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

11.30am – c.2pm WEDNESDAY 30TH SEPTEMBER 2015

THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
9-1	To receive apologies for absence	Chairman	Verbal
9-2	To declare interests relevant to agenda items	Chairman	Verbal
9-3	Minutes of the Part 1 meeting of 22nd July 2015	Chairman	1
9-4	To note progress with previous actions	Chairman	2
9-5	Safety moment	Medical Director	Verbal
9-6	Chairman's report	Chairman	Verbal
9-7	Chief Executive's report	Chief Executive	3
9-8	Integrated Performance Report for August 2015 ▪ Safe / Effectiveness / Caring ▪ Safe / Effectiveness (incl. HSMR) ▪ Safe (infection control) ▪ Well-Led (finance) ▪ Effectiveness / Responsiveness (incl. DTOCs) ▪ Well-led (workforce)	Chief Executive Chief Nurse Medical Director Dir. of Infection Prevention and Control Director of Finance Chief Operating Officer Director of Workforce and Communications	4
	Quality items		
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9-11	Annual Report from the Director of Infection Prevention and Control	Director of Infection Prevention and Control	7
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9-14	Review of the Board Assurance Framework, 2015/16	Trust Secretary	10
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	Reports from Board sub-committees (and the Trust Management Executive)		
9-16	Charitable Funds Committee, 20/07/15 (to include approval of revised Terms of Reference)	Committee Chairman	12
9-17	Audit and Governance Committee, 06/08/15	Committee Chairman	13
9-18	Quality Committee, 10/08/15 and 09/09/15	Committee Chairman	14
9-19	Trust Management Executive, 19/08/15 and 16/09/15	Committee Chairman	15
9-20	Finance Committee, 24/08 and 28/09/15	Committee Chairman	16 & 17 (to follow)
9-21	Workforce Committee, 15/09/15 (to include approval of the Workforce Strategy, 2015-20)	Committee Chairman	18
9-22	Patient Experience Committee, 21/09/15	Committee Chairman	19
	Other matters		
9-23	Proposal regarding the appointment of a "Freedom to Speak up Guardian"	Director of Workforce and Communications	20
9-24	**To consider any other business**		
9-25	**To receive any questions from members of the public**		
9-26	To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted	Chairman	Verbal
	Date of next meeting: 21st October 2015, 10.30am, The Education Centre, Tunbridge Wells Hospital		

Anthony Jones,
Chairman

Maidstone and Tunbridge Wells NHS
NHS Trust

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 22ND JULY 2015, 10.30 A.M. AT TUNBRIDGE WELLS HOSPITAL

FOR APPROVAL

Present:	Anthony Jones	Chairman of the Trust Board	(AJ)
	Avey Bhatia	Chief Nurse	(AB)
	Sylvia Denton	Non-Executive Director	(SD)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(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)
	Stephen Smith	Associate Non-Executive Director	(SS)
	Kevin Rowan	Trust Secretary	(KR)
	Caroline Harris	Patient Relative (for item 7-8)	(CH)
	David Harris	Patient (for item 7-8)	(DH)
Observing:	Darren Yates	Head of Communications	(DY)
	Annemieke Koper	Staff Side representative	(AKo)

7-1 To receive apologies for absence

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

7-2 To declare interests relevant to agenda items

There were no declarations of interest.

7-3 Minutes of the Part 1 meeting of 24th June 2015

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

[Post-meeting note: It was subsequently identified that Annemieke Koper (AKo), Staff Side representative, was not at the meeting, and should therefore be removed from the "Observing" list]

Action: Amend the minutes of the Part 1 meeting of 24th June 2015 (Trust Secretary, July 2015)

7-4 To note progress with previous actions

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

- **Item 6-6ii ("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").** PB noted that only 11 members of staff were affected, none of whom were Nurses. It was therefore agreed that it was not necessary to send a letter to local MPs. It was also agreed the action could be closed.
- **Item 6-8ii ("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"). AG reported that the adjustments required to the dashboard would be ready for the next meeting of the Trust Board.

- **Item 6-12i ("Submit a proposal to a future Trust Board meeting in relation to whether the Trust should continue to undertake Carotid endarterectomy procedures").** PS reported that only a small number of Carotid endarterectomy procedures were performed at the Trust, as most were undertaken at London hospitals, and stated that there was therefore no rationale for the Trust to continue performing the procedure. AJ asked why the procedure had been undertaken at all at the Trust. PS replied that the numbers performed had dwindled over the years, and confirmed that he was recommending that the Board approve a proposal that the Trust formally cease undertaking the procedure. SDu asked whether there were standards relating to the procedure. PS confirmed there were such standards, and although the Trust's complications rates were within national limits, the Trust was operating below the recommended critical mass of 50 cases per year. AJ asked which other Trusts performed the procedure. PS confirmed that the procedure was undertaken at Medway NHS Foundation Trust, Kent and Canterbury Hospital, King's College Hospital NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust . PS added that the Trust referred patients to each of these, depending on the needs of the patient. AJ asked whether it would be beneficial to have a full Vascular service at the Trust. PS replied that he did not believe this to be the case, as Vascular services needed to be provided to a recommended population of 1.2 million, but also noted that a review of Vascular services in Kent and Medway was currently taking place. KT highlighted that there had been some initial discussions regarding the Trust's strategic intent towards Vascular services. AJ acknowledged the point, and queried whether a decision to cease Carotid endarterectomy procedures would fetter any future intentions. JL confirmed this would not be the case. The Trust Board therefore approved the proposal that the Trust formally cease the undertaking of Carotid endarterectomy procedures.

7-5 Safety moment

AG reported that members of staff were using the A&E at Tunbridge Wells Hospital (TWH) as a shortcut thoroughfare, which involved staff walking past ambulances transferring patients, as well as patients receiving care. AG added that this was therefore a concern in terms of privacy and dignity, and the practice appeared to have become habitual for some staff. AG continued that the Health and Safety Committee had made efforts to address the situation, but a communications exercise had now commenced, and individuals would be challenged if they continued with such behaviour after 01.09.15. AG clarified that A&E staff would not be able to monitor occurrences, so efforts would be aimed at ensuring staff were aware of the privacy and dignity issues.

AJ stated that the issue was probably wider than that reported by AG, and included shortcuts that staff may take when, for example, walking from car parks across non-designated routes. KT agreed, and noted that some of those using the top staff car park at TWH disregarded the one-way traffic flow system when parking.

7-6 Chairman's report

AJ highlighted that this would be SS's last Board meeting, as he would be taking a role with the National Audit Office. AJ thanked SS for his contribution, and added that his incisive questioning would be missed by the Board. SS stated that he had been very grateful for the opportunity to sit on the Board, and he had learned much during that time. SS continued that in his view, running a hospital was the most complex operation in any sector, and encouraged the Board to seize the opportunities that would emerge in the future.

7-7 Chief Executive's report

GD referred to the circulated report and highlighted the following:

- The Trust had been visited by Ben Gummer MP and Helen Whately MP. The former's visit was largely related to Maternity care, and included meeting mothers, all of whom were effusive of the Trust's service
- The Trust's 'Step up to Safety' Conference was held on 03.07.15, and had gone well. The Conference would be used as a 'stepping stone' to assist in the Trust's safety efforts

- The Trust was the first hospital Trust in the South East to receive a quality mark for its Clinical Support Worker (CSW) training
- The Stoma Nurses Judy Mallett and Kirsty Craven had been presented with the Colostomy Association's "Purple Iris" Award, which they had won following a nomination by patients

SDu referred to the latter point, and asked whether the receipt of such awards by staff was promoted internally. GD confirmed that the award would be promoted. AJ proposed that a regular item be scheduled for future Trust Board meetings, to enable any awards and recognition issued to Trust staff to be reported. This was agreed.

Action: Schedule a regular item for future Trust Board meetings to enable any awards and recognition issued to Trust staff to be reported (Trust Secretary, July 2015 onwards)

SD commended the accolade regarding the Trust's CSW training, particularly given the fact that CSWs were not regulated, and stated she would like to see the receipt of the award promoted more widely. AB stated she was not surprised about the award, as the Trust had led the training of CSWs across the local area. KT noted that the Trust's 'Twitter' site did not contain reference to the CSW award. AJ asked DY to comment. DY noted that two other positive stories had been posted on the Trust's 'Facebook' site, and had been well received, but acknowledged that more could be done in relation to updating the 'Twitter' site.

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

AJ welcomed DH and CH to the meeting, and invited DH to relay the details of his experiences, including any areas for improvement. DH highlighted the following points:

- He awoke on 02/03/15 with chest pains. CH dialled 999 and an ambulance arrived within 15 minutes. The ambulance crew undertook an assessment, and transferred DH to TWH
- DH was assessed quickly, saw a doctor, had an x-ray, electrocardiogram (ECG), and blood taken, and saw a number of different specialists. The staff were extremely good, and kept DH and CH informed of progress
- It transpired that DH had severely stretched the muscles in his chest, as a result of work he had undertaken at home the previous day. However, the doctor who performed the final analysis detected a murmur, and therefore arranged for DH to attend the Rapid Access Chest Pain (RACP) Clinic at Maidstone Hospital (MH)
- DH attended the RACP clinic 3 to 4 times, and again had a very good experience. He was eventually given the 'all clear' and discharged.
- Prior to 02/03/15, DH experienced some pain, and blood in his urine, so he was referred by his GP to Mr M.S. Cynk at TWH. DH was consequently discovered to have a benign cyst on his kidney. Then, as a result of continued blood in the urine, a flexible cystoscopy was performed. This initially went well, but DH then experienced an infection. Antibiotics were prescribed, but these were ineffectual.
- Eventually DH had to call the "111" service, upon which he was asked to attend Crowborough War Memorial Hospital, to collect a prescription for stronger antibiotics. These had the desired effect, and DH and CH were therefore able to go on their pre-booked holiday
- There had been some problems in accessing DH's healthcare records. However, in summary, DH's experience was exemplary

AJ asked CH to provide her perspective. CH reiterated DH's sentiments, and noted that although Emergency Department staff must have been under intense pressure, due to the volume of patients in the department, there was no indication of this, and the staff were content to spend time to explain the situation, which gave CH confidence that the service being provided was safe.

AJ asked for CH's further comment on DH's subsequent procedures. CH confirmed all went well, and the timings were, more or less, as scheduled. DH added that even the car parking provision was good, though CH pointed out that the first letter that had been received from MH did not explain that it may take some time to find a parking space. CH elaborated that although they had arrived 30 minutes before DH's appointment, DH had to be dropped off prior to parking, to enable CH to continue to locate a space. CH suggested that it would therefore be useful to have a reference on the letter. AJ acknowledged the point, but noted that one of the problems with limited car parking was that patients tended to arrive early, which further increased the pressure on

spaces. GD confirmed that planning permission to increase the number of spaces at MH had been granted, and work on this was to commence in the near future.

AJ then asked PS and AB whether they wished to comment. PS thanked DH and CH for sharing their experiences. AB acknowledged the problems in obtaining DH's healthcare records, but highlighted that the Trust was working towards the introduction of electronic records. AB added that it was pleasing to hear that staff had communicated effectively with DH and CH.

AJ thanked DH and CH for attending, and noted that it was beneficial for the Trust Board to be reminded about the occasions that go well. AJ asked AG to ensure DH and CH's positive comments were passed on the relevant departments. AG agreed.

Action: Ensure that the positive comments made during the "patient story" heard at the July 2015 Trust Board are passed on the relevant departments (Chief Operating Officer, July 2015 onwards)

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

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

- The key issue was the number of beds "delayed by Social Services", which had adverse consequences, including the use of temporary staff, the need to have more beds open, the achievement of the A&E 4-hour waiting time target, and the achievement of the Trust's plans regarding elective care. Unless this issue was addressed, the Trust would struggle to cope with demand, even when the new Ward opened at TWH
- The local committee established to manage emergency care, the Urgent Care Network, had been ineffective, but a meeting had been scheduled, at a high level, with Kent County Council (KCC), and GD also had a meeting scheduled with Greg Clark MP, who was also Secretary of State for Communities and Local Government
- All Trusts within the South East were suffering unprecedented levels of Delayed Transfers of Care (DTOCs), but the Trust was suffering more, as a result of the particular problems in West Kent. Although the financial pressure that Social Services were under was understood, the lack of engagement from senior officials within Social Services was regrettable

KT queried whether the Trust could issue invoices to Kent County Council for DTOCs. GD replied that a letter giving notice to levy such charges had been sent to KCC, and the Trust intended to charge Social Services from 01/08/15. GD added that the Trust was unable to charge the full costs it incurred, but he hoped that the exercise would lead to engagement by Social Services.

SD noted that the issue had been a problem for the past two years, and asked whether anything further could be done. GD clarified that the situation had improved during that time, but concerted efforts were now required. AJ added that the Trust needed to do what it could, despite the fact that there was no solution on the horizon. GD noted that he believed an NHS-operated Nursing Home / Intermediate Care facility was likely to be a part of the solution, but it remained to be seen how this could be established and funded. GD did however report that the situation with East Sussex Social Services had improved. AJ welcomed this development.

PS then gave a presentation on the recent increase in Hospital Standardised Mortality Ratio (HSMR), and highlighted that the benchmark being used was that for the previous year, and this had changed in December 2014. SDu asked whether the Trust's HSMR for the previous year was therefore slightly higher as a result of the change in the benchmark. PS confirmed this was the case, but stated he would explain this further, and continued, as follows:

- Dr Foster Intelligence used the HSMR indicator, which was predicated on admission diagnosis, whilst the alternative Summary Hospital-level Mortality Indicator (SHMI) was predicated on discharge diagnosis. PS added that a representative from Dr Foster Intelligence had stated that 'A well-functioning MAU would give you a worse HSMR'
- The Trust's level of Palliative Care clinical coding was below the mean level, and although this had been the case for some time, this had had more of an impact recently

- The relevant data period for the increase was April 2014 to March 2015, and a number of factors were involved, but the mortality in 4 specific diagnostic groups was statistically significantly higher than expected
- There was also a difference between HSMR during weekdays and weekends, and HSMR for Sundays was a particular issue, although the reasons were not known
- The Trust's crude mortality rate was 4.11, which was lower than most other local Trusts. However, these local organisations had a higher expected mortality than the Trust, which therefore affected the relative rate

AJ asked why the Trust would have a lower expected mortality than others. PS replied that this may be related to clinical coding, in terms of co-morbidities and Palliative Care coding, as the Trust's crude mortality was reducing, despite its hospitals seeing increased clinical activity. PS proposed that a representative from Dr Foster Intelligence be invited to the Trust, to participate in a 'deep dive' review of the Trust's HSMR. AJ commended the proposal, which was agreed.

Action: Arrange for a 'deep dive', involving a representative from Dr Foster Intelligence, to be held into the Trust's Hospital Standardised Mortality Ratio (HSMR) (Medical Director / Trust Secretary, July 2015 onwards)

SO asked whether SHMI and HSMR were both operated by Dr Foster Intelligence. PS answered that he understood that SHMI was operated by the Health and Social Care Information Centre. PS added that he had been informed by Dr Foster Intelligence that the re-benchmarking had resulted in one-third of Trusts having an increased HSMR. PS continued that he had previously been reluctant to review clinical coding, as many of the Trusts that had been found to have higher mortality rates had changed their coding practice, and been accused of manipulation, which was a situation he wished to avoid.

SO noted that the correction of clinical coding had implications for finances, and noted that the Trust had engaged CHKS to review the healthcare records of circa 200 patients, to consider whether the coding used had captured all relevant information. SO confirmed that CHKS would be on site from September 2015, and the review findings were expected 3 to 4 weeks afterwards.

PB asked for an explanation of "relative risk" shown in PS's presentation. PS replied this was related to case mix / Palliative Care coding.

KT cautioned reaching a conclusion that the increase in HSMR was solely related to clinical coding. AJ acknowledged the point, but stated that the Trust's crude mortality rates had provided some assurance, and noted it had been agreed that a representative from Dr Foster Intelligence should be asked to advise the Trust. PS emphasised that the differences between the Trust and others in relation to Palliative Care coding were real, and added that he recognised that clinical coders were good at translating what was written in the healthcare records, so the issues with clinical coding may therefore may lie elsewhere.

AJ confirmed that he wished for an independent person to identify the nature of the issues, but if it was already recognised that the Trust had a problem with its clinical coding, efforts should be made to resolve this from that point forward. The point was acknowledged.

ST remarked that he was concerned, and would remain concerned until a detailed explanation of the increased HSMR was provided. SDu concurred, and stated that she knew from experience that other Trusts had concluded that their problems with mortality rates were related to clinical coding, but this had not proven to be the case. SDu added that PS's presentation had provided information about higher than expected mortality in some diagnostic groups about which she was unaware, and asserted that a full understanding was required before a conclusion was reached.

Comments or queries on the other aspects of the Integrated Performance Report for June 2015 were then invited. SDu commented that she understood that performance would be rated as 'red' when a target had been breached, and queried why the MRSA bacteraemia performance was not therefore rated 'red'. AB replied that the Root Cause Analysis into the recent case had not yet concluded, but if the case was confirmed, the indicator would indeed be rated as 'red'.

AG then reported that the performance on the 62-day Cancer waiting time target remained behind plan, but gave assurance that appropriate action was being taken, and patients were being tracked. AJ commended the division of the indicator to show the Trust's sole performance. SD asked when performance would recover. AG replied that analysis indicated this would be the end of Quarter 2 of 2015/16. SD noted that the Trust was experiencing problems in undertaking MRI scans, and highlighted that this could affect 62-day waiting time performance. AG confirmed there had been problems with MRIs, but the situation had now recovered.

KT commended the 'Story of the month' section of the report.

Quality items

7-10 Progress with the Quality Improvement Plan

AB referred to the circulated report and highlighted the following points:
- There were no 'red' rated compliance actions
- The enforcement action report from the Care Quality Commission (CQC) was imminent. A meeting had been held with the CQC's lead inspector on 21/07/15, but the report had been delayed due to the CQC's workload
- The CQC had confirmed they had been monitoring progress via the reports they were sent each month, and they had no issues to raise

KT commented that many of the 'amber' rated issues seemed relatively straightforward to complete, in terms of writing Policies etc. AB replied that it was important to ensure that all relevant staff were engaged in the process of agreeing, and embedding, pathways and Policies, which took time. KT queried whether this was appropriate, in the context of the CQC's concerns. AB emphasised that the CQC had not raised any issues regarding the timings involved in implementing actions. AJ agreed that it would be beneficial to expedite the completion of some actions. GD stated that this would be considered if the intended protocols were not able to be considered at the Standards Committee meeting in August.

7-11 Clinical Quality and Patient Safety Report

AB referred to the circulated report and highlighted the following:
- The response times for complaints had improved, and there had been positive feedback from clinicians regarding the new process being piloted
- Falls had increased recently, and involved 4 Wards in particular. This would be followed up further at the Quality Committee and Trust Management Executive (TME)

AJ stated that he expected the increase in Falls to involve more than just the central Falls prevention team. AB agreed, and confirmed this was the case. AJ asked for the cause of the increase. AB replied that a number of factors were involved, including the high use of temporary staff, and the use of alarm mat equipment, and highlighted that the embedding of every single principle relating to Falls prevention was required, including the documentation of Falls assessments. AJ asked whether the staff who were operating effectively were educating those who were not. AB acknowledged that there was an issue regarding sustainability. AJ asked that the position on Falls continue to be reported to the Board.

KT queried whether innovative solutions could be explored, to minimise the impact of a fall, noting that airbags were now available for use by horse riders. AB stated that she was not aware of an airbag that had been designed for use by patients, but acknowledged the need to continue to explore new innovations that could assist.

SD highlighted the efforts that had previously been undertaken to reduce Falls, and stated that although more action was required, this should be acknowledged.

7-12 Planned v actual ward staffing for June 2015

AB referred to the circulated report and highlighted the following points:
- The 'RAG' ratings were now applied to staffing levels that exceeded those planned

- The Registered Nurse fill rates on Ward 12 were low, and further work was being undertaken
- The 'plan versus actual' data was for June, but the financial information was for May, as a result of communication problems between AB and SO's staff. This would however be corrected for future reports.

AJ asked for confirmation that, in overall terms, budgets were being managed effectively. SO confirmed this was the case, but KT pointed out that some areas were operating with marked variances against budget. The point was acknowledged.

Planning and Strategy

7-13 To discuss the winter and operational resilience plans

AG referred to the circulated report and gave a presentation highlighting the following:

- The circulated Plan was a further iteration of that seen at the Trust Board in May, and the final plan was expected to be submitted to the TME in September
- The objectives of the plan were to: ensure the 'right bed, right time', maintain quality KPIs and all access targets; reduce DTOCs to less than 3.5%; ensure appropriate staffing and skill mix; and increase the flexibility of elective capacity
- Planning and implementation included a focus on recruitment and retention; bed modelling; demand and capacity assessment; the increase of elective activity between April and November; having early winter escalation; having a clear escalation Policy; and focussing on non-elective infrastructure
- The escalation triggers were being used now, and was a well-tested model used within acute hospitals. The model was based on the level of tolerance that could be accepted without affecting 'business as usual' activity
- It was as important to have a de-escalation plan, and it was acknowledged that work on recovery should commence as soon as possible after escalation
- There was an associated action plan, and the accompanying risks were still being assessed. Engagement with the wider system had however been recognised as a risk
- The Trust's plans had been shared with the System Resilience Group, but the equivalent plans from West Kent Clinical Commissioning Group (CCG), Kent and Medway NHS and Social Care Partnership Trust, and South East Coast Ambulance Service NHS Foundation Trust were awaited

SDu commended the plans, but asked why they ended in February. AG confirmed that it had been agreed to extend the plans to April.

KT commended the different levels of escalation, and added that monitoring the levels that occurred would assist in determining whether the plan had held, and thereby avoid the debates that had occurred regarding the previous year's plans.

SO then reported that the work to understand the financial consequences of the plan were being finalised, and noted that although some aspects of the plan, such as the new Ward at TWH, had been covered from a financial perspective, the extremities within the plan were unable to be covered. SO added that previously there had been an allocation of winter funding monies from CCGs, but the Trust had been informed that such funding had been included in the CCG's baseline funding for 2015/16. SO confirmed that the Trust's finances covered 'green', and some aspects of 'amber' escalation levels.

AJ asked whether the Trust could provide the staff required to implement the plan. AG confirmed that this was a risk, and there would likely be a reliance on temporary staffing. PB concurred with AG's assessment of the risk to staffing to the totality of the plan, despite the fact that good progress had been made in relation to substantive recruitment.

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)

SDu referred to the circulated report and highlighted the substantial improvement in performance regarding Stroke, which had been commended at the Quality Committee.

7-15 Charitable Funds Committee, 20/07/15

ST reported that the Trust was in final negotiations regarding two legacies, which could lead to substantial donations. ST also noted that much work had been undertaken to amalgamate the myriad of smaller funds, and added that the rate of expenditure had increased for 2015/16.

7-16 Finance Committee, 20/07/15 (to incl. approval of revised Terms of Reference)

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

The Terms of Reference were approved as circulated.

7-17 To approve revised Terms of Ref. for the Remun. Cttee

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

The Terms of Reference were approved as circulated.

Assurance and policy

7-18 To review the Board Assurance Framework for 2015/16

KR referred to the circulated report and highlighted the following:

- This was the first occasion in 2015/16 that the Board had received the populated Board Assurance Framework (BAF), following the discussion of the key risks, associated objectives and BAF format that had been held at the Board's meetings in April, May and June 2015
- The content of the BAF had originated from each relevant 'Responsible Director', and KR was therefore the conduit for the reporting of such information to the Board
- The Finance objective had been discussed at the Finance Committee on 20/07/15, while the full BAF was scheduled to be reviewed at the Audit and Governance Committee on 06/08/15

AJ commended the new format of the BAF, but queried the "No" response given for Key risk 1 (quality) to the question "Are the actions that have been taken sufficient to achieve the objective at year-end?". KR explained that the question was designed to test whether the actions that had been taken thus far would, in themselves, be sufficient to ensure that the objective was met at year-end, if no further actions were taken. AB added that she had given the "No" rating serious consideration, but felt that this was appropriate.

SDu stated that the "Unsure" response given for Key risk 2 (capacity) to the question "Are the actions that have been taken sufficient to achieve the objective at year-end?" conflicted with the message that AG had given earlier in the meeting, when reporting on the winter and operational resilience plans. KR stated that he did not believe there was a conflict. SDu elaborated that AG had not expressed any doubts that the new Ward at TWH would be open by January 2016, and queried whether the winter plan assessment should therefore be amended. AG acknowledged the need for consistency between the BAF and other documents.

SS queried whether the 'red' rating on Key risk 3 (staffing), in response to the question "How confident is the Responsible Director that the objective will be achieved by the end of 2015/16?", conflicted with the 'amber' rating given for Key risk 4 (finance). PB replied that be believed the 'red' rating was a fair reflection of his judgement at this point in time. SS queried whether the rating to the same question for Key risk 4 should also therefore be 'red'. GD noted that a 'red' rating for Key risk 3 in effect indicated that further actions were required to achieve the objective.

AJ queried why the ratings given in response to the questions "Are the actions that have been taken sufficient to achieve the objective at year-end?" and "How confident is the Responsible

Director that the objective will be achieved by the end of 2015/16?" differed. PB highlighted that the two questions were different.

SS commended the process of each 'Responsible Director' assessing their objectives separately, to then enable the Board to consider the situation as a whole. ST and AJ concurred.

KT commended the level of debate and discussion of the BAF, and noted this was far greater than had previously been the case at Board meetings. AJ agreed, and proposed that the review of the BAF be scheduled earlier on the agenda of future meetings, to enable a more detailed debate. This was agreed.

Action: Schedule "To review the Board Assurance Framework…" items earlier on the agenda of future Trust Board meetings (Trust Secretary, July 2015 onwards)

7-19 Health & Safety Annual Report, 2014/15 (incl. ratification of H&S Policy, & agreement of the 2015/16 programme)

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

- Sharps-related injuries had been a key focus during 2014/15
- Directorates had been encouraged to report incidents, and there had been increased engagement in relation to the culture being promoted
- The Health and Safety Policy had been updated, but no significant changes were proposed. The Policy had been discussed at the Health & Safety Committee.

The work programme for 2015/16 was agreed as circulated. It was also agreed to delegate the management of the programme to the Health and Safety committee.

The revised Health and Safety Policy was ratified as circulated.

7-20 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 by the Board in June 2015.

The submission was approved as circulated.

7-21 To receive the Annual Audit Letter for 2014/15

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

KT noted that the Audit and Governance Committee had considered the issues required to remove the qualification.

SS asked whether the Auditors intended to issue a report on internal controls. SO confirmed that a "Report to those charged with governance" had been issued, which made one recommendation, and added that this was on target to be addressed by December 2015.

AJ noted the qualified 'value for money' conclusion.

7-22 Update on Trust Membership

PB referred to the circulated report and highlighted the following:

- The Trust now had just over 9000 public members, against a target of 10,000
- The Membership was broadly representative of the population served by the Trust, in terms of demographic characteristics
- Four actions were proposed in the report

AJ referred to the proposal to "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", and questioned this, given that the Trust was some time away from submitting a credible application to be a Foundation Trust. AJ clarified that that he did not object to interested parties participating in Trust committees, but did not wish to expend efforts on the establishment of a

shadow governing body. PB acknowledged the point, but clarified that at this stage, the possibility was merely being explored.

SD suggested that the report would be of interest to members of the Patient Experience Committee, and asked that it be circulated to such members. This was agreed.

Action: Arrange for the "Update on Trust Membership" to be circulated to members of the Patient Experience Committee (Trust Secretary, July 2015 onwards)

7-23 To consider any other business

AJ reminded Board members that the Trust's Annual General Meeting was being held on 17/09/15 at 6.30pm in the Auditorium in the Academic Centre at MH, and noted that AG would be giving a presentation on "Preparing for the Future".

7-24 To receive any questions from members of the public

There were no questions.

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

The motion was approved.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – September 2015

9-4 Log of outstanding actions from previous meetings — Chairman

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
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	September 2015	The necessary changes require further discussion, as although the target is set quarterly for performance monitoring purposes (and the "forecast" column has therefore been amended to be a quarterly forecast), performance against the monthly target is important in terms of the CCG contract. It is therefore likely that both monthly and quarterly performance will be reported.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
7-3 (July 15)	Amend the minutes of the Part 1 meeting of 24th June 2015	Trust Secretary	July 2015	The minutes were amended
7-7 (July 15)	Schedule a regular item for future Trust Board meetings to enable any awards and recognition issued to Trust staff to be reported	Trust Secretary	August 2015	Following discussion with the Chairman and Chief Executive, it has been agreed that a separate section will be included in the "Chief Executive's report" each month listing the winners of the monthly staff awards, plus any external awards / recognition received by staff
7-8 (July 15)	Ensure that the positive comments made during the "patient story" heard at the July 2015 Trust Board are passed on the relevant departments	Chief Operating Officer	August 2015	The unapproved minutes from the meeting were forwarded to key staff, who were asked to pass on to the relevant staff with the best wishes of the Chairman and the rest of the Board.

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
7-9 (July 15)	Arrange for a 'deep dive', involving a representative from Dr Foster Intelligence, to be held into the Trust's Hospital Standardised Mortality Ratio (HSMR)	Medical Director / Trust Secretary	August 2015	It has been agreed that "Review of HSMR" will be the sole item at the Quality Committee 'deep dive' meeting on 05/10/15.
7-18 (July 15)	Schedule "To review the Board Assurance Framework…" items earlier on the agenda of future Trust Board meetings	Trust Secretary	July 2015	The "Assurance and policy" section of agenda items has been scheduled ahead of the "Reports from Board sub-committees (and the Trust Management Executive)" section, from September 2015 onwards
7-22 (July 15)	Arrange for the "Update on Trust Membership" to be circulated to members of the Patient Experience Committee	Trust Secretary	July 2015	The report was circulated to Patient Experience Committee members on 23/07/15

Actions not yet due (and still 'open')

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - September 2015

9-7	Chief Executive's update	Chief Executive

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

1. I have met with a variety of individuals and groups since our last Board meeting to help maintain and further improve upon the safety and quality of our services and shared experience of our patients and staff.

   We continue to work closely with colleagues throughout the NHS in Kent and Medway to assist and support Medway Maritime Hospital through its on-going journey of improvement. These are collective challenges for all care providers that require a system-wide approach, and we are working together to maintain high standards of care for all our patients.

   The NHS as a whole faces similar challenges with common links and themes. It is clear that increasing demand for our services, limited availability of healthcare professionals, and high agency charges are contributing to Trust deficits. At the same time, more of our older patients with complex underlying care needs are having their transfer of care from our hospitals delayed while they await community support. We are working hard to break this cycle but not all of the answers are in our gift.

   Where they are, we are finding ever more innovative and efficient ways to treat patients, and to the credit of our staff, have shown ingenuity and flair in areas such as paediatrics, where we will become one of a few providers to have on-site consultant paediatric cover at key times seven days a week. Similarly, we have embraced an increase in births and are appointing more midwives to support this successful service. Our Pharmacy Department are now running a seven day service, benefiting patients as well with greater access to pharmacist advice. We have extended our cardiac rehabilitation service into the community bringing our skills and expertise closer to people's homes, providing more seamless care.

2. The hard work of so many of our colleagues has been recognised locally and nationally since our last meeting.

- We have seen a marked improvement in this year's PLACE results for cleanliness, food, privacy, dignity and dementia care. We exceed the national benchmark in almost all areas and have some of the best scores in Kent and Medway.
- Estates and Facilities Department is the first in the NHS to achieve an internationally applied standard for occupational health and safety performance
- Cancer and Haematology Directorate have achieved the prestigious CHKS accreditation for internationally recognised standards of quality assurance and quality improvement. Inspectors commented on their excellent leadership and having quality improvement and patient safety embedded in their culture.
- The catering department at Tunbridge Wells Hospital has retained its 5-star Environmental Health rating.
- Our Trust has become the first organisation in Health Education Kent, Surrey and Sussex (HEKSS) region to be awarded the Skills for Health Quality Mark Award in recognition of the high quality delivery of education and training. These are all excellent achievements that deserve widespread recognition.

3. I want to pay tribute to over 150 colleagues throughout the Trust who celebrated long-service

milestones with us in August. It was a pleasure to help present their awards and reflect on their achievements.

4. Our latest employee of the month awards went to Vicky Lewis and Kiran Grewal. Vicky Lewis, who is a ward sister on Culpepper, was nominated for her outstanding leadership, the compassion she shows to patients, their families, and her colleagues, as well as her dedication to her job, which far exceeds expectations. Kiran Grewal, Quality and Patient Safety Assistant, was commended for her cheerful and helpful nature and her willingness to go above and beyond to help and support staff. Her nomination stated that she is always available to offer advice regarding patient safety and regularly visits wards to assist new staff.

   I also want to honour several colleagues who we sadly lost over the summer including Ian Cooper, Mr Mohamed Mossa, Mark Austin and Julie Bentley. Our heartfelt condolences remain with their families and colleagues and we will miss them dearly.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – September 2015

9-8 Integrated Performance Report for August 2015 Chief Executive / Executive Team

The enclosed report includes:

- The 'story of the month' for August 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 28/09/15.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 16/09/15
- Executive Team, 22/09/15
- Finance Committee, 28/09/15 (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 August 2015

Delayed transfers of care remains the key operational risk and the continuing high level is the main contributor to our inability to improve flows through the hospital and achieve the emergency access standard. The August level is 7.1% for the month accounting for 1400 lost bed days and half the delays are directly related to social care capacity and half due to health reasons. Nursing and Residential Home capacity, access to care packages and access to enablement remain the key causes.

Count of Hospital ID	Column Labels																	
Row Labels	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Grand Total
A : Awaiting Assessment	8	6	2	3	5	7	3	2		11	17	17	15	6	15	21	15	153
B : Awaiting Public Funding		2		2	7	7	6	1		1	3	2	2		1	1	4	39
C : Awaiting Further Non-Acute NHS Care	18	38	40	46	31	33	30	25	19	21	18	28	32	34	39	48	33	533
Di : Awaiting Residential Home	2	2		9	4		1	6	10	5	3	6	18	1	11	27	28	133
Dii : Awaiting Nursing Home	3	3	2	9	2	20	13	16	8	17	12	30	40	21	38	90	57	381
E : Awaiting Care Package	2	11	9	6	8	8	13	26	15	11	18	10	7	7	20	16	27	214
F : Awaiting Community Adoptions	7	8	3	6	7	2	7	8	6	9	1	8	1	11	2	1		87
G : Patient of Family Choice	36	39	44	36	59	32	46	47	36	39	47	60	60	44	44	45	16	730
H : Disputes						1							2	1			1	5
I : Housing		2	6	2				2		2		1	3	4	3	1		26
Grand Total	**76**	**111**	**106**	**119**	**123**	**110**	**119**	**133**	**94**	**116**	**119**	**162**	**180**	**129**	**173**	**250**	**181**	**2301**

The overall length of stay for non-elective admissions remains higher than expected and addressing this is one of our key priorities. Although A&E attendances were in line with plan in August the number of admissions were lower than plan which reflects the progress with the initiatives in place to prevent admissions where appropriate, such as ambulatory pathways, therapy assisted discharge and high impact team in A&E.

The Referral to Treatment (RTT) performance in August remained stable with a continued increase in elective and day case activity. Despite the improved levels of elective activity the 18 week backlog remains higher than plan which reflects earlier pressures from non-elective demand and increased referrals. This will reduce as restrictions on elective activity decrease and the application of the revised RTT rules.

The performance on Cancer targets in July (reported a month in arrears) shows a continued and expected underperformance on the 62 day target. There are 6.5 accountable breaches over the 104 day standard in July, this is 9 patients of which 4 were attributable to MTW and 5 patients who were referred in from other centres.

The Trust incurred 280 breaches of the 6 week standard for non-obstetric ultrasound in August. The service was already under close monitoring due to known risks re staffing and capacity. Although contingency plans were in place to manage the August demand a combination of late cancellations by agency staff, loss of week-end internal provision and late cancellation of outsourced capacity meant that we lost sessions without sufficient time to replace. We expect to be back on track in late Sept / early October as new staff start and another external provider has been secured.

July & August have seen 6 cases of Clostridium difficile (3 each month). This gives us a total of 9 cases year to date. The focus remains on ensuring correct antibiotic prescribing. The rate of falls remains steady for July and August but August has seen an increase in falls resulting in harm. There was one grade 3 hospital acquired pressure in July and one grade 4 in August where previously there had been no grade 3 or 4 ulcers for 9 months. Both cases have been fully investigated and concluded. There is learning and changes in practice associated with one of these very complex cases.

The month saw a small increase in the substantive workforce of the Trust, the month saw a significant level of reliance on temporary staff both nursing and medical, albeit that the number of vacant posts reduced from 525 WTE reported in July to 410 in August, Overall the worked WTE exceeded the establishment by circa 200 WTE. 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 remaining stable below 4%, and levels of statutory and mandatory slightly reduced but still above 85%. Appraisal levels are reported for the first time after the implementation period of Q1 and I am confident that the level will increase as the year progresses 2. An update on recruitment and retention will be given at the Board meeting.

