TRUST BOARD MEETING

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

NHS Maidstone and Tunbridge Wells NHS Trust

10am – c.12.30pm THURSDAY 7TH SEPTEMBER 2017

PENTECOST/SOUTH ROOMS, THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – 'PART 1'

Ref.	Item	Lead presenter	Attachment
9-1	To receive apologies for absence	Chair of the Trust Board	Verbal
9-2	To declare interests relevant to agenda items	Chair of the Trust Board	Verbal
9-3	Minutes of the 'Part 1' meeting of 19th July 2017	Chair of the Trust Board	1
9-4	To note progress with previous actions	Chair of the Trust Board	2
9-5	Safety moment	Chief Nurse	Verbal
9-6	Chair's report	Chair of the Trust Board	Verbal
9-7	Chief Executive's report	Chief Executive	3
9-8	Update on the 'Listening into Action' programme	Deputy Chief Executive	4
	Presentation from a Clinical Directorate		
9-9	Surgery	Clinical Director / General Manager	Presentation
9-10	Review of the Board Assurance Framework 2017/18	Trust Secretary	5
9-11	Integrated Performance Report for July 2017 ▪ Effectiveness / Responsiveness ▪ Safe / Effectiveness / Caring ▪ Safe (infection control) ▪ Well-Led (finance) ▪ Well-Led (workforce) ▪ Safe / Effectiveness (incl. mortality)	Chief Executive Chief Operating Officer Chief Nurse Dir. of Infection Prev. & Control Director of Finance Deputy Chief Executive Medical Director	6
	Quality items		
9-12	Update on the anticipated inspection by the CQC	Chief Nurse	7
9-13	The outcome of the investigations into the recent alleged assaults at the Trust	Chief Nurse	8
9-14	Annual Report from the Director of Infection Prevention and Control (including Trust Board annual refresher training)	Director of Infection Prevention and Control	9
9-15	Planned and actual ward staffing for June and July 2017	Chief Nurse	10
	Planning and strategy		
9-16	Update on the Kent & Medway Sustainability and Transformation Partnership (STP)	Chief Executive	Verbal
9-17	To discuss the Trust's strategy	Deputy Chief Executive	Presentation
	Assurance and policy		
9-18	Health & Safety Annual Report, 2016/17 (incl. agreement of the 2017/18 programme and annual refresher training on Health & Safety, Fire safety, and Moving & Handling)	Chief Operating Officer / Risk & Compliance Manager	11
9-19	Ratification of revised Risk Management Policy and Procedure	Trust Secretary	12
9-20	Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment	Chief Operating Officer	13
	Reports from Trust Board sub-committees (and the Trust Management Executive)		
9-21	Finance and Performance C'ttee, 21/08/17 (incl. quarterly progress update on Procurement Transformation Plan and approval of "Uncommitted Single Currency Interim Revenue Support Facility Agreement")	Committee Chair	14
9-22	**To consider any other business**		
9-23	**To receive any questions from members of the public**		
9-24	To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted (to enable the Trust Board to convene its 'Part 2' meeting)	Chair of the Trust Board	Verbal
	Date of next meeting: 18th October 2017, 10am, Academic Centre, Maidstone Hospital		

David Highton,
Chair of the Trust Board

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON WEDNESDAY 19TH JULY 2017, 10.30A.M, AT MAIDSTONE HOSPITAL

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Alex King	Non-Executive Director	(AK)
	Tim Livett	Non-Executive Director	(TL)
	Peter Maskell	Medical Director	(PM)
	Claire O'Brien	Interim Chief Nurse	(COB)
	Kevin Tallett	Non-Executive Director	(KT)
In attendance:	Karen Davies	Matron, Safeguarding Adults (for items 7-10 to 7-13)	(KD)
	Alison Jupp	Named Nurse, Safeguarding Children (for items 7-10 to 7-13)	(AJ)
	Jim Lusby	Deputy Chief Executive	(JL)
	Kevin Rowan	Trust Secretary	(KR)
	Sheila Stenson	Deputy Director of Finance (Financial Performance) (representing the Director of Finance)	(SS)
	Kerry Johnson	Patient (for item 7-8)	(KJ)
Observing:	Darren Yates	Head of Communications	(DY)

7-1 To receive apologies for absence

Apologies were received from Steve Orpin (SO), Director of Finance, but it was noted that SS was attending in SO's place. It was also noted that Sara Mumford (SM), Director of Infection Prevention and Control, would not be in attendance. DH then welcomed TL to his first Trust Board meeting.

7-2 To declare interests relevant to agenda items

No interests were declared.

7-3 Minutes of the Part 1 meeting of 28th June 2017

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

7-4 To note progress with previous actions

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

- **4-8 ("Liaise with the Chief Operating Officer and Chief Executive to agree the wording for an activity-related key objective for the 2017/18 Board Assurance Framework, and submit this to the Trust Board, for approval")**. KR reported that following liaison with AG and GD, the objective proposed to be added to the Board Assurance Framework (BAF) for 2017/18 was "To deliver the agreed Referral to Treatment (RTT) trajectory for patients on an 'incomplete' pathway". The Trust Board approved the proposal.
- **6-9 ("Submit a report to the Trust Board, in July 2017, providing the outcome of the investigations into the recent alleged assaults at the Trust".** The update was noted.

7-5 Safety moment

COB reported that the focus for July was Safeguarding Children, and made the following points:

- The first part of the month raised awareness of the Safeguarding Team, (and how they could be contacted), and also emphasised that Safeguarding was everyone's concern
- The Safeguarding Team provided supervision for staff involved in any Safeguarding issues
- The importance of training had been emphasised. There had also been a focus on the 'Prevent' (anti-radicalisation) initiative for children, which involved close working with the Safeguarding Adults lead

- The most recent efforts had been focused on child sexual exploitation. Unfortunately there had been some cases within Kent and Medway, and the Trust engaged with the Local Safeguarding Boards on such matters. Staff were supported to recognise children who may be at risk of such exploitation
- The remaining weeks in July would concentrate on Serious Case Reviews and the learning arising from these

DH noted that the Safeguarding Annual Report would be considered under item 7-12.

7-6 Chairman's report

DH reported the following points:

- The final Non-Executive Director (NED) vacancy had been approved by NHS Improvement (NHSI). Steve Phoenix would therefore start in the position on 01/12/17, for 2 years. DH was also considering offering an Associate NED position, but this was not yet finalised
- An offer had been made to Simon Hart to become the Trust's new Director of Workforce. Mr Hart, who had verbally accepted the offer, was currently the Director of Human Resources and Organisational Development at Oxleas NHS Foundation Trust, but had also had previous acute sector experience at Guy's and St Thomas' NHS Foundation Trust (GSTT)
- The Trust had had a further positive Financial Special Measures (FSM) Review Meeting with NHSI, and a further range of actions had been agreed. It was hoped that a recommendation regarding the Trust's position would be considered at the relevant NHSI committee in September (the committee did not meet in August)

7-7 Chief Executive's report

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

- The Listening into Action (LiA) initiative was progressing well, and would increasingly become the mechanism by which information was disseminated to staff. It was therefore important that everyone engaged with the process and became an active participant
- The Trust had an anonymous reporting system, but Trust Board Members may not always see the response to the reports received, so Attachment 3 contained some examples of these
- Since the last Board meeting, a new cultural diversity network had been established, and a series of events had been held. The Trust had a very good lead, who was committed to making a difference, and GD encouraged Trust Board Members to become involved
- In A&E, Stella Davey returned, despite leaving the Trust, to lead a session in which a group of people with learning disabilities visited Tunbridge Wells Hospital (TWH). Dr Milner was a great proponent of trying to make A&E a less daunting place for those with a learning disability, and again, GD encouraged Trust Board Members to become involved in any future sessions
- The promotion of health within the community was important, and the Health and Wellbeing day was a good example of this. The event also illustrated the very good relationship the Trust had with Macmillan Cancer Support

KT commended the positivity of the report, and stated that he would try to attend the next learning disabilities session. KT then asked whether the Trust had adopted the formal LiA process. JL confirmed this was the case. KT noted the cost involved in LiA, and suggested that the best approach would be to develop the capability to operate this in-house. JL agreed that the Trust did not want to depend on external support, and confirmed it was not therefore intending to renew the LiA license when this expired, but to have such in-house expertise. AK queried whether this could then be sold to other Trusts. JL agreed this could be considered, but emphasised that the in-house expertise needed to be developed first.

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

DH welcomed KJ to the meeting and invited her to speak about her experiences of the Trust's services. KJ duly gave an account which included the following points:

- KJ was an older mother, and was experiencing her first birth, and overall, KJ had a really positive experience, which led her to email the Trust to express her gratitude

- The pre-natal Midwives KJ had encountered were very good, and KJ felt that the Midwives had 'cocooned her in love'
- KJ had later experienced some difficulties. Her delivery was overdue, and she suffered some bleeding, which led to her being admitted to TWH
- One of the Trust's Midwives, Lauren Jones (LJ), had been outstanding
- KJ experienced some initial contractions, but was still in labour after 12 hours. She was however unable to be transferred to the Delivery Suite to be induced as there was no available capacity. KJ welcomed the openness and truthfulness of being informed of this
- Eventually however, KJ was transferred to the Delivery Suite, and LJ accompanied KJ
- Hours later, KJ was still unable to be induced, but during this time, LJ got to know KJ and her husband, to the point where KJ felt able to trust LJ
- When KJ's baby's heartbeat decreased, LJ told KJ that she would push an emergency button, and the room would be inundated with people
- A doctor, Brendan Gallagher (BG), should also be commended, as he made KJ feel at ease through smiling and by maintaining regular eye contact
- KJ had a 10-page Birthing Plan, which included a water birth, but the Plan was abandoned
- KJ trusted BG, which made her decision to have a Caesarean Section easier. However, BG then determined that an emergency Caesarean Section was required, and that KJ needed a General Anaesthetic. The procedure was duly undertaken, & KJ's baby, Jack, was born safely
- LJ was first person KJ saw, and despite KJ's concerns regarding appropriate protocol, KJ asked for a hug. LJ duly obliged the request
- KJ's husband later informed KJ that LJ had handed him KJ's baby, and showed him how to hold a baby properly. LJ had also given KJ's Colostrum to Jack
- LJ later came to visit KJ, even though at that point LJ was tending to another mother
- KJ felt that all of the staff she had encountered had given KJ their time, despite the time pressures they faced
- KJ's baby's weight had reduced after their discharge from TWH. However, the Community Midwives made KJ feel comfortable in administering formula feed, as well as breast milk, to increase Jack's weight

DH thanked KJ and invited questions and/or comments.

KT acknowledged the power, and humbling effect of KJ's story.

COB confirmed it was not against Trust protocol for Midwives to hug patients, provided the patient regarded this as acceptable. COB added that she would be confident that LJ, BG and the other staff involved in KJ's care would feel very positively about the experience.

PM asked KJ for an update on her baby's health. KJ confirmed that he was developing well.

SDu commended the story, and asked whether the staff involved were aware of KJ's views. COB confirmed that the aforementioned email KJ had sent had been shared with all the staff concerned, but it was agreed that it would be beneficial for such staff to be recognised more formally.

Action: Arrange for formal letters of gratitude to be sent to the Trust staff who were commended within the "A patient's experiences of the Trust's services" item at the Trust Board on 19/07/17 (Trust Secretary, July 2017 onwards)

COB asked what advice KJ would give to any new mothers who had developed detailed Birthing Plans. KJ replied that such mothers should be made aware that although it was important to have a Plan, it should not be regarded as anything other than that, and the outcome (i.e. of a healthy baby) was the most important aspect.

DH thanked KJ for attending the meeting and sharing her experiences.

7-9 Review of the Board Assurance Framework 2017/18

KR referred to the circulated report and drew attention to the following points:

- The was the first populated Board Assurance Framework (BAF) that the Trust Board had received in 2017/18, following the approval of the key objectives in April 2017

- The ratings for "How confident is the Responsible Director that the objective will be achieved by the end of 2017/18?" were based on the month 2 performance, as month 3 data was not available at the time the report was produced. However, KR had no reason to believe the ratings would have changed. A summary of the ratings was contained on page 1
- The objective approved under item 7-4 would be included in the next update of the BAF
- Following an action from the Audit and Governance Committee, and a recommendation from the latest annual Internal Audit review of the Assurance Framework and Risk Register, page 7 of 9 contained a summary of the Risk Register, and details of the 'red' rated risks. All of the 'red' rated risks should be familiar to Trust Board Members, as the issues were discussed regularly at the Trust Board, Quality Committee and/or the Trust Management Executive

DH asked when the next review was due. KR confirmed this was scheduled for September 2017.

KT expressed surprise that an 'amber' rating had been given for objective 4 ("To deliver the control total for 2017/18 (of a pre-STF deficit of no more £4.5m, or otherwise agreed by NHS Improvement)"), given DH's remarks, under item 7-6, about the positive FSM Review Meeting with NHSI. DH clarified that the Trust did not, technically, have to achieve the control total in order to exit FSM. KT continued that he believed the risk-averse nature that appeared to have influenced the ratings implied that the Trust was not confident of achieving the objectives. TL stated that the key issue to consider was the factors that gave rise to the uncertainty that had been reflected in the ratings, and whether these factors could be addressed. GD pointed out that the financial target involved a steeper trajectory toward the year-end.

SDu then referred to objective 2 ("To deliver the agreed 2017/18 trajectory for the A&E 4 hour waiting time target") and remarked that the content of the BAF was very focused on internal factors, and did not cover the system-wide issues that affected performance. AG acknowledged the point, and it was agreed to ensure that such factors were reflected in the BAF.

Action: Ensure that the external factors affecting the Trust's performance on the A&E 4-hour waiting time target were reflected within the relevant entry in the Board Assurance Framework (Trust Secretary / Chief Operating Officer, July 2017 onwards)

7-10 Integrated Performance Report for June 2017

GD referred to the circulated report and highlighted that the A&E 4-hour waiting time target trajectory had been achieved in June, and the Trust was rated in the top 50 of the 138 Trusts nationally. GD continued that the Trust's performance also compared favourably with all neighbouring Trusts, and only about 10 across the country were consistently achieving the national target. GD added that significant progress had therefore been made, despite the increasing activity, and the key aspect in addressing this was the management of ambulatory pathways. GD then invited colleagues to highlight key issues.

Effectiveness / Responsiveness (incl. DTOCs)

AG highlighted the following points:

- There had been a much better A&E 4-hour waiting time target performance in June, and July's performance was expected to be similar. Credit should be given to the Urgent Care Division management team, particularly the Director of Operations and Associate Director of Nursing
- The Frail Elderly Unit was now operational at Maidstone Hospital (MH), and the progress made had exceeded the milestones that had been set for the Unit. Work was also continuing with clinicians at Tunbridge Wells Hospital (TWH) to establish a Unit at that site
- Capital funding had now been received for (GP) streaming, and the operating model for this had now been agreed
- The Trust was working closely with West Kent Clinical Commissioning Group (CCG) to obtain their perspective on the key factors that were changing in relation to the volume of activity. Actions were therefore focusing on coping over the winter period with that increased volume
- There had been some reduction in Length of Stay (LOS), and a Ward had been able to be closed at MH on 13/07/17 (ahead of the plan), due to the culmination of a range of enablers
- Delayed Transfers of Care (DTOCs) remained a key area of focus, as these remained at 6% (of the bed base), which exceeded the 3.5% limit set by the Care Quality Commission (CQC)

KT referred to the latter point, and asked for clarification that the CQC had set the target for DTOCs. AG confirmed this was the case.

KT then stated that the Trust Board had recognised the existence of the 'new normal' levels of activity, but asked whether this was recognised by West Kent CCG. AG replied that it had been acknowledged that there was a new era of activity, but there was a need for the Trust to continually provide information to the CCG to illustrate the point. AG added that the increased activity had been seen in majors, not minors, and in patients aged over 85. JL noted that West Kent CCG had recently initiated a discussion regarding the increased activity, which was positive. GD acknowledged this, but added that the Local Authorities' position was different, and explained the difficulties the Authorities faced in trying to create a market for domiciliary care which did not currently exist.

KT referred to GD's last point, and pronounced that domiciliary care staff were more likely to be attracted to work for the NHS than for the local Council. GD concurred, but noted that this option was likely to cost more. GD also added that it should be noted that healthcare was free at the point of delivery, whereas Social Care was means-tested. AK opined that the dialogue with the Local Authority needed to continue, probably via the Sustainability and Transformation Plan (STP), and be reported publicly to the Trust Board. GD agreed.

AG then continued, and highlighted the following points:

- The Trust continued to forecast non-compliance in relation to elective activity, but AG was confident the appropriate actions were being taken
- AG accepted that progress was slow on the 62-day Cancer waiting time target, but the number of treatments per month had now been returned to previous levels (between 110 and 120), and the waiting list backlog was reducing. A daily Cancer 'huddle' was also being held, and AG met with the team each week, to review where breaches were being avoided. This review distinguished very clearly between the Trust-only patients and others, and the daily 'huddle' would continue until performance had recovered

KT asked what the current longest waiting time for elective Cardiology treatment was, and pointed out that this was of interest to the CQC. AG therefore agreed to confirm this.

Action: Confirm the current longest waiting time for elective Cardiology treatment (Chief Operating Officer, July 2017 onwards)

Safe / Effectiveness / Caring (including infection control)

COB then reported the following points:

- As was noted under item 7-4, a report would be submitted to the Trust Board in September 2017 on the recent allegations of abuse, but one of these investigations would be asked to be downgraded, as the Police had concluded there was no case to answer
- There had been 2 Clostridium difficile cases in June, against a limit of 2 per month (to achieve the year-end trajectory), & the Infection Prevention and Control Team were working with clinical teams to ensure, for example, that use of fans in hot weather did not lead to further cases
- There had been no MRSA bacteraemia cases, and MRSA screening levels were very good
- The Pressure Ulcer rate was satisfactory
- There had been 3 falls-related Serious Incidents (SIs) in June, and 2 in July (which was a reduction on previous months)
- 14 overall SIs had been reported for June, but the Trust had asked that West Kent CCG downgrade 2 of these (1 of which was the fatal road traffic accident at the rear of MH). It was intended to pool investigations and involve the relevant experts, but no themes had been identified thus far
- Complaints response times had increased, and performance had been adversely affected by staffing vacancies within Central Complaints Team
- The Friends and Family Test (FFT) response rate was generally in accordance with the target, but there continued to be challenges in achieving the required level of positive responses in Maternity. In the month, more women selected the "don't know" option, which was considered a negative response. COB had requested that the team engage with women to address this, as

other Trusts had been able to do so. The fact that women were asked to complete FFT surveys 4 times (via 4 separate questionnaires) may however be a factor

Well-Led (finance)

SS then highlighted the following points:

- In month, the deficit was £700k, which related to non-receipt of Sustainability and Transformation Fund (STF) monies, but guidance regarding the criteria for the STF had now been issued. The year to date deficit was £3.5m, which compared favourably to the £10.5m deficit at the same point in 2016/17
- Income was £100k favourable in the month, and the STF position was favourable in the month due to the GP streaming aspect
- Month 5 was expected to see an increase in Cost Improvement Programme (CIP) delivery, but £1.4m had been delivered in the month. The Trust was slightly adverse to its 'live' CIP plan, and work therefore continued with Divisions and the Procurement team
- The Trust had now reached agreement with NHS England and with the North Kent CCGs on the 2016/17 position, which would help the Trust's cash balance
- The Trust had been asked to attend a further NHSI FSM review meeting in August, to assess the latest CIP delivery in particular

DH elaborated that some large-value CIP schemes would start delivering benefit in July & August.

Well-led (workforce)

JL then reported the following points:

- The trend in performance was similar to that reported in recent meetings
- Bank staff usage had increased, and Agency staff usage decreased
- Temporary staffing expenditure was satisfactory
- There were still major issues with Medical workforce, but there would be a fresh opportunity to review this once the new Director of Workforce started in post, as their current Trust, Oxleas NHS Foundation Trust, had a good reputation for innovation
- JL proposed to submit a more formal LiA report to the September 2017 Trust Board meeting, and also include some LiA presentations at the Trust's 2017 Annual General Meeting (AGM)

GD then referred to the "Staff FFT % recommended work" indicator on page 7, and queried whether further work could be undertaken by the Human Resources department to explore this further. JL acknowledged the issue, but stated that the LiA survey data was expected to provide further information on this aspect.

Safe / Effectiveness (incl. Mortality)

PM then reported the following points:

- Mortality continued to be scrutinised by the Quality Committee
- The Trust's Summary Hospital-level Mortality Indicator (SHMI) was currently rated 'green'
- The Hospital Standardised Mortality Ratio (HSMR) was being monitored monthly, and there were ongoing reviews in relation to pneumonia and non-Hodgkin lymphoma
- NHSI and the National Quality Board had mandated a new Mortality Review process, and new data was expected to be reported. The data would be reported to the Trust Board quarterly. The Trust was also expected to have a new policy, and PM intended to submit this as an Appendix to the next Quarterly mortality report, to provide the Trust Board with assurance
- The Trust was an active participant in the Kent, Surrey and Sussex 'Community of Practice' for mortality, and PM had recently attended a meeting relating to this
- The only query in the aforementioned national mandate was whether "avoidable" deaths should be publicised in the Trust, as the definition was quite subjective. However, NHSI were clear that they would publish information on Trust's "avoidable" deaths in the future

PM then referred to the discussion of the ratings of "How confident is the Responsible Director that the objective will be achieved by the end of 2017/18?" within the BAF (under item 7-9), and stated that he would have reported "amber/green" for the rating if this had been possible, but confirmed that he expected the objective to be "green" at year-end.

KT declared that the CQC were very interested in Trust's response to their "Learning, candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England" report. The point was acknowledged, and DH asked COB for an update on the expected CQC inspection. COB reported that the Trust would receive an information request w/c 24/07/17, and despite being initially advised that there would be 9 weeks to respond, it had been confirmed that the Trust would in fact have to respond 3 weeks. DH proposed that a separate agenda item be considered at the next Trust Board regarding the anticipated CQC inspection. This was agreed.

Action: Schedule an item at the Trust Board meeting on 07/09/17 in relation to the Trust's anticipated inspection by the Care Quality Commission (Trust Secretary, July 2017)

DH then stated that he expected the Executive Team to enter a state of readiness ahead of the CQC inspection, and asked that information regarding this also be circulated before the next Board meeting, to enable Non-Executive Directors in particular to be assured. This was agreed.

Action: Arrange for information regarding the state of readiness for the Trust's anticipated inspection by the Care Quality Commission to be circulated to Trust Board Members ahead of the Board meeting scheduled for 07/09/17 (Chief Nurse, August 2017)

Quality Items

7-11 Staffing: 6-monthly review of Ward and non-Ward areas

COB referred to the circulated report and drew attention to the following points:

- The monthly "planned v actual" report had not been submitted, as the data was not available because of the earlier than usual scheduling of the Trust Board meeting. Two months' data would therefore be submitted to the September 2017 Board meeting
- The Trust was required by the National Quality Board to undertake 6-monthly Nurse staffing reviews. The last review took place in October 2016, which was a strategic review, and some changes in establishment were made, which included changing some posts from a Registered Nurse to a Clinical Support Worker
- The key issue from the current review was the awareness of some recruitment gaps. However, staffing levels were considered to be acceptable, and would be regarded as good if areas were able to recruit to their establishment levels
- The report only covered adult inpatient Wards, & reviews needed to be finished for other areas

DH asked whether the fact that the Critical Care Outreach team was separate to the ICU team made it harder to recruit to the former. COB replied that she did not recognise this, but acknowledged that there were particular issues in recruiting Critical Care Outreach staff at night, although actions were planned regarding this. COB then continued, and highlighted the following:

- Some concerns had been raised regarding Therapy staff, and these were being considered with AG and PM
- The Trust had recently visited the Republic of Ireland to try to recruit Nursing staff, but the trip did not yield any applications

KT referred to page 9, and noted the "Ratios" for Wards 2 and 20 and the association with patient falls. COB pointed out that these 2 Wards had been identified within recent "planned v actual" reports. The point was acknowledged, and KT remarked that he believed the reporting format of Attachment 6 was better than that of the usual "planned v actual" report. GD concurred.

SDu noted the difficulties in recruiting staff, and asked whether 'finder fees' had ever been considered, to incentivise staff who introduced others who were subsequently appointed to vacant Nursing positions. COB acknowledged the validity of the idea, and stated she was aware that some other Trusts had adopted this. It was therefore agreed that the feasibility of the proposal should be assessed.

Action: Arrange for an assessment of the feasibility of establishing a 'finder fee' arrangement for staff who introduce individuals who were subsequently appointed to vacant Nursing positions (Chief Nurse, July 2017 onwards)

GD then appealed for efforts to continue to try to recruit staff from the European Union (EU). COB confirmed that such efforts continued, but other factors were relevant, including the requirement for

staff to achieve a certain standard on the International English Language Testing System (IELTS), although the Nursing and Midwifery Council (NMC) had recently indicated a desire to review the current stringent language requirements.

7-12 Safeguarding children update (Annual Report to Board, including Trust Board annual refresher training)

DH welcomed AJ to the meeting. AJ referred to the circulated report and highlighted the following:

- AJ had joined the Trust from Kent Community Health NHS Foundation Trust, and significant progress had been made since she started in post
- Training attendance in particular had been successful, but further progress was needed to achieve the required levels of compliance

KT queried whether the challenges regarding training were related to capacity. AJ agreed this was a feature, but gave assurance that Level 3 training was being targeted, and was specifically focused on Maternity staff.

KT then asked whether the Safeguarding Children Team was fully staffed. AJ replied that the Team was technically fully staffed, but there was a 40% sickness absence rate, as 2 of the Team were currently on long-term sickness absence.

DH asked about the Child Protection –Information System (CP-IS), and noted that in his experience, Serious Case Reviews had often identified failures in communication as being a factor. AJ agreed, and stated that the plan for CP-IS was to have an interface with the Symphony A&E IT system, which would negate the need for the relevant records to be manually 'flagged', as an individual's record would be automatically noted to be subject to a child protection alert. AJ added that the new arrangement was expected to be operational by September 2017.

JL then asked whether more action was required in relation to mental health. AJ confirmed this was the case, and described the issues currently affecting the situation. AJ also noted the fact that the Woodlands Unit had been used to 'board' mental health patients, as a 'safe place', but it was hoped to convert a specific location to become a more permanent 'safe place'. AJ added that she expected the number of cases to increase in the long-term, and she was working with the Lead Matron for Paediatrics to agree a specific pathway.

KT referred to the statement that "No current audits planned" in section 10.1 (page 11), and asked for a comment. AJ clarified that an audit of the National Institute for Health and Care Excellence (NICE) clinical guidance on "Child maltreatment: when to suspect maltreatment in under 18s" was scheduled for October 2017.

KT queried whether it was beneficial to have specific Non-Executive Director 'champions' for Safeguarding (Adults and Children). DH replied that this could be considered.

Action: Consider appointing Non-Executive Director 'champions' for Safeguarding Adults and Children (Chair of the Trust Board, July 2017 onwards)

DH then asked for an update on the changes to the processes in the Emergency Department (ED) which meant that not all patients attending the ED would have their records reviewed. AJ confirmed this change had commenced, and noted that the new triage process enabled more detailed information to be provided for the more relevant cases. COB added that the change in practice reflected that at other Trusts.

7-13 Safeguarding adults update (Annual Report to Board, including Trust Board annual refresher training)

DH welcomed KD to the meeting. KD referred to the circulated report and highlighted the following:

- Safeguarding Adults was everyone's responsibility
- KD did not have a team, but had the support of the Deputy Chief Nurse
- Safeguarding alerts were being raised appropriately. Permission was not needed to raise such alerts, but KD asked that she receive a copy of all of those reported. KD read each alert to sense check how alerts were being raised & their appropriateness (which they generally were)

- The term “vulnerable adult” had now been replaced with “adult at risk”, and the change had led to some challenging discussions with the lead agency (the Local Authority) as to whether raised alerts met the new threshold. There was ongoing work to discuss and agree the thresholds within Kent
- The Local Authority trusted the Trust (i.e. as a “trusted provider”) to undertake its own investigations, and KD worked with external agencies as required
- The number of Deprivation of Liberty Safeguards (DoLS) alerts raised at the Trust was considered by KD to be relatively low, but this may have been affected by a previous legal case, which had led to a dramatic increase in the number of DoLS raised. However, there were insufficient Local Authority staff to respond to each DoLS requested, and therefore staff had had not seen the DOL safeguards being put into place for patients
- The application of the Mental Capacity Act (MCA) into everyday practice had been challenging, and PM had been asked for assistance with this. KD aimed to provide some MCA/DoLS ‘masterclass’ training, which was hoped to help staff feel more confident to put MCA into their practice
- The Trust had been involved in 2 external Safeguarding Adults reviews, and the outcome of both was awaited
- KD was the ‘Prevent’ lead for the Trust, but AJ and the Trust’s Security Manager were also Home Office-trained (previously KD had been the only person to have this training at the Trust). Bespoke ‘Prevent’ training can also be delivered in areas that request this
- The Intercollegiate training document for Safeguarding Adults was not yet ratified. Once this occurred, the Trust’s Training Needs Analysis would be reviewed. KD also needed to re-design the Level 3 training she provided, so this did not rely on external speakers

DH asked whether there were any groups of staff for which training was mandatory. KD confirmed this was the case, and elaborated that Level 1 (Basic Awareness) training was required by all staff, whilst Level 2 (which included MCA & DoLS) was mandatory for clinical staff. KD added that Level 1, 2 and 3 training included basic awareness of ‘Prevent. DH asked whether training compliance was monitored. KD confirmed this information was reported to the Safeguarding Committee.

KT then asked KD how well she believed the Trust would perform, on MCA and DoLS awareness, if the CQC visited the Trust on 20/07/17. KD replied that there were some areas of good practice, but also some areas where improvement was required. KT asked when KD would be able to state that she was confident on this, given the actions she had referred to earlier. KD stated that she was unable to provide a date with any certainty, as improvement required cultural change. AG noted that she had attended Matrons’ meetings where Matrons had demonstrated very strong leadership in relation to MCA and DoLS. KT then asked whether KD felt she had access to all of the support she needed. KD answered that it was difficult, as she was only one individual, and therefore did what she could.

