management Executive.

Patient Safety Incidents – reporting and handling

At the Trust Board in May it was acknowledged that MTW have a low reporting rate (this was also noted within the CQC inspection report 2014). This information was also substantiated by the staff Patient Safety Survey that provided some awareness of why reporting culture was low. In response there have been 3 work streams:

1. Improvements to the reporting page and system
2. Improvements to the management and handling of incidents
3. Improvements to the feedback and learning from incidents.

Actions completed to date:

1. Datix upgrade (March 2015)
2. Reporting page upgraded June 2015 – it is now much faster and easier to report
3. DATIX app incorporated onto I-pads as part of nerve centre roll out – for instant reporting access
4. A review and updating of the handlers within the system to ensure the system is up to date

Actions in next 4 months:

- Further work is planned to address the high number of 'open' incidents
- Improvements to RCA training with a more interactive approach
- Further work to streamline the investigation process
- Improvements to identifying, feeding back and sharing lessons learnt across the organisation
- Implementation of new framework for patient safety (this will be further informed by the governance review
- New Patient Safety Manager (6 month secondment) commences in post September 2015

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Trust Board Meeting – July 2015

7-12 Safe Staffing: Planned V Actual - June 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 confused patients, 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 – i.e. 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% but less than 110%
Amber Less than 90% **OR** greater than 110%
Red Less than 80% **OR** greater than 130%

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

High fill rates (those greater than 110%) would indicate significant changes in acuity and dependency. This results in the need for short notice additional staff.
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

Which Committees have reviewed the information prior to Board submission?

- None

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

- Assurance

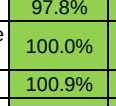
[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making;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

Jun-15		Day		Night		Nurse Sensitive Indicators						Financial review		
Hospital Site name	Ward name	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)	FFT Response Rate	FFT Score	Falls	PU - ward acquired	Overall RAG Status	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	100.0%	110.0%	95.6%	190.6%	39%	100.0%	4	0		Special required for 13 nights	112,576	97,737	14,839
MAIDSTONE	Romney	95.6%	103.3%	100.0%	100.0%			4	0			66,973	68,807	(1,834)
MAIDSTONE	Cornwallis	94.2%	138.3%	93.3%	93.3%	47%	93.9%	1	0		Additional dependency during 1st 2 weeks of month; ward relocated during month	85,672	80,912	4,760
MAIDSTONE	Coronary Care Unit (CCU)	97.8%	N/A	98.3%	N/A	74%	100.0%	0	0			110,266	98,499	11,767
MAIDSTONE	Culpepper	100.0%	98.3%	96.9%	100.0%	47%	100.0%	1	0					
MAIDSTONE	Foster Clark	102.0%	143.3%	107.5%	130.0%	30%	100.0%	3	3		Increaded dependency for core care at night over 18 nights	117,992	135,934	(17,942)
MAIDSTONE	Intensive Treatment Unit (ITU)	89.2%	N/A	85.0%	N/A	67%	100.0%	0	0		Decreased dependency staff redirected to TWH ICU	152,540	163,363	(10,823)
MAIDSTONE	Pye Oliver	85.3%	105.6%	96.4%	150.0%	17%	88.9%	6	0		**John Day relocated to Pye** - congnitive impairment support required during and immediately after ward move; varion in RN: CSW ratio concern remains however an improving	96,647	103,287	(6,640)
MAIDSTONE	Chaucer	96.0%	158.0%	93.6%	177.8%	100%	97.7%	6	0		**Jon Saunders relocated to Chaucer**; increased bed base.	85,347	88,769	(3,422)
MAIDSTONE	Lord North	103.3%	96.7%	98.9%	116.7%	75%	94.9%	0	1		Special required for 3 nights	97,867	88,489	9,378
MAIDSTONE	Mercer	98.3%	101.1%	97.8%	101.7%	12%	100.0%	7	0			97,664	90,315	7,349
MAIDSTONE	MOU	96.8%	125.7%	98.6%	144.7%			5	0		Additional staff required for IPC cohorting 4 days	100,528	104,659	(4,131)
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	95.5%	95.5%	130.0%	193.3%	14%	97.5%	5	0		Trolley bays escalated at night throughout the month	122,037	136,240	(14,203)
TWH	Acute Stroke	97.8%	101.7%	97.8%	130.0%	20%	80.0%	7	0		Patient special for 8 nights	69,020	76,929	(7,909)
TWH	Coronary Care Unit (CCU)	100.0%	93.3%	98.9%	N/A	83%	95.7%	0	0			61,163	64,308	(3,145)
TWH	Gynaecology	100.9%	92.1%	100.0%	96.7%	33%	93.8%	0	0			66,262	65,564	698
TWH	Intensive Treatment Unit (ITU)	100.4%	100.0%	101.7%	N/A	0%	0.0%	0	2			172,576	171,179	1,397
TWH	Medical Assessment Unit	91.5%	111.7%	95.0%	91.1%	12%	96.6%	14	0			158,497	163,879	(5,382)
TWH	SAU	105.6%	130.0%	145.0%	186.7%			0	0		Escalated throughout month	65,750	91,644	(25,894)
TWH	Ward 32	96.7%	100.0%	96.7%	103.3%	13%	100.0%	1	0			119,912	136,022	(16,110)
TWH	Ward 10	97.6%	95.0%	95.0%	110.0%	16%	100.0%	0	0	↑		126,842	135,443	(8,601)
TWH	Ward 11	97.1%	114.4%	90.0%	130.0%	42%	98.2%	0	0		Special required 22 nights	125,584	127,865	(2,281)
TWH	Ward 12	82.7%	101.1%	74.8%	138.3%	14%	100.0%	9	1		Increased dependency (cognitive impairment) requiring additional support for 12 nights. Ward holding a high level of vacancy	112,718	105,746	6,972
TWH	Ward 20	98.2%	106.7%	82.5%	141.7%	50%	77.8%	5	1		Cohort nursing of patients with cognitive impaitment for 20 nights	127,394	121,690	5,704
TWH	Ward 21	104.0%	93.3%	94.0%	101.7%	33%	95.0%	6	0			133,239	120,410	12,829
TWH	Ward 22	97.5%	121.1%	98.9%	101.1%	100%	85.2%	18	0			99,430	96,402	3,028
TWH	Ward 30	81.2%	117.9%	84.2%	128.3%	10%	100.0%	8	2		Minor impact on patient care due to change in RN:CSW split.	126,026	131,296	(5,270)
TWH	Ward 31	100.6%	99.3%	110.8%	94.4%	14%	100.0%	3	0			138,894	145,767	(6,873)
TCH	Stroke Rehab	88.5%	98.3%	98.3%	100.0%	46%	100.0%	1	0		Minimal impact on care, as mid-week short fall in RNs with good therapy support.	58,436	59,073	(637)
TWH	Ante-Natal	101.7%	90.0%	101.7%	100.0%	15.50%	94%	0	0		minor impact on care due to reduced CSW cover. All women in establihsed labour received 1:1 care from a midwife.	596,957	593,904	3,053
TWH	Delivery Suite	95.2%	90.0%	90.0%	98.3%			0	0					
TWH	Post-Natal	100.7%	81.7%	100.0%	88.3%			0	0					
TWH	Gynae Triage	90.0%	106.7%	100.0%	100.0%			0	0			14,087	13,826	261
TWH	Hedgehog	101.1%	92.3%	104.4%	86.7%	30.0%	100.0%	0	0			186,193	168,108	18,085
MAIDSTONE	Birth Centre	100.0%	96.7%	100.0%	100.0%			0	0			65,394	67,325	(1,931)
TWH	Neonatal Unit	100.0%	90.0%	100.6%	86.7%			0	0		Minimal impact resulting from reduce CSW at night.	160,644	156,554	4,090
MAIDSTONE	MSSU	105.8%	93.2%	86.4%	N/A	36%	99.6%	0	0			42,528	49,386	(6,858)
MAIDSTONE	Peel	94.0%	81.7%	95.6%	N/A	65%	95.5%	0	0			201,475	155,678	45,797
TWH	SSSU	105.6%	130.0%	146.7%	186.7%	20.0%	100.0%	0	0		Escalated thoughout month	36,096	21,478	14,618
												4,311,226	4,296,482	14,744

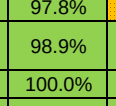
RAG Key

RAG Key

Underfill



Over fill



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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - July 2015

7-13 Winter Plans – Discussion Paper **Chief Operating Officer**

Summary / Key points

This plan has been produced to ensure operational resilience for the winter period of 2015/16. Provision of sufficient inpatient bed capacity over the winter period to match fluctuations in demand for both non-elective and elective inpatients will provide a positive impact on quality, safety, and patient experience, and help the Trust deliver operational and financial plans.

Pressures in A&E at MTW are predominantly due to two factors, mismatch between demand and capacity for inpatient beds and lack of alignment of resource with demand within the Trust but also with our partners across the wider health economy, in particular social services, community services, mental health and ambulance Trusts.

The objectives of the 15/16 Winter plan are:

- Ensure patients go into the right beds first time
- Maintain key quality KPIs during the winter - Safeguard key clinical pathways to support patient safety including reducing HCAIs, falls and Facility Acquired Pressures Ulcers.
- Ensure delivery of A&E, RTT and Cancer standards during the winter period.
- Reduce delayed transfers DToCs to <3.5% during the winter period
- Across the Trust <30 patients that are MFFD occupying an acute hospital bed in any 24 hour period.
- Maximise elective activity when non-elective activity is low and vice versa
- Ensure all clinical areas have the right level of staff and skill mix required to maintain safe service and to deliver operational standards during the winter period.

This Plan sets out:

- the objectives of the 15/16 winter plans
- key pressures that arise from winter
- demand and capacity plans
- planning and implementation
- Risks and contingency plans
- Governance and Stakeholder engagements
- Next steps

The “planned escalation” beds outlined in this plan therefore represent a best attempt to balance elective and non-elective pressures within the resource limitation of the beds available. Significant inpatient bed pressures at TWH are likely to remain until commissioning of the new 39 bed ward in January 2015. These pressures will be partially mitigated by reductions in average NEL LOS but, to the extent those reduction are not delivered, the Trust will rely on use of contingency escalation areas to manage the peaks in demand caused by increased admissions and delayed discharges. Implementation of LOS reduction programme therefore remains a vital part of the winter plan.

The objectives and the plan may be subject to further iterations taking into account changing situation.

Reason for receipt at the Trust Board (decision, discussion, information, assurance etc.)
Trust Board is asked to discuss and support the proposals outlined noting that it may be subject to further iterations.

2 Introduction

This plan has been produced to ensure operational resilience for the winter period of 2015/16. Provision of sufficient inpatient bed capacity over the winter period to match fluctuations in demand for both non-elective and elective inpatients will provide a positive impact on quality, safety, and patient experience, and help the Trust deliver operational and financial plans.

The objectives of the 15/16 Winter Plan are:

- Ensure patients go into the right bed first time
- Maintain key quality KPIs during the winter - safeguard key clinical pathways to support patient safety including reducing HCAIs, falls and Facility Acquired Pressures Ulcers. Ensure delivery of A&E, RTT and cancer standards during the winter period.
- Reduce delayed transfers DToCs to <3.5% during the winter period
- Across the Trust <30 patients that are MFFD occupying an acute hospital bed in any 24 hour period.
- Maximise elective activity when non-elective activity is low and vice versa though flexible working
- Ensure all clinical areas have the right level of staff and skill mix required to maintain safe service and to deliver operational standards during the winter period.

These objectives are based on experience and learning from last year and area designed to ensure focus although it is recognised that 14/15 winter was mild and that the Trust did not experience major outbreaks of infection.

The objectives and the plan as a whole may be subject to further iterations taking into account changing situation and continuous engagement with clinical teams, local health partners in particular, Kent Community services, South East Coast Ambulance Services, Kent Mental Health services and West Kent Social Services.

This Trust plan should be read in conjunction with the following Trust plans:

- Major Incident Plan
- Pandemic Influenza Plan
- Trust Escalation policy and procedure for emergency admissions
- Business Continuity Plans

3 Key pressures that arise from winter

Pressures in A&E at MTW are predominantly due to two factors, mismatch between demand and capacity for inpatient beds and lack of alignment of resource with demand within the Trust but also with our partners across the wider health economy, in particular Social Services, Community services, Mental Health and Ambulance Trusts. These mismatches are much more pronounced and acutely felt in the winter months because of:

- Delayed discharges of medically fit patients due to lack of capacity in community / social care access to enablement / nursing home placements (biggest issue at TW)
- Delayed discharges due to pressure on medical staffing resulting from increased number of admissions (TWH), and medical outliers (MH)
- The tendency for a more complex case mix & more demand on emergency services.
- Increased demand for acute services due to higher levels of infection within the community e.g. bronchopneumonia

- Higher levels of infection within the community with subsequent increase in demand for services, inability to discharge to community hospitals, residential or nursing homes.
- Bank holiday impact on services
- Pressure on adult critical care and paediatric high dependency capacity across the network
- Unplanned absence of staff due to seasonal illnesses e.g. flu like symptoms and winter vomiting (Norovirus)
- Adverse weather resulting in difficulty in discharging patients and affecting staff
- Adverse weather resulting in difficulty in getting to and from work
- Pressure on A&E due to diverted demand if GPs when GPs are closed
- Unplanned staff absence due to seasonal flu, D&V outbreaks etc.

4 Planning and Implementation

4.1 Maintain elective activity during the summer:

Directorates are required to plan and maintain elective activity in August and September. Robust planning of elective activity during the year is critical part of managing winter pressures proactively. Last year elective activity between August and September was more than 10% lower than in October and November. The main reason for the drop in elective activity is the unavailability of staff due to holidays. Whilst it is right that staff annual leave is accommodated, Directorates must find ways of maintaining elective activity during this period including considering annualised jobs and hiring locums staff.

4.2 Early winter escalation:

MTW winter escalation period will run from **01 November to 28 Feb 2016**, a month earlier than last year to ensure a steady transition and to maintain patient safety, and maintain optimum patient flows. A success story of last winter was how key quality measures were maintained within acceptable standards despite the winter pressures. However some quality and patient experience measures including mortality, pressure ulcers, number of falls, some stroke SENTIL measures, NEL LOS and patient involvement in decisions about treatment deteriorated somewhat from October/November (*note link is not cause*). A&E conversion rates also increased from 26.7% in September to 28.6% in October and delays transfers of care (DToC) peaked from 3.9% in October to 5.3% in November.

4.3 Elective Demand Management during the winter

Predictable peaks in NEL demand due to increase in admissions and delays in discharges following the seasonal holidays place substantial pressure of resources and negatively impacts patient and staff experience. Directorates are required to plan to reduce elective inpatient activity to minimum during this period and to reassign the junior medical staff to support the surge non-elective pressures.

4.4 Maintain patient flow during the winter:

Other than bed capacity, pressures in A&E and on wards are also due lack of alignment and mismatch of resource with demand, within the Trust but also with our partners across the wider health economy, in particular Social Services, Community services, Mental Health and Ambulance Trusts. Delays in discharges often occur due to pressure on medical staffing caused by a combination of increase in admissions and delays in discharges to community. Whilst it's recognised that all activities are important there is need to prioritise activity during this period to ensure that the hospital remains a safe environment for our patients. For example by reducing

scheduled outpatient clinics to support early review of sick patients on wards and facilitate their discharge.

It follows from the opening of escalation beds that additional staff will be required to manage and ensure a safe service and maintain patient flows during the winter period. Recruiting Locum or Agency/Bank staff during the winter period is inefficient and ineffective as all local providers are competing for the limited resource available. Directorates are therefore required to consider recruiting substantively to cover escalation areas. It is anticipated that the financial risk is mitigated by the turnover rate and savings from reduction in Bank and Agency spend.

4.5 Demand and Capacity

4.5.1 Bed Modelling

Remodelling of "core" inpatient beds to ensure that there are enough speciality beds to meet elective and non-elective demand 85% of the time. This in turn helps ensure that patients are admitted to the right beds first time.

Fig. 1: 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**

Fig.2: Additional "escalation" beds are required during winter months on top of core requirement.

	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**

Actions: The Programme Board is overseeing work to increase bed base and patient flow by:

1. Building a circa 39 inpatient bed facility at TWH – due to be completed in January 2016
2. Establish a 7 bed new ambulatory unit at TWH – completed
3. Open 12 beds on Old MOU at MH – completed
4. Reconfigure beds at MH to reduce surgical bed base and increase medical bed base. Current programme to refurbish John Day/John Saunders at Maidstone is scheduled to be completed before by December 2015.