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

******Emergency A&E 4hr Wait Forecast is for Quarter 4 only

	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)	21.7	15.3	20.3	9.1	-11.2	-4.1	11.5	9.7	
'1-02	Number of cases C.Difficile (Hospital)	4	3	19	9	-10	-4	27	23	
'1-03	Number of cases MRSA (Hospital)	0	0	1	1	0	1	0	1	
'1-04	Elective MRSA Screening	97.0%	98.0%	97.0%	98.0%		0.0%	98.0%	98.0%	
'1-05	% Non-Elective MRSA Screening	98.0%	97.52%	98.0%	97.52%		2.5%	95.0%	97.52%	
'1-06	**Rate of Hospital Pressure Ulcers	2.4	2.2	2.0	2.2	0.2	-0.8	*3.0*	2.2	3.0
'1-07	***Rate of Total Patient Falls	5.0	6.5	6.0	6.5	0.6	0.3	*6.2*	6.2	
'1-08	***Rate of Total Patient Falls Maidstone	4.7	5.4	5.3	5.7	0.4			5.6	
'1-09	***Rate of Total Patient Falls TWells	5.4	6.7	6.5	7.1	0.6			7.0	
'1-10	Falls - SIs in month		6		16	16				
'1-11	Number of Never Events	1	0	2	0	-2	0	*0*	0	
'1-12	Total No of SIs Open with MTW	29	24			-5				
'1-13	Number of New SIs in month	8	10	48	40	-8	-10			
'1-14	**Serious Incidents rate	0.43	0.51	0.51	0.41	-0.11	0.34	*0.0683 - 1.0115*	0.41	*0.0683 - 1.0115*
'1-15	**Medication errors causing serious harm	0	0	0	0	0	0	*0 - 0.045*	0	*0 - 0.045*
'1-16	Rate of Patient Safety Incidents - harmful	1.32	1.49	1.32	1.29	-0.03	-0.41	*0 - 1.698*	1.29	*0 - 1.698*
'1-17	Number of CAS Alerts Overdue	0	0			0	0	*0*		
'1-18	VTE Risk Assessment	95.5%	95.2%	95.6%	95.2%	-0.4%	0.2%	95.0%	95.2%	95.0%
'1-19	Safety Thermometer % of Harm Free Care	96.2%	96.6%	96.8%	96.9%	0.1%	1.9%	95.0%		93.4%
'1-20	Safety Thermometer % of New Harms	3.17%	2.49%	2.58%	2.33%	-0.26%	-0.67%	*3.00%*	2.33%	
'1-21	C-Section Rate (non-elective)	13.2%	13.6%	14.5%	12.7%	-1.75%	-2.29%	*15.0%*	12.7%	

	Effectiveness	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	Hospital-level Mortality Indicator (SHMI)******	Prev Yr: Oct 13 to Sept 14		103.4	104.0	0.6	4.0	*Lower confidence limit to be <100*		100.0
2-02	Standardised Mortality (Relative Risk)	Prev Yr: Oct 13 to Sept 14		106.9	105.0	-1.9	5.0			100.0
2-03	Crude Mortality	1.0%	0.9%	1.1%	1.1%	0.0%				
2-04	****Readmissions <30 days: Emergency	12.0%	9.9%	12.0%	11.1%	-0.8%	-2.5%	*13.6%*	11.1%	14.1%
2-05	****Readmissions <30 days: All	11.4%	9.1%	10.9%	10.2%	-0.6%	-4.4%	*14.7%*	10.2%	14.7%
2-06	Average LOS Elective	3.2	3.6	3.1	3.25	0.1	0.0	*3.2*	3.2	
2-07	Average LOS Non-Elective	6.3	7.5	6.6	7.3	0.8	0.9	*6.5*	6.5	
2-08	New:FU Ratio	1.49	1.46	1.52	1.45	-0.07	-0.07	*1.52*	1.52	
2-09	Day Case Rates	84.6%	83.0%	83.1%	83.5%	0.4%	3.5%	80.0%	83.5%	82.2%
2-10	Primary Referrals	7,681	7,481	42,266	43,759	3.5%	3.1%	102,995	106,211	
2-11	Cons to Cons Referrals	3,109	2,804	17,311	16,809	-2.9%	3.1%	39,585	40,799	
2-12	First OP Activity	10,858	10,524	58,984	57,052	-3.3%	0.8%	137,412	138,476	
2-13	Subsequent OP Activity	19,292	20,480	106,436	106,140	-0.3%	-1.2%	260,800	257,620	
2-14	Elective IP Activity	568	638	3,274	3,372	3.0%	2.5%	7,988	8,184	
2-15	Elective DC Activity	2,970	3,130	15,508	16,271	4.9%	2.4%	38,556	39,493	
2-16	Non-Elective Activity	3,840	3,611	19,973	19,080	-4.5%	-5.5%	48,289	45,642	
2-17	A&E Attendances (Calendar Mth)	10,189	11,271	57,026	57,601	1.0%	1.4%	135,922	137,791	
2-18	Oncology Fractions	5,389	5,160	29,003	27,604	-4.8%	-8.0%	71,761	66,033	
2-19	No of Births (Mothers Delivered)	476	469	2,386	2,479	3.9%	4.2%	5,708	5,950	
2-20	% Mothers initiating breastfeeding	82.8%	79.5%	81.3%	80.3%	-1.0%	2.3%	78.0%	78.0%	
2-21	% Stillbirths Rate	0.2%	0.00%	0.12%	0.32%	*0.2%*	*-0.2%*	*0.47%*	0.32%	0.47%

	Caring	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Single Sex Accommodation Breaches	5	0	5	0	-5	0	0	0	
3-02	*****Rate of New Complaints	1.79	2.14	3.79	1.98	-1.81	0.66	*1.318-3.92*	1.96	
3-03	% complaints responded to within target	50.0%	82.8%	50.0%	71.1%	21.1%	-3.9%	75.0%	73.4%	
3-04	****Staff Friends & Family (FFT) % rec care	New	84.0%	New	84.0%	New	9.0%	75.0%	75.0%	79.2%
3-05	*****IP Friends & Family (FFT) % Positive	New	96.2%	New	96.8%	New	1.8%	95.0%	95.0%	95.9%
3-06	A&E Friends & Family (FFT) % Positive	New	89.0%	New	89.0%	New	2.0%	87.0%	87.0%	88.2%
3-07	Maternity Combined FFT % Positive	90.5%	96.2%	91.4%	94.6%	3.2%	-0.4%	95.0%	95.0%	95.6%
3-08	OP Friends & Family (FFT) % Positive	New	80.5%	New	79.0%	New			79.0%	

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

	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	96.1%	89.9%	95.2%	90.8%	-4.4%	-4.2%	95.0%	95.0%	93.2%
4-02	Emergency A&E >12hr to Admission	0	0	2	0	-2	0	*0*	0	
4-03	Ambulance Handover Delays >30mins	New	No data	New	No data				No data	
4-04	Ambulance Handover Delays >60mins	New	No data	New	No data				No data	
4-05	18 week RTT - admitted patients	92.7%	90.2%	88.2%	92.1%	4.0%	2.1%	90%	92.1%	
4-06	18 week RTT - non admitted patients	96.5%	97.4%	96.3%	98.1%	1.8%	3.1%	95%	98.1%	
4-07	18 week RTT - Incomplete Pathways	95.5%	96.6%	95.5%	96.6%	1.2%	4.6%	92%	96.6%	
4-08	18 week RTT - Specialties not achieved	2	5	14	21	7	21	-	21	
4-09	18 week RTT - 52wk Waiters	0	1	-	8	8	8	-	8	
4-10	18 week RTT - Backlog 18wk Waiters	364	592	364	592				592	
4-11	% Diagnostics Tests WTimes <6wks	100.0%	96.24%	100.0%	96.24%	-3.7%	-2.8%	99.0%	99.0%	
4-12	*Cancer WTimes - Indicators achieved	9	7	8	7	-1	-2	9	9	
4-13	*Cancer two week wait	95.1%	93.5%	95.7%	93.2%	-2.5%	0.2%	93.0%	93.0%	
4-14	*Cancer two week wait-Breast Symptoms	95.4%	95.0%	94.4%	95.5%	1.1%	2.5%	93.0%	95.5%	
4-15	*Cancer 31 day wait - First Treatment	100.0%	98.5%	99.0%	98.7%	-0.3%	2.7%	96.0%	98.7%	
4-16	*Cancer 62 day wait - First Definitive	85.4%	79.4%	83.1%	81.2%	-1.9%	-3.8%	85.0%	85.0%	
4-17	*Cancer 62 day wait - First Definitive - MTW	90.8%	84.3%	86.9%	86.0%	-0.9%		85.0%		
4-18	*Cancer 104 Day wait Accountable	New	6.50	New	23.0	New	23.0	-	23.0	
4-19	Delayed Transfers of Care	5.1%	7.1%	4.0%	6.4%	2.4%	2.9%	3.5%	5.0%	
4-20	% TIA with high risk treated <24hrs	75.0%	74.2%	72.8%	71.4%	-1.4%	11.4%	60%	60.0%	
4-21	% spending 90% time on Stroke Ward	91.1%	82.8%	80.8%	85.2%	4.4%	5.2%	80%	80.0%	
4-22	Stroke:% to Stroke Unit <4hrs	49.0%	45.5%	38.5%	51.6%	13.0%	-3.4%	55.0%	55.0%	
4-23	Stroke: % scanned <1hr of arrival	40.8%	56.8%	45.0%	52.1%	7.2%	9.1%	43.0%	43.0%	
4-24	Stroke:% assessed by Cons <24hrs	75.5%	70.5%	73.1%	73.7%	0.7%	-11.3%	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%	

*CWT run one mth behind, ** Serious Incidents and Medication Errors Rate is per 1,000 Occupied Beddays

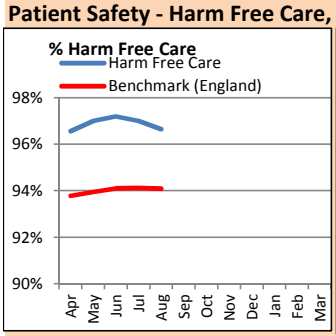
*** Contracted not worked includes Maternity /Long Term Sick **** Staff FFT is Quarterly therefore data is latest Quarter

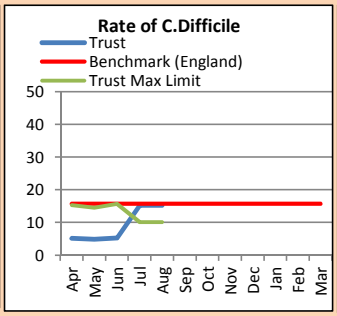
***** IP Friends and Family includes Inpatients and Day Cases ******SHMI is within confidence limit

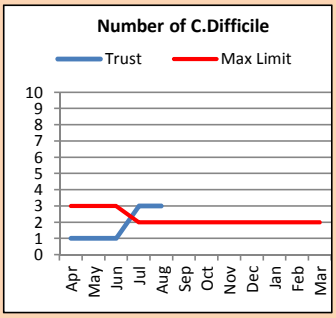
	Well-Led	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
5-01	Income	31,231	32,237	156,537	164,503	5.1%	1.2%	400,587	408,066	
5-02	EBITDA	1,608	537	7,032	5,198	-26.1%	-23.3%	23,671	23,671	
5-03	Surplus (Deficit) against B/E Duty	(1,242)	(2,397)	(7,981)	(9,090)			(12,132)	(12,132)	
5-04	CIP Savings	1,932	1,916	8,427	8,372	-0.7%	-6.6%	21,496	21,496	
5-05	Cash Balance	9,783	15,159	9,783	15,159	55.0%	-21.1%	2,127	2,127	
5-06	Capital Expenditure	293	1,282	1,176	3,261	177.3%	-21.2%	*16,313*	16,313	
5-07	Establishment (Budget WTE)	5,398.8	5,378.8	5,398.8	5,378.8	-0.4%	0.0%		-	
5-08	Contracted WTE	4,918.0	4,969.5	4,918.0	4,969.5	1.0%	-2.5%			
5-09	***Contracted not worked WTE	(113.0)	(98.5)	(113.0)	(98.5)					
5-10	Locum Staff (WTE)	11.3	50.8	11.3	50.8	347.9%				
5-11	Bank Staff (WTE)	325.2	317.1	325.2	317.1	-2.5%				
5-12	Agency Staff (WTE)	150.0	278.7	150.0	278.7	85.8%				
5-13	Overtime (WTE)	75.6	70.3	75.6	70.3	-7.1%				
5-14	Worked Staff WTE	5,387.4	5,587.4	5,387.4	5,587.4	3.7%	3.9%			
5-15	Vacancies WTE	480.9	409.4	480.9	409.4	-14.9%				
5-16	Vacancy %	8.9%	7.6%	8.9%	7.6%	-14.6%				
5-17	Nurse Agency Spend	(264)	(897)	(1,660)	(4,441)	167.6%				
5-18	Medical Locum & Agency Spend	(770)	(1,168)	(3,609)	(5,220)	44.6%				
5-19	Temp costs & overtime as % of total pay bill									
5-20	Staff Turnover Rate	9.7%	9.9%		9.7%	0.3%	-0.6%	*10.5%*	9.7%	8.4%
5-21	Sickness Absence	4.1%	3.9%		4.0%	-0.2%	0.6%	*3.3%*	3.3%	3.7%
5-22	Statutory and Mandatory Training	84.9%	87.3%		87.3%	2.4%	2.3%	85.0%	85.0%	
5-23	Appraisal Completeness	69.3%	77.1%		77.1%	7.8%	-12.9%	90.0%	90.0%	
5-24	Overall Safe staffing fill rate	99.8%	100.1%	100.3%	101.8%	0.4%		TBC	101.8%	
5-25	****Staff FFT % recommended work	New	58.8%	New	58.8%		0.8%	58.0%	58.8%	62.9%
5-26	***Staff Friends & Family -Number Responses	New	393	New	393					
5-27	*****IP Resp Rate Recmd to Friends & Family	New	24.4%	New	27.4%		-2.6%	30.0%	30.0%	27.6%
5-28	A&E Resp Rate Recmd to Friends & Family	New	22.7%	New	12.2%		-7.8%	20.0%	20.0%	15.2%
5-29	Mat Resp Rate Recmd to Friends & Family	19.5%	20.7%	21.2%	14.1%	-7.1%	-0.9%	15.0%	15.0%	22.4%

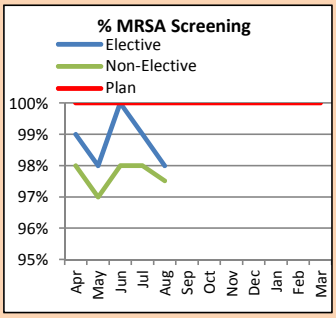
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

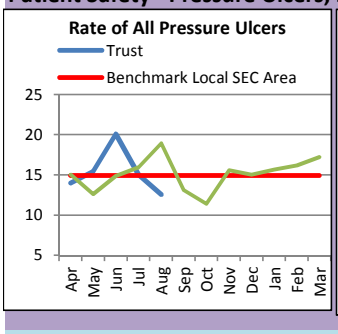


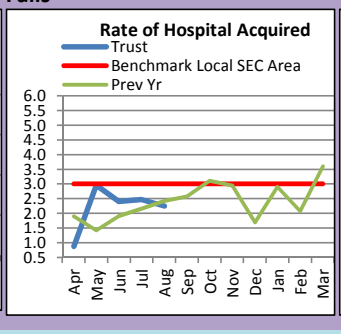


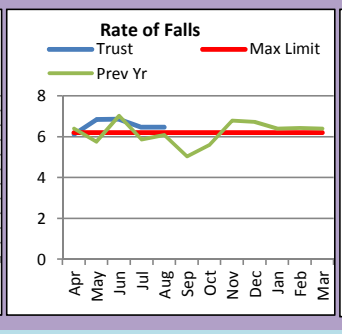


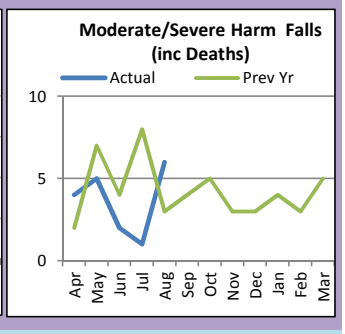


Patient Safety - Pressure Ulcers, Falls

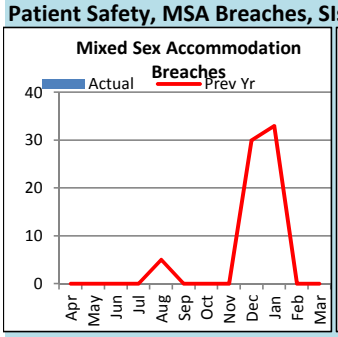


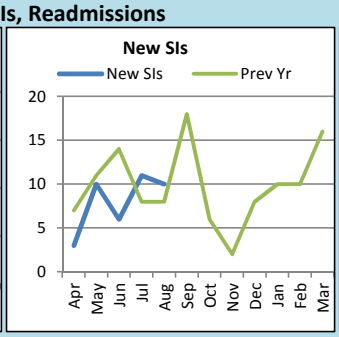


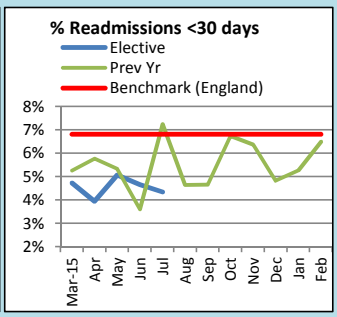


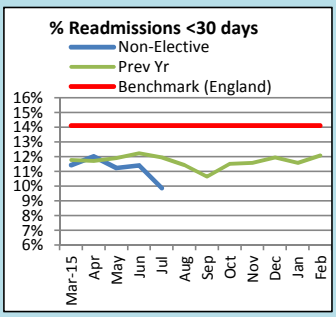


Patient Safety, MSA Breaches, SIs, Readmissions

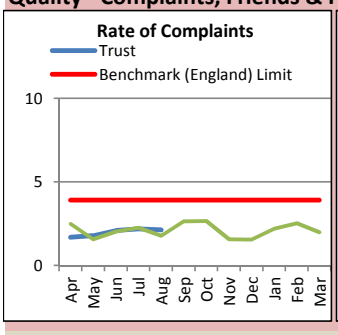


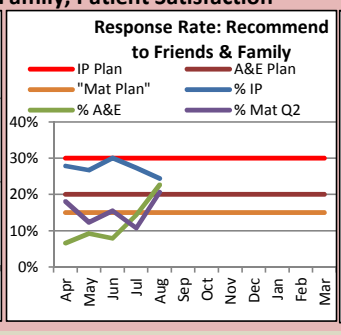


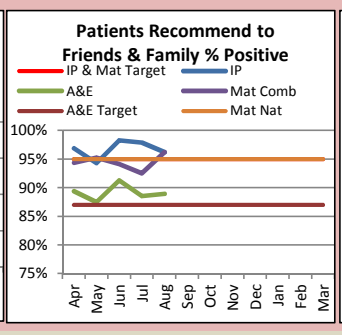


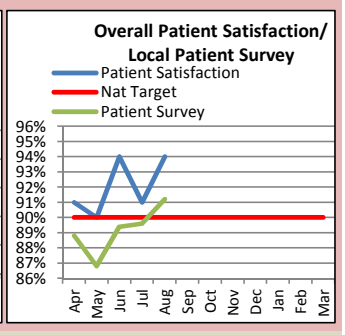


Quality - Complaints, Friends & Family, Patient Satisfaction

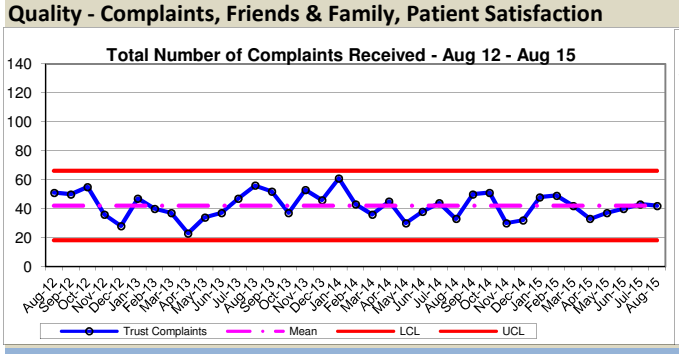


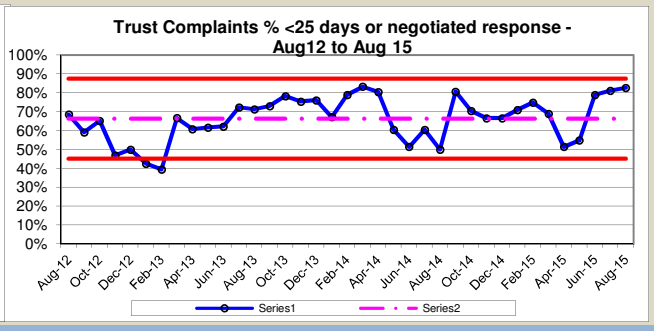




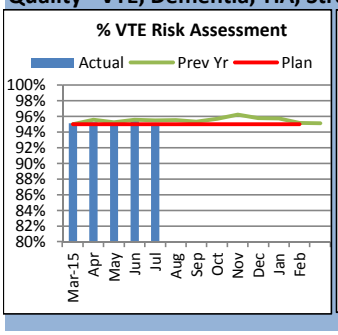


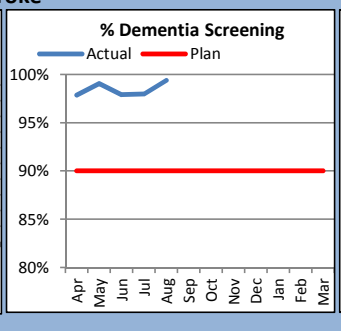
Quality - Complaints, Friends & Family, Patient Satisfaction

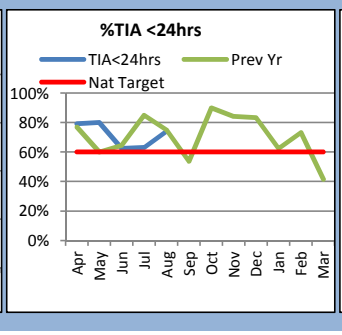


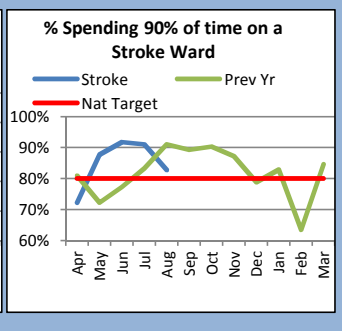


Quality - VTE, Dementia, TIA, Stroke



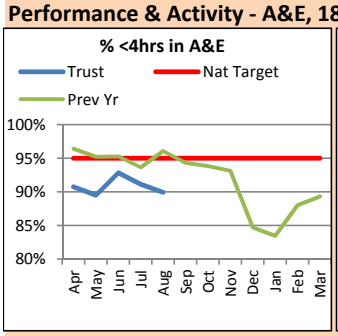


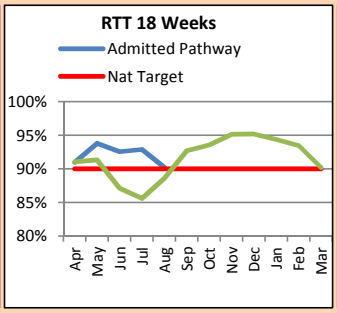


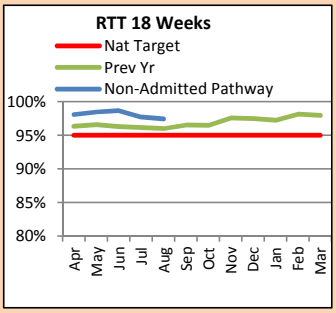


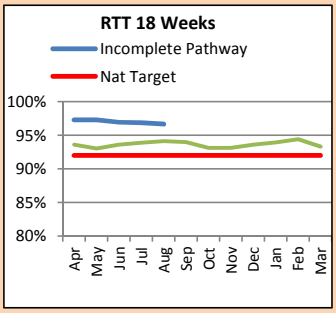
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

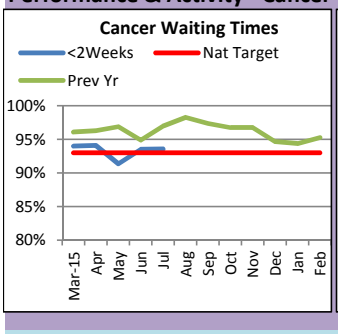


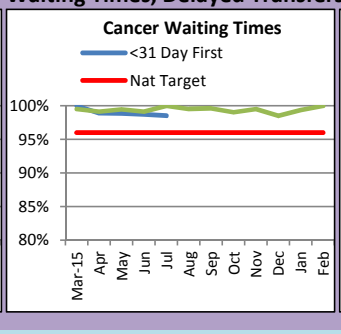


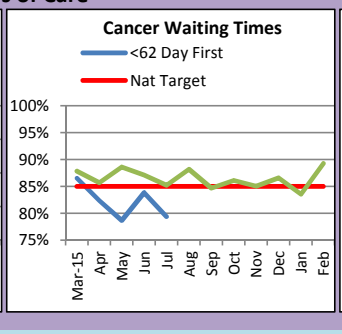


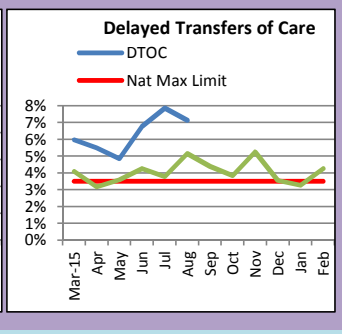


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

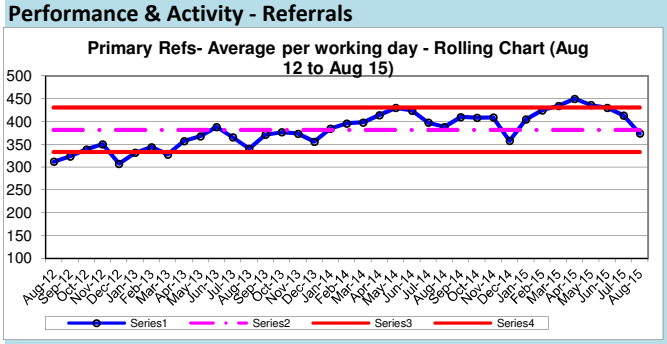


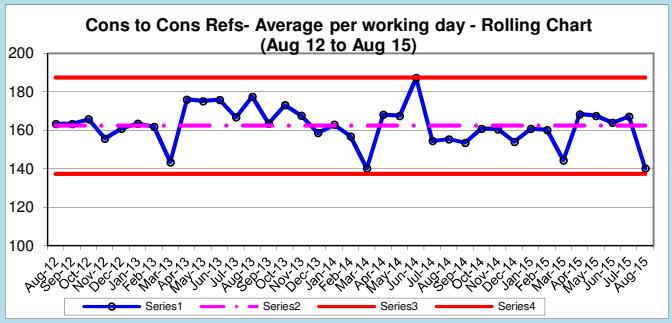




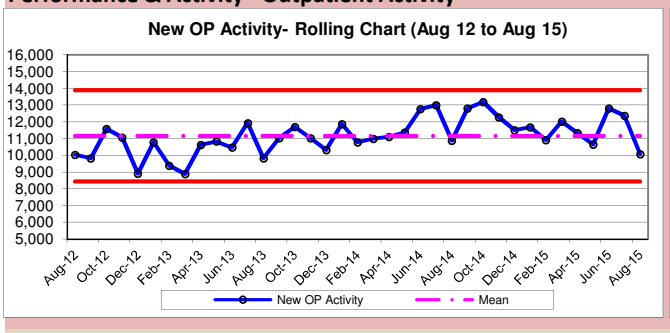


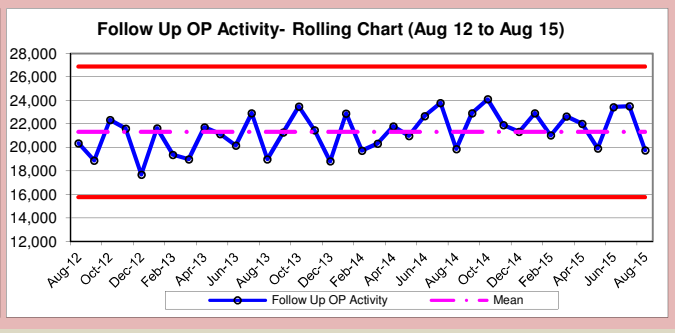
Performance & Activity - Referrals



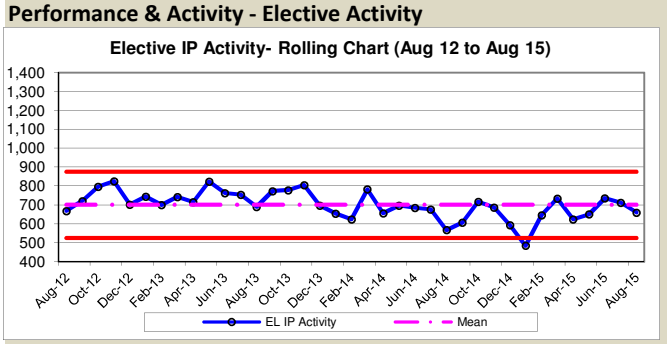


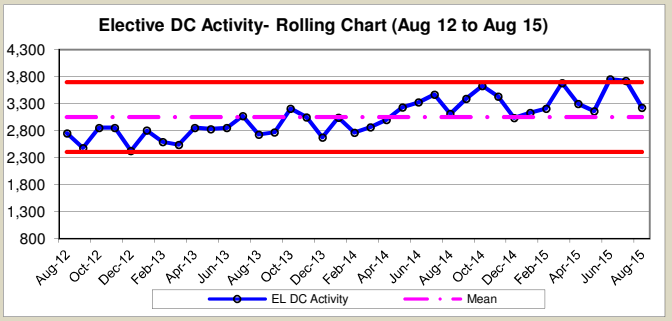
Performance & Activity - Outpatient Activity



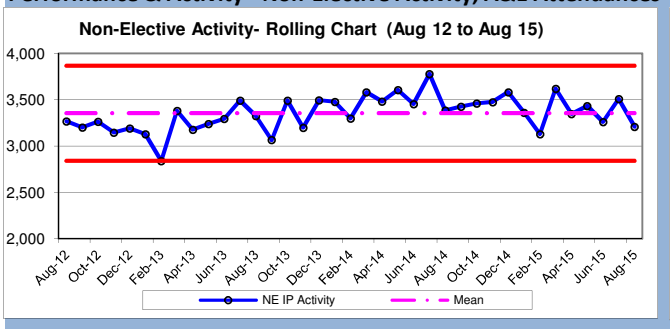


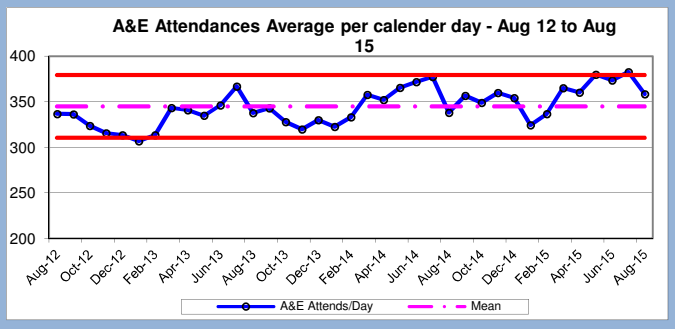
Performance & Activity - Elective Activity





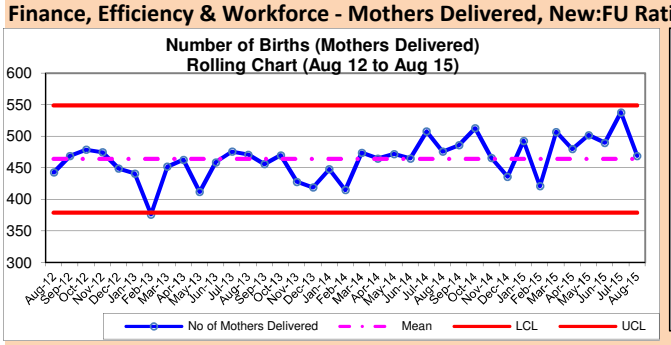
Performance & Activity - Non-Elective Activity, A&E Attendances

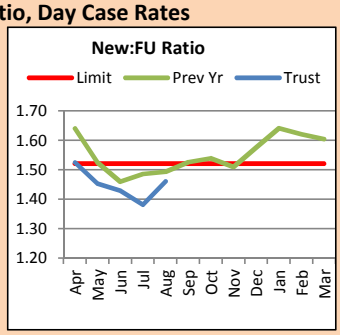


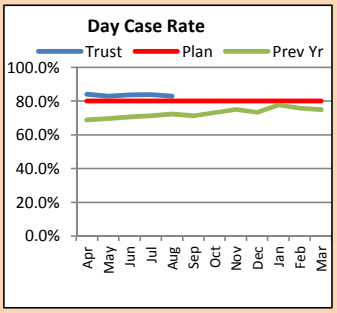


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

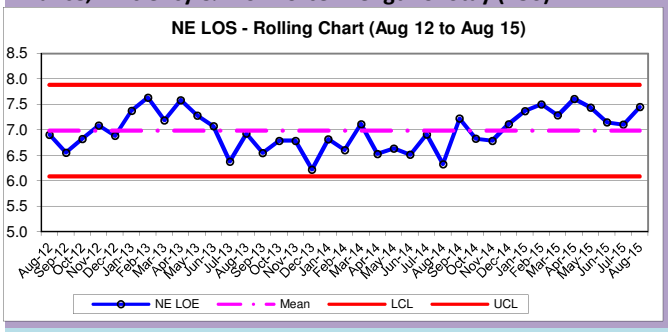
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

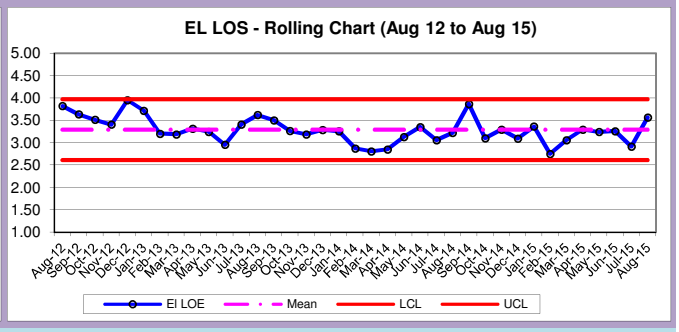




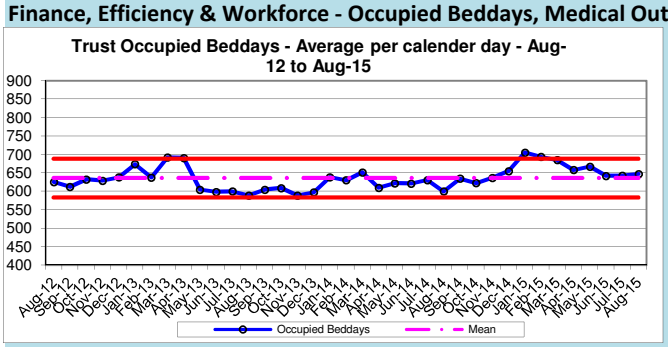


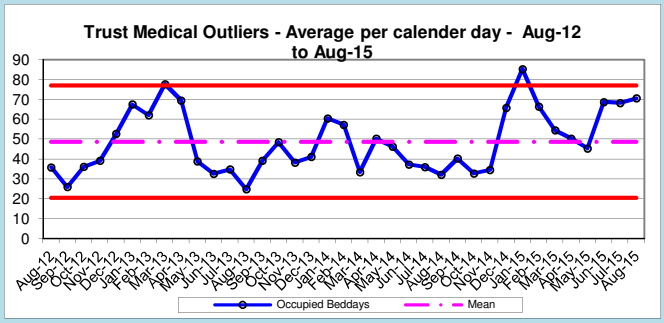
Finance, Efficiency & Workforce - Length of Stay (LOS)



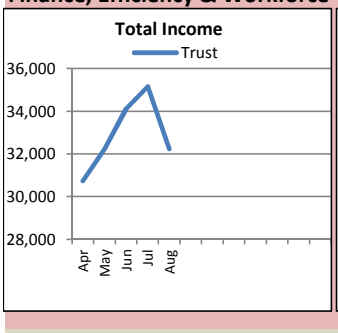


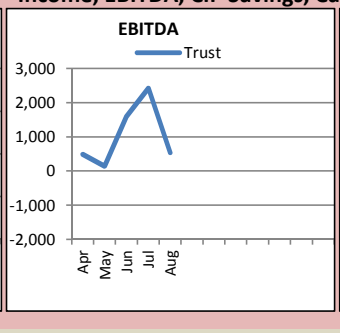
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

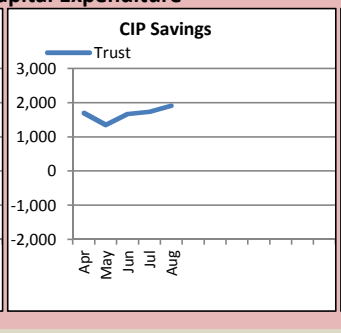


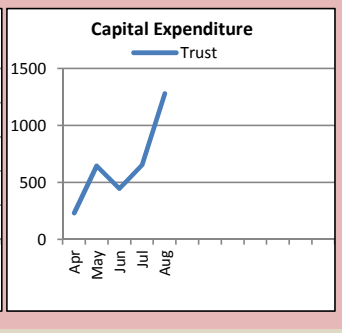


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

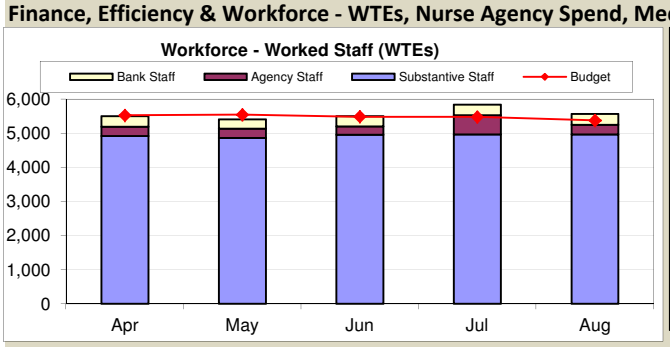


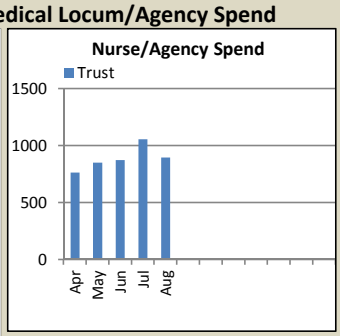


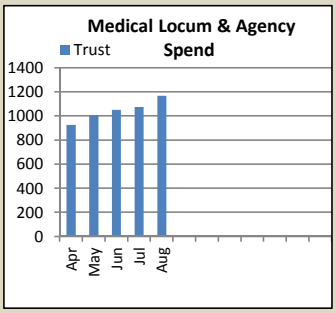




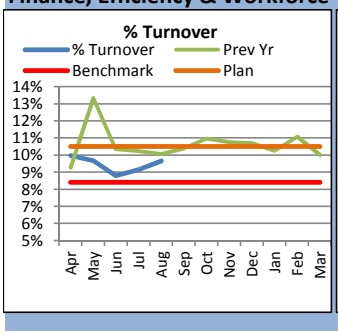
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

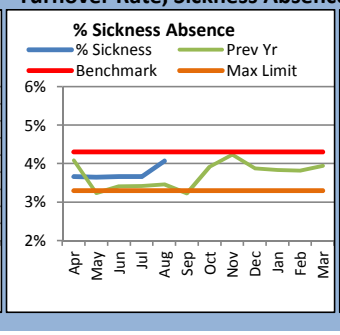


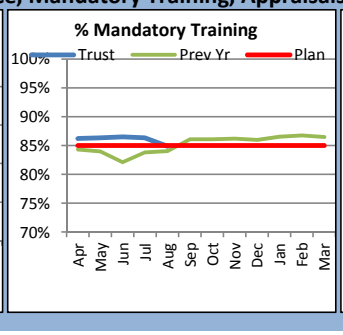


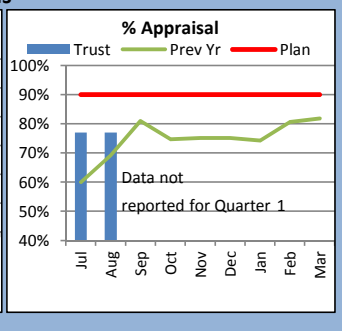


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Briefing paper – Trust Board

M5 Financial Performance overview

1. Overview of the Financial Position at M5 2015/16

1.1. This written summary provides an overview of the financial position at M5 of 2015/16. It should be read alongside the finance pack, which has also been circulated to Board members.

1.2. Under the TDA Accountability Framework the Trust is flagged as Red due to its reported financial position at month 5. The Finance pack shows for month 5 the Trust moved out adversely by £0.35m against its in-month deficit plan of £2.1m resulting in a year to date deficit of £9.1m against a planned deficit of £8.2m. This is an adverse year to date variance of £0.9m. These figures include the full utilisation of reserves available for the first five months of 2015/16.

1.3. Financing to support the Trust's liquidity has been planned but is yet to be agreed. The Trust is preparing the documentation needed to establish in the first place an Interim Revolving Working Capital facility (IRWCF), which may then be converted into a more formal loan or PDC product in 2016/17. The IRWCF documentation will require a Board resolution which is planned for the October Trust Board for approval.

Income

1.4. Total income for the year to date is £164.5m against a budget of £162.6m. Income for the month is £32.2m compared to the £32.1m plan for the month.

1.5. The income headlines are outlined below:

- Total income is £1.9m favourable to plan year to date. The "pure" SLA contract activity position is £5.9m over plan year to date, but this is offset by the plan expectations of additional income for CIP and additional service development schemes. The budget for these plans is currently in "other NHS clinical income" but will be analysed into the constituent point of delivery categories for month 6.
- All applicable contractual deductions and penalties have been included and a provision has been made for challenges. A total of £2.7m provisions/deductions and £1.8m threshold adjustments have been included in the year to date income position, with £9.97m provisions/deductions and £4.4m threshold adjustments in the forecast outturn.
- A&E attendances activity had its lowest YTD level
- Conversion rate remains unchanged from June 2015 level

1.6. There was a reduction in Elective inpatient and day case activity compared to last month's level (£4.76m in M5 compared to £5.38m in month 4, with YTD over performance of £0.46m) as expected in the plan. Overall the figures were relatively strong, and higher than in August last year. Even though there was some benefit realised from better bed management and a reduced number of escalation beds compared with July (Trust average 44 in April, 50 in May and June, 52 in July and 46 in August), capacity was still pressured as a result of a high level of cancellations, sustained occupancy rates and an increase in length of stay including sustained high levels of Delayed Transfers of Care.

1.7. A&E attendances reduced in August although income per attendance rose by 3% indicating more complex case mix. Overall the rate of conversion from A&E admission remained static at 25% resulting in a decreased level of Non - Elective admissions. The level of reduction in admissions was greater than that seen in the previous year and followed a level of non-elective activity in July that was also lower than in 2014/15.

1.8. As a result, Non Elective income decreased from £7.5m in M4 to £6.8m in M5 and the YTD performance is now £0.2m below plan. The decrease in income reflects a combination of reduced A&E attendances and reduced discharges in August. This is supported by the lack of a corresponding drop in bed occupancy for Non elective patients, increased LOS and the on-going high level of delayed transfers of care. The Non Elective patients in August present a less complex casemix for those patients that were discharged in the month and therefore a lower average income per spell.

The high level of bed occupancy and delayed transfers of care contributed to the Trust's continuing use of escalation beds with the associated impact temporary staffing use.

1.9. Outpatient activity has decreased from last month's level (£4.7m in M5 compared to £5.1m in M4). The decrease was expected in line with the previous year's trend as a result of the reduced number of working days in August and an adjustment was made in the plan for the expected seasonal effect. Year on year, the income from Outpatients was 10% higher than in M5 of the previous financial year.

