Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD MEETING

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

10.30am – c.1pm WEDNESDAY 25TH FEBRUARY 2015

THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment	Page
2-1	To receive apologies for absence	Chairman	Verbal	-
2-2	To declare interests relevant to agenda items	Chairman	Verbal	-
2-3	Minutes of the Part 1 meeting of 28th January 2015	Chairman	1	1-9
2-4	To note progress with previous actions	Chairman	2	10
2-5	Chairman's report	Chairman	Verbal	-
2-6	Chief Executive's report	Chief Executive	3	11
2-7	Integrated Performance Report for Jan 2015 (incorporating an update on recruitment & retention)	Chief Executive	4	12-23
	Additional quality items			
2-8	Care Quality Commission inspection, October 2014	Chief Executive	5	24-54
2-9	Planned & actual ward staffing for January 2015	Chief Nurse	6	55-57
2-10	A patient's experiences of the Trust's services[1]	Medical Director[2]	Verbal	-
2-11	Medical Devices – details of improvements and latest purchases	Medical Director	7	58
	Planning and strategy			
2-12	Update on the Trust's planning submissions, 2015/16 (including approval of the latest submission to the NHS Trust Development Authority)	Director of Finance	Verbal	-
	Reports from Board sub-committees (and the Trust Management Executive)			
2-13	Audit and Governance Committee, 12/02/15	Committee Chair	8	59-60
2-14	Trust Management Executive, 18/02/15	Committee Chair	9	61
2-15	Finance Committee, 23/02/15	Committee Chair	10 (to follow)	-
	Assurance and policy			
2-16	Approval of compliance oversight self-certification	Trust Secretary	11	62-73
2-17	Trust response to the "Freedom to Speak Up" review	Director of Workforce and Communications	12 (to follow)	-
2-18	**To consider any other business**			
2-19	**To receive any questions from members of the public**			
2-20	To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted	Chairman	Verbal	-

Date of next meetings:

- 25th March 2015, 10.30am, Education Centre, Tunbridge Wells Hospital
- 29th April 2015, 10.30am, Education Centre, Tunbridge Wells Hospital
- 27th May 2015, 10.30am, Academic Centre, Maidstone Hospital

Anthony Jones,
Chairman

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

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

Maidstone and Tunbridge Wells NHS
NHS Trust

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 28TH JANUARY 2015, 10.30 A.M. AT TUNBRIDGE WELLS HOSPITAL

DRAFT, FOR APPROVAL

Present:	Anthony Jones	Chairman (Chair)	(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)
	Steve Orpin	Director of Finance	(SO)
	Paul Sigston	Medical Director	(PS)
	Kevin Tallett	Non-Executive Director	(KT)
	Steve Tinton	Non-Executive Director (until item 1-8)	(ST)
In attendance:	Paul Bentley	Director of Workforce and Communications	(PB)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Stephen Smith	Associate Non-Executive Director	(SS)
	Amanda Allen	Amanda Allen (Therapy Manager) (for items 1-7 to 1-9)	(AA)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	Teresa Jarrett	PA to Chief Executive and Chairman	(TJ)
	Annemieke Koper	Staff side representative	(AKo)
	Erna Stuart-Black	Sister, Coronary Care Unit, Tunbridge Wells Hospital	(ESB)
	Darren Yates	Head of Communications	(DY)
	Chris Barass	Senior Business Development Manager, British Gas	(CB)
	Howard Stone	Head of Sales, British Gas	(HS)

1-1 To receive apologies for absence

Apologies were received from Alex King (AK), Non-Executive Director.

AJ welcomed ESB to the meeting, and noted that she was observing as part of her 'shadowing' AB.

1-2 To declare interests relevant to agenda items

There were no declarations of interest.

1-3 Minutes of the Part 1 meeting of 17th December 2014

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

- Item 12-7, Page 3: Add "…due to Delayed Transfers of Care" after "999 bed days had been lost in November…"

Action: Amend the minutes of the meeting of 17th December 2014 (Trust Secretary, January 2015)

1-4 To note progress with previous actions

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

- **Item 12-7 (Arrange for the Trust's plans in relation to workforce metrics on the Trust performance dashboard to be included within the "Plan/Limit" column):** PB reported that additional information had been provided, but acknowledged that further work was required.

1-5 Chairman's report

AJ reported that the Trust stood on the cusp of a difficult year ahead, and noted that the financial challenges would be great, but performance needed to be maintained.

1-6 Chief Executive's report

GD referred to the circulated report and highlighted that although the Integrated Performance Report covered the recent pressures in more detail, it needed to be acknowledged that the great efforts that had been made by the Trust and its partners during the recent period were insufficient, and therefore something different/else was required. GD added that he was unable to be more specific as yet, but the focus of the coming months would be to work with partner organisations to consider alternative options to the current situation.

GD then commended the commitment of the Trust's staff, and AG and PS in particular, and also apologised for the delays in elective care that had occurred to some patients as a result of recent cancellations.

AJ concurred with GD's comments, and proposed that the Board formally recognise the commitment that had been made by Trust staff. This was agreed.

GD then highlighted the Safety Climate Survey, which identified some positive points, as well as areas where further work was required to improve. AJ emphasised the importance of providing feedback to those people who had taken time to report incidents. GD noted that some areas were good at providing such feedback, but other areas could improve.

GD then highlighted the Trust's award for the most consistent top performing acute provider for Kent, Surrey and Sussex, and congratulated the teams involved in the work that led to the award. GD added that the Kent, Surrey and Sussex area included Trusts such as Frimley Park Hospital NHS Foundation Trust, so the achievement should not be underestimated.

Finally, GD noted that a delegation from the Chinese Health Department was visiting the Trust to review Kangaroo care.

1-7 Integrated Performance Report for December 2014 (incorporating updates on winter pressures and recruitment & retention)

GD referred to the circulated report and highlighted that the driver for the Trust's performance across the month was the high level of clinical activity.

AG then highlighted that

- The final week in December 2014 saw a surge in Ambulance arrivals, and increase in elderly patients with respiratory problems
- The impact was felt across the Trust, including non-clinical services (catering, domestics etc.)
- Staffing was a limiting factor (holiday absence was higher), and although this was expected to a degree, sickness absence also increased. Bank Staff were therefore encouraged to work extra shifts, to enable the 4-5 new escalation areas to be staffed safely. Recovery staff were also deployed to assist, as elective activity was not being undertaken during that period
- Ambulances had to cohort within A&E, to enable Ambulance patients to receive appropriate care. As a result, very few Ambulance delays were recorded.
- Contemporaneous records were made, to ensure that lessons were learned for the future
- As a result of the pressures, there had been a considerable reduction in elective activity, and although this had started to recover, full recovery would take some time. Specifically, the 18-week-wait backlog and Referral to Treatment (RTT) targets had been adversely affected

AJ asked about current performance. AG stated that the maximum performance that could now be achieved for the A&E 4-hour waiting time target was below the required 95%.

AJ referred to the comment on page 15 that "Bed mapping across Acute and Community services to ensure capacity matches expected demand is taking place" and emphasised the need to review

the capacity within the whole health and social care economy. AG concurred, and noted that there was no spare capacity within the system. AJ added that it was therefore important to recognise that the situation was a strategic issue.

SD referred to the number of bed days lost as a result of Delayed Transfers of Care as reported at the December 2014 Board, and highlighted that it was a major achievement for the Trust to manage as it had done. SD proposed that staff be formally notified of the Board's thanks. AJ proposed that GD's weekly update make specific reference to the Board's commendation. This was agreed.

Action: Ensure that the Chief Executive's update makes specific reference to the commendation given by the Trust Board to staff for their efforts in response to the recent capacity pressures (Chief Executive, January 2015)

KT queried whether the Trust's winter planning was sufficient, and added that it was difficult to know how much of the actual situation was planned for, given that the Trust did not declare a Major Incident. GD replied that the Trust was close to declaring a Major Incident, but this was not felt to be beneficial, as partner agencies were working as hard as possible. GD added that the Trust's performance was representative of the Trust's plans, albeit such plans were significantly stretched. AB added that the aforementioned surge was expected, but had been planned to occur later in January, and not in December. AJ noted that this would be discussed further in the Part 2 Board meeting scheduled for later that day.

ST supported the need to ensure a system wide solution was reached, but asked whether the practical processes existed to enable such a solution to be sought. AJ noted that the Board as a whole had met with the Governing Body of West Kent Clinical Commissioning Group (CCG) on the evening of 27/01/15, and commitments to achieving such a solution were made. AJ added that it was noted that West Kent CCG were liaising closely with High Weald and Havens CCG. GD highlighted that the Urgent Care Board needed to play a role, and the Trust would participate in that forum, but pointed out that other mechanisms would need to be deployed. GD continued that there had been a growing realisation, which had been confirmed by recent events, that the efforts being undertaken to shift care from the acute sector to the community sector should continue, but such efforts were insufficient, and intermediate tier facilities and capacity was likely to be required.

AG then continued, and highlighted that Delayed Transfers of Care had reduced slightly in the month, as most patients were not medically fit for discharge.

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

- Decisions were being made regularly to ensure that safety was maintained in the face of the current pressures, particularly in terms of staffing.
- Safety Thermometer scores were good, as was the Friends and Family Test (FFT) scores. The FFT score in A&E was being monitored closely during the recent pressures, and the performance was remarkable
- 30 Mixed Sex Accommodation (MSA) breaches did occur, however this reflected conscious decisions, based on safety. There was communication with affected patients throughout
- Serious Incidents and reported incidents that were specifically related to that period did not increase

PS then highlighted that there had been a surge in mortality, which would be shown in time via crude mortality data. PS added that he was however confident that the rationale for this surge was understood.

SM added that December saw 3 Clostridium difficile cases, but the Trust's rate remained below the national average.

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

- The recent period saw increased use of temporary staff, and increased sickness absence
- Steps were put in place to pay bank staff to work additional shifts, within the limits of the European Working Time Directive WTD, and this had been shown to be successful

- Recruitment and retention efforts were continuing and a Nurse Open Day was held on 17th January

AJ asked when the next Open Day was being held. PB replied that an Open Day in March was being held for non-clinical staff and Clinical Support Workers, but the next Open Day for Nurses was scheduled for May. PB added that the Trust's overseas recruitment efforts would next focus on Poland and Italy.

GD then referred to the "Where Have All the Nurses Gone?" "File on 4" radio programme broadcast on 27/01/15, and emphasised the national shortage of Nurses, as well as the time required to address the training shortfalls that had occurred in previous years.

SO then referred to the circulated report and highlighted the following points:
- Day Case activity income and elective income had reduced
- Non-elective activity had increased. SO reminded Board members that the Trust only received 30% of tariff for such patients, which equated to a four-fold loss of income, when compared to income for elective patients
- There had been an increase in Bank expenditure, but also a reliance on Nursing Agency staff
- There had been an £82k surplus in month, but the planned surplus was £400k
- For the year to date, the Trust was £200k below plan, but the forecast was still to deliver a marginal surplus (of £5k) by year end. SO elaborated that the impact of recent activity and associated costs had been analysed, and a break even position was still possible, but the Trust's flexibility had been significantly reduced
- CIP performance had reduced in month
- Cash was being managed effectively, and the statutory External Financing Limit duty remained on target
- Progress had been made with West Kent CCG in terms of funds being made available to the Trust
- Capital expenditure was behind trajectory, but some large expenditure items were scheduled for Quarter 4. There was however potential for slippage, and if the Board agreed, this would be addressed by bringing forward items from future years' capital programmes, to then enable some items from the 2014/15 plan to be deferred to future years

AJ referred to SO's last point, and expressed support for the approach proposed by SO.

KT asked whether the reduction in CIP performance was related to the recent pressures. SO confirmed this was the case, as costs had to be incurred earlier than had been planned.

SS referred to the scale of the aforementioned pressures and asked why the Trust only had a small deficit in December. SO replied that a reserve of circa £1m had been held for the type of situation that occurred, and this reserve had been deployed. SS asked whether the higher costs in December were likely to be seen in January. SO stated that costs for January were likely to be higher than for December, as a higher level of escalation would have been in place for a longer period. SO added that liaison was continuing with West Kent CCG to understand the exact impact of the higher level of escalation.

AJ asked AG to comment on Length of Stay. AG replied that as a result of the increased acuity of patients, length of stay had increased, but gave assurance that the matter was receiving attention.

AJ remarked that the increased acuity was likely to worsen over time, given the age of the population. GD acknowledged the point, and stated that the Trust needed to better understand the impact of acuity on length of stay. GD also emphasised that although many patients were deemed to be not fit for discharge during the recent period, such patients may have been able to be discharged if the aforementioned intermediate facilities were available.

Additional quality items

1-8 Planned & actual ward staffing for December 2014

AB referred to the circulated report and highlighted the following points:
- December had been the most difficult month in terms of staffing since AB had been in post
- The report did not include the escalation areas, but no area fell below 80% of planned levels

AJ then referred to the aforementioned “Where Have All the Nurses Gone?” “File on 4” radio programme, and asked for details of the Trust’s position regarding the ratio in the guidance from the National Institute for Health and Care Excellence (NICE) of 1 nurse for every 8 patients. AB clarified that NICE’s guidance on staffing did not stipulate a minimum staffing level for Wards but referred to a ratio range between 1:6 and 1:8. AB continued that the Trust’s planned staffing levels were between a ratio of 1:6 and 1:7. AB added that draft guidance on A&E staffing had also been issued by NICE, for consultation, and the Trust was reviewing the effects of this. AB added that the final guidance was intended to be launched in May 2015, and the Trust was expected to be compliant by that point.

Presentation from Clinical Director

1-9 Diagnostics, Therapies & Pharmacy

AJ welcomed AA to the meeting, and highlighted that this was the first presentation from a Clinical Director (CD), and these would now be received at alternate Board meetings, alternating with a ‘patient story’.

SM then gave a presentation highlighting the following points:
- The Directorate included Infection Control, Pathology, Pharmacy, Radiology and Therapies
- The workforce was 788.44 WTE, and the Senior Management Team consisted of SM as CD, plus 4 General Managers and a Nurse Consultant
- The budget was £7.9m, with £24.5m income (incl. £15m SLA income), and expenditure was £33.7m
- The key issues for Pharmacy included: the move to 7 day working; the need to update and expand Oncology Pharmacy; unplanned or in-resourced developments in the Trust due to capacity constraints; and the complexity and workload of administering Cancer Drugs Fund and High Cost Drugs reimbursement

AJ asked when the 7 day pharmacy service would start. SM stated that the full service was scheduled to be in place by April 2015.

SM continued that the key issues for Pathology included the implementation of the Kent Pathology Partnership (KPP); the difficulty in recruiting and retaining scientific staff, which was leading to high agency use; the delay in the implementation of the intelligent fridge (by circa 2 years), all laboratories were fully accredited, and Microbiology had recently achieved ISO accreditation ; a recent Serious Incident (SI) was being investigated; and the Mortuary had recently been inspected by the Human Tissue Authority, and the feedback had been very positive.

KT noted that on recent visits to Pathology by him and PS, staff had raised concerns regarding the communication of progress with KPP, and queried whether this identified a need for action. SM replied that there were communication processes in place, though on some occasions, there had been little or no news to report. KT highlighted the importance of ensuring communication occurred regularly, even in the absence of any news. SM acknowledged the point, but stated that she believed the staff’s views would be different if KT visited the Pathology department now.

SD asked what the timeframe was for the recovery of Histology reporting, noting that this could have an effect on Cancer performance. SM replied that the recent Cancer Board had heard that no Histology delays were related to Cancer cases, but added that she expected the reduction of general delays to continue week by week.

SM then continued and highlighted that the key issues for Radiology included: inability to recruit Ultrasonographers which was placing the Trust’s ability to meet the 6-week reporting KPI at risk; the Radiology Information System (RIS) still required an upgrade; a business case for new MRI facilities was being prepared; reporting capacity was a concern; the GP order comms re-launch;

the delays in MRI / CT reporting had been resolved; 2 new Consultant posts were currently being advertised; tomosynthesis was being introduced for the Breast Unit (following the receipt of charitable funds); and a static PET/CT scanner had been confirmed for the Maidstone Hospital site, by Specialist Commissioning

AJ asked for further details of MRI reporting and capacity. SM stated that most of the clinical guidance issued by NICE involved the need to undertake MRI scans. AJ queried whether 3-year projections of demand were therefore warranted. PS replied that there was some uncertainty associated with such projections.

SM then continued, and highlighted that the key issues for Infection Control included: being below trajectory for Clostridium difficile; implementing the Carbapenem resistant Enterobacteriaceae (CRE) / and Carbapenemase producing Enterobacteriacea (CPE) policy; a full Root Cause Analysis (RCA) programme; the appointment of Nurse Consultant and new Lead Nurse in post; she noted that the team had received an award for the Infection Prevention Society's acute team of the year.

AA then highlighted the following

- The Therapy Assisted Discharge Service (TADs) started in November 2013 and was funded by West Kent CCG
- TADs was a rapid access therapy service on discharge from hospital which involved Physiotherapy and Occupational Therapy. It enabled early recovery and reduced length of stay. The service was available from 8am to 6pm, 7 days per week
- The average length of stay saved in December was 2 days, and 214 bed days were saved in December

AJ asked whether all appropriate patients were referred to the TADs service. AA stated that there was no resistance to making such referrals, but the awareness of the service was steadily increasing, though this could be improved.

AJ asked whether the CCG was committed to continuing the funding of the TADs. AA replied that she understood the situation was positive. AG added that a recommendation would be made to the next Urgent Care Board to continue to support TAD (and the HIT service), which was currently funded to April 2015.

AA then continued as follows:

- The High Impact Team (HIT) was a Winter Surge Resilience scheme funded for 5 months from November 2014 to March 2015
- It involved a rapid assessment service based in A&E using the skills of the Trust's therapists, Community Liaison Nurses from Kent Community Healthcare NHS Trust, practitioners from the Enhanced Rapid Response Service (ERRS) and Social Services Assessment Officers
- HIT identified patients whose health and social care needs could be managed in the community and implemented proactive packages of care to prevent unnecessary hospital admissions

AJ commended the schemes, and other such initiatives.

SM then continued and highlighted the following:

- Current financial performance showed a £361k underspend, which included the over performance against the SLA of £501k
- The Pathology department includes the efficiency target for the Directorate

SO asked whether there were further items that could be incorporated within the Directorate's CIP performance. SM described the difficulty in attributing a value to some of the efficiencies applied within the Directorate. SO stated that it appeared that further work was required to ensure such efficiencies were correctly captured.

SM then continued and highlighted the following:

- Risks included recruitment and retention i.e. to maintain the service; demand outstripping capacity (which required complex workforce planning); and the impact of the tendering of services (e.g. Genito-Urinary Medicine)
- Challenges included: KPP; the Any Qualified Provider scheme; RIS; Capacity 'hot spots' e.g. Chemotherapy; and achieving ISAS (Imaging Services Accreditation Scheme)
- Opportunities included: new markets; new Interventional techniques and developments; expanding demand for molecular services; repatriation of immunology tests; E-prescribing; Digital breast tomosynthesis; New radio-isotopes therapies; young and enthusiastic Consultant staff; extended practice opportunities for non-medical staff (e.g. cut up practitioners, Consultant Nurses, Consultant Radiographers, reporting BMS and Radiographers etc.)
- Future strategy included the development of the capital programme for replacement imaging equipment; full implementation of KPP business case; the investigation of new markets; working towards full staffing in therapies; a fourth MRI scanner; the expansion of Consultant staff; E-prescribing as part of Trust IT strategy; and accreditation for radiology (ISAS)

AJ asked about progress with eprescribing, beyond Chemotherapy eprescribing. PS stated that this was currently on hold, and related to a national pause in the implementation of eprescribing.

AJ then asked whether the users of the Directorate's services were content with the appropriateness of the strategy as outlined by SM. PS confirmed this was the case.

AJ asked PS whether there were any serious concerns regarding the Directorate. PS and GD confirmed there were no such concerns.

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

1-10 Quality & Safety Committee, 15/12/14 & 21/01/15

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

1-11 Trust Management Executive, 14/01/15

GD referred to the circulated report and noted that most of the issues had already been covered, apart from the CQC inspection report, and confirmed that the Trust had received the report of the inspection and the CQC was likely to publish this w/c 02/02/15.

AJ asked for further details of the new Head of Midwifery. AG replied that the person appointed, Jenny Cleary, would start in July, but an interim would be appointed to cover the period when the current post-holder left at the end of February.

1-12 Finance Committee, 19/12/14 & 26/01/15

Attachment 8 was noted. SDu then referred to Attachment 9 and highlighted the following points:

- The work that SO and the Finance team had done with West Kent CCG to reach agreement on the contract should be commended, but efforts needed to continue to focus on reducing the Trust's cost base for the remainder of the year
- Procurement transformation had been discussed and agreement had been given to proceed with the development of a full business case
- Reference costs were also discussed, and further work would be undertaken

1-13 Charitable Funds Committee, 10/12/14

SDu referred to the circulated report and highlighted that the Committee had confirmed its previous agreement not to pursue independent charitable status for Maidstone and Tunbridge Wells NHS Trust Charitable Fund at the present time. SDu added that the Board was asked to approve the Charitable Funds Committee's recommendation.

AJ asked whether there was any adverse impact of not proceeding with independent status. SO confirmed there was no such impact.