4.6 Early Warning Escalation Indicators

Early warning indicators of pressure and / or increase in the normal activity of the Trust have been developed to identify occasions when there would cause to change the Trust status from 'business as usual' (Green) to escalation (Amber, Red and Black). At such times there is a need to manage pressure out of the system and when there will be at least one indicator identified from each category below, escalation would be considered by the Associate Director of the Day:

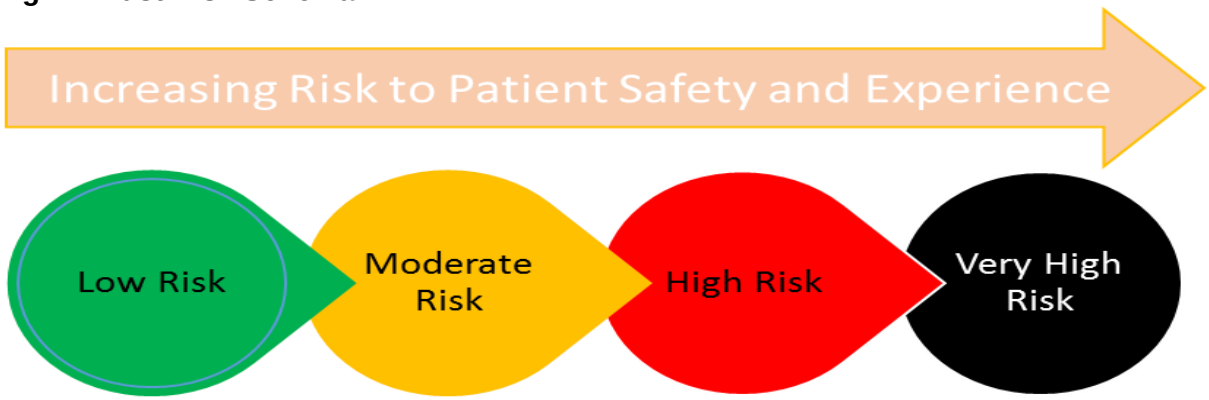
Fig.3: Early Warning Escalation Indicators

ED	>2 ambulances unable to offload for > 30mins in last 2 hours >1 patients requiring resuscitative care >19 patients in ED >9 new patients per hour registering in the last 2 consecutive hours >1 non-clinical breach (4hr standard) in previous 2 hours >1.5 hours to be seen by clinician in previous 2 hours >2 hours movement in or out of CDU if full <2 majors cubicles available
Bed State	Worse case predicted bed deficit at 0900 >-19; at 1300 >-9; at 1630 > -4 Number of allocated DTAs with no plans at 0900 >4; at 1300 >2; at 1630 >1 Number of attendances expected in excess of prediction before midnight >14 Number of critical Care beds available <2
Outliers	>9 Medical >1 surgical / trauma >1 patient to return from other units
Other	**Staffing** - Potentially unmanageable staffing issues likely to impact shift cover **Clinical Support Services** - Issues that could potentially impact on patient flow **Community Hospitals** – Infection control outbreaks, 100% occupancy with no expected discharges within 24 hours, staffing issues or all possible social service discharges undertaken

4.7 Risk/Escalation Status

MTW uses the schema below to help communicate the Trust escalation status. The Black, Red, Amber and Green (BRAG) colour code reflects the **level of risk to patient safety and the extent to which patient experience may be compromised**. This status setting applies to adult acute bed capacity (excluding paediatrics and maternity services).

Fig.4: Trust Risk Schema



Escalation from one level to the next triggers actions by staff at different levels; the purpose of this is to ensure early actions to protect patient safety and experience. These actions may include deployment of senior staff to triage or assessment areas, senior doctor review of all admissions, increased speciality support in A&E, increased ward rounds, deployment of non-clinical staff to support clinical staff on wards, opening of additional escalation beds, through to progressive cancellation of elective work.

The triggers (Appendix 2) help determine the escalation status and therefore, the appropriate response. The escalation status is decided by the AD of the Day at 0900hrs and reviewed at 1300hrs and at 1630hrs daily. When the status is determined, steps to create bed capacity are actioned. Fig. 5 and 6 below illustrate escalation actions to create bed capacity at both sites:

Fig. 5: TWH Winter Bed Escalation Plan

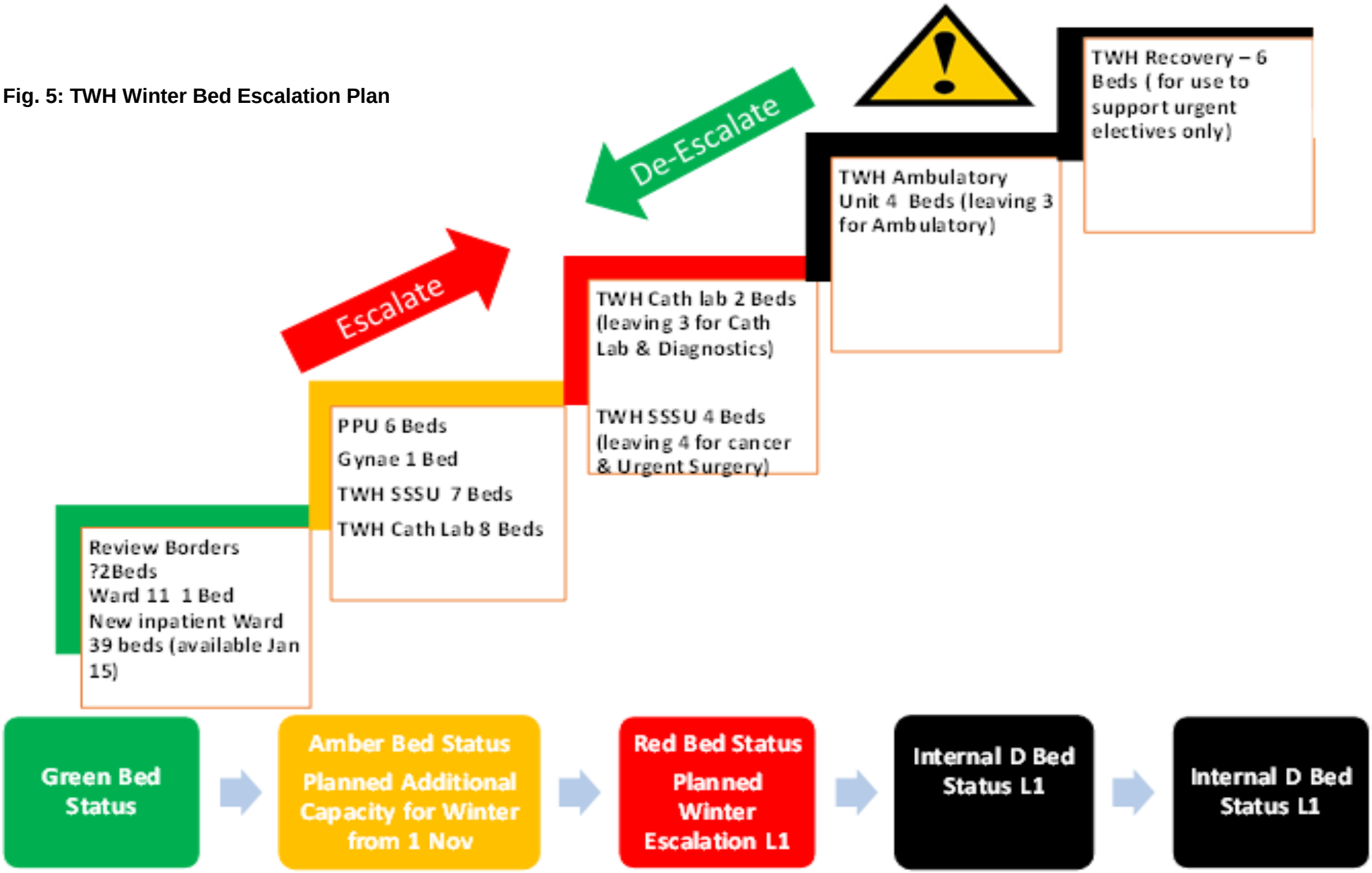
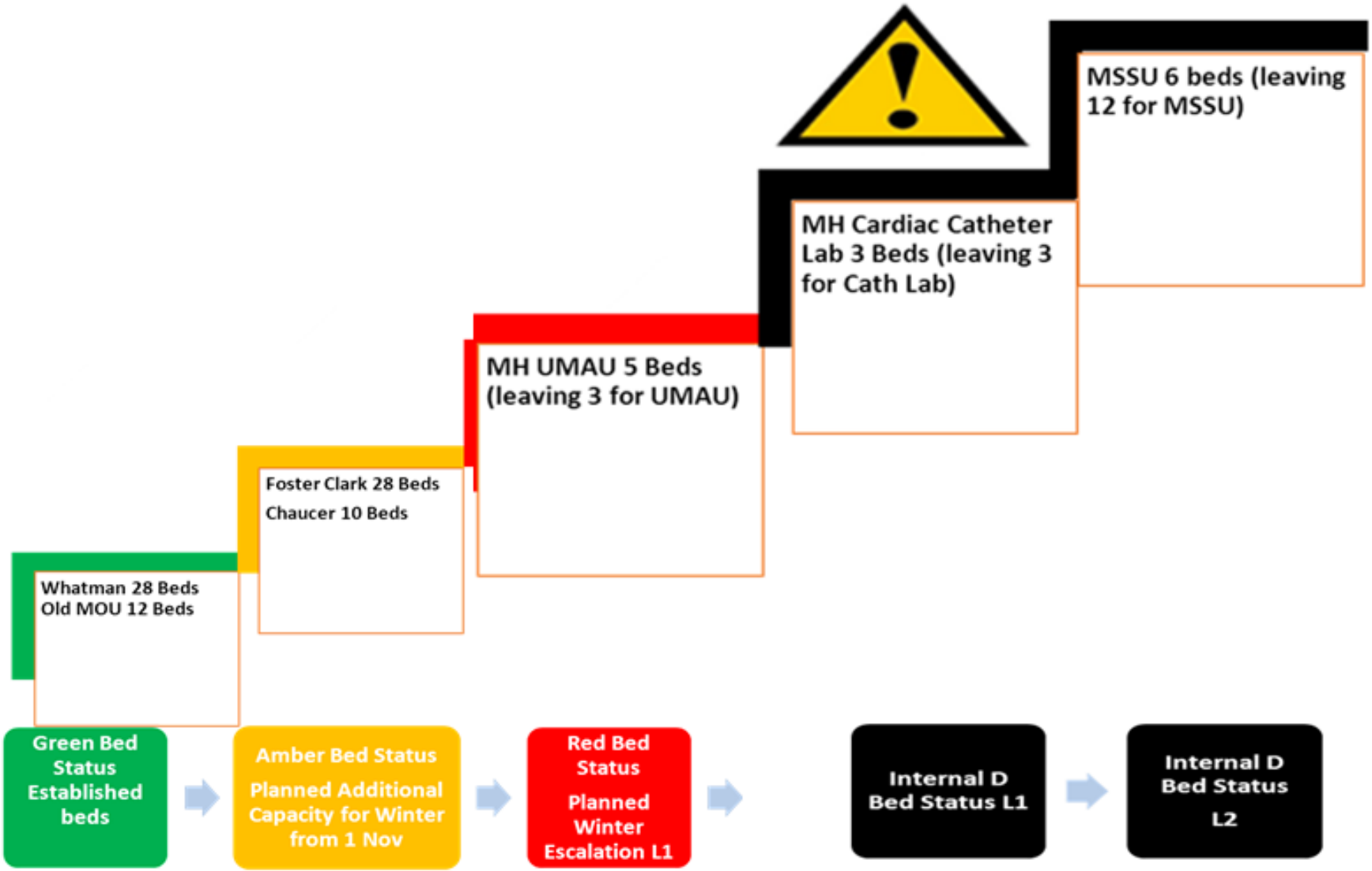


Fig. 6: TWH Winter Bed Escalation Plan



5 Risks & Contingency plans and Business Continuity

Risk Description	I	L	RAG	Key controls and assurances in place	I	L	RAG	Owner
Failure to recruit nursing and medical staff in a timely manner	5	5	25	Substantive recruitment to winter escalation beds International recruitment drive Engagement with LHE partners as outlined in Engagement plan below Establish Winter Planning Working Group to oversee implementation and manage risks				HR
Failure to reduce the numbers DToC	4	5	20	Engagement with SS as outlined in Engagement plan below SS Winter Plans and contingency plans shared Plans tested				ADO for Medicine
Failure to reduce the number of MFFD patients occupying an acute bed	4	4	16	Engagement with LHE partners as outlined in Engagement plan below SS Winter Plans and contingency plans shared Plans tested				ADO for Medicine
Rise in NEL admissions above plan	4	3	12	Engagement with LHE partners as outlined in Engagement plan below				COO
Delays in commissioning of 39 bed ward a TWH	3	3	9	Proceeding with plans at risk				Programme Board
Financial risk of over spend of winter plans	3	3	9	Substantive recruitment to winter escalation beds to reduce Band and Agency spend Early recruitment decisions Maximise summer elective activity				DoF
Risks to delays in completion of planned refurbishment work	4	2	8	Close project management – initially allocated contingency has been spent.				Programme Board
Patient safety risks due to cancelled elective procedures	4	4	16	Plans to reduce non urgent activity during peak periods Weekly Forward planning meeting to inform planning and priorities Plans to transfer lists to Private sector where possible	2	4	8	ADO Planned Care

6 Governance and Stakeholder Engagement Plan

Who?	How?	Other	Key message	Owner
Staff	Clinical Operations Group Meetings, Department & Ward meetings MTW winter planning e-mail address	Information of Intranet	Share improvement ideas Familiarise yourself with your role when in escalation Understand the agreed service leave policies and plan holiday well in advance to avoid disappointment Know where to find information Get your Flu vaccination	COO GMs and Matrons
Clinical Directors Site Leads Consultants	Directorate Management meetings Clinical Governance		Involvement with escalation planning Service Leave policies Flexing elective activity to match bed availability Roles when in escalated state	Clinical Directors
Executive Team	TME update paper		Plan, Risks and Mitigations Financial implications Recommendations/Decisions Monthly updates to TME Bi-monthly Progress updates to Board	COO
LHE partners (SS, KCHC, Mental Health, Local Hospices, SECAMB and West Kent CCG, East Sussex Healthcare NHS Trust)	System Resilience Group meeting Daily Sitrep Urgent Care Board		Share learning, risks and contingency plans Shared Planned Escalation plans for the Winter - What will each partner differently this winter? - Commissioned beds, escalation beds, and staffing NWB bed capacity for East Sussex Timing of arrival of patients referred directly by GPs Test plans	COO
Patients	Trust Website	Posters Link to NHS Choices Information from NHS West Kent and Local GPs	Signposting to alternative providers Flu vaccination Visiting the hospital – Infection controls Did not attend (DNAs)	Comms teams

7 Timetable:

July 2015	Cost Winter proposals	Mark Austin
July 2015	Decision on Winter Plan and escalation areas to be open for the winter finalised	Trust Board
July 2015	Recruitment of staff for escalated areas	Directorates
August 2015	Receive plans from LHE partners	COO
October 2015	Test plans and agree contingency	COO
1 November	Implement plan	COO

8 Next steps

- Further engagement with key stakeholders identified above
- Implement Action plan below
- Monthly progress reports to TME and bi-monthly assurance reports to Trust Board.

9 Appendix 1 – Draft Action Plan

Risk Description	Required Actions	Due	Owner	Progress Update	RAG
Failure to open escalation areas in a timely manner	The Programme Board to oversee work to increase bed base by: a) Building a circa 39 inpatient bed facility – work in due to be completed in January 2016	01/01/16	Steve Jones	In progress	
	b) Establish a 7 bed new ambulatory unit at TWH	30/06/15	Steve Jones	Completed	
	c) Open 12 beds on Old MOU – June 2015	30/06/15	Steve Jones	Completed	
	d) Reconfigure beds at Maidstone to reduce surgical bed base and increase medical bed base. Refurbish John Day/John Saunders at Maidstone is scheduled to be completed before by 1 December 2015.	01/12/15	Steve Jones	In progress	
Early pressures leading to unplanned escalation if implementation of Winter plan is delayed to December.	a) Approval for MTW winter escalation plans to be implemented from 01 November to 28 Feb 2016	30/06/15	TME	Completed	
Inadequate staffing on wards due to failure by directorates to adequately resource escalation beds in a timely manner	b) Approve bed escalation plan for the winter	30/06/15	TME	To CODC	
	c) Update the Trust Escalation policy and procedure for emergency admissions for escalation triggers to reflect learning points from 14/15 winter period and from breaking the cycle week.	30/06/15	ADO Medicine	Completed	
Risk of elective activity dropping in August and Sep due to staff holidays – a drop of 10-20% seen in previous years.	a) Directorates to review and publish agreed leave policy for each service area by end of June 2015 – policies must ensure delivery of safe service and of trust operational performance standards and balance staff well-being during the summer holidays and Winter months	30/06/15	CDs	All services apart from one completed	
	b) All directorates to finalise staff rotas and theatre schedules for August and September and identify Locum and Bank/Agency staff required to maintain elective activity during these months where necessary	30/06/15	GMs	In progress	
Deterioration in quality of service and patient experience caused by lack of adequate staff to support escalated demands in A&E and on ward	a) Directorates to submit revised Capacity and Demand plans for elective activity for the year, taking into account changes outlined in the winter plan.	30/08/15	GMs		
	b) Complete comprehensive staffing plan (including social services, therapies, diagnostics, pharmacy, phlebotomy, and transport) for all escalation areas - ensuring a/l is profiled to maintain capacity during December and especially first three weeks after Xmas.	30/08/15	GMs		

Risk Description	Required Actions	Due	Owner	Progress Update	RAG
	c) Develop operational policies for each identified escalation areas by July 2015 - Matrons	30/08/15	Matrons		
	d) Review staff skill mix and Submit plans to recruit substantive staff to cover all escalation areas for the winter period	30/08/15	Matrons		
	e) Review A&E attendances and GP referral patterns from Sevenoaks area and engage LHE to change borders and redirect appropriate patients to MH where there is better bed capacity – ADN Medicine	30/08/15	GM A&E		
	f) Submit plans to recruit fixed locum consultants to extend consultant cover to from 0730 – 2330hrs seven days a week - A&E, Acute Medicine and Geriatric Medicine	30/08/15	GMs		
	g) Identify & communicate Bank staffing needs for the winter period to HR Recruitment teams.	30/08/15	GMs		
	h) Finalise schedule of outpatient clinics for the Winter period to support early senior review of all patients on wards including outliers	30/08/15	GMs/CDs /Outpant Manager		
	i) Review jobs plans to reduce elective admissions and maximise non-admitted activity during for Surgery during winter period	30/07/15	CDs		
	j) Consider spreading activity over seven days where possible to match elective activity with bed availability	30/08/15	GMs/CDs		
	k) Publish Bank recruitment incentives in place for the winter	30/9/15	AD Workforc		
	l) Establish a central team to manage staff sickness during the winter period to assist managers and allow them to focus on operational pressures – October 2015 - HR	30/9/15	AD Workforc e		
	m) HR to work with operational managers to streamline the process for recruitment of locum staff and provide management training support where required – July 2015.	30/9/15	AD Work force		
Failure to reduce the numbers DToC and failure to reduce the number of MFFD patients occupying an acute bed.	Engagement with SS as outlined in Engagement plan below. Specific actions include: a) Institute daily site rep during the winter period to proactively manage discharges of patients that are MFFD from acute trust. Daily review of shared PTL will help bring transparency and better coordination of discharges across the health economy b) Agree robust plan for reducing DToC to <3.5% during the winter period. Between November and March 2015 DToC averaged 4.5% versus a target of 3.5%. This increase was especially felt at a time of heightened pressure for beds – ADO for Emergency Medicine – June 2015.	30/06/15	ADO for Medicine	In progress	