1.10. Readmissions, A&E waits and RTT penalties relating only to incomplete pathways were -£1.5m in August compared to the -£1.2m performance in July.

1.11. An 85% achievement rate for CQUINs has been assumed in the income position.

1.12. Transitional support of £1.5m year to date for Cancer received from NHS England to reduce the impact of the cancer tariff in 2015-16 has been included in the position.

Expenditure

1.13. Operating costs are £3.5m adverse YTD against a plan of £155.8m. Pay deteriorated against plan by £1.3m in August generating a year to date adverse variance of £3.8m. This continues the upward pressure on overall pay costs seen in the last three months.

1.14. Non pay costs were also favourable by £0.7m in the month and overall are now underspent by £0.2m.

1.15. Year to date substantive staffing was underspent year to date by £1.8m due to prior period vacancies in Scientific posts (£0.3m), medical staffing (£0.6m), clerical (£0.5m) and nursing (£0.4m). In the month substantive pay costs were largely on or over budget.

1.16. At the end of August agency Nursing (-£3.0m), Medical agency (-£1.4m) and Scientific/Therapeutic agency (-£0.5m) are the major overspends to plan year to date. In the month there was a small reduction from July's level in nurse agency spend, while medical and scientific staff costs increased. Bank and locum costs also increased to their highest levels of the year to date, with the result that they are collectively overspent by £0.1m.

1.17. A review of the underlying drivers of the nurse agency usage was reported to the Trust Management Executive by the Chief Operating Officer and to the Finance Committee.

1.18. Actions taken to address the nurse agency usage include:

- An updated and published temporary nursing recruitment process setting out requirements and necessary approvals
- Strengthened approvals for patient specials agency requests, with senior nursing team and Executive on call approval required
- Improvements to Rota management requiring 6 weeks advance rota production with challenge and sign off by the relevant matron

- A Trust trajectory plan for the migration from non-framework suppliers to framework contractors by January 2016 focussed in particular on the two agencies that supply on average 50% of the shifts requiring cover. As part of this migration plan approved shift requests are being issued to framework agencies two weeks in advance.
- A procurement strategy which has "tiered" preferred suppliers to achieve best rates
- Planned de-escalation of Whatman ward from 12th October and re-open in December as a winter ward. De-escalation of TWH SAU and Cath Lab from February 2016
- Overseas and local recruitment initiatives to reduce vacancies.
- Reconfiguration of the TWH bed base as part of the implementation of the new ward opening

1.19. The Trust has submitted a trajectory plan to the TDA in response to the new controls and agency ceiling of 6%. The Trust has requested an amendment to the ceiling for quarter 3 and quarter 4 this year in order to manage the migration to framework agencies safely and to implement the new ward at TWH. The table below shows the trajectory reduction (for trained nursing). Directorates have been asked to provide trajectory plans for each area that is over the target requirement.

	Actual	Plan	Monthly revised plan values					
Nursing Employee Benefits	Month ending 31-Aug-15	Month ending 30-Sep-15	Month Ending 31-Oct-15	Month Ending 30-Nov-15	Month Ending 31-Dec-15	Month Ending 31-Jan-16	Month Ending 29-Feb-16	Month Ending 31-Mar-16
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Nursing - Total Agency costs (excluding outsourced bank)	796	795	648	551	471	520	390	297
Nursing - Total Gross Employee Benefits (including agency)	6,032	6,044	5,910	5,844	5,764	5,901	5,817	5,725
Nursing agency costs as % of total nursing costs	13.20%	13.15%	10.96%	9.43%	8.17%	8.81%	6.70%	5.19%

1.20. Non pay underspent by £0.7m in August and is now £0.2m favourable to budget year to date.

1.21. Significant overspends for the year to date are:

- Drugs and medical gases £0.6m adverse (offset in the position by the over performance in HCD income to date of £0.6m)
- Clinical Supplies is £1.2m adverse to plan – this includes cardiology devices (e.g. ICDs) that are charged back to the CCGs.
- Purchase of Healthcare from non NHS is adverse to plan by £1.1m reflecting outsourced usage to date. This is largely offset by the corresponding activity based income.

1.22. The main areas of under-spending in non-pay are in "other non-pay costs" which includes the reserves and contingencies released into the position. This is now £2.5m underspent to date. Premises is £0.7m underspent to date; it includes the budget for the PAS replacement costs which are included in the budget to date but the costs are yet to materialise.

1.23. EBITDA is a £5.2m surplus and is now adverse to plan by -£1.6m.

1.24. The financing costs including those related to the PFI and deprecation total £14.6m year to date which is underspent against the plan by £0.8m. The plan was agreed prior to the finalisation of the revaluation in year-end accounts, which reduced planned levels of deprecation. In addition, the in-year capital plan reprioritisation and "capping" to provide

funding for the new TWH ward development has slowed down originally planned spend, and diverted it from shorter life, higher depreciating assets such as medical and IT equipment into build assets.

Forecast Outturn

1.25. The performance in August, particularly the sustained level of pay costs including agency reliance, is putting increased pressure on the Trust's ability to deliver the original planned deficit of £14.1m. The Trust needs to deliver on its CIP programme and achieve the planned reduction in agency spend, while maintaining control over substantive staffing and non-pay costs, and at the same time manage its non-elective flows, reducing length of stay and DTOCs, so as to optimise its ability to deliver its elective and OP activity. The Trust is considering further actions to support the delivery of its financial plan.

1.26. The outturn submitted to the TDA in month 5 has been revised down to £12.1m in line with the Trust's response to the TDA Finance Improvement letter. £0.3m of the improvement relates to the planned reduction in loan capital requests and associated capital programme prioritisation. The remaining £1.7m of improvements relate to income areas that require either CCG or NHS England support to achieve.

Balance Sheet & Capital

1.27. Cash balances of £15.2m were held at the end of August (£19.1m at the end of July). The Trust still has the benefit of the advance of one month's contract payment from CCGs along with its normal April payment.

1.28. Total debtors are £21m, £1.5m lower than the reported July figure. Debt over 90 days has reduced by £0.2m to £4.4m at the end of August. Debtors in excess of a £1m are;

- WKCCG £4.0m
- EK Hospitals FT £2.5m
- Medway FT £1.7m
- Medway CCG £1.7m
- NHS England £1.0m

90 day invoiced debt for private patients billed through Compucare is currently £0.3m (£1.2m in total for all invoiced debt) with other non NHS invoiced debt over 90 days old totalling £0.2m (£1.4m in total).

1.29. Total creditors are £42.3m. Against the 95% target for payments made within 30 days the Trust achieved in value 86.3% in August for Trade creditors (81.3% in March 2015) and 84.1% in August for NHS creditors (66.6% in March 2015).

1.30. Capital expenditure to month 5, net of donated assets, was £3.1m against the profiled plan £4.1m. The Trust has revised its planned outturn to the TDA in line with its Finance Improvement response, reducing its request for capital loans by £3m. The Trust is therefore committed to finance £2m of the planned new ward expenditure, whilst still seeking £2.5m as a loan. The radiotherapy satellite project has been reduced for 2015/16 to £1m loan request against the same level of planned costs.

1.31. The Trust has not yet agreed the disposal of the Hillcroft property so the assumed resource from this property sale of £0.9m has been removed from the capital position reducing the overall capital resource to £16.16m. With the estimated donated assets of £0.15m, this adds up to a revised planned capital spend of £16.3m.

1.32. The loans remain dependent upon approval from the TDA to the supporting business case. The "capped plan" was agreed internally in order to ensure the Trust has sufficient resource to finance the new ward if a loan is not agreed. If a loan is agreed, the deferred/delayed projects can be released subject to covering other issues e.g. the reduction in resource relating to the disposal of Hillcroft.

1.33. If the loans are not agreed, the Trust will need to reduce planned spend further by c.£1.4m, to a level of £13.8m for the year. This would be a very tight target for the Trust to achieve so in order to mitigate against the risk of CRL overspend, projects already agreed within the “capped” plan total, but not yet committed, will be paused until the decision on the loan applications is known. Latest information from the TDA suggests that this will not be until the Comprehensive Spending Review is completed, suggesting December at the earliest.

2. CIP Delivery

2.1. The month 5 position shows a CIP delivery of £8.4m against the target that was included in the TDA plan of £9.0m, so under-performing by £0.6m to date.

2.2. The schemes identified are forecast to deliver £20.3m by year end which is unchanged from the forecast reported at month 4, and leaves £1.2m of schemes that the Trust is working to identify.

2.3. Against the year to date total CIP expectation of £9.0m, shortfalls in Medical Efficiency (-£0.4m), Length of Stay (-£0.6m) and procurement (-£0.15m) are offset by overachievement in Contract Management (+£0.8m) and Nursing and Scientific staff efficiencies (+£0.1m).

3. Conclusion

3.1. August elective performance was lower than the previous month as planned, adjusted for seasonality, but nonetheless relatively strong compared with last year. A&E attendances and non-elective admissions reduced by a greater level than planned, and compared with the previous year, while at the same time bed occupancy and length of stay remained high, as sustained levels of delayed discharges impacted on the Trust. Consequently the Trust’s use of escalation beds continued around the levels seen during this financial year, though at the lower end of the range in August.

3.2. Staffing costs overall were the highest of the year to date, with the Trust both increasing establishment and remaining reliant on high levels of temporary staffing. Action to reduce both the use of temporary staffing and the cost of agency is being implemented with Directorates having trajectory targets to progressively reduce reliance on agency staffing, and to convert to framework contractors.

3.3. The risks identified in the previous months remain, with sustained costs of using temporary staffing. In order to achieve its financial targets the Trust will need to deliver its full CIP programme and ensure it reduces reliance on agency staff especially within nursing. The benefits from actions to reduce the rates paid to agencies and strengthen the controls on temporary staffing are planned to be seen from October onwards.

3.4. The Trust Board is requested to note this report.

Maidstone and Tunbridge Wells NHS Trust

Finance Pack

M5 - August 2015

August 2015

Maidstone and Tunbridge Wells NHS Trust

Contents

Key Performance Indicators as at Month 5 2015/16

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

Maidstone and Tunbridge Wells NHS Trust

Key Metrics (A) Accountability Framework	Current Month Metrics: Plan (mc 01) £000s	Actual / Forecast (mc 02) £000s	Variance (mc 03) £000s	RAG Rating (mc 04)
NHS Financial Performance				
1a) Forecast Outturn, Compared to Plan	(12,132)	(12,132)	0	RED
1b) Year to Date, Actual compared to Plan	(8,194)	(9,090)	(896)	AMBER
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	6,500	6,033	(467)	
- Recurrent Efficiencies for Year to Date compared to Plan	6,500	6,033	(467)	
2b) Actual Efficiency recurring/non-recurring compared to plan - Forecast compared to plan				GREEN
- Total Efficiencies for Forecast Outturn compared to Plan	18,146	18,274	128	
- Recurrent Efficiencies for Forecast Outturn compared to Plan	18,146	18,274	128	
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	16,163	16,163	0	GREEN
5) Permanent PDC accessed for liquidity purposes		0		GREEN

Trust Overall RAG Rating				
				RED

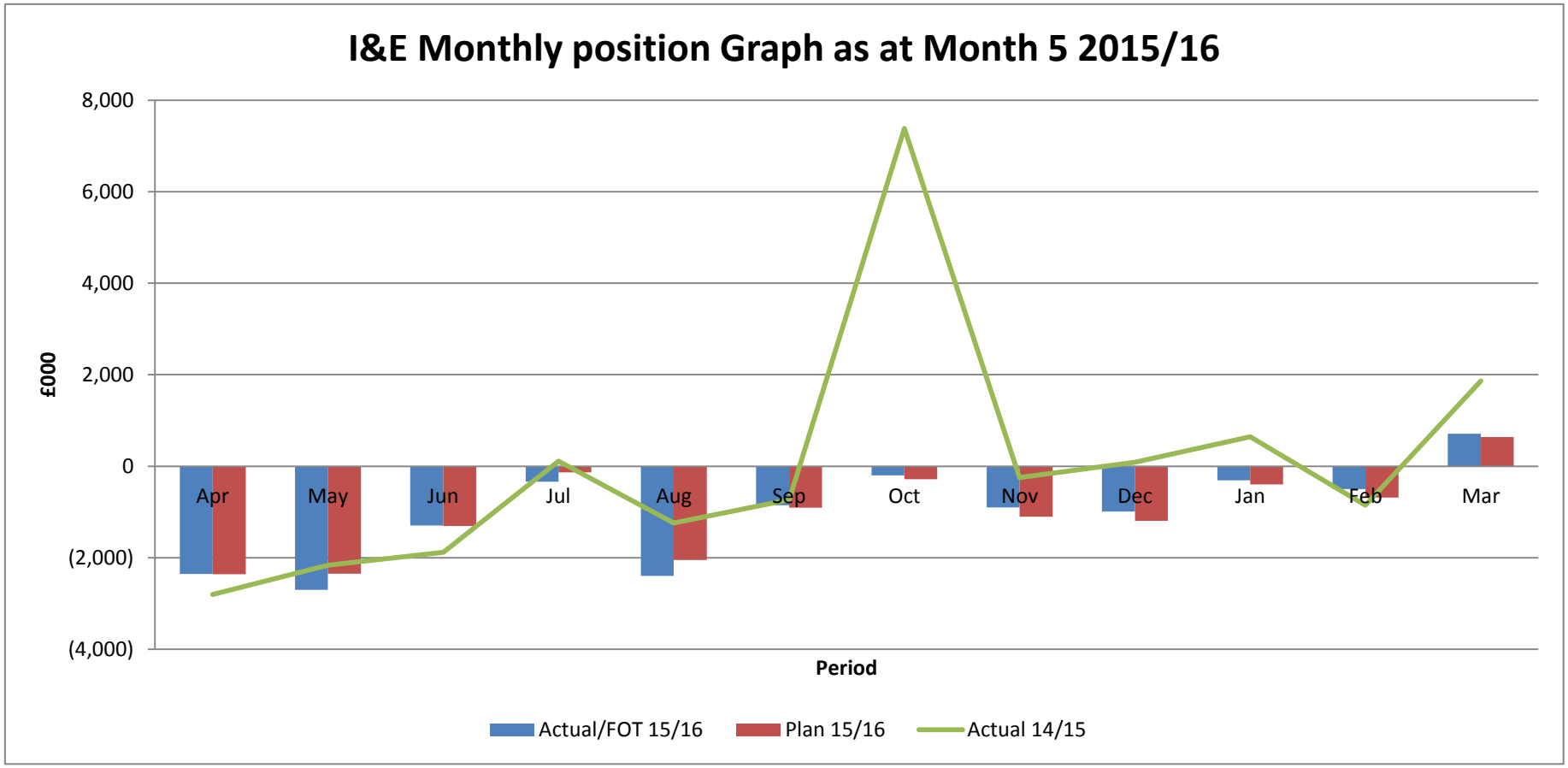
(B) Continuity of Service Risk Ratings				
Year to Date Rating	1.50	1.50	0.00	RED
Fotecast Outturn Rating	1.50	1.50	0.00	RED

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

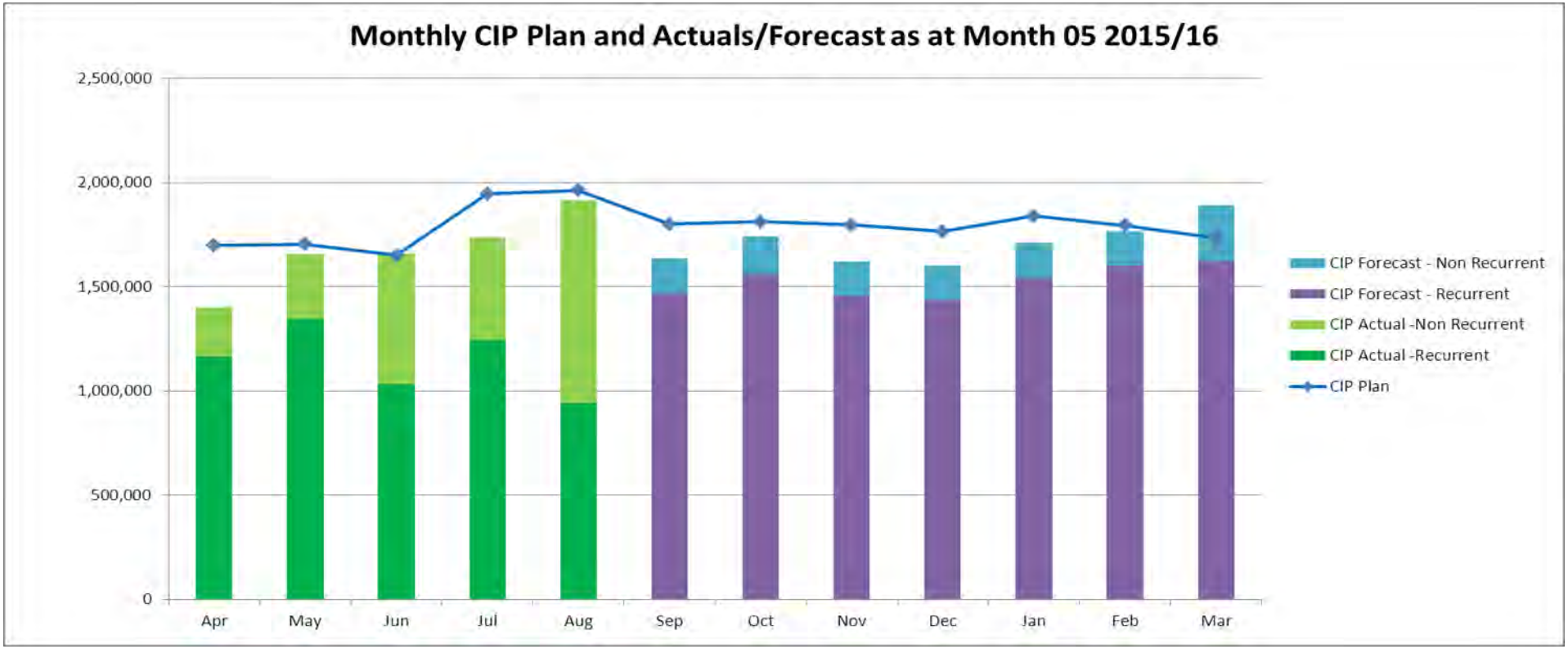
Maidstone and Tunbridge Wells NHS Trust

I&E monthly position graph as at Month 5 2015/16

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual/FOT 15/16	(2,357)	(2,700)	(1,296)	(340)	(2,397)	(850)	(200)	(900)	(990)	(310)	(500)	708
Plan 15/16	(2,361)	(2,348)	(1,306)	(133)	(2,048)	(909)	(282)	(1,102)	(1,195)	(400)	(687)	639
Actual 14/15	(2,805)	(2,163)	(1,882)	111	(1,242)	(734)	7,380	(251)	84	646	(856)	1,867



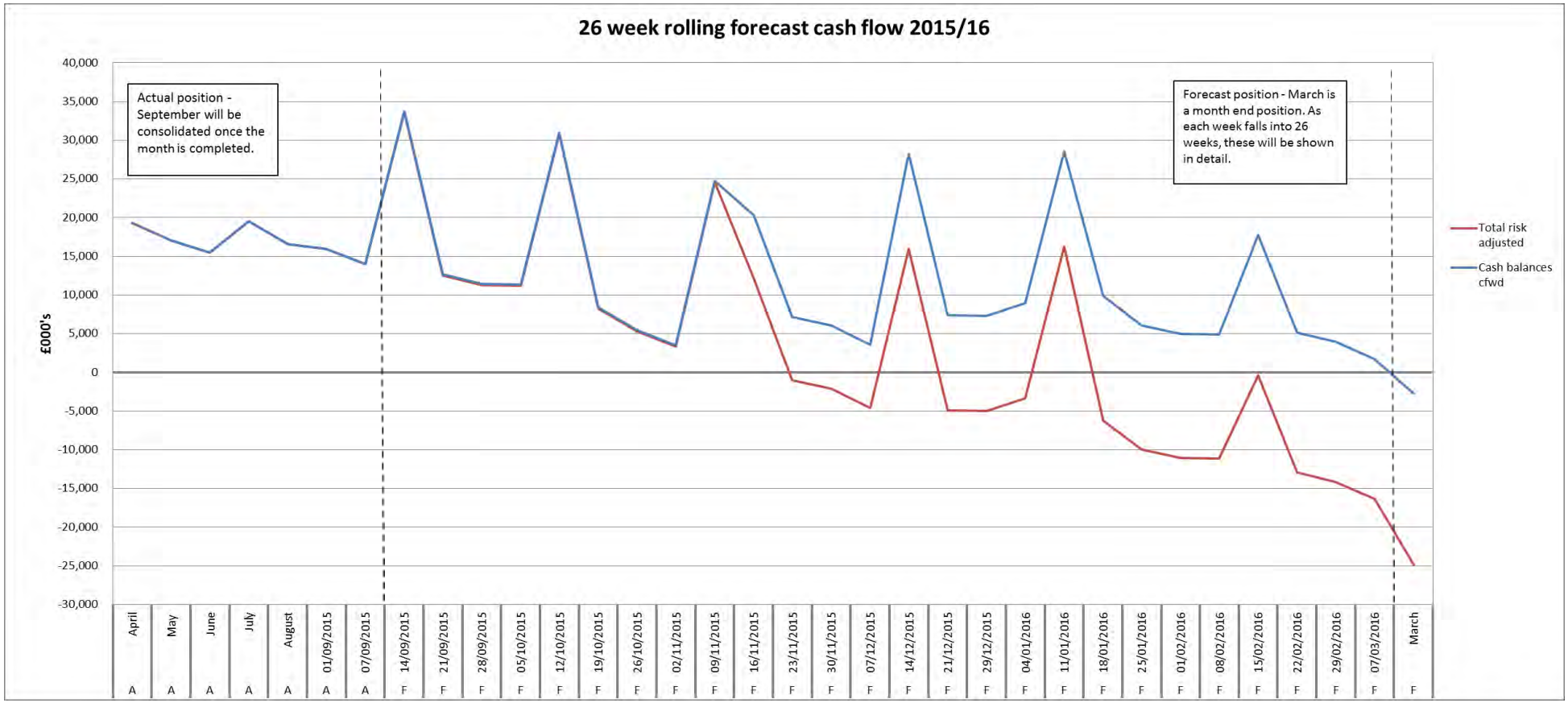
Maidstone and Tunbridge Wells NHS Trust



Recurrent Analysis	**£'000**	**£'000**
Recurrent	5,732	16,423
Non Recurrent	2,640	3,919
Total	**8,372**	**20,342**

NHS Commercial In Confidence

26 Week graphical presentation of forecast cash balances up to w/c 7th March 2015, actuals at 14th September 2015



	A	A	A	A	A	A	A	F	F	F	F	F	F	F	F	F	F	F
Week commencing	**April**	**May**	**June**	**July**	**August**	**01/09/2015**	**07/09/2015**	**14/09/2015**	**21/09/2015**	**28/09/2015**	**05/10/2015**	**12/10/2015**	**19/10/2015**	**26/10/2015**	**02/11/2015**	**09/11/2015**	**16/11/2015**	**23/11/2015**
Cash balances cfwd	19,276	17,036	15,452	19,552	15,159	17,407	13,988	33,735	12,706	11,408	11,340	30,954	8,397	5,474	3,474	24,756	20,276	7,155
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	8,000	8,000
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	146	146	146	146	146	146	146	146	146	146	146
Total risk adjusted	**19,276**	**17,036**	**15,452**	**19,552**	**15,159**	**17,407**	**13,988**	**33,589**	**12,560**	**11,262**	**11,194**	**30,808**	**8,251**	**5,328**	**3,328**	**24,610**	**12,130**	**-991**

	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Week commencing	**30/11/2015**	**07/12/2015**	**14/12/2015**	**21/12/2015**	**29/12/2015**	**04/01/2016**	**11/01/2016**	**18/01/2016**	**25/01/2016**	**01/02/2016**	**08/02/2016**	**15/02/2016**	**22/02/2016**	**29/02/2016**	**07/03/2016**	**March**
Cash balances cfwd	**6,037**	**3,589**	**28,249**	**7,378**	**7,323**	**8,949**	**28,567**	**9,886**	**6,106**	**5,013**	**4,935**	**17,706**	**5,134**	**3,961**	**1,738**	**-2,734**
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	2,000	2,000	2,000	2,000	4,000
External Financing - Revenue	8,000	8,000	8,000	8,000	8,000	8,000	8,000	11,800	11,800	11,800	11,800	11,800	11,800	11,800	11,800	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	0	0
NHD Support	146	146	4,292	4,292	4,292	4,292	4,292	4,292	4,292	4,292	4,292	4,292	4,292	4,292	4,292	4,292
Total risk adjusted	**-2,109**	**-4,557**	**15,957**	**-4,914**	**-4,969**	**-3,343**	**16,275**	**-6,206**	**-9,986**	**-11,079**	**-11,157**	**-386**	**-12,958**	**-14,131**	**-16,354**	**-24,826**

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - September 2015

9-9	CQC Quality Improvement Plan	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 updates from 'Should do' actions that were scheduled to be completed this month.

Overall significant progress has been made, actions are being addressed and changes implemented with no actions remaining red or amber rated.

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

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 16/09/15

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

Information and discussion

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

CQC Quality Improvement Plan

Assurance Report September 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.

This report presents the progress of the Enforcement notice and Compliance actions.

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 a report was received 4th August 2015 for factual accuracy checking. The report is favorable acknowledging areas of outstanding practice but we have sought absolute clarification on the formal lifting of the enforcement notice and are awaiting the final report.

Compliance actions – Paediatrics

The Trust-wide paediatric early warning system (PEWS) is now in place and all leads have been trained, with further training planned for September. The escalation protocol has been approved and is incorporated onto the PEWS chart. Work has commenced on implementing an electronic solution (Nervecentre) for PEWS and escalation, with estimated launch date in November.

A Standard Operating Procedure for care of children on a surgical pathway on paediatric wards has been agreed and is in place.

Compliance actions – Critical care

The Standard operating Procedure for ITU admission and discharges has been ratified and is in place. An intensivist rota compliant with Intensivist Care Society core standards is now in place and recruitment is underway to fill substantive posts. This allows travel time and distance to be compliant as per requirements (within 30 mins).

There are continued challenges with patent flow, but August showed an improved position with only 1 transfer out of ITU after 22.00hrs (compared with 8 in July). A longer term plan is in place to increase capacity at Tunbridge Wells Hospital.

The critical care outreach service will commence a 24/7 service from 24th September.

Compliance Action – Clinical Governance Strategy

The external report on Governance has been received and will be presented at Trust Board on 30th September. An initial response to the recommendations will also be presented and discussed at the TME following board. Moving forward at pace with the accepted recommendations will be the focus in the coming months.

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 judgment 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 final report from CQC
CA 1 - Paediatric Early Warning Scoring (PEWS) system	Jackie Tyler, Matron Children Services		PEWS in place in all required areas, training being rolled out
CA 2 – ICU weekend cover	Daniel Gaughan General Manager, Critical Care		Continued good progress rota compliance now in place. Recruitment September 2015 of substantive intensivists
CA 3 – ICU consultant within 30mins	Daniel Gaughan General Manager, Critical Care		
CA 4 – ICU delayed admissions	Jacqui Slingsby Matron, Critical Care Directorate		Standard Operating Procedure now in place
CA 5 – ICU delayed discharges	Jacqui Slingsby Matron, Critical Care Directorate		
CA 6 – ICU overnight discharges	Jacqui Slingsby Matron, Critical Care Directorate		During August no patients were transferred out of hours at Maidstone and 1 at Tunbridge Wells. This compares with 0 at Maidstone and 8 at Tunbridge Wells in July. Plan in place to create additional capacity at TWH.

	Operational lead	Progress rating	Issues / Comments
			Red over 5, Amber less than 5. Green less than 3.
CA 7 – Critical Care Outreach 24/7 service provision	Siobhan Callanan Associate Director of Nursing		Trust will commence 24/7 critical care outreach on 25th September
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 completed, action plan being developed
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 completed
CA 14 – Joint management of children with surgery	Hamudi Kisat / Jonathan Appleby Clinical Directors		Standard Operating Procedure completed and disseminated to staff
CA 15 – Children's Clinical governance	Karen Woods Risk and Governance Manager, Children and Women's Services		Completed compliance action
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

Maidstone and Tunbridge Wells NHS
NHS Trust

Enforcement Notice

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

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

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)	PEWS charts finalised with Paediatric ED and Paediatric Directorate Final charts delivered to all areas across MH and TW sites Training PowerPoint completed and circulated to leads in each areas Audit to be undertaken in 1 month	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 Fully implemented 1/9/15	
2. Escalation protocol reviewed alongside the PEWS chart review	Escalation protocol approved Summary of escalation protocol added to back of approved PEWs charts Sepsis 6 incorporated SBAR documentation available on back of PEWS chart			
3. Once agreed, PEWS chart and escalation protocol implemented across Children's services directorate via teaching sessions, ward level meetings, A&E and Children's services Clinical Governance meeting	Implementation programme commenced PEWS /escalation training of leads completed. Roll out training to all staff continues during September			
PHASE 2 Electronic solution (Nervecentre) for PEWS and escalation implemented (brought forward within existing IT plan). NB excludes paediatric A&E	Meeting with nerve centre completed 27/8/15 New PEWs charts submitted for building onto the nerve centre system Provisional launch nerve centre 9th November, Live by 23rd November 2015	6. Compliance audit from Nervecenter	31/12/15	
Action Plan running to time: YES				
Evidence submitted to support update (list):				
Assurance statement :				
PEWs chart in place and training being implemented across all relevant departments				
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	2a. Risk assessment undertaken with mitigation in place 2b. 1-8compliant rota in place to ensure a second ward round in person at weekend occurs.		2a. 31/3/15 2b. 1/10/15	
3a. The rota for the intensivists reviewed in line with the requirements of the ICS core standards 3b. Rota fully meeting the ICS requirements	3a. Rota reviewed 3b. Rota in line with ICS requirements now in place (1-8 compliant) Locum gaps being covered internally while recruitment of intensivist takes place. Consultant Job plans under review		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	Interviews for recruitment planned September 2015		1/4/16	
Action Plan running to time: YES				
Evidence submitted to support update (list):				
Assurance statement :				
Fully compliant rota, but supported by internal cum cover whilst recruitment for intensivists continues				
Areas of concern for escalation:				
Potential risk of inability to recruit suitable intensivists				

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 Risk assessment completed and on risk register. New rota commenced September 2015 will have intensivists based at hospital thus ensure compliance	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	Risk assessment completed, however following changes intensivists will be based on the site which is now within the 30 minute rule mitigating the risk.		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 :				
Areas of concern for escalation:				
Potential risk of inability to recruit suitable intensivists				

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: the ring-fencing of ITU bed will be implemented where possible. 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	SOP ratified at Standards committee in August 2015		31/5/15 New date: 31/8/15	
3. Review SOP for managing critically ill patients requiring ITU, when ITU capacity is full (for e.g. in recovery)	SOP ratified at Standards committee in August 2015. Task and finish group of all stakeholders working on pathways for patients in escalation areas formulated and draft pathway disseminated for comment. Amendments to be made and meeting arranged for September 2015		30/4/15 New date: 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: YES (to new date)				
Evidence submitted to support update (list): ICU Standard operational policy				
Assurance statement :				
No concerns				
Areas of concern for escalation:				
No improvement in delayed admissions due to bed availability at Tunbridge Wells Hospital. Long term solution planned for 2016 with further bed-stock being available (New Ward). 14 delayed admissions at TWH during August and 1 at Maidstone.				

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 discharge policy ratified at 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.	31/5/15 New Date: 31/8/15	
2. Transfers out of ITU to be followed up on a named patient basis at each site meeting	In place at site meetings		1/4/15	
3. To link in with Trust wide work around patient flow and delayed discharges improvement plan developed in line with D16 CQUIN and in collaboration with Chief Operating Officer and Clinical Site Management team	Monthly delayed discharge performance data captured on performance dashboard and within monthly unit reports. Performance against milestones reported at monthly CQUIN board. Incident forms completed for each delay, clinical site team identified as handlers. 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: completed				
Evidence submitted to support update (list):				
Assurance statement :				
Action completed				
Areas of concern for escalation:				
Continue challenges meeting required performance targets due to patient flow issues				

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 August no patients were transferred out of hours at Maidstone and 1 at Tunbridge Wells. This compares with 0 at Maidstone and 8 at Tunbridge Wells in July. 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.		1/3/15 New date 1/2/16	
Action Plan running to time: Yes (revised date)				
Evidence submitted to support update (list):				
Assurance statement :				
An improved position this month				
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 recruited into		1/9/15	
3. Implementation of a 24 hour 7 day out-reach service which will be fully integrated with critical care service	24 hour 7 day out-reach service rota commences 25th September		1/10/15	
Action Plan running to time: YES				
Evidence submitted to support update (list):				
Assurance statement :				
The trust will commence 24/7 Critical Care Outreach commencing on the 25th September 2015				
Areas of concern for escalation:				
None				

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: **completed**				
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 Job Description for substantive post holder developed and submitted for grading prior to recruitment Chief Nurse appointed as Board Lead	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	E&D training 89% compliant against 85% target (April 2015) 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	WF strategy approved June 2015. E&D priorities included & supported by project plan for approval by September 2015 Workforce Committee BME Forum established Trust has partnered with Stonewall to support LGBT staff. Trust will submit data for Stonewall Equality Index on 4 September		1/9/15	
4. Ensure current process for accessing translation services is communicated to all staff	Staff Communication circulated January 2015 – Recirculated 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	Meeting and agreed contact for best practice with Leicester 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 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		1/10/15	
8. Ensure appropriate organisational governance with assurance to Trust Board in relation to Equality and Diversity	Trust Executive agreed governance proposals in July 15.		1/9/15	

Action Plan running to time: YES

Evidence submitted to support update (list): Approved business case for E&D lead

Assurance statement :

In progress

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: completed				
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 completed with staff involvement. Action plan in development	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 (new date)

Evidence submitted to support update (list):

Assurance statement :

Audit shows reasonable compliance, however some areas for improvement. Action plan in development

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		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: completed				
Evidence submitted to support update (list):				
Assurance statement :				
L&D have allocated all our Security Team login details for the on-line induction.				
Areas of concern for escalation:				
We were finding that our Officers were missing MTW mandatory Training sessions due to operation tasking's, L&D have now arranged for on-line training for the Security Team				

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 completed	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 excepted to be completed 1/9/15	
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 Work on website commenced		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 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 RCA training identified. Incident reporting and patient safety included in induction training for new staff		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.				
Areas of concern for escalation:				

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 & Jonathan Appleby, Clinical Director*		**Operational Lead:** *Hamudi Kisat, Clinical Director & Jonathan 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	Clinical Director attended surgical CG meeting to present papers	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	SOP completed and circulated to staff		1/6/15 New date: 1/9/15	
3. Implementation of the SOP into routine daily practice	Patients admitted to Inpatient Ward now shared care between Paediatrics and Speciality Teams Audit planned September 2015		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 Governance report received, will be going to Trust Board 30th September. From this a new clinical governance framework will be developed.		1/9/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): SOP				
Assurance statement :				
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 plus induction groups	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): Risk update, Induction agenda's, CG agenda's				
Assurance statement :				
Work on-going within the directorate to increase staff awareness and involvement with paediatric risks				
Areas of concern for escalation:				
Nil				

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, distribution due for completion 1/9/15		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* *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. Full review and collaborative process involving all stakeholders for developing and implementing a cohesive and comprehensive clinical governance system from ward to board	Full review undertaken between April and July 2015 External Governance report with recommendations received August. Will be going to Trust Board with a plan on 30th September. Implementation will commence after this	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 New date: 1/11/15	
2. Development of a MTW Clinical Governance Strategy	Will commence once report and recommendations considered and plan made		1/7/15 New date: 1/11/15	
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. Agreement with IT/ health informatics to implement IT based system as a pilot in Autumn, however external visit to RBGH with good information sharing, identified further IT possibilities to explore. NTDA reviewed process in August, awaiting report. CCG invited to Trust Mortality Review Group		1/8/15 New date: 1/11/15	
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):

Assurance statement :

Continued work in this area

Areas of concern for escalation:

Delay due to waiting for the external Governance report. This will drive many of the required changes.

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	Information regarding PGDs including Standard operating policy available on intranet Lead for ward identified – Sister Rochelle Gilder PGD now available in all areas in purple PGD folders		1/5/15	
2. Topical anaesthetics for children prescribed in all areas of the Trust	Topical anaesthetic cream now prescribed at all pre-assessment clinics Audit undertaken in August, awaiting results		1/6/15 Audit results due September	
3. A number of key staff to undertake PGD training to facilitate appropriate timeliness of prescribing.	All key staff fully trained and signed off (100%) Training for other staff well in progress (75% trained) Assessors now trained within Paediatrics which will improve assessment processes		1/7/15	
Action Plan running to time: Yes				
Evidence submitted to support update (list): competency and training list				
Assurance statement :				
Running to schedule, awaiting audit results				
Areas of concern for escalation:				
None				

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – September 2015

9-10	Clinical Quality And Patient Safety Report	Chief Nurse

Summary / Key points

This report provides information on:

- Complaints
- Duty of Candour
- PLACE report

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

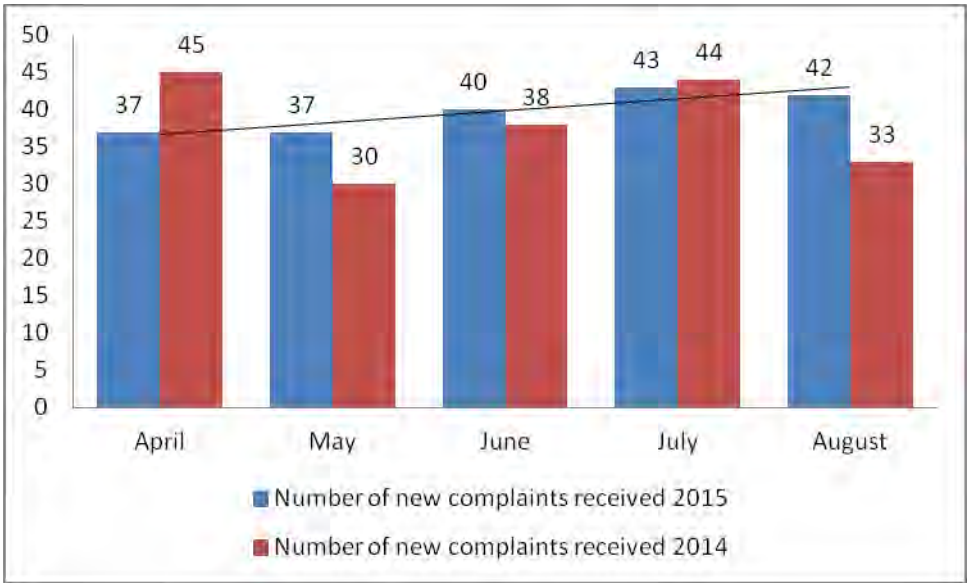
Quality Report - September 2015

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

In August, the Trust submitted its first quarterly data return to the Health and Social Care Information Centre, in line with their new reporting system. MTW received 114 new complaints during the first quarter of 2015-16. However, looking at the period April to August 2015, the number of complaints being received is showing a rising trend as can be seen below:



It is important to note that the Trust has seen high levels of activity throughout the year and it can therefore be expected that the number of complaints will increase in line with this. However, the Trust continues to remain below the national mean in terms of the rate of complaints received.

Commonly occurring themes raised in complaints received in July and August were discharge planning, delayed diagnosis, incorrect diagnosis, delayed treatment, incorrect treatment, poor communication with patients/relatives and patient fall/injury.

Having recognised that performance in meeting complaint response targets was poor, a pilot programme was launched at the end of June, increasing the role of the central team in the investigation phase. This has involved three directorates (Surgery, Trauma & Orthopaedics and Critical Care). Performance compliance has been shown to improve in response to this, as illustrated below:

The pilot is due to complete in December 2015, at which stage a decision will be made about rolling out this model across the Trust. We are hopeful that in addition to improving the timeliness of responding, when feedback is received via the satisfaction survey for complaints responded to during this period, this will reveal other quality improvements. However, this feedback will not be available until later this year.