The Board approved the Charitable Funds Committee's recommendation that the Maidstone and Tunbridge Wells NHS Trust Charitable Fund not pursue independent charitable status at the present time.

Assurance and policy

1-14 Review of the Board Assurance Framework, 2014/15

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

- This was the second time that the Board had received the Board Assurance Framework (BAF) in its revised format, and the version circulated contained an additional revision, in the form of a summary page
- The content had been updated to reflect the latest performance and assurance information, as well as the judgement of the Executive lead for each objective.
- The wording of objective 2.7 had been updated and the Board's approval was sought for the change
- Three of the objectives have been rated as 'red' for the forecast year end achievement and the reasons were outlined in the report
- The BAF was an assurance tool, and the Board had a number of options regarding its use, which were listed on page 36 of 63

KT referred to objective 2.4 and queried why the 'RAG' ratings for controls and year end performance were red. PB explained that the red ratings related to the risk of non-achievement of the objective, as worded, at year end. KT queried whether the performance had failed to be delivered in accordance with the plan. PB highlighted that the plan was to reduce usage of temporary staffing by 15%, and this would not be met.

KT highlighted the negative perception that may arise from 'red' ratings. AJ replied that 'red' ratings did not necessarily reflect a wholly negative situation. KR emphasised the importance of linking the ratings to the wording of the agreed objectives, and added that when he met with Executive Directors, the question he posed was 'will the objective (as worded) be met at year end'?

A discussion was then held regarding the use of the BAF and KR explained the process, including the intended process to link the BAF with the Integrated Performance report. GD queried whether there were conflicts between what was presented in the performance report and the BAF, and suggested that a combined document should be the aim. KR replied that such a combined document was possible, but this increased the risk of introducing unnecessary complexity. KR elaborated that the intention was to ensure there were effective links between the BAF and the performance report, and noted that the BAF that had been circulated contained the same information within the Integrated Performance Report that had been circulated. KR encouraged Board members to challenge ratings if they felt there were any conflicts.

The revised wording for objective 2.7 was approved.

1-15 Emergency Planning Update (annual report to Board)

AG referred to the circulated report and asked for comments or questions.

AJ referred to the power failure that took place on 25th February, and asked whether a full RCA had been undertaken. AG confirmed this was the case, and noted that a report had been submitted on the failure to the Audit and Governance Committee.

KT commented that the report provided assurance, but cautioned that such reports risked lulling the Board into a false sense of security, as detailed analysis of risks was not provided. KT elaborated by referring to the example risk of a cyber attack. AG stated that such elements were covered as part of Disaster Recovery Processes, but also noted that the Trust's Business Continuity Plans were relevant. KT emphasised that the Trust's preparation and response to such an attack was dependent on the scope and role of the Trust's Director of Health Informatics. The point was acknowledged.

1-16 Approval of compliance oversight self-certification

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

The submission was approved as circulated.

1-17 To consider any other business

There was no other business.

1-18 To receive any questions from members of the public

There were no questions.

1-19 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 – February 2015

2-4 Log of outstanding actions from previous meetings — Chairman

Actions due and still 'open'

Ref.	Action	Person responsible	Deadline	Progress [1]
12-7 (Dec 14)	Arrange for the Trust's plans in relation to workforce metrics on the Trust performance dashboard to be included within the "Plan/Limit" column	Director of Workforce and Communications	January 2015 onwards	In progress

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
1-3	Amend the minutes of the meeting of 17th December 2014	Trust Secretary	January 2015	The minutes were amended
1-7 (Jan 15)	Ensure that the Chief Executive's update makes specific reference to the commendation given by the Trust Board to staff for their efforts in response to the recent capacity pressures	Chief Executive	January 2015	This was included the Chief Executive's update that was issued on 06/02/15

Actions not yet due (and still 'open')

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

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - February 2015

2-6 Chief Executive's update Chief Executive

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

1. I held a series of staff meetings this month to discuss the findings of our latest Care Quality Commission inspection report with our staff.

1.1 Over 250 members of staff attended our meetings at Maidstone and Tunbridge Wells hospitals from all areas of the organisation. Although we are all disappointed not to be rated good or excellent on this occasion, there was a clear desire from our staff to use the report positively to drive through further improvements in patient care.

1.2 A Quality Summit was held by our Trust and CQC in January to openly discuss the reports with our many partners. It was recognized we have a clear understanding of our responsibilities, that actions are underway where any urgent improvements are required, and a robust process is in place to monitor progress. At the same time, we are collaboratively addressing some of our long-term challenges that require the assistance and support of our partners. I was gratified to see the support of all our partners in moving forward.

2. We welcome the recommendations made by Sir Robert Francis to further improve the culture of the NHS and will look to see how we can implement these improvements. The NHS as a whole has become a more transparent, safer and more compassionate place since the failings at Mid Staffs were exposed by the Francis Inquiry and we all want an open and honest culture in the NHS in which staff feel supported to speak out.

3. We are investing an additional £464,000 to recruit more physiotherapists, pharmacists and radiographers to support seven-day services. We are also delivering on our plans to enhance children's care with a £300,000 package to recruit four additional Paediatric Consultants and a new Consultant in Trauma and Orthopaedics specialising in Paediatric Orthopaedics. We are holding public drop-in sessions to discuss plans for a dedicated children's A&E department at Tunbridge Wells.

4. The Kent Pathology Partnership is due to go live on 1st April. This collaborative approach to providing Pathology services between our Trust and East Kent Hospitals University NHS Foundation Trust will provide an effective means of continuing to provide high quality Pathology services for patients and healthcare professionals who use our services.

5. We were delighted to share the insights behind some of our award-winning care with a team from the Chinese Health Department recently. The team believe our Kangaroo Care concept for transitional care babies is excellent and can help them shape changes on a national scale.

6. We have won a multi-million pound contract to provide integrated sexual health services for West Kent. The areas sexual health services were put out to tender in 2014. We have now added services across North Kent to our own service. We have developed a hub and spoke model of care in partnership with Kent Community Trust and Brook Young People's services which will significantly increase service provision within West Kent. The new service will consist of dedicated HIV and young persons' clinics in each district to reduce the incidence of STI's.

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 – February 2015

2-7	**Integrated Performance Report for January 2015** (incorporating an update on recruitment and retention)	**Chief Executive**

The key issue remains the impact on capacity and flow as a result of the non-elective demand. Although January's activity levels over the month are in line with expectation and the non-elective admissions are lower than January 2014, there was an increase in admissions for patients aged over 75 and an increase in the number of ambulance conveyances, both of which are indicators of acuity.

The non-elective pressures over late December and early January remained in the system throughout the month as patients remained ill for longer and most patients did not become medically fit for discharge until later in the month. This phenomenon was predicted and partners in the health and social care economy were alerted to when a surge in demand for community hospitals, nursing homes and enablement was likely to occur. The capacity in the community was impacted by a flu outbreak in the West Kent Community Hospitals which removed access to those beds for up to 2 weeks.

Specific actions have been taken to manage the current situation and to support our return to a more stable state. This includes using unspent resilience money on step-down and rehabilitation capacity at a local nursing home.

Plans to increase capacity within the system are being accelerated to bring more resilience and flexibility to managing the variations in demand that we are likely to see.

In terms of recruitment and retention (following the request at the December 2014 Board to provide an update on this each month), January saw continued reliance upon temporary staff with Locum, Bank and Agency nursing showing an increase on previous levels of usage. Whilst the incentives programme for our own staff to undertake additional hours led to more shifts being filled and a lesser dependence upon agency Nursing staff, we still had a reliance which reflected the number of additional beds open and the business of the hospitals in the month.

The increase in sickness levels was a reflection of the December levels, when staff were impacted by some of the illness which was prevalent in the community at the time, initial indications are that the sickness absence levels in January have dropped, however this is subject to confirmation when all the data is received.

59 new staff were recruited in January, whilst 37 staff left, making a net increase of 22 (across all staff groups). International recruitment of Nursing staff will now take place in forthcoming months, across Europe and further afield.

The enclosed report includes, as usual, the Trust performance dashboard; integrated performance charts; and financial performance overview.

Which Committees have reviewed the information prior to Board submission?

- Executive Team, 17/02/15
- Trust Management Executive, 18/02/15

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

Discussion and scrutiny

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

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

Governance (Quality of Service):	**1.0**	**Amber/Green**
Finance:	**TDA**	**Red**

Responsible Committee: Quality & Safety

	Patient Safety & Quality	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
'1-01	Hospital-level Mortality Indicator (SHMI)	Prev Yr: July 12 to June 13		100.3	101.5	1.2	1.5	*100*		100
'1-02	Standardised Mortality (Relative Risk)	Prev Yr: April 13 to Mar 14		104.2	104.1	-0.1	4.1	*100*		100
'1-03	Crude Mortality	1.4%	1.9%	1.3%	1.3%	0.0%				
'1-04	Safety Thermometer % of Harm Free Care	96.3%	97.3%	95.1%	96.5%		1.5%	95.0%		93.8%
'1-05	*Rate C-Diff (Hospital only)	5.1	4.6	16.2	13.0	-3.2	-4.7	*15.7*	15.1	15.7
'1-06	Number of cases C.Difficile (Hospital)	1	1	30	25	-5.0	-9.0	*35*	35	35
'1-07	Number of cases MRSA (Hospital)	0	0	2	1	-1	0	*0*	1	
'1-08	Elective MRSA Screening	0.0%	99.0%	0.0%	99.0%		1.0%	98.0%	99.0%	
'1-09	% Non-Elective MRSA Screening	95.0%	97.0%	95.0%	97.0%		2.0%	95.0%	97.0%	
'1-10	**Rate of Hospital Pressure Ulcers	2.3	2.9	2.5	2.3	-0.2	-0.7	*3.0*	2.3	3.0
'1-11	****Rate of Total Patient Falls	6.4	6.40	7.2	6.2	-1.0	-0.6	6.75	6.2	
'1-12	****Rate of Total Patient Falls Maidstone	5.3	4.43	6.3	5.0	-1.3	-1.7	6.75	5.0	
'1-13	****Rate of Total Patient Falls Tunbridge Wells	6.8	7.98	7.8	7.0	-0.8	0.3	6.75	7.1	
'1-14	Falls - SIs in month		2		28	28				
'1-15	MSA Breaches	0	33	10	68	58	68	0	68	
'1-16	Total No of SIs Open with MTW	25	19			-6				
'1-17	Number of New SIs in month	5	10	108	92	-16	-8			
'1-18	Number of Never Events	0	0	1	2	1	2	*0*	2	
'1-19	Number of CAS Alerts Overdue	5	0			-5	0	*0*		
'1-20	*****Readmissions <30 days: Emergency	12.4%	11.6%	11.2%	11.6%	0.4%	-2.0%	*13.6%*	11.6%	14.1%
'1-21	*****Readmissions <30 days: Elective	6.3%	5.0%	5.8%	5.6%	-0.3%	-0.7%	*6.3%*	5.6%	6.8%
'1-22	***Rate of New Complaints	5.5	5.23	5.1	3.96	-1.2	-2.30	*6.26*	4.01	6.26
'1-23	% complaints responded to within target	67.2%	71.1%	57.8%	67.0%	9.2%	-8.0%	75.0%	68.3%	
'1-24	IP Resp Rate Recmd to Friends & Family	19.9%	22.9%	17.4%	41.1%	23.7%	11.1%	**30% Q4**	40.7%	33.6%
'1-25	A&E Resp Rate Recmd to Friends & Family	13.1%	17.7%	4.0%	18.2%	14.2%	-1.8%	**20% Q4**	18.4%	18.1%
'1-26	Mat Resp Rate Recmd to Friends & Family	New	14.2%	New	19.0%	New	-1.0%	15%	19.0%	20.8%
'1-27	IP Friends & Family (FFT) Score	78	78	76	77	1	4	73	77	73
'1-28	A&E Friends & Family (FFT) Score	70	62	66	63	-2	10	53	63	53
'1-29	Maternity Combined Q1 to Q4 FFT Score	New	89	New	84	New	13	71	84	71
'1-30	Five Key Questions Local Patient Survey	91.4%	90.4%			-1.0%		90%	90.4%	
'1-31	VTE Risk Assessment	95.5%	95.8%	95.2%	95.6%	0.4%	0.6%	95%	95.6%	95%
'1-32	% Dementia Screening	98.4%	99.0%	99.0%	98.8%	-0.2%	8.8%	90%	98.8%	
'1-33	% TIA with high risk treated <24hrs (Dec)	64.3%	83.3%	62.0%	75.2%			60%	75.2%	
'1-34	% spending 90% time on Stroke Ward (Dec)	82.1%	76.5%	75.3%	83.1%	7.8%	3.1%	80%	80.1%	
'1-35	Stroke:% to Stroke Unit <4hrs (Dec)	New	31.3%	New	41.3%	New	New	75.0%	75.0%	
'1-36	Stroke: % scanned <1hr of arrival (Dec)	New	31.3%	New	43.6%	New	New	43.0%	43.0%	
'1-37	Stroke:% assessed by Cons <24hrs (Dec)	New	81.3%	New	73.4%	New	New	85.0%	85.0%	

Responsible Committee: Finance, Treasury & Investment

	Finance & Efficiency	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Average LOS Elective	3.3	3.3	3.3	3.2	-0.1	-0.1	*3.3*	3.3	3.3
3-02	Average LOS Non-Elective	6.8	7.4	6.8	6.8	0.0	1.1	*5.7*	6.5	5.7
3-03	New:FU Ratio	1.69	1.65	1.72	1.55	-0.17	0.03	*1.52*	1.52	
3-04	Day Case Rates	82.3%	86.6%	79.6%	83.7%	4.1%	3.7%	80.0%	80.0%	82.19%
	Finance & Efficiency	**Latest Month** *Plan*	**Latest Month** Curr Yr	**Year to Date** *Plan*	**Year to Date** Curr Yr	**YTD Variance** From Prev Yr	**YTD Variance** From Plan	**Year End** Plan	**Year End** Forecast	**Bench Mark**
3-05	Income	31,370	34,584	318,202	330,201	6.4%	3.8%	380,712	398,653	
3-06	EBITDA	2,688	3,462	20,067	28,304	66.8%	41.0%	24,718	34,667	
3-07	Surplus (Deficit) against B/E Duty	(384)	648	(10,667)	(854)			(12,303)	5	
3-08	CIP Savings	2,140	2,435	18,182	19,940	35.9%	9.7%	22,400	23,492	
3-09	Cash Balance	16,918	9,126	16,918	9,126	14.1%	-46.1%	926	926	
3-10	Capital Expenditure	776	1,315	13,131	4,991	-26.0%	-62.0%	*16,683*	13,386	
3-11	**Monitor Continuity of Service Risk Rating**	New	3	2	3	New	1	2	2.5	

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

Delivering or Exceeding Target	
Underachieving Target	
Failing Target	

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

Responsible Committee: Finance, Treasury & Investment

	Performance & Activity	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	**Monitor Indicative Risk Rating**	**1.0**	**1.0**	**1.0**	**1.0**	**Amber/Green**		**Amber/Red**		
2-02	Emergency A&E 4hr Wait (SITREP Wks)	95.0%	83.5%	95.6%	92.6%	-3.0%	-2.4%	95%	93.0%	94.6%
2-03	Emergency A&E >12hr to Admission	0	0	0	1	1	1	0	1	
2-04	***Ambulance Handover Delays >30mins	New	No data	New	No data	New		365	No data	
2-05	***Ambulance Handover Delays >60mins	New	0	New	0	`	0	0	0	
2-06	18 week RTT - admitted patients	91.9%	93.5%	91.7%	91.7%	0.0%	1.7%	90%	90.0%	
2-07	18 week RTT - non admitted patients	96.4%	98.1%	96.5%	96.8%	0.3%	1.8%	95%	95.0%	
2-08	18 week RTT - Incomplete Pathways	94.0%	95.5%	94.0%	95.5%	1.6%	3.5%	92%	92.0%	
2-09	18 week RTT - Specialties not achieved	2	4	26	19	-7	19	*0*	19	
2-10	18 week RTT - 52wk Waiters	0	1	0	1	1	1	*0*	1	
2-11	18 week RTT - Backlog 18wk Waiters	856	568	856	568				250	
2-12	% Diagnostics Tests WTimes <6wks	100.0%	99.86%	100.0%	99.98%	0.0%	1.0%	99.0%	99.98%	
2-13	Cancer WTimes - Indicators achieved	8	7	9	8	-1	-1	9	8	
2-14	*Cancer two week wait	96.7%	95.9%	96.7%	96.1%	-0.6%	3.1%	93%	93.0%	95.5%
2-15	*Cancer two week wait-Breast Symptoms	94.3%	90.3%	94.3%	94.6%	0.3%	1.6%	93%	93.0%	
2-16	*Cancer 31 day wait - First Treatment	99.5%	98.2%	99.5%	98.4%	-1.1%	2.4%	96%	96.0%	98.4%
2-17	*Cancer 62 day wait - First Definitive	85.1%	84.5%	85.1%	83.3%	-1.8%	-1.7%	85%	80.0%	87.1%
2-18	Delayed Transfers of Care	3.4%	3.3%	3.2%	4.0%	0.8%	0.5%	3.5%	4.0%	
2-19	Primary Referrals	8,466	8,226	78,462	85,038	8.4%	9.5%	93,129	101,965	
2-20	Cons to Cons Referrals	3,586	3,058	36,157	33,990	-6.0%	-4.0%	42,433	40,756	
2-21	First OP Activity	12,419	11,711	121,965	120,571	-1.1%	6.4%	135,344	144,571	
2-22	Subsequent OP Activity	21,621	22,400	209,806	217,760	3.8%	4.4%	250,125	261,106	
2-23	Elective IP Activity	640	462	7,442	6,364	-14.5%	-21.4%	9,584	7,631	
2-24	Elective DC Activity	2,954	2,905	28,643	31,071	8.5%	-4.1%	38,602	37,256	
2-25	Non-Elective Activity	4,014	3,787	38,705	39,603	2.3%	4.0%	*45,404*	47,239	
2-26	A&E Attendances (Calendar Mth)	10,108	10,185	104,561	109,909	5.1%	4.8%	*125,139*	131,101	
2-27	Oncology Fractions	5,674	5,816	55,965	58,679	4.8%	3.1%	67,876	69,993	
2-28	No of Births (Mothers Delivered)	448	494	4,502	4,781	6.2%	8.0%	5,310	5,737	
2-29	Midwife to Birth Ratio	New	1:28	New	1:28	New	0.00	1.28	1:28	
2-30	C-Section Rate (elective & non-elective)	25.4%	27.1%	25.5%	27.4%	1.9%	2.4%	25.0%	25.0%	
2-31	% Mothers initiating breastfeeding	82.6%	78.3%	82.1%	81.4%	-0.6%	3.4%	78.0%	81.4%	
2-32	Intra partum stillbirths Rate (%)	0.9%	0.4%	0.5%	0.3%				0.3%	

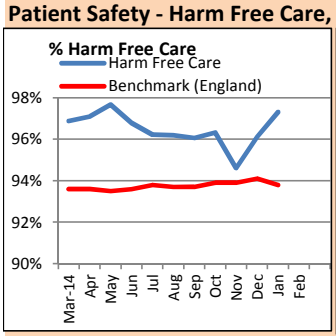
* Rate of C.Difficile per 100,000 Bed days, ** Rate of Pressure Sores per 1,000 admissions (excl Day Case), *** Rate of Complaints per 1,000 Episodes (incl Day Case), **** Rate of Falls per 1,000 Occupied Beddays, ***** Readmissions run one month behind.