KT proposed that a further report on MCA and DoLS be submitted to the Trust Board in September 2017. COB instead pointed out that a Quality Committee ‘deep dive’ on the MCA had been scheduled for August. PM explained that a Trust-wide audit of compliance with the MCA and DoLS had previously showed poor compliance, and a re-audit had repeated this finding, despite an action plan being in place.

PM then stated that when comparing KD’s remarks with those made by AJ under item 7-12, he was concerned to hear that there appeared to be more general support among staff for Safeguarding Children than for Safeguarding Adults, and it should be remembered that the latter affected a large number of patients. The point was acknowledged, and COB emphasised that a new Learning Disability Nurse would start in post soon, and would be able to support KD.

Assurance and policy

7-14 Estates and Facilities Annual Report 2016/17

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

- After some previous variable performance, the Trust now had a very stable & effective Estates Management Team, led by the Director, Estates and Facilities Management (Jeanette Rooke)

- Highlights of the year included the continued implementation of Ultraviolet (UV) cleaning, which had a very positive effect
- The report was straightforward, and there were no major issues that required the Trust Board's attention

KT asked whether all of the spare laundry capacity was being used. AG replied that a small amount of capacity was available, despite the Trust having been awarded the contract for Dartford and Gravesham NHS Trust, and the Trust would therefore be able to offer some short-term laundry support if asked to do so.

KT asked how long it would take to clear the Trust's backlog maintenance programme. AG stated that the plan was currently spread over 3 years, but this was reducing. KT stated that it would be useful to include details of the length of the programme in future year's reports. This was agreed.

Action: Arrange for details of the length of the Trust's backlog maintenance programme to be included in future Estates and Facilities Annual Reports (Chief Operating Officer, July 2018)

GD asked for an update on the external cladding situation (that had been raised in response to the Grenfell tower block fire). AG confirmed there were no cladding-related issues to report.

7-15 Responsible Officer's Annual Report 2016/17

PM referred to the report that had been circulated and drew attention the following points:

- The report contained a typographical error on the first page. In addition, although the Executive Summary (page 2 of 20) stated that there had been "18 deferral recommendations", there had actually only been 8 such recommendations (as described on page 6 of 20)
- The Trust was required to produce a Responsible Officer's Annual Report
- Doctors in Training were not included in the Trust's revalidation process, as their Responsible Officer was Health Education Kent, Surrey and Sussex (HEKSS). Middle Grade doctors (i.e. Specialty and Associate Specialists (SAS)) were however included
- Of the 392 relevant Trust doctors, 359 completed an appraisal in 2016/17, which was an overall appraisal rate of 92%
- The report did not include benchmarking data, but PM wanted to address this for the future
- A Deputy Medical Director oversaw the validation process. This had previously been Graham Russell, and PM wished to thank Dr Russell for his efforts, but in future, Paul Sigston would undertake this role
- Doctors should be encouraged by their appraiser to participate in reflection
- Appraisers did not seem to 'sign off' their appraisals quickly enough, so this was an area of focus for the next year. There was also no robust process for collating data on complaints
- Job Planning was intended to be linked to appraisals, and the Trust was considered to be advanced on this when compared to some others
- Consideration was needed as to whether a patient representative should be invited to sit on the Revalidation Panel. NHSI had advised the Trust to involve patients, and PM was considering this. The views of Trust Board Members were welcome

KT commended the report and welcomed the involvement of patients. SDu echoed KT's latter comment, and stated that she believed it appropriate to include patient feedback in the process. PM clarified that this was already part of the process, but his query related to whether there should be a patient representative on the Revalidation Panel.

The Statement of Compliance (Appendix F, pages 19 to 20) was approved, as circulated.

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

7-16 The Charitable Funds Committee, 26/06/17 (including approval of Annual Report and Accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund, 2016/17)

SDu referred to the circulated report and noted that a verbal report had been given at last Trust Board meeting. SDu added that the Trust Board was however required to approve the Annual Report and Accounts for the Charitable Fund for 2016/17, which was included in Attachment 11.

The Annual Report and Accounts of the Maidstone and Tunbridge Wells NHS Trust Charitable Fund for 2016/17 were approved as circulated.

7-17 Quality Committee, 05/07/17

SDu referred to the circulated report and confirmed there were no specific issues to draw to the Board's attention. SDu did however report that there was now a lot more engagement at the Committee, at all levels, than when, for example, she had joined the Trust Board.

7-18 Trust Management Executive, 12/07/17

The circulated report was noted.

7-19 Finance and Performance Committee, 17/07/17

DH referred to the circulated report (Attachment 14) and highlighted the following points:

- The Committee had approved a Memorandum of Understanding (MoU) relating to genetics testing re-procurement, following the Trust being invited by GSTT to join a consortium to help develop a bid for a Genetic Laboratory Hub
- The Committee had reviewed the finance reports in detail, and reviewed the presentation slide deck ahead of the aforementioned FSM Review Meeting with NHSI
- The content of a letter from the National Urgent and Emergency Care Director, which had been highlighted in the trade media, had been discussed

GD referred to the latter point, and confirmed that he had heard about the existence of the letter, but had not yet received it.

Assurance and policy

7-20 Board Members' hospital visits.

KR referred to the circulated report and for the avoidance of doubt clarified that the reference to "Site visits with DH" pertained to DH, and not the Department of Health. DH commented that further thought was needed on how to increase the visibility of Trust Board Members, following the initial feedback from the LiA pulse survey. JL agreed and noted that this was a common finding from other staff surveys.

COB then remarked that a number of visits she had undertaken, including one to the Frailty Unit, had not been reflected in the report. KR pointed out that that the onus was on Trust Board Members to inform the Trust Management office of any visits they made, to enable these to be included. SDu also noted that she had provided feedback on the observations from her visits to COB. KR acknowledged the point.

7-21 To consider any other business

No other business was raised.

7-22 To receive any questions from members of the public

No questions were posed.

7-23 To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted

The motion was approved, which enabled the 'Part 2' Trust Board meeting to be convened.

Trust Board Meeting – September 2017

NHS Maidstone and Tunbridge Wells NHS Trust

9-4 Log of outstanding actions from previous meetings — Chair of the Trust Board

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
7-11 (July 17)	Arrange for an assessment of the feasibility of establishing a 'finder fee' arrangement for staff who introduce individuals who were subsequently appointed to vacant Nursing positions	Chief Nurse	July 2017 onwards	The issue has been discussed at the Recruitment & Retention group and an outline paper has been prepared for Executive Team discussion and consideration. The Executive Team agreed to the principle, but asked that further work be undertaken on the specific details. This is now in progress, and an updated report will be considered in due course.
7-11 (July 17)	Consider appointing Non-Executive Director 'champions' for Safeguarding Adults and Children	Chair of the Trust Board	July 2017 onwards	The matter is being considered, and will be discussed during the 'Chair's report' at the September 2017 Trust Board

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
6-9 (June 17)	Submit a report to the Trust Board, in July 2017, providing the outcome of the investigations into the recent alleged assaults at the Trust	Chief Nurse	September 2017	The report was deferred to September to allow the conclusion of police investigations and so that all allegations may be reviewed collectively. However, the requested report has now been submitted to the Trust Board
7-8 (July 17)	Arrange for formal letters of gratitude to be sent to the Trust staff who were commended within the "A patient's experiences of the Trust's services" item at the Trust Board on 19/07/17	Trust Secretary	July 2017	Letters were sent from the Chair of the Trust Board on 21/07/17
7-9 (July 17)	Ensure that the external factors affecting the Trust's performance on the A&E 4-hour waiting time target were reflected within the relevant entry in the Board Assurance Framework	Trust Secretary / Chief Operating Officer	September 2017	The external factors have been reflect in the latest update to the Board Assurance Framework (BAF), which has been submitted to the Trust Board in September

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
7-10i (July 17)	Confirm the current longest waiting time for elective Cardiology treatment	Chief Operating Officer	September 2017	The longest is 90 days (12 weeks) which is for an Angiogram. The original date on list was 02/06/2017 and the expected 'To Come In' (TCI) date is 19/09/2107
7-10ii (July 17)	Schedule an item at the Trust Board meeting on 07/09/17 in relation to the Trust's anticipated inspection by the Care Quality Commission	Trust Secretary	July 2017	The item was scheduled
7-10iii (July 17)	Arrange for information regarding the state of readiness for the Trust's anticipated inspection by the Care Quality Commission to be circulated to Trust Board Members ahead of the Board meeting scheduled for 07/09/17	Chief Nurse	September 2017	Information was unable to be circulated ahead of the Trust Board meeting, but a report has been submitted to the Trust Board meeting on 07/09/17

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
7-14 (July 17)	Arrange for details of the length of the Trust's backlog maintenance programme to be included in future Estates and Facilities Annual Reports	Chief Operating Officer	July 2018	The Director of Estates and Facilities has been notified of the request, and been asked to ensure the information is included in the 2017/18 Annual Report, which is scheduled to be considered by the Trust Board in July 2018

Trust Board meeting - September 2017

NHS
Maidstone and Tunbridge Wells NHS Trust

9-7 Chief Executive's report — Chief Executive

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

1. We have continued to apply ourselves to the delivery of high standards of care for both our planned and unplanned patients throughout the summer months while looking ahead, and being very mindful of, people's future care needs.

   While we have seen some encouraging signs of improvement in areas of our performance (through service transformation), unplanned admissions (at 11% above July last year) continue to impact on planned care. Both areas remain the subject of intense focus through further capacity and patient flow initiatives to meet our patients' elective and non-elective care needs.

2. We continue to promote key points of learning with our staff from both the experiences our patients have shared with us and the issues/opportunities we have identified through our own reporting systems. Most recently, we have asked our staff to think about:
   - The way we interact with families to ensure appropriate consent is gained, how we manage expectations of treatment, and provide emotional support to patients and their loved ones in potentially distressing situations
   - Sufficiency of analgesia, taking into consideration patient factors such as size and levels of individual distress
   - Considering whether a patient's behaviour is normal or abnormal compared to usual and recording incidents rather than accepting them as part of a medical condition

   We are developing ways to help more of our staff think about the care they provide our patients from the Care Quality Commission's perspective. We are asking them to question how they provide outstanding care and safety that is effective, responsive and well-led.

3. We have received positive feedback from our patient-led assessments of how our environment supports people's privacy and dignity, quality of patient food, cleanliness of wards, and general building maintenance. Given the above challenges, this is a reflection of our staff endeavour.

   Patient-Led Assessments of the Care Environment (PLACE) inspections take place annually at every hospital in the country. This year, our hospitals exceed the national average scores in all categories and in most areas MTW is the best performing Trust in Kent.

   Of the 65 organisations accessed in the South of England, MTW came fifth for cleanliness and in the top 10 for both dementia and disability friendliness.

   Of the 52 NHS acute hospitals assessed (in the South of England), Tunbridge Wells Hospital was the highest rated for disability friendliness and Maidstone Hospital was third for cleanliness. Both hospitals also scored well for condition, appearance and maintenance, dementia friendliness and privacy, dignity and wellbeing.

4. At the beginning of June, the Chaucer Acute Frailty Unit (CAFU) opened at Maidstone Hospital. The Unit was designed to improve the experience and patient flow for our elderly patients when they come into the hospital through A&E.

   The Frailty Unit has received positive feedback from patients, our clinical teams, AMU and A&E particularly because the unit allows elderly patients to be treated by a specialist who completes a Comprehensive Geriatric Assessment. There are also services in place which support the unit and offer a prompt review or service which allows patients to safely be diagnosed, treated and safely discharged in a timely manner – this helps to create bed capacity for other patients. These services include:

- Mental Health (Assessment within 2hrs)
- Diagnostics (completed within 1 hour)
- Care Management (contacted via a pager and reviewed as a priority)
- HIT Team available on the unit
- Daily Board Round

The next phase of the project will aim to create a 7 day service. There are also plans to create hot clinics for patients who can be discharged but will require a specialist medical review promptly and for the unit to accept referrals from GPs.

The project leads are now working closely with clinicians at Tunbridge Wells Hospital to replicate the success of the Chaucer Frailty Unit at both sites.

5. Our Virtual Fracture Clinic (VFC) has just celebrated its one-year anniversary. The project team which includes T&O, Physiotherapy and West Kent Clinical Commissioning Group implemented the VFC service on 4th July 2016, based on best practice models implemented elsewhere in the UK.

   These VFC services demonstrated that not all patients who have a potential fracture need to be seen automatically as a follow up in an outpatient clinic setting. Instead VFC services have enabled patients to be triaged and managed more effectively by getting referrals/patients to the right medical professional, and so reduce follow-ups and the repeat of unnecessary diagnostics. Since the implementation of this model the benefits to our patients have been impressive, including:

   - 45% of patients have not needed to attend Fracture Clinic but have been managed in alternative ways suited to their care plan
   - 142 patients have been added straight to the Trauma board within 4 days of presentation at A&E prior to VFC patients may have waited weeks.

   There has also been very positive feedback from patients about the new service.

6. I would like to publicly acknowledge the generous donation made by the Kent and Sussex Hospital Fund Darts League to Ward 12 at the Tunbridge Wells Hospital. The charity raised over £8,400 to fund a new bladder scanner for the ward.

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for submission to 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

Trust Board meeting – September 2017

NHS Maidstone and Tunbridge Wells NHS Trust

9-8 Update on the 'Listening into Action' programme — Deputy Chief Executive

Trust Board Members are aware that Listening into Action (LiA) is a new way of working for the Trust that puts more of our staff, especially our frontline staff, at the forefront of our thinking when it comes to improvements in patient care and the services we deliver. Our aim is to engage and empower more of our staff to make the changes they feel are important to improving the patient experience and the work of the Trust.

LiA is a proven approach which has been successfully used by many other high performing NHS Trusts to largely deliver clinically driven and patient-focused improvements in a timely manner. We have signed up as a Trust to adopt this approach and we will be pioneering its use over the next 12 months. LiA is designed to be simple, compelling and different. There is no talk of projects, programmes and PIDs. It focuses on:

- Connecting all the right people around a common mission and outcomes they care about
- Collaborating around good ideas to improve things for patients and staff
- Collective ownership and permission to act on ideas

LiA started with understanding where we are now and a Pulse Check survey was undertaken. The results of this survey are enclosed. It is proposed that the findings be discussed in further detail at the next Trust Board 'Away Day' (which is likely to be in the autumn of 2017).

Two of the subjects covered by LiA (The Maidstone Antenatal Service and Pre-assessments) will be presented at the Trust's Annual General Meeting (AGM) on the afternoon of 07/09/17. On the same day, the first of a series of "Crowdfixing" events has been scheduled. These consist of up to 80 staff set up in tables of 5 or 6, and ask just two questions:

1. "What are the main things that get in the way of you delivering the very best care for our patients and their families?" and
2. "What changes can we make between us that would make the biggest difference?"

Whilst the Crowdfixing session will help identify key issues and actions, we also want to give people the tools needed to address the issues they raised individually, even if they didn't make the top 5 for the table. We will therefore talk through the LiA process, using examples from people within MTW on how to make the change staff want to make a reality.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and discussion

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

Listening into Action

Maidstone and Tunbridge Wells NHS Trust

LiA Pulse Check

Have your say in a no risk way

LiA Pulse Check Results – Executive Report

Listening into Action

Maidstone and Tunbridge Wells NHS Trust

Executive Summary – headlines and recommendations

1. This report is pitched at three levels: Trust Board, Executive Management Team, and local specialty directors/managers. Each group will be able to interpret, assimilate, address and action different aspects of the most comprehensive analysis of how staff and leaders feel ever done in the NHS

2. The Pulse Check had 1368 responses over three weeks which is 26% of the total workforce of 5269. This is relatively low compared with a response rate of up to 66% in other Trusts. The Exec Team should reflect on this, and start to plan a campaign for next year to generate much higher response rates based on highly visible actions and changes

3. A small number of staff (14) reported a 'missing specialty': all were personally redirected from 'job role' level to the appropriate category

4. In the Pulse Check, 6 out of 15 questions scored around or under 30% positive responses, with 9 out of 15 questions scoring under 50% positive responses. This constitutes tremendous opportunity for improvement

5. The good news is that the lowest scoring questions relate to issues that are relatively easy to fix with the right commitment from the right people. Each area has a clear accountable Executive 'whose job it is to fix this', and addressing these lag results should be part of their annual PDR:

    - Q4 Day-to-day frustrations (22%)
    - Q5 Communicating priorities and goals (35%)
    - Q10 Communications between senior management and staff (27%)
    - Q13 Structures and processes support staff (31%)
    - Q14 Systems and facilities support staff (29%)
    - Q15 Organisation support me to grow (27%)

LiA Pulse Check
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Listening into Action

Maidstone and Tunbridge Wells NHS Trust

Executive Summary – headlines and recommendations

6. The detailed LiA Pulse Check results show 35 Specialties with 8 or more responses. This is a good number. 20 further specialties had less responses and are, therefore, not reported in detail to protect anonymity, raising questions for local leaders/managers about response levels in their areas and an opportunity to improve this next year

7. Of the 35 specialties reported against the CQC 5 domains of Safe, Effective, Caring, Responsive, and Well-led, one is rated by staff as 'Outstanding' (Sexual Health and Reproductive (including GUM)). This team leader should be commended and involved in the transfer of good ideas to other areas

8. 8 specialties are rated by staff as 'Good', 16 as 'Requires Improvement', and 10 as 'Inadequate'. Of those rated 'Inadequate', 7 are rated as such across three or more of the CQC 5 domains: Ear, Nose and Throat (ENT), Maternity/Midwifery, Obstetrics and Gynaecology, Occupational Health, Pharmacy, Physiotherapy, Rheumatology

9. On the CQC domains 'heat map by role', all staff except Allied Health Professionals rate the Trust as 'Good' for Safe, with Medical/Dental and Support Services rating it 'Inadequate' for Responsive

10. The Leadership Audit had 121 responses over two weeks – a good response rate given the challenging context. This achieved the 'minimum of 100' requirement, but it is important to review how many did not respond and to shift this to 100% response rate for next year as part of the quest for all leaders to be fully involved

11. The Leadership Audit results show leaders 'self-assessing' themselves and the leadership culture positively in 11 out of 20 questions. The biggest issues are around: coherence of clinical improvement initiatives; seeking out what does and does not work for staff; eliminating 'non-value added' activities; addressing issues and challenges raised by leaders/staff; prioritising the important over the urgent; systems that enable staff to do their jobs well

LiA Pulse Check
Have your say in a no risk way

Listening into Action

Maidstone and Tunbridge Wells NHS Trust

Executive Summary – headlines and recommendations

12. Staff and leaders' views of how the Trust is faring against the CQC 5 domains aligns closely with the last CQC inspection in February 2015, although the CQC rated the Trust 'Inadequate' for Well-led. The way the leadership team responds to the 'best ever' insight in this report presents a great opportunity to show a turnaround on this front

13. Detailed feedback/free text from staff is provided by specialty (in alphabetical order) for you and local leaders to act upon. Your Trust received around 1600 ideas and comments. Each leadership group has a clear summary of how staff feel around the CQC 5 domains, along with a list of 'raw data' feedback from staff on issues and ideas for action. It is time to increase the responsibility and accountability of local specialty leaders to make changes that are 'within their gift', give teams 'permission to act' on their ideas, and routinely engage and empower staff to tackle issues and opportunities together over the next 12 months. The 2018 like-for-like results will be seminal in knowing who has succeeded at this

14. More detailed results from the Pulse Check and Leadership Audit are available at additional cost if required

15. Insight from the Pulse Check and Leadership Audit constitutes a 'dial shifter' in response to Francis and the national quest for high quality, safe and affordable care. It should be used as a 'call to arms' for all leaders, providing unprecedented insight about what needs to change and ideas from staff about how to make it happen. All of these results should be used by the Trust leadership to drive detailed annual planning; prepare for and respond to CQC inspections alongside required 'self-assessments'; engage leaders and managers at all levels; and, underpin a 'permission to act' culture

LiA Pulse Check
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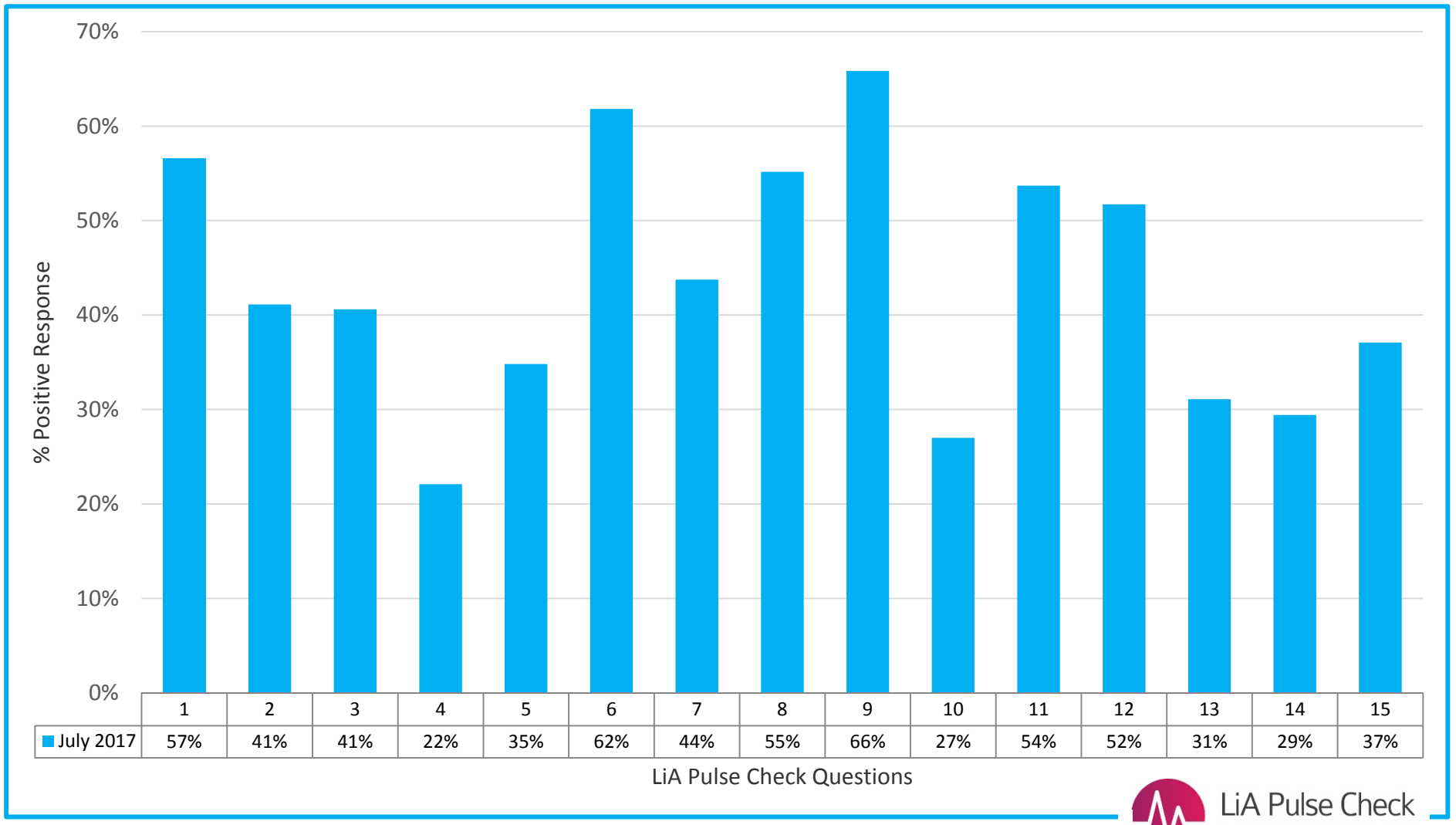
Listening into Action

Maidstone and Tunbridge Wells NHS Trust

Trust-wide results – based on 1368 responses – July 2017



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
July 2017	57%	41%	41%	22%	35%	62%	44%	55%	66%	27%	54%	52%	31%	29%	37%

LiA Pulse Check
Have your say in a no risk way

Listening into Action

Maidstone and Tunbridge Wells NHS Trust

Trust-wide results – based on 1368 responses – July 2017

57% 1. I feel happy and supported working in my team/department/service	62% 6. I believe we are providing high quality services to our patients/service users	54% 11. I feel that the quality and safety of patient care is our organisation's top priority
41% 2. Our organisational culture encourages me to contribute to changes that affect my team/department/service	44% 7. I feel valued for the contribution I make and the work I do	52% 12. I feel able to prioritise patient care over other work
41% 3. Managers and leaders seek my views about how we can improve our services	55% 8. I would recommend our Trust to my family and friends	31% 13. Our organisational structures and processes support and enable me to do my job well
22% 4. Day-to-day issues and frustrations that get in our way are quickly identified and resolved	66% 9. I understand how my role contributes to the wider organisational vision	29% 14. Our work environment, facilities and systems enable me to do my job well
35% 5. I feel that our organisation communicates clearly with staff about its priorities and goals	27% 10. Communication between senior management and staff is effective	37% 15. This organisation supports me to develop and grow in my role

LiA Pulse Check
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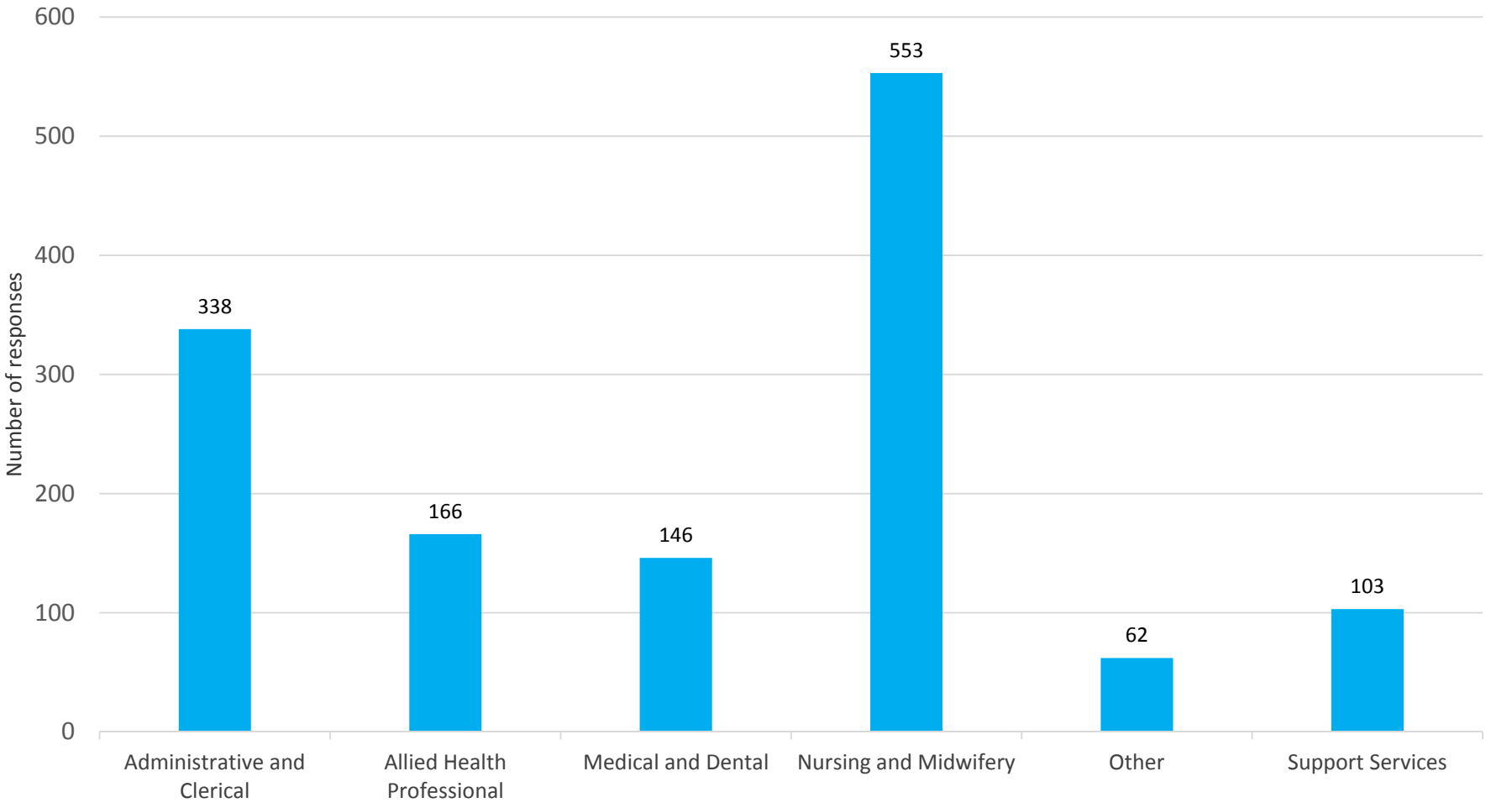
Listening into Action

