Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD MEETING

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

10.30AM – c.1PM WEDNESDAY 26TH MARCH 2014

EDUCATION CENTRE, TUNBRIDGE WELLS HOSPITAL

A G E N D A – PART 1

Ref.	Item	Presenter	Attachment	Page
3-1	To receive apologies for absence	Chairman	Verbal	-
3-2	To declare any interests relevant to agenda items	Chairman	Verbal	-
3-3	To agree the minutes of the Part 1 meeting of 29th January 2014	Chairman	1	1-16
3-4	To note progress with the actions agreed at previous meetings	Chairman	2	17-20
3-5	To receive a report from the Chairman	Chairman	Verbal	-
3-6	To receive a report from the Chief Executive	Chief Executive	3	21-22
	QUALITY			
3-7	To receive a report of the Quality & Safety Committee meeting of 05/03/14	Committee Chair (Non-Executive Director)	4	23-24
3-8	To receive a report of the Patient Experience Committee of 06/03/14	Committee Chair (Non-Executive Director)	5	25-28
3-9	To receive the Clinical Quality and Patient Safety Report (to month 11, 2013/14)	Chief Nurse / Medical Director	6	29-54
3-10	To agree an updated declaration of compliance with eliminating Mixed Sex Accommodation	Chief Nurse	7	55-56
3-11	To receive a Safeguarding children update (annual report to Board)	Chief Nurse	8	57-62
3-12	To receive a Safeguarding adults update (annual report to Board)	Chief Nurse	9	63-70
3-13	To receive details of a patient's experiences of the Trust's services	Chief Nurse	10	71-74
3-14	To receive details of the recent quality assurance activity undertaken by Board Members	Trust Secretary	11	75-78
	PERFORMANCE			
3-15	To receive a report of the Trust Management Executive meetings of 19/02/14 and 19/03/14	Committee Chair (Chief Executive)	12	79-80
3-16	To receive a report of the Workforce Committee meeting of 06/03/14	Committee Chair (Non-Executive Director)	13	81-82
3-17	To receive a report of the Finance Committee meetings of 24/02/14 and 20/03/14	Committee Chair (Non-Executive Director)	Verbal	-
3-18	To receive an update on performance, activity, finance and workforce (to month 11, 2013/14)	Chief Operating Officer / Director of Strategy and Workforce / Director of Finance	14	83-94
3-19	To approve the latest compliance oversight self-certification	Director of Corporate Affairs	15	95-106
3-20	To receive a report on the Nursing & Midwifery staffing review	Chief Nurse	16	107-134
3-21	To receive a report of performance against the KPIs for the new Clinical Administration Units	Chief Operating Officer	17	135-138

Ref.	Item	Presenter	Attachment	Page
	PLANNING			
3-22	To approve the business case for John Day / Jon Saunders Wards (second ward refurbishment)	Chief Operating Officer	18	139-168
	INFORMATION MANAGEMENT & TECHNOLOGY			
3-23	To receive an update from the Senior Information Risk Owner (SIRO) (incl. approval of the Information Governance Toolkit submission for 2013/14)	Chief Nurse (Senior Information Risk Owner)	19	169-172
	ASSURANCE AND POLICY			
3-24	To receive a report of the Audit and Governance Committee meeting of 24/02/14	Committee Chair (Non-Executive Director)	20	173-174
3-25	To receive the updated Assurance Framework and Board-level risk register	Trust Secretary	21	175-182
3-26	To receive the Estates and Facilities Annual Report 2013	Chief Operating Officer	22	183-194
3-27	To ratify the following policies: ▪ Risk Management Strategy & Policy ▪ Health and Safety Policy & Procedure	Trust Secretary	 23 24	 195-196 197-198
3-28	**TO CONSIDER ANY OTHER BUSINESS**			
3-29	**TO RECEIVE ANY QUESTIONS FROM MEMBERS OF THE PUBLIC**			
3-30	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	-
	DATES OF FUTURE MEETINGS: ▪ 28th May 2014, 10.30am, Academic Centre, Maidstone Hospital ▪ 23rd July 2014, 10.30am, Education Centre, Tunbridge Wells Hospital			

Anthony Jones,
Chairman

Maidstone and Tunbridge Wells NHS
NHS Trust

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 29TH JANUARY 2014, 10.30 A.M. AT MAIDSTONE HOSPITAL

DRAFT, FOR APPROVAL

Present:	Anthony Jones	Chairman	(AJ)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Kevin Tallett	Non-Executive Director	(KT)
	Avey Bhatia	Chief Nurse	(AB)
	Angela Gallagher	Chief Operating Officer	(AG)
	Ian Miller	Interim Director of Finance (apart from item 1-11)	(IM)
	Paul Sigston	Medical Director (from item 1-6 onwards)	(PS)
In attendance:	Paul Bentley	Director of Strategy and Workforce	(PB)
	Jayne Black	Director of Transformation	(JB)
	Terry Coode	Director of Corporate Affairs	(TC)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Stephen Smith	Associate Non-Executive Director	(SS)
	Hannah Alland	Communications and Marketing Officer	(HA)
	Liz Champion	Lead Nurse for Dementia Care (for items 1-6 and 1-10)	(LC)
	Sharon Chapman	Secretary to the Board	(SC)
	Annemieke Koper	Staff Side Chair	(AK)
	Kevin Rowan	Trust Secretary	(KR)
	Jill Johnson	Patient's relative (for items 1-6 and 1-10)	(JJ)
	Fritz Muhlschlegel	Interim Clinical Director / Consultant Microbiologist, East Kent Hospitals NHS Foundation Trust (for items 1-7 to 1-10 and 1-20)	(FM)

1-1 TO RECEIVE APOLOGIES FOR ABSENCE

Apologies were received from Sylvia Denton (SD); and Steve Tinton (ST), Non-Executive Directors.

AJ welcomed SDu to her first Board meeting. AJ also proposed that a formal letter of thanks be sent to Phil Wynn-Owen, Non-Executive Director, who left the Board in December 2013. This was agreed.

AJ also noted he had circulated to Board members a letter of thanks that had been received from a family member who resides in the USA, relating to the death of a relative.

1-2 TO DECLARE ANY INTERESTS RELEVANT TO AGENDA ITEMS

There were no declarations of interest.

1-3 TO AGREE THE MINUTES OF THE PART 1 MEETING OF 27TH NOVEMBER 2013

The minutes were accepted as an accurate record of the meeting.

KT referred to the discussion under item 120/13 regarding the plans to extend the Dementia Café on Ward 20 to other wards, and asked for an update. AB stated that the intention was to extend the initiative, subject to financial considerations, but the details of any extension needed to be assessed. AB continued that the Dementia Strategy Group would undertake this assessment in the first instance, as part of the Trust's Dementia Strategy, and proposed that plans for extending a Dementia Café-style initiative, based on specific ward needs, be submitted to the next Board meeting, for consideration. This was agreed.

Action: Provide the Trust Board with the proposed plans (as part of a wider Dementia Strategy) for extending the 'Dementia Café' that is in place on Ward 20 at Tunbridge Wells Hospital to other wards (Chief Nurse, March 2014)

1-4 TO NOTE PROGRESS WITH THE ACTIONS AGREED AT PREVIOUS MEETINGS

The circulated paper was noted, and the following actions were discussed in detail:

- 118/13. In PS's absence, GD proposed that he ascertain the progress with the previously-agreed action to arrange for the Chair of the Quality & Safety Committee to undertake a visit to a Maggie's Cancer Centre. This was agreed.

Action: Discuss with the Medical Director the progress with the previously-agreed action to arrange for the Chair of the Quality & Safety Committee to undertake a visit to a Maggie's Cancer Centre (Chief Executive, January 2014 onwards)

- 121/13 (extending the Stroke ward). AG reported that the matter was being considered at Directorate-level in the first instance, via the Stroke Lead and Matron. AG continued that options would then be considered at the Trust Management Executive in February.
- 035 (Francis Report). AJ stated that he and AB had been in communication regarding the nurse recruitment pipeline. AB added that the progress with the pipeline was recorded in detail, and monitored regularly.
- 118/13 (use of social media). AB confirmed that she and KT had discussed the matter.
- 118/13 (flu vaccination). AJ asked how the Trust's vaccination rate compared against others. PB replied that the Trust's rate was 2% above the national average. AJ asked about comparison with local NHS organisations. PB stated that he did possess exact details, but in general, the Trust compared favourably. AJ then referred to Medway NHS Foundation Trust, and noted that it had recently been announced that the A&E department at Medway Maritime Hospital would be re-developed. AJ asked whether the source of funding for the re-development was known. AG agreed to identify the source of the funding.

Action: Identify the source of the funding for the recently-announced re-development of the A&E department at Medway Maritime Hospital (Chief Operating Officer, March 2014)

- 121/13 (Stroke care). AG reported that the Stroke action plan would be submitted to the next Quality & Safety Committee, in March 2014.
- 121/13 (CQC whistleblowing alerts). SDu asked whether the concerns raised with the Care Quality Commission (CQC) were made known to the Trust. AB confirmed that such concerns were notified, anonymously, to the Deputy Chief Nurse, and were duly investigated. SDu asked whether the Board was made aware of the details of such concerns. AB replied that this step had not previously been taken, but proposed that she provide the Board with details of the 'whistleblowing alerts' that the CQC had received about the Trust. This was agreed.

Action: Provide the Board with details of the 'whistleblowing alerts' that the Care Quality Commission had received about the Trust (Chief Nurse, March 2014)

1-5 TO RECEIVE A REPORT FROM THE CHAIRMAN

AJ reported that the Non-Executive Directors (NEDs) had discussed the various reviews being undertaken at the Trust, including the forthcoming "Board to Board" meeting with the NHS Trust Development Authority (TDA). AJ highlighted that the Board would need to review the information to be submitted to the TDA, and would therefore likely need to schedule a separate meeting to do this. AJ continued that the final report of the review undertaken by Ruth Carnall, on behalf of the TDA, was not yet available, but noted that Ms Carnall would be at the aforementioned "Board to Board", and was scheduled to provide feedback to Board members on 11th March. GD clarified that the meeting on 11th March only involved NEDs.

AJ also highlighted that PricewaterhouseCoopers LLP (PwC) had been engaged to develop a recovery plan for the Trust, and had commenced their work. AJ reported that PwC would utilise previous reviews undertaken, including the costs associated with the PFI in place for Tunbridge

Wells Hospital. AJ continued that he had asked PwC to provide estimates of the financial impact of the Trust's future strategic options. IM confirmed that this aspect was contained within the terms of reference for the engagement, as submitted as part of the procurement exercise. IM added that the terms and the winning proposal from the procurement exercise had been sent to all Board members, and this work would form part of phase three, to take place between 5th April and 20th June, when the Trust was required to submit its 3-5 year section of the LTFM to the TDA.

GD referred to the aforementioned meeting of the Board ahead of the "Board to Board", and stated that it would be more beneficial to hold the meeting as close to the "Board to Board" as possible. AJ acknowledged the point, and proposed that the arrangements for a meeting of the Board be finalised after today's Board meeting. This was agreed.

Action: Finalise the arrangements for a meeting of the Board ahead of the 'Board to Board' with the NHS Trust Development Authority on 28th February 2014 (Chief Executive / Chairman / Trust Secretary, February 2014)

AJ also reported that Ernst and Young had been asked to check the conclusions of their previous review of the Trust's Board Governance Assurance Framework (BGAF) in light of the Trust's recent financial situation. GD added that he understood that Ernst and Young would be issuing a letter, rather than a revised report.

1-6 TO RECEIVE A REPORT FROM THE CHIEF EXECUTIVE

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

- The Trust was managing to achieve compliance with the A&E 4-hour-wait target, and although the target was not met in December, there was still confidence that it would be met for January. AJ commended all those involved in the achievement of the target so far.
- GD had visited most wards, and had spoken with portering & domestic staff. GD continued that such staff provided a different perspective from their clinical colleagues, and the underlying lesson from his visits was that despite their frustration with certain processes, their commitment was remarkable. GD made a plea to other Board members to ensure the role of such staff was recognised when ward visits were made. AJ made an additional plea for Board members to visit other non-clinical areas, including finance and estates. SDu suggested that Board members be paired with particular wards and departments. This was agreed, but AJ emphasised that this should not prevent Board members from visiting any area they wished.

Action: Arrange for Board members to be 'paired' with Wards and Departments (Trust Secretary / Chairman, January 2014 onwards)

QUALITY

1-7 TO RECEIVE A REPORT OF THE QUALITY & SAFETY COMMITTEE MEETING OF 15/01/14

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

- Maternity Never Events. AB confirmed that the events had been de-escalated to be 'Serious Incidents', but the underlying investigation process/response had still been followed. AB added that the external review of processes had started, & should be completed in February.
- The Royal College of Surgeons Invited Review of Upper Gastrointestinal Services would be discussed in more detail within the Part 2 Board meeting.
- Complaints and Serious Incidents needed to be handled more expeditiously in one particular Directorate.

KT referred to the definition of Never Events, and stated that he understood that if an object was left inside a patient, it should be labelled as a Never Event. PS explained that the most recent guidance on Never Events had clarified that if an object was left in situ intentionally by the surgical team (i.e. for removal at a later date), this should be excluded from the definition. AJ confirmed that he had seen the guidance.

AB noted that the first page of the report stated that there was no outsourcing of reporting, which was not the case. SM clarified that the Trust was only outsourcing CT scans between 10pm and 7am, as it had always done i.e. before the implementation of the new Radiology Implementation System (RIS). It was agreed that this point should be clarified within the minutes of the Quality & Safety Committee.

Action: Ensure the minutes of the January 2014 Quality & Safety Committee meeting accurately reflect the situation regarding the outsourcing of radiology investigations that relate to the implementation of the new RIS system (Trust Secretary / Chief Nurse, January 2014 onwards)

SDu asked whether the Board received specific details of the Trust's complaints. AJ replied that such details were not received formally at the Board, but could be provided to any Board member, should they so wish. SDu confirmed she wished to receive such details.

Action: Arrange for the recently-appointed Non-Executive Director to have access to details of the complaints made against the Trust (Chief Nurse, January 2014 onwards)

1-8 TO RECEIVE A REPORT OF THE PATIENT EXPERIENCE COMMITTEE OF 12/12/13

AJ referred to the circulated report and highlighted that the meeting had discussed the implementation of the new RIS system, and had also heard feedback from one of the Trust's doctors in training.

1-9 TO RECEIVE THE CLINICAL QUALITY AND PATIENT SAFETY REPORT (TO MONTH 9, 2013/14) (INCL. APPROVAL OF THE QUALITY STRATEGY)

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

- The number of clostridium difficile cases was still below the Trust's trajectory limit, with 30 cases occurring for the year to date (against a year-end limit of 42). There had been 1 case on January, 2 in December, and 3 in November.
- The Trust was performing well in relation to prevention of hospital acquired pressure ulcers, but there had been a recent increase in patients being admitted with ulcers. This was therefore being discussed with commissioners, with the aim of identifying the preventative actions that could be taken across the whole patient pathway. AG asked whether information was recorded on the numbers of patients admitted with pressure ulcers. AB confirmed that an incident form was completed for each case. PS added that an adult protection issue was also raised for such cases, particularly those admitted from nursing homes.
- Numbers of falls have reduced, but AB emphasised that she was unable to provide absolute assurance that the recent downward trend would continue. AB added that she was concerned at the level of harm resulting from the falls that had occurred, and therefore a review of the management of falls had been undertaken, using the "FallSafe" framework. AB continued that a new, more focused action plan, had now been developed, but progress would require the continued education of all clinical staff. AB also noted that the rate of falls between the two hospital sites was similar, and this fact should continue to be used to challenge the perception that an all-side room environment inevitably leads to more falls. AJ commented that the rate of falls at Tonbridge Cottage Hospital was disappointing. AB acknowledged the point.
- Complaints had increased in November and December. AB stated that the reasons for this have been investigated, and it has been acknowledged that the sickness absence experienced within the PALS office in November 2013 was likely to have had a negative impact on the ability to resolve issues at an early stage. AB continued that communication emerged as a key theme, as did staff attitude, and there was therefore a need to focus on attendance at the Trust's complaints training. AJ asked whether the existing training programme with Canterbury Christchurch University would be re-launched. AB confirmed this was the intention. GD remarked that the target attendance for such training needed to be made clear, so that efforts could then be made to ensure that all the audience attended.

SDu queried whether use of the term 'upheld' in relation to complaints was useful, given that complaints were always made from the perspective of the complainant. AB acknowledged the point and explained how a complaint would be classified as ‘upheld’, ‘partially upheld’ or ‘not upheld’, and stated that there was a rationale behind the term’s use. PS added that he found the use of the term beneficial, when discussing the need for improvements with medical staff.

SDu then referred to the tables on page 43, and opined that the information therein would be better presented as a chart. AB acknowledged the point.

- The Quality Strategy had been revised and re-submitted for approval. AB invited comments.

  KT referred to section 2, “Our Organisation”, and pointed out that the word “mnemonic” should be used instead of “pneumonic”. AB acknowledged the error. KT also commented that he felt the tone of the Strategy should be more tangible and measurable. KT elaborated that section 6, “What does high quality care look like?” included too many references to ‘reducing’, ‘maintained’ etc., without being specific as to the level of reduction.

  SDu referred to page 48, and queried whether “We take every opportunity to improve services” should be under the heading of “Innovation”. AJ agreed that the words should be amended. AB stated that this wording was taken directly from the Trust values and therefore would not be appropriate to change within the Quality Strategy alone until the Board reviewed the values.

  SDu also remarked that the ‘strategic objectives for quality’ on page 52 did not include reference to training. AJ acknowledged that training was referred to elsewhere, but agreed and stated that the strategic objectives should include a reference to training.

  SDu then referred to the “Positive patient experience” section on page 53, and proposed that the section contain a reference to outcomes. AJ stated he agreed with the comment.

  SS remarked that he remained unsure as to the things that the Trust was going to do differently in 2014 as a result of the Strategy, and asked AB to list the top three things that would be done differently, beyond the publication of information. AB replied that publication of certain information, for example in relation to staffing levels, was a driver in improving care. AB continued that the Care Assurance Audits would be developed and refreshed, using 'Road Map' methodology, and use of IT would also be expanded. AB also noted that the Strategy was also aimed at improving performance on key metrics, such as preventing pressure ulcers, clostridium difficile, and patient falls.

  SM proposed that the Strategy include reference to the aim of providing 7-day working.

  KT commented that he felt the Strategy should include something on patient-centred care plans, and also remarked that the Strategy would benefit from a 'you said, we did' section.

  PS and PB commented that the document was much improved since the version submitted to the November 2013 Board. AB noted that the revised version had been finalised following consultation with Ward Managers.

  The Strategy was approved subject to the above amendments.

  Action: Amend the Quality Strategy to reflect the comments agreed at the Board (Chief Nurse, January 2014 onwards)

1-10 TO RECEIVE DETAILS OF A PATIENT’S EXPERIENCES OF THE TRUST’S SERVICES

AJ welcomed JJ and LC to the meeting. JJ relayed the details of the experiences of her mother, Enid Gohl (EG), who was a patient at Maidstone Hospital, as follows:

- EG was 89, and had been showing signs of dementia. Before Christmas 2013, EG experienced a number of falls, one of which resulted in EG’s carer calling for an ambulance. JJ was notified of the call, and arrived to meet the ambulance crew, who advised that EG required hospital admission.

- EG arrived at Maidstone Hospital by ambulance. The ambulance drivers were excellent, and were very reassuring to EG.
- If JJ had not accompanied EG, EG would have been unable to cope with the questions posed in the A&E department. JJ elaborated that she provided EG's details several times: first to the Ambulance crew, then to the A&E nurse, then again to the A&E doctor.
- When EG was admitted to Urgent Medical and Ambulatory Unit (UMAU), JJ had to provide EG's details again, to a student nurse. JJ expressed concern at having to give such information on several occasions, which led her to believe that she was unable to leave the hospital.
- On the following morning, EG was admitted to Mercer Ward, where JJ had to provide a further account of EG's situation. JJ highlighted that EG would not have been able to cope on her own with repeated requests for similar information, and suggested the Trust could improve this.
- JJ stated that despite this, everyone she encountered was very pleasant and very efficient.
- However, once EG was admitted to Mercer Ward, JJ had difficulty in obtaining a clear understanding as to when EG would be discharged. JJ elaborated that staff made reference to patient confidentiality rules, despite JJ having power of attorney in place for EG. JJ remarked that she was being treated as an interfering daughter, who should 'know her place'.
- Whilst on Mercer ward, JJ visited every day to help EG feed, as she felt that Ward Staff were too busy. JJ noted that the staff were very accommodating of JJ's visits, and did not demand strict adherence to visiting hours.
- JJ filled in the "This is Me" booklet for EG, which she regarded as a very good initiative.
- The lack of eye contact from Ward staff was noticeable. JJ remarked that this was a shame, as eye contact could have helped to reduce feelings of embarrassment for relatives and patients.
- JJ did note that many of the other patients on the Ward required significant attention by nurses.
- As EG's discharge approached, there was some confusion about the arrangements. JJ stated that she spoke several times with the Case Manager, but was met with a 'professional knows best' attitude
- The transfer of EG's healthcare records to Social Services was also a challenge, and took 2-3 weeks to resolve. JJ added that she was surprised at the extent of 'pen and paper' processes.

AJ asked LC to comment. LC remarked that the feedback she had received in relation to EG's admission was that the Activity Coordinator on Mercer Ward had assisted EG with activities such as reading the newspaper, using the day room, eating, socialising with other patients, and watching films. LC added that having subsequently spoken to JJ, it was acknowledged that although such help was beneficial during EG's admission, this ceased on discharge.

JJ continued that the Hospital Care Manager had wanted EG to attend a Day Centre, but noted that since her discharge from hospital, EG had been largely limited to her bed. JJ stated that she was now therefore considering placing EG in a Residential Home.

AJ summarised that EG's experiences were reasonably good, but there were aspects that could have been improved. AJ asked AG and AB to comment on the requirement to provide EG's details several times. AB stated that the request to provide such details several times was likely to have been exacerbated by JJ's presence, in that staff may well have been taking advantage of JJ's knowledge, to ensure that no details were missed, and also to engage JJ in the assessment process. AB continued that this did not necessarily mean that staff were not reading the medical records, and if relative was not present, staff would have relied on EG's healthcare records. PS added that his own practice with patients was to take his own history, regardless of any history that had been taken previously. PS stated that this was common practice among his colleagues, as it reflected medical training. LC commented that the history-taking process was often not well managed, in terms of the use of language, so that rather than staff making reference to previously-given details (such as 'I see that your mother has...'), the process tended to begin with 'so, tell me what happened'. LC acknowledged that this would be rightly seen as frustrating by patients and relatives.

SS asked for a comment on the length of time taken to provide the notes to social services. AG stated that there were two sets of records, and the situation described by JJ was not uncommon. JB highlighted that Kent County Council was one of the pioneering sites to improve their management of records. The issue of technological solutions was then discussed. KT stated that

he regarded the issue to reflect a need for streamlined processes, rather than await IT-related solutions, and commented that the Trust could take a leadership role in improving matters.

SDu referred to JJ's comments about the support she provided for her mother to eat, and asked AB whether there was a 'red tray' system in place, and whether patients were receiving assistance with feeding, if required. AB confirmed that red tray and protected mealtime systems were in place. AB also noted that a cohort of volunteers was available, and that Ward staffing levels took the ability to support patients with feeding into account.

AB stated that the lesson she took from EG and JJ's experiences was that the communication from the Ward could have been far better, particularly if the impression was given that EG would not receive support with feeding in JJ's absence. JJ clarified that she took it upon herself to feed her mother, and stated that she was sure EG would have been fed if she had not visited. JJ elaborated that a factor in her decision was that she was aware of her mothers' likes & dislikes regarding food.

AB noted JJ's reference to visiting times, and reported that the Trust would soon be introducing open visiting, in recognition of the rights of relatives to be free to come and visit when they choose. AB added that mealtimes, medication rounds, and ward rounds would however need to be protected to a certain extent.

PB noted that the Trust had a programme of customer care training for staff, which used video recordings of patients and relatives. PB asked JJ if she would be willing to participate in the programme. JJ confirmed she would be willing to be involved.

PS asked JJ whether EG would have preferred to be a patient at Maidstone Hospital or Tunbridge Wells Hospital. JJ replied that she preferred EG to be admitted to Maidstone, due to the inconvenience of visiting Tunbridge Wells Hospital.

TC asked JJ whether she thought it appropriate for the Trust to allow and encourage relatives of in-patients to help with feeding and non-clinical care. LC felt that it was appropriate.

AJ asked LC what would happen if patients with dementia such as EG did not have a relative present on admission. LC stated that some information may already be available, such as the patient's GP, and in such cases, the GP would be contacted at the first available opportunity. LC added that efforts would also be made to contact the patient's next of kin, to obtain relevant information.

AJ thanked JJ for her attendance, and stated that JJ would be provided with the comments and actions arising from the discussion.

1-11 TO RECEIVE DETAILS OF THE RECENT QUALITY ASSURANCE ACTIVITY UNDERTAKEN BY BOARD MEMBERS

The circulated report was noted. AJ emphasised that all Board members should visit all areas of the hospitals, including undertaking visits out of hours. AJ also reminded Board members to ensure such visits were recorded.

PERFORMANCE

1-12 TO RECEIVE A REPORT OF THE TRUST MANAGEMENT EXECUTIVE MEETINGS OF 11/12/13 AND 22/01/14 (INCL. APPROVAL OF REVISED TERMS OF REFERENCE)

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

- The revised Terms of Reference reflected the fact that the Trust Management Executive was now the primary risk management committee for the Trust.
- The meeting on 22/01/14 discussed the forthcoming Joint Advisory Group (JAG) on GI endoscopy accreditation visits, which took place at both hospital sites in February. GD noted that JAG accreditation was already in place at Tunbridge Wells Hospital, and there was confidence that accreditation could be obtained at both sites.

- After the normal business meeting, there was a discussion of Directorate strategy, with each Directorate giving details of their strategic intentions.

AJ asked GD to update on the recent Care Quality Commission (CQC) visit to Tunbridge Wells Hospital. GD reported that the visit took place before Christmas, and although the final report has not been issued, the draft report includes two moderate areas of non-compliance: one relating to medicines management, and the other relating to medical cover. PS referred to the latter issue, and reported that a business case for two A&E Consultants had been approved. AB added that an action plan was being prepared to address the issues raised by the inspection.

GD asked for comments on the Terms of Reference. KT stated that he understood the Director of Transformation should be a member. It was agreed this should be the case.

Action: Amend the Terms of Reference for the Trust Management Executive to reflect the inclusion of the Director of Transformation as a member (Trust Secretary, January 2014 onwards)

The Terms of Reference were approved, subject to above amendment.

1-13 TO RECEIVE A REPORT OF THE WORKFORCE COMMITTEE MEETING OF 05/12/13

KT referred to the circulated report and highlighted that it was a constructive meeting, which concluded that the current process for reconciling workforce, activity and finance information was defective, and the actions to improve this had to therefore be aligned. PB added that the committee had considered the question as to whether the Trust was in control of its workforce, and had concluded that such control was in place. KT stated that a more accurate conclusion was that each element was in control of its own aspects, but the overall picture was not aligned.

IM emphasised that the aforementioned reconciliation was an important exercise for 2014/15 planning, but noted that such reconciliation may not be completed before the 2014/15 budgets were set. IM continued that if this was the case, the reconciliation should continue into 2014/15, and budgets may therefore need to be adjusted in-year.

1-14 TO RECEIVE A REPORT OF THE FINANCE COMMITTEE MEETING OF 23/01/14

KT highlighted that the Committee had discussed the risks to achievement of the forecast out-turn, which included the potential occurrence of staff sickness absence due to Norovirus.

1-15 TO RECEIVE AN UPDATE ON PERFORMANCE, ACTIVITY FINANCE AND WORKFORCE (TO MONTH 9, 2013/14)

AG referred to the circulated report and highlighted the following

- December was a busy month, with attendances, admissions and ambulance conveyances all at higher levels than for the previous year. AG added that this increase has continued into January, albeit at a lower level.
- A low average Length of Stay had however been maintained, and delayed transfers of care had not risen above 3.5%.

AJ commented that AG's summary did not reflect the challenges involved in ensuring patients pass through the hospitals in a timely manner. AG acknowledged the point and added that over 50 escalation beds had been open in recent times, to help manage the pressures on capacity.

SDu asked about compliance with the WHO surgical checklist. PS replied that compliance was now part of the Trust's culture. AG added that audits had shown the Trust to be 100% compliant.

AJ stated that in general, further work was required in relation to the content of the "benchmark" column of the Dashboard. AG acknowledged the point.

IM then referred to the circulated report and highlighted the following

- At the end of December, the Trust has a year-to-date deficit position of £13.9m

- The forecast out-turn for the year-end showed a £9.6m deficit. The Trust Financial Management System (TFMS) return for month 9 showed a £14.4m forecast out-turn, to reflect £4.8m of high risk items not within the Trust's control.
- The rules on temporary borrowing meant that the Trust was required to repay a £16m loan to the TDA by 17th March 2014. IM explained that the Trust had made an application for the £16m to be converted from a Temporary Borrowing Limit (TBL) into Public Dividend Capital (PDC), but highlighted that there was no guarantee that the application would be approved. IM continued that the Trust was required to submit a Long-Term Financial Model (LTFM) with the application, but given the timing of the submission, the LTFM would not reflect an agreed Board-approved strategy, which was required by the TDA's planning guidance to be submitted to the TDA by 20th June.
- The CCG have provided milestones for the agreement of the year-end position.

IM then referred to the aforementioned loan application and noted that formal Board approval was required. The Board duly approved the application.

[Post-meeting note: It has been identified that there was a typographical error in the month 9 financial information within Attachment 10 – This stated that "At the end of the M9 the Trust has a YTD deficit position of £13.9M which is £12.9M lower than the plans submitted to the Trust Development Authority (TDA) at the start of the year". The text should have read "At the end of the M9 the Trust has a YTD deficit position of £13.9M which is £12.9M higher than the plans..."]

1-16 TO RECEIVE AN UPDATE ON THE ACTIONS ARISING FROM THE 2013 MEDICAL WORKFORCE BENCHMARKING REPORT

PB referred to the circulated report and highlighted the following

- Table 1 listed the areas which were identified by the KPMG benchmarking as having potential for improvement. Table 2 showed the breakdown of these areas by Directorate
- Some progress had been made, and the work undertaken to date has been used by Directorates as a platform for their 2014/15 planning

KT referred to Table 2, and stated that he expected the medical productivity CIP for 2014/15 to be set at a more realistic level i.e. closer to £1m. PB stated that it was unlikely to be as low as £1m, but acknowledged the level would be unlikely to be as high as the £4m set in the previous year.

KT then asked whether the "IT system to support management of the consultant contact…" referred to on page 84 was included in the 'Inspire' IT programme. PB confirmed the system was not included in the programme, but noted that this only involved a small investment. AJ asked whether the "Roster Pro" IT system used by nurses could also be used for medical staff. PB confirmed that some elements of "Roster Pro" could be applied, but in general, this was not suited to the Trusts' requirements for management of Consultants' contracts.

PS emphasised the need to engage with medical staff to improve their efficiency. JB stated that the benchmarking work was very important, and needed to be built on for the future. AJ acknowledged the point, but stated that Board members were cognisant of the fact that medical productivity had been a CIP that had not been delivered in full for several years. JB accepted this, but commented that Directorate ownership was improving, as demonstrated via the business case process.

1-17 TO APPROVE THE LATEST COMPLIANCE OVERSIGHT SELF-CERTIFICATION

TC referred to the circulated report and pointed out that the changes from the previous submission had been highlighted. TC continued that only one of the proposed changes had a material effect on the overall position, namely the agreement of Referral and Treatment Criteria (RATC) where the Trust was now "compliant".

The self-certification was approved as circulated.

1-18 TO RECEIVE AN UPDATE ON THE TRUST'S PRIVATE PATIENT SERVICE

AG referred to the circulated report and highlighted the following

- Activity and income had increased, when compared to the previous year
- The Director of Private Patient Services had been in post for 8 months, and was responsible for private patient services across the whole Trust

KT asked for details of the Service's overall contribution to the Trust's income. AG stated that the contribution for this year was £700k. AJ asked how much income would have resulted if the private unit was utilised by NHS patients. GD acknowledged that this had yet to be calculated.

AB asked whether the private services operated by the Trust were the first choice of the Trust's Consultants. AG acknowledged that only a small proportion of the Trust's Consultants' private patient activity was undertaken at the Trust. PS added that this was affected by a number of considerations, including the absence of easily available theatre capacity.

AB stated she was surprised that the Friends and Family test score was not higher. AG agreed, and stated that a challenge has been made to the Unit to improve its score.

SDu queried the difference between the length of stay on the private unit and that on the Trust's NHS wards for the same procedures. AG replied that the length of stay was approximately 0.5 days less on the private unit. SDu highlighted that if the length of stay on the private unit was replicated to the NHS wards, the benefit over a full year would be significant. AG acknowledged the point.

STRATEGY AND PLANNING

1-19 TO RECEIVE AN UPDATE ON THE DEVELOPMENT OF THE ANNUAL PLAN FOR 2014/15

PB referred to the circulated report and highlighted the following

- The report described the process being followed, which would result in the Board being asked to approve the Plan at its meeting in March 2014;
- The themes emerging from the discussions to date include the need for workforce requirements to match capacity plans, particularly where there has been increased activity in the last 12 months;
- The process was aligned with the submissions required to be made to the TDA – 'first cut' plans were submitted to the TDA on 12th January; and a final submission, of a 5-year Plan, was required in June. Prior to this, a second-phase Plan was required to be submitted by 6th March, and PB had agreed with AJ that an update would be discussed at the Board Forum in February.
- To date, there has been a limited level of engagement from the Trust's primary commissioners, but such engagement had commenced.

SS asked for details of the submission made to the TDA on 12th January. PB replied that the submission was a high-level summary. IM clarified that the submission included a net deficit for 2014/15 of £14m.

IM then referred to the expectation from the TDA that Trust's should submit a balanced plan, and highlighted that given the Trust's situation, achieving such a Plan was unlikely, but the Trust would be required to identify a recovery of its financial position in the second year of the plan.

SDu commended the 'bottom-up' approach being taken, but queried whether the large-scale, transformational change required to meet the Trust's financial challenge would be met by such an approach. PB stated that the challenge posed to the Clinical Directors in January was to ask them to consider how services could be delivered in the future, and therefore such discussions were part of the process.

KT referred to the time commitment of the Clinical Directors, combined with an immature General Management structure, and asked how a 'bottom-up' process would achieve the desired aim. KT continued that the proposed key developments in Appendix 1 were not particularly transformational.

AG replied that there had been marked changes in relation to engaging with Directorates, and there was confidence that transformational ideas would emerge.

GD remarked that at the end of February, the Trust would know, from the work currently being undertaken by PwC, the actions within the Trust's control (i.e. operational efficiencies), and from this, the actions requiring a wider, systems approach, over the next 3 to 5 years would emerge. GD continued that the proposed developments in the circulated report should not therefore be regarded as comprehensive.

AJ reported that the NEDs had discussed the possibility of changing the Foundation Trust Committee into a Strategy Committee. GD remarked that the Board may be criticised if strategic discussions were not considered within Board meetings. SS stated that a further option would be to hold Board 'away day' sessions, to discuss strategic options, provided that focused work was undertaken to research and develop potential strategies. SDu supported the option of 'away days', rather than of delegating strategic discussions to a Board sub-committee. PB stated that if the Board agreed the principle that any strategy should be clinically-led, but Board approved, this could be established in practice. AJ therefore proposed that two Board 'away days' be scheduled, to be held off-site. This was agreed. It was also agreed to schedule the 'away days' in spring (late April/early May) and autumn 2014.

Action: 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, January 2014 onwards)

SDu then proposed that Clinical Directors be involved in the 'away days', to ensure there was clinical engagement in the Trust's future strategy, and also proposed that West Kent CCG be invited to attend one of the strategy sessions, to ensure there was health-economy-wide engagement. Both proposals were agreed.

Action: 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 and Workforce / Chief Operating Officer, January 2014 onwards)

Action: 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 (Chief Executive / Director of Strategy and Workforce, January 2014 onwards)

SS then asked for details about the information to be presented at the "Board to Board" meeting with the TDA. GD stated that given the timing of the meeting, the presentation to the TDA would merely represent the progress that had been made to date in developing the Trust's future strategy. SS asked for clarification that the presentation would cover: the forecast out-turn for 2013/14, the plans for 2014/15, an indication of the 2015/16 plans, and reference to the 'menu' of potential strategic options. GD confirmed this was the case. IM did however point out that it would not be possible to allocate detailed financial information to any strategic options before the "Board to Board" meeting, and cautioned against allocating estimates to such options. IM stated that the key point that needed to be considered was deciding when to undertake detailed background assessment of such options, as such assessment required considerable resource, and the involvement of other NHS organisations.

1-20 TO CONSIDER THE FULL BUSINESS CASE (FBC) FOR THE KENT PATHOLOGY PARTNERSHIP

AJ welcomed FM to the meeting. SM referred to the circulated report and gave a presentation, highlighting the following points.

- The key project drivers were: improved patient outcomes and clinical quality; quality improvements via standardisation and service consolidation; the ability to retain financial viability and future proof pathology services; implementation of workforce changes with flexible working and enhanced career progression; and improving procurement, via managed equipment service contracts resulting in savings

- Proposed workforce changes would be fully evaluated before changes are made, and the project would involve phased implementation, to ensure service quality was maintained. Changes would be risk assessed by clinical experts, to ensure they were clinically appropriate
- There would be regular governance reports to both Trust Boards, including obtaining NED agreement for all proposed workforce step-changes
- IT solutions would be fully evaluated to ensure system functionality compliance, and be risk assessed to ensure compliance with the Trust's networks. There would also be robust staff training before implementation
- The "do nothing" option was untenable, as this risked the loss of Direct Access income of £5.9m, and when combined with the current net cost of pathology services, equated to a net cost of £20.6m
- Option 5 was the preferred option, which involved a Central Services Laboratory (CSL) at Maidstone Hospital (with consolidated Microbiology and Histology services; a CSL at William Harvey Hospital, Ashford (with consolidated Blood Sciences, Molecular, Cytology and Andrology services); an integrated Essential Service Laboratory (ESL) at William Harvey Hospital; and ESLs at Kent & Canterbury Hospital, Maidstone Hospital, Queen Elizabeth the Queen Mother's Hospital and Tunbridge Wells Hospital (with ESLs providing essential blood sciences only)
- Option 5 scored highest on delivery of care to patients both primary and acute, and financial assessment, and also retained Consultant to Consultant interaction on hospital sites
- A contractual joint venture was the proposed option, and this would be supported by the Pathology workforce. The proposed Governance structure involved the establishment of a Kent Pathology Partnership (KPP) Board, which would provide reports to each Trust Board
- The Managing Director of KPP would be the Accountable Officer of KPP

KR clarified that the KPP Board would not be a formal sub-committee of either Trust Board.

Comments or queries were then invited. AJ asked for further explanation of the IT plans. SM stated that the plan was that the IT system ('Apex') in place at East Kent Hospitals NHS Foundation Trust (EKHUFT) would be migrated for use at Maidstone and Tunbridge Wells NHS Trust (MTW). KT added that he understood the plan was for an extension of the Apex system, which meant that no data would be migrated from the existing MTW system ('Telepath'). KT also expressed concern as to whether sufficient time had been allocated for implementation of the IT plans. AJ asked for assurance on the level of IT resource applied to the issue. SM gave assurance that resource had been allocated, from CSC, the software company, as well as from within the Pathology departments at both Trusts. FM added that there was a specific KPP IT workstream in place. AJ clarified that he was seeking assurance that there was no risk to patients as a result of the proposals. SM replied that it was intended that there would be dual-running of the IT systems, and therefore the MTW system would only be deactivated once the Apex system was fully functional. FM added that the Apex system had been in place at EKHUFT for a long time, and the situation was therefore different to, for example, the recent RIS replacement. SM also pointed out that access to the Telepath system would be maintained for some time, to enable MTW staff to access historical data, as this would not be migrated to Apex.

AJ then asked for details of the proposed profit share. SM explained that the share was 60% for EKHUFT, and 40% for MTW, with the same share being applied to risks. IM asked how clinical risks and incidents would be managed. GD replied that it would depend, as the majority of services would be provided by one of the two Trusts, and the Trust providing the service to the patient should lead the response in the first instance. GD added that a similar arrangement was in place in relation to the Cancer Centre. GD emphasised that if the FBC was approved, the partnership agreement would require formal approval by the Boards, and this would contain further detail of the practical working arrangements, including the management of any incidents and/or risks.

SM then continued with the presentation, and highlighted the following:

- Patients would benefit from the Partnership, via improved turnaround times
- Training for laboratory staff would be improved, as would Research and Development, as there would be a larger patient base, and greater patient enrolment in clinical trials

- Benchmarking had been undertaken, and the metrics within the FBC represented a realistic view of what could be achieved, though SM highlighted that the proposed configuration of services was different from that of the benchmarked parties.
- A marketing strategy was available, which focused on sustainability, seeking new markets, and responding to future tenders. It was noted that the latter market was increasing, especially in relation to public health.
- Risks include potential Human Resources issues, business risks (in particular, competition regulations), financial risks, and delays to key enablers.
- In summary, the creation of KPP will deliver a safe and high quality service to patients, GPs and acute care clinicians; Workforce changes that are delivered in a phased way, clinically assessed and efficient; retention of clinical adjacencies within the NHS environment; retention of direct access income; the ability to secure future markets and income generate; and a positive net cash flow of £20.7 million over the 7 year plan

KT commented that improved turnaround times would not make a difference unless these were able to be exploited by underlying processes i.e. even if diagnostic tests were reported quicker, medical staff may not be able to respond, as a result of their working practices. KT continued that that he would like this issue covered somewhere in the project workstreams. GD agreed but stated that such issues should be considered separately i.e. the benefits arising from the KPP should be realised, and then wider processes should respond, to take advantage of such benefits.

AJ referred to section 7.9, page 198, which noted that a penalty clause was associated with the early termination of an existing contract, and commented that it seemed optimistic to assume that the penalty would be negated during procurement negotiations. AJ asked IM whether the amount of the penalty had been included within the financial considerations for the FBC. IM stated that this had not been included, but could be addressed via the implementation plan, if the penalty was applied. KT added that he understood that the Project Team had been advised that the application of the penalty was low risk, and it was therefore up to the Board to decide whether they concurred. AJ asked KT whether he was therefore content with the proposed approach. KT confirmed that at this stage, he was content.

SDu asked whether the cost of the aforementioned dual-running of the IT systems had been calculated, and had been included within the FBC. SM confirmed this was the case.

SDu then referred to the market, and in particular the tariff assumptions and asked how confident the Team was that the assumptions were robust i.e. that the Trusts would receive tariff over the life of the contract. IM acknowledged that no assessment of the risk of being ‘undercut’ had been made, but pointed out that this risk existed under the current arrangements, and would therefore not be affected by the KPP. GD added that KPP would reduce the risk of alternative providers entering the local market.

AJ noted that the FBC had not been discussed in detail at the Finance Committee, and asked for assurance that the financial case had been submitted to detailed analysis. SM and GD confirmed that this was the case.

AJ queried whether the proposed staff Agenda for Change bandings had been reviewed by the Human Resources Department, as most of the bandings appeared to involve a reduction from the current arrangements. PB gave assurance that such a review had been undertaken, but highlighted that if any staff were placed at risk, the Trust would have a number of statutory obligations towards such staff.

KT asked IM how the 7-year plan compared with alternative opportunities for a £3m capital investment. IM replied that there was no alternative list of options for a £3m capital investment, but stated that in his view, the KPP represented a reasonable investment, and the option was better than the status quo.

AJ queried whether the Trust could absorb the projected £2.5m loss in the first year. AG clarified that MTW's share of the projected loss would be 40%, which equated to £1m. IM confirmed that this had been included within the Trust's plans for 2014/16.

SS asked whether the projected £2.5m loss assumed full benefit from cost savings. IM confirmed this was the case. SS suggested that it was therefore possible that the first-year loss would be greater than £2.5m. IM confirmed this was the case. SS continued that the major risk of the Partnership was related to implementation time, and asked how much the aforementioned dual-running of IT systems would cost per month, above the plan. SM replied that this level of detail had not yet been calculated. SS highlighted that the proposed £1m loss to MTW was therefore likely to be considerably more, and the Board should be aware of the implications of this on the Trust's 2014/15 financial position.

GD then summarised the decision required by the Board, as follows:

- The Trust Management Executive and Executive Team supported the proposed direction, though the Trust Management Executive had not formally received the FBC, and had therefore not reviewed this in detail.
- If the Board chose to approve the Case, it should do so with an awareness of the risks, as discussed at the meeting.
- If the Case was approved, the appointment of a Managing Director would be undertaken, and the implementation of the aforementioned IT plans would continue
- The projected costs of the Case would continue to be mitigated by all available options, including bidding for additional funding, when available.

GD stated that in his view, KPP was the best strategic option for the Trust. GD added that such Partnerships had already been implemented, or were being explored, by other local Trusts, and noted that it was possible for Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust, who were implementing their own Pathology partnership, to join the KPP at some future point. GD proposed that FBC be approved, but that Partnership agreement be submitted to the March 2014 Board for agreement. GD clarified that at that point, the Board's decision would be irrevocable.

The Board approved the Full Business Case as circulated.

1-21 TO RECEIVE AN UPDATE ON EMERGENCY PLANNING (ANNUAL REPORT TO THE BOARD)

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

KT commended the testing of business continuity arrangements for IT failures in para. 4.7.

ASSURANCE AND POLICY

1-22 TO RECEIVE THE UPDATED ASSURANCE FRAMEWORK AND BOARD-LEVEL RISK REGISTER

KR referred to the circulated report and highlighted that it reflected the Trust's existing process for review of risks. KR explained that the "24th December 2013" date on page 327 was the date on which the Trust's policy list was interrogated, and the policies with review dates beyond that date had been shaded red. KR continued that he was however in discussion with the Trust's Risk and Compliance Manager regarding a proposed revision of the Trust's policy approval process, and if his proposals were accepted, most of the policies listed on pages 327 and 328 would not require approval and/or ratification by the Trust Board.

Charitable Funds Committee

1-23 TO APPROVE THE 2012/13 ANNUAL REPORT AND ACCOUNTS OF MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST CHARITABLE FUND

IM referred to the circulated report and highlighted that The Charitable Funds Committee had reviewed the documents in detail, and had recommended that the Board give its approval.

AJ invited comments or queries. PS referred to note 3.2, on page 355, and stated that "Complimentary Therapies" should be "Complementary Therapies". KR agreed to amend the error.

Action: Amend the error contained in note 3.2 of the Annual Accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund 2012/13 (Trust Secretary, January 2014)

The Board approved the Annual Report and Accounts, subject to this amendment.

ITEMS FOR INFORMATION

1-24 TO RECEIVE AN UPDATE ON COMMUNICATIONS AND ENGAGEMENT

TC referred to the circulated report and highlighted the following:

- The Trust's Communications and Engagement Strategy had been updated and was presented for endorsement
- Efforts to develop the Trust's corporate identity were making good progress, and there had been positive feedback in relation to the "MTW" brand;
- A proposed format for a quarterly communications activity report was enclosed,

KT commented that the Trust's branding needed to be applied to all the sites from which the Trust provided services & noted that such branding was not in place at the Kent and Canterbury Hospital, even though the Trust provides cancer services from that site. TC acknowledged the point.

AJ referred to the 'media evaluation' data, and asked whether this included Downs Mail. TC confirmed this was the case. AJ then asked about details of the recent competition to identify a 'strapline' for the Trust. AB stated that the ideas emerging from the competition were all too long, but the Executive team had discussed the issue, and had proposed a strapline of "Care and Compassion". AJ asked for views. KT suggested that the proposal be tested with patients, via focus groups. AB suggested the Patient Experience Committee could be used for such testing.

1-25 TO CONSIDER ANY OTHER BUSINESS

There was no other business.

1-26 TO RECEIVE ANY QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions.

1-27 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 – MARCH 2014

3-4 LOG OF OUTSTANDING ACTIONS FROM PREVIOUS MEETINGS CHAIRMAN

Actions due and still 'open'

Ref.	Action	Person responsible	Deadline	Progress [1]
121/13	Explore the possibility of extending the boundary of the Stroke ward, to ensure that sufficient beds were available to enable all Stroke patients to receive their care on the Stroke ward	Chief Operating Officer	November 2013 onwards	**In progress** - In progress - Advice has been obtained from the Director of the South East Coast Strategic Clinical Network for Cardiovascular, confirming that it is within the Trust's own control to evaluate need and stroke bed designation. This has since been discussed within the Directorate and as there has been an improvement with the '80/90' performance over the last few months and given that the Trust is now urgently reviewing stroke services within the organisation, the Directorate would like this matter to be considered as part of the Trust's winder Stroke Services review. The Board is asked to agree to this request.
1-4	Discuss with the Medical Director the progress with the previously agreed action to arrange for the Chair of the Quality & Safety Committee to undertake a visit to a Maggie's Cancer Centre	Chief Executive	January 2014 onwards	**In progress** – Arrangements are being made for a small team (including the Clinical Director and General Manager for Cancer; Dr Rutter; and one of the local hospice Consultants) to visit to the Maggie's 'West London' Centre. Once this visit has been undertaken, efforts will be made to arrange for the Chair of Quality & Safety Committee to make a further visit.
1-6	Arrange for Board members to be 'paired' with Wards and Departments	Trust Secretary / Chairman	January 2014 onwards	**In progress** – Pairing arrangements are being developed and will be communicated to Board members in the near future.

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

Ref.	Action	Person responsible	Deadline	Progress [1]
1-19	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	January 2014 onwards	**In progress** – The first session has been scheduled for 9th May 2014. The autumn session will be scheduled in due course.
1-19	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 and Workforce / Chief Operating Officer	January 2014 onwards	**In progress** – The agenda for the first session (which has been scheduled for 9th May 2014) will be developed in the near future. This will include consideration as to which clinical leaders should be invited to attend.
1-19	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	Chief Executive / Director of Strategy and Workforce	January 2014 onwards	**In progress** – Consideration is being given as to when the most appropriate time to schedule a session with representatives from West Kent Clinical Commissioning Group.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
1-3	Provide the Trust Board with the proposed plans (as part of a wider Dementia Strategy) for extending the 'Dementia Café' that is in place on Ward 20 at Tunbridge Wells Hospital to other wards	Chief Nurse	March 2014	Details of the plans for extending the 'Dementia Café' have been included within the Clinical Quality and Patient Safety Report submitted to the March 2014 Trust Board.
1-4	Identify the source of the funding for the recently-announced re-development of the A&E department at Medway Maritime Hospital	Chief Operating Officer	January 2014 onwards	It has been established that Medway FT are seeking external project management and capital funding support, via NHS England, to rebuild their Emergency Department and up to 80 acute assessment spaces. The development comes under the "Transforming Medway" Project, with plans to start implementing a number of changes by the end of 2014.
1-4	Provide the Board with details of the 'whistleblowing alerts' that the Care Quality	Chief Nurse	March 2014	Details of the alerts received since November 2013 have been included within the Clinical Quality and Patient Safety

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	Commission had received about the Trust			Report submitted to the March Trust Board.
1-5	Finalise the arrangements for a meeting of the Board ahead of the 'Board to Board' with the NHS Trust Development Authority on 28th February 2014	Chief Executive / Chairman / Trust Secretary	February 2014	The Board discussed the 'Board to Board' with the NHS Trust Development Authority at its pre-scheduled Board Forum meeting on 26th February
1-7	Ensure the minutes of the January 2014 Quality & Safety Committee meeting accurately reflect the situation regarding the outsourcing of radiology investigations that relate to the implementation of the new RIS system	Trust Secretary / Chief Nurse	January 2014 onwards	The minutes of the January Quality & Safety Committee contain no reference to outsourcing of Radiology investigations
1-7	Arrange for the recently-appointed Non-Executive Director (Sarah Dunnett) to have access to details of the complaints made against the Trust	Chief Nurse	January 2014 onwards	A summary of the complaints received in January was provided. The same information will be provided for February.
1-7	Amend the Quality Strategy to reflect the comments agreed at the Board	Chief Nurse	January 2014 onwards	The Strategy was amended, and subsequently considered at the Quality & Safety Committee
1-23	Amend the error contained in note 3.2 of the Annual Accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund 2012/13	Trust Secretary	January 2014	The error (replacing "Complimentary Therapies" with "Complementary Therapies) was corrected and the signed Annual Report and Accounts were submitted to the Charity Commission ahead of the submission deadline (31st January 2014)

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 - MARCH 2014

3-6 CHIEF EXECUTIVE'S UPDATE CHIEF EXECUTIVE

Summary / Key points

The enclosed report provides information on recent events at the Trust between December 2013 and January 2014.

1. The overall quality and safety of the care we provided our patients during February continued to meet and in many ways exceed national standards despite a significant increase in the numbers of acutely unwell people attending our hospitals.

1.1 A&E attendances were up by 6% across our hospitals in February compared to the same month the previous year. Tunbridge Wells A&E Department was particularly busy, seeing 9% more patients (around more 400 people) over the same period.