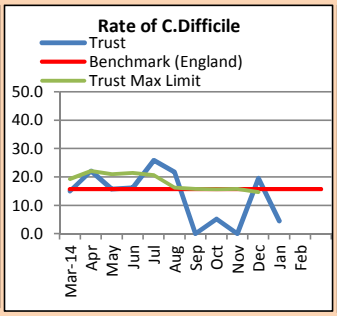
Responsible Committee: Workforce * Stroke & CWT run one mth behind, *** Ambulance Handover is unvalidated

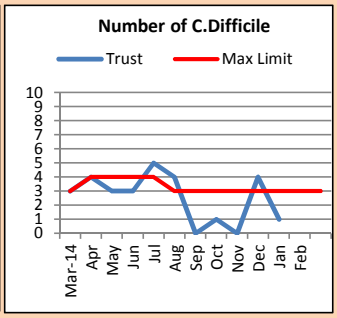
	Workforce	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ Limit	Year End Forecast	Bench Mark
4-01	Establishment (Budget WTE)	5,364.0	5,493.3	5,364.0	5,493.3	2.4%	0.0%	*5,490.5*	5,490.5	
4-02	Contracted WTE	4,933.3	4,941.9	4,933.3	4,941.9	0.2%	-6.2%	*5,271.5*		
4-03	**Contracted not worked WTE		(94.9)		(94.9)					
4-04	Locum Staff (WTE)	14.3	31.7	14.3	31.7	122.2%				
4-05	Bank Staff (WTE)	230.9	274.9	230.9	274.9	19.0%				
4-06	Agency Staff (WTE)	121.3	193.8	121.3	193.8	59.8%				
4-07	Overtime (WTE)	56.4	64.4	56.4	64.4	14.3%				
4-08	Worked Staff WTE	5,253.4	5,401.3	5,253.4	5,401.3	2.8%	-2.6%	*5,536.7*		
4-09	Vacancies WTE	430.7	551.4	430.7	551.4	28.0%			535.0	
4-10	Vacancy %	8.0%	10.0%	8.0%	10.0%	25.0%			9.7%	
4-11	Nurse Agency Spend	(367)	(587)	(3,458)	(4,440)	28.4%			(5,536)	
4-12	Medical Locum & Agency Spend	(556)	(998)	(6,676)	(8,325)	24.7%			(10,208)	
4-13	Staff Turnover Rate	10.3%	9.1%		9.39%	-1.2%	-1.4%	*10.5%*	9.39%	8.4%
4-14	Sickness Absence	3.8%	5.2%		4.1%	1.3%	1.9%	*3.3%*	3.3%	3.7%
4-15	Statutory and Mandatory Training	86.5%	83.6%		83.6%	-2.9%	-1.4%	85.0%	85.0%	
4-16	Appraisals	82.4%	74.3%	76.3%	74.3%	-8.0%	-15.7%	90.0%	90.0%	

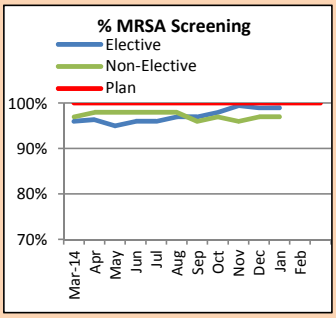
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

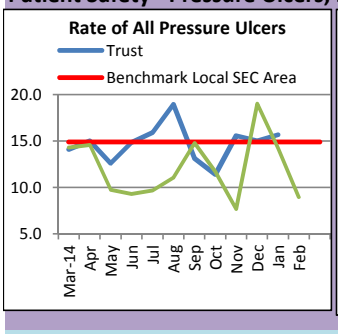


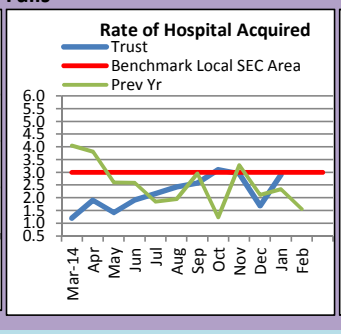


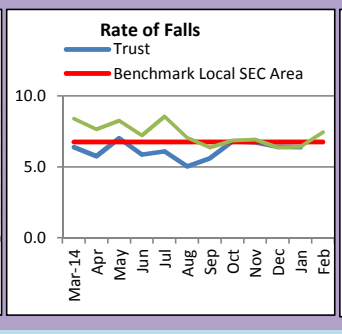


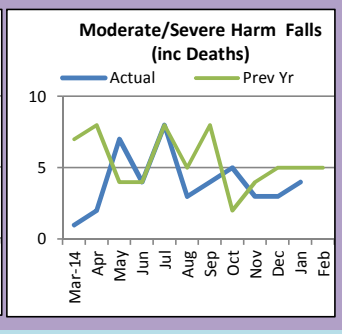


Patient Safety - Pressure Ulcers, Falls

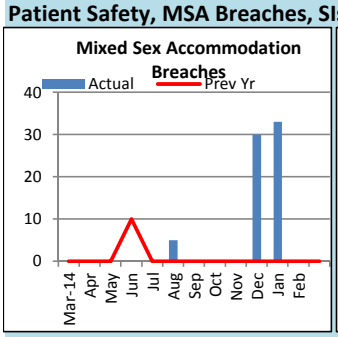


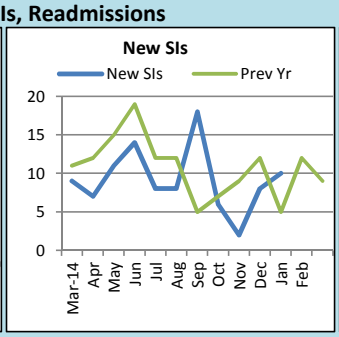


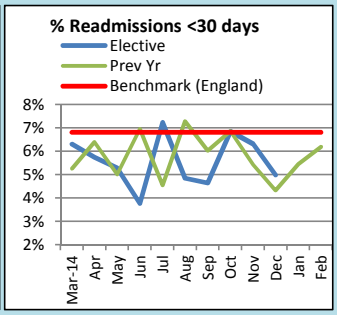


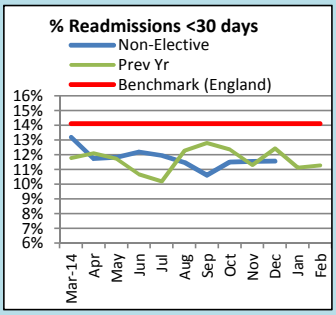


Patient Safety, MSA Breaches, SIs, Readmissions

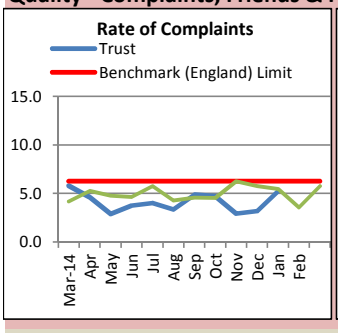


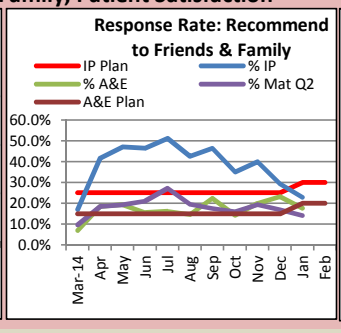


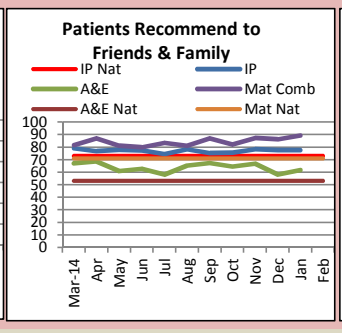


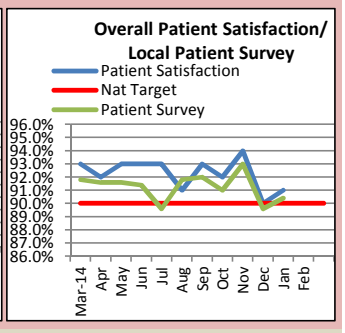


Quality - Complaints, Friends & Family, Patient Satisfaction

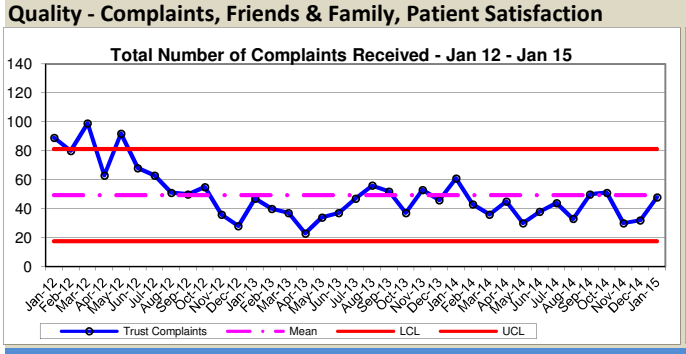


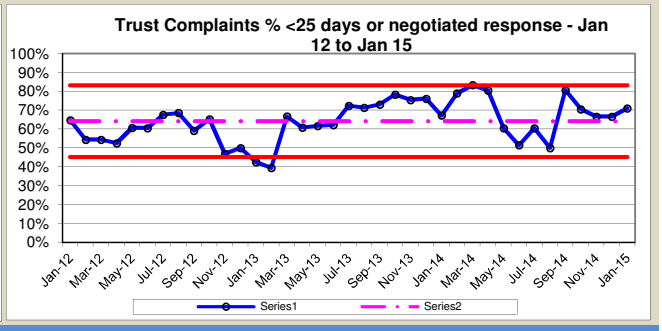




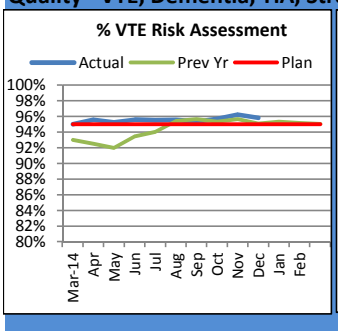


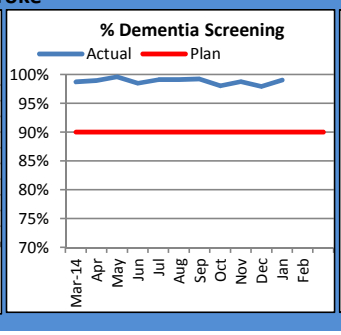
Quality - Complaints, Friends & Family, Patient Satisfaction

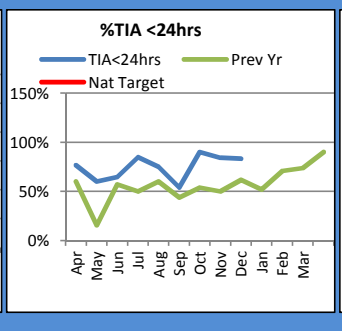


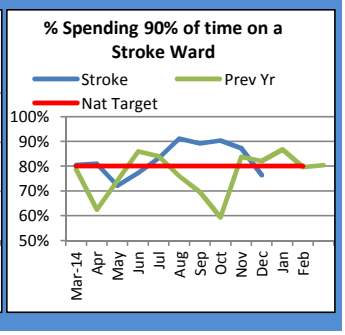


Quality - VTE, Dementia, TIA, Stroke



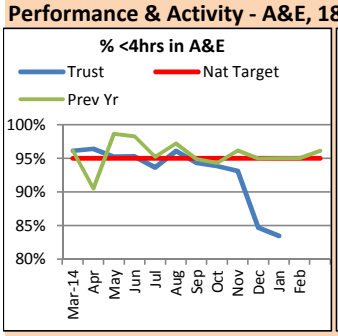


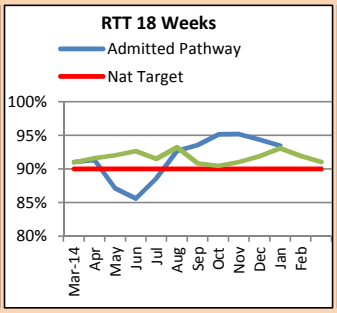


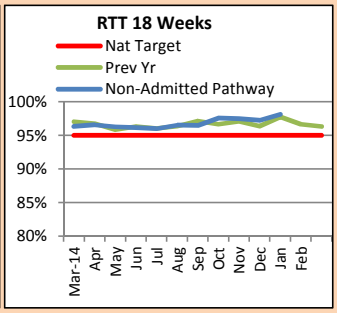


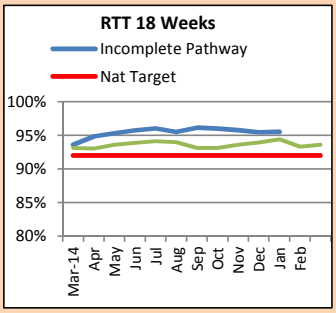
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

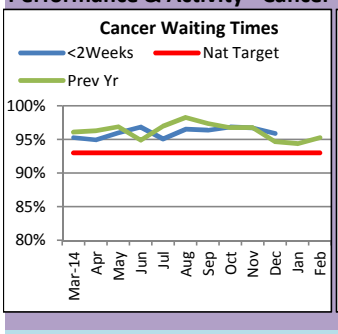


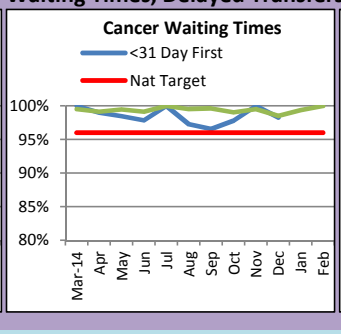


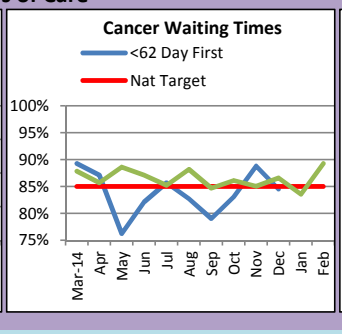


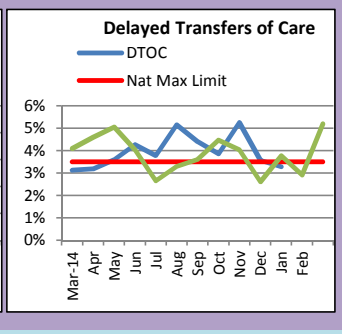


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

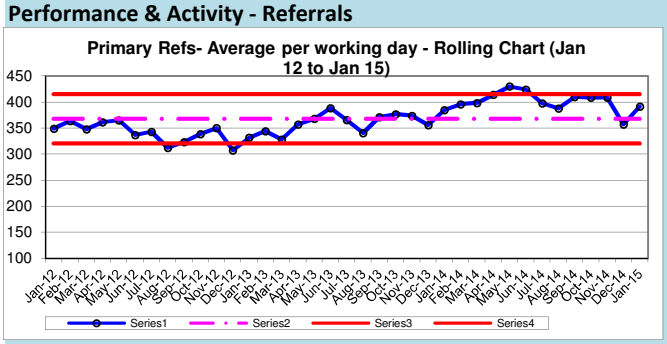


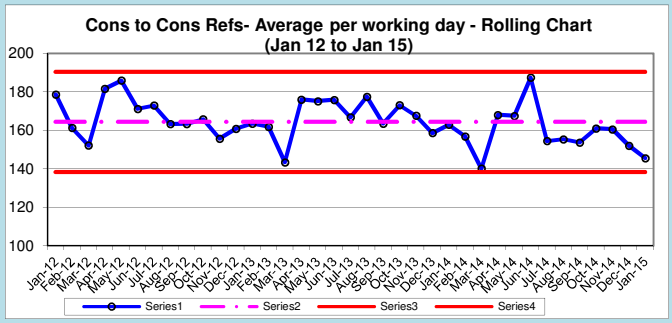




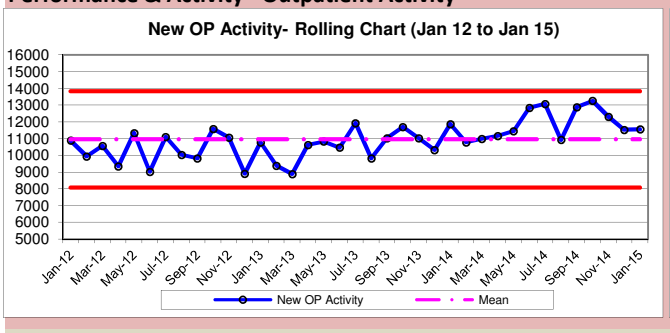


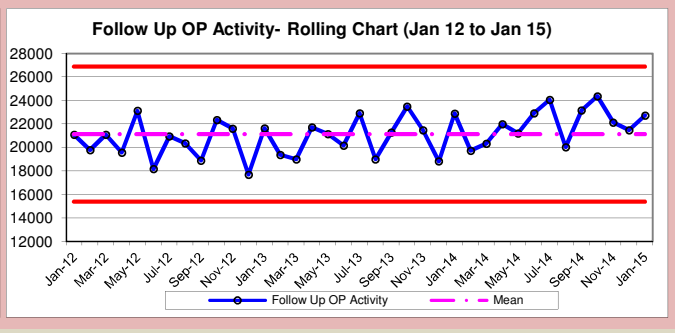
Performance & Activity - Referrals



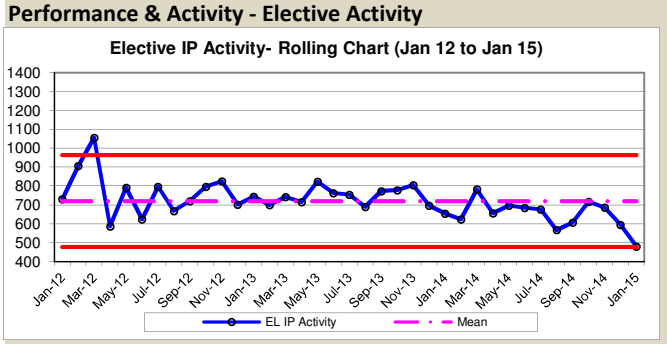


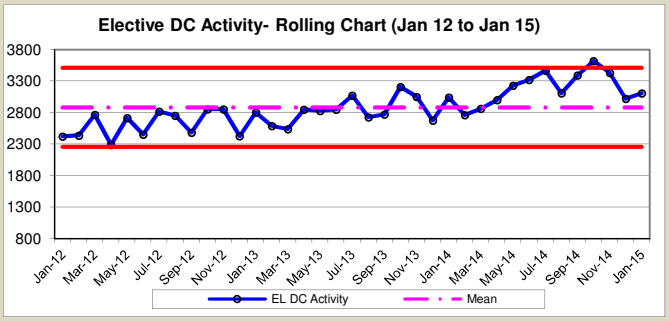
Performance & Activity - Outpatient Activity



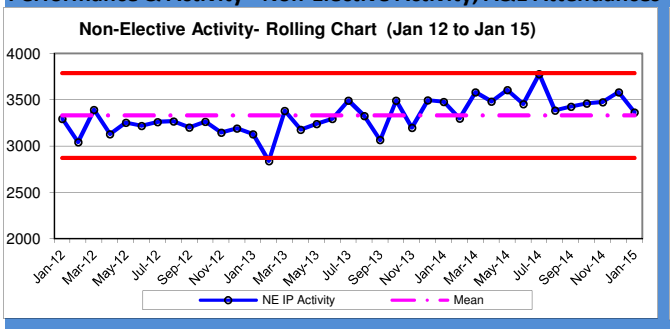


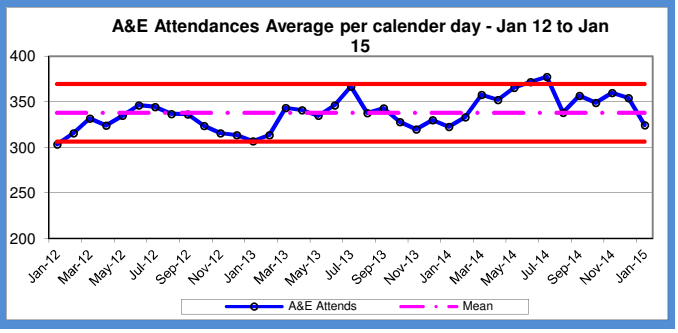
Performance & Activity - Elective Activity





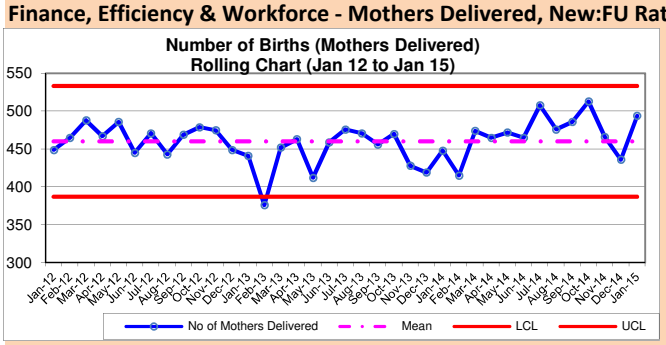
Performance & Activity - Non-Elective Activity, A&E Attendances

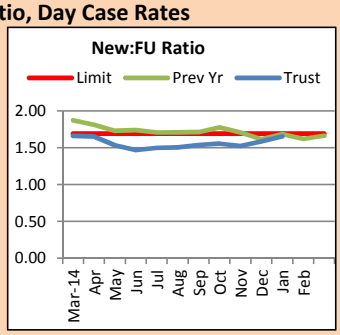


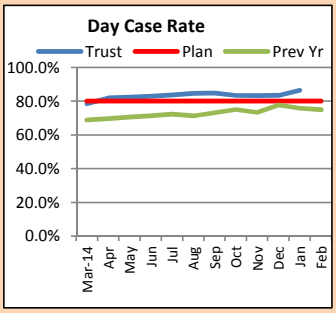


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

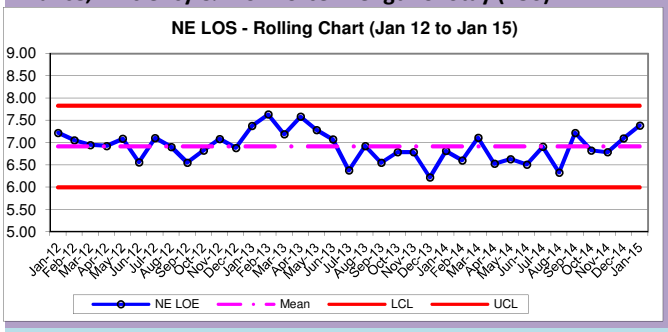
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