Maidstone and Tunbridge Wells NHS
NHS Trust

Response levels by role



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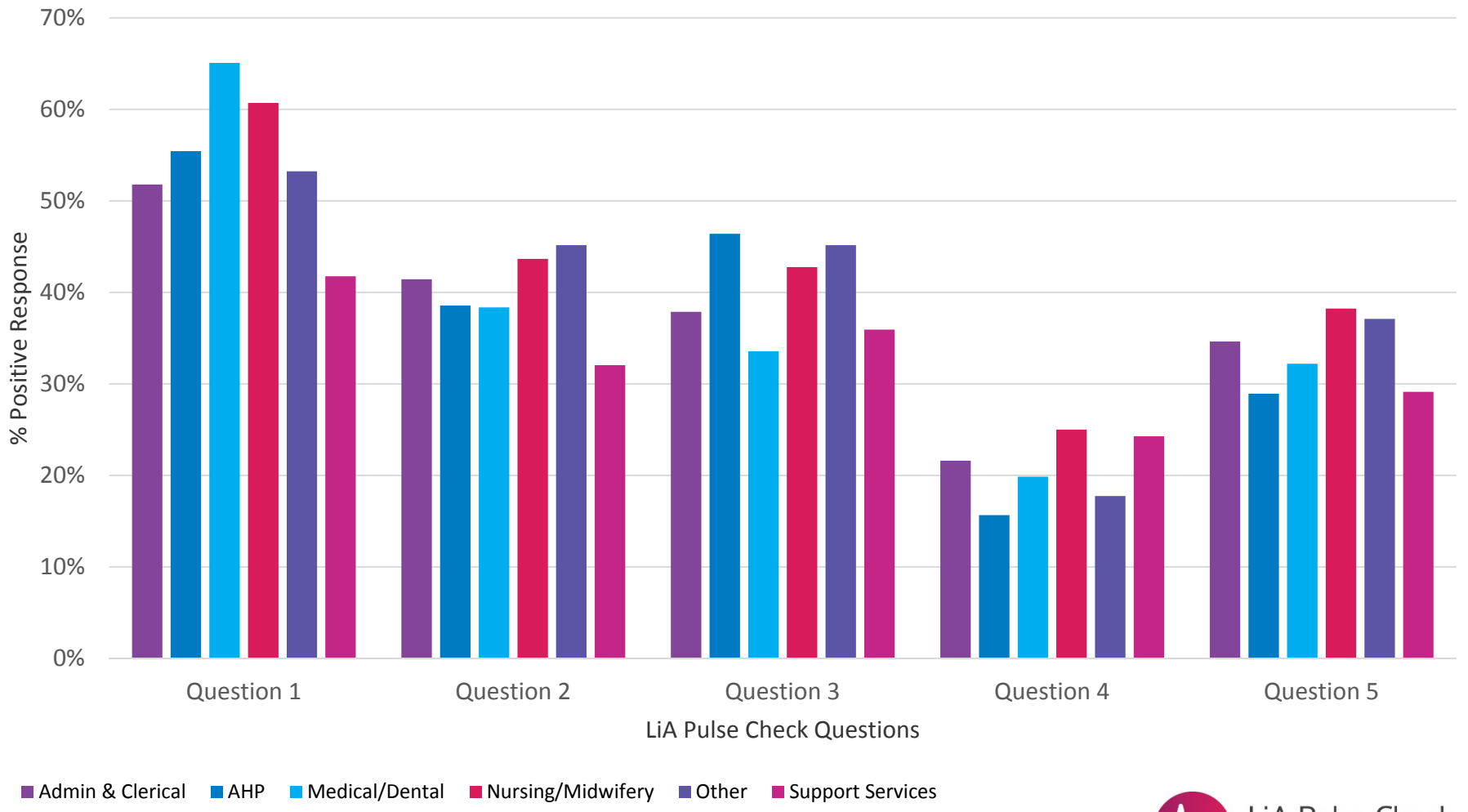
Listening into Action

Maidstone and Tunbridge Wells NHS
NHS Trust

Results by role (Questions 1-5)



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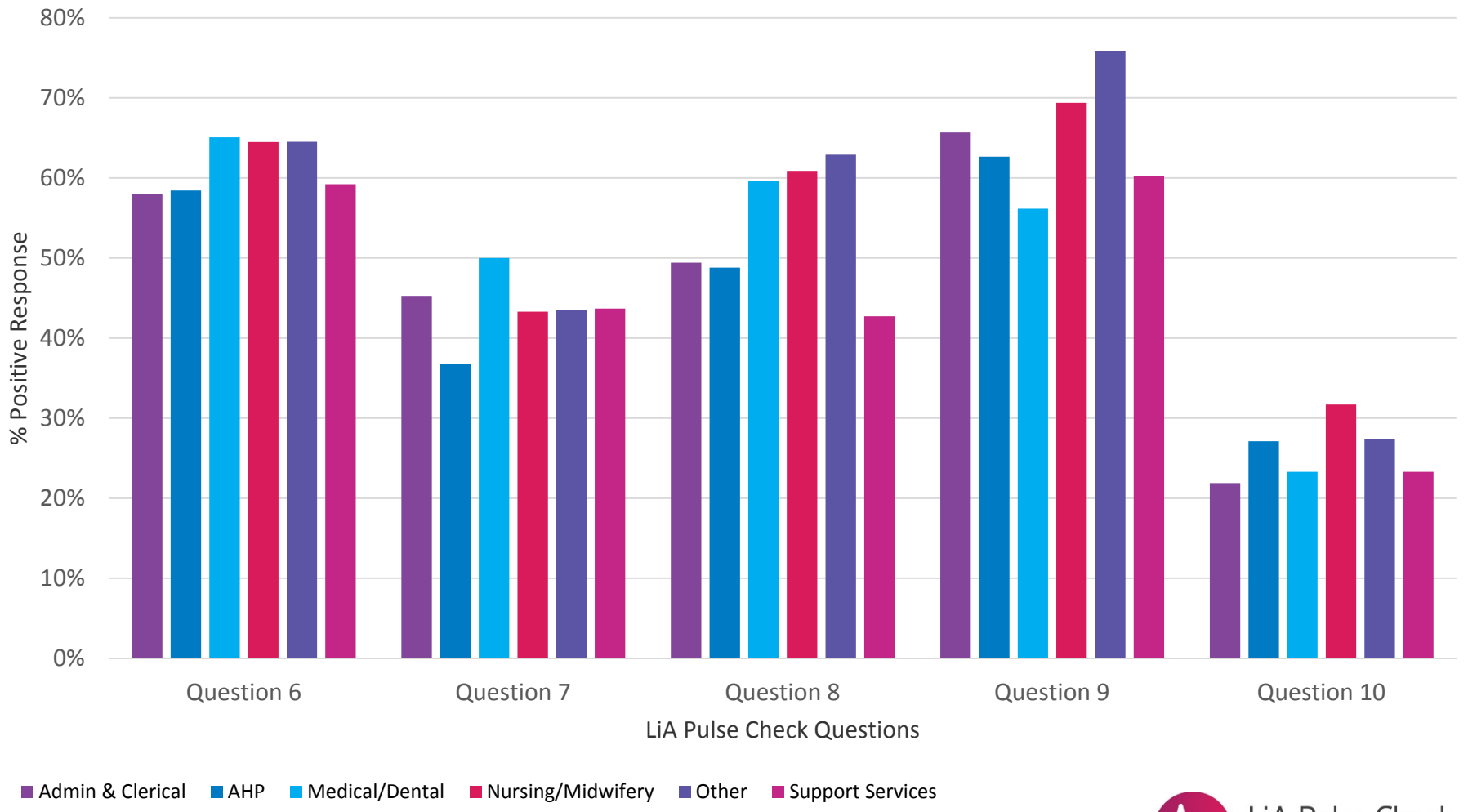
Listening into Action

Maidstone and Tunbridge Wells NHS Trust

Results by role (Questions 6-10)



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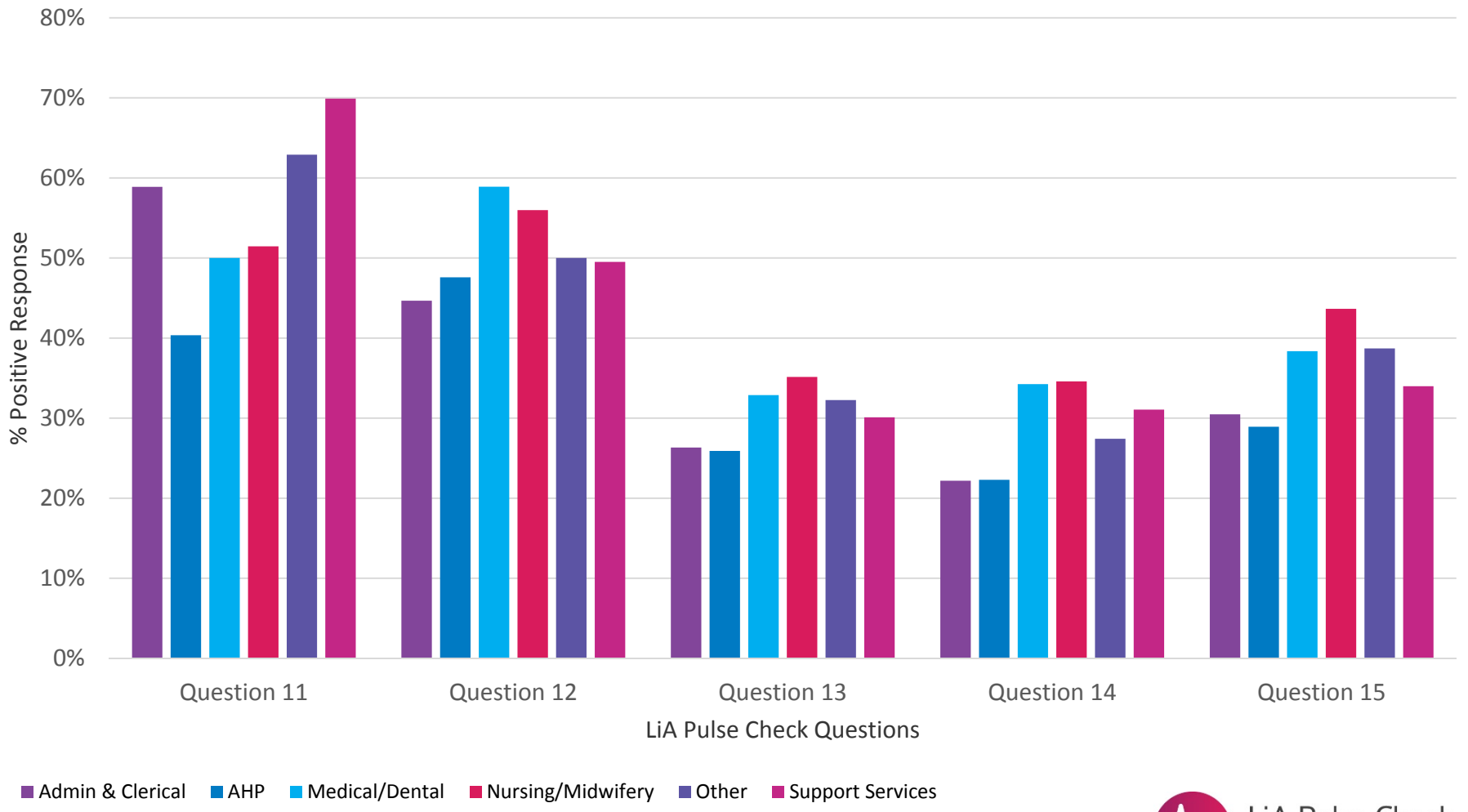
Listening into Action

Maidstone and Tunbridge Wells NHS Trust

Results by role (Questions 11-15)



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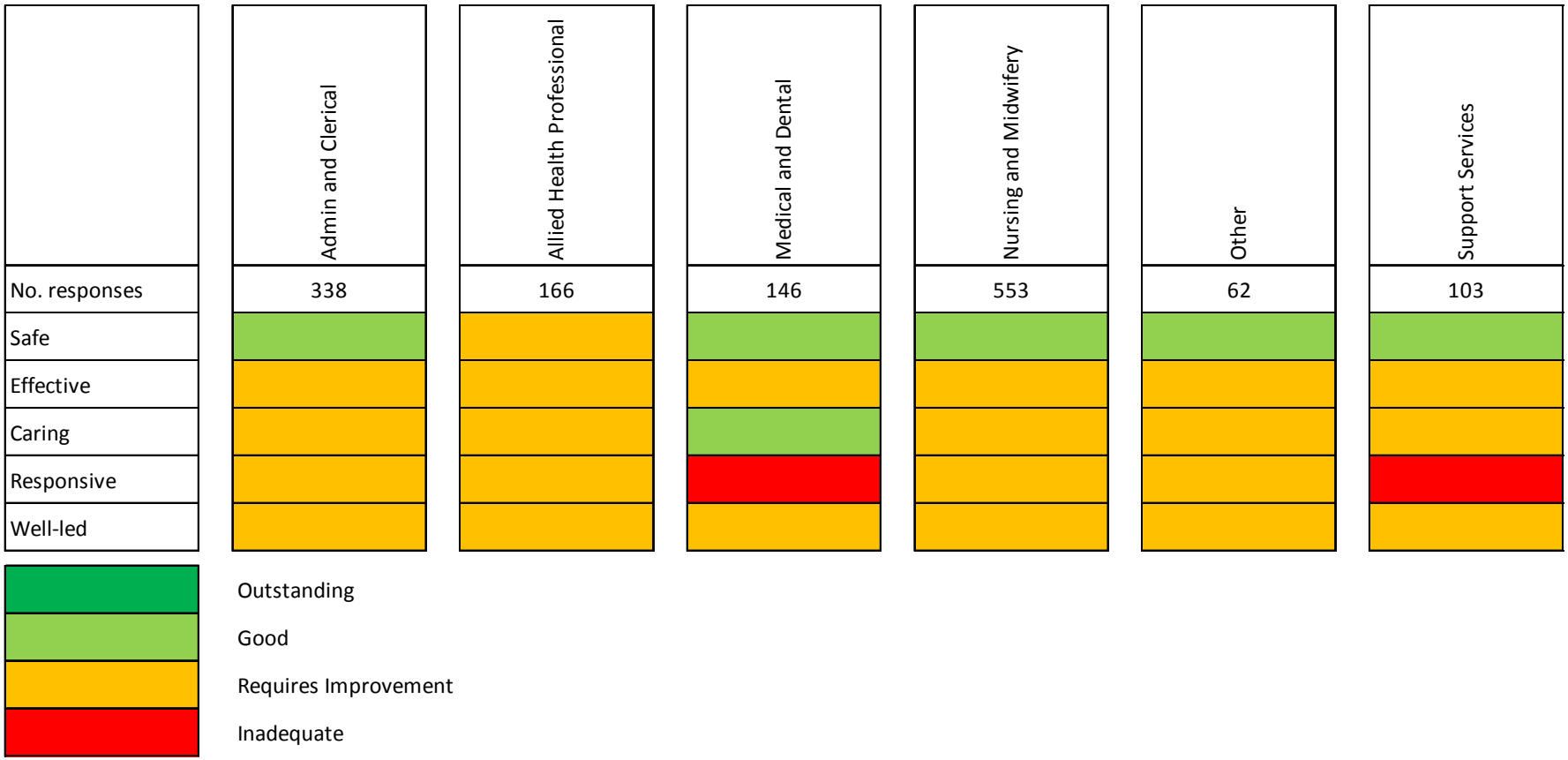
Listening into Action

Maidstone and Tunbridge Wells NHS Trust

CQC 5 domains 'heat map' by role



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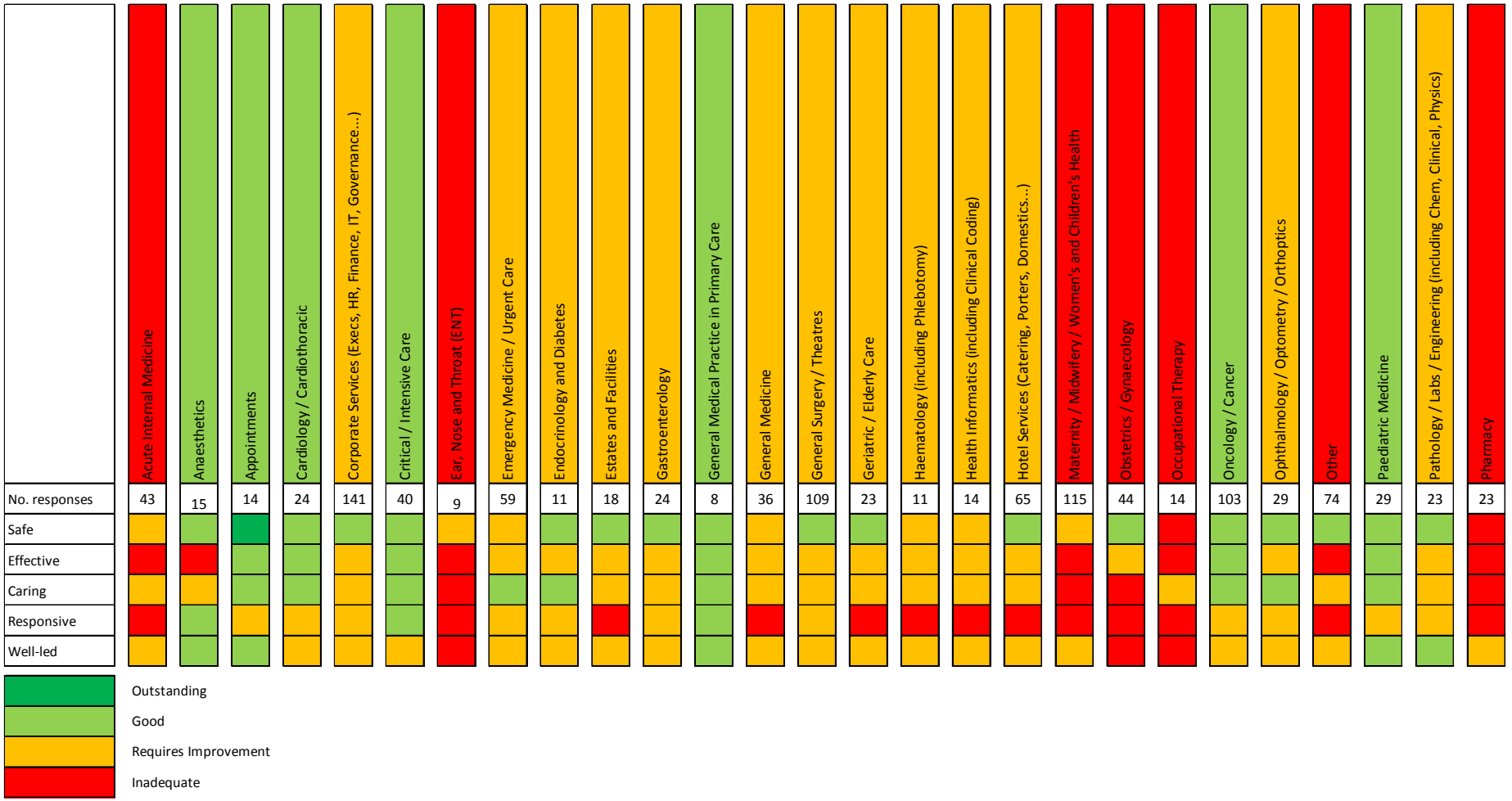
Listening into Action

Maidstone and Tunbridge Wells NHS Trust

CQC 5 domains 'heat map' by specialty (1/2)

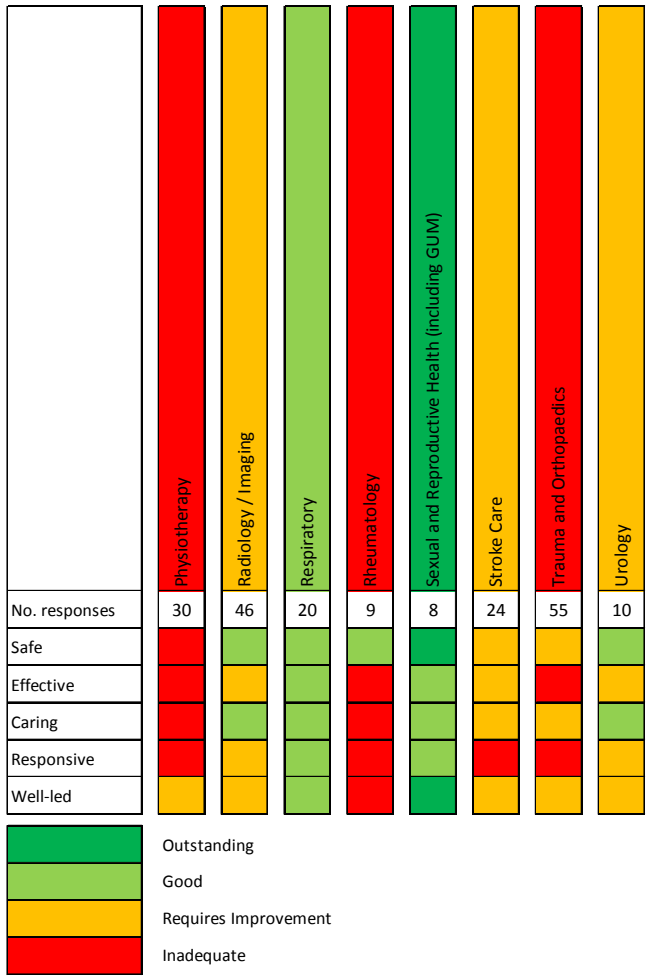


LiA Pulse Check
Have your say in a no risk way

Listening into Action

Maidstone and Tunbridge Wells NHS Trust

CQC 5 domains 'heat map' by specialty (2/2)



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Listening into Action

Maidstone and Tunbridge Wells NHS
NHS Trust

15 questions – % scores by specialty

	Pulse Check Question	Acute Internal Medicine	Anaesthetics	Appointments	Cardiology / Cardiothoracic	Corporate Services (Execs, HR, Finance, IT, Governance…)	Critical / Intensive Care	Ear, Nose and Throat (ENT)	Emergency Medicine / Urgent Care	Endocrinology and Diabetes	Estates and Facilities	Gastroenterology	General Medical Practice in Primary Care	General Medicine	General Surgery / Theatres	Geriatric / Elderly Care	Haematology (including Phlebotomy)	Health Informatics (including Clinical Coding)	Hotel Services (Catering, Porters, Domestics…)	Maternity / Midwifery / Women's and Children's Health	Obstetrics / Gynaecology	Occupational Therapy	Oncology / Cancer	Ophthalmology / Optometry / Orthoptics	Other	Paediatric Medicine	Pathology / Laboratories / Engineering (including Chemical, Clinical, Physics)	Pharmacy	Physiotherapy	Radiology / Imaging	Respiratory	Rheumatology	Sexual and Reproductive Health (including GUM)	Stroke Care	Trauma and Orthopaedics	Urology
	Number of staff responding	43	15	14	24	141	40	9	59	11	18	24	8	36	109	23	11	14	65	115	44	14	103	29	74	29	23	23	30	46	20	9	8	24	55	10
1	I feel happy and supported working in my team/department/service	58%	73%	57%	71%	62%	80%	44%	61%	55%	56%	54%	88%	53%	59%	52%	45%	43%	34%	42%	39%	64%	64%	59%	53%	66%	65%	43%	50%	72%	75%	44%	75%	54%	49%	70%
2	Our organisational culture encourages me to contribute to changes that affect my team/department/service	40%	33%	43%	54%	50%	63%	11%	49%	55%	44%	46%	75%	36%	37%	26%	18%	21%	31%	34%	25%	36%	50%	52%	35%	48%	61%	35%	27%	37%	70%	11%	50%	33%	25%	50%
3	Managers and leaders seek my views about how we can improve our services	28%	33%	50%	42%	48%	70%	22%	41%	45%	39%	33%	50%	25%	44%	17%	36%	36%	29%	27%	18%	36%	50%	48%	41%	41%	48%	39%	43%	57%	65%	22%	88%	33%	31%	50%
4	Day-to-day issues and frustrations that get in our way are quickly identified and resolved	19%	7%	50%	33%	19%	20%	22%	25%	18%	17%	38%	75%	33%	24%	22%	9%	7%	25%	11%	7%	7%	29%	28%	16%	31%	22%	9%	20%	17%	40%	0%	63%	29%	11%	30%
5	I feel that our organisation communicates clearly with staff about its priorities and goals	26%	20%	57%	50%	40%	33%	44%	37%	27%	39%	29%	50%	42%	32%	35%	36%	50%	25%	25%	18%	7%	41%	41%	32%	48%	39%	26%	30%	33%	45%	33%	88%	29%	33%	50%
6	I believe we are providing high quality services to our patients/service users	42%	60%	79%	75%	69%	68%	56%	56%	55%	50%	67%	63%	50%	61%	57%	82%	64%	57%	56%	59%	36%	79%	72%	51%	72%	70%	57%	17%	83%	65%	78%	100%	63%	49%	70%
7	I feel valued for the contribution I make and the work I do	33%	47%	57%	46%	50%	50%	33%	46%	55%	50%	50%	50%	44%	47%	52%	27%	43%	42%	32%	30%	21%	54%	59%	35%	55%	43%	26%	13%	65%	60%	22%	63%	29%	35%	60%
8	I would recommend our organisation to my family and friends	56%	60%	71%	58%	55%	68%	44%	39%	55%	56%	58%	63%	53%	60%	48%	36%	50%	37%	57%	43%	29%	69%	79%	50%	69%	57%	39%	20%	67%	65%	67%	75%	54%	47%	70%
9	I understand how my role contributes to the wider organisational vision	72%	67%	71%	63%	74%	75%	44%	66%	82%	67%	58%	50%	67%	68%	65%	36%	64%	60%	64%	43%	71%	68%	72%	61%	69%	78%	52%	50%	72%	75%	33%	88%	63%	60%	70%
10	Communication between senior management and staff is effective	19%	7%	57%	21%	24%	38%	11%	32%	18%	22%	29%	63%	42%	31%	43%	36%	29%	18%	12%	14%	14%	32%	31%	14%	41%	39%	35%	23%	33%	40%	0%	88%	29%	18%	30%
11	I feel that the quality and safety of patient care is our organisation\'s top priority	49%	60%	71%	67%	70%	43%	44%	49%	64%	78%	50%	63%	47%	50%	57%	55%	71%	65%	42%	50%	7%	60%	59%	61%	62%	61%	35%	13%	57%	65%	44%	75%	42%	36%	60%
12	I feel able to prioritise patient care over other work	35%	67%	71%	79%	43%	58%	33%	59%	73%	44%	50%	50%	47%	59%	61%	27%	14%	51%	40%	59%	64%	64%	55%	46%	62%	52%	26%	33%	65%	70%	44%	75%	50%	45%	70%
13	Our organisational structures and processes support and enable me to do my job well	23%	13%	57%	46%	28%	45%	11%	39%	45%	33%	38%	63%	36%	38%	35%	18%	29%	31%	17%	20%	7%	48%	34%	19%	34%	48%	17%	17%	33%	50%	22%	38%	33%	22%	30%
14	Our work environment, facilities and systems enable me to do my job well	21%	13%	57%	50%	28%	45%	0%	31%	36%	28%	46%	75%	36%	36%	26%	36%	14%	28%	23%	25%	14%	35%	21%	23%	48%	22%	13%	13%	26%	40%	0%	50%	29%	24%	40%
15	This organisation supports me to develop and grow in my role	35%	27%	57%	46%	38%	55%	22%	47%	55%	39%	38%	63%	33%	44%	26%	36%	21%	34%	25%	23%	21%	44%	41%	38%	52%	35%	17%	17%	35%	60%	11%	38%	33%	35%	50%

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Listening into Action

Maidstone and Tunbridge Wells NHS Trust

Ideas for action from your staff by specialty (raw data sent separately)

2600

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Listening into Action

Maidstone and Tunbridge Wells NHS Trust

LiA Leadership Audit – based on 121 responses – July 2017

1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree

		1	2	3	4	5	Total
1	Staff are clear on what is expected of them and how they contribute to our goals						3.5
2	Staff know who senior leaders are and leaders are visible across the organisation day-to-day						3.0
3	Leaders are role-models for staff in the way they manage/lead, and foster a positive work environment						3.5
4	Our clinical improvement initiatives are focused, joined up, and delivering effective change						2.9
5	Organisational structures and processes are designed to help us deliver our clinical goals						3.0
6	Our organisation is proactive at seeking out what works and does not work for staff, and acting on it						2.7
7	Quality and safety of patient care is prioritised over other operational and organisational imperatives						3.2
8	Organisational processes are designed to eliminate 'non-value added' activities						2.7
9	Teamwork and sharing is an integral part of how we work and operate at our Trust						3.4
10	Performance measurement systems for assessing staff contribution is fair, timely, effective and appropriate						3.1
11	Issues and challenges raised by leaders/staff are readily addressed and resolved						2.9
12	Organisational structures give clear accountability/responsibility to all staff at all levels						3.5
13	Staff at all levels are supported and encouraged to develop their skills, abilities and career opportunities						3.4
14	Leaders and staff are clear on our vision, goals and objectives						3.3
15	What is important is prioritised over what is urgent						2.7
16	Staff are enabled, empowered and encouraged to take responsibility for what they do to help patients						3.4
17	Management systems support and enable staff to do their jobs well						2.8
18	Staff receive - and are able to give - feedback and input through effective communication channels						3.3
19	Leaders foster a culture of collaboration and contribution - not 'command and control'						3.0
20	Information to aid decision making is available where and when we need it						3.1

LiA Pulse Check
Have your say in a no risk way

Listening into Action

Maidstone and Tunbridge Wells NHS Trust

CQC 5 domain triangulated results (CQC, staff, leaders)

	CQC Rating February 2015	Organisation-wide Pulse Check	Leadership Audit
No. responses	n/a	1368	121
Safe			
Effective			
Caring			
Responsive			
Well-led			

Outstanding

Good

Requires Improvement

Inadequate

LiA Pulse Check
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Trust Board Meeting – September 2017

NHS Maidstone and Tunbridge Wells NHS Trust

9-10 Board Assurance Framework (BAF) 2017/18 — Trust Secretary

The management of the Board Assurance Framework (BAF) and link with the Risk Register

The BAF is the document through which the Trust Board identifies the principal risks to the Trust meeting its agreed objectives, & to ensure adequate controls & measures are in place to manage those risks. The ultimate aim of the BAF is to help ensure that the objectives agreed by the Board are met. The BAF is managed by the Trust Secretary, who liaises with each "Responsible Director" to ensure it is updated through the year. The BAF differs from the Risk Register as the BAF only contains the risks posing a direct threat to the achievement of the Trust's objectives.

Additional aspects relating to the Risk Register

The last annual Internal Audit review of the Assurance Framework and Risk Register recommended that a summary of the status of the Risk Register be include in the BAF reports received at Board meetings. This summary is enclosed in Appendix 1. In addition, it was agreed at the Audit and Governance Committee in February 2017 that the substance of all 'red' rated risks in the Risk Register should be accounted for in the BAF, or where this is not the case, that the risk is identified for separate further consideration by the appropriate forum. Having reviewed the current list of red risks (Appendix 1), it is considered that the substance of each are either accounted for in the BAF or are being considered by an appropriate forum. Further details supporting this conclusion are contained in Appendix 1, but the Board is obviously free to challenge this.