1.2 As a consequence, our emergency admissions went up by 15% in February compared with 2013 and ambulance attendances rose by 14%. We had an 18% increase (174 more patients) in the number of people aged over 75 who were admitted into our hospitals.

1.3 While our standards of care remained high and within safe levels, these increased attendances and admissions further adversely effected our financial position by increasing our use of temporary staff, and creating additional cost pressures. We have been clear that while we must ensure our services are cost-effective, we will not jeopardise standards of patient care in the process. We can, however, improve care and reduce costs by replacing temporary agency staff with permanent recruits.

1.4 Reducing our reliance on agency staff is part of our action plan to address comments made by the Care Quality Commission following a recent inspection at Tunbridge Wells Hospital. While patients received good standards of care in a safe environment, the CQC identified that we can raise our standards even further by reviewing staffing needs in A&E and reducing agency use. We are actively addressing both of these points in what was an otherwise positive report.

1.5 A snapshot review of patient standards for February shows:

- 95.05% of our patients were assessed, treated, admitted or discharged from our A&E departments in February, meeting the four hour standard.
- We had no mixed sex breaches in our hospitals, maintaining our patients' privacy and dignity.
- We are on course to have fewer cases of Clostridium difficile in 2013-14 than we have previously ever had. Prudent antibiotic prescribing continues to be one of the key reasons for this success.
- We had our lowest number of complaints (32) in February compared with any of the preceding months in 2013-14. This is way below the national average for NHS hospitals.
- Our overall mortality rates remain within expected levels for a Trust of our size that provides many complex clinical services for acutely unwell patients.
- Despite seeing a small dip in overall patient satisfaction in February, patients taking part in our Friends and Family Test are still clearly more satisfied with our services than the national benchmark for organisations of our size.
- We have taken action to ensure women with possible breast cancers are seen within two weeks or sooner following an increase in referrals. We continue to take action to improve areas of stroke care.

2. We have launched a new physiotherapy-led service for patients with chronic lung conditions. The service is being provided in the community, closer to people's homes, and is just one of the ways in which we can help patients manage their conditions outside of our hospitals, to stay healthy for longer, and avoid potentially life-changing hospital admissions.

2.1 Our sexual health service is another example of how we are moving more of our services into the community to proactively help patients before they reach our doorstep. Our staff recently carried out sexual health screening in the community to help people of all ages take a more proactive stance in looking after their sexual health.

2.2 Both of these examples are part of our bigger overriding strategy to:

- Help reduce avoidable hospitalisation by caring for patients in the community with more integration of our services between our hospitals and their homes.
- Reduce avoidable emergency admissions, and increase the number of patients we see in a planned way, to main or increase our income
- Reduce our financial overspend by making the most cost-effective use of our resources

3. Patients can have confidence in the standard of our endoscopic services following the recent news that we have been awarded JAG accreditation not once, but twice.

3.1 Both of our units at Maidstone and Tunbridge Wells Hospitals have now received national accreditation, which places them in the top third of units nationally for standards of care & overall patient experience. The award at Maidstone follows our £1m+ investment in endoscopic services last June, underlining our ongoing commitment to improve patient care.

3.2 Patients can also be assured that the meals we serve at Tunbridge Wells Hospital are of a high standard. The hospital's catering team has been awarded a Five Star hygiene rating following a recent inspection by the local Environmental Health Office.

4. We delivered our 1,000th baby at Maidstone Birth Centre on Friday, March 14th. Our midwife-led unit opened in 2011 and continues to have good outcomes. It has: a normal delivery rate of 89.3%, an instrumental delivery rate (for example a birth with forceps) of 7%, and an overall caesarean section rate of just 3.6%

4.1 We are also pleased to receive £8,000 from the Department of Health's Maternity Care Settings Fund. The money is being used to purchase reclining chairs and folding beds so that new dads can stay overnight, more comfortably, with their partners and babies, at Tunbridge Wells Hospital Maternity Unit.

5. We are improving the patient/visitor experience at Maidstone Hospital by extending visiting hours there. Visitors can now see patients from 8am until 8pm every day, which is consistent with visiting hours at Tunbridge Wells Hospital.

5.1 Our aim is to give visitors more flexibility to see friends and loved ones, while enabling our patients to spend more time with friends and relatives. We know this can make a positive contribution to many people's recovery after an operation, injury or illness.

6. Finally we have begun a significant engagement piece with our senior clinicians and ultimately all staff and stakeholders about our future strategy and vision. This is vital to ensure we have a sustainable high performing Trust going forward.

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
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TRUST BOARD MEETING – MARCH 2014

3-7	SUMMARY REPORT FROM THE QUALITY & SAFETY COMMITTEE, 05/03/14	COMMITTEE CHAIR (NON-EXECUTIVE DIRECTOR)

Summary / Key points:

The minutes of the last meeting were agreed and action log reviewed and updated. The following updates were received and discussed:

- Upper GI service, it was noted that issues relating to the suspension of the services was now in the public domain and communication with the families and other key stakeholders was on-going. The Clinical Advisory Group continues to oversee the implementation of recommendations from the Royal College of Surgeons Report and the revised pathway.
- Clinical Administration Units, the newly established Units are still experiencing some teething problems but issues are being resolved and clinic backlogs are being very closely monitored and work is being distributed as required. The Clinical Directors acknowledged there had been challenges but these are now starting to resolve.
- Patient Transport, the service provided via NSL remains below standard expected and is having on-going impacts on patient experience. In house solutions have been put in place to mitigate patient safety concerns whilst Trusts across the sector continue to work with the commissioners to resolve the issues.

Directorate Reports:

- **Surgery, Urology, Gynae-Oncology, Head & Neck:** Complaints response rates within agreed timescale is 50% this has been due to sickness/absence. This has now resolved and significant improvements are anticipated. Escalation beds remain a concern for overall quality of care, however mitigation is in place. No red risks reported by the directorate.
- **Trauma & Orthopaedics:** CQUIN for infection met, acknowledged that supporting statement is required to provide full assurance. Confirmed that the directorate currently has no red risks.
- **Women's & Sexual Health:** The report was noted with no significant issues to discuss. The report should include a benchmark against stillbirths and maternal deaths.
- **Specialty & Elderly Medicine:** Key issues are with the provision of stroke services across the Trust which was discussed as a separate agenda item. Vacancies within nursing remain high and a concern for the directorate. The Directorate now has a dedicated Matron to coordinate recruitment initiatives across the Directorate with a plan in place to have current vacancies filled by July.
- **Acute & Emergency Medicine:** Key issue is the number of vacancies medical and nursing, compounded by a number of individuals who withdrew after an offer had been made.
- **Diagnostics, Therapies & Pharmacy:** No Directorate issues of note. Reminder to all for rigorous review of antibiotic therapy. 4 red risks within the directorate which are being managed.
- **Cancer & Haematology:** Key issue for the Directorate relates to the lack of a pathway agreement to manage transfer of cord compression patients to a tertiary centre. This is being addressed and the risk is mitigated.
- **Paediatrics:** No issues of note to discuss.
- **Critical Care:** JAG accreditation received; 4 consultant vacancies; job plans have been approved by the College and are now out to advertisement.

Stroke Services: The committee spent time reviewing the Stroke Improvement Report. The improvement plan is to be further developed via the Trust Management Executive and to be discussed by the Board. It was recommended that stroke performance should be on the Board level risk register.

Stroke Improvement Report: Stroke improvement report was presented and discussed in detail. SNAPP data has been collected for two quarters, demonstrating underperformance for the year on a number of indicators to date, though there are some improvements noted in quarter 4.
Discussion was held around potential options for improvement. It was agreed that the Directorate should review the improvement plan. This should be discussed in detail at Trust Management Executive and options presented to the Board for consideration.

Quality Planning Checklists – submissions to the Trust Development Authority
The committee were informed of the planning submissions being made and that it is an iterative process with compliance declarations against a number of questions developed around the Care Quality Commissions 5 domains. Each of the declarations requires narrative in support of the declaration being made. There are areas within which further work and development of processes is required to achieve full compliance e.g. review of all deaths and Trust wide process for mortality monitoring.

External Agencies Visit: Updated external visit list noted.

Quality & Governance Dashboard: Noted.

Serious Incident Update: Noted. Attention was drawn to the significant improvements in VTE incidents compared to last year.

Quality Strategy: Quality Strategy has now been approved by the Board. It was noted that the strategy will probably need to be reviewed in the next 6 months.

Sub Committee Reports: The Committee received reports from the following committees:
- Health and Safety Committee
- Standards Committee
- Infection, Prevention and Control Committee
- Safeguarding Children's Committee
- Safeguarding Adult's Committee
- Clinical Governance (including Terms of Reference)
- Patient Environment Steering Group

Internal Audit update: Report noted.

Policy List: Noted. A number of the outstanding policies were presented to this meeting for approval or ratification as appropriate.

Policies for Approval/Ratification: The following were approved / ratified.
- Management of Stress at Work
- Incident Management
- Serious Incidents
- Window Restraints
- Organ and Tissue Donations
- Administration of Trust Committees

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 – MARCH 2014

3-8	SUMMARY REPORT FROM THE PATIENT EXPERIENCE COMMITTEE, 06/03/14	COMMITTEE CHAIR (NON-EXECUTIVE DIRECTOR)

Summary / Key points:

Actions Log and Matters Arising

- Research project undertaken by National Nursing Research Unit at Kings College London is due for publication in June. Summary of paper and findings will be brought to the committee after that date.
- Cancer Survey: has been presented to this committee, action plan has been further strengthened and presented to the Quality & Safety Committee.

Complaint Themes: A report covering complaints over the last two quarters was presented. The key emerging themes are delays and cancellations in outpatients. Incorrect diagnosis as a theme is significant with a number of these being upheld. The upheld number is relatively low compared to overall numbers. Clinical care is normally correct and to a good standard, however the failing generally relates to communication with the patient at the time. It was noted that both upheld and these not formally upheld complaints should provide a platform for learning. It was also noted that complaints often span more than one provider, and care should be taken to ensure the complainant gets a single cohesive response. It was confirmed that where a complaint spans more than one organisation there is a protocol in place to identify the lead agency, and for all parties to coordinate their responses to the lead agency to ensure the complainant gets a single response, unless the complaint wishes for an individual response. Learning from complaints is noted centrally, the method of dissemination is via the Clinical Governance Committee and directorate clinical governance meetings. It was noted that there had been a recent increase in complaints from gynaecology. A 'deep dive' of this service was planned for the next Clinical Governance Committee.

It was noted that the complainant satisfaction survey (satisfaction with the complaints handling process) had deteriorated. This was being further analysed and further work was underway to review the survey process as well feedback mechanisms.

Patient Information Leaflets Group (PILG) Report: The committee received a report outlining the work of the PIL Group to date, including the statutory and local requirements for the production of patient leaflets. The Committee was informed that the majority of the review work is undertaken in a 'virtual' forum the PILG does meet formally in person at least twice a year, and more frequently if required. The PIL Group is seeking more users and lay people to join the editorial group. Terms of reference for the group have been through a review. The committee approved the revised Terms of Reference. The Policy and Procedure for the development and production of patient information has been reviewed and the committee ratified this document.

Medicines at Discharge – Helpline Leaflet: An update on the work the pharmacy team are undertaking to improve the information given to patients about their medication and side-effects post discharge was given. A draft information leaflet detailing the availability of a helpline was circulated for information and comment. Work is being undertaken to liaise with community pharmacists and GPs to ensure they are fully updated on any changes or modification following drug therapy reconciliation as part of the hospital admission so that any changes will continue post discharge. This would allow for further patient education and information confirmation post discharge.

Dementia: Activity Coordinator pilot: A paper on the pilot activity coordinator role on Mercer Ward at Maidstone was presented. The pilot has seen some significant changes in the way

patients with dementia and their carers are supported. Measure outputs include: An increase in the utilisation of the 'This is Me' documents; A reduction in the number of 'nursing specials'; Therapy input being maintained more consistently during the day, once the therapists have left the ward; and feedback from family and carers has been positive. The pilot is now coming to a close. The cost has been factored into this year's business planning by the Directorate to ensure continued support. This links with the aspirations set out in the Dementia Strategy.

Surgical Assessment Unit Tunbridge Wells Hospital: The committee received a presentation on the role and function of the Surgical Assessment Unit (SAU) at TWH. This unit was originally planned to be based on Ward 11. However the bed base there proved to be inappropriate and required a review of the surgical pathway. The rational for the SAU is to improve the patient journey, experience and to reduce avoidable admissions. The Unit is consultant led, and takes referrals from GPs, Emergency Care, Maidstone Hospital, Outpatients and Clinical Nurse Specialists. Patients are triaged, treatment commenced and then transferred, as appropriate, to short stay (<48hrs), in-patient bed (>48hrs). private patients unit or back to GP. Success criteria include the number of surgical A&E breaches – 74 this year to date compared to 207 in 2012/13.
Zero length of stay has increased. Plans for the future include; dedicated planned lists improved access to diagnostics, development of advanced practitioner role and the development and implementation of ambulatory care pathways

Healthwatch Update: The Chief Executive of Healthwatch Kevin was welcomed to the committee. An overview of the role and function of Healthwatch was given to the committee. It is about gather views across the whole community, including 'hard to reach' groups and working with health providers to respond to the feedback. Healthwatch have a number of initiatives in place such as a Freephone information signposting service. Healthwatch confirmed they do not deal directly with complaints but will assist a complainant by referring them back to the provider complaints team or to an advocacy service as appropriate. People who do not wish to complaint but who do wish to raise concerns can contact Healthwatch who will collate and feedback – complimenting the work of PALS. Healthwatch will engage with the public using networks that already exist. Healthwatch will continue with 'enter and view' visits (excluding children's services). Healthwatch are recruiting volunteers to help with research and visits. 26 have been appointed with interviews in place for a further 23 over the coming weeks.

Therapies update: The committee received a presentation on work the Therapies team are undertaking to improve the patient experience and work towards 7 day service.

- There are 13 areas being looked at currently including services/topics such as:
- Improved communication service for acquired communication disorders
- Oral care programme
- 7 day admission avoidance programme
- 7 day occupational therapy service
- 7 day physiotherapy service
- Improvements in equipment procurement and provision
- Working with CCG colleagues to develop a range of services for on-going care including TADS and STARs.

Patient Experience Dashboard: A patient experience dashboard is being developed to allow triangulation of a patient experience and a draft will be brought back to the committee for consideration.

Quality Strategy: The committee received an update on the Quality Strategy. This is the first document of this nature for the Trust. .It is likely to require further review in the next 6 months and will need regular review thereafter. The Strap Line 'Care and Compassion' is currently being tested.

Survey feedback: Overall satisfaction is remaining steady at >95%. Comments about food and nutrition remain positive overall. FFT – focus has been on returns for A&E and in-patients. As

response rates have risen, NET promoter scores have remained static which is good. Indicating that overall quality of care is good. Whilst response rates are improving, we could significantly improve these across all areas. The Trust is working further with IWantGreatCare to explore other strategies to improve response rates.

Cancer Survey Action plan: a verbal update was provided. The Action plan is addressing 10 key areas. Actions are in place and on-going. Work in being undertaken to provide information on prescription charges and recruiting a benefits advisor – the latter in collaboration with Macmillan Caner Care.

Maternity Survey: The committee was provided with feedback on the maternity services survey. This is undertaken nationally every three years. This is the 3rd such survey undertaken by the CQC. Target group was every woman who delivered in February 2013. The trust scored best in country in 5 areas: Ensuring a positive experience at the start of their care; Women felt listened to Women felt personal circumstances were taken into account; Hospital room was clean; and Toilets and bathrooms were clean. The trust scored poorly on staff not introducing themselves when entering a room. Action plans are in place to address this, along with local 'real time' survey to monitor impact of interventions.

Health Informatics Strategy: The committee was provided with a brief overview the health informatics strategy INSPIRE. The strategy has 6 key points. Near patient data entry providing real time information on patient care and clinical observations I s currently being trialled The committee is to receive a more detailed presentation about the near patient data pilot at the next meeting.

Committee Risk Report: Committee risk register reviewed. 1 principle risk related to patient satisfaction survey

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

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TRUST BOARD MEETING – MARCH 2014

3-9 QUALITY AND SAFETY REPORT — CHIEF NURSE / MEDICAL DIRECTOR

Summary / Key points

The attached paper provides a summary of key issues within the quality and patient safety agenda.

The report has been written to align with the Quality Governance Framework structure of Safety, Effectiveness and Experience.

The report covers the following key areas:

- Mortality
- Safety Thermometer
- Infection Prevention and Control
- Hospital Acquired Pressure Ulcers
- Falls
- Serious Incidents
- Incidents on Datix (update on current position)
- Stroke Performance
- Complaints (Appendix 1)
- Friends and Family Test
- Improvements in the patient environment
- CQC Intelligent Monitoring Report – March 2014
- CQC – Whistleblowing Alerts

Key area for the Board to note is further work and focus required to reduce harm caused from falls, February has seen the lowest rate of complaints per episodes for this financial year, C difficile objective for 2014/15 is a maximum of 40 cases and the CQC March Intelligent Monitoring Report has been published and the Trust has maintained a band 5 as previously.

Which Committees have reviewed the information prior to Board submission?

- Quality and Safety Committee, 05/03/14

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

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

[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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Clinical Quality and Patient Safety Report

March 2014

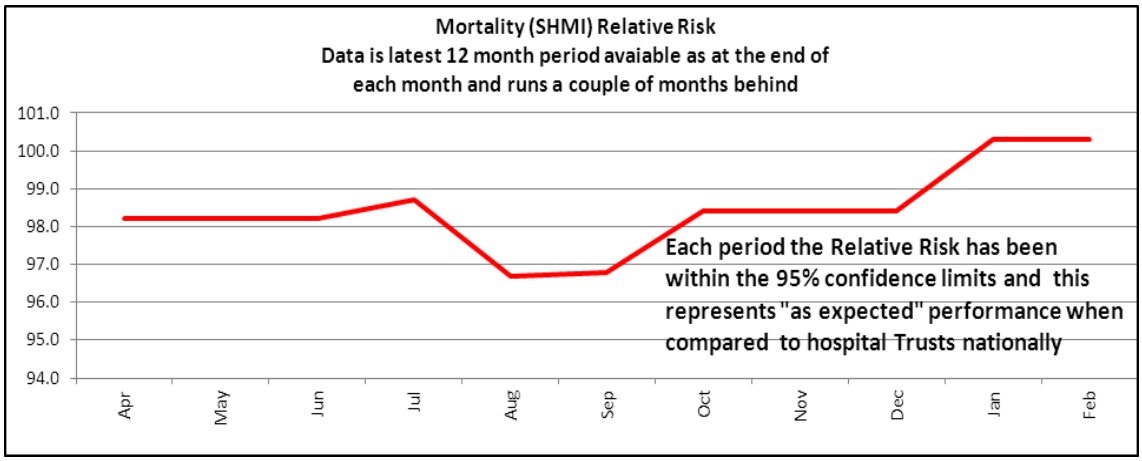
This report outlines the key patient safety and quality issues that have been reported through the governance framework year to date. A summary of key trends and actions of the Trust's performance against clinical quality and patient safety indicators in 2013/14 is provided in the Integrated Performance Report dashboard and supporting narrative. Performance is monitored via the Trust Management Executive and Quality and Safety Committee.

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

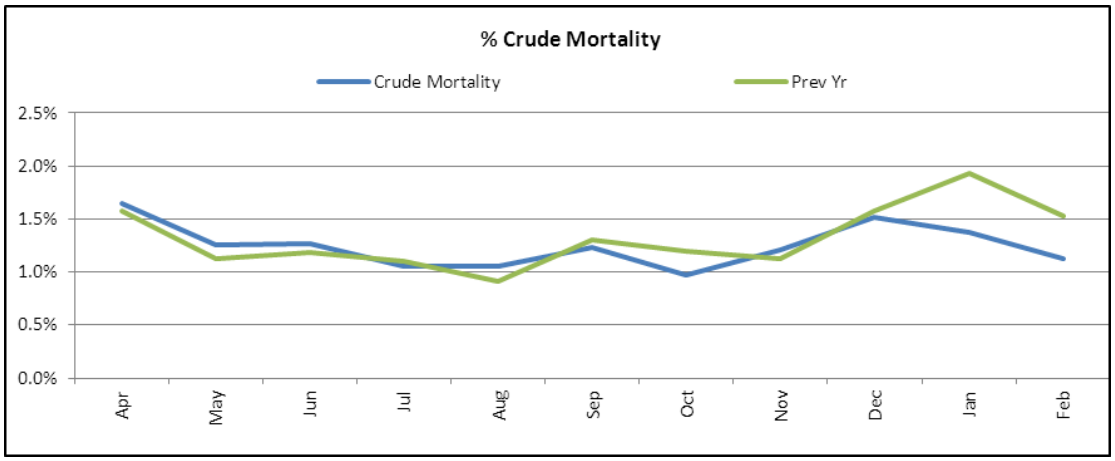
Patient safety

Mortality:

The Summary Hospital-level Mortality Indicator (SHMI) - The year to date data is 100.3.



Crude mortality rate remains low at 1.2%.



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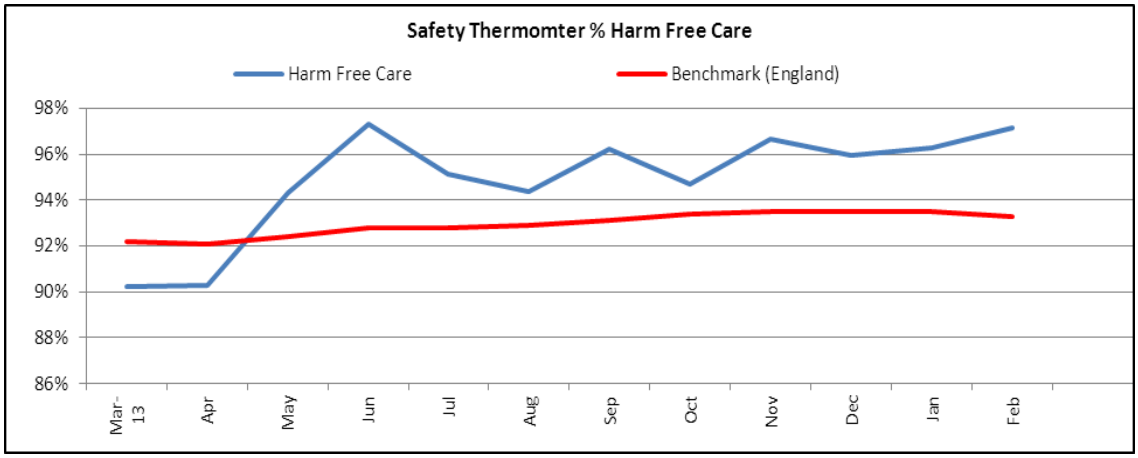
In hospital mortality reviews

It is a requirement that all deaths where care has been judged as being suboptimal undergo a multidisciplinary team review with outcomes reported to a Mortality Review Committee (MRC). The MRC, Chaired by the Medical Director, will receive information from directorate multidisciplinary teams regarding mortality within that area. In addition information will be brought to the MRC from the central governance team such as complaints, incidents and litigation. The MRC will meet in April and bi-monthly thereafter.

Safety Thermometer: - measures pressure ulcers, patient falls resulting in severe harm, catheter associated infections and hospital acquired venous thromboembolism).

The national benchmark is 93.5 % of patients receiving harm free care. The graph shows that the benchmark is now static whereas our position is being sustained and improved. We have been consistently delivering above the national standard. Of the 670 patients surveyed in February 97.2 % received harm free care. The internal audit report (audit undertaken in January) confirms significant assurance for the methodology used to collect and validate the data monthly.



Infection Prevention and Control

The Trust threshold for Clostridium difficile 2013/14 is 42 cases. The Trust position at the end of February 2013 is 32 cases against a maximum limit of 39 cases. This equates to a rate of 11.0 per 100,000 beddays (national benchmark rate is 18.9). The root cause investigations into C diff cases continue to show the on-going need for robust antibiotic stewardship, an area which still requires further improvements.

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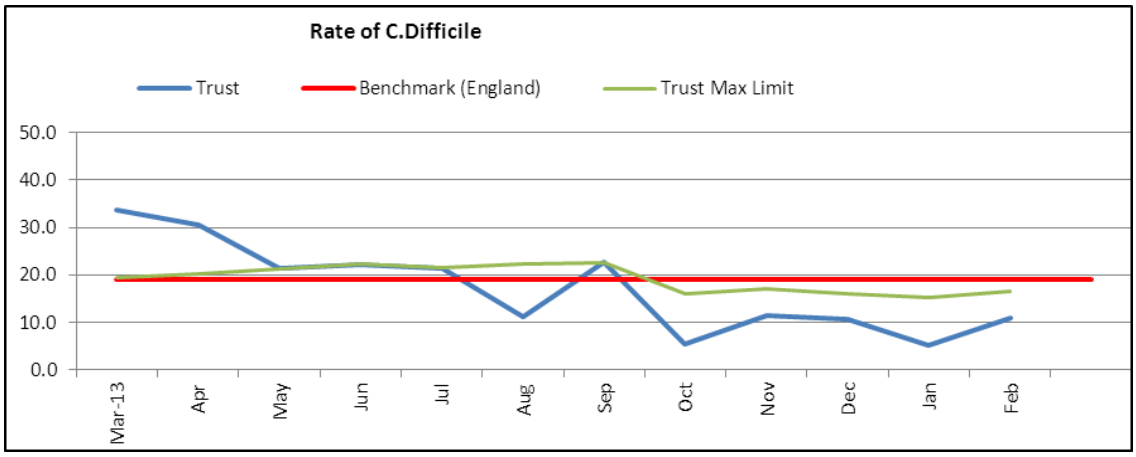
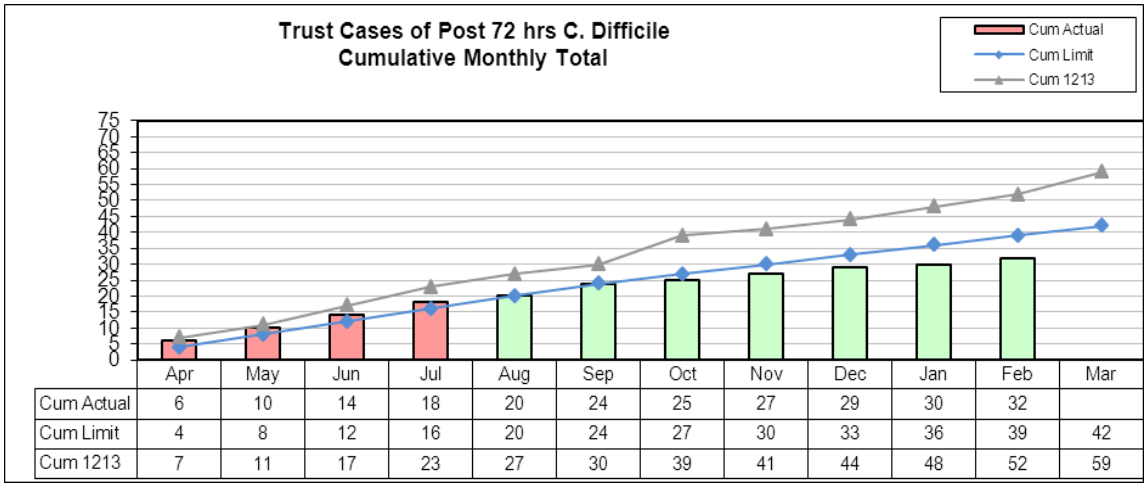




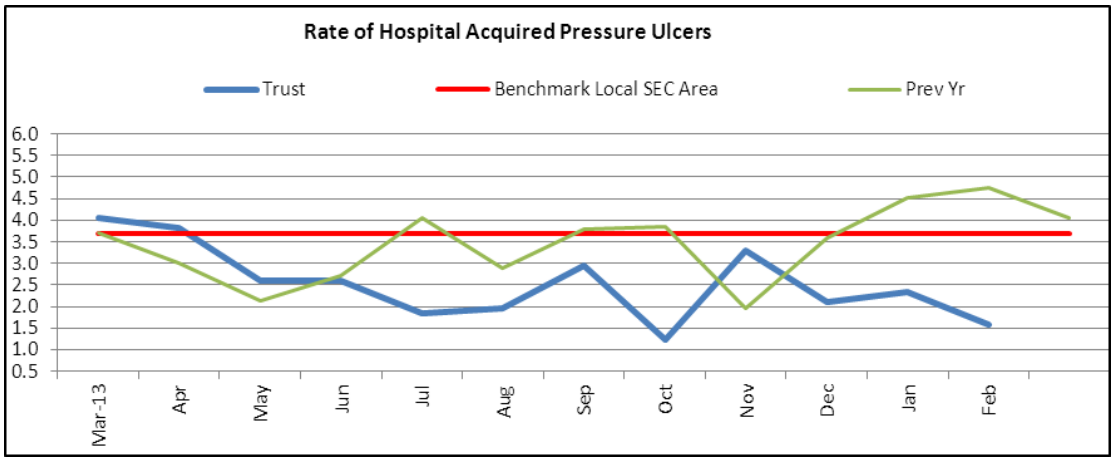
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cum Actual	6	10	14	18	20	24	25	27	29	30	32	
Cum Limit	4	8	12	16	20	24	27	30	33	36	39	42
Cum 1213	7	11	17	23	27	30	39	41	44	48	52	59

The objective for 2014/15 has now been published and the limit is 40 cases.

There was one case of MRSA bacteraemia declared for February. The Serious Incident investigation thus far has been unable to conclude the root cause of the bacteraemia.

Hospital Acquired Pressure Ulcers

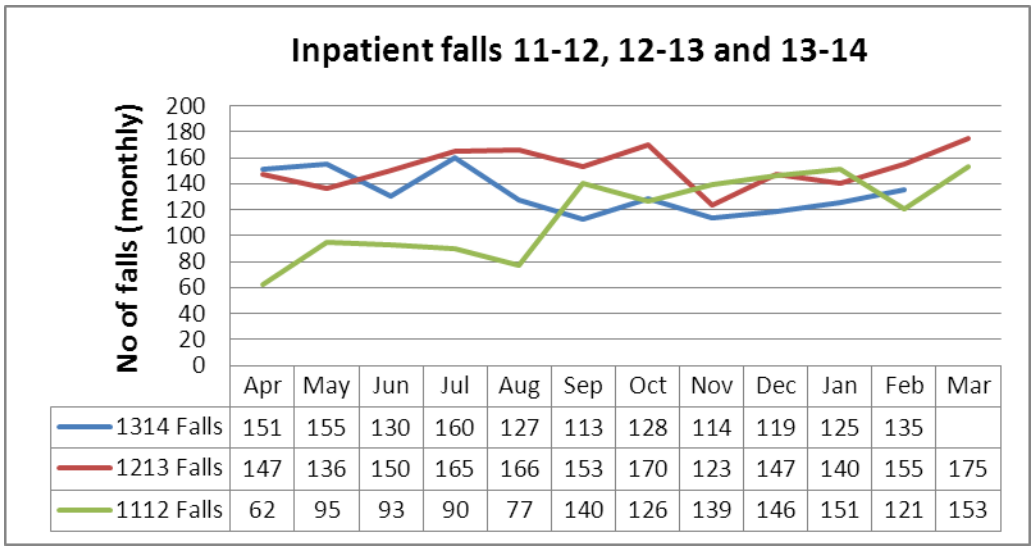
The threshold for hospital acquired pressure ulcers (HAPUs) is 3.0 per 1,000 admissions. There were 7 cases reported for February which equates to a rate of 1.6 per 1,000 admissions. No grade 3 or 4 pressure ulcers were reported for January and February. Pressure damage prevention data triangulated with safety thermometer data show the reductions are consistent.



Patient falls

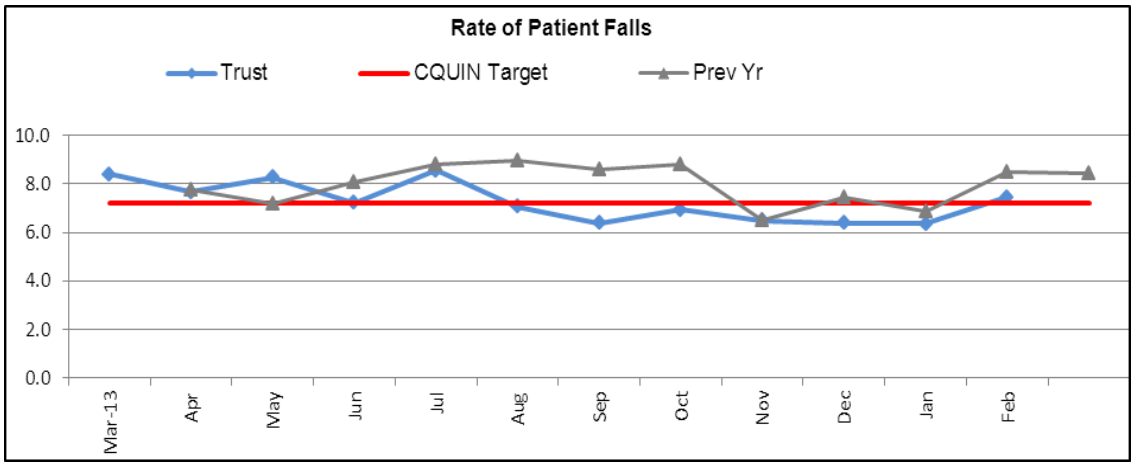
The threshold for patient falls is 7.2 per 1,000 occupied beddays. This threshold has been agreed with the Clinical Commissioning Group as part of the falls CQUIN in the absence of a national benchmark. In February 135 falls were reported and in January 125. The rate of falls for February is 7.5 per 1,000 occupied beddays.

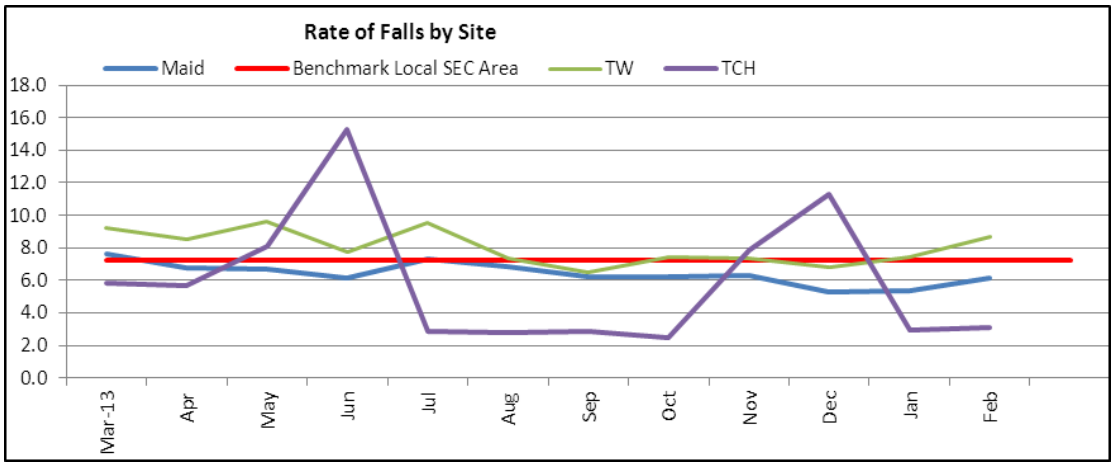
The graph below shows there has been significant improvement in overall numbers when compared with the same period last year. However this remains an area of concern.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1314 Falls	151	155	130	160	127	113	128	114	119	125	135	
1213 Falls	147	136	150	165	166	153	170	123	147	140	155	175
1112 Falls	62	95	93	90	77	140	126	139	146	151	121	153

The graphs below show the overall Trust position and the rate split by site.





The falls resulting in harm were discussed at the serious incident panel and it was noted that although overall numbers have been improving slowly the harm caused to patients following a fall has not reduced when compared with the same period last year with approximately 4 to 7 serious incidents relating to falls being declared per month. In addition to the work already underway in this area to achieve further improvements is going to require Trust wide multidisciplinary engagement to drive this forward as the next major patient safety area of focus.

Serious Incidents

There has been significant work undertaken both by us and the CCG to complete SI investigations within the stipulated timeframes. At the end of February there were 21 SIs open with MTW of which 4 had breached. The Trust ensures there is attendance at the CCG SI closure panel meetings by the Deputy Chief Nurse and a member of the patient safety team.

In January 5 SIs were declared and 12 for February; the key themes are as follows:

January

1. Allegation of Assault
2. Fall fracture
3. Fall fracture
4. Fall haemorrhage
5. Fall fracture

February

1) Delayed diagnosis
2) Delayed diagnosis
3) Electrical power failure
4) Unexpected admission to neonatal unit
5) Allegation of assault
6) Fall fracture
7) Fall fracture
8) Fall fracture
9) Fall fracture
10) Fall sub dural bleed
11) Fall sub dural bleed
12) Fall sub dural bleed

Incidents on DATIX (Risk Management System)

There has been a reduction in the number of open incidents on DATIX. At the last board 2,507 incidents were reported as being open. As of the 13th March there are a total of 1,446 open incidents, a decrease of 1064.

The directorates are focussed on investigating and following due process to close incidents with support from the patient safety team. Acute, emergency and specialist medicine have made particular progress in reducing number of incidents open.

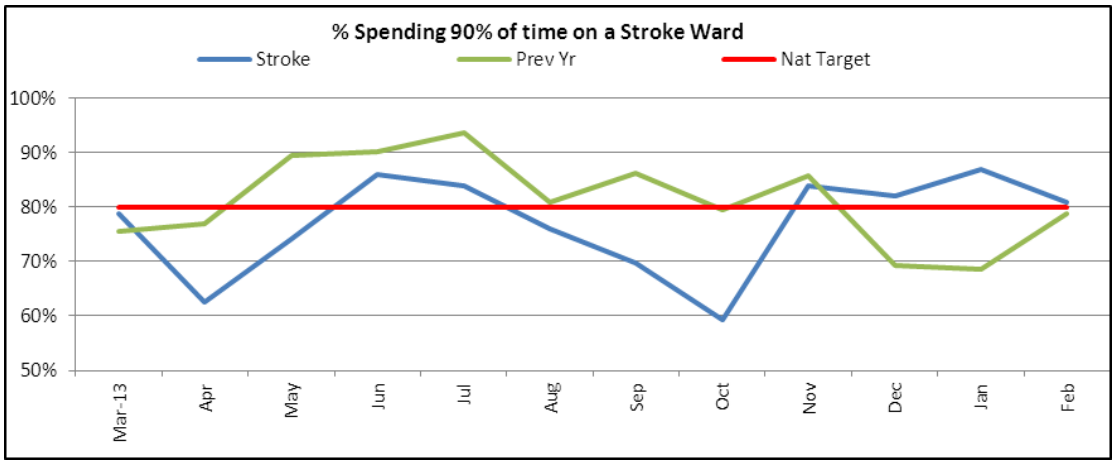
Key Areas of Concern

- Delay in reporting the incident onto Datix
- Handlers validating the incident information following investigation; for example severity of harm
- Length of time taken to investigate and request closure
- Attaching of evidence to the incident to enable closure
- Feedback to the reporter of the incident

Effectiveness

Stroke performance - % of patients spending 90% or more of their time on a stroke ward

Performance for February is 80.8%. YTD performance is 76.8 %. Although this standard will not be met for 2013/14 the December, January and February is a significant improvement.

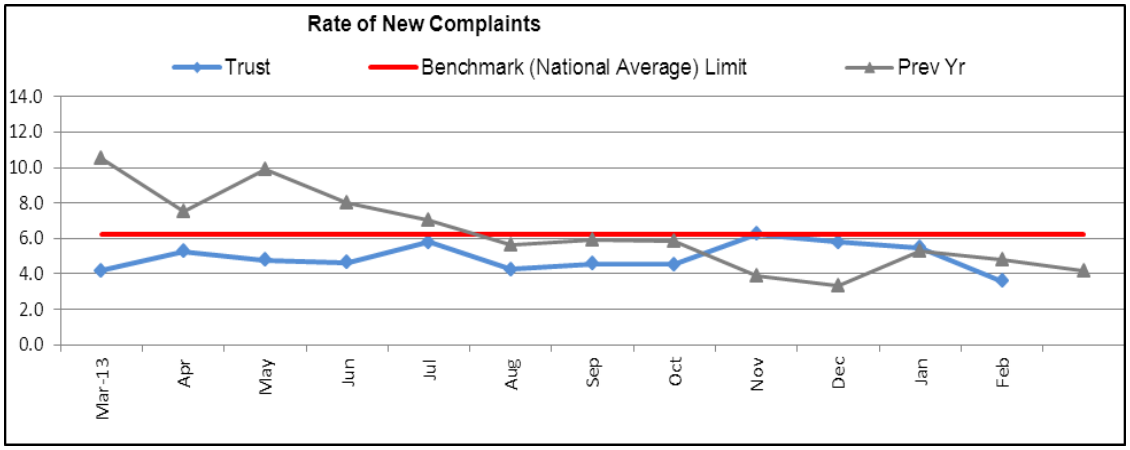


The stroke pathway is currently under review to ensure that all necessary steps are being taken to improve the service we deliver now and in the future.

Experience

Complaints

The threshold for complaints is a rate of 6.26 new complaints per 1,000 episodes. The YTD position is 5.01. In February the Trust received 32 new complaints (rate of 3.59 new complaints per 1,000 episodes. February has seen the lowest rate of complaints per episodes for this financial year.



79.1% of complaints in February were responded within the stipulated time frame. Following a dip in performance in January, February achieved the highest response times.

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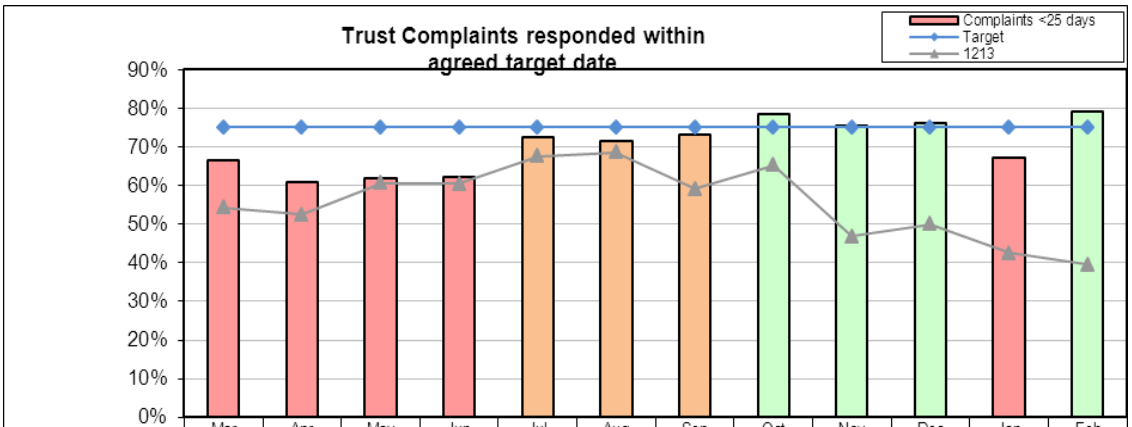


	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Complaints <25 days	66.7%	60.9%	61.8%	62.2%	72.3%	71.4%	73.1%	78.4%	75.5%	76.1%	67.2%	79.1%
Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%
1213	54%	53%	61%	60%	68%	69%	59%	65%	47%	50%	43%	40%

The patient experience committee received a report showing the analysis of complaints over quarters 2 and 3, 2013/14. (This is attached in appendix 1 for information). Poor communication is a key theme within the complaints received and this is an area for focus in the training being provided as well as how to respond effectively and efficiently to complaints.

An introduction to managing patient complaints and concerns is provided to every new member of staff as part of the corporate Trust induction programme. A session entitled 'Patient Experience' is presented by a senior member of the complaints and PALS staff, with emphasis on the need for a proactive response by staff to issues raised by patients and relatives. This aims to encourage staff to reflect on the response they would seek if they were raising a concern or complaint and highlights some key elements to successfully managing issues in the frontline environment.

Further training is delivered by the complaints staff internally, targeted at staff with responsibility for investigating and preparing responses to complaints. This session is underpinned by the principles of good complaints handling as identified by the Parliamentary and Health Service Ombudsman and their application in the investigation of complaints. The training explores case studies and offers opportunities for delegates to recognise features of good practice and discuss challenges or areas of uncertainty. Particular emphasis is placed on evidence gathering and the need to provide robust, evidence based conclusions.

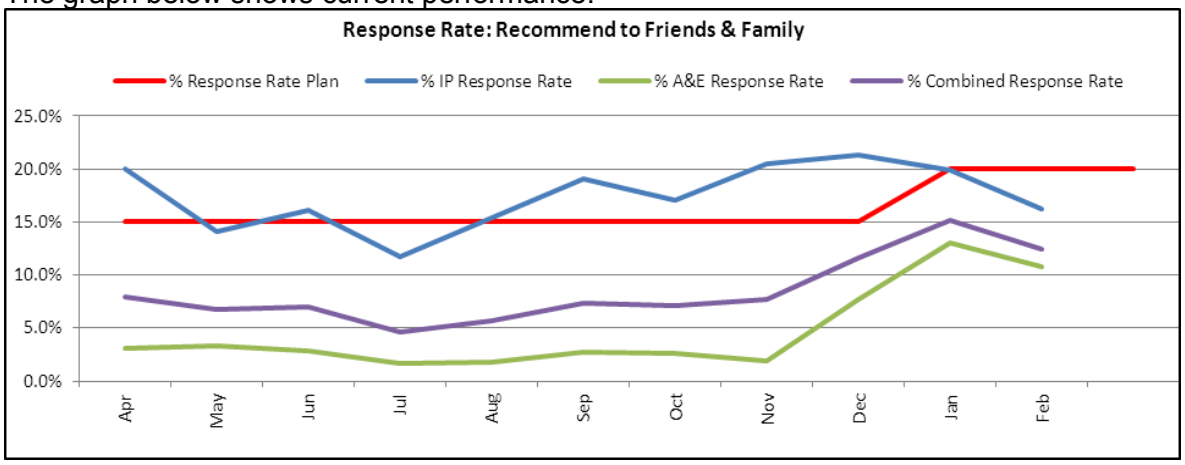
Over the last few years, the Trust has worked in partnership with Canterbury Christchurch College (CCC) to deliver an interactive training day on managing complaints. This was initially targeted at key staff Band 7 or above, but was then extended to other key frontline roles. This training involves actors playing the parts of patients or relatives and offers staff the opportunity to 'practice' resolving concerns in a 'safe space'. As part of the programme, delegates complete an activity which helps them to better understand their responses to situations when under pressure (as one might encounter when dealing with angry or distressed customers). There is also a session presented by Trust staff on responding to formal complaints which is based around the complaints training described above.

In terms of addressing the causes of complaints, the Trust runs a number of courses open to staff on effective communication and customer service although these are often targeted at more junior staff, for example, receptionists. Data gathered from complaints shows that the majority of complaints we receive are made against poor communication from doctors and training is already available to medical staff around communication, managing patient expectations and customer service. However, we are seeking how this can be further strengthened and effective techniques for engaging medical staff in any future e - training programmes.

The Learning and Development are continuing work with Christchurch Canterbury to develop a course focusing on how all Trust staff contribute to the overall patient experience utilising interactive training techniques and patient stories.

Friends and Family Test

The graph below shows current performance.



Data collection and results
A postcard style survey asking the mandatory friends and family question followed by the option to provide free text comments is given at the point of discharge to all A&E and inpatients, patients are then asked to return the card in the dedicated box located on the ward / department. In addition patients have the opportunity to complete their feedback via the MTW webpage.

The data is updated on a monthly basis following the Trust's submission of data via the Unify system. Although the national target is 15%, for the CQUIN the target is 20% for Quarter 4 (Jan, Feb and March combined). Response rates from April 2013 – February 2013 ranges from 11.77%- 20.06%. Our Emergency Department scores initially were poor but with increased focus from December 2013 there has been evidence of improvement; from April 2013 response rate 3.05% to up to 13.09% in January 2014. For January and February combined to date the combined response rate is 13.8%. This increased response rate is still currently below our 20% target. As the performance for January and February is currently 13.8%, the Trusts needs to achieve around a 32% response rate for March in order to get 20% for Quarter 4.

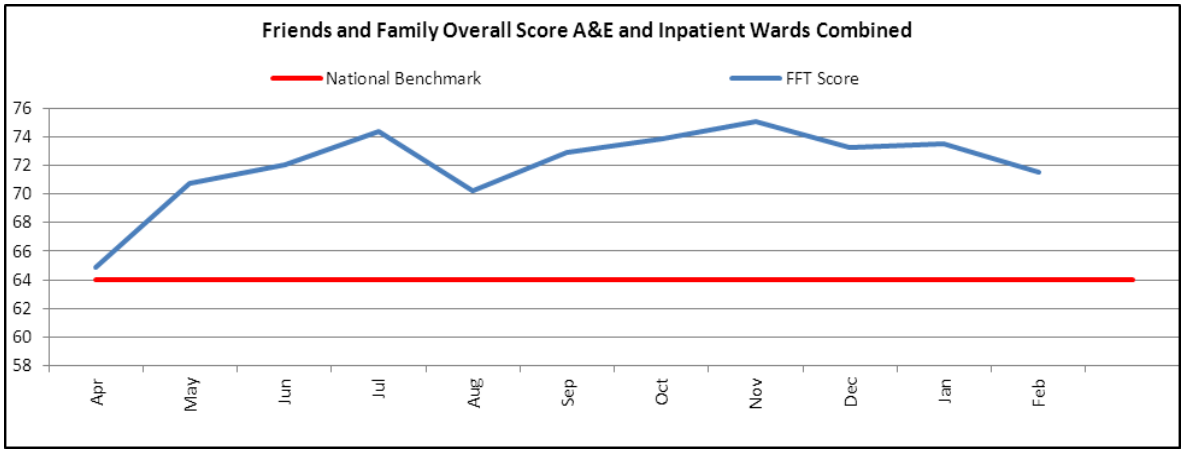
IWantGreatCare (IWGC) National league position
As a Trust we use a survey company 'I Want Great Care' to collate our response forms. The company produces a league table of response rates from all 32 trusts that they collect and review data for. Comparative trusts are achieving response rates of

up to 70% and with 75% of trusts within the league table achieving over 20% return rates. As such currently MTW are within IWGA league table bottom 5 Trusts with the lowest percentage response rates.

Currently, contact is being made to gain insight into how these Trusts achieve higher than average response rates. Initial feedback from two trusts, using the same parameters (survey cards and feedback from internet) stated that this is a high agenda initiative, with trust-wide support and an identified lead. Both trusts have high level of staff engagement and operational directorate support and accountability.

Next steps
The need to improve our response rates is a given and remedial measures to address this have been implemented, with all patients waiting in the discharge lounge to be transferred from hospital care reminded to complete their 'friends and family' survey. A&E response rate is recorded on the daily 'site report' to enable on-going monitoring. All Friends and Family free text comments are shared with Ward Sisters and Matrons, who are encouraged to share them with staff to identify any areas of good practice or any areas for action. Results are also displayed on ward public facing 'Knowing how we are doing' boards. Patient feedback to date has been very positive across all clinical areas, which has been very much appreciated by staff. However, it is evident collecting the data must be a priority for all staff and success of doing this requires further engagement and accountability from the Directorates and the clinical areas, with support and leadership to continue from Corporate Nursing & Trust Management Executive.

The combined Friends and Family score is consistently above the national average. 72 (net promoter score) was achieved for February.



<u>Improvements in the patient environment</u>

The inter-ward spaces at Tunbridge Wells Hospital have been recognised as an under utilised opportunity for some time. The use of this space had previously been considered as a potential waiting for discharge area. Some wards are using the space as a waiting area for arriving elective patients or for patient education sessions.

These areas were included in a mapping exercise as part of the Dementia Strategy along with the day rooms within the ward areas. The Dementia Strategy has as one of its strategic aims stated:

We will become a dementia friendly organisation with environments and processes that cause no avoidable harm to patients with dementia.

Objectives:

- By the end of 2013 all our care environments used by those with dementia will be assessed against the Kings Fund Enhancing the Healing Environment (EHE) Environmental Assessment Tool (2012). The results of this will support all new estates and facilities developments for our hospitals designs.

- All service and environmental improvements will consider the impact of change on patients with dementia.

Current Position:
A base line review was undertaken in 2012/13 to establish needs for all in-patient areas.

Patient Environment Action Team (PEAT) funds were utilised to provide clocks with day and date, provision of feeding aids, puzzles, and a variety of other items that would enable ward staff to keep patients with dementia or other cognitive impairment orientated and stimulated. The Dementia Collaborative provided monies to implement or run pilot schemes that would improve dementia in an acute setting.

Some of this money was used to create a 'Dementia Café' in the reception area to Ward 20 at Tunbridge Wells Hospital. A similar scheme was adopted on Mercer Ward, with investment made in the pre-existing day room.

These initiatives have been met with overwhelming enthusiasm and a desire to replicate across the whole trust.

Whilst these improvements are indeed positive, they are not necessarily appropriate for all areas.