Risk Description	Required Actions	Due	Owner	Progress Update	RAG
	c) Increase case manager resources to adequately cover leave, training, sickness and fluctuations in demand. d) Agree escalation pathway for operational staff to ensure transparency and visibility of issues at Executive levels e) Agree plans for enhanced services during the winter period. Plans must support 7 day working. f) Implement Discharge to assess facility				
Failure to reduce the numbers DToC and failure to reduce the number of MFFD patients occupying an acute bed.	Engagement with KCHC as outlined in Engagement plan below. Specific actions include: a) Institute daily site rep during the winter period to proactively respond to bed pressures at acute trust. For example it was felt that community services a failed to adjust their admission criteria to support discharges from hospital when in high escalation which meant that beds existing beds were not utilised. b) Share protocols on how admissions criteria into community beds will be flexed in response to heightened levels of escalation at the Trust. c) Agree escalation pathway for operational staff to ensure transparency and visibility of issues at Executive levels d) Agree plans for enhanced services during the winter period. Plans must support 7 day working. e) Daily review and update of shared PTL to bring transparency and coordinate discharge planning across the health economy.	30/06/15	ADO for Medicine	In progress	
A&E pressures due to failure to direct patients to more appropriate services	Engagement with SECAmb as outlined in Engagement plan below. Specific actions include: a) Institute daily site rep with HALOs and Clinical Operations Managers during the winter period to reduce inappropriate admissions / referrals to A&E and maintain close working relation with SECAmb– GM A&E b) Develop plans to respond to the new SECAmb policy on handover of patients – A&E Matrons.	30/06/15	GM for A&E	In progress	
Financial risk of over spend during the winter plans	Evaluate the financial impact of Winter plans	30/07/05	AD Finance		
Failure to deliver Winter plans	a) Establish Winter Planning Working Group to oversee implementation and manage risks	30/06/15	GMs		
Review possibility of involvement of hospice services at site meeting to pull appropriate patients from					

Risk Description	Required Actions	Due	Owner	Progress Update	RAG
wards					
Explore options for physicians out in the community with the CCG					
ED escalation	Plan for use of Outpatients area for minors patients in ED At TWH in event	30/08/15	GM for A&E / Outpatients Manager		

10 Appendix 2 – Escalation Triggers

Escalation Status	Bed State								Emergency Department								Outliers				Other		
	Predicted worst case bed deficit (-ve Beds)			Number of unallocated DTAs with no Plans			Number of attendances expected in excess of pridiction before midnight	Number of Critical Care beds available	Number of non-clinical breaches (4hr standard) in previous 2 hours	Number of patients in ED	Time to be seen (hours) by clinician in previous 2 hours	Number of ambulances unable to off-load for > 30 mins in last 2 hours	Number of new patients per hour registering in the last 2 consecutive hours	Number of patients requiring resuscitative care	Number of majors cubicles available	Time since movement (in or out) of CDU if full	Medical	Surgery/T&O in medical or oncology beds	Number patients to return from other units	Other (see Escalation Policy (✓)	Staffing	Clinical Support Services	Community Hospitals
	0900 hrs	1300 hrs	1630 hrs	0900 hrs	1300 hrs	1630 hrs															Issues likely to impact shift cover	Issues likely to impact patient flow	See Escalation Policy (✓)
B	>40	>30	>25	>15	>12	>8	>50	0	>10	>60	>3	>5	>25	>6	0 for >20 mins	>8	>24	>10	>4		S	S	
R	30-40	20-30	15-25	9-15	6-12	4-8	30-50	0	5-10	50-60	2-3	4	16-25	5-6		4-8	16-24	5-10	3-4		A	A	
A	20-29	10-19	5-15	5-8	3-5	2-3	15-29	1	2-4	20-49	1.5-2	3	10-15	2-4	<2	2-3	10-15	2-4	2-3		P	P	
G	<20	<10	<5	<5	<3	<2	<15	>1	<2	<20	<1.5	<3	<10	<2	>2	<2	<10	<2	<2		N	N	

S - Significant
A - Actual
P - Potential
N-None

Notes

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – July 2015

7-14	**Summary report from the Quality Committee meeting, 08/07/15 (incl. update on the latest Stroke performance)**	**Committee Chairman (Non-Executive Director)**

The Quality Committee had a 'main' meeting on 8th July 2015, and covered the following issues:

- The latest **Stroke care performance** was reported. The report that was received is enclosed at Appendix 1, as was agreed by the Board on 24/06/15
- The **Clinical Directorates** presented their reports. The key issues raised were as follows:
  - Trauma & Orthopaedics reported that the review of all deaths in the Directorate remained a problem, with the main challenge being access to Healthcare Records (all Directorates are required to review their deaths as a matter of routine). The Medical Director noted that it was intended that the Healthcare Records of deceased patients be made available in electronic form, and agreed to provide an update of progress to the next 'main' Quality Committee meeting. The Directorate's poor performance on the survey question "Did a member of staff tell about medication side effects to watch for when you went home?" was also discussed, and it was agreed that a representative from the Pharmacy department should be asked to contact Trusts who performed well on the question, to identify any factors that could assist in improving the Trust's performance. It was also agreed that the Chief Operating Officer would liaise with the Directorate and the Electro-Medical Engineering (EME) Department to aim to resolve the current difficulties regarding the approval for use of pre-operative warming devices.
  - Women's & Sexual Health reported that an External Cephalic Version (ECV) clinic had commenced in the Maternity Day Unit, and was progressing well thus far. It was also noted that Caesarean section rates were monitored, and the latest data was reviewed.
  - Cancer & Haematology reported that the introduction of chemotherapy e-prescribing was progressing, but the manual double-check of dose alterations would need to continue when the system was implemented.
  - Children's Services reported the findings from the National Children's Inpatient and Day Case survey 2014. It was noted that the Trust was mainly rated as 'amber', but was rated "Better" on two questions and "Worse" on none. It was however recognised that a few findings were close to the 'red' zone, and a response to each of these was being considered. It was also reported that there was an acute shortage of the BCG vaccine for the whole of the UK, and the Trust's last vial had now been used, so babies would be unable to have a BCG vaccine administered at present. The Chief Operating Officer also agreed to liaise with West Kent Clinical Commissioning Group over the potential funding of the introduction of "Metoject PEN" for patients with juvenile arthritis
  - Critical Care reported the findings from the Annual Report from the Intensive Care National Audit & Research Centre (ICNARC), and the positive picture was acknowledged. The challenges posed following the recent changes in the Consultant on call rota (which doubles the number of Consultants on call) were also reported.
  - Diagnostics, Therapies & Pharmacy highlighted that the reporting delays in Histopathology remained, even though clerical staffing was back at full strength. The matter continues to be monitored closely. It was also reported that there had been a successful UKAS (ISO 15189) inspection of Cellular Pathology, and the implementation of the 'intelligent fridge' at Tunbridge Wells Hospital was anticipated to take place in July.
  - Emergency & Medical Services highlighted that operational pressures were continuing, and staffing continues to be a cause of concern. Reference was also made to the recent review by the Emergency Care Intensive Support Team (ECIST), but it was noted that the recommendations were not yet finalised.
  - Surgery reported that although the crude mortality rate had increased, but this was not a cause for concern, as all deaths were reviewed. It was also noted that there had not been any cases of Endophthalmitis (Ophthalmology infection) since December 2014.
- An update on the external **Clinical Governance Review** was provided, and the Committee

heard that the first draft of the report would be received by the Chief Nurse on 22/07/15.

- The latest **Quality & Governance** report highlighted recent Legal services cases, and it was noted that the recruitment for a Trust Solicitor was underway
- The latest **Serious Incidents** were considered, and the **Complaints Annual Report 2014/15** was reviewed. The latter noted that the Trust received 485 formal complaints, a reduction of 89 from the 574 received in 2013/14.
- The recent findings from relevant **Internal Audit reviews** were received, and it was noted that a recent review of Discharge Processes had concluded "reasonable assurance"
- The full report of the **External Audit of the Quality Accounts 2014/15** was received, and it was noted that the Quality Accounts have now been published on the Trust's website, and on the Trust's pages on "NHS choices"
- The latest situation regarding **Catheter Associated Urinary Tract Infections** was considered, and it was noted that the baseline data obtained in May and June identified a rate of 7%. A 10% reduction of that 7% is required, and the Committee was given assurance that this was achievable.
- The **Mortality outlier alert letter** issued to the Trust from the Care Quality Commission in February 2015 was received, for completeness (as was agreed at the Board on 24/06/15)
- A written report was received on the latest media coverage / **reputational risk** issues
- The minutes of the **Quality & Safety Committee 'deep dive'** held on 10/06/15 were received
- Reports were received from the latest meetings of the **sub-committees** i.e. Standards; Safeguarding Children; Mortality Review Group; Infection Prevention & Control; Clinical Governance; Patient Environment Steering Group and Safeguarding Adults Committee. A summary report from the **Patient Experience Committee** was also received. There were no particular issues of concern raised, but the report from the Infection Prevention & Control Committee included the findings from the **HCAI prevalence survey** undertaken in April, and the significant improvement since the last survey in January 2013 was commended.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

- Information and assurance

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

Appendix 1: Stroke care report received at the 'main' Quality Committee on 08/07/15

Maidstone and Tunbridge Wells NHS
NHS Trust

QUALITY COMMITTEE - JULY 2015

7-5	**UPDATE ON LATEST STROKE CARE PERFORMANCE**	**CLINICAL DIRECTOR, EMERGENCY AND MEDICAL SERVICES**

Summary / Key points

The enclosed report provides information on

- Current stroke performance against national benchmarks
- Actions being taken to maintain and further improve standards

Reason for receipt at the Quality Committee (decision, discussion, information, assurance etc.)
Update and assurance

1. Introduction

Following the initial Quality & Safety Committee's 'Deep Dive' into the Trust Stroke services in July 2014, updates have been requested and produced for presentation at each Quality & Safety Committee. This provides both an update on the transformation of stroke services across the Trust in addition to regional benchmarking. The paper also allows assurance on the quality of care being delivered within the Trust. As from May 2015, a more compact report showing stroke headlines was requested to replace the full paper.

2. Performance Standards

Information is now collected monthly by the Trust to give internal assurance about delivery against the Sentinel Stroke National Audit Programme (SSNAP).

2.1 CT scan performed in under an hour:

- April data for scanning within 1 hour is encouraging with TWH scanning 55% within the hour and Maidstone scanning 33%.

- 12 hourly scanning indicates a steady performance with TWH scanning 86% within 12 hours and Maidstone 89%

- SSNAP data covering data collected January – March provided a stable performance at TWH who achieved a "B" rating, and a tremendous improvement at Maidstone who rose from a "D" rating in October-December to an "A" rating.

2.2 Proportion of all stroke patients given thrombolysis (all stroke types) and 2.3 Percentage of thrombolysed patients with a door-to-needle time <60mins is as follows:

- April data indicates that there were not any patients' thrombolysed at TWH in April and that Maidstone had 2 patients thrombolysed which were both thrombolysed under 60minutes which gave 100% achievement of the 60 minute target.

- SSNAP data covering data Jan-March 2015 Gave both Maidstone and Tunbridge wells sites a "D" rating for thrombolysis. This was due to both sites not achieving the national average of 11.1% for thrombolysis in addition to SSNAP adjusting their criteria for thrombolysis based on the research of IST3 by removing too severe as a sole reason for exclusion of thrombolysis. Reviews continue to take place to ensure that eligible patients receive treatment unless clinically indicated not to.

2.3 Proportion of Patients admitted to the stroke unit within four hours:

- April data within this performance indicator shows that MGH has admitted 44.4% of strokes to the stroke unit within 4 hours and TWH, has a modest improvement to 27.3%. This is currently the expected outcome with the current number of acute stroke beds at TWH.
- SSNAP results for Jan-March 15 put MGH above the national average at 55.2% of patients reaching the stroke unit within 4 hours, with TWH attaining 22.5%. This contributed to Maidstone receiving a "C" rating and TWH an "E" for the Stroke Unit domain.

2.4 Assessment by a stroke physician within 24 hours:

- Monthly data from April indicates specialist assessments were completed within 24 hours in 68.2% of cases at TWH and 69% at MGH, which shows a stable performance throughout the year.

- SSNAP data for this quarter is more encouraging with MGH achieving 73.5% and TWH achieving 76.5% which is just below the national average of 76.4%. This as a results assisted the commendable “B” rating at MGH and “C” rating at TWH within the specialist assessment domain.

2.5 Current 80/90 Performance

- May data is currently 89.7% and June88.9% with a current YTD performance of 81.7%

2.6 CQUIN achievement for 14-15

- 16 out of the 20 CQUIN targets were achieved for 14-15, which meant that £263,908 out of the £378,136 available reward was achieved.

- The new CQUIN for 15-16 has been agreed which is focused upon Early Supported Discharge (ESD) use to reduce Length of stay (LOS). A paper is to be submitted to board outlining more details.

3. Conclusion

Data above is encouraging as it shows either a stable performance within the KPI’S or an improving picture. Work continues locally to improve performance and Trust status for stroke within Kent. The Kent Stroke review is progressing well, with both nursing and medical clinical leads attending the Clinical Reference Group to represent the Trust. SSNAP results for Jan-March has maintained performance, with Maidstone hospital still remaining the top performing Stroke unit within North and West Kent with an overall banding of a “C”, just missing a “B” rating by 1 point. TWH remained a “D” banding with an improving score.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - July 2015

7-16	Summary report from Finance Committee, 20/07/15	Committee Chairman (Non-Executive Director)

The Finance Committee met on 20th July 2015.

1. **The key matters considered at the meeting were as follows:**
   - A "Safety moment" was held at the start of the meeting, which requested Committee members to consider patients when reviewing the financial information, particularly in terms of the balance between income and temporary staffing.
   - Month 3 financial performance was examined. The usual written reports were again supplemented by a presentation from the Director of Finance. The key points were:
     - For the year to date, the Trust was ahead of plan on income, but behind plan in terms of pay expenditure. The latter was affected by a continued increase in expenditure on temporary staff
     - Elective activity was higher than planned in June, and non-elective activity was now in accordance with Plan for the year to date
     - Delayed Transfers of Care were having an adverse impact, and the Trust intended to seek reimbursement for such discharges from Kent County Council from August 2015
   - Progress with the Cost Improvement Plan (CIP) was noted
   - The NHS Procurement and Efficiency Board's Interim Report of the "Review of Operational Productivity in NHS providers" was reviewed, and it was noted that the four areas of focus would be Workforce, Pharmacy, Procurement and Estates. Assurance was given that a number of initiatives that were either underway or planned at the Trust were focused on the areas highlighted in the report. A further report would be issued by the Board in the autumn.
   - The Committee reviewed the financial aspects of the Board Assurance Framework (which related to the objective to deliver the financial plan for 2015/16), and accepted the ratings proposed by the Director of Finance
   - The quarterly analysis of Consultancy use was undertaken, and it was reported that the downward trend was expected to continue, with the forecast expenditure for the year expected to be circa £800k
2. **The Committee agreed that:**
   - Further efforts should be made to improve the understanding of the relationship between clinical activity and workforce, to assist in future planning
   - Agenda items on "Review of the Finance Department" and Service Line Reporting should be scheduled for future meetings
3. **The issues that need to be drawn to the attention of the Board are as follows:**
   - N/A

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

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - July 2015

7-16	Finance Committee: Revised Terms of Reference	Committee Chairman (Non-Executive Director)

The Terms of Reference (ToR) for the Finance Committee are due their annual review. The ToR have duly been reviewed, and a number of changes are proposed. These are primarily 'housekeeping', and no material changes are proposed.

The proposals were reviewed, and agreed, at the Finance Committee on 22/06/15, and are now enclosed, for approval.

A 'clean' version of the revised ToR is enclosed, along with a 'track changes' version, which shows the specific proposed revisions, and provides explanation/rationale for the change where this is not self-explanatory.

The proposed changes do not inhibit any further changes that may be required in-year.

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 22/06/15

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
NHS Trust

FINANCE COMMITTEE

Terms of Reference

1. Purpose

The Trust Board has established the Committee to provide the Trust Board with:

- Assurance on the effectiveness of financial management, treasury management, investment and capital expenditure and financial governance
- An objective assessment of the financial position and standing of the Trust
- Advice and recommendations on all key issues of financial management and financial performance
- Assurance on Information Technology performance and business continuity
- Advice and recommendations on all aspects of informatics, including Information Technology and telecommunications

2. Membership

Membership of the Committee is as follows:

- The Committee Chair - a Non-Executive Director appointed by the Trust Board
- The Committee Vice-Chair - a Non-Executive Director appointed by the Trust Board
- The Director of Finance
- The Medical Director
- The Chief Operating Officer[2]
- The Chief Executive[1]

Members are expected to attend all relevant meetings.

3. Quorum

The Committee shall be quorate when one Non-Executive Director and two Executive Directors are present. If the Director of Finance cannot attend a meeting, their representative will attend.