Key objectives for 2017/18, and summary of year-to-date position

The key objectives in the 2017/18 BAF were approved at the Board on 26/04/17 (objectives 1-5) and 19/07/17 (objective 6). The latest rating of the 6 objectives in terms of the Responsible Director's confidence that it will be achieved by the year-end is as follows:

Objective	Confidence[1]
1. To reduce mortality (HSMR) in line with the national average	Green
2. To deliver the agreed 2017/18 trajectory for the A&E 4 hour waiting time target	Amber
3. To maintain a vacancy rate of no more than 8.5%	Amber
4. To deliver the control total for 2017/18 (of a pre-STF deficit of no more £4.5m, or otherwise agreed by NHS Improvement)	Amber
5. To deliver the agreed 2017/18 trajectory for the 62-day Cancer waiting time target	Amber
6. To deliver the agreed Referral to Treatment (RTT) trajectory for patients on an 'incomplete' pathway	Amber

Review by the Trust Board

This is the second time during 2017/18 that the Board has seen the populated BAF. Board members are asked to review and critique the content, by considering the following prompts:

- Are the key objectives appropriately described? Should the wording of any be amended?
- Do the RAG ratings of confidence that the objective will be achieved reflect the situation as understood by the Board (and its sub-committees)?
- Is the Board assured that actions reported as being undertaken are satisfactorily evidenced?
- Does any of the content require further explanation?
- Does the format of the BAF need to be amended?

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

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

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Review and discussion

[1] This is the confidence of the Responsible Director that the objective will be achieved by the end of 2017/18

[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

Board Assurance Framework 2017/18

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective)[3] *Key objective*

1 To reduce mortality (HSMR) in line with the national average

Relevant CQC domain/s: Safe ☒ Effective ☒ Caring ☒ Responsive ☐ Well-led ☒

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

1. If the issue is not afforded appropriate priority
2. If there is insufficient analytical support to understand the data
3. If there is failure to follow best practice in response
4. If there is lack of ownership by Clinical Directorates

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. The issue has a high profile at the Trust Board and Quality Committee, and the response has been led by the Medical Director. One of the new Deputy Medical Directors will also be asked to take the lead on this (although responsibility will remain with the Medical Director) (1)
b. The Assistant Director of Business Intelligence is directly involved in the analysis to understand the situation, & there is close liaison with Dr Foster (2)
c. The Trust is following the investigation pathway recommended by Dr Foster (i.e. checking coding, casemix, structure, process, individuals & teams) (3)
d. The Clinical Coding department restructure is underway, which is expected to result in improvements via closer working between clinical staff and Clinical Coders (3)
e. The Trust is adapting its process of detailed Mortality Reviews to comply with the latest guidance/recommendations from the National Quality Board (as is expected by NHS Improvement) (3)
f. Of the 4 'red flags' previously identified by Dr Foster (Congestive Heart Failure, #NOF, Pneumonia and Non-Hodgkin's lymphoma), a 'deep dive' review has been undertaken into Orthopaedics, and the review of pneumonia is at its mid-point. The reviews of the other areas are in development (4)

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

1. Written reports to the 'main' Quality Committee (May and July 2017) and Quality Committee 'deep dive' meeting (Jan, Feb & June 2017)
2. Monthly verbal reports to the Trust Board (Feb 2017 onwards)
3. Monthly Performance Dashboard reports to Trust Board (which reports the latest HSMR)

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

If "No", what other data is needed?

1. N/A

Risk owner/s:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Medical Director	Medical Director	Trust Clinical Governance Committee / Quality Committee / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2017/18?[4]

July 2017	September 2017	November 2017	February 2018
☐ ☒ ☐	☒ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The latest available 12-month rolling average HSMR is 103.8 (the baseline/expected rate is 100), which is rated as 'green', and the 1-month HSMR for May 2017 is 91.5 (N.B. Board members should note that the HSMR figure reported within the month 4 Trust Performance Dashboard (of 109.5) relates to the position at that point in time)

[3] In July 2016, the Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (a 'litmus test') for broader performance. The Board approved the key objectives for 2017/18 on 26/04 & 19/07/17. This objective is intended to manage the broad risk that "The Trust fails to improve key aspects of clinical care and safety"

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

Board Assurance Framework 2017/18

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective)[5] *Key objective*

2 To deliver the agreed 2017/18 trajectory for the A&E 4 hour waiting time target

Relevant CQC domain/s: Safe ☐ Effective ☒ Caring ☐ Responsive ☐ Well-led ☒

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

1. The capacity required to deliver the 'new norm' for non-elective activity being insufficient
2. A&E attendances continuing to remain higher than plan
3. Bed occupancy remaining above 92%
4. The level of Delayed Transfers of Care (DTOCs) remaining higher than the expected standard
5. The Trust failed to adopt and/or implement the latest best practice in relation to patient streaming and other aspects
6. The identified Social Care changes that create capacity failing to materialise

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. Demand and capacity planning for 2017/18 (including winter resilience planning) is based on the new normal for non-elective activity using the parameters of attendances, admissions, age-profile and reason for admission as basis for planning (1)
b. The Directorate management team and the Information Department have agreed a set of monthly targets to facilitate how the required performed is monitored (the Trust must achieve 90% or above for Q1, Q2 & Q3, and then 95% in March 2018). Monthly targets are also in place (2)
c. The Trust's bid for £645k national funding has been agreed, to provide dedicated co-located areas for GP-led care (which will enable up to 20% of A&E patients to be seen more appropriately by GPs) (5)
d. The Chaucer Acute Frailty Unit (CAFU) opened at Maidstone Hospital in June 2017 (5)
e. There has been intensive focus by the Urgent Care management team on resolving capacity and flow issues affecting the non-elective patient pathways (4, 5)
f. The Trust is still seeking clarification as to the allocation and spending plan of the new social care funding, which has been added to the Better Care Funding (2, 5)

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

1. The monthly Trust Performance report (including the 'story of the month')

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

If "No", what other data is needed?

1. N/A

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Chief Operating Officer	Chief Operating Officer	Trust Management Executive / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2017/18?[6]

July 2017	September 2017	November 2017	February 2018
☐ ☒ ☐	☐ ☒ ☐	☐ ☐ ☐	☐ ☐ ☐

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The latest performance for the year to date (at month 4, is 90%). The month 4 performance was 93.3%. There remain a number of unpredictable factors that may affect performance

[5] In July 2016, the Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (a 'litmus test') for broader performance. The Board approved the key objectives for 2017/18 on 26/04 & 19/07/17. This objective is intended to manage the broad risk that "The Trust is unable to manage (either clinically or financially) during the winter period"

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

Board Assurance Framework 2017/18

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective)[7] *Key objective*

3 To maintain a vacancy rate of no more than 8.5%

Relevant CQC domain/s: Safe ☐ Effective ☒ Caring ☐ Responsive ☐ Well-led ☒

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

1. A national shortage of certain staff groups
2. If there was a lack of clarity/focus on the key actions required
3. If there was a lack of clarity over the performance required by each Directorate, and the monitoring of such performance
4. If there was inefficiency of recruitment processes
5. If there was a lack of urgency/commitment by recruiting managers
6. If there was uncertainty over the status of vacancies

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. The Trust Workforce Strategy 2015-20 and associated workplan ("Recruitment & Retention" is the first of 6 workforce priorities) (1, 2, 3)
b. The establishment of the Nurse Recruitment and Retention Group (Chaired by the Chief Nurse) (5)
c. Increased recruitment staffing resource (4)
d. Divisional New Ways of Working Task and Finish Groups (4, 5)
e. Establishments and workforce requirements have been reviewed as part of the Business Planning process for 2017/18 and 2018/19

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

1. The Trust Performance Dashboard, which contains the "Vacancy Rate (%)" (as well as "Vacancies WTE")
2. Reports to the Workforce Committee (which includes a commentary on the latest issues regarding the vacancy rate)
3. Directorate performance dashboards
4. The Chief Nurse's report to the October 2016 Trust Board regarding Nursing staffing levels (N.B. the next detailed review is scheduled for submission to the Trust Board in July 2017)
5. The monthly Planned and Actual Ward Staffing reports to the Trust Board (re the establishments)

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

If "No", what other data is needed?

1. N/A

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Director of Workforce	Director of Workforce	Trust Management Executive / Workforce Committee / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2017/18?[8]

July 2017	September 2017	November 2017	February 2018
☐ ☒ ☐	☐ ☒ ☐	☐ ☐ ☐	☐ ☐ ☐

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The vacancy rate for the year to date (at month 4, 2017/18) is 9.5%. The actions already in place will continue, but no additional actions are considered to be required at this stage

[7] In July 2016, the Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (a 'litmus test') for broader performance. The Board approved the key objectives for 2017/18 on 26/04 & 19/07/17. This objective is intended to manage the broad risk that "The Trust does not have the correct level of substantive workforce for effective delivery"

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

Board Assurance Framework 2017/18

What does the Trust want to achieve? (i.e. the key objective)[9] *Key objective*

4 To deliver the control total for 2017/18 (of a pre-STF deficit of no more £4.5m, or otherwise agreed by NHS Improvement)

Relevant CQC domain/s: Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well-led ☒

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

1. If there was a lack of senior leadership and commitment
2. If there were poor financial controls (or if good controls were poorly applied)
3. If there was a lack of commitment by managers
4. If the level of CIP has not been fully identified
5. If the CIP schemes were not rated 'green'
6. If the Trust's plans for 2017/18 had been developed without consideration of best practice elsewhere
7. If NHS Improvement (NHSI) did not accept the Trust's plans
8. If there was insufficient engagement with external stakeholders

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. The Executive has continued to mobilise the organisation since the Trust was put into Financial Special Measures (1)
b. The Trust has signed up to its control total, and submitted a plan to achieve this (1, 7)
c. Control targets have been set for each Directorate to reduce their cost run rate (2)
d. A number of 'Grip and Control' measures have been implemented to ensure delivery (2, 3)
e. The Performance Management Framework is now embedded (3)
f. The Plans were informed by the Phase 1 Financial Improvement Programme report from KPMG LLP and by guidance and advice from NHSI (including that from the Finance Improvement Director) (6, 7)
g. Action has been taken to engage with external stakeholders, including agreeing an aligned incentives contract with West Kent CCG for 2017/18 (8)
h. A series of fortnightly CIP progress meetings with each Division have been established (which will continue throughout 2017/18) (2, 4, 5)

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

1. Monthly financial performance reports to TME, Finance and Performance Committee and Board
2. Monthly detailed CIP report to the Finance and Performance Committee

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

If "No", what other data is needed?

1. N/A

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Director of Finance	Director of Finance	Finance and Performance Committee / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2017/18?[10]

July 2017	September 2017	November 2017	February 2018
☐ ☒ ☐	☐ ☒ ☐	☐ ☐ ☐	☐ ☐ ☐

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- The year to deficit (at month 4) was £3.7m, which is £1.3m adverse to the submitted plan. Year to date CIP delivery (at month 4) is £1.6m adverse to the submitted plan. The adverse CIP position is the primary driver behind the pressure on the Trust's financial performance, although good budgetary control has mitigated some of the slippage on delivery.

[9] In July 2016, the Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (a 'litmus test') for broader performance. The Board approved the key objectives for 2017/18 on 26/04 & 19/07/17. This objective is intended to manage the broad risk that "The Trust fails to demonstrate an ability to achieve future financial viability"

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

Board Assurance Framework 2017/18

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective)[11] *Key objective*

5 To deliver the agreed 2017/18 trajectory for the 62-day Cancer waiting time target[12]

Relevant CQC domain/s: Safe ☐ Effective ☒ Caring ☐ Responsive ☒ Well-led ☒

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

1. Insufficient engagement by clinical staff outside of the Cancer and Haematology Directorate
2. Pathways not being optimal in relation to achieving the required performance
3. Insufficient communication of the performance needed beyond Cancer & Haem. (only $^1/_3$ of delivery is within that Directorate's control – the remainder is within Diagnostics, Surgery & Medicine)

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. Cancer Summits, and Tumour Site-specific mini-Summits have been held (1, 2, 3)
b. The issues have been discussed in Governance meetings & the Cancer Clinical Board (1, 2, 3)
c. Action/Recovery Plans are in place for each of the tumour sites (1, 2, 3)
d. The weekly Cancer Patient tracking Lists (PTLs) meeting is being further revised to include administrative staff responsible for booking inpatient and outpatient appointments. This will enable real time changing of appointments and for dates to be pre-booked for patients when a next key event is known (e.g. likely for surgery).
e. Changes have been made to pathways, including Straight to test triage clinics for colorectal referrals (which is reducing the interval between referral and initial diagnostic and OP appointments for these patients and will eventually enable the number of breaches to be reduced) (2)
f. Individual Cancer pathway workshops are taking place, to focus on key issues in those specific areas (i.e. Breast, Lung, Colorectal) (2)
g. There has been improved engagement with all specialties, which has increased focus & accountability (1,3)
h. Improvements in administrative processes will enable better performance especially for Urology, such as the implementation of the Endoview reporting system in Tun. Wells (to reduce the number of letters dictated & appropriate patients to be removed earlier from the pathway) & the clinic outcome proforma (to reduce the number of letters dictated & to remove the patient earlier) (2)
i. The 'To come in' (TCI) form for surgery is being updated to provide a reminder to clinicians to record the data needed to apply waiting time adjustments where appropriate (2)
j. Oncology has implemented a new process to identify patients referred after day 38 where breaches can be avoided if the patient is treated within 24 days. Oncologists will reserve 1 new patient appointment per week & the process is being piloted to book the 24-day patients to these
k. A daily 'huddle' has been implemented for patients between day 40 & day 61, to expedite actions on their pathways (2)

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

1. The monthly Trust Performance report (including the 'story of the month')

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

If "No", what other data is needed?

1. N/A

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Chief Operating Officer	Chief Operating Officer	Trust Management Executive / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2017/18?[13]

July 2017	September 2017	November 2017	February 2018
☒ ☐ ☐	☐ ☒ ☐	☐ ☐ ☐	☐ ☐ ☐

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- At month 3, 2017/18, the "Cancer 62 day wait - First Definitive" performance (overall) for the quarter to date is 67.1%, but for MTW patients only is 75%. However, there has been a reduction in the backlog of patients waiting over 62 days. Performance will remain low while the backlog is addressed

[11] In July 2016, the Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (a 'litmus test') for broader performance. The Board approved the key objectives for 2017/18 on 26/04 & 19/07/17. This objective is intended to manage the broad risk that "The Trust fails to maintain and improve its reputation as a Cancer provider"

[12] The agreed trajectory performance (%) is as follows

Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total	Q1	Q2	Q3	Q4
72.6	74.4	78.6	79.5	81.8	85.2	85.3	83.8	85.4	85.6	85.1	86.3	82	75.3	82.1	84.9	85.7

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

Board Assurance Framework 2017/18

NHS Maidstone and Tunbridge Wells NHS Trust

What does the Trust want to achieve? (i.e. the key objective)[14] *Key objective*

6 To deliver the agreed Referral to Treatment (RTT) trajectory for patients on an 'incomplete' pathway"[15]

Relevant CQC domain/s: Safe ☐ Effective ☒ Caring ☐ Responsive ☒ Well-led ☒

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

1. An insufficient level of elective and outpatient activity being undertaken
2. Non-elective activity continuing at current levels (incl. A&E attendances)

What actions have been taken in response to the above issues? (number/s in bracket refers to points above) *Controls*

a. Close monitoring continues for the highest-risk non-complaint specialties (T&O, Gynaecology, and Cardiology) against action plans put in place to reduce their longest waiters
b. These specialities are trying to continue to reduce their backlogs by maximising available capacity across both hospital sites and focusing capacity on booking patients within the backlog to all available sessions, including Saturdays
c. Operational teams are focused on their recovery plans to increase elective activity and 2 RTT summits are being held with the specialties in September
d. The Trust has engaged a productivity company, Four Eyes Insight Ltd, to optimise theatre productivity and efficiency, to maximise the level of elective activity undertaken

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

1. The monthly Trust Performance report (including the 'story of the month')

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

If "No", what other data is needed?

1. N/A

Risk owner:	**Responsible Director:**	**Main committee/s responsible for oversight:**
Chief Operating Officer	Chief Operating Officer	Trust Management Executive / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2017/18?[16]

July 2017[17]	September 2017	November 2017	February 2018
☐	☒	☐	☐

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):

- At month 4, 2017/18, performance was 85.6%, compared to a plan/limit of 92%

[14] In July 2016, the Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (a 'litmus test') for broader performance. The Board approved the key objectives for 2017/18 on 26/04 & 19/07/17. This objective is intended to manage the broad risk that "The Trust fails to maintain and improve its reputation as a Cancer provider"

[15] An 'incomplete' pathway is where a referral has been received and the patient is still waiting for something, be that an Outpatient appointment, diagnostic test, elective admission etc. 92% of patients on an incomplete pathway should be waiting less than 18 weeks from receipt of referral.

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

[17] A rating for July 2017 was not applicable as this objective was not approved by the Trust Board until 19/07/17.

Appendix 1: Summary of the status of the Trust's Risk Register

At 31/08/17, there are:
- 21 ‘red’ rated risks
- 45 ‘amber’ rated risks
- 25 ‘green’ rated risks
- 0 ‘blue’ rated risks

The risk matrix and associated guidance has been included in Appendix 2, for reference.

Each risk has a designated “Manager” and is allocated a review date. The management of the Risk Register is overseen by the Trust’s Risk and Compliance Manager, who instigates formal reviews every 2 months. The full Risk Register is submitted to the Trust Management Executive (TME) and Audit and Governance Committee. Clinical Directorate-based ‘red’ rated risks are discussed as part of the report that Directorates give to the ‘main’ Quality Committee. It is also intended that all ‘red’ rated risks will be subjected to regular review at Executive Team meetings.

The issues covered by the current 21 ‘red’ rated risks will be familiar to the Trust Board and its sub-committees, as these have been previously discussed (some very regularly) at the Trust Board, Quality Committee, Finance and Performance Committee and/or Workforce Committee. These issues are as follows:
- High staffing, vacancies and turnover, particularly for Nursing staff (in the Acute and Emergency and Specialist Medicine Directorates)
- Ability to manage patient flow due to capacity and demand issues
- Achieving the Cancer waiting time targets
- The gaps in relation to Medical devices training and a trainer/coordinator
- The delivery of the annual financial plan
- The cost pressures associated with the use of temporary staff
- The lack of appropriate Medical cover on night shifts for the Paediatric unit
- The shortage of Paediatric Specialty and Associate Specialist (SAS) (‘middle grade’) doctors on day shifts for paediatrics
- Medicines and Healthcare products Regulatory Agency (MHRA) compliance regarding the traceability of blood products
- Blood sciences and Pharmacy staffing shortages
- The delivery of the Cost Improvement Programme (CIP) for the Urgent Care Division
- The management of outstanding open incidents in A&E
- Nursing staffing levels on Ward 30 and 31
- The governance arrangements for Point of Care testing
- Delays in reporting of diagnostic tests at East Kent Hospitals University NHS Foundation Trust
- Lack of Consultant Oncologists specialising in Head & Neck, Lymphoma and Skin Cancers
- Staffing levels in the Nutrition and Dietetic teams affecting service delivery

As was noted on the cover page of this report, it was agreed at the Audit and Governance Committee in February 2017 that the substance of all ‘red’ rated risks in the Risk Register should be accounted for in the Board Assurance Framework (BAF), or where this is not the case, that the risk is identified for separate further consideration by the appropriate forum. Having reviewed the ‘red’ rated risks listed above, it is considered that the substance of each are either accounted for in the BAF or are being considered by an appropriate forum.

Appendix 2: Risk grading matrix and associated guidance

Guidance on consequences / severity

Score / Consequence	CLINICAL OUTCOME / SAFETY	QUALITY	AGREED TARGETS	FINANCE, DAMAGE & LITIGATION	IMPACT ON TRUST - CORPORATE RISK
1 NEGLIGIBLE	No obvious harm Some distress Temporary loss of dignity	Minor non-compliance of standards	No obvious effect	<£2K	No obvious risk
2 MINOR	No-permanent harm Increased length of stay <7 days Minor psychological harm Injury requiring first aid Resolved in <1 Month <3 days work absence	Single failure to meet internal standards Failure to follow procedure or protocol	1% off planned Target Fail to meet national target for 1 quarter	£2K - £20K Litigation unlikely Complaint possible	Local adverse publicity for <1d Clinical service disrupted for <1 day
3 MODERATE	Semi-permanent harm Increased length of stay 7-15 days Increased level of care Injury requires medical attention Resolved within 1 year >3 days work absence	Repeated failures to meet internal standards Single failure to meet national or professional standards Repeated failure to follow procedures or protocols	2% - 4% off planned Target Fail to meet national target for 2 quarters.	£20 K - £1M Litigation possible Complaint received	Local adverse publicity for >1d Clinical service disrupted for >1 day Temporary interruption of clinical service
4 MAJOR / SEVERE	Major permanent harm Increased length of stay >15 days Permanent disability > 10 people affected Major psychological harm Injury requires hospital admission Over 1 year to resolve >10 days work absence	Repeated failure to meet national or professional standards Failure to meet NICE guidelines.	5% - 10% off planned Target Fail to meet national target for >2 quarters.	£1M - £5M Litigation certain Breach of legislation Incident reported to external Agency (SI declared, RIDDOR etc) HSE investigation	National adverse publicity for <1d Clinical service disrupted for >1 day Sustained interruption of clinical service MP concerns
5 CATASTROPHIC	DEATH Many people affected (e.g. cervical screening)	Gross failure to meet national or professional standards	>10% off planned Target Fail to meet national target for >2 quarters by more than 20%.	>£5M Class litigation Major breach of legislation HSE prosecution or prohibition notice	Major national adverse Publicity Public enquiry Loss of clinical service

Guidance on likelihood / probability

Score / likelihood	DEFINITION	TIME SCALE	OCCURRENCE
1 **HIGHLY UNLIKELY**	Cannot believe that circumstances exist now or ever.	Could occur once in a lifetime.	Control measures are in place and will prevent harm from arising. Control measures have been put in place to prevent situation arising again
2 **UNLIKELY**	There is a theoretical risk of the problem causing harm	Could re-occur every few years A single issue	Investigation has been completed and action plan has been developed. Resources are available and guaranteed Project is being managed and timescale is acceptable Proposed control measures will prevent situation arising again.
3 **POSSIBLE**	Risk of harm is considered to be 50/50	Could re-occur annually An occasional issue	Control measures are not followed or ineffective to prevent occurrence Resources are inadequate to prevent occurrence Not known if control measures are effective or adequate. Low confidence the project will be completed or time scale is un-acceptable
4 **LIKELY**	It is only a question of time before harm occurs.	Could re-occur monthly A common issue	Control measures are limited and/ or ineffective. Resources are not available when required. Near misses may be occurring occasionally
5 **CERTAIN**	The risk of harm is considered real and imminent	Certain to re-occur A persistent issue	Circumstances for occurrence exist. Existing practices and processes would not prevent incident from occurring. Near misses may be occurring routinely

Risk grading matrix

	CONSEQUENCE/ SEVERITY				
LIKELIHOOD / PROBABILITY	**None 1**	**Low 2**	**Moderate 3**	**Severe 4**	**Catastrophic 5**
Highly Unlikely 1	**Blue 1**	**Blue 2**	**Blue 3**	**Blue 4**	**Green 5**
Unlikely 2	**Blue 2**	**Blue 4**	**Green 6**	**Green 8**	**Amber 10**
Possible 3	**Blue 3**	**Green 6**	**Green 9**	**Amber 12**	**Red 15**
Likely 4	**Blue 4**	**Green 8**	**Amber 12**	**Red 16**	**Red 20**
Certain 5	**Green 5**	**Green 10**	**Amber 15**	**Red 20**	**Red 25**

Trust Board meeting – September 2017

Maidstone and Tunbridge Wells NHS Trust

9-11	**Integrated Performance Report, July 2017**	**Chief Executive / Members of the Executive Team**

The enclosed report includes:

- The 'story of the month' for July 2017 (including Emergency Performance (4 hour standard); Delayed Transfers of Care (DTOCs); Cancer 62 day First Definitive Treatment) and Referral to Treatment (RTT)
- A Quality and Safety Report
- A financial commentary
- A workforce commentary
- The Trust performance dashboard
- An explanation of the Statistical Process Control charts which are featured in the "Integrated performance charts" section
- Integrated performance charts
- The Board finance pack

Which Committees have reviewed the information prior to Board submission?

- Finance & Performance Committee (in part)

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

Review and discussion

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

The 'story of the month' for July 2017

1. 4 hour emergency standard

Performance for the Trust for July (calendar) rose again to 93.3% (including MIU), achieving the Trust recovery plan of 89.69%. 1617 came in at 87.1%. This year, we are required to achieve +90% per quarter and 95% in March 2018 and the improvement plan is based on achieving this target.

- A&E Attendances remain higher than last year but the activity is returning to the previous expected levels rather than the continuous growth that we have seen over the last 18 months.
- Non-Elective Activity (excluding Maternity) however remains considerably above plan and was 18.0% higher than plan for July at 4,124 discharges, and 11.7% higher than July last year.
- There were 1,147 bed-days lost (5.43% of occupied bed-days) due to delayed transfers of care.
- Non-elective LOS was 6.68 days for July discharges after spiking at 8.68 in Jan. Average occupied bed days dropped to 691 in July

The intensive focus on managing capacity and flow remains in place with daily oversight at senior management and clinical level on the front door pathways and especially on reducing length of stay on the wards. The urgent care division are working collaboratively with system partners to address and change longstanding issues affecting patient transfers and discharges. The most effective changes to date have been

- Increasing the level of senior doctor cover in the ED at specific times of the day .
- Additional doctors working in the AMU
- Twice daily board rounds on AMUs
- Frail Elderly Unit at Maidstone
- Focus on SAFER.
- Weekly review of the KPI dashboard to monitor improvements
- Daily breach analysis

2. Delayed Transfers of Care

The percentage of delayed transfers of care decreased from 6.24% in June to 5.43% in July, a continuing improvement during the month. The number of bed days lost decreased slightly from 1,296 in June to 1,145 in July. We have experienced a greater focus from external partners on the exit routes from the hospital and have now rolled out Pathway 1 &2 of the Home First initiative in full and the Frail Elderly unit at Maidstone operating effectively. Plans for the TWH Frailty Unit are on course for a mid-September implementation.

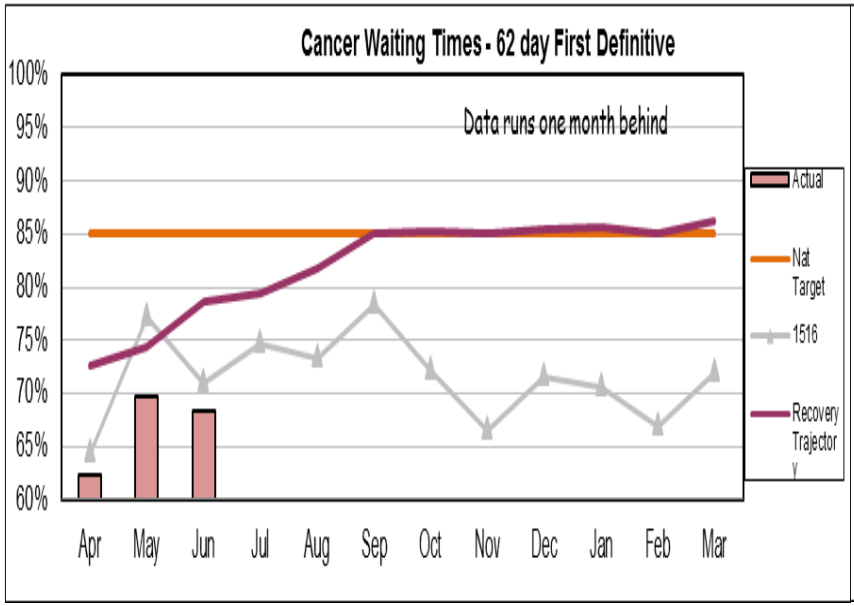
Row Labels	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
A : Awaiting Assessment	21	15	17	15	10	5	7	3	8	1	6	25	15	7	5	5	12	20	22	32	14	14	13	11	7
B : Awaiting Public Funding	1	4	8	7	3	1			1	1	1	8	12	25	21	5	3	6		4	3	1	3	3	3
C : Awaiting Further Non-Acute NHS Ca	48	33	30	20	6	3	8	15	18	17	13	11	10	8	10	14	6	23	8	13	16	17	21	27	11
Di : Awaiting Residential Home	27	28	26	22	16	21	15	15	27	32	20	37	21	33	43	34	19	21	30	24	35	21	8	16	16
Dii : Awaiting Nursing Home	90	57	52	56	40	73	53	80	73	58	67	65	67	69	83	69	63	112	78	77	76	57	70	94	53
E : Awaiting Care Package	16	27	17	32	26	43	28	36	36	28	24	39	41	41	76	58	51	89	49	30	38	35	39	43	27
F : Awaiting Community Adaptations	1		1	13	9	8	14	5	13	8	7	12	4	6	10	8	5	7	9	10	13	6	8	7	15
G : Patient or Family Choice	45	16	43	26	22	31	12	12	22	13	9	19	19	10	16	20	16	14	9	19	28	6	10	8	10
H : Disputes		1	3	1	1		1				3	1	1				1			1	1	1	1	2	
I : Housing	1		1	13	12	9	3	5	1			5	5	2	3	2	4	8	3	5	4	3	3	5	6
Grand Total	250	181	198	205	145	194	141	171	199	158	150	222	195	201	267	215	180	300	208	215	228	161	176	216	148
Trust delayed transfers of care	7.9%	7.1%	7.9%	6.6%	5.7%	6.0%	5.0%	5.8%	5.6%	5.5%	5.3%	6.2%	6.7%	6.7%	7.2%	7.9%	6.3%	8.1%	6.7%	7.1%	6.2%	5.6%	6.0%	6.1%	5.4%

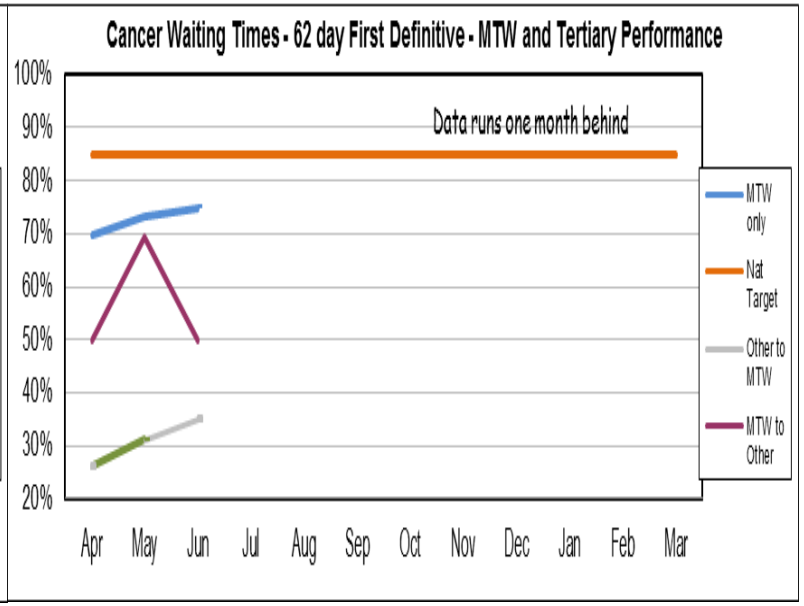
- There are 15+ patients being funded through the CCG commercial bed fund in private nursing homes, the vast majority of these are elderly patients with orthopaedic issues who are a waiting healing in order to regain function. This has significantly decreased in month due to patients coming to the end of their stay.
- Additional social care support has been allocated to the Maidstone Frailty Unit with start date in late August.
- Enablement capacity has been sufficient to meet the demand throughout the month.
- CHS (an external agency to locate and facilitate discharge to nursing homes and private POC within 5 days for privately funded patients) exceeded target in June, placing 24 patients against a target of 20.
- Senior staff from the integrated discharge team continue to lead the DTOC sign off meetings on Fridays with telephone attendance from the CCG, CHC and East Sussex leading to earlier identification of issues.
- Maidstone Borough Council presented plans to support discharge (using Disable Facility Grant) with a housing officer – this will mirror the scheme at Tunbridge Wells funded by TWBC, TMBC and Sevenoaks Councils.
- Good first month of activity using Pathway 1 and HILTON to support discharges.

