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

9.30am – c.12pm WEDNESDAY 24TH SEPTEMBER 2014

EDUCATION CENTRE, LEVEL -2, TUNBRIDGE WELLS HOSPITAL

A G E N D A – PART 1

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9-1	To receive apologies for absence	Chairman	Verbal	-
9-2	To declare interests relevant to agenda items	Chairman	Verbal	-
9-3	Minutes of the Part 1 meeting of 23rd July 2014	Chairman	1	1-9
9-4	To note progress with previous actions	Chairman	2	10-12
9-5	Chairman's report	Chairman	Verbal	-
9-6	Chief Executive's report	Chief Executive	3	13-14
9-7	Integrated Performance Report for August 2014.	Chief Executive	4	15-27
	Additional quality items			
9-8	Clinical Quality and Patient Safety Report	Chief Nurse	5	28-37
9-9	A patient's experiences of the Trust's services	Chief Nurse[1]	Verbal	-
9-10	Annual Report from the Director of Infection Prevention & Control	Director of Infection Prevention & Control	6	38-75
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9-12	Ward staffing review (6 monthly review)	Chief Nurse	9	82-101
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	Reports from Board sub-committees			
9-14	Trust Management Executive, 06/08, 03/09 & 17/09/14	Committee Chair	11	104-105
9-15	Finance Committee, 19/08/14	Committee Chair	12	106-106
9-16	Workforce Committee, 04/09/14 (incl. revised Terms of Ref)	Committee Chair	13	107-110
9-17	Quality & Safety Committee, 06/08/14 & 10/09/14	Committee Chair	14	111-113
9-18	Patient Experience Committee, 04/09/14	Committee Chair	15	114-116
9-19	Audit and Governance Committee, 18/09/14	Committee Chair	Verbal	-
9-20	Charitable Funds Committee, 21/07/14 (incl. revised Terms of Reference)	Committee Chair	16	117-124
	Planning and strategy			
9-21	To approve the Collaboration Agreement for the Kent Pathology Partnership	Chief Operating Officer	17	125-131
9-22	Approval of the Trust's objectives for 2014/15	Trust Secretary	18	132-134
	Assurance and policy			
9-23	Approval of compliance oversight self-certification	Trust Secretary	19	135-144
9-24	**To consider any other business**			
9-25	**To receive any questions from members of the public**			
9-26	To approve the motion that in pursuance of the Public bodies (Admissions to meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted	Chairman	Verbal	-

Date of next meetings:

- 22nd October 2014, 10.30am, Education Centre, Tunbridge Wells Hospital
- 26th November 2014, 10.30am, Academic Centre, Maidstone Hospital

Anthony Jones,
Chairman

[1] A patient will also be in attendance for this item, via video-link

Maidstone and Tunbridge Wells NHS
NHS Trust

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 23RD JULY 2014, 10.30 A.M. AT TUNBRIDGE WELLS HOSPITAL

DRAFT, FOR APPROVAL

Present:	Anthony Jones	Chairman (Chair)	(AJ)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Kevin Tallett	Non-Executive Director	(KT)
	Steve Tinton	Non-Executive Director	(ST)
	Avey Bhatia	Chief Nurse	(AB)
	Angela Gallagher	Chief Operating Officer	(AG)
	Paul Sigston	Medical Director	(PS)
In attendance:	Paul Bentley	Director of Workforce and Communications	(PB)
	Jayne Black	Director of Strategy & Transformation	(JB)
	Ian Miller	Financial Recovery Officer	(IM)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	Annemieke Koper	Staff Side Chair	(AK)
	Hilary McGuigan	Principal Pharmacist	(HMc)
	Darren Yates	Head of Communications	(DY)
	Anthony Hayward	Vice-Chairman, Tonbridge and Malling Seniors (TAMS) Forum	(AH)
	Anne Loveday	Member of the public (also member of the Trust's Patient Experience Committee) (until item 7-14)	(AL)
	Chris Oldham	Block Solutions Ltd	(CO)

7-1 To receive apologies for absence

Apologies were received from Sylvia Denton (SD), Non-Executive Director; Steve Orpin (SO), Director of Finance; Sara Mumford (SM), Director of Infection Prevention and Control; and Stephen Smith (SS), Associate Non-Executive Director.

7-2 To declare any interests relevant to agenda items

There were no declarations of interest.

7-3 To agree the minutes of the Part 1 meeting of 28th May 2014

The minutes were accepted as an accurate record of the meeting subject to the amendment below:

- Item 5-8, page 5. Change "The patient was also under the care of a Burns Consultant…" to "The patient was also under the care of a Plastics Consultant…"

Action: Amend the minutes of the meeting of 28th May 2014 (Trust Secretary, July 2014)

AB then referred to item 5-10, page 7, which referred to the agreement that the Mortality Review Committee and End of Life Steering Group should not be regarded as formal sub-committees of the Quality & Safety Committee. AB stated that further consideration was required as to whether this decision was appropriate. GD replied that he had no objection to the two groups being formal sub-committees of the Quality & Safety Committee, but emphasised that their output should firstly be reported into the clinical management of the Trust, rather than to the Quality & Safety Committee. The point was acknowledged.

7-4 To note progress with previous actions

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

- 1-4 (Maggie's Cancer Centre). PS reported that the Trust's Oncologists had visited Maggie's Cancer Centre, and although it provided a good environment for patients, they felt that the treatment offered did not go beyond that already offered. AJ proposed that to 'close' the action, PS should discuss this with the Chair of the Quality & Safety Committee, and inform the Trust Board of the final outcome of that discussion. This was agreed.
  Action: Discuss the outcome of the Oncologists visit to Maggie's Cancer Centre with the Chair of the Quality & Safety Committee (Medical Director, July 2014 onwards)

- 5-12 ("Temporary Staffing" data). PB reported that of the 42,588 hours of "actual" "temporary staffing" reported for April 2014, 15% of such hours were provided by 'agency' staff, and 85% were provided by 'bank' staff. It was agreed the action was closed.

  KT proposed that the breakdown of bank and agency staff be discussed further at the next meeting of the Workforce Committee. AJ asked whether the controls in place for booking bank staff were the same as those for booking agency staff. AB replied that there were additional controls in place when booking agency staff. AJ queried whether the controls in place for booking bank staff were adequate. AG stated that she believed that such controls were adequate. It was agreed that this point would be explored further during the aforementioned discussion at the next Workforce Committee.

- 1-19 (Board 'away days'). AJ asked whether there were any concerns with inviting representatives from West Kent Clinical Commissioning Group (CCG) to a future 'away day'. No such concerns were raised.
- 5-9 (revised operation and functioning of the 'main' Quality & Safety Committee). AJ highlighted that SD, AB and AJ needed to meet to discuss the future functioning of the Quality & Safety Committee.

7-5 Chairman's report

AJ reported that the format of the agenda and order of agenda items had been revised for this meeting, and added that comments on the revisions were welcome, and should be directed towards himself, GD or KR.

7-6 Chief Executive's report

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

- There had been recent adverse media coverage regarding a complaint made by a family into the care and treatment of their father. GD reported that an investigation was underway, but emphasised that the family's concerns were being taken very seriously by the Trust. GD confirmed that the investigation would be independent, and also confirmed that no immediate action was required to be taken in response to the concerns raised.
- Despite the concerns raised by the aforementioned complaint, indicators suggest that the Trust was running two hospitals with a high standard of quality and safety
- Capacity pressures usually associated with winter have continued into the summer months, and there has been continued increased clinical activity
- A major piece of work regarding the Trust's future clinical strategy was about to commence, and the aim was to engage with as many people & external agencies as possible. In this regard, several Executive Directors, including GD, attended the Kent Health Overview and Scrutiny Committee (HOSC) on 18th July, which represented the start of the engagement process.

Quality

7-7 Clinical Quality and Patient Safety Report (to month 3, 2014/15)

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

- There had been significant improvement in the reduction of pressure ulcers, which was regarded as a good indicator of basic nursing care

- The analysis of Serious Incidents (SIs) in the first quarter of 2014/15 showed that 'Falls resulting in head injury or fracture' and 'Delayed diagnosis' needed further work, and these issues would be the focus of priority action in the future

ST asked for details of the two most recent 'Never Events'. AB replied that these had been investigated, and would be reviewed at the SI panel on 11th August. ST asked whether any action had been taken against the staff involved in the Events. PS pointed out that one of the Events involved a systems error which was not restricted to the Trust, but confirmed that there was no evidence to warrant specific action being taken against individual members of staff. ST noted that PS's account was consistent with that presented at the last Quality & Safety Committee 'deep dive' meeting. PS did however note that the General Medical Council (GMC) now wished to be informed of any medical staff members involved in Never Events.

KT asked whether there were other immediate actions that had been implemented in response to the Never Events. PS confirmed a number of such actions had been taken. SDu added that the details of some of these were provided at the last Quality & Safety Committee 'deep dive' meeting. SDu also highlighted that the next Quality & Safety Committee 'deep dive' meeting on 6th August was scheduled to consider 'organisational learning', and therefore further assurance would be available by the next Trust Board meeting.

AJ then referred to the comments in the report about elective MRSA screening, and stated that although he could understand the challenges faced by UMAU, he did not understand why Oncology patients were not being screened. AB replied that such patients attended for treatment frequently, and staff may not have appreciated that patients needed to be screened every time they attended, but confirmed that the process was being adapted to take this into account.

SDu referred to Stroke performance, and asked why the data was subject to delay in being reported on the dashboard. PS replied that the data was only available when patients were discharged. AG added that the internal process of data validation also led to reporting delays.

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

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

- The Trust had undertaken much work with patients with Dementia, and the story being presented involved a situation where care was provided correctly, but not followed through
- The story involved a patient attending for Cataract surgery, under a Power of Attorney, and although this was known, a 'best interests' meeting was not held prior to the surgery
- On the day of the surgery, a Porter asked the patient if she understood what was about happen, and rightly raised his concerns with staff at the response he received. The subsequent response by staff (i.e. to prevent the surgery from continuing) was correct and appropriate, but the way this was done could have been improved.
- The individuals involved have learned from reflection on their handling of the situation, and on the complaint from the patient's family. The surgeon concerned had personally apologised to the patient and their family, and a 'best interests' meeting had now been held.

KT remarked that the report did not explain why a 'best interests' meeting was not held, and commented that the process seemed overly mechanistic, which may not be appropriate in such circumstances. PS noted that surgery was being increasingly undertaken on patients with Dementia, and therefore although such 'best interest' meetings were not routine for Surgical teams, they were likely to become more so in the future.

SDu observed that the story raised the wider issue of how patients with forms of cognitive impairment were managed, and asked whether the existence of cognitive impairment in patients was 'flagged' in any way to staff. AB replied that the Trust used the "This is Me" booklet, which contained everything that staff needed to know about such patients, including specific needs, and contact details of carers. SDu asked whether this information was held in electronic form. AB confirmed that the "This is Me" booklet was a paper-based document. SDu asked whether it was therefore appropriate to expect affected patients to bring this document with them on admission.

AB acknowledged that the process did not work effectively in all circumstances, but asserted that the process worked well for some patients.

SDu highlighted that it would be more beneficial for the Trust Board to hear patient stories delivered in person at Board meetings. AJ confirmed that this should indeed be the aim, and noted that the Board had applied this method in the past.

7-9 Report of the Quality & Safety Committee meetings of 18/06/14 & 09/07/14

In SD's absence, SDu referred to the circulated report and highlighted the following points:

- The Trust had recognised that it had learned from the response to the Upper Gastrointestinal (GI) issue, particularly in terms of its management of communications matters
- A revised Quality and Safety performance dashboard would be produced in September
- The action plans produced in response to the recent inspections by the Care Quality Commission (CQC) were received
- Stroke care was the subject of the last Quality & Safety Committee 'deep dive' meeting, and options for the future of the Stroke service would be discussed at the Part 2 Trust Board meeting to be held later that day
- The next Quality & Safety Committee 'deep dive' meeting will focus on 'organisational learning'

7-10 Report of the Patient Experience Committee, 05/06/14

In SD's absence, AJ referred to the circulated report and highlighted the following points:

- Upper GI and the report of the CQC's inspection at Maidstone Hospital were discussed
- A review of response to call bells was undertaken, and although it was noted that the Trust compared well with peers, the aim should be to perform better than average
- Kent Healthwatch had 50 volunteers signed up, but wished to have a far greater number
- The Trust's Friends and Family Test (FFT) scores were well received
- Food was discussed, and diverse views were tendered by Committee members
- A doctor in training attended and gave a positive report
- There was good representation of external personnel at the meeting

7-11 Reports on planned and actual ward staffing for May and June 2014

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

- Since the report was circulated, the National Institute of Health and Care Excellence (NICE) had issued a 'Safe staffing guideline' for nursing in adult inpatient wards in acute hospitals
- NICE had recommended that staffing levels had to be responsive to the acuity and dependence of patients, and therefore workforce levels needed to be adapted to suit
- NICE also referred to 'red flags', which should be monitored, and included whether staff were having the appropriate breaks, and whether protected meal times were able to be observed
- The NICE guideline also emphasised the need to review quality indicators, such as pressure ulcer rates, and complaints rates, and therefore, on one Ward, a staffing ratio of 1:8 may be adequate, whilst for other wards, a 1:12 ratio may be warranted
- The circulated reports showed that, on the whole, actual staffing was in accordance with planned levels, though there were some areas where actual levels exceeded plan, and some areas where planned levels exceeded actual. Occurrences of the latter had been responded to, whilst occurrences of the former may have arisen as a response to increased levels of patient acuity and dependence

ST remarked that when he recently visited Ward 22 at Tunbridge Wells Hospital, he was impressed by the Ward Sister's management and acuity of the patients on her ward, and that everything that AB had outlined in terms of approach to staffing was what he had witnessed when he visited the ward. AJ encouraged all Board Members to highlight such examples of good practice, when observed.

AJ referred to the level of reliance of temporary staff for April, which was reported as being 26.6%, and asked whether this was correct. AB confirmed this was the correct percentage. AJ asked for an explanation. AB replied that the percentage was affected by the use of escalation beds. PB

added that it was correct that circa 26% of ward nursing staff were temporary, including bank staff. AJ proposed that this be explored further during the aforementioned discussion at the next Workforce Committee. KT pointed out that this issue had been discussed in some detail at the last Workforce Committee meeting. ST confirmed this was the case.

SDu commented that the circulated reports would be improved by including the number of beds per ward, to provide a context. AB acknowledged the point, but stated that the reports were written according to a national template, though AB added that she had suggested that the template be amended as per SDu's suggestion.

7-12 Board members' ward visits

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

AJ requested that those making visits provide formal feedback to other Board members on their findings. AJ also asked AB whether Board Members were sufficiently engaged in Care Assurance Audits. AB confirmed this was the case.

[Post-meeting note: It was subsequently established that ST had in fact visited Ward 22 at Tunbridge Wells Hospital, rather than the Medical Assessment Unit (MAU), as had been reported in Attachment 10]

Finance, performance, activity and workforce

7-13 Financial update (month 3)

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

- The Trust's financial position was ahead of plan
- Operating costs were being controlled, and were below plan
- A prudent provision of £1.8m had been included into operating costs
- The forecast was to achieve the £12.3m planned deficit for the year, though there were a number of risks to this
- The likely need for an application for temporary cash support was discussed at the Finance Committee, and it was agreed that this should be discussed at the Trust Board.

ST elaborated on the last point, by stating that the Trust and CCG were unable to reach agreement on the settlement of the 2013/14 contract, and therefore arbitration was likely. ST continued that the continued absence of a resolution would have an adverse effect on the Trust's cash position, and a decision was therefore required as to whether the Trust should make an application for temporary cash support. AJ stated that the advice of the Finance Department was required on this matter. AJ asked for views on the likelihood of achieving a resolution without arbitration. GD stated that an agreement would have to be reached, one way or another, and emphasised that the final step in the process prior to arbitration (i.e. escalation to GD), had not yet been taken.

ST highlighted that he had asked whether the Trust was billing prospectively for clinical activity for 2014/15, rather than relying on retrospective billing, and reported that it had been confirmed that this was the case.

SDu suggested that an update on the latest situation be provided at the August Finance Committee. AJ replied that this would of course be the case, but urged GD and IM to provide any relevant update to Board members via email in the meantime.

GD remarked that he was less concerned with the situation regarding West Kent CCG, and was more concerned with the situation with NHS England pertaining to Specialist Commissioning, as there seemed to be an absence of an escalation process.

AJ commended the achievement of the Trust's financial targets thus far.

7-14 Report of the Finance Committee meetings of 23/06/14 and 21/07/14 (incl. revised Terms of Reference)

ST noted that the meeting held on 21st July was covered under item 7-13, whilst the meeting held on 23rd June was summarised in the circulated report. ST highlighted that this meeting had agreed revised Terms of Reference, which were now submitted for formal approval by the Trust Board.

KR referred to the revised Terms of Reference, and highlighted that there was a proposal for an additional section, relating to "Emergency powers and urgent decisions". KR elaborated that the text of the proposed additional section had been agreed with ST, and related to the exercise of powers in between Committee meetings, if the Committee members required for a quorum were consulted. AJ proposed that the wording be circulated to Board members, and for this to be considered as approved if no objections were raised. This was agreed.

Action: Circulate the proposed wording for an "Emergency powers and urgent decisions" section within the Terms of Reference for the Finance Committee (Trust Secretary, July 2014 onwards)

The Terms of Reference were approved as circulated, subject to the aforementioned circulation of the wording for an "Emergency powers and urgent decisions" section.

7-15 Performance and activity update (month 3)

AJ referred to the circulated report and invited questions.

AJ asked for a comment on the underperformance against the 62-day cancer wait target. AG replied that a recovery plan was in place, and delivery against the target was expected in quarter 2.

AJ commended the performance against the A&E 4-hour wait.

ST asked for details of the impact of elective activity being below plan. AG replied that some of the cause of being below plan related to the conversion of elective cases to day cases, whilst patients opting not to proceed with treatment, following validation of the waiting list, was also a factor.

ST then asked AG to outline the steps being taken with commissioners to address the increase in non-elective care. AG replied that she and GD had met with the CCG, and were continuing to press for action. ST stated that he was concerned about the impact of this, and whether the Trust would be paid for the care it was providing. GD stated that although emergency activity was only being paid at marginal tariff, the activity for which the Trust was being paid at full tariff had increased, and this was therefore masking the impact of the increase in non-elective activity. GD added that the Trust could not sustain the level of increased non-elective activity. AJ highlighted that Monitor and NHS England had recently announced that the marginal tariff for emergency admissions would continue for 2015/16.

SDu then asked for assurance that the Trust would be able to manage the 18-week referral to treatment (RTT) capacity that had been deferred, as well as managing the routine demand. AG replied that demand and capacity was monitored regularly, and expressed confidence that the Trust would be able to manage the situation.

SDu asked for an update on the re-modelling of the provision of care at the 'front-end'. AG replied that some action had been taken, and there were plans in place for assessment cubicles to enable therapy staff to provide care at the start of the patient pathway, and also plans to have a 'care of the elderly physician of the week' system. AG concluded that some of the actions implemented to date had been working to a degree, but further work was required.

JB added that she had been involved in recent discussions with the Accountable Officer for West Kent CCG, and noted that he intended to establish a 'whole systems' approach to the challenges being faced by the Local Health Economy. AG confirmed that a date had been set for the first meeting of the group leading this work.

7-16 Report of the Trust Management Executive, 18/06/14

GD referred to the circulated report and highlighted that the cost for the Linear Accelerator (LINAC) at Kent & Canterbury Hospital was more than originally planned, and the Committee had agreed that this additional cost was acceptable.

7-17 Workforce update (month 3)

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

- The number of contracted whole time equivalent (WTE) staff had been measured differently for month 3 than for previous months, which distorted the month 3 picture. The method used previously will therefore be reinstated for future months
- There had been an increase in use of agency staff and a decrease in the WTE being filled by bank staff. The need to recruit to substantive posts was recognised, and will be driven further by a Trust-wide recruitment campaign. However, the Trust's substantively employed staff base had increased by 36 WTE
- Compliance with appraisals was increasing, and a further increase was expected when the current backlog in reporting was addressed

7-18 Report of the Workforce Committee, 17/06/14

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

- A 'Friends and Family Test' for staff was being introduced
- The Lead Matron for Medicine attended to give a presentation on the use of temporary staff in nursing and to explain the roster system
- Revised Terms of Reference were reviewed and agreed
- The workforce implications over the next few years were discussed

7-19 Compliance oversight self-certification

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

- Changes from the self-certification agreed at the June Board Forum were highlighted
- The CQC would be undertaking a site visit in relation to the Trust's recent application to extend its registration regarding regulated activities, but this was not an inspection

The oversight self-certification was approved as circulated.

Planning and strategy

7-20 Update on the Kent Pathology Partnership

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

- The Collaboration Agreement was being reviewed by legal advisors, though the Trust's own solicitors had reviewed the document, with particular regard to the Human Resource-related aspects. The Agreement was scheduled to be submitted to the Board in September 2014
- The estates and IT workstreams were continuing
- A Kent Pathology Partnership (KPP) Project Manager had started in post, and an Interim KPP Managing Director had been appointed
- The expected date for the first transfer of services under the KPP was 1st April 2015, when Microbiology was intended to transfer to the Maidstone hospital site

Assurance and policy

7-21 To receive the Annual Audit Letter for 2013/14

KR referred to the circulated report and highlighted that the Audit Commission would publish the document in full on their website in due course. ST added that the Trust had received a qualified "except for" conclusion in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, as a result of the Trust's financial position in 2013/14.

7-22 Approval of the Trust's objectives for 2014/15

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

- The list of proposed objectives that had been discussed at the Board Forum in June 2014 had been amended by including an objective regarding the Trust's management of estates, and by reducing some of the objectives considered to be a lower priority
- The wording in the Trust's three Strategic Objectives had been unchanged, but re-labelled as "Strategic Objective themes", to make it clear that that the Strategic Objectives were intended to last beyond 2014/15, and therefore for 2014/15, these equated to a label under which more specific, time-bound objectives could be grouped
- The list of proposed objectives had been agreed at the Executive Directors meeting held on 15th July

AJ commented that the wording of several of the objectives would benefit from review and revision, to make them more specific and measurable. KR acknowledged the point.

KT queried whether there should be an objective related to the achievement of a more customer-focused approach at the Trust. KR asked whether KT was proposing that an additional objective be included. KT clarified that it may be possible to revise the wording of one the circulated objectives, to include this concept.

AJ proposed that the list of proposed objectives be subject to further revision, to reflect the points made, and be submitted for final agreement at the Trust Board meeting in September 2014. This was agreed. KR pointed out that September would be six months into the year in which the objectives were intended to apply. AJ acknowledged the point.

Action: Amend the proposed objectives for 2014/15 to reflect the points made at the Trust Board meeting on 23/07/14, and submit the list for final agreement at the Trust Board meeting in September 2014 (Trust Secretary, September 2014)

7-23 Health & Safety Annual Report for 2013/14 (and agreement of the 2014/15 programme)

AG referred to the circulated report and highlighted that the report provided an overview of the Trust's approach to Health and Safety, and included details of legal obligations, staff training, and efforts to protect staff from injury. Questions or comments were invited.

AJ referred to page 106, and queried why the number of the Trust's "employees" was listed as 8590. AG stated that she would clarify the number that should have been included in the table.

Action: Provide clarification of the number of "employees" that should have been included in the table in the Health & Safety Annual Report for 2013/14 that refers to RIDDOR Injuries and Injury Rate (Chief Operating Officer, July 2014 onwards)

KT referred to the concept of a "safety message of the day" and queried whether this could be implemented at the Trust. It was agreed that KT and AG would discuss this outside of the meeting.

Action: Liaise, to discuss the concept of "safety message of the day" and whether it could be implemented at the Trust (Chief Operating Officer / Chair of Workforce Committee, July 2014 onwards)

The Trust Board agreed the Health and Safety programme for 2014/15, and delegated the monitoring and management of the programme to the Health and Safety Committee.

7-24 Report of the Charitable Funds Committee, 21/07/14

ST reported the following key points from the meeting:

- The charity had a balance of approximately £1 million, and the Committee agreed the principle that expenditure should increase to reduce the balance held on account
- The Committee also agreed to the amalgamation of the large number of designated funds to a smaller number
- A revised draft Charitable Fund policy was reviewed, as were revised Terms of Reference

AJ pointed out that some of the funds had been donated to specific locations at the Trust. ST acknowledged the point, but stated that this did not negate the need to expend the funds.

7-25 To consider any other business

There was no other business.

7-26 To receive any questions from members of the public

There were no questions.

7-27 To approve the motion that in pursuance of the Public Bodies (Admissions to meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted.

The motion was approved.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – September 2014

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

Actions due and still 'open'

Ref.	Action	Person responsible	Deadline	Progress [1]
1-19 (Jan 14)	Arrange for key clinical leaders to be involved in the Board 'away days', to ensure there is clinical engagement in the Trust's future strategy	Director of Strategy & Transformation	January 2014 onwards	**In progress** – There is clinical engagement in the work to develop the strategy, via the Clinical Strategy Transformation Group and 4 associated workstreams. Consideration is being given to the involvement of staff in the next 'away' day, which is now confirmed for 10th October.
1-19 (Jan 14)	Arrange for representatives from West Kent Clinical Commissioning Group to be invited to a Board 'away day', to ensure there is health-economy-wide engagement in discussions regarding the Trust's future strategy	Director of Strategy & Transformation)	January 2014 onwards	**In progress** – Consideration is being given to inviting CCG representatives to the next 'away' day, which is now confirmed for 10th October.
5-3 (May 14)	Arrange for the Audit and Governance Committee to further discuss the need for a Responsibility Assignment ('RACI') matrix	Trust Secretary	May 2014 onwards	**In progress** – This will be discussed at the Audit and Governance Committee meeting in November 2014.
5-9 (May 14)	Submit a report to the July 2014 Trust Board outlining a revised approach to the operation and functioning of the 'main' Quality & Safety Committee	Chair of Quality & Safety Committee	July 2014	**In progress** – Discussions have commenced, but proposals are not yet ready for discussion at the Trust Board.
7-4 (July 14)	Discuss the outcome of the Oncologists visit to Maggie's Cancer Centre with the Chair of the Quality & Safety Committee	Medical Director	July 2014 onwards	

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

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
1-19 (Jan 14)	Schedule two Board 'away days' in spring (late April/early May) and autumn 2014, to enable discussion of the Trust's future strategy	Trust Secretary	September 2014	The autumn 'away day' has now been scheduled for 10th October
5-6 (May 14)	Arrange for the Trust's emergency paediatrics service to be subject of a future Quality & Safety Committee 'deep dive' meeting	Chief Nurse / Medical Director / Trust Secretary	May 2014 onwards	The Quality & Safety Committee 'deep dive' meeting held on 6th August discussed whether this should be scheduled for the next meeting, but agreed that this subject should be deferred for the time being, as by the time of the next meeting (which was originally scheduled for October), the situation with the pathway was expected to have been progressed significantly.
7-3 (July 14)	Amend the minutes of the meeting of 28th May 2014	Trust Secretary	July 2014	The minutes were amended
7-14 (July 14)	Circulate the proposed wording for an "Emergency powers and urgent decisions" section within the Terms of Reference for the Finance Committee	Trust Secretary	August 2014	The proposed wording ("The powers and authority which the Trust Board has delegated to the Finance Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least two Executive Director members. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the Finance Committee, for formal ratification") was circulated to Board members. No objections were raised and therefore the wording has now been added to the final Terms of Reference.
7-22 (July 14)	Amend the proposed objectives for 2014/15 to reflect the points made at the Trust Board meeting on 23/07/14, and submit the list for final agreement at the Trust Board meeting in September 2014	Trust Secretary	September 2014	Revised objectives have been submitted to the September 2014 Trust Board, for consideration

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
7-23 (July 14)	Provide clarification of the number of "employees" that should have been included in the table in the Health & Safety Annual Report for 2013/14 that refers to RIDDOR Injuries and Injury Rate	Chief Operating Officer	August 2014	The HSE use total number of employees (total head count) not whole time equivalents. The 8590 includes temporary staff, part time staff, bank staff and staff in hosted services such as the Kent and Medway Health Informatics Service (HIS).
7-23 (July 14)	Liaise, to discuss the concept of "safety message of the day" and whether it could be implemented at the Trust	Chief Operating Officer	July 2014 onwards	Liaison took place, and the concept has now been introduced at the Trust, in the form of a "Monthly Staff Safety Message". The first such message focused on Needle Stick Injuries

Actions not yet due (and still 'open')

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - September 2014

9-6	Chief Executive's update	Chief Executive

Summary / Key points

The enclosed report provides information on recent events at the Trust between August and September 2014.

1. **Visits** I visited Maidstone Hospital A&E department and wards 30 and 31 at Tunbridge Wells Hospital earlier this month as part of my on-going visits and clinical checks. All three areas displayed high standards of care and commitment to our patients. A&E staff report seeing unexplained surges in patient numbers on Fridays and are also focusing on ways to turnaround simple injuries/illnesses within an hour. While I was impressed with both wards overall, there are issues with outliers and improvements to facilities that can improve the patient experience.

2. **CQC** Maidstone and Tunbridge Wells NHS Trust is supporting Medway Hospital's immediate and long-term improvement plans to create clinically sustainable services capable of consistently providing high standards of patient care in safe surroundings.

2.2 We are also learning from East Kent Hospitals University NHS Foundation Trust, after it became the second hospital Trust in Kent to be placed in special measures in August, and from Kent Community Health NHS Trust, who were rated as good.

2.3 We are preparing for our own inspection by the Care Quality Commission, which takes place in October. This is a positive opportunity for the Trust to share many improvements in patient care with the CQC, promote the excellent work our staff do, and work in partnership with the organisation to identify further opportunities to enhance our services in the future.

2.4 Patients can share their experience of the care we provide with the CQC, as part of their forthcoming inspection, in the following ways:

Online: http://www.cqc.org.uk/contact-us
Email: enquiries@cqc.org.uk
Letter: CQC, Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA
Phone: 03000 61 61 61

3 **Trauma review** The Trust's trauma service has undergone a quality assessment by the South East London, Kent and Medway Trauma Network. The Network's initial feedback is positive, and states we have an exemplary service in place that is as an example to other Trusts. While impressed with both hospitals, the Network also stated Maidstone Hospital has robust procedures in place to deal with trauma cases, should the need arise, prior to transfer to our own dedicated trauma unit at Tunbridge Wells or specialist trauma centres in London.

4 **PLACE** The Trust is looking in detail at its Patient-Led Assessments of the Care Environment (PLACE), and in particular, hospital food. Although recent figures do not show our hospitals as being marked especially favourably for food and hydration, this relates to the food service and preparation of patients and ward environment prior to meals, rather than the quality of food which is generally good. New chilled water dispensers are being installed on every ward at Maidstone and we are investing in new food trolleys as part of our improvement plan.

5 **Nurse Investment** We now have 100 more registered nurses and midwives working at the Trust than we did a year ago and 200 more since the opening of the new Tunbridge Wells Hospital, which celebrates its third anniversary this month. The Trust takes on newly qualified graduate nurses this month and is recruiting overseas in October as part of proactive efforts to fill nurse vacancies.

6 **Eye care** The eye unit at Maidstone Hospital is leading the way in helping develop new and more effective national treatments for eye conditions.

6.2 Our clinical teams are aiding in the development of innovative treatments for macular degeneration, new techniques for preventing diabetic patients from going blind, and use of steroids in the treatment of eye injuries.

7 **New vision** We are asking 10,000 people on our public and patient membership group and our workforce of over 5,000 staff to comment on our new Vision, Mission and Objectives (VMO).

7.2 We have developed the following VMOs to support the development of our new five-year clinical strategy:

- **Our Mission is:** "Our purpose is to provide safe, compassionate and sustainable health services."
- **Our Vision is:** "To provide the highest, consistent, quality care to our patients, whether in or outside a hospital setting."
- **Strategic objective 1** To transform the way we deliver services so that they meet the needs of patients
- **Strategic objective 2** To deliver services that are clinically viable and financially sustainable
- **Strategic objective 3** To actively work in partnership to develop a joint approach to future local health care provision

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

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - September 2014

9-7 Integrated Performance Report Chief Executive

Summary of the Month

Maidstone and Tunbridge Wells NHS Trust continue to provide high overall standards of care in a safe environment in line with national standards.

This is evidenced by the 96.2% of 630 patients surveyed in August who received harm free care while in hospital. This continues to be above national benchmarks. The number of pressure ulcers also is below benchmark and we saw the lowest number of falls in August for the last 2 years.

Stroke care continues to be a concern although it is showing progress it remains a key issue from the trust.

The key issue facing the trust was the number of patients with complex discharge needs who stayed in hospital after they were medically fit for discharge, particularly those requiring a nursing home bed. This has been exacerbated by the exceptional urgent activity in late July early August and changes in configuration of Social Services staff at the Trust.

The impact of this has been to keep escalation beds open, reduce the amount of elective work able to be done by the Trust and consequently increase spend on nursing bank and agency staff putting pressure on the Trusts finances which although still on plan has reduced our financial flexibility.

We are in urgent talks with our system partners to unblock this issue to ensure our patients are treated in the most appropriate place for their needs.

Which Committees have reviewed the information prior to Board submission?

- Executive Team, 16/09/14

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

Discussion and Scrutiny

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

TRUST PERFORMANCE DASHBOARD **Position as at:** **31st August 2014**

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

Finance: **TDA** **Red**

Responsible Committee: Quality & Safety

	Delivering or Exceeding Target
	Underachieving Target
	Failing Target

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

	Patient Safety & Quality	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
'1-01	Hospital-level Mortality Indicator (SHMI)			101.26	102	0.74	2	*100*		100
'1-02	Standardised Mortality (Relative Risk)			91.3	91.8	0.5	-8.2	*100*		100
'1-03	Crude Mortality	1.1%	0.9%	1.3%	1.2%	-0.1%				
'1-04	Safety Thermometer % of Harm Free Care	94.4%	96.2%	94.2%	96.8%		1.8%	95.0%		93.7%
'1-05	*Rate C-Diff (Hospital only)	11.1	21.6	21.5	20.3	-1.2	0.0	*15.7*	15.6	15.7
'1-06	Number of cases C.Difficile (Hospital)	2	4	20	19	-1.0	0.0	*35*	35	35
'1-07	Number of cases MRSA (Hospital)	1	0	1	1	0	0	*0*	1	
'1-08	Elective MRSA Screening	97.0%	97.0%	97.0%	97.0%		-1.0%	98.0%	97.0%	
'1-09	% Non-Elective MRSA Screening	98.0%	98.0%	98.0%	98.0%		3.0%	95.0%	98.0%	
'1-10	**Rate of Hospital Pressure Ulcers	2.0	2.4	2.5	2.0	-0.6	-1.0	*3.0*	2.0	3.0
'1-11	****Rate of Total Patient Falls	7.1	5.0	7.8	6.0	-1.8	-0.8	6.75	6.0	
'1-12	****Rate of Total Patient Falls Maidstone	6.7	4.7	6.7	5.3	-1.4	-1.4	6.75	5.3	
'1-13	****Rate of Total Patient Falls Tunbridge Wells	9.6	5.3	8.5	6.4	-2.1	-0.3	6.75	6.4	
'1-14	Falls - SIs in month		3		15	15	0			
'1-15	MSA Breaches	0	5	10	5	-5	5	0	5	
'1-16	Total No of SIs Open with MTW	53	29			-24				
'1-17	Number of New SIs in month	12	8	70	48	-22	-2			
'1-18	Number of Never Events	0	0	0	2	2	2	*0*	2	
'1-19	Number of CAS Alerts Overdue	33	0			-33	0	*0*		
'1-20	*****Readmissions <30 days: Emergency	12.5%	7.7%	9.6%	10.7%	1.1%	-2.9%	*13.6%*	10.7%	14.1%
'1-21	*****Readmissions <30 days: Elective	6.1%	4.4%	4.5%	4.9%	0.4%	-1.4%	*6.3%*	4.9%	6.8%
'1-22	***Rate of New Complaints	4.3	3.60	5.0	3.78	-1.2	-2.48	*6.26*	3.93	6.26
'1-23	% complaints responded to within target	71.4%	50.0%	57.8%	61.6%	3.8%	-13.4%	75.0%	70.2%	
'1-24	IP Resp Rate Recmd to Friends & Family	15.3%	42.5%	15.3%	45.8%	30.5%	20.8%	25%	38.7%	38.2%
'1-25	A&E Resp Rate Recmd to Friends & Family	1.8%	14.6%	2.5%	16.8%	14.3%	1.8%	15%	15.1%	20.2%
'1-26	Mat Resp Rate Recmd to Friends & Family	New	18.2%	New	18.5%	New	-1.5%	15%	18.5%	20.3%
'1-27	IP Friends & Family (FFT) Score	75	78	191	77	-114	3	74	77	74
'1-28	A&E Friends & Family (FFT) Score	52	65	294	63	-231	10	53	63	53
'1-29	Maternity Combined Q1 to Q4 FFT Score	New	81	New	82	New	10	72	82	72
'1-30	Five Key Questions Local Patient Survey	90.6%	91.8%			1.2%		90%	91.8%	
'1-31	VTE Risk Assessment	95.3%	95.1%	95.3%	95.2%	-0.1%	0.2%	95%	95.0%	95%
'1-32	% Dementia Screening	99.1%	99.1%	99.2%	99.0%	-0.2%	9.0%	90%	99.0%	
'1-33	% TIA with high risk treated <24hrs	57.1%	84.2%	62.5%	71.9%			60%	71.9%	
'1-34	% spending 90% time on Stroke Ward (June)	84.0%	81.8%	76.4%	77.3%	0.9%	-2.7%	80%	80.1%	
'1-35	Stroke:% to Stroke Unit <4hrs (June)	New	50.9%	New	37.3%	New	New	75.0%	75.0%	
'1-36	Stroke: % scanned <1hr of arrival (June)	New	50.9%	New	46.4%	New	New	43.0%	43.0%	
'1-37	Stroke:% assessed by Cons <24hrs (June)	New	80.0%	New	73.7%	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	3.6	3.2	3.2	3.1	-0.1	-0.2	*3.3*	3.3	3.3
3-02	Average LOS Non-Elective	6.9	6.3	7.1	6.6	-0.5	0.9	*5.7*	5.7	5.7
3-03	New:FU Ratio	1.71	1.57	1.74	1.58	-0.15	0.07	*1.52*	1.52	
3-04	Day Case Rates	79.7%	84.5%	79.3%	83.1%	3.8%	3.1%	80.0%	80.0%	82.19%

	Finance & Efficiency	Latest Month *Plan*	Latest Month Curr Yr	Year to Date *Plan*	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan	Year End Forecast	Bench Mark
3-05	Income	30,430	31,231	156,605	156,537	0.9%	0.0%	376,849	385,544	
3-06	EBITDA	1,930	1,608	7,047	7,032	-32.5%	-0.2%	24,718	23,850	
3-07	Surplus (Deficit) against B/E Duty	(1,152)	(1,242)	(8,325)	(7,981)			(12,303)	(12,301)	
3-08	CIP Savings	1,904	1,902	8,229	8,273	44.1%	0.5%	22,400	22,424	
3-09	Cash Balance	17,387	9,847	17,387	9,783	289.3%	-43.7%	926	926	
3-10	Capital Expenditure	1,827	293	4,986	1,176	-22.6%	-76.4%	*13,516*	13,516	
3-11	**Monitor Continuity of Service Risk Rating**	New	2	2	2	New	0	2	2	

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

Responsible Committee: Finance, Treasury & Investment **** *RTT Admitted was a planned non-achievement of target*

	Performance & Activity	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	**Monitor Indicative Risk Rating**	**1.0**	**2.0**	**1.0**	**2.0**	**Amber/Red**		**Green**		
2-02	Emergency A&E 4hr Wait (SITREP Wks)	97.2%	96.1%	96.1%	95.2%	-0.9%	0.2%	95%	95.0%	94.6%
2-03	Emergency A&E >12hr to Admission	0	0	0	1	1	1	0	1	
2-04	***Ambulance Handover Delays >30mins	New	No data	New	No data	New		365	0	
2-05	***Ambulance Handover Delays >60mins	New	0	New	0	New	0	0	0	
2-06	****18 week RTT - admitted patients	93.2%	92.7%	92.2%	89.0%	-3.2%	-1.0%	90%	90.0%	
2-07	18 week RTT - non admitted patients	96.4%	96.5%	96.3%	96.3%	0.0%	1.3%	95%	95.0%	
2-08	18 week RTT - Incomplete Pathways	94.0%	95.5%	94.0%	95.5%	1.5%	3.5%	92%	92.0%	
2-09	18 week RTT - Specialties not achieved	3	2	17	15	-2	15	*0*	15	
2-10	18 week RTT - 52wk Waiters	0	0	0	0	0	0	*0*	0	
2-11	18 week RTT - Backlog 18wk Waiters	870	364	870	364				250	
2-12	% Diagnostics Tests WTimes <6wks	100.0%	100.0%	100.0%	99.96%	0.0%	1.0%	99.0%	99.96%	
2-13	Cancer WTimes - Indicators achieved	8	9	9	8	-1	-1	9	9	
2-14	*Cancer two week wait	94.9%	95.1%	94.9%	95.7%	0.8%	2.7%	93%	93.0%	95.5%
2-15	*Cancer two week wait-Breast Symptoms	93.0%	95.4%	93.0%	94.4%	1.4%	1.4%	93%	93.0%	
2-16	*Cancer 31 day wait - First Treatment	99.1%	100.0%	99.1%	98.9%	-0.3%	2.9%	96%	96.0%	98.4%
2-17	*Cancer 62 day wait - First Definitive	87.1%	85.4%	87.1%	82.7%	-4.4%	-2.3%	85%	85.0%	87.1%
2-18	Delayed Transfers of Care	3.7%	5.1%	3.1%	4.0%	0.9%	0.5%	3.5%	3.5%	
2-19	Primary Referrals	7153	7,518	38564	42,334	9.8%	10.6%	93,129	102,986	
2-20	Cons to Cons Referrals	3730	2,644	18460	16,601	-10.1%	-4.8%	42,433	40,385	
2-21	First OP Activity	10581	11,683	56846	59,142	4.0%	6.0%	133,266	143,874	
2-22	Subsequent OP Activity	19704	20,098	106310	106,795	0.5%	4.7%	247,680	259,799	
2-23	Elective IP Activity	793	553	3762	3,276	-12.9%	-22.0%	9,584	7,970	
2-24	Elective DC Activity	2976	2,987	14758	15,468	4.8%	-3.6%	37,735	37,629	
2-25	Non-Elective Activity	3424	3,820	19258	19,963	3.7%	5.2%	*45,264*	47,624	
2-26	A&E Attendances (Calendar Mth)	10615	10,687	53669	55,917	4.2%	6.6%	*125,139*	133,397	
2-27	Oncology Fractions	5176	5,374	27976	28,972	3.6%	1.8%	67,876	69,116	
2-28	No of Births (Mothers Delivered)	471	476	2,281	2,386	4.6%	7.8%	5,310	5,726	
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)	24.4%	24.6%	25.6%	26.6%	0.9%	1.6%	25.0%	25.0%	
2-31	% Mothers initiating breastfeeding	81.7%	81.3%	81.4%	80.8%	-0.5%	2.8%	78.0%	80.8%	
2-32	Intra partum stillbirths Rate (%)	0.6%	0.2%	0.3%	0.1%				0.1%	

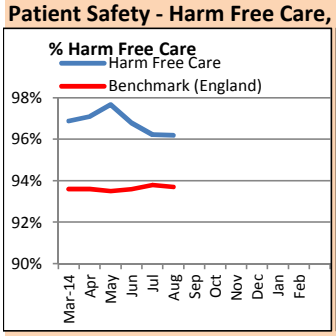
* Rate of C.Difficile per 100,000 Bed days, ** Rate of Pressure Sores per 1,000 admissions (excl Day Case), *** Rate of Complaints per 1,000 Episodes (incl Day Case), **** Rate of Falls per 1,000 Occupied Beddays, ***** Readmissions run one month behind.