For the purposes of being quorate, any Non-Executive Director (including the Chairman of the Trust Board) may be present; and any other Executive Director may be present in place of the Medical Director, should the latter be unable to attend the meeting.

4. Attendance

All other Non-Executive Directors (including the Chairman of the Trust Board) and Executive Directors are entitled to attend any meeting of the Committee.

The Committee Chair may also invite others to attend, as required, to meet the objectives of the Committee.

5. Frequency of meetings

The Committee shall generally meet each month.

6. Duties

The Committee has the following duties:

Financial Management

- Review financial plans and strategies and ensure they are consistent with the Trust's overall vision and strategic goals
- Ensure a comprehensive budgetary control framework is in place and operating effectively

[2] N.B. Either the Chief Operating Officer or Chief Executive should be present at each meeting

- Monitor financial performance against plan, and ensure corrective action is taken where appropriate
- Develop and monitor key financial performance indicators, and advise the Trust Board on action required to improve performance / address risks. Indicators will include:
  - Risk rating and associated financial ratios;
  - Other financial ratios;
  - Service line profitability;
  - Efficiency and productivity measures;
  - Benchmarking information;
- Review and assess the Trust's Cost Improvement Plan
- Obtain assurance that all Cost Improvement Plan initiatives and business cases have been subject to a Quality Impact Assessment, and to liaise with Quality & Safety Committee as appropriate to ensure the robustness of the process

Treasury Management

- Approve the Trust's detailed treasury management policies, processes and controls
- Approve external funding and borrowing arrangements, including approval of working capital facilities and capital investment loan applications (within delegated authority)
- Approve relevant benchmarks for measuring performance e.g. Better Payment Practice Code (BPPC)
- Ensure proper safeguards are in place for security of the Trust's funds by ensuring approved bank mandates are in place for all accounts, which are updated regularly for changes in signatories and authority levels;
- Monitor compliance with treasury management policies and procedures
- Specify and review detailed treasury reporting requirements
- Review the cash flow and balance sheet of the Trust, ensuring effective cash management plans are in place

Capital Expenditure and Investment

- Review the Trust's capital plan ensuring its alignment to strategic priorities
- Review and assess the financial implications of the PFI contract for Tunbridge Wells Hospital, including any options for re-financing
- Review major or contentious business cases above the threshold set-out in the Reservation of Powers and Scheme of Delegation, for capital and service development and advise the Trust Board on the financial implications and risks of the proposals
- Regularly review investment criteria, and the investment appraisal and approval process

Financial Governance, Reporting, Systems and Function

- Review and assess arrangements for financial governance
- Review and agree financial policies
- Ensure financial reporting to Trust Board meets the requirements of the Board
- Review and assess the effectiveness of financial information systems, and agree and monitor development plans, including the development of Service Line Reporting
- Review and assess the capacity and effectiveness of the finance function and ensure development plans are in place to meet the current and future requirements of the Trust (including the requirements of Foundation Trust status)
- Assess the organisational awareness and adherence to financial management disciplines and controls and promote congruence between quality patient care and the achievement of financial objectives.
- Review and approval of the Trust's approach to its Reference Cost submission/s

Procurement

- To monitor the Trust's adherence to 'Better Procurement, Better Value, Better Care' metrics
- To approve the Trust's Procurement Strategy, and monitor performance against the Strategy

Informatics (including Information Technology)

- Review informatics strategies and plans and ensure they are consistent with the Trust's overall vision and strategic goals

- Review plans and proposals for major development and investment in Information Technology, and advise the Trust Board on its alignment to the Trust's overall vision and strategy as well as the financial implications and risks of the proposals

Assurance and Risk

- Assure itself on (i) the identification of principal risks associated with the financial performance and financial management of the Trust, and Information Technology, (ii) the effective management of those risks and (iii) the escalation to the Trust Board of matters of significance

7. Parent Committees and reporting procedure

The Finance Committee is a sub-committee of the Trust Board.

A summary report of each Finance Committee meeting will be submitted to the Trust Board. The Chair of the Finance Committee will present the Committee report to the next available Trust Board meeting

8. Sub-Committees and reporting procedure

The Finance Committee has no standing sub-committees, but may establish fixed-term working groups, as required, to support the Committee in meeting the duties listed in these Terms of Reference.

9. Emergency powers and urgent decisions

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

10. Administration

The minutes of the Committee will be formally recorded and presented to the following meeting for agreement and the review of actions.

The Trust Secretary will ensure that each committee is given appropriate administrative support and will liaise with the Committee Chair on:

- The Committee's Forward Programme, setting out the dates of key meetings & agenda items
- The meeting agenda
- The meeting minutes and the action log

11. Review of Terms of Reference and monitoring compliance

The Terms of Reference of the Committee will be reviewed and agreed by the Finance Committee at least annually, and then formally approved by the Trust Board.

History

- Terms of Reference agreed by Finance Committee, May 2013
- Terms of Reference reviewed and agreed by Finance Committee, May 2014 (with a minor additional to duties agreed at the June 2014 Finance Committee)
- Terms of Reference approved by Trust Board, July 2014
- Terms of Reference (revised) agreed by Finance Committee, June 2015
- Terms of Reference approved by Trust Board, July 2015

Maidstone and Tunbridge Wells NHS
NHS Trust

FINANCE COMMITTEE

Terms of Reference

1. Purpose

The Trust Board has established the Committee to provide the Trust Board~~:~~ with:

- Assurance on the effectiveness of financial management, treasury management, investment and capital expenditure and financial governance
- ~~Assurance on Information Technology, performance and business continuity~~
- An objective assessment of the financial position and standing of the Trust
- Advice and recommendations on all key issues of financial management and financial performance
- Assurance on Information Technology performance and business continuity
- Advice and recommendations on all aspects of informatics, including I~~i~~nformation T~~t~~echnology and telecommunications

Comment [RK1]: I've just re-ordered these to put the 2 IT points together

2. Membership

Membership of the Committee is as follows:

- The Committee Chair - a Non-Executive Director appointed by the Trust Board
- The Committee V~~v~~ice-C~~c~~hair - a Non-Executive Director appointed by the Trust Board
- The Director of Finance
- The Medical Director
- The Chief Operating Officer[1]
- The Chief Executive[1]

Members are expected to attend all relevant meetings.

3. Quorum

The Committee shall be quorate when one Non-Executive Director and two Executive Directors are present. If the Director of Finance cannot attend a meeting, ~~his/her~~ their representative will attend.

For the purposes of being quorate, any Non-Executive Director (including the Chairman of the Trust Board) may be present; and any other Executive Director may be present in place of the Medical Director, should the latter be unable to attend the meeting.

4. Attendance

All other Non-Executive Directors (including the Chairman of the Trust Board) and Executive Directors are entitled ~~welcome~~ to attend any meeting of the Committee.

The Committee Chair may also invite others to attend, as required, to meet the objectives of the Committee.

5. Frequency of meetings

The Committee shall generally meet each month.

6. Duties

The Committee has the following duties:

Financial Management

[1] N.B. Either the Chief Operating Officer or Chief Executive should be present at each meeting

- Review financial plans and strategies and ensure they are consistent with the Trust's overall vision and strategic goals
- Ensure a comprehensive budgetary control framework is in place and operating effectively
- Monitor financial performance against plan, and ensure corrective action is taken where appropriate
- Develop and monitor key financial performance indicators, and advise the Trust Board on action required to improve performance / address risks. ~~-~~Indicators will include:
  - Risk rating and associated financial ratios;
  - Other financial ratios;
  - Service line profitability;
  - Efficiency and productivity measures;
  - Benchmarking information;
- Review and assess the Trust's ~~financial recovery and C~~cost ~~i~~improvement Plan~~programme~~
- Obtain assurance that all Cost Improvement Plan~~rogramme~~ initiatives and business cases have been subject to a Quality Impact Assessment, and to liaise with Quality & Safety Committee as appropriate to ensure the robustness of the process

Treasury Management

- Approve the Trust's detailed treasury management policies, processes and controls
- Approve external funding and borrowing arrangements, including approval of working capital facilities and capital investment loan applications (within delegated authority)~~;~~
- Approve relevant benchmarks for measuring performance e.g. Better Payment Practice Code (BPPC)
- ~~Review and monitor investment and borrowing policy and performance against the relevant benchmarks~~
- Ensure proper safeguards are in place for security of the Trust's funds by~~:~~
  - ~~approving a list of permitted institutions;~~
  - ~~approving investment limits for each permitted institution;~~
  - ~~approving permitted investment types; and~~

    ensuring approved bank mandates are in place for all accounts, which are updated regularly for changes in signatories and authority levels;
- Monitor compliance with treasury management policies and procedures ~~in particular as regards limits, approved counter parties and types of investments~~
- Specify and review detailed treasury reporting requirements~~.~~
- Review ~~regularly~~ the cash flow and balance sheet of the Trust, ensuring effective cash management plans are in place

Capital Expenditure and Investment

- Review the Trust's capital plan ~~programme~~ ensuring its alignment to strategic priorities
- Review and assess the financial implications of the PFI contract for Tunbridge Wells Hospital ~~(a Private Finance Initiative funded facility)~~, including any options for re-financing
- Review major or contentious business cases above the threshold set-out in the Reservation of Powers and Scheme of Delegation, for capital and service development ~~(currently £750k)~~ and advise the Trust Board on the financial implications and risks of the proposals
- Regularly review investment criteria, and the investment appraisal and approval process

Financial Governance, Reporting, Systems and Function

- Review and assess arrangements for financial governance
- Review and agree financial policies
- Ensure financial reporting to Trust Board meets the requirements of the Board ~~and individual members~~
- Review and assess the effectiveness of financial information systems, and agree and monitor development plans, including the development of Service Line Reporting
- Review and assess the capacity and effectiveness of the finance function and ensure development plans are in place to meet the current and future requirements of the Trust (including the requirements of Foundation Trust status)

Comment [RK2]: The proposed amendments reflect the changes to how surplus cash is now managed.

- Assess the organisational awareness and adherence to financial management disciplines and controls and promote congruence between quality patient care and the achievement of financial objectives.
- Review and approval of the Trust's approach to its Reference Cost submission/s

Procurement

- To monitor the Trust's adherence to 'Better Procurement, Better Value, Better Care' metrics
- To approve the Trust's Procurement Strategy, and monitor performance against the Strategy

Informatics (including Information Technology)

- Review informatics strategies and plans and ensure they are consistent with the Trust's overall vision and strategic goals
- Review plans and proposals for major development and investment in information technology, and advise the Trust Board on its alignment to the Trust's overall vision and strategy as well as the financial implications and risks of the proposals

Assurance and Risk

- Assure itself on (i) the identification of principal risks associated with the financial performance and financial management of the Trust, and information technology, (ii) the effective management of those risks and (iii) the escalation to the Trust Board of matters of significance.
  ~~To ensure that the Board Assurance Framework record of these risks and actions is comprehensive and up to date.~~

Comment [RK3]: This point is essentially covered by the point above

7. Parent Committees and reporting procedure

The Finance Committee is a sub-committee of the Trust Board.

A summary report of each Finance Committee meeting will be submitted to the Trust Board. The Chair of the Finance Committee will present the Committee report to the next available Trust Board meeting

8. Sub-Committees and reporting procedure

The Finance Committee has no standing sub-committees, but may establish fixed-term working groups, as required, to support the Committee in meeting the duties listed in these Terms of Reference.

9. Emergency powers and urgent decisions

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

10. Administration

The minutes of the Committee will be formally recorded and presented to the following meeting for agreement and the review of actions.

The Trust Secretary will ensure that each committee is given appropriate administrative support and will liaise with the Committee Chair on:

- The Committee's Forward Programme, setting out the dates of key meetings & agenda items
- The meeting agenda
- The meeting minutes and the action log

11. Review of Terms of Reference and monitoring compliance

The Terms of Reference of the Committee will be reviewed and agreed by the Finance Committee at least annually, and then formally approved by the Trust Board.

History

- Terms of Reference agreed by Finance Committee, ~~:~~ May 2013
- Terms of Reference reviewed and agreed by Finance Committee, ~~:~~ May 2014 (with a minor additional to duties agreed at the June 2014 Finance Committee)
- Terms of Reference approved by Trust Board, ~~:~~ July 2014
- Terms of Reference (revised) agreed by Finance Committee, June 2015
- Terms of Reference approved by Trust Board, July 2015

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - July 2015

7-17 Remuneration Committee Terms of Reference — Committee Chairman

The Terms of Reference of the Remuneration Committee are due their regular review.

The Terms of Reference have therefore been reviewed, and a number of changes are proposed, including a change of name, to the "Remuneration and Appointments Committee".

The revised Terms of Reference were discussed and agreed at the Remuneration Committee held on 24/06/15, and are enclosed, for approval.

Which Committees have reviewed the information prior to Board submission?

- Remuneration Committee, 24/06/15

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
NHS Trust

REMUNERATION AND APPOINTMENTS COMMITTEE

TERMS OF REFERENCE

1. Purpose

In accordance with the Code of Conduct and Code of Accountability[2], a Remuneration and Appointments Committee is constituted by the Trust Board.

2. Membership

- Chairman of the Trust Board (Chairman)
- Non-Executive Directors
- Chief Executive*

* for all elements other than the Chief Executive's remuneration and terms and conditions.

Members are expected to attend all relevant meetings.

3. Quorum

The Committee shall be quorate when the Chairman and 2 Non-Executive Directors are in attendance.

4. Attendance

The following are invited to attend each main meeting:

- Director of Workforce and Communications

Other staff may be invited to attend, to meet the Committee's purpose and duties.

5. Frequency of Meetings

There will be a minimum of two meetings per year.

The Chairman may arrange meetings as required.

6. Duties

6.1 To review, on behalf of the Trust Board, the appointment of Executive Directors and other staff appointed on Very Senior Manager (VSM) contracts, to ensure such appointments have been undertaken in accordance with Trust Policies.

6.2 Review, on behalf of the Trust Board, and at least annually, the remuneration, allowances and terms of service of Executive Directors and other staff appointed on VSM contracts, to ensure that they are fairly rewarded for their individual contribution to the organisation; and by having proper regard to whether such remuneration is justified as reasonable.

6.3 Review, with the Chief Executive, the performance of Executive Directors and other staff appointed on VSM contracts, at least annually.

6.4 To oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments, taking account of such national guidance, as appropriate. Any non-contractual payment to a staff member must be first reviewed and approved by the Committee.

6.5 To consider and approve, on behalf of the Trust Board, proposals on issues which represent significant change, e.g. "Agenda for Change" implementation, Consultant contract/incentive scheme[3].

[2] Department of Health, 1994 (and subsequent revisions)

7. Parent Committee and reporting procedure

The Remuneration and Appointments Committee is a sub-committee of the Trust Board.

8. Sub-committees and reporting procedure

The Remuneration and Appointments Committee has no sub-committees, but may establish fixed-term working groups, as required, to support the Committee in meeting the duties listed in these Terms of Reference

9. Administration

The minutes of the Committee will be formally recorded and presented to the following meeting for agreement and the review of actions.

The Committee will be serviced by administrative support from the Human Resources Directorate.

10. Emergency powers and urgent decisions

The powers and authority of the Remuneration Committee may, when an urgent decision is required between meetings, be exercised by the Chairman of the Committee, after having consulted the Chief Executive. The exercise of such powers by the Committee Chairman shall be reported to the next formal meeting of the Committee, for formal ratification.

11. Review of Terms of Reference

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

History

- Revised Terms of Reference agreed by the Remuneration Committee, 24/06/15
- Revised Terms of Reference approved by the Trust Board, 22/07/15

[3] The Committee will not consider matters relating to individual posts covered under the Agenda for Change national framework, or matters relating to individual medical staff

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - July 2015

7-18	Board Assurance Framework (BAF) 2015/16	Trust Secretary

The Board Assurance Framework (BAF) is the document through which the Trust Board identifies the principal risks to the Trust meeting its agreed objectives, and to ensure adequate controls and measures are in place to manage those risks. The ultimate aim of the BAF is to help ensure that the objectives agreed by the Board are met.

The management of the BAF
The BAF is managed by the Trust Secretary, who liaises with each "Responsible Director" to ensure that the document is updated throughout the year.

Review by the Trust Board
This is the first time during 2015/15 that the Board has seen the populated BAF, following the discussions regarding key risks, objectives and BAF format that were held at the Board meetings April, May and June. Board members are now asked to review and critique the content, by considering the following prompts:

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

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

- Accepting the information as submitted;
- Requesting amendments, to objectives, risks, ratings and/or content;
- Requesting further information on any of the BAF items;
- Requesting that a Board sub-committee review the risks to an objective in more detail

Review by the Audit and Governance Committee
The BAF will also be submitted to the Audit and Governance Committee on 6th August 2015, for detailed review (which reflects the recommended role of Audit Committees). However, the intention is that, where timing allows, the BAF will be reviewed by the Audit and Governance Committee prior to the BAF being submitted to the Trust Board.

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 20/07/15 (objective 4.a only)

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

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

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS
NHS Trust

What is the key risk? [2] *Main risk*

1 "Quality i.e. failure to provide care and treatment within the upper quartile (as recognised by patients, staff and the CQC); and the need to improve the standard of the Trust's clinical governance arrangements"

What does the Trust want to achieve? *Objective*

1.a To provide care & treatment within the upper quartile (as recognised by patients, staff and the CQC)

1.b To improve the standard of the Trust's clinical governance arrangements

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

1. A failure to recognise the improvement required following the CQC inspection in October 2014
2. A failure to adequately monitor care and treatment, and to challenge poor performance
3. A failure to implement the actions within the QIP
4. A failure to identify exactly what changes are needed in relation to clinical governance & culture
5. A failure to respond to current (and future) capacity pressures, resulting in increased potential for poor care and patient experience

What actions have been taken in response? *Controls*

a. A Quality Improvement Plan (QIP) has been developed and improvements are being monitored

b. The Trust's processes for monitoring care and treatment have been strengthened recently (in relation to the processes deployed by the Trust Board, Quality Cttee (including the 'deep dive' meetings) & Patient Experience Cttee)

c. An in-house 'assurance review', to further test compliance, was undertaken on 06/07/15

d. An external review of Governance and Culture has been commissioned

e. Plans to increase inpatient capacity and improve patient flow are being implemented (which will have a positive impact on the ability to provide quality care and patient experience)

Are the actions that have been taken sufficient to achieve the objective at year-end? *Gaps in control*

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No
☐	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐

If "Unsure" or "No", what other actions are planned?