3. Cancer 62 Day First Definitive Treatment

The 62 day performance in June has remained at a similar level to the previous month as the delivery plan is focused both on patients in the 40 -62 day category and those who have already breached to bring them in for treatment sooner to help reduce the backlog. Therefore the number of treatments has increased, the number of breached patients has reduced and the performance % has remained low. 132 treatments were completed in June with 109 of those being MTW only patients. Looking forward on the PTL the performance for MTW only patients starts to improve from August.

The key improvement initiative for the cancer services is the **daily huddle** where the focus is on the next event for individual patients (outpatient appt, test, result review, date for treatment) that is needed to pull them through the pathway, with any delays or blocks being actioned on the same day.





62 Day Performance - All Patients

Tumour	Total	Brch	%
Breast	20	2	90.0%
Lung	15.5	4.5	71.0%
Haemat.	5.5	1.5	72.7%
Upper GI	10	3	70.0%
Lower GI	20.5	9.5	53.7%
Skin	1.5	1.5	0.0%
Gynae.	20	4.5	77.5%
Urological	33.5	12	64.2%
Head & Nk.	2.5	1.5	40.0%
Sarcoma	1.5	1	33.3%
Other	1.5	0.5	66.7%
	132	**41.5**	**68.6%**

62 Day Performance - MTW Only

Tumour	Total	Brch	%
Breast	20	2	90.0%
Lung	9	0	100.0%
Haemat.	5	1	80.0%
Upper GI	7	1	85.7%
Lower GI	19	8	57.9%
Skin	1	1	0.0%
Gynae.	15	2	86.7%
Urological	30	10	66.7%
Head & Nk.	1	1	0.0%
Sarcoma	1	1	0.0%
Other	1	0	100.0%
	109	**27**	**75.2%**

In June, Urology has contributed the largest number of breaches overall. Lower GI contributed the second highest number of breaches. Lung breaches have significantly reduced compared to previous months, with no MTW only breaches.

MTW only patient performance in percentage terms continues to improve month on month. Breaches for lower GI in absolute numbers have remained high but this is balanced against significantly more treatments and this is due to backlog clearance.

4. Referral To Treatment – 18 weeks

July performance shows the Trust continues to forecast non-compliance with the Incomplete RTT standards at an aggregate level – 85.6%, with our trajectory requiring us to achieve 92% by the end of November 2017.

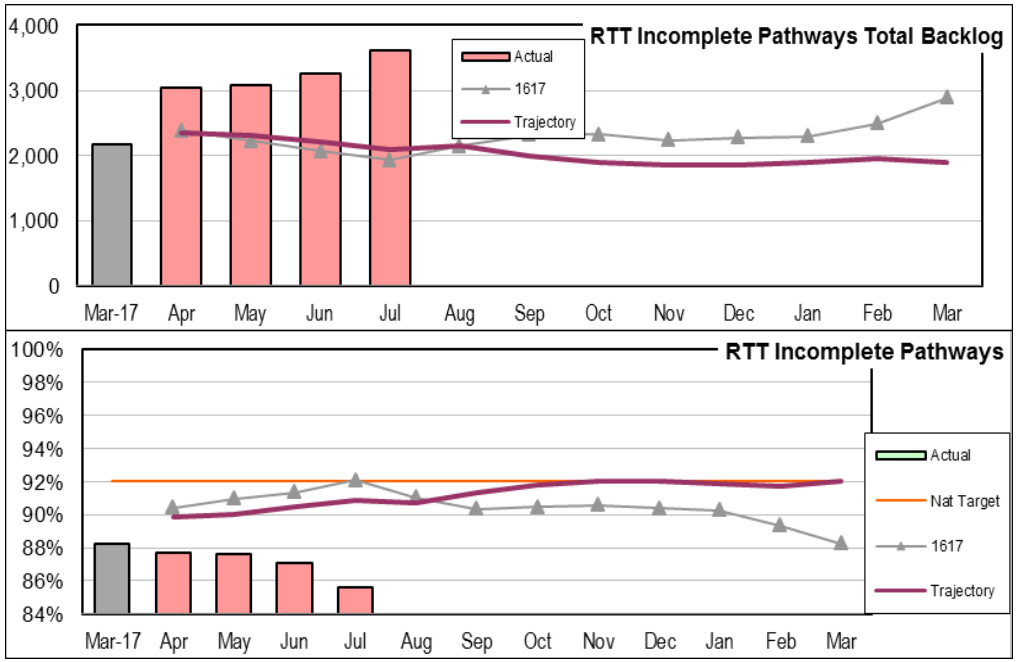
The Trust continues to be non-compliant at a speciality level for a number of specialties but T&O, Gynae, and cardiology present the most risk of underperforming against the November deadline, all of which are being carefully monitored against action plans put in place to reduce their longest waiters. All these specialities are trying to continue to reduce their backlogs by maximising available capacity across both sites and focusing capacity on booking patients within the backlog to all available sessions, including Saturdays.

	Jul-17	Jun-17 Trajectory	Variance from trajectory
RTT Backlog Incomplete	3,621	2,100	-1521
RTT Waiting List	25,217	23,053	-2067
RTT Incomplete performance %	85.6%	90.89%	-5.29

Operational teams are focused on their recovery plans to increase elective activity and we are holding 2 RTT summits with the specialties in September.

There were 152 operations cancelled on the day of which 30 were reportable.

- Improve overall theatre utilisation to increases levels of elective activity.
- Implement remedial actions to specialties furthest from trajectory - T&O, gynaecology, cardiology.
- Continue weekly PTL/RTT performance monitoring to maintain overall performance.



Quality and Safety

Mortality:

Standardised Mortality HSMR was recorded as 109.5 (red) for July, but has subsequently fallen to 103.5 (green).

Patient falls incidents:

There were 115 patient falls reported for July and a rate of 5.39 per 1000 bed days overall, which is a reduction compared to the same period last year. 77 falls (rate of 5.93) were at Tunbridge Wells and 38 (rate of 4.55) were at Maidstone. Of these incidents there were 6 serious incidents reported. Learning identified through recent investigation of serious incidents relating to falls includes the following actions:

- Patient at risk of falls to have risk assessment and falls prevention measures implemented promptly.
- Falls prevention care plan reviewed when patients condition changes (improve, deteriorate or on transfer).
- Assessment for enhanced care where appropriate in the management of patient at high risk of falls.
- Increase frequency of monitoring/ comfort checks of patient at risk of falls who has a decline in cognition.

Friends and Family test:

The response rates to the Friends and Family test have continued to remain largely stable, however there has been a reduction in the ED responses for the month with a total response rate of 11.3% which is below the Trust target of 15%. We are reviewing the results for July for ED as there is a considered view that some of the completed cards have not been included in the monthly figures. The monthly results are continued to be reviewed at the FFT project group and actions agreed for all areas where the results are below target. Some of the key headlines from our responses are as follows:

- Returns for July improved for Inpatients achieving above target. Maternity remains stable and above target for month.
- Positive scores remain at or above national benchmark for Inpatients, with Accident & Emergency well above the national benchmark. Maternity is below the national benchmark.
- FFT cards for Endoscopy under review to ensure appropriate links are made reduce duplication of data collection for GRS/JAG accreditation.

Complaints:

There were 50 new complaints reported for July, which equates to a rate of 2.34 new complaints per 1,000 occupied bed days.

68.8% of the complaints have been responded within target for July compared to a target of 75%.

This as against small numbers of complaint and were linked to significant delays occurring within Corporate Complaints Team (CCT) due to influx of new complaints and complexity of incoming complaints, coupled with a vacancy in the Corporate Complaints Team. This post has now been filled in August and there is an expectation that this will result in an increase in the Trust response to complaints. Other actions being supported include:

- Regular meetings continue with directorate links to monitor progress
- Weekly CCT review of all responses approaching deadlines continues Continued weekly monitoring of all open complaints with reports to the Chief Nurse

Single sex accommodation breaches:

There were 5 single sex breeches for July which occurred in the short stay surgical unit at Tunbridge Wells due to capacity challenges bed pressures and the surgical non-elective demand. This was related to one specific episode in TSSSU. There were four females in a bay with male patient for a short period of time. It is to be noted that the privacy and dignity of all patients was maintained by placing patients on opposite sides of ward, utilising curtains to screen and the availability of separate toilet facilities until the situation was resolved.

Financial commentary

- The Trust had an adverse variance against plan in July 2017 of £1.2m including STF, this is due to £0.5m STF slippage relating to the Trust missing the financial control target for July, £1.3m slippage against CIP partly offset by £0.6m underspends against budget.
- The Trust's net deficit (including technical adjustments) in July is £0.2m against a planned surplus of £1m, therefore £1.2m adverse to plan. The Trusts year to date net deficit (including technical adjustments) is £3.7m, £1.3m adverse to plan, £0.7m adverse relating to STF slippage, £1.6m adverse due to CIP slippage partly offset by underspends against budget.
- The Trust's YTD deficit is £5.4m (£0.6m adverse to plan), the Trust needs to generate a surplus of £0.9m between August and March 18 to achieve the Financial control target deficit of £4.5m.
- In July the Trust operated with an EBITDA surplus of £2.4m, an improvement of £0.5m between months.
- The key variances in the month are as follows:
    - Total income was £0.4m favourable in the month, Clinical Income was £0.1m adverse which included an Aligned Incentive adjustment of £0.1m (£0.9m positive YTD). STF was £0.5m adverse in July, HCD income £0.3m favourable to plan offsetting expenditure and other operating income was £0.7m favourable due to £0.9m STP income offsetting additional costs.
    - STF income of £0.3m was reported in July, this related to achieving quarter 1 A&E trajectories. The Trust has been able to access this income despite missing the A&E trajectory at a Trust level as the STF guidance states the trajectory is assessed at A&E delivery Board level, which achieved the quarter 1 target. The Trust did not achieve the financial control target for July. The guidance is clear the Trust cannot access the A&E trajectory despite achieving the A&E trajectory for July.
    - Pay was £0.4m adverse in the month, Medical staffing overspent by £0.35m mainly within Obs and Gynae (£100k adverse) and T&O (£100k adverse), Nursing overspent by £0.1m in the month which included £0.2m benefit by a release of 2016/17 agency accrual. Scientific and Technical staff continue to underspend against budget (£31k in month, £248k YTD), the main directorates are Specialist Medicine (mainly Therapy staff) £337k YTD favourable and Cancer Directorate (£156k favourable).
    - Non Pay was overspent by £1.2m in July, £1m adverse relating to pass through costs for STP. Julys financial position included £0.3m non recurrent benefit from release of 2016/17 financial year accruals and £0.9m unidentified CIP. Diagnostics clinical supplies increased between months by £0.2m, the main cause for the increase related to actual costs for Roche MLS activity being higher than previous estimates and plan.

- The CIP performance in July delivered efficiencies of £1.9m which was £1.3m adverse to plan, £1.6m adverse year to date. The adverse CIP position is the primary driver behind the pressure on the Trust's financial performance, although good budgetary control has mitigated some of the slippage on delivery. The Trust has a risk adjusted CIP forecast of £21.1m, £10.7m adverse to plan.
- The Trust held £7.237m of cash at the end of July which is £43k higher than the plan value of £7.194m. Following the year end agreement of balances exercise the Trust is in contact with NHS organisations trying to collect all agreed values and escalating any items disputed for resolution. It has also been agreed to switch to invoicing the STP budget in advance, rather than retrospectively.
- The Trust's normalised pre STF run rate in July was a deficit of £1.7m which was £0.2m improvement compared to June.
- The Trust requested in its Capital Plan for 2017/18 additional PDC funding for the 2 replacements Linacs at Maidstone. The Trust has received confirmation that funding for 1 Linac (£1.7m) has been awarded. The equipment will be put into storage until ready for delivery to the Trust in 2018/19 once the enabling works are completed (funded by the Trust). The Trust has also been awarded from NHS England £645k for GP A&E Streaming works, as additional PDC. The net impact of these two changes to plan is a revised forecast outturn of £16.1m, prior to donations and asset disposals.

Workforce commentary

As at the end of July 2017, the Trust employed 5,072 whole time equivalent substantive staff, a 13.6 WTE increase from the previous report. Temporary staffing remains higher than planned, though transition from agency to direct engagement remains on track to deliver anticipated savings.

Sickness absence in the month (June) remained consistent at 3.2% and represented a 0.8% improvement on the same period last year though effective sickness absence management remains a key area of focus for the HR and operational management teams.

Statutory and mandatory training compliance has increased to 88.9% from the previous report, and remains above the target percentage.

Turnover has remained higher than target in June at 11.9%, and HR Business Partners continue to work closely with divisional operational management teams in order to proactively improve turnover within areas which have a high turnover.

Appraisal compliance for July, following the end of the Trust's designated appraisal window in June, stands at 74.9%, a 37.7% increase from the last report.

TRUST PERFORMANCE DASHBOARD **Position as at:** **31 July 2017**

Delivering or Exceeding Target	
Underachieving Target	
Failing Target	

Please note a change in the layout of this Dashboard to the Five CQC/TDA Domains

******A&E 4hr Wait monthly plan is Trust Recovery Trajectory

	Safe	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	*Rate C-Diff (Hospital only)	36.06	14.1	18.3	13.9	-4.4	1.2	11.5	10.6	
'1-02	Number of cases C.Difficile (Hospital)	8	3	16	12	-4	1	27	28	
'1-03	Number of cases MRSA (Hospital)	0	0	0	0	0	0	0	0	
'1-04	Elective MRSA Screening	98.0%	98.0%	98.0%	98.0%	0.0%	0.0%	98.0%	98.0%	
'1-05	% Non-Elective MRSA Screening	97.0%	96.0%	97.0%	96.0%	-1.0%	1.0%	95.0%	96.0%	
'1-06	**Rate of Hospital Pressure Ulcers	2.8	1.1	2.6	1.6	- 1.0	- 1.4	*3.0*	1.8	3.0
'1-07	***Rate of Total Patient Falls	6.3	5.39	5.9	5.61	- 0.3	- 0.4	*6.00*	5.48	
'1-08	***Rate of Total Patient Falls Maidstone	5.4	4.6	5.0	5.0	-			4.7	
'1-09	***Rate of Total Patient Falls TWells	6.3	5.9	6.0	6.0	-			6.0	
'1-10	Falls - SIs in month	3	6	6	15	9				
'1-11	Number of Never Events	0	0	0	0	0	0	*0*	0	
'1-12	Total No of SIs Open with MTW	37	43			6				
'1-13	Number of New SIs in month	13	12	40	50	10	10			
'1-14	***Serious Incidents rate	0.59	0.56	0.46	0.58	0.12	0.52	*0.0584 - 0.6978*	0.58	*0.0584 - 0.6978*
'1-15	Rate of Patient Safety Incidents - harmful	1.55	1.12	0.79	1.28	0.49	0.05	*0 - 1.23*	1.28	*0 - 1.23*
'1-16	Number of CAS Alerts Overdue	0	0			0	0	*0*		
'1-17	VTE Risk Assessment	95.4%	96.5%	95.3%	96.4%	1.2%	1.4%	95.0%	96.4%	95.0%
'1-18	Safety Thermometer % of Harm Free Care	96.0%	97.5%	96.6%	97.1%	0.5%	2.1%	95.0%		93.4%
'1-19	Safety Thermometer % of New Harms	3.30%	2.53%	3.22%	2.81%	-0.41%	-0.2%	*3.00%*	2.81%	
'1-20	C-Section Rate (non-elective)	12.9%	13.6%	14.6%	14.3%	-0.25%	-0.7%	*15.0%*	14.3%	

	Effectiveness	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	Hospital-level Mortality Indicator (SHMI)******	Prev Yr: July 14 to June 15		1.0260	1.0878	0.1	0.1	Band 2	Band 2	1.0
2-02	Standardised Mortality HSMR	Prev Yr: Apr 15 to Mar 16		103.0	109.5	6.5	9.5	Lower confidence limit		100.0
2-03	Crude Mortality	1.1%	0.9%	1.3%	1.1%	-0.1%		to be <100		
2-04	****Readmissions <30 days: Emergency	11.8%	11.5%	11.6%	12.0%	0.4%	-1.6%	*13.6%*	12.0%	14.1%
2-05	****Readmissions <30 days: All	10.8%	11.2%	10.8%	11.4%	0.7%	-3.2%	*14.7%*	11.4%	14.7%
2-06	Average LOS Elective	3.58	3.47	3.24	3.28	0.05	0.08	*3.20*	3.28	
2-07	Average LOS Non-Elective	7.31	6.81	7.58	7.41	- 0.17	0.61	*6.80*	7.41	
2-08	******FollowUp : New Ratio	1.56	1.64	1.61	1.56	- 0.05	0.04	*1.52*	1.56	
2-09	Day Case Rates	84.4%	85.8%	84.5%	86.7%	2.2%	6.7%	80.0%	86.7%	82.2%
2-10	Primary Referrals	9,584	8,498	40,395	36,211	-10.4%	-6.1%	119,266	109,958	
2-11	Cons to Cons Referrals	5,156	4,046	19,828	17,611	-11.2%	-13.2%	58,644	53,477	
2-12	First OP Activity	16,276	15,044	65,853	62,365	-5.3%	-8.0%	201,705	189,377	
2-13	Subsequent OP Activity	29,726	28,126	124,772	116,794	-6.4%	-6.9%	384,419	354,655	
2-14	Elective IP Activity	731	576	2,874	2,228	-22.5%	-27.0%	8,303	6,766	
2-15	Elective DC Activity	3,860	3,465	15,316	14,375	-6.1%	-8.0%	43,602	43,651	
2-16	**Non-Elective Activity	4,323	4,741	16,980	18,668	9.9%	15.1%	46,435	55,851	
2-17	A&E Attendances (Inc Clinics. Calendar Mth)	15,098	14,834	56,792	57,605	1.4%	0.9%	168,161	169,483	
2-18	Oncology Fractions	5,830	6,021	24,436	23,221	-5.0%	-8.7%	75,273	69,663	
2-19	No of Births (Mothers Delivered)	515	515	1,976	1,991	0.8%	-0.1%	5,977	5,973	
2-20	% Mothers initiating breastfeeding	80.8%	80.1%	82.7%	80.8%	-1.9%	2.8%	78.0%	80.8%	
2-21	% Stillbirths Rate	0.4%	0.58%	0.19%	0.35%	*0.2%*	*-0.1%*	*0.47%*	0.35%	0.47%

	Caring	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	Single Sex Accommodation Breaches	0	5	0	5	5	5	0	5	
3-02	*****Rate of New Complaints	1.13	2.34	1.69	1.82	0.1	0.51	*1.318-3.92*	1.78	
3-03	% complaints responded to within target	84.0%	68.8%	74.3%	69.4%	-4.9%	-5.6%	75.0%	69.4%	
3-04	****Staff Friends & Family (FFT) % rec care	82.7%	76.0%	82.7%	76.0%	-6.6%	-3.0%	79.0%	76.0%	
3-05	*****IP Friends & Family (FFT) % Positive	95.4%	96.4%	95.7%	95.8%	0.1%	0.8%	95.0%	95.8%	95.8%
3-06	A&E Friends & Family (FFT) % Positive	90.2%	91.3%	91.4%	91.6%	0.2%	4.6%	87.0%	91.6%	85.5%
3-07	Maternity Combined FFT % Positive	97.8%	94.3%	94.8%	92.9%	-1.9%	-2.1%	95.0%	92.9%	95.6%
3-08	OP Friends & Family (FFT) % Positive	82.5%	84.5%	82.3%	84.3%	1.9%			84.3%	

	Responsiveness	Latest Month		Year/Quarter 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	******Emergency A&E 4hr Wait	87.7%	93.3%	90.2%	90.0%	-0.1%	0.1%	90.1%	90.1%	85.7%
4-02	Emergency A&E >12hr to Admission	0	-	0	0	0	0	*0*	0	
4-03	Ambulance Handover Delays >30mins	New	261	New	1561					
4-04	Ambulance Handover Delays >60mins	New	13	New	125					
4-05	RTT Incomplete Admitted Backlog	1,276	2415	1,276	2415	1,139	1,016	1,259	1259	
4-06	RTT Incomplete Non-Admitted Backlog	640	1206	640	1206	566	505	631	631	
4-07	RTT Incomplete Pathway	92.1%	85.6%	92.1%	85.6%	-6.4%	-4.7%	92%	92.0%	
4-08	RTT 52 Week Waiters	0	0	0	1	1	1	*0*	1	
4-09	RTT Incomplete Total Backlog	1,927	3621	1,927	3621	1,694	1,521	1,890	1890	
4-10	% Diagnostics Tests WTimes <6wks	99.93%	99.7%	99.7%	99.7%	-0.1%	0.7%	99.0%	99.0%	
4-11	*Cancer WTimes - Indicators achieved	2	3	2	2	-	- 7	9	9	
4-12	*Cancer two week wait	90.1%	93.0%	90.8%	92.4%	1.6%	-0.6%	93.0%	93.0%	
4-13	*Cancer two week wait-Breast Symptoms	87.6%	85.5%	84.4%	87.1%	2.8%	-5.9%	93.0%	93.0%	
4-14	*Cancer 31 day wait - First Treatment	96.1%	92.5%	96.4%	92.6%	-3.8%	-3.4%	96.0%	96.0%	
4-15	*Cancer 62 day wait - First Definitive	70.9%	68.4%	70.6%	67.1%	-3.5%	-8.2%	85.0%	85.0%	
4-16	*Cancer 62 day wait - First Definitive - MTW	75.0%	75.0%	75.0%	75.0%	0.0%		85.0%		
4-17	*Cancer 104 Day wait Accountable	13.5	13.5	36.0	28.5	-7.5	28.5	*0*	28.5	
4-18	*Cancer 62 Day Backlog with Diagnosis	91	58	91	58	-33				
4-19	*Cancer 62 Day Backlog with Diagnosis - MTW	55	44	55	44	-11				
4-20	Delayed Transfers of Care	6.8%	5.4%	5.9%	5.8%	-0.1%	2.3%	3.5%	5.8%	
4-21	% TIA with high risk treated <24hrs	65.0%	58.8%	78.3%	69.4%	-9.0%	9.4%	60%	69.4%	
4-22	*******% spending 90% time on Stroke Ward	81.8%	96.4%	84.3%	89.7%	5.5%	9.7%	80%	89.7%	
4-23	*******Stroke:% to Stroke Unit <4hrs	42.3%	58.9%	47.8%	56.9%	9.1%	-3.1%	60.0%	60.0%	
4-24	*******Stroke: % scanned <1hr of arrival	46.2%	58.6%	55.4%	57.8%	2.4%	9.8%	48.0%	57.8%	
4-25	*******Stroke:% assessed by Cons <24hrs	65.4%	77.6%	66.1%	74.0%	7.8%	-6.0%	80.0%	80.0%	
4-26	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	*0*	0	
4-27	Patients not treated <28 days of cancellation	3	2	6	11	5	11	*0*	11	

RTT Incomplete Pathway Monthly Plan is Trust Recovery Trajectory

**CWT run one mth behind, YTD is Quarter to date, Monthly Plan for 62 Day Wait First Definitive is Trust Recovery Trajectory*

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

	Well-Led	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	
5-01	Income	34,221	36,725	136,342	146,952	7.8%	1.6%	436,664	446,010	
5-02	EBITDA	(409)	2,381	(2,707)	6,464	-338.8%	-18.8%	38,055	37,656	
5-03	Surplus (Deficit) against B/E Duty	(3,050)	(693)	(13,525)	(3,703)			6,673	6,681	
5-04	CIP Savings	1,734	1,876	6,099	5,356	-12.2%	-23.2%	31,721	31,721	
5-05	Cash Balance	6,405	7,237	6,405	7,237	13.0%	0%	1,000	1,000	
5-06	Capital Expenditure	490	167	874	414	-52.6%	-92.6%	*16,948*	15,700	
5-07	Establishment WTE	5,722.3	5,601.7	5,722.3	5,601.7	-2.1%	0.0%	5,601.7	5,601.7	
5-08	Contracted WTE	5,165.0	5,072.0	5,165.0	5,072.0	-1.8%	-0.8%	5,112.9	5,112.9	
5-09	Vacancies WTE	557.3	529.7	557.3	529.7	-5.0%	8.4%	488.8	488.8	
5-11	Vacancy Rate (%)	9.7%	9.5%	9.7%	9.5%	-0.3%	0.7%	8.7%	8.7%	
5-12	Substantive Staff Used	4,983.5	4,873.5	4,983.5	4,873.5	-2.2%	-4.6%	5,110.9	5,110.9	
5-13	Bank Staff Used	332.7	425.9	332.7	425.9	28.0%	27.0%	335	335.3	
5-14	Agency Staff Used	253.9	128.0	253.9	128.0	-49.6%	-17.7%	155.5	155.5	
5-15	Overtime Used	52.6	43.8	52.6	43.8	-16.8%				
5-16	Worked WTE	5,622.7	5,471.2	5,622.7	5,471.2		-2.3%	5,601.7	5,601.7	
5-17	Nurse Agency Spend	(837)	(441)	(3,358)	(2,247)	-33.1%				
5-18	Medical Locum & Agency Spend	(1,345)	(1,091)	(5,426)	(4,466)	-17.7%				
5-19	Temp costs & overtime as % of total pay bill	16.4%	13.6%	16.6%	14.1%	-2.5%				
5-20	Staff Turnover Rate	10.7%	11.9%		11.6%	1.2%	1.1%	*10.5%*	11.6%	11.05%
5-21	Sickness Absence	4.0%	3.2%		3.4%	-0.8%	0.1%	*3.3%*	3.4%	4.3%
5-22	Statutory and Mandatory Training	89.2%	88.9%		87.7%	-0.3%	2.7%	85.0%	87.7%	
5-23	Appraisal Completeness	37.5%	74.9%		74.9%	37.4%	-15.1%	90.0%	74.9%	
5-24	Overall Safe staffing fill rate	98.8%	99.2%	100.8%	98.6%	-2.2%		93.5%	98.6%	
5-25	****Staff FFT % recommended work	60.2%	51%	60.2%	51%	-9.3%	-11.1%	62.0%	51%	
5-26	***Staff Friends & Family -Number Responses	98	701	98	701	603				
5-27	*****IP Resp Rate Recmd to Friends & Family	21.7%	28.1%	22.2%	24.7%	2.5%	-0.3%	25.0%	25.0%	25.7%
5-28	A&E Resp Rate Recmd to Friends & Family	17.5%	11.3%	13.6%	17.1%	3.5%	2.1%	15.0%	17.1%	12.7%
5-29	Mat Resp Rate Recmd to Friends & Family	6.3%	36.6%	17.0%	32.4%	15.4%	7.4%	25.0%	32.4%	24.0%

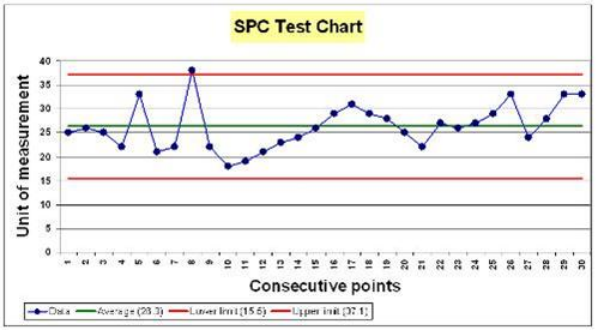
* Rate of C.Difficile per 100,000 Bed days, ** Rate of Pressure Sores per 1,000 admissions (excl Day Case), *** Rate of Falls per 1,000 Occupied Beddays, **** Readmissions run one month behind, ***** Rate of Complaints per 1,000 occupied beddays.