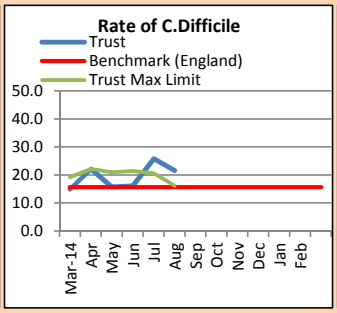
Responsible Committee: Workforce * Stroke & CWT run one mth behind, *** Ambulance Handover is unvalidated

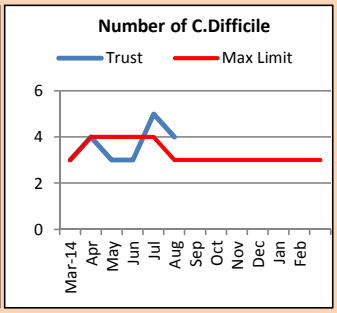
	Workforce	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ Limit	Year End Forecast	Bench Mark
4-01	Establishment (Budget WTE)	5,328.0	5,399.8	5,328.0	5,399.8	1.3%	0.0%	*5,450.5*	5,450.5	
4-02	Contracted WTE	4,968.8	4,919.0	4,968.8	4,919.0	-1.0%	-3.6%	*5,214.6*		
4-03	**Contracted not worked WTE		(112.0)		(112.0)					
4-04	Locum Staff (WTE)	31.7	11.3	31.7	11.3	-64.2%				
4-05	Bank Staff (WTE)	268.3	325.2	268.3	325.2	21.2%				
4-06	Agency Staff (WTE)	127.7	150.0	127.7	150.0	17.4%				
4-07	Overtime (WTE)	61.7	75.6	61.7	75.6	22.6%				
4-08	Worked Staff WTE	5,340.5	5,388.4	5,340.5	5,388.4	0.9%	-1.5%	*5,492.8*		
4-09	Vacancies WTE	359.2	480.9	359.2	480.9	33.9%			293.5	
4-10	Vacancy %	6.7%	8.9%	6.7%	8.9%	32.1%			5.4%	
4-11	Nurse Agency Spend	(434)	(264)	(1,876)	(1,660)	-11.5%			(3,110)	
4-12	Medical Locum & Agency Spend	(712)	(770)	(3,485)	(3,609)	3.6%			(8,386)	
4-13	Staff Turnover Rate	10.1%	9.7%		9.40%	-0.4%	-0.8%	*10.5%*	9.40%	8.4%
4-14	Sickness Absence	3.5%	4.1%		3.7%	0.6%	0.8%	*3.3%*	3.3%	3.7%
4-15	Statutory and Mandatory Training	84.0%	84.9%		84.9%	0.9%	-0.1%	85.0%	85.0%	
4-16	Appraisals	78.9%	69.3%	76.3%	69.3%	-9.6%	-20.7%	90.0%	90.0%	

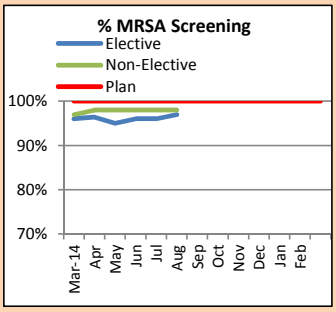
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

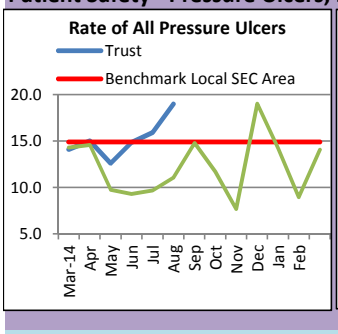


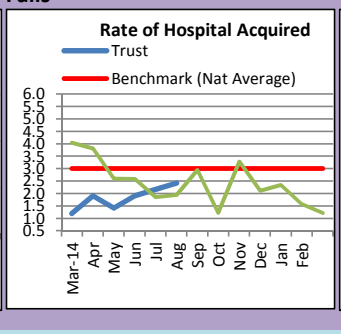


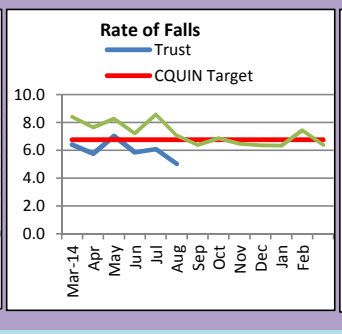


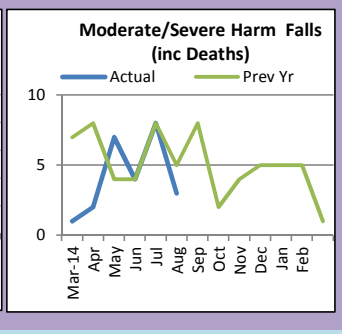


Patient Safety - Pressure Ulcers, Falls

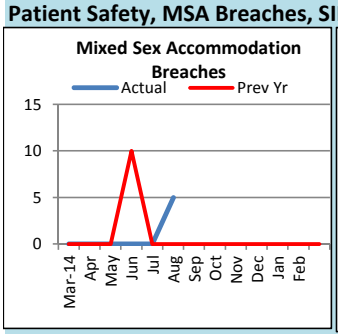


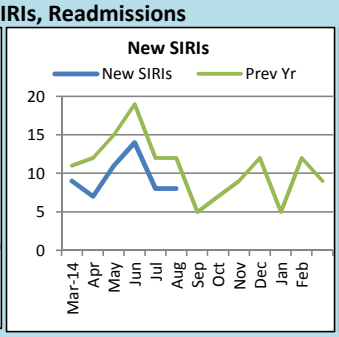


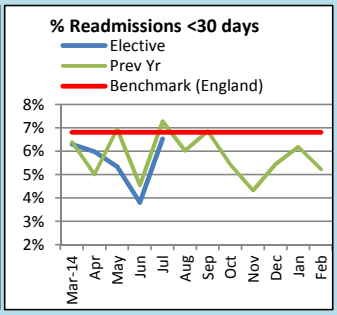


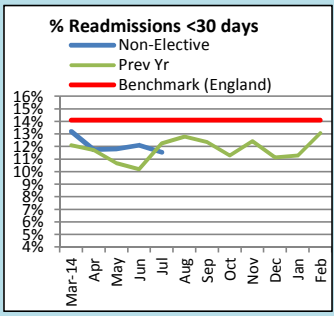


Patient Safety, MSA Breaches, SIRIs, Readmissions

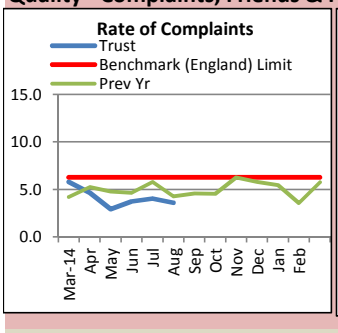


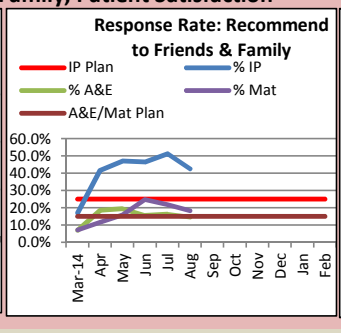


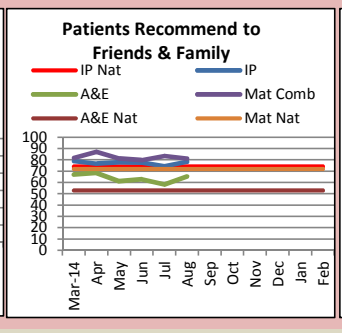


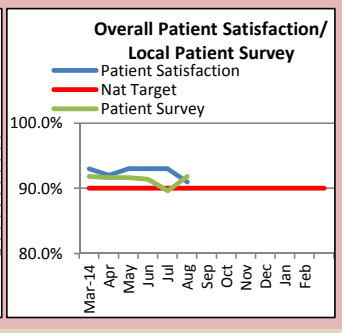


Quality - Complaints, Friends & Family, Patient Satisfaction

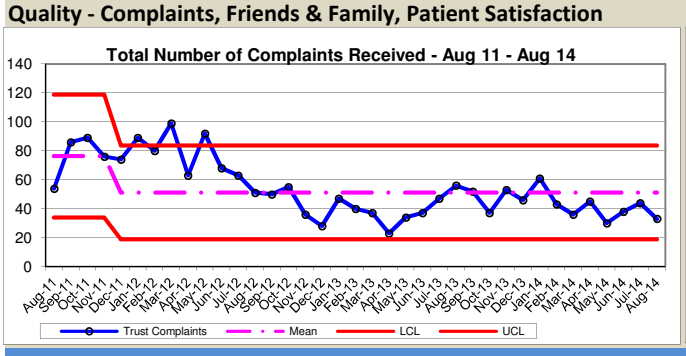


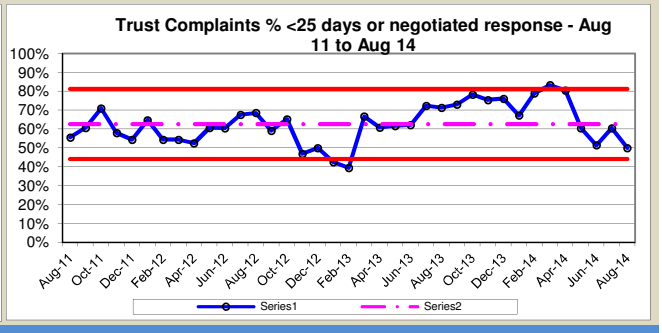




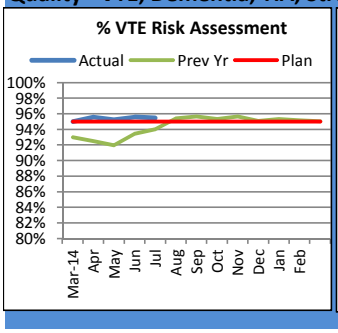


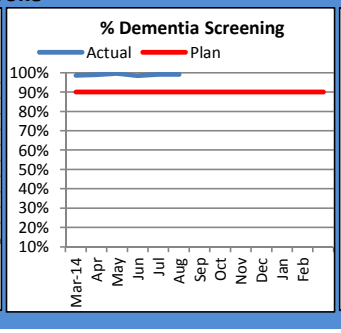
Quality - Complaints, Friends & Family, Patient Satisfaction

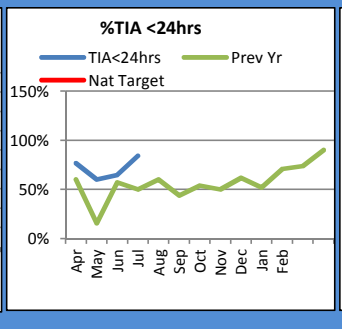


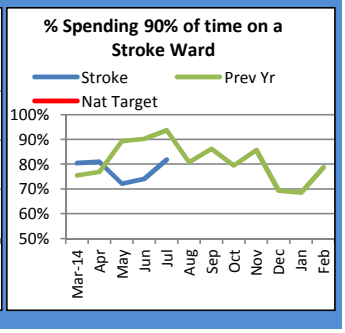


Quality - VTE, Dementia, TIA, Stroke



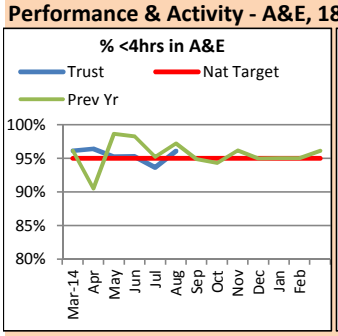


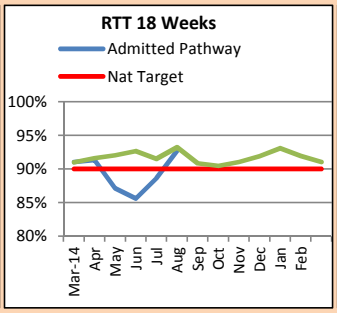


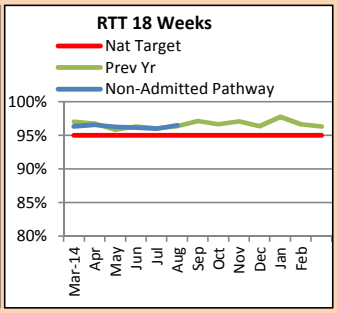


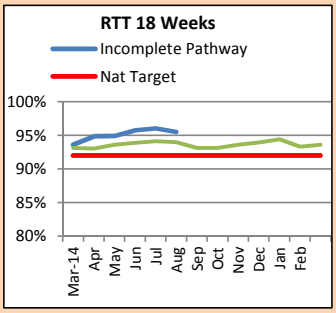
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

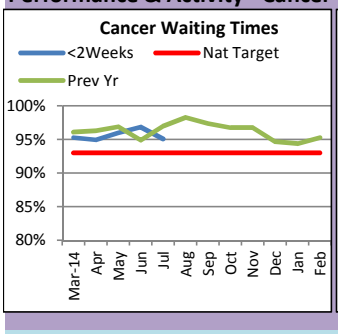


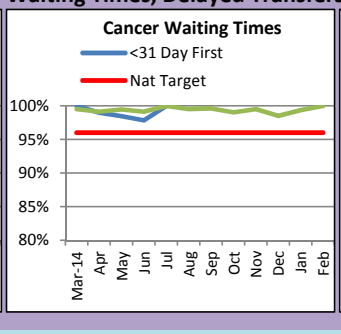


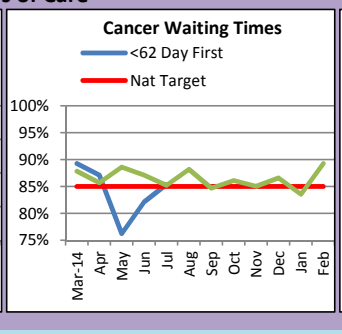


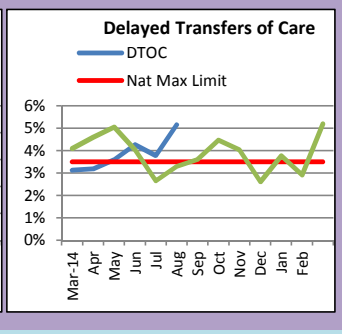


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

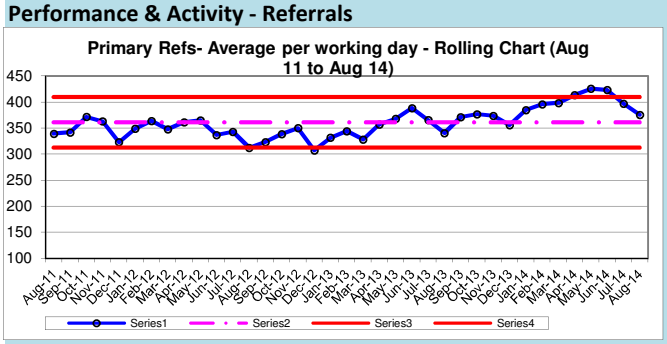


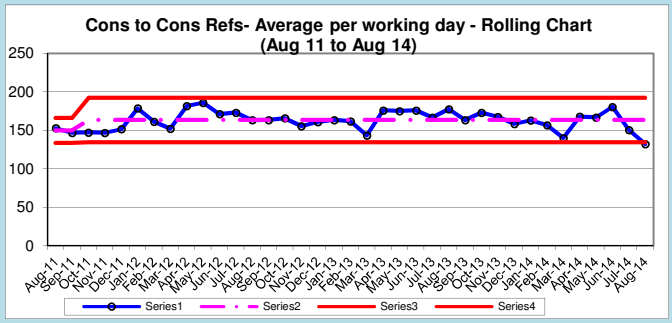




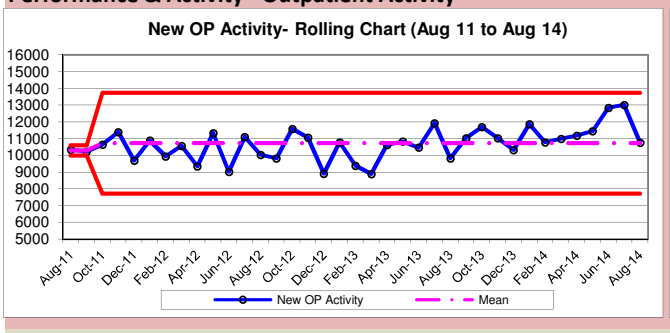


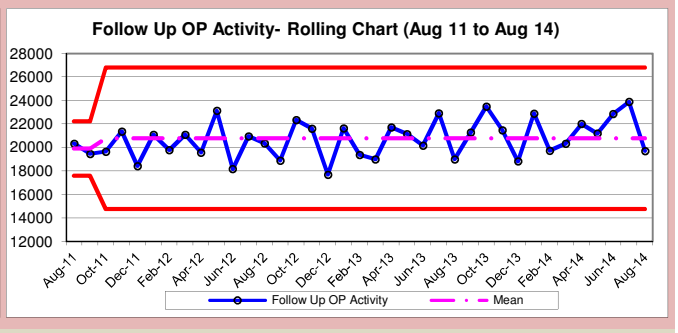
Performance & Activity - Referrals



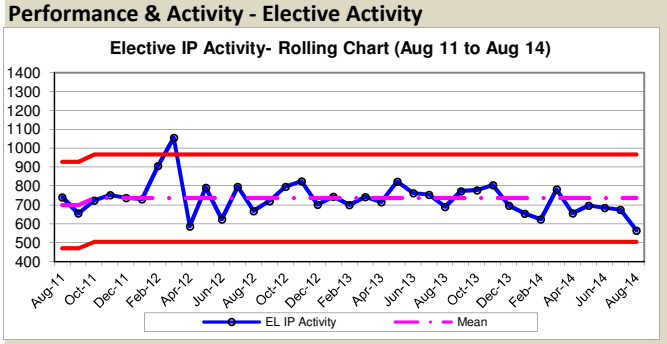


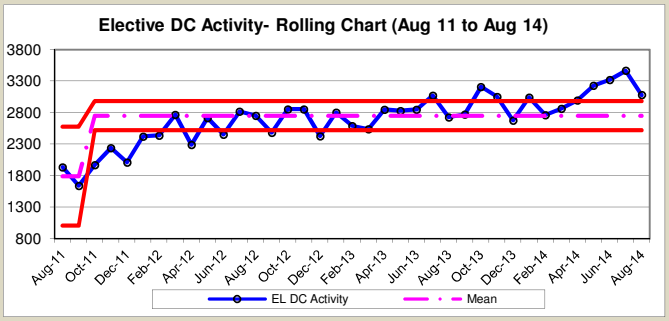
Performance & Activity - Outpatient Activity



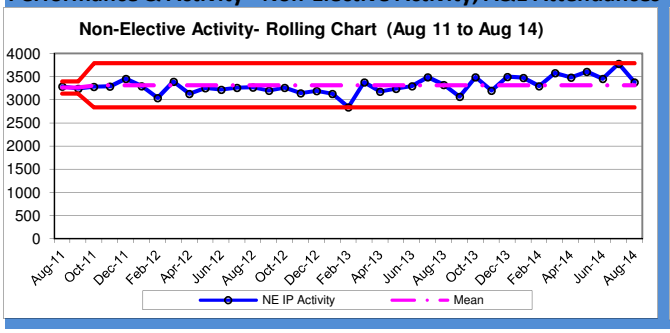


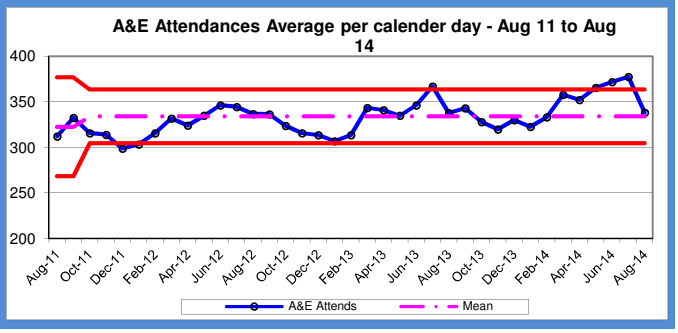
Performance & Activity - Elective Activity





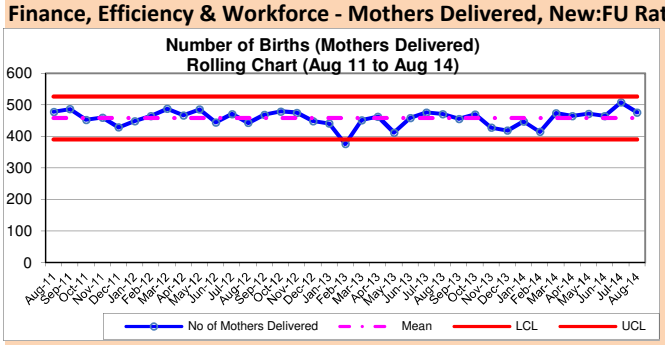
Performance & Activity - Non-Elective Activity, A&E Attendances

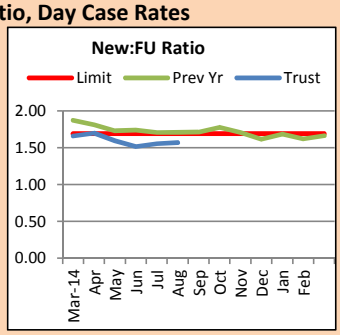


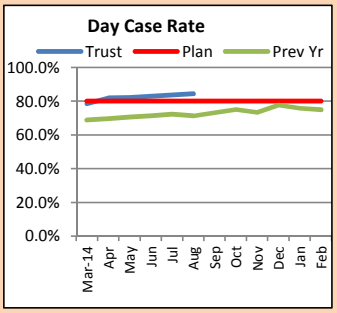


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

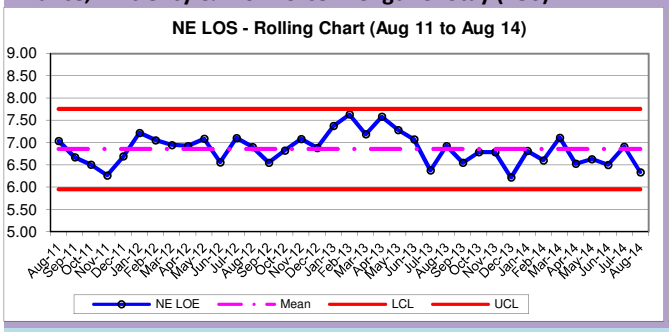
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

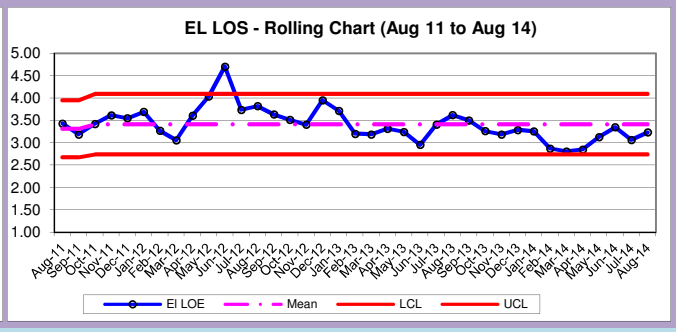




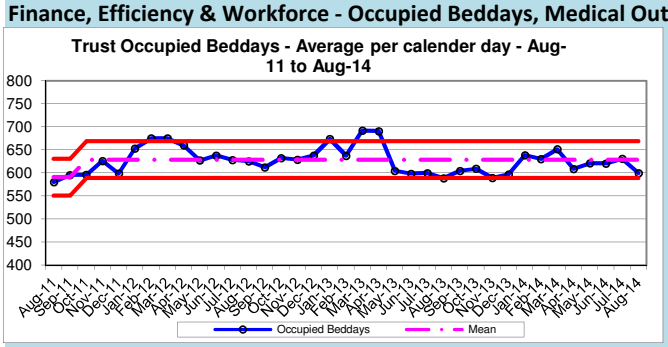


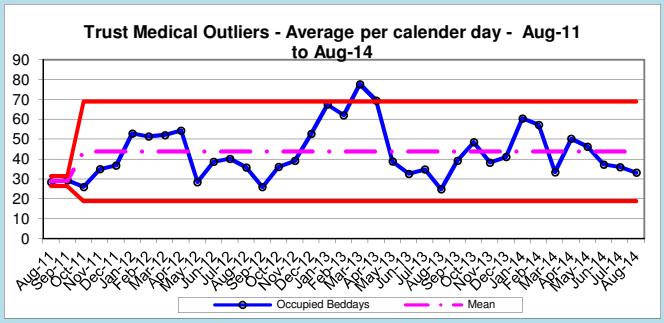
Finance, Efficiency & Workforce - Length of Stay (LOS)



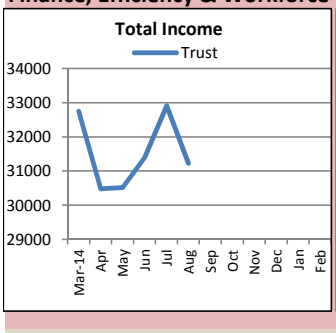


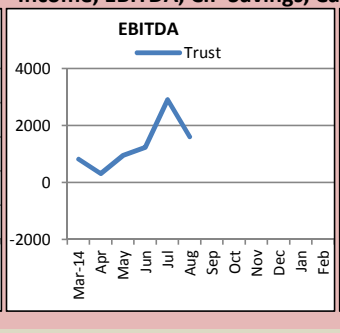
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

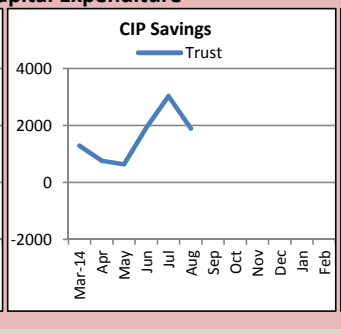


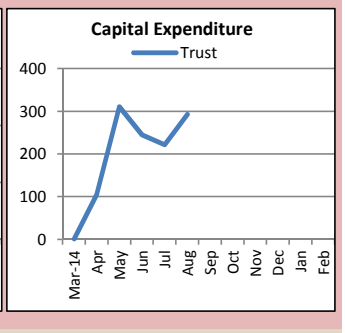


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

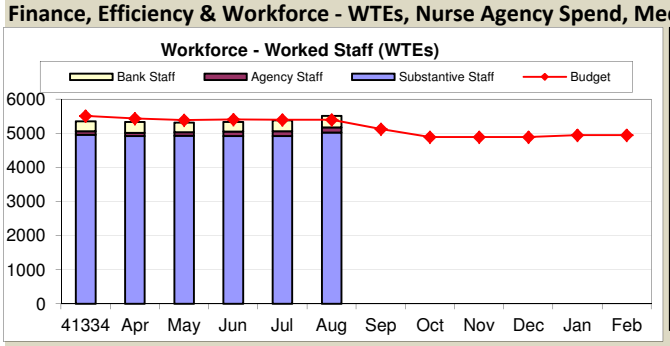


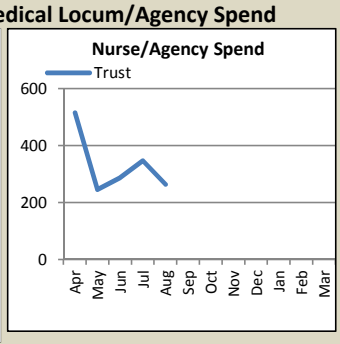


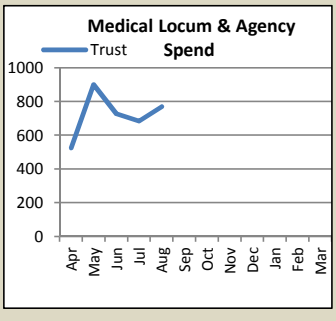




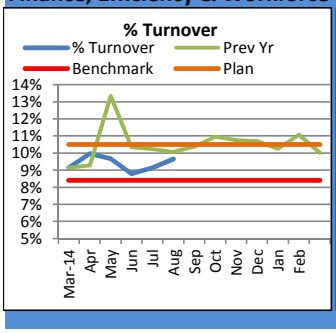
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

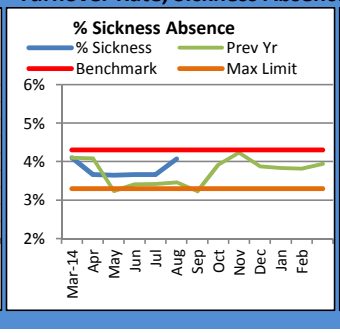


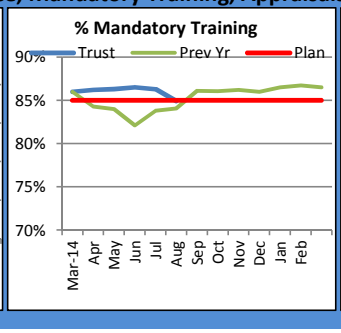


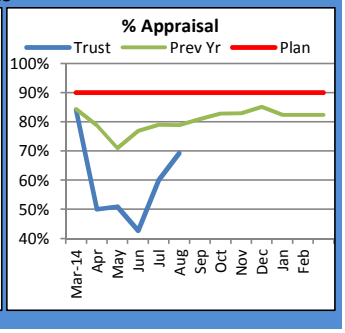


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Stephen Orpin - Director of Finance

M5 Financial Performance overview

1. Overview of the Financial Position at M5 2014/15

1.1. This written summary provides an overview of the financial position at M5 of 2014/15. It should be read alongside the finance pack.

1.2. The Finance pack shows for month 5 an in month deficit of £1.2m against a plan of £1.1m resulting in a year to date deficit of £8.0m against a planned deficit of £8.3m, a favourable variance of £0.3m. There is a prudent provision for £1.8m for additional costs included within the Month 5 position.

1.3. Total income is £156.5m against a budget of £156.6m; an underperformance of £0.1m. The main variances on income are outlined below :

- NHS Clinical income is over performing by £0.6m. However the outsourcing plan is underperforming £2.7m.
- 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 £0.8m however this is offset by NHS activity performed and by lower than planned expenditure in both pay and non-pay.

1.4. Non elective activity dropped this month and is now c5% higher than plan year to date (down 2% in month). This also correlates to a reduction in A&E activity this month against the trend in previous months. The increase above plan is mostly paid at 30% due to the threshold applied and is now 39% above plan (39% reduction in the month).

1.5. Although non elective activity reduced against the trend, elective activity did not increase in the month. Elective activity is now 22% behind plan (up 2% on last month) however 8% (no change in month) of the underperformance is caused by the outsourcing plan of 371 cases with 42 cases being achieved.

1.6. The non elective activity decrease has meant that some escalation beds were shut during this month (c 45 beds down 20 beds from last month).

Temporary nursing staff usage has reduced marginally in the month however the holiday period has negated some of the reduction in temporary staff spend.

1.7. Operating costs are £149.5m against a plan of £153.0m, however there is a net £3.5m of savings and reserves to be allocated which would reduce the plan to £149.5m if the whole amount was allocated to Operating expenditure.

1.8. Pay was breakeven in the month (for the second month running) and remains at £1.0m underspent. The underspend did not continue on the month 1 to 3 trend this month due to the continuing high temporary staffing £0.2m and original CIP plans impacting by £0.2m.

1.9. Non pay underspent by £0.3m in month and is now £2.5m underspent year to date. However, Purchase of healthcare from non NHS bodies is £2.7m (£0.5m in month) underspent and is offset by underperformance in day case and elective income relating to the original plan for outsourcing activity. Despite the reduction in activity this month additional costs relating to previous periods emerged.

1.10. EBITDA is a £7.0m surplus and is breakeven against the plan.

1.11. The financing costs including those related to the PFI and deprecation totalled £15.7m, which is now underspent against the in year plan by £0.6m 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 in against the capital plan reducing the depreciation cost against budget.

1.12. The year to date CIP delivery is £8.3m against a target of £8.2m and is forecast to deliver £22.4m against the plan of £22.4m.

1.13. The I&E forecast to the end of the financial year expects the Trust to deliver its planned deficit of £12.3m.

1.14. Cash balances of £9.8m were held at the end of M5. Discussions with NHS debtors over the settlement of 2013/14 outstanding debt are on-going. The operational cash forecast has receipt of this income of £7.4m in September.

1.15. The SLA team have been in negotiations with WKCCG in respect to 14/15 contract, currently the monthly SLA figure is invoiced based on £175m. As from Month 6 this has been increased against the revised baseline of £185m. A "catch-up" invoice for M1-6 has been raised in M6 circa £5.8m

which is expected to be paid in September. If the £5.8m is received as expected this will delay the temporary borrowing requirement to January 2015.

1.16. The 2014/15 plan highlights a requirement for additional permanent working capital support £14.3m. The TDA have confirmed that the Independent Trust Financing Facility (ITFF) for south patch Trusts meets on 16th January. The application process is similar to that followed in 2013/14 and will need to be based on an LTFM revised to a minimum of Month 4 actuals.

1.17. Due to the timing of the ITFF approvals, permanent working capital support will not be available for drawdown until mid-February. On this basis, and based on the agreements reached with commissioners, further temporary cash support may be needed as we approach the date of drawdown.

1.18. Total debtors are £47.6m (£46.1m in M4). The two largest debtors (invoiced) at the end of the period are WKCCG owing £14.4m gross and NHS England who owe £8.2m gross, primarily relating to invoices subject to year-end reconciliation. Included within the debtors balances are estimated 14/15 overperformance invoices for month's 1-3 activity, in total £7.3m. This element will reduce following agreement from West Kent CCG to move to a baseline of £185m. 90 day debt is £20.7m this has reduced since Month 1 by £1.4m (£22.1m) and is expected to reduce significantly when the year end position agreement is reached with commissioners.

1.19. Creditors are £54.3m (£55.6m in M4). The percentage of the value of payments made within 30 days was 84.7% against a target of 95%, 2013/14 cumulative year end performance was 56.2%.

1.20. Capital expenditure to month 5 was £1.2m of the revised forecast expenditure £14.3m. This was £3.8m less than the planned expenditure at month 5 of £5m based on the £18.8m original plan. The plan continues to be prioritised and aligned to the Trusts strategy.

1.21. The Trust's performance against the TDA Accountability framework is red due to its planned deficit position.

NHS Commercial In Confidence

Maidstone and Tunbridge Wells NHS Trust

Trust Summary by Directorate Year to Date as at Month 5 2014/15

	SLA Income			Other Income			Expenditure			Net Contribution Year to Date			
Directorates	**Budget £'000s**	**Actuals £'000s**	**Variance £'000s**	**Budget £'000s**	**Actuals £'000s**	**Variance £'000s**	**Budget £'000s**	**Actuals £'000s**	**Variance £'000s**	**Budget £'000s**	**Actuals £'000s**	**Variance £'000s**	
Clinical Directorates													
Surgery	25,257	25,325	68	3,461	3,702	242	(16,782)	(16,779)	3	11,935	12,248	313	Unallocated savings/reserves (£0.5m) YTD, overperforming on SLA net of outsourcing expectation £0.8m
T&O	14,539	11,716	(2,822)	513	493	(21)	(8,281)	(6,453)	1,829	6,771	5,757	(1,014)	Day cases/elective underachieving by (£1.0m) YTD, (£0.3m) in month, net of outsourcing plan underachieving offset by expenditure underspend
Critical Care	3,900	3,733	(167)	695	739	45	(13,697)	(14,133)	(437)	(9,102)	(9,661)	(559)	Unallocated savings/reserves (£0.7m) YTD partially offset by underspends in Nursing and Medical staffing against the agreed workforce plan (combined £0.3m) - . SLA now underperforming by (£0.2m)
Acute & Emergency Medicine	17,404	18,616	1,212	813	810	(3)	(11,353)	(12,372)	(1,019)	6,864	7,054	190	Non elective plan is currently under review (potential offset with Specialty Med) and £1.3m overperforming. Pay overspent by (£0.7m), non pay (£0.1m). Unallocated savings/reserves (£0.2m)
Specialty Medicine	18,626	17,853	(773)	2,307	2,206	(101)	(17,577)	(18,540)	(964)	3,357	1,519	(1,838)	Non elective plan is currently review (potential offset with Acute) (£1.1m) underperforming. Unallocated savings/reserves (£1.1m) YTD offset by overperformance on other SLA income
Cancer & Haematology	14,478	15,350	872	8,512	8,371	(141)	(15,465)	(15,672)	(207)	7,525	8,049	524	Unallocated savings/reserves (£0.7m) YTD, SLA showing a £0.9m overperformance. Pay and non pay underspending £0.5m. PP income underperforming by (£0.2m)
Diagnostics, Therapies & Pharmacy Services	5,585	6,156	571	3,931	3,963	32	(12,745)	(13,286)	(541)	(3,228)	(3,167)	61	Overperforming against SLA £0.6m, offsetting unallocated savings of (£0.5m)
Obstetrics, Gynaecology & Sexual Health	12,673	12,939	266	305	295	(10)	(8,497)	(9,135)	(638)	4,481	4,099	(382)	unallocated savings (£0.7m) YTD offset by £0.3m overperformance on SLA income
Paediatrics	4,050	4,121	70	345	316	(29)	(4,145)	(4,425)	(279)	250	12	(238)	unallocated savings (£0.3m) YTD
MTW-Healthcare	1,163	1,385	222	1,395	962	(433)	(2,267)	(1,985)	282	291	361	70	
Total Clinical Directorates	**117,675**	**117,194**	**(481)**	**22,277**	**21,857**	**(420)**	**(110,809)**	**(112,781)**	**(1,971)**	**29,143**	**26,271**	**(2,873)**	
Corporate Directorates													
Non Directorate	8,166	9,247	1,081	655	495	(160)	(18,393)	(15,378)	3,015	(9,572)	(5,637)	3,936	Budgets held in reserves to potentially be released to Directorates
HIS				4,084	4,154	70	(4,084)	(4,187)	(103)	0	(33)	(33)	
Total Trust	**125,841**	**126,441**	**600**	**30,764**	**30,096**	**(668)**	**(164,930)**	**(164,518)**	**413**	**(8,325)**	**(7,981)**	**344**	

Trust Summary by Directorate Forecast Out Turn as at Month 5 2014/15

	SLA Income			Other Income			Expenditure			Net Contribution FOT		
Directorates	**Budget £'000s**	**Actuals £'000s**	**Variance £'000s**	**Budget £'000s**	**Actuals £'000s**	**Variance £'000s**	**Budget £'000s**	**Actuals £'000s**	**Variance £'000s**	**Budget £'000s**	**Actuals £'000s**	**Variance £'000s**
Clinical Directorates												
Surgery	59,798	61,804	2,006	8,294	8,886	592	(38,205)	(40,536)	(2,330)	29,886	30,154	268
T&O	32,950	28,887	(4,063)	1,232	1,183	(50)	(17,566)	(16,056)	1,510	16,616	14,013	(2,603)
Critical Care	9,343	8,942	(401)	2,034	2,110	76	(32,990)	(34,294)	(1,304)	(21,613)	(23,241)	(1,629)
Acute & Emergency Medicine	41,561	44,946	3,384	1,961	1,955	(6)	(26,772)	(29,422)	(2,651)	16,751	17,479	728
Specialty Medicine	45,038	43,240	(1,798)	5,507	5,252	(255)	(42,306)	(44,934)	(2,628)	8,239	3,559	(4,680)
Cancer & Haematology	34,898	37,251	2,353	20,471	20,253	(218)	(37,145)	(38,085)	(940)	18,225	19,419	1,194
Diagnostics, Therapies & Pharmacy Services	13,587	14,979	1,392	9,406	9,518	112	(30,509)	(32,581)	(2,072)	(7,516)	(8,085)	(569)
Obstetrics, Gynaecology & Sexual Health	30,408	31,054	646	679	690	11	(20,235)	(22,086)	(1,851)	10,852	9,658	(1,194)
Paediatrics	9,754	10,055	301	828	760	(69)	(10,036)	(10,809)	(772)	545	6	(539)
MTW-Healthcare	1,409	3,368	1,959	3,605	2,297	(1,308)	(4,472)	(4,512)	(41)	542	1,153	610
Total Clinical Directorates	**278,746**	**284,525**	**5,780**	**54,018**	**52,904**	**(1,114)**	**(260,236)**	**(273,316)**	**(13,080)**	**72,528**	**64,114**	**(8,414)**
Corporate Directorates												
Non Directorate	23,602	27,065	3,463	1,697	2,025	328	(42,719)	(36,127)	6,591	(17,419)	(7,037)	10,382
HIS				9,801	10,176	375	(9,801)	(10,173)	(372)	0	2	2
Total Trust	**302,348**	**311,590**	**9,242**	**74,500**	**73,953**	**(547)**	**(389,151)**	**(397,844)**	**(8,693)**	**(12,303)**	**(12,300)**	**2**

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Maidstone and Tunbridge Wells NHS Trust

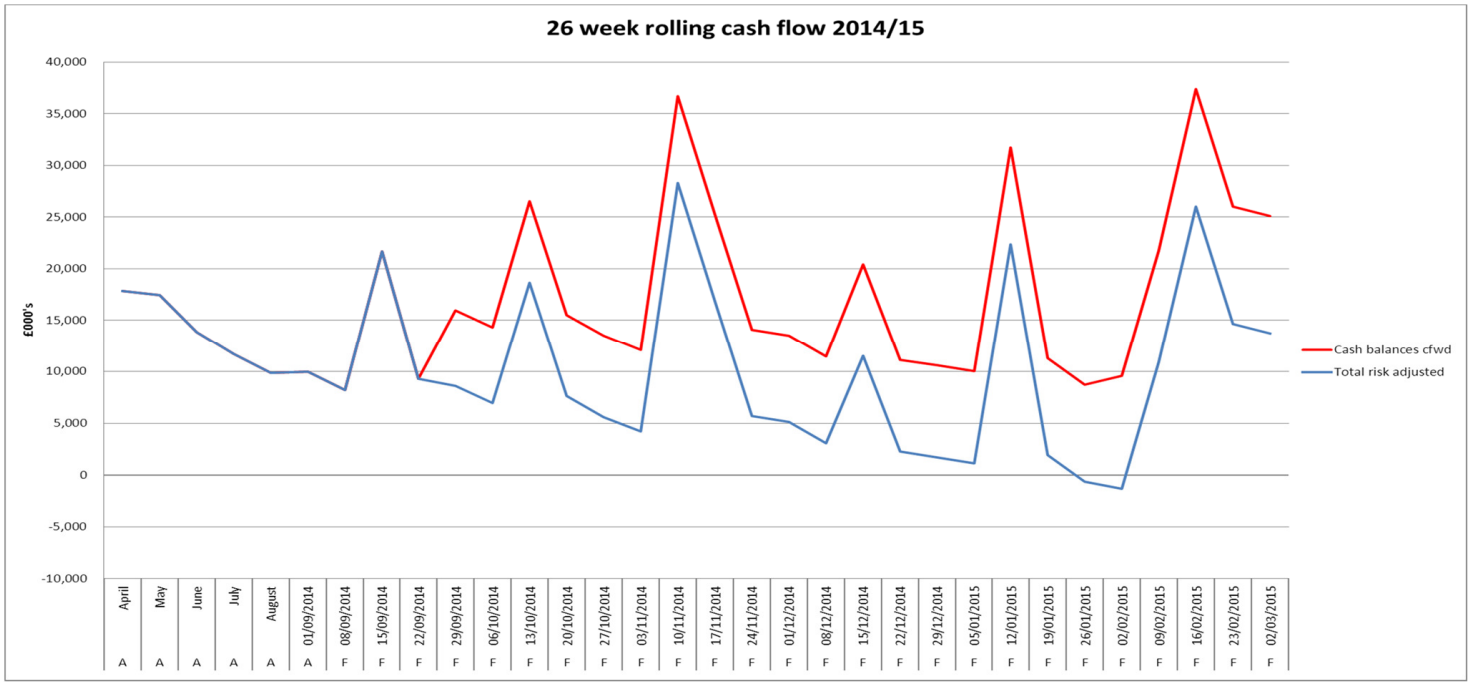
The year to date and FOT SLA position against the Trusts internal plan as at Month 5 2014/15

	Annual Plan	Phased plan (Month 5)	YTD Performance (Month 5)	Variance	% age Variance	FOT	FOT Variance	FOT % age Variance
	£'000	£'000	£'000	£'000	%	£'000	£'000	%
Daycase	34,236	14,754	14,145	-609	-4%	34,411	175	1%
Elective IP (in Excess days)	28,778	12,989	9,829	-3,159	-24%	23,912	-4,866	-17%
Non Elective IP (inc Excess days)	87,386	36,630	37,118	488	1%	88,550	1,164	1%
Non Elective Threshold	-3,937	-1,650	-2,297	-647	39%	-5,479	-1,543	39%
Outpatient New	21,493	8,961	9,771	811	9%	23,770	2,278	11%
Outpatient Follow up	23,764	9,781	10,561	780	8%	25,692	1,928	8%
Outpatient Unbundled imaging	6,448	2,651	3,634	983	37%	8,839	2,391	37%
Unbundled Imaging Threshold	-1,978	-813	-813	0	0%	-1,978	0	0%
Direct Access, A&E, other Direct	73,235	30,496	30,333	-163	-1%	72,889	-347	0%
Other NHS Clinical Income	12,164	4,633	5,478	845	18%	15,454	3,291	27%
Challenge provision	-7,067	-2,905	-3,043	-138	5%	-8,058	-992	14%
CQUIN	5,557	2,319	2,413	94	4%	5,569	12	0%
Transitional support - Cancer	0	0	2,396	2,396	0%	5,750	5,750	0%
Cost of Change	3,000	0	0	0	0%	3,000	0	0%
CCG Reinvestment	2,970	1,080	0	-1,080	-100%	2,970	0	0%
NHD Support	16,300	6,917	6,917	0	0%	16,300	0	0%
Total	**302,348**	**125,841**	**126,441**	**600**	**0%**	**311,590**	**9,242**	**3%**

NHS Commercial In Confidence

26 Week graphical presentation of cash balances up to w/c 2nd March, actuals at 5th September 2014

Maidstone and Tunbridge Wells NHS Trust



	A	A	A	A	A	A	F	F	F	F	F	F	F	F	F	F	F
Week commencing	April	May	June	July	August	01/09/2014	08/09/2014	15/09/2014	22/09/2014	29/09/2014	06/10/2014	13/10/2014	20/10/2014	27/10/2014	03/11/2014	10/11/2014	17/11/2014
Cash balances cfwd	17,840	17,446	13,852	11,677	9,870	9,977	8,181	21,697	9,263	15,990	14,316	26,551	15,527	13,482	12,088	36,696	25,263
13/14 o/performance	0	0	0	0	0	0	0	0	0	7,387	7,387	7,387	7,387	7,387	7,387	7,387	7,387
14/15 o/performance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reinvestment income	0	0	0	0	0	0	0	0	0	0	0	495	495	495	495	990	990
External Financing - capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total risk adjusted	**17,840**	**17,446**	**13,852**	**11,677**	**9,870**	**9,977**	**8,181**	**21,697**	**9,263**	**8,603**	**6,929**	**18,670**	**7,645**	**5,600**	**4,206**	**28,320**	**16,886**

	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Week commencing	24/11/2014	01/12/2014	08/12/2014	15/12/2014	22/12/2014	29/12/2014	05/01/2015	12/01/2015	19/01/2015	26/01/2015	02/02/2015	09/02/2015	16/02/2015	23/02/2015	02/03/2015
Cash balances cfwd	14,075	13,501	11,441	20,411	11,114	10,579	10,005	31,743	11,296	8,716	9,555	21,795	37,361	26,003	25,129
13/14 o/performance	7,387	7,387	7,387	7,387	7,387	7,387	7,387	7,387	7,387	7,387	7,387	7,387	7,387	7,387	7,387
14/15 o/performance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reinvestment income	990	990	990	1,485	1,485	1,485	1,485	1,980	1,980	1,980	1,980	1,980	2,475	2,475	2,475
External Financing - capital	0	0	0	0	0	0	0	0	0	0	1,500	1,500	1,500	1,500	1,500
Total risk adjusted	**5,698**	**5,124**	**3,064**	**11,539**	**2,242**	**1,707**	**1,133**	**22,377**	**1,929**	**-651**	**-1,312**	**10,928**	**25,999**	**14,641**	**13,767**

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.