The base line audits undertaken previously need to be reviewed and assessed with environmental investment in mind. Some areas will benefit from a replication of Ward 20, however other areas such as Wards 30 and 31 have a greater need for improved seating to provide a suitable waiting area for patients with weight bearing joint problems, as this area is utilised by the elective patient cohort prior to a bed being available for them on the ward.

Other wards use the inter-ward space for education activity for patients, carers and staff.

Consideration is also being given to enhancing the existing ward based day rooms. A number of wards are keen to utilise the space for lunch clubs and other patient centred activity. These rooms are currently uninviting and lack comfortable seating, writing or eating surfaces.

Next Steps:
A review of requirements is underway. This is supported via the Patient Experience Matron and Dementia Lead Nurse. Both the inter-ward spaces and ward day rooms have been included and initial discussions with ward teams for most appropriate use is almost complete.

Ward managers are best placed to guide on the operational demands of their service, the implications for staffing and patient safety and thus how best to use the space. This will inform the wider action plan and implementation programme.

The Patient Environment Steering Group will provide oversight to ensure any recommendations and action are in line with planned refurbishments or compatible with maintenance processes with PFI partners for the Tunbridge Wells Site. A full plan will be developed over the next 2 -3 months and will be factored into the estates work where appropriate.

Budgets will need to be identified, depending of scale of works required it may be possible to utilise the PEAT/PLACE Budget, however this budget has not yet been confirmed for 2014/15.

On going review of this will be monitored by the Patient Experience Committee via the Patient Environment Steering Group.

CQC Intelligent Monitoring Report

The CQC Intelligent Monitoring Report for March is now available on the public website. The Trust has band/score of 5 as previously.

There has been a change in the type and level of risk, but no elevated risk.

There 6 risks noted, though it should be noted that some data (Hip Fracture Data base for example) is significantly out of date by the time it reaches the public domain. The CQC will only use data that has already been published.

The risks noted relate to:

1. Secondary prevention medication for eligible patients
2. Cerebrovascular outcomes (composite mortality)
3. Hip Fracture database (compliance with all 9 standards)
4. ESR (Staff stability), non-clinical staff
5. Maternity Survey (staff introducing themselves)
6. NHS Trust Development Authority Escalation level

These risks have been subject to some internal scrutiny. There are some compelling clinical reasons for the apparent non-compliance with secondary prevention medication which needs to be explored further in terms of national reporting.

There have been improvements with compliance and data capture in relation to the Hip Fracture database. However, the improved dataset has not yet been published and therefore is not being used by the CQC for this reporting period.

Maternity services have in place an action plan to address the issue of staff introductions and this is being monitored locally with near real-time feedback surveys.

CQC – Whistleblowing Alerts

Since November 2013 the CQC has contacted the Trust three times to inform and discuss issues that have been brought to their attention either by patients that have used our services or members of our staff.

They have been informed of the following issues:

1. A patient who had been seen in an outpatient clinic at Maidstone Hospital informed the CQC that during the Consultation the Doctor had used inappropriate language. Although this had not been directed at the patient and was a more general expression of frustration this had clearly made the patient uncomfortable. This case has been investigated and managed accordingly.

2. Two staff members working at Tunbridge Wells Hospital had a heated exchange with allegations of physical assault outside of work. One of the staff members informed the CQC but not the Trust at the time. This incident was investigated internally and by the police.

3. The CQC informed us of a complaint they had received from a family who were distressed at the delay of their loved one being transferred to Kings Hospital from Tunbridge Wells Hospital. Although the family acknowledged that staff at TWH appeared to be doing everything they could to expedite the transfer they were becoming increasingly distressed. This case was declared and managed as a serious incident and concluded that the patient should have been transferred three days earlier if escalation (to site director level) had taken place sooner.

Maidstone and Tunbridge Wells NHS
NHS Trust

REPORT TO: **Patient Experience Committee**

REPORT FROM: **Angela Savage, Complaints & PALS Manager**

DATE: **27 February 2014**

SUBJECT: **Themes and learning from complaints**

Introduction

This paper has been produced by Angela Savage, Complaints & PALS manager, to offer the Patient Experience Committee an overview of the numbers of complaints the Trust has received from our service users, the main subjects raised in complaints and outline some of the learning which has taken place as a result of complaints.

Background

This is the third paper on complaints and concerns produced for the Patient Experience Committee and builds on previous reports presented to the Committee in 2013. It will concentrate on complaints received during quarters 2 and 3 of 2013-14 (July – Dec). The Trust received 139 formal complaints in quarter 2 (Jul – Sept) and 164 formal complaints in quarter 3 (Oct – Dec).

Complaint themes

Data is captured from every complaint made to the Trust. The Department of Health require the Trust to submit details of the number of complaints made about a defined list of subjects. However, as some of these are considered to be quite broad, the Trust break these down further into sub-subjects.

The main subject (as required to be reported to the Department of Health) raised in complaints received in quarters 2 and 3 2013-14 are shown in charts 1 and 2 and clearly demonstrate that the main subject raised related to all aspects of clinical treatment. Seventy-four complaints about all aspects of clinical care were received in July to September; 80 were received in October to December.

In addition to these, significant numbers of complaints have been received across both quarters relating to communication, outpatient appointment delays/cancellations, admissions and discharge arrangements and staff attitude.

Further detail on the complaints relating to clinical care can be found in charts 3 and 4.

Chart 1: Main subject of complaints received in Quarter 2 2013-14 (Jul – Dec)

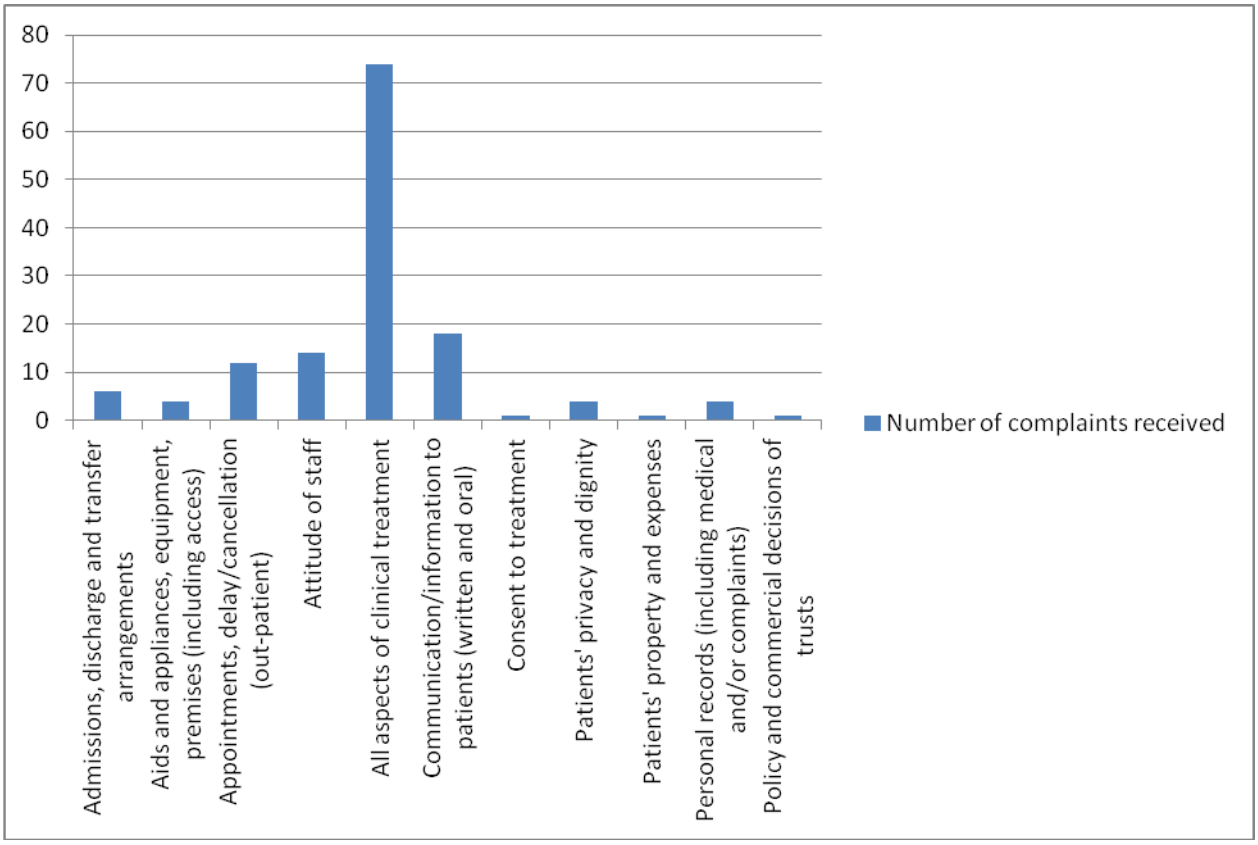


Chart 2: Main subject of complaints received in Quarter 3 2013-14 (Oct – Dec)

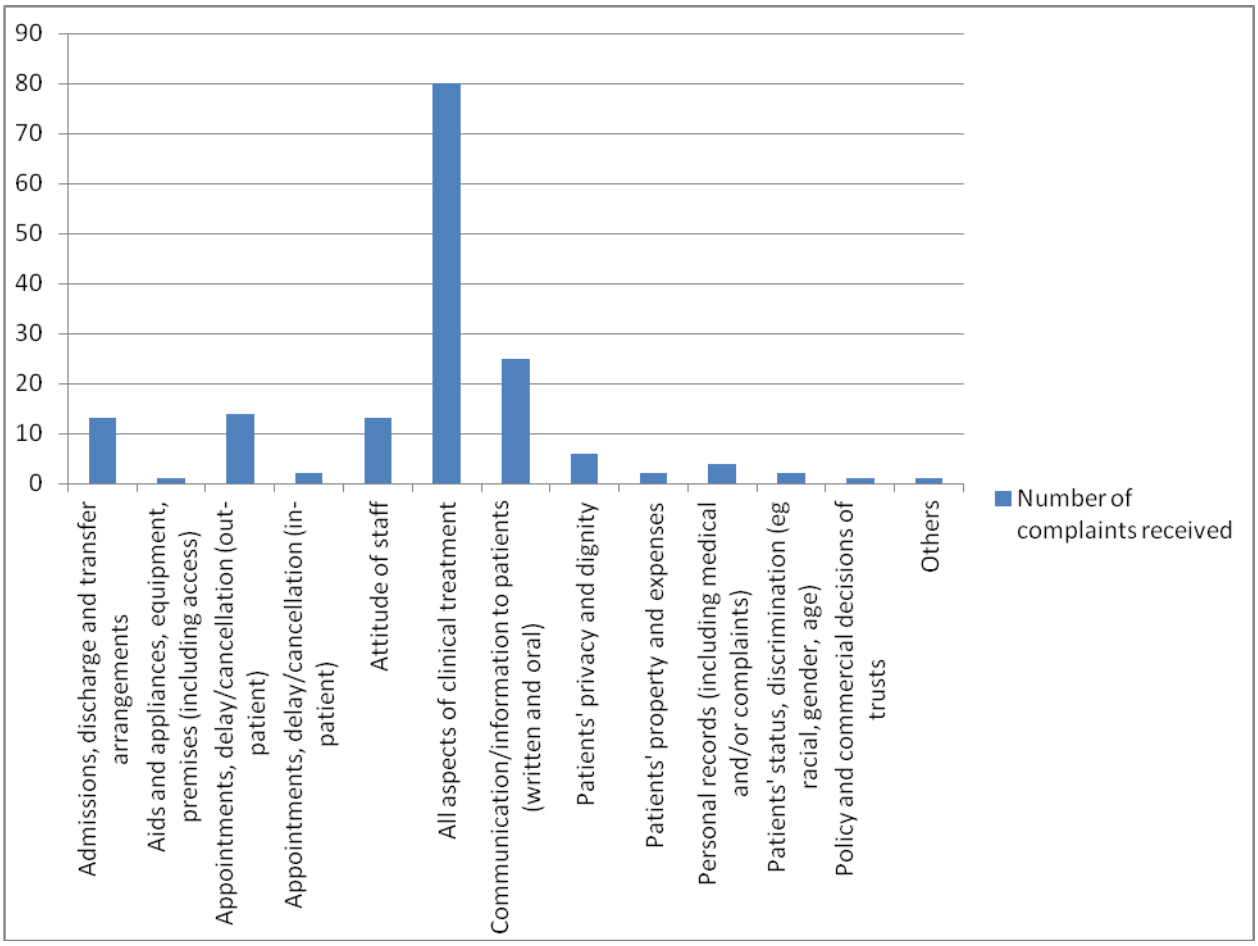


Chart 3: Primary sub-subjects of clinical care complaints received in Quarter 2 2013-14

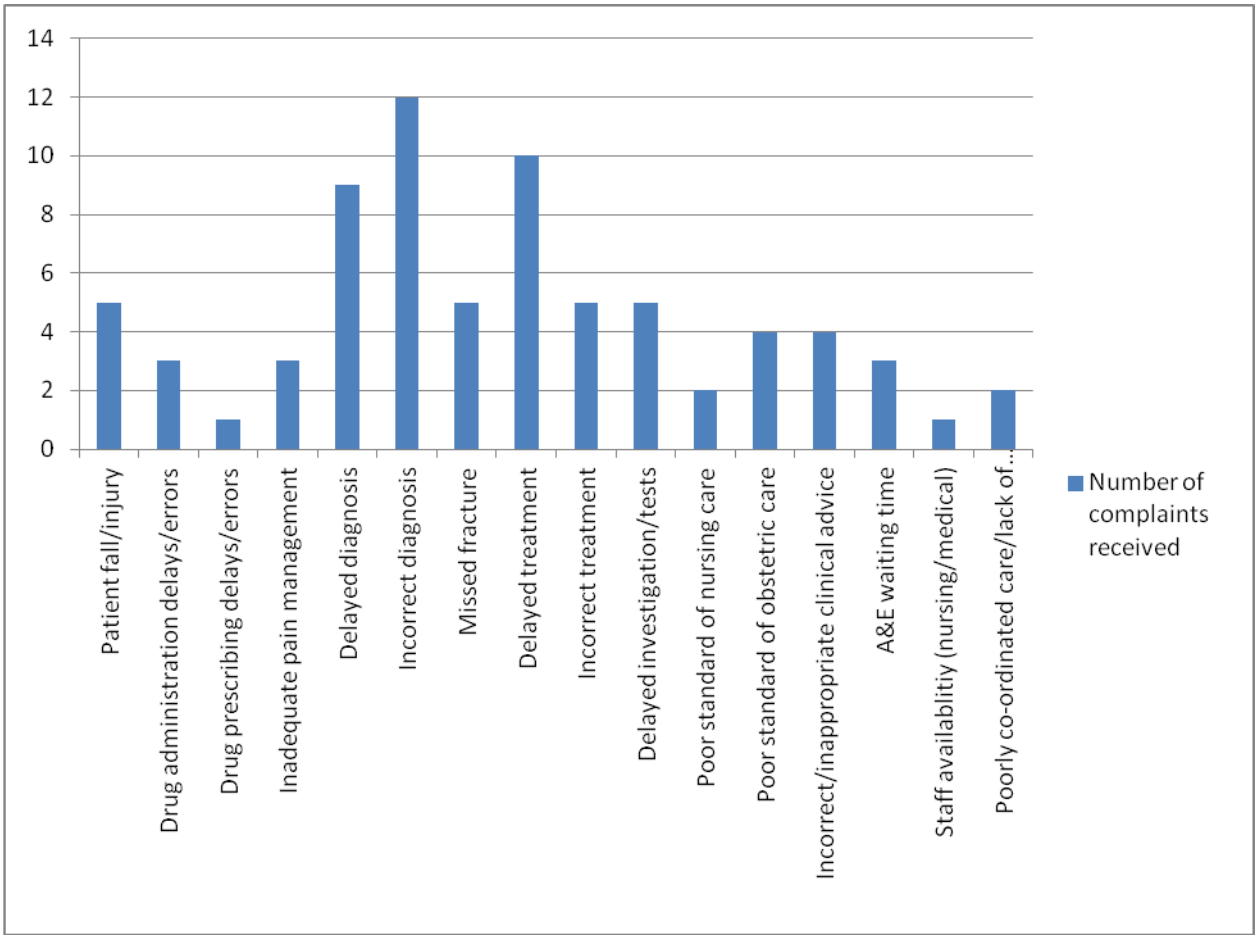
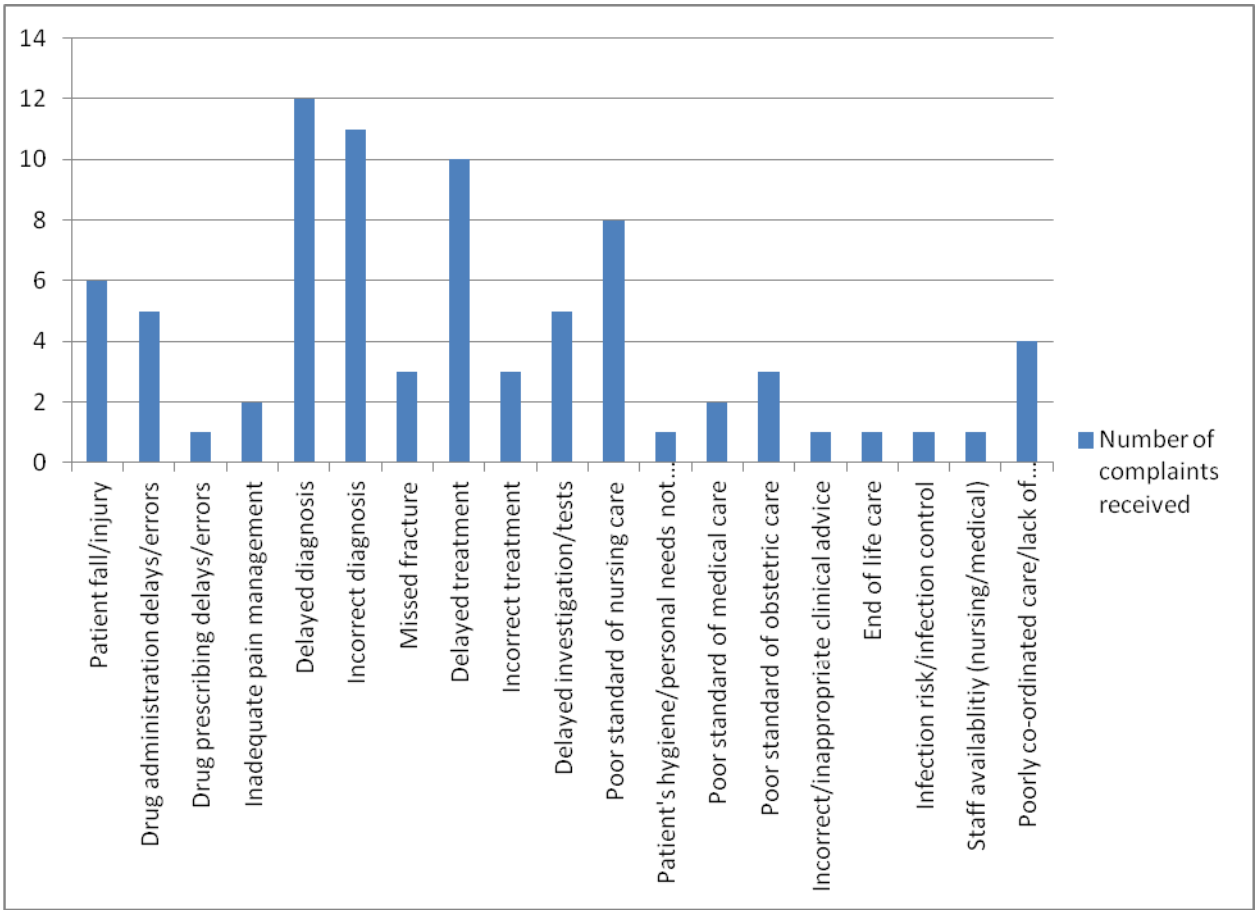


Chart 4: Primary sub-subjects of clinical care complaints received in Quarter 3 2013-14



Comparing the data for the quarters reported on, we can see that the most frequently raised primary sub-subject in complaints were:

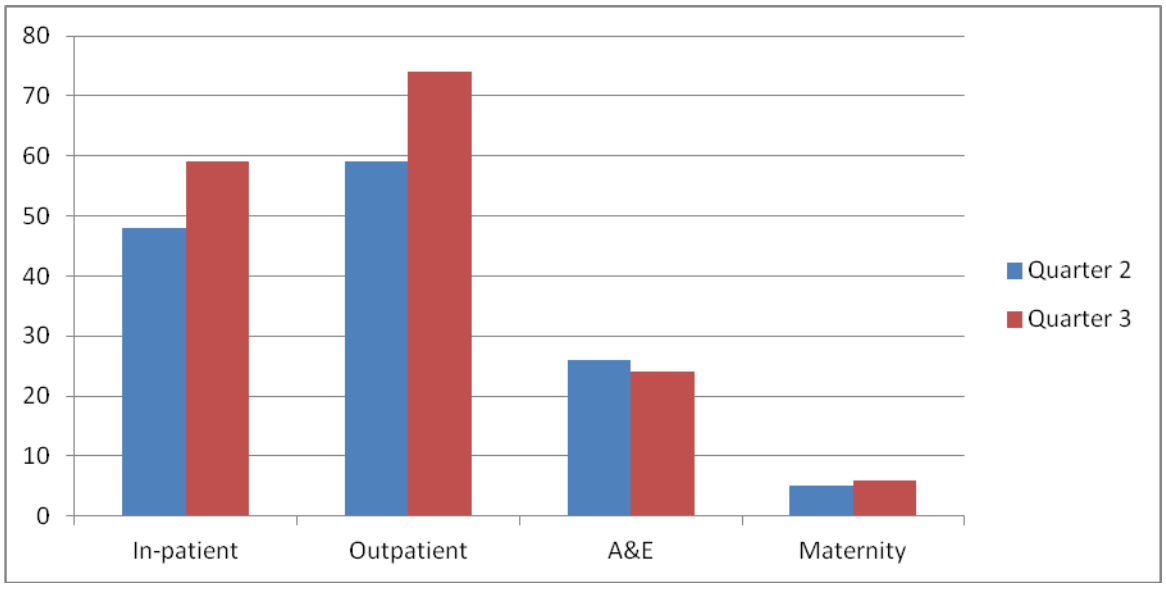
Quarter 2 2013-14 (Jul – Sept)	Number upheld or partially upheld	Quarter 3 2012-13 (Oct – Dec)	Number upheld or partially upheld
Incorrect diagnosis (12)	5	Delayed diagnosis (12)	5
Delayed treatment (10)	5	Incorrect diagnosis (11)	2
Delayed diagnosis (8)	2	Delayed treatment (10)	3
Patient fall/injury (5) =	3	Poor standard of nursing care (8)	4
Missed fracture (5) =	2	Patient fall/injury (6)	5
Incorrect treatment (5) =	2		
Delayed investigations/tests (5) =	2		

Improved data capture during this period has provided an enhanced picture as to the main clinical issues being highlighted in complaints compared to previous reports. Issues relating to delayed or incorrect diagnoses dominate this data. It is also worth noting that delays in treatment are also highlighted. As previously identified, relatively small numbers of these complaints have been upheld following investigation and it is not uncommon to conclude from investigation that while the clinical care given to a patient has been appropriate, this has been undermined by ineffective or poor quality communication from staff involved.

The increase in numbers of complaints received in quarter 3 2013-14 about poor standards of nursing care is also noted.

With regard to the service areas most frequently complained about, details for quarters 2 and 3 2013-14 are shown in chart 5.

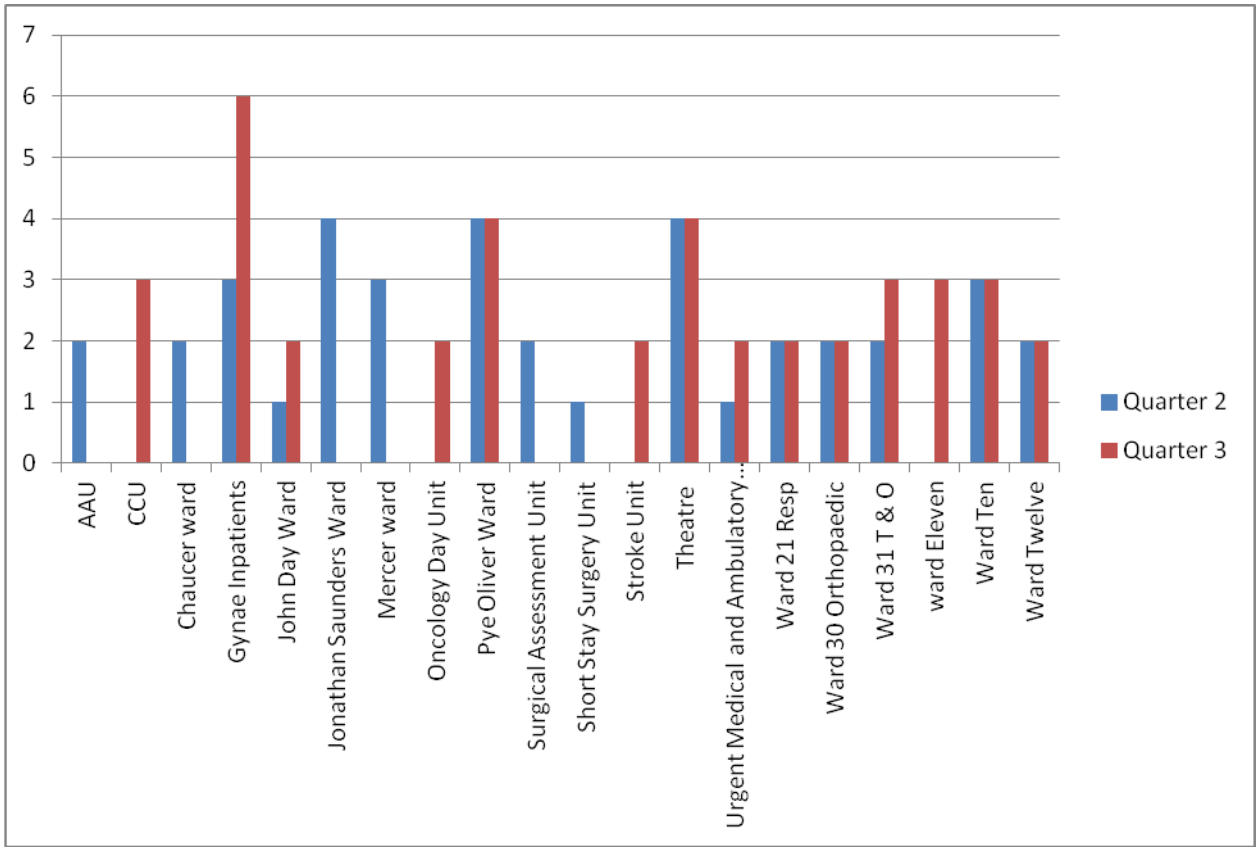
Chart 5: Complaints by service area



An increase in the number of complaints raised about inpatient and outpatient services is noted between quarters 2 and 3. Forty-eight inpatient complaints were received between July and September, rising to 59 between October and December; 59 outpatient complaints were received between July and September, rising to 74 between October and December.

Again, as these a quite broad categories, we are able to break it down further for our inpatient complaints. Chart 7 shows more specific detail relating to location. Any area receiving more than one complaint is highlighted below.

Chart 6: Inpatient complaints by location

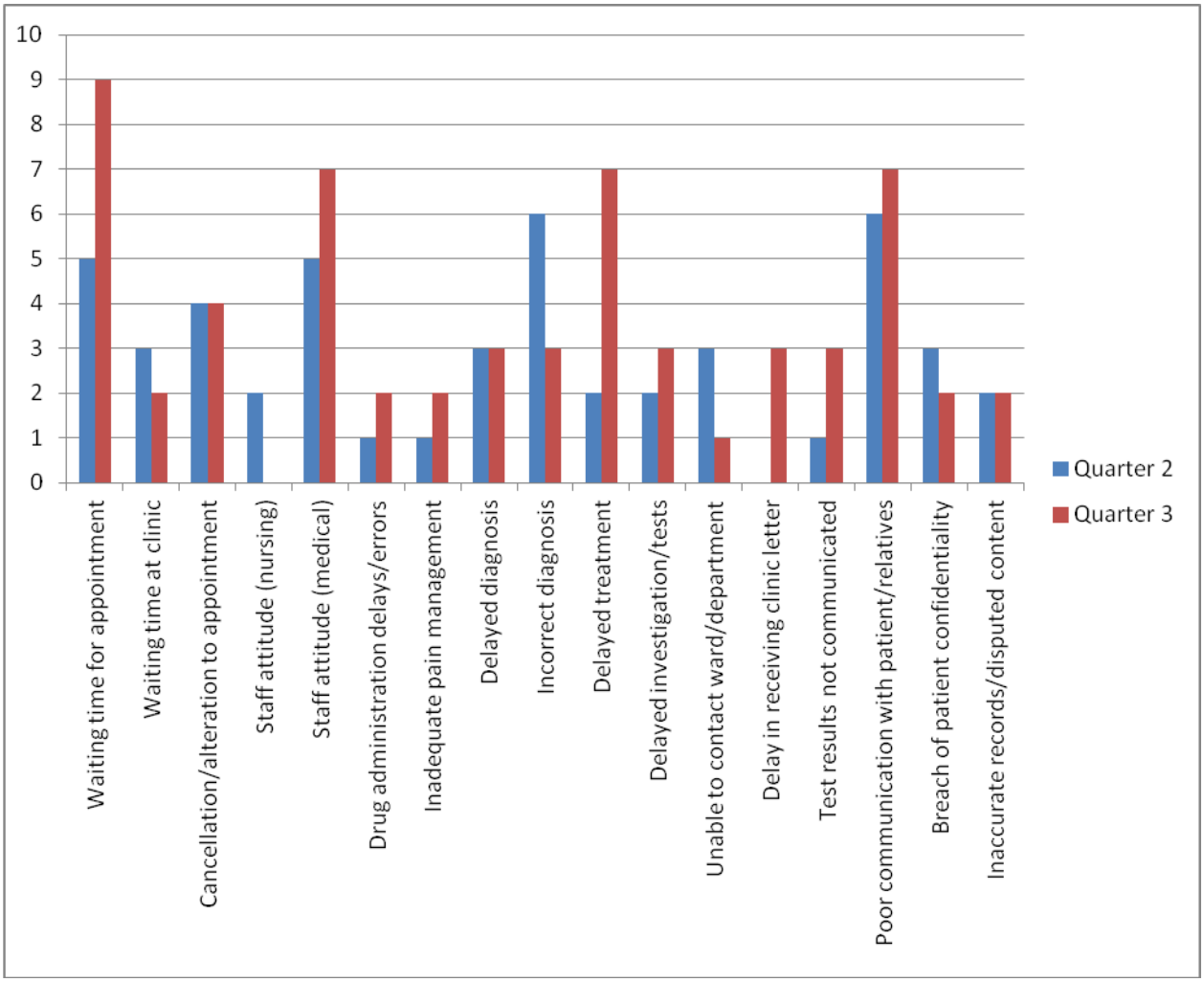


Comparing the 2 quarters reported on, we can see that the inpatient areas most frequently identified in complaints were:

Quarter 2 2013-14 (Jul – Sept)	**Number upheld or partially upheld**	**Quarter 3 2013-14 (Oct – Dec)**	**Number upheld or partially upheld**
Jonathon Saunders Ward (4) =	1	Gynae Inpatients (6)	2
Pye Oliver Ward (4) =	1	Pye Oliver Ward (4) =	0
Theatre (4) =	1	Theatre (4) =	1
Gynae inpatients (3) =	1	CCU (3) =	2
Mercer Ward (3) =	1	Ward 31 (3) =	0
Ward Ten (3) =	1	Ward Eleven (3) =	2
		Ward Ten (3)	0

Data on complaints received by each ward area was presented once a month to the Complaints, Litigation, Incidents and PALS (CLIP) meeting until it was dissolved in November 2013. The function of this committee has been replaced by the Clinical Governance Committee, chaired by the Chief Nurse.

Chart 7: Outpatient complaints by subject



Comparing the 2 quarters reported on, we can see that the issues raised most frequently in outpatient complaints were:

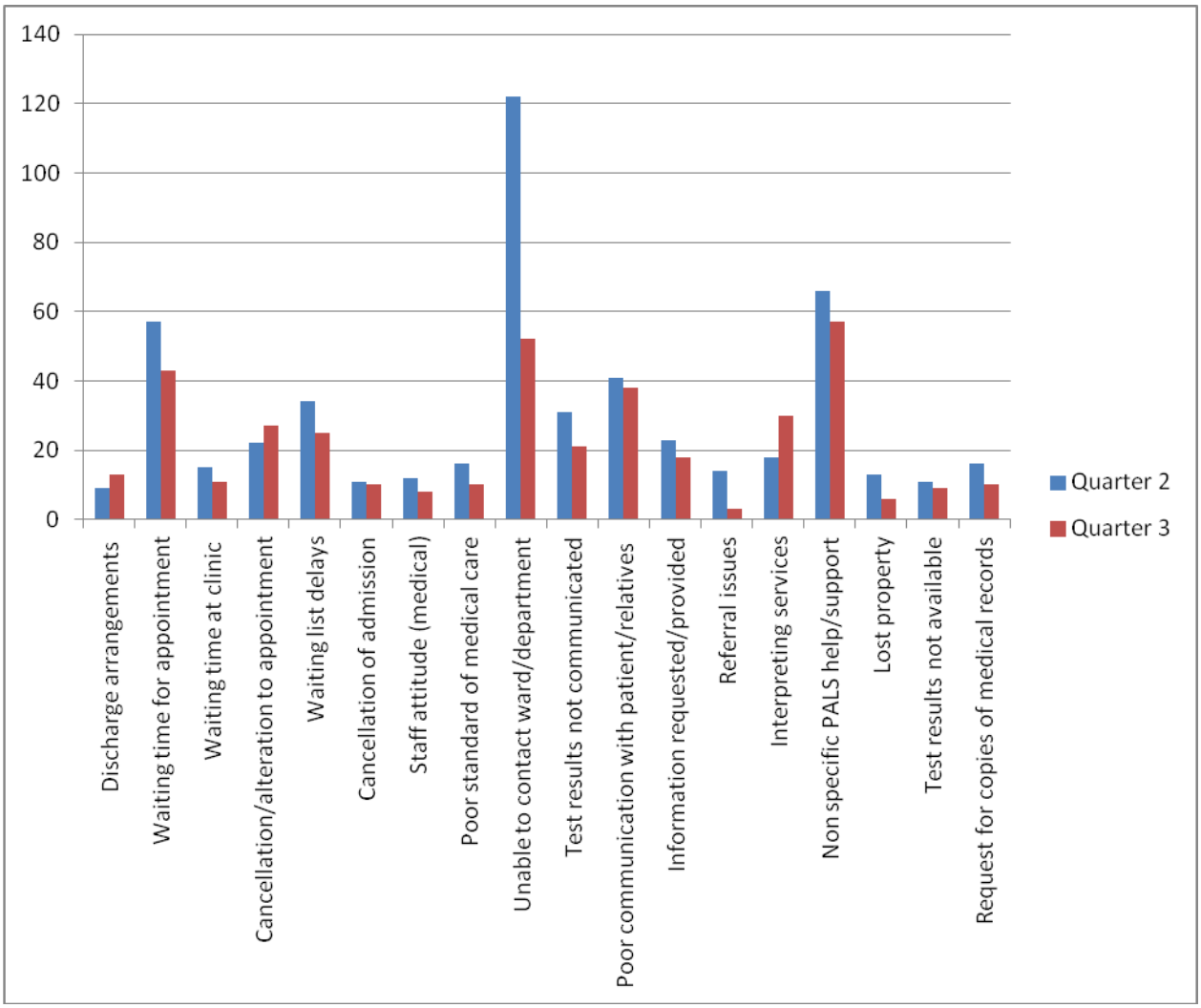
Quarter 2 2013-14 (Jul – Sept)	Number upheld or partially upheld	Quarter 3 2013-14 (Oct – Dec)	Number upheld or partially upheld
Incorrect diagnosis (6) =	2	Waiting time for appointment (9)	1
Poor communication with patients/relatives (6) =	4	Staff attitude – medical (7) =	3
Waiting time for appointment (5) =	2	Delayed treatment (7) =	2
Staff attitude - medical (5) =	4	Poor communication with patient/ relatives (7) =	1
Cancellation/alteration to appointment (4)	3	Cancellation/alteration to appointment (4)	3

Patient Advice and Liaison Service (PALS)

PALS received a total of 1188 contacts in quarter 2 2013-14 and 974 contacts in quarter 3. It is worth noting that the service has been operating with vacancies as a result of both staff progression and varying sickness absences throughout these quarters. We are mindful that this has on occasion affected the availability of the service and this may have impacted on the reduction in the number of contacts in quarter 3.

Data on trends around inpatient areas and the subjects raised in concerns managed via the PALS service was reported on a monthly basis to CLIP and will continue to be reported to the Clinical Governance Committee. A summary of the data gathered on subjects can be seen in chart 8. In view of the high number of contacts PALS receive, this chart reflects where there have been 10 or more contacts about the subject.

Chart 9: Primary sub-subject of concerns raised with PALS



The bulk of contacts made via PALS relate to outpatient services, which is reflected above with appointment issues and communication with outpatient departments highlighted as frequently raised subjects. The peak in contacts due to callers being unable to contact departments related to the introduction of the new administration system in radiology and resulting challenges around its implementation and issues in audiology. It is encouraging to note that this improved into quarter 3.

Compliments

PALS and complaints staff also record compliments received either direct via them or from the Chief Executive's office. Between July and Decemebr 2013, 138 compliments were captured, including those left via the NHS Choices website.

Innovations

Plans to introduce wall mounted telephones outside our PALS offices to aid enquirers seeking assistance outside of office hours have been reconsidered and we are exploring the option of

using existing telephone points at reception areas to support the provision of service. The PALS team underwent restructure during quarter 3 and we have successfully recruited to vacancies within the team. New staff are expected to take up posts in April 2014 and this should enable us to provide ammore consistent, accessible and responsive service. We would like to recruit patient representatives (members of the PEC) to assist in a review of a selection of complaints and concerns, to contribute to the service's annual report.

The Trust was contacted by the Patient Association offering an opportunity to work with them and the Complaints Manager has made contact with the Association to initiate discussion about what options are available and how we can maximise any involvement with them to benefit our service users.

Outcomes and learning

Once a complaint has been responded to, we capture the outcome from the investigation and classify all complaints as upheld, partially upheld or not upheld.

Outcome	% Quarter 2	% Quarter 3
Upheld	22	23
Partially Upheld	20	14
Not Upheld	58	63

It is encouraging to note that in over half of all formal complaints, the investigation showed that the complaint was not upheld. Review of the complaints which have been upheld or partially upheld has revealed service improvements including:

- Registrar underwent a period of supervised practice (13713)
- The subject of data protection in relation to patients aged between 16 and 18 discussed at directorate clinical governance meeting (13810)
- Falls pad training implemented, mobile desk sourced for clinical area to allow nursing staff to maintain better visual observation of patients and falls flow charts made available in clinical area (14233)
- Protocols around producing appointment letters reinforced with booking team (15687)
- Concerns relating to practice of agency nurse reported to the agency; decision made not to book this individual again (16176)
- Introduction of pre-procedure form highlighting need to check renal function (15042)
- Sign added to commode to remind staff it is not to be left in patient rooms (15249)
- Protocol for dealing with bereaved families reinforced to ward staff (15137)
- Copy of correct pathway referral form sent to staff (15544)
- Admissions staff asked to review admission arrangements for pt's using NSL to reduce excessive waiting times (15012)
- Supply of diet sheets sourced for ward, to provide information for patients and information made available on ward regarding car parking concessions (15397)
- New process introduced to pre-assessment clinic to ensure notes are transferred for appropriate follow-up (15693)
- Front sheet used by clerk amended to indicate that all current patient's contact information has been verified (14919)
- Agreement reached with staff at Medway that they must ensure any changes to personal details are update on shared patient database as well as their local system (16042)
- Training arranged for clinician in use of new needles with protective device (14225)
- Consultant to provide patients' unique hospital numbers as part of his dictation of clinic letters to reduce risk of confusing patients with the same name (15685)
- Rapid Access Clinic asked to review all processes around telephone call management (14904)

- Domestic staff on ward have been reminded to remove all equipment from patient areas when not in use (14165)
- Exploring possibility of changing 'no-smoking' option on the EDN drop down menu to better reflect when patients have stopped smoking for a longer period than 3 months (15095)
- Additional training provided to staff on gaining intravenous access (15257)

In additon, a number of cases were discussed at the revelant clinical governance meetings to share clinical lessons with colleagues. Opportunities were also taken to reinforce expected standards of good practice with ward teams. Reimbursement was provided in two cases; one for costs incurred by a patient who had arranged a private antenatal scan and another for travel expenses incurred by a patient.

Satisfaction survey

The results of the fifth round of the satisfaction survey can be found at Annex A. The sixth round is currently underway. The next satisfaction survey will be issued in April 2014.

The results for the fourth and fifth rounds are disappointing in so far as the scoring for the overall process. However, given the low return rate for both these rounds, this data may not be a reflection of overall satisfaction. Nonetheless, we are taking on board some of the feedback and have already taken steps to be more proactive in making the option of local resolution meetings clearer. It is worth noting that some complainants struggle to make the distinction between the service they have received and the outcome of their complaint. However, the results of the survey so far clearly illustrates that we have more to do to deliver the high standard of service we aim to offer.

Maidstone and Tunbridge Wells NHS Trust

ANNEX A

Complaints Questionnaire Comparison

150 questionnaires were sent out in the first round with **73** returned giving us a return rate of **48.7%**. For the second round **193** were sent out with **74** returned giving us a response rate of **38.3%**.
For the third round **153** were sent out with **63** returned giving us a response rate of **41.2%**

The questions below show the comparison between the five rounds:

Were the complaints team courteous and helpful?

	Round 5	%	Round 4	%	Round 3	%	Round 2	%	Round 1	%
Yes	15	38.5	13	50	29	47.5	39	54.2	36	50.0
Yes to a certain extent	16	41.0	9	34.6	24	39.3	22	30.6	26	36.1
No	5	12.8	2	7.7	1	1.6	3	4.2	2	2.8
No contact	3	7.7	2	7.7	7	11.5	8	11.1	8	11.1
Total	***39***		***26***		***61***		**72**		**72**	

Did you receive written acknowledgement of your complaint?

	Round 5	%	Round 4	%	Round 3	%	Round 2	%	Round 1	%
Yes	31	79.5	24	92.3	58	92.1	66	94.3	65	95.6
No	6	15.4	2	7.7	5	7.9	4	5.7	3	4.4
Other	2	5.1								
Total	***39***		***26***		***63***		**70**		**68**	

Was the chief execs response letter written in a way you could understand?

	Round 5	%	Round 4	%	Round 3	%	Round 2	%	Round 1	%
Yes	10	38.5	9	36	27	46.6	35	49.3	33	45.8
Yes to a certain extent	15	57.7	12	48	22	37.9	29	40.8	23	31.9
No	1	3.8	4	16	9	15.5	7	9.9	16	22.2
Total	***26***		***25***		***58***		**71**		**72**	

Did we address all of your concerns?

	Round 5	%	Round 4	%	Round 3	%	Round 2	%	Round 1	%
Yes	5	13.2	10	38.5	18	29.0	26	36.1	25	34.2
Yes to a certain extent	17	44.7	9	34.6	25	40.3	32	44.4	28	38.4
No	16	42.1	7	26.9	19	30.6	14	19.4	20	27.4
Total	***38***		***26***		***62***		**72**		**73**	

If you attended a meeting with staff, did you find this useful?

	Round 5	%	Round 4	%	Round 3	%	Round 2	%	Round 1	%
Yes	3	8.8	2	13.3	0	0.0	4	6.8	1	1.7
Yes to a certain extent	0	0.0	1	6.7	1	2.4	4	6.8	1	1.7
No	3	8.8	1	6.7	1	2.4	30	50.8	4	6.8
Meeting not offered but would have helped	17	50.0	6	6.7	19	46.3	0	0.0	24	40.7
Meeting not offered and not needed	11	32.4	5	33.3	20	48.8	21	35.6	29	49.2
Total	***34***		***15***		***41***		**59**		**59**	

Was your complaint resolved?

	Round 5	***%***	***Round 4***	***%***	***Round 3***	***%***	***Round 2***	***%***	***Round 1***	***%***
Yes with the first letter	10	27.8	6	28.6	17	29.8	22	32.4	14	20.3
Yes with the second letter	3	8.3	2	9.5	7	12.3	7	10.3	13	18.8
Yes with continued local resolution	5	13.9	2	9.5	5	8.8	4	5.9	9	13.0
No	17	47.2	10	47.6	27	47.4	12	17.6	30	43.5
No, I referred my concerns to Parliamentary and Health Service Ombudsman	1	2.8	1	4.8	1	1.8	23	33.8	3	4.3
Total					***57***		**68**		**69**	

Overall, how satisfied were you with the complaints process itself?

	Round 5	***%***	***Round 4***	***%***	***Round 3***	***%***	***Round 2***	***%***	***Round 1***	***%***
1 - Not at all satisfied	13	34.2	8	32.0	9	15.0	6	10.0	42	63.6
2	3	7.9	4	16.0	9	15.0	7	11.7	6	9.1
3	11	29.0	3	12.0	15	25.0	13	21.7	1	1.5
4	10	26.3	4	16.0	20	33.3	16	26.7	3	4.5
5 - Very satisfied	1	2.6	6	24.0	7	11.7	18	30.0	14	21.2
Total	***38***		***25***		***60***		**60**		**66**	

Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD MEETING - MARCH 2014

3-10	DESIGNATED SINGLE SEX ACCOMODATION COMPLIANCE STATEMENT	CHIEF NURSE

Summary / Key points

The Trust is required to publish a compliance statement on its website stating it is compliant with the Designated Single Sex Accommodation (DSSA) standard. The Trust is required to review and renew annually.

The enclosed statement indicates the Trust is compliant.

Risks associated with compliance relate primarily to patient perception. The local inpatient survey results indicate many patients being cared for at Tunbridge Wells Hospital respond as having being in a mixed-sex ward despite having their own room with en-suite bathroom and toilet.

The secondary, but acceptable, risk relates to the provision of specialist care, notably within critical care or stroke. In these cases patients are relocated to a gender appropriate bed once it is clinically safe to do so.

The Surgical Assessment Unit at Tunbridge Wells Hospital may have incidence of short-term mixed sex accommodation during the day as patients are moved from the unit to discharge or to an appropriate inpatient bed. During the evening and night and over weekends the assessment unit expands into the short-stay/day case area to provide gender specific sleeping accommodation.

The final risk is admissions after 22.00hrs. In this instance it would not be appropriate to move patients within a ward or between wards on the basis of gender alone. Patient who find they are in a mixed sex bay following a late night admission are relocated to a gender appropriate bed the following day.

All incidence of potential or actual breaches are reported daily on a daily return and via the daily site report. Mixing of sexes out of hours may only happen with the approval of the on-call manager and on-call Executive.

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

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

Declaration of compliance

“Maidstone and Tunbridge Wells NHS Trust is pleased to confirm that we are compliant with the Government’s requirement to eliminate mixed-sex accommodation except when it is in the patient’s overall best interest, or reflects their personal choice. We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area.

Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in Intensive Care (ICU), Coronary Care (CCU), or the Acute Stroke Unit), or when patients actively choose to share (for instance Chemotherapy Day Unit).

All in-patient care at Tunbridge Wells Hospital at Pembury is provided in single rooms including Intensive Care, Coronary Care and Acute Stroke. All rooms (except Intensive Care) have en-suite toilet and shower facilities.

If our care should fall short of the required standard, we will report it to our Quality & Safety Committee as a formal sub-committee of the Trust Board. We have also set up an audit mechanism to make sure that we do not misclassify any of our reports”.

Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD MEETING - MARCH 2014

3-11 SAFEGUARDING CHILDREN REPORT, JAN 2013 - MARCH 2014 CHIEF NURSE

Summary / Key points

The enclosed report updates the Trust Board on the progress made in relation to safeguarding children since the last report, in January 2013.

Significant work has been done in the last year in relation to improving services for children and safeguarding arrangements at Maidstone and Tunbridge Wells NHS Trust, and we remain vigilant to ensure we deliver against areas as identified to continue to make improvements.

The enclosed report provides information on:
- Children's Safeguarding Governance Arrangements
- Section 11 audit
- Ofsted/CQC inspections
- Coping with crying pilot programme
- Common assessment framework (CAF)
- New and revised policies in relation to safeguarding children
- Flagging children with child protection plans
- Serious Case Review
- Referrals to social services
- Safeguarding Children Training
- Areas of risk

The key areas for focus are:
- Level 2 and 3 training and focus on improving compliance
- A focus on Multi-Agency working particularly with reference to the completion of referrals to Social
- Services by A&E staff
- Ensuring all staff have access to regular supervision

Which Committees have reviewed the information prior to Board submission?

- Safeguarding Children Committee
- Quality and Safety Committee

Reason for receipt at the Board

Information and assurance

SAFEGUARDING CHILDREN
ANNUAL REPORT 2014

1.0 Introduction

1.1 The purpose of the enclosed report is to update the Trust Board on the governance arrangements and progress made in relation to safeguarding children since January 2013 through to December 2013. Every Trust Board requires an update at least every year advising of key issues relating to the safeguarding of children. The Board is reminded that children are defined by the Children Acts as young people up to but not including their 18th birthday.

1.2 Clearly there are many services that are accessed by children but the main responsibility for the care and safeguarding of children in hospital is with the Children's Directorate.

1.3 This report provides assurance to the Trust Board that the organisation meets its statutory requirements stated within The Children's Act (1989) and (2004) and Working Together to Safeguard Children (2013) framework. The following declarations are made as requested by the Department of Health. The organisation meets the statutory requirements in relation to the Disclosure and Barring Checks.

- Child protection policies are up to date
- Staff have undertaken safeguarding training
- Designated and/or named professionals are clear about their role and have sufficient time and support to undertake it
- There is a Board level Executive Director for safeguarding children. The Board reviews safeguarding across the organisation at least once a year to assure it that safeguarding systems and processes are working.
- The organisation meets the statutory requirements in relation to the Disclosure and Barring Checks.

1.4 Safeguarding Children Governance arrangements:

The Chief Nurse is responsible for:

- Ensuring child protection policies are up to date
- Safeguarding children practice and assumes a strategic lead on all aspects of the Trust's contribution to safeguarding children
- Representing Maidstone and Tunbridge Wells NHS Trust on the Health Safeguarding Group a sub - committee of the Kent Safeguarding Children Board (KSCB), and / or the KSCB itself.
- Ensuring that appropriate safeguarding processes are in place, including compliance with all legal, statutory and good practice requirements.

The Safeguarding Children Committee forms an integral part of the governance system and is chaired by the Chief Nurse. Membership of the committee includes the Head of Midwifery, Women, Children and Sexual Health Services, Named Doctor, Named Nurse, Named Midwife, Emergency Department Safeguarding Lead Doctor, Matron for Paediatrics, CCG Lead Nurse for Safeguarding Children and Lead for Learning and Development. The Named Doctor for Safeguarding Children is due to retire at the end of March but will return part time to continue in his role as Designated Doctor for child death until a replacement is found. A new Named Doctor for Safeguarding Children will be formally in post from the 1st April 2014. The Named Nurse has two Safeguarding Children's Nurses reporting to her.

1.5 The Trust supports staff in the identification and management of issues relating to Safeguarding Children.

1.6 The child's welfare is seen as paramount and staff ensure the child's safety is their first consideration.

1.7 Staff are working collaboratively with other agencies involved in safeguarding children.

1.8 Mandatory training updates for Child Protection are attended initially at Trust Induction, then, are required every three years by all staff within the Trust. Levels of training aim to encompass all National and Local guidance pertaining to content and competencies with specific reference to those most relevant to MTW.

Level	Venue	Attendance Criteria
1	Internal	Mandatory for all MTW staff (clinical and non-clinical). This level is part of the mandatory induction programme.
2	Internal	Mandatory for all MTW Clinical staff who have regular contact with children and young people and/or parents/carers.
3	Internal	Recommended for all MTW senior registered clinical staff working with children, young people and /or their parents/carers and in Emergency Services.

In addition the Named Nurses provide bespoke training sessions for clinical staff in midwifery, paediatric, emergency care areas and for the F1/F2 intakes.

Level 1 and 2 training is also available through an e-learning package on the Internet making it accessible off-site and out of hours and is linked to other resources.

1.9 Safeguarding Children Supervision is available as required for all staff involved in Safeguarding Children; the Trust has accessed such external supervision for its Named Nurse and Midwife. These individuals equally provide supervision for all staff including Medical and Nursing staff. The Named Nurse has established a formal record for supervision provided internally.

1.10 **Section 11 audit**

It was agreed by the Kent Safeguarding Children Board's Executive group that Section 11 compliance in Kent will be assessed in full on a two yearly basis, with a focused follow up in the intervening year. The next full round will begin in April 2014 and progress on a rolling cycle throughout the year. The KSCB will be requesting from individuals a completed self-assessment at the beginning of each period. MTW are requested to undertake their Section 11 audit in January 2015- March 2015.