1. A regular programme of in-house monitoring against the CQC standards will be introduced (which is likely to include a mixture of 'assurance reviews' (probably quarterly), desk-top reviews etc.). This will, as far as is possible, aim to mirror the challenges that the CQC will pose during a 'real' future inspection.

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

1. QIP progress reports (to the TME and Trust Board)
2. The agenda, minutes & reports to the TME, Quality Cttee, Patient Exp. Cttee & Trust Board (which includes a wide range of information on quality, incl. patient surveys, SIs, complaints, mortality etc.)
3. Performance report to TME and Trust Board (which is now structured around the 5 CQC domains)
4. Internal Audit "CQC Compliance Review" (due imminently)
5. CQC report re water quality testing (expected soon)

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

If "No", what other data is needed?

1. The data exists but there is a need for improved triangulation of all the data available from various sources

Responsible Director/s	**Committee/s responsible for oversight**
Chief Nurse / Medical Director	Quality Committee / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2015/16? [3]

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Explanation of any "Amber" or "Red" rating:

1. The level of confidence reflects the current position regarding implementation of the QIP and of the plans to increase capacity, plus the need to introduce the programme of in-house monitoring

[2] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future

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

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What is the key risk? [4] *Main risk*

2 Capacity i.e. the need to increase inpatient capacity to cope with rising non-elective demand

What does the Trust want to achieve? *Objective*

2.a To increase inpatient capacity to cope with rising non-elective demand

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

1. Failure to improve the flow of patients, by reducing LOS
2. Failure to implement the Trust's plans, as a result of system-wide issues not improving
3. Failure to recruit to the Trust's workforce establishments

What actions have been taken in response? *Controls*

a. Plans to open a 39-bedded ward at Tunbridge Wells Hospital (TWH) have been approved
b. A System-wide action plan has been developed, following a review by the Emergency Care Intensive Support Team (ECIST), and is overseen by the System Resilience Group
c. An internal Capacity and Flow improvement Plan has been developed
d. A fortnightly recruitment and retention group (Chaired by the Chief Nurse / Director of Workforce and Communications) will oversee progress against recruitment plans
e. Winter & operational resilience plans are being finalised

Are the actions that have been taken sufficient to achieve the objective at year-end? *Gaps in control*

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No
☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If "Unsure" or "No", what other actions are planned?

1. The new Ward at TWH is not scheduled to open until January 2016 (but progress with the development will be monitored via a fortnightly review group (chaired by the Chief Operating Officer)

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

1. There will be monthly reporting of progress to the Trust Management Executive
2. The Outline/Full Business Case (OBC/FBC) for the new ward at TWH (reviewed at Finance Committee / Board)
3. Updates are reported to the Trust Board (including LOS / Delayed Transfers of Care)

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

If "No", what other data is needed?

1. N/A

Responsible Director/s	**Committee/s responsible for oversight**
Chief Operating Officer	Trust Management Executive / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2015/16? [5]

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Explanation of any "Amber" or "Red" rating:

1. There are still some unknowns in terms of the new Ward development (i.e. building works have not yet commenced)
2. There is little evidence to date of the system-wide improvements that are required

[4] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future
[5] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What is the key risk? [6] *Main risk*

3 Staffing i.e. the need to reduce reliance on temporary staff and have the appropriate skill-mix

What does the Trust want to achieve? *Objective*

3.a Reduce the reliance on temporary staff

3.b To ensure the appropriate skill-mix of staff across the Trust

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

1. Failure to recruit to clinical vacancies
2. Failure to reduce / remove the agreed number of escalation beds within the Trust
3. Failure to reduce Length of Stay
4. Failure to utilise the existing workforce effectively
5. Lack of regular reviews of clinical skill mix

What actions have been taken in response? *Controls*

a. Trust Recruitment Plan – increased activity
b. Nurse Recruitment and Retention Group
c. Development of TWH New Ward Business Case
d. Increased recruitment staffing resource
e. NTDA Sponsored staffing toolkit
f. Nursing, Medical and Back Office CIP
g. Bi-annual Chief Nurse Staffing Assurance Reports
h. Workforce Strategy 2015-20
i. New ways of working task and finish group

Are the actions that have been taken sufficient to achieve the objective at year-end? *Gaps in control*

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No
☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If "Unsure" or "No", what other actions are planned?

1. Medical Director Staffing Assurance Report
2. Introduction of 'refer a friend' recruitment payment for agreed clinical posts
3. Development of new roles

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

1. Trust Board reports and minutes
2. Workforce Committee reports and minutes
3. Trust Management Executive reports and minutes

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

If "No", what other data is needed?

1. N/A

Responsible Director/s
Director of Workforce and Communications

Committee/s responsible for oversight
Workforce Committee

How confident is the Responsible Director that the objective will be achieved by the end of 2015/16? [7]

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
		☒									

Explanation of any "Amber" or "Red" rating:

1. The national shortage of qualified nursing staff; Home Office visa restrictions / government drive to reduce immigration; and system-wide failure to reduce increasing demand on acute services constrain the Trust ability to eradicate the risk in 2015/16

[6] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future
[7] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What is the key risk? [8] *Main risk*

4 Finances i.e. the need to deliver the financial plan for 2015/16

What does the Trust want to achieve? *Objective*

4.a To deliver the financial plan for 2015/16

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

1. Failing to deliver the required income levels across all contracts
2. Failure to contain costs within the budgets allocated
3. Failure to deliver the CIP programme in full
4. Not receiving full payment for patient activity performed
5. Impact of increased emergency activity through the winter period
6. Failure to mitigate reliance on temporary staffing (and Agency staffing in particular)

What actions have been taken in response? *Controls*

a. The cash flow forecast is reviewed on a weekly basis
b. Directorates are subject to Executive scrutiny
c. Weekly CIP Executive performance reviews
d. There is comprehensive reporting of the financial position to the Executive Team, TME, the Finance Committee and Trust Board
e. The main contract for 2015/16 with West Kent CCG was agreed in March (at the levels required to maintain the Trust's financial performance)
f. The Winter & Operational Resilience Plan has been strengthened in response to the previous winter
g. Action is underway to limit the Trust's use of non-Framework staffing Agencies

Are the actions that have been taken sufficient to achieve the objective at year-end? *Gaps in control*

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No
☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If "Unsure" or "No", what other actions are planned?

1. A Temporary Staffing working group has been set up, and an action plan is being constructed, which will be monitored through the weekly Executive Team meetings

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

1. Reporting of year to date financial performance
2. Agenda, reports and minutes of the Finance Committee, TME and Trust Board
3. External audit of accounts ('Value for Money' conclusion)
4. Internal audit reviews: "Financial Accounting and Non Pay" (Reasonable Assurance); "Budgetary Control" (Reasonable Assurance) "Payroll" (scheduled for Q3)
5. The winter and operational resilience plan (reviewed by the Trust Board in May 2015)

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

If "No", what other data is needed?

1. N/A
2. N/A

Responsible Director/s	**Committee/s responsible for oversight**
Director of Finance	

How confident is the Responsible Director that the objective will be achieved by the end of 2015/16? [9]

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Explanation of any "Amber" or "Red" rating:

1. The financial position is behind plan at the end of Quarter 1. Achieving the financial plan is contingent on the control and reduction of temporary staffing expenditure

[8] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future
[9] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What is the key risk? [10] *Main risk*

5 Culture i.e. the need to enhance and sustain a high-performing culture

What does the Trust want to achieve? *Objective*

5.a To enhance and sustain a high-performing culture

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

1. Dependence on temporary staffing
2. Staff non-alignment to Trust vision and values
3. Reputational damage from corporate manslaughter prosecution
4. Inconsistent and disjointed leadership
5. Staff morale resulting from national changes to terms and conditions of employment
6. Loss of key staff and lack of succession planning

What actions have been taken in response? *Controls*

a. Workforce Strategy 2015-2020
b. Development of integrated leadership development programmes.
c. Introduction of living our values programme
d. Increased staff engagement activity
e. Independent review of governance
f. Trust Recruitment Plan – increased activity
g. Improved recognition – monthly awards

Are the actions that have been taken sufficient to achieve the objective at year-end? *Gaps in control*

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No
☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If "Unsure" or "No", what other actions are planned?

1. N/A

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

1. Trust Board reports and minutes
2. Workforce Committee reports and minutes
3. The Workforce Risk Register
4. Trust Management Executive reports and minutes
5. National Staff and Patient Surveys
6. Friends and Family Test (FFT) Scores

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

If "No", what other data is needed?

1. The development of an MTW culture barometer is required

Responsible Director/s	**Committee/s responsible for oversight**
Director of Workforce and Communications	Workforce Committee

How confident is the Responsible Director that the objective will be achieved by the end of 2015/16? [11]

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Explanation of any "Amber" or "Red" rating:

1. Culture change takes 5 to 10 years to materialise. The Trust has an ambitious Workforce Strategy and supporting implementation plan which will drive improvements in the culture over the next five years – dependent upon resources being made available.

[10] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future
[11] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What is the key risk? [12] *Main risk*

6 Strategy i.e. the need for an updated cohesive strategy to deal with the instability and uncertainty in the wider health economy

What does the Trust want to achieve? *Objective*

6.a To develop a cohesive strategy to deal with the instability and uncertainty in the wider health economy

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

1. Competing priorities and operational pressures
2. Failure to broker agreed models and ways forward
3. Policy decisions, e.g. aspects of financing
4. External factors and instability in other organisations

What actions have been taken in response? *Controls*

a. Clear Board commitment and ownership
b. Active and continuing process of engagement
c. Close and transparent joint working with national organisations
d. Active scenario planning and engagement

Are the actions that have been taken sufficient to achieve the objective at year-end? *Gaps in control*

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No
☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If "Unsure" or "No", what other actions are planned?

1. The greatest area of uncertainty relates to broader strategic thinking
2. Opportunities to shape and influence thinking
3. Scenario planning to generate MTW views

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

1. Regular updates and briefings to the Trust Board (and Trust Management Executive)
2. Interaction with regulators and other national organisations, including formal feedback
3. Agreement of clear strategic direction, supported by partners

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

If "No", what other data is needed?

1. N/A
2. N/A

Responsible Director/s	**Committee/s responsible for oversight**
Deputy Chief Executive	Trust Management Executive / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2015/16? [13]

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Explanation of any "Amber" or "Red" rating:

1. The greatest risks lie in factors beyond the Trust's direct control –continuing external engagement and influencing will be crucial.

[12] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future
[13] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2015/16

Maidstone and Tunbridge Wells NHS Trust

What is the key risk? [14] *Main risk*

8 Senior workforce i.e. the need to ensure effective succession planning for key critical posts, to ensure the continual development of the Trust and its services

What does the Trust want to achieve? *Objective*

8.a To ensure there is effective succession planning for key critical posts

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

1. National Terms and Conditions of employment
2. Business needs - i.e. the ability to release staff for development opportunities
3. Individual aspirations to take-up critical roles
4. Insufficient talent for key critical roles
5. Reduction in training resources

What actions have been taken in response? *Controls*

a. Workforce Strategy 2015-20
b. Executive Team Succession Planning Meeting
c. Annual appraisal and Personal Development Plans
d. Review of 2014/15 earnings for key roles
e. Scoping of the implementation of local senior manager pay (SMP)

Are the actions that have been taken sufficient to achieve the objective at year-end? *Gaps in control*

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No
☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If "Unsure" or "No", what other actions are planned?

1. N/A

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

1. Workforce Committee reports and minutes
2. Trust Board reports and minutes

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

If "No", what other data is needed?

1. N/A

Responsible Director/s	**Committee/s responsible for oversight**
Director of Workforce and Communications	Workforce Committee

How confident is the Responsible Director that the objective will be achieved by the end of 2015/16? [15]

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Explanation of any "Amber" or "Red" rating:

1. The Trust will have in place a succession plan for critical roles within the organisation. However issues with supply (attraction and existing organisational talent) and development time will mean that the full implementation and assurance against each critical role will take time to deliver.

[14] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future
[15] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - July 2015

7-19 Health and Safety Annual Report 2014/15 Chief Operating Officer

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

- Discuss and agree the Trust's health and safety objectives
- Agree the work programme for 2015/16
- Formerly delegate the management to the Health and Safety Committee.

This annual report provides:

- A review of the Trust's Health and Safety performance for 2014/15
- Assessment against objectives and KPIs set in the previous year
- Discussion of the key health and safety issues identified within the year
- Discussion document for the Board to determine the objectives and KPIs for 2015/16
- Identifies the strategy and action plan for the next year and going forward

Our data shows that circa 20% of reported injuries relate to staff, contractors and visitors and 80% relate to patients. There are many programmes and initiatives focused on patient safety so this report concentrates on issues relating to staff safety only.

The Trust Health and Safety Policy has been revised (the HSE recommends annual review). Please see the enclosed synopsis form. The Policy was approved by the Health and Safety Committee and reviewed by the Policy Ratification Committee (PRC). The PRC recommended the Policy be ratified, but as the HSE advise that the Board should lead on health and safety, it would expect the Board to ratify the policy. Ratification is therefore requested.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

- To review and discuss the Annual report and Programme
- To agree the programme for 2015/16
- To delegate the management of the programme to the Health and Safety committee.
- To ratify the revised Trust Health and Safety policy

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

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Health and Safety – Annual Board Report and Programme for 2015/16

Requested/ Required by: Trust Board and the Quality and Safety Committee

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

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

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

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

Division: Corporate Quality and Governance

Specialty: Quality and Governance

Health and Safety – Annual Board Report and Programme for 2015/16

Requirement for document:	This annual report and programme is: • A review of the Trust's health and safety statistics and performance for 2014/15. • Assessment against objectives and KPI's set in the previous year. • Discussion of the key health and safety issues identified within the year. • Discussion document for the Board to determine the objectives and KPI's for 2015/16. • Identifies the strategy and action plan for the next year and going forward.
Cross references:	This report is in response to key health and safety legislation enacted under the Health and Safety at Work etc Act 1974. This report is supported by the Trust's key policies and procedures: • Maidstone and Tunbridge Wells NHS Trust. Health and Safety Policy. • MTW Risk Management Policy and Strategy.

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

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1. Executive Summary

Introduction

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

- Discuss and agree the Trust's health and safety objectives
- Agree the work programme for 2015/16
- Formerly delegate the management to the Health and Safety Committee.

This annual report provides:

- A review of the trust's health and safety statistics and performance for 2014/15.
- Assessment against objectives and KPI's set in the previous year.
- Discussion of the key health and safety issues identified within the year.
- Discussion document for the Board to determine the objectives and KPI's for 2015/16.
- Identifies the strategy and action plan for the next year and going forward.

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

Highlights

- Good progress has been made and the majority of the intended programme was completed.
- There was a conscious effort to improve reporting this year and there was a 13% increase compared to last year.
- This also resulted in a 13.5% increase in reported staff injuries and a significant increase in RIDDOR injuries. There was a significant increase in 7 day injuries (6 to 25). However, there was a decrease in specified injuries (12 to 6) and in dangerous occurrences (3 to 1). The reduction in the more serious injuries combined with an increase in the lesser injuries suggests that the level of reporting has improved.
- Falls account for about 15% of all staff injuries. The number of staff falls has changed little this year. The data for the last 4 years is showing an average of about 60 per year which is within the normal range based on the number of employees.
- Injuries from violence accounts for about 14% of all staff injuries. The data shows a small decrease of 5% this year. This is the same reduction as the previous year.
- Moving and handling account for 15% of staff injuries. Last year there was a significant 48% drop in moving and handling injuries and this could not be explained. This year there has been an increase of 51% and numbers are similar to previous years. There was likely under reporting in 2013/14 as it is not believed or demonstrated that there has been a fall in safety standards this year.
- Injuries from medical sharps at 28% account for the largest cause of all injuries to staff. Although there has not been a significant reduction in injuries we have been actively promoting reporting and reclassifying incidents coded as no harm events.
- The medical sharps task and finish group undertook a study of every injury in the previous 18 months. This produced a data set which the group analysed. The detailed findings will be shared with staff which should improve work planning and reduce injuries. The Trust purchases about 2 million medical sharps last year. We increased the proportion of safety sharps from 40% to 80%.
- The Trust has maintained a low occurrence of occupational ill health. The gap in Datix reporting for work-related stress remains high, compared to what is reported through Occupational health. Staff referred to occupational health for work related stress are not reporting the event through Datix. Therefore there is no record of an investigation and trends are not identified, though the level or work related stress remains constant from the previous year.

Health and Safety Executive

- Health is not considered a high risk injury so the HSE will not undertake proactive inspections or visits. However, they will undertake reactive visits based on intelligence.
- There have been no HSE visits, investigations or enforcement notices this year.
- The Trust was prosecuted following a patient burn in 2012 with a total cost of £256,200 (including fine, costs and fees for intervention.

Programme of Work

Objectives and a programme of work have been suggested by the Trust's Officers in section 11.