For complaints closed in July and August, 36% were upheld or partially upheld following investigation. Outcomes and actions taken in light of these complaints include:

- Distribution of best practice guidance to staff
- Letter templates being updated to provide named contact for patients
- Routine clinic review introduced for bladder cancer patients undergoing radical radiotherapy. Staff to also consider referring pts for discussion at MDM during radiotherapy course.
- Triage process to be reviewed
- Review of admission process on SAU around patient identification bands
- Respiratory service upgraded image viewing equipment and reviewing clinic timings
- Disciplinary action taken
- Further training on last offices provided to staff
- Written instruction provided to A&E medical staff around obtaining senior review of x-rays
- Training on caring for vulnerable adults and those on the autism spectrum to be provided to A&E nursing team
- New pathway test database introduced

Duty of Candour

The Department of Health introduced the Regulation 'Introducing the Statutory Duty of Candour' in October 2014 which requires all CQC registered providers to inform people when significant harm to them has occurred, and provide an explanation and apology. The Statutory Duty of Candour responds to issues and concerns identifies in a number of reviews and inquiries including the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Inquiry) and the Berwick Review into Patient Safety

Candour is the quality of being open and honest. Patients should, as a matter of course, be properly informed about all elements of their treatment and care organisations should sustain a culture which supports staff to be candid. Failure to comply with statutory Duty of Candour can result in a £2,500 fine.

An audit was undertaken on 63 Serious Incidents that occurred 2014/15 with the following results that relate to the 4 required elements of Duty of Candour:

Element	*Percentage compliance*
Verbal apology offered	*76%*
Apology documented in patients notes	*60%*
Letter of apology sent	*54%*
Final letter of apology sent	*2%*

We are currently not fully meeting the standard requirements for Duty of Candour. The standards are being met more within the serious incidents than the moderate incident process.
The audit noted that the standard is improving as training and support increased over the audit period. The Trust is aware that Duty of Candour requirements are not being fully met and this is on the Trust Risk Register.

The following actions are being put into place and will be monitored:
1. *Comprehensive review of DoC training and knowledge of staff within MTW*
2. *Implementation of required training updating and support for staff*
3. *Review of the DATIX system to see if a DoC prompt and data capture can be included as a mandatory field for moderate and above harm incidents.*
4. *Support resources for staff (leaflets, on line support, hotline) for ensuring DoC is achieved*
5. *Repeat audit in 6 months that includes training records and staff awareness.*

PLACE report

Patient-led Assessments of the Care Environment (PLACE) assessments apply to all hospitals delivering NHS-funded care, including day treatment centers and hospices.

PLACE assessments put patient views at the centre of the assessment process, and use information gleaned directly from patient assessors to report how well a hospital is performing in the areas assessed – privacy and dignity, cleanliness, food and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or staff behaviours.

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

Works undertaken since 2014
Following the assessment carried out in 2014 we have invested on making the improvements identified and this is reflected in this year's results.

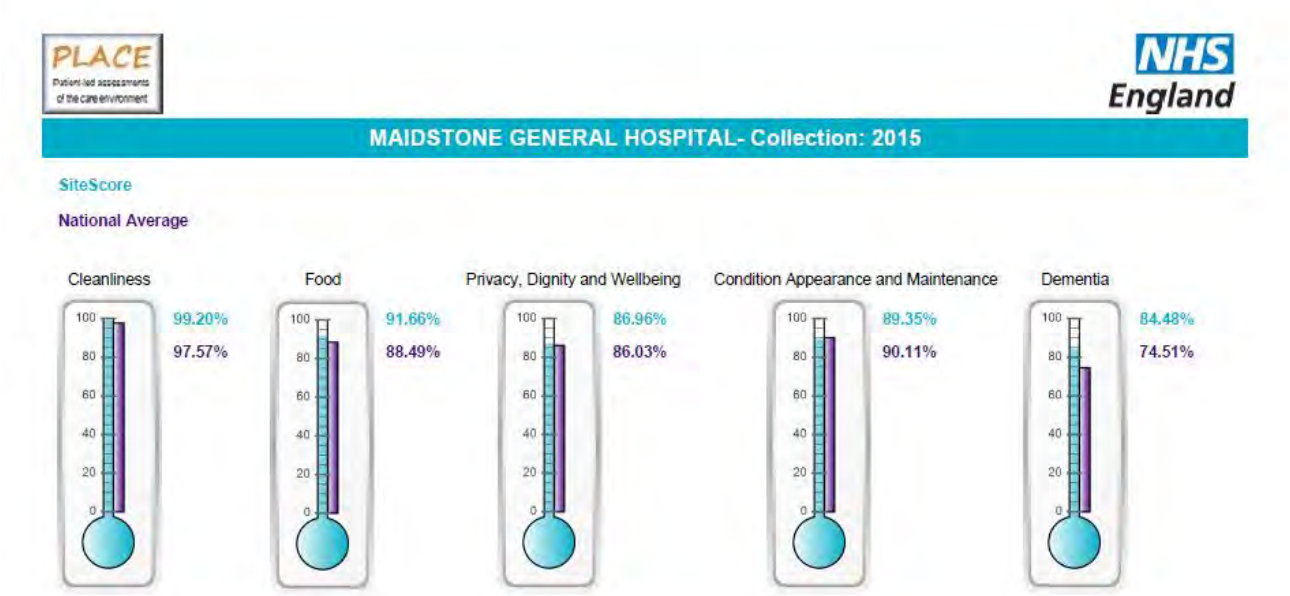
- Refreshed all the main wayfinding signage within the Hospital
- Refreshed external signage
- Installed chilled water dispensers on each ward at Maidstone
- Refurbishment of the main entrance with improve retail and café facilities at Maidstone
- Replaced patient chairs, tables
- Refurbishment of Admissions Lounge at Maidstone
- New Discharge Lounge at Maidstone
- WiFi installed
- Revision of the patient food menu at Tonbridge Cottage.

Results for 2015
This year's assessments were undertaken as follows;

- On each of the large sites the inspections were undertaken over three days – TWH 8th,14th and 15th April and Maidstone 29th & 30th April and 6th May.
- Tonbridge Cottage assessment was undertaken on 28th May.
- On each day there were two teams; each led by a patient representative with a senior nursing representative plus infection prevention matron and a GM or AGM from Facilities.
- At Maidstone and TWH we assessed 10 wards, 5 departments, Emergency Department, main reception and all public toilets and communal areas plus the external areas.
- Food tasting and meal and beverage service was undertaken on 3 wards on each site and also at Tonbridge Cottage.

In summary the results achieved for 2015 are all above the national average with the exception of building appearance and condition at Maidstone which was less than 1% under the national average.

For the first time this year the assessments have included questions on Dementia which will enable the Trust to assess how it is performing nationally and locally. The results for each site are shown in the graphs below.



PLACE
Patient-led assessments of the care environment

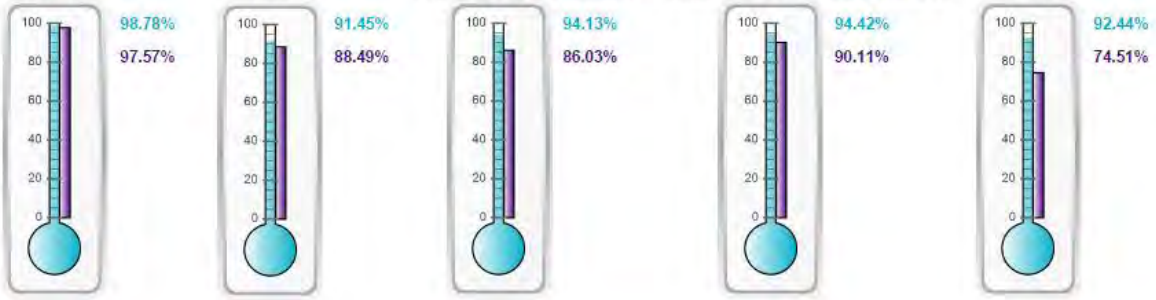
NHS England

THE TUNBRIDGE WELLS HOSPITAL- Collection: 2015

SiteScore

National Average

	Cleanliness	Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia
SiteScore	98.78%	91.45%	94.13%	94.42%	92.44%
National Average	97.57%	88.49%	86.03%	90.11%	74.51%



PLACE
Patient-led assessments of the care environment

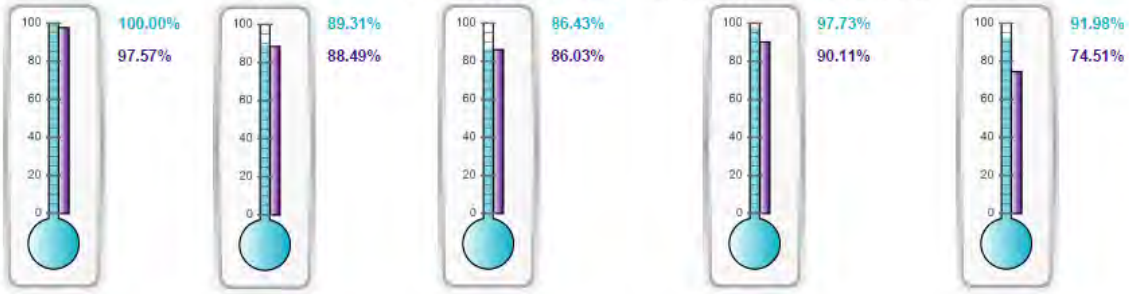
NHS England

TONBRIDGE COTTAGE HOSPITAL- Collection: 2015

SiteScore

National Average

	Cleanliness	Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia
SiteScore	100.00%	89.31%	86.43%	97.73%	91.98%
National Average	97.57%	88.49%	86.03%	90.11%	74.51%



Patient Representative Feedback

Below is a copy of some of the summary statements provided by our Patient Representatives at the end of the inspections.

Tunbridge Wells Hospital

“This modern hospital is well maintained and is light and airy, if a little daunting to find your way around. Patients are treated as valued customers and appreciate the care given to them.”

“Consider the age of the building it still looks good. Each dept/ward are run differently hence not always the same issues arise. The staff were very helpful and appeared happy with working/environment at TWH.”

“I feel the area of A&E I visited was generally clean and tidy and patients were being cared for with privacy and dignity. However, the poor decoration and damage to doorways, doors and walls detracted from the general environment.”

“This is a large hospital and I would like to see more colour coordination used in the signage to help make the area easier to navigate.

Maidstone Hospital

“Some areas are due for refurbishment, but the rest of the areas are generally clean and well cared for. Most problems discovered are of a minor nature.”

“The best thing about this site is that you feel somebody cares about it. The staff are its mainstay and they care about the hospital and the patients. The pictures/prints on the walls about the nursing staff and patients reflects this.”

“Cleaning standards are good. Some general maintenance required on floor and walls and some storage issues. As a whole the hospital performed well. The only issue which must be addressed as a matter of urgency is; One patient was missed when the lunch was served as the nurse assumed that he was nil-by-mouth. One inspector highlighted this and the error corrected and the gentlemen fed.”

“An elderly building that is looking and performing well. The birthing unit is an absolute delight of the highest order. It was faultless. If only the rest of the hospital was as good and showed as much dedication as that staff we would be very proud.”

Tonbridge Cottage

“I would be very pleased to spend time as a patient in this hospital.”

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board - September 2015

9-11	Infection Control Annual Report	Director Of Infection Prevention And Control

Summary / Key points

The enclosed report provides a summary of infection prevention and control activity in the Trust between April 2014 – March 2015.

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

This year has been important in consolidating the earlier improvement in the Trust's *C. difficile* performance. The Trust has now seen nine years of year on year reduction in cases of *C. difficile.*

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

By the end of the year the Trust had maintained very low levels of MRSA and achieved a further 20% reduction in *C. difficile* infections.

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

Director of Infection Prevention and Control – Annual Report to the Board 2014/15

1. Summary

This year has been important in consolidating the improvement in the Trust's *C. difficile* performance seen in the previous year and extending that improvement to other Healthcare Associated Infections (HCAI).

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

By the end of the year the Trust had maintained very low levels of MRSA and achieved an in-year 20% and cumulative two-year 53% reduction in *C. difficile* infections.

2. Successes

The Infection Prevention team (IPT) has had success in 2014/15, building on previous year's improvements, ensuring sustained reductions in healthcare associated infections (HCAIs) and achieving the planned reductions.

Notably, the Trust position with respect to *C. difficile* improved with a further 20% reduction in cases in year. We continued to receive support from the Trust Development Authority (TDA) and West Kent Clinical Commissioning Group (WKCCG) for the Trust to implement further changes in practice during the year.

In recognition of the reduction in *C. difficile*, the MTW IPT was named as runner-up (and best acute Trust team) in the Infection Prevention Team of the Year awards at the Infection Prevention Society conference in September 2014.

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

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

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

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

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

The restructure of the IPT has been completed with the appointment of a lead nurse in infection prevention and the appointment of Sarah Fielder to the Nurse Consultant role with a remit for Strategy and Education. Sarah has also taken over as Deputy DIPC (from April 2015) replacing Dr Grace Sluga who held the role on an interim basis during 2014/15.

3. Healthcare Associated Infection

3.1. HCAI action plan

A new HCAI action plan was developed in April 2014 and implemented throughout the year. The plan was monitored through the IPCC and reported to the Quality and Safety committee. The 2013/14 plan was completed with outstanding actions signposted to the new action plan.

Key actions include:

- Audit of compliance with IV to oral antibiotic switch
- Review of training in antimicrobials for all doctors, nurses and pharmacists
- Development of the outpatient antimicrobial therapy (OPAT) service
- Implementation of lapses of care assessment for C. difficile cases
- Training on diagnosis and management of catheter associated urinary tract infection (CA-UTI)
- Implement the Acute Trust toolkit for carbapenemase-producing enterobacteriaceae
- Implement screening for Glycopeptide enterococci in haemato-oncology patients
- Ensure compliance with NICE quality standards for Surgical Site infections
- Ensure compliance with NICE quality standard for Infection Prevention and Control
- Enhance assurance of cleaning standards
- Increase education and awareness amongst staff.

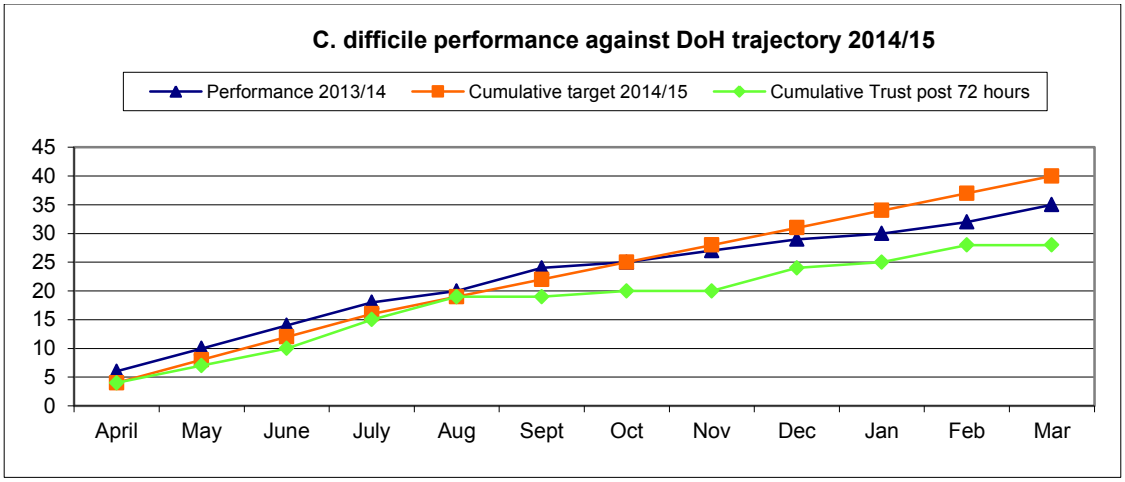
The action plan was also shared at the Trust Management Executive and agreed by the Clinical Directors.

Any outstanding actions at the end of the year were signposted into the 2015/16 action plan.

The completed plan is attached at Appendix 1

3.2. *Clostridium difficile*

Reducing *Clostridium difficile* infections was one of the key objectives for the Trust throughout 2014/15.



3.2.1. Rates of Infection

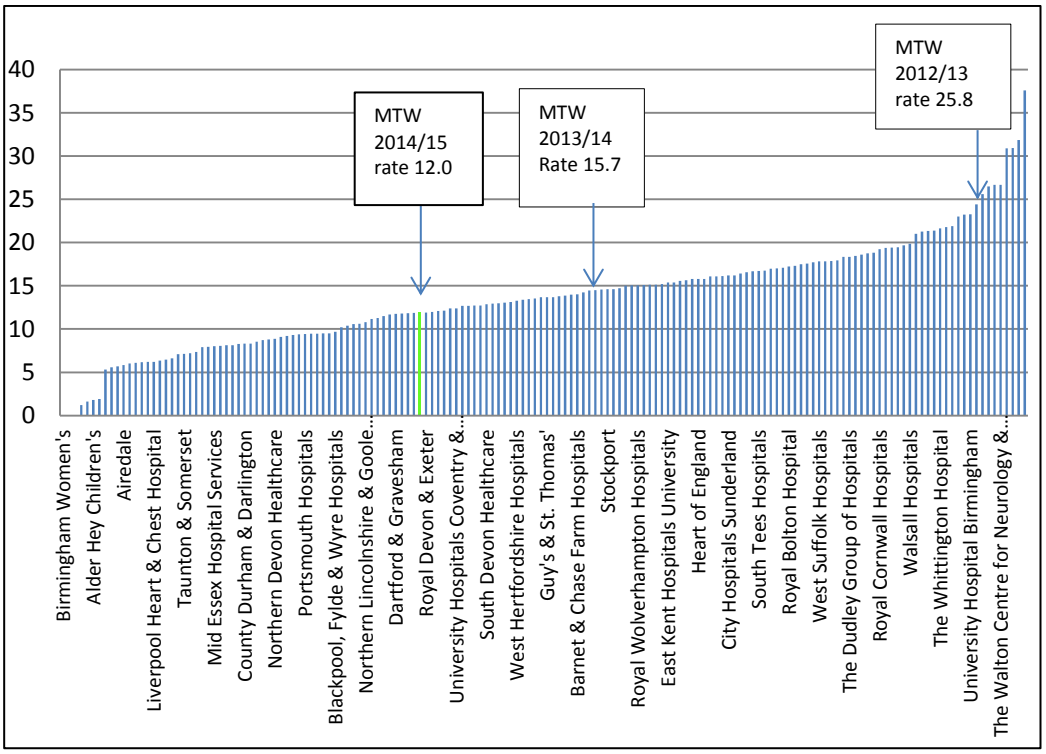
The Trust achieved a 20% reduction in *C. difficile* infection this year. The out-turn of 28 cases achieved the objective of 40 cases and improved upon the out-turn for the previous year. The rate of infection for the year was 12.0/100 000 bed days compared with a national benchmark of 15.7/100 000 bed days.

The Department of Health objective limit was designed to bring the Trust up to the best performing quartile for the previous year. Although the year started with a breach of the trajectory

in April, the actions of the recovery programme began to take effect in August with Maidstone Hospital having no cases for the three months from August to October.

The 2014-15 objective for *C. difficile* was based on rates of infection in 2013-14. The following graph demonstrates the improvement in MTW's position compared to other non-teaching acute Trusts in England.

Fig 1. Trust apportioned *C. difficile* rates for England. 2013-14



The Trust has made significant progress in reducing *C. difficile* infection rates over the last two years. We have now moved into the upper half of the Trusts in England and further improvement is achievable to bring us into the top quartile. The cumulative rate of *C. difficile* infections for Kent, Surrey and Sussex was 12.74/100 000 bed days and the England rate for acute Trusts was 12.16/100 000 bed days.

The year on year improvement following the 2006 outbreak has now been sustained over a period of nine years with reduction of over 90% in cases overall.

Fig 2: New cases of *C. difficile* from April 2005 to March 2015

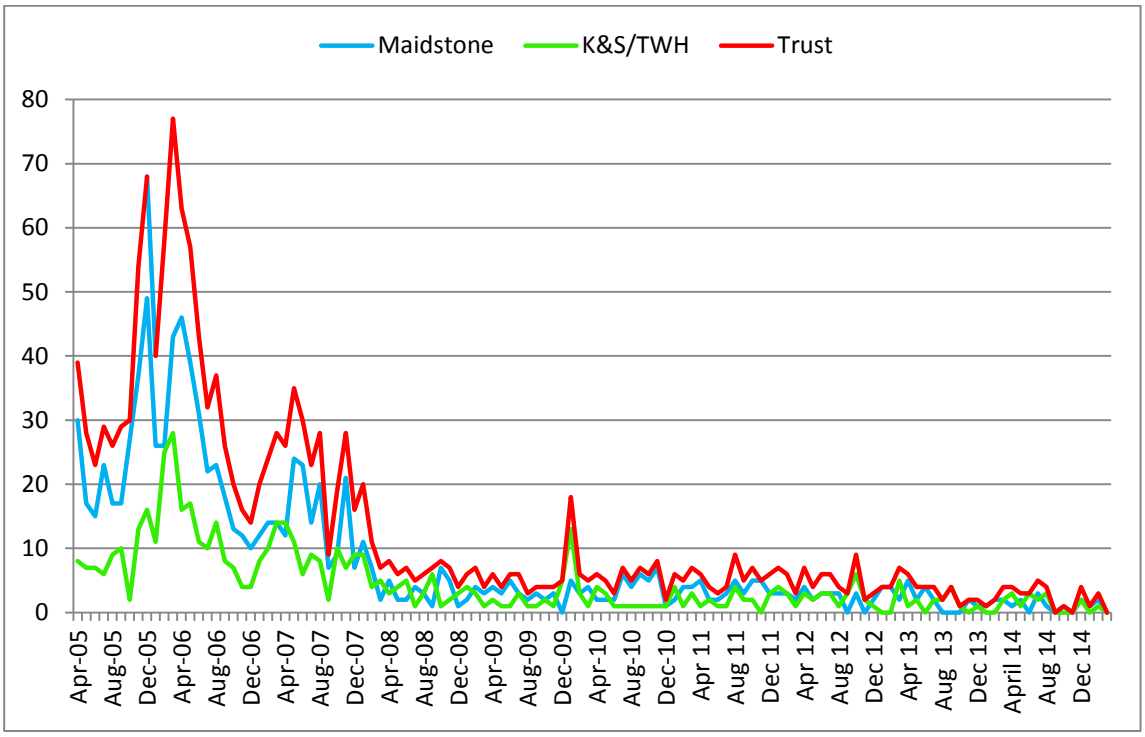


Fig 3: *C. difficile* cases by year

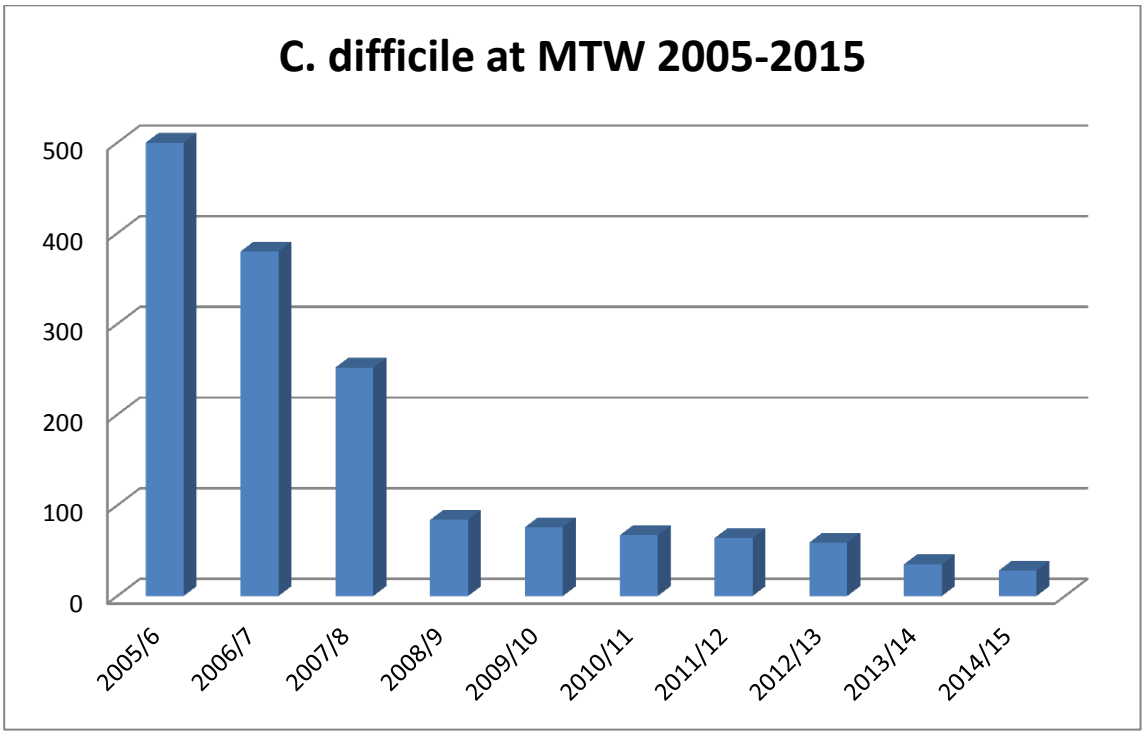
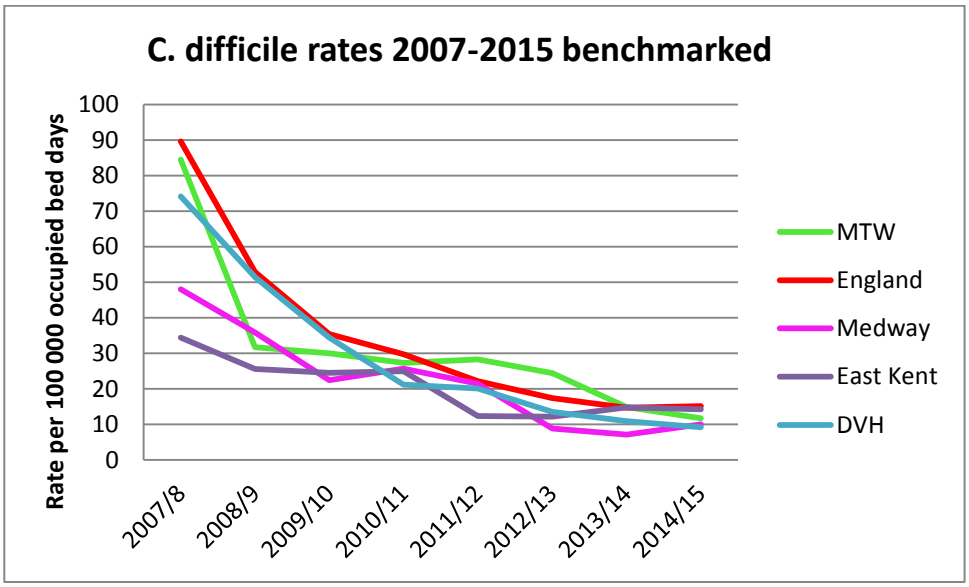


Fig 4: C. difficile rates benchmarks against local Trusts and National trend



The Trust objective for 2015/16 was released in February 2015. The calculation does not take into account the out-turn for the year, but instead a baseline of the rate of *C. difficile* infections for the year October 2013 to September 2014. The objective for MTW for 2015/16 is 27 cases.

3.2.2. Laboratory diagnosis

During 2014/15, the microbiology laboratory processed 8831 samples for *C. difficile* on 5055 patients. Of these 1759 were GP patients, the others being inpatients in acute or community settings, MTW A&E or outpatient attenders.

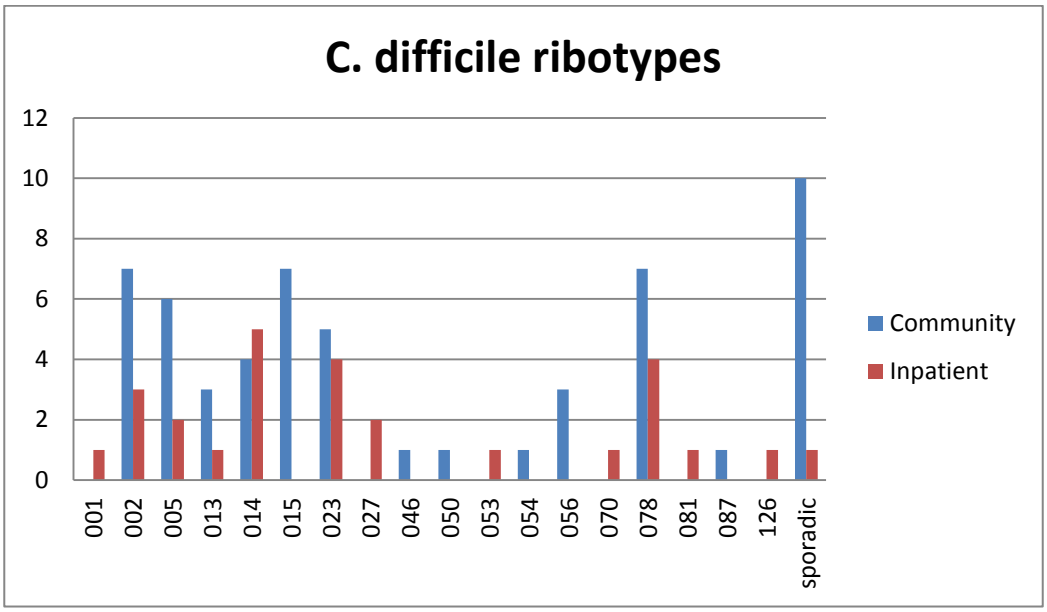
89 patients were newly identified as carriers of toxigenic *C. difficile* (159 in 2013/14), 64 inpatients and 25 community patients.

Ninety two patients were diagnosed with acute *C. difficile* infection. 28 cases were attributable to the acute Trust and 64 to the community. Of the community acquired infections, 32 were diagnosed on samples sent in by their GPs and 32 were diagnosed during the first 72 hours of their hospital admission. Five of the community cases had had recent hospital admission at MTW.

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

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

Fig 5: Ribotyping of all C. difficile cases 14/15



A treatment algorithm is in place to enable identified carriers to be treated to avoid progression on to acute infection. In 2014/15 there were no known in-patient carriers of *C. difficile* who progressed to acute infection. One patient who was mis-identified at admission, and therefore not identified as a known carrier, progressed to infection following appropriate antibiotics.

3.2.3. Isolation

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

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

All *C. difficile* cases are assessed on a case by case basis and those who have an overriding clinical need are isolated and nursed in their specialist areas rather than being transferred to one of the *C. difficile* cohort areas. Two rooms on Lord North have been adapted with positive pressure lobbies to enable *C. difficile* positive haematology patients to remain on the ward safely.

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

3.2.4. Case review

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

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

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

The panel considered all 28 hospital-attributable cases and a further 10 GP and pre-72 hour cases where the patient had recent MTW admission.

The average age of cases was 75.2 years. Ten of the patients died during the same admission to hospital; however *C. difficile* was not the cause of death in any of the cases.

The root causes for the hospital attributable cases for 2014/15 are summarised below:

Table 1: Outcomes of RCA for hospital-attributable cases April 2014- March 2015

Organism	Unavoidable (appropriate antibiotics)	Inappropriate antibiotics	Delayed diagnosis of community acquired infection	Cross infection	Wrong ID	Inappropriate GP prescribed antibiotics
C. difficile	18	7	1	0	1	1

There were no instances of cross infection during the year.

Most (18/28) cases were judged to be due to appropriately prescribed antibiotics. It is likely that these patients were carriers of the organism and the use of antibiotics destroyed their normal bacterial flora and allowed the *C. difficile* to grow and produce toxin.

Antibiotics were considered inappropriate if they were prescribed outside the Trust guidance without agreement from a consultant microbiologist, continued for too long, or prescribed for the wrong indication. Sixteen cases received third-line antibiotics (Tazocin or Meropenem or both) during their admission. Only three of these cases were judged to be avoidable at RCA. This demonstrates that the improvement in prescribing seen last year as a result of the change to the antimicrobial guidance has continued and is becoming embedded in the organisation.

Use of antibiotics within the Trust is considered further in section 4.

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

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

	Acute and Emergency medicine	Specialist Medicine	Surgery	Trauma and Orthopaedics	Critical care	Cancer	Total
April 14		2	2				4
May 14		1				2	3
June 14		2	1				3
July 14	1	1	2			1	5
August 14		3	1				4
September 14							0
October 14		1					1

	Acute and Emergency medicine	Specialist Medicine	Surgery	Trauma and Orthopaedics	Critical care	Cancer	Total
November 14							0
December 14		3	1				4
January 15		1					1
February 15		2	1				3
March 15							0
Total	1	16	8	0	0	3	**28**

Despite the overall decrease in cases, Surgery saw an increase in cases overall; eight cases compared with six the previous year. Three of the cases were potentially avoidable.

3.2.5. Periods of Increased Incidence

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

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

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

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

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

Additional actions taken when an incident is declared include
- Multidisciplinary investigation meeting held
- Intensive infection prevention team support
- Escalation of cleaning – all rooms are fogged on discharge

During 2014/15, twenty two PIIs were declared for *C. difficile*, twelve at Maidstone and ten at TWH. Two wards had two PIIs during the year and one ward had three. The PIIs lasted an average of six weeks with the longest period being 11 weeks. Where a ward does not show improvement or remains on a PII for five weeks, there is an escalation process involving the ward manager, matron and infection prevention team to address the issues.

3.2.6. Joint working across the Healthcare economy - Lapses of Care

A meeting was held with the four local acute trusts and representatives from the Kent and Medway CCG's to discuss implementation of a standardised approach to lapses of care in *C. difficile* cases.

The concept of lapses of care was introduced with the DoH 2014/15 *C. difficile* objectives guidance document. Organisations are encouraged to assess each CDI case they identify to determine whether the case was linked with a lapse in the quality of care provided to patients. This is designed to increase the organisation's understanding of the quality of the care they are providing and highlight areas where care could be improved.

Where CDI cases are not linked with identifiable lapses in care, it is proposed that those cases are not considered when contractual sanctions are being calculated. This means that only avoidable cases are considered when applying sanctions if the *C. difficile* trajectory is breached.

The Guidance document sets out the areas which should be assessed:

1. Was there evidence of transmission in hospital (confirmed by Enhanced Fingerprinting (MVLA))
2. Was there evidence that the most recent 13 week rolling average cleaning scores fell below the required National Standard for that area? (Threshold: 95% minimum for high risk areas, 98% for very high risk)
3. Was there evidence of non-compliance with the choice, duration or documentation of antimicrobials prescribed for the case under review in the preceding 8 week period (to include primary care prescribing
4. Was there evidence that the stool sample was sent in accordance with the Trust diarrhoea pathway?
5. Was there evidence that the patient was isolated in accordance with Trust Policy
6. Was there evidence that the Trust Policy for monitoring hand hygiene compliance was implemented and the ward/dept achieved the Trust minimum target for compliance?

Any lapses identified are then graded as follows:

0 – No sub-optimal care

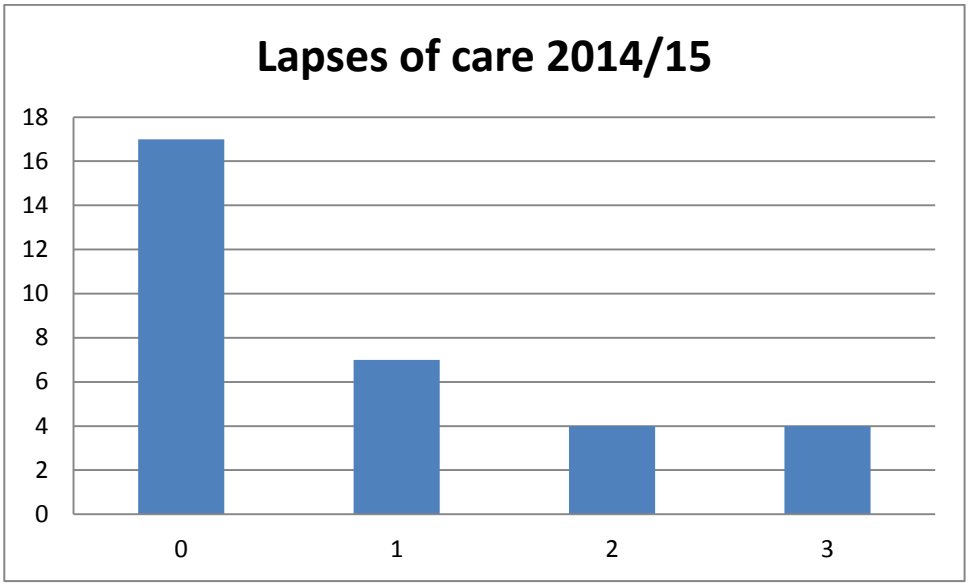
1- Lapse of care but different management would not have made a difference to the outcome

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

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

This approach was agreed across Kent and Medway and is now an integral part of the root cause analysis process. The analysis was applied to all cases reviewed at panel during 2014/15. Some were completed retrospectively after the process had been agreed.

Fig 6: Lapses of care for hospital-attributable *C. difficile* 2014/15

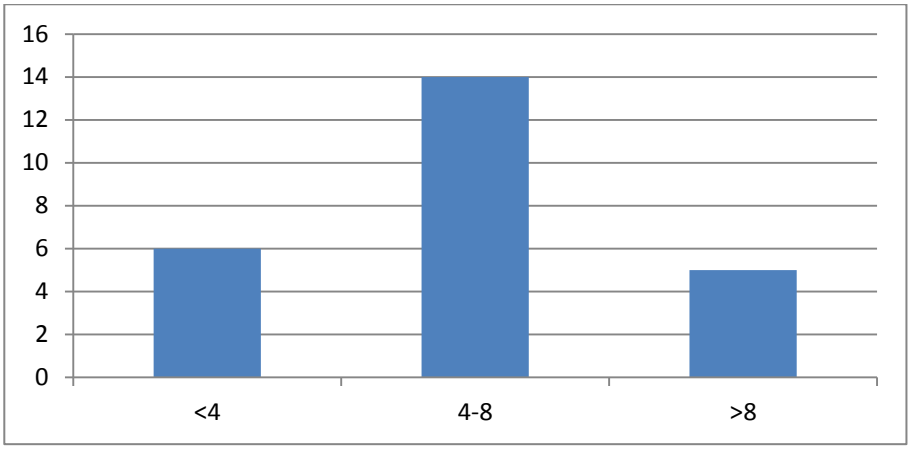


The grading of the lapses of care means that identification of a lapse of care does not necessarily imply that the case was avoidable.

3.2.7. Risk assessment

All adult patients admitted have a *C. difficile* risk assessment completed on admission and at weekly intervals. Nineteen of the new cases had a moderate or high risk of developing *C. difficile* in the week before diagnosis.

Fig 7: Risk assessment scores in the week prior to diagnosis



In order to allow staff to identify patients with past infection or known carriage, alerts are placed on Patient Centre

3.2.8. NICE publications

In March 2015, the National Institute for Health and Care Excellence (NICE) published an evidence summary for *C. difficile* setting out the evidence assessing the risk of infection associated with individual broad spectrum antibiotics.

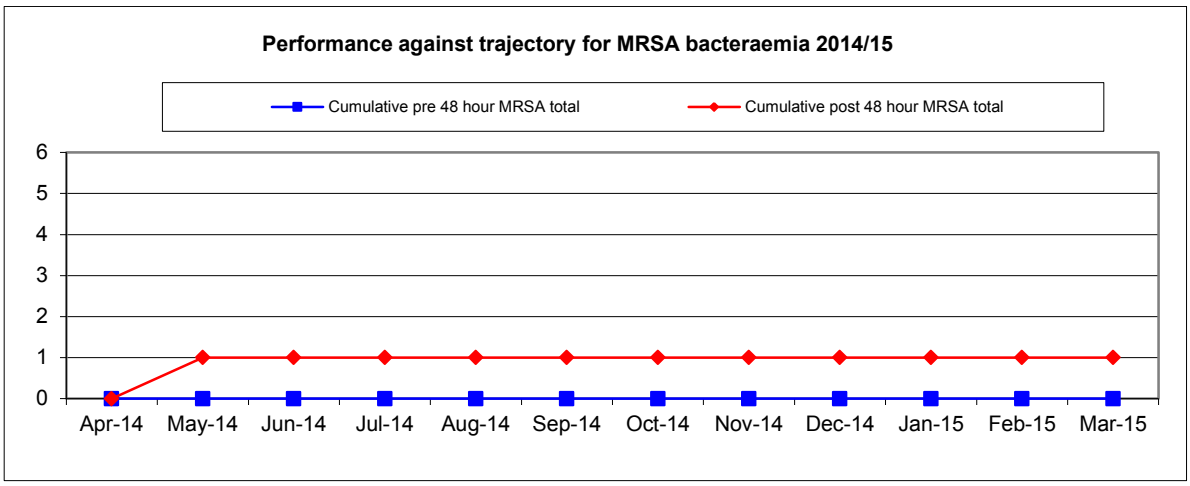
The conclusion of the document is that based on the limitations of the data available, it is not possible to definitively assign relative risks to antibiotics or subgroups of antibiotic class.