1.11 **Ofsted Inspections**

In February 2013 Ofsted graded the Kent County Council (KCC) as 'adequate with capacity for improvement' for their safeguarding arrangements. This is an improvement on the report from 2010 which graded the KCC as 'inadequate'. In July 2013 Ofsted judged KCC Looked after Children services as adequate overall, with a 'good' rating for its 'capacity to improve'.

1.12 **CQC inspection**

In March 2013 a routine inspection was carried out by CQC, the standard for safeguarding people who use services from abuse' was met by the Trust

2.0 Summary of Achievements

2.1 Coping with crying pilot programme

Non–accidental head injury (NAHI) is the most common cause of infant death or long term disability from maltreatment (Sidebotham and Fleming 2007). NAHI are most common in babies under 6 months with the incidence of NAHI following a similar pattern to the incidence curve of crying starting to peak at about 2 months. The NSPCC have invited MTW to participate in a programme aimed at supporting parents and reducing the risk of them losing their temper and harming their baby. Midwives will be introducing a DVD to parents at their first home visit following birth followed up by leaflets with coping strategies for babies crying. This is expected to be rolled out in April 2014 for 18 months and then evaluated.

2.2 Common Assessment Framework (CAF)

CAF is discussed in Induction, Level 2 and 3 training to ensure that staff have an understanding of what it means and where it fits in terms of thresholds for intervention. CAF training has been rolled out to Community Midwives in 2010-2012 and Community Paediatric Nurses in 2013. In order to encourage completion of more CAFs, there are three CAF Champions nominated in the Trust (two Midwives and a Safeguarding Children Nurse), this a recent development aimed at supporting staff with the CAF process.

2.3 Safeguarding Children Supervision Policy

Following recommendation from a Serious Case Review, a Safeguarding Children Supervision Policy has been put in place to ensure that Community Midwives/Community Paediatric Nurses who carry caseloads with complex families receive formal supervision either on an individual basis or in groups. This is facilitated by the Named Nurse, Safeguarding Children Nurses and the Named Midwife. Midwifery Team Leaders also facilitate supervision in their teams. Formal supervision has been useful not only to identify whether children require a CAF or whether they meet the threshold for referral to Social Services, but also as a source of support to staff.

2.4 Trust Safeguarding Children Policy and Practice Guidance

This policy was revised and updated in 2013 and is available on Q-Pulse.

2.5 Trust Domestic Abuse Policy

This policy is currently in the consultation phase and will shortly be completed and available on Q-Pulse.

2.6 Flagging of children with child protection plans (CPP)

In 2013 MTW signed up to the Joint Information Sharing Protocol for children and young people subject to a CPP. Kent County Council Children's Social Care share information on a weekly basis to the Named Nurse and a flag is put against the child's name both on Symphony and Patient Centre. There are approximately 1266 children in Kent with CPP in place. MTW are flagging <u>all</u> children in Kent as opposed to just our local area as it is acknowledged that families may visit hospitals outside their local area if they are looking to avoid attention. This process is approaching completion and the information includes name and number of allocated Social Worker so staff can contact if necessary.

3.0 Serious Case Reviews (SCRs), Internal Management Reviews (IMRs) and Serious Incidents Requiring Investigation (SIRIs).

There have been no SCRs or IMRs for MTW in the last year.

All child deaths are designated as SIRIs and are reported to the Clinical Commissioning Group (CCG). A process is in place for the multiagency investigation of deaths and reporting into a county-wide overview panel, to which the Trust contributes.

4.0 Referral to social services

Staff are required to send copies of referrals to social services to the Named Nurse so that data can be recorded. Data has been gathered for 1st January 2013- 31st December 2013. There have been 164 referrals into the Central Referral Unit (CRU) from MTW.

- 24 made by A/E staff
- 75 referrals have been made by the Safeguarding Children Team on behalf of A/E
- 45 of these referrals were for adults attending with mental health issues/domestic assaults
- 30 were for children attending A/E with issues such as:
  - Poor supervision, parenting/alleged sexual assault/delay in seeking treatment/frequent attendances related to injuries/unofficial private fostering arrangements.

5.0 Training

5.1 The Trust's current compliance with level 1 training is 84.1% and is just below the Trust's minimum compliance target for statutory and mandatory training of 85%. Compliance at level 2 is at 78.1% and efforts are being made to increase communications with regards to statutory and mandatory training. Non-compliance lists for training are being distributed by the HR Business Partners and the Learning & Development team. Reminder emails are being sent out on a regular basis. Compliance is a standing item on the sub-group agenda

Level 3 training was introduced in September 2012 aimed at all clinical staff working with children who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns. The main focus of the training is the assessment of risk, early identification/help and multi-agency working. Compliance is currently at 42.2% with 162 staff booked on courses up to August 2014 with extra courses undertaken over the last 4 months to improve compliance. By end of August compliance with level 3 should be 70%.

Every month as part of Trust Induction training pocket cards detailing key information and contacts for Safeguarding Children are distributed enabling staff to keep these important details close to hand at all times.

6.0 Areas of risk for on-going monitoring and review

6.1 The Safeguarding Children Committee will continue to monitor compliance with training with a particular focus on improving the compliance at level 2 and level 3.

6.2 A focus on Multi-Agency working particularly with reference to the completion of referrals to social services by A/E staff.

7.0 Conclusion

7.1 Significant work has been done in the last year in relation to improving services for children and safeguarding arrangements at Maidstone and Tunbridge Wells NHS Trust, with our commissioners and KSCB. There is still work to do to further improve the standards but we are assured that we have the right people and systems in place.

7.2 In the meantime the Safeguarding Children's Committee will continue to report regularly to the Quality and Safety Committee.

Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD MEETING - MARCH 2014

3-12 SAFEGUARDING ADULTS REPORT CHIEF NURSE

Summary / Key points

The enclosed report provides information on activity within the Trust in relation to Safeguarding Adults.

Key messages are that the Trusts policies and procedures in relation to Safeguarding Adults, Mental Capacity Act and Deprivation of Liberty safeguards have been reviewed and updated this year.

A Domestic Abuse Policy has been written and will be published for use in 2014.

Staff in the Trust continue to raise safeguarding Alerts appropriately and this is an indicator that the current training provided is enabling staff to feel confident to raise these alerts to our multi-agency partners.

Level 2 Safeguarding Adults Training will be developed and offered in 2014.

Level 2 Safeguarding Adults E-Learning has been developed and is planned to be offered from April 2014.

Trust staff are keen to learn from allegations of abuse and put in place remedial actions when investigations highlight any shortcomings in practice.

Which Committees have reviewed the information prior to Board submission?

- Safeguarding Adults Committee
- Quality and Safety Committee

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

Safeguarding Adults Annual Report
January 2013 – December 2013

1.0 Introduction

The purpose of this report is to inform the Trust Board with regards to the work undertaken by the Safeguarding Adults Committee during the year 2013. It is also to give the Trust Board assurance that there are effective mechanisms in place to ensure that our patients are safe from abuse and are safeguarded appropriately whilst they are in our care.

2.0 Compliance

The Trust continues to declare compliance with Care Quality Commission (CQC) Outcome 7 'Safeguarding people who use the service from abuse'. In recent inspections this Outcome has not been inspected however, the published reports from previous CQC inspections have highlighted that staff understand how to report concerns, record incidents and whistle blow their concerns when required.

The Trust has in place a Safeguarding Adults Committee with both multi-professional and multi-agency representation. The Committee has been chaired by the Chief Nurse in the last year. Chairmanship of this Committee is expected to be handed to the Deputy Chief Nurse in the forthcoming year.

The Safeguarding Adults Committee continues to report to the Quality and Safety Committee and the Trust Board gain periodic assurance throughout the year via this route.

3.0 Policies and Procedures Drafted, Reviewed and Updated

The Mental Capacity Act and Deprivation of Liberty Safeguards (MCA and DoLS) Policy and Procedure has been reviewed, updated and published on the Trust Intranet. The updated policy has been strengthened in a number of areas including:

- Courses of action available in disputed cases
- Confirmed when cases **have** to go to the Court of Protection
- Updated tools to assist practitioners to document clearly assessments of mental Capacity and Best Interest Decisions
- Tightened the Independent Mental Capacity Advocate (IMCA) referral process
- Inclusion of definition of Serious Medical Treatment (SMT)

The majority of the updates to this policy are as a direct result of MCA cases informing us that changes were required i.e. Definition of SMT, when to refer to the Court of Protection. The remainder were in relation to changes in external services such as IMCA and DoLS practices.

Work is underway with a Trust Domestic Abuse Policy and Procedure. This will cover Domestic Abuse responses for both patients and staff members and will strengthen our safeguards in place for this vulnerable group of victims and their children.

The Trusts Safeguarding Adults Policy and Procedure went through a further review to include all the recommendations from the previous year's review of the Trusts safeguarding practices and applications of definitions in relation to Vulnerable Adults. This is now published on the Trusts Intranet.

4.0 Levels of Safeguarding Referrals and Outcomes of Investigations

Trust staff continue to refer safeguarding alerts directly to the Kent County Council Central Referral Unit. Trust staff raise safeguarding alerts about concerns for patients when they arrive at hospital and these alerts will cause Kent County Council Family and Social Care Departments to arrange an investigation into the concerns raised.

Trust staff also raise safeguarding alerts about practice within the Acute Trust environment about harm that has occurred to vulnerable adults. Practitioners and providers from outside of the Trust have also made referrals about harm that is suspected to have been caused when patients have been in-patients in the Trust. For these alerts the Trust co-ordinates the investigations and provides feedback to Kent County Council as the lead agency.

Staff are reminded to copy Matron for Safeguarding Adults into all Safeguarding Alerts made. On the whole safeguarding alerts raised are appropriate and where inappropriate referrals have been made e.g. Self Neglect remedial action and educational opportunities have been taken.

From January 1st 2013 – December 31st 2013 staff raised a total of **113** Safeguarding Alerts of which **76** were for Community investigations and **37** were for Hospital investigations. The Trust do not always receive feedback with regards to Community Investigation outcomes however, as we co-ordinate the Hospital investigations the following are the outcomes for the allegations of abuse made against, or from within the Hospital

Table 1: Safeguarding Alerts for Hospital Investigations and Outcomes

2013 Month Outcomes	TWH		Maidstone		Total
	Upheld	Not Upheld	Upheld	Not upheld	
January	2	1	1	0	4
February	1	2	0	1	5
March	1	1	0	1	3
April	1*	1	0	2	4
May	0	2	0	2	4
June	1	2*	0	1	4
July	0	3	0	1	4
August	0	3*	0	0	3
September	0	1	0	0	1
October	1	0	0	0	1
November	0	1	0	2	3
December	0	0	0	1	1
YTD/Year End	**7**	**17**	**1**	**12**	**37**

***Denotes that although one of the incidents occurred in the hospital, the alleged perpetrator was <u>not</u> a Trust Member of staff. The alleged perpetrators were as follows:-**

- **1 was an alleged sexual touch by a carer from a Community Care Agency**
- **1 was a husband to wife physical incident**
- **1 the parent and or carers from the community care agency were alleged to have given an unprescribed substance to our patient.**

Therefore, out of the 37 alleged hospital incidents 34 were alleged to have involved Trust staff or Trust systems. Of these 34:-

- 21 were alleged neglect, with all 8 of the allegations of abuse that were upheld being within this category.
- 5 in this category were with regards to Hospital Acquired Pressure Ulcers and were reviewed at the Trusts Pressure Ulcer SIRI Panel.
- 1 was in relation to the incorrect application of the Mental Capacity Act when completing a DNACPR Form.

- 1 was with regards to nursing staff non-adherence to community carer guidelines leaving a vulnerable patient to scratch himself.
- 1 was in relation to a catering assistant giving a patient a hot drink without a lid against the care plan guidance, leaving the patient to spill a hot drink on himself – no injuries sustained.

There were 8 allegations of physical abuse ranging from rough handling to hitting or kicking a patient.

- In 7 cases where a crime was suspected the Police were informed and invited to lead the investigation.
- The Police led on 2 of these investigations.
- All 8 were not upheld.

There were 4 allegations of sexual touching and all these allegations were reported to the police and investigated by Kent Police.

- None of these allegations were upheld. This was either due to patient delirium at the time, or the story did not match with staff on duty, no corroborating evidence or due to unreliable witness testimony.

There was 1 allegation of emotional abuse and this was not upheld.

The Safeguarding terminology with regards to outcomes of cases used in the Table 1 has been simplified for ease of the table requirements to **upheld or not upheld**.

In Safeguarding Adults the following terminology is used:

a. Unsubstantiated - Discounted
b. Substantiated - Confirmed
c. Partially Substantiated - Some aspects of abuse confirmed
d. Not determined/inconclusive or evaluated as not being abuse

Therefore in cases above where the allegation was partially substantiated these have been counted as upheld.

All allegations of abuse alleged to have occurred in the Hospital setting are managed through the Serious Incident Reporting mechanism. However, the Trust also adheres to the Kent & Medway Multi-agency Safeguarding Adults Policy, Procedure and Guidance and raises these as Safeguarding Alerts with the Local Authority.

5.0 Multi-agency Partnership Working

The Trust has strong representation within the Multi-agency both strategically and operationally. Providers have now been invited to participate in the Kent & Medway Safeguarding Adults Executive Board and the Deputy Chief Nurse represents the Trust at this level.

This provides the Trust with the opportunity to contribute to the strategic development of safeguarding adults activity within the County ensuring that the interests of acute care providers is represented at a senior level.

The Executive Board has health representatives from the Clinical Commissioning Groups (CCGs) across Kent and East Sussex, NHS England Local Area Team, and Mental Health & Community Partnership Trusts.

This Executive Board communicates strategic intention and operational requirements via a sub-committee/group structure.

There are four sub-groups to the Executive Board:-

1. **Quality Assurance Working Group**
2. **Learning and Development Group**
3. **Policies, Procedures Group, (PPG)**
4. **Serious Case Review Panel – when SCR referrals are made**

It was agreed at Executive Board level that the Acute Trusts would have one nominated Safeguarding Adults' representative and a deputy for the first two meetings listed above and that information and actions would be shared as a result of the representative attending the meeting. Minutes of the meetings are shared promptly via email. This gives feedback throughout the Acute Trusts however it can not replicate the dynamic of each practitioner being present to participate in debate and decision making.

The PPG group is attended by the Safeguarding Matron who has participated in updating the Kent & Medway Policies, Procedures and Guidance accordingly with focus in the last year being given to changing Protocol 19 (Pressure Ulcer Protocol), Protocol 17 (Acute Trusts carrying out their own safeguarding adults investigations). Focus in the first quarter of 2014 will be given to Medication Administration and Safeguarding, and also changing the Adult Protection 1 (AP1) format in order for it to be user friendly by Multi-agency partners.

Matron for Safeguarding also attends the Mental Capacity Act (MCA) Local Implementation Network Meeting and its subgroups assisting with emerging problems with the application of the MCA in practice and training delivery.

Attendance at the two local Multi-Agency Risk Assessment Conferences (MARAC) is shared equally between the Children's Safeguarding Lead Nurse and Matron for Safeguarding Adults.

The Trust maintains high visibility with regards to partnership working in the Safeguarding Multi-agency arena.

The Trust continues to work closely with the Community Learning Disability Link Nurses and they have an agreed work plan for this year to ensure that their liaison role is understood by trust practitioners and that their expertise and skill is used effectively to ensure that patients with a Learning Disability have a positive patient experience.

Matron for Safeguarding Adults, or delegated representative, represents the Trust on the Learning Disability Commissioning Meeting the Good Health Group to ensure that the Trusts work streams in relation to meeting the needs of people with Learning Disability remain current and on track.

6.0 Education and Training in Safeguarding Adults

There is a suite of training programmes coordinated by the Learning & Development team ranging from basic awareness training provided at Trust Induction, through to inclusion on the mandatory update programmes. Additional training is in place for Mental Capacity Act and Deprivation of Liberty Safeguards, PREVENT and Awareness of Domestic Abuse.

The Training packages have been developed in collaboration with the wider Safeguarding Adults team and training beyond initial awareness is available from our Multi-agency training delivered by the Kent Medway Safeguarding Adults Board.

E-learning packages are available via the Trust intranet for all staff groups. The basic awareness e-learning package has been reviewed and updated. The Trust has agreed to purchase a Safeguarding Adults Level 2 training programme and this is currently under development with a 'go-live' date of 01.04.2014.

Level 2 training delivery is now not delivered within the Multi-agency training package. Safeguarding competencies have been discussed and towards the end of 2013 these have been formulated by CCG Safeguarding Partners and shared with the Acute Trust Leads. Work is underway to devise and deliver this training in 2014 in order for the Trust to give assurance that our practitioners are competent to the required level.

Level 2 is aimed at all clinical staff who have some degree of contact with adults, carers and their families. It will include more in depth information about:-

- Recognising their ability and duty to use their professional and clinical knowledge of what constitutes harm to identify abuse or neglect.
- Recognising potential indicators of adult harm; it could be any one or a combination of physical, psychological, sexual neglect, institutional, financial and discriminatory.
- Taking appropriate action if they have concerns, including appropriately reporting and seeking advice.
- Knowledge of safeguarding policies and procedures
- Uses professional and clinical knowledge and understanding of consent and refusing treatment and best interests in relation to the principles of the MCA.
- Has a positive obligation to take additional measures for people who may be less able to protect themselves
- Recognises the potential impact of omission to act on unsafe environment
- Be clear about own and colleagues' roles responsibilities, accountabilities and professional boundaries
- Be able to refer, as appropriate to role to Family and Social Care Services if safeguarding concern is recognised.
- Documents safeguarding/adult protection concerns in order to be able to inform the relevant staff and agencies, maintains appropriate record keeping, and differentiates between fact and opinion.
- Share appropriate and relevant information with other teams
- Awareness of Acts in accordance with key statutory and non-statutory guidance including No Secrets, The Human Rights Act, Data Protection Act, Mental Capacity Act, DOLs and Domestic Violence Act.
- Acts in accordance with professional Codes of Practice.
- Is Competent in applying the decision making process when gathering information following a safeguarding alert.

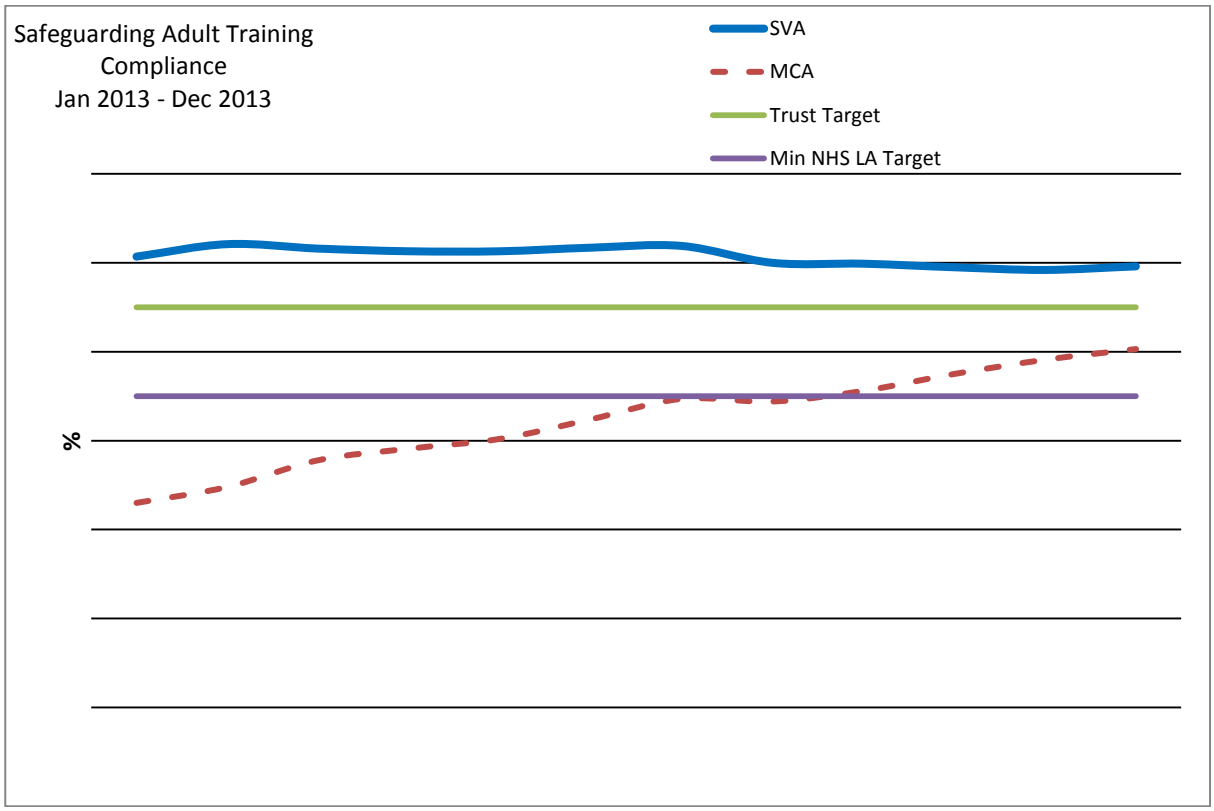
The above are included briefly in Clinical Update training delivery but it is the intention of the Matron for Safeguarding Adults to explore these topics in more detail in Level 2 training with Clinical Staff

The Trust has been required to deliver PREVENT training to practitioners within the Trust. PREVENT is part of the Government's counter-terrorism strategy CONTEST and so raising awareness of what staff can do if they are concerned that either a patient or colleague is becoming radicalised is advocated by the DoH and Home Office. Matron for safeguarding is the trusts trained, trainer and the PREVENT Lead. To date 62 Clinicians have received this training and there are plans to offer further PREVENT training in 2014. The Trust reports this activity to the Regional Prevent Lead who in turn, reports to NHS England and the Local CCGs.

Given below is the up to date graph with regards to training compliance within the Trust. Overall compliance with regards to Safeguarding Adults remains above the Trust minimum standard. Those areas that are below 80% compliant are routinely targeted by the Learning and Development Department to encourage improvement in these areas. The Safeguarding Adults Committee continues to monitor this compliance.

Mental Capacity Act compliance continues on an upward trend and it is the intention of the Safeguarding Adults Matron to continue to focus on MCA within the Mandatory Clinical Update.

Table 2: Safeguarding Adults Training Compliance Jan 2013 – Dec 2013



7.0 Audit and Monitoring

The Trust Safeguarding Adults Committee reviews all Safeguarding Cases that have been raised by Trust staff and ensures that when these are Hospital investigations that the investigation progresses in a timely manner.

It remains a challenge implementing the Mental Capacity Act into everyday practice. An audit of practice is planned for early 2014 and outcomes will be reported to the Trusts Safeguarding Adults Committee.

Safeguarding Adult Matron monitors all Adult Protection 1 (AP1) referrals completed by Trust staff and is able to respond promptly to ensure that appropriate and accurate information is recorded to ensure that appropriate levels of investigations can be initiated.

The information that staff are recording to raise alerts is informative and shows that Trust staff understand the Multi-agency processes and take Safeguarding Adults Seriously.

8.0 Serious Case Reviews, Domestic Homicide Reviews, Independent Management Reviews

There have been no serious case reviews or domestic homicide reviews published in 2013 that involved Maidstone & Tunbridge Wells NHS Trust. However, recommendations from Kent and Medway reviews will be revised and acted upon when relevant.

9.0 Learning and Action Plans

At a local level learning from alerts is distilled at the Safeguarding Adults Committee and disseminated to relevant groups. Learning is incorporated into future training and raised at key departmental meetings.

The Trust has in place a core action plan to address the issues resulting from audit, and outcomes from safeguarding investigations. This action plan informs local departmental improvement plans. It also informs work that is required within the Multi-agency across Kent to improve responses and systems, policies and procedures, in place, to address safeguarding concerns.

Improvement plans are in place to specifically address learning disability, mental capacity assessment, and PREVENT training.

Action plans are monitored by the Safeguarding Adults Committee. A quarterly report is submitted to the Quality and Safety Committee by the Deputy Chief Nurse highlighting issues of both contention and good practice.

The Safeguarding Adults Committee has the operational responsibility for the development and implementation of the action of the plans.

10.0 Conclusion

As identified in the paper eight of the investigations in relation to abuse by Trust staff were upheld whilst the remaining twenty-six were not upheld.

Staff are confident to raise AP1 alerts as the number of alerts raised from 2012 to 2013 have significantly increased. That is from 68 alerts in 2012 to 113 alerts in 2014, showing a 64% increase in alerts raised by Trust staff.

Training with regards to Safeguarding Adults is enabling staff to feel confident about the Multi-agency processes and the importance of raising their concerns appropriately and in a timely fashion.

There is a plan to continue focussing on Mental Capacity Act training in year 2014.

Safeguarding adults continues to have a high profile with continuing significant improvements seen overall.

All key elements are in place to ensure patients are kept safe and that Hospital investigations are managed in a robust manner.

Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD MEETING - MARCH 2014

3-13	DETAILS OF A PATIENT'S EXPERIENCES OF THE TRUST'S SERVICES ('PATIENT STORY')	CHIEF NURSE

Summary / Key points

This paper gives the outline of a patient story/experience from the daughter's perspective.

The learning centres on communication skills, perception of compassion and care.

Patient stories can be powerful tools to illustrate areas of good practice or areas where practice could be improved.

Ideally the patient should tell their own story; however this needs careful management and support, and for many patients 'presenting' their story can be a daunting experience.

Senior leaders need to be mindful that patient stories are not reflective of the organisation as a whole, nor do they reflect the experience of the many. However, when combined with other intelligence relating to organisational performance they can provide an element of reassurance or an early warning that 'all is not well'.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Discussion

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

Introduction:

This paper gives an overview of a patient story for the Board to consider and debate. Ideally the patient should tell their own story; however this needs careful management and support, and for many patients 'presenting' their story can be a daunting experience. In this instance the patient's relative was keen for senior managers to know what had happened, and is happy for the outline to be discussed.

The story relates to the last admission of the lady in question, and is related to end of life care. Whilst consent has been sought to re-tell this story, the lady's initials have been changed to provide a degree of anonymity.

Mrs B.

Mrs B was an 86 year old lady who lived in warden assisted accommodation.

Late evening on a Saturday Mrs B became increasing unwell and developed excruciating abdominal pain. Mrs B activated her 'lifeline' call system as a result was seen by her own general practitioner.

Mrs B's own General Practitioner prescribed pain killers for her, but did not venture any diagnosis to her, however he did refer her to Tunbridge Wells Hospital.

Once at Tunbridge Wells Hospital Mrs B was seen in the Accident & Emergency department. Mrs B was seen rapidly by a doctor and examined. The doctor informed Mrs B and her daughter that the probable diagnosis was a perforated bowel, however a scan was required to confirm this. The scan was duly arranged and done a few hours later. The scan did reveal that this was the case.

Mrs B's daughters attended the hospital with their mother, waited with her for several hours. They eventually returned to their own homes in the early hours of the morning. Soon after they received a call to return to the hospital to speak with a surgeon.

The daughters were informed that in view of the diagnosis, Mrs B's severe weight loss and general condition he would not recommend operating. The surgeon's view was that Mrs B would not survive the operation.

Mrs B's daughter asked the surgeon how long he thought her mother would survive without an operation. The surgeon would not commit other than to say 'ask me again next Wednesday'. The surgeon stated the only thing which could be done was to make sure Mrs B was comfortable and as free from pain as possible.

Mrs B was transferred to a surgical ward, where her care was managed for the next three days.

Mrs B's daughter felt that one member of the nursing team in particular lacked any compassion for her mother.

The daughter states that the whole time she was with Mrs B, her mother was in constant pain. Whilst Mrs B had a cannula in place and was being given morphine it was not having effect. The daughter had to ask for the doctors to be called in order to give Mrs B more pain relief.

At one point the cannula had to be re-sited. Mrs B was, at this point, delirious and in pain, the daughter stated the nurse asked her mother to keep still, in a less than sympathetic manner.

Mrs B died three days after being admitted to hospital. The daughter indicated that she was told the death certificate gave the cause of death as subarachnoid haemorrhage.

Lessons/points for discussion:

The common theme centres on communication and compassion.

The daughters had been given distressing news and information. Whilst this can be challenging for health care professionals also, staff must be mindful that apparently innocent comments or light humour may not always be as such, particularly in such distressing circumstances.

It is difficult to manage a request for information about life expectancy when in the end stages of life. This should be explained and an opportunity given to the patient and family to digest this information before moving on to management options.

The issue of pain control is also a challenge; in this case there were clear instructions for involvement of the palliative care team. It was unfortunate that the palliative care team were not contacted until the second day.

Lack of communication skills and compassion was further demonstrated, in the eyes of the daughter, with the nurse attempting to resite the cannula. Whilst a request to 'hold still' may reasonable with a patient who is able to understand, is not in pain and able to cooperate, when delirious and in pain other strategies are required. The lasting impact for the daughter with this encounter is the lack of compassion shown to her mother.

The issue of the stated cause of death remains unclear. The death certificate copy in the Mrs B's record clearly states the cause of death as a) sepsis b) bowel perforation.

The daughter took several months before raising her concerns, as she found the recollection painful.

It could be argued that recollections may be inaccurate, or that this is a cathartic element of the grieving process. It should be remembered that every encounter matters, regardless of how insignificant it may seem at the time.

The tone through out this story is not about the wider aspects of clinical or the surgeon's decision, it is about how that information was imparted, and how care tasks were done with no outward demonstration of care and compassion.

Actions:

- Local actions have taken place at ward level, with the team as a whole and with the particular staff identified.
- The case has been discussed at ward and directorate team meetings to share learning about the impact of staff behaviour.
- Further education and training has been invested in the surgical nursing team in relation to palliative care, and how and when to access the palliative care team for advice.
- The individual member of staff has been spoken to, and there is development plan in place.
- Wider changes implemented after the admission of Mrs B, but not as direct result of her experience relates to the Bereavement Service. Historically families were told to come at their convenience, this often resulted in delays if the death certificate had not been completed when they arrived. Families are now offered a confirmed time, so they are expected and the Bereavement Team ensure that all appropriate documentation and property (if we are holding any) is available when they arrive. This allows for any questions to be asked, and an opportunity to raise any concerns or provide positive feedback on their experiences.
- The Best Practice Guidance for End of Life Care has been produced by the Palliative Care Team and being rolled out across the organisation. This guidance directs clinical staff in producing individualised care plans providing guidance on symptoms management, information sharing, clinical decision making and planning.

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TRUST BOARD MEETING - MARCH 2014

3-14	RECENT QUALITY ASSURANCE ACTIVITY UNDERTAKEN BY BOARD MEMBERS	TRUST SECRETARY

Summary / Key points

Undertaking direct quality assurance activity (e.g. "Board to Ward" visits, safety 'walkarounds' etc.) is regarded a key governance tool[1] available to Board members. Such activity can aid understanding of the care and treatment provided by the Trust; and provide assurance information to supplement the written and verbal assurance received at the Board and/or its sub-committees. It is also recognised that direct engagement with staff, patients and relatives can assist in shaping the culture of the Trust.

The enclosed report therefore provides information on…

- Details of the recent quality assurance activity undertaken by Board Members between January and March 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, for the following reasons:
  - 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.
  - Board members may have undertaken visits but not logged these with the Trust Management office (Board members are therefore encouraged to register all such visits).

The report is submitted primarily for information, and to encourage Board members to continue to undertake quality assurance activity. However, those Board members undertaking visits are also invited to share any matters of note from their observations with the Board, to share the knowledge gained.

The Board will be aware that it was agreed (in January 2014) to arrange for Board members to be 'paired' with Wards and Departments. Pairing arrangements are being developed and will be communicated to Board members in the near future.

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;
- Those Board members undertaking visits are also invited to impart any observations with the Board, to share the knowledge gained

[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

Quality Assurance activity undertaken by Board members, January to March 2014

Board member	Areas logged as being visited (MH: Maidstone Hospital; TW: Tunbridge Wells Hospital)	Formal feedback provided?
Associate Non-Executive Director	-	-
Chairman	1. A&E - MH 2. Urgent Medical and Ambulatory Unit - MH 1. Ophthalmology – MH	-
Chief Executive	1. Catering – MH 2. Domestics - MH 3. Mercer Ward MH 4. Porters - MH 5. Pye Oliver Ward - MH 6. Transport - MH 7. Whatman Ward - MH 8. Catering – TWH 9. Domestics – TWH 10. Laundry - TWH 11. Loading Bay - TWH 12. Porters - TWH 13. Post room - TWH 14. Ward 32 - TWH	-
Chief Nurse	1. Foster Clark Ward – MH 2. Pye Oliver Ward – MH 3. Whatman Ward – MH 4. Mercer Ward – MH 5. Stroke Unit – MH 6. ITU – MH 7. Lord North Ward – MH 8. Cornwallis Ward – MH 9. ITU - TW	-
Chief Operating Officer	1. Cardiac Cath Lab - MH 2. Cornwallis Ward - MH 3. Culpepper Ward - MH 4. Pye Oliver Ward - MH 5. Stroke Unit - MH 6. Whatman Ward - MH 7. Foster Clark Ward – MH 8. Pye Oliver Ward – MH 9. Whatman Ward – MH 10. Mercer Ward – MH 11. Stroke Unit – MH 12. ITU – MH 13. Lord North Ward – MH 14. Cornwallis Ward – MH 15. ITU – TW	6
Director of Corporate Affairs	1. Cornwallis Ward - MH 2. A&E – TWH 3. MAU - TWH 4. Ward 30 - TWH 5. Ward 31 – TWH	5
Director of Finance	-	-
Director of Infection Prevention and Control	-	-
Director of Strategy and Workforce	1. Short Stay Surgery - TWH 2. Ward 32 - TWH	-

Board member	Areas logged as being visited (MH: Maidstone Hospital; TW: Tunbridge Wells Hospital)	Formal feedback provided?
Director of Transformation	1. Birthing Centre - MH	-
Medical Director	-	-
Non-Executive Director (KT)	-	-
Non-Executive Director (SD)	Tours of both hospital sites, incorporating: 1. A&E – MH 2. ITU – MH 3. Urgent Medical and Ambulatory Unit – MH 4. Romney Ward – MH 5. Mercer Ward – MH 6. Short stay surgical unit – MH 7. A&E – TWH 8. MAU – TWH 9. Short Stay Surgical Unit – TWH 10. Ward 10 - TWH 11. Ward 20 - TWH	-
Non-Executive Director (ST)	1. Mortuary – TWH 2. Pathology - TWH	2

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TRUST BOARD MEETING - MARCH 2014

3-15	SUMMARY OF THE TRUST MANAGEMENT EXECUTIVE (TME) MEETINGS, 19/02/14 & 19/03/14	COMMITTEE CHAIR (CHIEF EXECUTIVE)

Summary / Key points

This report provides information on the TME meetings held on 19th February & 19th March.

The key points at the meeting on 19th February were as follows:

- The major changes to the NHS standard contract were discussed, and it was noted that the contract introduced patient-level penalties (rather than having penalties based on percentages, as is currently the case). This included £200 per patient for breaches of the 2-week cancer-wait target (specifically, breaches of the 93% operating standard in the quarter), and £10,000 per patient that breaches the published annual threshold for clostridium difficile.
- The external review of the Trust's Finance Department was discussed, and representatives from Grant Thornton (who undertook the review) attended to present their findings.
- The initial feedback from the care quality commission's unannounced visit to Maidstone Hospital was shared
- An update of the development of the Annual Plan for 2014/15 was provided.
- The latest performance issues were discussed (this is a standing item each month), in terms of operational and clinical performance, quality and safety, workforce and financial matters.
- Updates on key issues / challenges / risks were given by the Clinical Directors. These included an issue relating to concerns raised following the introduction of the "CUBE" document management system.
- A business case for 4 new Consultant Anaesthetists was approved.

Meetings on 19th March

Two meetings were held this day. The first was an extraordinary meeting, consisting of a joint session with the Trust Board. This arose following an agreed action at the December 2013 Board Forum. The session was focused on Annual Planning for 2014/15 and beyond, and in particular on the Directorate's plans (in relation to Activity; Workforce; Cost Improvement Programme (CIP); Budget; Quality; and Service Developments), including any issues still to be resolved.

The key points from the second (usual business) meeting held on the day were as follows:

- An update on the Clinical Administration Units was received, including the outcome of the investigation regarding the "CUBE" document management system that had been discussed at the February meeting (see above)
- The findings from the National NHS staff survey 2013 were presented.
- The latest performance issues were discussed (this is a standing item each month), in terms of operational and clinical performance, quality and safety, workforce, infection control, and financial matters.
- A revised protocol for out-of-hours CT scanning was agreed.
- A business case for a replacement Consultant Radiologist was agreed.
- The business case for the John Day / Jon Saunders ward refurbishment was approved (this features as a separate agenda item at the March Trust Board)
- The Trust Management Executive endorsed the proposed Information Governance Toolkit return for 2013/14 (this also features as a separate agenda item at the March Trust Board)

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

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TRUST BOARD MEETING – MARCH 2014

3-16	SUMMARY REPORT FROM THE WORKFORCE COMMITTEE, 06/03/14	COMMITTEE CHAIR (NON-EXECUTIVE DIRECTOR)

Summary / Key points:

This report provides information on the Workforce Committee meeting held on 6th February.

The key points considered at the meeting were as follows:

- The actions from previous meetings were discussed (all were considered to have been addressed)
- The findings of the national NHS Staff survey 2013 were discussed in detail. The committee reviewed the finding related to the proportion of staff who stated they had experienced physical violence from colleagues (which was raised as a concern at the Board Forum meeting held in February). It was noted that to date, no evidence had been found to triangulate the finding.
- An update on the development of workforce plans for 2014/15 was provided
- An update of medical education was provided by the Director of Medical Education.
- A report was received on the Trust's future strategy for the recruitment of 'generation y' (individuals born between 1979 & 1995), & the 'millennium generation' (those born post-1995).
- A report was received on the progress regarding the plans for the future provision of payroll services to the Trust.
- The risks allocated to the committee were received
- Two amended policies were ratified:
  - Dress, Uniform and Identification and identification badge policy and procedure
  - Maternity Leave policy
- It was agreed that the review date of a further policy (Job Planning and Senior Medical Staff) could be extended.

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 - MARCH 2014

3-18	PERFORMANCE REPORT, MONTH 11, 2013/14	CHIEF OPERATING OFFICER / DIRECTOR OF STRATEGY & WORKFORCE / DIRECTOR OF FINANCE

Summary / Key points

The performance data to the end of month 11 (February) is enclosed.

Summary:

- The emergency pressures during January continued into February with significantly increased non-elective activity. Whilst the numbers of patients attending A&E activity where as expected the proportion requiring admission increased further, particularly at Maidstone, putting pressure on beds.
- The Trust performed well on most quality measures with pressure ulcers dropping further to a rate of 9.0 which is better than the previous year and below the target of 14.8. C diff performance continued below trajectory for the year with just 2 cases in February. There was, however, one case of MRSA. The trust has slightly better than average responses to the friends and family test for inpatients and the response rate for A&E improved further to 15%.
- The financial position is remains challenging with a year to date deficit improving to £12.4m against a breakeven plan.

Which Committees have reviewed the information prior to Board submission?

- Executive Team, 18/03/14
- Trust Management Executive, 19/03/14

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

February 2014 Performance

Summary

The emergency pressures during January continued into February with significantly increased non-elective activity. Whilst the numbers of patients attending A&E activity where as expected the proportion requiring admission increased further, particularly at Maidstone, putting pressure on beds.

The Trust performed well on most quality measures with pressure ulcers dropping further to a rate of 9.0 which is better than the previous year and below the target of 14.8. C diff performance continued below trajectory for the year with just 2 cases in February. There was, however, one case of MRSA. The trust has slightly better than average responses to the friends and family test for inpatients and the response rate for A&E improved further to 15%.

The financial position is remains challenging with a year to date deficit improving to £12.4m against a breakeven plan.

Quality

Overall the key performance indicators for quality show an improving trend. The position for end of February is as follows:

- The year to date position for delivering Harm Free Care increased slightly to 97.2% against a national average of 93.5%.
- The rate of hospital acquired pressure ulcers dropped February. As a result the overall rate of all pressure ulcers has reduced to 9.0, well below the latest national average.
- The rate of falls in February worsened to 7.4 increasing the year to date position to 7.2. This remains the Trusts main focus for quality improvement.
- In February there were just 2 cases of C diff giving a year to date rate for hospital acquired c diff of 11.0 against a national average of 18.9
- 1 further cases of MRSA.
- Unfortunately data for elective MRSA screening is not available however non-elective screening stayed at 95%.
- February saw the lowest number of complaints received for this financial year, a rate of 3.59 compared to a national average of 6.26. The response rate also improved to 79.1% for February
- Stroke performance dropped slightly to 80.8% of patients spending 90% of their stay on a stroke ward and year to date is still below the expected standard.

Performance & Activity

- The demand for A&E was at slightly above average levels in February bringing the year to date position to just 2.2% higher than last year. However the rate of A&E attendances needing admission increased to 29.1% which resulted in increased levels of non-elective admissions. The income for non-elective admissions is above plan suggesting a more complex case mix than expected.
- There was a reduction in length of stay for non-elective patients to 6.6 days with a corresponding decrease in occupancy to 630 beds.
- Elective inpatient activity was on plan for the month at 690 cases whilst day cases continued to over perform significantly at 13.3% above plan. This is being driven by the increased demand from primary care.

- Referrals from Primary Care continued to be high at 8.3% above plan and previous year. This is mainly driven by increased referrals from West Kent GP's except for Ophthalmology where the increase is driven by Medway and Swale GPs. Consultant to consultant referrals dropped significantly and this is being investigated.

Finance

The Trust reported a year to date deficit of £13.1m (£1.3m surplus in month) which represents a variance against the deficit plan after technical adjustments of £12.7m (£1.5m surplus variance in month).

The main overspends in the month continue to relate to Medical and Nursing staffing where temporary staff costs exceed the substantive underspends and non-pay predominantly driven by activity increases and also other non-pay with offsetting income.

Non pay is overspent YTD due to drugs, clinical supplies and outsourcing activity which have offsetting additional income.

The year-end forecast is a £12.4m deficit, a £2m improvement against the upper range of £14.4m. This includes delivery of £8.4m of the £11.0m recovery plan. The high risk items have been removed from the FOT this month (CCG reinvestment £3m and Outpatient Procedures £1.5m). Remaining risk to achieving the £12.4m is believed manageable.

CIP delivered £18.5m (£3.0m in month) against the £21.5m target with slippage on cost reduction schemes of £8.0m offset by overachievement on income schemes £2.2m and Other Financing savings £0.2m and the recovery plan items of £0.6m. Cost reduction CIPs within the total CIP delivery was £0.9m in month, £9.1m year to date and £10.3m FOT (adverse variance of £8.7m.)

The CCG contracts are £8.1m, 3.4% above the purchased plan in month 11, the SLA team are reconciling the SLA position with the Commissioning Support Units (CSU's).

The Trust is reporting a £8.4m favourable variance against the Trust phased budget to month 11, this favourable variance is made up as follows:-

- GROSS Activity related income of £5.6m (2%) above the phased budget, in the following areas:-
  - Day case - £3.7m favourable variance
  - Elective Spells £1.1m favourable variance
  - Non Elective Spells - £2.3m favourable variance
  - Outpatients - £122k negative variance
  - Regular Attenders - £749k favourable variance

The month 11 reported positions include £997k for the Trusts allocation from WKCCG for winter pressure funding; this value was agreed by the Trust and the CCG following a meeting earlier this month. In addition the Trust is reflecting £2.3m of funding for unbundled diagnostic imaging within the YTD month 11 position.

The Outturn position includes a number of income expectations that to date the CCG's have not confirmed will be reimbursed. These are being worked through with the CCG leads; the risk associated with these items within the recovery plan and the impact on the year end position should be noted. Other income from the additional items expected as part of the recovery plan has been agreed to date by the CCG, these should be considered a risk.

The Outturn position includes a number of income expectations that to date the CCG's have not confirmed will be reimbursed. These are being worked through with the CCG leads; the risk associated with these items within the recovery plan and the impact on the year end position should be noted.

Workforce

Following the analysis of the workforce data for the month of February 2014 the following is drawn to the attention of the Board

1. That the total number of whole time equivalents used, a combination of substantive staff, bank, agency, locum and overtime, in month was lower than the establishment by approximately 73 whole time equivalents, this incorporates all worked staff, it is helpful to compare the increase in workload with the reduction in the size of the workforce when comparing 2012/2013 with 2013/2104. Effectively showing that the increase in activity is being undertaken by a workforce reduced by circa 120 wte.

2. that the level of sickness absence in the Trust is some margin below the benchmark for comparative trusts 3.8% compared with 4.3%

3. That the Trust appraisal rates recorded are shown as 82.4% compared with the full year target of 90%, remedial action is being taken to improve the level of appraisal. It is helpful to note that when we survey our own staff they believe that appraisal rates run above 90%, which suggests a lack of recording rather than a lack of undertaking the appraisals.

TRUST PERFORMANCE DASHBOARD | **Position as at:** | **28th February 2014**

Governance (Quality of Service): 1.5 Amber/Green

Finance: 1.0 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		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
'1-01	Hospital-level Mortality Indicator (SHMI)			101.26	100.3	-0.96	0.3	*100*		100
'1-02	Standardised Mortality (Relative Risk)			98.91	98.8	-0.11	-1.2	*100*		100
'1-03	Crude Mortality	1.5%	1.1%	1.3%	1.2%	-0.1%			1.2%	
'1-04	Safety Thermometer % of Harm Free Care	New	97.2%	New	95.3%		1.8%	93.5%		93.5%
'1-05	*Rate C-Diff (Hospital only)	21.9	11.0	25.0	15.7	-9.2	-3.4	*19.7*	15.8	18.9
'1-06	Number of cases C.Difficile (Hospital)	4	2	52	32	-20.0	-7.0	*42*	35	43
'1-07	Number of cases MRSA (Hospital)	0	1	2	3	1	2	*1*	3	
'1-08	Elective MRSA Screening	No data	No data	No data	No data			98.0%	No data	
'1-09	% Non-Elective MRSA Screening	No data	95.0%	No data	95.0%		0.0%	95.0%	95.0%	
'1-10	**Rate of All Pressure Ulcers	16.7	9.0	8.2	11.9		-2.9	*14.8*	11.9	14.8
'1-11	**Rate of Hospital Pressure Ulcers	4.7	1.6	3.4	2.4	-1.0	-0.6	*3.0*	2.4	3.0
'1-12	****Rate of Total Patient Falls	8.5	7.5	7.9	7.2	-0.8	0.0	7.2	7.2	
'1-13	****Rate of Total Patient Falls Maidstone	8.9	6.1	7.0	6.3	-0.7	-0.9	7.2	6.3	
'1-14	****Rate of Total Patient Falls Tunbridge Wells	8.2	8.7	8.7	7.9	-0.8	0.7	7.2	7.9	
'1-15	Falls - Moderate/Severe Injury	7	5	62	58	-4	3	*60*	60	
'1-16	MSA Breaches	5	0	39	10	-29	10	0	10	
'1-17	Total No of SIRIs Open with MTW	48	21			-27				
'1-18	Number of SIRIs open past breach MTW	New	4						0	
'1-19	Number of New SIRIs in month	15	12	130	120	-10	10	120	120	
'1-20	Number of SIRIs open (with CCGs/LATs)	New	36	New					0	
'1-21	Number of Never Events	0	0	0	1	1	1	*0*	1	
'1-22	Readmissions <30 days: Emergency	11.1%	11.0%	11.7%	11.1%	-0.6%	2.1%	*9%*	11.1%	14.3%
1-23	Readmissions <30 days: Elective	5.5%	4.8%	5.8%	5.8%	0.0%	0.8%	*5%*	5.8%	6.7%
'1-24	***Rate of New Complaints	4.8	3.59	6.1	5.01	-1.1	-1.25	*6.26*	5.03	6.26
'1-25	% complaints responded to within target	39.5%	79.1%	57.3%	70.6%	13.3%	-4.4%	75.0%	70.6%	
'1-26	IP Resp Rate Recmd to Friends & Family	New	16.2%	New	17.3%	New	2.3%	15%	17.3%	31.0%
'1-27	A&E Resp Rate Recmd to Friends & Family	New	10.8%	New	4.5%	New	-10.5%	15%	4.5%	17.4%
'1-28	Comb Resp Rate Recmd to Friends & Family	New	12.5%	New	8.4%	New	-11.6%	20% #	15.0%	22.0%
'1-29	Combined FFT Score	New	72	New	72	New	8	64	72	64
'1-30	Five Key Questions Local Patient Survey	89.8%	91.8%			2.0%		90%	91.8%	
'1-31	VTE Risk Assessment Local Target	95.1%	95.5%	94.5%	95.3%	0.8%	0.3%	95%	95.3%	96%
'1-32	% Dementia Screening	New	98.5%	New	99.0%	New	9.0%	90%	99.0%	
'1-33	% TIA with high risk treated <24hrs	73.7%	No data	54.3%	63.6%	9.4%	3.6%	60%	63.6%	
'1-34	% spending 90% time on Stroke Ward	68.5%	80.8%	81.5%	76.8%	-4.7%	-3.2%	80%	76.8%	

Responsible Committee: Finance, Treasury & Investment — Monitor FRR to be replaced by continuity of service metric

	Finance & Efficiency	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
3-01	Average LOS Elective	3.2	2.9	3.7	3.3	-0.5	-0.4	*3.7*	3.3	3.7
3-02	Average LOS Non-Elective	7.6	6.6	7.0	6.8	-0.2	0.7	*6.1*	6.8	6.1
3-03	New:FU Ratio	1.82	1.72	1.77	1.76	-0.01	0.15	*1.60*	1.76	
3-04	Day Case Rates	78.7%	81.5%	78.5%	79.8%	1.3%	-0.2%	80.0%	80.0%	82.19%
	Finance & Efficiency	**Latest Month**		**Year to Date**		**YTD Variance**		**Year End**		**Bench Mark**
		Plan	Curr Yr	*Plan*	Curr Yr	From Prev Yr	From Plan	Plan	Forecast	
3-05	Income	28,708	29,552	332,935	339,958	1.4%	2.1%	365,823	374,243	
3-06	EBITDA	3,148	1,417	34,612	18,384	-45.4%	-46.9%	36,430	23,102	
3-07	Surplus (Deficit) against B/E Duty	(200)	(1,707)	(390)	(16,087)			24	(12,384)	
3-08	CIP Savings	2,090	3,859	21,530	18,540	19.4%	-13.9%	23,624	23,529	
3-09	Cash Balance	6,399	13,242	6,399	13,242	-13.2%	106.9%	8,909	966	
3-10	Capital Expenditure	1,032	876	13,078	7,621	-14.1%	-41.7%	*14,510*	11,053	
3-11	**Monitor Financial Risk Rating**	0	1	0	1			3	1	

Responsible Committee: Finance, Treasury & Investment

	Performance & Activity	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
2-01	**Monitor Indicative Risk Rating	New	1.5	New	1.5	Amber/Green		Amber/Green		
2-02	**Monitor Overiding Rules Rating	New	0.0	New	0.0					
2-03	Emergency A&E 4hr Wait	91.0%	95.05%	93.3%	95.5%	2.2%	0.5%	95%	95.7%	94.6%
2-04	Emergency A&E >12hr to Admission	0	0	0	0	0	0	0	0	
2-05	***Ambulance Handover Delays >30mins	New	0	New	90	New	-1	365	154	
2-06	***Ambulance Handover Delays >60mins	New	0	New	1	New	1	0	1	
2-07	18 week RTT - admitted patients	91.5%	91.9%	92.0%	91.8%	-0.2%	1.8%	90%	91.8%	
2-08	18 week RTT - non admitted patients	97.0%	96.7%	97.8%	96.6%	-1.1%	1.6%	95%	96.6%	
2-09	18 week RTT - Incomplete Pathways	93.3%	93.3%	93.3%	93.3%	0.0%	1.3%	92%	93.3%	
2-10	18 week RTT - Specialties not achieved	3	3	30	31	1	31	*0*	31	
2-11	18 week RTT - 52wk Waiters	0	0	2	1	-1	1	*0*	1	
2-12	Diagnostics Tests WTimes >6wks	0.0%	0.00%	0.0%	0.01%	0.0%	0.0%	*0.0%*	0.0%	
2-13	Cancer WTimes - Indicators achieved	9	8	9	9	0	0	9	9	
2-14	****Cancer two week wait	97.9%	94.7%	98.0%	96.5%	-1.5%	3.5%	93%	96.5%	95.5%
2-15	****Cancer 31 day wait - First Treatment	99.5%	98.5%	99.5%	99.3%	-0.2%	3.3%	96%	99.3%	98.4%
2-16	****Cancer 62 day wait - First Definitive	90.5%	86.6%	88.7%	86.4%	-2.3%	1.4%	85%	86.4%	87.1%
2-17	****Cancer 62 day wait - Screening	100.0%	100.0%	89.4%	94.1%	4.7%	4.1%	90%	94.1%	
2-18	Delayed Transfers of Care	2.9%	3.9%	3.8%	3.3%	-0.5%	-0.2%	3.5%	3.3%	
2-19	Primary Referrals *	7348	7,796	83459	89,817	7.6%	8.3%	90,451	97,912	
2-20	Cons to Cons Referrals *	3956	2,849	46621	45,734	-1.9%	-0.6%	50,188	49,856	
2-21	First OP Activity	10745	12,538	127529	134,503	5.5%	4.0%	141,020	146,626	
2-22	Subsequent OP Activity	19455	21,235	224553	231,041	2.9%	1.5%	248,254	251,864	
2-23	Elective IP Activity	690	627	7886	8,069	2.3%	0.6%	8,740	8,796	
2-24	Elective DC Activity	2555	2,682	28401	31,325	10.3%	13.3%	30,150	34,148	
2-25	Non-Elective Activity	3301	3,817	40950	42,522	3.8%	-3.1%	*47,835*	46,469	
2-26	A&E Attendances	8965	9,409	111562	113,970	2.2%	0.6%	*123,560*	124,548	
2-27	Oncology Fractions	5489	5,252	62970	61,217	-2.8%	-4.7%	70,030	66,899	
2-28	No of Births (Mothers Delivered)	376	415	5,001	4,917	-1.7%	5.7%	5,580	5,409	