Total risk adjusted	**-1,806**	**-3,035**	**20,892**	**9,414**	**-1,220**	**-1,629**	**-3,534**	**4,910**	**-4,187**	**-4,722**	**-5,761**	**9,956**	**-11,606**	**-461**	**-1,087**	**-3,322**

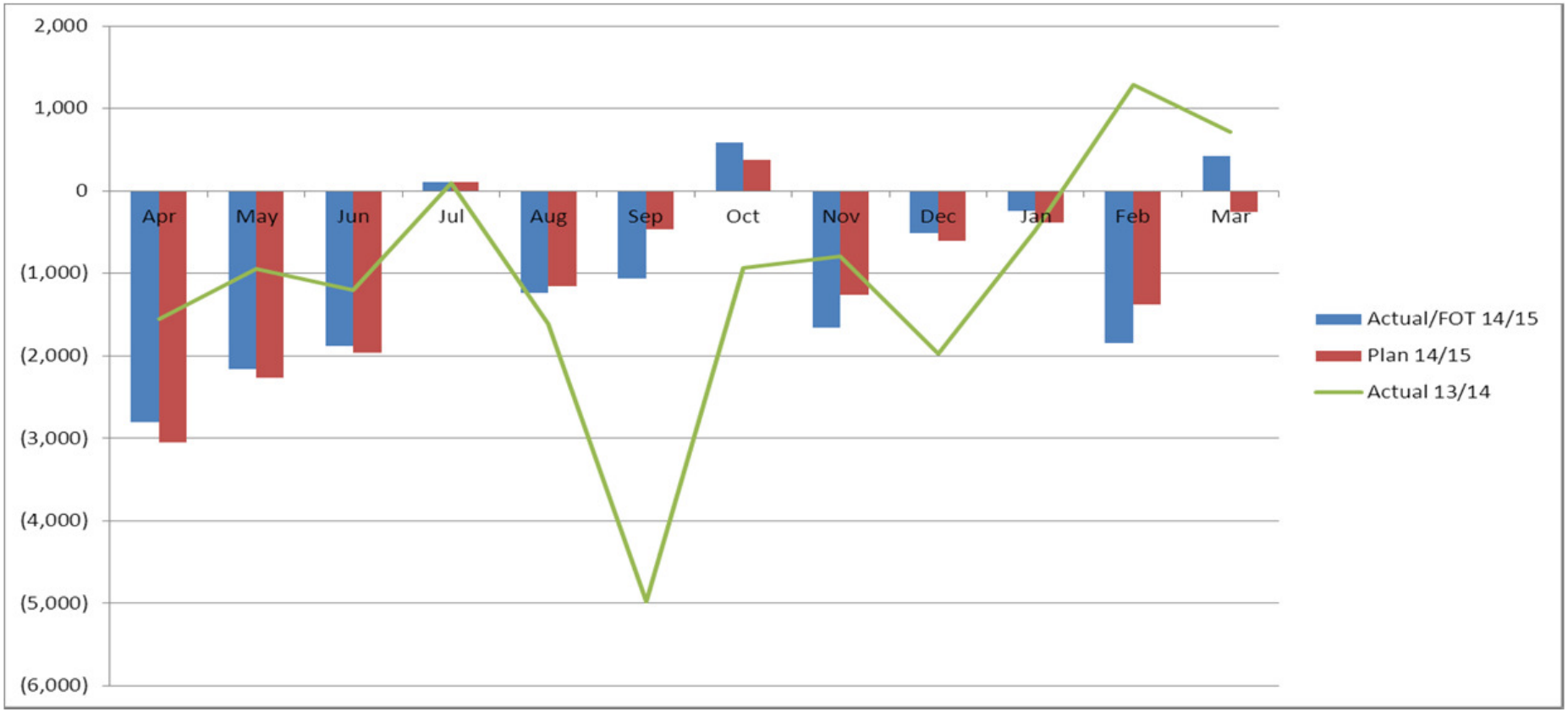
NB - although the risk adjusted line shows a negative balance, the Trust is not permitted to go overdrawn, therefore action would be taken to ensure no negative balance.

NHS Commercial In Confidence

I&E Monthly Position Graph as at Month 5 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)	(1,062)	581	(1,662)	(511)	(245)	(1,846)	426
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



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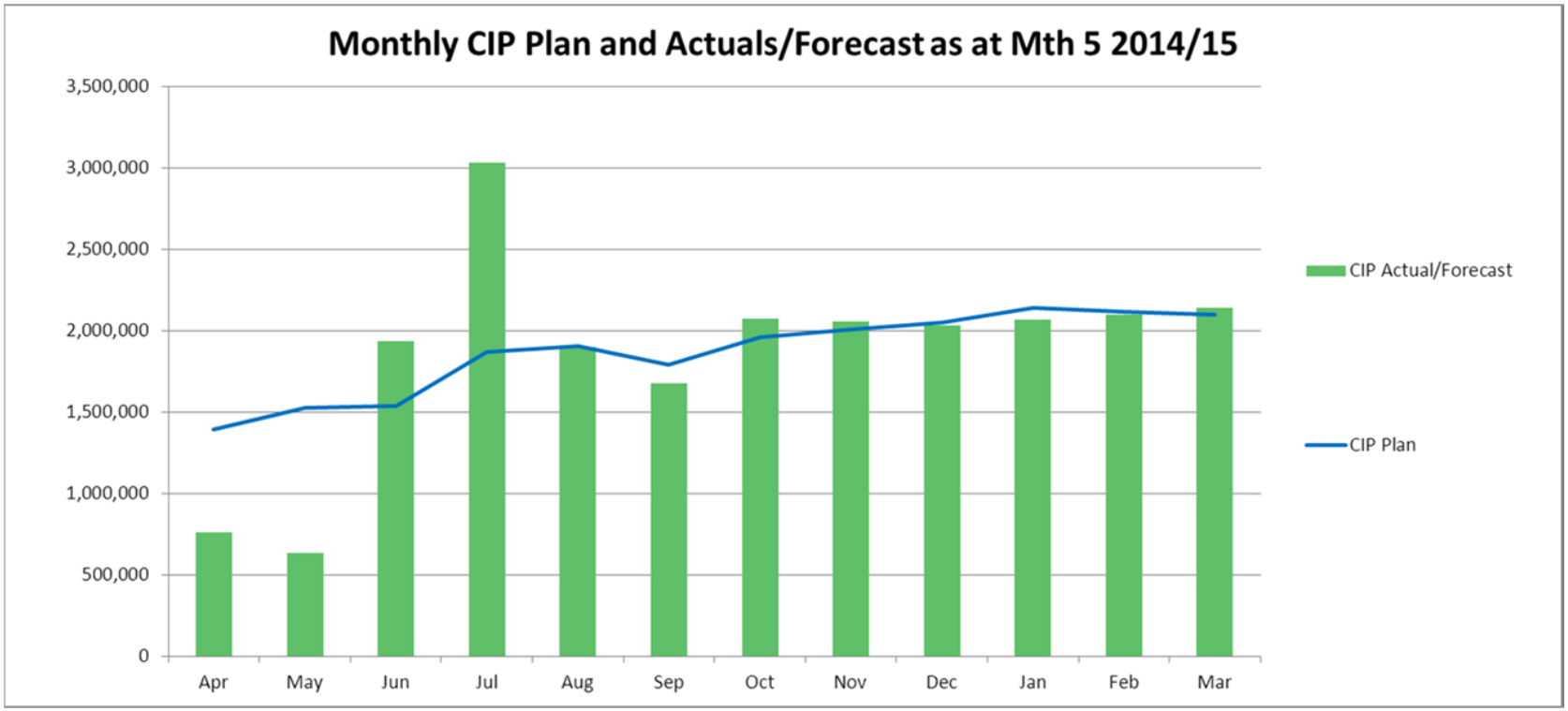
Maidstone and Tunbridge Wells NHS Trust



Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – September 2014

9-8 Clinical Quality and Patient Safety Report Chief Nurse

Summary / Key points

The attached paper provides the Board with an update on the progress being made against the action plan developed following the National Care of the Dying Audit findings in May 2014. The paper also informs the Board on the results of the 2014 Patient-Led Assessment of the Care Environment (PLACE).

National Care of the Dying Audit – Action Plan
The audit findings (presented to Board in May 2014) showed that Maidstone and Tunbridge Wells performed below the national average for organisational and clinical performance indicators. An action plan attached to the report details the key areas of focus. Best practice guidance has been developed to support staff in managing symptom control, decision making and producing individualised care plans.

Place 2014 results
The results for 2014 show that MTW performed above the national average for cleanliness and environment but below the national average for food and hydration and wellbeing. The significant factors contributing to the below national average performance are quality of food at Tonbridge Cottage and other factors around food service at Maidstone hospital. The privacy and dignity concerns centred on outpatient areas and provision of facilities at Maidstone Hospital. Action is already underway to address concerns raised.

Which Committees have reviewed the information prior to Board submission?

- End of Life Steering Committee
- Patient Environment Steering Group

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

The Trust Board is asked to note the report and discuss any issues of concern.

Clinical Quality and Patient Safety Report

September 2014

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

This report provides an update to the board on progress against the National Care of the Dying Audit action plan and the results of the Patient – led Assessment of the Care Environment 2014 self-assessment (PLACE).

The Board is asked to note the contents of this report and make any recommendations as necessary.

End of Life Care

The National Care of the Dying Audit for Hospital, England was published 15 May 2014. The report is produced by the Royal College of Physicians and the Marie Curie Palliative Care Institute, Liverpool.

This audit was of the documentation of care recorded in 51 sets of medical notes of patients that died in the Trust during May 2013.

The audit reviewed areas including prescribing, interventions, communication, spirituality, nutrition/hydration and care of the patients/next of kin after death. There were themes in each of these realms that require addressing although in the majority of cases MTW was comparable with scores achieved in other Trusts.

It is important to highlight this is a report of the documentation of care rather than the care itself. However this is a useful surrogate measure of care and emphasises the importance of high quality contemporaneous documentation.

Results from the audit showed that Maidstone and Tunbridge Wells performed below the national average in clinical and organisational key performance indicators.

An action plan has been developed in response to the audit (appendix 1) and is being progressed through the End of Life Steering Group and is being led by Dag Rutter, Consultant in Palliative Medicine. The focus has been on putting in place guidance for staff to use following the withdrawal of the Liverpool Care Pathway (LCP). The Trust has developed New Best Practice Guidance for Care of the Dying Adult Patients which includes guidance on symptom control and steps to creating an individualised care plan. This is currently being trialled on 8 wards for the final time prior to being formally agreed.

Patient-led Assessment of the Care Environment

1 Introduction

The Patient-Led Assessments of the Care Environment (PLACE) are a self-assessment of a range of non-clinical services which contribute to the environment in which healthcare is delivered. These assessments were introduced in April 2013 to replace the former Patient Environment Action Team (PEAT) assessments which had been undertaken from 2000-2012 inclusive.

2 2014 key results

PLACE 2014	Cleanliness	Food and Hydration	Privacy, Dignity and Wellbeing	Condition appearance and maintenance
National Ave	**97.25%**	**88.79%**	**87.73%**	**91.76%**
MTW	**99.27%**	**79.61%**	**78.12%**	**93.94%**

3 Cleanliness

MTW scores for cleanliness have risen 2% since 2013 to an average of 99.27% and also remain 2% above the national average. This is an excellent achievement for the teams.

4 Food and Hydration

The assessment of Food and Hydration includes a range of questions relating to the organisational aspects of the catering service (e.g. choice, 24-hour availability, meal times, and access to menus) as well as an assessment of the food service at ward level and the taste and temperature of food. This year the methodology relating to the organisational questions element of the food and hydration score was changed to introduce a weighting mechanism.

Figures released nationally do not show our hospitals as being marked especially favourably for food and hydration, it must be emphasised that a large proportion of this score does not relate to the quality of the food served to patients and, when broken down, the figures show that the quality of food was considered to be good by the assessors except at Tonbridge Cottage Hospital (TCH). At the time of the inspection the menus had been changed at Tonbridge Cottage. The services at Tonbridge Cottage are provided through an Service Level Agreement with Kent Community Health. We are working closely with Kent community in the on-going monitoring of the food provided for stroke patients. The other areas needing improvement were more focused around the food service and preparation of the patients and ward environment prior to meals, such as the accessibility of chilled water, patients being sat up and ready to receive their meals, a napkin being provided to patients and courses of food being served separately.

5 Privacy, Dignity and Wellbeing

MTW average score was low at 78.12 the large proportion of the low scores related to outpatient areas. The particular areas of concern were clinics being overbooked, waiting areas to close to the reception desk which prevent privacy, no discreet exit from the consultation rooms for patients to use rather than back through the main waiting area. Specific comments noted in regards to Maidstone inpatient areas were the lack of treatment and private consulting rooms within the wards.

6 Condition, Appearance and Maintenance

MTW average score is 93.94% a 2% increase from 2013 and 2% above the national average.

7 Action

A full action plan for each site, covering each element will be monitored by the Patient Environment Steering Group.

CLINICAL AUDIT ACTION PLAN **Audit id: 150 14/15**
Audit Title: National Care of the Dying (NCDAH) Round 4

Auditor(s): Dr D Rutter, Dr B Mackay **Date: 9/9/14**

Consultant / Supervisor **(Audit Lead)**	Name: Dag Rutter Title: Consultant in Palliative Care	Signature:	Date of signature:
General Manager / ADO / Matron	Name: Batsi Katsande	Signature:	Date of signature:
Forum where audit presented and action plan agreed:	End of Life Care Steering Group	Date of discussion: July & August meetings 2014	

Recommendation *(Ensure that the recommendations detailed in this action plan mirror those recorded in the "Recommendations" section of the report.)*	**Action(s) required to implement the recommendation** *(The "Actions required" should specifically state what needs to be done to implement the recommendations. A recommendation may require more than one action to achieve the desired outcome.)*	**Person responsible for leading on the action. (Name and grade / job title)**	**Date action due to be completed**	**Update on progress towards implementation of action** *(Provide details of action implemented, changes in practices, barriers to facilitating change, reasons why recommendation has not been implemented etc)*	**Date action completed**
Organisational Measures:					
KPI 1: Access to information relating to death and dying Requirement, 5/5 leaflets providing information about: 1. A leaflet outlining the changes that may occur in patients in the hours before death. 2. A leaflet explaining the facilities that are available for relatives and friends. 3. A leaflet explaining the grieving	• Macmillan Cancer support produce a generic booklet 'End of Life: a guide' that was reviewed by the EoLC steering committee and was agreed to be used in the Trust. This booklet addresses the requirements of leaflets 1 & 3. NB it was noted that the booklet does mention the LCP and its planned withdrawal, so further work on Trust specific leaflets will be	S Badcott Lead Nurse palliative care to request 1000 copies from Macmillan (we have been advised by Macmillan that there is no charge for the supply of these booklets)		Leaflets being sourced and produced whilst acknowledging that some already exist and the need to pull together information from key leaflets into one core leaflet	

Recommendation *(Ensure that the recommendations detailed in this action plan mirror those recorded in the "Recommendations" section of the report.)*	**Action(s) required to implement the recommendation** *(The "Actions required" should specifically state what needs to be done to implement the recommendations. A recommendation may require more than one action to achieve the desired outcome.)*	**Person responsible for leading on the action. (Name and grade / job title)**	**Date action due to be completed**	**Update on progress towards implementation of action** *(Provide details of action implemented, changes in practices, barriers to facilitating change, reasons why recommendation has not been implemented etc)*	**Date action completed**
process for relatives and friends. 4. A leaflet explaining local procedures to be undertaken after the death of a patient 5. Department of Work and Pensions (DWP) leaflet 1027, What to Do After A Death in England and Wales or equivalent. 4/5 leaflets in MTW at time of audit	reviewed at future EoLC steering group meetings. • Although there are already separate leaflets in the Trust meeting the requirement for leaflet 2, Neve Mann will be asked to compile a specific EoLC information leaflet. • Leaflet 5 produced by DWP is already in use in the Bereavement offices.	D Rutter, Consultant To contact J Harris to confirm existing leaflet(s) 2 exist N Mann EoLC CNS To develop new local EoLC specific Information leaflet	October 2014		
KPI 2: Access to a specialist support service for care in last hours or days of life. Currently: Palliative care team provides 5/7 day working 9-5pm with access to 24hrs out of hours advise. Required: 7/7 9-5pm visiting service	• A joint business case between MTW and Macmillan Cancer Support to provide additional Palliative CNS's deliver this service.	A Bhatia Chief Nurse J Kennedy Deputy Chief Nurse S Badcott Lead Nurse palliative care D Rutter Consultant	January 2015	Working with Macmillan cancer support and as part of 7 day working strategy for MTW.	
KPI 3: Care of the dying education, training and audit. This measure requires training availability for medical, nursing (qualified), nursing (non-qualified) and allied health professional via the following categories: e-learning, update sessions, session in Trust induction programme.	AB to review mandatory training for nurses. Investigate available eLearning packages for EoLC	A Bhatia Chief Nurse P Bridger Senior Nurse Practice Development S Badcott Lead Nurse palliative care D Rutter Consultant	September 2014 November 2014		

Recommendation *(Ensure that the recommendations detailed in this action plan mirror those recorded in the "Recommendations" section of the report.)*	**Action(s) required to implement the recommendation** *(The "Actions required" should specifically state what needs to be done to implement the recommendations. A recommendation may require more than one action to achieve the desired outcome.)*	**Person responsible for leading on the action. (Name and grade / job title)**	**Date action due to be completed**	**Update on progress towards implementation of action** *(Provide details of action implemented, changes in practices, barriers to facilitating change, reasons why recommendation has not been implemented etc)*	**Date action completed**
Communication skills Training for medical, nursing (qualified), nursing (non-qualified) and allied health professional. Cut off point to achieve this KPI was10/20. MTW achieved 9/20					
KPI 4: Trust board representation and planning for care of the dying. Required: • Named member of the trust board for care of the dying. • Formal trust board reporting. • Patient and public representation within the trust	Present Trust's EoLC plans to Patient Experience Committee. Invite representative from CRUSE (Ann Munro) and the Pickering Centre (A Stevenson) to attend the Trust EoLC committee	A Bhatia Chief Nurse S Badcott Lead Nurse palliative care D Rutter Consultant A Munro Trust Ethicist A Stevenson Macmillan CNS	December 2014.	• EOLC Steering Group now operational and chaired by Chief Nurse for MTW. • End of life care Group reports to the Standards Committee, chaired by the Medical Director • The Medical Director (Trust lead for EoLC) and Chief Nurse report on EoLC Matters to the Board	
KPI 5: Clinical protocols for the prescription of medications for the 5 key symptoms at the end of life.	LCP included prescribing guidance for end of life care. Since withdrawl of LCP replacement guidance required.	S Badcott Lead Nurse palliative care D Rutter Consultant		• New end of life care best practice guidance includes prescribing guidance. Currently in use in Trust	
KPI 6: Clinical provision of protocols promoting patient privacy, dignity and respect, up to and including death of the patient. The audit required: 9/9 protocols/policies relating to care of the dying patient.	• Trust wide mouth care policy thought to be in place (DR to contact T Collins for clarification) • Pastoral care team to develop referral guidelines for inclusion in the revised Care of the Dying Policy	D Rutter Consultant N Mitra, Hospital Chaplain S Baker, Hospital Chaplain	October 2014 December 2014	• New Best Practice Guidance for Dying patients defines need for multidisciplinary decision-making process for diagnosing dying. • Regular Trust wide mortality	

Recommendation *(Ensure that the recommendations detailed in this action plan mirror those recorded in the "Recommendations" section of the report.)*	**Action(s) required to implement the recommendation** *(The "Actions required" should specifically state what needs to be done to implement the recommendations. A recommendation may require more than one action to achieve the desired outcome.)*	**Person responsible for leading on the action. (Name and grade / job title)**	**Date action due to be completed**	**Update on progress towards implementation of action** *(Provide details of action implemented, changes in practices, barriers to facilitating change, reasons why recommendation has not been implemented etc)*	**Date action completed**
• Formal multidisciplinary decision-making process for diagnosing dying. • Designated regular mortality meetings to review recent deaths • Guidelines for the assessment and delivery of mouth care. • Guidelines for referral to pastoral care/chaplaincy team. • Policy for the decision and documentation of a 'do not attempt cardiopulmonary resuscitation (DNACPR) order'. • Policy for the deactivation of implantable cardioverter defibrillators' (ICDs). • Policy for carrying out care of the body in the immediate time after the death of a patient. • Policy for providing relatives/friends regarding the verification and certification of the patient's death. • Policy for viewing the body in the immediate time after the death of a patient. • Designated formal quiet spaces available for relatives/friends. • Designated religious/spiritual rooms MTW achieved - 4/9 polices/protocols	• Policy for deactivation of ICD's. DR to contact J Harris to confirm policy active • Care of the Dying Policy to include guidance for relatives or friends re: verification and certification of the patient's death. NB although designated formal quiet spaces available for relatives/friends do exist, AB to explore provision of dayrooms at MGH	D Rutter Consultant Liz Champion Matron Dementia A Bhatia Chief Nurse	October 2014 October 2014 March 2014	group chaired by the MD operational.	

Recommendation *(Ensure that the recommendations detailed in this action plan mirror those recorded in the "Recommendations" section of the report.)*	**Action(s) required to implement the recommendation** *(The "Actions required" should specifically state what needs to be done to implement the recommendations. A recommendation may require more than one action to achieve the desired outcome.)*	**Person responsible for leading on the action. (Name and grade / job title)**	**Date action due to be completed**	**Update on progress towards implementation of action** *(Provide details of action implemented, changes in practices, barriers to facilitating change, reasons why recommendation has not been implemented etc)*	**Date action completed**
KPI7: Formal feedback processes regarding bereaved relatives/friends views of care delivery. Required: • Process to elicit bereaved relatives views and action plan developed to address the issues identified	Required: • Bereaved relative's survey of care delivery. • Results shared with clinical team. • Development of action plan based on information elicited from survey. Action: AM to investigate VOICES survey (nationally recognised validated bereavement tool) to see if it meets need to review care delivery. SB to liaise with colleagues at regional Macmillan CNS meeting for tools used by other organisations. Once suitable tool identified Trust to undertake survey	A Munro Trust Ethicist S Badcott Lead Nurse palliative care	November 2014 November 2014 March 2015		
Clinical Measures:					
The decision that the patient is in the last hours or days of life should be made by the multidisciplinary team and documented by the senior doctor responsible for the patient's care. Required: • Greater use of the MDT and improved documentation of the MDT's discussions.	Imbed the use of the best practice guidance in EoLC in all areas of the Trust	Palliative Care Team & members of the EoLC Committee to lead	On-going		

Recommendation *(Ensure that the recommendations detailed in this action plan mirror those recorded in the "Recommendations" section of the report.)*	**Action(s) required to implement the recommendation** *(The "Actions required" should specifically state what needs to be done to implement the recommendations. A recommendation may require more than one action to achieve the desired outcome.)*	**Person responsible for leading on the action. (Name and grade / job title)**	**Date action due to be completed**	**Update on progress towards implementation of action** *(Provide details of action implemented, changes in practices, barriers to facilitating change, reasons why recommendation has not been implemented etc)*	**Date action completed**
• Continue to encourage teams to communicate openly with patients and their NOK regarding awareness and planning around end of life care.					
Pain control and other symptoms in dying patients should be assessed at least 4- hourly and medication given promptly if necessary. The audit demonstrated that patients were being regularly reviewed in the last 24 hours prior to death by doctors and/or nurses. This KPI was achieved in 96% of cases at MTW compared with 82% in the Audit as a whole.	Continued encouragement of teams to regularly review dying patients	Palliative Care Team & members of the EoLC Committee to lead	On-going		
Decisions about the use of Clinically Assisted Nutrition (CAN) and Clinically Assisted Hydration (CAH) are complex and should be taken by a senior experienced clinician supported by a multidisciplinary team. The KPI for CAN and CAH was achieved in 40% (39%) and 47% (48%) respectively at MTW – the figures in parenthesis represent the national figure achieved by all trusts contributing to the audit. Although comparable with other	Required: • Incorporation of routine assessment and review of both CAH & CAN in patients approaching the end of life. • Documentation of the above assessments to be routinely recorded in the medical notes. Action: • New template to be piloted on 8 wards (2 medical & 2 surgical on each site) to assist teams in creating an individualised care plan	S Badcott Lead Nurse palliative care D Rutter Consultant	Finalised document: December 2014		

Recommendation *(Ensure that the recommendations detailed in this action plan mirror those recorded in the "Recommendations" section of the report.)*	**Action(s) required to implement the recommendation** *(The "Actions required" should specifically state what needs to be done to implement the recommendations. A recommendation may require more than one action to achieve the desired outcome.)*	**Person responsible for leading on the action. (Name and grade / job title)**	**Date action due to be completed**	**Update on progress towards implementation of action** *(Provide details of action implemented, changes in practices, barriers to facilitating change, reasons why recommendation has not been implemented etc)*	**Date action completed**
Trusts there is clearly scope for improvement.	for EoLC with specific reference to CAN & CAH.				
Hospitals should have an adequately staffed and accessible pastoral care team to ensure that the spiritual needs of dying patients and those close to them are met. The KPI for spirituality was achieved in 24% of patients in the Trust's audit, compared with 37% achieved nationally.	Required: • Doctors and nurses to be encouraged to explore the spiritual needs of the patient and document the subsequent plan. • Spiritual advisers to be encouraged to record in the notes when meetings with patients or relatives have taken place. Action: • New template to be piloted on 8 wards (2 medical & 2 surgical on each site) to assist teams in creating an individualised care plan for EoLC with specific reference to the spiritual needs of the patient and the role of the pastoral care team.	S Badcott Lead Nurse palliative care D Rutter Consultant	Finalised document: December 2014		

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - September 2014

9-10	Infection Control Annual Report	Director of Infection Prevention and Control

Summary / Key points

The enclosed report provides a summary of infection prevention and control activity in the Trust between April 2013 and March 2014.

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

This year has been important in turning around the Trust's *C. difficile* performance. Despite seeing six years of continual reduction in the number of cases of *C. difficile* infection, the latter two years have seen the Trust breach the Department of Health objective. Urgent work to address this trend began in 2012/13 but did not have an impact until this year.

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

By the end of the year the Trust had maintained very low levels of MRSA and achieved a 40% reduction in *C. difficile* infections.

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

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

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

Director of Infection Prevention and Control – Annual Report to the Board 2013/14

1. Summary

This year has been important in turning around the Trust's *C. difficile* performance. Despite seeing six years of continual reduction in the number of cases of *C. difficile* infection, the latter two years have seen the Trust breach the Department of Health objective. Urgent work to address this trend began in 2012/13 but did not have an impact until this year.

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

By the end of the year the Trust had maintained very low levels of MRSA and achieved a 40% reduction in *C. difficile* infections.

2. Successes

The Infection Prevention team (IPT) has had success in 2013/14, building on previous year's improvements and ensuring sustained reductions in healthcare associated infections (HCAIs) and achieving the planned reductions.

Notably the Trust position with respect to *C. difficile* improved with a 40% reduction in cases in year. The multi-agency approach towards making this reduction provided support for the Trust to implement major changes in practice during the year.

The Trust position with respect to MRSA bacteraemia was maintained with just three cases seen for the year. The number of bacteraemia cases has been reduced by 97% since 2004.

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

Monitoring of infection prevention practice and performance throughout the Trust has been extended and a system of triangulation audits introduced. The audits are reported by the directorates to the Infection Prevention and Control committee (IPCC)

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

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

The IPT has been restructured with the development of the Nurse Consultant in Infection Control role and a more operationally robust structure.

3. Healthcare Associated Infection

3.1. HCAI recovery action plan

A recovery action plan was developed in February 2013 and implemented throughout the year. The plan was monitored through the IPCC and reported to the Quality and Safety committee.

Key actions include:

- Introduction of the 'Green Card' system
- Peer review for infection prevention and antimicrobial stewardship
- Joint working group with the CCGs, LAT and PHE
- Review of antimicrobial guidance
- Development and review of risk assessment tools
- Task and Finish group to continue work from 2013/14
- Revise RCA process
- Improve performance monitoring and reporting
- Review cleaning levels
- Increase education and awareness amongst staff.

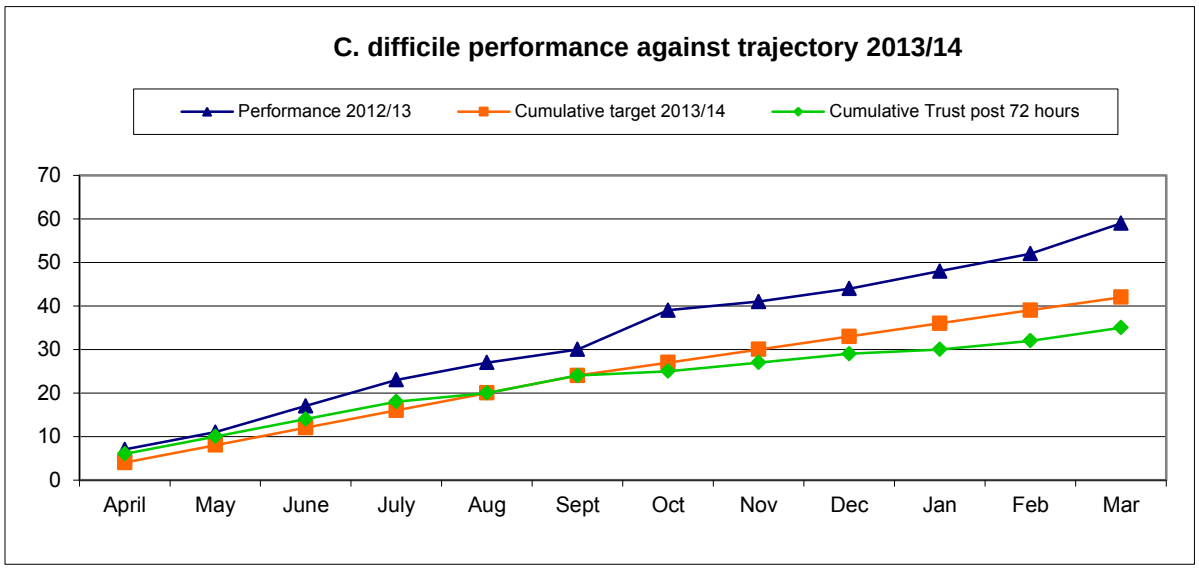
The action plan was also shared at the Trust Management Executive and agreed by the Clinical Directors.

Any outstanding actions at the end of the year were signposted into the 2014/15 action plan.

The completed plan is attached at Appendix 1

3.2. *Clostridium difficile*

Reducing *Clostridium difficile* infections was one of the key priorities for the Trust throughout 2013/14.

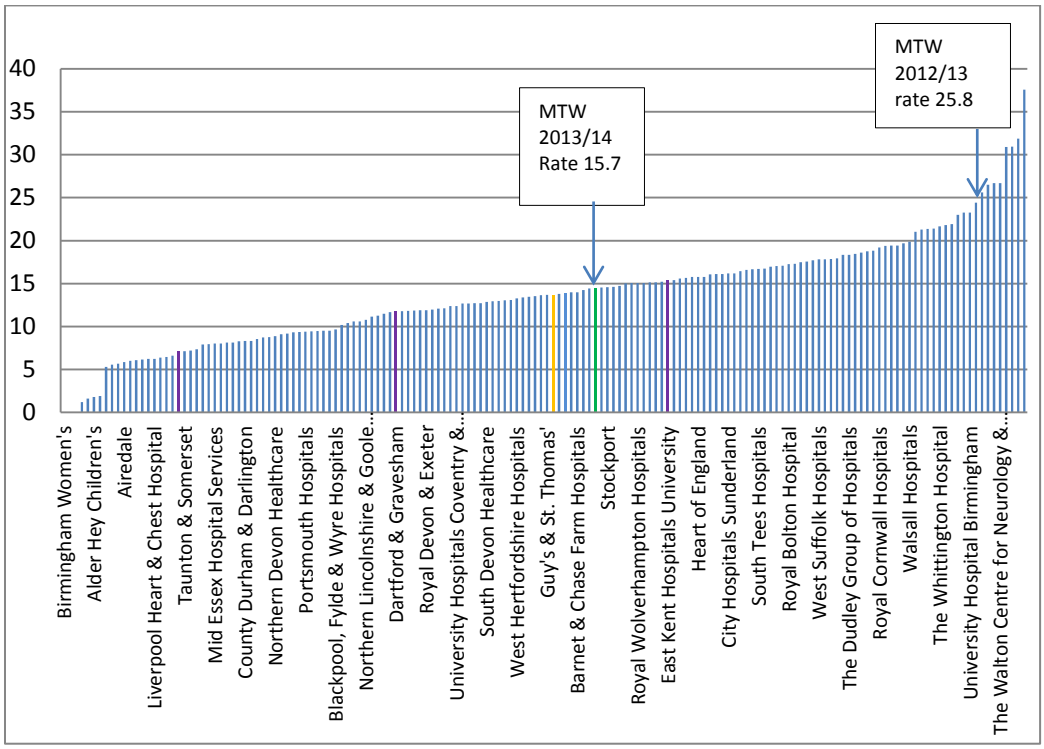


3.2.1. Rates of Infection

The Trust achieved a 40% reduction in *C. difficile* infection this year. The out turn of 35 cases achieved the objective of 42 cases and improving upon it. The rate of infection for the year was 15.7/100 000 bed days.

The Department of Health objective limit was designed to bring the Trust up to the best performing quartile for the previous year. Although the year started with a breach of the trajectory in April, the actions of the recovery programme began to take effect in August with Maidstone Hospital having no cases for the three months from August to October.