****** New :FU Ratio is only for certain specialties -plan still being agreed so currently last year plan

****** IP Friends and Family includes Inpatients and Day Cases* *******SHMI is at Band 2 "As Expected"* ** NE Activity Includes Maternity

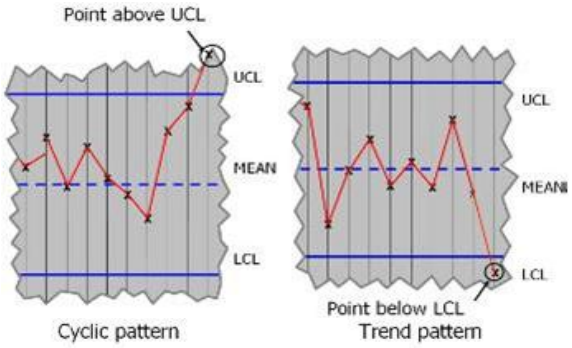
Explanation of Statistical Process Control (SPC) Charts

In order to better understand how performance is changing over time, data on the Trusts performance reports are often displayed as SPC Charts. *A*n SPC chart looks like this:

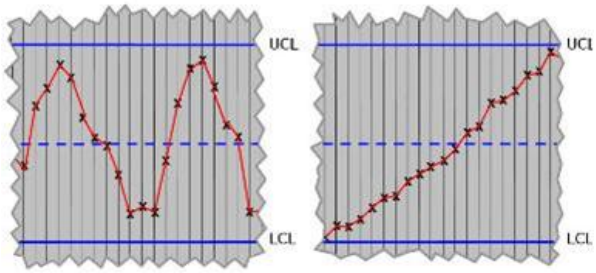


SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause ' variation is present in the system. It is also perfectly normal for a process to show no signs of special cause. This means that only 'common cause ' variation is present.

Rule 1: Any point outside one of the control limits. Typically this will be some form of significant event, for example unusually severe weather. However if the data points continue outside of the control limits then that significant change is permanent. When we are aware of a significant change to a service such as Tunbridge Wells Hospital opening, then we will recalculate the centre and control lines. This is called a step change.

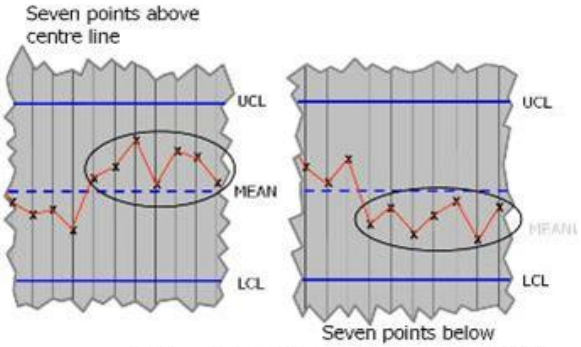


Rule 2: Any unusual pattern or trends within the control limits. The most obvious example of a cyclical pattern is seasonality but we also see it when looking at daily discharges where the weekends have low numbers. To qualify as a trend there must be at least 6 points in a row. This is one of the key reasons we use SPC charts as it helps us differentiate between natural variation & variation due to some action we have taken.

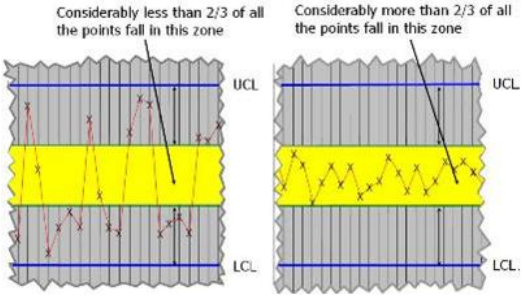


Rules 1 and 2 are the main reason for displaying SPC charts on our performance reports as it makes abnormally high or low values and trends immediately obvious. However there are two other rules that are also used to interpret the graphs.

Rule 3: A run of seven points all above or all below the centre line, or all increasing or decreasing. This shows some longer term change in the process such as a new piece of equipment that allows us to perform a procedure in an outpatient setting rather than admitting them. However alternating runs of points above the line then points below the line can also invoke rule 3.

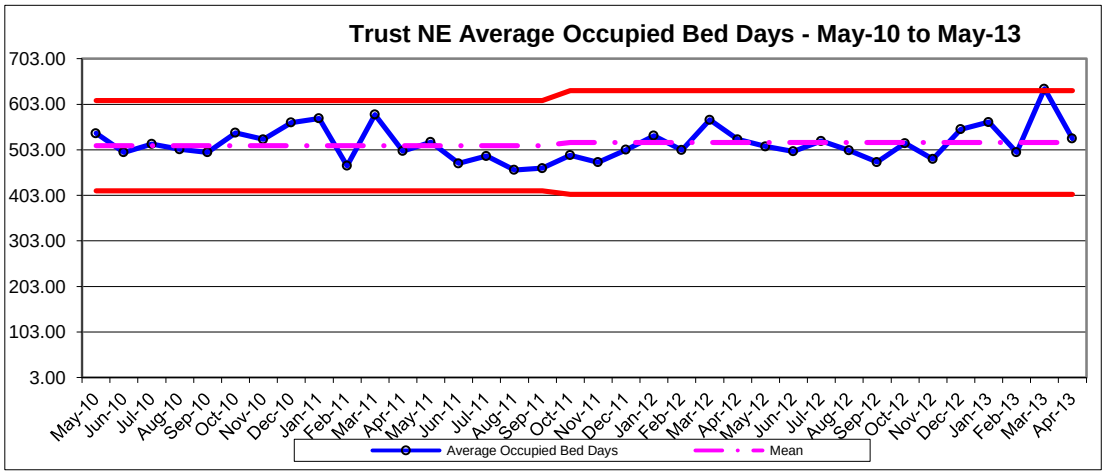


Rule 4: The number of points within the middle third of the region between the control limits differs markedly from two -thirds of the total number of points. This gives an indication of how stable a process is. If controlled variation (common cause) is displayed in the SPC chart, the process is stable and predictable, which means that the variation is inherent in the process. To change performance you will have to change the entire system.

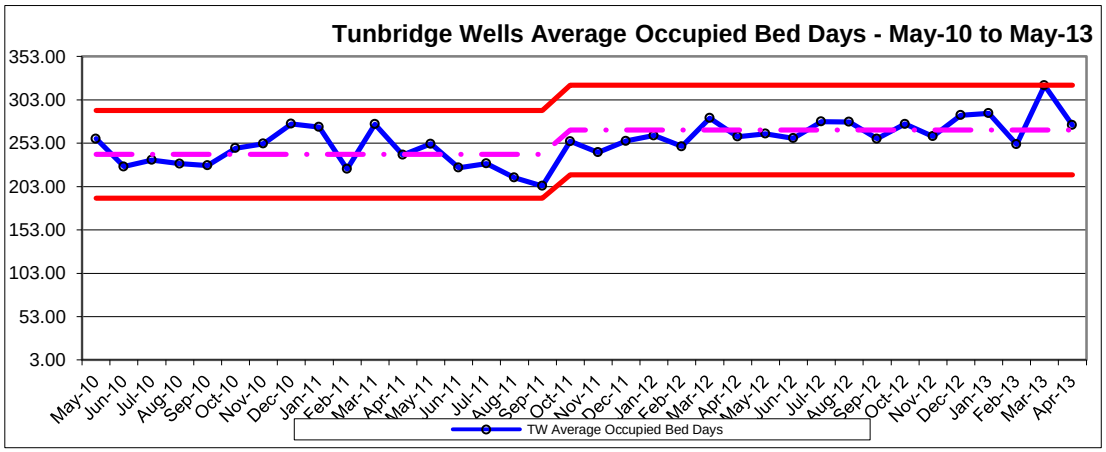


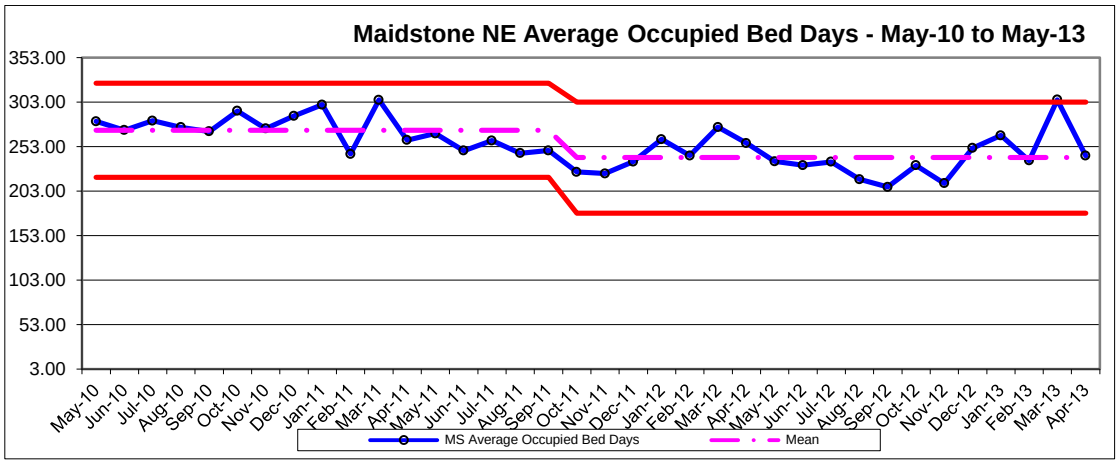
Changes to Control Lines

When there are known changes to the services we provide we reset the calculations as at the date of that change. For example you will see in the graph below that we have re-calculated the control lines from October 2011 onwards. This is to reflect the move of services to the new Tunbridge Wells Hospital in late September.



The change is not immediately obvious in the graph above if you look at just the blue line, but we know there were major changes to our inpatient beds. Looking at site level the change is more obvious:

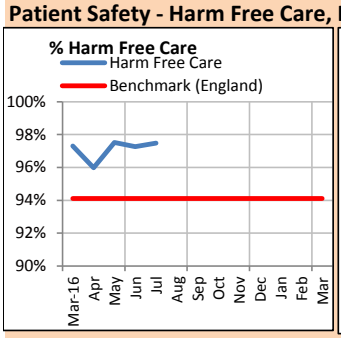


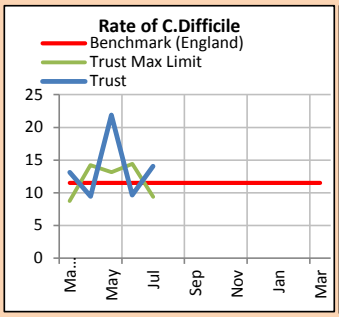


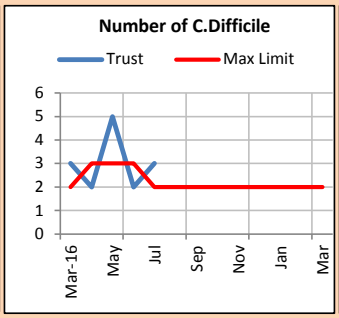
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information team based on a real life changes in process or service.

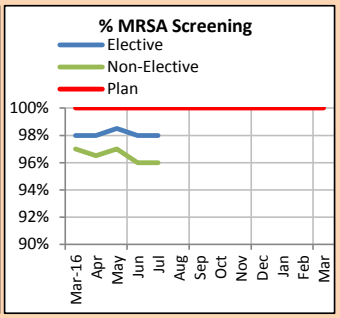
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

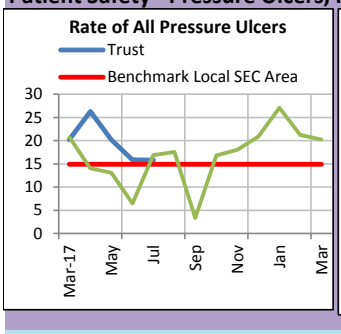


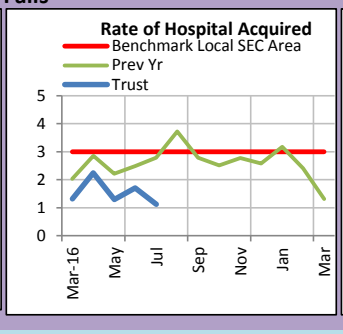


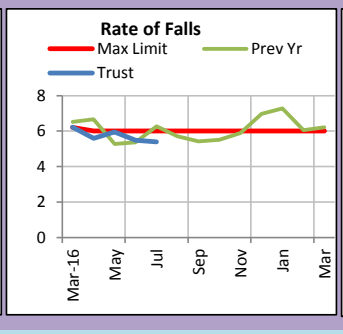


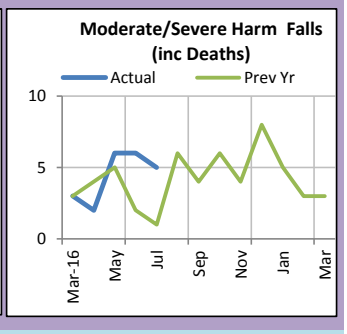


Patient Safety - Pressure Ulcers, Falls

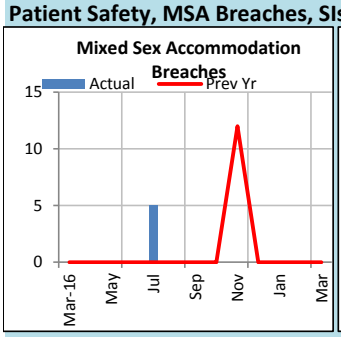


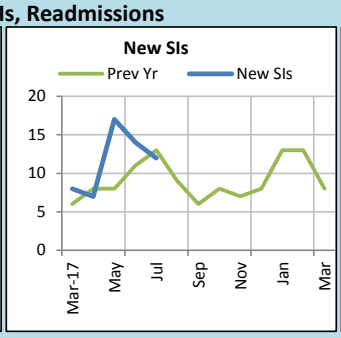


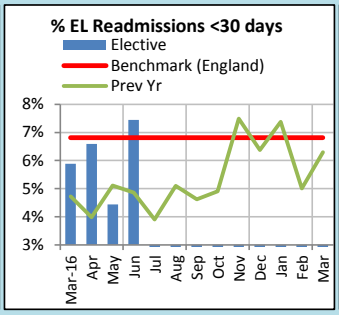


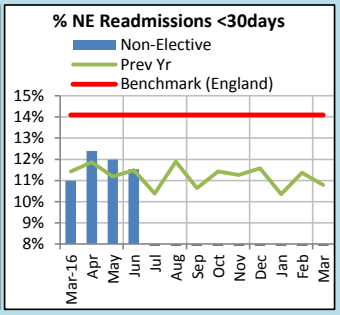


Patient Safety, MSA Breaches, SIs, Readmissions

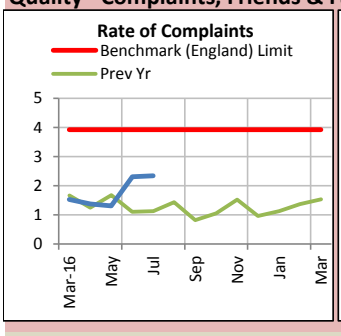


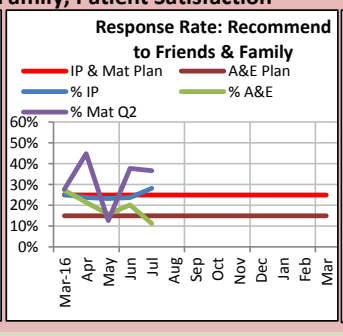


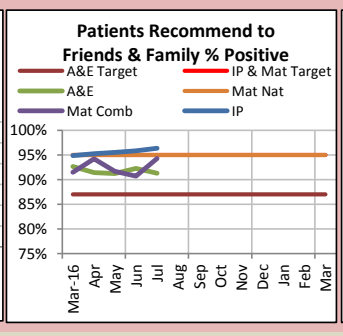


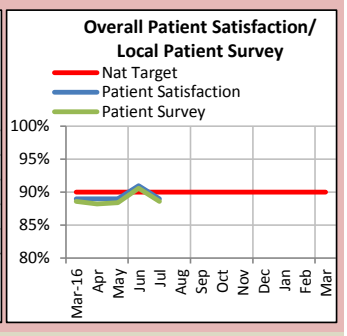


Quality - Complaints, Friends & Family, Patient Satisfaction

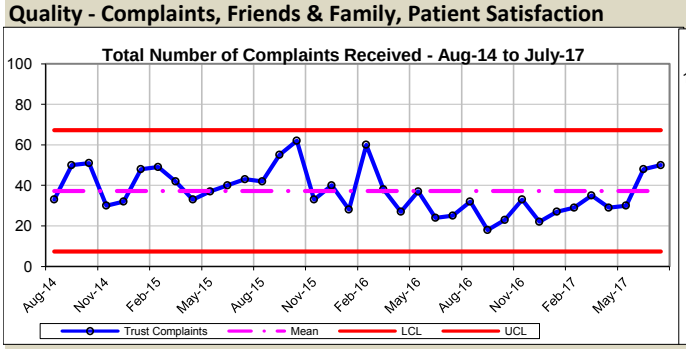


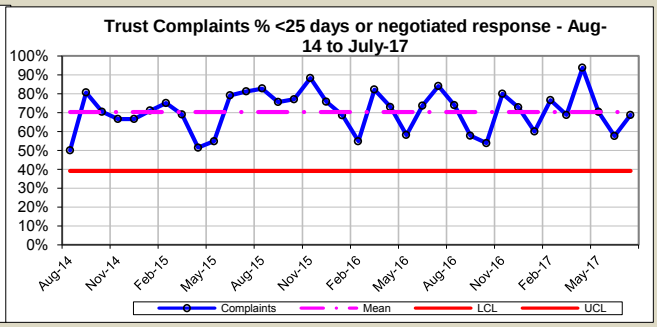




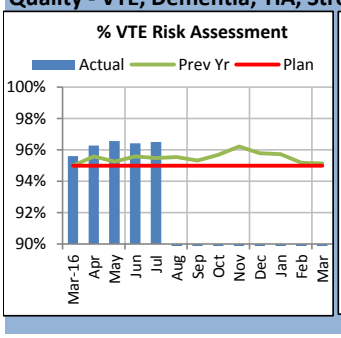


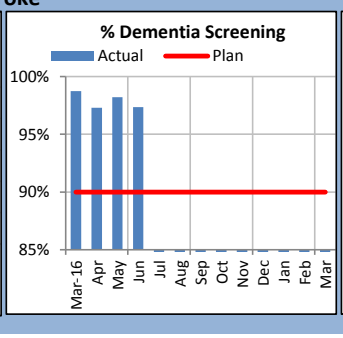
Quality - Complaints, Friends & Family, Patient Satisfaction

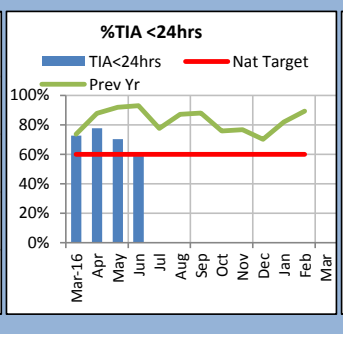


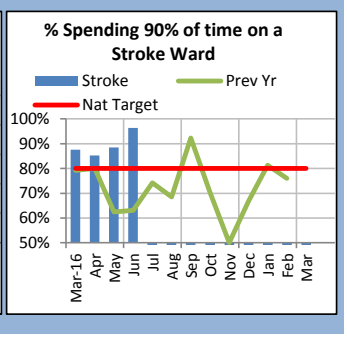


Quality - VTE, Dementia, TIA, Stroke



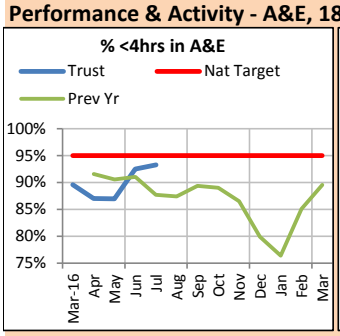


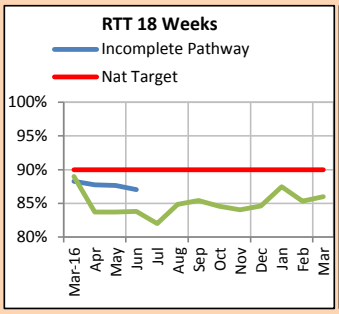


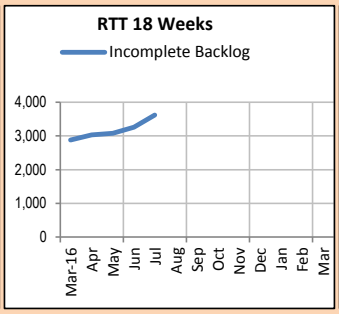


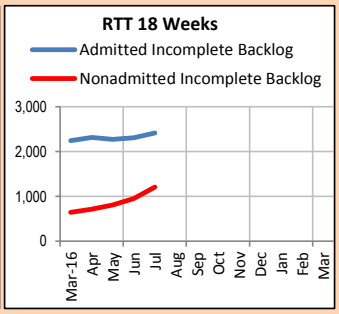
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

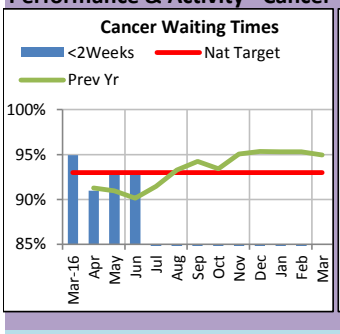


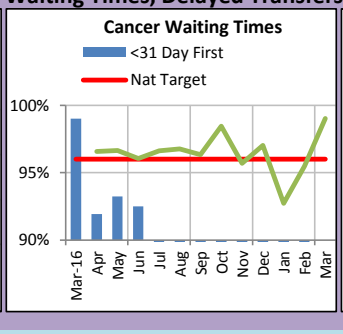


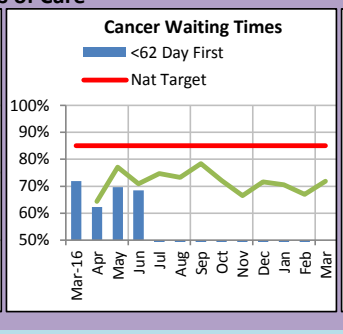


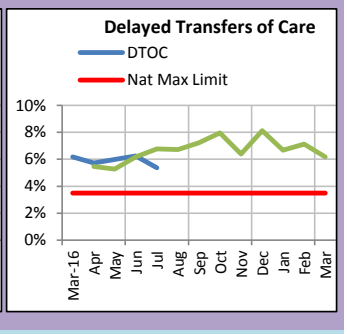


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

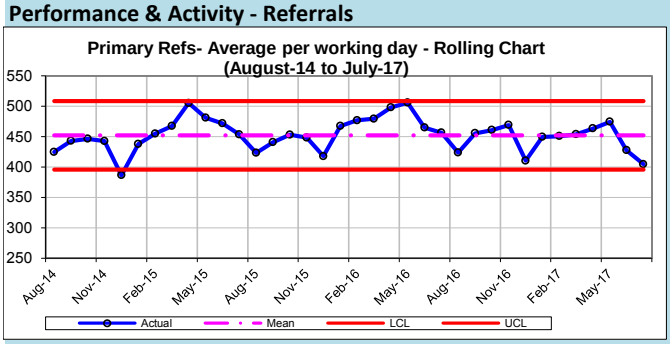


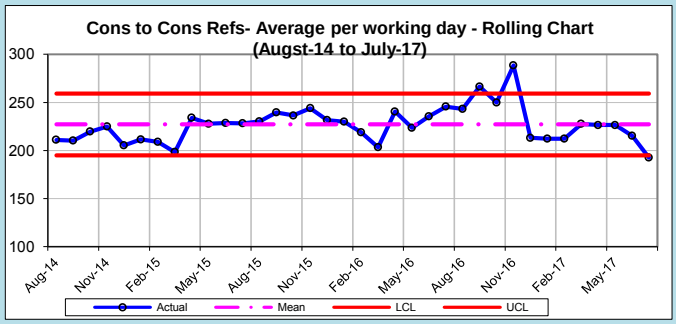




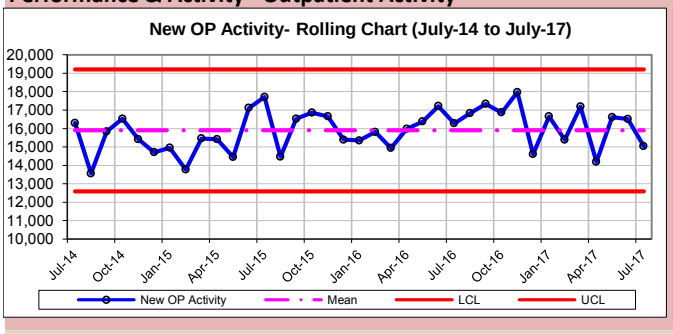


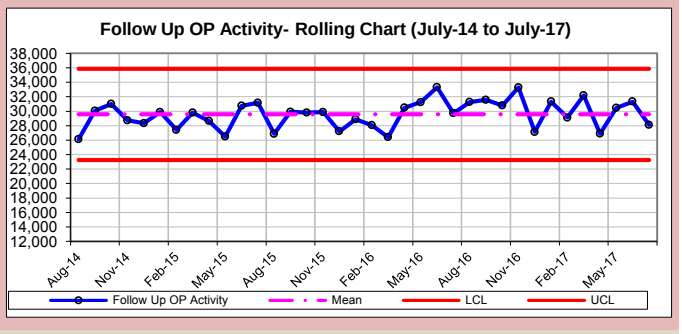
Performance & Activity - Referrals



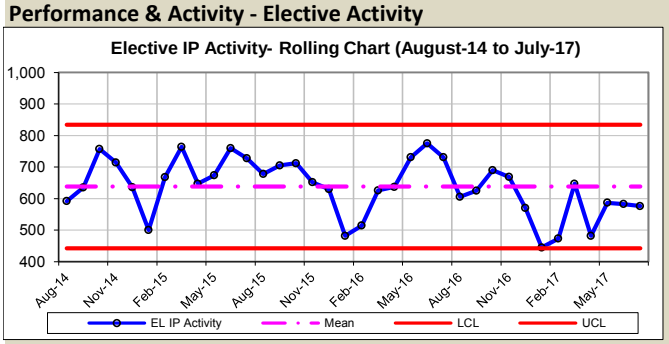


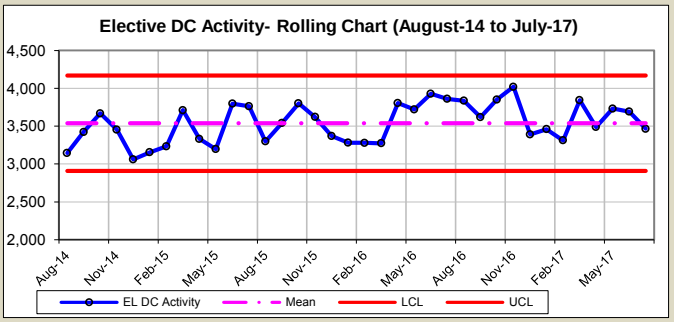
Performance & Activity - Outpatient Activity



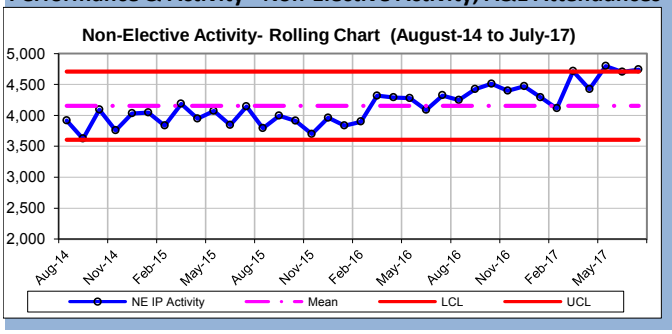


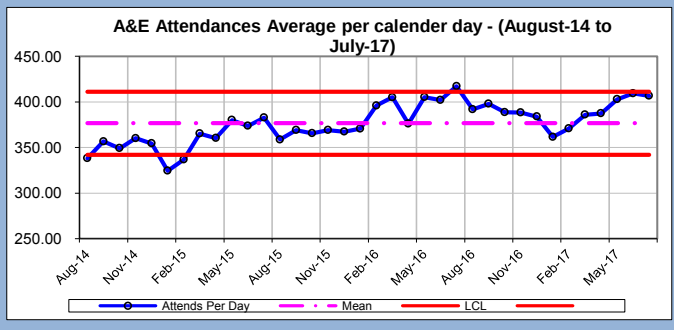
Performance & Activity - Elective Activity





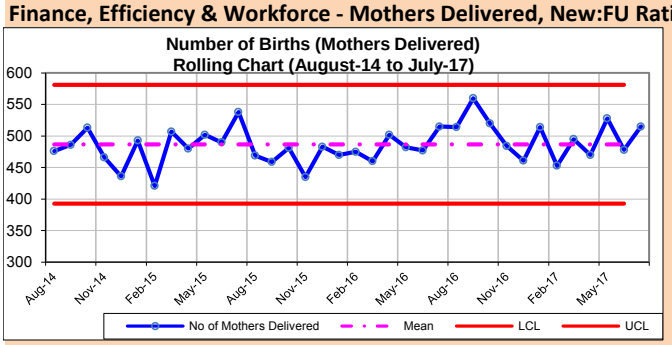
Performance & Activity - Non-Elective Activity, A&E Attendances

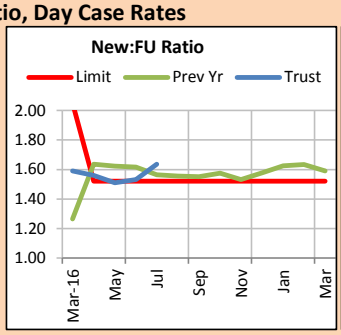


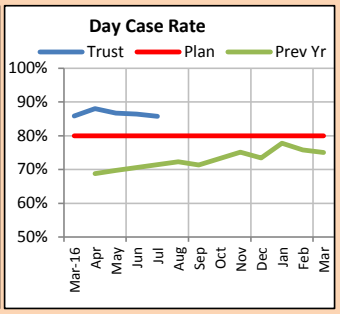


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

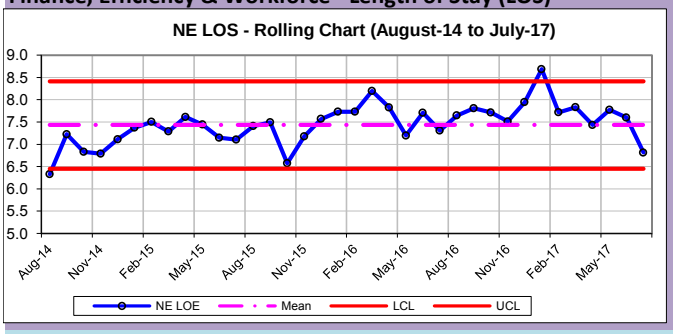
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