** 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, # CQUIN target 20% Q4 (Forecast is Q4)*

* Referrals plan is prev yr adjusted for w/days, ** Montior Rating is latest Quarter, ****CWT run one month behind

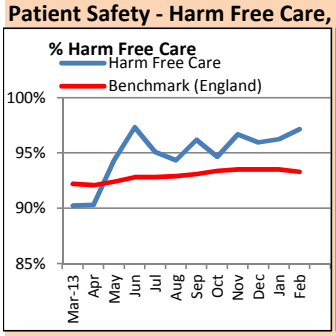
***Ambulance Handover is unvalidated

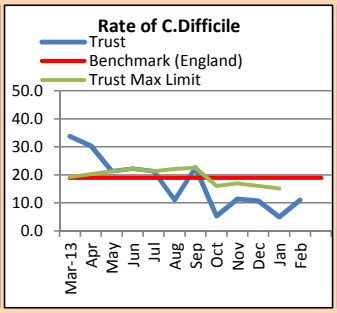
Responsible Committee: Workforce

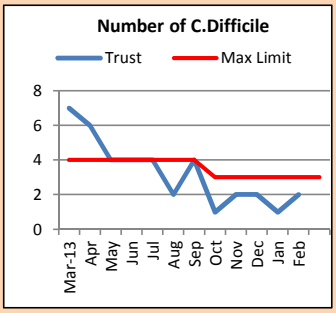
	Workforce	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ Limit	Forecast	
4-01	Establishment (Budget WTE)	5,525.9	5,359.0	5,525.9	5,359.0	-3.0%	0.0%	*5,351.3*	5,351.3	
4-02	Contracted WTE	4,972.4	4,973.2	4,972.4	4,973.2	0.0%	-7.2%	*5,351.3*		
4-03	Locum Staff (WTE)	44.3	21.4	44.3	21.4	-51.8%				
4-04	Bank Staff (WTE)	316.5	226.2	316.5	226.2	-28.6%				
4-05	Agency Staff (WTE)	120.3	113.8	120.3	113.8	-5.4%				
4-06	Overtime (WTE)	67.2	59.0	67.2	59.0	-12.3%				
4-07	Worked Staff WTE	5,401.6	5,285.6	5,401.6	5,285.6	-2.1%	-1.5%	*5,357.5*		
4-08	Vacancies WTE	553.6	385.7	553.6	385.7	-30.3%			362.6	
4-09	Vacancy %	10.0%	7.2%	10.0%	7.2%	-28.1%			6.8%	
4-10	Nurse Agency Spend	(372)	(275)	(3,988)	(3,733)	-6.4%			(3,982)	
4-11	Medical Locum & Agency Spend	(777)	(691)	(6,893)	(7,367)	6.9%			(8,047)	
4-12	Staff Turnover Rate	9.0%	11.1%		10.64%	2.1%	0.6%	*10.5%*	10.64%	8.4%
4-13	Sickness Absence	3.9%	3.8%		3.7%	-0.1%	0.5%	*3.3%*	3.7%	4.3%
4-14	Statutory and Mandatory Training	84.7%	86.7%		86.7%	2.0%	1.7%	85.0%	85.0%	
4-15	Appraisals	85.2%	82.4%		82.4%	-2.8%	-7.6%	90.0%	90.0%	

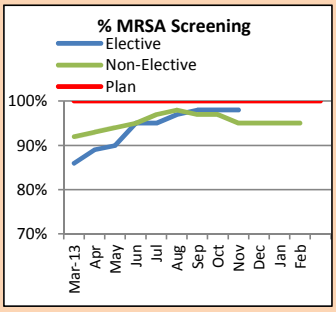
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

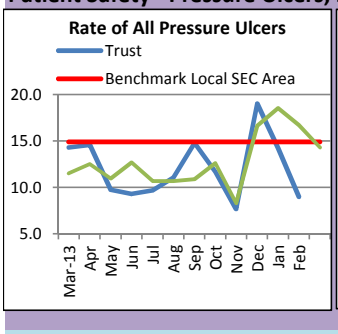


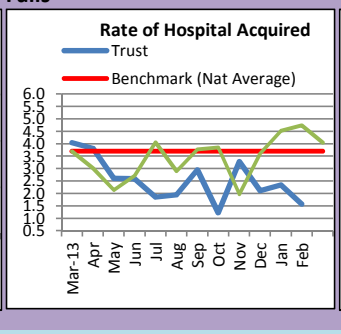


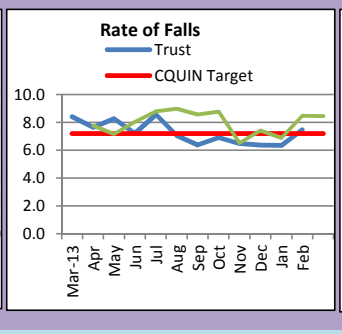


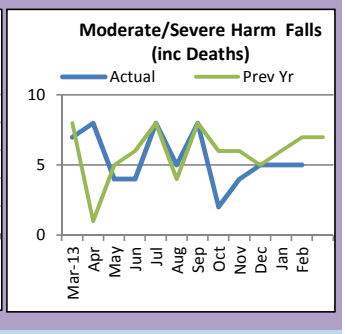


Patient Safety - Pressure Ulcers, Falls

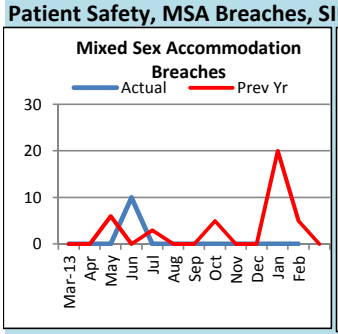


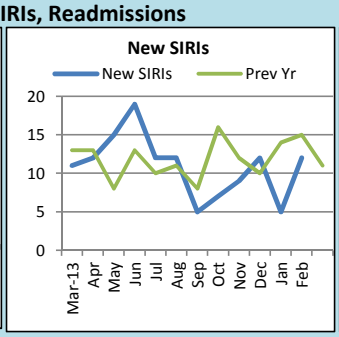


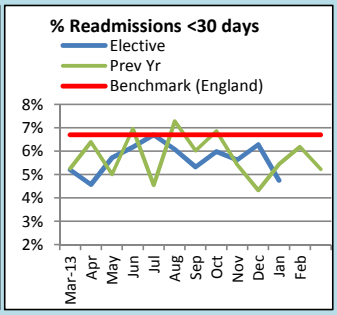


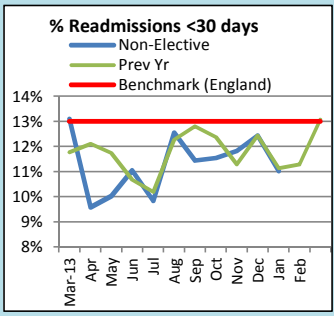


Patient Safety, MSA Breaches, SIRIs, Readmissions

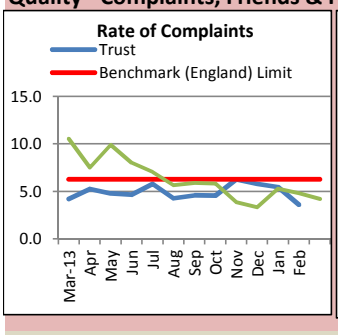


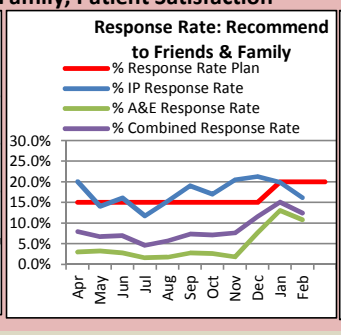


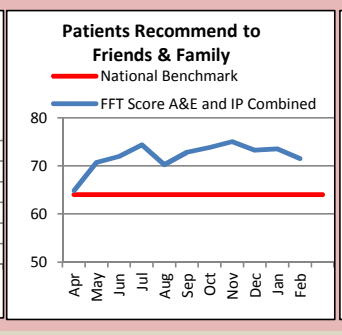


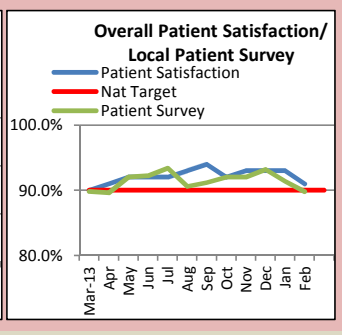


Quality - Complaints, Friends & Family, Patient Satisfaction

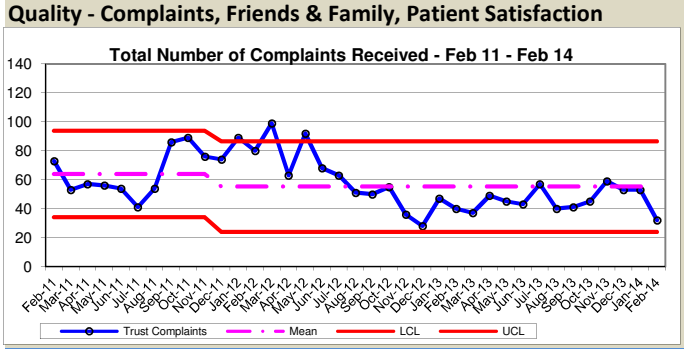


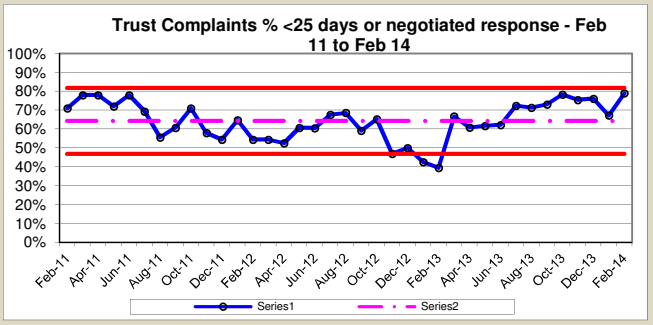




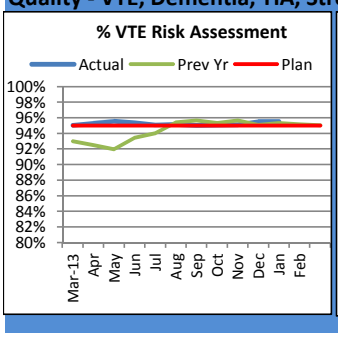


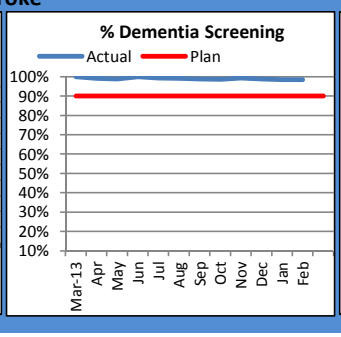
Quality - Complaints, Friends & Family, Patient Satisfaction

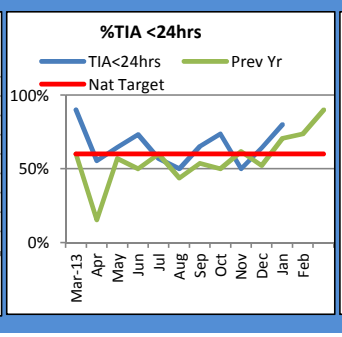


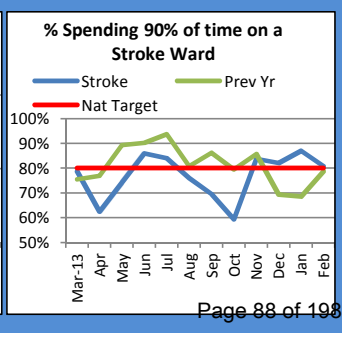


Quality - VTE, Dementia, TIA, Stroke









Safer Thermometer: Of the 670 patients surveyed for the Safety Thermometer in February 97.2% of patients had Harm Free Care which is above the national benchmark of 93.5%. This is an improving trend. In total 99% of patients in hospital on the snapshot date were surveyed.

CDifficile: 2 cases reported for February (2 fewer than last year). YTD Trust is below the maximum trajectory with 32 cases reported (52 last year). Rate for February is 11.0 and YTD rate is 15.7 (national benchmark of 18.9). The Trust target for 2013/14 is 42 cases which would equate to a rate of 19.7.

MRSA: There was 1 case of MRSA reported for February. 3 YTD against a maximum limit of 1. **MRSA Screening** compliance is not available for Elective. Non-elective compliance remained at 95%.

MSSA and E Coli: 1 case of post 48hrs MSSA reported for February. 13 reported YTD compared to 19 YTD last year. 3 cases of post 48hrs E.Coli bacteraemia reported for February, 55 reported YTD compared with 46 reported YTD last year.

Pressure Ulcers: The rate of hospital acquired pressure sores for February per 1,000 admissions reduced to 1.6. YTD the rate is 2.4 which is below the National Benchmark of 3.0. The number of pressure ulcers decreased by 4 in February to 7 (compared to 19 last year). YTD there have been 121 Pressure Ulcers reported compared to 166 last year. Of the 7 pressure ulcers reported for February, 5 were at the Tunbridge Wells site and 2 were at the Maidstone site. There was 1 Grade 3 Pressure Ulcer reported in February at the Tunbridge Wells site.

Falls: The number of Falls increased by 10 in February to 135. The rate per 1,000 occupied beddays is 7.5 for February. YTD the rate is at 7.2 which is the target agreed with the CCG for CQUINs. YTD there have been 1458 Falls (compared to 1652 last year). The number of Falls resulting in moderate to severe harm was 5 in February (compared to 7 reported for February last year). YTD there have been 58 falls resulting in moderate to severe harm compared to 62 for the previous year.

Mixed Sex Accommodation Breaches:

There were zero breaches recorded in February 2014, 10 reported YTD compared to 39 reported year to date for the previous year.

SIRIs: The number of SIRIs reported in the month for February increased to 12 (15 for February last year) . The number of SIRIs open with MTW has reduced to 21 as at the end of February (48 open with MTW as at the end of February last year).

Never Events: No Never Events reported in February. 1 Never Event reported YTD (August).

Readmissions <30 Days: Non-Elective readmissions decreased slightly in January at 11% (394) which is below the national benchmark limit of 14.3% but above the Trust internal target of 9%. The specialties showing the biggest increase remain Medical specialties as well as T&O and General Surgery. Elective Readmissions have decreased in January to 4.8% (25).

Complaints:

The number of complaints has significantly reduced in February at 32 which is lowest number recorded in any one month during the year (40 last year). The monthly open cases has decreased further to 80. The rate of complaints per 1,000 episodes is below the national maximum benchmark of 6.26 for February at 3.59 (5.01 YTD).

Complaints open >60 but <90 days has decreased remained the same in February at 8 (compared to 19 last year). The number open >90 days has decreased to 7. The number of nursing complaints received has decreased to 6 (the number reported YTD is 82 compared to 121 YTD last year). The number of medical complaints received has also decreased significantly to 17 in February.

Performance for compliance within target response date has increased significantly to 79.1% which is the highest performance reported in the last two years. Women & Sexual Health, Critical Care, Acute & Emergency and Diagnostics, Therapies and Pharmacy all achieved 100%. Specialist Medicine 71.4%, Surgery 66.7% and Cancer & Haematology 50%. T&O had 2 complaints that was due to close that was not closed within the timescale. No complaints for Corporate Services or Private Patients.

Friends & Family: Response rates for February decreased to 10.8% for A&E. Inpatients decreased slightly to 16.2% giving a combined response rate of 12.5% against the national target of 15%. For Quarter 4 to date (January and February) the combined response rate is 13.8% against the CQUIN target of 20% for the Quarter. The overall Friends & Family (FFT) Score is 72 (national benchmark is 64), IP FFT Score is 77 (national benchmark 72) and A&E FFT Score is 68 (national benchmark 56).

Patient Satisfaction: has decreased slightly in February at 91%.

Patient Survey: Local data for February shows the aggregate local score has decreased to 89.8%. Local Performance for each of the 5 questions for February 2014 is as follows: Involvement in Decisions about treatment/care: 89% (-4%)
Hospital Staff being available to talk about worries/concerns: 92% (-2%)
Privacy when discussing condition/treatment: 98% (-1%)
Being informed of side effects of medication: 80% (+3%)
Being informed of who to contact if worried about condition after leaving hospital: 90% (-4%)

VTE: Performance remains consistent at 95.5% for January (data one month behind) therefore achieving the national target of 95%.

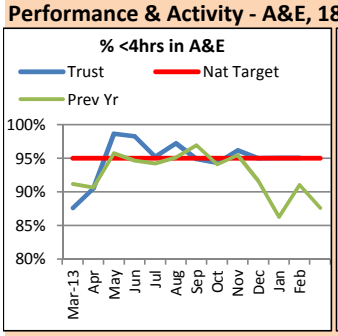
Dementia: The Trust has achieved 98.5% for Screening (therefore above the 90% target). Performance YTD is 99% for Screening.

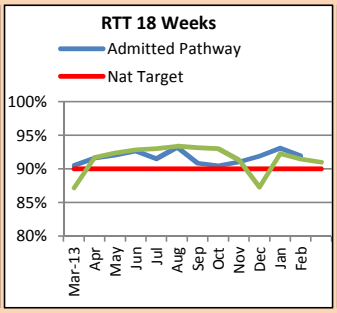
TIA: Performance for TIA is not available for February . Performance increased in January to 80%. The YTD position remains above the national 60% target at 63.6%. In order to achieve the target for the year the Trust needs to achieve around 58.5% compliance per month for the remainder of the year.

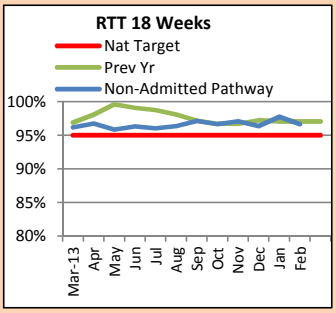
Stroke: Performance for February is 80.8%. The YTD position remains below the national target at 76.8%. This standard will not be met for 2013/14 but the Improvement Plan is focused on delivery for Quarter 4 at +80%. Quarter 4 to date is 84%.

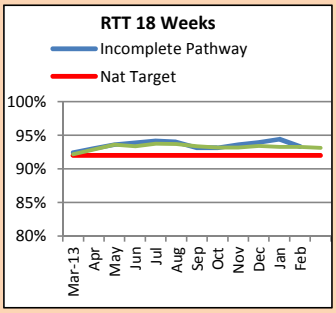
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

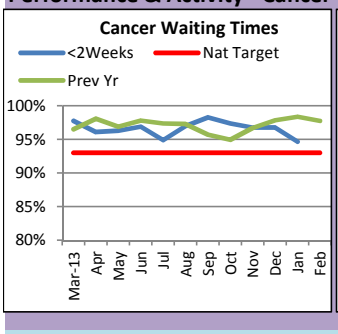


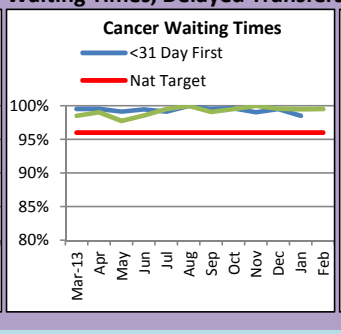


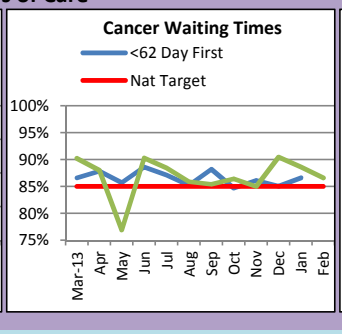


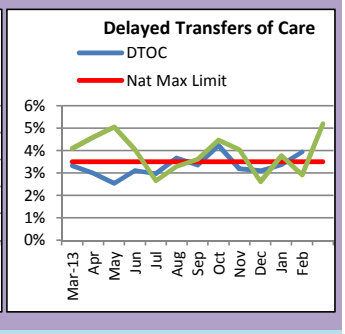


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

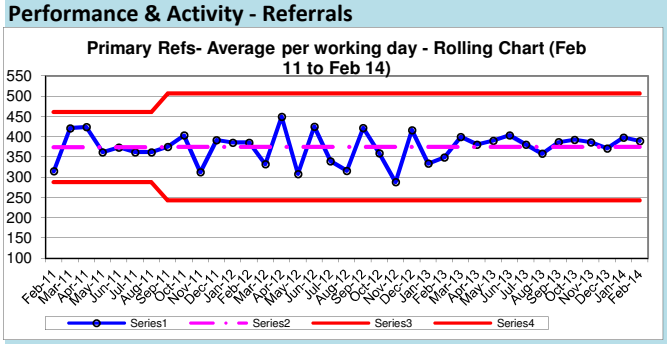


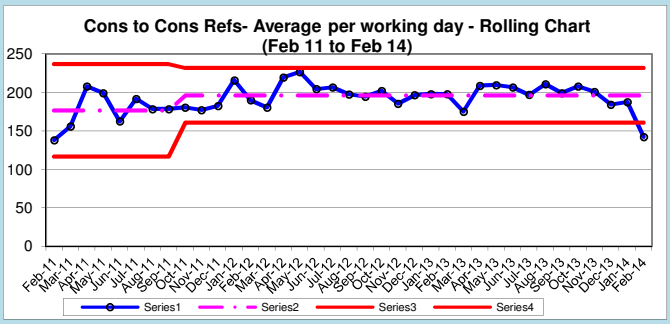




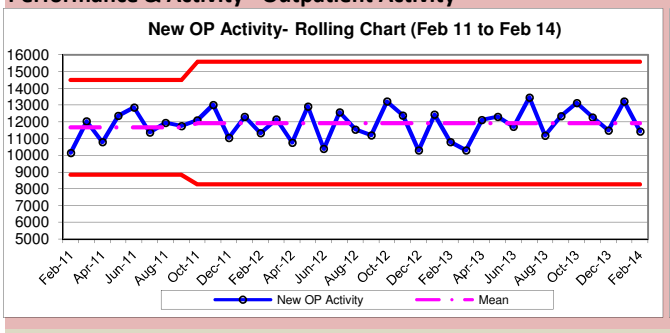


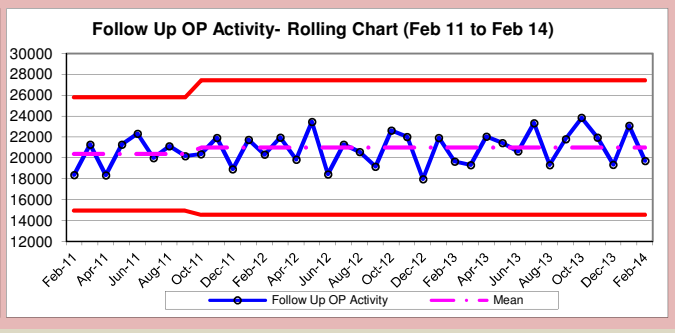
Performance & Activity - Referrals



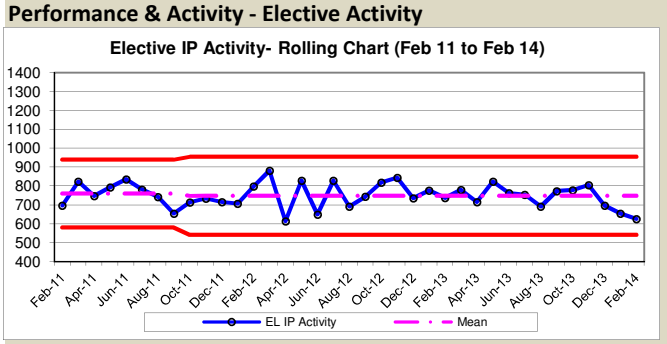


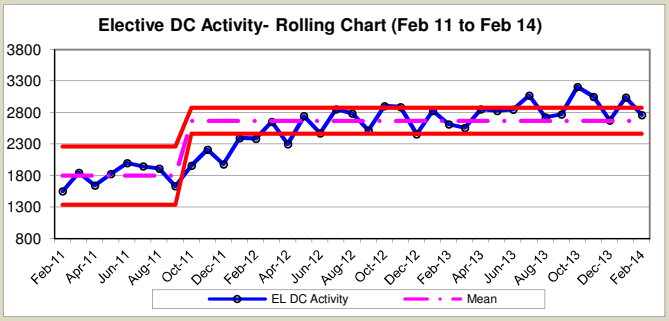
Performance & Activity - Outpatient Activity



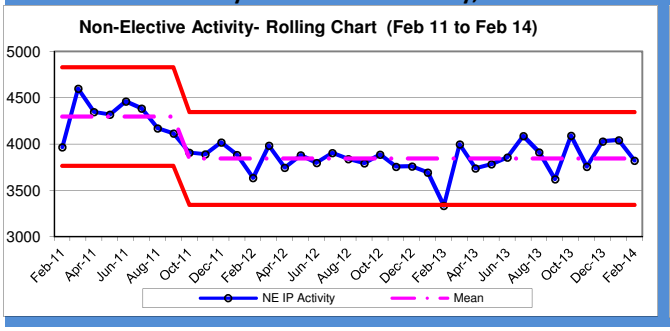


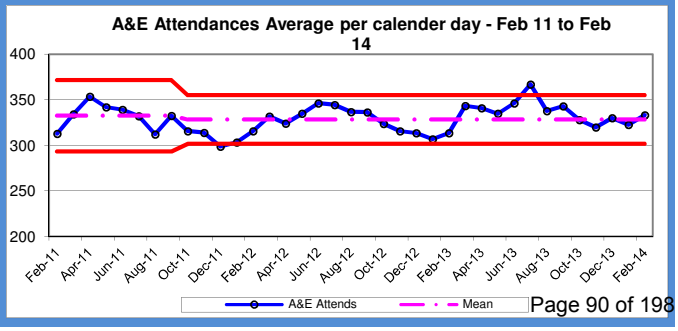
Performance & Activity - Elective Activity





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





INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

A&E: 4hr standard increased to 95.05% in February (97.1% MH, 93.2% TWH). Year to date performance is 95.5%. The projected score for the Year is 95.6%. Year to Date A&E Attendances are 2.1% higher than the previous year and just above the long term average. 14% increase in Ambulance Conveyances for month compared to last year (19% increase at TWH). Non-elective activity increased by 5% from January to February and was 15% higher in February than last year. Patients >75 showed an 18% increase in February compared to last year, 9.5% YTD. YTD Non-Elective activity is 3.6% higher than the previous year and now above the long term average across both sites. Emergency admissions via A&E remained similar in February to January (when adjusted for calender days) but YTD are 4.8% lower than the previous year. The A&E Conversion rate increased slightly in February to 28.9% (same as the previous year).

18 weeks (RTT): The Trust achieved the aggregate target for admitted, non-admitted & incomplete pathways for February 2014. All specialties achieved the admitted target with the exception of T&O. T&O and Ophthalmology did not achieve the Incomplete target.

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

Cancer Waiting Times: The Trust achieved all CWT Targets for January with the exception of 2WW Breast Symptoms. • 2WW standard 93%. Achieved January 2014 94.7%, YTD achieving 96.5%
• Breast Symptoms standard 93%. Achieved January 2014 89%, YTD achieving 94.1%
• 31 day FDT standard is 96%. Achieved January 2014 98.5%. YTD achieving 99.3%
• 62 day FDT standard is 85%. Achieved January 2014 86.6%, YTD achieving 86.4%
• 62 day screening standard is 90%. Achieved January 2014 100%, YTD achieving 94.1%

Delayed Transfers of Care: Performance for February was 3.9% and 3.3% YTD (maximum limit 3.5%). The number of bed days lost due to delayed transfers of care has increased in February to 714. Of the bed days lost due to delays reported for February 26% were awaiting a non-acute NHS bed, 46% were due to Patient/Family Choice, 14% were due to waiting for a Nursing/Residential Home, 1% were due to community adaptations, 7.8% due to awaiting care package, 1% were awaiting Public Funding and 1% were due to housing. There have been 105 patients admitted to and discharged from Romney Ward during January.

Performance & Activity - Referrals

Primary Care Referrals: Referrals remained similar in February and were 9.5% above plan and 6.1% higher than February last year. Referrals remain 8.3% above plan YTD (previous year outturn adjusted for 13/14 monthly working days) and 7.6% above the previous year. Referrals remain at the longer term average. The specialties that are the highest above plan YTD remain T&O, Haematology, General Surgery, Urology , Gynaecology, GU Medicine, Cardiology, ENT, Neurology, Paediatrics and Rheumatology. T&O referrals remain 16% above plan and previous year, year to date.

Consultant to Consultant Referrals: Referrals have decreased (when adjusted for working days and in-month under reporting) in February and were 19% below plan and Previous Year. Consultant to Consultant referrals are now below the lower control limit and are 0.2% below plan once adjusted for in-month under-reporting. Referrals are 1.9% lower than the previous year (1.1% below once adjusted for in-month under reporting). The specialties showing an increase YTD compared to the previous YTD are ENT and Neurology. Oncology, Cardiology, Care of the Elderly, Respiratory, Endocrinology and Haematology are showing the biggest decrease.

Performance & Activity - Outpatient Activity

New Outpatient Activity: New Outpatient activity 3% above plan for February 2014 (4.2% above plan YTD). Activity YTD is 4.8% higher than for the previous year. The increase in Activity directly correlates to the increase in referrals in that it is same specialties that have seen an increase in referrals that are the highest above plan ie: T&O, General Surgery, Urology , Gynaecology, Cardiology, ENT, Paediatrics and Rheumatology. The large increase in GUM activity is just bringing it back to previous levels as the activity for 12/13 saw a decrease in activity - there is still a small growth for 13/14. The Outpatient Waiting List has increased in February to 9846 which is a 12.8% increase compared to February 1213. All specialties have seen an increase except for Gynae-Oncology.

Follow Up Outpatient Activity: Activity was on plan for February and at a similar level to the previous year. YTD activity is 3.9% above plan (previous year outturn adjusted for 13/14 working days) and 4.2% above the previous year. Since April Paediatrics has increased significantly from the previous year due to a change in recording practice for telephone contacts in line with best practice tariff guidelines, however this seems to have reduced back to similar levels over the last few months. With Paediatrics excluded the activity YTD would be 2.7% higher than the previous year. Oncology are 12.6% lower YTD than the previous year. Respiratory Medicine is 19.4% higher and both Rheumatology and Care of the Elderly are 10.5% lower than previous year.

Performance & Activity - Elective Activity

Elective Activity: Activity was 8.7% below plan for February (1.3% above plan YTD). Activity is 2.2% lower YTD than for the previous year. Urology, Ophthalmology, Gynaecology, T&O, ENT & Gastroenterology are showing higher levels YTD than for the previous year. General Surgery, T&O & Cardiology have seen a shift from IP to DC in February. Of the total elective activity YTD, 1017 NHS patients have been via the Private Patient Unit.

Day Case Activity: Day Case Activity was 12.4% above plan for February (11.2% above plan YTD). Activity is 8.4% higher YTD than for the previous year. The over-performance is driven mainly by Urology, ENT, T&O, Ophthalmology and Gynaecology. Day Case Activity remains higher than previous years due to the improved day case rate. Of the total day case activity for the year, 681 NHS patients have been via the Private Patient Unit.

Overall Elective Activity: Overall Activity (IP and DC Combined) is 9% above plan YTD and 6% higher than the previous year. Of the overall activity 1698 NHS patients have been via the Private Patient Unit.

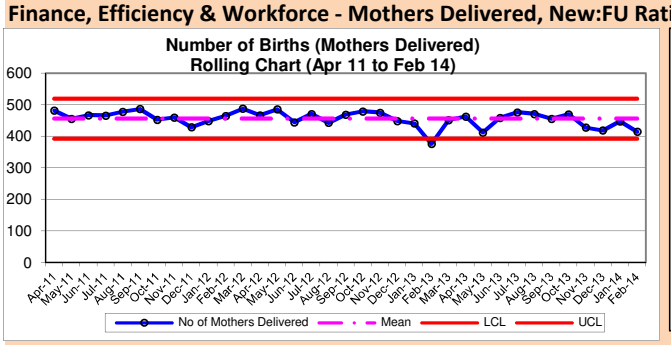
Performance & Activity - Non-Elective Activity, A&E Attendances

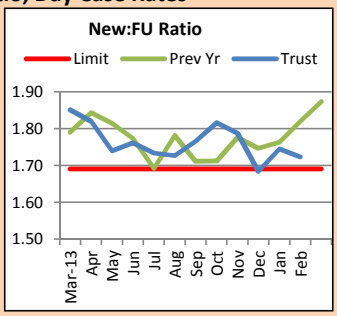
Non-Elective Activity: Non-Elective Activity increased by 5% (when adjusted for calender days)in February compared to January and was 9.4% above plan and 14.5% higher than the previous year in February. YTD Non-Elective activity is 3.6% higher than the previous year and 2.6% above plan. Activity is now above the long term average across both sites. Following the downward trend for Gynaecology this increased slightly in February but continues to be 36% lower than last year YTD. General Surgery is showing an upward trend (8.1% higher than last year YTD). Medical specialties are above the long term average at February (8.9% higher than last year YTD).

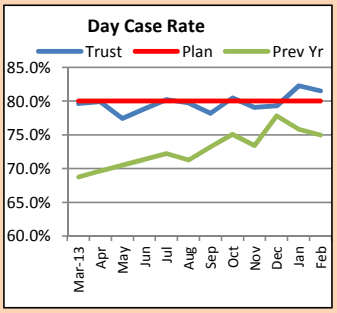
A&E Attendances: Attendances increased by 3% (when adjusted for calender days) in February compared to January and were 6% higher than February for the previous year. Attendances remain at the long term average. Attendances are 2.1% higher than the previous year YTD. Emergency admissions via A&E remained similar in February to January (when adjusted for calender days) but YTD are 4.8% lower than the previous year. The A&E Conversion rate increased slightly in February to 28.9% (same as the previous year).

INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

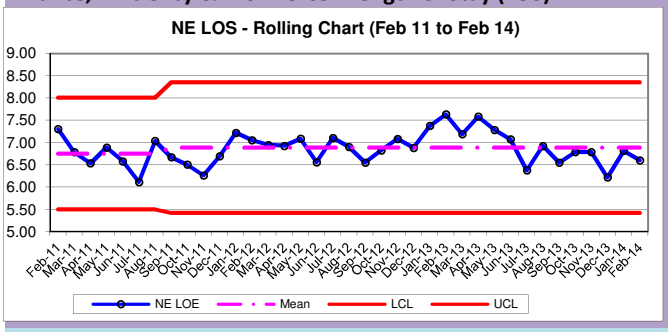
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

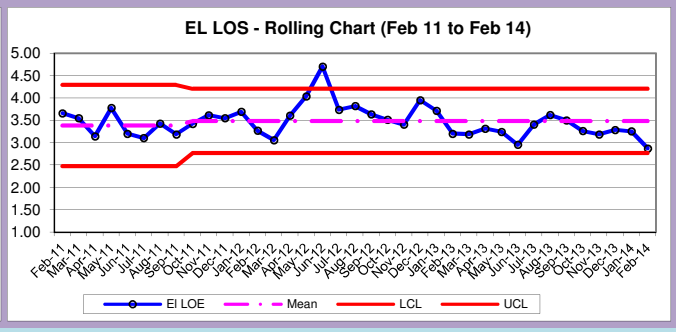




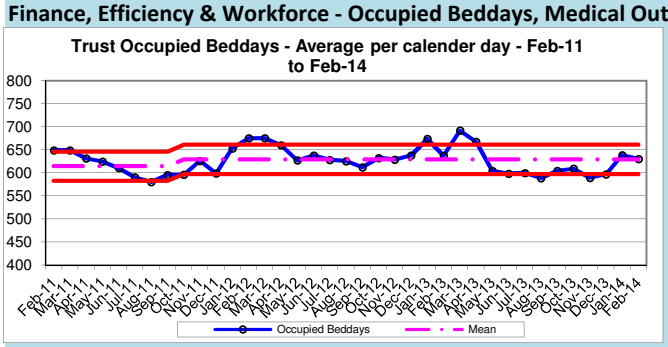


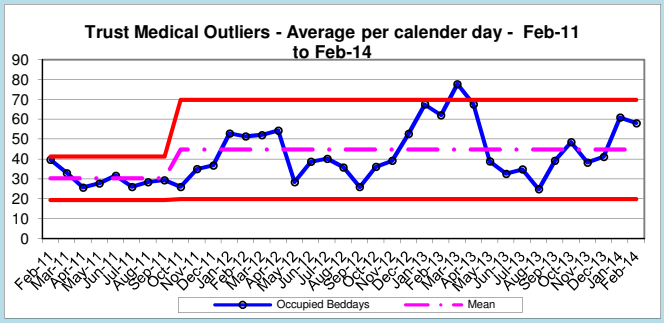
Finance, Efficiency & Workforce - Length of Stay (LOS)



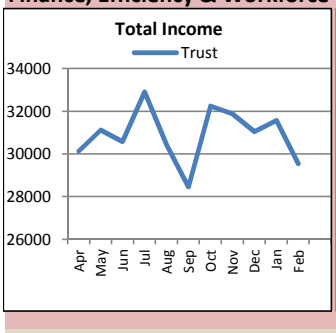


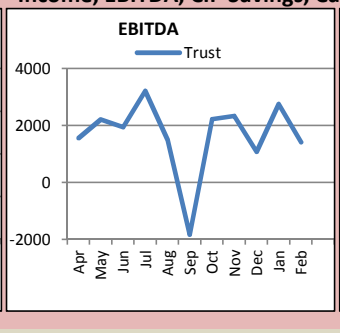
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

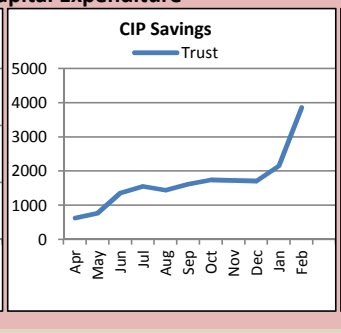


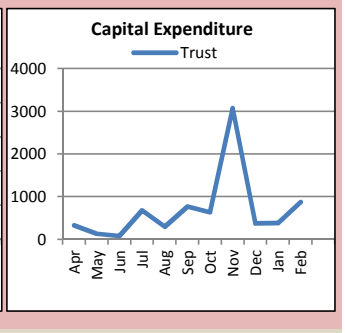


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

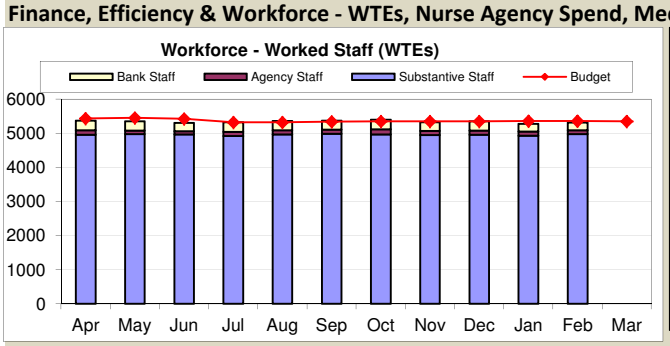


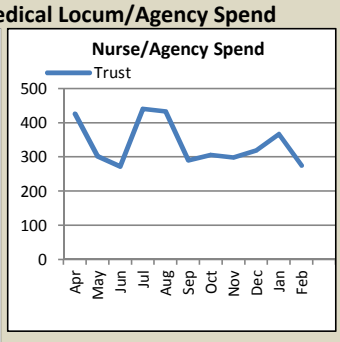


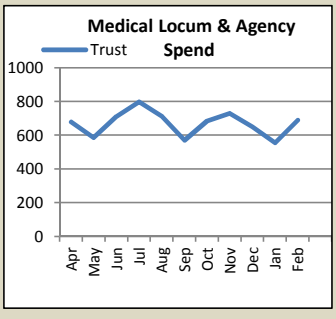




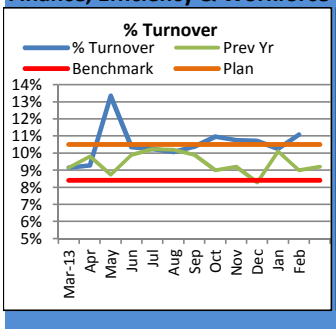
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

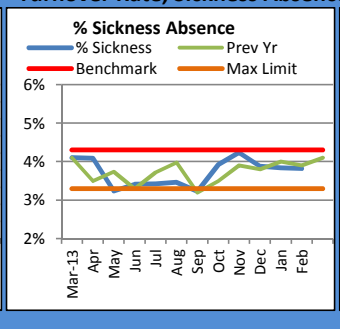


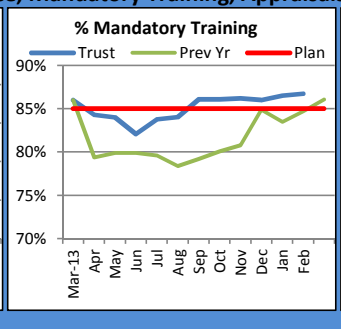


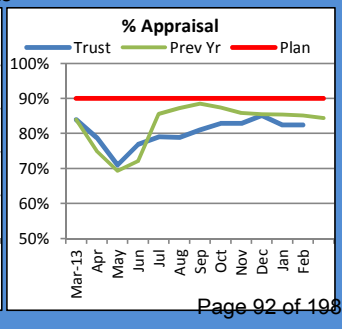


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Cash Balance

Income, EBITDA, CIP Savings, Cash Balance:

Finance, Efficiency & Workforce - Capital Expenditure, Contract Penalties, New:FU Ratio, Day Case Rates

Capital Expenditure:

New:FU Ratio: The overall Trust ratio for February 2014 has decreased slightly to 1.72. Based on the Trusts' plans for New and Follow Up Activity the planned ratio for February would be 1.76. However, the imposed target from the CCGs is 1.60. The specialties that are furthest away from their target are Cardiology, General Surgery, Trauma & Orthopaedics and Respiratory Medicine.

Day Case Rates: The Trusts' Day Case rate has decreased slightly in February to 81.5%. Performance is at 79.8% YTD therefore just below the Trust target of 80% and slightly below the national benchmark of 82.19%. The specialties with the lower day case rates are Urology (52%), T&O (60%), Gynaecology (65%) and (Paediatrics 29%).

Non-Elective LOS: Non-elective LOS has decreased slightly in February across both sites to 6.6 days (compared to 7.6 for February last year). The National Median is 6.1 days. The average LOS YTD remains at 6.8 days (7.0 for previous year YTD). The number of zero length of Stay patients has increased slightly in February. Medical specialties had shown a decreasing trend (slight increase in January & February) and are just above the lower control limit for February. Gynaecology continues to show a decreasing trend. General Surgery decreased from 5.6 days in January to 4.5 days February and Urology decreased from 5.9 to 3.9. The percentage of patients with a >10 day length of stay is 15% compared to 21% for February last year.

Elective LOS: Elective LOS has remained at a similar level and is at 3.3 days for January compared against 3.7 for the previous year and is now at the long term average. The average LOS is now lower than the national median of 3.7 days. General Surgery is showing a downward trend since July 2013 as is now below the lower control limit. Gynaecology is also showing a downward trend.

Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

Occupied Beddays: Occupied bed days decreased slightly in February across both sites but remain at the longer term average. The decrease in Elective Occupied bed days last month has been sustained in February (down trend)slight increase in February at TWells. Following the significant increase in non-elective occupied bed days over the last few months the numbers decreased slightly in February across both sites.

Medical Outliers: Following the increase in medical outliers shown over the last couple of months the medical outliers have decreased slightly in February at Maidstone but increased further at Tunbridge Wells. They remain at the long term average at Maidstone and just under the upper control limit at Tunbridge Wells. Surgical Outliers are showing a slight increase in January at Tunbridge Wells but remain at the long term average.

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

Nurse Agency Spend, Medical Locum/Agency Spend:

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

Turnover: As at the end of the February the staff turnover has increased to 11.1%. This is higher than the national benchmark of 8.4%. YTD the turnover is 10.64% which is slightly higher than the Trust maximum limit of 10.5%.

Sickness: As at the end of January (data runs one month behind) the sickness rate has remained the same at 3.8% (above the Trusts' maximum limit of 3.3% but below the national benchmark of 4.3%). YTD the sickness rate is 3.7%.

Mandatory Training: As at the end of February the compliance for Mandatory Training has remained the same at 86.7% therefore achieving the 85% target.

Appraisal: Compliance for February 2014 remained the same at 82.4% against the target of 90%.

Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD MEETING - MARCH 2014

3-19 OVERSIGHT SELF-CERTIFICATION DIRECTOR OF CORPORATE AFFAIRS

Summary / Key points

The attached schedule sets out the proposed Oversight self-certification submission based on performance as at 28 February 2014.

This next submission must be sent to the Trust Development Authority (TDA) by 31 March 2014.

As a reminder, each month the Trust Board is required self-assess against the questions contained in two self-certification documents under the TDA Oversight process: (i) Monitor Licence Conditions and (ii) Board Statements.

Please note that where the Trust self-assesses as "not compliant" or "risk" a commentary on the actions being taken, and a target date for completion, are a mandatory requirement (otherwise the submission cannot be made). *The proposed self-assessment (and responses where required) are included in the compliance column.*

The February 2014 Board Forum scrutinised a number of statements and the amendments to that previous submission are also reflected in this proposal. Further updates are highlighted for ease of reference.

In relation to the Monitor Licence conditions, there are some items which, as an aspirant Trust, the Board does not need to consider now. Instead they will need to be understood and implemented as part of the trajectory to submit a Foundation Trust application. For the sake of this self-assessment I propose that where appropriate we continue to self declare as not compliant and assume that we will be compliant by 31 March 2016 (i.e. the date from which we expect the Trust to be financially sustainable).

In relation to Board Statement 10 concerning compliance with all targets the Trust will not be compliant this year due to MRSA performance but I propose to show that we will be compliant next year, i.e. by 31/03/15. The performance data has also been updated to reflect the data contained in the performance dashboard.

The further independent review of the Board Governance & Assurance Framework (BGAF) by Ernst & Young has been received. It confirms that no changes to the BGAF assessment are required although it does make recommendations to improve Board governance. These recommendations will be reflected in a separate review of the BGAF (and QGF) through which all the outstanding actions will be identified. The Foundation Trust Committee on 2 April 2014 will review the BGAF and QGAF actions.

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:

(i) endorse the evidence presented to support the self-assessment;
(ii) agree 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

Oversight Self Certification – Monitor Licence Conditions applicable to aspirant Foundation Trusts

Condition	Evidence of Trust compliance	Assessment at 28/02/14
GENERAL CONDITIONS		
G4 – Fit and proper persons as Governors and Directors No unfit persons – undischarged bankrupts – imprisoned during last 5 years – disqualified Directors	All Trust Directors are "fit and proper" persons; confirmed through appointment process. The Directors Representation Form to be reviewed to ensure that it provides an annual confirmation from Directors of their continued fitness to be a Director – action : Trust Secretary	Compliant
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 *Compliant by 31/03/16*
G7 – Registration with the CQC	The Trust is registered with the CQC.	Compliant
G8 – Patient eligibility and selection criteria (for services and accepting referrals) • Criteria are transparent • Criteria are published	The Trust has agreed with the CCG the Referral and Treatment Criteria (RATC) for 2013/14. The document is published on the CCG website. A RATC for 2014/15 is under discussion with West Kent CCG	Compliant

Condition	Evidence of Trust compliance	Assessment at 28/02/14
PRICING CONDITIONS		
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 required to ensure readiness to comply with all Monitor Pricing conditions at the required time – action: Director of Finance.	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

Condition	Evidence of Trust compliance	Assessment at 28/02/14
COMPETITION CONDITIONS		
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. 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). Guidance is awaited.	The Trust does not seek to inhibit competition.	Compliant
INTEGRATED CARE CONDITONS		
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	Assessment at 28/02/14
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	(i) Board integrated performance dashboard is reviewed monthly and includes the TDA's "routine quality & governance indicators" (ii) Quarterly "East Midlands dashboard" is reviewed by the Board to provide additional benchmarks (iii) A quality report is submitted at each Board meeting (iv) Quality & Safety Committee, and its sub-committees, provides a focus on quality issues arising from Directorates; each meeting is reported to the Board (v) Patient Experience Committee provides a patient perspective and input (vi) Chief Nurse, a Board member, is accountable for quality (vii) Dedicated complaints and serious incidents management functions (viii) Ongoing conduct of family and friends test and reported through the Board performance dashboard (ix) Patient stories are a standing Board agenda item (x) SI report summaries are circulated to all Board members (xi) Board member visits to wards and departments. enable triangulation of quality and other performance indicators (xii) Board members participate in the conduct of Care Assurance Audits (xiii) Systems investment (e.g. Q-Pulse, Symbiotix, Dr Fosters) supports effective quality information/data management (xiv) Quality Accounts have been developed in liaison with stakeholders (xv) Quality Impact Assessments conducted on all CIP initiatives (xvi) 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 proces CQC intelligent monitoring assessment announced in October 2013 rated the Trust as "5" (with 6 being the highest/best score).	Compliant

Statement	Evidence of Trust compliance	Assessment at 28/02/14
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) transport. The Trust has been the subject of a number of CQC and other inspections, covering both sites, which have resulted in positive feedback and an appreciation of the openness and transparency of the organisation. A CQC inspection reported in January 2014 was satisfied on 14 of the 16 outcomes applicable to the Trust. Moderate concerns were expressed about the Management of Medicines outcome and the Staffing outcome. A total of 18 actions are being progressed which will ensure full compliance on both outcomes by 31 March 2014.	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. All consultants have an annual appraisal and PDP. An annual Clinical Excellence Awards process is established. Centrally administered recruitment processes ensure professional registrations are checked prior to appointment.	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 has reported a forecast deficit for 2013/4 and the financial situation is under ongoing review with the TDA. By 31/03/14 the Trust will have prepared a 2 year plan to achieve financial sustainability.***	Not compliant *Compliant by 31/03/16*
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	Assessment at 28/02/14
5. continued	(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: (a) local accountability – e.g. liaison with CCG's, patient experience committee, patient satisfaction monitoring, whistleblowing & complaints management (b) 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 and both external &, internal communications channels; a growing membership (c) 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 integrate 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 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.	Compliant

Statement	Evidence of Trust compliance	Assessment at 28/02/14
	An annual 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.	
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 All risks are RAG rated according to severity and likelihood; mitigating actions are monitored and reported. The Trust Management Executive (ED's and CD's) 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 & Governance Committee, like all Board committees, submit a written 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. The Board has reviewed and re-affirmed the integrated governance model through which risks and issues arising from triangulated evidence are escalated.	Compliant

Statement	Evidence of Trust compliance	Assessment at 28/02/14
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 2012/13 was agreed by the Trust Board in May 2013. The statement received a "significant assurance" rating following an audit review.	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 had a second case of MRSA during August 2013 and a third case which occurred in February and was investigated and declared in March. Therefore the annual limit of one case has been breached. For Clostridium difficile infections, the Trust had 2 cases in February against a monthly limit of 3. The Trust remains below trajectory year to date with a total of 32 cases against a year to date limit of 39 cases; there were 52 cases this time last year. The Trust forecast is for 35 cases against the year-end limit of 42 and regional benchmark of 43. *Trust response*: ***the MRSA limit of one case in 2013/14 has been breached with a second case arising in August 2013 and third case occurring in February 2014; this has been subject to investigation and review. In relation to clostridium difficile the Trust is under trajectory and the year-end forecast is 35 cases against a limit of 42 cases and regional benchmark of 43. The A&E 4 hour target of 95% is being achieved with year to date performance at 95.5%. A&E performance in February 2014 was 95.05%.***	Not compliant *Compliant by 31/03/15*
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 level 2	Compliant
For governance, that:	A Trust Board Code of Conduct is in place which confirms the requirement to	Compliant

Statement	Evidence of Trust compliance	Assessment at 28/02/14
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.	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. A new Non-Executive Director commenced in January 2014. A further vacancy exists and recruitment is being discussed with the TDA.	
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 outcomes are awaited. 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, with the exception of Director of Finance; an experienced interim Director is in place and a substantive jobholder has been appointed (due to commence in April 2014).. A new position of Director of Strategy has been created and recruitment planning is underway. The objectives of Executive Directors cascade from the Trust's corporate objectives which are set by the Trust Board.	Compliant

Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD MEETING - MARCH 2014

3-30 SAFE STAFFING REVIEW (NURSING AND MIDWIFERY) CHIEF NURSE

Summary / Key points

The enclosed report provides information on the nursing and midwifery staffing review. The first part of this review was undertaken in the summer of 2013 and presented to the Board in September 2013. This paper builds on that work detailing the review of the specialist areas.