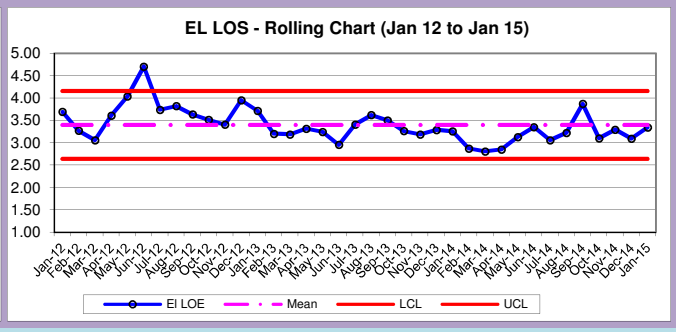




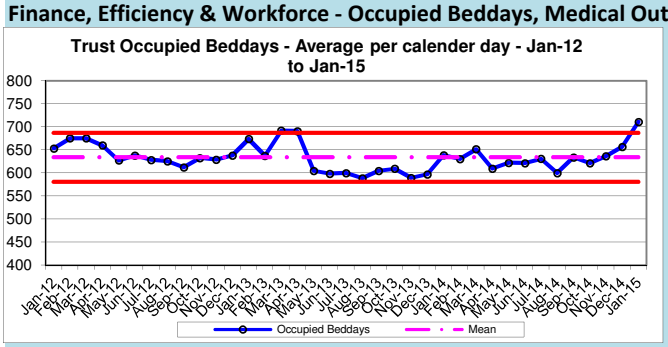


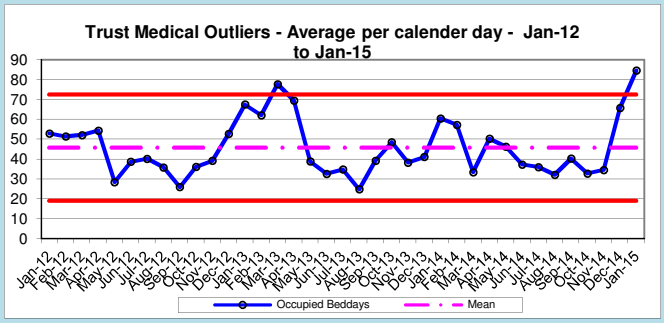
Finance, Efficiency & Workforce - Length of Stay (LOS)



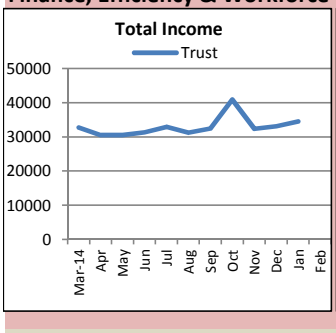


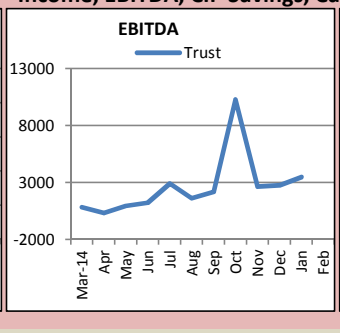
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

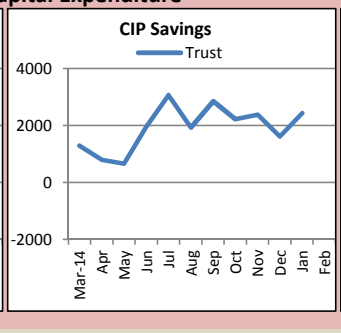


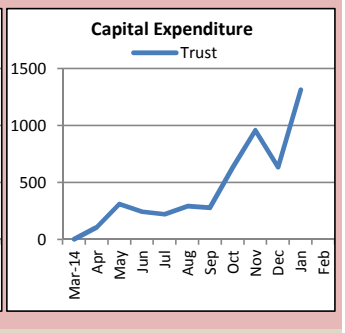


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

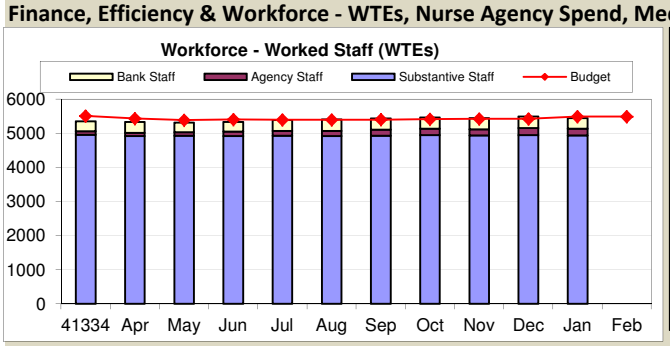


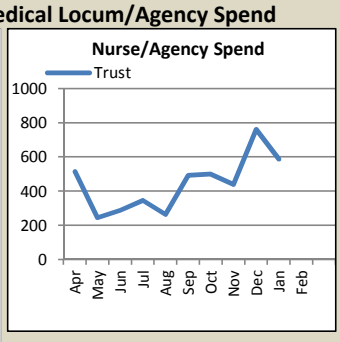


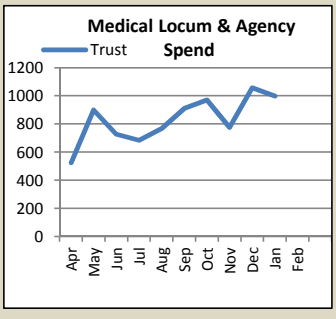




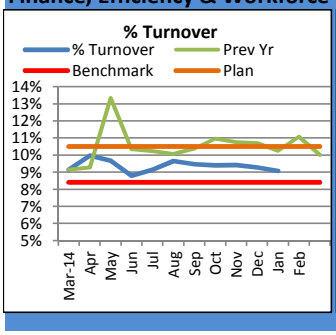
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

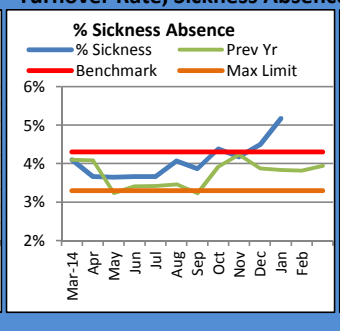


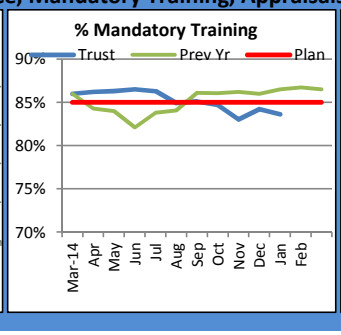


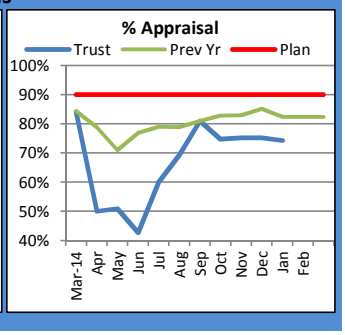


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









M10 Financial Performance overview

1. Overview of the Financial Position at M10 2014/15

1.1. This written summary provides an overview of the financial position at M10 of 2014/15. It should be read alongside the finance pack.

1.2. The Finance pack shows for month 10 an in month surplus of £0.6m against a plan of a (£0.4m) deficit (£1.0m favourable movement) resulting in a year to date deficit of £0.9m against a planned deficit of (£10.7m), a favourable variance of £9.8m.

1.3. The in month favourable movement of £1.0m includes £1m related to inclusion of 1/12th of the £12m non-recurrent deficit support funding as notified by the TDA. The £12m additional income has resulted in a year to date improvement of £10m; being 10/12ths of the £12m. This funding has now been received in full.

1.4. The total year to date total income is £330.2m against a budget of £318.2m; an overperformance of £12.0m, (£3.2m overperformance in the month). The month 10 favourable variance relates to £1.0m being 1/12ths of the £12m deficit support funding as highlighted in 1.3 above, the inclusion of £0.8m additional operational resilience funding and £1.5m SLA overperformance relating to the phasing of the year end agreement secured with West Kent CCG . The main variances on income are outlined below :

- Excluding the £10m deficit support funding, SLA income is overperforming by £1.5m year to date (overperformance of £1.5m in the month), but the outsourcing plan (daycases and elective inpatient) is underperforming £2.1m, therefore the SLA is still overperforming on non-outsourced activity (predominantly outpatient activities) and also the phasing of the year end West Kent CCG agreement (as highlighted in 1.4 above).
- All applicable contractual deductions and penalties have been applied and a provision has been made for challenges.
- Antiveg activity is the main over performance in other activities.
- Private Patient income is underperforming by £1.6m however this is offset by NHS activity performed and by lower than planned expenditure in both pay and non-pay.

1.5. Non elective activity in month 10 was lower than the trend seen in previous months and is now 4.0% higher than the year to date plan (4.7% higher last month). A&E activity reduced against the trend again this month (4.8%) against the trend in previous months (5.8%). The increase in non-elective activity above plan is mostly paid at 30% due to the threshold applied and is now 71% above plan (5% increase in the month, which is much smaller than last month's increase). The threshold has increased above the activity trend as the threshold is calculated on the income related to that activity and not activity itself. The non elective income has increased by 0.7% and is now overperforming by 3.4%. The patients seen in December and January have a higher acuity (hence higher income this month) and are also staying longer. The Trust has therefore had to open additional escalation beds in order to cope with the non elective patients staying longer in the Trust. An analysis of the admissions in the last week of the month that were discharged in the following month has shown a decrease of 59 patients staying in the hospital over the month end. This level is back to that which was seen in November.

1.6. Elective inpatient activity reduced slightly on trend in the month. Elective activity is 21% behind plan (20% last month) however 4.0% (down 0.8% in month) of the underperformance is caused by the outsourcing plan of 445 cases with 120 cases being achieved. Day case activity increased against the trend in previous months and is now 4.1% behind plan (0.2% up in the month). 340 reportable cases were cancelled during the month at short notice (day before or on the day) against 353 cases last month.

1.7. Escalation bed usage remained similar to December levels (100 beds) however the very end of the month saw a reduction of c20 beds. This reflects continuation of non elective patients levels from December. Temporary nursing costs also remained similar to last month's spend.

1.8. Operating costs are £301.9m against a plan of £300.7m, an adverse variance of £1.2m (£1.7m adverse in the month), however there is a net £2.6m of savings and reserves which would reduce the plan to £298.1m if the whole amount was allocated to Operating expenditure.

1.9. Pay was overspent by £0.8m in the month and is now £1.6m overspent year to date. In actual expenditure terms the Trust experienced another month of very high pay costs £20.1m (£0.7m above the trend). The key variances are in Nursing and Medical staff, with significant pressures being felt in premium cost temporary staffing, a large part due to increased escalation bed usage.

1.10. Non pay overspent by £0.9m in month and is now £0.4m underspent year to date (£1.3m last month). However, Purchase of healthcare from non NHS bodies is £2.8m underspent (£0.2m overspent in month) and is offset by underperformance in day case and elective income relating to the original plan for outsourcing activity of £2.1m. Non pay costs in month 10 were slightly higher than the underlying trend (£0.3m). Activity related non pay spends (Drugs, Blood, Clinical Supplies and Purchase of healthcare from non NHS organisations) remained similar to month 9 this month which is in line with the number of calendar and working days each month. Transport costs overspent this month by £0.1m taking the YTD overspend to £0.4m.

1.11. EBITDA is a £28.3m surplus and is now overperforming by £8.2m year to date (£0.8m in month) against the plan. This significant variance is due to the inclusion of the £10m year to date impact of the £12m deficit support funding.

1.12. The financing costs including those related to the PFI and deprecation totalled £30.5m, which is now underspent against the in year plan by £2.1m (£0.3m underspent in month) due to the year to date impact of the revised calculation of PDC based on the forecast statement of financial position as opposed to the original plan and the slippage against the capital plan reducing the depreciation cost against budget.

1.13. The year to date CIP delivery is £19.9m against a target of £18.2m and is forecast to deliver £23.5m (£23.0m last month) against the plan of £22.4m.

1.14. The I&E forecast to the end of the financial year shows the Trust delivering an in year breakeven position against the NHS breakeven duty, after including the £12m deficit support funding. This is against the Trusts planned deficit of £12.3m. The financial position seen in month 9 and 10 has increased the risk to delivering the breakeven

position. The details of the forecast including key assumptions and risks is subject to a separate paper to the Finance Committee this month.

1.15. Cash balances of £9.1m were held at the end of M10. Discussions with NHS organisations over the settlement of 2013/14 outstanding debt are on-going. There is an expectation the Trust will seek resolution of the remaining 2013/14 debt by the end of the financial year. The operational cash forecast has an expectation of receipt of this income circa £4.6m in March.

1.16. 14/15 reconciliation of overperformance activity for quarter 1 is expected to be finalised by the end of February. The operational cash forecast has receipts from WKCCG £1.5m and High Weald, Lewes and Haven CCG £0.5m expected in March. Quarter 2 has been removed from the cash forecast.

1.17. The Trust received £12m non-recurrent deficit support funding in February.

1.18. The operational cash flow is based on the Income and Expenditure forecast therefore as long as both Income and Expenditure remain per forecast cash requirements until the end of the financial year will be planned to be managed through debt collection and creditor management.

1.19. However, due to the uncertainties surrounding the receipt of 13/14 and 14/15 overperformance included within the cash flow, creditors have been managed in line with available cash to manage the potential cash shortfall manage the potential cash shortfall of £6.6m in the event this income is not received in March. An agreement is being discussed with the commissioners on the 2014/15 contracts which includes a cash settlement.

1.20. Total debtors are £60.3m (£53.9m in M9). The two largest debtors (invoiced) at the end of the period are WKCCG owing £18.2m (£17.5m m9) gross and NHS Commissioning who owe £9m (£9.7m m9) gross, primarily relating to invoices subject to year-end reconciliation. Included within the debtors balances are estimated 14/15 overperformance invoices for month's 1-5 activity of £11.7m. NHS over 90 day debt is £34.1m this has increased since Month 1 by £12m (£22.1m), but is expected to reduce significantly when the 13/14 year end position agreement is reached with commissioners, and the 14/15 quarter 1 and 2 reconciliation has been completed.

1.21. Total creditors are £59.8m (£50.9m in M9). The percentage of the value of payments made within 30 days was 87.4% against a target of 95%, this was represented by a performance 89.9% in respect of trade creditors and 71.8% of NHS creditors. From January the Trust has been restricting supplier payments due to the uncertainty around the income expectation within the last quarter.

1.22. Capital expenditure to month 10 was £5m of the revised forecast expenditure £13.3m. This was £10.1m less than the planned expenditure at month 10 of £15.1m based on the £18.8m original plan. The plan continues to be prioritised and aligned to the Trusts strategy.

1.23. The Trust's performance against the TDA Accountability framework is Amber due to the receipt of the £12m deficit support funding.

Key Performance Indicators as at Month 10 2014/15

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

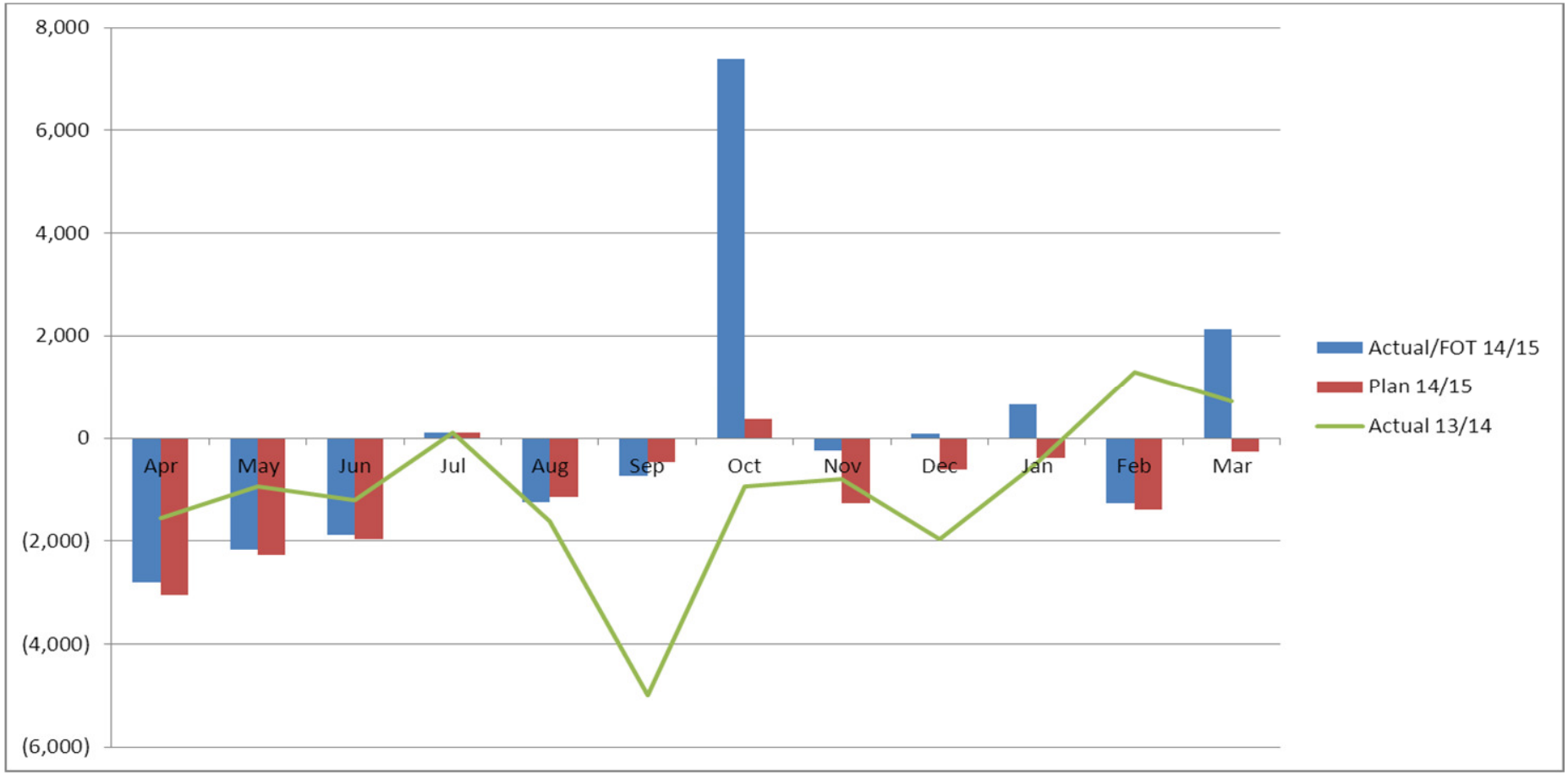
Maidstone and Tunbridge Wells NHS Trust

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)	RAG STATUS: Red	Amber	Green
NHS Financial Performance							
1a) Forecast Outturn, Compared to Plan	(12,301)	5	12,306	GREEN	A deficit position or 20% worse than plan	A position between 5% - 20% worse than plan	Within 5% or better than plan
1b) Year to Date, Actual compared to Plan	(10,667)	(853)	9,814	GREEN	20% worse than plan	A position between 10% - 20% worse than plan	Within 10% or better than plan
Financial Efficiency							
2a) Actual Efficiency recurring/non-recurring compared to plan -				AMBER	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
- Total Efficiencies for Year to Date compared to Plan	17,385	19,940	2,555				
- Recurrent Efficiencies for Year to Date compared to Plan	17,385	14,868	(2,517)				
2b) Actual Efficiency recurring/non-recurring compared to plan - Forecast compared to plan				RED	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
- Total Efficiencies for Forecast Outturn compared to Plan	22,400	23,491	1,091				
- Recurrent Efficiencies for Forecast Outturn compared to Plan	22,400	17,612	(4,788)				
Underlying Revenue Position							
3) Forecast Underlying surplus / (deficit) compared to Plan	(16,254)	(20,739)	(4,485)	RED	20% worse than plan	A position between 10% - 20% worse than plan	Within 10% or exceeding plan
Cash and Capital							
4) Forecast Year End Charge to Capital Resource Limit	13,386	13,386	0	GREEN	either greater than plan or 20% lower than plan	between 10% - 20% lower than plan	Within 10% of plan
5) Permanent PDC accessed for liquidity purposes		0		GREEN	PDC accessed	Not applicable	PDC not accessed
Trust Overall RAG Rating				AMBER	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
(B) Continuity of Service Risk Ratings							
Year to Date Rating	2.50	3.00	0.50	GREEN	If score is 2.5 or lower	Not applicable	Score of over 2.5
Fotecast Outturn Rating	2.00	2.50	0.50	GREEN	If score is 2.5 or lower	Not applicable	Score of over 2.5

I&E Monthly Position Graph as at Month 10 2014/15

Maidstone and Tunbridge Wells NHS Trust

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual/FOT 14/15	(2,805)	(2,163)	(1,882)	111	(1,242)	(734)	7,380	(251)	82	648	(1,269)	2,129
Plan 14/15	(3,053)	(2,261)	(1,962)	103	(1,152)	(466)	375	(1,259)	(608)	(384)	(1,382)	(254)
Actual 13/14	(1,553)	(949)	(1,201)	97	(1,616)	(4,982)	(931)	(796)	(1,968)	(480)	1,290	716