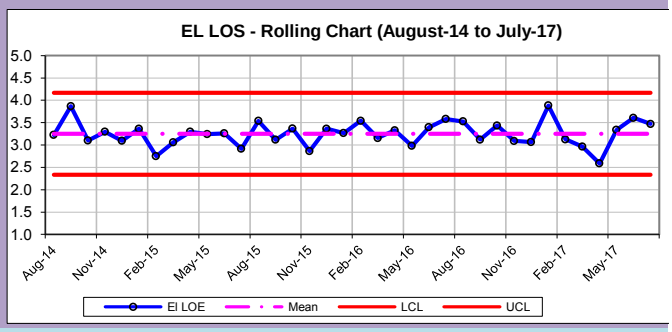




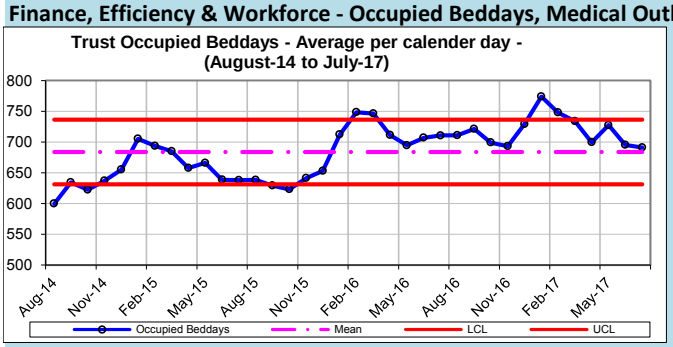


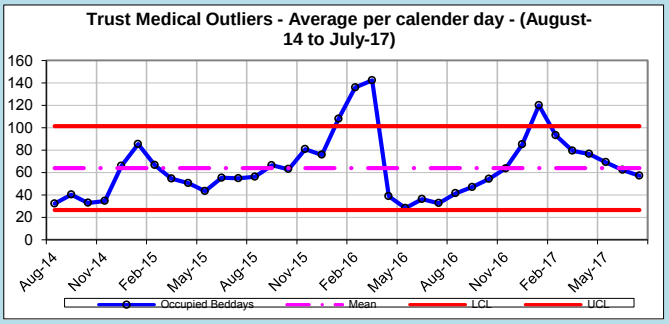
Finance, Efficiency & Workforce - Length of Stay (LOS)



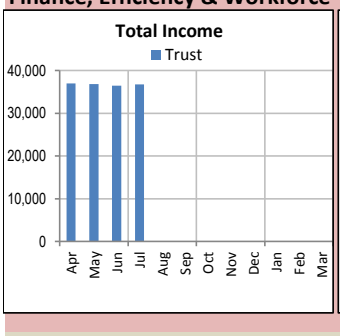


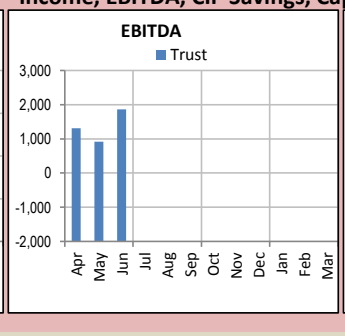
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

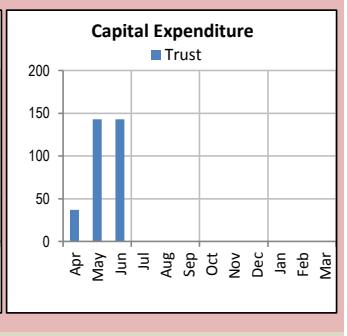




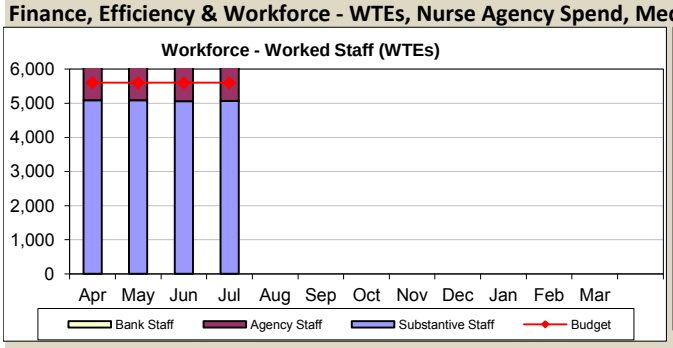
Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

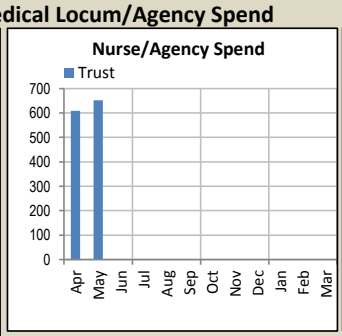


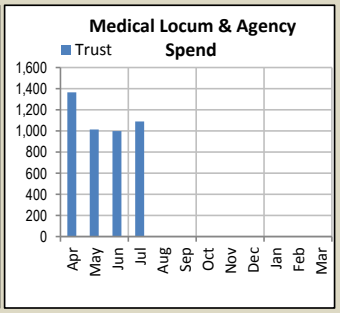




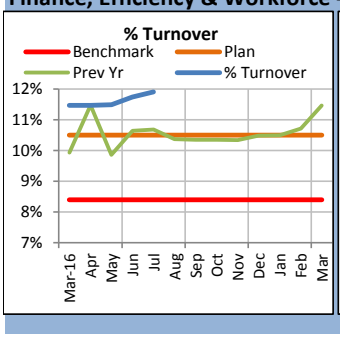
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

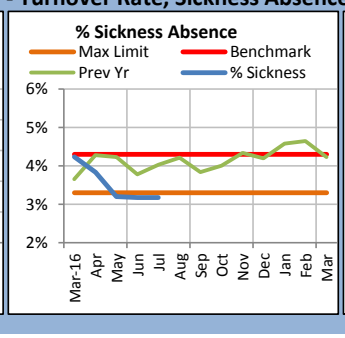


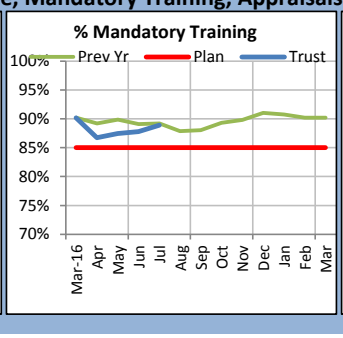


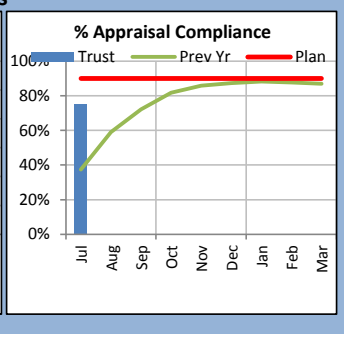


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Maidstone and Tunbridge Wells NHS Trust

Trust Board Finance Pack

Month 4
2017/18

Maidstone and Tunbridge Wells NHS Trust

Content

Trust Board Finance Pack for July 2017

1. Executive Summary

a. Executive Summary

b. Executive Summary KPI's

2. Financial Performance

a. Consolidated I&E

3. Expenditure Analysis

a. Run Rate Analysis £

4. Cost Improvement Programme

a. Current Month Savings by Directorate

b.YTD Savings by Directorate

c. Forecast Savings by Directorate

5. Balance Sheet

a. Balance Sheet

b. Cash Flow

6. Capital

a. Capital Plan

1.Executive Summary

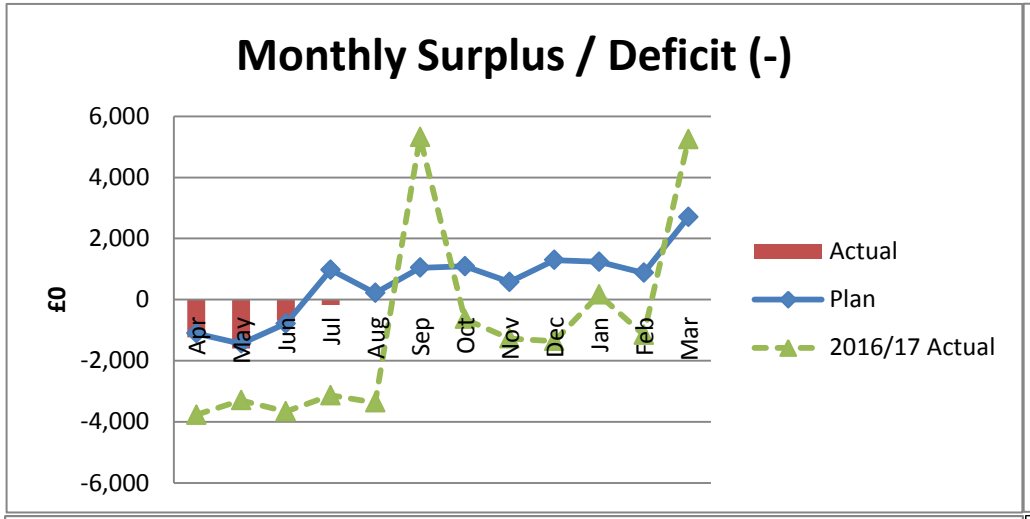
1a. Executive Summary July 2017

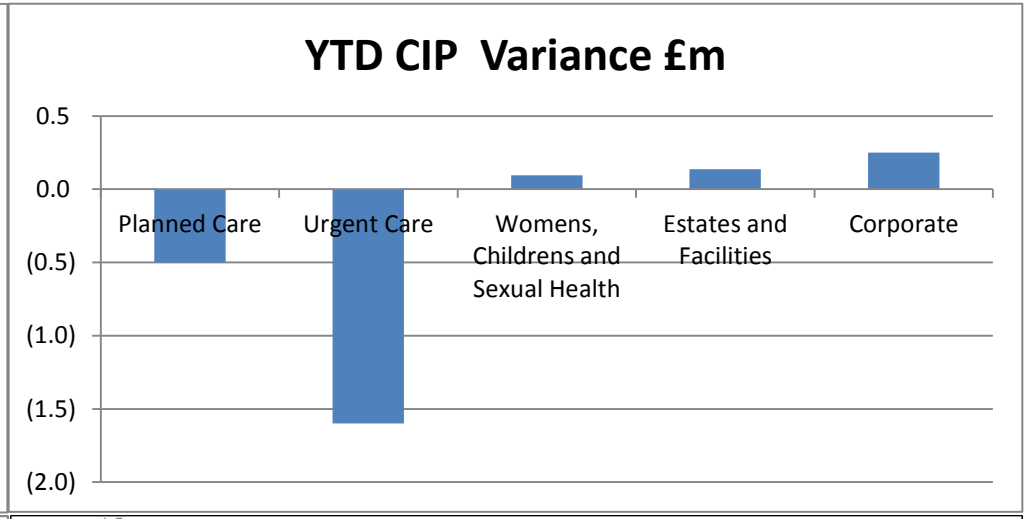
Key Variances £m

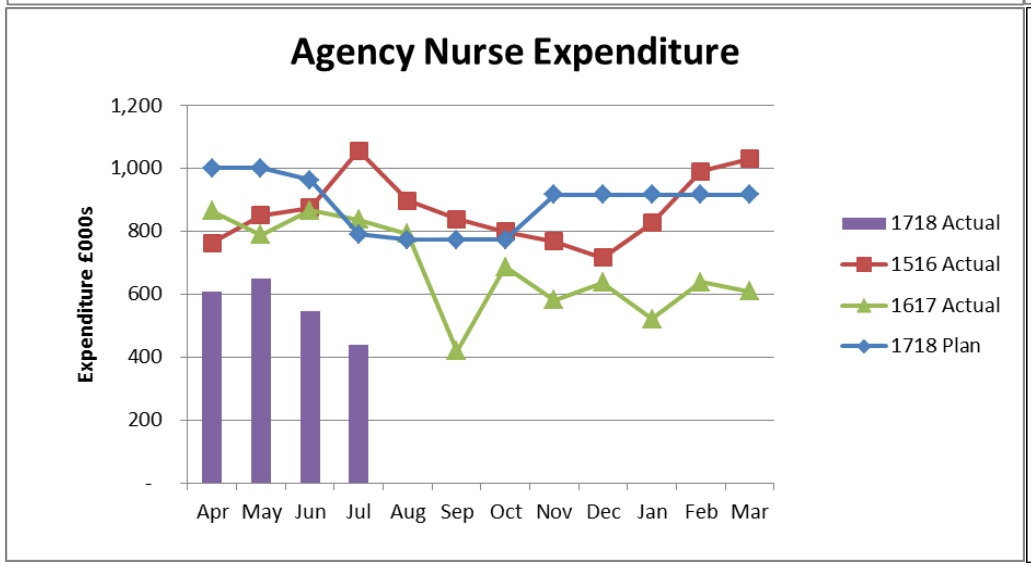
	July	YTD		Headlines
Total Surplus (+) / Deficit (-)	**(1.2)**	**(1.3)**	**Adverse**	The Trusts deficit including STF was £0.2m in July which was £1.2m adverse to plan, £0.5m STF slippage relating to missing the financial control total for July, £1.3m slippage against CIP partly offset by £0.6m underspends against budget. The Trust has a YTD deficit of £5.4m excluding STF and £3.7m including STF, thi sis £1.3m adverse to plan.
Clinical Income	**(0.1)**	**(1.0)**	**Adverse**	Clinical Income was £0.1m adverse in the month, which included a £0.1m benefit relating to the aligned incentive contract (£0.9m positive YTD). The key adverse variances in July were Elective & Day Cases (£0.7m) and Out Patient Activity (£0.3m) offset by favourable variances within non elective £0.7m and prior period adjustment £1m.
Other Operating Income	**0.7**	**2.5**	**Favourable**	Other Operating Income £0.7m favourable in the month, £0.9m favourable relating to STP costs (offset by additional costs), £0.2m favourable due to COS VAT rebate for 1617 partly offset by adverse variance relating to private patient income and £0.25m.
Pay	**(0.4)**	**0.5**	**Favourable**	Pay was £0.4m adverse in the month, Medical staffing overspent by £0.35m mainly within Obs and Gynae (£100k adverse) and T&O (£100k adverse), Nursing overspent by £0.1m in the month which included £0.2m benefit by a release of 2016/17 agency accrual. Scientific and Technical staff continue to underspend against budget (£31k in month, £248k YTD), the main directorates are Specialist Medicine (mainly Therapy staff) £337k YTD favourable and Cancer Directorate (£156k favourable).
Non Pay	**(1.2)**	**(4.3)**	**Adverse**	Non Pay was overspent by £1.2m in July, £1m adverse relating to pass through costs for STP. Julys financial position included £0.3m non recurrent benefit from release of 2016/17 financial year accruals and £0.9m unidentified CIP. Diagnostics clinical supplies increased between months by £0.2m, the main cause for the increase related to actual costs for Roche MLS activity being higher than previous estimates and plan.
Elective IP and DC	**(0.7)**	**(2.6)**	**Adverse**	Elective and Day Case activity is adverse to plan in month by £0.7m in month and £2.6m year to date. This is due to a reduction in outsourcing in 2017/18. T&O day cases is particularly low in month, discussions are underway within the Directorate to take action and increase activity in future months.
Sustainability and Transformation Fund	**(0.5)**	**(0.7)**	**Adverse**	STF income of £0.3m was reported in July, this related to achieving quarter 1 A&E trajectories. The Trust has been able to access this income despite missing the A&E trajectory at a Trust level as the STF guidance states the trajectory is assessed at A&E delivery Board level, which achieved the quarter 1 target. The Trust did not achieve the financial control target for July. The guidance is clear the Trust cannot access the A&E trajectory despite achieving the A&E trajectory for July.
CIP / FRP	**(1.3)**	**(1.6)**	**Adverse**	The Trust achieved £1.9m savings in July which was £0.5m more than June however this was £1.3m adverse to plan. The Trust has delivered £5.4m savings YTD and is £1.6m adverse to plan.

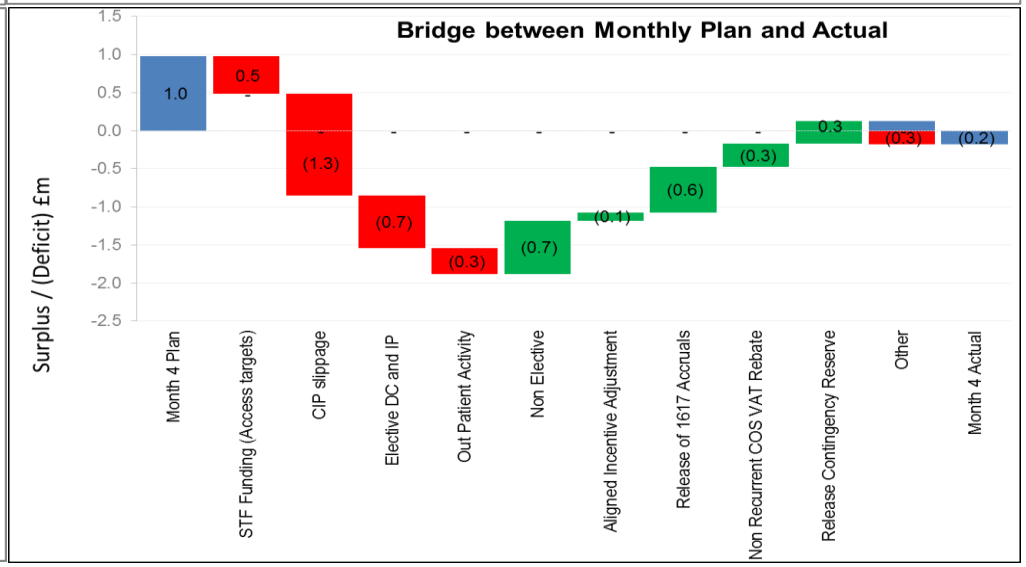
Maidstone and Tunbridge Wells NHS Trust

1b. Executive Summary KPI's July 2017









2.Income and Expenditure

Maidstone and Tunbridge Wells NHS Trust

Income & Expenditure July 2017/18

		Current Month			Year to Date			Annual Forecast		
		Actual £m	*Plan* £m	*Variance* £m	*Actual* £m	*Plan* £m	*Variance* £m	*Forecast* £m	*Plan* £m	*Variance* £m
Revenue										
	Clinical Income	28.6	28.7	(0.1)	113.7	114.7	(1.0)	324.9	339.9	(15.0)
	STF	0.3	0.7	(0.5)	1.7	2.4	(0.7)	11.2	11.2	0
	High Cost Drugs	3.5	3.2	0.3	14.5	12.9	1.6	57.9	42.0	15.9
	Other Operating Income	4.3	3.6	0.7	17.1	14.5	2.5	52.0	43.6	8.4
	Total Revenue	36.7	36.3	0.4	147.0	144.6	2.4	446.0	436.7	9.3
Expenditure										
	Substantive	(17.8)	(17.8)	(0.0)	(71.8)	(72.8)	1.0	(215.7)	(215.3)	(0.4)
	Bank	(1.1)	(0.5)	(0.6)	(3.8)	(2.3)	(1.5)	(11.3)	(6.1)	(5.2)
	Locum	(1.1)	(0.8)	(0.3)	(4.5)	(3.6)	(0.9)	(15.1)	(10.2)	(4.9)
	Agency	(0.5)	(1.0)	0.5	(3.0)	(4.8)	1.8	(9.0)	(13.4)	4.4
	Pay Reserves	(0.2)	(0.3)	0.0	(0.9)	(1.0)	0.1	6.7	(3.0)	9.7
	Total Pay	(20.8)	(20.4)	(0.4)	(84.1)	(84.6)	0.5	(244.4)	(248.1)	3.7
	Drugs & Medical Gases	(4.2)	(4.2)	0.0	(17.6)	(17.1)	(0.5)	(53.2)	(50.9)	(2.2)
	Blood	(0.2)	(0.2)	0.0	(0.9)	(0.8)	(0.0)	(2.5)	(2.5)	(0.0)
	Supplies & Services - Clinical	(2.7)	(1.9)	(0.8)	(10.7)	(8.8)	(1.9)	(31.5)	(23.7)	(7.8)
	Supplies & Services - General	(0.5)	(0.4)	(0.1)	(2.0)	(1.7)	(0.3)	(5.5)	(5.1)	(0.5)
	Services from Other NHS Bodies	(0.7)	(0.6)	(0.1)	(2.8)	(2.5)	(0.2)	(8.0)	(7.6)	(0.4)
	Purchase of Healthcare from Non-NHS	(0.3)	(0.6)	0.3	(1.5)	(3.2)	1.7	(4.5)	(7.9)	3.4
	Clinical Negligence	(1.7)	(1.7)	(0.0)	(6.9)	(6.9)	(0.0)	(20.6)	(20.6)	(0.0)
	Establishment	(0.3)	(0.3)	0.0	(1.2)	(1.3)	0.1	(3.4)	(3.7)	0.3
	Premises	(1.7)	(1.8)	0.1	(7.6)	(7.4)	(0.3)	(22.9)	(21.5)	(1.4)
	Transport	(0.1)	(0.1)	0.0	(0.4)	(0.5)	0.0	(1.3)	(1.4)	0.1
	Other Non-Pay Costs	(1.4)	(0.4)	(1.0)	(4.7)	(1.6)	(3.1)	(14.7)	(4.9)	(9.8)
	Non-Pay Reserves	0.2	(0.1)	0.3	(0.1)	(0.2)	0.1	4.1	(0.8)	4.9
	Total Non Pay	(13.6)	(12.4)	(1.2)	(56.4)	(52.1)	(4.3)	(164.0)	(150.5)	(13.5)
	Total Expenditure	(34.3)	(32.7)	(1.6)	(140.5)	(136.6)	(3.8)	(408.4)	(398.6)	(9.7)
EBITDA	**EBITDA**	2.4	3.6	(1.2)	6.5	8.0	(1.5)	37.7	38.1	(0.4)
		0.0	*0.0*	*(0.0)*	*4.4%*	*5.5%*	*-63.5%*	*8.4%*	*8.7%*	*-4%*
Other Finance Costs										
	Depreciation	(1.2)	(1.2)	0.0	(4.8)	(4.8)	0.0	(14.7)	(14.8)	0.1
	Interest	(0.1)	(0.1)	0.0	(0.4)	(0.4)	0.0	(1.3)	(1.3)	0.0
	Dividend	(0.1)	(0.1)	0.0	(0.5)	(0.5)	0.0	(1.4)	(1.5)	0.1
	PFI and Impairments	(1.2)	(1.2)	(0.0)	(4.6)	(4.6)	0.0	(14.9)	(14.9)	0.0
	Total Finance Costs	(2.6)	(2.6)	0.0	(10.3)	(10.3)	0.0	(32.2)	(32.4)	0.3
Net Surplus / Deficit (-)	**Net Surplus / Deficit (-)**	(0.2)	1.0	(1.2)	(3.8)	(2.3)	(1.5)	5.5	5.7	(0.1)
Technical Adjustments	**Technical Adjustments**	0.0	0.0	0.0	0.1	(0.0)	0.1	1.2	1.0	0.2
Surplus/ Deficit (-) to B/E Duty	**Surplus/ Deficit (-) to B/E Duty Incl STF**	(0.2)	1.0	(1.2)	(3.7)	(2.4)	(1.3)	6.7	6.7	0.0
	Surplus/ Deficit (-) to B/E Duty Excl STF	(0.4)	0.2	(0.7)	(5.4)	(4.8)	(0.6)	(4.5)	(4.5)	0.0

Commentary

The Trusts deficit including STF was £0.2m in July which was £1.2m adverse to plan, £0.5m STF slippage relating to missing the financial control total for July, £1.3m slippage against CIP partly offset by £0.6m underspends against budget

The Financial plan for July included £2m unidentified CIP, this was split £0.1m income, £1m pay and £0.9m nonpay.

The Trust's normalised pre STF run rate in July was a deficit of £1.7m which was £0.2m improvement compared to June.

Clinical Income was £0.1m adverse in the month, which included a £0.1m benefit relating to the aligned incentive contract (£0.9m positive YTD). The key adverse variances in July were Elective & Day Cases (£0.7m) and Out Patient Activity (£0.3m) offset by favourable variances within non elective £0.7m and prior period adjustment £1m.

STF income of £0.3m was reported in July, this related to achieving quarter 1 A&E trajectories. The Trust has been able to access this income despite missing the A&E trajectory at a Trust level as the STF guidance states the trajectory is assessed at A&E delivery Board level, which achieved the quarter 1 target. The Trust did not achieve the financial control target for July. The guidance is clear the Trust cannot access the A&E trajectory despite achieving the A&E trajectory for July.

Other Operating Income £0.7m favourable in the month, £0.9m favourable relating to STP costs (offset by additional costs), £0.2m favourable due to COS VAT rebate for 1617 partly offset by adverse variance relating to private patient income and £0.25m.

Pay was £0.4m adverse in the month, Medical staffing overspent by £0.35m mainly within Obs and Gynae (£100k adverse) and T&O (£100k adverse), Nursing overspent by £0.1m in the month which included £0.2m benefit by a release of 2016/17 agency accrual. Scientific and Technical staff continue to underspend against budget (£31k in month, £248k YTD), the main directorates are Specialist Medicine (mainly Therapy staff) £337k YTD favourable and Cancer Directorate (£156k favourable).

Non Pay was overspent by £1.2m in July, £1m adverse relating to pass through costs for STP. Julys financial position included £0.3m non recurrent benefit from release of 2016/17 financial year accruals and £0.9m unidentified CIP. Diagnostics clinical supplies increased between months by £0.2m, the main cause for the increase related to actual costs for Roche MLS activity being higher than previous estimates and plan.

Contingency reserves, the July financial position includes a reduction of £0.3m benefiting the position on a non recurrent basis. The YTD contingency value is £0.7m (4/12ths of the remaining contingency reserve) which is unallocated.