2. Introduction

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

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

For several years the Trust has been recording staff injury statistics. These have included contractors and visitors. These only make up about 25% of the total injuries which is dominated by patients. These have been divided into groups based on severity:

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

The injuries have been divided into 7 types based on the categories used by the HSE in their national statistics. About 98% of the total injuries fit into these categories. This allows for bench marking against all industry and the health sector:

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

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

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

3. Review of Objectives and Programme set for 2014/15

In July 2014 the Trust Board agreed a programme for 2014/15:

Action	Leads	Progress and Comments
Health and Safety Management		
Ensure that all Clinical and high risk departments have completed H&S Audits.	Trust H&S advisor E&F H&S advisor Risk Manager	Audits have been completed for all departments identified (total of 142). At the end of March 2015 88% of the Trust was fully compliant, 11% were amber and only one department was non-compliant (red). Progress is monitored by the H&S committee.
Ensure that the annual reviews of H&S Audits are completed.		
Significantly improve compliance through the audit scores.		
Health and Safety Management		
Initiate a program of audits of the documents uploaded to the H&S audit software.	Trust H&S advisor	A program of ward visits has been established to review their risk assessments and procedures. All wards will be audited each year.
Falls		
Continue with awareness and training to further reduce staff falls.	Falls Prevention Practitioner	Falls has been included in the H&S update training. This is provided face to face every 3 years. An e-learning package is provided for other times.
Implement the tool box talks for domestic staff following departmental reorganisation.	Domestics Managers	Talks are regularly provided for domestic staff.
Violence and abuse		
Complete a training needs analysis to ensure that each staff group receives the correct training to reduce their risk of injury.	Trust LSMS	Training need analysis was completed. Deliver CRT on induction and include managing difficult and challenging behaviour.
For each staff group to achieve the required target for Violence and abuse training.	Trust LSMS	CTR training at 69% against a target of 85%. This is a small improvement on the previous year (65%).
Discuss the implications of the Webley case and make recommendations.	Trust LSMS	Recommendations made including : • Physical restraint training for security, porters and front line nursing. • Review of mental health training for porters and security staff. • The provision of a section 136 room in A&E on each site.
Moving and Handling		
Review all patient handling generic risk assessments and safe systems of work This will be over a 2 year cycle.	M&H Co-ordinator	Patient handling generic risk assessments have been reviewed on a priority basis. The oldest, those that have changed and the most commonly used were reviewed first. 60% of assessments have been reviewed so we are ahead of the 2 year schedule.
Need to develop a risk assessment and safe system of work for Spinal handling.	M&H Co-ordinator	Completed a training risk assessment and training programme established. Spinal handling is being included in each patient handling generic assessment. This will be completed as part of the 2 year assessment review.1 spinal handling training session is delivered each month. MTW is a pilot Trust for the South and share the programme with other Trusts.
Extend spinal handling training to A&E at Maidstone.	M&H Co-ordinator	Completed – Moving forward A&E will include staff in the enhanced training that includes spinal handling.
Develop the “At-Learning” system to	M&H	“At-Learning” can not be used as a

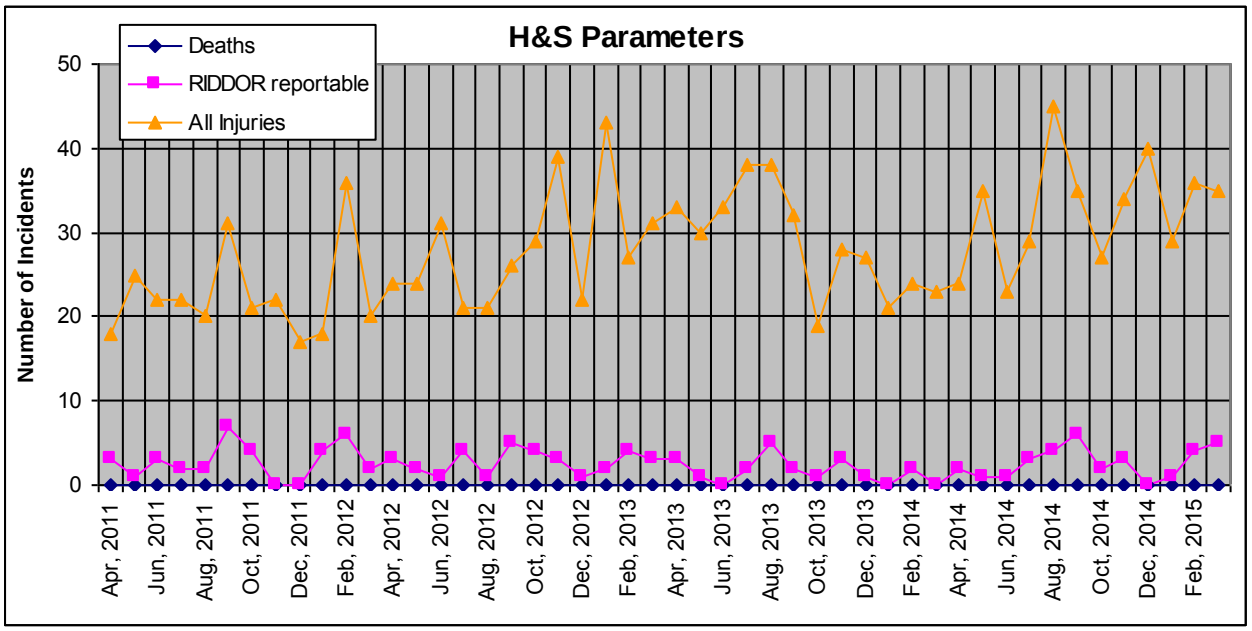
Action	Leads	Progress and Comments
become database of training and competency evidence	Co-ordinator	database for competency and training evidence. The Deputy Director of Estates and Facilities has developed a database to record training and competency evidence.
Sharps		
Will re-launch the sharps task and finish group to: • Address the unacceptable number of sharps injuries and dangerous occurrences. • Investigate effect of safety sharps.	Risk Manager Occupational Health Manager. IV Access Educator.	Group launched and undertook a study of all injuries for 18 months. Reported findings to H&S committee. Issued a special edition of the Governance Gazette. Produced a power point presentation and will share with all clinical staff.
Continue to review the injuries that occur to examine the causative factors & actions.		
Sharps		
Review and standardise blood gas syringes across the trust	Vascular Access Specialist Practitioner	Delayed by departure of the IV Access Educator. Review is in progress with A&E Nurse Consultant. Trials will begin this summer.
Occupational Health		
Increase awareness of the need to report work place stress and other ill health events on Datix via a safety alert.	Occupational Health Manager.	OH Staff are aware of the need to remind staff and managers of the need to report work place stress
Increase awareness of the need to report work place stress and other ill health events on Datix via H&S training.	Training and Development	Need to report is emphasised in refresher training. However, this is now every 3 years.
Encourage staff and there managers to report work related stress and other ill health events through Datix.	Occupational Health Department	OH Clinicians discuss stress risk assessments and the need to report work place stress

4. Statistics for 2014/15

The datix incident database was interrogated on the 9th April 2015 for all non-patient injuries.

Injuries

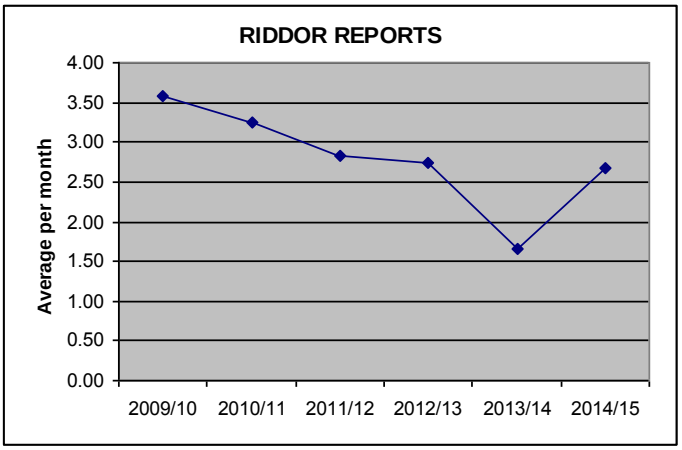
The data for 2014/15 has been compared with the data from previous 2 years.

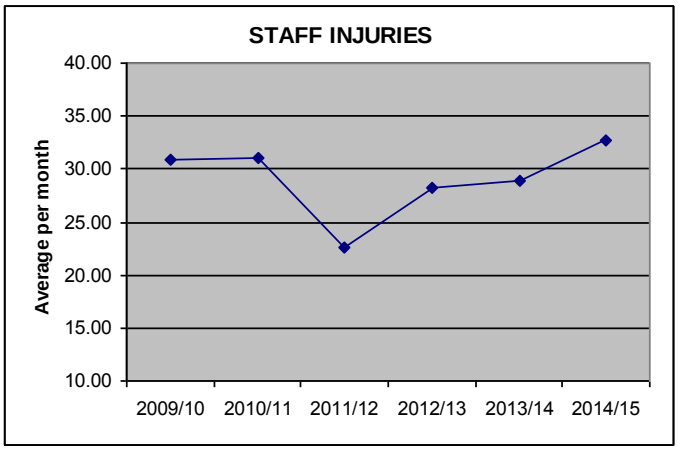


The Trust submitted 32 RIDDOR reports in the year at an average of 2.67 per month. This is a significant increase from 1.67 the previous year.

However, the numbers are similar to the 2 preceding years. The dip last year was not fully explained and could be a result of underreporting. A conscious effort has been made to increase reporting this year.

There was a significant increase in 7 day injuries (6 to 25). However, there was a decrease in specified injuries (12 to 6) and in dangerous occurrences (3 to 1). The reduction in the more serious injuries combined with an increase in the lesser injuries suggests increased reporting.





There was 392 staff injuries (an average of 32.7 injuries per month). This compares with an average of 28.8 for the previous year. This is an increase of 13.5%. This could also be a result of increased reporting.

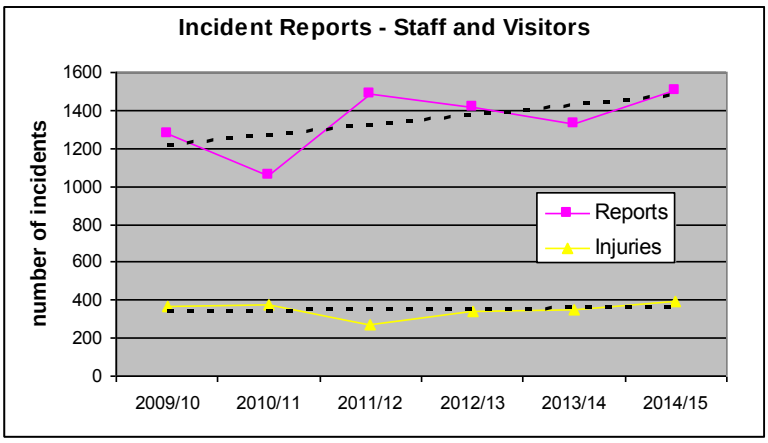
Many sharps incidents were reclassified as injuries giving a higher figure than in previous years.

There have been no Deaths.

Reporting

There were 1505 non-patient incidents reported in 2014/15. This is a 13% increase on the previous year. A conscious effort was made to increase reporting this year.

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



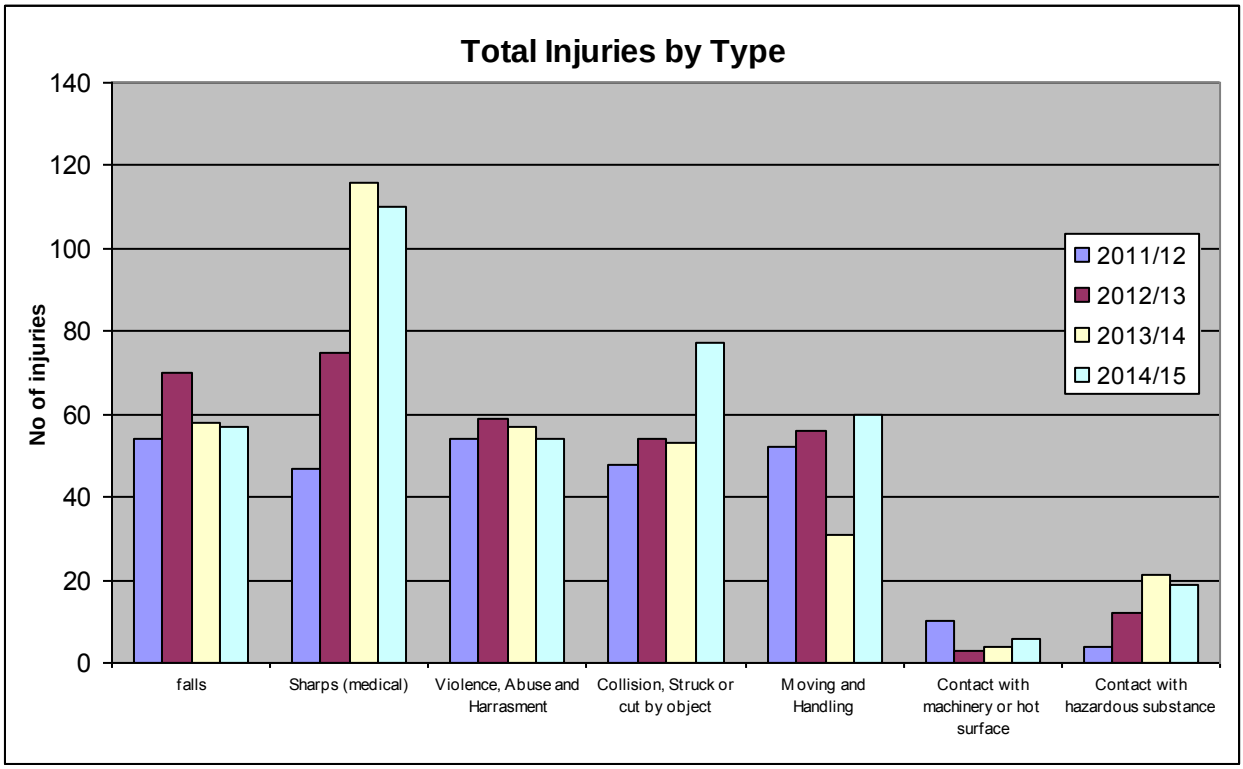
The total number of injuries has remained steady while incident reporting shown an upward trend.

Categories of Incidents resulting in injury

The seven largest categories make up 98% of all staff injuries.

Three have increased.
Two have shown a decrease.
Two are unchanged.

	2013/14	2014/15 Injuries		Change
Falls	58	57	15%	⇔
Sharps (medical)	116	110	28%	⇔
Violence, Abuse and Harrasment	57	54	14%	↓
Collision, Struck or cut by object	53	77	20%	↑
Moving and Handling	31	60	15%	↑↑
Contact with machinery or hot surface	4	6	2%	↑
Contact with hazardous substance	21	19	5%	↓
cuts non-medical sharps		8	2%	
Others	6	1	0%	
	346	392	100%	↑



Occupational Ill Health

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

ILL HEALTH	2014/15	2014/15	2014/15
Skin and dermatitis	3	1	0
Work related stress	0	0	0
Occupational respiratory disease	0	0	0
Enviromental causes of ill health	1	0	1
	4	1	1
Others (not occupational)	1	2	1
	5	3	2

5. Benchmarking

Accident Rates

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

All industries (2013/14)	Death	0.44	per 100,000 employees
Health sector (2013/14)		0	
MTW (2014/15)		0	
All industries (2013/14)	All RIDDOR injuries	305	
Health sector (2013/14)		436	per 100,000 employees
MTW (2010/11)	All RIDDOR injuries	**721**	per 100,000 employees
MTW (2011/12)		**585**	
MTW (2012/13)		**383**	
MTW (2013/14)		**232**	
MTW (2014/15)		**329**	

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

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

Trust	Total RIDDOR Injuries	Employees	Injury Rate (per 100000 employees)	
MTW	32	9735*	**329**	2014/15
Epsom and St Helier University Hospital NHS Trust	50	4404	**1135**	2013/14
Royal Marsden Hospital	12	4500	**267**	2013/14
Western Sussex Hospitals NHS Trust	23	6500	**354**	2013/14
Ashford & St Peters Hospital NHS Foundation Trust	10	3300	**303**	2013/14
Acute and Community Trust 1	24	3606	**665**	2013/14
Acute and Community Trust 2	36	7210	**499**	
St Anthony's Hospital (Private)	1	700	**143**	2013/14
Benenden Hospital (Private)	2	358	**559**	2013/14
Mental Health Trust 1	42	5400	**778**	2013/14
Mental Health Trust 2	70	6000	**1167**	2013/14

Our injury rate compares well against the national rate for health care organisations. However, mental health and ambulance trusts have much higher rates than acute trusts and this increases the average.

The Trust also compares well against other acute Trust's.

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

6. Key Health and Safety Areas

6.1 Falls

Falls account for about 15% of all staff injuries. The number of staff falls has decreased this year by less than 2% to 57. The data for the last 4 years is showing an average of about 60 per year. This is not high for 9,700 employees and achieving a significant reduction is unlikely.

To verify this, an analysis of last years staff and visitors falls will be undertaken. This will look at root causes and trends.

6.2 Violence and Abuse

Injuries from violence accounts for about 14% of all staff injuries. The data shows a small decrease of 5% this year. This is the same reduction as the previous year.

Two of the three violence and abuse actions in the 2013/14 programme were completed. However, training is still a challenge.

In February 2014 there was a judgement on a case (Webley v St.George's Hospital). A sectioned patient was taken in to an A&E department by the police who subsequently left. The patient absconded and suffered a severe injury. The judgement stated that the A&E hospital was responsible for the patient and legal penalties resulted. This has been reviewed and recommendations made:

- Considering physical restraint training for security, porters and front line nursing.
- Review of all training for porters and security staff around the mental health act.
- The provision of a secure room (section 136 room) for patients sectioned under section 136 of the mental health Act in A&E on both sites

The Trust has a working agreement with the Kent police for handling mental health patients. We are a member of the steering group and working on a joint protocol

6.3 Moving and Handling

Last year there was a significant 48% drop in moving and handling injuries and this could not be fully explained. This year there has been an increase of 51% and numbers are similar to previous years.