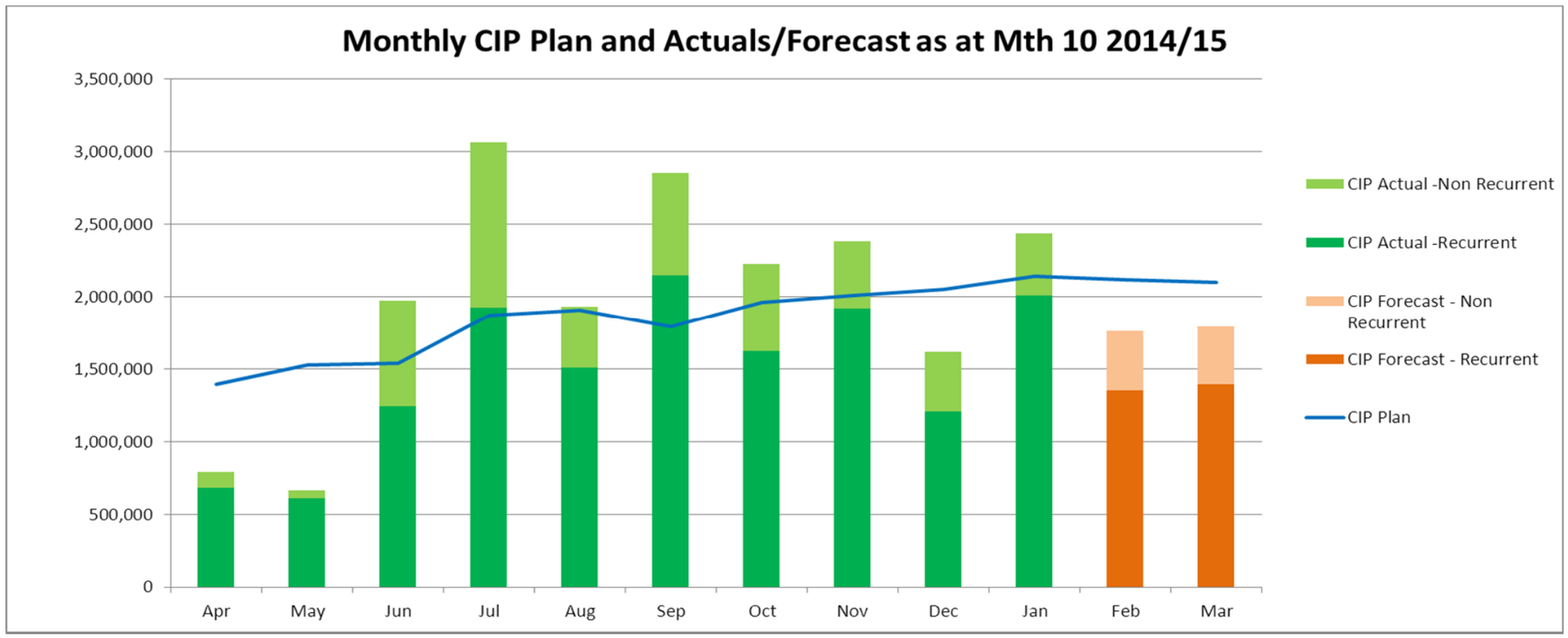
CIP Summary & Graph: as at Month 10 2014/15

Maidstone and Tunbridge Wells NHS

Maidstone and Tunbridge Wells NHS Trust

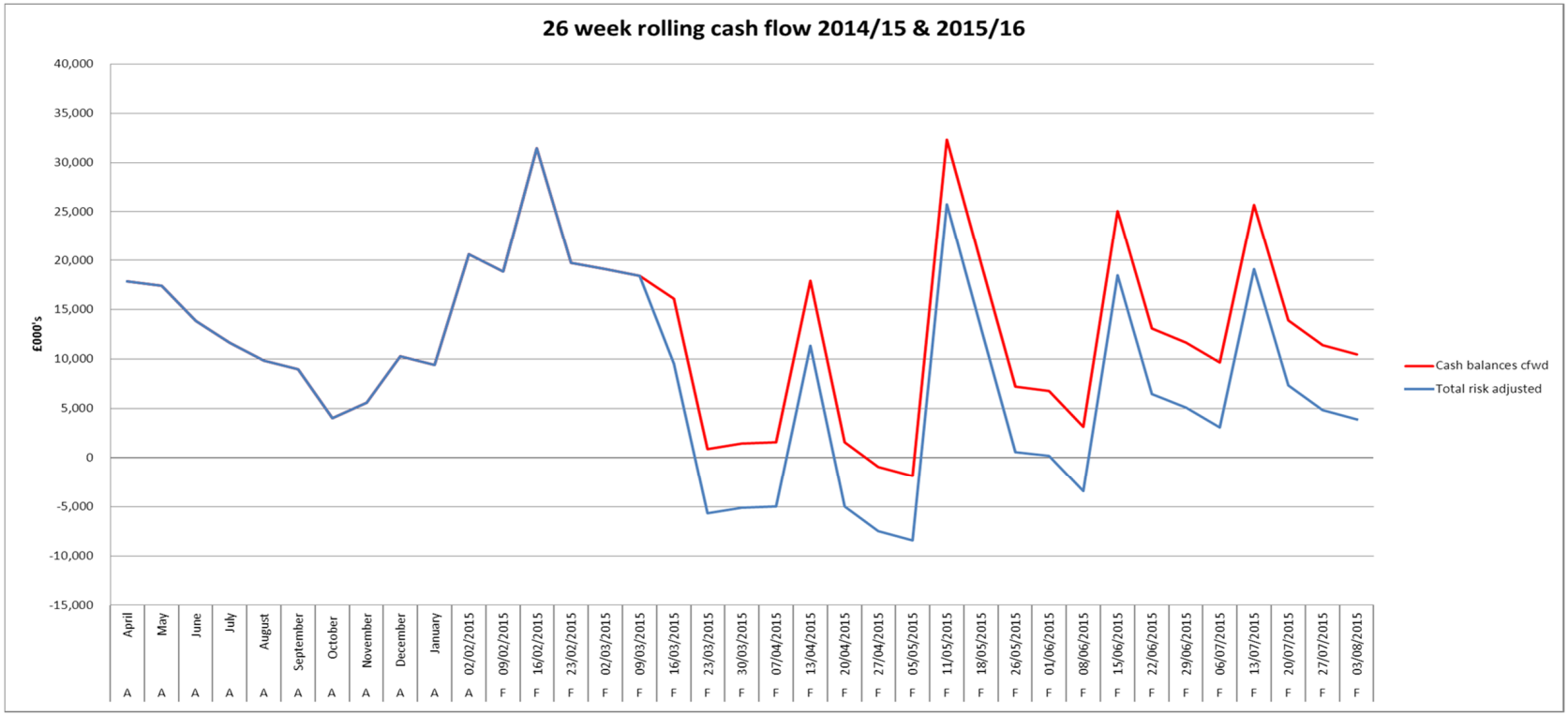
WORKSTREAMS BY DIRECTORATE BUDGET		Year To Date Plan £'000	Year To Date Actual £'000	Year To Date Variance £'000	Forecast Plan £'000	Forecast Actual £'000	Forecast Variance £'000
Back Office	Paul Bentley	3,432	3,048	(383)	4,234	3,678	(556)
Corporate (PPU)	Angela Gallagher	299	142	(158)	385	226	(159)
Surgery	Simon Bailey	1,491	2,294	803	1,804	2,824	1,020
Surgery (Head & Neck)	Simon Bailey	802	1,213	411	979	1,458	479
Emergency & Medical Services	Akbar Sorma	4,611	2,034	(2,577)	5,592	2,469	(3,123)
Diagnostics & Therapies	Sarah Mumford	1,788	1,979	192	2,306	2,232	(75)
T&O	Guy Slater	947	545	(402)	1,160	663	(497)
Women's & Sexual Health	M.Wilcox	1,373	1,034	(339)	1,687	1,062	(625)
Paediatrics	Hamudi Kisat	671	360	(311)	841	379	(462)
Critical Care	Richard Leech	2,238	1,537	(701)	2,690	1,898	(792)
Cancer	Sharon Beesley	1,651	2,093	441	2,068	2,210	142
Corporate Finance		0	3,662	3,662	0	4,394	4,394
Overprogramme		(1,122)	0	1,122	(1,346)	0	1,346
Total By Directorate (includes all workstreams)		**18,182**	**19,940**	**1,758**	**22,400**	**23,491**	**1,091**

Recurrent v Non Recurrent Analysis	YTD £'000	FOT £'000
Recurrent	14,868	17,612
Non Recurrent	5,072	5,879
Total	**19,940**	**23,491**



Maidstone and Tunbridge Wells NHS Trust

26 Week graphical presentation of cash balances up to w/c 3rd August 2015, actuals at 6th February 2015



	A	A	A	A	A	A	A	A	A	A	A	F	F	F	F	F	F	F	F	F
Week commencing	April	May	June	July	August	September	October	November	December	January	02/02/2015	09/02/2015	16/02/2015	23/02/2015	02/03/2015	09/03/2015	16/03/2015	23/03/2015	30/03/2015
Cash balances cfwd	**17,839**	**17,445**	**13,852**	**11,677**	**9,869**	**8,953**	**4,009**	**5,619**	**10,293**	**9,392**	**20,595**	**18,871**	**31,436**	**19,740**	**19,108**	**18,430**	**16,100**	**926**	**1,461**
13/14 o/performance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,584	4,584	4,584
14/15 o/performance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,000	2,000	2,000
External Financing - Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
External Financing - capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total risk adjusted	**17,839**	**17,445**	**13,852**	**11,677**	**9,869**	**8,953**	**4,009**	**5,619**	**10,293**	**9,392**	**20,595**	**18,871**	**31,436**	**19,740**	**19,108**	**18,430**	**9,516**	**-5,658**	**-5,123**

	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	
Week commencing	07/04/2015	13/04/2015	20/04/2015	27/04/2015	05/05/2015	11/05/2015	18/05/2015	26/05/2015	01/06/2015	08/06/2015	15/06/2015	22/06/2015	29/06/2015	06/07/2015	13/07/2015	20/07/2015	27/07/2015	03/08/2015	
Cash balances cfwd	**1,568**	**17,917**	**1,573**	**-925**	**-1,848**	**32,308**	**19,685**	**7,199**	**6,776**	**3,175**	**25,089**	**13,078**	**11,680**	**9,657**	**25,713**	**13,902**	**11,404**	**10,481**	
13/14 o/performance	4,584	4,584	4,584	4,584	4,584	4,584	4,584	4,584	4,584	4,584	4,584	4,584	4,584	4,584	4,584	4,584	4,584	4,584	
14/15 o/performance	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	
External Financing - Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
External Financing - capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total risk adjusted	**-5,016**	**11,333**	**-5,011**	**-7,509**	**-8,432**	**25,724**	**13,101**	**615**	**192**	**-3,409**	**18,505**	**6,494**	**5,096**	**3,073**	**19,129**	**7,318**	**4,820**	**3,897**	

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – February 2015

2-8 Care Quality Commission inspection, October 2014 Chief Executive

The Care Quality Commission (CQC) published the reports of their October 2014 inspection at the Trust on 2nd February 2015. The summary report is enclosed. The separate inspection reports for Maidstone Hospital and Tunbridge Wells Hospital have been issued to all staff, and are available on the Trust's website, at www.mtw.nhs.uk/about-the-trust/cqc-reports.asp.

A Quality Summit was held at the Trust on 29th January to discuss the reports and the actions being taken. A wide range of bodies were represented, including West Kent and High Weald Lewes Havens Clinical Commissioning Groups, Kent County Council, Social Services, Healthwatch Kent, the NHS Trust Development Authority, NHS England and Health Education England.

The CQC's recommendations are welcome, particularly the endorsement of the care we give. Actions to address the areas requiring improvement are underway. A detailed action plan is being developed in conjunction with all levels in the Trust and external stakeholders. An action plan is required to be submitted to the CQC in the near future, and the specific details will be discussed further with the February Part 2 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.) [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 Trust

Quality Report

Tonbridge Road
Pembury
Tunbridge Wells
Kent
TN2 4QJ
Tel: 01892 823535
Website: www.mtw.nhs.uk

Date of inspection visit: To Be Confirmed
Date of publication: 03/02/2015

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Maidstone and Tunbridge Wells NHS Trust is a medium sized acute trust with two main clinical sites and other small community and satellite services. The trust underwent a reconfiguration of services in maternity, gynaecology, paediatrics, trauma and orthopaedics and surgery in 2011. The trust has around 700 beds across two sites and employs around 4,700 staff. The trust is working towards achieving foundation status, however predicts a 12million deficit in 2014/15.

We carried out an announced inspection of Maidstone and Tunbridge Wells NHS Trust between 14 and 16 October 2014. We also undertook two unannounced visits of the trust on 23 and 28 October 2014.

Overall, the trust requires improvement. We rated the trust as good for caring, however we rated the trust as requires improvement for providing safe care, providing effective care, being responsive to people's needs. We rated the trust inadequate for being well-led.

Our key findings were as follows:

Safe:

- The concept of learning from incidents varied from service to service. Whilst some departments had grasped the important role that incident reporting and investigation had in improving patient safety, this ethos was not replicated throughout the trust.
- The anaesthetic department utilised an independent incident reporting tool which fell outside the auspices of the trust's quality and risk strategy; there was a lack of robust oversight of this reporting tool into the overarching trust-wide governance structure.
- The hospitals were found to be visibly clean. Infection rates across the trust were noted to be falling when compared to previous years. There was however, some localised poor performance of hand hygiene practices which had been identified through audit data and the trusts performance for surgical site infection rates for those undergoing total hip replacements was worse than the national benchmark standard.
- Medicines management required improvement in some areas including, but not limited to the provisions for the storage and administration of medicines.
- Medical cover within the Intensive Care unit was not consistent with national core standards; this posed a potential risk to patients. In the lead up to the publication of this report, we have written to the trust's medical director to advise them of our concerns in this area in order that they can start to address the issues we have discussed within this report.
- The application of early warning systems to assist staff in the early recognition of a deteriorating patient was varied. The use of early warning systems was embedded within the medicines directorate, whilst in A&E and the children's and young people's service, its use was inconsistent.
- Nursing levels were generally found to be good, This was not always the case for the children's and young person's service, which had a nursing establishment based on historical activity. Every mother in active labour could expect to receive 1:1 support from a qualified midwife.
- Patient records were not always found to be kept securely, nor were they always well organised or accessible.
- Some junior medical staff were not aware of their statutory duty of candour; this had been recognised as an area of risk by the trust and there was a plan in place to heighten staff awareness.

Effective:

- The use of national clinical guidelines was evident throughout the majority of services. However, there was lack of clinical guidelines within the ICU setting and staff were not routinely using national guidance for the care and treatment of critically ill patients.
- The Specialist Palliative Care Team had introduced an end of life pathway to replace the existing Liverpool Care Pathway.
- The pre-operative management of children and adults was not consistent with national guidance. There were inconsistencies in the advice patients were offered with regards to nil-by-mouth times, with some patients experiencing excessively long fasting periods.

Summary of findings

- Whilst staff were afforded training in understanding the concepts of, and the application of the Mental Capacity Act (MCA), we found that staff were not routinely implementing the MCA policy into their practice.

Caring:

- Staff were caring and compassionate and treated patients with dignity and respect.
- The Accident and Emergency and the maternity service at Maidstone hospital consistently scored better than the national average in the Friends and Family test. Responses to the friends and family test for patients undergoing surgery was varied, however, it was noted that overall, the hospital scored better than the national average.
- Patients considered that they had been given sufficient information and counselling by qualified healthcare professionals to enable them to make informed decisions about their care and treatment.

Responsive:

- Patient flow across the trust was poor. Patients deemed fit to be discharged from intensive care units frequently experienced significant delays in being transferred to a ward and elective surgical patients were cancelled due to a lack of available beds.
- The provision of interpreting services across the trust was poor.
- There were insufficient numbers of single rooms at Maidstone hospital to meet people's needs which impacted on the privacy and dignity of patients, especially for those patients who were on an end of life pathway.
- Capacity issues within the trust led to a high proportion of medical "outliers". The result of this included patients being moved from ward to ward on more than one occasion, alongside late night transfers.
- All medical specialities were meeting national standards for referral-to-treatment times, including all national cancer care waiting time standards. However, some surgical patients were experiencing delays of more than 18 weeks from referral to treatment. The trust had responded to this by introducing additional surgical lists on Saturday mornings.

Well-led:

- High quality care was not assured by the governance processes or the culture in place in some areas of the trust.
- The governance and risk management systems used throughout the trust were unclear, not robust and did not demonstrate consistent and effective management of the risks throughout the organisation.
- The ability of the senior directorate management teams to effectively lead their respective service was varied. Whilst the directorates of medicine, maternity and end of life were rated to be well-led, the same could not be said for the remaining five services.
- The application of clinical governance was varied, with some services lacking any formal, robust oversight.
- The system for identifying, capturing and managing issues and risks at team, directorate and organisation level through risk registers was not consistent or effective. Risk registers were poorly applied in some clinical areas which led to some risks not being escalated to the executive board.
- There were examples where there were isolated specialities who demonstrated values and behaviours which were not aligned to the trusts values and despite this being an ongoing issue, there was not clear action being taken by the trust to address this effectively.
- Some staff did not feel there was an open culture that allowed them to express themselves freely in raising concerns. The CEO was beginning to take steps to ensure all staff felt able to raise concerns in a proactive manner.
- Staff engagement was something that was recognised that required improvement in the trust and the executive team described how they were engaging with staff in relation to the future strategy of the trust to ensure it was 'owned' by staff.
- Innovation was seen to be encouraged in the trust; however there was some confusion among staff about how innovation combined with the cost improvement plan and sustainability of the services in the longer term.

We saw areas of outstanding practice including:

Summary of findings

- The Maidstone Birth Centre had developed, designed and produced the Maidstone birth couch, which was used by women in labour.
- On Mercer Ward, the role of dementia care worker had been created to focus on the needs of people with dementia and their families. An activities room had been designed, furnished and equipped to meet the specific needs of people with dementia, and was widely used. This project was the subject of an article published in the professional nursing literature.
- The breast care service provided very good care from before the initial diagnosis of cancer through to completion of treatment. Good support and holistic care was provided to patients requiring breast surgery.
- On Ward 20 there was a focus on dementia care. Staff had bid and won funds from the Dementia Challenge fund to create a Dementia Café for use by people living with dementia, their friends and families. This area was designed using current guidance to be dementia friendly and was equipped to meet the special needs of people living with dementia.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust **must**:

Tunbridge Wells Hospital

- Ensure that care and treatment provided to service users has due regard to their cultural and linguistic background and any disability they may have.
- Ensure that people who use the service are protected against the risks associated with unsafe or unsuitable premises.
- Improve the environment in the Intensive Care Unit with regards to toilet/shower facilities for patients.
- Have adequate Consultant cover at weekends for ICU
- Ensure patients are not delayed more than 4 hours once a decision has been made to admit them to the intensive care unit (ICU).
- Ensure discharge from the ICU takes place within 4 hours of decision.
- Ensure that where possible, patients are not discharged from the ICU during the night.
- Ensure outreach service meets current guidelines. (NCEPOD, 2011)
- Ensure that level 3 intensive care patients are observed in line with their needs.
- Make arrangements to ensure that contracted security staff have appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs.
- Make suitable arrangements to ensure the dignity and privacy of patients accommodated in the Clinical Decisions Unit.
- Ensure that service users are 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.
- Ensure that staff and patients have access to a competent and independent translator when necessary.
- Review the process for incident reporting to ensure that staff are aware of and act in accordance with the trust quality and risk policy.
- Review the clinical governance strategy within children's services to ensure there is engagement and involvement with the surgical directorate.
- Review the arrangement for the management and administration of topical anaesthetics
- Review the children's directorate risk register to ensure that risks are recorded and resolved in a timely manner.
- Review the current PEWS system to ensure that it has been appropriately validated, is supported by a robust escalation protocol and is fit for purpose. Its use must be standardised across the children's directorate (excluding neonates).

Maidstone Hospital

- Make arrangements to make sure contracted security staff have appropriate knowledge and skills to work safely with vulnerable patients with a range of physical and mental ill health needs.
- Ensure that intensivist consultant cover at weekends is adequate.
- Ensure that sufficient numbers of ward rounds take place in the intensive care unit (ICU) to ensure the department complies with national standards.
- Ensure that once a decision to admit a patient to the ICU is taken, the patient is admitted within four hours.

Summary of findings

- Ensure that patients are discharged from the ICU within four hours of a decision being made.
- Ensure that discharges from the ICU to other wards do not take place at night.
- Ensure that the governance structure within the ICU supports a framework to ensure clinical improvements using a multidisciplinary approach.
- Review the existing management arrangements for the Riverbank Unit to ensure that the unit operates effectively and efficiently.
- Take action to ensure that medical and nursing records are accurate, complete and fit for purpose.
- Ensure that staff and patients have access to a competent and independent translator when necessary.
- Ensure that the water supply is tested for pathogens and that appropriate systems are in place for monitoring water quality and water safety.
- Take action to ensure that all patient clinic letters are sent out in a timely manner.