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



Amber = national median Green = MTW

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

Fig 2: New cases of *C. difficile* from April 2005 to March 2014

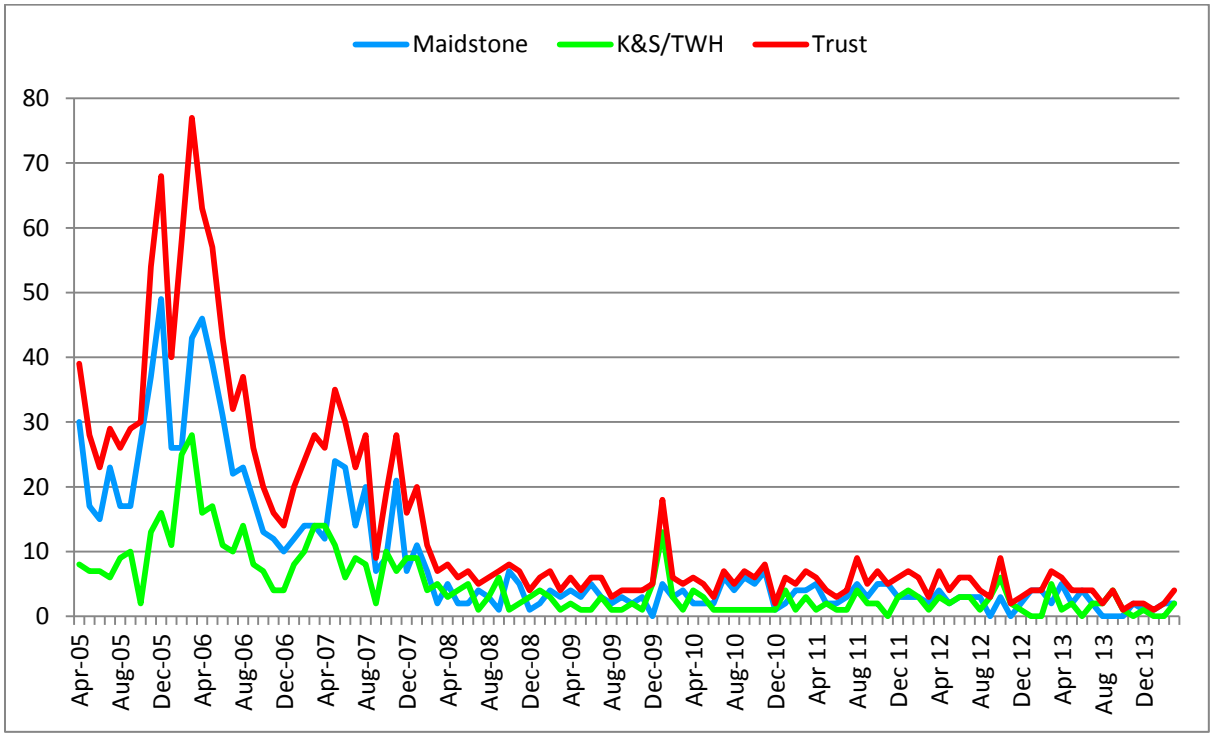
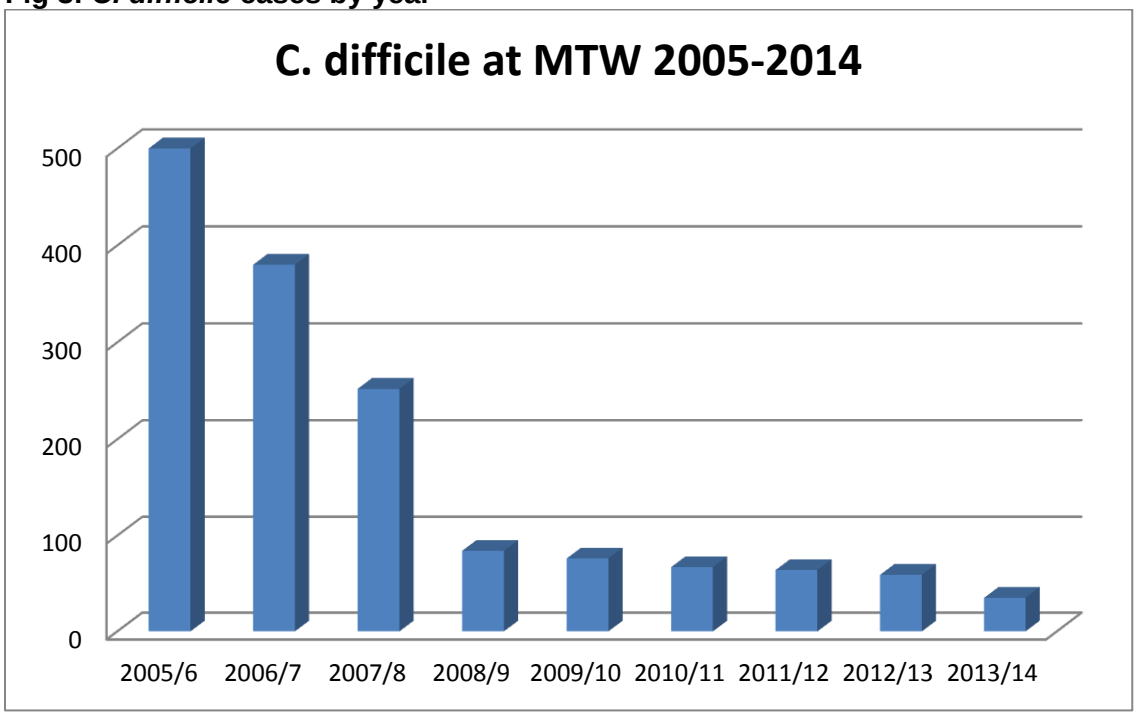


Fig 3: *C. difficile* cases by year



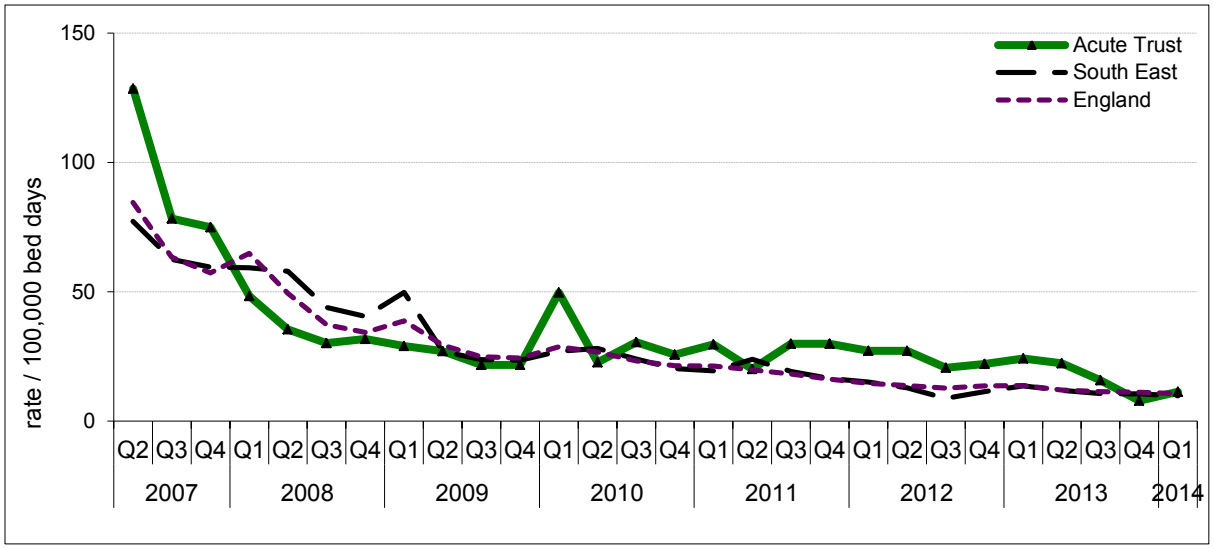
For 2014/15 a new DoH *C difficile* objective has been introduced which is based on the median rate of reduction of cases in similar Trusts (acute hospitals, teaching acute, specialist trusts and CCGs). The baseline used is the data for the year up to November 2013. For this period MTW saw 45 cases or a rate of 18.6 cases per 100 000 bed days.

Trusts with a current CDI rate above (worse than) their cohort median have an objective of their CDI rate for the current year (to Nov 2013) minus the current percentage reduction in

median CDI rate seen for their cohort between the previous year (to Nov 2012) and the current year (to Nov 2013).

The calculation does not take into account the out turn for the year, therefore the objective for MTW for 2014/15 is 40 cases.

Figure 4 shows the MTW rate benchmarked against the national and regional rates.



3.2.2. Laboratory diagnosis

During 2013/14, the microbiology laboratory processed 7206 samples for *C. difficile* on 4223 patients.

Of these 159 patients were identified as carriers of toxigenic *C. difficile* (177 in 2012/13), 106 inpatients and 53 community patients.

Ninety one patients were diagnosed with acute *C. difficile* infection. 35 cases were attributable to the acute Trust and 56 to the community. Of the community acquired infections, 29 were diagnosed on samples sent in by their GPs and 27 were diagnosed during the first 72 hours of their hospital admission. Eleven of the community cases had had recent hospital admission at MTW

All cases are sent to the reference laboratory for ribotyping to detect any possible links between cases. Where there is suspicion of a link a request is made to the Regional Microbiologist for multi-variant loci analysis (a type of genetic finger-printing) to confirm or rule out an association between cases. This was request on three pairs of cases this year.

A treatment algorithm is in place to enable identified carriers to be treated to avoid progression on to acute infection. In 2013/14 there were no known in-patient carriers of *C. difficile* who progressed to acute infection.

3.2.3. Isolation

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

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

The surgical directorate provides 4 beds on ward 10 at TWH and the specialist medicine directorate provides 4 side rooms on Mercer ward at Maidstone Hospital for the cohorting of *C. difficile* patients. This strategy provides continuity of care for the patients avoids cross site transfer wherever possible and has enabled the nursing staff in these areas to develop specialist knowledge in the care and management of *C. difficile*.

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

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

3.2.4. Case review

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

During 2013/14 the RCA documentation has been completely revised and a timeline is completed for all patients in additional to the data collection form. Following the multidisciplinary meeting the case goes to the *C. difficile* panel where the RCA is examined by the DIPC and Chief Nurse. There is an expectation that the ward manager and consultant for the case will attend as a minimum.

The root causes for 2013/14 are summarised below:

Table 1: Outcomes of RCA for hospital-attributable cases April 2013- March 2014

Organism	Unavoidable (appropriate antibiotics)	Inappropriate antibiotics	Delayed discharge resulting in HCAI	Cross infection	PPI usage alone	Laxative use	GP prescribed antibiotics
C. difficile	17	14	2	0	0	1	1

There were no instances of cross infection during the year.

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

Antibiotics were considered inappropriate if they were prescribed outside the Trust guidance, continued for too long, or prescribed for the wrong indication. Two thirds of cases received third-line antibiotics (Tazocin or Meropenem) during their admission. Nine of these cases were judged to be avoidable at RCA.

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

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

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

	Acute and Emergency medicine	Specialist Medicine	Surgery	Trauma and Orthopaedics	Critical care	Cancer	Total
April 13		4				2	6
May 13		2		2			4
June 13		2	2				4
July 13	1	3					4
August 13		2					2
September 13		3		1			4
October 13				1			1
November 13		1	1				2
December 13		2					2
January 14		1					1
February 14			2				2
March 14		2	1				3
Total	1	22	6	4	0	2	**35**

3.2.5. Periods of Increased Incidence

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

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

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

- Weekly audits of antibiotic use by the antimicrobial pharmacist
- Weekly audit of the ward using the *C. difficile* High Impact Intervention audit tool until a score of >90% is achieved for three consecutive weeks and there have been no more cases during that time

- When a PII is stepped down the ward is subject to random spot checks over the next month to ensure that improvement is sustained
- Increased cleaning with throughout the ward
- Weekly review by the infection control team
- Additional training by the IPT where required

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

3.2.6. Risk summits

Three wards gave particular cause for concern during the year. Whilst there was no evidence of cross infection they had a sustained increased incidence of *C. difficile* and remained on a PII for an extended period of time.

Risk summits were arranged for each ward between the ward teams, including nursing and medical staff with the matron and Clinical Director, and executive and non-executive directors. Relevant areas of performance and infection prevention were examined and challenged and the expectation of improvement was set out.

In all cases the risk summits were successful in changing practice which resulted in a subsequent reduction in the number of cases seen.

3.2.7. Joint working across the Healthcare economy

In November 2012 an all-systems approach to dealing with the *C. difficile* challenge was developed. Weekly multidisciplinary meetings were held between the Trust and the West Kent Clinical Commissioning Group (WKCCG), the West Kent Primary Care Trust (WKPCT), Public Health England (Kent) and the national Trust Development Agency. Discussions were also held with the Care Quality Commission.

From April 2013 these meeting were held less frequently until September when it was agreed that the Trust was on an improvement trajectory and that the actions taken were effective.

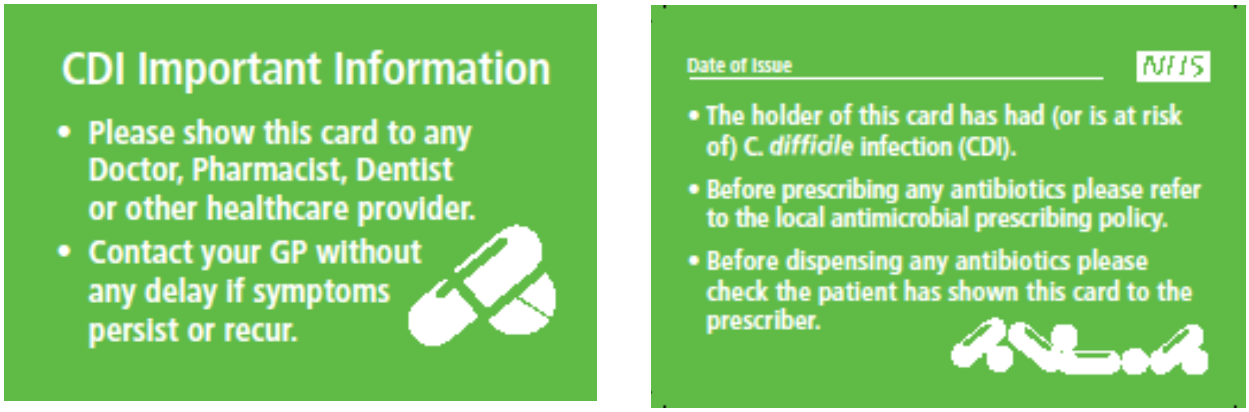
In September 2013 a multidisciplinary *C. difficile* summit was held hosted by WKCCG. Attendees included nurses from acute Trusts and the community, GPs, MTW consultants, community nurses, local area team members, PHE representatives and patients affected by *C. difficile*. This enabled sharing of experience and learning and included the launch of the green card (see below). A patient and his wife shared their story and powerfully described the devastating effect that the infection had had upon their lives

3.2.8. Green card

The green card is a credit card sized card which is given to all *C. difficile* patients and carriers together with information about the disease. It is intended that the patient will show the card to any healthcare provider and enable them to feel better informed and more in control.

It will improve awareness amongst healthcare professionals and encourage prudent prescribing, potentially avoiding recurrent infection and avoiding hospital admission.

Fig 5: The green card – front and back views



The cards are now fully implemented at MTW and are given to all patients identified with either *C. difficile* infection or carriage. The IPT issues the cards for all patients in hospital and sending them to the GP for community patients.

An awareness campaign was also undertaken to ensure that general practice and A&E staff and pharmacists understood the purpose of the cards.

3.2.9. Peer review

The Trust requested peer review of both its infection prevention practices and antibiotic guidelines and policy.

The DIPC and lead infection prevention nurse from Frimley Park Hospital NHS Foundation Trust were asked to review the infection prevention policies and practices within the Trust. Feedback was very positive and did not reveal any deficient areas. The main area for improvement was extending the reporting into the IPCC to improve the level of assurance gained. This led to the development of triangulation audits and the direct reporting of the directorates into the IPCC (see section 11).

Other actions were incorporated into the recovery action plan.

The consultant Pharmacist for Guys and St Thomas' Hospitals NHS Foundation Trust reviewed the antibiotic policy and guidance. This is discussed further in section 4.

In addition, the HCAI lead for the Trust Development Authority, Mercia Spare, carried out an infection prevention inspection in both hospitals. Again the feedback was positive and highlighted the good practice in place although highlighted some areas for improvement. Again these actions were incorporated into the action plan and taken to completion. Mercia continues to provide support to the IPT and visits the Trust several times each year.

3.2.10. Risk assessment

During the year there has been a drive to identify those patients most at risk of developing C. difficile in order to take additional precautions in antibiotics prescribing to protect them. A risk assessment was developed which is completed on every patient on admission and

on a weekly basis for the whole admission. High risk patients include those who are known to be carriers and those who have received antibiotics in the preceding three months.

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

A rapid risk assessment for patients with diarrhoea has been in place for several years. However, this has been reviewed this year together with the associated isolation flow chart which prioritises patients for isolation rooms on the Maidstone site.

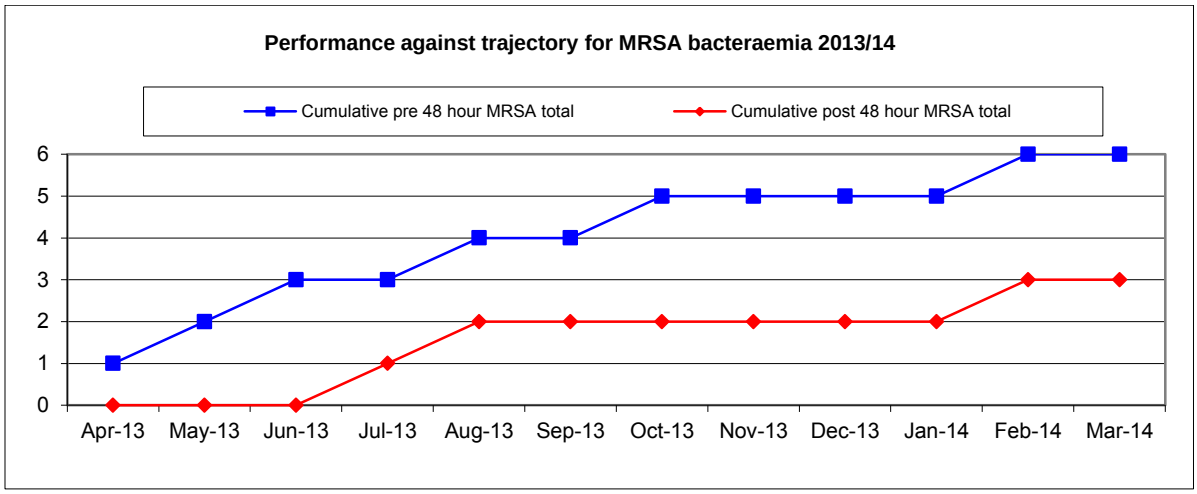
In addition a flow chart has been developed to assist staff in making the decision to take a sample from patients with diarrhoea.

3.3. Methicillin resistant *Staphylococcus aureus*

3.3.1. Cases

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

Fig 6: Performance 2013/14 – Trust and community cases



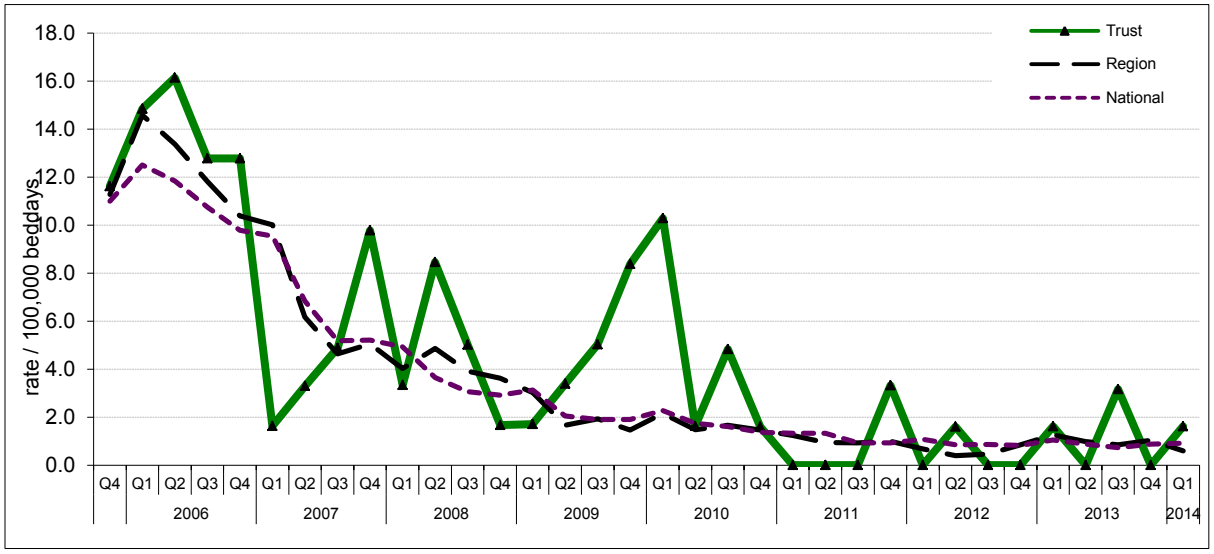
The rate of trust apportioned MRSA bacteraemia for 2013/14 was 1.3/100 000 occupied bed days. To put this in context, the national rate was 0.9/100 000. (fig 7)

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

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

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

Fig 7: MTW rate benchmarked against the national and regional rates



3.3.2. Root Cause Analysis

All cases of MRSA bacteraemia have root cause analysis carried out. This is a multidisciplinary team approach and where appropriate includes colleagues from the CCG and community health trust. A serious incident is declared for all cases of trust attributable cases of MRSA bacteraemia. For pre 48 hour cases, the IPT and the relevant clinical team take part in the RCA led by the CCG. One community patient was diagnosed with MRSA bacteraemia on two separate occasions this year

The process also requires a submission to the PHE post infection review process which apportions responsibility for cases to either the acute Trust or the CCG. There is no provision for apportioning cases to a community or mental health trust. Where there is disagreement, the Director of Public Health (DPH) is asked to adjudicate.

During this year two cases involving MTW were referred to the DPH for adjudication. One of these cases was reassigned from WKCCG to MTW

The findings at RCA for the three trust apportioned cases were as follows:

Case 1: Patient was identified as MRSA positive on admission. Decolonisation was completed. Patient had poor skin integrity which is likely to have been the entry site for infection.
Case 2: Patient transferred to rehab ward following surgery. Another patient in the bay, known to be colonised had open infected wound. Confirmed cross infection. Lessons learned around placement of patients on orthopaedic pathway.
Case 3: Patient screened on admission and found to be negative. Later found that wounds including a pressure area had not been screened and were MRSA positive. Pressure area was the likely source of bacteraemia.

The findings in the reassigned case were that the process for following up a patient identified as MRSA outside the pre-admission process broke down and led to a patient having surgery without pre-operative MRSA decolonisation.

Action plans were developed for all cases and fully implemented.

3.3.3. Screening

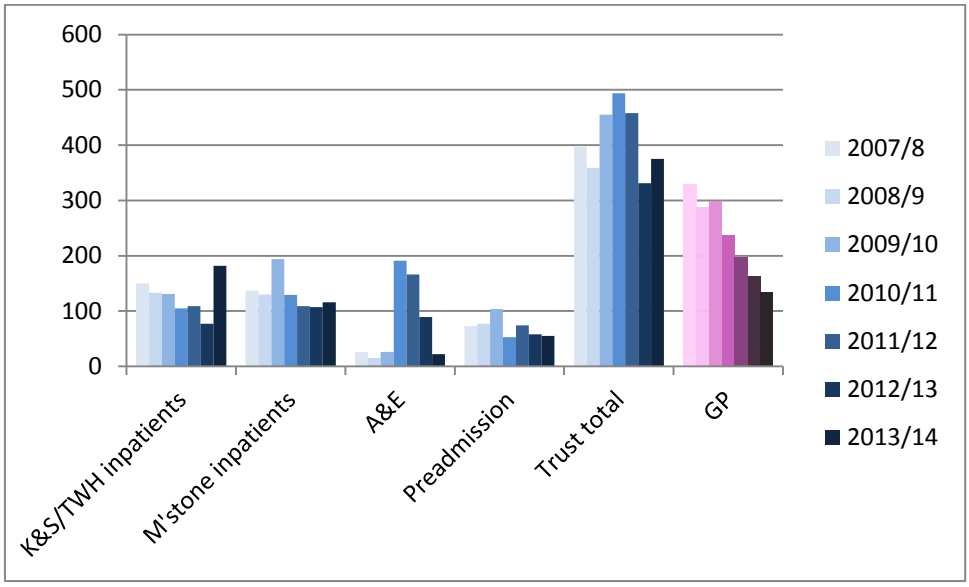
It is Trust policy to screen all elective admissions (except for certain excluded groups) to comply with Department of Health policy. The policy has been fully implemented since March 2009.

In addition the Trust complies with the DoH policy to screen non-elective admissions. This has been in place since March 2010. Maternity and high risk paediatric patients have also been screened at MTW since August 2010.

A notice of compliance with the DoH policy was placed on the Trust website in December 2010.

Compliance with the screening policy is audited monthly. All audits are reported to the IPCC. By March 2014 the compliance with non-elective screening was 97% and with elective screening was 96.3%. The challenge to achieve 100% elective screening has been difficult to achieve and is only consistently seen in Surgery and Trauma and Orthopaedics. The directorates each have action plans to address any low screening scores.

Fig 8: New MRSA colonisations 2007-2014



As a result of the increase in screening, new patients who are colonised are identified within 24 hours of admission. Advances in laboratory testing enable a positive result to be available 18 hours after the specimen arrives in the laboratory. In turn, this allows effective decolonisation of the patient to be started in a timely manner, reducing the risk of infection and spread to other patients.

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

A total of 84 490 screens were carried out during 2013/14. 556 patients were identified as new carriers. The current new positive rate of screening swabs is 0.7%.

3.3.4. Periods of Increased Incidence

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

When the PII is declared the following actions are taken:

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

During 2013/14, twelve PIIs were declared for MRSA, seven at Maidstone and five at TWH. One ward had two PIIs during the year. The PIIs lasted an average of five weeks. Staff were screened as part of two investigations.

Linked cases were found on three wards – each cross infection incident affecting one patient. Serious incidents were declared for these outbreaks.

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

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

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

There is no seasonal variation or trend in the number of cases seen. New isolates are reported as in-patients if the sample is taken from a patient in hospital. There is no differentiation between those acquired in hospital or the community. There has been no significant change in the number of new hospital cases. The numbers seen across the health economy have increased over the last year. It is not clear whether or not this will be a continuing trend.

Fig 9: New ESBL isolates

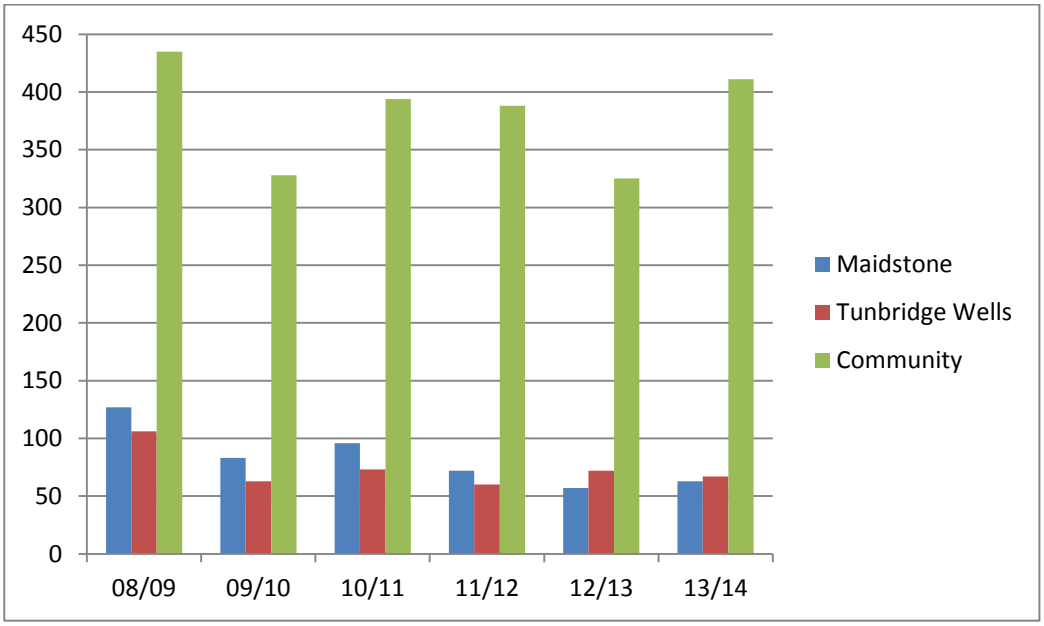
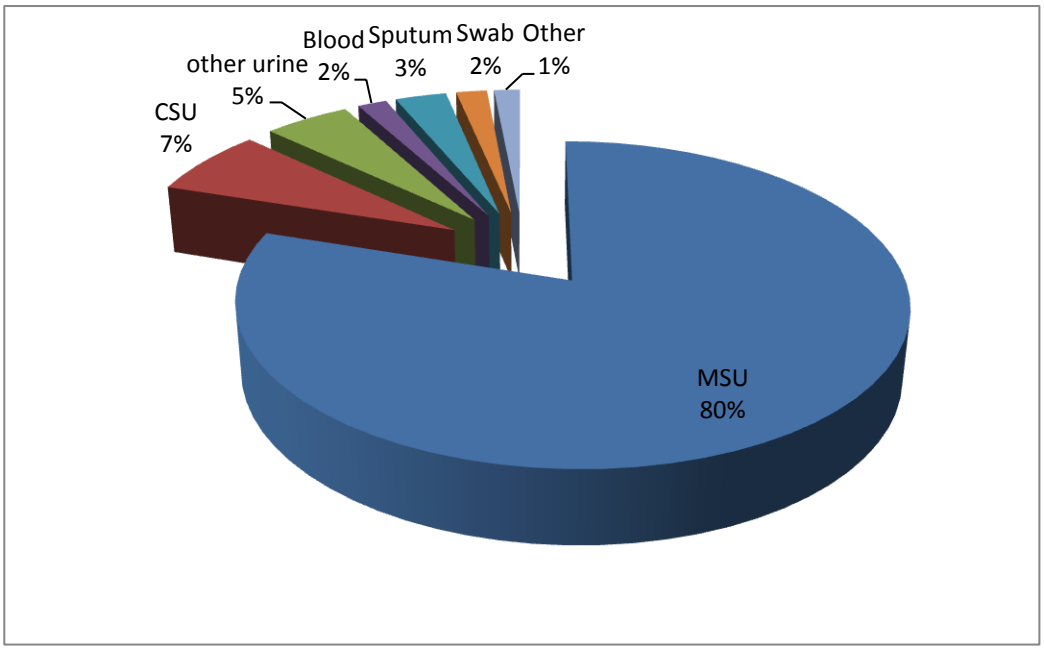


Fig 10: New ESBL isolates by specimen site 2013-14



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

3.5. Routine surveillance and Alert organisms

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

The following gives an overview of local activity.

3.5.1. Blood cultures

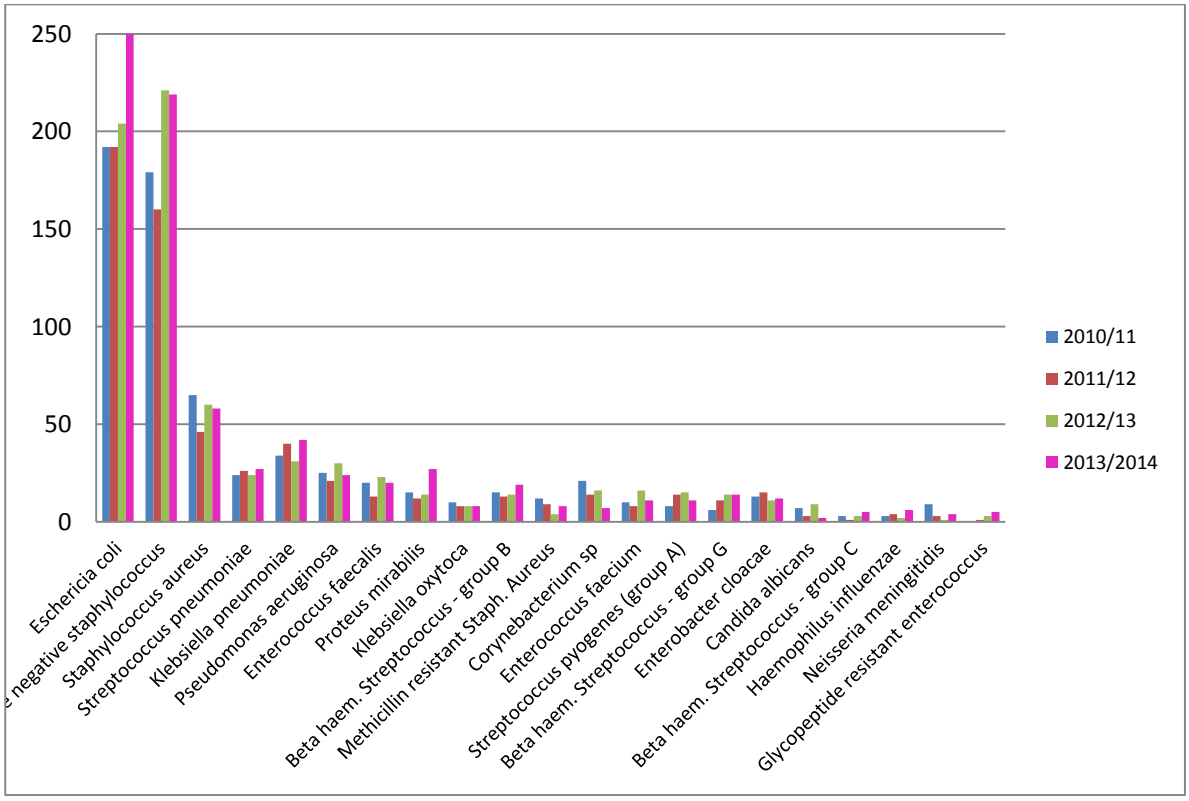
A total of 827 patients had positive blood cultures during 2013/14, an increase of 95 (13%) on the previous year.

The commonest isolate was E. coli which is often associated with urinary tract infection. There has been a 25% increase in E. coli isolates alone compared with last year.

Some isolates are seen in small numbers but are highly significant for their ability to cause serious infection. These include *Neisseria meningitidis* (a cause of meningitis), *Staphylococcus aureus*, beta haemolytic streptococci and *Streptococcus pneumoniae.*

The number of coagulase negative staphylococcus isolates has not risen over the last year. Although this organism can cause infection in certain groups of patients such as those who are immunosuppressed, it is the commonest cause of contamination in blood cultures and suggests that the blood culture training programme is reducing contamination across the board and not just in respect to MRSA.

Fig 11: Commonest significant isolates from blood cultures 2010-2014



3.5.2. Methicillin sensitive *Staphylococcus aureus*

58 patients were diagnosed with methicillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia in 2013/14 compared with 62 patients the previous year

67% of the cultures were taken in A&E or an admissions unit indicating that the infections arose in the community. Any isolate from a blood culture taken within 48 hours of admission is classified as community acquired.

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

Cases were equally spread between male and female patients which is contrary to the national trend where males predominate in a ratio of 3:2

The age range of cases was 37-95 years. Over 70% of the cases were aged 60 years or more.

Since January 2010, MSSA bacteraemia has been part of the mandatory surveillance for HCAI. Epidemiological information is now collected on these cases. There is no objective limit for MSSA and there is currently no Department of Health plan to impose one in the future. The first full year of MTW mandatory data collection showed a decrease in both community and hospital acquired MSSA bacteraemia, with the second year showing an increase in cases. 2013/14 showed a small decrease in cases, against the national trend which shows increasing numbers of cases.

3.5.3. Invasive Group A streptococci (iGAS)

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

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

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

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

3.5.4. Glycopeptide Resistant Enterococcus

In early 2014 there were three patients with blood cultures positive for glycopeptide resistant enterococci (GRE) within an eight week period on the haematology ward. The isolates were unrelated but this was a sudden increase in incidence and the only hospital acquired cases for the year.

An incident meeting was held to determine whether or not this was part of a larger problem and if there was any evidence of cross infection.

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

In order to determine the carriage rate in our haematology patients, the entire ward was screened with 20% of patients found to carry the organism. The significance of this was uncertain so a randomised anonymous survey of 100 in patient stool specimens was undertaken. 12% of this sample was found to contain GRE. The carriage rate in haematology patients is significantly higher than the general inpatient population.

A screening programme was put in place in March 2014 with all haematology patients screened on admission and discharge. This enables antibiotic regimens to be tailored to individual patients depending on their carrier status.

The background rate of carriage is monitored every three months by repeating the anonymous survey.

3.5.5. Norovirus

Norovirus infection was seen in the Trust during April 2013. The number of cases for the rest of the year was relatively low, with no cases seen over the winter period.

In April, Maidstone Hospital had cases on three wards with a total of 16 patients and 3 staff affected. Two wards had one bay closed each and one ward was completely closed with the loss of 8 bed days. The last bay reopened 6 days after closure.

At TWH, four wards were affected with a total of 56 patients and 25 staff affected. Cases were managed in the single room environment by cohorting and restricting staff movement around the wards. Despite the measures taken, ward 30 was completely closed for three days when staff shortages created a risk to patient safety with a loss of 4 bed days.

In addition, the stroke rehab unit at Tonbridge Cottage hospital saw cases with 5 patients and 2 members of staff affected.

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

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

4. Antibiotic Stewardship

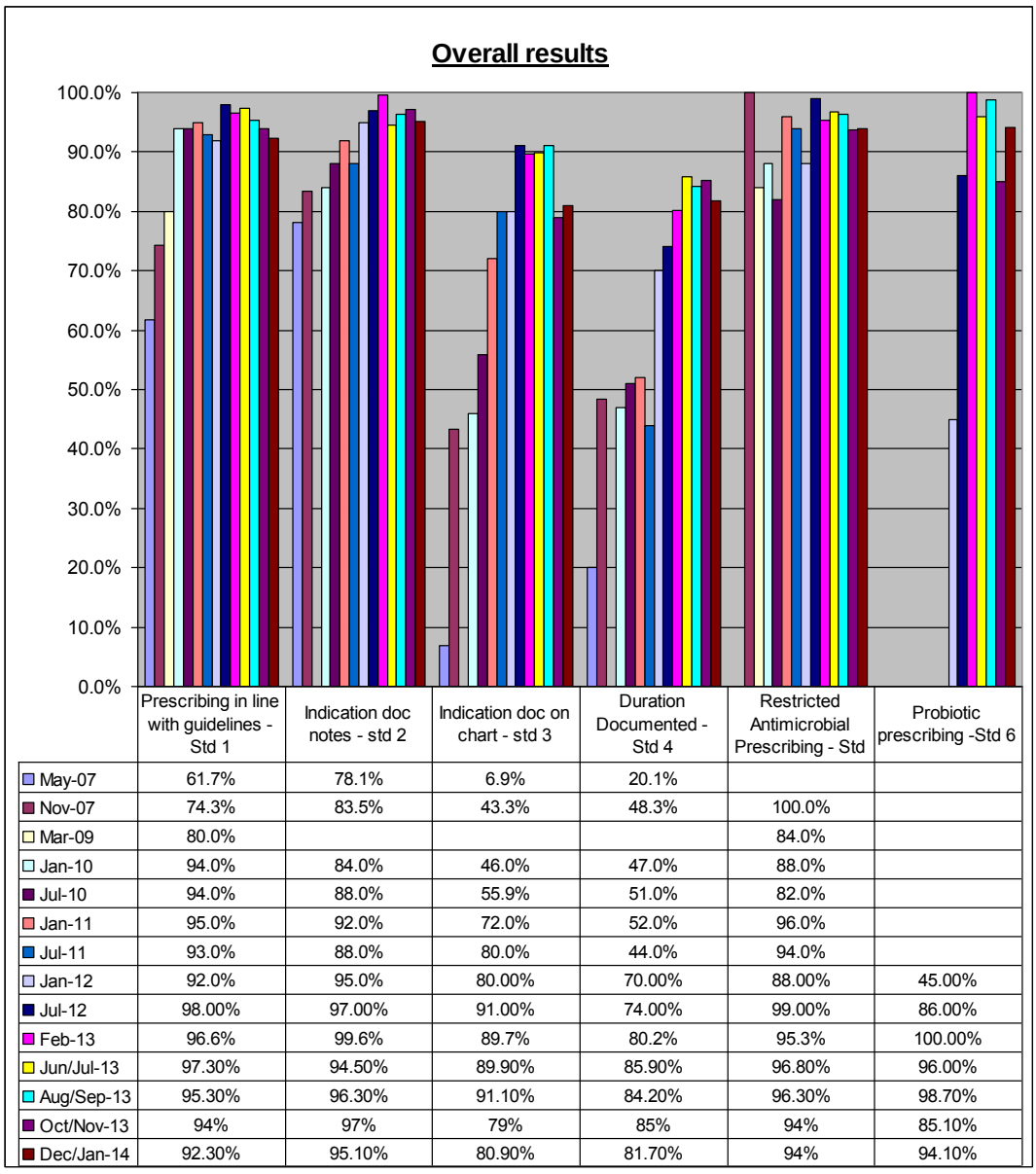
The Antibiotic Stewardship Group (ASG) has been active in the Trust for several years. The group includes the consultant microbiologists and antibiotic pharmacists and meets monthly to discuss the ongoing review of antimicrobial guidelines, antimicrobial usage, the introduction of new antibiotics and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

pharmacist who attends the monthly meetings. The group reports to the Drugs and Therapeutics committee.

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

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

Fig 12: Antibiotic prescribing audit to March 2014



	Prescribing in line with guidelines - Std 1	Indication doc notes - std 2	Indication doc on chart - std 3	Duration Documented - Std 4	Restricted Antimicrobial Prescribing - Std	Probiotic prescribing -Std 6
May-07	61.7%	78.1%	6.9%	20.1%		
Nov-07	74.3%	83.5%	43.3%	48.3%	100.0%	
Mar-09	80.0%				84.0%	
Jan-10	94.0%	84.0%	46.0%	47.0%	88.0%	
Jul-10	94.0%	88.0%	55.9%	51.0%	82.0%	
Jan-11	95.0%	92.0%	72.0%	52.0%	96.0%	
Jul-11	93.0%	88.0%	80.0%	44.0%	94.0%	
Jan-12	92.0%	95.0%	80.00%	70.00%	88.00%	45.00%
Jul-12	98.00%	97.00%	91.00%	74.00%	99.00%	86.00%
Feb-13	96.6%	99.6%	89.7%	80.2%	95.3%	100.00%
Jun/Jul-13	97.30%	94.50%	89.90%	85.90%	96.80%	96.00%
Aug/Sep-13	95.30%	96.30%	91.10%	84.20%	96.30%	98.70%
Oct/Nov-13	94%	97%	79%	85%	94%	85.10%
Dec/Jan-14	92.30%	95.10%	80.90%	81.70%	94%	94.10%

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

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

With the introduction of the triangulation audits this year, all wards now have a bi-monthly audit. All audits are carried out by the two antibiotic pharmacists.

4.1. Peer review

Recognising that the antibiotic usage in the Trust was the main barrier to reducing the rate of *C. difficile*, the Trust invited the Consultant Antimicrobial Pharmacist at Guys and St Thomas' Hospitals NHS Foundation Trust (GSTS) to carry out a peer review of the MTW antimicrobial policy and guideline. The following recommendations were made:

- Review sepsis guideline
- Enforce 5 day stop of antibiotic prescriptions
- Make better use of oral antibiotics and reduce the reliance on IV antibiotics
- Appointment of a second antimicrobial pharmacist

Following these recommendations the following actions were identified:

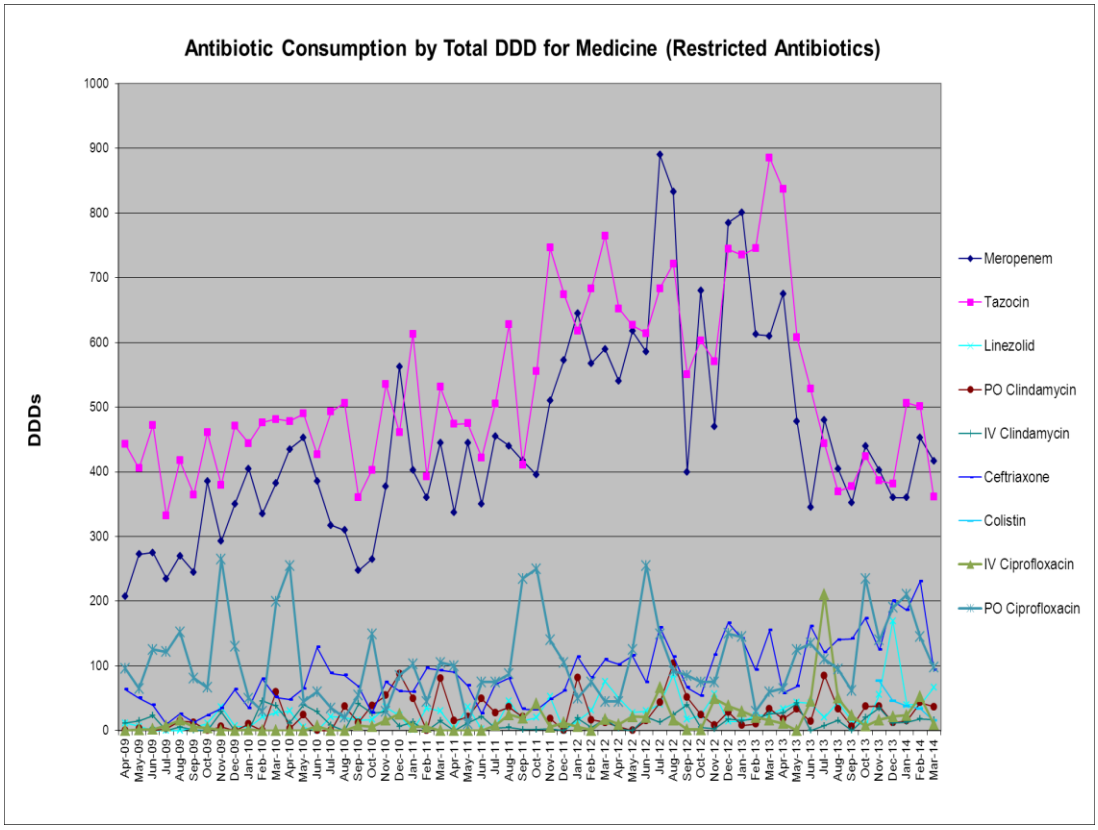
- Review the sepsis protocol with the sepsis group
- Introduce 5 day stop sticker to prevent over prescribing
- Full review of antimicrobial guidance with completion in time for the new junior doctors induction in August 2013
- Reduction in prescribing of Tazocin and Meropenem
- Re-introduction of the IV to oral step down.
- Re-launch the 'Start Smart, then Focus' strategy
- On-going education programme for junior doctors including antibiotic prescribing training at induction
- Bi-monthly antibiotic policy compliance audits on all wards
- Appointment of a second antibiotic pharmacist

4.2. Antimicrobial usage

Antibiotic usage is monitored on a monthly basis; however the trend in usage is upwards with the most marked increase seen in the third line antibiotics, Tazocin and Meropenem. The increase is particularly marked since the opening of Tunbridge Wells Hospital which also coincided with the re-launch of the Sepsis Six protocol. These two antibiotics were identified as being a risk factor in the development of C. difficile infection with over 70% of hospital attributable C. difficile cases having received one of them prior to the development of infection.