There was probably under reporting in 2013/14 and it is not believed that there has been a fall in safety standards this year. Moving and handling account for 15% of staff injuries.

Introduced a combined falls/moving and handling course in association with the falls coordinator. This covers the handling of patients with complex injury following falls. Two sessions per month are planned with a spinal handling course each month. This has increased risk awareness in all staff and promotes best practise to prevent further injury following falls.

This year we purchased new equipment for lifting fallen patients:

- Ferno-scoops and hover jacks allow patients to be lifted and transferred to a bed.
- Attachments to allow fallen patients to be scooped and hoisted.

The Trust also purchased Bariatric simulation suits to assist with training. This allows staff to think about and plan for the care of bariatric patients.

6.4 Sharps

Injuries from medical sharps accounts for about 28% of all injuries to staff and is the easily the largest cause. There was no significant reduction in injuries, however, we have been actively promoting reporting and reclassifying incidents coded as no harm events.

The medical sharps task and finish group was reformed. The group undertook a study where every injury in the previous 18 months was reviewed. Questionnaires were sent to all injured staff to obtain their views on the incidents. This produced a data set which the group tidied (standardised on various types of sharp, staff groups, root causes etc). A full analysis was then carried out on the dataset.

A report was produced detailing the findings. An awareness campaign was then initiated to share the findings with all Trust staff. A special edition of the Governance Gazette was published. A power point presentation has been prepared. Posters, banners and cards are being designed.

The Trust purchases about 2 million medical sharps each year. We increased the proportion of safety sharps from 40% to 80% over the year. This has not reduced the number of injuries; however, only 20% of the injuries were from safety sharps. The remaining conventional sharps include suture needles and scalpels (over 7%) where a safety alternative is not yet available. The HSE will visit Trusts with the lowest uptake of safety sharps in 2015/16.

The Vascular Access Specialist Practitioner has continued to train all new staff, where appropriate in venepuncture, Cannulation, blood cultures and venous access devices.

6.5 Eye Splash Injury

Following a report that was tabled at the Health and Safety Committee on 3rd March 2015 into eye splash related staff injuries, a task and finish group has been established to look at eye splash injury. This is led by the Risk Lead for Critical care and focuses on eye splash injuries in Theatres and Maternity.

The group is looking at eye protection available, raising staff awareness in high risk areas and the possible introduction of eye protection zones and making eye protection compulsory for some procedures.

6.6 Occupational Ill Health

Occupational ill health is identified and reported by the Occupational health department. Only 1 incident of occupational ill health was reported on Datix and this was following exposure to cleaning materials. There were no reported cases of respiratory disease, work related stress or dermatitis. The cases have reduced over recent years.

Actions identified in previous years have continued:

- Increasing awareness through ongoing induction and refresher training and information leaflets.
- All staff referred to/attending occupational health are advised to report accidents.
- All staff complete skin questionnaires on commencing employment.
- Encourage skin assessments through training.
- Encourage early self-referral.
- Continued to promote best practice, policy and procedures regarding occupational illness.
- Continue to deliver stress awareness training for staff to improve self help and early identification of stress to enable timely intervention and support

New actions introduced;

- Working with Infection Control to look at adding regular skin surveillance to hand hygiene audits to increase awareness and early identification of potential cases
- OH is working to deliver “Creating a Mentally Healthy Workplace” training package for managers to better support managers and equip them to support staff to remain resilient in work.

Hence occupational illness remains low and effectively managed.

There were no cases of occupational stress recorded on Datix. However, Occupational Health Department recorded 42 referrals for work related stress (63% of all referrals). These were not reported on Datix and therefore there is no record of an investigation. It is also not possible to determine trends and causes. This is a reduction over the previous year but still a concern. The most common reasons given are increased workloads accompanied with reduced resources.

These events need to be recorded on Datix and properly investigated. An awareness campaign will be initiated and Occupational Health will encourage staff to report.

7. Health and Safety Executive Inspections and Investigations in 2013/14

7.1 Trust Inspection

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

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

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

Prosecuted by HSE	Prosecuted by CQC
Medical sharps (staff)	Medical sharps (patients)
Falls (staff)	Falls (patients)
Falls (visitors)	Falls from windows

7.2 Investigation Visits

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

7.3 Patient Burn Investigation

In October 2012 the HSE visited the Trust to undertake an investigation in to a patient burn. This was reported under RIDDOR as a “Major Injury”. The burn was from a warming blanket called the “hot dog”. Two inspectors made several visits to the Trust and took signed statements form many staff. This involved massive disruption and lost theatre staff time.

Our own investigation has shown that the hot dog safety devices can fail under certain circumstances and hence it is a design fault with the equipment. However, as a result of a lack of documentary evidence for training or risk assessment, the Trust was prosecuted and pleaded guilty. In December 2014 the Trust was sentenced; £174,970 fine and costs. Trust also charged £86,100 under fees for intervention. Total cost £256,200.

7.4 HSE Priorities, Projects and Targets

In April 2015 the Principal Inspector for Kent presented the HSE’s Priorities, Projects and Targets for 2015/16.

- Late reporting under RIDDOR – they will seek information on all late RIDDOR reports. MTW last year had 32 RIDDORS of which 5 were late (84% compliant). A late report is a technical breech so any visits will be automatically charged under FFI.
- Insufficient competent H&S assistance – There is concern that Trust Boards do not employ sufficiently qualified H&S staff. For a Trust the size of MTW with 2 major sites they would expect to see 2 advisors suitably qualified to achieve chartered membership of the institute of occupational safety and health (CMIOSH). Acute Trusts in Kent has been issued with notices. Proper funding of H&S teams is seen as evidence of commitment to H&S. They will also wish to see all senior managers having a H&S KPI on their job descriptions.

- Safer Sharps – The HSE is gathering data from safety sharps suppliers to ascertain what proportion of their sharps are safety sharps. In 2014/15 we increased our usage from 40%to 80% safety sharps. A further 7% are suture needles and scalpels which do not have safety versions. The HSE will visit the worst performing trusts.
- And 4 Estates and Facilities issues:
    - Control of Contractors – this follows revised CDM regulations.
    - Electrical risk.
    - Lifting equipment and operations (LOLER 98) – may include patient hoists.
    - Asbestos – continues from last year.

8. Health and Safety Legislation

8.1 The Construction Design and Management regulations 2013 (CDM 13).

The Construction Design and Management regulations were revised from 6th April 2015 (CDM 2015). There will be a 6 month transition. Estates Directorate are aware of these changes.

8.2 Fees For Interventions (FFI)

Fees for FFI have increased to £124 per hour. Invoices must be paid within 30 days. The HSE nationally has issued about 16,800 FFI invoices totalling about £10.8 million (average £640 per invoice).

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9. Summary and Conclusions

Good progress has been made and the majority of the 2014/15 programme was completed.

There was a conscious effort to increase reporting this year and there was a 13% increase. This also resulted in a 13.5% increase in reported staff injuries and a significant increase in RIDDOR injuries. There was a significant increase in 7 day injuries (6 to 25). However, there was a decrease in specified injuries (12 to 6) and in dangerous occurrences (3 to 1). The reduction in the more serious injuries combined with an increase in the lesser injuries suggests increased reporting.

<u>Falls</u>

Falls account for about 15% of all staff injuries. The number of staff falls has changed little this year. The data for the last 4 years is showing an average of about 60 per year. This is not high for 9,700 employees and achieving a significant reduction is unlikely.

<u>Violence and abuse</u>

Injuries from violence accounts for about 14% of all staff injuries. The data shows a small decrease of 5% this year. This is the same reduction as the previous year.

The Webley case (Webley v St.George's Hospital 2014) has been considered and recommendations made:

- Considering physical restraint training for security, porters and front line nursing.
- Review of all training for porters and security staff around the mental health act.

- The provision of a secure room (section 136 room) for patients sectioned under section 136 of the mental health Act in A&E on both sites.
- The Trust has a working agreement with the Kent police for handling mental health patients.

Moving and Handling

Last year there was a significant 48% drop in moving and handling injuries and this could not be fully explained. This year there has been an increase of 51% and numbers are similar to previous years.

There was probably under reporting in 2013/14 and it is not believed that there has been a fall in safety standards this year.

Sharps

Injuries from medical sharps accounts for about 28% of all injuries to staff and is the easily the largest cause. There was no significant reduction in injuries, however, we have been actively promoting reporting and reclassifying incidents coded as no harm events.

The medical sharps task and finish group undertook a study of every injury in the previous 18 months. This produced a data set which the group analysed. The detailed findings will be shared with staff which should improve work planning and reduce injuries.

The Trust purchases about 2 million medical sharps last year. We increased the proportion of safety sharps from 40% to 80% over the year. This has not reduced the number of injuries; however, only 20% of the injuries were from safety sharps. The remaining conventional sharps include suture needles and scalpels (over 7%) where a safety alternative is not yet available. The HSE will visit Trusts with the lowest uptake of safety sharps in 2015/16.

Occupational Ill Health

Incidences of occupational illness remain low and effectively managed.

41 staff were referred to occupational health department for work related stress, 29 referred with a combination of work and personal stress. This has remained relatively constant on the previous year and as such still a concern.

These events need to be recorded on Datix and properly investigated in order to better target workplace interventions. Awareness has been raised of the need to report and better support staff to remain in work and Occupational Health continue to encourage staff to report. Health and Wellbeing initiatives are being developed to target stress at work and enable staff to become more resilient.

The Health and Safety Executive

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

In October 2012 the HSE visited the Trust to undertake an investigation in to a patient burn. Because of a lack of documentary evidence for training or risk assessment, the Trust was prosecuted and pleaded guilty. In December 2014 the Trust was sentenced; £174,970 fine and costs. Trust also charged £86,100 under fees for intervention. Total cost £256,200.

10. Objectives for 2015/16

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
Health and Safety Management (Health and Safety Advisor)					
Ensure that all Clinical and high risk departments have completed their annual review of H&S Audits.	All departments to have completed an audit by August 2014.	H&S advisor	Risk Manager	Progress will be monitored by lead and reported to the H&S committee.	Will monitor audits that have expired.
Embed the program of audits of the documents uploaded to the H&S audit software.	Will complete the annual program of Ward and department visits.	H&S advisor	Risk Manager	Progress will be monitored by lead and reported to the H&S committee.	To be developed.
Falls (Falls Prevention Practitioner)					
Continue with awareness and training to further reduce staff falls.	(The focus of the falls team is on reducing Patient falls)	Falls Prevention Practitioner	H&S Advisor (E&F) Trust H&S Advisor	Continue with regular refresher training. All falls will be investigated	Training targets will be monitored
A detailed analysis of last years staff and visitors falls will be undertaken. This will look at root causes.	To be completed during the Summer.	Risk Manager	Falls Prevention Practitioner	Progress will be monitored by lead and reported to the Falls group and the H&S committee.	
Violence and abuse (Local Security Management Specialist - LSMS)					
Provide physical restraint training for security staff, porters and front line nursing.	Provide training by March 2016	Head of Safety and Security	LSMS Learning and Development.	Progress will be reported to the H&S committee as part of Trust Officer's reports.	Training delivered to identified staff
For each staff group to achieve the required target for Violence and abuse training (CRT training).	Steadily improve uptake to meet Trust targets by March 2016.	LSMS	Learning and Development.	Progress will be reported to the H&S committee as part of the Learning and Development report.	Meet Trust target
Provide a secure room for patients sectioned under section 136 of the mental health Act in A&E on both sites	Provide a room by March 2016 or include in Estates plan.	Head of Safety and Security	LSMS	Progress will be reported to the H&S committee as part of Trust Officer's reports.	Rooms provided.
Support Kent police as a member of the steering group for the development of a joint protocol for handling mental health patients.	Throughout the year	LSMS	Head of Safety and Security	Progress will be reported to the H&S committee as part of Trust Officer's reports.	Develop of a joint protocol for handling mental health patients.

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
Moving and Handling (Moving and Handling Coordinator)					
Complete the 2 year review of all patient handling generic risk assessments and safe systems of work	By 31-3-2016.	Sue Tizzard M&H Co-ordinator		ST to include on H&S committee report.	After the first year 60% of assessments have been reviewed.
Need to continue the inclusion of spinal handling in generic risk assessments and continue the training programme.	By 31-3-2016.	Sue Tizzard M&H Co-ordinator	Spinal Pathway Group	To be completed as part of the 2 year review cycle. Spinal Group will review progress ST to include on H&S committee report.	Continue to deliver the monthly training sessions.
Develop the in house database to adequately record training and competency evidence	By 31-3-2016.	M&H Co-ordinator	Head of Safety and Security	ST to include on H&S committee report.	Adequate database in place providing evidence.
Need to address the lack of patient canvasses resulting in an inability to follow safe practise.	By 31-3-2016.	M&H Co-ordinator	Head of Safety and Security	ST to include on H&S committee report.	Have sufficient canvasses across the Trust.
Sharps (Sharps Task and Finish Group)					
The sharps task and finish group will share the detailed findings of the injury study with all clinical staff through: • Posters. • Banners. • Laminated cards.	Throughout the year	Risk Manager	Sharps task and finish group.	Sharps group will report to medical device and H&S committees.	Increase awareness and reduce injury. However, this may also increase reporting.
Will share the detailed findings of the injury study through presentations to clinical groups.	Throughout the year	Risk Manager	Sharps task and finish group.	Sharps group will report to medical device and H&S committees.	Reach all clinical staff.
Complete the trials on blood gas syringes across the trust and standardise on one design	Complete in 2015/16	Vascular Access Specialist Practitioner	A&E Nurse Consultant	Sharps group will report to medical device and H&S committees.	Must be compliant with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
Continue to review new safety devices in the market place across the Trust.	Complete in 2015/16	Vascular Access Specialist Practitioner	Procurement		
Review safety sharps training to assess if refresher training is required and how this can be delivered.	Complete in 2015/16	Vascular Access Specialist Practitioner	Sharps task and finish group.	Sharps group will report to the H&S committee.	Reduce injuries as a result of lack of training

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
Eye Splashes (Risk Lead for Critical Care)					
The task and finish will: • Investigate various forms of eye protection. • Formulate a staff awareness campaign • Consider the possibility of eye protection zones or compulsory use for some procedures in: o Theatres. o Maternity.	This is an ongoing project throughout the year.	Risk Lead for Critical Care	Risk Manager	Progress will be reported to the H&S committee.	Discussion will increase awareness and implement controls that should reduce incidents.
Occupational Health (Occupational Health Manager)					
Increase awareness of the need to report work place stress and other ill health events on Datix via a safety alert.	Complete throughout 2016/16	Risk Manager.	Occupational Health Manager.	Reported to H&S Committee via Occupational health report.	Comparison of numbers referred to numbers reported.
Increase awareness of the need to report work place stress and other ill health events on Datix via H&S training.	Complete throughout 2016/16	Health and Safety Advisor	Training and Development	Reported to H&S Committee via Occupational health report.	Comparison of numbers referred to numbers reported.
Encourage staff and there managers to report work related stress and other ill health events through Datix.	Complete throughout 2016/16	Occupational Health Manager.	Occupational Health Department	Reported to H&S Committee via Occupational health report.	Comparison of numbers referred to numbers reported.

TRUST WIDE DOCUMENT SYNOPSIS

Committee name:	Trust Board	Committee Date	July 2015
Document submitted for Ratification: (The HSE expect the Board to lead on health and safety and hence ratify the policy).		**RATIFY**	

Document Title:	**Health and Safety Policy and Procedure**
Document Author:	J Harris – Risk and Compliance Manager
Reason for Review:	Annual review and update

Main Changes

The Board is asked to ratify the revised Health & Safety policy.

- The Policy was discussed and approved by the Health and Safety Committee on the 11/05/15 who recommended the document for ratification by the Board.
- The Policy was reviewed by the Policy Ratification Committee on 02/07/15, and it was agreed to recommend for ratification
- Minor changes made as part of planned review. These include:
  - Committee structure and responsibilities – Health and Safety Committee reporting to Trust Management Executive.
  - Update of key staff.

Consultation Process and Feedback

- The full, amended, document was sent out for consultation on 16/02/15 (which included all members of the Board). The consultation ended on 02/03/15 (the Trust's policy requires a minimum period of 2 weeks). Minor amendments were made as a result of comments received.

Approving Committee	Trust Health and safety Committee

Points of Potential Controversy

- None.

Procedural Checks

Please tick to confirm the following procedural requirements

The document has undergone consultation.	YES
The consultation exceeded a minimum of 2 weeks.	YES
The Consultation included all members of the approving and ratifying committees	YES
The document follows Trust policy and template.	YES

(It is the responsibility of the committee to ensure that the document meets Trust and DOH policy)

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – July 2015

7-20	Oversight Self-Certification, Month 3, 2015/16	Trust Secretary

The enclosed schedule sets out the proposed oversight self-certification submission for month 3, 2015/16, based on performance as at 30th June. This submission must be sent to the NHS Trust Development Authority (TDA) by the end of July (i.e. by 31st).

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 June 2015. Additions are highlighted, whilst deletions are shown as ~~struckthrough~~.