In addition the trust **should**:

Tunbridge Wells Hospital

- Consider collating performance information on individual consultants. Where exceptions are identified these should be investigated and recorded.
- Provide written information in a format that is accessible to people with learning difficulties or learning disabilities.
- Ensure the protocol for monitoring patients at risk is embedded and used effectively to make sure patients are escalated in a timely manner if their condition deteriorates.
- Ensure that all medical staff in the ED have completed training in safeguarding children at the level appropriate to their grade.
- Make appropriate arrangements for recording and storing patients' own medicines in the CDU to minimise the risk of medicine misuse.
- Respond to the outcome of their own audits and CEM audits to improve outcomes for patients using the service.
- Review the arrangements for meeting the needs of patients presenting with mental ill health so they are seen in a timely manner.
- Review the management of patient flow in the ED to improve the number of patients who are treated and admitted or discharged within timescales which meet national targets
- Review the systems in place in the ED for developing, implementing and reviewing plans on quality, risk and improvement.
- Review the way complaints are managed in the ED to improve the response time for closing complaints.
- Ensure there is strategic oversight and plan for driving improvement.
- Review the quality of root cause analysis investigations and action plans following a serious incident or complaint and improve systems for the dissemination of learning from incidents and complaints.
- On the Medical Assessment unit the trust should ensure that point of care blood glucose monitoring equipment is checked. It should also consider how this checking should be managed to be integrated as part of an overall policy that forms part of a pathology quality assurance system.
- Develop systems to ensure the competence of medical staff is assessed for key procedures.
- Develop systems to ensure that medicines are stored at temperatures that keep them in optimal condition.
- Ensure that patients' clinical records are stored securely in ward areas.
- Review the ways in which staff can refer to current clinical guidance to ensure that it is easily accessible and from a reputable source.
- Review current nil-by-mouth guidance to ensure that it is consistent with national standards; patient information leaflets should be standardised and reflect national guidance.
- Review the process for the management of patients presenting with febrile neutropenia to ensure they are managed in a timely and effective manner.
- Standardise the post-operative management and guidance of children undergoing urology surgery
- Review the process for the hand-over of pre-operative children to ensure they have support from a health care professional with whom the child and family are familiar with.
- Ensure that all staff introduce themselves and wear name badges at appropriate times.
- Review the location of the vending machine currently located between Hedgehog ward and the Woodlands Unit.

Summary of findings

- Review the managerial oversight of staff working in children's outpatients.
- Review the current clinic provision to ensure that women who have recently miscarried or who are under review for ante-natal complications are seen in a separate area to children who are also awaiting their appointment
- Review the facilities and admission process for elective surgical patients.
- Monitor the transfers between sites, for both clinical and non-clinical reasons. The monitoring process should include the age of the patients transferring and the time they arrived after transfer
- Have clarity about the definition of what constitutes an SI or Never Event in relation to the retained swabs.
- Ensure policies that have not been reviewed and impact on current evidenced-based knowledge/care are updated.
- Address staffing levels and recruitment On the gynaecology ward/unit
- Ensure appropriate reporting and recording of incidents on the trust system on the gynaecology ward.
- Implement actions for the findings of the gynaecology ward audit undertaken in June 2014.
- Improve management of non-gynaecology outliers placed on the ward, including review by consultants, ward rounds and patient discharges.

Maidstone Hospital

- Arrange for the safe storage of medicines so that unauthorised access is restricted.
- Make sure that all medical staff in the A&E department have completed training in safeguarding children at the level appropriate to their grade and job role.
- Make sure that a sufficient number of consultants are in post to provide the necessary cover for the ED.
- Ensure that up-to-date clinical guidelines are available in the ED
- Review the arrangements for meeting the needs of patients presenting with mental health conditions, so they are seen in a timely manner.
- Review the way complaints are managed in the ED to improve the response time for closing complaints.
- Review the governance arrangements for nursing staff in the ED to ensure effective leadership and devolution of responsibilities.
- Review the current provisions of the ICU outreach service, to ensure that the service operates both day and night, in line with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations.
- Ensure that medical care services comply with its infection prevention and control policies.
- Develop robust arrangements to ensure that agency staff have the necessary competency before administering intravenous medicines in medical care services.
- Develop systems within the directorate of speciality and elderly medicine to ensure that the competence of medical staff for key procedures is assessed.
- Ensure that systems are in place to ensure that the system of digital locks used to secure medicines storage keys can be accessed only by authorised people.
- Develop systems to ensure that medicines are stored at temperatures that are in line with manufacturers' recommendations.
- Ensure within medical care services that patients' clinical records used in ward areas are stored securely.
- Ensure that the directorate of speciality and elderly medicine further monitors and embeds a robust system of medical handover that ensures patients' safe care and treatment.
- Review the ways in which staff working in medical care services can access current clinical guidance to ensure it is easily accessible for them to refer to.
- Review the way in which in medical care services it authorises and manages urgent applications under the Deprivation of Liberty Safeguards.
- Ensure that patients have access to appropriate interpreting services when required.
- Ensure that the directorate of speciality and elderly medicine reviews its capacity in medical care services to ensure capacity is sufficient to meet demand, including the provision of single rooms.
- Consider reviewing the processes for the capturing information to help the service better understand and measure its overall clinical effectiveness.
- Consider reviewing the current arrangements for the providing elective day case surgical services to ensure parity of services across the hospital campus.

Summary of findings

- Ensure that the provider reviews the quality of root cause analysis investigations and action plans following a serious incident or complaint and improves systems for disseminating learning from incidents and complaints.
- Ensure that the provider monitors transfers between sites for both clinical and non-clinical reasons. The monitoring process should include the age of the patients transferred and the time they arrived after transfer.
- Consider collating performance information on individual consultants. Where exceptions are identified, these should be investigated and recorded.
- Provide written information in a format that is accessible to people with learning difficulties.
- Reduce delays for clinics and reduce patient waiting times.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust is a medium sized acute trust with two main clinical sites and other small community and satellite services. The trust underwent a reconfiguration of services in maternity, gynaecology, paediatrics, trauma and orthopaedics and surgery in 2011. The trust has around 700 beds across two sites and employs around 4,700 staff. The trust is working towards achieving Foundation Status, however predicts a 12million deficit in 2014/15.

Maidstone and Tunbridge Wells NHS Trust is in the boroughs of Maidstone and Tunbridge Wells, and serves the population living in south west Kent. The population is mainly white (97.3%), and the highest ethnic minority is Asian, making up 1.1% of the local population. Maidstone ranks 117th out of 326 local authorities for deprivation. (The local authority that ranks first is the most deprived and the one ranked 326th is the least deprived.) Life expectancy for both men and women is slightly higher (better) than the England average.

Our inspection team

Our inspection team was led by:

Chair: Professor Edward Baker, Deputy Chief Inspector (CQC)

Head of Hospital Inspections: Heidi Smoult, Care Quality Commission (CQC)

The team of 41 included CQC inspectors and analysts and a variety of specialists: consultants in emergency medicine, medical services, gynaecology and obstetrics, palliative care medicine; consultant surgeon, anaesthetist, physician and junior doctor; midwife; surgical, medical, paediatric, board level, critical care and palliative care nurses' a student nurse; and experts by experience.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always inspects the following core services at each inspection:

- Urgent & emergency services (A&E)
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity & gynaecology
- Services for children and young People
- End of life care
- Outpatients & diagnostic imaging

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group; NHS Trust Development Authority; Health Education England; General Medical Council; Nursing and Midwifery Council; Royal College of Nursing; NHS Litigation Authority and the local Healthwatch.

We carried out an announced visit between 14 and 16 October 2014 and unannounced visits on 23 and 28 October 2014. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients.

Summary of findings

We held focus groups with a range of staff in the hospital including doctors, nurses, allied health professionals, administration staff and pharmacists. We also interviewed senior members of staff at the hospital.

The CQC inspection model focuses on putting the service user at the heart of our work. We held a listening event in Tunbridge Wells on 9 October 2014, when people shared their views and experiences of Maidstone and Tunbridge Wells NHS Trust.

What people who use the trust's services say

Adult Inpatient Survey

In the Adult Inpatient Survey in 2013 Maidstone and Tunbridge Wells NHS Trust performance across all areas of care measured were average in comparison with other trusts.

Patient-led assessments of the Care Environment (PLACE)

The PLACE scores for the trust were better than national average in two areas and worse in two areas. The scores for Maidstone and Tunbridge Wells NHS Trust included:

- Cleanliness score of 99 against a national average of 98
- Facilities score of 93 against a national average of 92
- Food score of 75 against a national average of 90
- Privacy, dignity and well-being score of 78 against a national average of 87

Friends and Family Test

Friends and Family Test results showed the average scores for all scores including inpatients, A&E and Maternity were better than the national figure for 2012/13. In addition, the response rate for inpatient and A&E was better than the national percentage. Specific figures for each were:

A&E

- Response rate was better than the England average 22.6% (England average 20.2%)
- The average score was 60, higher than England average of 53.

In patient

- Response rate was better than the England average 50.7% (England average 38%)
- The average score was 77, slightly higher than England average of 73.

Maternity

- On average across the four areas measured the trust scores for people who would recommend the service were higher than the England average.
- The average score for maternity (antenatal) was 71, which was better than the England average of 62. The average score for maternity (birth) was 91, which was better than the England average of 77.
- The average score for maternity (postnatal) was 85, which was better than the England average of 65.

Cancer Inpatient Survey

The Cancer Patient Experience Survey (CPES), Department of Health, 2012/13, showed that the trust as a whole had a 90% rating for 'Patient`s rating of care `excellent`/ `very good. This was higher than the threshold for the lowest 20% of trusts (86%) but lower than the threshold for the highest 20% of trusts (92%).

The trust performed below average in eight questions, average in 24 questions and above average in two questions; Possible side effects explained in an understandable way and their GP given enough information about patient`s condition and treatment

Facts and data about this trust

Context

- Around 700 beds across two sites
  - 416 beds at Tunbridge Wells Hospital
  - 284 beds at Maidstone (excluding Midwifery Led Unit)
- Serves a population of around 500,000

Summary of findings

- Employs around 4,700 whole time equivalent (WTE) members of staff

Activity

- Around 400,000 outpatient attendances per annum across two locations
- Around 126,000 urgent and emergency care attendances per annum

Key Intelligence Indicators

Safety

- Two never events in last 12 months (one in surgery, one in radiology)
- STEIS: 118 Serious Untoward Incidents (April 2013 - March 2014)
- Elevated risk for the percentage of CAS alerts with closing dates during the preceding 12 months which the trust has closed late
- C-difficile: 35 overall - target of 42
- MRSA: 3 overall - target of 0

Effective

- Hospital Standardised Mortality Ratio (HSMR) indicator – No evidence of risk
- Summary Hospital-level Mortality Indicator (**SHMI**) - No evidence of risk

Caring

- NHS Friends and Family Test (July 2014) – average score for urgent and emergency care was 60, which was better than the national average of 53. The response rate was 22.6%, which was better than the national average of 20.2%.
- The average score for inpatients was 77 which was better than the national average of 73. The response rate was 50.7%, which was better than the national average of 38%.
- The average score for maternity (antenatal) was 71, which was better than the England average of 62. The average score for maternity (birth) was 91, which was better than the England average of 77. The average score for maternity (postnatal) was 85, which was better than the England average of 65.
- Cancer Patient Experience Survey – the trust as a whole had a 90% rating for 'Patient`s rating of care `excellent` or `very good. This was higher than the threshold for the lowest 20% of trusts (86%) but lower than the threshold for the highest 20% of trusts (92%).
- CQC Adult Inpatient Survey – no risks were identified in the trust as a whole in the nine questions asked.

Responsive

- A&E, four-hour target – met the 95% target in the previous 12 months
- Referral to treatment times – met the admitted and non-admitted pathways target times
- Cancer: two-week wait – met the national target
- Cancer: 31-day wait – met the national target
- Cancer: 62-day wait – met the national target

Well-led

NHS Staff Survey

- Staff survey 2013 (trust as a whole): 3.73. Slightly worse than the England average of 3.74.
- The results of the 2013 NHS Staff Survey demonstrated that Maidstone and Tunbridge Wells NHS Trust performance showed that the majority of scores were as expected in line with the national average over the 28 key areas covered in the survey, which included:
- as expected in 24 key areas
- better than average in 2 key areas
- worse than average in 2 key areas

The response rate for the staff survey was higher than the national average with a response rate of 55% compared to 49% national average.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall we rated the safety of services in the trust as requires improvement. For specific information relating to each hospital location, please refer to the reports for Tunbridge Wells Hospital and Maidstone Hospital. The majority of staff demonstrated a good incident reporting culture, however some staff groups had low rates of incident reporting, such as doctors; and the trust had not undertaken any work to improve incident reporting by these staff groups. In addition, some clinical areas were not clear on the incident reporting process. Whilst there were some areas that were able to demonstrate learning from incidents being embedded as part of improving patient safety, this was not consistent across the trust. The concept of learning from incidents varied from service to service. The critical care department utilised a separate incident reporting tool which did not follow the standardised process in accordance with the trust's quality and risk strategy. Whilst this was considered to be a pilot by staff there was a lack of robust oversight of this reporting tool into the overall governance processes, which consequently impacted on the trusts ability to aggregate and review incidents trust-wide. The majority of staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns. However, compliance with Statutory and Mandatory training in all levels of Safeguarding training was not meeting the trust target. Medical staffing within the Intensive Care unit was not consistent with national core standards; this posed a potential risk to patients. There were vacancies in the nursing workforce and the trust were taking steps to recruit from overseas. As a result of the level of vacancies in the nursing workforce there was a significant reliance on bank and agency staff. Staffing levels were displayed on each ward and staff reported that they did were able to staff the wards according to the required ratios and in some cases above the required ratios. Medicines management required improvement in some areas including, but not limited to the storage and administration of medicines.	**Requires improvement** 

Summary of findings

Some junior medical staff were not aware of the statutory duty of candour; this had been recognised as an area of risk by the trust and there was a plan in place to heighten staff awareness.

We identified that the trust had failed to adhere to national standards and guidance regarding water safety; specifically this related to lapses in the trusts governance of legionella testing at Maidstone Hospital. We raised this with the trust during the inspection and the necessary testing was scheduled to be undertaken.

The application of early warning systems to assist staff in the early recognition of a deteriorating patient was varied. The use of early warning systems was embedded within the medicines directorate, whilst in A&E, its use was inconsistent.

Are services at this trust effective?

Requires improvement

Overall, we rated the effectiveness of the services in the trust as requires improvement. For specific information relating to each hospital location, please refer to the reports for Tunbridge Wells Hospital and Maidstone Hospital.

The use of national clinical guidelines was found to be embedded throughout the majority of clinical services in care pathways, policies and procedures. The Specialist Palliative Care Team had introduced an end of life pathway to replace the Liverpool Care Pathway. However, there was lack of clinical guidelines within the ICU setting and staff were not routinely using national guidance for the care and treatment of critically ill patients.

The A&E department generally performed poorly with regards to the management of patients presenting to the department in severe pain with fractured neck of femur injuries. Post-operative patients reported that their pain was well managed on the wards.

The pre-operative management of children and adults was not consistent with national guidance. There were inconsistencies in the advice patients were offered with regards to nil-by-mouth times, with some patients experiencing excessively long fasting periods.

Whilst staff were given training in understanding the concepts of, and the application of the Mental Capacity Act (MCA), we found that staff were not routinely implementing the MCA policy into their practice.

Multidisciplinary team working across the trust was varied with some areas such as medicine that demonstrated good multidisciplinary team working, but other areas not demonstrating

Summary of findings

it was embedded into practice. In addition, in some areas there were good examples of audit informing practice and subsequent learning but other areas where audit proactively carried out or used to improve practice.

Are services at this trust caring?

Good

Overall, we rated the caring aspects of services in the trust as good. For specific information relating to each hospital location, please refer to the reports for Tunbridge Wells Hospital and Maidstone Hospital.

We observed staff to be caring and compassionate and treated patients with dignity and respect during our inspection. Patients and relatives told us that they were treated with dignity and respect, considering their individual needs.

The Friends and Family test scores were better than national average overall in Accident and Emergency, Inpatients services and Maternity services. The response rates were also higher than the national average. An exception was the responses to the friends and family test for patients undergoing surgery which was varied, however, it was noted that overall, they scored better than the national average.

Patients considered that they had been given sufficient information and counselling by qualified healthcare professionals to enable them to make informed decisions about their care and treatment.

Are services at this trust responsive?

Requires improvement

Overall we rated the responsiveness of services in the trust as requires improvement. For specific information relating to each hospital location, please refer to the reports for Tunbridge Wells Hospital and Maidstone Hospital.

Patient flow across the hospital was poor with lack of alignment between departments. Patients deemed fit to be discharged from intensive care units frequently experienced significant delays in being transferred to a ward and elective surgical patients were cancelled due to a lack of available beds.

The accident and emergency department consistently met the national target of ensuring that patients were admitted, transferred or discharged within four hours at Maidstone Hospital although this was not the case at Tunbridge Wells hospital. Patients could expect to experience delays of 60 minutes or more before receiving treatment within the A&E.

The provision of interpreting services across the hospital was inconsistent and poor. There was an insufficient number of single

Summary of findings

rooms at Maidstone hospital to meet people's needs. This shortage of single rooms impacted on the privacy and dignity of patients, especially for those patients who were on an end of life pathway. Conversely, at Tunbridge Wells the provision was mainly single room configuration.

Capacity issues within the trust led to a high proportion of medical "outliers" in surgical wards. The result of this included patients being moved from ward to ward on more than one occasion, alongside late night transfers.

All medical specialities were meeting national standards for referral-to-treatment times, including all national cancer care waiting time standards. However, some surgical patients were experiencing delays of more than 18 weeks from referral to treatment. The trust had responded to this by introducing additional surgical lists on Saturday mornings.

The trust did not have sufficient provision to meet the needs of patients with learning disabilities to meet their individual needs.

Whilst there had been a significant amount of work undertaken to improve the process of responding to complaints in a timely manner, learning from complaints and concerns was not embedded in the trust.

Are services at this trust well-led?

Inadequate

The trust's overall leadership was rated as inadequate. For specific information relating to each hospital location, please refer to the reports for Tunbridge Wells Hospital and Maidstone Hospital.

High quality care was not assured by the governance processes or the culture in place in some areas of the trust. In addition, the leadership at directorate and service varied, with some areas providing good leadership and other areas requiring significant improvements in the leadership.

The governance and risk management systems used throughout the trust were unclear, not robust and did not demonstrate consistent and effective management of the risks throughout the organisation. The trust wide committees were complicated and not always clearly understood by staff. The responsibilities and remit of each sub-committee of the board was not always clear, however the trust recognised this and were taking steps to review the committee structure throughout the trust. There was limited evidence of constructive challenge and holding to account at an executive level. Whilst the executive team recognised this and had taken steps to improve this following the financial challenges not being recognised

Summary of findings

in a proactive and timely manner. The system for identifying, capturing and managing issues and risks at team, directorate and organisation level through risk registers was not consistent or effective.

There remained examples where there were isolated specialities who demonstrated values and behaviours which were not aligned to the trusts values; whilst the executive team were aware of these issues, they had not been fully addressed.

The overall strategy for the trust was described to have been in a period of consolidation following the reconfiguration of services in 2011 and the overall trust strategy was being reviewed at the time of the inspection and therefore staff were unclear what the strategy was for the trust longer term. The trust values “pride” were known by the majority of staff; however some staff did not feel all the values were embedded throughout the trust in terms of values and behaviours. The trust overall vision was “to be a successful, integrated healthcare provider in the top 20% of trust nationally for the quality of services which we deliver”; however staff throughout the trust were not always able to describe the trust vision.

The executive team were all permanent and ranged from the CEO in post since 2007 to the Director of Finance joining the trust in 2014. Whilst staff described there was some visibility of the executive team, particularly the CEO, they felt the visibility could be significantly improved from all members of the team. Some members of staff stated that they were unaware of who some of the executive team members were in the trust. Staff told us that the chairman and some members of the non-executive team walked around and asked staff about working in the trust and improvements that needed to be made.

Staff demonstrated a sense of pride in their work and there was a clear sense of teamwork among staff at a local level in the clinical areas, with a commitment to delivering high quality patient care. However, there had been examples in the past of members of the clinical teams working in silos and not demonstrating the values of the organisation in how they work as part of the team. Staff described that some of these behaviours were still present among the clinical teams in some areas.

Some staff did not feel there was an open culture that allowed them to express themselves freely in raising concerns. The CEO was taking steps to ensure all staff felt able to raise concerns in a proactive manner through an open door policy and increasing visibility throughout the trust and described the trust to on a journey.

Summary of findings

The trust was recognised by partners to be open and transparent with a culture of improvement in their journey to improvement and operated in a manner that allowed them to work collaboratively.

Staff engagement was something that was recognised that required improvement in the trust and the executive team described how they intended to engage with staff in relation to the future strategy of the trust to ensure it was 'owned' by staff. However, this was too early in the process to see any evidence at the time of the inspection. The CEO did engage with staff in a weekly email to ensure communication was maintained to all staff.

Innovation was seen to be encouraged in the trust by some staff, however there were not clear processes in place to promote innovation or share innovations trust-wide. There was some confusion among staff about how innovation combined with the cost improvement plan and sustainability of the services in the longer term.

Vision and strategy

- The trust reconfigured some of the clinical services in 2011 including maternity, surgery, gynaecology and trauma and orthopaedics and described a period of consolidation following this reconfiguration and the new build of Tunbridge Wells Hospital.
- The strategy for the trust was being reviewed at the time of the inspection and therefore staff were unclear what the overall strategy was for the trust longer term.
- The trust overall vision was "to be a successful, integrated healthcare provider in the top 20% of trust nationally for the quality of services which we deliver", however it was not clear what the benchmarks for measurement included to monitor achievement against the vision.
- Staff throughout the trust were not always able to describe the trust vision
- The trust values "pride" were more widely known by staff; however some staff did not feel all the values were embedded throughout the trust in terms of values and behaviours.