Although restricted in usage, the over diagnosis of 'sepsis' led to excessive use of these antibiotics and the pharmacists were unable to challenge where the indication was identified as sepsis. Review of both the Sepsis Six protocol and the antimicrobial guidelines enabled this anomaly to be corrected with a resulting reduction in usage.

Fig 13: Restricted antimicrobial usage to March 2014



The introduction of the new antimicrobial in June 2013 saw a rapid 40% reduction in the amount of Tazocin and Meropenem prescribed within the Trust and reversed the trend of the previous two years.

4.3. Changes to antimicrobial guidelines

The ASG was challenged to review the entire antimicrobial guideline in six weeks. This process is normally undertaken on a rolling two year basis so this was a significant challenge. The guideline remains evidence based but takes into account the experience of GSTS in using oral antibiotics without increasing the incidence of *C. difficile* infection

The antibiotic guidance review was completed and the revised guidance was launched on 15 June. The Medical Director and DIPC wrote to all doctors, pharmacists and nursing staff to inform them of the changes. Key changes are:

- Distinction between severe sepsis and non-severe sepsis. Non-severe sepsis to be treated according to the source of the infection. Severe sepsis continues to be treated with Tazocin
- Distinction between mild, moderate and severe lower respiratory tract infection for both community and hospital acquired cases. Only severe hospital acquired LRTI with x-ray changes should be treated with Tazocin, with doxycycline recommended for less severe hospital acquired infections
- Re-introduction of oral co-amoxiclav for inpatients to enable a robust IV to oral switch when patients are well enough.

- Restriction of treatment of catheter associated UTI to only those patients with systemic symptoms.
- Introduction of 'five-day stop' stickers which will be placed on the drug charts by pharmacists except where a longer duration has been written.

It is expected that all prescriptions for Tazocin and Meropenem will have consultant review within 24 hours for new admissions and at the earliest opportunity for inpatients.

4.3.1. Sepsis protocol

Working with the Sepsis group, the sepsis assessment was revised to differentiate between severe sepsis and sepsis. Immediate third line antibiotics are only indicated in patients with severe sepsis allowing further system based assessment to determine the correct antibiotics for other patients. This change was reflected in the antimicrobial guideline and a direct hyperlink to the assessment was added to the guideline.

4.3.2. Start smart, then focus

This is an initiative from the Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) originally launched in 2011. Implementation at MTW was incomplete at that time because of the reliance on IV antibiotics.

Start Smart:
- Do not start antibiotics in the absence of evidence of bacterial infection
- Start prompt effective treatment in patients with life-threatening infection
- Prescribe in accordance with local antibiotic policies/guidelines and resistance patterns. Consult microbiologist if appropriate
- Document indication and duration for antibiotic prescription on prescription chart and in clinical notes
- Collect appropriate cultures before starting antibiotic therapy.

Then Focus:
At 48 hours review the patient and make a clinical decision

- Stop antibiotic therapy (if no evidence of infection)
- Switch from intravenous to oral therapy
- Change: de-escalation / substitution / addition of agents
- Continuation - review again at 72 hours

This process is now fully incorporated into the training given to all junior doctors and implemented within the Trust.

4.3.3. IV to oral switch

The IV to oral switch supports the Start Smart process and reduces the damage to the gut flora caused by higher dose IV antibiotics.

As part of the antimicrobial guideline review, advice on suitable oral alternatives (or 'step downs') for IV antibiotics was added and in some areas e.g. mild to moderate hospital acquired chest infection, the only option recommended for treatment is an oral antibiotic.

The Consultant Microbiologists reinforce this message regularly when giving advice to junior doctors.

4.3.4. Five day stop

Prescriptions for antibiotics are for a maximum of five days unless specified otherwise in the Trust antibiotic guidelines or approved by a consultant microbiologist. The duration of treatment or a specific review date must be stated on the prescription at the time of writing. Pharmacists will place a sticker on the prescription chart at the end of the indicated course to prevent further doses being given
The pharmacists are authorised to terminate a course of antibiotics where five days total have been completed unless one of the following applies:

- The length of course is stated on the prescription chart and/or in the medical notes and complies with Trust guidelines or is approved by a consultant microbiologist.
- An indication in patient's notes suggests that an extended course is likely to be required or has been recommended by a consultant microbiologist.

Pharmacists are also authorised to discontinue oral antibiotic courses after three days for uncomplicated UTIs in accordance with guidance, taking into account any culture results and reported sensitivities.

4.3.5. Training and education

The revised guideline was uploaded to the Trust intranet in June and training on antibiotic prescribing was given to all new junior doctors joining the Trust in August 2013. All doctors undergoing training were given a printed copy of the antibiotic guideline and a copy of the sepsis assessment document. All signed to confirm that they had received it and would read it prior to starting work on the wards.

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

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

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

5. Care Quality Commission

The Health Act 2003, now superseded by the Health and Social Care Act 2013, contains a Code of Practice usually referred to as the Hygiene Code. An earlier version, the 2008 Act requires acute Trusts to comply with the Code and outlines penalties for non-compliance.

There was no formal Outcome 8 inspection for 2013/14. However, infection control and specifically *C. difficile* rates have been examined as part of the regular CQC challenge visits and infection control is invariably observed as part of unannounced visits.

We continue to comply with the Hygiene Code and CQC outcome 8 and to collate evidence to support compliance.

6. Saving Lives

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

The high impact interventions which are audited monthly are:

- Peripheral line insertion and continuing care
- Central line insertion and continuing care
- Urinary catheter insertion and continuing care

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

7. Surveillance

The Trust participates in Health Protection Agency (HPA) national surveillance schemes for surgical site infection in orthopaedic surgery.

MTW also collects surveillance data on caesarean section wounds having found a pilot scheme useful for clinicians.

7.1. Orthopaedic Surgical Site Surveillance

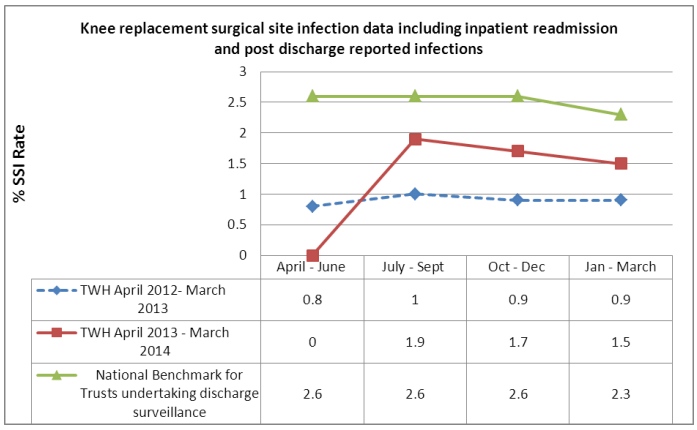
As a Trust, MTW performs well against national benchmarks for surgical site infection. All cases of surgical wound infection in the surveillance programme are subject to root cause analysis. Patients are asked to fill in a questionnaire six weeks after discharge detailing any problems with their surgical wound. This system has the advantage of detecting minor wound infections treated by the GP in the community.
Following the reconfiguration of services the infection rates increased. Full root cause analysis has been carried out and an action plan has been implemented. Changes have been made to reflect NICE guidance and the routine skin preparation has been changed to 2% Chlorhexidine in 70% isopropyl alcohol.

Table 3: SSI rates Jan –March 2014

Surgery	Number of Operations	No. of SSI's Inpatient and Readmissions	% Rate	No. of SSI's Post Discharge	% Rate	Total no. of SSI	% Rate	National SSI % Rate Inpatients and Readmissions for Trusts undertaking discharge surveillance	National SSI % Rate Inpatients, Readmissions and Post Discharge
Hips	147	2	1.4	0	0	2	1.4	0.4	1.5
# NOF	115	4	2.6	1		5	3.5	0.9	1.5
Knees	131)	2	1.5	0	0	2	1.5	0.4	2.3

The data for our total SSI rate compares favourably with the national data. MTW had fewer post discharge infections reported that other Trusts.

Fig 14: SSSI rates for elective hips and knees



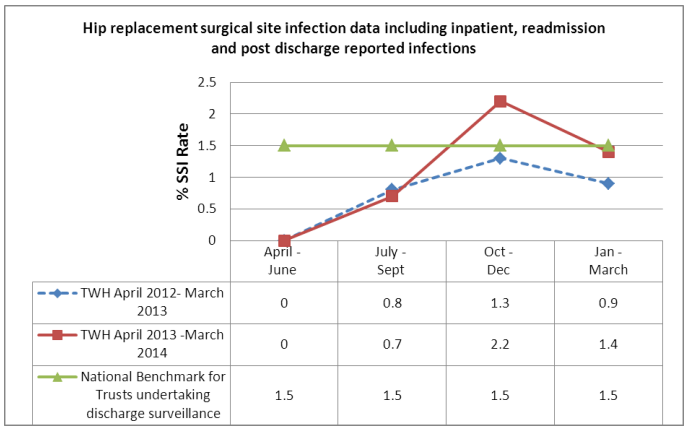
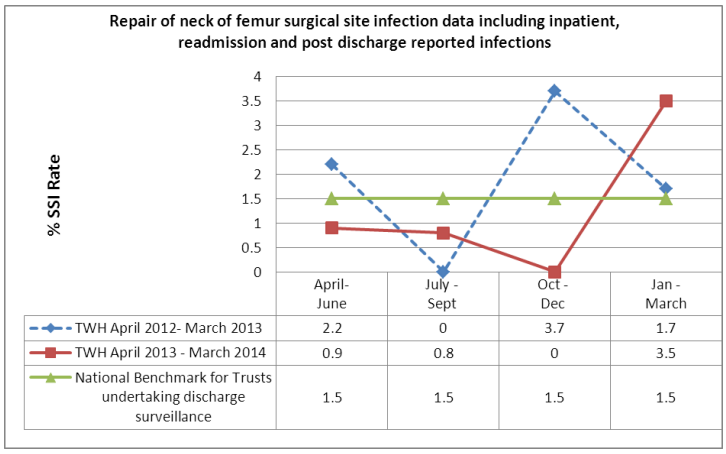


Fig 15: Infection rates for fractured neck of femur



The Trust has higher than average returns of post discharge questionnaire data for elective hips and knees. Nationally patient discharge data is collected on 69.4% of elective hip patients whereas we managed to gather data on 82.6% of our patients. This gives us reassurance that our post discharge data is comparable to the national data. However, only

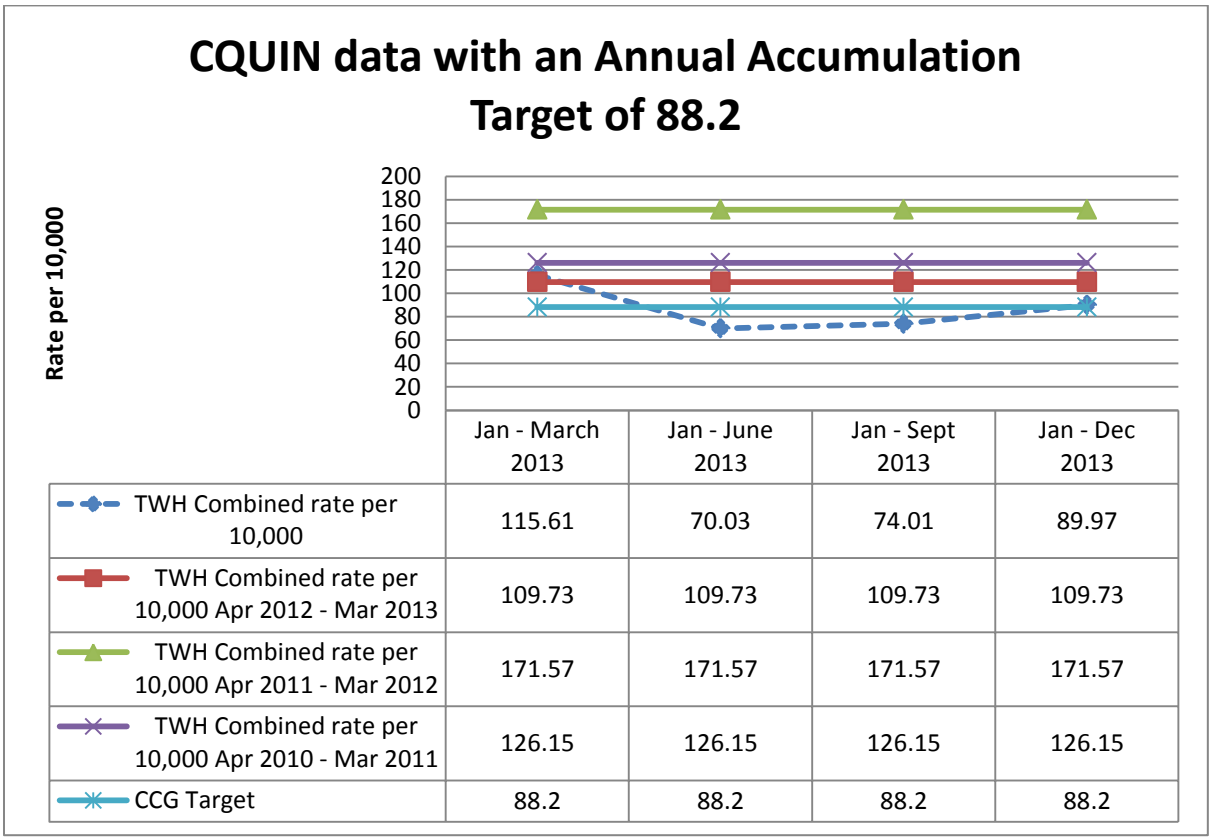
57.9% of discharge questionnaires for fractured neck of femur are returned despite telephone follow up of all cases. The national benchmark for questionnaire return is 72.7%.

Numbers of infection are low so a single infection can move the Trust from below the national benchmark rate to above it.

7.1.1. CQUIN target

The CQUIN target is measured this year for the period January – December. The CQUIN is designed to improve infection rates overall across all orthopaedic surgery

The performance just missed the target due to an improved performance between April – September 2013 with a combined SSI CQUIN rate of 89.97 per 10 000 procedures against a target of 88.2.



	Jan - March 2013	Jan - June 2013	Jan - Sept 2013	Jan - Dec 2013
TWH Combined rate per 10,000	115.61	70.03	74.01	89.97
TWH Combined rate per 10,000 Apr 2012 - Mar 2013	109.73	109.73	109.73	109.73
TWH Combined rate per 10,000 Apr 2011 - Mar 2012	171.57	171.57	171.57	171.57
TWH Combined rate per 10,000 Apr 2010 - Mar 2011	126.15	126.15	126.15	126.15
CCG Target	88.2	88.2	88.2	88.2

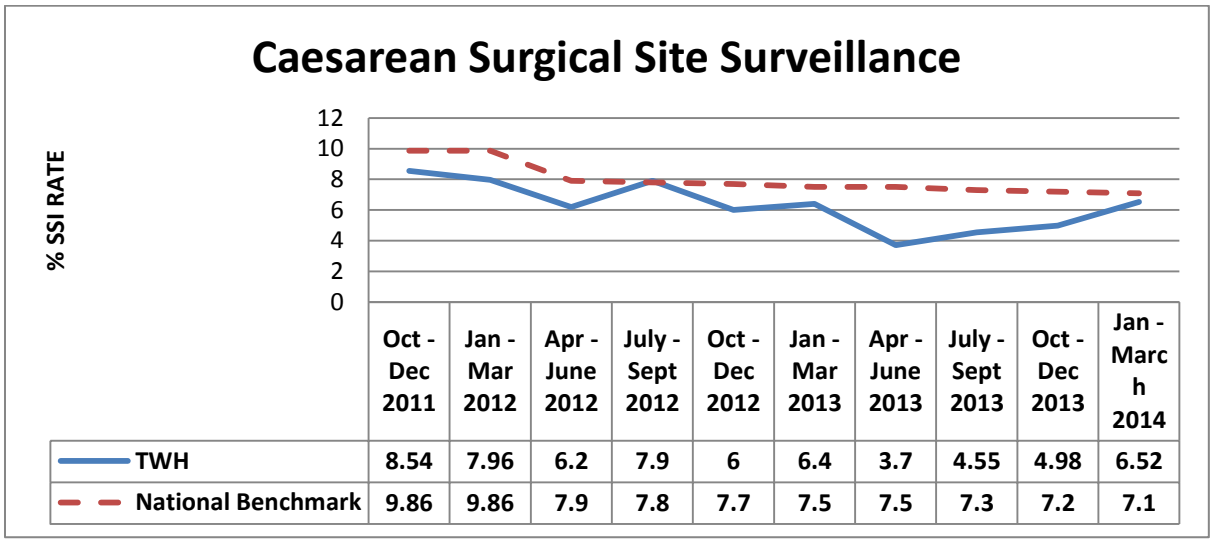
7.2. Caesarean section Surgical Site Surveillance

The HPA pilot for surgical site wound infections took place over the two quarters April-June and July–September 2009. Initially there were 6 pilot hospitals and this increased to 15 for the second quarter.

The benchmark infection rate following the pilot was initially set at 9.86% but is currently down to 7.1%. Infection rates at MTW are already well below this benchmark.

During September 2009 the NICE recommendations for the reduction of surgical site infections were implemented at Maidstone and have since been implemented at TWH.

Fig 15: Caesarean section rates



	Oct - Dec 2011	Jan - Mar 2012	Apr - June 2012	July - Sept 2012	Oct - Dec 2012	Jan - Mar 2013	Apr - June 2013	July - Sept 2013	Oct - Dec 2013	Jan - March 2014
TWH	8.54	7.96	6.2	7.9	6	6.4	3.7	4.55	4.98	6.52
National Benchmark	9.86	9.86	7.9	7.8	7.7	7.5	7.5	7.3	7.2	7.1

Two thirds of infections are seen in emergency patients and one third in elective. Root cause analysis is carried out for all infections

8. Outbreaks and Serious Infections

For the period April 2013 to March 2014, the following events were investigated as infection control incidents:

- Whatman ward – two cases of *C. difficile* infection within 28 days. No cross infection. Areas for improvement included domestic staffing levels and documentation of antibiotic prescribing. Antibiotic ward rounds with a consultant microbiologist were put in place.
- Lord North – two cases of *C. difficile* within a 10 day period. No cross infection. Areas for improvement included documentation of antibiotic prescribing.
- Lord North – GRE bacteraemia – see section 3.5.4
- TW20 and TW22 – two cases of *C. difficile* on each ward within a 28 day period. Investigated as a single incident. No cross infection found. Areas for improvement included the timeliness of specimen collection and the use of antibiotics
- TW12 – three cases of post 48 hour acquisition of MRSA colonisation. No cross infection found but areas of concern included hand hygiene and antibiotic documentation.
- TW ITU – Confirmed cross infection of MRSA colonisation in two patients. A Serious Incident was declared for this incident.
- Chaucer – two cases of *C. difficile* within a 28 day period. It was recognised in this investigation that escalation wards require additional ICT support.

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

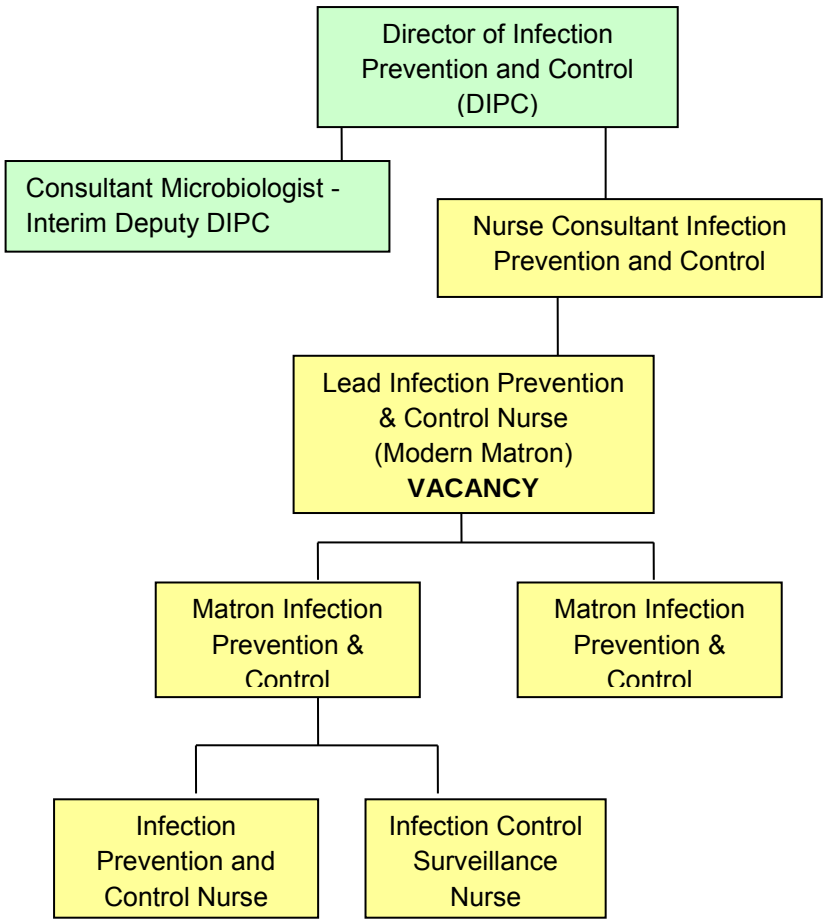
9. Infection Prevention and Control Team

During the year there were changes within the staffing of the infection prevention team. Gail Locock, lead infection control nurse and deputy DIPC, was seconded to WK CCG from September 2013. Initially this was for three months but the secondment was extended and ultimately Gail moved to a permanent post with the North Kent CCGs.

After a review of the team structure it was agreed that the new post of Nurse Consultant in Infection Prevention would be created with a strategic and educational remit. Our senior matron in infection control, Sarah Fielder, who had been acting up into the lead nurse post, was appointed to this role.

The IV access educator, Susannah Lowe also left the Trust to take up another post. This post has now been transferred to the critical care outreach team.

Fig 16: Structure of IPT going forward



10. Infection Prevention and Control Committee

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

The chair of the IPCC has changed in year with the Chief Nurse taking over the chair from the DIPC in February.

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

The committee has ratified 11 infection control policies during this period and received 12 completed audits. In addition, the committee has received RCA feedback and performance reports from the directorates and monitored action plan implementation. Major challenges for the committee included:

- Ensuring compliance with the Hygiene Code.
- Developing and implementing the C. difficile recovery action plan
- Monitoring of the annual infection control audit programme.
- Monitoring HCAI within the Trust
- Monitoring Saving Lives compliance
- Developing hand hygiene strategy
- Challenging the directorate performance with respect to HCAI
- Monitoring MRSA screening rates

11. Training

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

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

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

Link nurse meetings are held monthly on alternate sites. The programme is replicated on each site to enable more staff to attend. Each meeting has an educational element followed by a round table session leading to discussion about issues raised. In addition a Link nurse study day is held annually with invited speakers and this is also open to healthcare staff from other organisations.

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

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

12. Audit

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

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

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

The triangulation audits are conducted on:

- Bare below the elbows
- Hand hygiene
- Commode cleanliness
- MRSA decolonisation
- MRSA care pathway compliance
- MRSA non-elective screening

13. HCAI Task and Finish group

Root cause analysis of C. difficile cases showed that around 25% of cases were caused by antibiotic use secondary to healthcare associated chest infection. A Task and Finish group was set up in February 2012 chaired by the deputy Medical Director.

The terms of reference were to:

- develop a Trust strategy for reduction of HCAI
- develop an action plan and reduction plan
- develop a benchmark and inform strategy

The work of the group focussed on four key areas:

- **Mouth care** – the 'BRUSHED' oral hygiene assessment was developed and implemented within the Trust. A training scheme was also developed and this is now a routine part of the clinical Trust induction
- **Chest Infection** – this focus was on the diagnosis and treatment of hospital acquired chest infection and included an awareness campaign and new antibiotic guidance.
- **Urinary Tract Infection** – particularly catheter associated infection. The catheter policy was revised and updated. An audit of management of patients with catheter associated UTI was developed and an action plan implemented to educate staff and raise awareness of the issue.
- **Patient Mobility** – early mobilisation was identified as an important strategy in the prevention of both chest infection and UTI. Clarity was given to ward staff around mobilising patients early rather than waiting for physiotherapy input.

The group completed its work in November 2013.

14. Challenges for 2014/15

The main challenges for infection prevention and control in the year ahead are:

- Sustaining the previous gains in the rate of *C. difficile* and meeting the objective
- Developing a protocol with other Trusts for identifying lapses of care in *C. difficile* infection
- Continuing compliance with the hygiene code
- Ensuring compliance with the recently published NICE standards for HCAI and surgical site infection
- Reducing surgical site infection rates in orthopaedics
- Implementation of the acute Trust toolkit for the management of Carbapenemase producing Enterobacteriaceae
- Controlling and monitoring the development of antibiotic resistance
- Monitoring the incidence of GRE
- Developing surveillance for breast surgical site infection
- Sustaining high levels of screening for MRSA and responding to recent new guidance

15. Recommendation

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

Appendix 1: HCAI action plan 2013/14

Table 4: Actions to Improve Performance (*including Actions following the Preliminary Report from the Peer Review Process*) **APPENDIX 1**

These actions seek to address the issues identified from routine embedded processes as described above and the focus is on four main themes – antibiotics, environment, hand hygiene and training and awareness. This plan is monitored by the Infection Prevention and Control Committee and the Quality & Safety Committee.

No:	Recommendation / Issue	Action(s) to be taken	Nominated lead(s)	Start date	Estimated completion date	Progress	RAG for Progress	Evidence to support completion	Completion date	Monitoring committee	Regulatory link	Signposting to 14/15 plan
Antibiotic/Clinical Issues												
4a	Improve patient awareness post discharge of implications of C. difficile - Implementation of patient ID cards to highlight C. difficile diagnosis and key actions required by healthcare professionals	Develop implementation programme with CCG	Sara Mumford, DIPC and Gail Locock, Deputy DIPC	1st April 2013	31st Aug 2013	GL working with KCC lead for IC to progress.	G	Final version of card	Implementation complete 1/9/13	IPCC	CQC Outcome 8	Closed
		Presentation to CCG CSG 14.05.13	Steve Beaumont (CCG Chief Nurse)			Presented to WKCCG CSG 14.5.13	G	Audit awareness amongst GPs	14/05/2013			Closed
		Roll out implementation for affected patients back dated to 01.04.12	Gail Locock, Deputy DIPC			New stock of cards in place. Press statement drafted, Patient names and addresses collated for previous toxin and PCR +ve cases back to April 2013. Aim to role out from 19/08/13	G	Collated list of patients sent cards. Ongoing process	Implementation complete 1/9/13	IPCC	CQC Outcome 8	Closed
4b	Need to take learning from experience of other health communities	Attend meetings and participate in online discussions.	Sara Mumford, DIPC and Gail Locock, Deputy DIPC to work with CCG	1st April 2013	Ongoing 31st Mar 14	This will be ongoing throughout the year	G	Meeting minutes where this is discussed	Ongoing	IPCC	CQC Outcome 8	Closed
		Share learning with CCG and TDA				Forums in place to facilitae this shared learning. C. diff summit scheduled for 10/09/13 to include CCG and TDA presentations	G	Report and press releasse following summit meeting	10/09/2013	Joint strategic committee	CQC Outcome 8	Closed
		Peer review from DIPC at Frimley Park Hospital				Peer review set for 28/05/13. Awaiting final report. Actions from verbal feedback incorporated into action plan	A					No further expectation of formal report. Closed
		Review of antimicrobial guidelines by Consultant Pharmacist, GSTT				Antimicrobial review set for 15/05/13. Awaiting final report. Actions from verbal feedback incorporated into action plan	A					No further expectation of formal report. Closed

No:	Recommendation / Issue	Action(s) to be taken	Nominated lead(s)	Start date	Estimated completion date	Progress	RAG for Progress	Evidence to support completion	Completion date	Monitoring committee	Regulatory link	Signposting to 14/15 plan
4c	Joint working with the CCG	Fortnightly operational meetings and monthly strategy meetings	Sara Mumford & Steve Beaumont	1st November 2012	Ongoing	Meetings reduced to monthly. July 13. Meetings reduced to bimonthly from Oct 13	G	Minutes of meetings	Commenced from April 2013			Six monthly meetings planned going forwards. Closed
		Widen to include KMPT and KCHT				MTW now included as part of the improvement plan meetings for KCHT. Yet to develop links with KMPT.	A					Increased IP provision in CCG - for CCG to take forwards. Closed for Trust
4d	Antibiotic therapy modulation	Monthly prescribing audits to be conducted and shared through clinical governance	Vicki Simmons, Antimicrobial pharmacist through the antimicrobial steering group Consultants to share audit results through Clinical Governance	1st April 2013	Ongoing 31st Mar 14	**07.05.13 –** CSG presentation scheduled for 14th May Antibiotic prescribing policy ratified by Standards Committee April 2013. Prescribing audits performed as part of the PII process and shared with the relevant clinical teams.	G	Antibiotic audits.	Implemeted from July 13	IPCC	CQC Outcome 8	In place and continuing. No new action. Closed
		Work with CCG to develop community antibiotic audit process to reduce prescribing	Sara Mumford			Through the strategic meetings with the CCG these processes are now developing under the lead or the community prescribing lead.	G	Minutes of meetings this will be discussed. Ongoing process through ASG as well as strategic meetings				Community medicines management representative attends ASG. To continue. No new action for Trust
		Review of antimicrobial prescribing guidelines by Consultant pharmacist GSTT	Vicki Simmons	15th May 2013		Complete	G	Report from Consultant Pharmacist post visit	15/05/2013			Complete
		Presentation to Medical Clinical Governance	Sara Mumford	15th May 2013		Medical director also presented 11.7.13	G		11/07/2013			Complete
		Antibiotic prescribing policy	Vicki Simmons	10th December 2012	1st April 2013	Complete	G	Final antibiotic prescribing policy.	14/07/2013			Complete
		Benchmarking with other antimicrobial guidelines from other Acute Trusts	Vicki Simmons	1st April 2013	30th June 2013	Complete	G	Evidence of scoping process				Complete with review fo antimicrobial guidelines
		Benchmark defined daily doses of common antimicrobials with other Acute Trusts	Vicki Simmons	1st April 2013	30th June 2013							Not to be taken forward to 14/15 plan

No:	Recommendation / Issue	Action(s) to be taken	Nominated lead(s)	Start date	Estimated completion date	Progress	RAG for Progress	Evidence to support completion	Completion date	Monitoring committee	Regulatory link	Signposting to 14/15 plan
		Review and reinforce IV to oral switch	Vicki Simmons	1st April 2013	31st July 2013	Complete with launch of revised guidelines and 5 day stop stickers. Letter to all docs, nurses and pharmacists from MD and DIPC 15.7.13.	G	Final antibiotic prescribing policy.	15/07/2013			In place. For audit in new plan
		Work-up outpatient antimicrobial therapy as part of clinical strategy	Grace Sluga & Paul Bentley	1st May 2013	31st March 2014							Continuing. Take forward into new plan
		Training in safe and appropriate use of antimicrobials for Drs & nurses – source e-learning package	Grace Sluga & Paul Bentley	1st May 2013	31st August 2013	Sessions booked for junior doctor induction training in August 2013. Complete	G	Teaching sessions delivered including Antibiotic audit data	Aug 13. Further induction sessions completed as required			Continuing. Take forward into new plan
			Jeannette Barlow & Sara Mumford			Unable to source training e-package to date	R					Unable to take forward. Closed
		Review sepsis protocol	Sara Mumford & Lee Baldwin	1st May 2013	31st July 2013	Reviewed and updated. Included in Drs induction August 2013	G	Training sessions delivered. Protocol available on intranet. Ongoing monitoring by sepsis group for adverse incidents	Aug-13			Complete
4e	PPI usage reduction	Trust wide roll out of the C. difficile risk assessment tool to roll out from May 2013	Gail Locock, Deputy DIPC	1st May 2013	31st July 2013	Updated tool following pilot. Roll out week commencing 15.7.13	G	Finalised risk assessment tool. Evidence of completed risk assessment tools	14/07/2013	IPCC	CQC Outcome 8	Complete - further revision March 2014
						Discussed at KPI meeting with nursing staff						Complete
						Letter to all nurses and doctors describing change		Training given to all new doctors on induction	Aug 13. Further induction sessions completed as required			Complete
4f	Task & Finish group for the reduction of HCAIs	6 weekly meetings chaired by deputy medical director	Gail Locock, Deputy DIPC	19th February 2013	TBA	07.05.13 – roll out of oral hygiene and hydration actions as part of the 'Focus on…' series	G	Repeat HCAI prevalence survey January 2014	May-13	IPCC & Standards Committee	CQC Outcome 8	Complete
		UTI and Chest Infection reduction workstreams in progress and to report back to main meeting	HONs			Further work to be done to reinvigorate the T&F groupFurther work to increase profile of T&F group within Trust	G	Audit of practice implementation	January 2014 Dr Sluga has fed back Audit findings to Directorate meetings			Complete

No:	Recommendation / Issue	Action(s) to be taken	Nominated lead(s)	Start date	Estimated completion date	Progress	RAG for Progress	Evidence to support completion	Completion date	Monitoring committee	Regulatory link	Signposting to 14/15 plan
4g	Reduce inappropriate stool sampling	Review the rapid risk assessment pathways to ensure they match the new stool sampling flow chart	Gail Locock and the IPT	1st May 2013	1st July 2013	07.05.13 rapid risk assessment review ongoing. Developing a guide for appropriate stool sampling to complement the rapid risk asessment tool.	G	Reduction in stool samples sent from Acute Trust. Flow chart sent out	Oct-13	IPCC	CQC Outcome 8	Complete
		Implement stool sampling flow chart				CDI risk assessment piloted and ready to be rolled out across Trust – see 4e	G	Roll out complete	Sep-13			Complete
4h	Determine risk associated with C. difficile carriers	Prospectively ribotype samples of PCR positive carriers for 3 month pilot	Sara Mumford, DIPC	1st May 2013	31st July 2013	No incidents of cross infection involving carriers	G	Pilot completed. Carriers only to be typed in incident investigations	31/07/2013	IPCC	CQC Outcome 8	Complete
		MVLA genetic fingerprinting where appropriate					G		Ongoing as an when required when cross infection suspected			Ongoing. Carry forward to 14/15 plan
4i	Revise RCA process	Revise paperwork to conform with SI paperwork	Sara Mumford & Gail Locock	1st May 2013	31st May 2013	Revised paperwork rolled out across Trust.	G	New CDI paperwork	30/06/2013	IPCC	CQC Outcome 8	complete
		Create CDI panel with exec support and attendance				Dates booked for CDI panel with DIPC and DoN 15.7.13. First two sessions held. System in place	G	Improved outcomes from RCA. Embedded system	30/06/2013	IPCC	CQC Outcome 8	complete
		Disciplinary action for individuals				New process sent out and discussed at CDs meeting	G	Only used where appropriate	Jun-13			Complete
		NED-led review of RCA outcomes	Steve Tinton, Sylvia Denton			TOR to be agreed. Initial meeting held. Process started	A	Report from NEDs	Dec-13	Trust Board		Not taken forward
4j	Improve reporting to IPCC	Reporting from directorates to be revised	Sara Mumford	1st May 2013	30th June 2013	New template consulted on and rolled out across Trust. Reviewed at CD meeting.	G	Completed templates	20/6/13 – first IPCC with new reporting template in use	Quality and Safety	CQC outcome 8	Complete
		New template for reporting				Matrons nominated to attend	G	IPCC minutes	20/06/2013			Complete
						Template implemented at full IPCC. To discuss implementation at business meetings	G		20/06/2013			Complete - main meetings only

No:	Recommendation / Issue	Action(s) to be taken	Nominated lead(s)	Start date	Estimated completion date	Progress	RAG for Progress	Evidence to support completion	Completion date	Monitoring committee	Regulatory link	Signposting to 14/15 plan
4k	Appoint additional antibiotic pharmacist	Prepare JD and advert	Jim Reside/ Sara Mumford	15.7.13	30.9.13	Exec support for additional resource. Advertisement to be placed for antimicrobial pharmacist. Appointment completed	G	Individual in post	Sep-13	IPCC	CQC Outcome 8	Complete
4l	Improve knowledge of IV antibiotic usage	Develop log of patients on IV antibiotics including rationale for prescription and consultant review	Avey Bhatia/ Jim Reside			Discussions ongoing as to potential methods of implementation	A					Take forward in to 14/15 plan
Environment												
4m	Increase levels of cleaning for high risk areas	Highest risk areas reviewed on a weekly basis	Sue Hedges, Pat Demian and Site Practitioners	1st May 2013	Ongoing	In place. Wards and depts with cases are placed on enhanced cleaning measures.	G	Reports from Facilities Dept	01/04/2013	IPCC	CQC Outcome 8	Complete
		Identified high risk areas to have rooms/bed spaces level 3 cleaned after every discharge and rooms level 4 cleaned after every pt with diarrhoea discharged				Ongoing. No areas currently identified for increased measures	G		01/04/2013			Complete
4n	Confidence in cleaning products	Change from difficil-s back to actichlor for Trust wide environmental disinfection	Sue Hedges, Pat Demian and Gail Locock	1st May 2013	1st July 2013	Some concerns re microfibre and actichlor. Agreement not to proceed with change	G	Not implemented	01/07/2013	IPCC	CQC Outcome 8	Complete
4o	Confidence in cleaning audits	Weekly joint audits between ward manager and domestic supervisor	Ward sisters and domestic supervisors	1st April 2013	Ongoing	07.05.13 – joint audits have been in place prior to 01.04.13, need to ensure early escalation of problems and issues embedded as part of the process. Embedded at TWH. Further work at Maidstone	A			IPCC & weekly KPI meetings	CQC Outcome 8	Take forward to ensure sustainable practice
		Immediate escalation to infection prevention team of poor audit scores				Cleaning scores part of directorate report to IPCC. Escalation process not yet embedded	A					Take forward to ensure sustainable practice

No:	Recommendation / Issue	Action(s) to be taken	Nominated lead(s)	Start date	Estimated completion date	Progress	RAG for Progress	Evidence to support completion	Completion date	Monitoring committee	Regulatory link	Signposting to 14/15 plan
Hand Hygiene												
4p	Improve hand hygiene auditing in a single room environment	Investigate and implement innovative ways to assess compliance with hand hygiene standards	Gail Locock, Deputy DIPC	10th December 2012	31st December 2013	Implementation of the WHO auditing and training tool with Ecolab . 5.3.13 – report from Ecolab still awaited. 04.04.13 – Final report received from Ecolab and currently formulating actions which will become part of this action plan to make improvements. Ecolab now working with the key wards that have been audited to plan their improvements. Training packs being rolled out to other wards via the link nurse network	G	Completed audits and reports from Ecolab Infection Control team undertake monthly 20 min spot check audit of hand hygiene in all wards and A&E		IPCC	CQC Outcome 8	Take forward to ensure sustainable practice
Training & Awareness												
4q	Need to reinvigorate infection prevention messages throughout the Trust	Renew messages to staff around HCAI	Sara Mumford, DIPC; Gail Locock Deputy DIPC and Paul Newman, Coms	1st April 2013	30th Sept 2013	IPC discussed at directorate meetings.	G	Weekly report email messages	Ongoing as part of the weekly reporting process	IPCC	CQC Outcome 8	In place - continue with new actions into 14/15
		Utilise screen saver system to get messages out to staff				Awaiting IT update	R					Take forward into 14/15
		Develop business case to fund new hand hygiene signage					A					Trust action to improve signage - take forward into 14/15
		Trust intranet page for infection control to be redeveloped	Sarah Fielder, Interim lead IP nurse			Discussions ongoing Waiting information from Comms team re implementation date for IC page	A					Ongoing. Carry forward to 14/15 plan
4r	Requirement for Senior Medical leadership	Visible medical leadership from Clinical Directors to be improved through attendance at meetings and contribution to action planning for their teams.	Sara Mumford, DIPC, and Paul Sigston, Medical Director	1st May 2013	Ongoing	07.05.13 – risk summits held for two wards (TW20 and Lord North).	A			IPCC	CQC Outcome 8	Complete
		Greater engagement from CDs and Consultants with the RCA process				See actions related to RCA process (4i)	G		See 4i			Ongoing. Carry forward to 14/15 plan

No:	Recommendation / Issue	Action(s) to be taken	Nominated lead(s)	Start date	Estimated completion date	Progress	RAG for Progress	Evidence to support completion	Completion date	Monitoring committee	Regulatory link	Signposting to 14/15 plan
		Risk summit process for areas of concern	Avey Bhatia			Risk summit held for Whatman ward, Lord North Ward and Ward 20.	G		Ongoing process following a case of CDI			complete
						Medical attendance required at CDI panel.	G	Good attendance recorded at panel	Ongoing process following a case of CDI			Ongoing. Carry forward to 14/15 plan
						Directorates asked to nominate IPC champions.	A					Closed

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board –September 2014

9-11 Safe Staffing: Planned Vs. Actual – July 2014 Chief Nurse

Summary / Key points

The attached appendix 1 is a copy of the planned vs. actual nursing staffing as uploaded to UNIFY and published via NHS Choices on the Trust website for the month of July 2014.

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

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

Intensive Care Units (ICU) – both sites show that the actual hours provided for Clinical Support Workers (CSW) was below plan. This was due to decreased dependency so staff were either 'stood down', redeployed or temporary staffing solutions not utilised. This is also the case for the Maidstone ICU where staffing levels are less than 100%. At all times the Critical Care Standard for the provision of 1:1 or 1:2 nursing was maintained.