3.3. Methicillin resistant *Staphylococcus aureus*

3.3.1. Cases

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

Fig 8: Performance 2014/15 – Trust and community cases



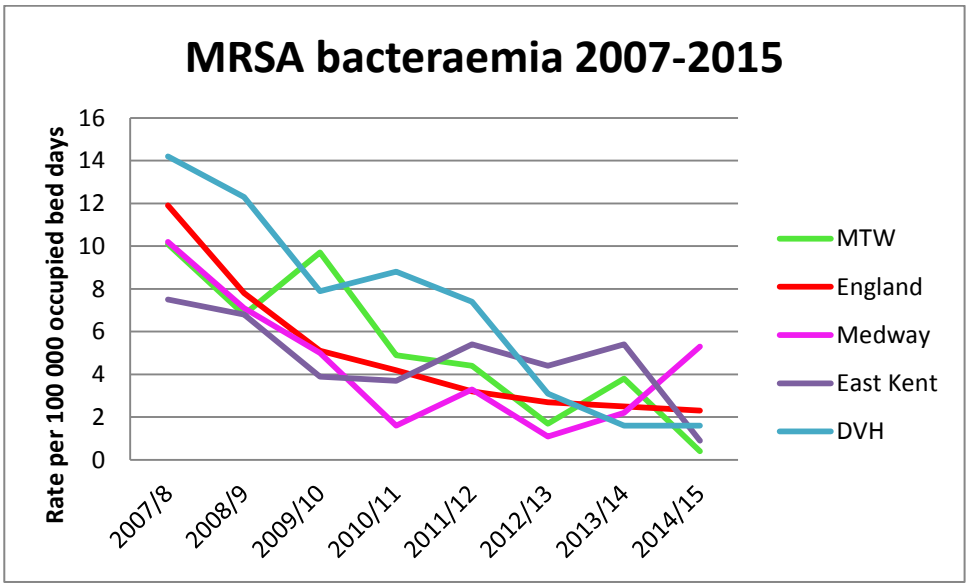
The rate of Trust apportioned MRSA bacteraemia for 2014/15 was 0.42/100 000 occupied bed days. To put this in context, the national (England) rate was 0.75/100 000. (fig 9)

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

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

- Dedicated IV trainer to provide training and competencies for junior doctors and registered nursing staff
- MRSA screening for all non-elective admissions and eligible elective admissions.
- screening all patients prior to elective caesarean sections and other obstetric patients at 36 weeks or on admission (in response to RCA findings)
- Antibiotic prophylaxis for known carriers having high risk invasive procedures (following RCA findings).

Fig 9: MTW rate benchmarked against local trusts and the National trend



3.3.2. Root Cause Analysis

All cases of MRSA bacteraemia have root cause analysis completed. This is a multidisciplinary team approach and where appropriate includes colleagues from the CCG and community health Trust. A serious incident is declared for all cases of Trust-attributable cases of MRSA bacteraemia. For pre 48 hour cases, the IPT and the relevant clinical team take part in the RCA led by the CCG. There were no community acquired MRSA bacteraemia cases diagnosed at MTW this year

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

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

Case 1: Patient was identified as MRSA positive on admission. Decolonisation was completed. Patient had poor skin integrity due to scratching which is likely to have been the entry site for infection. All care was found to have been compliant with policies. Although the case was apportioned to the Trust, it was also found to be unavoidable.

3.3.3. Screening

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

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

There is an acknowledgement within the guidance that with current prevalence of MRSA colonisation, no screening strategy is likely to be cost effective at conventional NHS levels of 'willingness to pay', although targeted screening on high risk specialities was the most cost effective.

The guidance is based on the 'NOW' study which suggests that the current mandatory screening policy is followed in less than two-thirds of admissions – audit data shows that this is not the picture seen at MTW.

The objective of the revised guidance is to focus and maximise the clinical impact for patients (adults and children) who are most likely to benefit (ie those patients for whom MRSA colonisation carries the greatest risk of infection or poor outcome).

The guidance suggests that efforts are focussed on:
- All patients admitted to high risk units
- All patients previously identified as colonised with or infected by MRSA.

High risk specialties are defined as vascular, renal/dialysis, neurosurgery, cardiothoracic surgery, haematology/oncology/bone marrow transplant, trauma/orthopaedics and all ITUs including NICU, HDU, CCU.

However, the guidance also advises local variation to include other patients, depending on local risk assessment, who are at risk of poor outcome from MRSA infection. This is against a background of intensive screening and decolonisation over a period of several years where our MRSA bacteraemia rates have significantly decreased at MTW.

Knowledge of MRSA colonisation allows us to decolonise patients early and reduce the risk of bacteraemia.

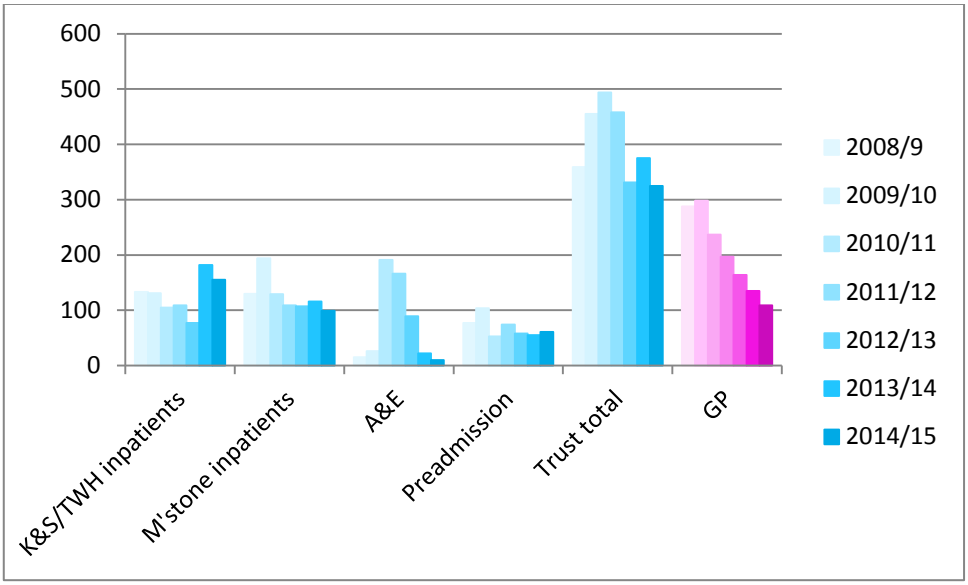
To assess the impact of changing the screening policy to match that suggested in the guidance, a look-back exercise was completed to determine how many elective MRSA positive patients would have been missed if screening was carried out strictly according to the new guidance. Three months (July-September 2014) of screening data was examined. For each month, 8 days of data is audited. Over the three months, a total of 18 elective patients were identified as MRSA positive during the 24 days audited. Of these, eight were previously known to be colonised with MRSA and ten were newly identified cases.

As a result the following recommendation, which takes into account the local risks and audit findings, was made to, and subsequently approved by, the Infection Prevention and Control Committee:
- Continue elective screening for Surgery (including ENT, general surgery, urology, gynae-oncology, plastic surgery, vascular), Trauma and Orthopaedics, Gynaecology, elective caesarean sections, cardiac catheter, pain clinic interventions and interventional radiology.
- Discontinue elective screening for medical day cases (chest, rheumatology, endocrinology, neurology etc) and UMAU day attenders.
- Discontinue screening for haematology/oncology day attenders **with the exception of** those undergoing intravascular central line insertions (PICC, Groschong, Hickman etc)
- Continue non-elective screening as in the current policy
- Continue with current guidance for screening for obstetric patients and paediatrics.

The change was implemented in November 2014.
New patients who are colonised are identified within 24 hours of admission. Advances in laboratory testing enable a positive result to be available 18 hours after the specimen arrives in the laboratory. Colonised patients are also identified as a result of clinical samples.

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

Fig 10: New MRSA colonisations 2008-2015



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

A total of 93483 screens (230296 swabs) were carried out during 2014/15. 435 patients were identified as new carriers. The current new positive rate of screening swabs is 0.5%.

3.3.4. Periods of Increased Incidence

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

When the PII is declared the following actions are taken:

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

During 2014/15, eight PIIs were declared for MRSA, six at Maidstone and two at TWH. One ward had two PIIs during the year. The PIIs lasted an average of six weeks. Staff were screened as part of two investigations.

Linked cases were found on two occasions on a single ward. Serious incidents were declared for these outbreaks (see section 8).

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

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

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

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

Fig 11: New ESBL isolates 2008-2015

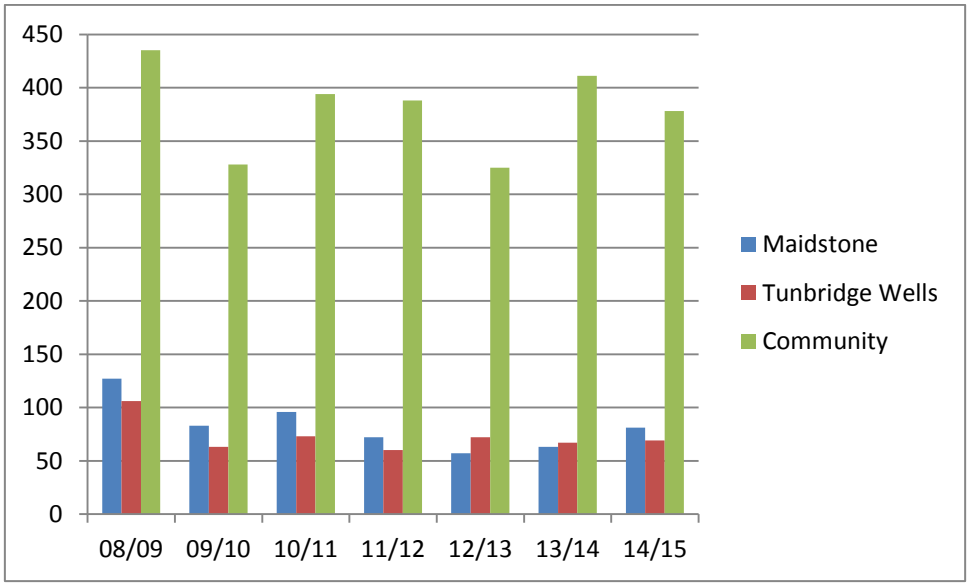
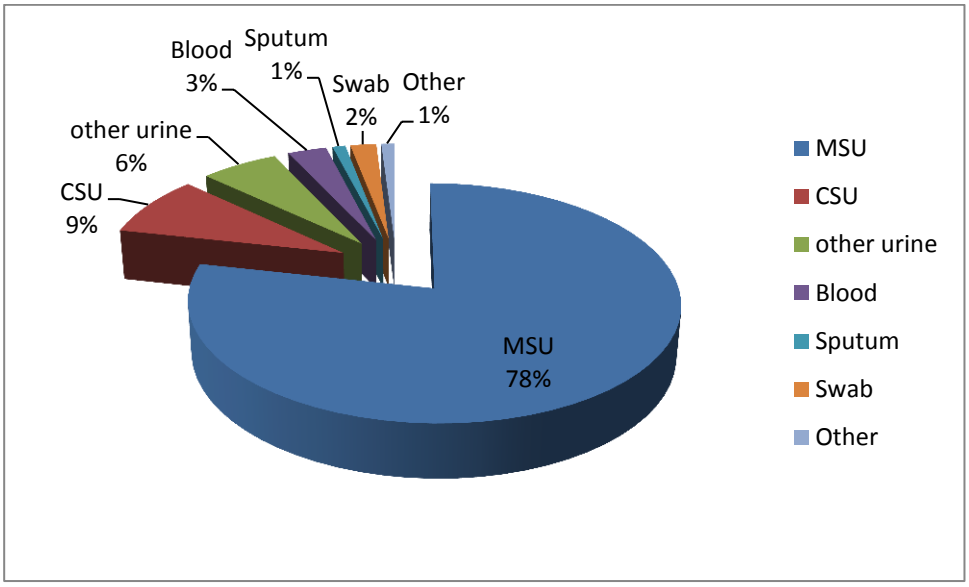


Fig 12: New ESBL isolates by specimen site 2014-15



The percentage of cases arising in mid-stream urine specimens has decreased slightly this year compared with the previous year with a similar increase in the number associated with urinary catheters. Although long term catheters are a recognised risk factor of acquiring an ESBL organism, non-catheterised patients account for the vast majority of patients with ESBL organisms. This is likely to be due to the treatment of recurrent urinary tract infection with broad spectrum antibiotics, selecting out resistant strains which then colonise the individual's gastrointestinal tract and form a reservoir of infection.

3.5. Ebola virus

The outbreak of Ebola virus disease (EVD) first reported in March 2014 affected three countries: Guinea, Liberia and Sierra Leone. This was the first documented EVD outbreak in West Africa, and is the largest known outbreak of this disease.

Trusts were asked to prepare contingency procedures to receive suspected cases of Ebola virus infection. The Infection Prevention team worked closely with the Emergency Planning team to develop local guidance.

The Trust already had a Viral Haemorrhagic Fever Policy and Procedure, however this required updating and expanding in the light of the information released during the outbreak.

Procedures were developed for the A&E departments to receive suspected cases and to use Personal Protective Equipment. Training was given to a large number of front line staff and 'walk through' checks were made to ensure that the procedures in place would work should a suspected patient arrive.

Documents were placed on the Trust intranet for staff to access and posters were put up in the A&E departments giving advice on the immediate action to be taken. The advice from Public Health England was regularly updated and the information on the intranet was updated promptly to reflect this.

Less than ten suspected patients attended A&E during the outbreak and none was proven to have the infection.

3.6. Non-MRSA screening

Two new screening programmes were introduced in 2014/15 in additional to the existing MRSA screening which is well established and GRE screening which was introduced in March 2014 in response to an increased incidence of infection.

3.6.1. Glycopeptide resistant Enterococci (GRE)

A screening programme amongst haematology patients was put in place in March 2014 with all haematology patients screened on admission and discharge. The carriage rate amongst this cohort of patients has remained constant at around 20%.

113 carriers of GRE were newly identified from April 2014 - March 2015. 76 were screened on Lord North as part of the routine admission and discharge screening protocol. Others were screened as outlying haematology patients.

3.6.2. Methicillin Sensitive *Staphylococcus aureus* (MSSA)

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

Those found to be colonised on nasal screen are treated pre-operatively with nasal antibiotic cream to reduce their risk of post-op infection. See section 7 for further information.

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

A patient safety alert : *Addressing rising trends and outbreaks in carbapenemase-producing Enterobacteriaceae,* was published on 6th March 2014 for implementation by 30 June 2014.

Public Health England

NHS England

Patient Safety Alert

Stage Two: Resources

Addressing rising trends and outbreaks in carbapenemase-producing Enterobacteriaceae

6th March 2014

Alert reference number: NHS/PSA/Re/2014/004

Alert stage: Two - Resources

Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals, but, in the wrong place, can cause serious infections. Worldwide, a small but increasing number of strains of enterobacteriaceae have become resistant to carbapenem antibiotics, which have been defined by WHO as critically important antibiotics. Carbapenemases are enzymes made by some strains of these bacteria, which allow them to destroy carbapenem antibiotics and cause resistance. Increasing trends in sporadic infections, clusters and outbreaks of carbapenemase-producing Enterobacteriaceae (CPE) have been observed in a number of NHS trusts in England. There is a high risk of this problem becoming more widespread unless early and decisive action is taken by Trusts. These bacteria represent a significant challenge in terms of prevention, treatment and control. Inadequate measures to prevent and control transmission can have serious consequences for both patients, who may require more complex treatment to manage their infection, and hospitals in terms of ward closures and protracted patient stays. As a result of the escalating problem, Public Health England (PHE) is providing national support for ongoing efforts to control and reverse rising trends with the aim of minimising morbidity and preventing further outbreaks. Because the PHE resources are now available NHS England has been able to proceed to issuing a Stage 2 alert without a previous Stage 1 alert.

PHE have recently published a toolkit for acute trusts to assist them with the early detection, management and control of carbapenemase-producing Enterobacteriaceae. A key aspect of the control measures is to take special precautions for patients recently treated in countries known to have high levels of CPE or in UK hospitals with recent clusters or outbreaks of CPE.

This alert is to bring this significant infection prevention and control challenge to the attention of the NHS and to signpost the toolkit developed to support the NHS in both controlling existing transmission problems and preventing further spread.

The toolkit along with 'UK Standards for Microbiology Investigations: Laboratory Detection and Reporting of Bacteria with Carbapenem-Hydrolysing ß-lactamases (Carbapenemases)' can be found at: www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1317140378529

BSAC antibiotic susceptibility testing guidance is available at: www.bsac.org.uk/wp-content/uploads/2012/02/AST-testing-and-Reporting-guidance-v1-Final.pdf

Implementation advice on the toolkit can be obtained from local PHE Centres: www.gov.uk/government/publications/phe-centre-addresses-and-phone-numbers/phe-local-and-regional-contact-details

Actions

Who: Chief Executives of NHS trusts and foundation trusts providing acute care and independent hospitals.

When: To commence immediately and completed by 30 June 2014

1. Bring this alert to the notice of the Director for Infection Prevention and Control (DIPC) and infection control staff to instigate the development of the board level CPE management plan.
2. In discussion with relevant clinical experts establish if there are / have been cases of CPE in the organisation and consider if immediate action is required locally to reduce the risk of such an incident / outbreak occurring.
3. In the light of the local situation the Infection Prevention and Control Committee to plan for local adoption and dissemination of the Acute Trust CPE toolkit to influence clinical practice. This will include advising front line staff of the issue and the Trust's plans for addressing CPE.

Note: This alert is being sent to GPs for information

Patient Safety | Domain 5
www.england.nhs.uk/patientsafety

Contact us: patientsafety.enquiries@nhs.net
Visit our website: www.england.nhs.uk/patientsafety
Report incidents: www.england.nhs.uk/reportingpsincidents

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

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

An action plan was put in place and the Trust declared compliance with the PSA in June 2014.

A policy was developed to introduce the screening programme into the Trust by a risk based approach – focussing on screening patients transferred in from healthcare abroad and patients who are transferred from (or have

recently been in patients in) other UK hospitals and tertiary referral centres, including haematology patients and neonates. The policy was approved by the IPCC and Quality and Safety committee in September 2014 with implementation training starting shortly afterwards and aimed to be complete by December.

In 2013/14 the Trust saw three patients with these organisms. One was transferred from Turkey, one from India and one from London. We have not identified any 'home grown' cases.

Patients requiring screening are identified on or before admission and are screened by three rectal swabs on different days. Whilst awaiting the outcome of the screening swabs patients are isolated with enhanced barrier nursing precautions including the use of long-sleeved gowns.

Since implementation of the screening programme, 346 swabs have been processed in the laboratory on 137 patients. Only one carrier has been identified, however this patient was already identified as a carrier prior to transfer.

3.7. Routine surveillance and Alert organisms

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

The following gives an overview of local activity.

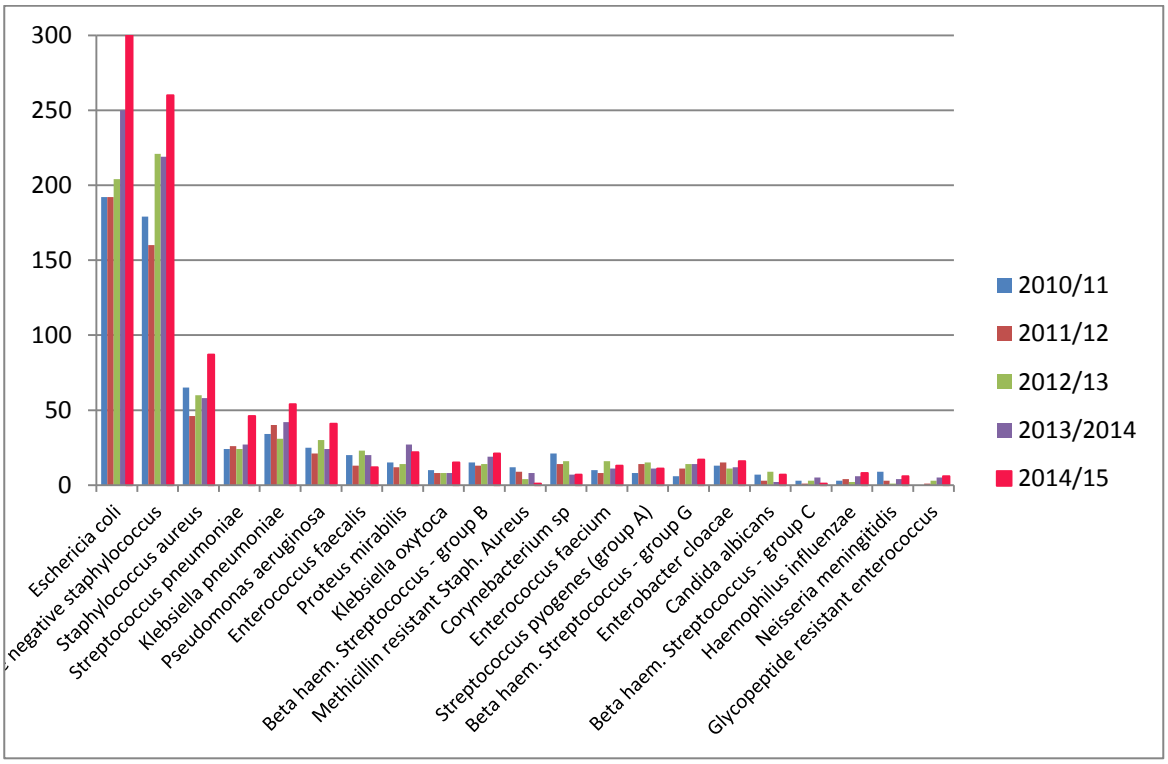
3.7.1. Blood cultures

A total of 955 patients had positive blood cultures during 2014/15, an increase of 128 (15%) on the previous year. This may be partly due to the increased activity in non-elective patients in the first few months of 2015 but is also likely to reflect the perceived increase in acuity of patients admitted.

A total of 13767 blood cultures were taken from patients, with 1269 sets positive, an overall rate of 9.2%.

The commonest isolate was *E. coli* which is often associated with urinary tract infection. There has been a 20% (51 additional cases) increase in E. coli isolates alone compared with last year with an increase of a similar size also seen the previous year.

Fig 13: Commonest significant isolates from blood cultures 2010-2015



Some isolates are seen in small numbers but are highly significant for their ability to cause serious infection. These include *Neisseria meningitidis* (a cause of meningitis), *Staphylococcus aureus*, beta haemolytic streptococci and *Streptococcus pneumoniae*. Glycopeptide-resistant enterococci are a particular risk to immune-compromised patients and the number of isolates is increasing slowly year on year.

3.7.2. Methicillin sensitive *Staphylococcus aureus*

66 patients were diagnosed with methicillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia in 2014/15 compared with 58 patients the previous year

64% of the positive cultures were taken in A&E or an admissions unit indicating that the infections arose in the community. Any isolate from a blood culture taken within 48 hours of admission is classified as community acquired.

Seventeen of the patients had hospital-attributable (post 48 hour) MSSA bacteraemia. Root cause analysis was completed on all cases with learning shared at directorate meetings and reported to the IPCC

Cases were spread between male and female patients in step with the national trend where males predominate in a ratio of 3:2

Since January 2010, MSSA bacteraemia has been part of the mandatory surveillance for HCAI. Epidemiological information is now collected on these cases. There is no objective limit for MSSA and there is currently no Department of Health plan to impose one in the future. The first full year of MTW mandatory data collection showed a decrease in both community and hospital acquired MSSA bacteraemia, with the second and third years showing an increase in cases. 2014/15 again showed an increase in community acquired cases but a small decrease in hospital-attributable cases.

3.7.3. Invasive Group A streptococci (iGAS)

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

Case fatality rates are high at approximately 15-20% within one week of diagnosis although in the national outbreak in 2009 the case fatality rate has been reported as up to 23%.

Invasive GAS infections have a seasonal pattern, with highest incidence from December to April. When a national increase in invasive GAS infection over and above the expected trend is seen, enhanced national surveillance is carried out and microbiology laboratories are required to contribute to the surveillance data.

Just eleven cases of bacteraemia were seen at MTW last year. It is likely the low numbers reflect the cyclical nature of the epidemiology of iGAS infection.

3.7.4. Glycopeptide Resistant Enterococcus (GRE)

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

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

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

3.7.5. Norovirus

Norovirus infection was seen in the Trust intermittently throughout the year.

Table 3: Summary of Norovirus incidents

Month	Ward	Patients affected	Staff affected	Bed days lost	Closure	Days closed
April 14	J Saunders	8	4	12	Whole ward	10
	Mercer	14	17	20	Whole ward	8
	UMAU	7	0	2	2 bays	2
	Foster	4	1	0	1 bay	2
	John Day	4	4	2	1 bay	4
April 14	TW CCU	6	7	0	Whole ward	5
October 14	J Saunders	11	6	27	Whole ward	7
December 14	TW Stroke	7	9	0	Whole ward	6
February 15	Chaucer	12	0	21	Whole ward	8
	Whatman	6	0	10	1 bay	6

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

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

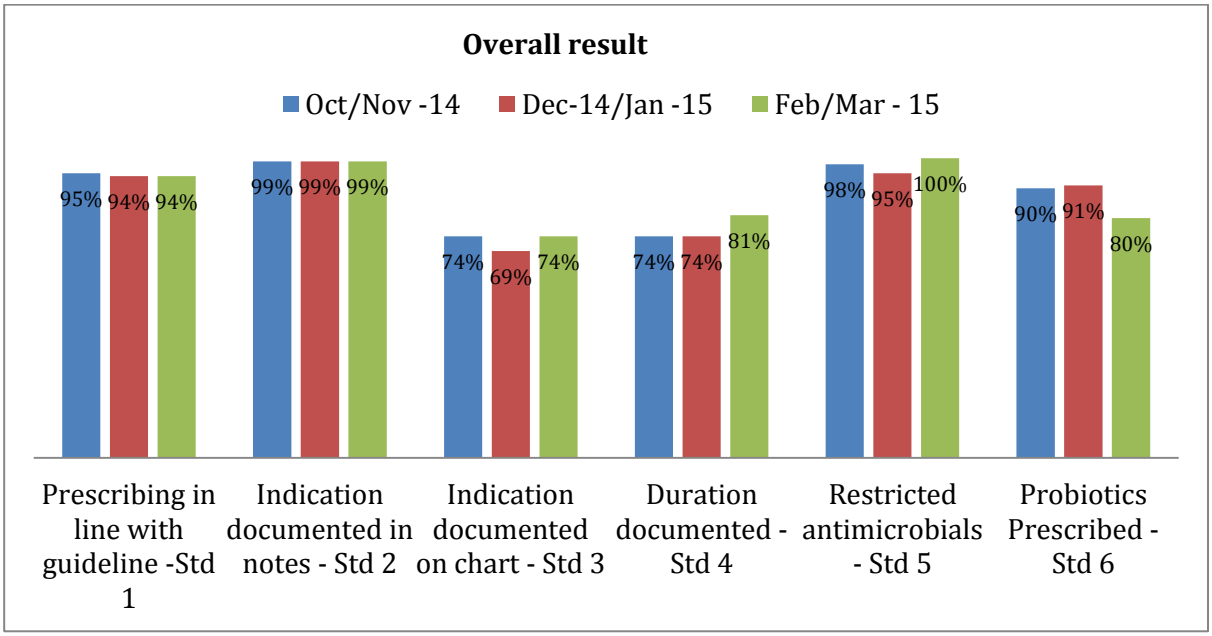
4. Antimicrobial Stewardship

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

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

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

Fig 14: Antibiotic prescribing audit to March 2015



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

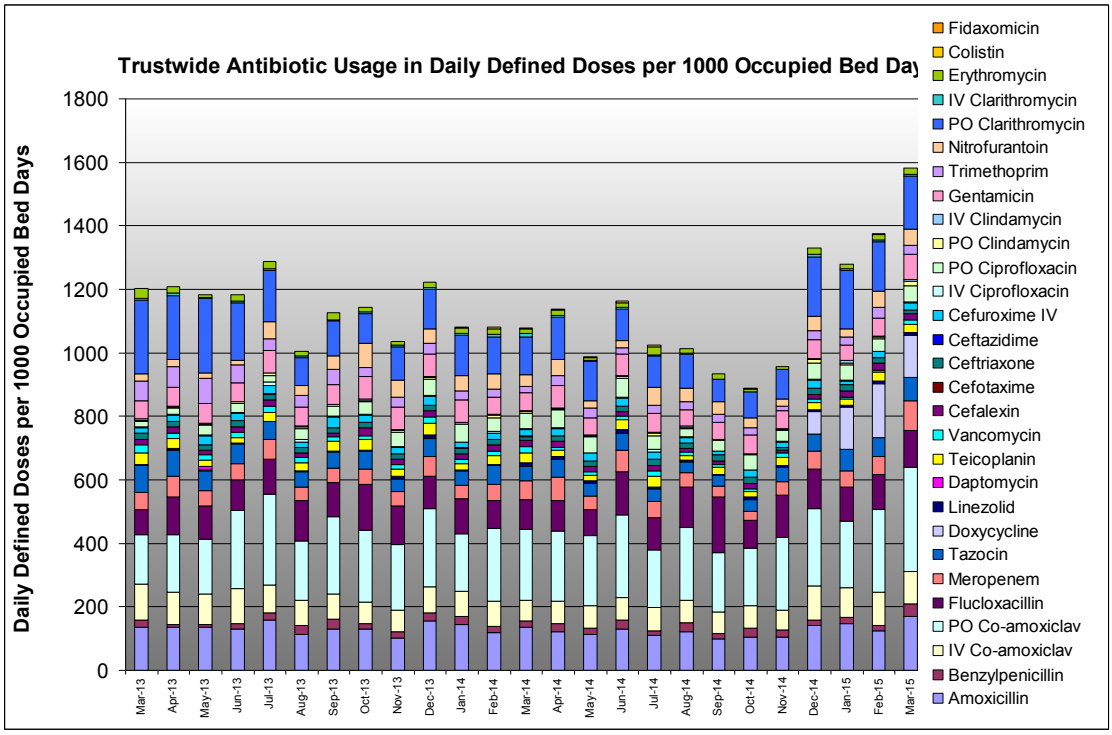
Whole Trust audits against the antibiotic prescribing policy are completed bimonthly and the surgical prophylaxis guidelines audit is carried out twice a year. In addition, wards in a Period of Increased Incidence for *C. difficile* or MRSA are audited against the policy weekly. Wards invariably achieve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

4.1. Antimicrobial usage

Antibiotic usage is monitored on a monthly basis and discussed by the ASG. In December 2014, Doxycycline was added to the number of antibiotics included in the routine surveillance. A further change to the manner in which the data was presented was to include the usage in ‘daily defined doses’ per 1000 occupied bed days

Following a decrease in overall consumption when the formulary was changed in July 2013, A sharp increase (partly accounted for by the inclusion of doxycycline) was seen in December 2014 associated with the increase in escalation beds and the acuity of patients admitted.

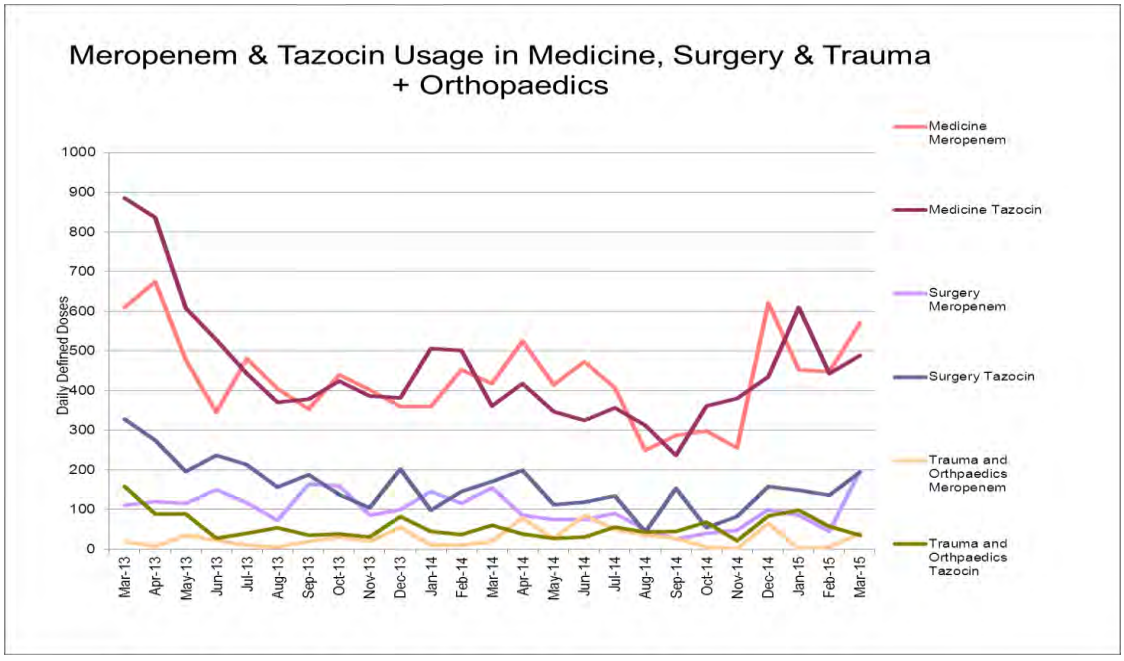
Fig 15: Trust wide antibiotic consumption in DDDs per 1000 obd



As can be seen from Fig 16, there was an associated increase in the use of restricted antibiotics (Meropenem and Tazocin), particularly in the Specialist Medicine directorate.

In the past these two antibiotics have been identified as being a risk factor in the development of *C. difficile* infection with over 70% of hospital-attributable *C. difficile* cases at MTW having received one of them prior to the development of infection (57% in 2014/15).

Fig 16: Restricted antimicrobial usage to March 2015



4.2. UK strategy on antimicrobial resistance(AMR)

The UK 5 year antimicrobial resistance strategy was published in 2013. This is an overarching strategy document focussing activity around three strategic aims:

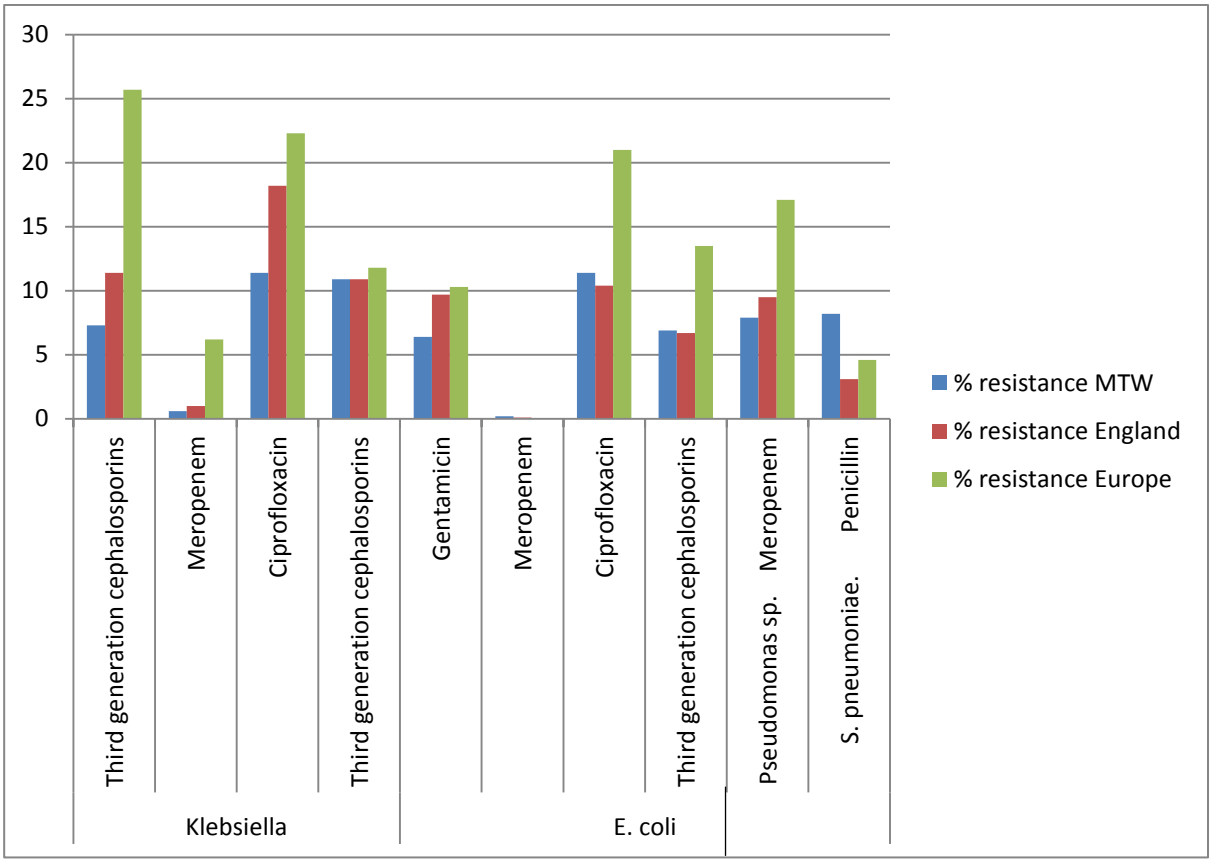
- To improve the knowledge and understanding of antimicrobial resistance
- To conserve and steward the effectiveness of existing treatments
- To stimulate the development of new antibiotics, diagnostics and novel therapies

It lists preliminary actions for healthcare organisation, animal health organisation and the pharmaceutical industry.

The actions for acute Trusts are many of the antibiotic stewardship and infection control actions that we already have in place plus developing an understanding of our baseline position with respect to multi-resistant organisms.

As part of the UK strategy for tackling AMR, Public Health England (PHE) has developed a new national programme, English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR), to bring together the elements of antimicrobial utilisation and resistance surveillance from both primary and secondary care alongside the development of quality measures and methods to monitor unintended clinical outcomes of future antimicrobial stewardship and both public and professional behaviour interventions. The group will report on progress annually to the Department of Health, as well as its Expert Committee on Antimicrobial Resistance and Healthcare-Associated Infections through a publicly available report.

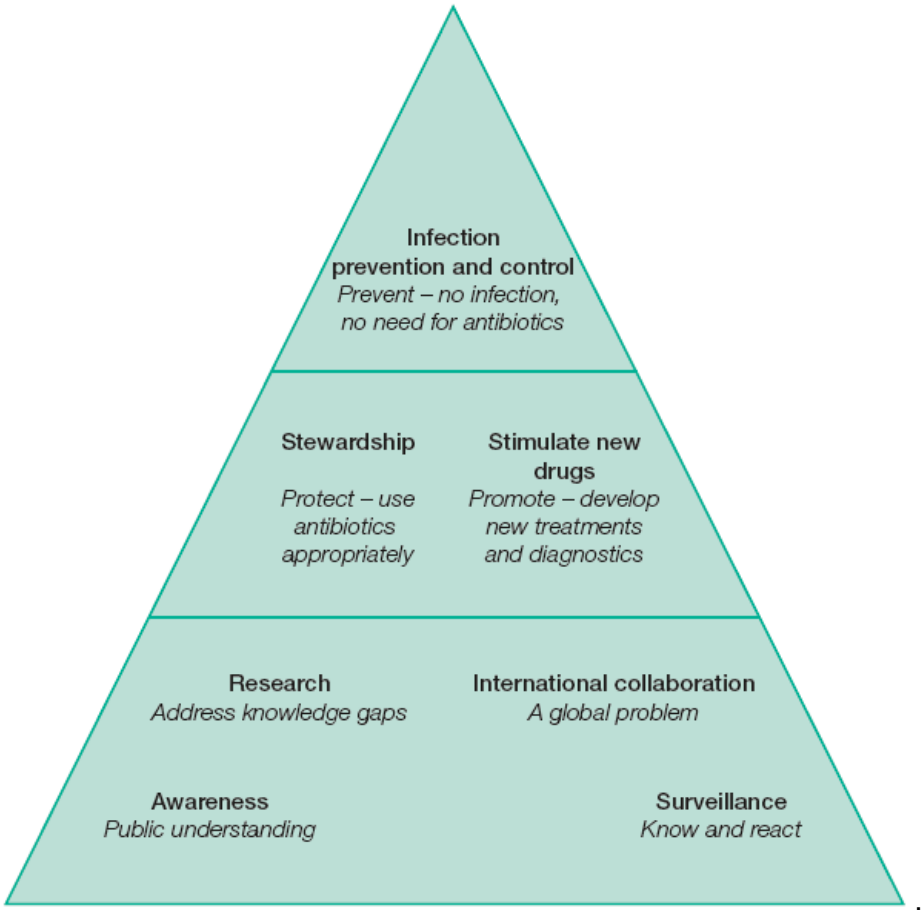
Fig 17: Resistance to antibiotics compared with England and Europe



In 2014, antimicrobial resistance became a key government priority with the Prime Minister stating that '*We are in danger of going back to the dark ages of medicine*..' in response to concerns about the growing threat of AMR.