Governance, risk management and quality measurement

- The governance and risk management systems used throughout the trust were not robust and did not demonstrate consistent and effective management of the risks throughout the organisation. The trust did acknowledge their governance systems were not robust and had recently recruited a member of staff to lead the required change and improvements.

Summary of findings

- An example of the governance processes not being sufficiently robust was demonstrated during the inspection when it was recognised that the water testing at Maidstone Hospital had not been carried out since March 2014. Additionally, legionella risk assessments had not been carried out since 2011 further raising concerns regarding the overall governance of water safety,
- The responsibilities and remit of each sub-committee of the board was not always clear, however the trust recognised this and were taking steps to review the committee structure throughout the trust.
- There was limited evidence of constructive challenge and holding to account at an executive level as the governance processes did not support proactive and robust management of trust wide issues. The executive team recognised this and had taken steps to improve this following the financial challenges not being recognised through the systems and processes in a proactive and timely manner.
- Risk registers were not managed in a systematic manner with risks remaining on some risk registers for a significant amount of time without clear action or escalation. Some staff managing risk registers were unable to describe the process for escalating risks onto the corporate risk register.
- The system for identifying, capturing and managing issues and risks at team, directorate and organisation level through risk registers was not consistent or effective.
- The process for incident reporting was not clear to all staff throughout the trust and feedback was neither embedded nor consistently given to those reporting incidents. In addition, shared learning from incidents was not systematic or robust in the process.
- The committee structure in the trust was complicated and there were extensive committees for staff to attend. As a consequence, it was not always clear how risks were being escalated to sub-committees of the board and in some cases the same issues were escalated to different committees without decisions being shared across committees.
- However, it was noted that a reconfiguration of the range of assurance committee's had been proposed, with the appointment of key executive and non-executive directors assuming responsibilities for chairing those committees.
- Whilst there were examples of the continuous improvement cycle in some areas, this was not embedded and shared learning was not implemented into practice trust wide.
- There was a 'Governance Gazette' available to staff as a new initiative to share learning and information to staff trust-wide.

Leadership of the trust

Summary of findings

- The executive team were all permanent and comprised of some executives who had worked in the trust for a significant amount of time in various roles and some team members who has joined more recently ranging from the CEO in post since 2007 to the Director of Finance joining the trust in 2014.
- The CEO did a weekly 'blog' email to all staff and during the inspection staff referred to the email as a way of update from the executive team and monthly open staff meetings on both hospital locations.
- Whilst staff described there was some visibility of the executive team, particularly the CEO, they felt the visibility could be significantly improved from all members of the team. Some members of staff stated that they were unaware of who some of the executive team members were in the trust.
- Staff told us that the chairman and some members of the non-executive team walked around and asked staff about working in the trust and improvements that needed to be made.
- Staff reported that the medical director had a wide scope of autonomy with regards to the day-to-day management of the trust.
- It was the opinion of some staff that one member of the executive team was more likely to "direct" actions rather than engage with staff to resolve issues. In addition, that there was a level of "Favouritism" from them towards specific staff groups, which had led to a level of animosity amongst health professionals.
- The director of nursing was seen to be collaborative with stakeholders and making some improvements by staff, however some nursing staff did not feel able to raise concerns openly.

Culture within the trust

- Staff demonstrated a sense of pride in their work and there was a clear sense of teamwork among staff at a local level in the clinical areas, with a commitment to delivering high quality patient care.
- However, there had been examples in the past of members of the clinical teams working in silos and not demonstrating the values of the organisation in how they work as part of the team. Staff described that some of these behaviours were still present among the clinical teams in some areas. We could therefore not be assured that cultural and behavioural issues at a local directorate level were always being addressed. Furthermore, there was a lack of robust evidence to demonstrate that leaders at a local, directorate level were being held to account.

Summary of findings

- Whilst the trust merged in 2000 and there had been significant amount of work to ensure they were seen as one organisation, there remained examples of a culture of two hospitals.
- Some staff did not feel there was an open culture that allowed them to express themselves freely in raising concerns. They did not feel all the executive team would welcome them to openly raise concerns. The CEO was beginning to take steps to ensure all staff felt able to raise concerns in a proactive manner through an open door policy and increasing visibility throughout the trust.
- The CEO described the trust to on a journey in terms of improving the culture and reducing the single site working to ensure they operate as one organisation.

Fit and Proper Persons

- The trust were in the process of confirming the process for ensuring they meet the requirements related to Fit and Proper Person, but this process was not confirmed at the time of the inspection.

Public, staff and stakeholder engagement

- The trust was recognised by partners to be open and transparent with a culture of improvement in their journey to improvement.
- Partners described the trust as having gone from a trust they had significant concerns about in recent years to a trust they felt were on a journey to improvement but operated in a manner that allowed them to work collaboratively.
- Staff engagement was something that was recognised that required improvement in the trust and the executive team described how they intended to engage with staff in relation to the future strategy of the trust to ensure it was 'owned' by staff. However, this was too early in the process to see any evidence at the time of the inspection.
- The CEO did engage with staff in a weekly email to ensure communication was maintained to all staff.
- The staff survey demonstrated that in the majority of questions staff responses were in line with the national expectations.
- During the reconfiguration of services the trust engaged with the public under consultation, however there was no consistent ongoing route to engage with public in relation to developments within the trust or to gain feedback from the public in a proactive manner.

Innovation, improvement and sustainability

Summary of findings

- Innovation was seen to be encouraged in the trust, however there were not clear processes in place to share innovations trust-wide.
- There were examples of innovative practice at a local level such as the dementia café as the estate at Tunbridge Wells consisted of single rooms and prevented patients being able interact.
- There was some confusion among staff about how innovation combined with the cost improvement plan and sustainability of the services in the longer term.
- Sustainability of some services across both sites was a concern raised by some staff and the executive team were reviewing the strategy and sustainability of some services in the trust being on both sites.
- The trust were working towards Foundation Status and were forecasting a deficit of 12 million in 2014/15.

Overview of ratings

Our ratings for Tunbridge Wells Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Inadequate	Inadequate	Inadequate
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

Our ratings for Maidstone Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Inadequate	Inadequate	Inadequate
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

Overview of ratings

End of life care	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

Our ratings for Maidstone and Tunbridge Wells NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging.

Outstanding practice and areas for improvement

Outstanding practice

- The Maidstone Birth Centre had developed, designed and produced the Maidstone birth couch, which was used by women in labour.
- On Mercer Ward, the role of dementia care worker had been created to focus on the needs of people with dementia and their families. An activities room had been designed, furnished and equipped to meet the specific needs of people with dementia, and was widely used. This project was the subject of an article published in the professional nursing literature.
- The breast care service provided very good care from before the initial diagnosis of cancer through to completion of treatment. Good support and holistic care was provided to patients requiring breast surgery.
- On Ward 20 there was a focus on dementia care. Staff had bid and won funds from the Dementia Challenge fund to create a Dementia Café for use by people living with dementia, their friends and families. This area was designed using current guidance to be dementia friendly and was equipped to meet the special needs of people living with dementia.

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

Tunbridge Wells Hospital

- Ensure that care and treatment provided to service users has due regard to their cultural and linguistic background and any disability they may have.
- Ensure that people who use the service are protected against the risks associated with unsafe or unsuitable premises.
- Improve the environment in the Intensive Care Unit with regards to toilet/shower facilities for patients.
- Have adequate Consultant cover at weekends for ICU. For example, one Consultant covering more than 15 patients on two sites. Consultant not always available within 30 minutes. Two ward rounds to comply with core standards-only one takes place.
- Ensure patients are not delayed more than 4 hours once a decision has been made to admit them to the intensive care unit (ICU).
- Ensure discharge from the ICU takes place within 4 hours of decision.
- Ensure that where possible, patients are not discharged from the ICU during the night.
- Ensure outreach service meets current guidelines. (NCEPOD, 2011)
- Ensure that level 3 intensive care patients are observed in line with their needs.
- Make arrangements to ensure that contracted security staff have appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs.
- Make suitable arrangements to ensure the dignity and privacy of patients accommodated in the Clinical Decisions Unit.
- Ensure that service users are 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.
- Ensure that staff and patients have access to a competent and independent translator when necessary.
- Review the process for incident reporting to ensure that staff are aware of and act in accordance with the trust quality and risk policy.
- Review the clinical governance strategy within children's services to ensure there is engagement and involvement with the surgical directorate.
- Review the arrangement for the management and administration of topical anaesthetics
- Review the children's directorate risk register to ensure that risks are recorded and resolved in a timely manner.

Outstanding practice and areas for improvement

- Review the current PEWS system to ensure that it has been appropriately validated, is supported by a robust escalation protocol and is fit for purpose. Its use must be standardised across the children's directorate (excluding neonates).

Maidstone Hospital

- Make arrangements to make sure contracted security staff have appropriate knowledge and skills to work safely with vulnerable patients with a range of physical and mental ill health needs.
- Ensure that intensivist consultant cover at weekends is adequate.
- Ensure that sufficient numbers of ward rounds take place in the intensive care unit (ICU) to ensure the department complies with national standards.
- Ensure that once a decision to admit a patient to the ICU is taken, the patient is admitted within four hours.
- Ensure that patients are discharged from the ICU within four hours of a decision being made.
- Ensure that discharges from the ICU to other wards do not take place at night.
- Ensure that the governance structure within the ICU supports a framework to ensure clinical improvements using a multidisciplinary approach.
- Review the existing management arrangements for the Riverbank Unit to ensure that the unit operates effectively and efficiently.
- Take action to ensure that medical and nursing records are accurate, complete and fit for purpose.
- Ensure that staff and patients have access to a competent and independent translator when necessary.
- Ensure that the water supply is tested for pathogens and that appropriate systems are in place for monitoring water quality and water safety.
- Take action to ensure that all patient clinic letters are sent out in a timely manner.

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Care and welfare of service users **9.**—(1) The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of— (b) the planning and delivery of care and, where appropriate, treatment in such a way as to— (i) meet the service user's individual needs, (ii) ensure the welfare and safety of the service user, (iii) reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment. The Regulation was not being met because: 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 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. 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. Admissions were delayed for more than four hours once the decision was made to admit a patient to the intensive care unit (ICU).

This section is primarily information for the provider

Compliance actions

Discharges from the ICU were delayed for up to a week. Of all discharges, 82% were delayed for more than 24 hours.

Overnight discharges take place from the ICU.

All contrary to the core standards of the Intensive Care Society.

The outreach service does not comply with current guidelines (National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2011)).

Regulation 9 (1)(b)(i)(ii)(iii)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010: Safety and Suitability of Premises People who use the service were not protected against the risks associated with unsafe or unsuitable premises. Improvements are needed in relation to the environment in the Intensive Care Unit with regards to toilet/shower facilities for patients. Regulation 15 (1)(a)

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Regulation 17 (1)(h) HSCA 2008 (Regulated Activities) Regulations 2010: respecting and involving services users The Regulation was not being met because: 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.

This section is primarily information for the provider

Compliance actions

Dignity and privacy of patients was not being met in the Clinical Decisions Unit.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Regulation 20 (1) HSCA 2008 (Regulated Activities) Regulations 2010: records The Regulation was not being met because: 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. Regulation 20 (1) (a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010: Supporting workers The Regulation was not being met because: 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.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

This section is primarily information for the provider

Compliance actions

Regulation 10(1)(a)(b)(2)(c)(i)(ii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Assessing and monitoring the quality of service provision

The provider did not protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to:

(a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this part of these regulations; and

(b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

The Regulation was not being met because:

The process for incident reporting did not ensure that staff were aware of and acted in accordance with the trust quality and risk policy.

The clinical governance strategy within children's services did not ensure engagement and involvement with the surgical directorate.

The children's directorate risk register did not ensure that risks are recorded and resolved in a timely manner.

There were two incident reporting systems, the trust electronic recording system and another developed by consultant anaesthetists 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.

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.

Regulation 10(1)(a)(b(2)(c)(i)(ii)

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Treatment of disease, disorder or injury

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010: Medicines

The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

The Regulation was not being met because:

The arrangement for the management and administration of topical anaesthetics was ineffective.

Regulation 13

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control** **12. (1) The registered person must, so far as reasonably practicable, ensure that –** 1. Service users; 2. Persons employed for the purpose of the carrying on of the regulated activity; and 3. 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 –** 1. 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; **The Regulation was not being met because:** **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, the management and control of Legionella at Maidstone Hospital. Regulation 12(1)(a)(b)(c)(2)(a)(c)**

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2-9 Safe Staffing: Planned V Actual – Jan'15 CHIEF NURSE

Summary / Key points

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for the month of January 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 and latterly by the NICE review of ward staffing published in July 2014 but additional guidance for these indicators is being provided..

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
- Nurse sensitive indicators
- Overall staffing levels
- Risks posed to patients as a result of the above
- Patient experience

The 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 thresholds for which are:

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 obersvations, 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

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

Which Committees have reviewed the information prior to Board submission?
None

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

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

Safe Staffing - January 2015.

			Day		Night		Nurse sensitive indicators						
Hospital Site name	Ward name	Specialty 1	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	FFT Score	C.Diff	Falls	PU - ward acquired	Complaints (related to nursing	RAG Status	Comments
Maidstone Hospital	Acute Stroke	300 - GENERAL MEDICINE	99.2%	119.4%	98.9%	193.5%	88	0	4	0	0		Additional care staff required to special patients with cognitive impairments.
Maidstone Hospital	Romney	314 - REHABILITATION	94.6%	101.1%	100.0%	98.4%		0	3	0	0		FFT not recorded for Romeny as part of DH exclusion criteria (continuing care beds) patient feedback opportunity utilised from transfering ward.
Maidstone Hospital	Cornwallis	100 - GENERAL SURGERY	98.5%	100.0%	94.6%	N/A	100	0	1	0	0		
Maidstone Hospital	Coronary Care Unit (CCU)	320 - CARDIOLOGY	89.2%	N/A	100.0%	N/A	71	0	1	0	0		Unit safe, as cross-covered by Culpepper. Unit co-located on Culpepper.
Maidstone Hospital	Culpepper	320 - CARDIOLOGY	103.2%	98.4%	100.0%	100.0%	100	0	1	0	0		
Maidstone Hospital	Foster Clark	340 - RESPIRATORY MEDICINE	84.5%	118.3%	99.2%	108.1%	60	0	1	0	1		Ward supported by CNS and outreach, acuity higher than anticipated (high numbers of patients requiring NIV support) Ward Manager supervisory time utilised to provide direct patient care.
Maidstone Hospital	Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE	98.0%	64.5%	98.4%	N/A	67	0	0	0	0		RN to patient ratio not impacted. Care staff provide support patient repositioning and provision of supplies. Shift coordinator able to support shortfall. Overall acuity within acceptable limits
Maidstone Hospital	John Day	301 - GASTROENTEROLOGY	91.6%	122.6%	98.9%	100.0%	39	0	5	1	1		Care support staff increased during the day to manage general patient supervision. RN ratios acceptable for acuity. FFT reviewed over 6 months score 30 - 60 coomments reviewed and plan in place
Maidstone Hospital	Jonathan Saunders	430 - GERIATRIC MEDICINE	99.2%	96.8%	98.9%	103.2%	0	0	4	1	0		No FFT cards completed
Maidstone Hospital	Lord North	370 - MEDICAL ONCOLOGY	96.1%	100.0%	94.6%	100.0%	94	0	1	0	0		
Maidstone Hospital	Mercer	430 - GERIATRIC MEDICINE	96.8%	92.5%	93.5%	103.2%	71	0	3	0	1		
Maidstone Hospital	Pye Oliver	100 - GENERAL SURGERY	99.3%	150.0%	97.8%	112.9%	60	0	4	0	0		High number of medical patients outlaying on ward. High number of RN vacancies (6wte) High usage of temporary staffing
Maidstone Hospital	Urgent Medical Ambulatory Unit (UMAU)	180 - ACCIDENT & EMERGENCY	95.2%	91.2%	97.6%	95.2%	80	0	3	1	1		
Tunbridge Wells Hospital	Acute Stroke	430 - GERIATRIC MEDICINE	95.7%	103.2%	102.2%	93.5%	50	0	4	0	0		FFT usually 80 - 100 % but last 2 months 50%
Tunbridge Wells Hospital	Coronary Care Unit (CCU)	320 - CARDIOLOGY	97.8%	93.5%	94.6%	N/A	79	0	3	0	0		
Tunbridge Wells Hospital	Gynaecology	502 - GYNAECOLOGY	93.7%	85.1%	98.4%	100.0%	91	0	3	0	0		Care support staff lower than anticipated. Minial impact on care delivery.
Tunbridge Wells Hospital	Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE	104.4%	96.8%	103.2%	96.8%	0	0	0	1	0		FFT only completed for patients discharged home directly from ICU
Tunbridge Wells Hospital	Medical Assessment Unit	180 - ACCIDENT & EMERGENCY	92.2%	110.8%	97.8%	96.8%	No FFT Cards	0	9	2	1		Procurement issue with cards
Tunbridge Wells Hospital	SSSU	100 - GENERAL SURGERY	92.3%	114.3%	N/A	N/A	100	0	1	0	0		
Tunbridge Wells Hospital	Ward 32	110 - TRAUMA & ORTHOPAEDICS	100.0%	100.0%	100.0%	100.0%	90	0	4	0	0		
Tunbridge Wells Hospital	Ward 10	100 - GENERAL SURGERY	94.5%	113.7%	91.1%	167.7%	77	0	5	0	1		High number of cognitively impaired patients. Managed as a cohort during the day, needed additional support at night.
Tunbridge Wells Hospital	Ward 11	100 - GENERAL SURGERY	103.7%	122.6%	99.2%	141.9%	92	0	2	1	0		1 patient (Room 9) required continous supervision. Managed during the day with help from family, additional staff quired at night.
Tunbridge Wells Hospital	Ward 12	320 - CARDIOLOGY	99.5%	94.6%	87.0%	122.6%	100	0	10	1	0		RN ratio moderate impact at night. Acuity allowed for uplift with CSW. Oversight provided by Site Practitioner.
Tunbridge Wells Hospital	Ward 20	430 - GERIATRIC MEDICINE	89.8%	103.2%	100.0%	141.9%	67	0	10	1	0		RN below anticipated levels. Care not adversly impacted. High numbers (19) of cognitive impairment - cohort nursed.
Tunbridge Wells Hospital	Ward 21	340 - RESPIRATORY MEDICINE	94.2%	102.2%	100.0%	101.6%	86	0	9	1	0		Rated amber as whilst staffing numbers were within acceptable limits, overalL acutiy was higher than anticipated. Moderate impact on care delivery
Tunbridge Wells Hospital	Ward 22	430 - GERIATRIC MEDICINE	91.1%	100.0%	97.8%	100.0%	85	0	9	0	0		
Tunbridge Wells Hospital	30	110 - TRAUMA & ORTHOPAEDICS	104.3%	113.0%	128.2%	127.4%	80	0	6	1	0		Wards 30 & 31 cross cover and redeploy staff to meet patient care needs. Whilst staffing numbers and nurse to patient ratios are within acceptable limits, there is a heavy reliance on temp staff due to vancancies. FFT 31 score over 6 months usually above 70
Tunbridge Wells Hospital	Ward 31	110 - TRAUMA & ORTHOPAEDICS	114.0%	75.5%	96.8%	116.1%	33	0	8	1	0		
Tonbridge Cottage Hospital	Stroke Rehab	430 - GERIATRIC MEDICINE	98.1%	101.6%	100.0%	109.7%	100	0	1	0	0		
Tunbridge Wells Hospital	ante-natal	501 - OBSTETRICS	104.8%	77.4%	103.2%	87.1%		0	0	0	0		Overall staffing meets demand. Midwives move during the course of shift with the mother to or from delivery suite.
Tunbridge Wells Hospital	delivery suite	501 - OBSTETRICS	105.9%	88.3%	99.3%	95.0%		0	0	0	0		
Tunbridge Wells Hospital	post-natal	501 - OBSTETRICS	112.8%	86.3%	98.4%	89.5%		0	0	0	0		FFt for maternity is not reported by location but by point in pathway.
Tunbridge Wells Hospital	Gynae Triage	502 - GYNAECOLOGY	87.1%	100.0%	96.8%	93.5%		0	0	0	0		No impact on patient care.
Tunbridge Wells Hospital	Hedgehog	420 - PAEDIATRICS	98.9%	71.2%	101.6%	96.8%		0	0	0	1		4 episodes of escalation into Woodlands. RSCN/child ratio remained within accpetable limits
Maidstone Hospital	Birth Centre	501 - OBSTETRICS	100.0%	93.5%	100.0%	100.0%		0	0	0	0		
Tunbridge Wells Hospital	Neonatal Unit	420 - PAEDIATRICS	109.7%	64.5%	97.8%	96.8%		0	0	0	0		Care staff was covered by shift co-ordinator role. Minor or no impact on patient care.
Maidstone Hospital	MSSU	100 - GENERAL SURGERY	113.5%	130.0%	158.7%	100.0%		0	1	0	0		National FFT excluded currently as not an in-patient service
Maidstone Hospital	Chaucer	180 - ACCIDENT & EMERGENCY	106.2%	104.0%	99.2%	103.2%	73	1	2	1	0		
Tunbridge Wells Hospital	SAU	180 - ACCIDENT & EMERGENCY	121.5%	104.2%	117.2%	101.6%		0	1	0	0		National FFT excluded currently as not an in-patient service

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2-11 Medical Devices – details of improvements and latest purchases — Medical Director

Following an investigation into a patient who sustained a severe burn, a number of changes have taken place within the Trust to ensure that medical devices are managed appropriately to deliver as safe a service as possible to patients. The prosecution by the Health and Safety Executive identified that the Trust did not act correctly in 3 areas:

1. Procurement: The equipment was purchased without following the Trust Medical Devices policy, in particular, without assessing the risks of using the equipment for its intended uses.
2. Training: The teams using this equipment were inadequately trained and there was no assessment of the quality of the training.
3. Maintenance: The correct servicing of the equipment was not carried out.