Coronary Care Unit (CCU) - Maidstone was at 91% provision against plan. The CCU at Maidstone is sited on Culpepper Ward, where the CCU can gain support when required. There was a clear assessment of need, and adequate staffing on Culpepper to allow this approach to be applied safely.

Medical Assessment Unit (MAU) - at TWH was below plan for CSWs during the day. This was due to short notice sickness, which could not be filled by temporary staff. This was risk assessed and contingencies employed (such as cover from A&E or Site Practitioners to support patient transfers). The overall numbers of shifts uncovered was minimal.

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

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

Urgent Medical Assessment Unit (UMAU) – increased requirement met for staff at night.

Foster Clark – increased requirement for support workers to meet increased dependency care needs during the day and at night.

Hedgehog – increased demand on capacity at night. The need for Registered Nurse and Clinical Support Worker cover was met.

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

Acuity needs for all wards was met with actual staff available meeting the planned requirements.
Across the Trust in July there were a high number of patients who were at significantly increased risk of falls, or had confusional states. These patients were spread across the following wards.

Jonathon Saunders had increased risks for falls over 9 nights.

Ward 10 had increased need for clinical support workers at night due a higher than usual number of patients with either confirmed dementia or short-term condition induced delirium.

Ward 20 required additional clinical support worker support at night due to a high number of confused/delirious patients prone to wandering.

Mercer ward required an additional support worker every night due to high numbers of patients with either dementia or delirium and increased number of high risk of falls.

Stroke Unit at Maidstone required two additional Clinical Support Workers every night through the month, as two patients' required 1:1 care. These patients could not have been cohorted together as one required isolation for infection control purposes.

Stroke and Mercer both indicate significant additional support when expressed as a percentage; in effect this was one additional staff member for Mercer and two for Stroke. The Stroke Unit issues are now resolving. Mercer is more complex and this is being reviewed as part of the bi-annual staffing review programme and the Directorate service and budget review process.

The attached appendix gives the beak down by ward.

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

Reason for receipt at the Board.
Assurance

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RWF Maidstone And Tunbridge Wells NHS Trust

Period: July_2014-15

Please provide the URL to the page on your trust website where your staffing information is available

http://www.mtw.nhs.uk/about-the-trust/safe-staffing-levels.asp

Validation alerts (see control panel)	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day: Registered midwives/nurses		Day: Care Staff		Night: Registered midwives/nurses		Night: Care Staff		Day		Night	
	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
		Maidstone District General Hospital - RWF03	Acute Stroke	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1488	1716	1488	1800	1116	1212	372	1032	115.3%	121.0%	108.6%	277.4%
		Maidstone District General Hospital - RWF03	Romney	314 - REHABILITATION	300 - GENERAL MEDICINE	1116	1116	1116	1104	744	732	756	756	100.0%	98.9%	98.4%	100.0%
		Maidstone District General Hospital - RWF03	Cornwallis	100 - GENERAL SURGERY	101 - UROLOGY	1644	1524	744	804	1116	1116		60	92.7%	108.1%	100.0%	
		Maidstone District General Hospital - RWF03	Coronary Care Unit (CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1116	1020			744	744			91.4%		100.0%	
		Maidstone District General Hospital - RWF03	Culpepper	320 - CARDIOLOGY	300 - GENERAL MEDICINE	744	876	744	588	744	744	372	372	117.7%	79.0%	100.0%	100.0%
		Maidstone District General Hospital - RWF03	Foster Clark	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	1764	1824	1104	1320	1476	1488	744	912	103.4%	119.6%	100.8%	122.6%
		Maidstone District General Hospital - RWF03	Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		2976	2652	276	252	2976	2568			89.1%	91.3%	86.3%	
		Maidstone District General Hospital - RWF03	John Day	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1860	1692	1116	1080	1116	1104	372	396	91.0%	96.8%	98.9%	106.5%
		Maidstone District General Hospital - RWF03	Jonathan Saunders	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1488	1476	744	780	1116	1104	372	492	99.2%	104.8%	98.9%	132.3%
		Maidstone District General Hospital - RWF03	Lord North	370 - MEDICAL ONCOLOGY	800 - CLINICAL ONCOLOGY	1860	1860	372	372	744	768	372	372	100.0%	100.0%	103.2%	100.0%
		Maidstone District General Hospital - RWF03	Mercer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1488	1476	1116	1128	1116	1104	372	744	99.2%	101.1%	98.9%	200.0%
		Maidstone District General Hospital - RWF03	Pye Oliver	100 - GENERAL SURGERY	101 - UROLOGY	1500	1584	1116	1080	1116	1140	372	372	105.6%	96.8%	102.2%	100.0%
		Maidstone District General Hospital - RWF03	Urgent Medical Ambulatory Unit (UMAU)	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	2784	2784	1392	1320	1116	1452	372	672	100.0%	94.8%	130.1%	180.6%
		The Tunbridge Wells Hospital - RWFTW	Acute Stroke	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1116	1116	744	684	1116	1104	372	384	100.0%	91.9%	98.9%	103.2%
		The Tunbridge Wells Hospital - RWFTW	Coronary Care Unit (CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1116	1104	372	372	1116	1104			98.9%	100.0%	98.9%	
		The Tunbridge Wells Hospital - RWFTW	Gynaecology	502 - GYNAECOLOGY		744	744	552	504	744	744	372	372	100.0%	91.3%	100.0%	100.0%
		The Tunbridge Wells Hospital - RWFTW	Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		2976	2988	372	360	2976	3036	372	264	100.4%	96.8%	102.0%	71.0%
		The Tunbridge Wells Hospital - RWFTW	Medical Assessment Unit	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	2604	2796	1488	1116	2232	2352	1116	996	107.4%	75.0%	105.4%	89.2%
		The Tunbridge Wells Hospital - RWFTW	SDU	100 - GENERAL SURGERY	101 - UROLOGY	1944	2184	672	636	744	708	372	372	112.3%	94.6%	95.2%	100.0%
		The Tunbridge Wells Hospital - RWFTW	Ward 32	110 - TRAUMA & ORTHOPAEDICS	100 - GENERAL SURGERY	744	744	372	372	372	372	372	372	100.0%	100.0%	100.0%	100.0%
		The Tunbridge Wells Hospital - RWFTW	Ward 10	100 - GENERAL SURGERY		2604	2556	1488	1524	1488	1488	744	984	98.2%	102.4%	100.0%	132.3%
		The Tunbridge Wells Hospital - RWFTW	Ward 11	100 - GENERAL SURGERY		2604	2604	1164	1212	1488	1512	744	816	100.0%	104.1%	101.6%	109.7%
		The Tunbridge Wells Hospital - RWFTW	Ward 12	320 - CARDIOLOGY	301 - GASTROENTEROLOGY	2172	2520	1272	1128	1440	1488	744	744	116.0%	88.7%	103.3%	100.0%
		The Tunbridge Wells Hospital - RWFTW	Ward 20	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	2136	2052	1488	1476	1488	1512	744	1044	96.1%	99.2%	101.6%	140.3%
		The Tunbridge Wells Hospital - RWFTW	Ward 21	340 - RESPIRATORY MEDICINE	302 - ENDOCRINOLOGY	2508	2472	1116	1092	1860	1836	744	744	98.6%	97.8%	98.7%	100.0%
		The Tunbridge Wells Hospital - RWFTW	Ward 22	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1488	1452	1116	1224	1116	1044	1116	1020	97.6%	109.7%	93.5%	91.4%
		The Tunbridge Wells Hospital - RWFTW	Ward 30	110 - TRAUMA & ORTHOPAEDICS		2508	2400	1392	1404	1488	1452	744	924	95.7%	100.9%	97.6%	124.2%
		The Tunbridge Wells Hospital - RWFTW	Ward 31	110 - TRAUMA & ORTHOPAEDICS		2232	2208	1764	1236	1488	1428	1116	1104	98.9%	70.1%	96.0%	98.9%
		Tonbridge Cottage Hospital - RWF10	Stroke Rehab	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1272	1212	744	732	744	744	372	372	95.3%	98.4%	100.0%	100.0%
		The Tunbridge Wells Hospital - RWFTW	ante-natal	501 - OBSTETRICS		744	720	372	348	744	708	372	324	96.8%	93.5%	95.2%	87.1%
		The Tunbridge Wells Hospital - RWFTW	delivery suite	501 - OBSTETRICS		3240	3204	720	708	3240	2892	720	720	98.9%	98.3%	89.3%	100.0%
		The Tunbridge Wells Hospital - RWFTW	post-natal	501 - OBSTETRICS		1764	1740	1488	1596	1488	1428	1488	1296	98.6%	107.3%	96.0%	87.1%
		The Tunbridge Wells Hospital - RWFTW	Gynae Triage	502 - GYNAECOLOGY		744	744	372	336	744	744	372	372	100.0%	90.3%	100.0%	100.0%
		The Tunbridge Wells Hospital - RWFTW	Hedgehog	420 - PAEDIATRICS		2232	2280	648	540	2232	2412	372	564	102.2%	83.3%	108.1%	151.6%
		Maidstone District General Hospital - RWF03	Birth Centre	501 - OBSTETRICS		744	732	372	372	744	744	372	360	98.4%	100.0%	100.0%	96.8%
		The Tunbridge Wells Hospital - RWFTW	Neonatal Unit	420 - PAEDIATRICS		2232	2244	372	408	2232	2304	372	252	100.5%	109.7%	103.2%	67.7%
		Maidstone District General Hospital - RWF03	MSSU	100 - GENERAL SURGERY		936	972	684	696	456	456			103.8%	101.8%	100.0%	
			Total			65232	65388	32472	31704	49020	48888	18588	20580				

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board – September 2014

9-11 Safe Staffing: Planned Vs. Actual – August 2014 Chief Nurse

Summary / Key points

The attached appendix is a copy of the planned vs. actual nursing and midwifery staffing as uploaded to UNIFY and published via NHS Choices on the Trust website for the month of August 2014.

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

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

Intensive Care Unit (ICU) – Maidstone site: Staffing was at 90% for Registered Nurses during the day and fell to 85% at night. The unit had 14 days during the month where acuity was significantly lower than expected. The unit was able to support any emergency admissions and was, at all times, able to provide the appropriate levels of care.

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

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

Urgent Medical Assessment Unit (UMAU) – increased requirement met for staff at night.

Hedgehog – increased demand on capacity at night. The need for Registered Nurse and Clinical Support Worker cover was met.

Increased acuity and dependency: Acuity refers to clinical need and skill, dependency refers to the assistance required to carry out activities of daily living such as assistance with eating, washing or mobility. Increased care needs were identified on the following wards and additional staff were used to meet these needs:

Foster Clark – increased requirement for support workers to meet basic nursing care needs was met both during the day and at night.

Ward 10 had increased need for clinical support workers at night due a higher than usual number of patients with either confirmed dementia or short-term condition induced delirium. Ward 10 also had a patient with additional needs (learning disability) requiring additional support overnight.

Ward 20 required additional clinical support workers at night due to a high number of confused/delirious patients prone to wandering.

Mercer ward required an additional support worker every night due to high numbers of patients with either dementia or delirium and increased number of patients requiring significant support with toileting and personal hygiene needs..

Stroke Unit at Maidstone required two additional Clinical Support Workers for 21 nights, reducing to 1 additional support worker for a further 9 nights through the month, as two patients required 1:1 continuous nurse presence.

Stroke and Mercer both indicate significant additional support when expressed as a percentage, in effect this was one additional staff member for Mercer and 2 for Stroke. Mercer is more complex

and this is being reviewed as part of the bi-annual staffing review programme and the Directorate service and budget review process.

The attached appendix gives the beak down by ward.

Overall the trust is able to meet the nursing care time demands, and has systems in place to allow for a flexible responsive provision of care with the support and use of temporary staffing..

Reason for receipt at the Board.
Assurance

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RWF Maidstone And Tunbridge Wells NHS Trust

Period: August_2014-15

Please provide the URL to the page on your trust website where your staffing information is available

http://www.mtw.nhs.uk/about-the-trust/safe-staffing-levels.asp

Validation alerts (see control panel)	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night	
						Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff					
	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
		Maidstone District General Hospital - RWF03	Acute Stroke	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	1488	1476	1488	1800	1116	1104	396	984	99.2%	121.0%	98.9%	248.5%
		Maidstone District General Hospital - RWF03	Romney	314 - REHABILITATION	300 - GENERAL MEDICINE	1116	1116	1116	1104	744	744	744	744	100.0%	98.9%	100.0%	100.0%
		Maidstone District General Hospital - RWF03	Cornwallis	100 - GENERAL SURGERY	101 - UROLOGY	1632	1608	744	768	1116	1116			98.5%	103.2%	100.0%	
		Maidstone District General Hospital - RWF03	Coronary Care Unit (CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1116	1020			744	720			91.4%		96.8%	
		Maidstone District General Hospital - RWF03	Culpepper	320 - CARDIOLOGY	300 - GENERAL MEDICINE	744	816	744	636	744	732	372	372	109.7%	85.5%	98.4%	100.0%
		Maidstone District General Hospital - RWF03	Foster Clark	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	1860	1860	1116	1320	1488	1488	744	912	100.0%	118.3%	100.0%	122.6%
		Maidstone District General Hospital - RWF03	Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		2976	2694	252	120	2976	2544			90.5%	47.6%	85.5%	
		Maidstone District General Hospital - RWF03	John Day	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	1860	1824	1116	1404	1116	1116	372	432	98.1%	125.8%	100.0%	116.1%
		Maidstone District General Hospital - RWF03	Jonathan Saunders	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1488	1488	744	756	1116	1104	372	372	100.0%	101.6%	98.9%	100.0%
		Maidstone District General Hospital - RWF03	Lord North	370 - MEDICAL ONCOLOGY	800 - CLINICAL ONCOLOGY	1860	1860	372	372	744	768	372	372	100.0%	100.0%	103.2%	100.0%
		Maidstone District General Hospital - RWF03	Mercer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1488	1440	1116	1212	1116	1104	372	372	96.8%	108.6%	98.9%	100.0%
		Maidstone District General Hospital - RWF03	Pye Oliver	100 - GENERAL SURGERY	101 - UROLOGY	1644	1608	744	816	1116	1296	372	420	97.8%	109.7%	116.1%	112.9%
		Maidstone District General Hospital - RWF03	Urgent Medical Ambulatory Unit (UMAU)	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	2736	2640	1368	1272	1116	1248	372	672	96.5%	93.0%	111.8%	180.6%
		The Tunbridge Wells Hospital - RWFTW	Acute Stroke	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1116	1068	744	720	1116	1092	372	432	95.7%	96.8%	97.8%	116.1%
		The Tunbridge Wells Hospital - RWFTW	Coronary Care Unit (CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	1116	1092	372	372	1116	1116			97.8%	100.0%	100.0%	
		The Tunbridge Wells Hospital - RWFTW	Gynaecology	502 - GYNAECOLOGY		744	732	528	480	744	744	372	372	98.4%	90.9%	100.0%	100.0%
		The Tunbridge Wells Hospital - RWFTW	Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		3000	3036	372	372	2976	2976	372	204	101.2%	100.0%	100.0%	54.8%
		The Tunbridge Wells Hospital - RWFTW	Medical Assessment Unit	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	2604	2820	1488	1224	2232	2280	1116	888	108.3%	82.3%	102.2%	79.6%
		The Tunbridge Wells Hospital - RWFTW	SDU	100 - GENERAL SURGERY	101 - UROLOGY	1836	1812	612	528	744	780	372	336	98.7%	86.3%	104.8%	90.3%
		The Tunbridge Wells Hospital - RWFTW	Ward 32	110 - TRAUMA & ORTHOPAEDICS	100 - GENERAL SURGERY	744	744	372	372	372	372	372	372	100.0%	100.0%	100.0%	100.0%
		The Tunbridge Wells Hospital - RWFTW	Ward 10	100 - GENERAL SURGERY		2604	2556	1488	1524	1488	1488	744	984	98.2%	102.4%	100.0%	132.3%
		The Tunbridge Wells Hospital - RWFTW	Ward 11	100 - GENERAL SURGERY		2604	2520	1116	1176	1488	1428	744	768	96.8%	105.4%	96.0%	103.2%
		The Tunbridge Wells Hospital - RWFTW	Ward 12	320 - CARDIOLOGY	301 - GASTROENTEROLOGY	2484	2460	1116	1116	1476	1440	744	828	99.0%	100.0%	97.6%	111.3%
		The Tunbridge Wells Hospital - RWFTW	Ward 20	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	2112	1956	1488	1464	1488	1332	744	936	92.6%	98.4%	89.5%	125.8%
		The Tunbridge Wells Hospital - RWFTW	Ward 21	340 - RESPIRATORY MEDICINE	302 - ENDOCRINOLOGY	2484	2364	1116	1152	1860	1776	744	768	95.2%	103.2%	95.5%	103.2%
		The Tunbridge Wells Hospital - RWFTW	Ward 22	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1488	1368	1116	1020	1116	1104	1116	1044	91.9%	91.4%	98.9%	93.5%
		The Tunbridge Wells Hospital - RWFTW	Ward 30	110 - TRAUMA & ORTHOPAEDICS		2484	2424	1332	1476	1488	1440	744	732	97.6%	110.8%	96.8%	98.4%
		The Tunbridge Wells Hospital - RWFTW	Ward 31	110 - TRAUMA & ORTHOPAEDICS		2232	2532	1560	1308	1488	1380	1116	1128	113.4%	83.8%	92.7%	101.1%
		Tonbridge Cottage Hospital - RWF10	Stroke Rehab	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	1248	1212	756	792	744	744	372	372	97.1%	104.8%	100.0%	100.0%
		The Tunbridge Wells Hospital - RWFTW	ante-natal	501 - OBSTETRICS		744	756	372	324	744	744	372	312	101.6%	87.1%	100.0%	83.9%
		The Tunbridge Wells Hospital - RWFTW	delivery suite	501 - OBSTETRICS		3348	3192	744	696	3348	2964	744	768	95.3%	93.5%	88.5%	103.2%
		The Tunbridge Wells Hospital - RWFTW	post-natal	501 - OBSTETRICS		1728	1788	1488	1296	1488	1476	1488	1308	103.5%	87.1%	99.2%	87.9%
		The Tunbridge Wells Hospital - RWFTW	Gynae Triage	502 - GYNAECOLOGY		744	744	372	372	744	744	372	372	100.0%	100.0%	100.0%	100.0%
		The Tunbridge Wells Hospital - RWFTW	Hedgehog	420 - PAEDIATRICS		2232	2364	624	792	2232	2580	372	480	105.9%	126.9%	115.6%	129.0%
		Maidstone District General Hospital - RWF03	Birth Centre	501 - OBSTETRICS		744	732	372	336	744	696	372	288	98.4%	90.3%	93.5%	77.4%
		The Tunbridge Wells Hospital - RWFTW	Neonatal Unit	420 - PAEDIATRICS		2232	2242	372	288	2232	2292	372	312	100.4%	77.4%	102.7%	83.9%
		Maidstone District General Hospital - RWF03	MSSU	100 - GENERAL SURGERY		936	972	684	696	456	456			103.8%	101.8%	100.0%	
			Total			65616	64936	31524	31476	49176	48528	18624	19656				

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - September 2014

9-12 Ward Staffing Review **Chief Nurse**

Summary / Key points

The enclosed report provides information on the ward nursing establishment review undertaken in July and August 2014. The methodology is compliant with the NICE Guidance published in July 2014, and a summary of compliance by standard is contained within the report.

The methodology for the ward establishment review included the use of the Safe Staffing tool for measuring acuity & dependency. This was triangulated against a professional judgement tool, nurse sensitive indicators, including hospital acquired pressure ulcers, falls and medication errors. Data on complaints relating to nursing care, and Quality Trigger tools (QuEST) were also used.

The process involved meeting directly with the Ward Managers to ensure that front line intelligence was accurately and consistently captured and to enable Ward Managers to be part of the process that reviews and approves establishments set for areas that full under their remit of responsibility and accountability.

The paper also details key risks relating to vacancies and temporary staffing reliance as well as providing an assurance on safe staffing escalation processes.

The paper details some recommendations for changes to staffing levels; 6 areas would significantly benefit from some level of up lift in staffing. These include Foster Clark, Ward 21, John Day, Lord North, Ward 20, Mercer and Stroke (Maidstone). Most of these areas are already using higher levels than planned workforce.

Two service provision changes (merger of Culpepper and Maidstone Coronary Care Unit and redesign of leadership of elective short stay surgery) have been evaluated as part of the review and professional nursing endorsement given for these changes. Ward Manager supervisory time has also been considered and recommendations made in light of plans for enhancing 7 day working provision.

In conclusion in-patient care is supported by effective processes for ensuring safe delivery of nursing care. There are a small number of recommendations to enhance this to make safe care delivery more secure.

Nurse to patient ratios fall within acceptable limits and are in line with current national guidance. There are currently no key clinical or patient experience themes emerging to suggest our wards consistently lack sufficient staff to deliver safe and effective nursing care, however this is reliant on usage of temporary staff especially bank staff.

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

1.0 Introduction:

This paper sets out to inform and update the Board on staffing levels for in-patient wards. It provides an update on the paper presented to board in March 2013.

The paper provides detail on the current staffing position against national recommendations, and makes recommendations to support either current course or to build a case for change.

It also aims to provide the Board with an update on the Trust's compliance with the recently published National Institute for Health and Care Excellence (NICE) guidance 'Safe staffing for nursing in adult inpatient wards in acute hospitals' (July 2014).

2.0 Background:

The relationship between the quality of patient care and nurse establishments has been under significant public and professional scrutiny since the publication of the Francis report (2013) into the poor standards of care in an acute Trust. Subsequent reports supported this link. The reports included the 'Review into the quality of care and treatment provided in 14 hospital trusts in England (Keogh 2013), 'An independent enquiry into healthcare assistants and support workers in the NHS and social care setting' (Cavendish 2013) and the report on 'Improving the safety of patients in England' (Berwick 2013).

There is an emerging body of evidence to suggest a direct correlation to failings in care, poor outcomes and increased mortality to inadequately staffed wards.

The National Quality Board (NQB) guidance 'How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability' (July 2013) acknowledged that safe staffing is more than just numbers; it is also about skills, development and clinical leadership.

Factors that significantly underpin the delivery good quality care, that is patient centred, delivered with, compassion and competence include:

- Strong empowered ward level leadership
- Resources directed to supporting ward leaders
- Consistent use of clinical and patient experience indicators to assess, monitor and change practice
- Clinical practice development (mentorship, leadership programmes, preceptorship, clinical support workers skills acquisition and development).
- Senior and local level leadership that promotes and fosters a positive learning environment.

There are two key issues that the professional nursing community have been debating at length:

- Nationally set mandatory nurse-patient ratios for adult medical & surgical wards
- Universal agreement on a tool to measure and model ward staffing requirements.

To date, there is still no consensus on agreed ratios, though there is now an emerging body of evidence to support the professional judgement approach in surgical and care of the elderly (Aitken et al 2014, RCN 2012, & RCN 2010).

The use of an acuity and dependency tool developed by the Association of United Kingdom University Hospitals (latterly the Shelford Group) has been used widely over the last 2 years.

This tool, now known as the Safe Staffing Tool, has been subjected to review by the National Institute for Health and Care Excellence (NICE), the results and subsequent guidance having been published in July 2014.

The three commonest workforce planning methods used in the UK are, and remain:

- Professional Judgement approach
- Nurse to occupied bed/patient ratio
- Acuity & dependency method.

Both the NQB and NICE recognise that the use of different tools applied to the same area will provide different results. The recommendation is that more than one tool should be used to enable some level of validation, along with triangulation against a series of nurse sensitive indicators and patient experience matrix.

Maidstone and Tunbridge Wells NHS Trust (MTW) has undertaken a review of ward establishments on an annual basis, and has systems in place to ensure regular review of establishments over each 6 month period.

MTW has in place a method of triangulation to support staffing reviews which is in line with the recommendations stipulated by the NQB and NICE. These include the use of nurse sensitive indicators (previously known as Safer Smarter Nursing Metrics) which includes a review of incidents, by ward, on falls, pressure ulcers and medication errors. The trust also utilises a Quality, Effectiveness and Safety Trigger Tool (QuESTT: NHS South West 2012) and Safer Staffing Acuity & Dependency. For the establishment review this year, results from Friends & Family (FFT), local ward surveys and complaints (where they related specifically to nursing care) were also considered.

3.0 Evidence base

There is a paucity of evidence specifically related to the UK healthcare system, with the majority of studies been observational studies undertaken in North America and Europe.

The European study, RN4CAST was led by the National Nursing Research Unit at Kings College London, and explored the relationship between nurse staffing levels, aspects of hospital organisation and patient outcomes across Europe. MTW contributed to this research activity which was undertaken during 2010/11. The overarching findings were published in June 2012, with a further subsequent report published in February 2014. The findings of this study suggested the recommended ratios are:

Ratio of Registered Nurses to untrained staff – skill mix

Royal College of Nursing (RCN) guidelines stipulate the recommended aim within acute NHS Trusts should be to achieve a 65%:35% split of registered to untrained staff, in order to provide safe levels of nursing care.

Ratio of Registered Nurses to patients and mortality rates

Dr Linda Aitkin is a world leading researcher in this field and her work is well recognised in the UK, including by the DH and RCN. She describes the optimum level of RNs to patient ratio, according to her research to be 1:6. This has a mortality risk for patients of 4%, rising to 31% with a ratio of 1:8. Every additional patient increase thereafter, raises the mortality risk by 7%.

Aitkin's published report (February 2014) goes on to indicate that where there is an increase in degree level education within the RN workforce by 10% then mortality rate is likely to drop by 7%.

The association implies that patients in hospitals where 60% or more nurses are degree level educated and cared for an average of 6 patients would have an almost 30% lower mortality than patients in hospitals in which only 30% of nurses had a degree level education and cared for an average of 8 patients.

The evidence for this comes from a study undertaken in 9 European countries across 300 hospitals. Data for 422,730 patients were reviewed along with surveys on staffing, patient ratios and levels of education from 26,516 nurses. (Aitkin et al; Lancet 2014).

Safe Staffing Acuity & Dependency Tool:

This tool was developed and validated by the Shelford Group of Hospitals (10 NHS university teaching hospitals across the country). This tool provides a system of identifying patient acuity and dependency, patient turnover including admissions, discharges, transfers and escorts. The underpinning formulae then convert these scores into recommended whole time equivalence.

Acuity is a term used to identify the level of technical or interventional tasks required for patient care, and is based on factors such as diagnosis and complexity of therapy regimes.

Dependency refers to the support a patient requires to meet fundamental needs (often referred to as activities of daily living) this includes the patient's ability to ensure their own safety. Thus a patient may have low acuity needs (simple clinical observations, single drug intravenous therapy regimes) but will score high in terms of dependency if they, for example, have a delirium and prone to wandering or falling, thus requiring a high level of nursing care/input.

High level definitions for scoring acuity and dependency can be found in appendix 1.

Following the series of reports published in 2012/13 in to failings in care in the NHS, NICE were commissioned to review the evidence base for safe staffing methodologies including the use of an acuity and dependency tool.

4.0 NICE guidance for Safe Staffing: recommendations and current position regarding compliance.

NICE published their guidance in July 2014, which included the following recommendations:

- *Focus on patient care*:

  Patients should receive the nursing care they need, including specialist nursing, regardless of the ward to which they are allocated, the time of day or the day of the week. This includes planning to locate patients where their clinical needs can best be met.

The Trust has a system in place to monitor the placement and movement of patients. The placement of patients is reviewed at least three times a day at the Clinical Site Operations meetings.

There are systems in place to alert specialist teams, including Clinical Nurse Specialists, of patient's care requirements. Referrals to specialist teams are not driven or dependent on ward location.

- *Accountability for ward nursing staff establishments*

  Develop procedures to ensure that ward nursing establishments are sufficient to provide safe nursing care to each patient at all times.
  Ensure that the final ward nursing staff establishments are developed with the Registered Nurses who are responsible for determining nursing staff requirements at ward level, and approved by the Chief Nurse.

  When agreeing ward nursing staff establishment, ensure it is sufficient to provide planned nursing staff requirements at all times. This should include capacity to deal with planned and predictable variation in nursing staff such as annual, maternity, paternity and study leave (commonly known as uplift).

Nursing utilisation is reviewed at directorate level weekly, with daily reviews of requirements undertaken by the Matrons and Clinical Site Practitioners out of hours.

All budgeted ward establishments have a contingency to manage predictable variation. Wards currently have an absence uplift of 22% to cover annual leave, study leave, and compassionate leave. This year an alternative method of managing maternity leave is being utilised, as some areas have a higher maternity related absence than others at different times in the year. The revised centralisation of this fund is intended to even this out to enable wards to be more responsive to changing staffing needs.

- *Responsiveness to unplanned changes*

  Hospitals should have a system in place for nursing red flag events, and responding to unplanned variations in predicted patients' nursing needs or availability of nursing staff.

  Ensure there is a separate organisational contingency plan and response for patients who require the continuous presence of a member of the nursing team (often referred to as 'specialing').

A 'Red Flag' event in this context refers to a nursing intervention that could not be undertaken or was undertaken late due to lack of available staff. This includes response to pain relief, clinical observations and safety/quality checks. The system for reporting these events is the Datix incident system. There is a Safe Staffing Escalation procedure in place that identifies these key 'Red Flag' indicators to enable staff to escalate their concerns, and to provide direction for the Clinical Site Practitioners and on-call managers to manage safe staffing out of hours (Appendix 2).

There is a well utilised process in place for the management of patients who require continuous nursing presence or 'specialing'. There is a specific policy in place to manage this. This policy is currently under review to ensure it matches the key indicators and definitions utilised by the Safe Staffing Acuity & Dependency Tool.

- *Monitor adequacy of ward nursing staffing establishments*

  Ensure that there is a systematic on-going monitoring of safe nursing indicators and formal review of nursing staff establishments of individual wards at least twice a year.

The Trust has a system in place for the regular review of staffing levels. In the last year these have taken place in Quarters 2 and 4 (in 2012/13 the board received reports in September 2013, and March 2014).

The Board also receives monthly exception reports based on the planned versus actual staffing for all inpatient wards.

Safe staffing indicators are monitored via the QuESTT tool. Any ward scoring above or below the expected level is reviewed at the Clinical Governance Committee.

- *Promote staff training and education*

  Enable nursing staff to have the appropriate training for the care they are required to provide.

The Trust has processes in place to ensure staff receive the appropriate training required for their role. This includes both in-house training and development and links with academic providers for formal professional development.

The Trust is utilising funds from Health Education England to support four Clinical Practice Facilitator posts. These posts are aligned to groups of wards. The post-holders work primarily with more junior members of the ward team, but also support the middle ranking staff, and support the Ward Manager in undertaking quality reviews of practice at a local level (essence of care audits, care assurance audits).

5.0 Methodology for staffing review:

The methodology for the staffing reviews undertaken in July/August 2014 has followed the key recommendations from the NQB and NICE. Two methods were utilised as part of the review, the professional judgement tool and the Safe Staffing Tool.

In addition intelligence was sourced from data relating to patient experience, including local ward satisfaction surveys, friends and family feedback and complaints relating to nursing care.

Patient safety nurse sensitive indicators were also considered. These included the number of hospital acquired pressure ulcers, falls and medication errors. There is strong reliability for pressure ulcer and falls incidence, however it is acknowledged that there is under reporting of incidents related to medication errors. This is forming a specific strand of work in collaboration with pharmacy, patient safety and ward teams.

Further sources of intelligence included QuESTT Scores which included a review of factors that altered the score from month to month.

The data set was reviewed for the previous 6 months.

6.0 Principles:

A number of key principles for setting staffing levels were already in place. These were reviewed against the recommendations from NQB published last year. Further review against recommendations from NICE was also taken into account. These were largely unchanged when published in July 2014, and support the findings from the NQB and the Royal College of Nursing.

NICE recommend using a decision support tool (Safe Staffing Tool) and informed professional judgement to make the final assessment of requirements.

The key principles utilised are:

- Supervisory time for ward managers to be built into establishments. The ward manager should be responsible for taking charge of the ward
- Number of Band 6's per ward (usually 2 per ward)
- RN to patient ratio (between 1:5 and 1:7)
- RN to Clinical Support Worker ratio (aim for 65/35 split)
- Headroom allowance (to cover leave, sickness, study)
- Practice Educator support and supervision

7.0 Process:

Historically reviews have been undertaken at matron level, with matrons presenting their data to the Chief Nurse, Deputy Chief Nurse and Associate Directors of Nursing.

For this review, the Ward Managers were directly involved in the reviews, and were afforded the opportunity to discuss their data, their wider concerns, and to be equal partners in agreeing any recommendations for change or assurance that staffing levels were satisfactory.

Each ward review meeting consisted of the Ward Manager, Matron, Associate Director of Nursing and the Deputy Chief Nurse. Patient Safety data is already provided to the Ward Managers and Matrons by the Patient Safety team on a monthly basis, so Ward Managers were already fully conversant with their incident data and this formed part of the discussion.

Finance support was provided by the relevant Directorate Finance Manager who provided data on current budget position for both budgeted establishment and staff in post. Any proposals for change are supported by the Finance Manager and Matron and built into the Directorate planning meetings.

This review concentrated solely on established adult in-patient wards. Women's & Children's Services and specialist areas (ICU, Theatres) will be reviewed in the coming months. Both these services are kept under regular review via the weekly Chief Nurse Senior Team meeting.

Chaucer Ward was not subject to a formal review during this period, as it was not an established ward. However staffing levels, nurse to patient ratios and reliance on temporary staffing have been kept under regular review at directorate level, with regular reports to the Chief Nurse from the Associate Director of Nursing for Emergency Services.

8.0 Current Position:

All established adult inpatient wards were reviewed during July and August using the methodology and process describe above.

Budgeted establishment and current shift profiles were confirmed and any anomalies from expected outcomes were explored. A small number of areas had anomalies in budget between April 2014 and review date due to revisions of budgets following wider workforce reviews.

Budgets for 2014/15 were set in line with commissioning intensions and previous years established budget. In some instances this did not factor in uplifts in nursing establishments

recommended from the previous review, or were amended following changes in commissioned or contracted activity.

Overall ward establishments are broadly in line with requirements, and meet the currently agreed principles. All wards except one have a Registered Nurse (RN) to Clinical Support Worker (CSW) ratio in the region of 60/40. Details of individual wards are shown in Appendix 3.

There are 6 wards where there are recommendations for change and further investment.

These are:
Foster Clark: Respiratory ward supporting Non-Invasive Ventilation (NIV) and about to implement 'Opti-flow' oxygen therapy.

- RN to patient ratio 1:7.
- Challenged by ward layout – bays mean in order to meet single-sex standards, patients requiring NIV and/or close monitoring are spread across more than one bay.
- 22 falls since April 2014, with the majority occurring during the day (8am – 6pm).
- 5 medication errors reported since April 2014, 3 systems related and 1 patient self-administration related.
- Serious incident related to omission of medication by nursing staff

Acuity & dependency tool would suggest levels about right (2 WTE variation) however the acuity scoring is not consistent with similar patient groups on Ward 21.
Ward 21: Respiratory ward supporting NIV and opti-flow oxygen therapy.

- RN to patient ratio 1:5 reducing to 1:6 late afternoon and night.
- 34 falls April to date
- 7 hospital acquired category 2 pressure ulcers since April, 4 related to oxygen delivery devices and, in part, due to organisational constrains around delivery devices.
- 2 nursing care complaints since April – both these relate to issue around hygiene, pain control and end of life care.
- Acuity & dependency tool would suggest the ward is running consistently low on RN availability.

Both wards are not fully British Thoracic Society complaint in terms of RN to patient ratios for the delivery of NIV.

Recommendation: for both wards: review acuity & dependency scoring to ensure 'like for like' application of definitions.

Foster Clark:

Consider uplift of 1 RN for day time (as majority of incidents happen during day rather than night.)

Consider link to wider Directorate improvement plans and consider uplifting staff to meet BTS guidance for High Dependency Unit style bay now, rather than waiting for the revised respiratory ward to open next year.

Ward 21:

Directorate need to review current demand for NIV and include seasonal variation for NIV demand. Acuity & dependency suggest an increase of 4 WTE required. Professional Judgement would suggest an uplift of 2 WTE given recognised variations in acuity scoring.

John Day: Gastroenterology and General Medicine.

This ward is challenged by the patient group being cared for (detoxing alcoholic patients) and by the ward layout/location. Two bays are not in a direct line of sight thus require constant nursing presence within the bay, this is compounded by the ward being on ground floor. A bay has direct access to the car park via a fire door. This represents an elopement risk for the detoxing alcoholic group requiring increased nursing presence.

RN ratio is formally 1:9 at night – which is border line. To meet the demand and logistics described above it means 2 RNs are responsible for 7 patients each with the 3rd RN having to take a case load 12.

- 6 hospital acquired category 2 pressure ulcers since April 2014.
- Period of Increased Incidence (PII) for falls for 5 weeks. Pattern of falls is between 4am – 8am.

Recommendation: Increase by 1 RN at night.

Potential to off-set this by a decrease in CSWs however this will increase the risk of elopement when dealing with complex patients or covering statutory rest breaks.

Lord North: Oncology/Haematology.

RN to patient ratio: 1:5 day, 1:9 at night.

Additional demands include provision of chemotherapy trained nurse to support ICU when sepsis patient admitted/transferred. Complex regimes also result in one RN off the ward for significant periods.

Chemotherapy regimes frequently start late in the day, and day unit preparation takes precedence over in-patient preparation (to ensure day case therapy starts on time to avoid conversion to overnight stay).

- Incident rate generally low, with no hospital acquired pressure damage.
- 18 falls since April 2014, with no discernible pattern.

Recommendation: Increase RNs by 1 per night with a subsequent decrease in CSW at night, moving from 2/1 to 3/0 ratio.

Mercer: medical/care of the elderly (including dementia)

- RN to patient ratios generally good at 1:6 day and 1:8 at night.
- Dementia Key worker role not yet fully established in budget, this role works Monday to Friday 8am – 4pm.
- 1 pressure damage related case since April.
- 33 falls since April 2014, of which 21 occurred at night.
- Elopements/absconders average less than 1 per week usually occurs around tea time (between 4pm and 6pm).
- No nursing care related complaints.
- Acuity & dependency score would suggest an increase required.
- Key challenge is the frequency of assistance with toileting and hygiene.

Recommendation: Increase the CSW by 1 per night.

Ward 20: Medicine/care of the elderly (including dementia and designated c.diff cohort ward).

- Nurse to patient ratio 1:6 day and 1:8 nights.
- 38 falls since April 2014. Improvements made, specifically at night by adopting a cohort approach and utilising an additional CSW at night over and above establishment – via the escalation/specials process. Under NICE guidance this would be considered a Red Flag approach.
- Zero hospital acquired pressure damage for more than 90 days.
- Acuity and dependency would suggest that ward staffing levels are about right with a variation of +/- 2 WTE
  Professional judgement would generally support this, with the addition of a CSW at night.

Recommendation: Increase CSW by 1 per night to support cohort nursing. This has been the practice for several months, and has demonstrated improvements in both pressure damage and falls prevention.

The Stroke wards on both sites require further more detailed review, to align with the strategic direction of the wider stroke improvement plans. Currently neither unit would be fully compliant with recommendations for hyper acute stroke. Both units face challenges of providing cover for the thrombolysis bleep, particularly at night. The Directorate Matron has a clear view on the requirements depending on the options and is currently working with the Directorate on this. Further review of this will occur as plans develop and mature.

The Stroke unit at Maidstone has some unique issues, most notably the mix of acute and rehabilitation patients which frequently means an increased demand for continuous nursing presence. The detail for this ward is:

Stroke – Maidstone:
- RN to Patient ratios1:7 days and 1:8 at night.
- This increases to 1:13 at night if RN off the ward for a thrombolysis call.
- Zero pressure ulcers for >90 days
- 17 falls since April 2014, with the majority occurring at night
- Acuity & dependency indicates under by 5 WTE.

Other activity that impacts on nursing time include multi-disciplinary team (MDT) meetings, goal setting and review meetings and discharge planning meetings. MDT meetings typically last for 2 hours, and care/discharge planning meetings can take around 45 minutes each.

The key area of risk for the Stroke Unit at Maidstone is night, where there is the greatest demand for managing confused or disorientated patients, and toileting needs. The ward has a history of increasing CSW utilisation at night, with the last two months demonstrating significant increase in demand and increase in actual staff used vs. planned.

Recommendation: Increase CSW by 1 per night.

Directorate need to further assess the RN requirements for thrombolysis cover at night.

Two further wards need to be kept under close scrutiny are **Ward 22** and **Ward 31**.
Both these wards have an RN to CSW ration of less than 60/40.

Ward 22 has an RN: CSW ratio of 50:50. The RN to Patient ratio is 1:6 for the day, and 1:7 for the night, so within acceptable limits. There is a requirement for increased numbers of CSWs to support environmental safety (fall prevention and elopement risks).

Ward 31 has an RN: CSW ratio of 53:47 and a RN to Patient ratio of 1:6 for the day, and 1:8 at night. This is boarder line acceptable.

All other indicators for both these wards are within acceptable limits and do not give rise to concern. Both Ward Managers are content with their current establishments and are confident in the escalation processes should patient acuity and dependency change.

Ward Manager supervisory status:

All wards have supervisory time for Ward Manager built into their establishments; however there is variation across wards and sites.

The majority of wards at Tunbridge Wells Hospital have 5 days supervisory time included in their budgeted establishments. Some smaller wards, such as the Acute Stroke Unit, have 3 days. The wards at Maidstone are more variable with a range between 3 and 5 days supervisory time in their budgeted establishments. The short stay/day case units have no supervisory time in their budgeted establishments.

This will be addressed as part of the work to improve 7 day working, with workforce planning to include having a Ward Manager presence at weekends to provide senior level leadership and professional advice to a number of wards across a specialty or directorate.

9.0 Impact of recent service development/reconfiguration on ward establishments:

There have been a couple of significant changes to the way some wards work which should be noted.

Coronary Care and Culpepper Wards have been combined. This has been noted as a positive by the Ward Manager. This provides greater opportunity for flexing available nursing time according to acuity and dependency and allows for safer more timely response to changes in nursing requirements.

Changes to the way surgical day care is to be managed, include the separation of the Surgical Assessment Unit form the Short Stay Surgical Unit at Tunbridge Wells. This will allow for greater focus on the needs of urgent surgical admissions and allow for the development of acute assessment skills for this cohort of the nursing workforce.

Bringing the Surgical Short Stay Unit at Tunbridge Wells under the leadership of the Ward Manager for the Maidstone Short Stay Surgical Unit will enable a change in nursing practice and improvements in consistency in the management of elective surgical day case care across both sites.

The key risks to this initiative is the lack of supervisory/management time currently in the establishment for these units. The Ward Manager for the elective day surgery units will be working across two sites. If the Ward Manager is to have a strong leadership presence on both sites, then supervisory time has to be considered.

Similarly to ensure the skill set for the Surgical Assessment Unit nurses is enhanced to support more effective use of the unit, some supervisory time would be considered.

This is currently being worked through as part of the directorate management, and will be subject to further review as the implementation progresses.