The implementation plan associated with the 5 year strategy document was published in December 2014. Actions include:

- Improving infection prevention and control practices in human and animal health (prevent)
- Optimising prescribing practice, through good antibiotic stewardship, to promote better use of antibiotics and new diagnostics (protect).
    - NICE to develop guidelines on Antimicrobial Stewardship – published August 2015
- Improving professional education, training and public engagement to improve practice and increase understanding
- Developing new drugs, treatments and diagnostics through better collaboration between research councils, academia, industry and others (promote)
- Better access to and use of surveillance data in human and animal sectors
- Better identification and prioritisation of AMR research needs, to focus activity and inform our understanding of AMR
- Strengthened international collaboration working with a wide range of governmental and non-governmental organisations



4.3 Antimicrobial Training and Education

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

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

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

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

5. Care Quality Commission

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

Infection control was reviewed as part of the Chief Inspector of Hospitals Inspection in October 2014.

It was found that the annual water sampling for legionella was six months overdue at Maidstone Hospital and an Enforcement Notice was issued. Pseudomonas tests and records were found to be compliant. Tunbridge Wells Hospital is compliant for all areas in water hygiene management in accordance with statutory regulations. It was clear that there was inaccurate and incomplete reporting of water hygiene management to the Director of EFM.

The Water Compliance Action Plan was developed and the implementationmonitored by the Water Steering group. Implementation commenced on 22 October 2014. Progress and sampling results were also reported to the IPCC.

No other Infection Control issues were raised by the inspection

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

6. Saving Lives

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

The high impact interventions which are audited monthly are:
- Peripheral line insertion and continuing care
- Central line insertion and continuing care
- Urinary catheter insertion and continuing care

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

7. Surveillance

Orthopaedic surgical site infection (SSI) has been included in the mandatory healthcare associated infection surveillance system from April 2004. All NHS Trusts or facilities undertaking orthopaedic surgery must do surveillance in one or more of the orthopaedic categories - total hip replacement, hip hemi-arthroplasty, knee replacement and open reduction of long bone fracture.

In any financial year, surveillance must be continued for a minimum of three consecutive months, commencing at the start of a calendar quarter.
The surveillance scheme is coordinated by the Healthcare-associated Infection and Antimicrobial Resistance (HCAI & AMR) Department of the Communicable Disease Surveillance Centre (CDSC) at the Public Health England (PHE) in Colindale.

The PHE web based data capture system also collates data from a number of other categories of surgery which Trusts can complete on a voluntary basis. MTW have completed surveillance for both breast and caesarean section surgeries during 2014/15.

7.1. Orthopaedic Surgical Site Surveillance

All cases of surgical wound infection in the surveillance programme are subject to root cause analysis. Patients are asked to fill in a questionnaire six weeks after discharge detailing any problems with their surgical wound. This system has the advantage of detecting minor wound infections treated by the GP in the community.
Following the reconfiguration of services in 2012 the infection rates increased and the directorate has struggled to reduce the rates back to baseline. Full root cause analysis has been carried out, a task and finish group is in place and an action plan has been implemented. Changes have been made to reflect NICE guidance on surgical site infection.

Key Actions:

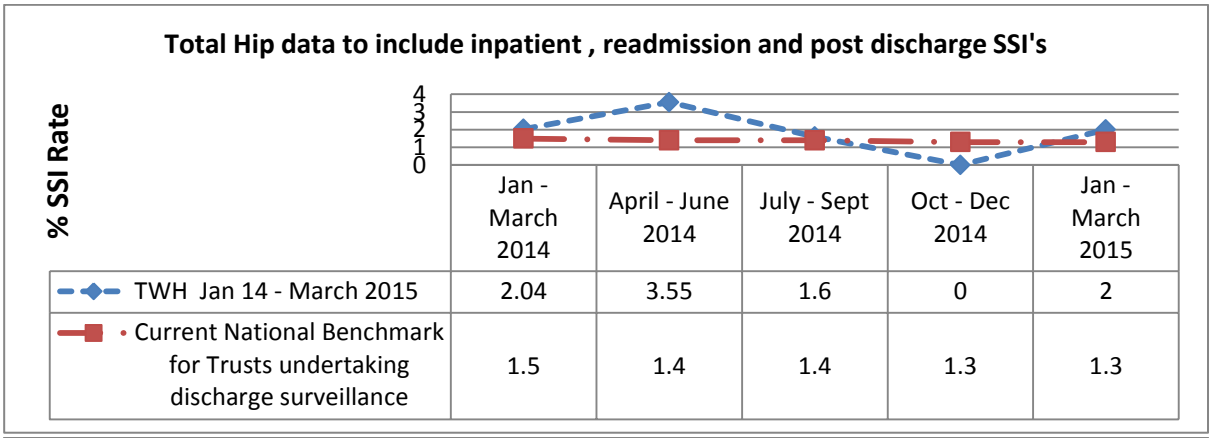
Pre Operative:
- MSSA screening
- Preoperative washing with Chlorhexidine
- Clean towels and bedding to be used at home for the night prior to surgery
- Pre warming of patient to maintain normothermia

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

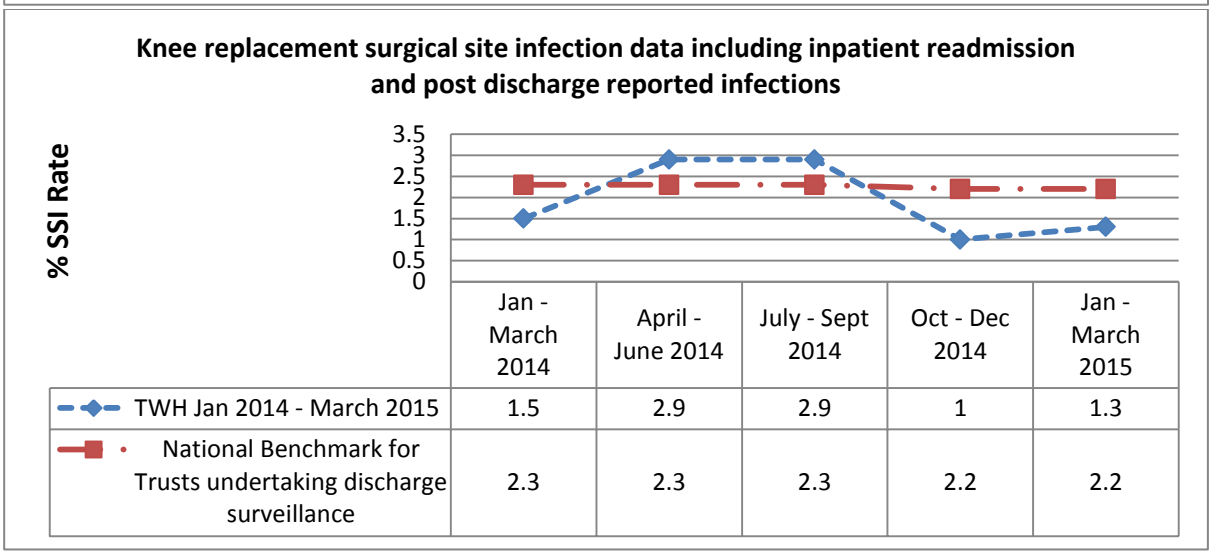
Post operative
- Patient warmed post op
- Blood glucose monitoring
- Consistent management of oozing wounds
- Ward policy for managing surgical dressings.

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

Fig 18: SSSI rates for elective hips and knees



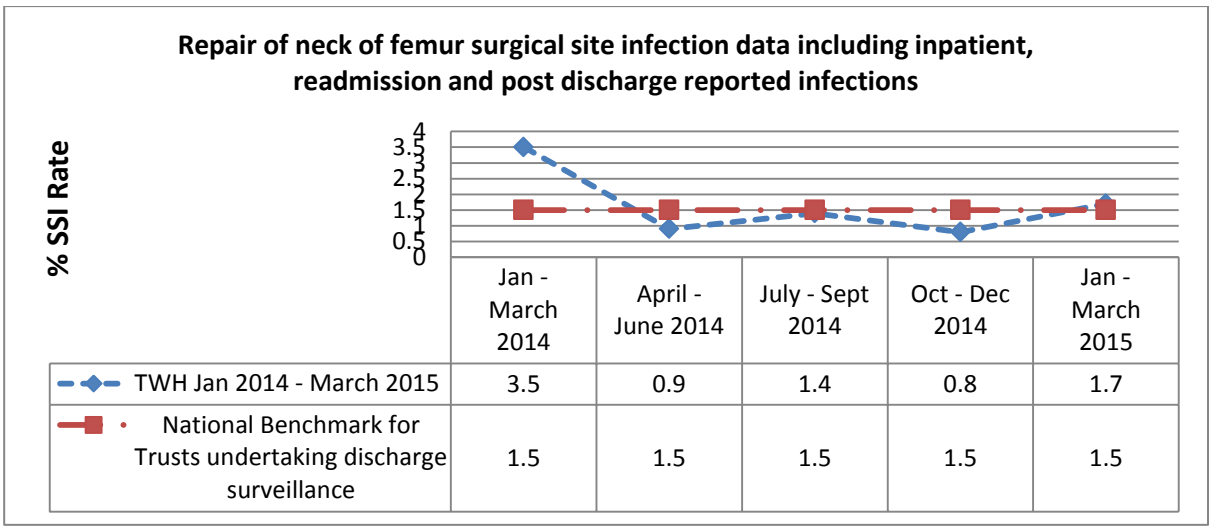
	Jan - March 2014	April - June 2014	July - Sept 2014	Oct - Dec 2014	Jan - March 2015
TWH Jan 14 - March 2015	2.04	3.55	1.6	0	2
Current National Benchmark for Trusts undertaking discharge surveillance	1.5	1.4	1.4	1.3	1.3



	Jan - March 2014	April - June 2014	July - Sept 2014	Oct - Dec 2014	Jan - March 2015
TWH Jan 2014 - March 2015	1.5	2.9	2.9	1	1.3
National Benchmark for Trusts undertaking discharge surveillance	2.3	2.3	2.3	2.2	2.2

Rates are more stable for repair of fractured neck of femur.

Fig 19: Infection rates for fractured neck of femur



	Jan - March 2014	April - June 2014	July - Sept 2014	Oct - Dec 2014	Jan - March 2015
TWH Jan 2014 - March 2015	3.5	0.9	1.4	0.8	1.7
National Benchmark for Trusts undertaking discharge surveillance	1.5	1.5	1.5	1.5	1.5

There have been no MSSA infections reported since the introduction of MSSA screening, decolonisation and Chlorhexidine body wash prior to surgery were introduced during December 2014 up to March 2015.

Table 4: Annual (Jan – Dec 2014) infection rate data compared with National benchmarks

Surgical Site	Annual SSI rate for MTW	National annual benchmark rate
Total Hip	**1.5%**	**0.4%**
Knee	**1.5%**	**0.4%**
NOF	**1.4%**	**0.9%**

The Trust has higher than average returns of post discharge questionnaire data for elective hips and knees. Nationally patient discharge data is collected on 69.4% of elective hip patients whereas we managed to gather data on 82.6% of our patients. This gives us assurance that our post discharge data is comparable to the national data. However, only 57.9% of discharge questionnaires for fractured neck of femur are returned despite telephone follow up of all cases. The national benchmark for questionnaire return is 72.7%.

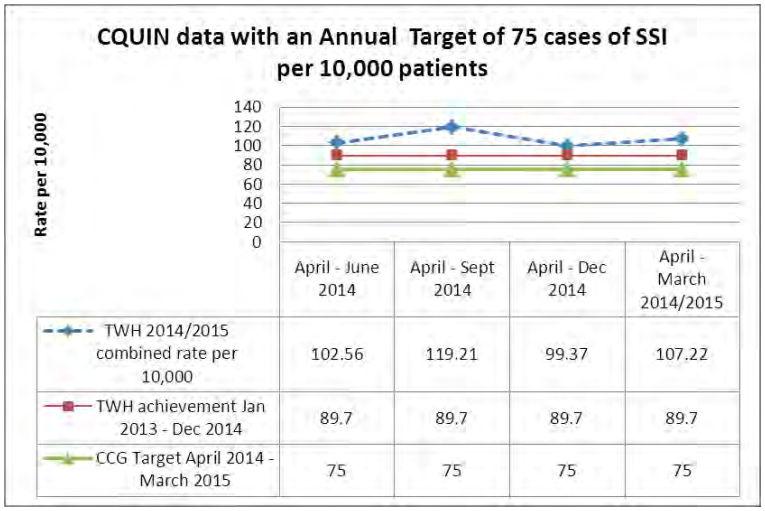
On-going actions to reduce orthopaedic surgical site infection:

- Task and finish group continues to meet and monitor performance and implementation of the action plan
- Introduction of pre-surgery Chlorhexidine wash cloths
- Additional training on dressing application and management
- Audit of theatre practice
- Further investigation of options for pre and post operative warming

7.1.1. CQUIN target

The CQUIN target is measured this year for the period January – December. The CQUIN is designed to improve infection rates overall across all orthopaedic surgery
The Trust target was set at the previous year's out turn of 89.97.

Fig 18: CQUIN data for 2014



The CQUIN target was not achieved.

7.2. Breast Surgical site surveillance

Collection of surveillance data for Breast surgery has been undertaken since January 2014. This was continued beyond the initial 6 months to 15 months in order to gain a clearer statistical picture of our surgical site infection (SSI) rates.

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

Table 5: Surgical site Infection data for breast surgery.

Whole Trust Data	Jan – March 2014	April – June 2014	July - Sept 2014	Oct - Dec 2014	Jan - March 2015
Number of procedures	201	203	176	170	201
Number of SSI's – Readmissions (there were no inpatient SSI's)	3	2	1	2	2
% Rate of SSI-Inpatients and Readmissions	1.49%	1%	0.57%	1.18%	1.00%
National % Rate of SSI-Inpatients and Readmissions	0.60%	0.70%	0.70%	0.70%	0.60%
Number of post discharge SSI's confirmed in Clinic	4	4	5	4	2
Number of post discharge SSI's patient report only	1	0	2	3	3
Total Number of SSI's reported	8	6	8	9	7
% Rate of Total SSI's reported	3.98%	2.96%	4.55%	5.29%	3.48%
National % Rate of Total SSI's reported by hospitals with discharge Data	4.20%	4.20%	4.30%	4.30%	4.20%

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

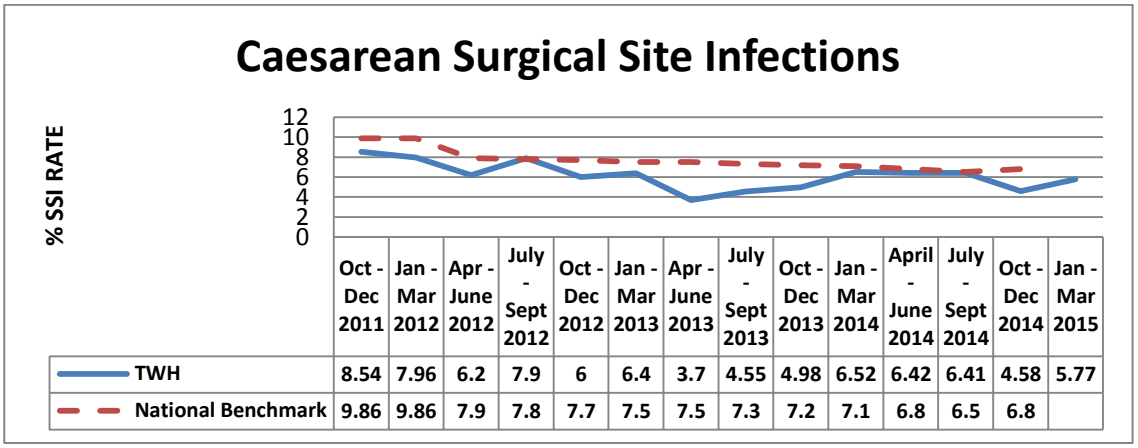
- Antibiotic prophylaxis given too late (i.e not within 30 minutes prior to knife-to-skin)
- BMI >26
- Pre-existing diabetes
- Dressing removed within 48 hours

Surveillance will continue for 2015-16 to ensure that the infection rate remains below the benchmark.

7.3. Caesarean section Surgical Site Surveillance

Caesarean section wound infections have remained stable and below the national benchmark for the last two years. Surveillance will be stepped down with one quarter per annum monitored.

Fig 19: Caesarean section rates



	Oct - Dec 2011	Jan - Mar 2012	Apr - June 2012	July - Sept 2012	Oct - Dec 2012	Jan - Mar 2013	Apr - June 2013	July - Sept 2013	Oct - Dec 2013	Jan - Mar 2014	April - June 2014	July - Sept 2014	Oct - Dec 2014	Jan - Mar 2015
TWH	8.54	7.96	6.2	7.9	6	6.4	3.7	4.55	4.98	6.52	6.42	6.41	4.58	5.77
National Benchmark	9.86	9.86	7.9	7.8	7.7	7.5	7.5	7.3	7.2	7.1	6.8	6.5	6.8	

8. Incidents, Outbreaks and Serious Infections

For the period April 2014 to March 2015, the following events were investigated as infection control incidents:

- Norovirus – five wards at Maidstone Hospital affected by Norovirus. (see section 3.6.5)
- Lord North – two cases of *C. difficile* within a 20 day period. No cross infection. Areas for improvement included assurance of terminal cleaning.
- TW21 – Two cases of *C. difficile* within a three day period – No cross infection.
- TW10 – Two cases of *C. difficile* within a 16 day period. No cross infection.
- Mercer – Cross infection of MRSA colonisation. SI declared. Additional IC support and training put in place.
- Charles Dickens Unit – Sewage leak in Brachytherapy theatre. No risk to patients. Repairs completed and theatre reopened within three days.
- Mercer – Second cross infection of MRSA colonisation. SI declared. Full action plan in place and implemented. No further incidents.
- Increased incidence of endophthalmitis following cataract surgery associated with EEMU theatre, Maidstone. Incidence was not outside acceptable limits but upward trend investigated as an outbreak. No confirmed links between cases. Changes made to antibiotic prophylaxis, changes to escalation procedures when infections are identified, theatre etiquette and de-cluttering. Theatre underwent deep cleaning. Audits completed to confirm sustained improvement. DIPC attended clinical governance to discuss outcomes with Ophthalmology team.
- Maidstone acute Stroke unit – Two cases of *C. difficile* within a 16 day period. No cross infection.

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

9. Infection Prevention and Control Team

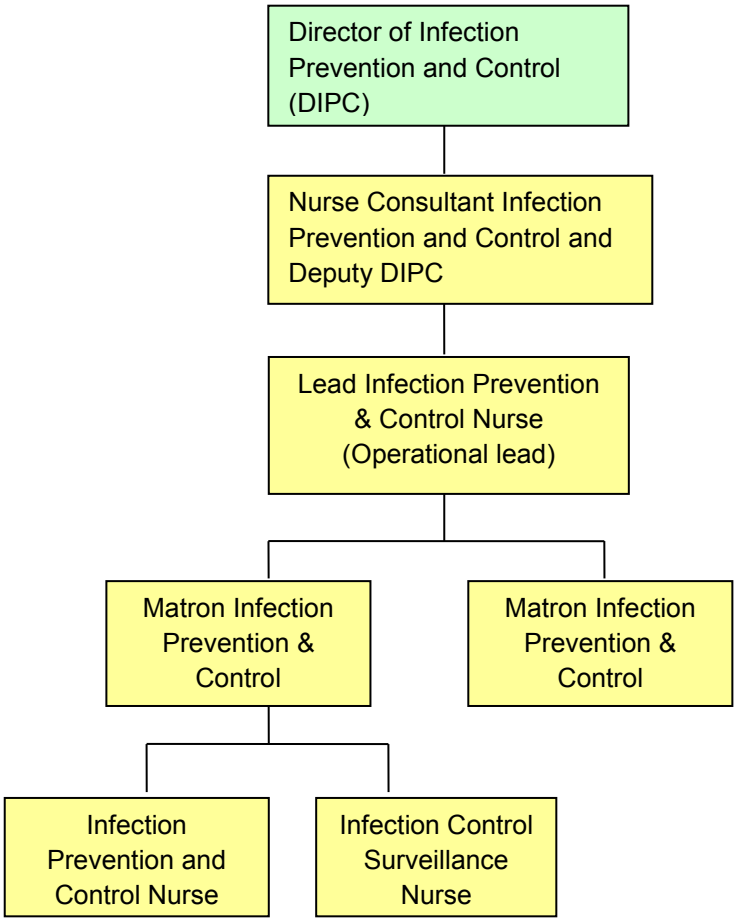
During the year there were changes within the staffing of the infection prevention team.

Sarah Fielder took up her new post as Nurse Consultant in Infection Control with a remit around strategy and Education. Sarah also took on the role of Deputy DIPC from April 2015.

I am grateful to Dr Grace Sluga for stepping into the role of interim deputy DIPC for the year 2014/15.

Pamela Howe joined the team in January 2015 as Lead Infection Prevention Nurse and operational lead.

Fig 20: Structure of IPT going forward



In recognition of the reduction in *C. difficile*, the MTW IPT was named as runner-up (and best acute Trust team) in the Infection Prevention Team of the Year awards at the Infection Prevention Society conference in September 2014.

The team also submitted a poster to the same conference describing the bespoke IC training packages developed for our multilingual domestic and catering staff.

10. Infection Prevention and Control Committee

The infection Prevention and Control committee (IPCC) meets bi-monthly for the full committee and a smaller group consisting of the DIPC, Chief Nurse, IPT and matrons meet on the alternate months to review infection prevention performance and RCA outcomes.

The IPCC has been well supported with >60% attendance by the members including executive and non-executive directors. The committee supports the Infection Prevention Team in its work.

The committee has ratified 29 infection control policies during this period and received five completed audits plus monthly audit reports on elective and non-elective MRSA screening. In

addition, the committee has received RCA feedback and performance (triangulation audit) reports from the directorates and monitored action plan implementation. Major challenges for the committee included:

- Ensuring compliance with the Hygiene Code.
- Developing and implementing the C. difficile recovery action plan
- Monitoring of the annual infection control audit programme.
- Monitoring HCAI within the Trust
- Monitoring Saving Lives compliance
- Developing hand hygiene strategy
- Challenging the directorate performance with respect to HCAI
- Monitoring MRSA screening rates
- Providing assurance that the trust response to the Ebola epidemic was in place and robust.

The Hand Hygiene strategy was supported by a poster campaign fronted by TV personality Kim Woodburn.

11. Training and education

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

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

An on-line package is available for staff to use to fulfil the requirement for annual training. It is recommended that staff attend face to face training one year and access online training the next. The team also participates in the induction training for junior doctors with the DIPC leading the infection control training. The consultant microbiologists provide training in antibiotic prescribing during induction training. In addition training on infectious diseases and the use of antibiotics is provided as part of the post graduate educational programme.

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

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

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

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

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

12. Audit

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

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

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

The triangulation audits are conducted on:
- Bare below the elbows
- Hand hygiene
- Commode cleanliness
- MRSA decolonisation
- MRSA care pathway compliance
- MRSA non-elective screening

As part of the PII process additional audits are completed on
- Ward laundry management
- Decontamination of reusable devices

Audits are reported to the IPCC

13. Challenges for 2014/15

The main challenges for infection prevention and control in the year ahead are:
- Sustaining the previous gains in the rate of *C. difficile* and meeting the objective
- Ensuring compliance with the recently published NICE guidance for antimicrobial stewardship
- Ensuring compliance with the updated Code of Practice on the prevention and control of infections and related guidance (Hygiene Code) (July 2015)
- Reducing surgical site infection rates in orthopaedics
- Controlling and monitoring the development of antibiotic resistance
- Additional proactive infection control training for new ward staff with face to face support
- Working with commercial company in development of UVC light disinfection and introducing to Trust as part of a review of cleaning processes
- Participation in LUCID study - A European surveillance study of *C. difficile*
- Compliance with Patient Safety Alert (PSA 2015/007)to address antimicrobial resistance through effective antimicrobial stewardship
- MTW HCAI point prevalence survey
- Introduction of Enteric PCR test to diagnose enteric infections such as *Salmonella*, *Shigella*, *Campylobacter* and *E. coli 0157*
- Working with local CCGs and TDA to assist in peer review of other Trusts infection control
- Control use of broad spectrum antibiotics
- Introduce ‘Action on..’ topics in Infection Control to raise awareness of issues throughout the year

14. Recommendation

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

Appendix 1: HCAI action plan 2014/15

HCAI Action plan 2014/15 Updated and closed: 18/04/15

No:	Recommendation / Issue	Action(s) to be taken	Nominated lead(s)	Start date	Estimated completion date	Progress	RAG for Progress	Evidence to support completion	Completion date	Monitoring committee	Regulatory link/ source of action/ guidance doc
Antibiotic/Clinical Issues											
1a	Ensure IV to oral switch fully implemented	Audit of compliance	Antibiotic pharmacists	Jul-14	Sep-14	To be included into bi-monthly audits To audit wards with high IV usage Audit methodology remains outstanding	A	Audit report	T/F to 15/16 plan	ASG / IPCC	From 13/14 action plan
1b	Antibiotic therapy modulation	Implementation of out patient antibiotic therapy (OPAT)/ integrate with ERRS service	Grace Sluga	Apr-14	Mar-15	Referrals to ERRS being made successfully. However no coordinating MDT between KCHT and MTW. HB to develop business case for OPAT service for MTW	A		T/F to 15/16 plan	Q&S	From 13/14 action plan
		Training in safe and appropriate use of antibiotics for junior doctors	Consultant microbiologists	Apr-13	Jun-14	Antibiotic training now standard for all new junior doctors as part of induction training. Further training delivered as part of education programme	B	Training in place including induction training. Induction programme	Completed Jun14	IPCC	From 13/14 action plan
		Review pharmacist training in safe and appropriate use of antibiotics	Antibiotic pharmacists	Jun-14	Oct-14	Antibiotics training to become standard for all new starters an further training delivered as continuing education	B	Training package in place	Completed Dec 14		PHE/ARHAI: Antimicrobial prescribing and stewardship competencies 2013
		Review PHE/ARHAI antimicrobial competencies and incorporate into training	Antimicrobial stewardship group	Jun-14	Mar-15	To adapt APC competencies into antibiotics training packages for all prescribers	R	Revised training package	T/F to 15/16 plan		PHE/ARHAI: Antimicrobial prescribing and stewardship competencies 2013

No:	Recommendation / Issue	Action(s) to be taken	Nominated lead(s)	Start date	Estimated completion date	Progress	RAG for Progress	Evidence to support completion	Completion date	Monitoring committee	Regulatory link/ source of action/ guidance doc
1c	Additional checks required on admission	Introduce admission lounge risk assessment for HCAI	Sarah Fielder	Apr-14	Jul-14	Risk asessment prepared. Implementation Sept 14 Audit of compliance needed. Audit due Jan 15	B	Risk assessment form	Complated Jul 14		Extension of 'Awareness of HCAI risks' action from 13/14 action plan
		Audit of compliance	Sarah Fielder	Jul-14	Jan-15	Due jan 15	A	Audit report	T/F to 15/16 plan	IPCC	
1d	Possible links between cases of C. difficile	Ribotyping on all cases of C. difficile and MVLA typing on any potential links	Sara Mumford	Apr-14	Ongoing	Embedded in laboratory SOP to ribotype all cases. MVLA carried out at reference lab on request of DIPC to regional microbiologist	B	IPCC minutes. DIPC annual report to Board. Laboratory SOP	Completed - now routine practice	IPCC	From 13/14 action plan
1e	Avoidable causes of C. difficile infection	Review trends and outcomes from C. difficile panel	Sara Mumford	Apr-14	Oct-14	All Panel reviews complete for 13/14. Review started of year.	B	Report to IPCC DIPC annual report to Board	Completed - now routine practice	Q&S	CQC Outcome 8
1f	Assess lapses of care for all C. difficile cases	Agree assessment tool across Kent and Medway. Embed tool within RCA form. Add to 2014/15 retrospectively where necessary. Quarterly meetings with CCG HCAI lead to agree outcomes	Sara Mumford	Apr-14	Aug-14	Assessment tool agreed. Tool embedded within RCA form First quarter forms updated with lapses of care tool Reported up to TDA HCAI lead Quarterly meetings tba when new HCAI lead in post (Sept 14) Meetings arranged and held. Sysytem for sharing information developed	B	Updated RCA form RCA file and database	Completed - now routine practice	IPCC	2014/15 CDI objective and associated guidance
1g	Improve knowledge of IV antibiotic usage	Develop monitoring method for patients on IV antibiotics	Antimicrobial pharmacists	Jul-14	Jan-15	Lead antimicrobial pharmacist in post June 14 Increased audit programme	A	Report to IPCC	T/F to 15/16 plan	Q&S	From 13/14 action plan

No:	Recommendation / Issue	Action(s) to be taken	Nominated lead(s)	Start date	Estimated completion date	Progress	RAG for Progress	Evidence to support completion	Completion date	Monitoring committee	Regulatory link/ source of action/ guidance doc
	Increase awareness of the diagnosis and management of symptomatic CA-UTI and asymptomatic bacteriuria to avoid unnecessary antibiotic prescribing	Teaching sessions for F1s, F2s, and CMT doctors on diagnosis and management of CA-UTI	Grace Sluga	Mar-14		Teaching sessions arranged and delivered. GP meeting attended and training given by GS. Avoidance of dipstick diagnosis emphasised. Now routine part of teaching	B	Teaching timetable, academic centres	Closed	IPCC	Audit report - The diagnosis and treatment of CA-UTI in inpatients in Maidstone hospital
		Re-audit	Grace Sluga		Jun-15	Not started	A	Audit report	T/F to 15/16 plan	IPCC	
1h	Understand baseline antimicrobial resistance levels	Gather baseline data from telepath	Sara Mumford	Apr-14	May-14	Baseline data available	B	Report to IPCC Aug 14	Completed Aug 14	IPCC	UK 5 year antimicrobial resistance strategy
		Repeat data collection every 6 months	Sara Mumford	Oct-14		Data collection to be done post end of December 14	A	Regular reports to IPCC	T/F to 15/16 plan	IPCC	
1i	Assurance of good antimicrobial stewardship	Develop antimicrobial quality measures	Sara Mumford and ASG	Apr-14	Jan-15	To be discussed and agreed by ASG Awating NICE publication of Quality standards for ASG	A	Quality measures defined and monitored. Report to IPCC and D&TC	T/F to 15/16 plan	IPCC and D&TC	UK 5 year antimicrobial resistance strategy
		Participate as stakeholder in development of NICE quality standards for ASG	Helen Burn and Sara Mumford	Apr-14		Registered as stakeholders	B	Registration complete	Closed		UK 5 year antimicrobial resistance strategy / NICE
		Implement standards when published	Helen Burn and Sara Mumford			Awaiting publication - no date for publication	R		T/F to 15/16 plan		UK 5 year antimicrobial resistance strategy / NICE

No:	Recommendation / Issue	Action(s) to be taken	Nominated lead(s)	Start date	Estimated completion date	Progress	RAG for Progress	Evidence to support completion	Completion date	Monitoring committee	Regulatory link/ source of action/ guidance doc
1j	Compliance with Acute Trust toolkit for the early detection, management and control of carbapenemase-producing Enterobacteriaceae	Review resistant organism (excluding GRE and CPE) policy to bring up to date	Sarah Fielder	Apr-14	Jun-14	To IPCC for approval Jun 14 and Q&S for ratification July 14	B	Ratified policy	Completed Jul 14	Q&S	
		Comply with Patient Safety Alert NHS/PSA/Re/2014/004	Sara Mumford	Mar-14	Jun-14	CEO and DIPC aware. Discussed at TME June 14. Board informed via escalation report June 14. Local situation reviewed - no immediate action required. Action plan for local adoption developed (incorporated into this plan	B	Board minutes. This action plan. Compliance declared June 14	Completed Jun 14	Q&S	
		Implement changes:									PHE Acute Trust toolkit
		Develop new policy	Sarah Fielder	May-14	Aug-14	SM and SF attended PHE toolkit launch meeting. High risk areas identified. Polcy to IPCC Aug 14 and to be ratified by Q&S Spet 14	B	IPCC minutes. Q&S mintues	Completed Sep 14	Q&S	
		Implement training to support policy	Sarah Fielder	Oct-14	Dec-14	Process written into policy.	B	IPCC minutes	Completed Dec 14	IPCC	
		Review laboratory screening methods	Mark Holland	Jul-14	Jul-14	Screening method in place. SOP written	B	SOP for screening method	Completed Aug 14	IPCC	
		Develop information leaflets for patients	Sarah Fielder	Jun-14		Completed and implemented	B	Approved leaflet	Completed		
		Implement screening programme	Sarah Fielder	Dec-14		Implemented. Audit due Feb 15	A	Audit of screening completion	Completed Feb 15 Audit T/F to 15/16 plan	IPCC	
		Implement transfer questionnaire	Sarah Fielder	Dec-14		Implemented	B	Audit	Completed Feb 15	IPCC	

No:	Recommendation / Issue	Action(s) to be taken	Nominated lead(s)	Start date	Estimated completion date	Progress	RAG for Progress	Evidence to support completion	Completion date	Monitoring committee	Regulatory link/ source of action/ guidance doc
1k	Increased incidence of GRE	Implement admission and discharge GRE screening for all admissions to Lord North and all haematology outliers	Charlotte Belsom & Sarah Fielder	Apr-14		Implemented on ward March 14. Extended to outliers April 14. Additional training tba for UMAU and Chaucer (Kathy Ward).	B	Audit	Completed	IPCC	Recent incident
		Audit of compliance	Charlotte Belsom & Sarah Fielder	May-14		Audit to be done Jan 15	B	Report to IPCC	Completed Feb15	IPCC	
		Assess background level of GRE carriage in non-haematology patients	Sara Mumford	Apr-14	ongoing	Lab anonymised study completedApril 14. 12% carriage found in inpatient population. To be repeated every three months to monitor change	G	Report to IPCC	Repeat every 3 months T/F to 15/16 plan	IPCC	UK 5 year antimicrobial resistance strategy
1l	epic 3 guidelines published Jan 14	Review infection prevention policies to ensure compliance with guidance where appropriate	Sarah Fielder	Apr-14	Sep-14	Review of IC policies underway. Complete. Final policies approved Aug IPCC	B	Updated policies	Completed Sep 14		epic3 (National Evidence based guidelines for preventing HCAI in NHS Hospitals in England
1m	**Comply with NICE quality standards for Surgical Site Infections (QS49)**	Review standard and implement actions to comply with areas of current partial compliance	Sara Mumford	Apr-14	Jun-14	Review complete. Action plan submitted to Clinical Audit Department. Fully compliant with Standards 2,4 and 7	G				
	Std 1.People having surgery are advised not to remove hair from the surgical site and are advised to have (or are helped to have) a shower, bath or bed bath the day before or on the day of surgery.	Ensure that all patients are given written advice on hair removal and bathing	Pre-admission clinic team Matrons	Jun-14	Sep-14	In place	B	Information leaflet	Completed Sep 14		NICE quality standards for Surgical Site Infections (QS49)

No:	Recommendation / Issue	Action(s) to be taken	Nominated lead(s)	Start date	Estimated completion date	Progress	RAG for Progress	Evidence to support completion	Completion date	Monitoring committee	Regulatory link/ source of action/ guidance doc
	Std 3. Adults having surgery under general or regional anaesthesia have normothermia maintained before, during (unless active cooling is part of the procedure) and after surgery	Investigate safe methods of warming patients pre operatively including day patients	Helen Gregson Guy Slater Sarah Miles	Feb-14	Oct-14	Pre-op warming gowns (Bear Paws) under evaluation. Identify area with couches / trolleys to prepare patients for surgery. Ring fenced beds for orthopaedics. Patients not undressed until immediately before surgery in SSU Disposable warming gowns remain under evaluation	G	New procedures in place in SSU. Ring fenced beds	Partially complete Mar 15 T/F outstanding issues to 15/16 plan		NICE quality standards for Surgical Site Infections (QS49)
	Std 5. People having surgery and their carers receive information and advice on wound and dressing care, including how to recognise problems with the wound and who to contact if they are concerned.	All patients to receive written advice before they leave the hospital	Matrons	Apr-14	Jul-14	Wound care leaflet available for Caesareans and Orthopaedics Evidence required for Surgery, Gynae and H&N	A	Wound care leaflet	T/F to 15/16 plan		NICE quality standards for Surgical Site Infections (QS49)
	Std 6. People with a surgical site infection are offered treatment with an antibiotic that covers the likely causative organisms and is selected based on local resistance patterns and the results of microbiological tests.	Review antibiotic guidance to ensure that empirical treatment advice is available for a range of surgical wounds	ASG	Jul-14	Feb-15	ASG to review available advice	A	Revised antimicrobial guidelines	T/F to 15/16 plan	IPCC	NICE quality standards for Surgical Site Infections (QS49)

No:	Recommendation / Issue	Action(s) to be taken	Nominated lead(s)	Start date	Estimated completion date	Progress	RAG for Progress	Evidence to support completion	Completion date	Monitoring committee	Regulatory link/ source of action/ guidance doc
1n	**Comply with NICE quality standard for Infection Prevention and Control (QS61)**	Review quality standard and implement actions to ensure compliance	Sara Mumford	Apr-14	Jun-14	Compliant with Std 1 - Antibiotics prescribed in accordance with local formularies. Compliant with Std 2 - Stratgey for continuous improvement Compliant with Std 3 - hand hygiene Compliant with Std 4 - urinary catheter management Compliant with Std 5 - Intravascular devices Partially compliant with	G	1. Regular audit data for antibiotic use. Guidance on intranet and prescribing P&P 2. This action plan 3. Monthly hand hygiene audits including triangulation. IC policies 4. Saving Lives programme embedded in organisation. Monthly audits including bi-monthly triangulation . Catheter P&P 5. Saving Lives programme embedded in organisation. Monthly audits including bi-monthly triangulation. P&P	Completed for standards 1-5. Standard 6 T/F to 15/16 plan		

No:	Recommendation / Issue	Action(s) to be taken	Nominated lead(s)	Start date	Estimated completion date	Progress	RAG for Progress	Evidence to support completion	Completion date	Monitoring committee	Regulatory link/ source of action/ guidance doc
	Std 6. people with a urinary catheter, vascular access device or enteral feeding tube, and their family members or carers (as appropriate) are educated about the safe management of the device or equipment, including techniques to prevent infection	Review current practice to identify gaps. Develop training aids for patients, families and carers.			Mar-15	Std 6. Require evidence on patient and carer education on catheter management. Funding issues with printin of catheter passport. Need evidence on leaflets for enteral feeding patients and carers. Vascular access leafelts in place	A	Leaflet for patients and carers widely used	T/F to 15/16 plan		**NICE quality standard for Infection Prevention and Control (QS61)**
Environment											
2a	Confidence in cleaning audit scores	Weekly joint audits between ward managers and domestic supervisors	Ward managers and domestic supervisors	2013	Jun-14	In place. Joint audits at agreed times/dates	**G**	Audit results	T/F to 15/16 plan		
		Immediate escalation to Infection Prevention team of poor audit scores	Ward managers	Jan-14	Apr-14	In place	**G**		T/F to 15/16 plan		CQC outcome 8
		Ensure that audit reports are readily available to ward managers	Pat Demian	Jan-14	Jun-14	Audit reports available on N drive	**B**	File on N drive	Completed Jun 14		
2b	Ensure cleaning levels correct for new risks	Increase cleaning level 4 to include steam cleaning for multiresistant organisms (GRE/CPE)	Sarah Fielder and Pat Demian	Apr-14	Jul-14	Environmental cleaning policy awaiting approval and ratification	**B**	Ratified policy	Completed	Q&S	CQC outcome 8
		Reissue cleaning posters	Sarah Fielder	Apr-14	Jul-14	Complete	**B**	Posters	Completed		

No:	Recommendation / Issue	Action(s) to be taken	Nominated lead(s)	Start date	Estimated completion date	Progress	RAG for Progress	Evidence to support completion	Completion date	Monitoring committee	Regulatory link/ source of action/ guidance doc
Training and Awareness											
3a	Need to reinvigorate infection prevention messages throughout Trust	Continuing renewal of messages to staff around HCAI	Sara Mumford, Sarah Fielder,	Apr-14		Awareness raised. Improved HCAI picture within Trust. Training levels high	B	Training data	Closed		CQC Outcome 8
		Utilise screen savers to improve messaging	Sarah Fielder			No progress	R		T/F to 15/16 plan		
		New hand hygiene signage around Trust	Jeanette Rooke, Sarah Fielder		Mar-15	With designer	A		T/F to 15/16 plan		
		Intranet page for Infection Control to be redeveloped	Sarah Fielder and Comms team	Sep-14		Completed	B	Intranet page available for staff	Completed Sep 14		
3b	Need training strategy	Appoint Nurse Consultant with education and Strategy responsibility	Avey Bhatia Sara mumford	Sep-13	Apr-14	Appointment made	B	Appointment made	Completed Apr 14		Also link to 1b. PHE/ARHAI Antimicrobial prescribing and stewardship competencies NICE QS 61 Infection Prevention and Control
		Develop antimicrobial education and awareness strategy	ASG	Jul-14	Oct-14	Antibiotics training now standard for new doctors and pharmacists to the Trust. To develop ongoing rolling training programme at directorate level (as part of clinical governance) SM and GS have attended clinical governance meetings to give update training	G		T/F to 15/16 plan		
		Review infection prevention training and align to Quality Standards	Sarah Fielder Sara Mumford	Jun-14	Feb-15		A		T/F to 15/16 plan		

No:	Recommendation / Issue	Action(s) to be taken	Nominated lead(s)	Start date	Estimated completion date	Progress	RAG for Progress	Evidence to support completion	Completion date	Monitoring committee	Regulatory link/ source of action/ guidance doc
3c	Need to improve awareness of safe antimicrobial prescribing	Participate in European Antibiotic Awareness Day November 2014	ASG Grace Sluga, Sarah Fielder			Displays both ends of Trust and newsletter	B		Completed Nov 14		
		Training in antimicrobial resistance awareness and responsible prescribing for doctors, nurses and pharmacists	Grace Sluga, Sara Mumford			SM - grand round in global threat of antimicrobial resistance Need to review in line with expected UK 5year strategy action plan	G		T/F to 15/16 plan		PHE/ARHAI Antimicrobial prescribing and stewardship competencies
		Develop competency for antimicrobial prescribing	ASG		Mar-15	Under discussion	A		T/F to 15/16 plan		PHE/ARHAI Antimicrobial prescribing and stewardship competencies
		Improve information for patients and relatives on antibmicrobials	Antimicrobial pharmacists				A		T/F to 15/16 plan		
		Develop policy forproviding information on antimicrobials to patients	Antimicrobial pharmacists				A		T/F to 15/16 plan		

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9-12 Safe Staffing: Planned V Actual - July & August 2015 **Chief Nurse**

Summary / Key points

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

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

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

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

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

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

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

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

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

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

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

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

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

The key underlying reasons for amber overall ratings are vacancy resulting in an adverse shift of the RN to CSW ratios and high levels of acuity and dependency.