Since that time, a number of changes have been made, as follows:

- All medical devices will be subject to control by the Medical Devices Policy. This policy defines all aspects of obtaining equipment, assessing it, training of staff & audit of appropriate training
- The Medical Devices Group will be a sub-committee of the Standards Committee, on which many clinicians sit
- The Medical Devices Group will audit the appropriate ongoing training of staff in clinical areas

The Procurement and Medical Devices departments will coordinate their functions and prevent any circumventing of the appropriate policies.

In December 2014, the Board (Part 2) received information on Medical Device purchases since April 2014, & it was agreed to provide updates on subsequent device purchases to the Board every two months. The Medical Device Purchases that are in process or awaiting delivery are as follows:

Delivered to service since last report: Mortara ELI250c

Delivered, but not deployed:

- Fisher & Paykell AIRVO2 – Stability issues with delivered product
- GE Voluson e7 Diagnostic Ultrasound – Awaiting completion of User Training
- Conmed 5000 Surgical Diathermy – Awaiting completion of User Training
- Sigmacon Holmium Surgical Laser – Awaiting installation

Approved, but not yet purchased: GE Voluson e8 Diagnostic Ultrasound

Business Case signed off, but devices not yet approved:

- Cell Saver - Theatres
- Diagnostic Ultrasound - Radiology

Trust Standard Devices purchased and deployed:

- Pharmacy Fridge
- 0-15LPM Flowmeter (O2 & Air)
- Nebuliser Compressor System
- Pulse Oximeter
- ECG Recorder
- Patient Beds

The Board is asked to consider whether it wishes to receive further updates on such purchases (and if so, at which frequency)

Which Committees have reviewed the information prior to Board submission?

- Medical Devices Group

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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2-13	Summary report from Audit and Governance Committee, 12/02/15	Committee Chair (Non-Executive Director)

The Audit and Governance Committee met on 12th February 2015.

1. **The key matters considered at the meeting were as follows:**
   - Some proposed methods by which the Committee should fulfil the duty in its Terms of Reference to "…review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives" were considered
   - A review of the management of risks within the Estates and Facilities Directorate was undertaken (along with a review of the Directorate's financial position)
   - The Board Assurance Framework (BAF) and Risk Register for 2014/15 were reviewed
   - An update on progress with the Internal Audit plan for 2014/15 was received
   - The Internal Audit Plan for 2015/16 was approved. Support was also given for the Kent & Medway HIS Audit Plan
   - An update on Counter Fraud was received
   - A 'Progress and emerging issues report' was received from external audit, and the External Audit plan for 2014/15 was approved
   - An update was provided on the 2014/15 accounts process, and the Accounting policies were approved (subject to the final guidance from the Department of Health being adopted)
   - A summary of the latest financial issues was provided
   - The latest losses and compensations and single tender waivers data was reviewed
2. **The Committee received details of the following Internal Audit reviews:**
   - "Consultant Job Plans Follow Up" (which received a Limited Assurance conclusion)
   - "Core Financial Assurance – Payroll" (which received a Reasonable Assurance conclusion)
   - "Application Management Policies and Procedures" (which received a Limited Assurance conclusion)
3. **The Committee was also notified of the following "high" priority outstanding actions from Internal Audit reviews:**
   - "Clinical Activity Recording". It was agreed to invite the action owner to the September Audit and Governance Committee if the action remained outstanding at that point
   - "Data Centre Facilities Review". Three actions were noted as being outstanding, which prompted a discussion regarding the management response to Internal Audit recommendations (see below)
4. **The Committee agreed that:**
   - The Medical Director should oversee the implementation of the actions required to ensure that the Trust's Job Planning process is robust, and thereby enable the private healthcare practise undertaken by the Trust's Consultant staff to be recorded comprehensively (and be available for scrutiny by Non-Executive Directors, on request)
   - The Director of Finance should develop a high-level RACI (Responsible, Accountable, Consult, Inform) matrix
   - The scheduling of Audit and Governance Committee meetings should be adjusted, to enable an even gap between the main meetings, and therefore enable updates of the BAF to be specifically linked to Committee meetings (thereby enabling the BAF to be received there for detailed review before being submitted to the Board). The BAF report received at the Board would then highlight any issues raised at the Committee, along with any conclusions (the BAF itself would be received at the Board as an Appendix to the summary report from the Committee)
   - The Committee should introduce the 'tool' of selecting one or more of the BAF objectives to detailed scrutiny, by having a separate agenda item whereby the Executive Lead for an

objective is invited to attend, to discuss how the risks to the achievement of that objective are being managed in further detail
- The Director of Estates & Facilities Management should ensure that the Estates & Facilities Annual Report for 2014 incorporates further assurances on the management of risks
- The Trust Secretary should arrange for a message to be provided to the members of the Trust Management Executive that a) recommendations from Internal Audit reviews can be rebutted (if a rationale is provided) but b) any actions agreed in response to such reviews should be realistic and achievable
- The Director of Finance should Liaise with Internal Audit to agree the best option for incorporating a review of waiting time data quality indicators within the 2014/15 Internal Audit plan
- A review of "Nurse Revalidation" should be included within the Internal Audit plan for 2015/16 (but be undertaken within Quarter 4)

5. The issues that need to be drawn to the attention of the Board are as follows:
- It was felt that the above agreements regarding the role of the Audit and Governance Committee in overseeing the Board Assurance Framework should be agreed with the Board; and
- The Committee was concerned with the Trust's process for Consultant Job Planning, in the light of the 'limited assurance' conclusion from the latest Internal Audit follow-up review (see 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]

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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2-14	**Summary of the Trust Management Executive (TME) meeting, 18/02/15**	**Chief Executive**

This report provides information on the TME meeting held on the 18th February 2015. The key points from the meeting were as follows:

- An update on the **response to CQC inspection** was given by the Chief Nurse
- The latest **performance, for month 10**, 2014/15 was reported (including the latest position regarding infection prevention and control)
- The Director of Finance updated on the development of the **2015/16 business plan**
- The latest **Reference Cost information** was received
- The Clinical Director for Emergency and Medical Services reported the latest position on the **future options for Stroke**
- An update on the **implementation of the Southern Acute Programme** (SAcP - replacement PAS+) was provided by the Director of Health Informatics (and the Clinical Lead for the project)
- Updates were provided on the implementation of **Chemotherapy E-Prescribing** and the establishment of the **Ambulatory Care Unit** at Tunbridge Wells Hospital
- The **Directorate reports** highlighted that Directorates were continuing to develop their responses to the CQC inspection report. Some specific incidents that had occurred were also discussed, and assurance was given that these were being investigated and managed in accordance with the appropriate processes
- The Director of Workforce and Communications presented the findings from the **2014 National Staff Survey**. It was noted that overall, the survey demonstrated an improved set of results. It was agreed to provide Clinical Directors with the findings by Directorate
- The actions planned to address concerns regarding **staff access to policies, clinical guidelines, protocols and procedures** were reported
- Assurance was provided regarding **Domestic Water Hygiene Management** (and it was noted that future assurance would be provided via the Health and Safety Committee)
- The **Board Assurance Framework** and **Trust Risk Register** were reviewed. It was agreed that a future meeting of the TME should consider & agree how the risks currently rated as 'red' on the Risk Register should be treated (including whether the risks needed to be accepted)
- The **recently-approved business cases** were noted
- Approval was granted to replace a **Consultant Trauma & Orthopaedics post**
- Updates were received on the work of the **TME's sub-committees** (Capital meetings; Private Patients Board, Clinical Operations and Delivery Committee and the Policy Ratification Committee)
- It was noted that the next meeting, on 18th March, would be a **joint meeting with the Trust Board** focusing on the plans for 2015/16 and beyond. The intention is that Clinical Directors will deliver a brief presentation on the plans for their Directorates (this mirrors the approach taken at the joint meeting with the Board that took place in March 2014)

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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2-16 Oversight Self-Certification, Month 10, 2014/15 — Trust Secretary

The enclosed schedule sets out the proposed oversight self-certification submission for month 10, based on performance as at 31st January. This submission must be sent to the NHS Trust Development Authority (TDA) by the end of February (i.e. by 27th).

As Board members are aware, each month the Trust Board is required self-assess against the questions contained in two self-certification documents under the TDA oversight process:

1. Monitor licence conditions; and
2. Board statements

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

Board members are asked to pay particular attention to Board statement 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"), in the light of the Trust now not being able to meet the A&E 4-hour waiting time target for 2014/15.

In relation to the Monitor licence conditions, there are some items which, as an aspirant Foundation Trust, the Board does not need to consider at the present time. These will however need to be understood and implemented as part of the trajectory to submit a Foundation Trust (FT) application. As with the previous month's self-assessment, and as was agreed at the Board Forum meeting in February 2014, it is proposed that, where appropriate, where the Trust continues to declare non-compliance, and that the date by which the Trust will become compliant should be listed as 31st March 2017. This is a change from the previous date provided of 31/03/16, and reflects the Trust's current status with regards to obtaining FT status.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

The Board is asked to:

- Review the evidence presented to support the self-assessment (and amend if required);
- Consider whether the status of the "Latest assessment – Compliant?" column accurately reflects the current situation regarding compliance. Specific attention is drawn to Board statement 10; and
- 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~~se are the~~ Regulations ~~that will~~ introduce~~d~~ 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]~~[3], and have the health, qualifications, skills and experience to undertake the role. Finally, Directors should not have "been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity…". This latter restriction ~~will~~ enables a judgement ~~the CQC to decide~~ that a person is not fit to be a Director on the basis of any previous misconduct or incompetence in a previous role for a service provider. This would be the case even if the individual was working in a more junior capacity at that time (or working outside England). The Regulations apply to all Directors and "equivalents", which will include Executive Directors of NHS Trusts and Foundation Trusts. It is ~~will be~~ the responsibility of the provider and, in the case of NHS bodies, the chair, to ensure that all Directors meet the fitness test and do not meet any of the 'unfit' criteria. The Chair of a provider's board will need to confirm to the CQC that the fitness of all new Directors has been assessed in line with the new regulations; and declare to the CQC in writing that they are satisfied that they are fit and proper individuals for that role.	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?
	The CQC may also ask the provider to check the fitness of existing Directors and provide the same assurance to them, where concerns about such Director come to the CQC's attention. Although the Regulations will not, strictly speaking, be applied retrospectively, the Trust will likely need to ensure current Board members meet the Regulations' requirements for being "fit and proper". ~~The Trust Secretary is currently liaising with the Chairman and the Human Resources team to consider how best to respond to the new requirements.~~ A proposed approach to the new Regulations was approved at the December 2014 Trust Board, and ~~will be implemented in the coming weeks/months~~ implementation has commenced.	
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 31/03/201~~6~~7
G7 – Registration with the Care Quality Commission	The Trust has full registration with the CQC. The Trust is registered to deliver the following regulated activities at both main hospital sites: Treatment of disease, disorder or injury'; 'Surgical procedures'; 'Diagnostic and screening procedures'; 'Maternity and midwifery services' and 'Family planning'. In addition, the Trust is registered to undertake 'Termination of pregnancies' at Tunbridge Wells Hospital.	Yes
G8 – Patient eligibility and selection criteria (for services and accepting referrals) ▪ Criteria are transparent ▪ Criteria are published	The Referral and Treatment Criteria (RATC) which apply from 1st April 2014 are published on the West Kent CCG website ("Kent and Medway clinical commissioning groups' (CCGs') [sic] schedule of policy statements for health care interventions, and referral and treatment criteria").	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 31/03/201~~6~~7
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 31/03/201~~6~~7
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 31/03/201~~6~~7
P4 – Compliance with the national tariff (or to agree local prices in line with rules contained in the National tariff)	The Trust is compliant with the national tariff and where local tariffs are applied, are subject to negotiation and agreement with the CCG/Commissioners.	Yes
P5 – Constructive engagement concerning local tariff modifications The aim is to encourage local agreement between commissioners and providers where it is uneconomical to provide a service at national tariff; thereby minimising Monitors need to set a modified tariff.	The Trust is compliant with the national tariff and where local tariffs are applied, are subject to negotiation and agreement with the CCG/Commissioners.	Yes

Competition conditions

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

Integrated care conditions

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

Oversight Self Certification – Board Statements

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
For clinical quality, that: 1. the Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	▪ The Trust's integrated performance dashboard is reviewed monthly and includes the TDA's "routine quality & governance indicators" ▪ A "Clinical Quality & Patient Safety Report" report is submitted to the Trust Board ▪ The Quality & Safety Committee, and its sub-committees, provides a focus on quality issues arising from Directorates. A summary of each Quality & Safety Committee meeting is reported to the Board ▪ The Patient Experience Committee provides a patient perspective and input ▪ The Chief Nurse, a Board member, is accountable for quality ▪ There are dedicated complaints and Serious Incidents (SI) management functions ▪ Ongoing conduct of Family and Friends Test is reported through the Trust performance dashboard ▪ Patient stories are heard at Trust Board meetings ▪ SI report summaries are circulated to all Board members ▪ Board member visits to wards and departments enable triangulation of quality and other performance indicators. Pairings of NED and Executive Board members, to further promote such visits, have now been issued. Board members also participate in the conduct of Care Assurance Audits ▪ Systems investment (e.g. Q-Pulse, Symbiotix, Dr Foster) supports effective quality information/data management ▪ Quality Accounts have been developed in liaison with stakeholders ▪ Quality Impact Assessments conducted on all CIP initiatives ▪ Priority of patient care reflected in Trust values & embedded in staff appraisal The independent assessment of the Trust's Quality Governance Framework has largely endorsed the Trust's self-assessment and gave a validated score of 3.5; an action plan has been drafted to	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	achieve further improvements. Further improvements include: - strengthening the processes through which learning is shared and embedded has been recognised, and - developing further benchmarks to support the assurance & target setting process The latest CQC Intelligent Monitoring data was published by the CQC in December 2014. The Trust was not issued with a "Priority banding for inspection" because the Trust was "Recently Inspected". However, the overall risk score was 8 which approximately equates to a Band 4. The ~~publication of the~~ final report of the Trust's inspection by the Care Quality Commission in October 2014 ~~is awaited.~~ was published in February 2015, and confirms that Trust's overall rating as 'Requires Improvement'. An action plan is in development, and this will be discussed further at the February 2015 Board meetings.	
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. A CQC inspection of Tunbridge Wells Hospital reported in January 2014 concluded 'moderate concerns' about the Management of Medicines and Staffing outcomes. Actions are underway to address the areas of concern identified by the inspection, and the latest position was reported to the Trust Management Executive on 17th September. A Care Quality Commission inspection of Maidstone Hospital was undertaken in February 2014. Actions are underway to address the areas of concern identified by the inspection, and the latest position was reported to the Trust Management Executive on 17th September.	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	The ~~publication of the~~ final report of the Trust's inspection by the Care Quality Commission in October 2014 ~~is awaited.~~ was published in February 2015, and confirms that Trust's overall rating as 'Requires Improvement'. An action plan is in development, and this will be discussed further at the February 2015 Board meetings.	
For clinical quality, that: 3. the board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	The Medical Director is the responsible officer for medical practitioner revalidation. The Trust Board in May 2014 received the 2013/14 Annual Report from the Responsible Officer, and approved a 'statement of compliance' confirming that the Trust, as a designated body, was in compliance with the regulations governing appraisal and revalidation.	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	Trust response: The Trust reported a deficit for 2013/14 and the financial situation is under ongoing review with the TDA. The Trust was recently awarded £12m of non-recurrent funding by the TDA for 2014/15. The Trust continues to operate as a going concern, and the 2014/15 financial accounts are being prepared on this basis.	Yes
For governance, that 5. the board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times	The NTDA accountability framework aims to ensure that Trusts have a real focus on the quality of care provided. Under this framework, quality focus is achieved through: (i) Planning – the Trust conducts an annual process of service and budget planning and the Board reviews and agrees the IBP (ii) Oversight – the Trust participates fully in the oversight model (self-certification, review meetings) (iii) Escalation – The Trust welcomes support from the TDA and will cooperate fully with escalation decisions. The Trust, has fully engaged with a risk summit of performance issues (c.diff, surgical trainees, A&E) (iv) Development – the Trust will embrace the development model as appropriate. The Trust has committed to development programmes for (i) Board members; (ii) Executive team, (iii) Clinical Directors and (iv) General Managers/Matrons. (v) Approvals – the Trust is fully engaged in the FT application process and is awaiting dialogue with the TDA on the timetable towards authorisation.	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	Trust values and priorities mirror the TDA's underpinning principles: ▪ local accountability – e.g. liaison with CCGs, Patient Experience Committee, patient satisfaction monitoring, whistleblowing & complaints management ▪ openness and transparency – e.g. embedded in Trust value on respect; duty of candour in Board Code of Conduct; open approach to Public Board meetings (which now take place each month) and both external &, internal communications channels; a growing membership ▪ making better care easy to achieve – the Trust's stated priority, above all things, is the provision of high quality & safe care to patients (Patient First). ▪ an integrated approach to business – the Trust has adopted an integrated governance approach including an integrated performance dashboard.	
For governance, that: 6. all current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.	See 5 above. In addition: ▪ The Trust monitors performance each month in accordance with the TDA Quality and Governance indicators. A Board Assurance Framework and Board level risk register, supported by an overall Risk management Policy, are established and scrutinised by accountable Executive Directors ▪ Risks receive ongoing scrutiny and assurance ▪ Mitigating actions have agreed dates for delivery ▪ An annual Internal Audit plan is agreed and focuses on areas of key risk ▪ A professional Trust Secretary is employed ▪ A dedicated Risk Manager is employed ▪ The Trust fully participates in the TDA Oversight process ▪ The independent assessment of the BGAF & QGF was conducted in July 2013 and the positive results reported to the Trust Board in September 2013; a follow up review conducted in December 2103 re-affirmed the assessment.	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
For governance, that: 7. the board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance	See 6 above. In addition: All risks are RAG rated according to severity and likelihood; mitigating actions are monitored and reported. Key risks to the Trust's agreed objectives are reported via the Board Assurance Framework. The Trust Management Executive (EDs and CDs) is the designated risk management committee of the Trust and provides summary reports of its activity to the Trust Board.	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 Chair (a NED). The Board is fully engaged to 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-treasury.gov.uk).	The Annual Governance Statement 2013/14 was agreed by the Trust Board in May 2014. The guidance for the 2014/15 Governance Statement has now been issued, and is being reviewed by the Trust Secretary. The Statement will be prepared by the required deadlines.	Yes
For governance, that: 10. the Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward	Quality and governance indicators are monitored by the Board each month through the integrated performance dashboard. The Board is committed to achieving all targets and has set the vision of being in the best 20% of acute trusts nationally. ~~The Trust is currently performing against the requirements of the NTDA oversight model.~~ The Trust is now unable to meet the required performance (95%) in terms of the A&E 4 hour waiting time target for the 2014/15 year. In	Yes (?)

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	the light of this, the Board is asked to consider whether it wishes to continue to declare compliance with statement 10, or whether the Trust's compliance status should be changed to 'No'. If the Board does agree to declare 'No', a "target date for completion" would need to be provided (in such circumstances, 01/04/15 is proposed, as this is the earliest date at which the target becomes achievable again).	
For governance, that: 11. the trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit	The Trust has achieved IG toolkit level 2 for 2013/14	Compliant
For governance, that: 12. the board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.	A Trust Board Code of Conduct is in place which confirms the requirement to comply with the Nolan principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership. A register of interests is maintained and Board members are invited to declare any interests relevant to the agenda at the beginning of each Board meeting, and each Board sub-committee. A new Non-Executive Director commenced in September 2014, which means that all formal Board positions are now filled substantively.	Compliant
For governance, that: 13. the board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	▪ The composition and operation of the Board has been debated in Board development activity and a paper produced to enable the further review of Board composition when vacancies occur. ▪ A launch session for the Board development programme for 2014 took place in December 2013, facilitated by Hay Group; this will synchronise with separate Executive Director, Clinical Director, General Manager/Matron development programmes. ▪ The Remuneration Committee reviews the performance of Executive Directors. ▪ The TDA has conducted a review of the Trust Board. ▪ The Trust continues to adhere to the Oversight process ▪ A proposed approach to the new 'fit and proper persons' Regulations was approved at the December 2014 Trust Board,	Compliant

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	and ~~will be implemented in the coming weeks/months~~ implementation has commenced.	
For governance, that: 14. the board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan	▪ All Executive Director (and Clinical Director) positions are filled. ▪ The objectives of Executive Directors cascade from the Trust's corporate objectives which are agreed by the Trust Board. The Trust Board agreed the Trust's objectives for 2014/15 in September 2014, and agreed that these objectives should also apply for the 2015/16 year (subject to minor amendments regarding specific targets)	Compliant