10.0 Vacancies and Recruitment :

Vacancy figures are monitored and managed at directorate level. To ensure the Trust is fully aware of the risks associated with vacancies to and ensure a proactive approach is taken; recruitment is also supported and monitored via a Recruitment & Retention Strategy Group chaired jointly by the Chief Nurse and Director of Workforce This group has representation from all the directorates, Human Resources and Recruitment Team.

The current vacancy rate is in the region of 10% overall, however there are some areas with higher vacancy rates 10 – 15%..

The delays in closing Chaucer have led to delays in the medical ward recruitment as the plan was to fill these from the Chaucer staff cohort. Now that Chaucer will remain open as a 20 bed unit, with the capacity to increase to 33 if required, means the overall vacancy factor has increased. This has impacted on UMAU, Foster Clark and John Day.

Several Ward Managers took the decision earlier in the year to actively target student nurses who will qualify in September, which has inflated the immediate vacancy position. Recruiting externally has become increasingly challenging.

There are plans in place to address this, including a campaign with the Nursing Times, international recruitment in October and recruitment fair in November as well as using social media strategies more effectively.

11.0 Temporary Staffing

There are systems and processes in place to ensure that there are sufficient staff on duty to provide safe nursing care.

Whilst wards have in place a ‘head room allowance’ to cover annual leave, short term sickness and training & education activity this does not always allow for increased acuity and dependency.

Many ward areas have reported an increase in the number of patients being admitted with cognitive impairments and increased risk of falls. The latter has been a key focus for the trust in recent times, and there is clearly an increased awareness of associated risks and the need to ensure a ‘nursing presence’ to ensure the risks are kept to a minimum.

The current vacancy rates combined with a sickness/absence in nursing between 3 -4% results in a significant reliance on temporary staffing to ensure safe levels of staff are maintained. The expected decrease in demand for additional beds adds to this pressure, and the anticipated reduction in demand for additional beds usually seen during the summer months did not materialise this year.

Temporary staffing usage is monitored by the Associate Directors of Nursing and the Deputy Chief Nurse on a weekly basis. This is triangulated with other sources of intelligence related to quality.

Following the last review, where action was taken to improve nurse to patient ratios, minor increases in temporary staffing were seen, implying that Ward Managers are able to manage their teams effectively. Where there has been an increase in usage, this has been in areas

where either recruitment to vacant posts has been delayed or where there are additional bed capacity issues.

The key wards that are, or remain, high users of temporary staffing are:

Stoke Unit at Maidstone: this unit has been particularly challenged in meeting the demands of continuous nursing presence, having had two months where the needs of patients prevent safe cohorting of needs. There are additional pressures to this unit in terms of providing cover for the thrombolysis bleep.

Foster Clark: This ward has an inflated vacancy factor and a higher than average acuity demand due to the nature of the specialty.

Pye Oliver: This ward was established at the start of the year for 22 beds; however, it has been open to additional capacity beds for several months. This has necessitated the use of temporary staffing to meet fundamental care needs.

UMAU: this Unit has also faced challenges in staff as a result of Chaucer Ward not closing as anticipated. This combined with the conversion of trolleys to beds to provide over-night care has adversely impacted on the Unit's ability cover all shifts from within their existing establishment.

Mercer Ward: this ward has noticed an increase in the number of patients requiring significantly more assistance with personal care needs. Whilst this ward had an uplift in RN staffing earlier in the year to improve RN to patient ratios, there remains a need for addition 'nursing presence' in the form of clinical support workers to meet care needs to ensure patient safety with high numbers of cogitatively impaired patients.

John Day: due to the increasing numbers of patient with cognitive impairments due to alcohol withdrawal, there has been a need to use additional staff. The layout of the ward and its location on the ground floor add to the challenges of maintaining patient safety. Being on the ground floor provides several options for patients to abscond.

Ward 20: This ward has adopted a cohort nursing approach to managing high numbers of cogitatively impaired patients and those of increased risk of falls. In order to achieve this, the ward has consistently utilised an additional clinical support work at night.

12.0 Conclusion:

Overall staffing levels meet the needs of our patients, with a number of exceptions as detailed above.

In these cases plans are being developed to make a case for change.

The respiratory wards (Foster and Ward 21) represent the more significant longer term risk. Ward 20, Mercer and Stroke have already addressed some of their key risks by utilising the escalation procedure; however for this to be sustainable the establishment needs to be adjusted to reflect this.

There are currently no key clinical or patient experience themes emerging to suggest our wards consistently lack sufficient staff to deliver safe and effective nursing care.

Adult Acuity/Dependency Tool **Appendix 1**

Levels of Care	Inclusion Criteria	Guidance on Care Required
Level 0 Patient requires hospitalisation. Needs met through normal ward care.	Elective Medical or Surgical Admission, Routine Post Diagnostic/Surgical Procedure care, May have underlying medical condition requiring on-going treatment, Patient awaiting discharge.	Routine post-op/ post procedure care (Incl ½ hry obs until stable), Regular observations 2 - 4 hourly, ECG monitoring to establish stability, Fluid management, PCA, Oxygen therapy 24 – 40% (Specialist Surgical Areas ONLY – single chest drain). Requires routine nursing assistance
Appropriately managed on in-patient ward but requires more than baseline resources. **Level 1a** Acutely ill patient requiring intervention or those who are **UNSTABLE** with a **GREATER POTENTIAL** to deteriorate.	Observation & Therapeutic Intervention - "Step Down" from Level 2 care, Post-Op care following Emergency or Complex Surgery, or following peri-operative event. Emergency Admission requiring immediate therapeutic intervention. Deteriorating Condition or Fluctuating vital signs.	Instability requiring continual observation/ invasive monitoring, Support of Outreach Team but **NOT** higher level of care. Oxygen Therapy greater than 40% +/- Chest Physiotherapy 2 – 6 hourly. Arterial Blood Gas analysis – intermittent. 24 - 48 hours following Tracheostomy, insertion Central lines/ Epidurals/ Chest drains.
Level 1b Patients who are in a **STABLE** condition but have an increased dependence on nursing support.	Severe Infection, Sepsis, Complex wound management. Compromised Immune system. Psychological Support/Preparation. Requires Continual Supervision. Spinal Instability / Mobility Difficulties.	Complex Drug regimes, Patient and/or carers require continued support owing to poor disease prognosis or clinical outcome. Completely dependent on nursing assistance for all activities of daily living. Constant observation due to risk of harm.
Level 2 Patients who are unstable and at risk of deteriorating and should **NOT** be cared for in areas currently resourced as general wards. (May be managed within clearly identified, designated beds, resourced with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility/unit).	Deteriorating /Compromised Single Organ System, Post-op Mgt following Major Surgery, Post-operative optimisation/ extended post-op care. "Step Down" from Level 3 Care. Uncorrected Major Physiological Abnormalities.	Patients requiring Non-invasive ventilation/ resp support. Routine short-term post-operative ventilation. First 24 hrs following Tracheostomy insertion. Requires a range of therapeutic interventions including; Greater than 60% oxygen, Continuous ECG & invasive pressure monitoring, Vasoactive drug infusions (amiodarone, potassium, inotropes, GTN, magnesium), Haemodynamic instability. Pain Management; IV analgesic infusions, CNS depression of airway & protective reflexes, Neuro monitoring.
Level 3 Patients needing advanced respiratory support and therapeutic support of multiple organs.	Monitoring and Supportive Therapy for Compromise or Collapse of two or more Organ Systems.	Respiratory or CNS depression/ compromise requires Mechanical/ Invasive ventilation, Invasive monitoring, vasoactive drugs, treatment of hypervolemia/haemorrhage/ sepsis or neuro protection

Appendix 2

Safer staffing escalation procedure (nursing)

Overarching policy: Nursing and Midwifery E-Rostering Policy and Management Guidelines

Approved by: Nursing, Midwifery & Allied Health Professions Steering Group, 25th February 2014

Workforce Committee, 17th June 2014: Agreed to extend review period by one additional year to August 2015 [Version 2.2]

Ratified by: Standards Committee, 16th April 2014

Document history

Requirement for document:	
Cross references:	• *Safe Staffing Acuity & Dependency monitoring definitions*
Associated documents:	• Maidstone and Tunbridge Wells NHS Trust. *Escalation policy and procedure for emergency admissions* [RWF-OPPPES-C-AEM8] • Maidstone and Tunbridge Wells NHS Trust. *E-Rostering Policy and Management Guidelines, Nursing and Midwifery* [RWF-OPPPCS-NC-WF12]

Version Control: *Details of approved versions*		
Issue:	**Description of changes:**	**Date:**
1.0	New document	February 2014
1.1	Workforce Committee (17th June 2014) agreed to extend the review period for a further year, to August 2015, until new E-Roster provider has been secured.	June 2014

1.0 Introduction and scope

This document describes the process for assessing managing nursing staffing levels across Maidstone & Tunbridge Wells NHS Trust on a shift by shift basis.

The nurse in charge of the ward/department is responsible for assessing staffing numbers are as expected on the rota and the ward is assessed as being safely staffed taking into consideration workload, patient acuity and skill mix. **Appendix A** summarises the definitions and actions listed below.

2.0 Actions

2.1 GREEN status

Staffing numbers are not as expected, but reasonable given current workload.

Action by:
Ward Manager or Nurse in Charge of the shift.

Actions to be taken:

- Review the staffing numbers, skill mix and specific skills and competencies of the ward nurses for the current shift.
- Make a professional judgement about the ability of the team to manage workload and any known changes in patient case mix and/or dependency or reduced numbers of staff.
- Allocate staff to patient workload demand in the most efficient manner
- Assess the need for additional staff and if required review rota in relation to staff rostered on days off, study leave and other leave to assess if these are essential and may be changed
- Keep Matron informed of decisions at all times

Escalation criteria:
Ascertain whether remaining staff could safely complete:

- Observations (especially post-operative, PAR triggers)
- Adequately provide observation of patients at increased risk (falls/confusion etc) without ‘specials’ nurse
- Mealtimes and feeding of all patients requiring support
- Hydration of patients (drinks, IV or NG)
- Pressure Area Care
- Drug administration and oxygen therapy on time
- Staff can take statutory rest breaks

NOTE: Wards may be busy without a staff member but is more likely to be unsafe if you cannot complete these 7 tasks/

If a problem in staffing is identified i.e.: the nurse in charge considers the situation to be ‘unsafe’ in relation to staff numbers and the ability to deliver patient care the following escalation should be applied.

2.2 AMBER status

Staffing numbers are not as expected and minor adjustments are made to bring staffing to a reasonable level given workload, acuity and skill mix

OR

Staffing numbers are as expected, but given workload, acuity and skill mix, additional staff may be required

Action by:
Ward Manager or Nurse in Charge of the shift.

Actions to be taken:

- Contact Matron or Site Practitioner to ascertain a broader perspective of available staff
- Review rota in relation to staff rostered on days off, study leave, and other leave to assess if these are essential and may be changed.
- Matron/Site Practitioner will review the unit provision of staffing and reallocate staff across the unit as necessary
- Ward Manager or Nurse in Charge will contact the Bank Office to submit a request to provide additional bank staff. If this exceeds the available budget then permission from the Matron must be sought first. The Bank Office will liaise with the ward first if bank staff are unavailable and agency staff are required.
- Contact the Associate Director of Nursing or nominated deputy for permission to request agency staff.
- Document all actions and complete an e-reporting incident form.

If the problem remains and safe skill mix/numbers as agreed are not achieved as a result of these actions, the following stage should be followed.

2.3 RED status

Staffing levels inadequate to manage current needs.

Action by:
Matron/ Associate Director of Nursing

Action: Monday to Friday 08.00 – 17.00

- If bank or agency staff are unavailable then Matron to contact Associate Director of Nursing to review Trust wide allocation of staff and liaise with peers to action staff movement between wards, departments and where necessary between sites.
- Consider distribution of nurses including nurse specialists and non-ward nurses
- Consider actions for reducing in-house training requirements to redeploy staff
- Consider movement of patients/case mix/dependency within the unit to safety manage the patients within available skill mix. Liaise with Site Practitioner
- Consider at the same time, planning staff and patient movement for forthcoming shifts across the unit
- Inform the Associate Director of Nursing (who will decide if the Chief Nurse, Chief Operating Officer need to be informed) with a view to moving patients across the Trust or need to consider the temporary closure of a bed for **less than** 2 hours.
- Associate Director of Nursing to contact the Chief Nurse and Chief Operating Officer to review the need to reduce planned patient activity and the possibility of closing beds.
- Document all actions and complete e-reporting incident form.

Out of Hours:

Site Practitioner/On-call manager:

- Review and ensure actions for earlier escalation in place
- Ensure Matron/Site Practitioner have reviewed Trust wide staffing levels and acuity together
- Contact on-call manager to review the need to redirect admissions and the possibility of closing beds

At no time will be beds be closed without prior consultation with the Chief Operating Officer or the Chief Nurse in hours and the on-call Director out of hours.

Appendix 3

Staffing Review by ward:

						Ratios		Nurse Sensitive Indicators (incidence April to July '14)					Comments
Site	Ward	Budgeted Est. (WTE)	Safe Staff (WTE)	Vacancy (WTE)	Sickness (%)	RN:CSW	RN:Pt (E, L & N)	Hospital Acquired P'Ulcers (cat 2+)	Falls	Med Errors	QuESTT	Nursing Care Complaints	
TCH	Stroke Rehab	20.19	19	0.9	4.5	60/40	1;6	0 >90 days	9	0	3	0	Revise shift calculator to reflect 1 long day shift rather than 2. no case for further investment currently
M'stone	Cornwallis	25.66	25	2	4	81/19	1;5	0 for 6/12	6	1	8	0	no change required
	Culpepper (incl CCU)	19.79	21.8	5.02	2.8	55/45	1;6,1;7 (CCU 1,2, 1;3)	1	7	0	3	2	Ratios boarder line, skewed by merger of two units. Need to keep under review.
	Foster Clark	39.11	37.66	8	5	65/35	1;7	4	22	5	7	0	requires investment - uplift in RNs to improve RN:pt ratio in line with BTS guidance. Some anomolies in A&D scoring to be resolved.
	john Day	33.57	36.6	3	4	63/37	1;7, 1;7, 1;9	4	5	4	7	1	consider increasing RN at night
	Jon Saunders	28.92	31.8	1.74	9	67/33	1;6,1;6,1;8	1	13	2	5	1	No change required
	Lord North	27	28	0*	6%	69/31	1:5,1:5, 1:9	0	18	2	3	0	0 vacancy - Band 5 in pipeline with confirmed start date. 2 wte CSW held pending review. Need to consider increase in RN at night. Challenge of managing sepsis patient in side rooms and supporting chemo therapy on ICU.
	Mercer	31.62	38.2	3	2.8	60/40	1;7,1;7,1;9	0	33	0	5	0	Falls predominantly at night. High levels of ADL support at night. Consider uplift of CSW by 1 at night
	MSSSU	15.34	no data	1	2	60/40	1;9	0	0	0	5	0	no safe staffing data, as tool not designed for short stay/day case activity. Currently reviewing available tools. Need to consider Ward Manager supervisory time as plans in place for 1 WM to cover elective day surgery across both sites.
	Pye Oliver	29.19	32.3	7	2.1	68/32	1;7, 1;6, 1;9	1	5	6	7	1	Currently running to 28 beds (funded for 22), estb agreed for 28 beds at 32.39, this reflects the 7 wte vacancy rate. RN;patient ratios will remain stable at this revised establishment. Plan supported.
	Romney	29.32	no data	4.49	4	50/50	1;7, 1;11	2	5	0	3	1	RN:CSW ratio of 50/50 is acceptable for a community care type ward, and is in line with peers.
	Stroke	32.88	42.3	0*	6	65/35	1;7,1;7,1;9	0	17	1	5	3	Ratios increase if RN off ward for thrombolysis, ratios increase to 1:9 and 1:13 (day & night). High demand for ADL support at night. Need to consider wider stroke improvement plans. Recommend increase in CSW support at night.
	UMAU	41.91	no data*	4	5	70/30	1;5**	0	6	8***	10	7	*safe staffing data not used; consider use of A&E approach, or newly developed med assessment unit tool. High vacancy rate relates to the failure to close Chaucer as anticipated which has adversely impacted on recruitment plans. **Ratio 1:5 refers to bed area, trolleys had 1:4. ***8 medication errors related to a single individual who has since been performance managed.
TWH	Ward 10	44.97	44.3	3	3	63/37	1;5,1;6,1;7	0	3	1	3	0	no change required
	Ward 11	42.18	39.2	1	5	68/32	1;5,1;5, 1;7	0	5	0	4	3 pals	no change required/

						Ratios		Nurse Sensitive Indicators (incidence April to July '14)					Comments
Site	Ward	Budgeted Est. (WTE)	Safe Staff (WTE)	Vacancy (WTE)	Sickness (%)	RN:CSW	RN:Pt (E, L & N)	Hospital Acquired P'Ulcers (cat 2+)	Falls	Med Errors	QuESTT	Nursing Care Complaints	
	Ward 12	42.16	38.6	7	3.8	62/38	1:5, 1:8. 1:8	0	6	0	9	1	Recruitment plan in place for vacancy. Consider revision of shift plan to enable additional RN on late (could use CSW monies from existing vacancy), No recommendation for investment.
	ward 20	41.05	44	1	3	61/39	1;6,1;6, 1;8		34	1	2	0	pattern of falls at night, Ward Manager increasing CSW at night to manage this along with cohort nursing high risk patients. Recommend uplift of CSW by 1 at night.
	Ward 21	43.78	47.9	2.05	3	67/33	1;5, 1;6, 1;6	7	7	1	7	2	7 pressure damage cases related predominantly to 02 delivery devices. Need to considering increasing demand for NIV. Professional Judgement and Acuity Scores would suggest a need for a minimum uplift of 2 WTE RNs.
	Ward 22	38.19	37	3.77	3	50/50	1;6,1;7, 1;7	1	15	0	7	2	50:50 split needs close monitoring. May need to consider increase in RN on late shift. No strong case for change at present.
	Ward 30	42.17	38	5	3	64/36	1;6,1;5,1;8	0	10	2	2	2	No case for change.
	Ward 31	46.9	46.2	5	6	53/47	1;6,1;6,1;8	2	12	0	5	1	Falls rate reducing since increase in CSW at night from March/April. This addition has altered the RN;CSW ratio, but is currently acceptable. No further case for change.
	Ward 32/Wells	30.96	incomplete	3	<3	60/30	1;5,1;5,1;8	0	3	3	3	3	Generally stable: no case for change.
	Acute Stroke	24.33	18	0	5	64/36	1;5,1;5,1;5	0	6	0	5	1	Need to link to wider stroke improvement plan and cover for thrombolysis bleed. Staffing currently about right. Supervisory role of Ward Manager to be considered in wider review of 7 day working.
	CCU	19.79	10	3	3	83/17	1;3	2	1	0	5	1	Unit had a budget uplift to recognise 2 unfunded beds. Monies used to increase CSW workforce. No evidence currently to suggest increase in establishment. High portion of new staff, need to settle.
	MAU	53.58	35.83	3	3	66/34	1;5,1;6	1	40	0	2	2	Acuity score not fully validated and may not fully account for turn-over of patients (2 -3 times full ward per 24hrs). High turnover also accounts for higher proportion of falls. Ward Manager happy with skill mix and levels currently. Therefore no recommendation for change.
	SSSAU/SAU	30/71	no data		3	67/33	1;5	0	1	1	4		plans in progress to manage elective short stay across both sites, and fully establish SAU as a stand-alone unit. Ratios appear to be about right and are supported. Some consideration needs to be given to the Ward Manager supervisory time to allow for change management and skills acquisition.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - September 2014

9-13 Board members' ward visits (01/08 to 10/09) — Trust Secretary

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

This report therefore provides details of the visits undertaken by Board Members between 1st August and 10th September 2014. This includes ward/department visits, involvement in Care Assurance Audits and related activity. It should however be noted that the report does not claim to be a comprehensive record of such activity, as some Board members (notably the Chief Executive, Chief Operating Officer, Chief Nurse, Medical Director, and Director of Infection Prevention and Control), visit wards and other patient areas regularly, as part of their day-to-day responsibility for service delivery and the quality of care. It is not intended to capture all such routine visits within this report. In addition, Board members may have undertaken visits but not registered these with the Trust Management office (Board members are therefore encouraged to register all such visits).

The report is primarily for information, and to encourage Board members to continue to undertake visits. Some of the key issues arising from the visits that have been recorded are as follows:

- The areas visited during the out of hours visit to Tunbridge Wells Hospital by the Chief Nurse all had safe staffing levels (this conclusion was reached by viewing the staffing boards and asking the nurse in charge of each clinical area whether there were safe staffing levels for the acuity and dependency of the patients being cared for).
- The Chief Executive's visit to the A&E at Maidstone was overall a very positive visit, and relations between the nurses and doctors (particularly Consultants) seemed good. It was also noted that there had been an increase in referrals from the Medway catchment and this was likely to continue. Work is underway to look at contingencies.
- The Chief Operating Officer's visits at Maidstone Hospital included viewing the recent upgrade to Whatman Ward (to which Mercer Ward has moved, to enable some upgrade works and deep cleaning to occur). All staff were very welcoming and had no specific issues to raise. The move had gone well and they were settled in. All medication cupboards and fridges were observed to be locked, and fridge temperatures recordings were all up to date.
- The Chair of the Finance Committee's visit to Wards 30 and 31 at Tunbridge Wells Hospital was linked to the Trauma Unit revalidation visit. It was noted that the wards were very busy but looked organised. There were no issues observed with signage, drug cupboards, staffing, notices, cleanliness or hand washing, but issues that did arise included the time to CT scan, & the relationship with different Social Services. These issues were dealt with at the revalidation.

Board members should also note that the finalised 'pairing' arrangements which the Board had agreed to introduce (& which were reviewed at the May 2014 Board), have now been issued.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

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

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

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

Ward visits undertaken by Board members, 1st August to 10th September 2014

Board member	Areas registered as being visited (MH: Maidstone Hospital; TW: Tunbridge Wells Hospital)	Formal feedback provided?
Associate Non-Executive Director	-	-
Chairman	-	-
Chief Executive	1. A&E, MH 2. Ward 30, TW 3. Ward 31, TW	Yes
Chief Nurse	1. Admissions, MH 2. Cornwallis, MH 3. A&E, TW 4. Cardiac Cath Lab, TW 5. CCU, TW 6. Gynaecology, TW 7. Haemato-Oncology day Unit, TW 8. Mortuary, TW 9. Nuclear Medicine, TW 10. PALs, TW 11. Short Stay Surgery, TW 12. Ward 20, TW 13. Ward 21, TW 14. Ward 22, TW 15. Ward 30 (x2), TW 16. Ward 31 (x2), TW 17. Ward 32 (x2), TW 18. Tonbridge Cottage Hospital 19. All clinical areas (out of hours), TW	Yes
Chief Operating Officer	1. Chronic Pain, MH 2. Endoscopy, MH 3. GU Clinic, MH 4. Whatman Ward, MH 5. Endoscopy, TW 6. ENT OPD, TW 7. Haemato-Oncology Day Unit, TW 8. Out Patients, TW 9. Reception, TW 10. Short Stay Surgery, TW 11. Ward 11, TW 12. Ward 30, TW 13. Ward 31, TW	Yes
Director of Finance	-	-
Director of Infection Prevention and Control	-	-
Director of Workforce and Communications	-	-
Director of Strategy and Transformation	-	-
Medical Director	-	-
Non-Executive Director (KT)	-	-
Non-Executive Director (AK)	-	-
Non-Executive Director (SD)	-	-
Non-Executive Director (SDu)	-	-
Non-Executive Director (ST)	1. Ward 30, TW 2. Ward 31, TW	Yes

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - September 2014

9-14	Summary of the Trust Management Executive (TME) meetings, 06/08/14, 03/09/14 & 17/09/14	Committee Chair (Chief Executive)

Summary / Key points

This report provides information on the three TME meetings held since the last Trust Board meeting (6th August, 3rd September and 17th September).

The key points from the meeting on 6th August were as follows:

- The action plan developed in response to the Internal Audit review of Outpatient clinic maintenance (which concluded 'limited assurance') was reviewed. It was noted that an Outpatients group had been established, and an action plan developed, and all actions were either in progress or complete
- An update on the future options for the Stroke Service was given by the Clinical Director for Speciality Medicine
- The Director of Strategy & Transformation reported on the work and output of the Clinical Strategy Transformation Group (CSTG)
- The Director of Finance reported on the progress with implementing the Service Line Reporting strategy (and it was agreed that a presentation should be scheduled for future Clinical Directors meeting, explaining Service Line Reporting in further detail)
- The committee confirmed its support for the identified preferred supplier for the South Acute Programme (SAcP i.e. the replacement 'PAS+')
- The latest performance issues (to month 3, 2014/15) were discussed, including the occurrence of recent cases of Clostridium difficile, and the potential causative factors
- It was noted that the date of the Care Quality Commission's (CQC) Chief Inspector of Hospitals inspection had now been set
- Each Clinical Director reported on their key issues / challenges / risks / issues from latest Directorate performance reviews. Such issues included reporting times in Radiology, the recent positive Clinical Pathology Accreditation (CPA) visit in Microbiology; and the exceptional level of recent emergency activity at both hospital sites.
- The Terms of Reference for the Policy Ratification Committee were approved

The agenda for the meeting on 3rd September was primarily devoted to the forthcoming CQC inspection. Representatives from the external agency engaged by the Trust to support its preparedness for the inspection attended, and gave a presentation on the methodology of the inspection, and the themes that would be covered. In addition, meeting discussed the potential impact on the Trust (and local health economy) of the CQC's enforcement action in relation to Medway NHS Foundation Trust.

The key points from the meeting on 17th September were as follows:

- Representatives from the external agency engaged by the Trust to support its preparedness for the CQC inspection attended, and presented the findings of the 'mock' inspection that has recently been undertaken.
- The Chief Nurse reported on the progress with the actions taken as a result of the previous CQC inspections (with regards to both hospitals, and also for medicines management)
- The mitigations being developed in response to the CQC's enforcement action at Medway NHS Foundation Trust were discussed
- An update on the Kent Pathology Partnership was received
- The Director of Workforce and Communications gave a follow-up report on the response to the National NHS staff survey 2013
- Clinical Directors were reminded of the forthcoming Annual General Meeting, and encouraged to promote the attendance of their staff
- An update was given on progress regarding the future options for the Stroke Service
- The Director of Finance delivered a presentation on the Business planning process and requirements for 2015/16

- The Director of Estates attended, to report on the plans for the Trust's estate, including the planned refurbishments to the wards and main entrance at Maidstone Hospital; and the plans for a dedicated paediatric A&E facility at Tunbridge Wells Hospital
- The latest performance issues (to month 5, 2014/15) were reviewed, which included a marked increase in the level of delayed transfers of care
- The lessons learned, and actions taken, in response to the power outage that occurred in February 2014 were discussed

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive

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

- Information and assurance

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - September 2014

9-15 Summary report from Finance Committee, 19/08/14 Chair of Finance Committee

The Finance Committee met on 19th August 2014.

1. **The key matters considered at the meeting were as follows:**
   - Month 4 financial performance (including CIP);
   - The Capital Programme for 2014/15;
   - The timeline for the Trust's 2015/16 planning process;
   - The financial aspects of the Kent Pathology Partnership (KPP);
   - The Finance Directorate Improvement Plan; and
   - Review of in-year performance of the Private Patient Unit

2. **The Committee agreed that:**
   - A review should be undertaken to determine whether all the private patient work undertaken at the Trust should be under the remit of the Wells Suite / Director of Private Patient Services
   - A report should be submitted to the Finance Committee explaining the confidence underlying the expected 90% achievement of CQUIN for 2014/15
   - The timetable within the Trust's 2015/16 planning process should be amended to ensure that the Trust Board has the opportunity to approve the initial 2015/16 plans, prior to their submission to the NHS Trust Development Authority
   - A joint Trust Management Executive / Trust Board session should be included within the timetable for the Trust's 2015/16 planning process

3. **The issues that need to be drawn to the attention of the Board are as follows:**
   - The Finance Directorate Improvement Plan is progressing well, and the ultimate aim is that the transactional process of 'back office' financing becomes as efficient as possible, to enable the majority of Finance department staff to provide a service to Directorates
   - The financial position of the Wells Suite for 2014/15 was lower than plan, but was projected to be 8% higher than 2013/14.
   - The future provision of private patients' services is to be covered as part of the current strategic review.

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

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

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – September 2014

9-16	Workforce Committee Report	Committee Chair (Non-Executive Director)

The following report provides information on the Workforce Committee held on 4 September 2014.

Employee engagement
The Committee received a report outlining an Employee Engagement Strategy covering 5 key areas of work:

- Leadership and management
- Employee voice
- Culture
- Supporting personal development
- Partnership working

The strategy will improve engagement with staff, and the document contains an outline of what this means. The Committee discussed the report and suggested further areas for inclusion in the strategy. Following approval of the outline strategy further discussions would take place about how these suggestions could be converted into actions.

Assurance from Department of Health and associated investigations into Savile
The Committee received a report providing information on the position of MTW in relation to 3 issues highlighted in Kate Lampard's Assurance Report:

- Unfettered access to hospital premises
- The provision of office and in some cases residential accommodation within hospitals
- Access of 'celebrities' to the senior leadership team, including the Board

The report strongly highlighted that cultural changes since the time Savile was operating provided the greatest protection, and moreover that the principle of challenging and reporting behaviours which gave cause for concern. The Committee discussed the report at length and accepted the assurance provided but requested examples of the actions which have been taken to provide the assurance.

KPP Collaboration Agreement
The Committee expected an assurance report on the workforce implications arising from the Kent Pathology Partnership, but given the CQC observations about East Kent Hospitals Trust and the subsequent action of Monitor to place the Trust in the special measures regime, further assurances are being sought from East Kent which includes the workforce aspects of the partnership. The Committee noted this update and it was agreed that the updated position would be reported at the Board in September 2014.

Medical Education Update
The Director of Medical Education summarised his report, highlighting the following:

- The Foundation Programme is being broadened. HEE has recommended that by August 2015, 80% must have a 4 month community placement. The Director of Medical Education (DME) is meeting the clinical tutors to discuss how this can be achieved. Currently 20% takes place in the community. This covers general practice, community psychiatry and hospice.
- The DME meets regularly with the Director of Workforce and Communications.
- A costing of education exercise is underway to attempt to establish the cost of training each level of trainee in every training post in the Trust.
- The aim is to move towards a single integrated contract for all the different education programmes in the Trust.
- There have been changes to the training tariff from a lump sum to 50% of salary already paid plus a placement fee
- There are proposals from HEKSS for an education CQUIN, which will bring in funding if criteria are met.

Friends and family test
The Committee received a report and its attention was drawn to the following:
- In the next survey, there will be changes to the way the score is made up.
- The second survey will ask supplementary questions to find out more specifically about the Trust, eg, terms and conditions and environment. In the first survey, it was not clear if staff were replying generally about the NHS or specifically about MTW. The Trust received the assurance that staff are happy for their loved ones to be cared for in the Trust.
- A survey to measure medical engagement will be launched in September, which will also benchmark against other providers of healthcare.

Fit and Proper Person requirement for directors
The Committee was informed that subject to consultation and legislation, from October 2014, the directors of NHS providers must meet a fit and proper person test. The organisation will need to demonstrate that existing and new recruits to director positions have met the test. For the test to be met the named individual is expected:
- To be of good character.
- To have the necessary qualifications, skills and experience.
- To be able to perform the work that they are employed for.
- To supply information, including 'vetting and barring checks and a full employment history.
- To have never been responsible for, or involved in, any serious misconduct or mismanagement relating to any office or employment with a service provider.

In addition, a duty of candour regulation is being introduced for directors. An accountable officer is required to annually sign off all directors in the organisation as a fit and proper person.

Workforce Risk Register
The Committee received a report indicating that there are 5 main risks relating to the workforce, which are used to inform the work programme of the HR directorate:
- Recruitment
- Temporary staffing
- Performance management (appraisal, sickness absence, management of numbers)
- Employee engagement
- Achieving culture of excellence in the organisation

Workforce Dashboard
The workforce dashboard was reviewed and discussed. The following points were highlighted:
- The total WTE includes 112 WTE who are contracted but not been paid, and have not worked within the month (eg, staff on maternity leave, sick leave, seconded).
- Over 100 WTE additional registered nurses are employed compared to the same time last year
- The Trust will be starting another recruitment campaign for nurses from Spain, Portugal and Ireland. There will also be a focus on retaining those recruited.
- Higher than the previous month sickness rates during July caused increased use of bank staff
- The ambition is to fill vacancies up to the level of the establishment, and for nursing areas to fill to the anticipated level of turnover.
- Paid overtime occurs mainly in estates and facilities, critical care and theatres. This is more cost effective than using bank staff.

Terms of reference: The Committee agreed updated Terms of Reference for the Workforce Committee which are enclosed for formal approval.

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
- Information and assurance; and
- To approve the revised terms of reference

[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 & TUNBRIDGE WELLS NHS TRUST

Workforce Committee

Terms of reference

1 Purpose

The Workforce Committee is constituted at the request of the Trust Board to provide assurance to the Board in the areas of workforce development, planning, performance and employee engagement.

The Committee will work to assure the Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that is supporting business success.

2 Membership

Non-executive Chairman
Non-executive Director (Chair)
Non-executive Director
Chief Operating Officer
Director of Workforce and Communications

Other Non-Executive Directors and Executive Directors may attend by open invitation.

The Director of Medical Education and the Associate Director of Workforce will attend by invitation of the Chair.

3 Quorum

The Committee shall be quorate when two Executive Directors and two Non-executive Directors are in attendance.

4 Attendance

Other staff, including members of the Human Resources Directorate, may attend to address specific agenda items.

5 Frequency of meeting

The Committee will meet quarterly. The Chair can call a meeting at any time if issues arise.

6 Duties

To provide assurance to the Board on:

- workforce planning and development, including alignment with business planning and development;

- equality and diversity in the workforce;
- employee relations trends and issues, e.g. discipline, grievance, bullying/harassment, sickness absence, disputes;
- occupational health and wellbeing in the workforce
- external developments, best practice and industry trends in employment practice;
- the performance management system;
- staff recruitment, retention and satisfaction;
- employee engagement
- terms and conditions of employment, including reward;
- organisation development, organisational change management and leadership development in the Trust;
- training and development activity in the Trust including prioritisation;

To convene task & finish groups to undertake specific work identified by itself or the Trust Board.

To review and advise upon any other significant matters relating to the performance and development of the workforce.

7 Parent committees and reporting procedure

The Committee Chairman will report activities to the Trust Board following each meeting or as required.

8 Sub-committees and reporting procedure

LAB (Local Academic Board).

9 Administration

The Committee will be serviced by administrative support from the Trust Management Secretariat.

10 Review of terms of reference and monitoring compliance

Terms of reference agreed by Workforce Committee: 17 June 2014
Terms of reference approved by Trust Board: date XXX 2014
Terms of reference to be reviewed: June 2015

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - September 2014

9-17	Summary report from the Quality & Safety Committee meetings, 06/08/14 and 10/09/14	Committee Chair (Non-Executive Director)

Summary / Key points

The Quality & Safety Committee has met twice since the last Board meeting in July.

A **Quality & Safety Committee 'deep dive' meeting** was held on 6th August. The two issues discussed were:

1. A follow-up report on Stroke care. The following points were covered:
   - Progress had been made on the main performance indicators, such as receiving a scan within 1 hour, being reviewed by a Consultant within the first 24 hours etc. It was recognised that further improvement was required, but the Trust's performance was heading in the right direction.
   - It was noted that performance regarding patients receiving thrombolysis within 1 hour would be improved if thrombolysis cover was available '24/7'. The availability of staff to undertake thrombolysis was recognised as an important factor, and it was reported that a supernumerary bleep holder who was able to undertake thrombolysis out-of-hours would be introduced in October 2014. It was agreed that data regarding the arrival times of those receiving (and not receiving) thrombolysis within the required time period would be obtained, and submitted to the next 'main' Quality & Safety Committee.
   - It was noted that the next set of Sentinel Stroke National Audit Programme (SSNAP) data would be available in December 2014, but the relevant indicators were monitored internally, and would therefore be reported to the next 'main' Quality & Safety Committee.
   - It was noted that national average performance had already been achieved for some indicators, but the focus was on the 4 main Key Performance Indicators (KPIs) i.e. 'proportion of patients scanned within 1 hour of clock start'; 'proportion of patients directly admitted to a stroke unit within 4 hours of clock start'; 'proportion of patients who were thrombolysed within 1 hour of clock start'; and 'median time between clock start and being assessed by a stroke consultant (minutes)'. It was noted that achieving national average performance on these 4 indicators was unlikely to occur before the next SSNAP data was issued.
   - Progress regarding the options for the future delivery of the Stroke service at the Trust was also discussed briefly.

2. A review of the Trust's processes for 'organisational learning (this was the main subject of discussion). Dr DJ Brown (Clinical Fellow, Emergency Medicine); Dr Jorge De Fonseca (Consultant Anaesthetist); & Michelle Archibald (Ward Manager, John Day Ward) were in attendance, and the following points were covered:
   - The meeting considered the range of sources that exist from which the Trust learned, including patient safety incidents, complaints, PALS contacts, Serious Incidents (SIs); anonymous reporting, feedback from the Friends and Family Test (FFT) for patients; local and national patient surveys; the FFT for staff ('impressions' survey); staff open forum meetings; observations; inspections; and inquests
   - The range of systems in place to ensure learning takes place were noted as including Clinical Governance meetings; action planning; Ward meetings; staff briefings; key performance meetings; the SI panel; and Executive sign off for SIs and complaints
   - Outcomes of learning included policy reviews; staff training / education; pathway / process reviews; safety alerts; referral to professional bodies / formal action (when staff have been offered training and education, as required); and the provision of additional resources
   - The concepts of a learning culture and Human Factors were discussed, as was learning in

anaesthetics from safety alerts. The Trust's own safety and learning culture was also examined, along with potential actions to be taken. It was proposed that a team of individuals should be established to identify such actions, make recommendations, and prompt ideas. It was therefore agreed that a 'patient safety action group' (which has now been formally named as the 'Patient Safety Think Tank') should be established.
    - It was considered whether the next Quality & Safety Committee 'deep dive' meeting should be focused on the Trust's emergency paediatrics pathway (as had been suggested at the May 2014 Trust Board). However, it was agreed that this subject should be deferred for the time being, as the pathway was expected to have been progressed significantly by October 2014. It was therefore agreed that "clinical outcomes" should be the subject of the next 'deep dive' meeting (which is scheduled for 29th September).

The **'main' Quality & Safety Committee** met on 10th September, and covered the following issues:

- The latest 'Out of Hours Treat and Transfer' audit findings were presented, for the period 1st April to 30th June. 425 patients were transferred from The Tunbridge Wells Hospital (TWH) to Maidstone Hospital (MH) in this period, whilst 14 were transferred from TWH to MH. Of the 425 patients transferred from MH, 109 (25%) of these were transferred after 11pm. However, assurance was given that such transfers were undertaken for clinical reasons.
- The safe storage of medicines was discussed, and the need for constant vigilance in relation to locking drugs cupboards was emphasised.
- The lack of an optimum location to undertake pre-operative warming in Trauma and Orthopaedics was discussed. It was noted that a commitment had been made by the Executive team to protect elective beds for Orthopaedics, which would solve the issue. It was agreed that an update on the protection of the elective beds would be provided at the next 'main' Quality & Safety Committee.
- The Trust's recent media coverage was reported, under the "Reputational Risk" standing item
- A report from the Quality & Safety Committee 'deep dive' meeting on 6th August (including the unapproved minutes) was received. A Stroke performance update report was also received (as referred to above) and discussed.
- Details of the latest Serious Incidents were received, and discussed.
- The latest Quality & Governance Dashboard was reviewed. It was noted that the format and content of the dashboard had been revised following a discussion between relevant staff, including the Deputy Chair of the Quality & Safety Committee. The dashboard contains fewer indicators than previously, and is based around the Care Quality Commission's (CQC) 5 domains framework.
- The work of the newly-established Mortality Review Group was reported
- The Medical Director gave a verbal briefing on the processes in place for the monitoring of clinical outcomes at the Trust
- The work of the Emergency Paediatric Pathway Working Group was reviewed, and it was noted that Stage 1 involved establishing a separate paediatric pathway at both hospital sites, whilst Stage 2 involved creating a dedicated paediatric emergency department at TWH. It was noted that the latter would require refurbishment works.
- The draft Terms of Reference of the newly-established 'Patient Safety Think Tank' (see above) were received and reviewed.
- The Directorate exception reports were reviewed. Points of particular note included:
    - The Trauma Unit designation re-visit was reported as having gone well
    - The current concerns regarding West Kent CCG's commissioning of Child and Adolescent Mental Health Services (the representative from the CCG agreed to provide an update on the action being taken by the CCG on this matter)
    - Some issues regarding the performance of certain Clinical Administration Units remain, but these are being actively addressed.
    - The continuing problems with a backlog of report typing of histology reports. It was noted that an action plan was in place to reduce the backlog.
    - The quality aspects of the Kent Pathology Partnership (KPP) were reported, which

included the fact that both this Trust and East Kent Hospitals University NHS Foundation Trust currently ran fully accredited Pathology services; and the fact that the Quality and Governance Workstream for the KPP was tasked with ensuring that systems and processes were in place to continue to provide assurance that the quality of the service is maintained.

- Reports were received from a number of the committee's sub-committees (Standards; Infection Prevention & Control; Safeguarding Children's; Safeguarding Adult's; Clinical Governance; and the Patient Environment Steering Group). No major issues of note were highlighted.
- The Committee ratified 11 policies under the Trust's existing policy process (it was noted that the revised process, which had been agreed, had commenced, but the 11 policies were required to be ratified ahead of the next meeting of the newly-established Policy Ratification Committee)
- The Committee was notified that the CQC had been on-site at Maidstone Hospital on the day of the meeting, to determine whether the Trust's application to have "Family Planning" (i.e. insertion of intrauterine contraceptive devices) and "Termination of Pregnancies" added to its CQC registration for Maidstone Hospital (and thereby legally offer these services to patients) could be approved. The Committee was notified that following discussion with the CQC team on the day, it was agreed that the Trust would withdraw its request to register "Termination of Pregnancies", and the outcome of the application to add "Family Planning" to the Trust's registration would be made known in due course.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

- Information and assurance

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

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Trust Board meeting – September 2014

9-18	Summary report from the Patient Experience Committee, 04/09/14	Committee Chair (Non-Executive Director)

Research Projects: The patient experience single room report being undertaken by Kings would be published in the autumn although a date was still to be confirmed.

Review of Call Bells: A trial of a new wireless device was taking place on Whatman and Mercer wards at Maidstone Hospital. There were issues to resolve including how call bells would be managed and how they would be recharged.

Cancer Findings and Actions Update: The action plan had identified several issues. Actions being taken included improved benefits and financial advice for patients and understanding prescriptions. A clear information pack would be provided and a nurse led session held including a DVD being shown and peer group support, there would also be the opportunity for patients to discuss individual concerns. Some issues were still on-going but the 2013-14 survey is due and a comparison could be undertaken.