Financial variance between months is noted as being due to a £41k reduction for posts changing from temporary to substantive with a subsequent reduction in agency premium.
Expenditure between months has increased by £332k. This is mainly within the Emergency Directorate with £286k attributed to temporary staffing. The Trust accrued for £153k of additional agency costs centrally in July, as an upsurge in usage was documented at the end of the month. However, this could not be identified to areas in the time available, so was accrued for centrally. This will have contributed to the increase between months, with the rest due to increased demand and usage.

RAG	Details
	Minor or No impact: Staffing levels are as expected and the ward is considered to be safely staffed taking into consideration workloads, patient acuity and skill mix. RN to patient ratio of 1:7 or better Skill mix within recommended guidance Routine sickness/absence not impacting on safe care delivery Clinical Care given as planned including clinical observations, food and hydration needs met, and drug rounds on time. OR Staffing numbers not as expected but reasonable given current workload and patient acuity.
	Moderate Impact: Staffing levels are not as expected and minor adjustments are made to bring staffing to a reasonable level. OR Staffing numbers are as expected, but given workloads, acuity and skill mix additional staff may be required. Requires redeployment of staff from other wards RN to Patient ratio >1:8 Elements of clinical care not being delivered as planned

	Significant Impact: Staffing levels are inadequate to manage current demand in terms of workloads, patient acuity and skill mix. Key clinical interventions such as intravenous therapy, clinical observations or nutrition and hydration needs not being met. Systemic staffing issues impacting on delivery of care. Use of non-ward based nurses to support services RN to Patient ratio >1:9 Need to instigate Business Continuity

Which Committees have reviewed the information prior to Board submission?

- N/A

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

- Assurance

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

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9-13 Board members' hospital visits (11/06/15 to 24/09/15) Trust Secretary

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

This quarterly report therefore provides details of the hospital visits undertaken by Board Members between 11th June and 24th September 2015 (the last report submitted to the Board, in June 2015, covered visits up to 10th June).

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

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

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

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

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

Ward visits undertaken by Board members, 11th June 2015 to 24th September 2015

Board member	Areas registered as being visited (MH: Maidstone Hospital; TW: Tunbridge Wells Hospital)	Formal feedback provided?
Chairman	▪ League of Friends MH ▪ Stroke Unit MH ▪ Transport MH ▪ Laundry MH ▪ A&E MH ▪ Chaplaincy volunteers TW	-
Chief Executive	▪ A&E MH ▪ Maternity TW ▪ Hedgehog TW ▪ Out Patients TW	-
Chief Nurse	▪ Pye Oliver MH ▪ MOU MH ▪ A&E TWH ▪ AAU TWH ▪ W20 TWH ▪ W30 TWH ▪ W31 TWH	-
Chief Operating Officer	▪ A&E MH ▪ Birth Centre MH ▪ Mercer Ward MH X2 ▪ Oncology MH ▪ Peale Unit MH ▪ Radiotherapy MH ▪ UMAU MH ▪ Whatman MH ▪ Cardiac Cath Lab TW ▪ Endoscopy TW ▪ Haemato-Oncology Day unit TW ▪ Outpatients TW ▪ Surgical Assessment Unit TW ▪ Oncology Unit, Kent and Canterbury Hospital	-
Deputy Chief Executive	▪ Birth Centre MH ▪ Mercer Ward MH ▪ Oncology MH ▪ Radiotherapy MH ▪ Theatre TW	-
Director of Finance	-	-
Director of Infection Prevention and Control	-	-
Director of Workforce and Communications	-	-
Medical Director	-	-
Non-Executive Director (KT)	-	-
Non-Executive Director (AK)	-	-
Non-Executive Director (SD)	-	-
Non-Executive Director (SDu)	-	-
Non-Executive Director (ST)	-	-

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9-14	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.

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

Review by the Trust Board
This is the second time during 2015/16 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 in April, May and June. The content has been updated from the BAF reviewed at the Board in July. Board members are asked to review and critique the content, by considering the following prompts:

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

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

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

Review by the Audit and Governance Committee
The BAF that was received at the July Trust Board was also reviewed at the Audit and Governance Committee on 06/08/15. Details of the review are provided in the summary report from the Committee, which has been submitted to the September Board under a separate agenda item.

Review by the Trust Management Executive
The BAF that was received at the July Trust Board was also reviewed at the Trust Management Executive on 19/08/15.

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 28/09/15 (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 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 significant progress has been made

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 Committee (including the 'deep dive' meetings) & Patient Experience Committee)

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

d. 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)

e. An external review of Governance and Culture has been done, and the final report and response will be discussed at the Trust Board on 30/09/15

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 is in development (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. Performance report to TME and Trust Board
3. Internal Audit "CQC Compliance Review"
4. CQC report re water quality testing (expected soon)
5. 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.)

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 Length of Stay (LOS) and reducing the number of Delayed Transfers of Care (DTIC)
2. Failure to recruit to the Trust's workforce establishments

What actions have been taken in response? *Controls*

a. Plans to open a 38-bedded ward at Tunbridge Wells Hospital (TWH) are being implemented, and the 'go live' date is 11/01/16
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, and has become part of the operational resilience plans
d. A fortnightly recruitment and retention group (Chaired by the Chief Nurse / Director of Workforce and Communications) is overseeing progress against recruitment plans
e. Winter & operational resilience plans are 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 actions undertaken by the Trust are sufficient, but there is dependency on the wider system (where failure is occurring)

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 Tunbridge Wells Hospital (reviewed at Finance Committee / Board)
3. Updates are reported to the Trust Board (including LOS / DTOC)

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 unresolved dependencies i.e. staffing and DTOC numbers

[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 Report
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	**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? [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 are in place 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 in place, which is 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 and July 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
Director of Finance

Committee/s responsible for oversight
Finance Committee / Trust Management Executive

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
2. The trend on temporary staffing is currently partially being offset by increased income. Should this not continue, the position would worsen

[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*

7 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*

7.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 – September 2015

9-15 Oversight Self-Certification, Month 5, 2015/16 Trust Secretary

As the Board did not meet during August, to consider the self-certification for month 4, the certification submitted to the TDA for that month mirrored that for month 3 (i.e. the certification approved by the Board in July 2015). This approach was agreed with the Chairman of the Trust Board and Chief Executive.

The enclosed schedule sets out the proposed oversight self-certification submission for month 5, 2015/16, based on performance as at 31st August. This submission must be sent to the NHS Trust Development Authority (TDA) by the end of September (i.e. by 30th).

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

No change in compliant status is proposed from that agreed by the Board in July 2015 (and submitted to the TDA in August).

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). It is proposed that the process agreed by the Board be formalised by being incorporated into the Trust's Standing Orders, which have been revised to this effect, and issued for consultation.	
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. The Trust has also made a recent application to have the Regulated Activity of "Assessment or medical treatment for persons detained under the Mental Health Act 1983" added to its registration, following a review of the CQC's latest "The scope of registration" guidance (March 2015). The Trust is not a provider of Mental Health services, but sometimes, the Trust's patients are detained under the Mental Health Act (i.e. on the Trust's acute hospital sites), in order for assessment and/or treatment by staff from the local Mental Health Trust (Kent and Medway NHS and Social Care Partnership Trust). It has been noted that other local acute NHS providers have added "Assessment or medical treatment for people detained under the Mental Health Act 1983)" to their Registration, to ensure that the assessment of such patients is covered via their registration, and the Trust wishes to do the same. A CQC assessor	Yes

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
	will be visiting the Trust in October to consider the Trust's application.	
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	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

Condition	Evidence of Trust compliance	Latest assessment – Compliant?
Monitors need to set a modified tariff.		

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.	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~~ discussed by the Board in September 2015 The final report of the Trust's inspection by the Care Quality	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	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 Trust has also made a recent application to have the Regulated Activity of "Assessment or medical treatment for persons detained under the Mental Health Act 1983" added to its registration (refer to the evidence for General Condition G7 above). 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 standards in force from time to time	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 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	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	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 performance dashboard.	Yes
For governance, that: 6. all current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either	See 5 above. In addition: ▪ The Trust monitors performance each month in accordance with the TDA Quality and Governance indicators. A Board	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
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.	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)	
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 format of the BAF was revised for 2015/16, and was reviewed by the Board in July 2015 ~~is currently being finalised was revised~~.	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
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-	The Annual Governance Statement 2014/15 was approved by the Trust Board in May 2015.	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
treasury.gov.uk).		
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. The Trust's revised "Gifts, Hospitality, Sponsorship and Interests Policy and Procedure" (which strengthens the Trust's processes for monitoring interests) has been issued for consultation. 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). It is proposed that the process agreed by the Board be formalised by being incorporated into the Trust's Standing Orders, which	Compliant

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	have been revised to this effect, and issued for consultation.	
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.	Compliant

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Trust Board Meeting – September 2015

9-16	Summary report from Charitable Funds Committee, 20/07/15	Committee Chairman (Non-Executive Director)

The Charitable Funds Committee met on 20th July 2015.

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

- Progress with the previously-agreed action to group the current list of designated Funds by Directorate was reviewed, and some decisions were made regarding the treatment of particular funds
- The draft Annual Report and Accounts 2014/15 were reviewed, prior to their independent examination, and a number of amendments were agreed
- The income, expenditure and balance sheet, at quarter 1 2015/16 were reviewed, along with fund transactions over £1k and the balances by individual fund. The one occasion of expenditure refused was also notified to the Committee
- The Committee heard about progress with the development of Fund Holders' annual spending plans
- The Committee undertook an annual review of Investment Strategy, and approved the current Strategy for a further year
- The management and administration fee for 2015/16 was set (at £39.5k)
- The annual review of the Terms of Reference (ToR)was undertaken (see below)
- A proposal regarding small scale fundraising activity was considered (see below)
- Two documents were received for information: The Government response to the consultation on charity audit and independent examination; and the Association of NHS Charities' financial comparison survey for 2014

2. The Committee agreed…

- The proposed changes to the Terms of Reference. The ToR are required to be approved by the Trust Board, and these are therefore enclosed. The proposed changes are 'tracked'.
- That the proposals regarding small scale fundraising activity should proceed. Specifically, this involves the production of a project plan for the next two years identifying the key elements of the approach to fund raising; and testing of the employment options for a charitable fundraiser

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.) [1]

1. Assurance and
2. To approve the revised Terms of Reference for the Charitable Funds Committee

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

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CHARITABLE FUNDS COMMITTEE

Terms of Reference

1. Purpose

The Charitable Funds Committee has been established as a committee of the Board to ensure that the Maidstone and Tunbridge Wells NHS Trust Charitable Fund is managed efficiently and effectively in accordance with the directions of the Charity Commission, relevant NHS legislation and the wishes of donors.

2. Membership

Membership of the Committee is as follows:

- The Committee Chairman – a Non-Executive Director appointed by the Trust Board
- The Committee vice-chairman - a Non-Executive Director appointed by the Trust Board
- Director of Finance
- Director of Workforce and Communications
- The Head of Financial Services
- The Trust Secretary

3. Quorum

The Committee shall be quorate when one Non-Executive Director and one Executive Director are present.

4. Attendance

The Committee chairman may invite other Directors or Managers to attend, including Clinical Directors and Directorate Managers, as required to meet the objectives of the Committee.

5. Frequency

The Committee shall meet at least three times per year and more frequently if required to meet the objectives of the Committee. ~~The Chairman will decide the frequency of meetings at the start of each financial year.~~

6. Duties

The Committee will act on behalf of the Corporate Trustee (Maidstone and Tunbridge Wells NHS Trust) and will:

- Develop and approve the strategy and objectives of the Charitable Fund
- Ensure that the Charitable Fund complies with relevant law, and with the requirements of the Charity Commission as regulator; in particular ensuring the submission of Annual Returns and accounts
- Oversee the development and delivery of the Trust's fundraising strategy
- Oversee the Charitable Fund's expenditure and investment plans:
  - Approve policies and procedures
  - Agree approval and authorisation limits for expenditure from charitable funds
  - Consider applications for support
  - Approve and monitor investment strategies

The specific duties of the Committee in relation to Charitable Funds are to:

Policy matters

- To approve~~set~~, on behalf of the corporate Trustee:
  - A Reserves policy
  - An Investment strategy~~policy~~ (and to formally review the strategy annually)
  - A Grant Making policy
  - Guidance for fund raising activities

Operational matters

- Approve~~Set~~ the annual management and administration fee payable to the Trust
- Be advised of and consider the application of all new legacies
- Approve ~~Sanction~~proposals regarding the establishment of any~~all~~ new funds
- Authorise financial procedures and financial limits
- Receive details of any expenditure refused
- To approve the banking arrangements of Maidstone and Tunbridge Wells NHS Trust Charitable Fund
- To authorise expenditure in accordance with the Trust's Reservation of Powers and Scheme of Delegation

Internal and External control

- Seek assurances that all income is secured and that expenditure is within the objects of the Fund
- Ensure compliance of all statutory legislation and Charity regulations, and seek assurance on compliance
- Ensure there is adequate provision for the independent monitoring of investment activity
- Receive all relevant internal and external audit reports, and ensure compliance with recommendations

Financial reporting

- Review income and expenditure reports for each of the reporting periods
- Review and agree the Principal Accounting Policies to be adopted
- Review, and agree~~Endorse~~ the Annual Report and Annual financial accounts, for approval by the Trust Board
- Receive where appropriate the annual investment report
- Ensure the Director of Finance is compliant with the reporting requirements of the committee and the Trustee
- To review Fundholders' spending plans, on an annual basis

7. Parent committees and reporting procedure

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

A summary report of each Charitable Funds Committee meeting will be provided to the Trust Board. The Chairman of the Charitable Funds Committee will present the Committee report to the next available Trust Board meeting.

8. Sub-committees and reporting procedure

The Charitable Funds 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 Charitable Funds Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least one Executive Director member. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Charitable Funds 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 Chairman on:

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

11. Review

The Terms of Reference of the Committee will be reviewed annually, and approved by the Trust Board

Agreed at Charitable Funds Committee, July 2014
Approved at Trust Board, September 2014
Agreed at Charitable Funds Committee, July 2015
Approved at Trust Board, September 2015

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Trust Board Meeting - September 2015

9-17	Summary report from Audit and Governance Committee, 06/08/15	Committee Chair (Non-Executive Director)

The Audit and Governance Committee met on 6th August 2015 (though it was noted that the meeting did not meet the quorum requirements within the Committee's Terms of Reference).

1. **The key matters considered at the meeting were as follows:**
   - The Board Assurance Framework (BAF) was reviewed, and it was agreed that the BAF be allowed to evolve throughout the coming months, and be reviewed again at the next Committee. It was also recognised that the Committee had the option to undertake a 'deep dive' review into particular BAF items, should it wish to exercise this.
   - The Risk Register was reviewed, and a discussion was held regarding the judgements applied to risk ratings. The TME's commitment to reviewing the 'red' rated risks, to consider how they should be treated, was supported.
   - An update on progress with the Internal Audit plan for 2015/16 was received, which included some recent reviews relating to the Kent and Medway Health Informatics Service (see below)
   - An update on Counter Fraud was received, and the Work Plan for 2015/16 was formally approved. The fact that the Trust had been selected for a "Focussed Assessment" by NHS Protect in August was noted.
   - A 'Progress and emerging issues report' was received from external audit, and the Annual Audit Letter for 2014/15 was received
   - A review of details of the NHS organisations rated as performing ahead of the Trust in relation to the 2013/14 Annual Report was undertaken, and it was agreed to review the Annual Reports of 2-3 such Trusts, to consider whether anything could be learned
   - A summary of the latest financial issues was received
   - The latest losses and compensations and single tender waivers data was reviewed
   - The revised Standing Orders, Standing Financial Instructions and Reservation of Powers and Scheme of Delegation were reviewed, ahead of the documents being issued for formal consultation. Comments were made, and support was given for the proposal that the threshold for business cases requiring Finance Committee approval be left at £500k, but the threshold for cases requiring the approval of the Trust Board be changed to £1m
   - A revised "Gifts, hospitality, sponsorship and interests policy and procedure" was discussed prior to it being issued for formal consultation

2. **The Committee received details of the following Internal Audit reviews:**
   - "Data Accuracy (18 Week RTT)" (which received a "Substantial Assurance" conclusion)
   - "Private Patient Income" (which received a "Limited Assurance" conclusion);
   - "Discharge Processes" (which received a "Reasonable Assurance" conclusion);
   - "Use of Temporary Medical Staff" (which received a "Limited Assurance" conclusion);
   - "NHS In-House Information Governance Toolkit: Training Material Checklist" (which identified some gaps in training material, but these had now been addressed);
   - "K&M HIS IT Controls Assurance - Configuration Management Database Review" (which received a "Limited Assurance" conclusion);
   - "K&M HIS IT Controls Assurance - Backup and Restore Processes Review" (which received a "Limited Assurance" conclusion);
   - "K&M HIS IT Controls Assurance – Active Directory Security Controls" (which received a "Reasonable Assurance" conclusion); and
   - "K&M HIS IT Controls Assurance – Active Directory Security Controls" (which received a "Reasonable Assurance" conclusion)

3. **The Committee was also notified of the following "high" priority outstanding actions from Internal Audit reviews:**
   - "Clinical Activity Recording". It had already been agreed to invite the action owner to the

November Committee if the action remained outstanding at that point
- "Application Management Policies & Procedures"; and
- "Local Registration Authority Management" (3 actions)

Internal Audit reported that it had been agreed that the Director of Finance would be provided with regular reports of Outstanding Recommendations, for him to pursue a resolution

4. The Committee agreed that (in addition to any actions noted above):
- Internal Audit should check and confirm the situation regarding the existence of an "up to date policy/procedure for requesting, booking and approving temporary medical staff" in relation to the "Use of Temporary Medical Staff" Internal Audit review
- The Director of Workforce and Communications should be invited to the November Committee, to respond to the reported absence of the Policy referred to in the point above
- The draft "Gifts, hospitality, sponsorship and interests policy and procedure" should be revised, to include an upper limit of £25 for the acceptance of gifts, and create a distinction between gifts of cash (which are not acceptable) and "cash equivalents" (which would be acceptable if below £25)

5. The issues that need to be drawn to the attention of the Board are as follows:
- The Committee recognised the need for greater consistency in risk management processes (though it was also noted that the external review of Clinical Governance may have implications for the Trust's risk management processes

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

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

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

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Trust Board meeting – September 2015

9-18	Summary report from the Quality Committee meetings, 10/08 & 09/09 (incl. update on the latest Stroke performance)	Committee Chairman (Non-Exec. Director)

A Quality Committee 'deep dive' meeting was held on 10/08, and covered the following issues:

"Review of Cancer Multidisciplinary Team (MDT) meetings"

- The Trust Lead Cancer Clinician presented a report on the background and current challenges faced by the Cancer MDT meetings hosted by the Trust
- It was noted that MDT meetings were currently held at the Trust for 9 Cancers: Breast; Lung; Upper GI; Lower GI; Head and neck; Thyroid; Gynaecology; Urology; and Haematology/Lymphoma, but MDT meetings were not currently held for the "Cancer of unknown primary" and "Teenage and young adults" groups
- It was also noted that the workload of MDTs had increased markedly, and all MDTs discussed more cases than before.
- There was a particular issue with administrative support for MDT meetings, and the importance of the role of MDT Coordinator was highlighted. The constraints of the InfoFlex IT system were also discussed.
- The Committee found the report and discussion assuring, and agreed that the Trust Lead Cancer Clinician should be allowed time to address the identified challenges, and that a further review be undertaken at the Quality Committee 'deep dive' meeting in December 2015. It was further agreed that the December 2015 meeting should include an update on the latest situation regarding the oversight of patients in the "Cancer of unknown primary" group

"Review of Discharge arrangements"

- The Chief Operating Officer and Integrated Discharge Manager provided details of the latest situation regarding Delayed Transfers of Care (DTOCs)
- It was noted that a recent Internal Audit review of Discharge process arrangements had concluded "reasonable assurance", and that the "Length of Stay Steering Group" had been re-launched as the "Timely, Safe and Effective Discharge Steering Group"
- The national target for DTOCs, in terms of the proportion of bed days occupied by patients who were delayed, was noted to be 3.5%, & at its worst point, the Trust's level had been 8.1%
- The absence of a visible long-term solution was acknowledged, but it was recognised that the issues had drawn the Trust and Kent Community Health NHS Foundation Trust closer together, at all levels

Future meetings

- It was agreed that that a "Review of HSMR" should be scheduled as the sole item for the October 2015 'deep dive' meeting
- It was also agreed to schedule "Update on Cancer Multidisciplinary Team (MDT) meetings"; "Review of plans for 7-day services"; and "Review of Pharmacy" for the Quality Committee 'deep dive' meeting in December 2015

The Committee also had a 'main' meeting on 09/09. Unfortunately, this was not quorate, as there was only one Non-Executive Director present. It was noted that any key decisions would therefore require ratification by the Trust Board, so the following summary of the meeting should be regarded as a request to ratify the decisions made. The following issues were covered:

- The latest **Stroke care performance** was reported. The report that was received is enclosed at Appendix 1, and has been included as a result of a previous request from the Board. The Board is asked to consider whether it still wishes to receive such reports in the future
- A **response to the recent increase in Hospital Standardised Mortality Ratio** (HSMR) was received, which highlighted that the Trust's level of Palliative Care coding was now very low in comparison with other Trusts; and also that increase in HSMR had not been noted previously as this only became apparent following the latest change in the national benchmark

- The **Clinical Directorates** presented their reports. The key issues raised were as follows:
  - **Critical Care** submitted the latest quarterly Quality Report from the South East Coast Critical Care Network, which showed that the Trust was the worst in the area for "Admissions delayed 4 hours or more as % of all admissions", but performed better on "Readmissions as % of live discharges" and "% of discharges delayed > 24 hours as a % of live discharges". It was also reported that one Serious Incident (SI) was under investigation, and Spinal surgery for patients with a high BMI had had to be suspended until the investigation was complete
  - **Diagnostics, Therapies & Pharmacy** reported that a recent UKAS (ISO 15189) inspection of blood sciences had been successful, and the Trust could soon become the only in the region to achieve UKAS accreditation for all its specialties. It was also reported that the Interim Managing Director of the Kent Pathology Partnership (KPP) had left their post, and further discussions were therefore being held regarding a way forward. Finally, implementation of intelligent fridges was reported to have progressed, and once a fridge had been installed in the Labour Ward, the risk relating to 'Step 1' of the implementation will be resolved (although there was a 'Step 2')
  - **Emergency & Medical Services** reported that vacancies in the Directorate were still above 20%, and the situation had been exacerbated by the recent resignation of 3 Consultants. It was reported that a Grade 4 Pressure Ulcer had occurred, but the investigation was not yet complete. The John Day/Jonathan Saunders Ward refurbishment was reported as progressing, and it was noted that the plan to close Whatman Ward by the end of September was still in place
  - **Surgery** reported that the Short Stay Surgical Unit remained in escalation with emergency Surgical patients, but a Standard Operating Procedure had been developed, which should assist. It was also noted that the level of Nurse vacancies remained static, but there had been some recent retention issues. Spending on Locum Medical staff remained high
  - **Trauma & Orthopaedics** reported that 2 Clostridium difficile infections had occurred, but the Committee also heard that there was no apparent link between the 2 cases. The latest data from the National Hip Fracture Database was submitted, which showed that there was a decline in the ability to enable timely provision of Surgery every summer (although despite this, the Trust was at, or near to, national average performance). The data also showed that there was a rising trend for Length of Stay for Tunbridge Wells Hospital (which was believed to be related to access to social care), but improvements on some "Patient Safety" aspects, including Pressure Ulcers and 30-day mortality.
  - **Women's & Sexual Health** reported that work was continuing regarding the establishment of a Gynaecology Outpatient Department quiet waiting area; and the Directorate was also keen to increase level of user engagement, and would be holding some user engagement events for Maternity.
  - **Cancer & Haematology** reported that the revised 'go live' date for Chemotherapy ePrescribing was now October 2015. It was also highlighted that CHKS accreditation had now been confirmed in full; and the Directorate had now recruited to almost all of its Clinical Nurse Specialist posts
  - **Children's Services** reported that the new Consultants had been appointed, but problems with Registrars had led to the cancellation of Registrar-led clinics in the coming months (though it was noted that the Deanery was aware of the situation). It was also reported that Paediatric Early Warning Score (PEWS) charts were now finalised and available, and an audit would be undertaken by the end of September. In addition, a child death had been investigated as an SI, and concluded that the death could not have been predicted or prevented. However, a "Sepsis Six" pathway was to be implemented.
  - All Directorates were asked to ensure that their future Directorate reports contained a reference to the occurrence of **Directorate Clinical Governance meetings**
  - In response to some queries regarding the **Crude Mortality data** that features within the Directorate reports, it was agreed that the Associate Director of Governance, Quality and Patient Safety should establish how such data was generated
- An update on the external **"Good Governance and Culture"** review was provided, and reference was made to the Board discussing the report at its September 2015 meeting

- An update on the **Patient Safety Think Tank** (PSTT) was also given, and the Chief Nurse confirmed that she had now disbanded the PSTT, as the ideas were well developed and many had already been implemented. It was noted that attention was now being paid to the other, more general, actions required; and identifying the action the Trust wished to take.
- A presentation on **falls prevention** was given, which included 2 short films demonstrating the concept of "Safety Huddles" (which was a succinct way of communicating as a multidisciplinary team). It was noted that a High Impact Intervention Team would be created; resources would be identified; and Wards to pilot the Huddle approach would be agreed.
- The latest **Quality & Governance** report was noted, but it was agreed that the report would no longer be received, as the content duplicated many of the issues that were already discussed during the Directorate reports.
- The latest **SIs** were considered, & it was noted that a number of recent SIs had identified a theme where a member of the clinical team other than the Consultant knew an alternative course of action that could/should have been taken, but they did not feel able to propose this.
- An update on implementation of **Quality Accounts priorities 2015/16** was received, and it was noted that good progress had been made.
- The latest situation regarding **Catheter Associated Urinary Tract Infections** was reported, and it was noted that performance had been good, but needed to be maintained.
- Reports on the latest findings from relevant **Internal Audit reviews**, and latest media coverage / **reputational risk** issues were received
- An update on **visits from external agencies** was noted, and the minutes of the **Quality Committee 'deep dive'** held on 10/08/15 were received
- Reports from the latest meetings of the **sub-committees** were received i.e. Safeguarding Adults, Standards, Mortality Review Group, Safeguarding Children (where it was noted that Level 3 training compliance had improved), Clinical Governance, Patient Environment Steering Group, & the Infection Prevention & Control Committee (which included a request to approve **revised Terms of Reference**, and these were approved, subject to liaison between the Chief Nurse, Director of Infection Prevention & Control and Trust Secretary).

Which Committees have reviewed the information prior to Board submission?

- N/A

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

1. Information and assurance
2. To consider whether the Board wishes to receive updates on the latest Stroke Care performance, as part of future summary reports from the Quality Committee

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

Appendix 1: Stroke care update report received at the 'main' Quality Committee on 09/09/15

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. This is the second short headline paper to be presented to the Quality and Safety Committee.

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:

- July data for scanning within 1 hour is encouraging with TWH scanning 55% within the hour and Maidstone scanning 54%.
- 12 hourly scanning indicates a welcomed further improvement in performance with TWH scanning 95% within 12 hours and Maidstone 100%.
- SSNAP information covering data collected April-June has not yet been reported on. However, the performance in scanning throughout this timescale is predicted to achieve an "A" or "B" rating if the national average remains consistent to previous quarters.

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:

- July data indicates that there was a significant increase in patients' thrombolysed at TWH with 18.2% of admissions receiving the treatment. Retrospectively June also saw a high number of patients' thrombolysed at 13.8%. Both months saw 50% of these patients thrombolysed under an hour. At Maidstone 7.1% of patients were thrombolysed, which equated to 2 patients. Neither of whom achieved the 60 minute target.
- Thrombolysis rates and the 60 minute door to needle target remains a challenge with fluctuating results. However, improvements have been shown over the quarter which is encouraging.

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

- July data within this performance indicator shows that MGH has admitted 70.4% of strokes to the stroke unit within 4 hours. TWH has had a significant improvement to 63.6%. This is extremely rewarding due to the constraints currently faced with the current number of acute stroke beds at TWH.

2.5 Assessment by a stroke physician within 24 hours:

- Monthly data from July indicates specialist assessments were completed within 24 hours in 77.3% of cases at TWH and 71.4% at MGH, which shows a stable performance throughout the year.
- SSNAP data for this quarter has not yet been reported on. However with a steady performance throughout the last two quarters, it is predicted that there should be no or little change to last quarters results where Maidstone achieved a commendable "B" rating and a "C" rating at TWH within the specialist assessment domain.

2.6 Current 80/90 Performance

- July data is currently 91.1% with a current YTD performance of 84.9%

2.7: CQUIN achievement for 15-16

- 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 working party has been formed to identify steps to assist in achieving the required outcome.

3. Conclusion

Data above is encouraging as it shows that the majority of Key performance indicators continue to improve, especially in access to a stroke unit and certainly this quarter within thrombolysis rates. Work continues locally with site specific action plans and meetings taking place to improve performance and drive up standards of care. 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 April – June 2015 are expected to be released to teams in September where an improving and encouraging picture is expected.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – September 2015

9-19 Summary of the TME meetings, 19/08/15 and 16/09/15 Chief Executive

The Trust Management Executive (TME) met on 19/08 and 16/09. The key items covered at the meeting on 19/08 were as follows:

- The Chief Operating Officer gave a **safety message** to raise awareness of the importance of new members of staff receiving their inoculations from Occupational Health.
- The **Directorate reports** highlighted the following issues:
  - Pharmacy would launch a 7-day dispensary service from 05/09/15, operating 9am-4pm on Saturdays, and 10am-4pm on Sundays, with Ward visits being undertaken as required
  - The PET-CT project was on target to deliver a static scanner early in 2016
  - There has been an increase in deliveries compared to last year and the Women's and Sexual Health Directorate will revisit Obstetrics as part of their future planning
  - Discussion took place regarding the strategic direction of Paediatric Orthopaedic Surgery, and it was acknowledged that clarification was required
- The latest **performance, for month 4**, 2015/16 was reported (including the latest position regarding infection prevention and control). The challenge in meeting Cancer targets and the A&E 4-hour waiting time target were noted
- The Director of Workforce and Communications presented a proposed **indicator to monitor nursing staff numbers against clinical activity**. It was agreed to revise the indicator to distinguish between Bank, Agency and unfilled posts, and re-submit this to a future meeting
- The Chief Operating Officer submitted a report on **Temporary staffing controls**, which noted that a Temporary Staffing Control group had been formed to focus on reducing reliance of staff provided by premium and non-framework agencies
- The Chief Nurse provided the latest update on progress in implementing **the Quality Improvement Plan** developed in response to the findings from the CQC's inspection; and gave a verbal update on **implementation of Quality Accounts priorities** 2015/16
- The Director of Workforce and Communications reported on **Junior medical staff rota compliance**, and highlighted that although changes made to the medical staffing function at the start of the year, combined with a review of the approach and deployment of Directorate resources for the large intake, had proven to be successful, more work was needed in relation to rota management and ensuring that gaps were filled within an acceptable timeframe.
- An update on the **Corporate Manslaughter prosecution** was provided
- The **2015/16 Finance Improvement letter** from the NHS Trust Development Authority was noted, along with the Trust's response
- The Chief Operating Officer gave an update on the Trust's **Winter and Operational Resilience Plan**, and the revised Escalation & Patient Flow Management Policy was approved
- Progress with the various **Estates and Facilities projects**, including the new Ward at Tunbridge Wells Hospital was also reported
- The Deputy Chief Executive gave an update on the development of the **clinical strategy**, and the key milestones involved in the **Business planning process for 2016/17** were also reported
- The recently-approved **business cases** were noted, and 4 business cases were approved (relating to "Endoscopy Stack"; "Inflammatory Bowel Disease CNS"; "Consultant Neurologist"; "Equality and Diversity Post"; and "Paediatric Dietetic Service"), as was a request for a replacement Consultant Gastroenterologist. The **Full Business Case to increase the Capacity of the ENT service** was also reviewed, and supported.
- The **Board Assurance Framework** received at the July Trust Board was reviewed.
- An update on the **Internal Audit reviews** within the 2015/16 plan was provided, and updates were received on the work of the **TME's sub-committees** - Capital meetings; Health & Safety Committee; Clinical Operations and Delivery Group; Policy Ratification Committee (which included approval of revised Terms of Reference); and Information Governance Committee.
- The **Information Governance Management Framework**, which describes the arrangements for how information governance is managed within the Trust, was ratified
- The results of the 2015 Patient Led Assessments of the Care Environment (**PLACE**) were noted

The key items covered at the meeting on 16/09 were as follows:

- Prior to the meeting, a demonstration was given of the **new Trust website**
- The Medical Director gave a **safety message** emphasising the importance of staff not coming to work whilst ill, particularly if they had potential contagious symptoms
- The **Directorate reports** highlighted the following issues:
  - Concern regarding the privacy and dignity at the Admissions Unit at Tunbridge Wells Hospital were discussed, and it was noted that the next step required was to arrange for the timing of the required physical changes to be incorporated into the Trust's capital plans
  - There was increasing concern at the state of the site for the proposed Linear Accelerator at the Kent and Canterbury hospital, and the Cancer and Haematology Directorate were seeking clarification regarding the future strategy for that site. The Directorate also reported that they were liaising with East Kent Hospitals University NHS Foundation Trust regarding the provision of Chemotherapy, following the cessation of this service from the William Harvey Hospital in Ashford
- The latest **performance, for month 5**, 2015/16 was reported, and it was noted that the key risks remain i.e. capacity and flow, which was primarily affected by Delayed Transfers of Care, which were nearly 3 times above the expected level
- An update was given on the latest situation relating to the Trust's recent response to challenges experienced at **Medway NHS Foundation Trust**
- The Director of Workforce and Communications reported on the **recruitment plans for nursing and medical staff**, and invited ideas to increase the attractiveness of the Trust as an employer
- The latest position regarding **infection prevention and control** was reported, which included an update on the potential introduction of an Ultraviolet light decontamination device
- The Chief Nurse provided the latest update on progress in implementing **the Quality Improvement Plan** developed in response to the findings from the CQC's inspection
- The meeting was formally notified of the occurrence of the **Annual General Meeting** on 17/09/15
- It was noted that there had been no further progress regarding the **future of the Stroke service**
- A revised **2016/17 Business planning process** timeline was submitted
- Progress with the **implementation of the SAcP** (replacement PAS+) was reported
- The proposed **Workforce Strategy for 2015-20** was received and supported
- The recently-approved **business cases** were noted, and a request for a **replacement Consultant post** (for a Respiratory Consultant at the Tunbridge Wells site) was approved
- The **Risk Register** was received, & a detailed **review of current red-rated risks** was undertaken
- Updates were received on the work of the **TME's sub-committees** - Capital meetings; Clinical Operations and Delivery Group; Sustainable Development & Environment Committee; and Information Governance Committee
- The New **John Day Ward Maidstone Hospital Operational Policy & Procedure** was approved
- Progress regarding an options appraisal for the Trust's **document management system** was reported (to improve access to policies, clinical guidelines, protocols & procedures). It was agreed to explore the potential offered by external systems, and then bring a recommendation back for a decision

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

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

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - September 2015

9-20	Summary report from Finance Committee, 24/08/15	Committee Chairman (Non-Executive Director)

The Finance Committee met on 24th August 2015.

1. **The key matters considered at the meeting were as follows:**
   - At the start of the meeting, respect was paid to Mark Austin, Deputy Director of Finance (Financial Performance), who passed away in August. Mark's contribution to the Trust was commended, and it was noted that representatives from the Trust would be attending the forthcoming funeral.
   - A "Safety moment" was then held, which highlighted the importance of ensuring that members of the Executive Team and senior management had due consideration for their health, given the high levels of stress they often faced during the performance of their roles.
   - Month 4 financial performance was examined. The usual written reports were again supplemented by a presentation from the Director of Finance. The key points were:
     - The Trust had a year-to-date deficit of £6.7m
     - The main issues of note were the continued increase in expenditure on temporary staff; and the adverse variance of elective income for the month, compared to the plan. Non-elective activity was above plan in July, whilst elective activity was lower than expected
     - In terms of other workforce trends, the Trust had reached the highest number of substantive staff during 2015, but had also reached the highest number of Locum and Agency staff. The change in staffing since January 2015 was discussed in detail.
   - Progress with the Cost Improvement Plan (CIP) was noted, and the variance in relation to plans relating to cost reduction were discussed
   - The 2015/16 Finance Improvement letter from the NHS Trust Development Authority (TDA), and the Trust response, was discussed. It was noted that the TDA had issued a further communiqué, asking for revised planning submissions to supplement the response to the original letter.
   - The timeline for the Trust's 2016/17 planning process was reviewed, and it was noted that further work would take place in the coming weeks
   - The Committee approved a business case for ENT development
   - The Committee reviewed the financial aspects of the Risk Register (which related to the delivery of the financial plan for 2015/16, and the usage of temporary staff), and requested that the action noted below regarding the change in staffing be included within the "Action Plan" section
   - The revised "Overseas Visitor Policy and Procedure" was reviewed and approved
   - The Committee considered a proposal to dispose of the "Hillcroft" property as surplus to requirement (see below)
2. **The Committee agreed that:**
   a) The September 2015 Trust Board should be provided with an explanation of the increased workforce (i.e. WTE) that had occurred since January 2015, despite the lower levels of clinical activity / escalation beds
   b) The Committee's concerns regarding the proposal to dispose of the "Hillcroft" property as surplus to requirement should aim to be addressed, and the proposal should be re-submitted to the September 2015 Committee
3. **The issues that need to be drawn to the attention of the Board are as follows:**
   - See a) above

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

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - September 2015

9-20	Summary report from Finance Committee, 28/09/15	Committee Chairman (Non-Executive Director)

The Finance Committee met on 28th September 2015.