No change in compliant status is proposed from that agreed by the Board in June 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 Committee, and its sub-committees, provides a focus on quality issues arising from Directorates. A summary of each Quality 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 Trust has commissioned an external review of Clinical Governance, the findings of which will be reported in the summer of 2015 ~~The independent assessment of the Trust's Quality Governance~~	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	~~Framework has largely endorsed the Trust's self-assessment and gave a validated score of 3.5; an action plan has been drafted to achieve further improvements. Further improvements include:~~ ~~- strengthening the processes through which learning is shared and embedded has been recognised, and~~ ~~- developing further benchmarks to support the assurance & target setting process~~ The 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 May 2015 Trust Board 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: 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	The Trust continues to operate as a going concern, and the 2014/15 financial accounts were prepared on this basis. The External "Audit Findings" report for 2014/15 stated that "We have	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
standards in force from time to time	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 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 (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 ▪ 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	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	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 (see 1 above)	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 finalised ~~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 plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	The Board and its sub-committees are involved in the development of the Trust's annual plans, including specific aspects as required (financial, winter pressures, infection control, health and safety etc.). Key risks to the Trust's agreed objectives are reported via the Board Assurance Framework. The Audit and Governance Committee, like all Board committees, provides a report to the Board following each meeting which is presented by the Committee Chairman (a NED). The Board is fully engaged with the development of the IBP and the Clinical Strategy that underpins it.	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
For governance, that: 9. an Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	The Annual Governance Statement 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	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 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, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.	A Trust Board Code of Conduct is in place which confirms the requirement to comply with the Nolan principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership. A register of 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 approved in May 2015. All formal Board positions are filled substantively.	Compliant
For governance, that: 13. the board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	▪ The Remuneration Committee reviews the performance of Executive Directors. ▪ The TDA 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

Statement	Evidence of Trust compliance	Latest assessment – 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 objectives for 2015/16~~.	Compliant

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - July 2015

7-21 Annual Audit Letter for 2014/15 Director of Finance

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

The Letter for 2014/15 from the Trust's External Auditors (Grant Thornton LLP) is duly enclosed. The Letter will also be received at the Audit and Governance Committee on 06/08/15, for completeness (and in reflection of that Committee role in oversight of the Audit process).

Which Committees have reviewed the information prior to Board submission?

- N/A

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

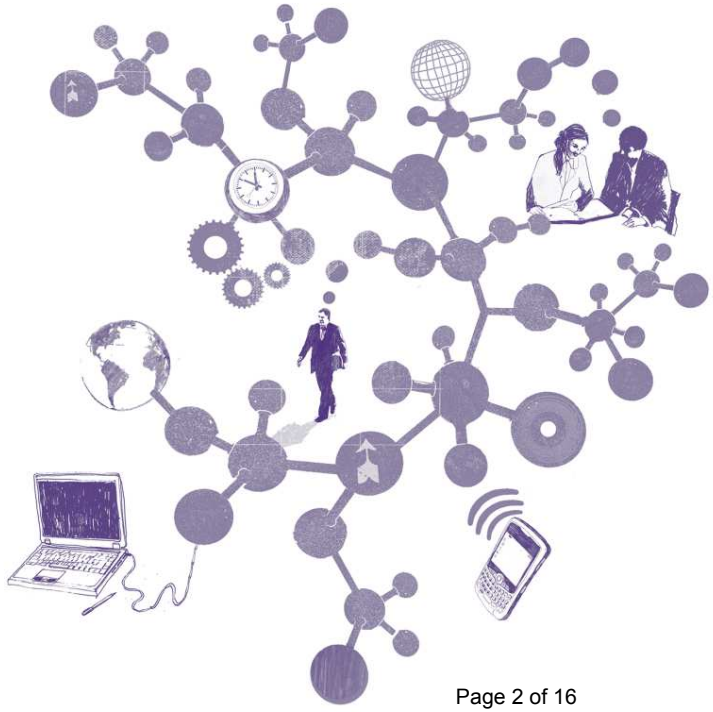
Information and assurance

[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

The Annual Audit Letter for Maidstone and Tunbridge Wells NHS Trust

Year ended 31 March 2015

June 2015



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Contents

Section 1: Executive summary

Executive summary

Purpose of this Letter

Our Annual Audit Letter (Letter) summarises the key findings arising from the following work that we have carried out at Maidstone and Tunbridge Wells NHS Trust (the Trust) for the year ended 31 March 2015:

- auditing the accounts (Section two)
- assessing the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (Section three)
- other audit related services carried out for the Trust during the year - reviewing the Trust's Quality Account (Sections four**).**

The Letter is intended to communicate key messages to the Trust and external stakeholders, including members of the public.

We reported the detailed findings from our audit work on the accounts and arrangements for securing economy, efficiency and effectiveness in its use of resources to those charged with governance in the Audit Findings Report on 27 May 2015 and we will report the detailed findings from our work on the Trust's Quality Account in our separate Quality Account Report to the Quality and Safety Committee in July 2015.

Responsibilities of the external auditors and the Trust

This Letter has been prepared in the context of the Statement of Responsibilities of Auditors and Audited Bodies issued by the Audit Commission (www.audit-commission.gov.uk).

The Trust is responsible for preparing and publishing its financial statements, accompanied by an Annual Governance Statement. It is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources (Value for Money).

Our annual work programme, which includes nationally prescribed and locally determined work, has been undertaken in accordance with our Audit Plan issued in February 2015 and was conducted in accordance with the Audit Commission's Code of Audit Practice (the Code), International Standards on Auditing (UK and Ireland) and other guidance issued by the Audit Commission.

Audit conclusions

The audit conclusions which we have provided in relation to 2014/15 are as follows:

- an unqualified opinion on the accounts which give a true and fair view of the Trust 's financial position as at 31 March 2015 and the Trust's income and expenditure for the year
- a qualified "except for" conclusion in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. The Trust's arrangements are appropriate except for its strategic financial planning arrangements.

We are also expecting to issue an unqualified limited assurance report in respect of the Trust's Quality Account by 30 June 2015 in relation to this separate engagement.

Executive summary (continued)

Key areas for Trust attention

The Trust continues to face significant financial challenge, particularly due to the financial issues identified in 2013/14 and the significant increase in activity over the winter months.

The Trust delivered a £157k surplus in 2014/15, after receiving £12m support funding from the TDA. It is forecasting an in year annual deficit until 2016/17, albeit the planned deficit decreases each year. Breakeven is planned in 2017/18. The Trust will fail the statutory three year cumulative break even in 2017/18.

The Trust has made good progress in addressing the financial issues identified in 2013/14. It has made improvements in its financial planning processes, reporting to Board and budget setting arrangements. For 2015/16, cost improvement programmes are in place to meet the £ 21.5m target and the challenge for the Trust is to ensure that savings are recurrent.

In common with other Trusts, the Trust has continued high levels of agency staff. There has been a recent government drive to curtail this and the Trust recognises its plans must include the continuing challenge to recruit permanent staff.

It submitted a five year financial strategy, "Moving forward 2015/16-2019/20", to the TDA in May 2015/16 and is currently working to develop a detailed strategic plan of exactly how it will move from the current financial position to breakeven. The Trust has a significant capital programme in place, including the establishment of a new ward at Tunbridge Wells hospital in 2015/16, to support the expected activity levels.

The Trust was subject to a CQC inspection in 2014/15 and has responded well to the visit with a clear action plan in place to address recommendations made.

Acknowledgements

This Letter has been agreed with the Chief Executive and Deputy Director of Finance.

We would like to record our appreciation for the assistance and co-operation provided to us during our audit by the Trust's staff.

Grant Thornton UK LLP
June 2015

Section 2: Audit of the accounts

Audit of the accounts

Audit of the accounts

The key findings of our audit of the accounts are summarised below:

Preparation of the accounts

The Trust presented us with draft accounts in accordance with the national deadline. Appropriate working papers were made available from the start of the audit fieldwork and staff responded quickly and efficiently to all audit queries.

Issues arising from the audit of the accounts

We did not identify any adjustments affected the Trust's retained surplus position. The adjustments made were mainly in relation to improvements in presentation and disclosure.

Annual Governance Statement and Annual Report

The Trust presented the Annual Governance Statement and Annual Report in a timely manner and to a good standard. The draft Annual Governance Statement did not include specific inclusion of key risks, as required by guidance. The Trust updated the risk assessment section of its Statement accordingly.

Conclusion

Prior to giving our opinion on the accounts, we are required to report significant matters arising from the audit to 'those charged with governance' (defined as the Audit and Governance Committee at the Trust). We presented our report to the Audit and Governance Committee on 27 May 2015 and summarise only the key messages in this Letter.

We issued an unqualified opinion on the Trust's 2014/15 accounts on 1 June 2015, meeting the deadline set by the Department of Health (DH). Our opinion confirms that the accounts give a true and fair view of the Trust's financial affairs and of the income and expenditure recorded by the Trust.

Financial performance 2014/15

The Trust's Performance against its financial targets is set out in the table below:

	Target	Actual	Met?
Surplus/ (deficit)	Breakeven	£157k surplus	Yes*
Capital cost absorption rate	3.5%	3.5%	Yes
Capital resource limit	Not to exceed	£56k underspend	Yes
External finance limit	Not to exceed	£2,870k underspend	Yes

* The £157k surplus for 2014/15 was achieved with £12m TDA non-recurrent support in year.

The Trust has a statutory target to breakeven within a 3 year period, with the potential to extend to 5 years. The 3 year target will not be met in 2015/16.

Looking forward

The Trust continues to face significant financial pressures. In line with budget, it achieved a surplus of £157k in 2014/15 (after the IFRS adjustment), with the aid of £12m non-recurrent support from the Trust Development Agency (TDA).

The Trust has submitted a 5 year plan to the TDA, which includes a projected deficit of £14.1 million for 2015-16,. The projected deficit reduces annually to a forecast breakeven position in 2017/18.

The 2015/16 forecasts include achieving cost improvement savings of £21.5m. Of this, £18.1m represent schemes starting in 2015/16. The Trust has historically performed well against its cost improvement targets, achieving savings of £23.8m against a forecast of £22.4m in 2014/15. However, of these savings, 26% were non-recurrent.

The Trust is currently working on detailed strategic plans to get from the current financial position to financial balance in 2017/18. The effective setting, reporting and reviewing of these will be essential in improving its financial performance.

As reported in the financial statements, the Trust is also facing charges under the Corporate Manslaughter and Corporate Homicide Act 2007. The implications of this will need to be factored into its long term financial model.

Section 3: Value for Money

Value for Money

Value for Money conclusion

The Code describes the Trust's responsibilities to put in place proper arrangements to:

- secure economy, efficiency and effectiveness in its use of resources
- ensure proper stewardship and governance
- review regularly the adequacy and effectiveness of these arrangements.

We are required to give our VfM conclusion based on the following two criteria specified by the Audit Commission which support our reporting responsibilities under the Code:

The Trust has proper arrangements in place for securing financial resilience. The Trust has robust systems and processes to manage effectively financial risks and opportunities, and to secure a stable financial position that enables it to continue to operate for the foreseeable future.

The Trust has proper arrangements for challenging how it secures economy, efficiency and effectiveness. The Trust is prioritising its resources within tighter budgets, for example by achieving cost reductions and by improving efficiency and productivity.

Key findings

Securing financial resilience

We have undertaken a review which considered the Trust's arrangements against the three expected characteristics of proper arrangements as defined by the Audit Commission:

- Financial governance
- Financial planning
- Financial control.

Our work highlighted that the Trust remains in a challenging position following the financial pressures that became apparent in 2013/14. The Board and the organisation has responded proactively and has a good understanding of its current financial position and of the challenges ahead.

Challenging economy, efficiency and effectiveness

We have reviewed whether the Trust has prioritised its resources to take account of the tighter constraints it is required to operate within and whether it has achieved cost reductions and improved productivity and efficiencies.

Our work highlighted that the Trust has adequate arrangements in place to prioritise its resources and deliver economy, efficiency and effectiveness in its use of resources.

Overall VfM conclusion

On the basis that the Trust required £12 million financial support to deliver a balanced budget and continues to face significant financial challenges, we issued a qualified value for money conclusion. This was on an except for basis recognising that our work, having regard to the guidance on the specified criteria published by the Audit Commission, has found that in all other significant respects the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

Section 4: Audit related services

Audit related services

Quality Accounts

For 2014/15 the Trust is required to obtain external audit assurance on its Quality Account. In order to provide this assurance we have undertaken limited assurance procedures in accordance with guidance issued by the Audit Commission to assess whether:

- the Quality Account is prepared in all material respects in line with the criteria set out in the Regulations
- the Quality Account is consistent in all material respects with the sources specified in the *NHS Quality Accounts Auditor Guidance 2014/15* issued by the Audit Commission ('the Guidance')
- the indicators in the Quality Account identified as having been the subject of limited assurance, are reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Key findings

We will provide the Trust with a report setting out the detailed findings of our work by 30 June 2015 and this will be presented to the Quality and Safety Committee in July 2015. Our work is substantially complete and the key matters arising from our work to date are:

- The content of the draft Quality Account, provided for our review in May 2014, complied with the majority of the Regulations
- From our sample testing, we did not identify any errors in the published data included in the Quality Account for the two indicators we reviewed.

Conclusions

We expect to issue an unqualified limited assurance opinion on the Trust's Quality Account, in accordance with requirements, by 30 June 2015.

Appendices

Appendix A: Reports issued and fees

We confirm below our final fees charged for the audit and non-audit services.

Fees for audit services

	Per Audit plan £	Actual fees £
Trust audit	100,092	100,092
Charitable fund audit	2,500	2,500*
Total audit fees	**102,592**	**102,592**

* The charitable fund independent examination is scheduled for October 2015 and we will confirm the actual fee on completion of this work.

Fees for other services

Service	Fees £
Audit related services	
• Quality Accounts	10,000

Reports issued

Report	Date issued
Audit Plan	Feb 2015
Audit Findings Report	May 2015
Quality Account Report	June 2015
Annual Audit Letter	June 2015

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Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - July 2015

7-22 Trust Membership **Director Of Workforce And Communications**

1. Maidstone and Tunbridge Wells NHS Trust has built up a public membership as part of its aspiration to create greater involvement in the community which we serve and in preparation for Foundation Trust (FT) status.

2. Public membership currently stands at 9,212 people. The prescribed public membership figure for an organisation of the Trust's size is 10,000. This will be met through the completion of planned recruitment in the North of East Sussex this year.

3. Members have been recruited from the Trust's core catchment areas (including neighbouring small towns and villages) of Maidstone, Tunbridge Wells, Sevenoaks, Tonbridge and Malling, North of East Sussex, and Kent and Medway as a whole (the latter making up 9% of members to reflect the wider demography of patients using the Trust's cancer services). Membership levels for each catchment area are based on population size and Trust inpatient activity.

4. The Trust membership database is cleansed on an annual basis to help identify people who have moved out of the area and/or no longer wish to be members. The 2014 cleanse identified 235 members (3% of members) in this category. This was below anticipated levels experienced by other Trusts.

5. Members of Trust staff will be invited to become members as the Trust approaches FT status and begins the process of setting up a governing body of public/patient and staff representatives.

6. The Trust has members living in over 220 council wards spread across Kent and Medway and North of East Sussex. Ward areas with over 100 members now include:

Tunbridge Wells	Southborough and High Brooms, Sherwood, Pembury, Park, Culverden, Broadwater, Pantiles and St Marks, Rusthall, St Johns, St James, Benenden and Cranbrook
Tonbridge and Malling	Higham, Borough Green and Long Mill, Cage Green, Castle, Judd and Trench
Kent and Medway	25 areas with members but no areas over 100 members
Maidstone	South, North, High Street, East, Allington, Bearsted, Coxheath and Hunton, Fant, Shepway North, Shepway South, Staplehurst, Marden and Yalding
North of East Sussex	27 areas with members but no areas over 100 members
Sevenoaks	Sevenoaks Town, St Johns, Otford and Shoreham, Kemsing, Dunton Green and Riverhead, Sevenoaks North, Sevenoaks East, Seal and Weald, Brasted Chevening and Sundridge, Kippington

7. Membership is diverse and reflects the socio-economic mix found within West Kent with areas of both high prosperity and significant deprivation. A number of wards with high membership counts are areas of high deprivation. This is a positive move as it shows we have a highly diverse membership and extend our communications/engagement to audiences who can be hard to reach.

8. While the Trust's membership spans a wide age range, the majority of members fall within the

40 to 80 age bracket (70%). Over 1,500 members are below the age of 40, over 600 are below the age of 30 and 85 are below the age of 20.

9. While the membership is socio-economically diverse and all-age encompassing, 93.5% of members self-define their ethnic origin as white and there is limited black and minority ethnic membership. This is broadly reflective of the Trust's inpatient activity. The membership is also made up of twice as many women as men and three-quarters of members no longer have children living at home.

10. The Trust has asked members for their views on local health services. Re-occurring themes during 2014 related to the general convenience, efficiency (appointment date and clinic waiting time) and associated user cost of accessing services. The main health topics of member interest are care of the elderly, cancer, arthritis, emergency care, and infection control.

11. The Trust has held several members' events to discuss the above areas of care. Members also receive a Trust newsletter four times a year and a covering letter from the Executive team on key issues and opportunities to share feedback. 40% of members receive information from the Trust by email and the remaining 60% by post.

12. The Trust has used members' comments to improve services. Members' comments about inadequate car parking facilities at Maidstone Hospital were included in a successful application to the local council for more parking spaces.

13. To date, over 900 members would be happy to be involved in the development of, or comment on, public information leaflets, 700 members have expressed an interest in being part of a panel or working group (relevant to their interests), 700 have expressed an interest in attending events and 3,000 members would be happy to respond to surveys.

Recommendations

14. The Trust Board is asked to note this report and support the following recommendations:

- Continue recruitment in North of East Sussex with a focus on current and future service users
- Continue to develop two-way relationships with Trust members that influence the quality of our health services through events, publication of newsletters and use of digital media
- Look at the most cost-effective means of enabling members to take part in surveys and comment on leaflets to support good clinical governance
- Explore the possibilities of setting up a shadow governing body ahead of an FT application and/or members presence on Trust committees and working groups

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Responding to a request from a Board member earlier in 2015 and for 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