Following a number of high profile reviews and public enquires in to standards of care over the last 3 years and the publication of the National Quality Board (NQB) guidance on staffing – 'How to ensure the right people with the right skills, are in the right place at the right time' (2013), NHS Trusts are now required to report to the Board every 6 months on staffing levels (Nursing, Midwifery and Care Staff), and to state whether or not they meet the acuity and dependency needs.

Trusts are required to use a variety of sources of data to arrive that their conclusions and use, where available, evidence based validated tools to establish required budgeted staffing levels.

The trust is currently in the process of collecting data for the safe staffing acuity and dependency tool, as recommended by the NQB. Comprehensive data collection started in January 2014 following a programme of teaching to ensure the required quality control. This tool is currently undergoing NICE appraisal.

The use of acuity data, where available, along with incidence and complaints data and Professional Judgement would indicate that in the majority of areas the nursing workforce meets the demands. The key exceptions are the provision of children's nurses within the Accident & Emergency department for the full 24 hour cycle of care, and the ability to consistently maintain nurse to patient ratios on the Maidstone Acute Stroke Unit out of hours if the nurse covering the thrombolysis service has to be away from the ward for any period of time.

The Trust has in place processes for reviewing staffing shortfalls on a daily basis, and has an escalation process and pathway when this occurs. The Trust is currently displaying planned versus actual staffing levels at ward level, and will to publish this data at a trust-wide level from April (one month in arrears).

A further review of staffing will commence in the next 3 months utilising the data obtained form the Safe Staffing Tool. The data collection for this is already underway and is in its second month of data capture.

The only areas that have not been reviewed are The Wells Suite, Non Ward Based Nurses (excluding Clinical Nurse Specialists and Endoscopy. Endoscopy staffing was reviewed as part of the recent JAG accreditation.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Assurance

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

1.0 Introduction:

This paper sets out to inform and update the Board about the staffing levels for nursing and midwifery. It builds on the paper presented to the Board in September 2013.

The paper provides an update on actions taken as a result of that review, and to inform the Board on the outcomes of the review of staffing specialist areas. The paper provides some detail on methodology, staffing including temporary staffing, vacancies and escalation protocols.

The paper also informs the Board of the expectations of the National Quality Board 'How to ensure the right people, with the right skills, are in the right place at the right time, and to provide assurance that measures are in place to enable compliance with the expectations set out within this guidance.

2.0 Background:

Since the publication of the Francis (2013) report into the poor standards of care at an acute Trust the relationship between nurse establishments and the quality of patient care on hospital wards has and will continue to come under increasing scrutiny. Evidence is now available to directly attribute failings in care and increased mortality rates to inadequately staffed wards. Evidence also suggests that inadequately staffed wards increase staff sickness, burnout and reduce staff being all of which have a direct consequence on the quality of care being delivered and the patient's experience. However, it is not just about the number of staff. Other key factors which underpin the delivery of care with compassion and dignity include:

- Strong and empowered leadership at ward level
- Resources directed at supporting the ward leaders
- Use of clinical and patient experience metrics
- Clinical practice development (mentorship, preceptorship, leadership programmes, clinical support worker skills and competencies).
- Appropriate environment to ensure positive student learning experience.

To date there is no consensus in the UK or internationally about two key issues:

- Nationally set mandatory nurse-patient ratios for adult medical & surgical wards
- Universal agreement about a tool to measure and model ward staffing requirements although the acuity and dependency tool is now widely used alongside the professional judgement model.

Although there have been calls for nationally mandated, minimum nurse-patient ratios by speciality the NQB guidance did not specifically stipulate minimum nurse to patient ratios. There is recognition that there must be the ability to flex the ratios (up or down) depending on acuity and dependency. The accepted range however from the evidence base concludes between 1:6 – 1:8 trained nurse to patient ratio.

The 3 commonest workforce planning methods used in the UK are:

- Professional Judgement Approach
- Nurse to occupied bed / patient ratio
- Acuity / dependency method (AUKUH) – now known as the Safer Nursing Care Tool

It is acknowledged that different systems applied to the same care environment can give different answers and so at least two methods should be applied to improve validity of the results.

Maidstone and Tunbridge Wells NHS Trust (MTW) undertakes a review of ward establishments on an annual basis to ensure the correct nursing and midwifery workforce is in place to meet the demands of clinical care provision, ensuring delivery of safe care with a positive patient experience. The review also triangulates against other quality indicators both local and national. This work is led by the Chief Nurse, supported by the Associate Directors of Nursing, Matrons, Ward Sisters, Human Resources and Finance.

Work over the last three years has included the development of triangulation methodology to support the Professional Judgement model with data on incidence and Safer Smarter Nursing Metrics (NHS SEC) and more recently Association of United Kingdom University Hospitals Acuity and Dependency Scoring tool (AUKUH), East Midlands Quality Dashboard and Quality, Effectiveness and Safety Trigger Tool (QuESTT: NHS SW).

Any significant changes to the nursing establishments will be agreed through the Trust Management Executive.

3.0 Evidence base

The evidence supporting an association between registered nurse (RN) staffing and patient care and outcomes derives mainly from large observational studies conducted in North America that focus on patient safety in hospitals. A European study across 15 countries, RN4CAST, led by the National Nursing Research Unit at King's College explored the relationship between nurse staffing levels, aspects of hospital organisation and patient outcome across Europe. This research was undertaken in 2010/11 and published in June 2012. The research covered 401 general medical and surgical wards, in 31 Trusts in England. Taking this research as the evidence base the ratios are recommended as follows:

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%.
- This 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 and Dependency Tool
The Safe Staffing Acuity and Dependency Tool, previously known as the Association of United Kingdom University Hospitals (AUKUH) Acuity Tool, is the tool of choice for triangulation of acuity, dependency and professional judgement.

The Safe Staffing model takes into account patient activity as well as dependency including transfers, admissions and discharges.

The tool has been further developed and refined by the Shelford Group of Hospitals (10 NHS trusts across the country) and processes for linking with nurse sensitive indicators defined. The data for these indicators is already collected and monitored via Safety Thermometer, QuESTT, Saving Lives and complaints theme datasets.

The Safe Staffing Tool is currently undergoing NICE appraisal.

The Trust has been formally using this tool to collect acuity and dependency data over the last two months. This data will inform the ward staffing review for the coming year. In addition an interim review will be undertaken once a full three month data set is available to confirm assumptions already made.

National Quality Board: How to ensure the right people, with the right skills, are in the right place at the right time:
The National Quality Board (NQB) published guidance on nursing and midwifery staffing capacity and capability in November 2013.

This document sets out to articulate the underpinning principles of setting safe staffing levels, ensuring that wards not only have the right numbers but the right skills. The document acknowledges that mandating for minimum numbers or ratios 'misses the point', rather hospitals should use an evidence base approach to support professional judgement, as no one model will fit all specialties at all times.

The NQB set out 10 standards or 'Expectations' that cover decision making, openness, future workforce planning requirements and the role of commissioning.

These expectations are;

1. Boards to take full responsibility for the quality of care provided to patients, and as ka key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.
2. Processes are in place to enable staffing establishments to be met on a shift-to-shift basis.
3. Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability.
4. Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns
5. A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments

6. Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.
7. Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public board meeting at least every six months on the basis of a full nursing and midwifery establishment review.
8. NHS Providers clearly display information about nurses, midwifes and care staff present on each ward, clinical setting, department or service on each shift.
9. Providers of NHS services take an active role in securing staff in line with their workforce requirements.
10. Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.

4.0 Methodology

The key methodology used for the establishment review is the Professional Judgement model as described by the National Audit Commission and endorsed by the Royal College of Nursing (RCN). A number of supplementary documents published since support the key assumptions; namely Francis Report (2013), Keogh Review (2013), Setting Safe Staffing for Older People's Wards (RCN 2012), Guidance on Setting Safe Staffing Levels in the UK (RCN 2010), and The Role of the Ward Sister and Charge Nurse (RCN 2009). These documents summarise a wider body of evidence, including evidence detailed above to support the key principles adopted to inform the review.

The review should ideally be a combination of 'bottom-up'; that is informed by the Ward team led by the Ward Sister, and 'top-down'; informed by the Chief Nurse and Associate Directors of Nursing/Midwifery by triangulation of ward quality indicators, performance and incidence.

To facilitate this approach the reviews have been staged over a six week period at the weekly Chief Nurse Team meeting. Matrons have been invited to attend these meeting when their wards are being reviewed. Also in attendance at these meeting is the Head of Quality and Governance and a Finance Manager, where there are significant changes to be recommended, further discussion was had with both the Finance Team and the relevant Human Resource Business Partner.

A similar approach has been used for the review for specialist and non-ward areas including maternity services, paediatric services, theatres, critical care and Accident & Emergency. The reviews thus far have not looked at nurses working above ward level i.e. Matrons, Tissue Viability Service.

Evidence and guidance from specialist networks and associations were taken into account including recommendations from Birthrate Plus, Critical Care Society (2009), British Association of Critical Care Nurses & Royal College of Nursing Critical Care Forum (2001), Association of Perioperative Practice (2008 & 2009), and RCN Emergency Care Association tool (BASE) 2013.

5.0 Principles

In order to arrive at a safe budgeted establishment using the Professional Judgement model (which identified the number of staff required for a specific shift as the starting point), a number of key principles have to be agreed to underpin the final calculation.

The key principles are:

- Supervisory time for ward managers to be built into establishments. The ward manager should be responsible for 'running the ward' Mon-Fri.
- 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
- Seek to clarify role of housekeeper, ward clerk and discharge facilitator.

For specialist areas and non-ward areas these principles were also applied, although it was recognised that role and function of a labour ward coordinator and a generic ward shift coordinator require different clinical skills, the ethos remains the same.

These principles find support from the case studies of good practice described in the NQB guidance (2013).

6.0 Process

Current ward establishments and shift patterns were reviewed. Key to this is a direct comparison between what the budget indicates is available to what is happening in practice. Ratios as described above were checked and challenged against current and predicted case loads and specialty requirements. Reference is made to intelligence from the Clinical Governance Committee which reviews any ward triggering a review from either a high or low QuESTT Score.

7.0 Current Position

All adult in-patient wards were reviewed during the July and August 2013 and reported to the Board in September 2013. A summary table of the findings is attached in Appendix 1

There were four wards that required additional investment in staffing. These wards were:

John Day Ward – ratios of RN to patients was at 1:8, uplift in establishment recommended to achieve a ratio of 1:6.5. Skill mix – split of RN to CSW was 57/43 the recruitment of RNs to achieve the 1:6.5 ratio will also achieve a 65/35 split of RNs to CSWs

Mercer – RN to patient ratio at 1:9 for afternoon/evenings and 1:13 for nights. Uplift in establishment recommended to achieve a 1:6.5 for days and 1:8 for nights. RN to CSW ration was 52/48, recruitment of RNs to achieve the recommended nurse to patient ratio will provide a 65.35 RN to CSW split.

Jonathon Saunders – RN to patient ratio was at 1:12 for nights. Uplift in establishment recommended to achieve a ratio of 1:7.6. RN to CSW split is 50/50, recommended this to be revised as part of business planning to achieve a RN to CSW split of 65/35.

Foster Clark – RN to patient ratio for the afternoon/evening was 1:7. This ward caters for non-invasive ventilation (NIV) and should have a higher nurse to patient ratio than a generic medical ward (patients on NIV require 1:2 RN to patient ratio. Uplift in establishment recommended to achieve an RN to patient ratio of 1:5.5

Following the in-patient ward reviews two Ward Managers expressed concerns that staffing was still insufficient for safe high quality patient care. These areas were reviewed for a second time.

Maidstone Stroke Unit – the Ward Manager met with the senior team to discuss her case load and staffing skill mix. Further triangulation was undertaken utilising data from incident reporting, Safety Thermometer and QuESTT review. The rationale for staffing levels agreed post review was discussed. The Ward Manager agreed that further evidence was required from the implementation of the Safer Staffing tool which would not only capture data relating to acuity but also data supporting nurse sensitive indicators over the same time period. The key issue relates to the 'bleep holder' nurse who may have to leave the ward to attend A&E (if a patient with a stroke is admitted to A&E and thus may require thrombolysis, and may be gone for several hours. This increases the RN to Patient ratio significantly.

Recommendation: Associate Director of Nursing for Emergency Care to work with the Matron and Ward Manager to develop an option for inclusion in budget setting.

Ward 30 – the matron for this area requested to meet with the senior nursing team to review the staffing for Ward 30, having particular concern about the support of pre-operative patient care during the first part of the morning shift. Detailed review of the staffing numbers, skill mix and rota management suggested that there was scope for more effective use of the existing workforce. The Matron agreed with this approach combined with the collection of data for the Safer Staffing tool. The Safer Staffing tool identifies turn-over of patients (i.e. the number of admissions and discharges in a 24 hour period) which the previous AUKUH tool did not. The Associate Director of Nursing for Planned Care is working closely with the Matron and Ward Manager for Elective Orthopaedics to ensure that any early warning indicators are readily identified and managed appropriately.

8.0 Specialist Areas:

A review of the specialist areas, theatres, accident & emergency, critical care, paediatrics and maternity services was undertaken during January and February 2014 to complete the full nursing staffing review.

8.1 Theatres:

The methodology used for setting safe staffing levels for theatres is as described previously. Evidence base and guidance from the Association of Perioperative Practitioners (AfPP 2008 & 2009) was referenced to.

In order to arrive at a safe budgeted establishment a set of key principles need to be agreed and adhered to. These principles have been referred to earlier in this paper. Nurse to patient ratios as described for generic wards are not applicable to operating theatres, and so a different set of criteria needs to be considered. These criterion find support nationally and from the AfPP.

The principles for a single operating theatre are:

- Operating Department Practitioner (ODP) x 1
- Scrub Practitioner (either ODP or RN) x 2
- Runner x 1 (may be a CSW)
- Recovery RN x 1

A theatre suite may consist of several theatres, and as such there is a degree of flexibility in requirements for recovery personnel. However these fundamental principles need to be met for each theatre with a theatre suite to ensure safe delivery of care.

Tunbridge Wells Hospital has a theatre suite comprising of 8 theatres (including 8 anaesthetic rooms), 2 dedicated obstetric theatres and 3 recovery areas.

The staffing requirements per day are:

ODP = 8
Scrub = 16
Runner = 8
Recovery = 8

Obstetric Theatres are staffed to the same principles with an additional recovery RN for elective lists. This has been put in place by the team in response to learning from previous incidents and Serious Incidents (SIs).

A night service is in place with 1 ODP and 1 CSW on site 21.00 to 08.00 to open and prepare the theatre. The scrub personnel are on-call from home during this time.

For out of hours obstetric theatre cover the minimum staffing set for 1 theatre is on-call on site.

Maidstone Hospital has 8 theatres but not contained in a full suite. The theatre complex comprises of:

4 main theatres (1 suite)
2 head & neck theatres
2 day case theatres
2 procedure rooms (chronic pain and brachy therapy)

The theatres are staffed to the same principles as Tunbridge Wells Hospital and have a daily staffing ratio for 8 theatres.

The Maidstone Hospital theatre case mix is predominately elective however the staff also provide cover to a range of satellite services including electrophysiology studies, interventional radiology, line insertion and cover to Priority House for electroconvulsive therapy.

Out of hours cover is provided by a core ‘theatre team’ with an additional scrub RN due to the isolation from the main surgical team at Tunbridge Wells. The theatre team provide an out of hours service on an ‘on call from home’ basis.

The ensure the smooth running of the theatre suites the above staffing compliment is supported by a Theatre Coordinator, holding bay coordinator and professional development nurse (1 wte).

The Theatre Coordinator (Band 7) provides a liaison between the site management team, the wards and the individual theatre shift leaders ensuring staff are deployed according to work load demands and skills. Each theatre is led by a Band 6 and is overseen by the Theatre Coordinator.

The Theatre Coordinator is supernumerary.

Each Band 7 with budget or management accountabilities is provided with 0.5 days per week for management functions.

The Professional Development Nurse oversee the delivery of the Foundations for Theatre Practice and supports the theatre staff gain or maintain competencies in the various sub-specialties.

The team have a number of vacancies with staff in 'pipeline' for recruitment. There are currently no challenges with recruitment and there is the potential to over recruit.

No recommendations for further staffing investment made.

8.2 Accident & Emergency

The methodology used for setting safe staffing levels for Accident & Emergency (A&E) was as described previously, with engagement from the Accident & Emergency Matron and the Urgent Care Matron.

The underpinning approach for setting safe staffing levels within the A&E is primarily Professional Judgement aligned to capacity, and demand modelling.

The Team are now piloting the use of Baseline Emergency Staffing Tool (BAST) published by the RCN in 2013. This tool is based on the Jones Dependency modelling tool for emergency care.

The fundamental principles of nurse to patient ratios for a generic ward has been used as a starting point for setting safe staffing levels; the geography and layout of the A&E department also needs to be considered.

The A&E department has a number of routes or 'streams' for access for which staffing levels and ratios are set out in table 1 below.

Table 1

TWH						
	AM		**PM**		**Night**	
	RN	CSW	RN	CSW	RN	CSW
Minors	1xENP*	1	1 2 x ENP*	1	CLOSED	
Majors	5		5		4	
ratio	1:5		1:5/1:4		1:5/1:4	
Resus	2		2		2	
Triage	1		1		1	
CDU (7 beds)	1	1	1	1	1	1
ratio	1:7		1:7		1:7	
Maidstone						
	AM		**PM**		**Night**	
	RN	CSW	RN	CSW	RN	CSW
Minors	1 ENP*	1	2x ENP*	1	CLOSED (from 02.00)	
Majors	2		2		2	
ratio	1.5/1.4		1.5/1.4		1.5/1.4	
Resus	1		1		1	
ratio	1:2/1:4		1:2/1:4		1:2/1:4	
Triage	1		1		1	
CDU (5 chairs)	1		1		1	

*****ENP = Emergency Nurse Practitioner

Both sites have a shift coordinator in a supervisor role for the full 24 hour cycle of care. In addition there is an RN 'flow coordinator' to facilitate the movement of patients through their relevant care pathway.

Paediatric care pathways provide for children to be directed to Woodlands or Riverbank (TWH or Maidstone respectively) unless acutely unwell and require immediate attention within the A&E Department. Operational and practitioner derived constraints often make compliance with the pathway difficult. This was noted on a recent unannounced Care Quality Commission (CQC) inspection visit over a weekend. The department is working closely with Paediatric colleagues to resolve the problem as the challenges cross both teams, in terms of both recruitment of staff and department capacity.

There a number of recommendations to be made to further strengthen the view that staffing levels are safe and meet the current and potential demand on service.

- *Implementation of Jones (BEST) Dependency & Acuity tool*
- *Review RSCN/RN profiling within existing establishment*
- *Explore opportunities for rotation posts between A&E and Children's wards*

8.3 UMAU/Chaucer

The emergency care pathway is supported by an Urgent Medical Ambulatory Unit (UMAU) and a Winter Ward (Chaucer).

UMAU has three streams or flows of patients, via in-patient beds (<48hrs), trolleys and treatment rooms.

The ratios of RN to patients are:

Inpatients: 1:4/1:5
Trolleys 1:4
Treatments 1:6.5

Chaucer Ward is staffed for 27 beds but has potential physical capacity for 33 Beds.

The RN to patient ratio is 1:6.6 though the 24hr cycle of care; however this is heavily reliant on the use of temporary staff particularly when operating at full physical capacity.

Both areas have a shift coordinator role that is supervisory, 7 days per week. There is also a clinical manager who is supervisory for 5 days per week.

There are a number of recommendations which include:

- Review of shift times of manager and shift coordinator.
- Review the flexing of staff between UMAU and Chaucer to ensure appropriate skill mix is maintained consistently.

There are currently no recommendations for further investment in staffing

8.4 Critical Care

The underpinning approach for setting safe staffing levels within Critical Care is based on a concordance of recommendations from the British Association of Critical Care Nursing, the RCN Critical Care Forum and the Critical Care Society published as the Core Standards for

Intensive Care Units (2013). The recommendations for setting safe staffing levels are based on the acuity and levels of care provided based on national definitions.

The historical definitions have been levels 1, 2 and 3 with level 3 being either full mechanical ventilation plus support for one or more organ/system failure. Level 2 being respiratory support or support for a single organ/system failure. Level 1 being 'ward fit' care.

This approach has been rationalised for the purposes of staffing establishments and capacity planning.

The traditional level 3 bed is now rated as 1 and level 2 or HDU style care being rated as 0.5. This means a critical care unit can flex both bed base and staffing accordingly.

The trust has provision for critical care beds on both sites. Both sites have a capacity equivalent to a dependency score of 7, with both units having physical capacity for 9 beds each.

Both units are staffed to the same level; some staff have been redeployed across site following a restructure of the service provision to meet the variation in demand identified over the last two years.

Both units have a shift leader or coordinator who is supervisory, with a unit manager providing overarching supervision and support Monday to Friday as part of their overall leadership role.

The nursing workforce involved in direct patient care all Registered Nurses, with a small number of CSWs utilised for 'runner' activity and support direct patient care on an ad hoc basis.

There is a clinical educator on both sites who supports the accredited Foundations of Critical Care Course.

Vacancies across the trust for critical care are minimal and there is generally no difficulty with recruitment, particularly at the lower bands.

There are currently no recommendations for further investment in staffing

8.5 Paediatrics

The methodology used for setting safe staffing levels for paediatrics is as described previously. The national standard for safe staffing is widely debated with no clear consensus on what constitutes safe staffing over and above Professional Judgement.

The majority of paediatric care is provided on the Tunbridge Wells Hospital site, with a day care/assessment unit at Maidstone Hospital.

Riverbank provides a 5 day service on the Maidstone site with a bed capacity of 13.The unit provides an assessment service to A&E and day case care. There is planned day case care for three days a week and during this time an extra RN (Children's) is on duty.

The RN to child ratio is 1:4 and is inline with comparable units nationally.

Hedgehog provides a full range of inpatient paediatric care including 2 HDU beds. The total bed base is 23. The Unit is currently trialling a specific paediatric acuity and dependency tool. The local paediatric network are in agreement that the current tool (PANDA) is not

sufficiently sensitive for district general paediatric care, have being developed primarily in tertiary referral centres for use in critical care and ward based intensive care settings.

The unit has a shift coordinator who is supervisory 24/7 and covers both Hedgehog and Woodlands.

There are 2 whole time Band 7 Ward managers who provide managerial support and professional leadership to Hedgehog, Woodlands and Riverbank.

Hedgehog staff are combined on the rota to provide cover across both Hedgehog and Woodlands as Woodlands will flex in-patient beds according to emergency care demands.

Woodlands provides 10 beds for day case activity 3 days per week. This includes a pre-assessment service.

Woodlands also provides an assessment service through 5 rooms. Woodlands receives direct referrals from General Practitioners, ward follow up attenders, chemotherapy outpatient service and ambulatory care.

The current staffing levels may be considered low by national standards, but without accurate benchmarking on acuity and dependency levels this is difficult to quantify.

Based on current and past safety performance the current ratio of 1:4.6 is considered to be safe.

Neonatal Unit – provides level 2 neonatal intensive care. If a neonate requires extended ventilation or is of low gestation s/he will be transferred to a level 3 unit.
The unit is staffed and budgeted for 18 cots, however this is often flexed upwards due to lack of capacity across the network.

The RN to Cot ratio is currently in line with recommendations, bed base is determined by the Neonatal Network based on network capacity and staffing profile.

The shift coordinator is supervisory, however will take a case load when network pressures demand.

Overall paediatric staffing levels are adequate as vacancies are minimal to zero. There is an aging workforce within the Neonatal Unit which may herald staffing challenges in the future. The key current risk in paediatric staffing is the escalation requirement for woodlands particularly out of hours.

The paediatric team are currently preparing a business case for a bid to provide a service from Woodlands 24/7.

Recommendation is the review the pathway for paediatrics from A&E, provision of paediatrics services and future needs of Woodlands and activity.

8.6 Maternity

The methodology used for setting safe staffing levels for maternity services is based on Birthrate Plus.

Maternity services are provided across 4 areas (or cost centres). These being Tunbridge Wells Hospital (primary service provision) Maidstone Birth Centre, Maidstone Fetal

Assessment Unit and Community Services. Midwifery staff rotate through the service to provide consistent cover, within a specific locality.

There are 3 ward manager type roles covering antenatal ward, labour ward and post-natal ward. One of these post-holders will take operational bed management responsibility for the maternity unit between 08.00 and 20.00.

Delivery suite coordinator is supervisory but will often take a case load. This role is staffed 24/7.

The Delivery suite is rarely full with women in established labour. The ratio for established labour is 1:1 which is met.

HDU (2 beds) require a ratio of 1:1 however the dependency is frequently such that this can be flexed either to cover labour ward or to cover HDU as appropriate.

Birthrate Plus indicates an acuity and dependency ratio of 1:28.5 locally against a national benchmark of 1:28.

Acuity and dependency is recorded daily and staffing is flexed accordingly.

Ante-natal ward provides 17 beds plus 4 triage beds open 24/7
The staffing ratio for ante-natal 1:8.5

Post-natal ward provides care in 31 single rooms. The Unit has a 24% section rate meaning that potentially 1 in 4 women will require surgical nursing care.

The Post-natal ward shift coordinator is supervisory for 5 days.

The ratio based on 4 RMs for 31 beds is 1:7.5

Discharge is fully midwifery led.

Maidstone Birth Centre provides a midwifery led service in a ‘stand alone’ building on the Maidstone site.

It is staffed by 2 RMs and 1 support worker 24/7.
Additional support is provided by the Community Midwifery team if a transfer to Tunbridge Wells is required. It should be noted the transfer rate for the Maidstone Birth Centre is lower than the national average.

Maidstone Fetal Assessment provides a Monday to Friday service between 08.00 and 17.00.
It is staffed by 3 RMs and 3 support workers.

Community Teams – the majority of the work in the community is ante-natal care with some home deliveries. Midwives are aligned to GP practices, however all community care is provided by midwives. The case loads for the community team is currently being reviewed. The national recommendation is 120 cases per midwife.

There are currently no significant concerns relating to midwifery staffing.

There are currently no recommendations for further investment in staffing

8.7 CNS Review

A review of clinical nurse specialists was undertaken concurrently with the specialist ward areas.

Connect Health Advisory Ltd. was commissioned to undertake the review, having done similar reviews in other comparable organisations.

The approach to the review included the following:

- A mapping of all clinical nurse specialist posts across Trust including individual current educational levels
- A review of the current job plans in place.
- How chargeable CNS activity is captured currently and any potential to increase income generated.
- Assessment of current CNS post holders and if they working at the required level;
- what level of administrative support exists for CNS roles and what is required to release additional clinical time and assess the opportunity for changes in the CNS WTE numbers & band mix;
- Assessment of how the CNS workforce contribute to research, and identification of research activity being undertaken
- Identification of the education role undertaken by the post holders for both staff and patients
- Identification of how the roles contribute to clinical leadership and their reporting arrangements
- Application of best practice principles/guidance - NMC/RCN
- The corporate identity of the CNS role and how they contribute to the wider corporate nursing agenda

There are 85 WTE Clinical Nurse Specialists; this includes Emergency Nurse Practitioners and Consultant Nurses / Midwife. This excludes other senior non-ward based nursing posts for example safeguarding children's nurses.

Findings show that that there are issues to be addressed in all areas reviewed. The main issues to be addressed in order to develop the CNS model are detailed in Appendix 2. There is scope for improvements which will ensure continuing high quality care to patients as well as financial efficiencies through more effective ways of working. A summary of the recommendations can be found in Appendix 2.

The fundamental purpose of this review was to provide a baseline position of the CNS workforce. The next stage is to agree which recommendations to prioritise to ensure financial efficiencies and improvements required improving care and experience for patients.

8.8 Critical Care Outreach Service.

The critical care outreach team provides a service across the Trust between 08.30 -18.30 Monday to Friday. The outreach team consists of experienced critical care nurses (6.35 WTE band 7) who have a skill set that is compliant to the National Critical Care Outreach Forum (NOrF) operational standards for outreach nurses. The service was established in 2001 following the Department of Health's Comprehensive Review of Critical Care Services and there are similar services established within the UK.

The evidence demonstrates morbidity and mortality rates are significantly higher for emergency patient admissions who suffer an acute illness episode out-of hours and that NHS services should be available 7 days a week. (Keogh Report 2013, Francis Report 2012, NCEPOD 2005 – 2012, NICE 2007, DOH 2000 – 2007, Organisation Patient Safety Reports, NPSA , Dr. Foster UK Medical 2013, Patient Reported Outcome Measures (PROMS) in England, Apr 2010 – March 2011, Royal College of Physicians 2013 & NHS Commissioning Board 2013). Recently the publication of the Everyone Counts: Planning for Patients 2013/14 document signals that the NHS needs to move towards routine services being available seven days a week, a development which is essential to delivering a more patient-focused service and one which offers the opportunity to improve clinical outcomes.

The Trust continues to experience an increase in the numbers of sick patients in line with the national increase in demand for critical care, so the need for critical care outreach to support this is arguably now more important than ever. The total number of outreach visits made during 2012/2013 being 2879, which is similar to previous years. These figures include patients discharged from Intensive Care Unit (ICU) who are aimed to be visited within 24hrs following ICU discharge as per NICE & DH recommendations but with no current outreach weekend cover this is not possible. All these visits occurred during Monday-Friday 8.30 - 18.30. The data demonstrates that outreach are supporting the care of a number of acutely unwell patients requiring level 1 & 2 care on the wards. There are many other patients that require outreach support at the weekend and out of hours where currently this support is not available.

Currently MTW critical care outreach team is the only team in Kent, Surrey & Sussex that does not provide evening and weekend cover. However the current Mon-Fri service is delivered by 2 outreach nurses on each site between the hours of 8.30 – 18.30

Recommendation:

Critical Care Outreach Service to develop a model for 7 day working and to interface with the work already underway for the provision of consultant cover for 7 day working.

To review current arrangements for service delivery to allow for single working covering extended period during the week and weekend cover.

9.0 Vacancy:

Proactive recruitment is vital to maintaining safe staffing levels and ensuring staff have the correct skills. Vacancy figures are monitored and managed at directorate level. Information on turnover rates and short-term absence due to sickness is monitored at directorate level and reported through to the Board via the Workforce Committee.

All staff who resign from a post are offered the opportunity for an exit interview and provided with an exit questionnaire in order to identify any emerging theme that would suggest a problem with retention.

In order to ensure the Trust is fully aware of the risks posed by vacancy, and to enable a proactive approach to recruitment a Recruitment & Retention Strategy Group has been established, chaired by the Chief Nurse with support from the Director of Workforce
This committee has representation from all directorates with Matrons playing a key role. The committee is also attended by the representation from Human Resources and Recruitment Team and Education providers. The committee monitors vacancies, ensure recruitment pipeline functions smoothly and provide senior support and direction to all aspects of recruitment activity.

The committee undertook a full stock take of vacancies in January, in preparation for its inaugural meeting in February. This stock take included all vacancies that existed at the time regardless of where the recruitment pipeline.

The Recruitment Team provide a suite of data on vacancies, staff in post (SIP) turn-over rates and sickness to each directorate. This information as at **1st March 2014** is detailed in Appendix 3.

The Specialist Medicine Directorate is currently the area with highest number of vacancies (this directorate includes Foster Clark, Jonathon Saunders, Mercer, John Day and Acute Stroke).

The Specialist Medicine Directorate has identified a Matron to focus specifically on recruitment and to ensure focus across the directorate to maximise all and any opportunity for high quality recruitment.

The Associate Director of Nursing and the Matron leading on recruitment have produced a directorate level strategy and action plan, which has been discussed at the Recruitment & Retention Strategy Group to ensure all parties are aware and signed up to delivery. Lessons learnt from this approach are being shared with other directorates, most notably Emergency Care Directorate who also have had recruitment and retention challenges in the latter part of last year.

The strategy addresses three key themes:

1) Streamlining local process
2) Recruitment of staff
3) Retention of staff

Streamlining of local processes centre around proactive working and ensuring a full range of up to date job descriptions, structure charts and interview outlines are in place.

Recruitment of staff will focus on high profile presence at job fairs, working with education providers and considering other opportunities to make working for the Trust more attractive including the establishment of rotation posts, defined education pathways including ‘top up’ degree and more effective use of social media.

A Task and Finish group has also been set up to look at ‘How’ we actually recruit in terms of interview process, assessment of skills and values.

Retention of staff will not only focus on exit interviews and revisiting past exit interview results, but will also focus on support for new starters including the creation of a new starters forum within the directorate to obtain immediate feedback.

10.0 Temporary Staffing

To ensure ward staffing levels remain safe at all times, a degree of reliance will always be placed on the use of temporary staff. Whilst wards have in place a 'head room allowance' to cover annual leave, short term sickness and training and education activity this not allow for increased acuity and dependency and use of expensive agency staff.

Many ward areas have seen an increase in reliance on temporary staffing due to an increase in the number of patients being admitted with cognitive impairments and increased awareness of falls prevention.

The current vacancy rate is 10% combined with a sickness/absence rate in the region of 3.3%. This means there remains a heavy reliance on temporary staffing to maintain agreed levels of staffing within specific areas.

There is a strong desire at Ward Manager and Matron level to decrease reliance on temporary staffing as this is known to have an adverse impact on the quality of care. It is interesting to note that where complaints are received about the standard of nursing care, there is frequently a heavy reliance on temporary staffing at that time.

Temporary staffing usage is monitored on a weekly basis. The Deputy Chief Nurse meets every Matron on a fortnightly basis to review temporary staffing usage. This is triangulated with other sources of intelligence related to quality care. Where there is a raising trend in a directorate the meetings are increased to weekly to ensure that potential avenues for reduction in temporary staffing are explored.

The ward areas that required immediate action to improve their nurse to patient ratios had only minor increases in temporary staffing following this action implying that ward managers are able to effectively manage their teams, and were able to anticipate fairly accurately the emerging requirements.

The overall usage of temporary staffing in hours is presented in Appendix 4.

The highest users of temporary staffing include Maternity Services, Accident & Emergency at Tunbridge Wells, Medical Assessment Unit at Tunbridge Wells and Chaucer Ward at Maidstone.

Maternity Services usage is driven primarily by case loads in community teams and the '2nd on' on-call system in operation to ensure flexibility and provision of 1:1 care in labour.

Accident & Emergency at Tunbridge Wells

The trend in temporary staffing reliance demonstrated an increasing trend in the early part of 2013, this was due in part to staff turnover. A recruitment campaign led by Kate Cowhig International was commissioned to recruit from Scotland, Northern Ireland, Ireland and Portugal. The phased introduction of this staff group commenced in September 2013.

11.0 Rota production, monitoring of staffing levels and escalation.

The Trust has in place an electronic rota system that enables a set of key principles or 'rules' to be applied to enable the production of a core rota.

The system allows for a number of variances to account for the planned day to day known variations in workflows. The system provides a platform of the monitoring hours worked, and is the underpinning system for the validation for payroll.

Whilst the system does have some sophisticated functionality it is not particularly 'user friendly' and is slow to load, making the practicalities of use as a 'live' system less attractive. A product review is currently underway via the Employee Services Team (who oversee the management of the Nurse Bank Office), with a view to tendering for an improved and more user friendly system.

Ward or Department Managers are expected to produce a rota six weeks in advance, this is reviewed by the relevant Matron to ensure all potential for safe cover is maximised. Consideration is given to whether neighbouring wards could 'second' staff to support in times of significant gaps in rotas.

Staffing levels are now published on a daily basis on notice boards at or near ward entrances. A number of different approaches have been piloted, and an agreed format has now been arrived at. Dedicated white boards are currently on order. A pilot is also underway at Maidstone Hospital to utilise the flat screens previously used by an electronic bed management system. If successful this will be integrated into the overall Information Technology strategy for the Maidstone site. How this can achieved on the TV screens at Tunbridge Hospital is also being explored.

Staffing levels will be published on a monthly basis detailing Trust level staffing comparing planned numbers against actual numbers. This will be published on the Trust's web-page from April 2014, in line with the NQB recommendations.

The public trust-level data will be posted on the web-site one month in retrospect, however the numbers at ward level are updated on a daily basis by the nurse in charge.

Shortfalls or gaps in the rota are monitored daily by the Matrons as part of their daily review of ward activity and standards of care. Any gaps or short-notice absence is discussed at the daily Site Operations meetings to ensure all team members are aware and ensure steps are taken to address the issue or reduce the overall risk.

The Escalation Policy in place addresses the issues of staffing, particularly around guidance for the opening of additional beds.

In February of this year, a specific staffing escalation standard operating procedure was developed which clearly sets out the steps and processes for managing shortfalls in staffing. This operating procedure provides guidance on key indicators or tasks, which if not met, would render the ward potentially unsafe.

12.0 Triangulation for Patient Safety

Triangulation of data is undertaken regularly to identify emerging trends and themes, particularly in root causes where these relate to staffing levels, capability or leadership.

Data sources include Safety Thermometer and Safer Smarter Care Matrix with particular emphasis on falls, pressure ulcers, nutrition assessments, medication errors and nursing care complaints.

Detailed review of complaints, litigation, incidents and PALS concerns (CLIP) are reviewed by the Clinical Governance Committee. This committee was previously the Clinical Governance Overview Committee. This committee use to meet three times a year. The committee was restructured last year, to combine the functions of overview and CLIP on a more regular basis. The Clinical Governance Committee now meets bi-monthly and, as previously, has multi-disciplinary input

The Trust utilises a frame work developed by NHS South-West in 2012, known as QuESTT – the Quality, Effectiveness and Safety Trigger Tool.

This has a series of trigger questions which attract a weighted score, giving an early indication of the level of quality and safety risk the ward may have.

The QuESTT scores inform the focus of the Clinical Governance Committee agenda, where deep dives to specific wards or department can be undertaken.

The Chief Nurse and the Senior Nursing Team meet weekly and review any 'soft intelligence' including any formal or informal concerns raised during ward visits or via the Speaking Out Safely (whistleblowing) policy.

A further process of review is undertaken via a structured process of care assurance audit work. This currently uses the CQC inspection methodology. This process is currently under review to ensure it is better aligned to the five domains of care, safety, well led, effect, and responsiveness as described by the CQC and NHS England.

The outcomes of the care assurance audits and Clinical Governance Committee reviews are fed back to the directorate leads for information and action. Where there are significant risk, or failing, a Quality Risk Summit methodology is employed, meeting with the multi-disciplinary team to identify and address the issues and providing support from the Corporate Teams where required.

13.0 Conclusion

This paper provides a conclusion to the base line review of staffing across the trust for nursing and midwifery except non-ward nurses as previously mentioned and The Wells Suite. Endoscopy was not reviewed as it was undergoing JAG accreditation and workforce analysis is a fundamental part of the accreditation process.

Overall staffing levels meet the needs of our patients, with a small number of exceptions as detailed above. In all cases, remedial action had either been taken by the Ward Manager and Matron, or was done so immediately after the identification of the gap.

The approach is in line with the expectations set out by the National Quality Board and other professional bodies.

This review provides the foundations for on-going bi-annual reviews and reporting to the board to provide assurance that staffing levels remain safe and set according to local need informed by evidenced based tools

There are processes in place to ensure appropriate staffing is available on a day to day basis, with clear monitoring and escalation processes in place.

The Trust uses approved evidence based tools such as Safe Staffing, to set and review staffing levels, and will review this again once a full Safe Staffing data set is available (within the next three months).

The Trust will publish staffing levels one month in retrospect from the e-roster system from April 2014.

The Trust is making visible to visitors the number of nurse planned on duty versus actual for each ward.

The Trust adopts a multi-disciplinary approach to setting nursing and midwifery staffing levels and takes into account the issues and concerned raised by staff.

The Trust is taking a proactive approach to workforce planning and to the management of vacancies within the nursing, Midwifery and care staff workforce.

A number of recommendations have been made to strengthen the resilience of the nursing establishments in some areas, most notably paediatric nursing cover in accident & emergency, collection of acuity and dependency within accident & emergency using a validated tool, the inclusion of ‘bleep’ cover in the business planning process for the Maidstone Acute Stroke Unit and extending services of the Critical Care Outreach Team.

Appendix 1

	Tunbridge Wells Hospital						
Ward / speciality	**Number of Beds**	**RN/CSW Ratio (%)**	**RN to Bed Ratio (E,L,N)**			**Nurse in Charge Supervisory**	**Comment/Action**
			E	**L**	**N**	**No of days**	
Coronary Care Unit	8 (6)*	100	1:2	1:2	1:2	3/7	*Funded for 6 beds operating at 8
10 Acute /General Surgery	30	65/35	1:5	1:7.5	1:7.5	5/7	Reviewed rota management to achieve 1:6 for early and late shift. No investment required
11 Surgery ENT	29	70/30	1:5	1:5	1:7.5	5/7	No change
12 Cardiology	30	62/38	1:5	1;5	1:7.5	5/7	No change
20 0rtho-geriatrics	30	60/40	1:6	1:6	1:7.5	5/7	No change
21 Respiratory	30	67/33	1:5	1:6	1:6	5/7	No change
22 Elderly Care	22	53/47	1:5	1:7	1:7	5/7	Late shift has 4 CSWs and 3 RNs and early and late shifts have a 50/50 split which accounts for the low skill mix ratio .The acuity and dependency of the patients doesn't justify the need for additional RNs
30 Elective Orthopaedics	30	63/37	1:6	1:6	1:7.5	5/7	No change
31 Trauma	30	60/40	1:6	1:7.5	1:7.5	5/7	As part of business planning need to consider having additional RN on late shift to achieve 1:6. Currently ward is overspent on 'specials'
TCH Stroke Rehab	12	60/40	1:4	1:6	1:6	3/7	No change
Acute Stroke Unit W22	10 (8)*	80/20	1:3	1:3	1;3	3/7	Set in line with the National guidelines for Hyper acute stroke unit

	Maidstone Hospital						
Ward / speciality	**Number of Beds**	**RN/CSW Ratio (%)**	**RN to Bed Ratio (E,L,N)**			**Nurse in Charge Supervisory**	**Comment/Action**
Coronary Care Unit	8	100	1:2	1:2	1:2	3/7	CCU and Culpepper are working as a joint area and thus sharing resources and clinical expertise
Culpepper	13	65/35	1:5	1:6.5	1:6.5	3/7	
Cornwallis Female Surgery	19	81/19	1:4.7	1:4.7	1:4.7	3/7	Higher RN ratio to meet increase acuity of Gynae Oncology pts.
Foster Clarke Respiratory	22	67/33	1:5.5	1:7	1:5.5	3/7	Late shift increased to 4 trained to achieve 1:5.5
John Day Gastroenterology	26	57/43	1:8.6	1:8.6	1:8.6	5/7	Establishment and skill mix on this ward has been reviewed to achieve a 1:6.5 during the day and 65/35 ratio. Band 5's are currently being recruited to achieve this ratio.
Jonathan Saunders Ortho-geriatrics	23	50/50	1:7.6	1:7.6	1:12	3/7	Establishment increased for nights with immediate effect to achieve 1:7.6 and being increased for early and late shifts as part of business planning.
Mercer Elderly Care	26	52/48	1:7	1:9	1:13	5/7	Establishment increased for nights with immediate effect to achieve 1:8.6 and days to achieve 1:6.5 ratio and 65/35 split
Pye Oliver Elective surgery	22	65/35	1:5.5	1:5.5	1:5.5	3/7	This ward can go up 28 beds if required for escalation.
Acute Stroke Unit	22 (26)*	62/38	1:5.5	1;5.5	1:7	4/7	Based on 22 beds decreases if 4 escalation beds opened without additional staff. Considering need for 4 trained on nights as well as days due to having to review patients in A&E.

Appendix 2: Executive Summary - Themes, issues and recommendations

Theme	Issue	Recommendations
Workforce Profile	The majority of the specialist nursing and midwifery workforce is working at Band 7 level	*It is recommended that the Band 7 component of the workforce is maintained at its current level although a clear pathway and minimum role requirements need to be established.*
	9% of the specialist workforce are working at Band 6 level	*It is recommended that opportunities for increasing the number of Band 6 specialist posts is considered to ensure that succession plans can be fulfilled.*
	12% of the specialist workforce are working at Band 8a, b and c and service structures are inconsistent	*It is recommended that clear role definitions for Band 8 specialist roles are set with defined minimum requirements*
	There are varying titles among the specialist workforce	*It is recommended that the number of titles currently in use are reduced and that clear consistent titles are applied appropriately*
	No consistency in the Consultant Nurse/Midwife Role and the requirement for services to have a Consultant Role is not clear	*It is recommended that the consultant role within the Trust needs to have a clear framework to support expected delivery*
Engagement	The specialist workforce spends far more time in external meetings and forums than they do at internal forums	*It is recommended that a forum for the specialist workforce is established that has a clear terms of reference which will enable information exchange and encourage active participation in wider nursing issues*
	The specialist workforce are influencing practice and standards in their specialist areas which is not being transferred into the organisations work plan	*It is recommended that a clear framework for embedding external learning and developments into both service organisational strategy is implemented into existing governance arrangements*
	The expectations of the role are not clear and therefore there is a lack of engagement at a trust wide level	*It is recommended that clear expectations of specialist roles are articulated to encompass not only their role as a specialist but also their role as a member of the senior nursing workforce*
	There is a number of innovative initiatives underway that demonstrate excellent practice	*It is recommended that the specialist workforce have a clear process for presenting their work internally to ensure their skills and experience are shared with the wider nursing workforce*

Theme	Issue	Recommendations
Job Planning	There is no standardised job planning process for CNS staff at MTW	*It is recommended that a standardised Job planning process is developed and implemented*
	Where job plans do exist there is no formalised approach for monitoring adherence to those job plans	*It is recommended that monitoring job plan adherence becomes part of the performance appraisal process for the specialist workforce*
	80% of the CNS workforce have job plans	*It is recommended that current job plans are reviewed and transferred onto a uniform Trust template once this is in place and that those without job plans develop these once the new process is established*
	The review templates and focus group process articulated that between 0 and 50% of the CNS workforce time is spent on administrative tasks	*It is recommended that admin support to the specialist role is considered on a service by service basis to maximise their capacity*
Education Qualifications	Over half the participants were educated to either Degree or Masters level	*It is recommended that clear minimum educational requirements are defined for each role and band*
	There is a perception that education and training funding has been cut / withdrawn	*It is recommended that the availability of opportunities for further education are clarified and communicated*
	There is a perception that the opportunities for education and training are not fairly distributed across the services	*It is recommended that service leads review the education & development needs of each service to ensure education and development can be commissioned to meet the needs of the entire workforce*
Rescue Work	Rescue work at MTW undoubtedly leads to admission avoidance and an improved patient experience	*It is recommended that rescue work is defined and measured as part of the service delivery*
	Rescue work can be difficult to define and quantify	*It is recommended that's each service defines their rescue work activities in line with local definition and captures activity accordingly*
	The Cassandra tool can help the CNS workforce to capture some of their 'rescue' interventions	*It is recommended that the Trust reviews the process of measuring specialist nurse activity and considers the use of the Cassandra tool or a suitable time and motion alternative*

Theme	Issue	
Line Management and Succession Planning	There is an inequity in the number of CNS direct reports to the line managers	*It is recommended that consistent reporting structures are implemented for all specialist roles*
	There is little succession planning for CNS posts in the Trust	*It is recommended that a clear succession plans are developed to ensure that posts are filled*
Finance and activity	There are a number of databases in use capturing information with incompatible interfaces	*It is recommended that the current activity databases are reviewed to ensure that activity is consistently and accurately recorded and to minimise duplication*
	There is confusion over whether certain aspects of activity are chargeable and whether activity is coded and paid for correctly.	*Its is recommended that the criteria for chargeable activity is clearly defined and that all non coded activity is reviewed against that criteria to ensure that maximum income generation for activity is achieved*
	Telephone activity is not clearly captured or coded	*It is recommended that in line with a review of activity all telephone activity is reviewed and appropriately captured*
	There is a difference of 2 WTE in the total of WTE reported by the participants and the finance information provided-	*It is recommended that the information with regards to establishment at service level is reconciled with the information held by finance as there are differences between the two*
Advanced Nurse Practitioners	The title Advanced Nurse practitioner is not widely used at MTW although there are specialists who are potentially working within the scope outlined by the RCN	*It is recommended that the role of the advanced nurse practitioner is defined locally with a clear criteria for achievement*
	The future of the role is unclear	*It is recommended that the trust clarify their position on advanced nurse practitioners locally and hold a local register of those who meet the criteria*
	Nearly a quarter of participants had completed non medical prescriber training.	*It is recommended that the scope to expand non medical prescribing is explored in those services where non medical prescribing would benefit patients*

Appendix 3

Temporary Staffing Hours													
	March	April	May	June	July	August	Septemb	Octobe	Novemb	Decemb	Januar	Februa	Grand Tot
Midwifery Joint Bank - NF102	5140.45	4183.15	4142.05	4349.3	4767.2	4420.65	4939.25	5221.3	5077.9	4141.85	4318	4406.733	55107.83333
Accident & Emergency - NA301(TW)	3578.25	2927.9	3051.5	2905.05	3451.85	3607.8	3800.45	3292.55	2442.3	1848.2	1807.25	2034.583	34747.68333
Medical Assessment Unit (TWH) - NA901	2749.15	2261.5	2259.2	2027.25	2769.75	2848.1	2258.5	1806.5	1642	911.1	1201.25	1065	23799.3
Chaucer (MAI) - NS451	2367.233	2327.95	1842.25	2335.5	1674.75	1640.75	39	124.25	151	2190.5	2856.983	2611	20161.16667
John Day (EMERG) (MAI) - NK251	1317.5	1572	1137.5	1329	1731.25	3001.7	1599.75	1855.5	1805.25	1543	1442.917	1496.5	19831.86667
Romney Community Ward - NC851	2568.967	2381.85	1836.8	1864	1332	1439.05	1424.25	1511.75	1759.5	1365	1166.5	1131.983	19781.65
Ward 31 (Trauma) - NG331(TW)	2218.25	1605	1451.75	1527.75	1521.8	1763	1824.5	1333.5	1400.5	1648	1650	1504.25	19448.3
Ward 10 (Emergency Surgery)- NG130 (TW)	1613	1123	1330.25	1297	1578.75	2306.5	1403.5	1181.75	1135.5	1593.5	1815.5	1933.95	18312.2
Ward 30 - NG330(TW)	1685.25	1257	946.2	894	1643.7	1504.75	1507	1401.75	1468	1186	1485.167	1321.5	16300.31667
Short Stay Surgical Unit (TWH) - NE701	1437.75	1473.75	1394	1170.5	1114.25	1594.95	1348.5	1102.75	1040.75	1133.75	1218.75	1053.667	15083.36667
Urgent Medical and Ambulatory Unit - NG551	1287.167	795.5	758.75	716.25	900	1068.1	1223.1	2683.25	1827.5	810.75	1130.667	1158	14359.03333
Ward 21 (respiratory) - NG231(TW)	1422.333	1956	1183.25	788.25	1107.25	908.5	1069.2	1003.75	722.5	759.7	1314.75	1274.25	13509.73333
The Wells Suite - PP010 (TW)	1802.333	1247.25	717.75	498.55	803.3	1018.25	1002	1035.7	1184	1338.25	1519	1265.333	13431.71667
Jonathon Saunders Medical Rehab (MAI) - NK951	1009.75	634.9	673.75	792	898.75	1498.25	1232.75	1271.5	1283.5	1251.25	1166	716.25	12428.65
Accident & Emergency - NA351 (M)	1826.833	1459.5	1104.75	940.5	756.7	996.8	1462.75	891.25	922.75	849.05	518.75	515.5	12245.13333
Ward 11 (SAU/23 hr Surg) - NG131(TW)	1310	987.25	732.5	885.2	1048.75	953.5	841.5	911	821.75	1146.5	1097.5	1275	12010.45
Pye Oliver Ward Days (MAI) - NS151	982.75	700	625.75	648.3	788.8	797.5	1215.7	1433.3	1020.95	1021.5	1245.167	1284.25	11763.96667
Charles Dickens Chemotherapy Day Unit (MAI) - NF571	1289.917	1560.75	923.25	831.9	842.2	873.75	976.45	1074.25	711.5	770.75	810.5	771.5	11436.71667
Ward 22 (Care of the Elderly) - NG232(TW)	1238.25	1057.25	1121.5	852.5	681.5	697.95	1098	854.25	904.5	756.5	1209.25	923.5	11394.95
Ward 20- NG230 (TW)	1240.75	1036.5	690.25	898.5	609.25	1048.75	959	1309.8	1013.5	551.5	704.5	1138.167	11200.46667
Mercer Ward (MAI) - NJ251	1079.483	1650	722.5	814	877.2	1272	741.5	1057	755.25	615	830.75	557.25	10971.93333
Paediatrics Cross Site - ND702	990.75	590.35	863.75	499.5	606.8	605.3	771.75	599.5	1491	1645.45	918.5	1139.25	10721.9
Stroke Unit - NK551(M)	942.75	656.5	636	650	963.75	1043.05	663	705	1016.25	899	843.8333	820.5	9839.633333
Ward 12 (Cardiology) - NG132(TW)	1131.333	698.45	651.15	972.45	625	846.25	526	649	663	1141.7	603	601.5	9108.833333
Intensive Care - NA201(TW)	1191.75	625.25	576.25	855.5	332	1179.5	547.5	522.25	654.05	703.75	827.25	877	8892.05
Elective Theatre (TWH) - TA101	651	492.25	426.75	440	842.25	805.25	1041.25	857.5	937.75	783.8	763.5	845	8886.3
Stroke Rehabilitation Unit (TCH) - NC901	548.5167	657.75	429.95	638.75	853	565	583.4	376	506.5	773.5	869	871	7672.366667
Foster Clarke (Medicine) NK451					326.95	509.75	656	1463	1192.25	1332	1025.5	1008.5	7513.95
Acute Stroke Unit - NC201(TW)	1327.75	1286.8	638.2	306.7	174.5	640.25	387	367.7	719.5	609	548.5	284.5	7290.4
Intensive Care- NA251 (M)	633.5	348.75	368.75	305.75	513.75	582.85	819	857	544.75	439.5	290.25	185	5888.85
Lord North Ward (MAI) - NF651	543.3333	269.5	414	493.5	451.75	486.25	508.5	553	411.5	339	465	411.75	5347.083333
Gynae (TWH) - ND302	606.75	424	437.75	528.5	310	208.5	404.25	344.25	457.5	351	524.25	592	5188.75
Coronary Care Unit - NP301(TW)	791	510	612.75	525	476.25	583.5	637.75	366	193.5	118	105.5	161.5	5080.75

Appendix 4

Directorate	Nurse Establishment WTE				HR KPI	
	Grade	Budget	SIP	Vacant	Turnover (%)	Sickness (%)
Acute & Emergency Medicine	Band 8a/b	2.00	2.00	0.00	12.01	4.26
	Band 7	36.01	39.56	-3.55		
	Band 6	41.39	44.74	-3.35		
	Band 5	146.89	116.08	30.81		
	CSW	66.94	59.49	7.45	11.74	7.29
	Total	293.23	261.87	31.36	11.94	4.95
Cancer & Haematology	Band 8a/b	1.67	1.85	-0.18	11.03	3.27
	Band 7	11.60	11.20	0.40		
	Band 6	10.13	8.93	1.20		
	Band 5	33.03	28.33	4.70		
	CSW	16.31	12.48	3.83	18.97	3.60
	Total	72.74	62.79	9.95	14.29	3.42
Children's Services	Band 8a/b	3.18	3.18	0.00	6.98	2.46
	Band 7	12.73	12.47	0.26		
	Band 6	31.42	29.04	2.38		
	Band 5	57.96	54.16	3.80		
	CSW	20.65	19.73	0.92	4.49	5.21
	Total	125.94	118.58	7.36	6.51	2.92
Critical Care	Band 8a/b	4.00	4.00	0.00	6.80	2.03
	Band 7	36.80	32.39	4.41		
	Band 6	47.66	44.84	2.82		
	Band 5	170.03	168.96	1.07		
	CSW	78.42	76.44	1.98		4.13
	Total	336.91	326.63	10.28	9.24	2.53
Diagnostics, Therapies & Pharmacy	Band 8a/b	3.00	3.00	0.00	4.44	2.90
	Band 7	3.09	3.09	0.00		
	Band 6	8.28	8.03	0.25		
	Band 5	5.28	5.69	-0.41		
	CSW	0.00	0.00	0.00	0.00	5.57
	Total	19.65	19.81	-0.16	4.44	5.29

Directorate	Nurse Establishment WTE				HR KPI	
	Grade	Budget	SIP	Vacant	Turnover (%)	Sickness (%)
Speciality Medicine	Band 8a/b	8.80	8.80	0.00	6.99	3.44
	Band 7	41.55	38.37	3.18		
	Band 6	37.52	34.13	3.39		
	Band 5	265.82	231.37	34.45		
	CSW	173.63	152.86	20.77	6.86	6.52
	Total	527.32	465.53	61.79	6.97	4.47
Surgery, Urology, Head & Neck and Gynae	Band 8a/b	1.40	1.40	0.00	7.99	5.76
	Band 7	35.74	34.71	1.03		
	Band 6	20.34	19.53	0.81		
	Band 5	116.54	100.49	16.05		
	CSW	66.27	57.94	8.33	12.82	6.07
	Total	240.29	214.07	26.22	9.51	5.84
Trauma & Orthopaedics	Band 8a/b	1.00	1.00	0.00	7.45	2.52
	Band 7	4.00	4.00	0.00		
	Band 6	6.00	6.72	-0.72		
	Band 5	46.58	44.70	1.88		
	CSW	30.65	21.52	9.13	8.79	9.23
	Total	88.23	77.94	10.29	7.89	4.37
Women's & Sexual Health	Band 8a/b	5.50	5.50	0.00	6.75	5.88
	Band 7	61.23	59.37	1.86		
	Band 6	101.56	99.98	1.58		
	Band 5	50.94	36.12	14.82		
	CSW	59.01	54.74	4.27	3.94	6.90
	Total	278.24	255.71	22.53	4.52	6.10
Total	Band 8a/b	**30.55**	**30.73**	**-0.18**	**9.42**	**4.33**
	Band 7	**243.75**	**236.16**	**7.59**		
	Band 6	**306.90**	**298.40**	**8.50**		
	Band 5	**911.22**	**802.55**	**108.67**		
	CSW	**520.38**	**470.20**	**50.18**	**7.71**	**6.06**
	Total	**2012.80**	**1838.04**	**174.76**	**6.74**	**5.65**

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TRUST BOARD MEETING – MARCH 2014

3-21	PERFORMANCE AGAINST THE KPIs FOR THE NEW CLINICAL ADMINISTRATION UNITS	CHIEF OPERATING OFFICER

Summary / Key points

At the Board Forum meeting in November 2013, a discussion was held regarding the service standards in place regarding the Trust's administrative functions.