1. **The key matters considered at the meeting were as follows:**
   - The "Safety moment" acknowledged the severe pressures being faced, and queried the need for a future discussion as to whether all of the services currently provided by the Trust should continue to be provided. It was however agreed that such discussions needed to be held after the full introduction of Service Line Reporting.
   - A proposal to amend the Committee's Terms of Reference was agreed. This involved the Deputy Chief Executive being added to the Committee's membership, and amending the current requirement so that only one from three listed roles (i.e. Chief Executive, Chief Operating Officer or Deputy Chief Executive) be present at each meeting. The Board is therefore asked to approve the proposed amendment.
   - Month 5 financial performance was examined. The usual written reports were supplemented by a presentation from the Director of Finance, which included a detailed explanation of the 'next steps' planned, which involved: the implementation of Agency framework migration, control and reduction; improvements in rota planning; and continued recruitment campaigns, both local and overseas. The Committee was assured that although the programme of actions was ambitious, all of the key issues were covered.
   - The latest position regarding cashflow was reported; as was the position with the Capital Plan. Progress with the Cost Improvement Plan (CIP) was also noted
   - The latest situation regarding the Trust's application for a working capital facility was reported, and it was noted that the application was likely to be submitted to the Finance Committee and Trust Board in October 2015. It was noted that a formal resolution from the Trust Board was required as part of the application.
   - A presentation was received from the Clinical Director and General Manager of the Surgery Directorate, which concluded the round of Directorate presentations to the Committee
   - The financial aspects of the Board Assurance Framework (which related to objective 4.a – delivery of the financial plan for 2015/16) was reviewed, and it was agreed that the content of the "What actions have been taken in response?" section should be amended, to better reflect the full range of actions that had been taken
   - The key proposed changes to the Standing Financial Instructions, Scheme of Delegation and Standing Orders were reported, and on a related matter, it was agreed that the Trust Board should be asked to "approve" the "Gifts, Hospitality, Sponsorship and Interests Policy and Procedure" following the Policy's current consultation
   - A report on the financial software systems was received, which noted the progress that had been made in improving the Trust's systems, as well as the improvements still planned
   - A proposal to make the Procurement Strategy Committee a formal sub-committee of the Finance Committee was considered, but it was agreed to defer the decision to the October meeting, to enable the comments made at September's meeting to be taken into account
2. **In addition the agreements referred to above, the Committee agreed that:**
   - The Director of Finance should provide further analysis regarding the increase in Medical Locum staff in 2015
   - A report on the functioning of the Finance Department should be submitted to the Finance Committee in November 2015
3. **The issues that need to be drawn to the attention of the Board are as follows:**
   - The proposed revision to the Terms of Reference need to be approved (see the second bullet point in section 1. above)

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
2. To approve the proposed amendment to the Finance Committee's Terms of Reference

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - September 2015

9-21	**Summary report from the Workforce Committee, 15/09/15 (incl. the Workforce Strategy, 2015-20)**	**Committee Chairman (Non-Exec. Director)**

This report provides a summary of the issues discussed at the Workforce Committee on 15 September 2015. The substantive Chair having sent his apologies the meeting was chaired by the Vice Chair.

Workforce Strategy

Having debated it for a second time, and having reviewed the strategy at the Trust Management Executive (TME) and with the staff side, the Committee recommend the approval of the Workforce Strategy by the Trust Board. The 6 interrelated workforce priorities each has a work programme developed to deliver the priority and will be monitored against achievement and reported to the TME, examples of these work programmes were shared with the committee.

Temporary Staffing

The Committee received a report on temporary staffing within the Trust, incorporating an in-house indicator monitoring nursing staff numbers against clinical activity, which aims to assist the Trust in better workforce planning and enhance the management of the nursing workforce. The committee also took the opportunity to better understand the nurse agency rules produced by the TDA and Monitor, and their application to the Trust. The committee heard of the actions which were being taken to reduce the levels of temporary staff usage including heightened control and permanent recruitment. The committee were made aware that whilst the initial emphasis is on nursing staff other staff groups will follow in due course.

7 Day Services

The Medical Director informed the Committee that 7 day services mean that a patient has access to the care they need on any day of the week. The focus is currently on acute medicine, surgery and orthopaedic services. The majority of consultants are caring for patients at weekends with colleagues. Many departments in the Trust already have 7 day services.

Statutory and Mandatory Training

The Committee received a report outlining the current level of compliance and details of the plans and associated activities to improve performance against each subject. Overall statutory and mandatory training compliance continues to increase. New training software is being used which generates automatic e-mail reminders when a member of staff is going out of compliance.

Medical Education Update

The report provided information on medical education and training programmes in the Trust, in particular:

- Following the HEKSS visit of ophthalmology, a number of mandatory requirements and recommendations have been answered
- The Trust has been asked to be a centre of excellence for Ophthalmology, 1 of only 2 in the country
- The GMC is currently updating *Promoting Excellence*, to be implemented in January 2016
- The effect of the “Nerve Centre” roll out on the handover process to support learners is being monitored
- The Trust is supporting Canterbury Christ Church University setting up a training programme for Physician Associates

Medical Engagement

The Medical Director informed the Committee that there was one area of concern in the report relating to a department within the Trust and actions were being taken to address the shortcomings.

Workforce Risk Register

The 3 principal risks relating to the workforce are:

1. Recruitment and retention
2. Temporary staffing
3. Culture including employee engagement.

The report provided information on the key workforce risks, current controls and planned actions to mitigate the risks. The Committee agreed the 3 key risks and expressed enthusiasm for the use of a cultural barometer to monitor progress.

Workforce Performance Dashboard

The Committee received a report on the workforce dashboard which highlighted the issues of temporary workforce and vacancies.

Conclusion

The Board is asked to approve the Workforce Strategy, and to reverse its decision taken previously and support the introduction of a suitable cultural barometer.

Which Committees have reviewed the information prior to Board submission?

- Workforce Committee, 15/09/15 (for the Workforce Strategy)

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

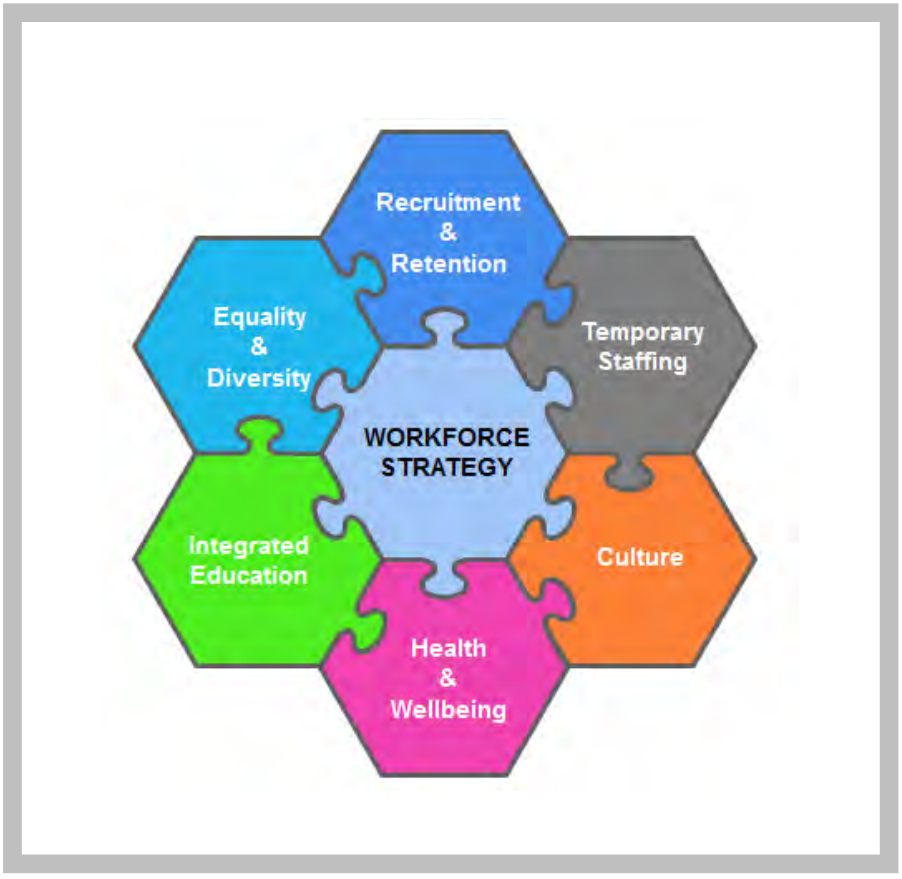
1. Information and assurance
2. To approve the enclosed Workforce Strategy
3. To reverse the decision taken previously by the Trust Board (in September 2014) and support the introduction of a suitable cultural barometer

[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

Workforce Strategy

SHAPING OUR FUTURE TOGETHER
2015 - 2020



Workforce Strategy 2015-2020
Version 1.3
Authors: Paul Bentley & Richard Hayden

Director of Workforce and Communications Foreword

Maidstone and Tunbridge Wells NHS Trust (MTW), in common with other health provider organisations, faces both opportunity and challenge in relation to the delivery of ongoing, quality, affordable health care within tighter financial parameters, in response to the increased needs of the population which we serve.

The most effective response to these challenges is to remain committed to the continuous development of our workforce and to not deviate from our guiding principle: patient care, safety and quality of care.

Our on-going commitment to workforce planning and leadership development will ensure that the Trust has the right people, in the right place and at the right time to deliver the organisational objectives which enable us to provide excellent patient care to the population that we serve.

As a Trust we understand the importance of change, we have delivered wide scale change with the reconfiguration of clinical services enabled by the opening of a new hospital in Tunbridge Wells but we recognise the need to adapt and continuously improve thereby enabling us to succeed in line with the rapidly changing healthcare environment and meet the needs of our stakeholders, within a challenged health economy and within a Trust with specific challenges.

Our greatest asset is our workforce. The workforce strategy is fundamental to realising the corporate vision, strategy, priorities and delivering excellent patient care. To do so we are dependent on getting the very best from our workforce; now and in the future. The contribution that each person makes either directly or indirectly to our patients at MTW is greatly valued and at the heart of our success. We need to be innovative in our offer to our workforce to enable us to fulfil our ambition of being the employer of choice in our local health economy.

The workforce strategy is an enabling document with a simple aim: to develop an organisation where people deliver excellence each day and feel engaged, enabled and empowered to work for the Trust.

Paul Bentley
Director of Workforce and Communications
June 2015

Contents

1. INTRODUCTION

The workforce strategy has one aim: to develop an organisation where people deliver excellence each day and feel engaged, empowered and enabled to deliver the care our patients need.

The Trust has made significant progress in recent years to transform our services and the way in which they are delivered. It is important to acknowledge that there have been many key successes emerging from a turbulent and challenging period in the organisations history. Substantial progress has been made in relation to infection control, changing management culture, focus on quality, clinical governance, clinical leadership, staff engagement and the patient experience that we provide to name just a few areas.

The Trust is now well into a second phase of organisational development. However, the challenge is to build on our achievements and maximise the potential that we have as an organisation to deliver first class services for our local population, to be an employer of choice and recognised for our commitment to continuous improvement.

This strategy document sets out the strategic workforce priorities that Maidstone and Tunbridge Wells NHS Trust has identified for the next five years (reviewed annually) and the work that is required to realise our workforce ambitions. This document outlines the approach we will take to deliver the Workforce Strategy. We will be ambitious, creative whilst building on our strong foundations which already exist. Our strategy will support a culture of "can do" that enables engaged and empowered staff to deliver excellent patient care.

We face a reduction in the supply of some staff groups within our workforce and we need new roles to fill that gap. Our workforce, as well as our patients, is ageing and we need to make sure that we support and nurture our staff and find ways to enable them to continue working as they age.

We aim to develop the talents of all our employees, and whilst career development and succession planning for healthcare professions is more developed the requirement to enable robust succession planning processes to enable a constant supply of emerging leaders is an area of focus for the next five years.

We need to be innovative in our offer to our workforce, both existing and future to enable us to fulfil our ambition of being the organisation that healthcare workers select to come and work. Our people are vital to the delivery of the Trust's strategy, vision and values.

1.1. Our mission

The Trust mission is:

Our purpose is to provide safe, compassionate and sustainable health services

1.2. The Trust vision

The Trust vision sets out what we aspire to be:

To provide the highest, consistent, quality care to our patients, whether in or outside hospital setting

1.3. The objectives of the Trust are:

The Trust has three key objectives:

1) **To transform the way we deliver services so that they meet the needs of the patients**
2) **To deliver services that are clinically viable and financially sustainable**
3) **To actively work in partnership to develop a joint approach to future local health provision**

1.4. Our values

Successful organisations not only ensure that all objectives and priorities are aligned to corporate vision, but they also have a clear and single set of values that defines "how things are done". It defines how we do things and how we behave. The Trust has established five values (PRIDE):

P	**Patient First**	**We always put the patient first**
R	**Respect**	**We respect and value our patients, visitors and staff**
I	**Innovation**	**We take every opportunity to improve services**
D	**Delivery**	**We aim to deliver high standards of quality and efficiency in everything we do**
E	**Excellence**	**We take every opportunity to enhance our reputation**

The culture that we adopt and sustain as an organisation will be key to our ability to deliver a high quality service to our patients. The behaviour of all staff, whether directly clinically facing or supporting those who do, needs to incorporate these values for the organisation to realise its full potential.

2. THE WORKFORCE PRIORITIES

The Workforce Strategy is one of the core strategies to enable the Trust to meet its strategic objectives and be ready for future changes and challenges. It is a key governance document because it describes what the Trust will do with its workforce, and how it will measure its performance as it relates to our workforce.

The workforce priorities on which this strategy are based were determined by reflecting on the strategic objectives of the Trust, results of successive national staff surveys and local pulse surveys, workforce risks identified in relevant risk registers, the national and local priorities of the NHS, and feedback from our patients. The strategy as presented will enable the Trust to deliver the requirement of the NHS Trust Development Authority (TDA) and Care Quality Commission (CQC), as defined primarily on the 'well-led' element of the TDA accountability framework. The six workforce priorities are outlined below:

PRIORITY 1	**Recruitment & Retention**
PRIORITY 2	**Temporary Staffing**
PRIORITY 3	**Culture**
PRIORITY 4	**Health & Wellbeing**
PRIORITY 5	**Integrated Education**
PRIORITY 6	**Equality & Diversity**

Six programmes of work have been identified to deliver the above priorities. These programmes are outlined in detail in this strategy and implementation plans will be reviewed and refreshed on a quarterly basis, for assurance these will be reported to the Trust Board through the Workforce Committee. For management purposes the progress will be reported to the Trust management executive, both reporting arrangements will reflect progress, feedback received during the 5 year cycle of the strategy and any external changes to the management of the workforce such as employment law or recommendations from partner bodies.

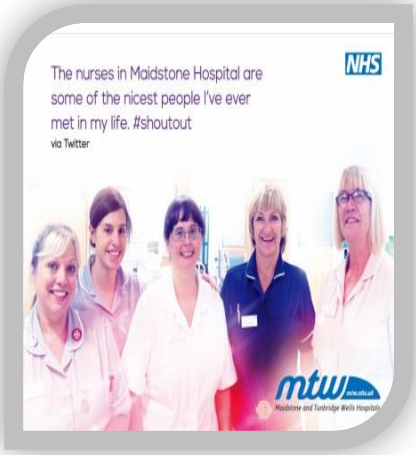
The following sections describe in more detail the 6 component parts of the strategy.

3. RECRUITMENT & RETENTION

We will attract, recruit and retain appropriately skilled, qualified and experienced staff who share our values, demonstrate our agreed behaviours and who will deliver safe, compassionate, excellent care.

The NHS is undergoing a period of change and is constantly in the spotlight for safe staffing levels. The recruitment and retention of good staff remains a huge challenge to ensure the Trust meets key targets including the lessons learnt from the Francis Report and how we can ensure the recruitment of excellent staff who not only exhibit the key skills and experience to undertake their job roles effectively but also demonstrate the right attitudes and behaviours to deliver compassionate care.

MTW needs to employ more staff in some areas to ensure that our workforce requirements continue to be at the levels that accommodate safe and effective service delivery needs and reduces the dependency on variable quality and expensive temporary cover.



The demographic realities of an ageing workforce and the increasingly attractive career opportunities in the London sector and outside the NHS make the recruitment and retention of staff one of the biggest challenges MTW faces. The shortage of candidates with the right skills, abilities and experience in some NHS professions has created a highly competitive market both locally and nationally.

We consider that a workforce who represents the local community, not just in total numbers but properly represented throughout all professions and all levels of the Trust, is fundamental in creating an inclusive environment and the Trust must have the right numbers of staff with the appropriate skills, knowledge and experience to deliver the services that we provide.

The diversity of our employees as a fair representation of the local community is essential to the way we work and, to absorb the personal and cultural perspectives from the community at large will enrich our values and deepen our understanding of our healthcare responsibilities for the community that we serve.

Key objectives are:

- Develop and deliver an annual recruitment plan which is proactive, creative and generates the reduction in the number of vacant posts and the dependence upon temporary staff.
- Explore and deliver creative options to attract, recruit, motivate and retain appropriately skilled, qualified and experienced employees who share our values.

4. TEMPORARY STAFFING

We will reduce our dependency on temporary staffing whilst effectively utilising our flexible workforce so that the Trust can adapt and respond safely to changes in demand & service needs within the available financial envelope.

Robust management of temporary staffing makes a significant contribution to the delivery of quality care and financial well-being of the organisation.

Bank and agency/locum usage provides an important flexible resource. In order to minimise service disruption and to ensure service standards are maintained MTW utilises bank or agency/locum as supplementary staff. Normally this is in response to increased activity needs, staff absence or alternatively to provide cover for vacancies, in the short to medium term, the duration of cover being variable dependent on circumstance.

The Trust will continue to promote opportunities within the local community and with existing staff to join the staff bank and will regularly review the terms and conditions to ensure that the Trust can compete with neighbouring organisations to attract and retain high calibre and competent staff.

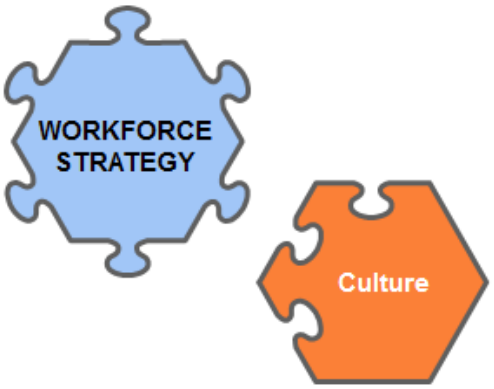
However the use of temporary staffing has grown significantly in recent years, this has been at a time when the substantive workforce has also grown, and therefore it is important that we continue to explore all options to reduce the dependency and improve workforce planning capability of our managers to manage our substantive resources more effectively.

Key objectives are:

- A significant bank recruitment drive for all staff will be undertaken.
- Improved bank terms and conditions will be scoped to aid attraction and retention of substantive nurses.
- Implementation of a new rostering system accessible for all staff anywhere and with greater capability and accuracy for reporting.
- Minimise agency costs ensuring value for money.
- Improve monitoring and performance systems within the directorates
- Changing the employment offering in response to feedback from our workforce, where possible and appropriate.

5. CULTURE

We will create a culture whereby our organisational values and behaviours support compassionate care, respect, openness and honesty.



Organisational success and delivering excellent patient care is dependent on getting the best out of the workforce.

In the past few years there have been a number of significant organisational achievements and successes emerging from a turbulent and challenging period in the organisations history. Substantial progress and organisational development (OD) has been delivered in relation to a number of areas including but not limited to infection control, changing management culture, improved focus on quality, clinical governance, clinical leadership and the patient experience that we provide. However for the Trust to move forward we will need to do more, and in a more consistent manner.

The Trust is committed to creating and sustaining a culture of:

- Compassion
- Respect
- Openness, transparency and candour
- Collective leadership, accountability and responsibility
- Questioning, learning and innovation

The challenge is to build on our achievements and maximise the potential that we have as an organisation to deliver high quality services and care for our local population. The OD component is focused on four organisational objectives:

- Leadership development
- Staff engagement
- Talent and succession planning
- MTW 'climate'

5.1. Leadership development

Leadership capability is critical to the success of the organisation both in the short and long term. The Trust has been developing its capability over the past few years but more needs to be done to build the leadership capability of senior and middle leaders within the Trust to improve safe, high quality patient care, an excellent patient and carer experience and the overall Trust performance.

The senior leadership team plays a crucial role in setting the tone at the top of the organisation. The requirement to be visible and approachable throughout the organisation and to ensure there is regular and effective two way communication between senior clinical leaders and employees, through a variety of channels.

Although the Trust Management Executive sets the tone, line managers are the people who really make the difference. Our line managers need to coach and support employees, helping to remove the barriers that get in the way of people and teams doing their jobs. Managers need to facilitate and empower rather than control or restrict their staff and show appreciation and respect. Line managers must ensure effective appraisals, as part of a continuous process of performance management, encourage team working, innovation, provide routine meaningful feedback, and encourage staff to get involved in decision making. Line managers need to be visible, open and accountable as well as being engaged themselves.

The Trust requires a fully integrated leadership development approach that spans Board, Executive, senior and middle leaders. This integrated approach should enable the development of leaders at these differing levels to be consistent in its alignment with Trust strategy and objectives and relevant to role at each level. The objective is to deliver a step-change in leadership capability, in a consistent and inter-linked way at each of these levels – resulting in an improved overall leadership performance across the Trust.

The Trust will also actively utilise the national leadership programmes, contracted universities and local in house courses to drive clinical and non-clinical leadership at all levels of the organisation.

Key objectives are:

- Development and implementation of integrated leadership programmes.
- Improving leadership and management capability within the organisation.
- Shift in predominant directive management style and movement away from short term management to longer term sustainable management.
- We will ensure that our leaders are visible, approachable, open and transparent in their actions and communications.

5.2. Patient and customer care

Organisational success is dependent on maximising the productivity of the workforce and ensuring all that we do is aligned to delivering excellent patient care. At the heart of the Trusts organisational development plan is the creation and delivery of a systematic customer care approach enabling sustained organisational performance and to become a truly patient and customer centred organisation.

The Trust is developing a series of workshops and training interventions to help embed the Trust values into the everyday practice of the staff and management that work at MTW and instil high quality customer care in every aspect of what the organisation does. This behavioural change will go much further than the creation of documents, statements and posters that support the concept of excellent patient care; it will become part of the accepted culture of the organisation and we will be recognised for it.

Staff and patients will notice a significant difference, patients will expect excellence every time they have a need to use the services of the Trust, not just as measured by clinical outcomes but as measured by the patient experience, which incorporates some of the softer areas which do not get

delivered consistently. The desired output will be a measurable change to the patient care culture with the development of services built around the patient. This shift will put the patient at the heart of the organisation and make customer care the focus of everything that staff do.

This is a bold ambition, one that will take time to implement and become embedded in the organisation and one that will require focus and commitment from everyone in the Trust to make it happen. However the Board and senior leadership of the Trust support the ambition and the approach and as such the programme will start to help deliver a key strategic objective: to become and be recognised as a truly patient and customer centred organisation.

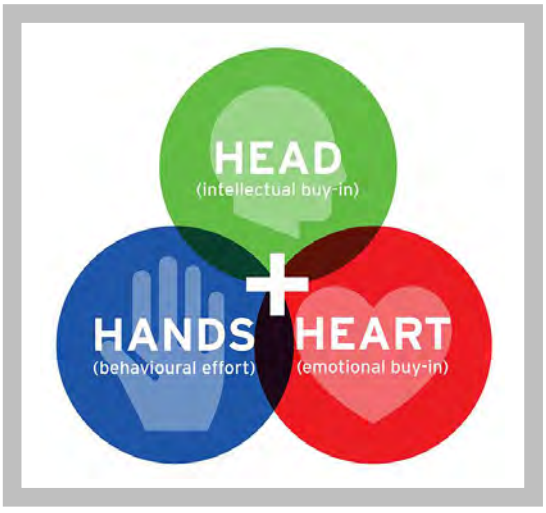
Key objectives are:

- Development and delivery of multi-disciplinary customer care programmes.
- Improved feedback from patients and staff.
- Reduction in number of complaints received.
- Improved feedback mechanisms for patients and staff.
- Empowerment of all staff to challenge any colleague who is not demonstrating the agreed MTW values, behaviour and customer care.

5.3. Staff engagement

Strong and consistent staff engagement is key to the success of MTW and the quality of care that we provide to our patients. Research has shown that NHS organisations with high levels of staff engagement have improved patient outcomes and often better use of resources. Whilst there have been a number of developments over the past few years to improve staff engagement, we need to go even further.

Effective engagement involves two way communication, enabling staff to increase motivation and giving them the opportunity to participate.



Engagement cannot be one way and the establishment and continuation of it must be a mutual act with all staff. Employees need to determine the level of engagement that they wish to offer the organisation, thus the emphasis needs to be on listening to staff and asking for their opinion, rather than simply communicating with them which will achieve limited results. Engaged staff will experience a blend of job satisfaction, organisational commitment, job involvement and a feeling of empowerment.

To achieve a high level of engagement requires a concerted, long-term campaign, utilising a range of media and activities. It is an ongoing process and failure to embed and sustain commitment to engaging employees will undermine such efforts.

"Engagement is about establishing mutual respect in the workplace for what people can do and be, given the right context." (Macleod Report – 2009 - Engaging for Success: Enhancing performance through employee engagement)

Staff engagement is critical if we are to achieve our vision, ensure patients are the driving force behind all that we do and to excel as an organisation.

Key objectives are:

- Measure and improve engagement with the medical workforce and clinical leaders.
- Develop more staff face-to-face engagement sessions including: staff summits on key topics, clinical senates on clinical issues including strategy. The aims of these sessions are to inform, listen, shape and engage staff in the drivers and enablers going forward.
- Improve the speed of action in response to survey results under the 'You Said, We Did, We Will' umbrella.
- Expand Open Staff Meetings to include Directorate meetings facilitated by the senior leadership team of the clinical directorate.
- Continual development of Trade Union Partnership Working.

5.4. Talent and succession planning

Talent management and succession planning, to date, has focused on career management for the top leaders in the Trust and relied upon the traditional career pathways available to clinical staff, whilst both have merit they do not provide a combined approach which would serve the trust more effectively. As with other NHS organisations, the Trust has historically struggled to ensure a pipeline of talent is ready to feed the system to take up senior management and specialist roles in spite of initiatives aimed at doing so. Research has shown that the ability to match organisational and individual needs is one of the factors that separate the mediocre from the high performing organisations. Talent Management at MTW is imperative in order to ensure that the organisation can recruit, retain and develop high potential and key employees and accelerate future organisational development and success.

Talent management is imperative to ensure that the Trust has the right people, optimally deployed and properly engaged to deliver the organisational objectives and high quality patient care measured through outcomes.

Key objectives are:

- Development of succession plans for critical roles within Directorates.
- Review of succession plan by Executive for critical 50 roles.
- Development of PDP's and review process for key roles and individuals.
- Creation and delivery of development roles and pathway within organisation to grow and retain talent.

5.5. MTW climate

It is widely recognised that different organisations have distinctive cultures and climates. The organisational climate is fundamental to the performance of the Trust. The climate refers to how it feels to work at the Trust, the leadership style, values, how we behave and how we interact with each other. The climate influences the discretionary effort and commitment that we all put in. The culture that we adopt and climate that we generate as an organisation will reflect the success we have in delivering a high quality service to our patients. The behaviour of all staff needs to truly express these values for the organisation to realise its full potential.

We want to develop our culture and climate so that we can attract and retain staff who can deliver excellent patient care through excellent practice.

It is valuable for leaders to be able to measure the climate they experience and create. This will be built into all leadership development programmes and diagnostic tools will be utilised to assess the climate regularly. Through regular measurement the Trust will be able to assess its performance against the climate which it wishes to deliver.

We will undertake an evaluation of our existing culture and values (PRIDE), and use this as a benchmark for developing the Trust culture and values. We will identify initiatives which will help all staff develop the behaviours and values expected at MTW.

Key objectives are:

- To improve the organisational climate for staff and patients.
- To conduct a review of the Trust values with staff, patients and key stakeholders to ensure that the organisation has the right values moving forward.
- In partnership with the above group agreed norms of behaviour will be developed and aligned to the performance management framework.
- Review of Trust recognition system to create a manager/leader of the month/year.
- Implementation of 360 appraisals for all key leaders and managers.
- Deployment of climate tool to measure and monitor.

6. HEALTH & WELLBEING

To be recognised as a health promoting Trust, one that makes an active contribution to promoting and improving the wider health and wellbeing of those with whom we come into contact.

Health and wellbeing is central to the vision, values and long term development of MTW. The Trust recognises the evidence that a healthy workforce leads to improved patient experiences, performance and a healthy workplace. Health and wellbeing is about being emotionally as well as physically healthy. It's about feeling able to cope with normal stresses and living a fulfilled life. It can be affected by things like worries about money, work, home-life, the people around you and the environment you live in. Your wellbeing is also affected by whether or not you feel in control of your life, are involved with people and communities and feelings of anxiety and isolation.

In recent years we have seen major change in the issues which affect the whole wellbeing of our own workforce, a significant increase in stress, and work related stress being the stand out issue, but others are having major impacts on health, increases in obesity, alcohol and non-prescription drug abuse, increased levels of self-harm in health care professionals are all areas which we need to support our workforce to address. It is also important to understand that for a number of staff, health and wellbeing is a very sensitive issue and it is important that the Trust does not lecture or state the obvious which can be counter-productive. There may be a number of staff who wish to change their lifestyle, whether in terms of smoking, alcohol consumption, diet or exercise and would happily do so publicly and draw support from a peer group, whereas for others, it would be preferable to do so privately. We need to ensure that whatever the preference of staff, there are opportunities internally and externally to do so.

A healthy workforce will lead to:

- A healthier and motivated workforce with increased morale and productivity;
- Employee retention and lower employee turnover;
- Reduced sickness absence and improved ability to return to work after sickness;
- A positive image in the eyes of both employees and patients;
- An environment that supports the promotion of healthy lifestyles;
- Improvements to the health of the wider community-families and patients.

Key objectives are:

- Development of a health and wellbeing group in partnership with large local employers.
- Undertake a comprehensive review of occupational health services.
- Investment in mental health support services and wellbeing initiatives for all staff.
- Undertake refresher training for existing managers on sickness, health and wellbeing.
- Reduce sickness absence.

7. INTEGRATED EDUCATION

To be recognised as a centre of excellence for integrated education.

The Trust values the importance of education and training both to develop its own workforce to support the delivery of high quality care on a sustainable basis, and to play a part in the wider training of the future NHS workforce. Significant education and training also supports the creation of a learning culture so that the organisation keeps itself up to date with academic and research developments informing innovation and improvement in care and delivery to benefit patients and staff.

We aim to be a learning organisation that is underpinned by strong academic and research links and we will celebrate the talents of individuals and teams. It is important that we work closely with individuals and teams to understand their needs, we will be responsive and flexible in meeting those needs and we will be inquiring and innovative in our practice. We will continue to support staff to maintain and develop their knowledge and skills relevant to their role.

We will ensure that all staff have the opportunity of an open and honest appraisal at least once a year which will include the development of a personal development plan.

To support the Trust in ensuring its continuing role in education and training, in an increasingly competitive environment, the Trust needs to integrate its education functions and offerings to staff.

The Trust has a very positive reputation for developing its workforce which is evidenced by successive staff surveys and also feedback from students.

However the creation of an integrated education function has at its heart the desire to bring medical and non-medical education together under one structure, merging medical and non-medical education teams to ensure the maximisation of Trust funds to meet our educational business priorities and also national requirements.

The second benefit of this approach is to enable barriers between professional groups to be reduced, if teams treat patients then the logical extension is that teams should be educated together not in professional silos.

The Trust is keen to move away from a reactive method to funding training to a more planned and strategic approach to ensure that these resources are allocated to best support the Trust's strategic aims, annual KPIs and our desired behaviours and values.

It will be the responsibility of a newly created Integrated Education Committee to develop and implement the strategy, policies, procedures and plans to achieve this.

The new function will be critical to the ability of the Trust to develop and create new roles (role redesign) and ensure we can 'grow our own' in response to hard to recruit to posts and the current workforce supply shortages. Education will need to underpin these new roles and the development of staff. The newly created integrated education function will help facilitate looking beyond existing roles and professional group constraints.

Key objectives are:

- Integration and thereby increased effectiveness of Trust education teams and resources.
- Ensure the development of a competent, caring and capable workforce.
- Be a national leader in multi-professional team training.
- Ensure the development of high quality learning environments and opportunities.
- Development and delivery of new training pathways.

8. EQUALITY & DIVERSITY

We will actively promote equality, inclusion and human rights, tackling discrimination and promoting the rights of the many and diverse communities we serve to ensure that we provide a safe environment, free from discrimination, and a place where all individuals are valued and are treated fairly.

MTW is committed to creating a culture that promotes equality and embraces diversity in all its functions as both an employer and a service provider.

The Trust's aim is to provide a safe environment, free from discrimination, and a place where all individuals are valued and are treated fairly. The Trust adheres to legal requirements and seeks to mainstream the principles of equality and diversity through all its policies, procedures and processes.

The Trust takes a zero tolerance approach to all forms of discrimination, harassment and victimisation and will make every effort to ensure that no patient or employee is disadvantaged, either directly or indirectly, on the basis that they possess any of the 'protected characteristics' as defined by the Equality Act 2010.

The Trust is fully committed to a policy of equality of opportunity in all its employment practices and all protected groups have equal access to employment, training and promotion opportunities. The Trust is committed to taking positive action for disabled people and has been awarded the Two Tick disability symbol.

Despite the above commitment and progress to date, the Trust has a lot more that it needs to do in relation to achieving the above aim. To ensure the equality and diversity agenda is moved forward, the Trust will dedicate resource to work with staff, patients and the local community to drive improvements.

Key objectives are:

- Appointment of an Executive Director Champion for equality and diversity.
- Implementation of the refreshed Equality Delivery System for the NHS (EDS2).
- Recognise discriminatory behaviour when it happens and empower all staff to challenge and act to eliminate it.
- Develop an E&D awareness programme for all staff
- Conduct a comprehensive review of all existing Trust practices in relation to E&D requirements - for example information, translation, clinical practices, food, facilities.
- Develop links with local support groups and communities to engage them in the improvement plan for the Trust with assistance from Healthwatch.
- Identify an existing NHS centre of excellence and partner with them to ensure best practice and learning implemented in a timely fashion.

9. CONCLUSION

Maidstone and Tunbridge wells NHS Trust is one of the largest employers in Kent, this strategy if enacted will take our workforce from good to great, in line with our purpose which is to deliver the best healthcare possible. To deliver this ambition we will have to make significant progress towards each of the six elements of the strategy. The elements are modular and delivery of one is not enough to deliver the strategy because the trust cannot succeed in being the employer of choice through only one or even a number of the elements. It has to deliver across the landscape of the elements.

The elements are designed to balance the needs of the employer with the needs of the employee. The idea of a partnership where both parties benefit is the principle which drives the strategy, where gain or benefit for both is delivered and thereby making MTW the employer of choice, making the service we provide to our patients the best it can be and playing an active part in the community which we serve. These are values which will appeal to our staff and drive our ability to deliver the strategy.

The trust does not start from a 'zero baseline', many successes already exist however the scale and the pace of delivery will need to quicken, our responsiveness will need to be sharper and our management capability will need to increase. We will need to be more integrated than has previously been the case and have better mechanism to listen to the people who work for us; however all of this is deliverable.

The trust will be bold in investing the necessary time, energy and resources to ensure that the strategy is fully delivered. Assurance of progress against each of the six elements will be reported to the Trust Board through the Workforce Committee.

The strategy moves the workforce into the next 5 year cycle, builds momentum and when delivered will make the Trust the employer of choice.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – September 2015

9-22	**Summary report from the Patient Experience Committee meeting, 21/09/15**	**Committee Chairman (Non-Executive Director)**

A Patient Experience Committee meeting was held on 21st September, and covered the following issues:

- The Committee received data on **Switchboard response times** and **mixed sex accommodation breaches**
- The latest **Complaints and PALS contacts data** was reviewed; and an update on the latest activity of **Healthwatch Kent** was given by the Healthwatch representative
- The **Quality Accounts priorities** for 2015/16, were reviewed and the latest progress noted
- The Deputy Chief Nurse provided the results from the **2015 PLACE inspections** including comments made by the Patient Representatives
- The Communications Officer gave a **Communications and Membership update**
- The Committee received **notification of planned service changes**, which included an update on a new Ward at the Tunbridge Wells Hospital and the implementation of 7 day Pharmacy services.
- The latest findings from the **local patient survey (incl. Friends and Family)** were reviewed, as was the Trust's response to the national **NHS Inpatient Survey 2014**
- The Committee approved both the Terms of Reference of the **Patient Information and Leaflets Group** (PILG) and the Development and Production of Written Patient Information Policy and Procedure.
- The Committee received a presentation from the Children's Services Directorate on the findings and response to the **National Children and Young People Inpatient Survey 2014**
- Summary reports from the two most recent meetings of the **Quality Committee** were received
- The latest position regarding **Care Assurance Audits** was noted and the key theme highlighted was communication

A number of actions were agreed at the meeting, including the following:

- A Workstream report on cancelled and missed appointments would be provided to the next Committee (and the programme manager be invited to attend to answer questions)
- Regular reports would be received at the Committee on translation services and from West Kent Clinical Commissioning Group (CCG) on current work being undertaken
- The reported non-receipt of appointment letters and/or investigation results would be investigated with the Clinical Administration Units
- The possibility of GP practices making routine contact with patients following discharge would be investigated by the CCG

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - September 2015

9-23	Supporting people who speak out about patient safety	Director of Workforce and Communications

Maidstone and Tunbridge Wells NHS Trust is committed to creating, sustaining and promoting a culture and climate of openness and honesty, ensuring that all staff are confident and encouraged to raise concerns in accordance with Professional Codes of Conduct and Trust policy. The Trust wants staff to have confidence that their concerns will be taken seriously and that the issues are resolved thus ensuring that all activities of the Trust are carried out in a way that promotes the highest standards of patient car and business practices. Free expression by individuals of their genuine concerns is welcomed by management as a contribution towards protecting patients, staff and the public and improving services. The Trust is committed to dealing responsibly, openly and professionally with all concerns that are raised. The Trust understands that at one time or another staff may have a concern about what is happening at work. The Trust encourages staff with such concerns to resolved these through a quick discussion with the person best placed to resolve the problem, whether that be the line manager, a colleague, or other person within the organisation. However, the Trust recognises that occasionally concerns cannot be resolved in this way and needs escalation through a different route and the Trust has implemented a Speak Out Safely (SOS) Policy and Procedure (formerly Whistle Blowing) and an anonymous reporting mechanism. As the Accountable Director, I will provide the Board with a report on activity from the above every 12 months.

In June last year the Secretary of State for Health commissioned Sir Robert Francis to carry out an independent review into creating an open and honest reporting culture in the NHS. Sir Robert's report (Freedom to speak up) was published in February and included recommendations to introduce:

- A Freedom to Speak Up Guardian in every NHS trust. This will be a named person in every hospital who will give independent support and advice to staff who want to speak up and hold the board to account if it fails to focus on issues around patient safety.
- A National Independent Officer who can support local guardians, intervene when cases are going wrong, and identify any failing to address dangers to patient safety, the integrity of the NHS or injustice to staff

After a period of consultation, the Secretary of State announced on 16 July that the National Independent Officer, now known as the independent National Speak Up Guardian, would be hosted by the Care Quality Commission.

The appointment of a Freedom to Speak Up Guardian is another step forward to ensuring that our Trust leads the way in supporting staff whenever they need it. The role will be integral to ensuring all staff within the trust feel able to raise any issues or concerns, or challenge any wrongdoing – safe in the knowledge that they will be addressed confidentially, promptly, and in line with best practice. The recommendation from the Executive team is that Richard Hayden (Deputy Director of Workforce) is appointed to this role. Richard already acts as a designated officer under the Trust Speaking Out Safely Policy and will execute his responsibility to hold the Board to account in order to make a difference for our staff and patients. The postholder will have the right to discuss issues with the Senior Independent Director and obtain clinical expertise or independent advice to fulfil the duties of the post.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Decision

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