Patient Experience Dashboard: The Committee received a presentation highlighting the following points:

- The data is publically available and provides local and national benchmarks
- Some data is run several months behind
- Moderate concerns on Outcome 4, Care and Welfare of service users due to privacy and dignity issues in the admissions lounge.
- The inpatient and A&E response rate has improved since June 2014

The dashboard is still in its early stages and is web based; it gives a snap shot of the Trust and should be triangulated against a number of other data sources.

Clinical Services Strategy: The importance of the strategy delivering and the financial consequences of this locally and nationally was emphasised to the Committee, noting that demand would increase in future years as the population rises. The PFI at TWH is at a fixed point for 30 years and the Trust can use this to the advantage as well as Maidstone which has a linear accelerator (LINAC) as demand increases.

The Committee received a presentation highlighting the following points:

- The strategy must meet the clinical and financial challenges of patients changing health needs.
- The strategy will involve external stakeholder engagement and not all strategic pathways have been identified.
- Discussion took place regarding local health economy changes including at Medway, East Kent and Sussex.
- MTW has set up 4 work streams led by clinicians; Emergency, Centres of Excellence, Seven Day working and Collaboration/Innovation, and will be working closely with external stakeholders and local health providers.
- The benefits will include better access to services, new specialist services and improved outcomes and patients seen by senior decision-makers

Question was raised whether GPs and Social Services were involved in 7 day working and it was confirmed that they and the Trust would be working and participating together.

Chief Inspector of Hospitals CQC inspection: A presentation was given to the Committee highlighting the following points:

- The Trust would be undergoing an inspection in October.
- It was an opportunity to showcase and acknowledge the areas where improvement was

required.
- The CQC will rate each hospital site and the Trust overall.
- A data pack will be produced from which direct lines of enquiry will be developed
- Announced and unannounced site visits will take place
- Staff and Trust Board members will be interviewed as part of the process
- Will look at 5 key domains– Safety, Effectiveness, Caring, Responsive and Well-led.

E-Prescribing Project: The Committee received a presentation highlighting the following points:
- The chemotherapy e -prescribing project is separate to general e -prescribing and covers the process from clinicians reviewing prescriptions on line to dispensing drugs, reviewing patients and recording drug administration.
- E -prescribing includes all 4 Trusts in Kent and Medway so patients records can follow the pathway if they change provider
- If the project is not implemented then the Trusts are at risk of not being commissioned to provide cancer services and will face financial penalties
- Each Trust Chief Executive has been involved and a Programme Board set up with clinical specialists.
- Tender process undertaken and the preferred supplier has been selected
- Implementation has already started and the system will go live March 2015.

Discussion took place regarding the contract and it was confirmed if the system did not work there were penalties and if the Trust has to revert to manual methods then the Trust will be refunded but if it is clinically wrong then the Trust is liable. The Trust solicitors have been heavily involved in the contract.

It was emphasised that the Trust was responsible for the care it gives and if it is deemed appropriate to continue with manual methods then they will do this and all issues are being closely managed.

A further update will be given in March after the system is up and running.

PLACE results: The inspection was undertaken in Apr/May 2013 and the Trust undertook a self-assessment methodology and was patient led. There were 4 domains:
- Cleanliness
- Environment
- Food
- Privacy and dignity

It was reported that the Trust had an above average rating for environment but was below average in privacy and dignity and significantly below in food. It was confirmed that the quality of food was not an issue but Tonbridge Cottage Hospital had changed the food menu and this had caused problems. The low score was due to the availability of chilled water, toast and practical issues such as ensuring the opportunity to wash hands prior to meals was taken by opening and giving patients wipes. It was also noted that patients were not always given 3 separate courses.

Privacy and dignity scored low in Outpatients due to the location of the reception area and patient conversations could be overheard. Practical responses were being looked into including the introduction of a waiting line for people to stay behind.

A local Kent Messenger journalist had been contacted following the results being known to ensure explanation was given and to invite them to the Trust to follow the catering pathway. The journalist visited the Trust and saw the preparation of food from the kitchen to the patient and the different variations on offer and the red tray system. The journalist stayed and sampled the food and their view was positive.

Any Other Business:

Question was raised whether the nurses at the Trust could administer medication from syringes directly into a patient's mouth. It was stated that this was not a practice widely encouraged

although syringes were produced for this purpose after guidance had been taken from the speech and language therapists regarding the swallow reflex.

The Trust's AGM would be taking place on the 25th September at 6.30pm in the Auditorium, Academic Centre, Maidstone Hospital. Presentations would be given by the Chief Executive, Medical Director and Chief Nurse and the Annual Report and Accounts would be available. All Committee members were invited to attend.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

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Trust Board meeting - September 2014

9-20	Summary of the Charitable Funds Committee meeting, 21/07/14 (incl. revised Terms of Reference)	Committee Chair (Non-Executive Director)

Summary / Key points

This report provides information on the Charitable Funds Committee meeting held on 21st July. The key issues discussed were as follows:

- The charity had a balance of approximately £1 million, and the Committee agreed the principle that expenditure should increase to reduce the balance held on account
- The Committee also agreed to the amalgamation of the large number of designated funds to a smaller number
- A revised draft Charitable Fund policy was reviewed

At the Committee, revised Terms of Reference were discussed, and agreed. The revised Terms of Reference are now submitted to the Trust Board, for formal approval. A 'track changes' version is included, along with explanatory comments, so Board members can easily see the amendments proposed, and the rationale for the change. A 'clean' version is also enclosed.

Which Committees have reviewed the information prior to Board submission?

- Charitable Funds Committee

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

- Information and assurance
- To approve the revised Terms of Reference for the Charitable Funds Committee

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

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CHARITABLE FUNDS COMMITTEE

Terms of Reference

1. Purpose

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

~~2. CONSTITUTION~~

~~3.~~2. Membership

Membership of the Committee is as follows:

~~**Chairman**~~

- The Committee Chair – a Non-Executive Director appointed by the Trust Board

~~**Other Members**~~

- The Committee vice-chair - a Non-Executive Director appointed by the Trust Board~~All Non-Executive Directors appointed by the Trust Board~~
- ~~All Executive Directors~~
- ~~Chief Executive~~
- Director of Finance
- Director of Workforce and Communications
- The Head of Financial Services
- The Trust Secretary

3. Quorum

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

4. ~~IN~~ Aattendance

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

5. Frequency

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

~~**Delegated Authority**~~

~~5.1 The Committee is a formally constituted committee of the Trust Board and has delegated authority in accordance with the Trust's Scheme of Delegation in relation to the investment and expenditure of charitable funds.~~

Comment [RK1]: This reflects the membership principles agreed by the Trust Board in relation to all Board sub-committees

Comment [RK2]: It is proposed that the Head of Financial Services and Trust Secretary be made formal members of the committee

Comment [RK3]: It is proposed that the quorate requirements be made less onerous

Comment [RK4]: It is proposed the minimum number of times the committee must meet each year is reduced

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~~5.2 The Committee shall be quorate when two Non-executive Director and two Executive Directors are present.~~

6. ~~AREAS OF REPONSIBILITY~~Duties

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

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

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

Policy Matters

- To ~~S~~set, on behalf of the corporate Trustee:
  - A Reserves policy
  - An Investment policy
  - A Grant Making policy
  - Guidance for fund raising activities

Operational Matters

- Set the annual management and administration fee payable to the Trust
- Be advised of and consider the application of all new legacies
- Sanction the establishment ~~setting up~~ of all new funds
- Authorise financial procedures and financial limits

Internal and External Control

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

Financial Reporting

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- ~~Approve the annual financial accounts~~ Review ~~and the~~ income and expenditure reports for each of the reporting periods
- Endorse the Annual Report and Annual financial accounts, for approval by the Trust Board
- Receive where appropriate the annual investment report
- Ensure the Director of Finance is compliant with the reporting requirements of the committee and the Trustee

Comment [RK5]: It is recommended that the Annual Report and Accounts should be approved by the Trust Board, as the agent of the corporate Trustee.

~~**7. WORK PROGRAMME**~~

~~7.1 The Committee will agree a work programme at the start of each financial year with regular reviews during the course of the year~~

7. ~~REPORTING~~Parent committees and reporting procedure

~~**8.**~~

~~The minutes of the Committee shall be formally recorded and submitted to the Board. The Chair of the Committee will provide a report to the Board quarterly.~~ The Charitable Funds Committee is a sub-committee of the Trust Board.

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

8. Sub-committees and reporting procedure

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

9. Emergency powers and urgent decisions

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

Comment [RK6]: This section is intended to be included in all Board sub-committee Terms of Reference. The personnel involved (chair and one Exec) matches the quorum for the meeting.

~~**9.**~~**10. ~~ADMINISTRATIVE ARRANGEMENTS~~Administration**

~~9.1 The Committee will be supported by the Head of Financial Services whose responsibilities will include agreement with the Chairman of the Committee of:~~

- ~~an Annual Work Programme setting out the dates of key meetings and agenda items;~~
- ~~quarterly agendas and the collation and distribution of papers.~~

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

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

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

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- The meeting agenda
- The meeting minutes and the action log

~~10.~~11. REVIEW

~~10.1~~11.1 The terms of reference of the Committee will be reviewed annually, and approved by the Trust Board

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CHARITABLE FUNDS COMMITTEE

Terms of Reference

1. Purpose

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

2. Membership

Membership of the Committee is as follows:

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

3. Quorum

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

4. Attendance

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

5. Frequency

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

6. Duties

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

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

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

Policy matters

- To set, on behalf of the corporate Trustee:
  - A Reserves policy
  - An Investment policy
  - A Grant Making policy
  - Guidance for fund raising activities

Operational matters

- Set the annual management and administration fee payable to the Trust
- Be advised of and consider the application of all new legacies
- Sanction the establishment of all new funds
- Authorise financial procedures and financial limits

Internal and External control

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

Financial reporting

- Review income and expenditure reports for each of the reporting periods
- Endorse the Annual Report and Annual financial accounts, for approval by the Trust Board
- Receive where appropriate the annual investment report
- Ensure the Director of Finance is compliant with the reporting requirements of the committee and the Trustee

7. Parent committees and reporting procedure

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

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

8. Sub-committees and reporting procedure

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

9. Emergency powers and urgent decisions

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

10. Administration

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

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

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

11. Review

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

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

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Trust Board Meeting - September 2014

9-21	**Collaboration Agreement for the Kent Pathology Partnership (KPP)**	**Chief Operating Officer**

The January 2014 Trust Board approved the Full Business Case (FBC) for the Kent Pathology Partnership (KPP). The FBC was also approved by the Board of East Kent Hospitals University NHS Foundation Trust (EKHUFT) during that month. It was noted at that point that the next stage in the process was for the Collaboration Agreement to be submitted to the Boards of both Trusts, for approval (at which point, the Boards' decisions would be irrevocable).

Since January, detailed work to agree the terms and conditions under which the KPP would operate and be governed, has been undertaken, primarily via the KPP Project Board (which consists of selected Executive Directors from both Trusts). Legal advice has also been sought and acted upon. The Collaboration Agreement is now enclosed (Appendix 2), for approval by the Trust Board. Appendix 1 contains some points of note that are drawn to the attention of the Board.

In addition, it should however be noted that some aspects of the Agreement require final amendment by the legal advisors, following discussions held at the KPP Project Board meeting of 12th September, and subsequent follow-up correspondence during w/c 15th September. These aspects are outlined in Appendix 1. The timing of these discussions prevented the amendments being incorporated into the Agreement. However, it has been agreed to submit the Collaboration Agreement to both Boards in September, highlighting these aspects, rather than wait until such aspects were completely finalised (which would have meant deferring submission of the Agreement until the October 2014 Board meetings). None of the final amendments are considered to be material, nor prevent the Board from approving the Agreement, but have been included in this report, for completeness.

Board members should note that although they have been provided with the Collaboration Agreement in its entirety (Appendix 2), this has not been made available as part of the Part 1 (meeting in public) papers, due to commercial confidentiality. The same applies to Appendix 1 (and Annex A). Therefore should Board members wish to discuss any of the aspects of the Collaboration Agreement, or the points in Appendix 1 in detail, it is suggested that such discussion takes place within the Part 2 (private) meeting scheduled for 24th September.

In addition to the Collaboration Agreement, the following information has been provided:

- Appendix 3: A financial schedule, consisting of the draft KPP budget for 2015/16, and implementation costs. Although these schedules have not been reviewed by the Trust's Finance Committee, the main financial aspects of the Collaboration Agreement (such as they were at that point in time) were discussed at the Finance Committee held on 20th August;
- Appendix 4: A timeline / project plan for the establishment of KPP;
- Appendix 5: A commentary on the quality aspects of the KPP (these details were also reported to the Trust's Quality & Safety Committee, held on 10th September); and
- Appendix 6: A communications plan

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 20/08/14 (financial aspects only)
- Quality & Safety Committee, 10/09/14 (quality aspects only)

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

Approval

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

KPP DRAFT BUDGET 2015-16

KPP Baseline costs (FOT 14-15)	EKHUFT	MTW	KPP Total
	£m	£m	£m
Direct Pay	-12.8	-13.7	-26.5
Direct Non Pay	-10.9	-7.5	-18.4
Total Expenditure	**-23.7**	**-21.2**	**-44.9**
Direct Access SLA income	9.4	8.6	18.0
Other Income	2.2	5.8	8.0
Total Income	**11.6**	**14.4**	**26.0**
Overheads	**-3.4**	**-3.4**	**-6.7**
Total Net Cost	**-15.5**	**-10.2**	**-25.7**
%	*60%*	*40%*	*100%*
KPP Pay Savings	0.1	0.1	0.2
KPP Non Pay Savings	0.1	0.1	0.2
KPP Project Costs	-0.2	-0.1	-0.3
KPP Staff costs (Protection / Redn.)	-0.9	-0.6	-1.5
KPP Capital charges	-0.2	-0.1	-0.3
Savings net of project costs	**-1.0**	**-0.7**	**-1.7**
%	*60%*	*40%*	*100%*

Draft KPP Budget 2015-16	EKHUFT	MTW	KPP Total
	£m	£m	£m
Direct Pay	-13.6	-14.2	-27.8
Direct Non Pay	-11.0	-7.5	-18.5
Total Expenditure	**-24.5**	**-21.8**	**-46.3**
Direct Access SLA income	9.4	8.6	18.0
Other Income	2.2	5.8	8.0
Total Income	**11.6**	**14.4**	**26.0**
Overheads	**-3.5**	**-3.5**	**-7.0**
Total Net Planned Cost	**-16.5**	**-10.9**	**-27.3**
%	*60%*	*40%*	*100%*

Assumptions

1. No overall movement in income
2. Pay costs and non-pay costs will be paid by legal host when systems are in place, above shows the denominations they will be charged.
3. Budgets based on estimates of costs of known changes at 16.9.14
4. Draft budget only does not include growth or inflation

KPP Implementation Costs	2013-14	2014-15	2015-16	2015-17	2015-18	2015-19	2015-20	2015-21	Total Planned
Revenue Costs	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Professional & Project Support	0.3	0.4	0.1	0.0	0.0	0.0	0.0	0.0	0.8
Staff Costs	0.0	0.1	1.5	2.4	0.6	0.2	0.2	0.2	5.3
IM&T and Logistics	0.0	0.1	0.3	0.2	0.1	0.1	0.1	0.1	0.9
Capital charges	0.0	0.1	0.3	0.4	0.4	0.4	0.4	0.4	2.3
Total Revenue Costs	**0.3**	**0.8**	**2.1**	**2.9**	**1.1**	**0.7**	**0.7**	**0.7**	**9.3**
Capital Costs									
IM&T	0.0	0.9	0.6	0.0	0.0	0.0	0.0	0.0	1.6
Estates	0.0	1.1	2.4	0.0	0.0	0.0	0.0	0.0	3.5
Total Capital Costs	**0.0**	**2.0**	**3.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**5.0**
Total KPP Implementation Costs	**0.3**	**2.8**	**5.1**	**2.9**	**1.1**	**0.7**	**0.7**	**0.7**	**14.3**
Savings									
Pay	0.0	0.0	-0.2	-4.0	-4.2	-4.2	-4.2	-4.2	-21.1
Non-pay	0.0	0.0	-0.2	-0.8	-1.2	-1.2	-1.2	-1.2	-6.0
Total Savings	**0.0**	**0.0**	**-0.4**	**-4.8**	**-5.5**	**-5.5**	**-5.5**	**-5.5**	**-27.1**

nb. Savings assumed slippage of 1 year & TBC following MLS tender

Net Revenue savings	**0.3**	**0.8**	**1.7**	**-1.9**	**-4.4**	**-4.8**	**-4.8**	**-4.8**	**-17.8**

net savings reduction driven mainly by slippage due to delays in implementation (£4.9m)

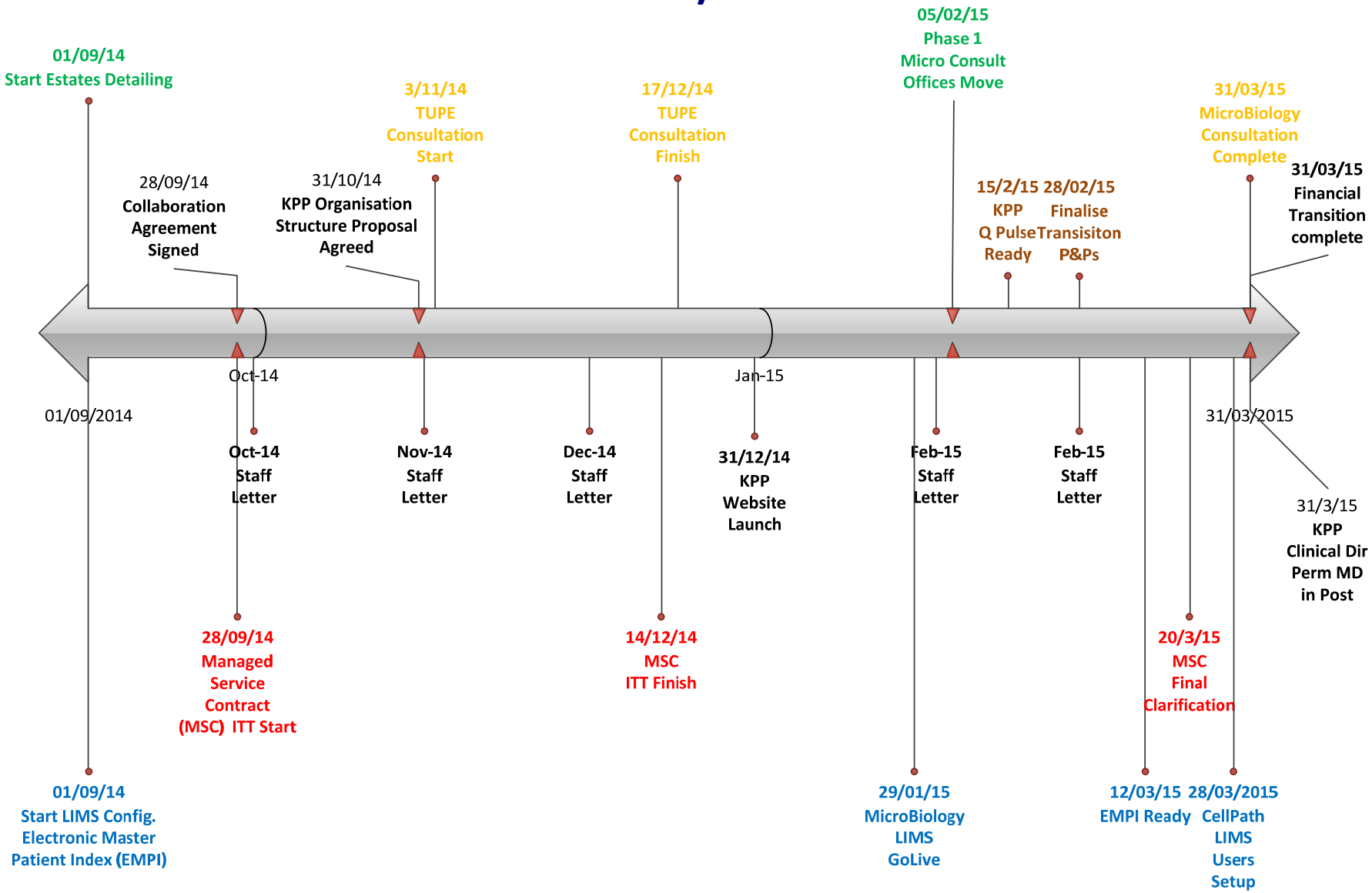
notes

Managing Director & Transport costs added in to implementation costs. These were offset in savings in FBC. Resulting in savings increase & cost increase

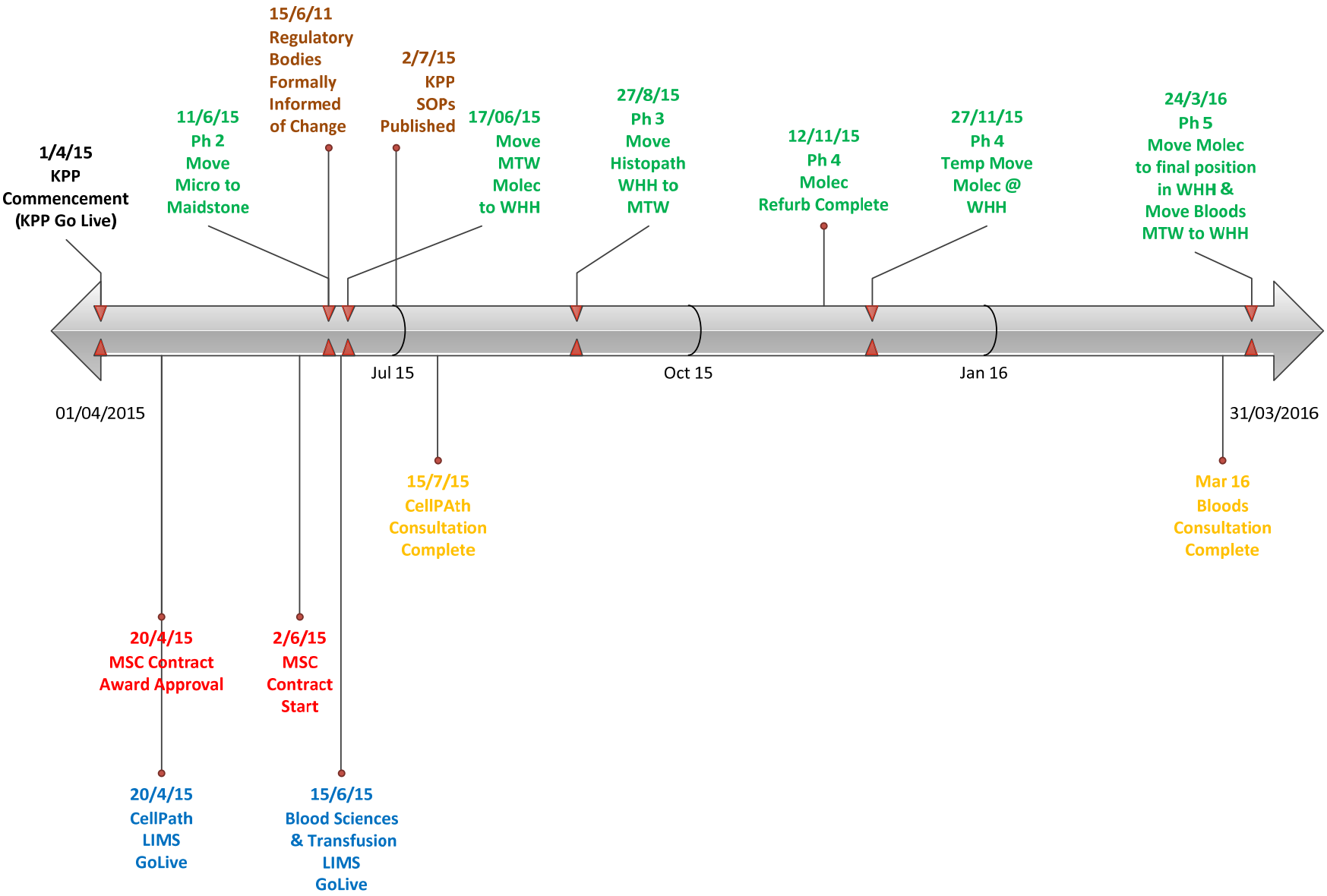
Reduction in net revenue savings compared with FBC is driven by slippage -5.0

Pay savings adjusted to reflect Blood sciences will not move until later in the year.

KPP High Level Project Timeline
FY 2014/15



KPP High Level Project Timeline
FY 2015/16



Appendix 5: Commentary on the quality aspects of KPP

It should be noted that both Trusts currently run fully accredited Pathology services. This accreditation includes the Human Tissue Authority (HTA), Medicines and Healthcare products Regulatory Agency (MHRA) and importantly Clinical Pathology Accreditation (CPA) (currently in transition to ISO standards). These all require regular inspection and actions taken as necessary to rectify any non-conformances raised.

Both General Managers have discussed the KPP project with the respective CPA inspectors and a process has been identified to phase in the change from single Trust accreditation to accreditation across the whole KPP. This will be quicker and simpler in microbiology which will be centralised on the Maidstone site and a slower, more complex process for blood sciences which will have laboratories on all five hospital sites. The CPA inspectors are clear that the transition period will not cause a problem with maintaining accreditation throughout.

The Quality and Governance Workstream for the KPP is chaired by Prof Fritz Muhlschlegel, Clinical Director for Laboratory Medicine at EKHUFT. This work-stream is tasked with ensuring that systems and processes are in place to continue to provide assurance that the quality of the service is maintained. This includes full audit programmes and monitoring of performance indicators and adherence to the HTA, MHRA and CPA/ISO standards. It is also tasked with developing robust incident and complaints management pathways. The work-stream reporting is embedded into the overall KPP governance system currently reporting to the KPP Board through the KPP Project Team.

Transition teams have been set up for all disciplines. These teams are tasked with planning and managing the transition to the new structure and configuration of the pathology service within KPP. The most advanced of these is microbiology as this service will be the first to transition to the new configuration.

Concern has been raised, and discussed at the KPP Project Board, KPP Project Team and individual KPP Workstreams, around the recent Care Quality Commission (CQC) report for EKHUFT. Although not subjected to a full formal inspection Pathology has staff and services had numerous contacts, and were asked questions, during the inspection process. No issues of note were identified and the service was not mentioned in the final report. The issues raised in the CQC report for Maidstone around histopathology has also been discussed and the histopathology action plan (now complete) have been shared and all relevant actions completed.

Appendix 6: KPP Stakeholders, communication methods and frequency

Stakeholder	What is to be Communicated?	Method & Frequency of Communication	Comms Owner
Project Board	• Regular project update incl. timescales. • Project Board approval requests	• Monthly Project Board meetings as arranged. • Ad hoc verbal/written communication may be required outside Project Board meetings as issues arise.	JB (SRO) AG (SRO) FM / SM
Pathology Staff	• All issues related to KPP in the transitional stage and thereafter commencement date. • Regular project Board/Team updates incl. timescales. • Any changes to terms	• Fortnightly newsletter • Website when launched • Road shows at all sites – every 3 months • Update at monthly Team / Management Meeting • Regular email and verbal updates as required • Consultation documents	MD / FM / SM IT/Quality MD/CD/GM GM HR Dept
CCG / GP's	• High-level information about KPP– any impact on patients, sample transport, reporting and contracts / pricing	• Communications as deemed necessary by KPP Board: GP newsletter, mail shots, meetings	Comms / Finance
Suppliers	• High-level information about KPP– any impact on current or future SLA's	• Communications as deemed necessary by KPP Project Team & Heads of Service • Emails	Heads of Service / Procurement Team
Non-Pathology Clinical Users	• High-level information about the KPP – Clinical impact on service	• Feed into respective Trust Bulletin • Update at monthly team / Trust management meetings	Divisional Director of CSSD at both Trusts
Patients/Public	• High-level information about the KPP – impact on service	• Website when launched	IT/Quality
Unions/Staff bodies	• All staff related issues including TUPE	• Attendance at work stream implementation meetings • Emails • Workshops	Workforce work stream / HR
Regulatory Bodies	• All changes to KPP service delivery, reconfiguration etc	• Communications as deemed necessary by Quality & Governance:	Quality & Governance

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - September 2014

9-22 The Trust's objectives for 2014/15 Trust Secretary

Summary / Key points

The July 2014 Trust Board reviewed a proposed list of objectives for 2014/15.

It was agreed that several of the objectives would benefit from review and revision, to make them more specific and measurable. It was also agreed to include the intention to achieve a more customer-focused approach at the Trust.

The list of proposed objectives has therefore been reviewed and several of them have been revised, to reflect the above points. The objectives are now submitted for final agreement.

When agreed, the objectives will form the basis of a new Board Assurance Framework.

Given the time in the year that the objectives are being finalised, it is proposed that the objectives continue as worded into 2015/16 (subject to minor amendments to reflect changes in specific targets).

Which Committees have reviewed the information prior to Board submission?

- N/A (though discussion has been held with the Executive Director responsible for the objectives that have been revised)

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

Approval

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

Proposed revised objectives for 2014/15

Strategic Objective theme 1: To transform the way we deliver services so that they meet the needs of patients

Proposed objective	Lead Director
1.1. "Reduce the Clostridium difficile cases to less than 40 for the year, and sustain or decrease the rate of MRSA bacteraemia"	Director of Infection Prevention and Control
1.2. "Implement the appropriate national guidance regarding the prevention and control of multi-resistant organisms"	Director of Infection Prevention and Control
1.3. "Enhance the emergency provision for children within the Emergency Department, by ensuring a separate paediatric emergency pathway at both hospital sites, and then introduce a dedicated paediatric emergency department at Tunbridge Wells Hospital"	Chief Nurse (supported by the Chief Operating Officer)
1.4 "Significantly improve the Trust's response rate for the Friends & Family Test (from 2013/14 levels), whilst maintaining the overall Net Promoter score"	Chief Nurse
1.5 "Increase the level of routine clinical services that are available seven days a week"	Medical Director
1.6 "Ensure that the Trust delivers the highest quality Transient Ischaemic Attack (TIA) and Stroke service, via the safe implementation of a revised Stroke pathway"	Medical Director (supported by the Chief Operating Officer)
1.7 "Ensure that all Specialist Services provided by the Trust operate without derogation (from NHS England) with regards to compliance with national service specifications"	Chief Operating Officer
1.8 Promote a more customer-focussed approach with the Trust's workforce, through a Trust-wide education programme (and demonstrated by improved findings from patient surveys and the Friends and Family Test)	Director of Workforce and Communications

Strategic Objective theme 2: To deliver services that are clinically viable and financially sustainable

Proposed objective	Lead Director
2.1 "Ensure compliance with the Care Quality Commission essential standards of quality and safety (and their successor, 'fundamental standards')"	Chief Nurse
2.2 "Promote a safety culture among the Trust's staff, via ensuring that the recommendations of the Patient Safety Think Tank are considered and endorsed by the Board (and then delivered in the Trust)"	Chief Nurse (supported by the Medical Director and Director of Workforce and Communications)
2.3 "Ensure the Trust has a workforce establishment that meets the needs of the organisation (specifically, setting an establishment, and reviewing this in-year; recruiting to that establishment; and reducing vacancies by 15% from 2013/14 levels)"	Director of Workforce and Communications
2.4 "Reduce the Trust's dependence on temporary staff, whilst maintaining safe services (specifically, reducing usage of temporary staffing by 15%)"	Director of Workforce and Communications
2.5 "Ensure that Ward and Specialist Nurse staffing levels are within safe levels agreed by the Board, and endorsed through external review, and based on patient volumes and acuity as well as	Chief Nurse

Proposed objective	Lead Director
Trust operating protocols and physical environment"	
2.6 "Achieve a rating of at least 'Amber-Green' on the indicative 'Governance' rating under Monitor's Risk Assessment Framework" **[N.B. This relates to the rating of the collective performance against the key access targets (A&E 4-hour wait, cancer waits, 18-week waits etc.)]**	Chief Operating Officer
2.7 "Deliver the Trust's forecast financial position for 2014/15 of a maximum of a £12.3m deficit"	Director of Finance
2.8 "Achieve an average length of stay of 3.3 days for elective patients, and 6.6 for non-elective patients, through pathway improvements and process changes"	Chief Operating Officer
2.9 "Ensure the milestones within the agreed Project Plan (September 2014) for the Kent Pathology Partnership (KPP) are achieved"	Chief Operating Officer

Strategic Objective theme 3: To actively work in partnership to develop a joint approach to future local health care provision

Proposed objective	Lead Director
3.1 "Develop a 5-year clinical strategy that meets patient needs and delivers a sustainable future for the Trust"	Director of Strategy & Transformation
3.2 "Align the Trust's Estates strategy with the 5-year clinical strategy"	Chief Operating Officer
3.3 "Provide strategic direction, with our clinical partners, to ensure our patient's care needs are met whatever their location, minimising, where appropriate, secondary care admission"	Director of Strategy & Transformation
3.4 "Work with our clinical partners (tertiary, primary and specialist commissioning) to ensure Upper GI cancer surgery is provided in the best location for patients, taking into account outcomes and patient experience"	Medical Director

Maidstone and Tunbridge Wells NHS
NHS Trust

Board Meeting - September 2014

9-23 Oversight Self-Certification, Month 5, 2014/15 — Trust Secretary

As the Board did not meet during August, to consider the self-certification for month 4, the certification submitted to the TDA for that month mirrored that for month 3 (i.e. the certification approved by the Board in July 2014).

The enclosed schedule sets out the proposed oversight self-certification submission for month 5, based on performance as at 31st August 2014. This submission must be sent to the NHS Trust Development Authority (TDA) by the end of (30th) September.

Significant changes from the previous submission, agreed at the Board meeting in July 2014, are highlighted. Any new explanatory notes are listed in *italics*.

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

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

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

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
The Board is asked to:
- Review the evidence presented to support the self-assessment (and amend if required); 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	Latest assessment
G4 – Fit and proper persons as Governors and Directors No unfit persons – undischarged bankrupts – imprisoned during last 5 years – disqualified Directors	All Trust Directors are "fit and proper" persons; confirmed through appointment process. From October 2014, subject to parliamentary approval, Directors of NHS providers must meet a 'fit and proper person test'. The Care Quality Commission will be able to insist on the removal of directors that fail this test. The test is being introduced as part of the fundamental standard requirements for all providers. ~~The Trust Secretary is currently digesting the content of the requirements, and will advise Board members in due course. However, no problems are anticipated.~~ In addition to the usual requirements of good character[2], health, qualifications, skills and experience, the regulation[3] goes further by barring individuals who are prevented from holding the office (for example, under a Directors' disqualification order) and significantly, excluding from office people who: "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, or discharging any functions relating to any office or employment with a service provider". This restriction will enable the CQC to decide that a person is not fit to be a Director on the basis of any previous misconduct or incompetence in a previous role for a service provider. This would be the case even if the individual was working in a more junior capacity at that time (or working outside England). It will apply to all directors and "equivalents", which will include Executive Directors of NHS Trusts and Foundation Trusts. It will be the responsibility of the provider and, in the case of NHS bodies, the chair, to ensure that all Directors meet the fitness test and do not meet any of the 'unfit' criteria. The Chair of a provider's board will need to confirm to the CQC that the fitness of all new Directors has been assessed in line with the new regulations; and declare to the CQC in writing that they are satisfied that they are fit and proper individuals for that role. The CQC may also 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. The Trust will obviously monitor the approval of the Regulations carefully, and respond to the requirements by adapting its processes accordingly.	Compliant

[2] Defined according 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.
[3] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Condition	Evidence of Trust compliance	Latest assessment
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 Trust, the guidance has not yet been fully reviewed and embedded. However the Trust will receive a summary of Monitor guidance requirements so that it can ensure compliance at a time appropriate to its foundation trust application trajectory.**	Not Compliant Not Compliant Compliant by 31/03/16
G7 – Registration with the Care Quality Commission	~~The Trust is registered with the Care Quality Commission.~~ The Trust has full registration with the CQC. The Trust is registered to deliver the following regulated activities: (i) treatment of disease, disorder and injury; (ii) surgical procedures; (iii) diagnostic screening procedures; (iv) maternity and midwifery services; (v) termination of pregnancy; (vi) family planning. A recent application had been made to the CQC to amend the Trust's registration to reflect the fact that all these activities occur at both of the Trust's hospital sites (at present, (v) and (vi) do not apply to Maidstone Hospital. ~~This application is being considered by the CQC at present and will involve a site visit to Maidstone Hospital as part of the process (most likely in the autumn of 2014). This is not an inspection, and is to assist the CQC in determining whether the hospital had the necessary facilities to undertake the requested regulated activities~~. This application resulted in the CQC undertaking a site visit to Maidstone Hospital on 10th September. Following discussion with the CQC team on the day, it was agreed that the Trust would withdraw its request to register "Termination of Pregnancies" (this was always understood as an anticipated outcome, and does not cause any problems, as this service can still continue to be provided at Tunbridge Wells Hospital). For the "Family Planning" registration, the main CQC assessor will assemble his report alongside his two colleagues and progress with the application. The only step required to facilitate this is for the Trust to provide the assessor with details of the action the Trust has taken in response to the CQC's previous compliance inspection at Maidstone Hospital (this step is in hand).	Compliant
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").	Compliant

Pricing conditions

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

Competition conditions

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

Integrated care conditions

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

Oversight Self Certification – Board Statements

Statement	Evidence of Trust compliance	Latest assessment
For clinical quality, that: 1. the Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	▪ The Trust's integrated performance dashboard is reviewed monthly and includes the TDA's "routine quality & governance indicators" ▪ ~~Quarterly "East Midlands dashboard" is reviewed by the Board to provide additional benchmarks~~ ▪ A quality report is submitted at each Trust Board meeting ▪ The Quality & Safety Committee, and its sub-committees, provides a focus on quality issues arising from Directorates; each 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 management functions ▪ Ongoing conduct of Family and Friends Test is ~~and~~ reported through the Trust performance dashboard ▪ Patient stories are a standing agenda item at Trust Board meetings ▪ SI report summaries are circulated to all Board members ▪ Board member visits to wards and departments enable triangulation of quality and other performance indicators. Pairings of NED and Executive Board members, to further promote such visits, have now been issued. Board members also participate in the conduct of Care Assurance Audits ▪ Systems investment (e.g. Q-Pulse, Symbiotix, Dr Foster) supports effective quality information/data management ▪ Quality Accounts have been developed in liaison with stakeholders ▪ Quality Impact Assessments conducted on all CIP initiatives ▪ Priority of patient care reflected in Trust values & embedded in staff appraisal The independent assessment of the Trust's Quality Governance Framework has largely endorsed the Trust's self-assessment and gave a validated score of 3.5; an action plan has been drafted to achieve further improvements. Further improvements include: - strengthening the processes through which learning is shared and embedded has been recognised, and - developing further benchmarks to support the assurance & target setting process CQC intelligent monitoring assessment updated in ~~March~~ July 2014 rated the Trust as ~~"5"~~ "3" (with 6 being the highest/best score).	Compliant

Statement	Evidence of Trust compliance	Latest assessment
For clinical quality, that: 2. the board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements	The Trust has full registration with the CQC. The Trust is registered to deliver the following regulated activities: (i) treatment of disease, disorder and injury; (ii) surgical procedures; (iii) diagnostic screening procedures; (iv) maternity and midwifery services; (v) termination of pregnancy; (vi) family planning. A recent application had been made to the CQC to amend the Trust's registration to reflect the fact that all these activities occur at both of the Trust's hospital sites. This application is being considered by the CQC at present and will involve a site visit to Maidstone Hospital as part of the process (most likely in the autumn of 2014). This is not an inspection, and is to assist the CQC in determining whether the hospital had the necessary facilities to undertake the requested regulated activities. 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.	Compliant
For clinical quality, that: 3. the board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	The Medical Director is the responsible officer for medical practitioner revalidation. The Trust Board in May 2014 received the 2013/14 Annual Report from the Responsible Officer, and approved a 'statement of compliance' confirming that the Trust, as a designated body, was in compliance with the regulations governing appraisal and revalidation.	Compliant
For finance, that: 4. the board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time	Trust response: The Trust reported a deficit for 2013/14 and the financial situation is under ongoing review with the TDA. However, the Trust continues to operate as a going concern.	Compliant
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	Compliant

Statement	Evidence of Trust compliance	Latest assessment
	(ii) Oversight – the Trust participates fully in the oversight model (self- certification, review meetings) (iii) Escalation – The Trust welcomes support from the TDA and will cooperate fully with escalation decisions. The Trust, has fully engaged with a risk summit of performance issues (c.diff, surgical trainees, A&E) (iv) Development – the Trust will embrace the development model as appropriate. The Trust has committed to development programmes for (i) Board members; (ii) Executive team, (iii) Clinical Directors and (iv) General Managers/Matrons. (v) Approvals – the Trust is fully engaged in the FT application process and is awaiting dialogue with the TDA on the timetable towards authorisation. Trust values and priorities mirror the TDA's underpinning principles: ▪ local accountability – e.g. liaison with CCGs, Patient Experience Committee, patient satisfaction monitoring, whistleblowing & complaints management ▪ openness and transparency – e.g. embedded in Trust value on respect; duty of candour in Board Code of Conduct; open approach to Public Board meetings (which have now been agreed to take place each month) and both external &, internal communications channels; a growing membership ▪ making better care easy to achieve – the Trust's stated priority, above all things, is the provision of high quality & safe care to patients (Patient First). ▪ (d) an integrated approach to business – the Trust has adopted an integrated governance approach including an integrated performance dashboard.	
For governance, that: 6. all current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.	See 5 above. In addition: ▪ The Trust monitors performance each month in accordance with the TDA Quality and Governance indicators. A Board Assurance Framework and Board level risk register, supported by an overall Risk management Policy, are established and scrutinised by accountable Executive Directors, and reported~~, every two months~~. ▪ Risks are assigned to Committees for 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.	Compliant

Statement	Evidence of Trust compliance	Latest assessment
For governance, that: 7. the board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance	See 6 above. In addition: All risks are RAG rated according to severity and likelihood; mitigating actions are monitored and reported. The Trust Management Executive (EDs and CDs) is the designated risk management committee of the Trust and reports to the Trust Board.	Compliant
For governance, that: 8. the necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	The Board annual plan confirms the process to: (i) reaffirm the Trust strategic priorities (ii) set the corporate objectives for the year (iii) agree the budget for the year (iv) agree the Board level assurance and risk issues (v) review the integrated performance dashboard each month The Audit and Governance Committee, like all Board committees, provides a report to the Board following each meeting which is presented by the Committee Chair (a NED). The Board is fully engaged to the development of the IBP and the Clinical Strategy that underpins it.	Compliant
For governance, that: 9. an Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	The Annual Governance Statement 2013/14 was agreed by the Trust Board in May 2014.	Compliant
For governance, that: 10. the Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward	Quality and governance indicators are monitored by the Board each month through the integrated performance dashboard. The Board is committed to achieving all targets and has set the vision of being in the best 20% of acute trusts nationally. The Trust is currently performing against the requirements of the NTDA oversight model.	Compliant

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