The introduction of the new Clinical Administration Units was discussed, and it was agreed that a report of performance against the recently-agreed Key Performance Indicators (KPIs) for the Units should be received by the Trust Board.

The requested report is enclosed.

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

Summary

Implementation of the 5 x Clinical Admin Units (CAU) took place on 6th January 2014, the move programme to support the CAUs concluded as planned on 14th February, resulting in a move of approximately 200 personnel across both sites, with the exception of 3 x personnel who are scheduled to move at the end of March, when their new office will be available. The final move of HR records, will be completed by the end of March.

The KPIs linked to the CAUs are based upon existing KPIs, which are:
1. Clinical Outcome Letters stored via hospital system within 10 working days
2. Clinical Outcome Letters copied to GP within 10 working days
3. Clinical Outcome Letters to patient within 10 working days
4. Patient incoming calls answered within 1 mins, remaining calls 3 mins
5. Referral to readiness to appoint < 5 working days

The Cube which is the digital dictation platform and UKiMail allows the CAU team leaders to monitor/manage backlog in terms of Clinical Correspondence against KPIs 1/2/3, Netcall provides monitoring against KPI 4 & Patient Centre/eReferral provide data to support KPI 5.

eReferral will be rolled out in its entirety once the CAUs have had a period of stabilisation, in terms of the move programme and adopting new ways of working. All staff has been trained on all applications appropriate to their role and for those who have requested re-fresher training this will be done on 17th March. The CAU team leaders have been trained as Super Users to trouble shoot any frequent issues on site.

At present the CAU Team Leaders are able to extract the data from the Cube to monitor performance against KPIs. A snapshot of the data from 18th March, compared to manual capture from 2nd October 2013, is shown below:

Clinical Outcome Letters – GP/Hospital System/Patient within 10 working days

Speciality		Turnaround Time 18th March 2014	Turnaround Time 2nd October 2013
Cardiology	Routine Correspondence	5 days	5 days
	Urgent Correspondence	48 hours	48 hours
Care of Elderly	Routine Correspondence	10 days	5 days
	Urgent Correspondence	48 hours	48 hours
Rheumatology	Routine Correspondence	7 days	15 days
	Urgent Correspondence	48 hours	48 hours
Neurology	Routine Correspondence	5 days	20 days
	Urgent Correspondence	48 hours	48 hours
Gastro	Routine Correspondence	7 days	10 days
	Urgent Correspondence	48 hours	48 hours
Diabetes	Routine Correspondence	10 days	10 days
	Urgent Correspondence	48 hours	48 hours
T&O	Routine Correspondence (Maidst)	15 days	5 days
	Routine Correspondence (TWH)	25 days	20 days
	Urgent Correspondence	24 hours	24 hours
Urology	Routine Correspondence	30 days	15 days
	Urgent Correspondence	48 hours	48 hours

Please note that there are 200 routine letters waiting at the maximum of the 30 day turnaround time for Urology, these will all be sent out by Wednesday 26th March and the

action plan for the remaining back log will be resolved within the next 3 weeks. A Medical Secretary joins this area on 31st March, who will assist with the backlog.

Patient incoming calls answered within 1 mins, remaining calls 3 mins

Speciality	Time to answer calls (m:s)	No. of calls taken
T&O	2 m 1 s	32
H&N	3 m 13 s	103
W&C	1 m 4 s	34
General Surgery	1 m 43s	55
Specialist Medicine	1 m 49 s	50

Monitoring of KPI 5 is subject to roll out of eReferral. The T&O CAU has started the rollout of eReferral, which is a web based application, which enables booking clerks to scan the GP paper referrals and assign to a consultant, who reviews and responds online. Bookings can then been made online.

The turnaround noted is the worst case scenario and the concept of the CAUs is that the staff regardless of speciality will support and recover any backlog, as they have the technology to access the data on the web based applications. For the areas which are breaching the KPIs, a recovery plan is in place in terms of outsourcing, overtime and temporary staff support until substantive staff are in post.

Since the implementation of the CAU, staff have taken annual leave as they did not wish to take leave during the consultation period of October to December, plus during the consultation period and implementation, a number of positions became vacant (14 x WTE Support Secretaries), the final recruitment to these posts will take place week commencing 17th March, unfortunately this was delayed as NHS Jobs Website was unavailable due to an upgrade to a new design.

Although data can be extracted from the technology enablers, it has been agreed that this data extractions needs to be automated, in the form of a CAU Dashboard.

The User Requirements has been drafted for the CAU Dashboard and would provide a GUI based application linking to the Trusts existing applications such as The Cube, Netcall, Patient Centre etc. The dashboard needs to provide real time or pre-determined timed updates to support the above KPIs and targets and provide a central repository of the data regardless of the source.

The above information will provide the CAU team leaders with data, allowing them to proactively manage their speciality demand and to successful achieve KPIs/CQUINS.

The User Requirements have been reviewed by the CAU Team Leaders and will be circulated for internal approval by week ending 28th March. Discussions will then commence with software providers for initial timescales and development costs.

The proposal is to implement the CAU dashboard and stabilise the units, by achieving the agreed KPIs/CQUINs by end of June 2014.

The above data will equally allow the General Managers to establish whether as part of the Clinical Administration Unit Project, that the workforce allocation was correctly apportioned to specialities and to make any necessary changes if required.

Glossary

CAU – Clinical Administration Unit

Clinical Administration Unit – 5 Units created for:

- Head & Neck
- Surgery / Critical Care
- Specialist Medicine / Acute
- T&O
- Womens, Childrens & Sexual Health

Cube – Digital Dictation Platform

Software system to provide enhanced support for digital dictation, it is an online central repository that provides enhanced access to, and a range of functions for uploading, downloading and storing digital dictation.

UKiMail

Innovative imail sytem to speed up patient and GP communications, all correspondence is sent electronically to UKiMail via a secure online system for same day printing and dispatch.

Automated Appointment Contact System (Netcall)

System to improve patient experience when contacting the Trust and appointment management by ensuring correct contact is reached; using the call centre approach and management.

Electronic Referral Management (eReferral)

Web based application, booking clerks scan the GP paper referrals and assign to a consultant, who reviews and responds online. Bookings can then been made online.

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TRUST BOARD MEETING - MARCH 2014

3-22	BUSINESS CASE FOR JOHN DAY / JON SAUNDERS WARD REFURBISHMENT	CHIEF OPERATING OFFICER

Summary / Key points

- In September 2012, the Trust Board received a presentation on the Maidstone Hospital re-development, which included plans to undertake ward refurbishments, including John Day / John Saunders.
- The presentation noted that "2 Adjacent wards per year, approx. £2m investment per ward over 5 year time scale".
- It was agreed that the Finance Committee would review each stage of the development, to ensure financial viability. An associated action was allocated to the then Director of Finance.
- When this action was discussed again, at the November 2012 Board meeting, the Director of Finance confirmed that a business case for each phase would go through "…appropriate governance and sign-off arrangements".
- The Terms of Reference for the Finance Committee states that it has a role to "Review major or contentious business cases above the threshold set-out [sic] in the Reservation of Powers and Scheme of Delegation, for capital and service development (currently £750k) and advise the Board on the financial implications and risks of the proposals".
- The Trust's Reservation of Powers and Scheme of Delegation confirms that the Trust Board is required to approve business cases involving investment greater than £750k.
- The case was considered by the Trust Management Executive on 19/03/14, and the case recommended for approval.
- The case was also considered at the Finance Committee on 20/03/14.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 19/03/14
- Finance Committee, 20/03/14

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

BUSINESS CASE SUMMARY

ID	**JOHN DAY/JONATHAN SAUNDERS WARD REFURBISHMENT**
Project Sponsor	**Angela Gallagher, Chief Operating Officer**
Directorate	**Respiratory Medicine**
Clinical Director	**Clive Lawson**

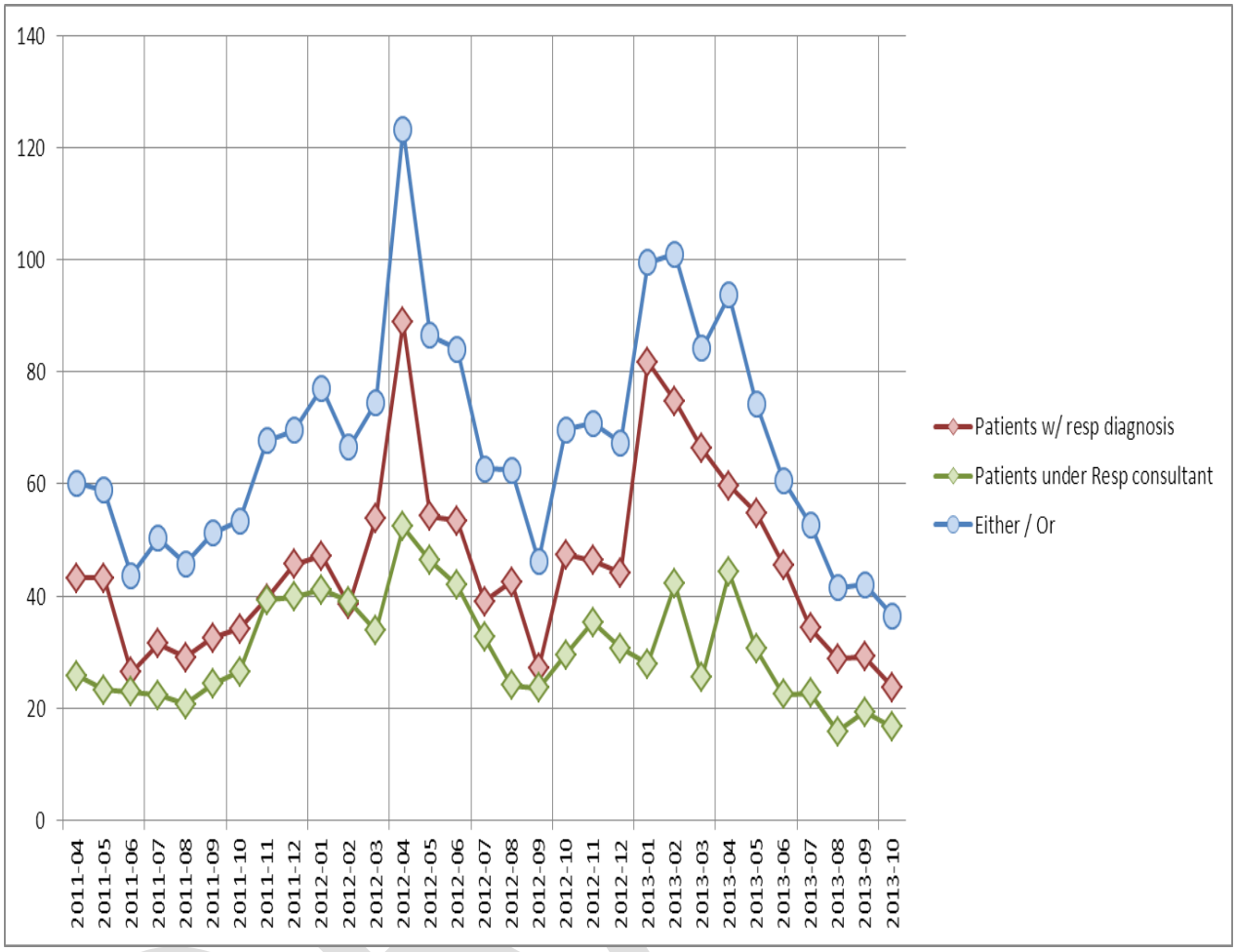
PURPOSE	
	Development of a new ward based on the footprint of the existing John Day/Jonathan Saunders ward to - Provide 24 hour acute care respiratory service by Autumn 2014 - Provide negative pressure room for TB and HIV patients Improve clinical pathway for NIV/BIPAP patients thereby avoiding admissions to ITU/HDU - Support integrated care pathway for COPD patients - Meet Estate category B standard (from D)

PREFERRED OPTION - Option 4 - Refurbishment full vent	
Description	This is the second ward block in our ward refurbishment programme which involves merging two wards J Saunders/ J Day (49 beds) into a new 31 bedded ward . The new ward templates have been design around a standard approach but will be able to Including the provision of 6 enhanced care beds for cohort level 2 patients. Admissions predominantly from UMAU or Emergency resus for the respiratory specialty
Quality impact	Proposed staffing model (nurses based in bays) increases patient visibility and thus benefits eg reduction in falls. Automated medication management and dispensing system should increase efficiencies and reduce errors. Increased space between beds in line with infection control recommendations. Increased patient experience through additional toilets/shower facilities. Meets CQC best practice standards for ventilation.
Workforce impact	1 RN to 2 patients - for 6 enhanced care beds 1 RN to 6.25 patients (early/late shifts) 1 RN to 8.33 patients (night) – 25 acute beds 1 wte b5 discharge nurse; 0.5wte ward clerk, 5 supervisory shifts for the ward sister/charge nurse This meets current guidance of RCN and the safer staffing national quality board recommendations
Financial impact	New layout and ways of working will enable increased throughput of patients and reduction in LOS.
	Capital cost £3.1m (phased over three years 12/13 to 14/15). Accounted for in Trust Capital plan Revenue projection: current cost for two wards (JS/JD 49 beds) = £2.1M . Cost of a new 31 bedded ward which can accommodate the respiratory specialty £1.7m = cost reduction £400k .
Impact on other Directorates	Timely repatriation of level 2 patients from Critical Care Reduce number of medical outliers in Surgery beds

Timetable	Building programme May - October 2014 Ward open 3 November 2014 (updated plan indicates 1st Dec)
Risks (mitigating action)	Capacity to decant existing wards, de-escalation of winter ward required (plan in place linked to LOS programme) Meeting project deadlines (time line understood by bidding contractors with- regular project groups meeting set up to manage time line and prevent slippage) Comprehensive implementation of the new Operational Policy and Training staff in line with this policy (full involvement and ownership of clinical team in developing the new policy, time identified for training)
Project management	JD/JS Project Group chaired by Dr Chris Thom reporting to Maidstone Programme Steering group to TME Project kpis to be monitored by Specialist Medicine Directorate
Exclusions	Cost of blood gas analyser (separate case to be presented)

APPROVAL	
who	**when**
Directorate	December 2013
Business Case Panel	December 2013
Execs	21 January 2014 (pending)
TME	19th March
Finance Committee	20th March
Trust Board	26 March 2014

NE Admissions under Clinical Management of Respiratory Team (Maidstone)



Figures from April 2011 to date suggest that the Directorate would require more than 31 beds on the new reconfigured ward. However, we are expecting a reduction in the number (as yet undetermined) of NE admissions supported by the following initiatives:

- Enhanced Rapid Response Recovery Service
- Pulmonary Rehabilitation
- Hot Clinics (MAU)
- Integrated COPD pathway

The above data justifies the need for a 31 bedded ward to match activity level. It is expected that when demand is in excess of 31 beds, the respiratory team will work collaboratively with the Site Team to prioritise admission of respiratory patients on the newly refurbished ward. On the other hand, the Directorate is aiming to stream the requirements for the number of beds in line with changes in demand as well as the impact of the above listed initiatives.

1.3. Business Case Aims & Objectives

The 2 key drivers for this investment are:

- The need to upgrade the patient environment from Estate Category D to Category B, to provide contemporary standards of ward accommodation at Maidstone on a par basis with that of the Tunbridge Wells Hospital. Most of the core estate dates from 1983 and has been classified as Category D standard, which is defined as operationally unsound and in danger of breakdown.

- The NHS document "A Risk Based methodology for Establishing and managing backlog identifies the differences between the Condition rankings of buildings as follows

Ranking for Physical Condition

The physical condition of each sub-element should be categorised as follows:

A as new and can be expected to perform adequately to its full normal life

B sound, operationally safe and exhibits only minor deterioration

B(C)† currently as B but will fall below B within five years

C operational but major repair* or replacement is currently needed to bring up to condition B

D operationally unsound and in imminent danger of breakdown**

Supplementary rating added to C or D to indicate that it is impossible to improve without replacement

Refer to appendix 1(Extract from a risk based methodology)

- The need to modernise the medical ward configuration, recognising the needs to provide more efficient and effective services, with fewer beds in order to improve patient experience and quality advantages, which include:

  - Realisation of efficiencies from a new ward layout and ways of working that enable increased throughput of patients and reduced length of stay.
  - Bed reductions (as outlined in the UMAU business case)
  - Staffing efficiencies as a result of the reduction in bed numbers;
  - Improved patient experience and quality advantages, which include:

    - Increase the number and provide larger single rooms

- Increase the space between beds (in line with HBN Guidelines) to reduce the risk of cross infection;
- Provide more space in the patient bays to facilitate efficient moving and handling and reduce the risk of falls;
- Improve privacy and dignity, increase and improve en-suite facilities
- The proposed staffing model enables nurses to be based in each patient bay. This will increase patient visibility, and should result in closer observation of patients, time efficiencies and a reduction in falls.
- There will be 6 enhanced care beds which will centralise and cohort level 2 patients, and provide enhanced management for this cohort of patients who require more intense observation and intervention
- The proposal includes an automated medication management and dispensing system which increases efficiencies and reduces errors.
- The new ward layout and ways of working will enable an increased throughput of patients and enable a reduction to length of stay.

1.4. Background/Context

This investment forms the second phase of the 7 year strategy for Maidstone medical ward reconfiguration, set out by Dr Chris Thom in May 2013. The strategy recognises that the hospital needs to do more, and better, with fewer beds and sets out a vision to:

1. Provide timely care to patients with urgent and emergency medical conditions;
2. Reduce the proportion of patients requiring admission to hospital;
3. Reduce the length of hospital stay for those admitted;
4. Ensure care by the most appropriate clinicians in the most appropriate location;
5. Support the Critical Care Directorate by ensuring timely repatriation of level 2 patients to the new reconfigured ward;
6. Support surgical directorate by reducing the number of medical outliers;
7. Support acute and emergency medicine in achieving the A&E performance standards by ensuring right patient in right place and at the right time.

The strategy is based on a projected bed requirement of 166 as per the bed capacity plan (refer or appendix Steve Jones plan) previously agreed by the Trust Executive Team, as follows:

Date	Ward Refurbishment	New Speciality	Beds
2012	UMAU	Acute medicine	14
2014	John Day/Jonathan Saunders	Respiratory medicine	31
2015	Whatman/Mercer	Gastroenterology and diabetes & endocrinology	32
2016	Stroke/Chaucer	Stroke and rehabilitation	32
2017	Cornwallis/CCU/Culpepper	Cardiology	23
2018	Romney/Peale	Elderly care	34
	TOTAL		**166**

1.5. Ward Design

The ward layout design (appendix 3) includes:

- 5 x 4-bedded bays

- 1 x 3 bedded bay with shower en suite and toilet facilities;
- 7 x single rooms with en suite facilities;
- 1 x negative pressure isolation room for isolation of patients with airborne contagious respiratory diseases such as tuberculosis;
- 6 x bedded enhanced care area located within in 2 bays for patients requiring more intense observation and intervention e.g. patients requiring non-invasive ventilation;
- A work stations in each bay;
- A large central store for ward stocks and equipment
- A multidisciplinary meeting room for case discussions and meetings with relatives.

1.6. The Model of Care

The ward vision is to provide a 24 hour high quality patient centred service for in-patients who require an episode of acute care for respiratory conditions. Admissions will predominantly be via UMAU or directly from the Emergency Care Centre Resus area. The ward will be an exemplar for enhanced care for acute respiratory conditions with 6 beds for level 2 patients. See the draft Operational Policy (Appendix 6).

1.6.1 Ward Staffing

The nursing model is based on the following ratios

- 6 Enhanced Care Beds (Level 2 patients): 1 RN to 2 patients
- 25 General Acute Beds (Level 0/1 patients): 1 RN to 6.25 patients (Early/Late shifts)
  1 RN to 8.33 patients (Night shift).

The staffing model incorporates:

- 1 WTE Band 5 RN Discharge Nurse post to expedite discharges
- 0.5 WTE Ward Clerk provision at weekends to expedite discharges
- 5 supervisory shifts for the Ward Sister/Charge Nurse.

- **Geography:** With a larger layout there is reduced visibility of all clinical areas from a central nursing station, therefore this staffing model allows for nurses to be based in the bays, increasing visibility of patients which will bring benefits including reduction in falls.

- **Enhanced Care Beds:** A recent data collection exercise, (using a respiratory ward acuity tool) has demonstrated that an average of 5-6, Level 2 patients, in the hospital, and require level 2 nursing. It also shows that in addition, there are a high number of patients with likelihood to deteriorate to level 2. Based on this data, a provision for up to 6 enhanced care patient beds has been allocated on the ward. This provision has not been historically been incorporated into the ward establishment, and special nursing is usually booked on an ad-hoc basis depending on location and need.

- **Increased turnover and efficiency**: In order to achieve a reduction in the Length of Stay, staffing levels have been evaluated to cope with the increased turnover and provide a safe level of service to ensure the efficiencies are realised.

1.4 Options

The following business case considers 4 options:

1.	**Do nothing**
2.	**"Like for like"** refurbishment of John Day and Jonathans Saunders Wards
3.	**"Non-vent"**: Total refurbishment and development of a new 31 bedded ward, with ventilation to internal rooms and dirty extract only.
4.	**Preferred option – "Full vent" :** Total refurbishment and development of a new 31 bedded ward, with full ventilation to comply with HTM requirements

1.5. Finance

1.5.1. Capital - Capital costs are broken down into 4 components as follows:

	Build Works £m	Equipment £k	Total £m
Option 1 – Do nothing	0	0	0
Option 2 – Like for Like	1.55	58.89	1,552
Option 3 – Refurbishment non-vent	2.73	85.89	2,798
Option 4 –Refurbishment full-vent	2.,988.6	91.3	3,079.9

For details of full breakdown refer to attachments

Business Case Options Appraisal

Evaluation Criteria

1. **Financial**: Option must be financially viable and demonstrate value for money.
2. **Clinical Service Delivery**: Produce efficiencies that support reduction in length of stay and bed reduction.
3. **Patient Experience:** Improves the patient environment experience – to be monitored by patient survey results.
4. **Strategic link:** Consistency with the Maidstone Programme Board Strategic Vision

Option 1 - Do Nothing

(i) Description of Option – Maidstone Estate would continue to be at Category D - which is defined as operationally unsound and in danger of breakdown.

(ii) Key assumptions

- John Day and Jonathan Saunders remain two separate ward areas at Category D
- Patient environment is not enhanced
- Efficiencies from new ward layout and new ways of working not realised

(iii) Key financial indicators

- No new build costs incurred.
- Increased risk of ad hoc costs as the estate deteriorates

(iv) Risk assessment

- The estate at Maidstone is over 30 years old in many areas, requiring refurbishment which will be a mandatory requirement over the next few years. By

doing nothing, the Trust is at risk of not being compliant with mandatory NHS estate requirements to maintain the estate
- Efficiencies will not be realised, which would impact on the ability to adapt to future service demands.
- Quality advantages of the new ward layout will not be realised.

(v) Reason(s) for ~~acceptance/~~rejection: Option 1 is rejected on the basis of failing to meet any of the evaluation criteria

Evaluation Criteria	Option 1
Financial: Option must be financially viable and demonstrate value for money.	X
Clinical service delivery: Produce efficiencies that support reduction in length of stay and bed reduction	X
Patient Experience: improve the patient environment and patient experience.	X
Strategic link: consistent with the Maidstone Programme Board Strategy.	X

Option 2 "Like for Like"

(i) Description of Option – A "like for like" refurbishment of John Day and Jonathans Saunders Wards as they are currently configure

(ii) Key assumptions

- John Day and Jonathan Saunders Wards will remain as separate wards and will be restored to a 30 year old design.
- Each individual ward will be updated from a category D standard to a category B standard in order to remain operational in the future.

(iii) Key financial indicators

- A "like for like" clinical refurbishment to category B standard is estimated to cost £1.55m.

(iv) Risk assessment

- The "like for like" option would improve the backlog risk profile for this block, from the current position (4 red risks) to all low (blue) risks
- No opportunity for rectification of functional suitability and improvements in design standards
- This option will not bring the estate condition up to CQC best practice standards.
- No opportunity to provide additional space between beds in line with infection control recommendations;
- No increase in the number of single rooms;
- No improvements to the energy efficiency in line with the Trust's environmental improvement programme;
- No reduction in beds per bay or increase in toilet/shower facilities to maximise the patient experience /privacy and dignity;
- The patient environment will be moderately improved but quality advantages associated with a new layout will not be realised.
- Efficiencies associated with alignment of specialities and new ways of working to support sustained reduction in LOS will not be maximised.

(v) Reason(s) for ~~acceptance/~~rejection - Option 2 does not provide an opportunity to improve the functional suitability of the wards or provide value for money. Whilst the

ward would be refurbished to a category B standard the design is 30 year old and does not meet CQC practice standards. This option is rejected on the basis it does not meet the Evaluation Criteria (1), (2), and (4).

Evaluation Criteria	Option 2
Financial: Option must be financially viable and demonstrate value for money.	X
Clinical service delivery: Produce efficiencies that support reduction in length of stay and bed reduction	X
Patient Experience: improve the patient environment and patient experience.	√
Strategic link: consistent with the Maidstone Programme Board Strategy.	X

Option 3 – "Refurbishment non-vent" (information on complete detail is available)

(i) Description of Option - Develop a new acute respiratory ward on the footprint of the current John Day and Jonathan Saunders Wards, with ventilation to internal rooms and dirty extract only.

(ii) Reason for rejection: This option has been rejected on the basis that the partial ventilation does not comply with HTM requirements. It would rely on opening windows to control temperature and ventilation some existing windows have restricted opening. As any new build will be in place for 30 years, this option does not provide the Trust with the ability to effectively respond to future changes in climate to maintain a satisfactory and comfortable patient environment. It does not comply with CQC best practice standards for ventilation.

Evaluation Criteria	Option 3
Financial: Option must be financially viable and demonstrate value for money.	X
Clinical service delivery: Produce efficiencies that support reduction in length of stay and bed reduction	√
Patient Experience: improve the patient environment and patient experience.	√
Strategic link: consistent with the Maidstone Programme Board Strategy.	√

Option 4 – "Refurbishment – full vent" (Preferred option)

(i) Description of Option - Development of a new acute respiratory ward on the footprint of the current John Day and Jonathan Saunders Wards, with full ventilation to comply with HTM requirements.

- As for Option 3, but will include full ventilation.

(ii) Key assumptions –

- The footprint of John Day (26 beds) and Jonathan Saunders (23 beds) will amalgamate to form one unit of 31 beds run by one nursing team.
- The building programme will commence on site in May/June 2014 and the ward will be completed by 1st November 2014.
- Both John Day Ward and Jonathan Saunders will be decanted to alternative locations in Spring 2014 to enable the building work to commence
- Trauma and Orthopaedic offices situated at the entrance to John Day/Jonathan Saunders will be relocated to the old Discharge Lounge.
- This business case excludes the cost of a blood gas analyser and a separate case will be presented for this kit.
- This option will improve the backlog risk profile for this block, from the current position (4 red risks) to all low (blue) risks.

- This option will provide an opportunity for rectification of functional suitability and improvements in design standards
- This option will provide additional space between beds in line with infection control recommendations;
- Increase in the percentage of single rooms;
- Provide energy efficiency in line with the Trust's environmental improvement programme;
- Reduce beds per bay and increase in toilet/shower facilities to maximise the patient experience /privacy and dignity;
- Efficiencies associated with alignment of specialities and new ways of working will be maximised.
- Complies with CQC best practice standards for ventilation.
- All rooms will be fully ventilated, in compliance with HTM requirements.

(iii) Key financial indicators

- Capital cost: 3,079.9m for full ventilation to comply with HTM requirements

	John Day, John Saunders refurbishment - Vent Option
Option Description:	
Capital Projections £000s:	
Departmental Costs	2,231.8
On - Costs	240.7
Fees (including in house resource)	374.5
Equipment Cost	91.3
Contingency	60.0
TOTAL Cost Before Inflation	**2,998.3**
Inflation Adjustments	**81.6**
Capital Cost including VAT (+ve):	**3,079.9**
Capital included in Trust Capital Programme (yes/ no)	**No**
Revenue Projections £000s Full Year:	
Income Projection (+ve)	
Pay Cost (-ve) / Efficiency Saving (+ve)	400.0
Non Pay Cost (-ve) / Efficiency Saving (+ve)	
EBITDA Contribution	**400.0**
Capital Charges & Financing Costs (-ve)	-152.3
I&E Surplus (+ve) / Deficit (-ve)	**247.7**
Non Recurrent Revenue Costs £000s	
Key Financial Indicators:	

The above cost reduction is subject to the following enablers:

- Consistently achieving median LOS (8.4 days) from April 2014.
- The full implementation of the Seven Standards .This includes effective daily board rounds and the commencement of a dedicated discharge co-ordinator from the 1st April 2014.
- Successful pilot of nurse-led discharges for all Trust respiratory patients.
- The implementation of 7 day working and daily consultant ward rounds (subject to business case approval).
- The re-introduction of Early Supported Discharge as part of the integrated care pathway for COPD.
- Continuation of the pulmonary rehabilitation programme and provision of the home oxygen service.
- Successful reduction in overall LOS on the TWH site to enable cessation of the divert to Maidstone Hospital.

All of the above form part of the 2014/15 CIP Planning.

Capital Phasing			
2012-13 £000	2013-14 £000	2014-15 £000	Total Capital £000
183.7	184.0	2,712.2	3,079.9

(iv) Risk assessment - There are risks associated to the new build programme:

- To ensure that the build is complete by 1st November 2014, the project must adhere to the timeline set out in (5) Project Timetable.
- Identifying capacity to decant John Day, Jonathan Saunders and wards above to mitigate noise disruption.

(v) Reason for acceptance

- This option meets all the Evaluation Criteria above and provides value for money in comparison to Option 2 and Option 3.
- It will support the implementation of the modernisation of the medical ward clinical services.
- It will also improve the patient environment and provide quality advantages.
- Full installation of ventilation will ensure a comfortable patient environment can be maintained in the future, fully complying with HTM requirements.
- This option meets CQC best practice requirements

Evaluation Criteria	Option 4
Financial: Option must be financially viable and demonstrate value for money.	√
Clinical service delivery: Produc efficiencies that support reduction in length of stay and bed reduction	√
Patient Experience: improve the patient environment and patient experience.	√√
Strategic link: consiste t with the Maidstone Programme Bo rd Strategy.	√√

Recommendation of preferred option

Evaluation Criteria	Option 1	Option 2	Option 3	Option 4
Financial: Option must be financially viable and demonstrate value for money.	X	X	X	√
Clinical service delivery: Produce efficiencies that support reduction in length of stay a d bed reduction	X	X	√	√
Patient Experience: improve the patient environment and patient experience.	X	√	√	√√
Strategic link: consistent with the Maidstone Programme Board Stra egy	X	X	√	√√

It is proposed that the case is approved to progress with Option 4.

Benefits Realisation - preferred option

- The project will be implemented by the John Day/Jonathan Saunders Project Group, chaired by Dr Chris Thom and responsible to TME.
- The environmental benefits and quality advantages will be realised in November 2014, with the completion of the new build.
- The success of the new build, including the operational and staffing revenue benefits Will be measured using financial, clinical and patient experience key performance Indicators. The KPIs will be monitored by the Specialist Medicine Directorate.

Project timetable - preferred option

- March 2013 – November 2014. See appendix 2 for full details of build programme
- Design completion 29th April 2013
- Business case Panel December 2013
- Finance committee January 2014
- Trust Board January 2014
- Operational policy – Continue to develop
- Project out to tender 17th January 2014
  - Tender bids received by 28th February
  - 2 weeks Tender evaluation to 14th March 2014
  - Appointment of the contractor 21st March 2014
  - Contractor's lead in time 21st March to 26th May 2014
  - Build commences 26th May 2014
  - Build complete 13th October 2014
  - Clean and commissioning complete 31st October
  - New ward opens 3rd November 2014

6. Business Case Assessment Criteria

Project Name					
Self Assessment Framework for	**Zero**	**Poor**	**Fair**	**Good**	**Excellent**

Effectiveness Criteria					
Is it Patient Centred?				**x**	
Is it clearly linked to Corporate Objectives, Integrated Business and Annual Business Plans?				**x**	
Are the Objectives and KPIs SMART?				**x**	
Is there a balanced Financial proposal with a thorough financial and general risk assessment?				**x**	
Is there evidence that the approach has worked before?					
Is there evidence that desired outcome will be achieved?					
Is there Commitment from Stakeholders?					
	YES / NO / NOT APPLICABLE				
Comments: Stakeholder commitment to be achieved through TME					

Appendix 1: Extract from a risk based methodology

The NHS document "A Risk Based methodology for Establishing and managing backlog identifies the differences between the Condition rankings of buildings as follows

Table 3.1 Ranking for Physical Condition

The physical condition of each sub-element should be categorised as follows:

A	as new and can be expected to perform adequately to its full normal life
B	sound, operationally safe and exhibits only minor deterioration
B(C) †	currently as B but will fall below B within five years
C	operational but major repair* or replacement is currently needed to bring up to condition B
D	operationally unsound and in imminent danger of breakdown**
X	supplementary rating added to C or D to indicate that it is impossible to improve without replacement

Table 3.2 Rankings for compliance with mandatory fire safety requirements and Statutory Safety Legislation

Each sub-element should be ranked according to compliance with mandatory fire safety requirements (including „Firecode') and statutory safety legislation as follows:

A	complies fully with current mandatory fire safety requirement and statutory safety legislation
B	complies with all necessary mandatory fire safety requirements and statutory safety legislation with minor deviations of a non-serious nature*

B(C)† currently as B but will fall below B within five years as a consequence of unabated deterioration or knowledge of impending mandatory fire safety requirements or statutory safety legislation

C contravention of one or more mandatory fire safety requirements and statutory safety legislation, which falls short of B

D dangerously below conditions A and B

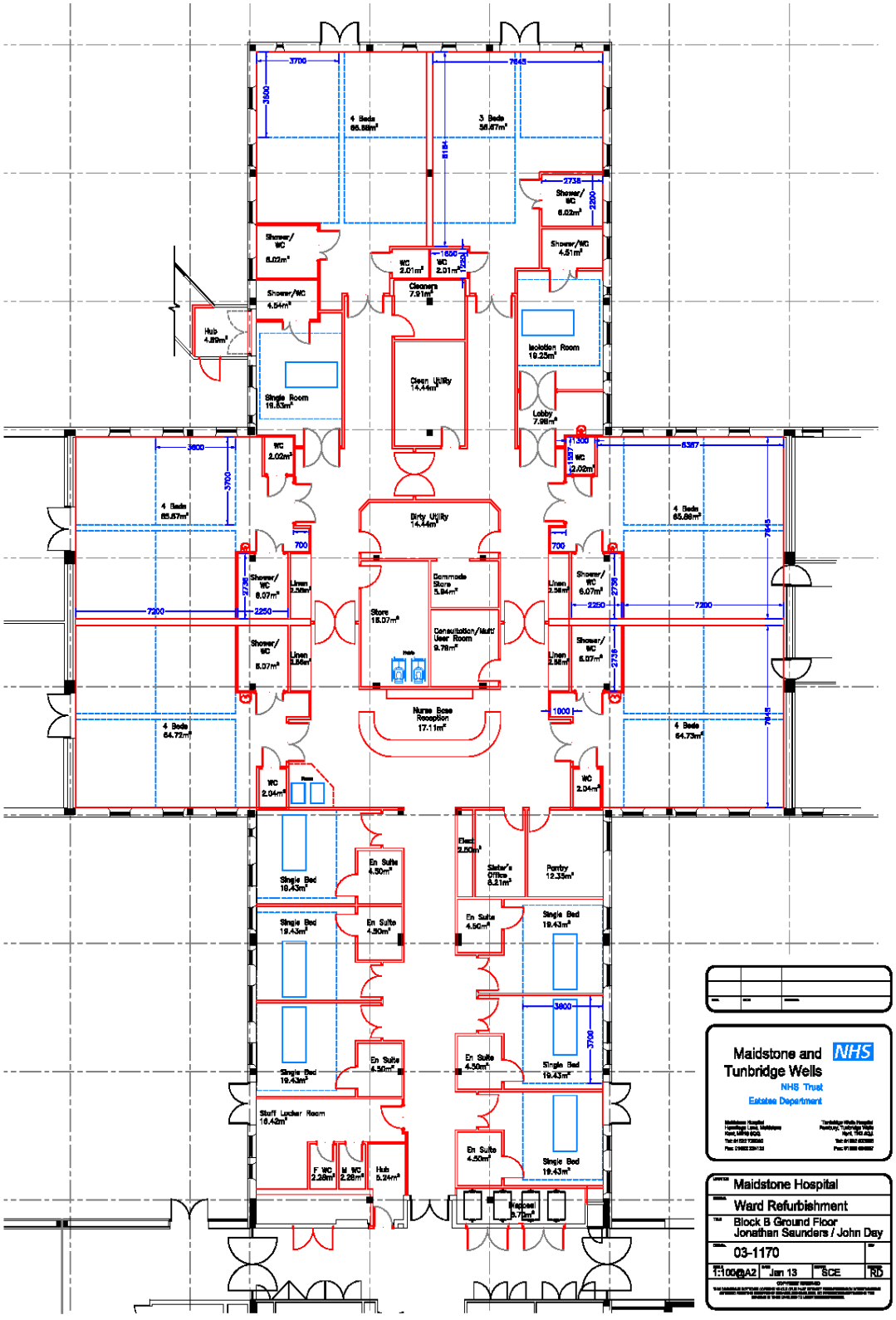
The same document in chapter 4 refers to the use of Capital backlog funds that are used predominantly to return the building fabric to a condition that is currently Category C or below to Condition B

The condition status does not reflect on the functional suitability of any development. Which needs to be considered separately against the requirements identified within the relevant HBN and HTM documents

Appendix 2: Project Build Timetable

	Duration	Start	Finish
Building Design Complete	70 days	29/04/2013	02/08/2013
Build Final Design	0 days	29/04/2013	29/04/2013
M&E Final Design Review	10 days	29/04/2013	10/05/2013
Drawings and specification documents issued to Trust	60 days	13/05/2013	02/08/2013
Assemble tender packages	45 days	02/12/2013	31/01/2014
Prepare preliminaries package for scheme	35 days	02/12/2013	17/01/2014
Contractor selection process and review	10 days	20/01/2014	31/01/2014
Assemble Tender package	20 days	30/12/2013	24/01/2014
Send out tender documetation	0 days	31/01/2014	31/01/2014
Tender Period	40 days	03/02/2014	28/03/2014
Contractor pricing	40 days	03/02/2014	28/03/2014
Contractor interviews	20 days	17/02/2014	14/03/2014
Tender Review	20 days	28/03/2014	25/04/2014
Tender Submission	0 days	28/03/2014	28/03/2014
Tender Review and recommendation	20 days	31/03/2014	25/04/2014
Contractor Appointment and Works	140 days	28/04/2014	07/11/2014
Order Issue	1 day	28/04/2014	28/04/2014
Contractors Lead / mobilisation	25 days	28/04/2014	30/05/2014
Start on Site	1 day	02/06/2014	02/06/2014
Works on Site	115 days	02/06/2014	07/11/2014
Clinical Commissioning	16 days	10/11/2014	01/12/2014
Domenstic Clean	10 days	10/11/2014	21/11/2014
Equip unit	5 days	24/11/2014	28/11/2014
Functional Unit	0 days	01/12/2014	01/12/2014

Appendix 3: Ward Layout



NHS Trust

Appendix 4: Operational Policy and Procedure – Reconfigured Respiratory Ward(Maidstone Hospital)

Requested/ Required by:	Specialist Medicine (Maidstone); Emergency Services
Main author:	Lead Matron for Specialist Medicine, Emergency Services. Contact Details**:** 01622 22**4977**
Other contributors:	Head of Nursing, Emergency Services; Consultant Physicians; Project Nurse, Service Improvement Team; Matron for Specialist Medicine, Maidstone Hospital; Ward Sister for Respiratory Ward, Maidstone Hospital;
Document lead:	Lead Matron for Specialist Medicine Directorate
Directorate:	Specialist Medicine and Elderly Care Directorate
Specialty:	Respiratory Medicine Ward
Supersedes:	None
Approved by:	Trust Management Executive Committee,
Ratified by:	N/A
Review date:	January 2014

Document History

Requirement for document:	The Operational Policy and Procedure is required for the new respiratory ward, which has been opened on John Day/Jonathan Saunders Ward, as part of the refurbishment at Maidstone Hospital
Cross references:	
Associated documents:	**Maidstone and Tunbridge Wells NHS Trust:** • All clinical policies • Fire Safety Policy and Procedure • Healthcare Waste, Policy and Procedure for the Management of • Major Incident Plan • Medical Devices Policy and Procedure • Moving and Handling Policy and Procedure • Medical Gases Policy and Procedure • Patient Property Policy and Procedure • Dress, Uniform and Identification Badge Policy and Procedure • Patient Transfer Policy and Procedure • Infection Control Policy and Procedure • Isolation Policy and Procedure • Clostridium Difficile, Control and Management of • Discharge Policy and Procedure • Safeguarding Adults: Protection and Support of Vulnerable Adults Policy and Procedure • Protected Mealtimes and Red Tray Policy and Procedure

Version Control:		
Issue:	**Description of changes:**	**Date:**
1.0	First iteration of policy	4.1.12
1.1	Revised (Respiratory only)	13.6.13

Policy Statement for

Reconfigured Respiratory Ward(Maidstone Hospital)

This policy is required to facilitate effective management and operational services on the new respiratory ward at Maidstone Hospital.

This ward has been developed as the next phase of the refurbishment programme for Maidstone Hospital and is open from November 2014.

Operational Procedure for Reconfigured Respiratory Ward(Maidstone Hospital)

Contents **Page**

1.0 Introduction and scope

The new reconfigured respiratory Ward is a 31 bedded acute respiratory ward providing a 24 hour service for patients who require an episode of acute care for respiratory conditions.

2.0 Definitions

- Levels of Care (from "Levels of Critical Care Standards and Guidelines", 2009)

  Level 0
  Patient whose needs can be met through normal ward care in an acute hospital

  Level 1
  Patient at risk of their condition deteriorating, or those recently relocated from higher levels of care whose needs can be met on an acute ward with additional advice and support from the critical care team.

  Level 2
  Patients who require more detailed observation or intervention, including those stepping down from higher levels of care. Level 2 patients may require :
  - Hourly vital signs and close observation for signs of acute deterioration. This includes non-invasive ventilation and patients on the sepsis pathway;
  - Tracheotomy care with 2 hourly suctioning;
  - Central venous pressure monitoring or titrating fluids to monitor Hypotension
  - Anti-arrhythmic medication intravenously, i.e. amiodorone, digoxin and nitrates;
  - Central nervous depression or intravenous medication for seizures;
  - Oxygen therapy involving more than 50% oxygen via a face mask or tracheotomy.

- MDT – Multidisciplinary Team

- COPD – Chronic Obstructive Pulmonary Disease

- N.I.V. - Non-invasive ventilation

3.0 Duties

Duties are embedded within sections 11.0 and 12.0 below and within the associated job descriptions.

4.0 Training / competency requirements

All new staff will be required to undertake MTW induction/orientation and a local induction to the area.

All staff will maintain a level of knowledge and skill through specialist and mandatory update sessions and the completion of relevant competency assessment tools at the required intervals, as identified within the Trust Statutory and Mandatory Training Matrix.

Nursing staff are required to have competency in relation to the management of a range of respiratory conditions, including the management of patients with non-invasive ventilation, chest drains and tracheotomies.

5.0 Philosophy of care

The ward vision is to provide safe, high quality patient centred care through a committed team of competent health care professionals, who have specialist knowledge in respiratory care.

Patients, staff and visitors will be treated with compassion, respect and dignity in a non-judgemental way using good communication skills, within a clean, safe and happy environment.

The ward is established to assist patients and their families during the acute phase of illness related to respiratory conditions, including:

- Type 1 Respiratory Failure e.g., chest infections, pneumonia, acute asthma
- Type 2 Respiratory Failure e.g. COPD,
- Respiratory conditions requiring a chest drain
- Tuberculosis
- Tracheotomy

The ward will provide an appropriate environment which will include an enhanced care bay for Level 2 patients.

The layout of the ward is provided in Appendix 4 and includes:

- 5 x 4-bedded bays, 1 x 3 bedded bays; all with shower rooms and WCs providing separate accommodation for male and female patients;
- 7 single rooms with ensuite shower and WC facilities;
- 1 x negative pressure room for patients with airborne transmitted diseases such as Tuberculosis, who require isolation.
- A multidisciplinary team room/consultation room to provide privacy for discussions with team members, patients and relatives;
- A central nurse base and workstation for the MDT team.
- I.T. stations/work bases in each bay close to the patients' location, which will have the potential to accommodate docking stations for future use of hand held devices.
- Clean and dirty utilities
- Ward Sister's office
- Staff locker room, change, WCs.
- Cleaner's room
- General ward storage and linen stores.

6.0 Functional relationships

John Day/Jonathan Saunders Ward will work closely with UMAU, the Emergency Care Centre, the clinical site managers, clinical nurse specialists, Discharge and Community Liaison teams and Social Services at Maidstone Hospital to ensure a smooth and effective admission and discharge process for patients.

A close relationship will be required with Respiratory Consultant Physicians, Respiratory Nurse Specialists, MacMillan Lung Cancer Nurse Specialists, Therapists and Social Services, to ensure that patients receive the appropriate treatment and care.

In addition, the ward is to be an exemplar for enhanced care for patients with acute respiratory conditions. This operational policy should be used in conjunction with specific Trust pathways and protocols e.g. sepsis pathway, non-invasive ventilation protocols.

7.0 Hours of operation and predicted workload

The ward will be open 24 hours a day, 7 days a week.

It is expected that the ward will maintain an occupancy of at least 85% and the Consultant Physicians/Registrar will undertake ward rounds daily.

8.0 Client / patient flow

Admissions to the ward will predominantly be acute non-elective medical patients admitted directly from the Emergency Care Centre or via UMAU.

There may be transfers from other wards, when a patient requires specialist respiratory interventions e.g. non-invasive ventilation or insertion of a chest drain.

Patients may also be transferred to the Respiratory Ward from the Intensive Care Unit.

Any admissions to the Respiratory Ward will be made via the Site Management Team.

Patients will be discharged directly home, with additional enablement services when needed, or transferred to other hospitals, or a long term care facility from the ward or via the discharge lounge.

9.0 Patients appropriate for admission to Respiratory Ward

9.1 Patients with a tracheostomy
9.2 Patients with a respiratory failure requiring Non Invasive Ventilation (BiPAP or CPAP)
9.3 Patients with severe pneumonia
9.4 Patients with an acute exacerbation of asthma or COPD
9.5 Patients with suspected/confirmed diagnosis of tuberculosis
9.6 Patients with chest infections complicated by other co-morbidities
9.7 Patients with bronchiectasis who require an admission
9.8 Patients with suspected or recently diagnosed lung cancer and other thoracic malignancies
9.9 Patients with intercostal chest drains for pleural effusion, empyema or pneumothorax.

10.0 Patients excluded from admission to Respiratory Ward

Patients who do not require specialist respiratory acute intervention.

11.0 Work flow

There will be a daily medical ward round between 9am and 11am, which will also include OT/Physiotherapist, a nursing representative, and other members of the MDT as needed, e.g. clinical nurse specialist, social services.

A weekly MDT meetings for full patient reviews, including nursing, medical, social services, and OT/physiotherapy representatives will also take place.

- **Stores**
  Stores will be delivered on a twice weekly basis.

- **Pharmacy**
  The ward will have an allocated Pharmacist/Pharmacy Technician visit Monday to Friday. Medication will be dispensed via a new storage system using 3 storage cabinets with individual logins. The system will provide faster access to medications, removing the need to locate keys and releasing nursing time for direct patient care. The system will also improve stock management efficiency and medication errors.

- **Linen**
  Linen supplies to the ward will be provided by Estates and Facilities Directorate. Supplies will be replenished on a daily basis.

- **Catering**
  The catering department will serve three meals a day, seven days a week to all patients within the ward, in addition other patient requirements, i.e. snacks, sandwiches, etc., will be provided on an ad hoc basis as required. Patients' meals will be provided at a time suitable to meet the ward's operational requirements and in line with the Trust Policy on Protected Mealtimes. Patients will be provided with a menu card daily from which to select their meals. Special diet requests should be referred through the Dietetic team initially and all requests must be made to the main kitchen through the Head Chef or their nominated deputy.

  The ward will use the services of Materials Management for ordering all „dry' ward issues e.g. tea, coffee, etc.

- **Domestic services**
  The Domestic Services Department is responsible for cleaning the ward to provide a hygienic and clean patient environmental in accordance with Trust policy and the National Standards of Cleanliness.

  Domestic Services will liaise with the Matron Manager to deliver the cleaning service 24hours 365 days of the year. The domestic team is an integral part of the ward in contributing to patient experience.

  There will be dedicated cleaning operatives for the ward from 7.30 am to 7.45 pm, seven days a week. Emergency requirements outside this time will be provided by the Rapid Response Team.

  The ward will have a named Domestic Supervisor and Team Leader who will visit the ward on a daily basis and foster good working relations with the ward staff.

- **Portering services**
  The ward will be provided with routine portering services, e.g. rubbish collection, postal collections and deliveries, blood sample collections, etc., in line with services provided to all wards throughout the hospital.

Ad hoc portering services can be requested 24 hours a day, seven days a week by request through the Porters' Lodge.

12.0 Staffing arrangements

12.1 Leadership

The lead for the ward will be the Matron for Specialist Medicine.
There will be Band 7 Ward Manager who will be supervisory 5 days per week.

12.2 Nursing

The agreed model is:

Early	7 RNs + 3 CSWs
Late	7 RNs + 3 CSWs
Night	6 RNs + 2 CSWs

12.3 Administration

Ward clerk 7 days a week (8.00am – 4pm Monday to Friday and 3 ½ hours on Saturday and Sunday.

12.4 Medical staff

Consultant cover for the new Respiratory Ward will be provided by MTW Consultant Respiratory Physicians. There will be a Consultant/Registrar ward/board rounds daily and a Consultant/Registrar attendance at the weekly Multidisciplinary Meeting.

Medical cover out of normal hours (after 5pm weekdays and at weekends) will be provided by the medical on call team.

13.0 Budget

Funding via Specialist Medicine Directorate and monitored through Directorate Financial Reporting.

14.0 Monitoring and audit

The policy and key performance indicators will be monitored monthly by the Specialist Medicine Directorate Board.

Process Requirements

1.0 Implementation and awareness

- Once approved the Document Lead or Author will send this policy/procedural document to the Clinical Governance Assistant who will publish it on the Trust intranet.
- A monthly table of Trust publications will be produced by the Clinical Governance Assistant; this will be published on the Bulletin Board (Trust intranet) under "Trust Publications", and a notification email circulated Trust wide by the COMMS team.
- On receipt of the Trust wide Bulletin Board notification all managers should ensure that their staff members are aware of the new publications.

2.0 Review

Review of the policy will be by undertaken by the author on a yearly basis or earlier to support changes in legislation or practice.

3.0 Archiving

The Trust intranet retains all superseded files in an archive directory in order to maintain document history.

CONSULTATION ON: Operational Policy and Procedure – Reconfigured Respiratory Ward (Maidstone Hospital)

Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Project Nurse, Service Improvement Team
By date: 18.1.13

Name:	**Date sent dd/mm/yy**	**Date reply received**	**Modification suggested? Y/N**	**Modification made? Y/N**
The following staff MUST be included in ALL consultations:				
Local Counter Fraud Specialist				
Clinical Governance Assistant				
Head of Pharmacy	9.1.13			
List key staff whose reply is compulsory before approval can be granted:				
Chief Operating Officer	9.1.13			
Interim Deputy Chief Operating Officer	9.1.13			

Director of Nursing	9.1.13			
Medical Director				
Clinical Director for Specialist Medicine	9.1.13			
Head of Nursing for Emergency Services	4.1.13			
ADO for Emergency Services	4.1.13			
Lead Matron for Specialist Medicine	4.1.13			
Deputy Director of Infection Prevention and Control	4.1.13			
Consultant Physicians for Respiratory Medicine and Gastroenterology	4.1.13			
List other staff to be included in the consultation whose reply is not compulsory:				
All General Managers, Matrons, Clinical Directors				
All members of Trust Management Executive Committee				
Ward Managers				
Head of SLA and Income , MTW				
Head of Governance				
Respiratory Nurse Specialists	18.12.12	20.12.12	Y	Y
Ward Manager Whatman Ward	18.12.12			
Ward Manager John Day Ward	18.12.12			
Therapies Manager	9.1.13			
Facilities Manager	9.1.13			
Radiology Manager	9.1.13			

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of Policy or Practice	Respiratory Ward(Maidstone Hospital) Operational Policy and Procedure
What are the aims of the policy or practice?	To guide people on correct procedures for this new unit
Identify the data and research used to assist the analysis and assessment	None known
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no). If yes give details.**
Males or Females	N
People of different ages	N
People of different ethnic groups	N
People of different religious beliefs	N
People who do not speak English as a first language	N
People who have a physical disability	N
People who have a mental disability	N
Women who are pregnant or on maternity leave	N
Single parent families	N
People with different sexual orientations	N
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	N
People in deprived areas and people from different socio-economic groups	N
Asylum seekers and refugees	N
Prisoners and people confined to closed institutions, community offenders	N
Carers	N
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	NA
When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As an attachment to this policy/procedure on the Trust Intranet.

Maidstone and Tunbridge Wells NHS
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TRUST BOARD MEETING - MARCH 2014

3-28	**SIRO REPORT (INFORMATION GOVERNANCE TOOLKIT SUBMISSION, 2013/14**	**CHIEF NURSE (SENIOR INFORMATION RISK OWNER / SIRO)**

The Trust is required to make its year end submission to the IG Toolkit by 31 March 2014. During the year, evidence rolled over from prior years has been reviewed to ensure it meets the requirements of the 2013/14 toolkit and additional evidence has been posted where possible to support the Trust position.

At July 2013 the Trust target was for an improvement in the toolkit return to 88% (from a submitted position in 2012/13 of 80%). This improvement to be accounted by the achievement of level 3 attainment against a number of the requirements.

A detailed breakdown of the toolkit requirements and proposed submission details by attainment level is enclosed.

Whilst work continues to gather and post evidence the Trust has not fully achieved the improvement anticipated in year in respect to the following areas:

- Requirement 11-202 - Satisfaction surveys are used to check that service users understand their consent choices and feel that their wishes are respected. The Trust has not gathered sufficient evidence, in the form of completed satisfaction surveys with questions specific to disclosure of personal information that is held in confidence, to meet the level 3 attainment requirements.
- Requirement 11-303: There is routine monitoring and auditing of the robustness and reliability of the fully implemented RA arrangements and improvements are made where necessary. Audit of RA arrangements and processes has not been conducted during the current year. Discussions have been held with the RA Manager for an audit to be conducted during 2014/15.
- Requirement 11–305: The appropriateness of the access control functionality of information assets is regularly reviewed and maintained. Information Asset Administrators have not provided robust evidence of audit of access control functionality to enable level 3 attainment to be achieved. An audit scope has been produced for 2014/15 to address this shortfall.
- Requirement 11–506: An improvement plan has been developed and necessary actions are taken to address areas of poor data quality. The Info. Governance Committee at its last meeting agreed revised terms of reference for the Data Quality Steering Group to refocus the group to meet the requirements of the new National Contract in terms of Data Quality and Timeliness.

The Trust is continuing to gather and post evidence in relation to the following requirements with a view to achieving level 3 attainment:

- Requirement 11-401: The NHS Number implementation programme has been successfully completed and closed and a process is in place to ensure that all new IT systems are compliant with applicable NHS Number standards and/or guidance.
- Requirement 11–406: Staff compliance checks are routinely undertaken to ensure staff are following the record tracking process and appropriately reporting unavailable or missing records.
- Requirement 11–505: The clinical coding audit percentage accuracy scores found by the clinical coding auditors should reach level 3 scores outlined in the table in **paragraph 11e** of the guidance for this requirement. This audit will be concluded during the last week of March.
- Requirement 11–507: The completeness and validity check has been completed to the standard required for at least level 3 attainment. This audit will be concluded over the next 2 weeks.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 19/03/14

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

To approve the proposed year-end submission

[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

Version 11 (2013-2014) Assessment - Requirements List

Req No	Description	Status	Attainment Level
Information Governance Management			
11-101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	Reviewed And Updated	Level 3
11-105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	Reviewed And Updated	Level 3
11-110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	Reviewed And Updated	Level 3
11-111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	Reviewed And Updated	Level 3
11-112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	Reviewed And Updated	Level 2
Confidentiality and Data Protection Assurance			
11-200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	Reviewed And Updated	Level 3
11-201	Staff are provided with clear guidance on keeping personal information secure and on respecting the confidentiality of service users	Reviewed And Updated	Level 3
11-202	Personal information is only used in ways that do not directly contribute to the delivery of care services where there is a lawful basis to do so and objections to the disclosure of confidential personal information are appropriately respected	Reviewed And Updated	Level 2
11-203	Individuals are informed about the proposed uses of their personal information	Reviewed And Updated	Level 3
11-205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	Reviewed	Level 3
11-206	There are appropriate confidentiality audit procedures to monitor access to confidential personal information	Reviewed And Updated	Level 3
11-207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	Reviewed	Level 2
11-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	Reviewed	Level 3
11-210	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	Reviewed	Level 2
Information Security Assurance			
11-300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	Reviewed And Updated	Level 3

Req No	Description	Status	Attainment Level
11-301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	Reviewed And Updated	Level 3
11-302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	Reviewed And Updated	Level 3
11-303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	Reviewed	Level 2
11-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	Reviewed And Updated	Level 3
11-305	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	Reviewed And Updated	Level 2
11-307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	Reviewed	Level 3
11-308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	Reviewed And Updated	Level 2
11-309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	Reviewed And Updated	Level 3
11-310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	Reviewed	Level 2
11-311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	Reviewed	Level 2
11-313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	Reviewed	Level 2
11-314	Policy and procedures ensure that mobile computing and teleworking are secure	Reviewed	Level 2
11-323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	Reviewed And Updated	Level 2
11-324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	Reviewed And Updated	Level 3
Clinical Information Assurance			
11-400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	Reviewed And Updated	Level 3
11-401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	Reviewed And Updated	Level 2
11-402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	Reviewed And Updated	Level 3

Req No	Description	Status	Attainment Level
11-404	A multi-professional audit of clinical records across all specialties has been undertaken	Reviewed And Updated	Level 2
11-406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	Reviewed And Updated	Level 2
Secondary Use Assurance			
11-501	National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as standards develop	Reviewed	Level 2
11-502	External data quality reports are used for monitoring and improving data quality	Reviewed	Level 2
11-504	Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained	Reviewed	Level 2
11-505	An audit of clinical coding, based on national standards, has been undertaken by a NHS Classifications Service approved clinical coding auditor within the last 12 months	Reviewed	Level 2
11-506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	Reviewed And Updated	Level 2
11-507	The Completeness and Validity check for data has been completed and passed	Reviewed And Updated	Level 2
11-508	Clinical/care staff are involved in validating information derived from the recording of clinical/care activity	Reviewed And Updated	Level 2
11-510	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national standards	Reviewed	Level 3
Corporate Information Assurance			
11-601	Documented and implemented procedures are in place for the effective management of corporate records	Reviewed	Level 2
11-603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	Reviewed And Updated	Level 2
11-604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	Reviewed And Updated	Level 2

Maidstone and Tunbridge Wells NHS
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TRUST BOARD MEETING - MARCH 2014

3-24	SUMMARY OF THE AUDIT AND GOVERNANCE COMMITTEE, 24/02/14	COMMITTEE CHAIR (NON-EXECUTIVE DIRECTOR)

Summary / Key points

This report provides information on the Audit and Governance Committee meeting held on 24th February. The key points considered at the meeting were as follows:

- The actions from previous meetings were noted.
- A 'deep dive' review of the Paediatrics Directorate was held. The Head of Service for Women's, Children's and Sexual Health and Matron for Paediatrics attended, to discuss how their Directorate was managed and monitored. This was the first such 'deep dive' item considered by the Committee, and positive feedback was received from members with regards to the format enabling greater understanding of how Directorates operate, and the triangulation with other information received.
- The usual progress reports from Internal Audit and the Local Counter Fraud Specialist (LCFS) were received. For the former, a number of internal audit reviews were discussed in detail, due to the 'limited assurance' conclusion. These included use of Temporary Staff; non-patient income flows; Clinical Activity Recording; Travel & Expense Claims; and Windows Update Service Review (the assurance conclusion of the latter review was split between significant and limited). The Director of Strategy and Workforce attended to discuss the response being taken to the Temporary Staff review, and the Director of Health Informatics has been invited to the next meeting, to discuss (among other things) the Windows Update Service Review.
- The limited assurance reviews prompted a comment to the effect that the Trust lacked a Responsibility Assignment or 'RACI' matrix, which outlined the Responsible and Accountable persons for a task/duty, along with those expected to be Consulted and Informed. It was agreed that the absence of a 'RACI' matrix be discussed further, at a future meeting of the Trust Board. The Board is therefore invited to discuss this point at the March Board meeting.
- The external audit plan for 2013/14 was approved.
- The usual standing reports on losses and compensations and standing orders were received.
- An update on the 2013/14 Accounts process was received, and the Committee approved the accounting policies / approach to be applied. As part of this, the Committee agreed that the Accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund should not be consolidated with the Trust's own (i.e. exchequer) accounts. This agreement was made on the basis of materiality i.e. that the flow into the Charitable Fund accounts was less than £0.5m per year, whilst the value of the Funds on the balance sheet was circa £1.3m. The Trust's turnover is circa £380m and the Statement of Financial position showed total assets employed of circa £190m at the end of the year. Therefore incorporation of the Charitable Funds into Trust's main statements would not allow the reader any greater understanding of the Trust's or Charities' financial position. It was confirmed that this had been discussed and agreed with the Trust's External Auditors. However, as the Trust Board acts as the agent to the sole Trustee of the Charity (the Trust), it was agreed that the Trust Board should be asked to support the Audit and Governance Committee's position. The Board is therefore asked to confirm its support for the proposal not to consolidate the Accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund with the Trust's own accounts
- The Board Assurance Framework was reviewed. It was agreed that proposals for the operation of a revised framework would be considered in full at the next Audit and Governance Committee meeting.

Which Committees have reviewed the information prior to Board submission?

- N/A

Continued overleaf

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

1. Information and assurance;
2. To discuss the need for a Responsibility Assignment ('RACI') matrix; and
3. To confirm the Board's support for the proposal not to consolidate the Accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund with the Trust's own accounts

[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
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TRUST BOARD MEETING - MARCH 2014

3-25	ASSURANCE FRAMEWORK AND BOARD-LEVEL RISK REGISTER	TRUST SECRETARY

Summary / Key points

- The 2013/14 Board Assurance framework was reviewed with Directors in February 2014.
- There are no risks on the Board level risk register that are not managed by other Board committees. The register was reviewed with directors in December.
- Under the Trust's existing 'Policy on Policies', there are 34 policies and procedures that are required to be either 'approved' or 'ratified' by the Trust Board either approved or ratified by the Board.
- Two of the policies on the list have been submitted to the March Board, under separate agenda items, for ratification. Of the other 32, 16 have exceeded their scheduled review dates. However, as reported at the January 2014 Board, discussions have commenced in relation to revising the Trust's existing 'Policy on Policies'. The proposal being considered will negate the need for the vast majority of the policies listed below to be considered at the Trust Board. It is intended to submit a formal proposal to revise the Trust's existing 'Policy on policies' to the next meeting of the Trust Management Executive (and then to submit to the May Trust Board, for approval).

Which Committees have reviewed the information prior to Board submission?

- N/A

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

To consider whether the principal risks are being discussed and managed through the Board (or Board sub-committees)

[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

RISK REPORT

THE BOARD LEVEL RISK REGISTER – DECEMBER 2013

There are no risks on the Board level risk register that are not managed by sub-committees of the Board.

BOARD ASSURANCE FRAMEWORK

The 2013/14 Board Assurance framework was reviewed with Directors in February.
There are 7 principal risks that are not reviewed by Board Committees.

ASSURANCE FRAMEWORK 2013/2014 - PROGRESS SUMMARY – FEBRUARY 2014

Reference and Strategic Aim	Lead	Reviewing Board or Board Sub-Committee	Principal Risk	Registration Outcomes and other standards	Current Risk Rating							Target controlled risk on completion
					APR	JUN	AUG	OCT	DEC	FEB	APR	
1. To become a truly patient and customer centered organisation [Patient Focus]	COO	Trust Board	1.3 Failure to meet emergency care access targets	Outcome 4	20	20	15	10	10	10		10
2. To deliver services that are viable and sustainable [Service Mix]	COO	Trust Board	2.2 Failure to reduce length of stay to median level of Trusts nationally	Outcome 4	12	12	12	12	12	12		8
	CEO/DCA	Trust Board	2.4 Failure to submit a successful application to become a NHS Foundation Trust		20	20	20	20	20	15		10
3. To take the system leadership role to deliver integrated care in our locality [Integrated Care]	DSW	Trust Board	3.1 Failure to deliver a clinical strategy agreed with the Commissioners and local health economy	Outcome 4 and 16	10	10	10	10	20	20		10
	DSW	Trust Board	3.2 Failure to develop an effective and constructive relationship with our Commissioners	Outcome 6	12	12	12	12	12	16		8
	DSW	Trust Board	3.3 Failure to increaser integrated care approaches	Outcome 4 and 6	16	16	12	12	12	12		5
	COO/ MD	Trust Board	3.4 Failure to increase Consultant presence across 7 days each week	Outcome 4	12	12	12	12	12	12		8

ASSURANCE FRAMEWORK 2013/2014 – FEBRUARY 2014

Reference.	Executive Lead	Principal Risk (Obstacle to achievement Of strategic aim)	Uncontrolled Risk (impact) Severity	Probability	Risk Score	Current controls and assurances, Internal and External (Including KPI's) (Evidence that controls are in place and effective)	Current status RAG)	Planned actions to mitigate the risk	Target date	Controlled Risk on completion (RAG)
1. To become a truly patient and customer centred organisation [Patient Focus]										
1.3	COO	Failure to meet emergency care access targets	5	5	25	• Additional clinical staff in A&E • GP based in A&E • Romney Ward and UMAU initiatives implemented • Weekly performance monitoring by Directorate team of all emergency pathways. • Strengthened daily site meetings • Re-launch of escalation policy • Regular forward planning meeting (capacity & demand) • Opened the surgical assessment unit at TW site. • Completed review of the use of SSAU at TWH. • Met target for 1st and 2nd Quarter. • Liaised with SECAMB regarding boundaries and protocols • Critically reviewed impact of UMAU • Reviewed use of MAU at TWH	10	• Continued review of emergency pathway and service configuration [also see Length of Stay principal risk below) Met emergency access targets for Quarters 1, 2 and 3. On trajectory for Quarter 4.	Ongoing	10
2. To deliver services that are viable and sustainable [Service Mix]										
2.2	COO	Failure to reduce length of stay to median level of Trusts nationally	4	4	16	• Monthly monitoring of LOS • LOS project team established, including strong clinical engagements to deliver KPI's • Discussion in open staff meetings • LOS year to date better than last year (occupying 20 beds less). – Still below target but reducing.	12	• Monthly monitoring and reporting of LOS by service, ward and Consultant and measures agreed to achieve desired reductions. • Complete the clear action plan that is in place	31/03/14 13-3-14	8

Reference.	Executive Lead	Principal Risk (Obstacle to achievement Of strategic aim)	Uncontrolled Risk (impact) Severity	Probability	Risk Score	Current controls and assurances, Internal and External (Including KPI's) (Evidence that controls are in place and effective)	Current status RAG)	Planned actions to mitigate the risk	Target date	Controlled Risk on completion (RAG)
2.4	CEO/ DCA	Failure to submit a successful application to become a NHS Foundation Trust	5	5	25	• FT Committee established • Monthly Board review of FT Oversight Certification and performance issues • Monthly Oversight review meetings with SHA • Membership with FT Network and learning from events • SHA feedback on BGAF and QGF sought and received • Board development programme with McKinsey conducted • Membership scheme launched • Monthly Oversight meetings with TDA arranged. • Additional meetings of FT Committee have been held • BGAF and QGF have been developed and externally reviewed • BGAF and QGF have been updated by the FT Committee and agreed by the Trust Board. • Independent assessment of BGAF & QGF has been completed and action plan developed • A further review by Ernst and Young has been completed and will be incorporated in to the action plan.	15	• Need to agree submission date and trajectory with TDA • Additional meetings of FT Committee to be timetabled • Membership recruitment monitored • Constitution to be drafted and reviewed by Lawyers • Public Consultation to be completed & shadow Governors Council to be convened ,with TDA approval • Complete action plan developed from the Independent assessment of BGAF & QGF. FT application trajectory changed in agreement with TDA reducing the risk.	TDA Ongoing Ongoing 1-4-14 Tba with TDA 1-4-14	10
3. To take the system leadership role to deliver integrated care in our locality [Integrated Care]										
3.1	DSW	Failure to deliver a clinical strategy agreed with the Commissioners and local health economy	5	5	25	The Board debated chapter 4 of IBP in June • Clinical strategy & IBP debates at Trust Board • Clinical strategy & IBP submissions to SHA as per TFA • Clinical strategy & IBP discussed with Clinical leaders • CCG Commissioners engaged in Discussions about the clinical strategy & IBP. • Board approved the Clinical strategy in May • Board approved the IBP in May and submitted on 1st June.	20	• Direction to be included in Public Consultation • Consultation with local health economy • Completion of the mapping the future programme CCG not engaged and have not completed the mapping.	TBA Ongoing 1/4/14	10
3.2	DSW	Failure to develop an effective and constructive relationship with our Commissioners	4	4	16	• Constructive liaison with the CCG by Trust Directors and senior clinicians • Trust attendance at health care economy events (e.g mapping the future) • Consultation on draft Clinical strategy & IBP* • Held Board to board meeting with CCG • Hay group leadership programme has joint sessions with nominated leads from the CCG (part of leadership programme) • Holding periodic joint events with the CCG including presentations from clinicians, Board to Board meetings etc • Explored opportunities for joint working and joint projects	16	• Completion of the mapping the future programme CCG not engaged and have not completed the mapping.	1/4/14	8

Reference.	Executive Lead	Principal Risk (Obstacle to achievement Of strategic aim)	Uncontrolled Risk (impact) Severity	Probability	Risk Score	Current controls and assurances, Internal and External (Including KPI's) (Evidence that controls are in place and effective)	Current status RAG)	Planned actions to mitigate the risk	Target date	Controlled Risk on completion (RAG)
3.3	DSW COO	Failure to increase integrated care approaches	4	4	**16**	• Clinical Directorates empowered to develop directorate strategies and plans • Trust Board commitment to integrated services where in the interests of patients and the Trust • Board, Executive, CCG & SHA engagement in clinical strategy development • Clinical strategy agreed • Established a 2 year Clinical strategy implementation group • Submitted a bid to West Kent CCG for 4 programmes of integrated care. • Further modelling of integrated services opportunities for debate in clinical strategy reviews	12	• Continued engagement of CCG and TDA in clinical strategy development • Further debate at Trust Board 4 Programmes of integrated care in place - respiratory - stroke - trauma - extended rapid response	Ongoing Ongoing	8
3.4	COO/ MD	Failure to increase Consultant presence across 7 days each week	3	4	**12**	Discussed at Directorate level and at TME • On-call provision at Consultant and junior doctor level • Surgery and T&O have robust 7 day working in place • Paediatrics have 7 day attendance • Anaesthetics have 7 day attendance • Cardiology have 7 day attendance • Interim arrangement in place to increase level of service - including allied health professionals and clinical support services.	12	New national document published regarding 7 day working • Focus on Acute and General Medicine • Engagement activity with Clinical leaders and the Consultant body • Develop an action plan for changes to medical workforce skill mix and rostering. • Need to review compliance with new national document	30/03/14 Ongoing 1-4-14 1-4-14	6

TRUST BOARD – POLICIES APPROVED BY THE BOARD – 5th MARCH 2-14

Document Number	Document Title	Author	Active Date	Review Date	Owner	Ratifying Committee
RWF-OPPCS-NC-TM20	Reimbursement, Protocols for Delayed Transfer of Care	Beckett, Shelagh	27/02/04	27/02/06	Committee, Trust Board	Committee, Trust Board
RWF-OPPCS-NC-TM18	Freedom of Information Complaints Procedure	Spinks, Gail	16/08/05	16/08/06	Committee, Trust Board	Committee, Trust Board
RWF-OPPCS-NC-TM30	Covert Surveillance, Policy on	Jarrett, Donna-Marie	16/08/05	16/08/08	Committee, Trust Board	Committee, Trust Board
RWF-OPPPCS-NC-WF11	Equality and Human Rights Policy	Pike, Tammy	20/03/08	31/01/11	Committee, Trust Board	Committee, Trust Board
RWF-OPPPCS-NC-WF49	Equality and Human Rights Procedure	Pike, Tammy	20/03/08	31/01/11	Committee, Trust Board	Committee, Trust Board

TRUST BOARD – POLICIES RATIFIED BY THE BOARD – 5th MARCH 2-14

Document Number	Document Title	Author	Active Date	Review Date	Owner	Approving Committee
RWF-OPPCS-NC-TM24	Overseas Visitors Policy	Hammond, David	31/01/06	31/12/08	Committee, Finance	Committee, Finance
RWF-OPPPPS-C-OP1	Outpatient Operational Policy and Procedure	Gallagher, Angela	15/07/09	31/03/10	Gallagher, Angela	Trust Management Executive
RWF-OPPPES-C-AEM7	Emergency admission of patients from other non-NHS hospitals, Procedure for	Martin, Alistair	23/01/08	24/01/11	Soorma, Akbar	Trust Management Executive
RWF-OPPPCS-NC-WF55	Registration Authority (Smartcard) Policy and Procedures, Connecting for Health	Oliver, Sharon	21/04/10	31/03/11	Trust Management Executive	Trust Management Executive
RWF-OPPPES-C-SM1	Stroke Rehabilitation Unit at Tonbridge Cottage Hospital, Operational Policy and Procedure for MTW	Hockley, Joanne	26/08/11	31/01/12	Trust Management Executive	Trust Management Executive
RWF-OPPPCS-NC-EST7	Estate Utilisation Policy and Procedure	Rooke, Jeanette	18/08/10	18/08/12	Trust Management Executive	Trust Management Executive
RWF-OPPPES-C-AEM8	Escalation policy and procedure for emergency admissions	Gallagher, Angela	29/02/12	28/02/13	Gallagher, Angela	Trust Management Executive
RWF-OPPPCS-C-NUR7	Visiting Adult Wards and Departments, Policy and Procedure for	Kennedy, John	10/08/11	10/08/13	Bhatia, Avey	Trust Management Executive
RWF-OPPPES-NC-AEM1	Urgent Medical and Ambulatory Unit (UMAU), Maidstone Hospital Operational Policy and Procedure	Martin, Alistair	16/10/12	16/10/13	Soorma, Akbar	Trust Management Executive
RWF-OPPCS-NC-TM29	Corporate Governance Policy and Procedure	Spinks, Gail	30/09/10	08/01/14	Coode, Terry	Trust Management Executive
RWF-OPPPCS-C-NUR4	Restraint Policy and Procedure	Davies, Karen	26/01/11	26/01/14	Bhatia, Avey	Committee, Quality & Safety

Document Number	Document Title	Author	Active Date	Review Date	Owner	Approving Committee
RWF-OPPPCS-NC-CG1	Health and Safety Policy and Procedure	Harris, Jeff	18/11/13	27/03/14	Gallagher, Angela	Committee, Health & Safety
RWF-OPPPCS-NC-CG13	Risk Management Policy and Strategy	Harris, Jeff	27/03/13	27/03/14	Coode, Terry	Committee, Quality & Safety
RWF-OPPPES-C-AEM4	Care Home Discharge Policy and Procedure	Humphries, Jain	31/05/11	30/05/14	Trust Management Executive	Trust Management Executive
RWF-OPPPES-C-AEM1	Acute and Emergency Medical Services, Operational Policy and Procedures	Champion, Liz	02/04/12	31/08/14	Trust Management Executive	Trust Management Executive
RWF-OPPCS-NC-TM21	Reservation of Powers and Scheme of Delegation	Maher, Wendy	09/10/13	09/10/14	Headley, John	Committee, Audit
RWF-OPPCS-NC-TM22	Standing Financial Instruction	Maher, Wendy	09/10/13	09/10/14	Headley, John	Committee, Audit
RWF-OPPCS-NC-TM23	Standing Orders	Maher, Wendy	09/10/13	09/10/14	Headley, John	Committee, Audit
RWF-OPPPCS-NC-WF4	Appointment of Consultant Medical Staff	Sigston, Paul	16/11/11	16/11/14	Sigston, Paul	Trust Management Executive
RWF-OPPCS-NC-TM36	Pandemic Influenza Plan	Weeks, John	28/11/12	28/11/14	Black, Jayne	Committee, Resilience
RWF-OPPP-CS-NC1	Major Incident Plan	Weeks, John	12/12/12	22/12/14	Black, Jayne	Committee, Resilience
RWF-OPPPCS-NC-CG26	Essential Standards of Quality and Safety (CQC Outcomes) Policy and Procedure	Roberts, Claire	16/01/13	16/01/15	Bhatia, Avey	Committee, Quality & Safety
RWF-OPPPCS-NC-NUR1	Patient Property Policy & Procedure	Spence, Claire	18/01/12	18/01/15	Bhatia, Avey	Trust Management Executive
RWF-OPPPES-C-AEM6	Discharge Policy and Procedure, Operational	Black, Jayne	18/04/12	18/04/15	Trust Management Executive	Trust Management Executive
RWF-OPPPCS-NC-WF52	Pay Protection Policy and Procedure	Hayden, Sarah	04/09/12	04/09/15	Committee, Workforce	Committee, Workforce
RWF-OPPPCS-NC-WF62	Relocation Expenses Policy and Procedure	Hayden, Sarah	04/09/12	04/09/15	Committee, Workforce	Committee, Workforce
RWF-OPPPCS-C-TM2	Patient Access to Treatment Policy and Procedure	Peach, Diane	18/09/13	18/09/15	Peach, Diane	Clinical Operations
RWF-OPPPCS-NC-FH5	Staff Car Parking Policy and Procedures	Hoile, Stuart	20/03/13	20/03/16	Trust Management Executive	Trust Management Executive

	Aug-13	Oct-13	Dec-13	March 14
Total Documents	36	36	34	33
Current Documents	19	19	18	17
Compliance	53%	53%	53%	52%

Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD MEETING - MARCH 2014

3-26 ESTATES AND FACILITIES ANNUAL REPORT 2013 CHIEF OPERATING OFFICER

Summary / Key points

The enclosed report provides information on…

- The Annual Review of the Estates and Facilities Management services for year 2013
- This is the such Annual Report, and aims to update the Board with a broad perspective of the Estates, Capital and Facilities function and includes a review of the key development and improvements achieved in the financial year 2013/14 and to look ahead to the planned areas of focus for the financial year 2014/15.
- The Estate development team are working collaboratively with colleagues to develop a joint approach to estate strategy planning. The Estate Strategy is being prepared for future presentation to the Trust Board and will set out high level plans to indicate the sequencing of investments required over the next 3-5 years, with long term recommendations for the 5-10 year period.

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

1 Introduction

This is the first Estates and Facilities Management (EFM) annual report to update the board with a broad perspective of the Estates, Capital and Facilities function and includes a review of the key development and improvements achieved in the financial year 2013/14 and to look ahead to the planned areas of focus for the financial year 2014/15.

Following the resignation of the then post holder in March 2013, Jeanette Rooke was formally appointed as the Director of Estates and Facilities in June 2013.

2 Financial Overview

2.1 Financial Position – Revenue

2.1.1 The Directorate has a balanced business plan for 2013/14, with a proposed cost improvement programme (CIP) of almost 9% (3% higher than the Trust agreed target) equating to £3m. The savings are being monitored on a fortnightly basis to ensure these are delivered and any risks which materialise during the year will be managed and mitigated accordingly. EFM successfully delivered savings as required by the Trust with a XX% cost reduction recurrent delivered in 2011/12.

2.1.2 The 2013/14 month 9 position for the Directorate is formally reported as being £297k adverse year to date and forecast to be £91k adverse at year end against an annual budget of £25.8m excluding the PFI unitary payment.

2.1.3 The analysis below identifies costs which were not anticipated by the Directorate and are affecting the year to date and forecast outturn:

Cost Type	Year to Date Impact	Forecast Impact
Energy and Utilities	(£399k)	(£403k)
Car Park Income – 50% staff income increase	(£116k)	(£163k)
Soft FM Pay Pressures	(£334k)	(£325k)

If the costs highlighted in the above table were not incurred, the financial position for Directorate of EFM would be £800k favourable at year end.

2.1.4 EFM and Finance meet on a monthly basis to review current financial performance and issues which are impacting adversely on the Directorate's ability to deliver a balanced plan. The quarterly meetings over the past year have been productive and have resulted in successful outcomes, with a number of financial and non financial issues being resolved as a result of the ongoing engagement.

2.2 Financial Position – Capital

2.2.1 The Trust Capital plan is under review in light of the projected I&E position of the Trust. The review will identify the implications of the Trust not being able to achieve its target contribution to capital investment. Alternative funding sources are being sought to achieve the aspirations of the Trust.

2.3 Financial Position – Income

2.3.1 The Directorate income to date is under performing by £11k and forecasting a year end over performance of £15k. The year to date adverse movement is predominantly due to the board decision to delay the staff car parking charge increase and reduce by 50% for year 1. The improvement to the year end is due to the part year savings achieved by increasing the visitor parking tariff and the catering prices. Estates income will move adversely in quarter 4 due to the loss of the Preston Hall maintenance income.

3 Workforce Overview

3.1 Recruitment

3.1.1 As at the end of December 2013, month 9; 568.03 Whole Time Equivalents (WTE) permanent staff filled 91.7% of the Directorates budgeted establishment of 619.64 WTE.

3.1.2 There are a further 6 posts in the recruitment pipeline as the Directorate continues to reduce reliance on agency staff.

3.1.3 The Engineering team remains relatively stable since the removal of the National RRP.

3.2 Bank, Agency and Overtime

3.2.1 Overtime is forecasted by the year end to be 7.2% of the annual pay bill which has reduced from 7.6% in previous years. There is continued focus in high usage areas to reduce overtime and to review other ways of working. A Directorate procedure for the control of overtime has been implemented during the year which is achieving further reductions.

3.3 Sickness Absence

3.3.1 The Directorates sickness rate is 4.79% against the Trust average absence rate of 3.75% and the target of 3% by March 2014.

3.4 Training and Development

3.4.1 Workshop training was provided for over 30 managers in conjunction with InterserveFM on Customer Engagement and Managing Staff Performance.

3.4.2 Staff continue to progress through the NVQ system.

3.5 Restructures and Consultations

3.5.1 A consultation has taken place on the significant restructure of Facilities creating zones within each of the hospitals which will each be led by a zone manager, integrating the FM services into a key role. This has created for the first time in Facilities an identifiable career path and will be monitored for recruitment and retention.

3.6 On-call payments

3.6.1 The recently agreed changes to the way that on call payments are calculated have an impact on a small number of staff within the Directorate who work with clinical colleagues to provide site management cover. The Directorate are working with HR colleagues to ensure the fair implementation of the new system.

3.7 Awards and Recognition

3.7.1 Staff Awards 2013 Winner – Sylvia Denton Award for Care and Compassion: Cliff Vidler, Porter, TWH.

3.7.2 Staff Awards 2013 Runner up – individual: Jan Nemes, Domestic Assistant, Wards 20, 21 TWH.

3.7.3 Staff Awards 2013 Winner – Individual: Sirirat (Jane) Edwards, Domestic, Birth Centre.

3.7.4 October Team of the Month – Facilities Contracts Team, for Patient Transport Services.

3.7.5 The EFM team in collaboration with InterserveFM at Tunbridge Wells won the award from Tunbridge Wells Civic Society Award for the restoration and landscaping of the chapel at Tunbridge Wells Hospital.

3.8 Invest to Save

3.8.1 The Directorate are currently implementing its new electronic Time and Attendance system. This will enable staff to electronically sign in using their current access card and a biometric finger scan, thus reducing the need for manual records and allowing Supervisors and Managers time to deal with exceptions promptly. The system will be used by every member of the Estates and Facilities Directorate to ensure fairness.

3.8.2 A summary of the measurable benefits include:

- Reduces post-payroll run queries by staff
- Increased fairness of timekeeping for staff
- Increased control of attendance with reduced administrative overheads
- More productive use of staff
- Attendance information captured once and used for multiple purposes
- Eliminates manual systems, thereby increasing the accuracy of payroll data
- Easy access to workforce information
- Improved absence management
- Reduction in scope for fraud
- Help to maximise the Trust's flexible working policy
- Allows job costing if required for additional work carried out for other Departments

4 Estate Strategy and Capital Development Projects

4.1 Refreshing the Estate

4.1.1 The Estate development team are working collaboratively with colleagues to develop a joint approach to estate strategy planning.

4.1.2 The Estate Strategy is being prepared for presentation to the Trust Board and will set out high level plans to indicate the sequencing of investments required over the next 3-5 years, with long term recommendations for the 5-10 year period.

4.2 Capital Projects

4.2.1 Projects Approved

During the year the team have been asked to manage the following new projects;

- 32 High Street, Pembury – redevelopment
- John Day/Jonathan Saunders – redevelopment
- Maidstone Main Theatre replacement
- Clinical Admin Unit office reconfiguration
- Maidstone main entrance redevelopment

4.2.2 Projects started on site

The following projects have commenced;

- 32 High Street, Pembury
- Clinical Admin Unit office reconfiguration

4.2.3 Project Progress

An Asset Management Portfolio Summary, which provides an update on all capital schemes for the reporting period to the end of December 2013 is attached. The summary shows a "RAG rating" for each scheme, based on the programme, budget and scope. Schemes which are progressing to budget and plan are rated green. Any schemes which are over budget or which are not progressing to plan are shown as red. Projects are indicated as amber, if programme delays are anticipated or the budget is likely to be exceeded.

During 2013/14 over £6 million capital expenditure was invested in Trust Assets.

An update for each of the significant projects are as follows;

- **Nurses Homes and Oakapple House – Maidstone**

  Following the failure to sell the Nurses Home and Oakapple House during 2012/13 the property has been re-marketed and following a lengthy process, outside of the control of the Trust, Outline Planning Application was given. The Trust are now proceeding to exchange and complete on this sale with Bellway Homes within the financial year 2013/14.

- **Car Parking Extension – Maidstone**

  Planning application for the extension to staff car parking at Maidstone was finally achieved this year which will enable the site to expand by a further 140 spaces. It is proposed that this work is undertaken during 2014/15 in order to meet the current demand.

- **Staff Accommodation – Tunbridge Wells**

  Following the sale of the Kent and Sussex Hospital the Trust retained the residential accommodation; Burslem House until 28 March 2014. The handover of the site to Berkeley Homes will release the £8.4m charge. The Trust had purchased alternative properties in Pembury; Hillcroft and Spring in a bid to redevelop the land for residential accommodation however, no work had commenced on these at the start of the year. The Director of EFM commissioned an assessment on the development opportunity and timescales on the land which predicated that a development by March 2014 was unachievable due to a number of planning and ecological factors.

  A review of the local market was undertaken and a number of properties considered before the opportunity in November to purchase the property; 32 High Street, Pembury. This property was previously owned by Town and Country who the Trust in previous years had been negotiating with in regards to a long term rent but had made decision to withdraw.

  Planning permission had already been granted on the redevelopment property and therefore despite a challenging project programme to achieve the timescales to hand back Burslem House and release the £8.4m charge, the Trust purchased the property on a fast track exchange and completion. Construction works immediately commenced on site and aim to complete to programme.

4.2.4 Estate Profile

The following properties have been agreed for release and/or sold within 2013/14;

Property	Status	CIP
Queens Road, Maidstone	Sold	£30,000
Nurses Home and Oakapple House, Maidstone	Under offer	£1,865,000
Magnolia House	Under offer	£100,000
Burslem House, Tunbridge Wells	Release of charge through sale of K&S	£8,450,000

In addition to the above, the Trust purchased the property 32 High Street, Pembury for the purpose of providing 40 residential accommodation units as a replacement programme for the release of Burslem House, on a fast track exchange and completion.

5 Directorate Activity and Operational Performance 2013/14

During 2013/14 estates operational progress included:

5.1 Estates Reactive Helpdesk

Implementation of a Trust wide Estates Reactive Helpdesk including the implementation of a unique room identification system at Maidstone.

5.2 Estates and Facilities Advisory Group

The Director of EFM has established an EFM Governance and Advisory Group to consider and monitor progress of the Estates Infrastructure and responsibilities. The group will receive formal reporting of performance lodged at the Estates and Facilities led sub-committees;

- Asbestos
- Catering
- Cleaning
- Control of Contractors
- Decontamination
- Electrical Infrastructure
- Fire Compliance
- Forced Ventilation Compliance
- Medical Devices
- Medical Gas
- Moving and Handling
- PLACE
- Non Emergency Patient Transport Service
- Security
- Sustainability
- Waste
- Water Safety

5.3 Maidstone Estate Audit

The Director of EFM has commissioned an independent audit of the Maidstone Estates Planned and Reactive Service against Statutory, Legislative and HTM compliance criteria.

5.4 Sustainability

5.4.1 Inter-site shuttle bus service

A new inter-site shuttle bus service contract was awarded and introduced for both staff and public use.

5.5 Security

The Directorate commissioned a new Security and Car Park Management service which now provides a full 24 hour 7 day week service.

5.6 Non Emergency Patient Transport Services (NEPTS)

The West Kent Clinical Commissioning Group (CCG) made the decision to move to one provider, to ensure a comprehensive and efficient service for patients across Kent and Medway. The NEPTS contract was awarded to NSL Care Services in January 2013 and went live throughout Kent and Medway on 1 July 2013.

Since the commencement of the service there have been significant issues with its delivery and performance and the Directorate continues to support the clinical operations with necessary contingency measures. The cost implication of this is to be recovered from the West Kent CCG.

5.7 Compliance with National Targets and Standards

5.7.1 Risk

The directorate is continuing to proactively manage its risk register with open risks reviewed monthly. Where necessary red and amber items are escalated to the Trust risk register and Board Assurance Framework.

5.8 Tunbridge Wells Hospital – PFI

The Tunbridge Wells Hospital PFI Project Agreement continues to perform well and there is an excellent working relationship between all parties. The site has full statutory and good contractual compliance.

5.9 Patient Environment

5.9.1 Patient-Led Assessments of the Care Environment (PLACE) Programme

The new style PLACE programme which replaced PEAT was introduced in April 2013 and involved collaboration between hospital staff and patient assessors. There is a formal annual inspection undertaken during April/May which the Trust are given 6 weeks notification to arrange and undertake. The multi-disciplinary team continue to undertake similar inspections on a monthly basis. The results of the audits and progress are monitored at the Patient Environment Steering Group (PESG), reported to the Estates and Facilities Governance and Advisory Group, Infection Prevention and Control Committee and Trust Board.

The performance outcomes were published nationally on 20 September 2013 and the Trust scores against the averages are shown below, the Trust scores for cleanliness were higher than the national average and the highest in Kent and Medway;

PLACE 2013	Cleanliness	Food and Hydration	Privacy, Dignity and Wellbeing	Condition appearance and maintenance
National Ave	**95.74%**	**84.98%**	**88.87%**	**88.75%**
MTW	**97.58%**	**81.70%**	**85.39%**	**91.74%**
Dartford	96.93%	82.30%	85.00%	87.48%
Medway	93.03%	73.27%	79.62%	77.83%
East Kent	85.53%	89.07%	86.60%	81.38%

The scores per site;

PLACE 2013	Cleanliness	Food and Hydration	Privacy, Dignity and Wellbeing	Condition appearance and maintenance
National Ave	**95.74%**	**84.98%**	**88.87%**	**88.75%**
Maidstone	97.49%	84.20%	79.76%	90.20%
TWH	97.65%	80.51%	90.02%	93.21%
Tonb Cottage*	97.17%	58.14%	68.46%	79.82%

*The services at Tonbridge Cottage are not provided by MTW, but through an SLA.

An action plan has been agreed and is monitored through the PESG.

5.9.2 **Wayfinding and Signage**

A significant project was undertaken within the year as a result of the PLACE inspection to change all main pathway and department signage at Maidstone. Following public consultation, the new signs were colour coordinated in accordance with a new colour wayfinding strategy. Zones were created throughout the hospital and each zone is now clearly identified by their own unique colour by the colour signs and wall finish. Location maps have also been installed near the car parks and at the entrances into the building. Positive feedback has been received from visitors and staff on the notable improvement in the environment.

5.9.3 **Parking Improvements**

The parking facilities at Maidstone have been upgraded to the same specification as Tunbridge Wells Hospital and visitors now park and pay on exiting the car park. This reduces the anxiety of patients watching time due to the expiry of a car park pay and display ticket and ensure they pay only the fee for the amount of time that they have parked for. Reinforcement of the visitors car parks ensuring staff no longer park in them has made a significant improvement for visitors and positive feedback is received, including social media messages.

5.9.4 **Equipment and Furniture expenditure**

A large range of equipment and furniture has been purchased through the year from the PLACE budget, including; bariatric chairs, patient lockers, plates, overbed tables, leaflet stands, walking frames, recliners and signage.

6 Estates and Facilities Management 2014/15

6.1 Estates and Facilities

6.1.1 The Director of EFM is preparing for presentation to the Trust Board the five year Estates Strategy 2014 – 2019.

6.1.2 Significant capital projects are planned for 2014/15 which are being prioritised.

6.1.3 The Directorate is working towards developing and agreeing SLAs with all its customers.

Jeanette Rooke
Director of Estates and Facilities Management
24 March 2014

Appendix 1

Project Title	Brief Description of Project	Site	Dir	RAG
Backlog projects	Estates will be reviewing and prioritising projects on ongoing basis throughout the year	M	E&F	
Switchgear mod standby generator		M	E&F	
Office reconfiguration		M	E&F	
Clinical waste compound canopy		M	E&F	
Physio dda compliance		M	E&F	
Fire alarms in oncology		M	E&F	
HSDU H&S works		M	E&F	
Asbestos Removal		M	E&F	
Plant Room 2 - Low loss header	Major pipework alterations in Plant Room 2	M	E&F	
Fire Alarm Replacement (Blocks P & B)	Upgrade of non-compliant systems. Work being undertaken along side the Deep Cleaning Prog	M	E&F	
Basin and tap replacement programme	Upgrade of non-compliant systems. Work being undertaken along side the Deep Cleaning Prog	M	E&F	
Final Connection and commissioning	Work associated with emergency generators across sites	M	E&F	
Joining of Medical air and vacuum systems	Sitewide system upgrade	M	E&F	
Fire damper replacement	Fire damper replacement to Blocks F & A	M	E&F	
Lifts - lighting to shaft and other works	General lift issues across site	M	E&F	
Replacement of fire doors - Service Centre	Replacement of Fire Doors to ground floor service centre and adjacent expansion joints.	M	E&F	
Laundry – Fire Alarm upgrade	To upgrade the fire alarms at the Laundry	M	E&F	
Works associated with deep clean programme		M	E&F	
Service Centre Roofs	To replace roofing membrane in Service Centre	M	E&F	
Breast Care Entrance Door Controls	Introducing access controls to the Unit and replacing the automatic controls in that area.	M	E&F	
Medical Gases Works General		M	E&F	
Ophthalmic Theatre Pendant Replacement	To replace pendant that is in use, but cannot be repaired if it breaks	M	E&F	
Fixed Wire Testing	Ongoing testing of wiring across MS & to do any remedial work as required	M	E&F	
Main Kitchen Flooring upgrade		M	E&F	
Microbiology Chillers	Replacement of evaporator unit	M	E&F	
General Flooring upgrade		M	E&F	
Replacement of defective Roof Top Doors		M	E&F	
Replacement Sewage Pumping Equipment		M	E&F	
Birch House Bathrooms & Kitchens		M	E&F	
Restaurant Heating		M	E&F	
Improvements to BMS Systems		M	E&F	
Replacement Signage		M	E&F	

UMAU at Maidstone	Minor spend on delayed invoices from 12/13	M	E&F	
Maidstone Car Park Extension	Development of up to 160 additional staff car parking spaces near Oncology.	M	E&F	
Traffic Management - barriers/access system	Changes required to fully control the car parking areas on the Maidstone site, to bring it in line with TWH.	M	E&F	
Admissions Lounge (Travers)	Looking at Ground Floor and 1st Floor layout plans. Potential to convert on-call rooms to an open plan office on 1st Floor and office relocations on the Ground Floor.	M	E&F	
HIS Move to New Premises			ICT	
Discharge Lounge Relocation	To build a purpose built modular unit between Clinic 4 and the helipad	M	Corp	
Re Routing Utility services	Re Routing Utility services from the Nurses Home to other residences	M	E&F	
Clinical Admin Moves				
VAT adjustments from 12/13				
DMO Service	To change use of fluorescein room to a lucentis room for Diabetic Macular Oedema (DMO) patients. There are other rooms that needs to be relocated elsewhere	M	critca re	
Ward Improvements (Phase 1) JSA/JDA	Jday refurb has been delayed until 14/15, however, some costs will be incurred in 13/14 for design and planning costs	M	E&F	
Staff Accommodation at Twells	Springs/Hillcroft Development	P	E&F	
North Car Park Deck	To provide additional parking deck to the North Car park.	P	E&F	
ETC entry system		P	E&F	
Electronic Door Hold Opens for A&E - OV129	Install Electronic door hold opens on seven doors in the Accident and Emergency Department linked to the fire system	P	E&F	
Endoscopy Scoping Room	To upgrade the room for JAG specification and reduce current risks to falls and trip hazards	P	Critca re	

Maidstone and Tunbridge Wells NHS
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TRUST BOARD MEETING - MARCH 2014

3-27 RISK MANAGEMENT POLICY AND STRATEGY TRUST SECRETARY

Summary / Key points

- The Trust's Risk Management Strategy is required to be updated annually.
- A synopsis of the document was received at Trust Management Executive on 22/01/14. The Committee agreed the document and recommended approval (and ratification) by the Board.
- The Board is therefore asked to approve and ratify the Strategy.
- Only minor changes made as part of planned review (these were highlighted in the consultation document). These include:
  - Revised definition of integrated Governance
  - Included the role of the Trust Secretary
  - Revised the role of the Patient Safety Lead
  - Revised the functions of the Trust Management Executive (TME) and the Quality and Safety Committee. The TME is now the committee with overarching responsibility for integrated risk
  - Revised role of the Audit and Governance Committee
- The full, amended, document was sent out for consultation on 30/10/13 (which included all members of the TME and members of the Board). The consultation ended on 01/12/13 (the Trust's policy requires a minimum period of 2 weeks). Seven replies received and minor amendments were made as a result.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 22/01/14

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

The Board is asked to approve and ratify the Strategy, based on the above synopsis

[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 - MARCH 2014

3-27 HEALTH & SAFETY POLICY & PROCEDURE TRUST SECRETARY

Summary / Key points

- The Board is asked to approve and ratify the revised Health & Safety policy.
- The Policy was discussed and agreed at the Health and Safety Committee on the 08/01/14 who recommended the document for approval/ratification by the Board.
- The Board is therefore asked to approve and ratify the Strategy.
- Minor changes made as part of planned review. These include:
  - Introduction of workplace H&S standards
  - Inclusion of terms of reference of the H&S committee as an appendix (new requirement from standards).
  - Introduction of RIDDOR 2013.
  - Introduction of the Trust 'Speak out Safely Policy and Procedure' (Whistleblowing)
- The full, amended, document was sent out for consultation on 15/11/13 (which included all members of the Board). The consultation ended on 15/12/13 (the Trust's policy requires a minimum period of 2 weeks). Minor amendments were made as a result of comments received.

Which Committees have reviewed the information prior to Board submission?
- Health and Safety Committee, 08/01/14

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
The Board is asked to approve and ratify the Policy, based on the above synopsis

[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