3. Expenditure Analysis

Maidstone and Tunbridge Wells NHS Trust

3a. Run Rate Analysis

Analysis of 13 Monthly Performance (£m's)

		Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Change between Months
Revenue	Clinical Income	27.2	27.2	31.4	27.9	28.0	27.5	26.9	26.4	28.7	28.5	28.0	28.8	28.6	(0.1)
	STF	0.0	0.0	2.7	0.9	0.7	0.6	(0.0)	0.0	0.8	0.4	0.4	0.6	0.3	(0.4)
	High Cost Drugs	3.1	3.3	3.5	3.5	3.4	4.4	3.7	3.3	3.6	3.3	3.9	3.5	3.5	0.0
	Other Operating Income	4.0	3.6	1.0	3.2	3.9	3.9	4.5	3.9	8.4	4.7	4.6	3.5	4.3	0.8
	Total Revenue	**34.2**	**34.1**	**38.6**	**35.4**	**36.1**	**36.3**	**35.1**	**33.5**	**41.5**	**37.0**	**36.8**	**36.5**	**36.7**	**0.3**
Expenditure	Substantive	(17.9)	(17.9)	(18.1)	(18.0)	(18.1)	(18.1)	(17.6)	(17.8)	(17.3)	(17.9)	(18.0)	(18.1)	(17.8)	0.3
	Bank	(0.7)	(0.9)	(0.8)	(0.8)	(0.8)	(1.0)	(1.1)	(0.8)	(1.0)	(0.9)	(0.9)	(0.9)	(1.1)	(0.2)
	Locum	(1.1)	(1.1)	(0.8)	(0.9)	(0.5)	(1.9)	(1.1)	(0.9)	(1.6)	(1.4)	(1.0)	(1.0)	(1.1)	(0.1)
	Agency	(1.5)	(1.3)	(1.2)	(1.4)	(1.6)	(0.1)	(0.8)	(0.9)	(1.0)	(0.8)	(0.8)	(0.8)	(0.5)	0.3
	Pay Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.2)	(0.2)	(0.2)	(0.2)	0.0
	Total Pay	(21.3)	(21.2)	(20.9)	(21.1)	(20.9)	(21.1)	(20.5)	(20.5)	(20.8)	(21.3)	(21.0)	(21.1)	(20.8)	0.3
Non-Pay	Drugs & Medical Gases	(3.8)	(4.0)	(4.5)	(3.9)	(4.8)	(4.6)	(4.2)	(4.0)	(5.1)	(4.2)	(4.6)	(4.6)	(4.2)	0.4
	Blood	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	0.0
	Supplies & Services - Clinical	(2.7)	(3.0)	(2.7)	(2.7)	(2.6)	(2.8)	(2.7)	(2.5)	(3.1)	(2.6)	(2.8)	(2.7)	(2.7)	0.0
	Supplies & Services - General	(0.4)	(0.5)	(0.4)	(0.5)	(0.5)	(0.5)	(0.4)	(0.4)	(0.6)	(0.4)	(0.5)	(0.5)	(0.5)	0.0
	Services from Other NHS Bodies	(0.6)	(0.6)	(0.7)	(0.7)	(0.6)	(0.7)	(0.6)	(0.7)	(0.5)	(0.8)	(0.7)	(0.6)	(0.7)	(0.0)
	Purchase of Healthcare from Non-NHS	(0.9)	(0.9)	(0.6)	(0.8)	(0.7)	(0.7)	(0.8)	(0.5)	(0.5)	(0.5)	(0.5)	(0.2)	(0.3)	(0.1)
	Clinical Negligence	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.7)	(1.7)	(1.7)	(1.7)	(0.0)
	Establishment	(0.4)	(0.3)	(0.4)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	0.1
	Premises	(1.9)	(1.7)	(1.2)	(1.7)	(1.4)	(1.8)	(1.8)	(1.7)	(1.7)	(2.0)	(2.3)	(1.6)	(1.7)	(0.0)
	Transport	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	Other Non-Pay Costs	(0.4)	(0.2)	(0.3)	(0.3)	(0.9)	(0.9)	(1.2)	(0.7)	(0.5)	(1.5)	(1.1)	(0.7)	(1.4)	(0.7)
	Non-Pay Reserves	(0.4)	(0.4)	0.4	0.0	0.0	0.0	0.0	0.0	1.3	(0.1)	(0.1)	(0.1)	0.2	0.3
	Total Non Pay	(13.3)	(13.4)	(12.3)	(12.9)	(13.6)	(14.1)	(13.8)	(12.7)	(12.9)	(14.4)	(14.9)	(13.5)	(13.6)	(0.1)
	Total Expenditure	(34.6)	(34.6)	(33.1)	(34.0)	(34.5)	(35.2)	(34.3)	(33.2)	(33.7)	(35.7)	(35.9)	(34.6)	(34.3)	0.2
EBITDA	EBITDA	(0.4)	(0.5)	5.5	1.4	1.6	1.2	0.8	0.3	7.8	1.3	0.9	1.9	2.4	0.5
		-1%	*-1%*	*14%*	*4%*	*4%*	*3%*	*2%*	*1%*	*19%*	*4%*	*2%*	*5%*	*6%*	
Other Finance Costs	Depreciation	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(0.8)	0.8	(1.0)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(0.0)
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	0.0
	Dividend	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	0.7	0.1	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	PFI and Impairments	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.2)	(1.1)	(42.3)	(1.2)	(1.2)	(1.2)	(1.2)	(1.2)	(0.0)
		(2.8)	**(2.8)**	**(2.9)**	**(2.9)**	**(2.9)**	**(2.4)**	**(0.7)**	**(42.7)**	**(2.4)**	**(2.6)**	**(2.5)**	**(2.6)**	**(2.6)**	**(0.0)**
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(3.2)	(3.3)	2.6	(1.5)	(1.3)	(1.2)	0.1	(42.4)	5.4	(1.3)	(1.6)	(0.7)	(0.2)	0.5
Technical Adjustments	Technical Adjustments	0.1	0.1	0.1	0.1	0.1	(0.0)	0.1	40.3	(0.1)	0.0	0.0	0.0	0.0	(0.0)
Surplus/ Deficit (-) to B/E Duty Incl STF	Surplus/ Deficit (-) to B/E Duty	(3.1)	(3.3)	2.7	(1.4)	(1.2)	(1.3)	0.3	(2.0)	5.3	(1.2)	(1.6)	(0.7)	(0.2)	0.5
Surplus/ Deficit (-) to B/E Duty Excl STF	Surplus/ Deficit (-) to B/E Duty	(3.1)	(3.3)	(0.0)	(2.3)	(1.9)	(1.9)	0.3	(2.0)	4.5	(1.6)	(2.0)	(1.3)	(0.4)	0.9

Maidstone and Tunbridge Wells NHS Trust

4. Cost Improvement Programme

4a. Current Month Savings by Directorate

	Current Month		
	Actual	*Original Plan*	*Variance*
	£m	£m	£m
Cancer and Haematology	0.1	0.2	(0.1)
Critical Care	(0.0)	0.2	(0.2)
Diagnostics	0.1	0.2	(0.2)
Head and Neck	0.1	0.1	(0.0)
Surgery	0.1	0.2	(0.1)
Trauma and Orthopaedics	0.5	0.6	(0.1)
Patient Admin	0.0	0.0	(0.0)
Private Patients Unit	0.0	0.0	(0.0)
Total Planned Care	**0.8**	**1.5**	**(0.7)**
Urgent Care	**0.3**	**0.8**	**(0.5)**
Womens, Childrens and Sexual Health	**0.2**	**0.4**	**(0.2)**
Estates and Facilities	**0.3**	**0.3**	**0.0**
Corporate	**0.3**	**0.2**	**0.1**
Total	**1.9**	**3.2**	**(1.3)**

Comment

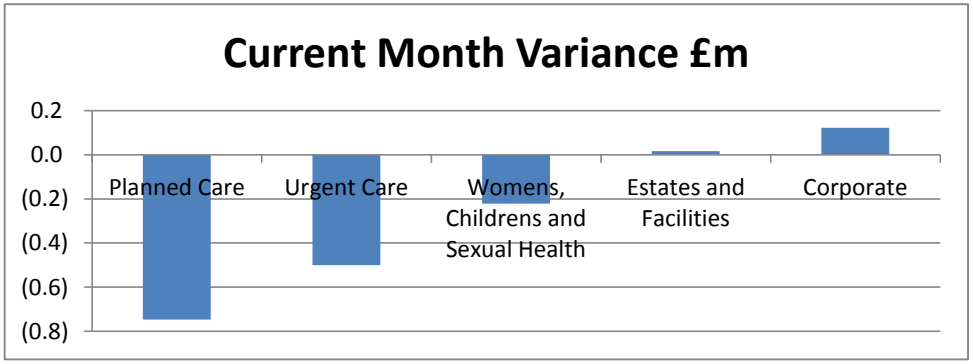
The Trust achieved £1.9m savings in July, an increase of £0.5m compared to June however this was £1.3m adverse to plan. The plan includes £2m unidentified savings phased from July.

The plan value is based upon the Trusts submitted plan to NHSI in December 16 and March 17. The Trust has a 'live' plan for monitoring the actuals and phasing of the CIP programme. Based upon the 'live plan the savings achieved in July were £1m below plan.

Planned Care: £748k adverse compared to original CIP planned phasing, and £798k adverse in July when compared to the 'live' plan. The main directorates adverse to plan are T&O (£297k) due to outsourcing and procurement savings, Critical care (£162k adverse) all of which relate to procurement savings (£140K) and Diagnostics (£114k) which relates to procurement.

Urgent Care: £0.5m adverse compared to the original plan, when compared to the 'live' plan the directorate are £103k adverse in the month which is mainly due to slippage in closing 1 ward (£0.1m) and drugs (£66k).

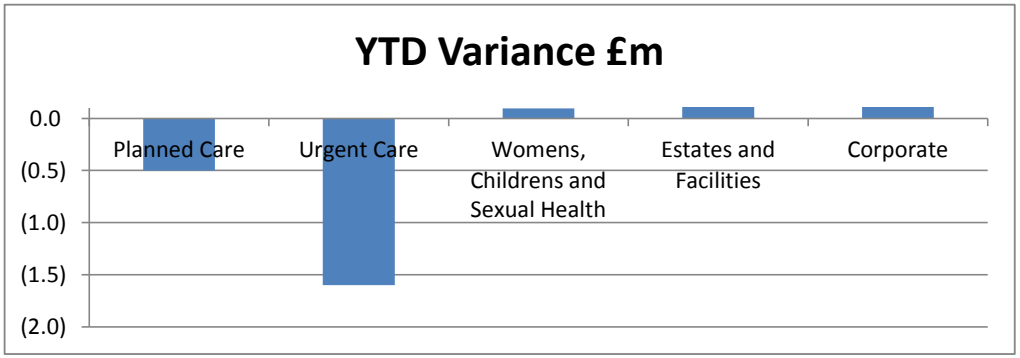
Womens, Childrens and Sexual Health: £0.2m adverse compared to the original plan however when compared to the 'live' plan the directorate were £27k favourable, the adverse variance is caused by unidentified CIP.



Maidstone and Tunbridge Wells NHS Trust

4b. Year to Date savings by Directorate

	YTD		
	Actual	*Original Plan*	*Variance*
	£m	£m	£m
Cancer and Haematology	0.3	0.5	(0.2)
Critical Care	0.2	0.5	(0.3)
Diagnostics	0.2	0.4	(0.2)
Head and Neck	0.2	0.2	0.0
Surgery	0.3	0.4	(0.1)
Trauma and Orthopaedics	1.7	1.4	0.2
Patient Admin	0.0	0.0	0.0
Private Patients Unit	0.0	0.0	(0.0)
Total Planned Care	**3.0**	**3.5**	**(0.5)**
Urgent Care	**0.6**	**2.2**	**(1.6)**
Womens, Childrens and Sexual Health	**0.6**	**0.5**	**0.1**
Estates and Facilities	**0.5**	**0.3**	**0.1**
Corporate	**0.7**	**0.4**	**0.3**
Total	**5.4**	**7.0**	**(1.6)**



Comment

The Trust has achieved £5.4m savings YTD which is £1.6m adverse to plan.

The plan value is based upon the Trusts submitted plan to NHSI in December 16 and March 17. The Trust has a 'live' plan for monitoring the actuals and phasing of the CIP programme. Based upon the 'live plan the savings achieved YTD were £1.8m below plan.

Planned Care: £0.5m adverse compared to original CIP planned phasing, £1.2m slippage YTD when compared to the 'live' plan. The main directorate adverse to plan is Diagnostics (£408k adverse) which is due to procurement 10% savings target £280k and £50k delay in implementation of the new MLS contract. Critical Care directorate (£230k adverse) due to procurement schemes slipping (£170k), Cancer Directorate (£212k adverse) . There was also a £50k delay in charging for private MDM appointments.

Urgent Care: £1.6m adverse compared to the original plan, when compared to the 'live' plan the directorate are £411k adverse YTD. This is due to delay in closing 1 ward, £300k slippage in procurement savings and £66k slippage in drug savings.

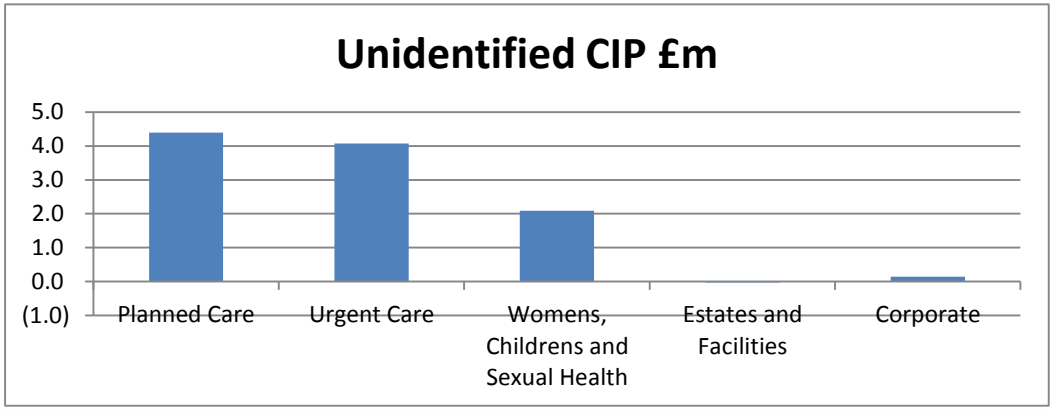
Womens, Childrens and Sexual Health: £0.1m favourable compared to the original plan, when compared to the 'live' plan the directorate are on plan although the division has £2.1m risk adjusted unidentified CIP.

Maidstone and Tunbridge Wells NHS Trust

4c. Forecast savings by Directorate

Directorate Performance

	Forecast Savings			
	Risk Adjusted Forecast	*Unidentified (Risk Adjusted)*	*Plan*	*% Unidentified*
	£m	£m	£m	
Cancer and Haematology	1.2	0.8	2.0	40%
Critical Care	1.0	1.2	2.2	55%
Diagnostics	1.2	0.9	2.2	43%
Head and Neck	0.7	0.3	1.0	31%
Surgery	1.0	0.8	1.8	45%
Trauma and Orthopaedics	4.8	0.3	5.1	6%
Patient Admin	0.1	0.0	0.1	45%
Private Patients Unit	0.1	0.0	0.2	18%
Total Planned Care	**10.1**	**4.4**	**14.5**	**30%**
Urgent Care	**4.8**	**4.1**	**8.9**	**46%**
Womens, Childrens and Sexual Health	**1.6**	**2.1**	**3.7**	**57%**
Estates and Facilities	**2.9**	**(0.0)**	**2.9**	**-1%**
Corporate	**1.7**	**0.1**	**1.9**	**7%**
Total	**21.1**	**10.7**	**31.7**	34%



The Trust has a £31.7m CIP plan for 2017/18 and has identified £25.5m (non risk adjusted) , £6.2m unidentified. The current forecasted risk adjusted identified savings is £21.1m, a shortfall of £10.6m.

Planned Care Division have identified £12.6m savings which is risk adjusted to deliver £10.1m. The division has £4.4m risk adjusted shortfall (30%).

Urgent Care Division have identified £6.6m savings which is risk adjusted to deliver £4.8m. The division has £4.1m risk adjusted shortfall (46%).

W&CH Division have identified £1.7m savings which is risk adjusted to deliver £1.5m. The division has £2.1m risk adjusted shortfall (58%).

5. Balance Sheet

Maidstone and Tunbridge Wells NHS Trust

5a. Balance Sheet

July 2017

The Trust Balance Sheet is produced on a monthly basis and reflects changes in the asset values, as well as movement in liabilities.

	July			June	Full year	
£m's	**Reported**	**Plan**	**Variance**	**Reported**	**Plan**	**Forecast**
Property, Plant and Equipment (Fixed Assets)	276.3	275.9	0.4	277.1	282.1	282.1
Intangibles	2.9	2.8	0.1	3.0	2.1	2.1
PFI Lifecycle	0.0	0.0	0.0	0.0	0.0	0.0
Debtors Long Term	1.5	1.2	0.3	1.6	1.2	1.2
Total Non-Current Assets	**280.7**	**279.9**	**0.8**	**281.7**	**285.4**	**285.4**
Current Assets						
Inventory (Stock)	7.5	8.3	(0.8)	7.4	8.3	8.3
Receivables (Debtors) - NHS	42.3	30.3	12.0	42.0	21.0	21.0
Receivables (Debtors) - Non-NHS	16.9	9.5	7.5	15.9	9.5	9.5
Cash	7.2	7.3	(0.0)	4.9	1.0	1.0
Assets Held For Sale	1.7	0.0	1.7	1.7	0.0	0.0
Total Current Assets	**75.7**	**55.3**	**20.4**	**72.0**	**39.8**	**39.8**
Current Liabilities						
Payables (Creditors) - NHS	(4.4)	(4.5)	0.1	(4.2)	(4.5)	(4.5)
Payables (Creditors) - Non-NHS	(73.8)	(38.9)	(34.9)	(70.6)	(13.6)	(13.6)
Capital & Working Capital Loan	(2.2)	(2.2)	0.0	(2.2)	(19.1)	(19.1)
Temporary Borrowing	0.0	0.0	0.0	0.0	0.0	0.0
Borrowings - PFI	(5.0)	(5.0)	(0.0)	(5.0)	(5.5)	(5.5)
Provisions for Liabilities and Charges	(1.8)	(1.1)	(0.7)	(1.8)	(1.3)	(1.3)
Total Current Liabilities	**(87.2)**	**(51.7)**	**(35.5)**	**(83.7)**	**(44.0)**	**(44.0)**
Net Current Assets	(11.5)	3.6	(15.1)	(11.8)	(4.2)	(4.2)
Finance Lease - Non- Current	(196.4)	(196.9)	0.5	(196.8)	(192.7)	(192.7)
Capital Loan - (interest Bearing Borrowings)	(12.3)	(12.3)	0.0	(12.3)	(10.2)	(10.2)
Interim Revolving Working Capital Facility	(29.0)	(29.3)	0.3	(29.0)	(16.1)	(16.1)
Provisions for Liabilities and Charges	(1.2)	(0.6)	(0.6)	(1.2)	(0.4)	(0.4)
Total Assets Employed	**30.2**	**44.3**	**(14.0)**	**30.4**	**61.8**	**61.8**
Financed By						
Capital & Reserves						
Public dividend capital	(205.0)	(205.0)	(0.0)	(205.0)	(208.6)	(208.6)
Revaluation reserve	(30.3)	(30.3)	0.0	(30.3)	(36.2)	(36.2)
Retained Earnings Reserve	205.0	190.9	14.1	204.8	182.9	182.9
Total Capital & Reserves	**(30.2)**	**(44.3)**	**14.1**	**(30.4)**	**(61.8)**	**(61.8)**

Commentary:
The balance sheet is £14.1m or 32% less than plan, primarily due to significant variations in current assets and current liabilities. Key movements to July are in working capital where Total Current Liabilities increased to 68.7% over plan. The teams are continuing to focus on reducing the aged debtors and creditors and reviewing current processes to ensure improvement in working capital going forward.

Non-Current Assets (PPE) - The value of PPE has decreased from the June's position as assets are depreciated. The in-year capital programme has been prioritised and business cases are currently being prepared.

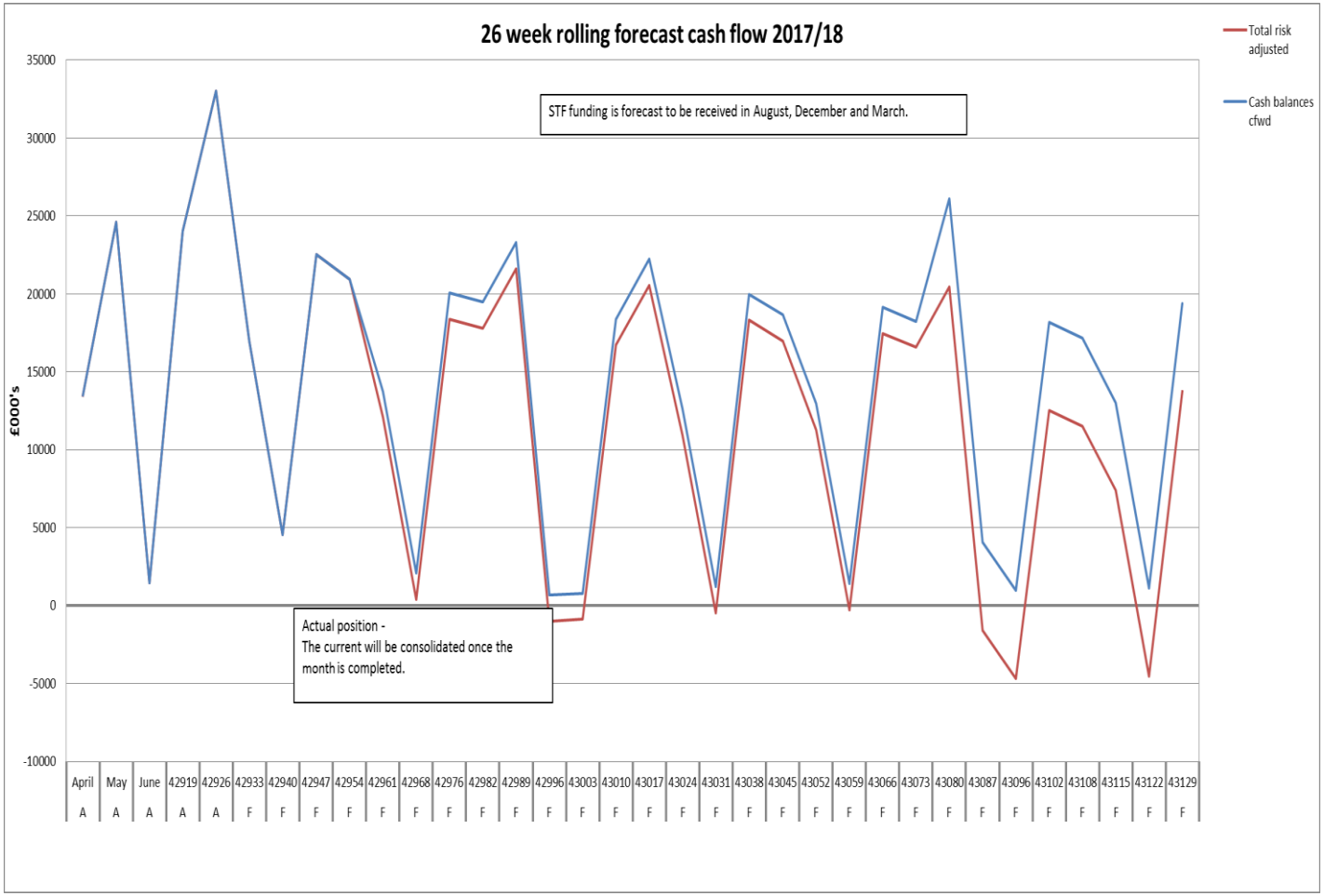
Current Assets - Inventory has increased slightly from the reported June's position, pharmacy stock remains at £3.3, materials management stock remains at £1m. Inventory reduction is a cash management strategy.
NHS Receivables have increased by £0.3m over the June reported position, being above the plan value by £12.0m. Of the £42.3m balance, £18.9m relates to invoiced debt of which £6.2m is aged debt over 90 days. Debt over 90 days has increased by £1.1m compared with the June reported position. The remaining £23.4m relates to accrued income. Due to the financial situation of many neighbouring NHS organisations regular communication is continuing and "like for like" arrangements are being actioned.
Trade receivables has increased compared with the June reported position by £1m, and is above plan by £7.5m. Included within this balance is trade invoiced debt of £2.7m which has increased by £207k compared to June and private patient invoiced debt of £0.4m which has reduced from the June position by £148k.

Current Liabilities - NHS payables have increased from the June reported position by £0.3m and are below the plan of £4.5m. Non-NHS trade payables has increased since June by £3.2m and remain significantly above the plan of £38.9m.

Of the £78.2m creditor balances, £27.3m relates to invoices, £27.99m is deferred income primarily relating to double block from West Kent CCG, High Weald CCG and Medway CCG, and other funding for PAS AllScript and LDA. The remaining £22.9m relates to accruals, including TAX, NI, Superannuation, PDC and deferred income.

Maidstone and Tunbridge Wells NHS Trust

5b. Cash Flow



Commentary

The blue line shows the Trust's cash position from the start of April, after receiving double block from West Kent CCG, High Weald CCG and Medway CCG

For 17/18 the Trust is assuming no receipt of External Revenue Financing, compared to 2016/17 where the Trust received £12.1m IRWCF.

The risk adjusted items on the graph relate to STF Funding for Qrts 1,2 and 3, along with £1.7m asset sales forecast for receipt in December. If this income is not received these will be mitigated by proposed strategies.

The other risk adjusted item relates to a capital loan of £4m which is mitigated by reducing the capital spend.

The cash flow is based on the Income and Expenditure plan along with working capital adjustments.

6. Capital

Maidstone and Tunbridge Wells NHS Trust

6a. Capital Programme

Capital Projects/Schemes

	Year to Date			Annual		
	Actual	*Plan*	*Variance*	*Plan*	*Forecast*	*Variance*
	£000	£000	£000	£000	£000	£m
Estates	114	3,573	3,459	8,873	9,518	-645
ICT	211	730	519	1,664	1,664	0
Equipment	89	1,317	1,228	5,909	4,016	1,893
PFI Lifecycle (IFRIC 12)	0	0	0	502	502	0
Donated Assets	0	150	150	450	450	0
Total	**414**	**5,770**	**5,356**	**17,398**	**16,150**	**1,248**
Less donated assets	0	-150	-150	-450	-450	0
Asset Sales (net book value)	0	0	0	-1,727	-1,727	0
Contingency Against Non-Disposal	0	0	0	0	0	0
Adjusted Total	**414**	**5,620**	**5,206**	**15,221**	**13,973**	**1,248**

The Trust approved an initial Capital Plan of £17.4m, made up by Capital resources of £14.8m depreciation; the Net Book Value of £1.7m for the proposed asset sales (Springs and Hillcroft properties); an estimate of donated assets of £0.45m; requested Central PDC funding for 2 Linacs of £3.6m ; and a proposed Salix loan of £4m for the Energy Infrastructure programme; less £7.7m of existing capital loan repayments.

A major scheme for the Energy Infrastructure will be dependent on the successful application for a Salix loan. Build work on Linac 1 bunker at Maidstone started in mid May, the Linac machine was delivered onsite on 29th July, commissioning the equipment will start ready for clinical use by Dec17. The Trust requested additional PDC funding for the next 2 Linacs, however, only 1 Linac has been approved for 17/18 (£1.7m). The equipment will be put into storage until ready for delivery to the Trust in 18/19.

The Trust has been awarded £645k for GP A&E Streaming works, as additional PDC. The net impact of these 2 changes to Plan is a revised FOT of £16.1m, prior to donations and asset disposals.

The donated equipment is mainly made up of the remaining Cardiology legacies.

Trust Board meeting - September 2017

NHS Maidstone and Tunbridge Wells NHS Trust

9-12 Update on the anticipated inspection by the CQC Chief Nurse

The purpose of this report is to provide members of the Trust Board an update on the anticipated unannounced and announced inspection by the CQC.

The Trust received the Routine Provider Information Request (PRIR) from the CQC on the 24th July 2017. The requirement consisted of quantative and qualitative questions for the Acute provider RPIR and the Universal RPIR which included associated document logs for the provision of evidence. The Trust successfully submitted the completed RPIR's and evidence requested on the 14th August 2017.

The Trust is one of the early adopters to be part of the changes to the CQC's new inspections and framework strategy. The RPIR which is now an annual process, and future inspections use a new framework around the five Key Ley Lines of Enquiries (KLOEs);

Is the practice SAFE
Is the practice EFFECTIVE
Is the practice CARING
Is the practice RESPONSIVE
Is the practice WELL-LED

Inspections will take on a more targeted, responsive and collaborative approach using intelligent monitoring through a new "insight model". The new framework will require the Trust to complete the RPIR on an annual basis. The Trust anticipate the unannounced visit to inspect ALL aspects of the KLOE's but have been advised that the planned visit will focus on the WELL-LED domain. The Trust anticipates the unannounced visit to take place any time from now with the announced visit due in December 2017, exact date to be announced.

A central project team has been formed to manage the CQC inspections to ensure the Trust's preparation for these visits both now and for the future management to progress to a business as usual approach aligned to the new annual CQC strategy and framework. This project group meets weekly and is accountable to and reports into the Executive Management team meeting, the Trust Management Executive, and the Clinical Governance Committee. Its duties include monitoring progress and assurance of actions pertaining to the Trust's overarching Quality Improvement Plan, the project plan, issues log and communication strategy. Nominated leads within the group will receive issues and actions from the project group and / or daily escalation of issues / actions raised at the daily conference call known as the "huddle". Membership is representative of the Trusts organisational structure to include all Divisions, Directorates and Specialities / Core services.

The overarching project plan has been developed with input from key stake holders in the project group to map clear objectives, timelines, and activities and to ensure the monitoring and achievement against these. There are 6 key phases which include;

- PHASE 1 - Provider Information Request (PIR) Data Collection/Submission - Completed on schedule
- PHASE 2A - Replies to Phase 1 Data Submission – in progress
- PHASE 2B - Preparation for Unannounced CQC Visit – in progress
- PHASE 2C – Communication – in progress and ongoing
- PHASE 3 - Well Led Domain Self-Assessment (in preparation for Announced Visit) - in progress
- PHASE 4 - Announced Visit (Dec 2017 TBC) – in progress
- PHASE 5 - Post Inspection
- PHASE 6 - Wrap up/Handover/BAU

The management of the project plan is on schedule with Phase 1 completed and Phases 2– 4 running co currently. Activities for preparation have included:

- Quality Improvement plan monitoring, evaluation and assurances against actions in progress and will be ongoing with review against “Must do’s”, “Should do’s” and the addition of “New do’s”.
- CQC presentation which has been shared at the project group and is being disseminated through the nominated leads to deliver the presentation within the Divisions, Directorates and speciality settings through local meetings. This has also been presented at the Nursing Engagement Learning Forum (NELF) and is scheduled for Clinical Directors and at Grand Rounds.
- The CQC intranet page has been updated which is easily accessed via a direct link available from the intranet “home” page. This provides general information for the anticipated inspections; the RPIR’s are available for all staff to review, a “Frequently Asked Questions”(FAQs) page and the Trust reports from 2014.
- The mtw-tr.cqc@nhs.net e-mail address has been shared widely providing an opportunity for all staff to raise any issues or concerns relating to CQC preparedness and is a platform for the Trusts responsiveness in resolving any issues.
- The issues and risk log is managed on a daily basis and monitored through the daily huddle.
- Continued roll out of the Corporate Quality Rounds to;
    - Reinforce standards, raise awareness and enhance high quality care
    - Ensure a highly visible and approachable corporate team,
    - Enable auditable senior level “walk arounds” which are credible and add value
    - Encourage engagement and foster an open culture
- The Internal Assurance inspection process has also been increased with the intention of undertaking 2 inspections per month to maximise the potential to identify areas of good practice, identify key concerns and opportunities to make improvements.
- A weekly ‘Take 5 Talk 5’ campaign has been launched to heighten awareness of key areas of focus and are aligned to the 5 KLOEs which is shared via global e-mail for all staff each Friday
- Cascade information and hospitality plan designed for arrival of inspectors.
- “Welcome to Maidstone and Tunbridge Wells NHS Trust” information pack for inspectors written.
- Communications in place to send to local MP’s to advise of anticipated inspections
- Staff letters will be attached to the September pay slip to provide information to all staff regarding the Trusts CQC inspections and preparation alongside the FAQs.

The aspiration and intention of this project plan is to ensure that MTW can transition from a ‘Requires Improvement’ status to one of ‘Good’ but most importantly to ensure that we continue to strive to improve the standard of care that we provide to our patients and improve work processes which will benefit our staff in the way they deliver this care. The project plan will establish a new way of monitoring progress and achievements against the quality improvement plan with the continuation of CQC project group post inspection to embed CQC management into our business as usual and align the Trusts ongoing preparedness to the CQCs new strategy.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

For 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

Trust Board meeting - September 2017

NHS Maidstone and Tunbridge Wells NHS Trust

9-13	The outcome of the investigations into the recent alleged assaults at the Trust	Chief Nurse

Summary / Key points

Since the start of the year there has been a number of serious incidents (SI) declared that related to alleged assault to patients. The Serious Incident Reporting Framework requires any such allegation to be declared within 48hrs of becoming aware of the occurrence. The allegations can be grouped as follows:

Site	Location	Alleged victim (Adult/Child*)	Alleged perpetrator	Outcome
TWH	AMU	Adult patient	Adult patient	Partially upheld
	ED	Child patient	Staff	Partially upheld
	Endoscopy x 3^	Adult patient	Staff	Not upheld
Maidstone	ED	Adult patient	Staff	Not upheld
	ED	Adult patient	Staff	Not upheld
	Foster	Child patient	Adult patient	Upheld
	AMU	Adult patient	Adult visitor	Not upheld
	Foster x 2	Adult patient	Staff	Case open
	Endoscopy x 3^	Adult patient	Staff	Not upheld

*Child = patient up to the age of 18 years.

^ of the 6 endoscopy allegations only 3 were raised as SIs

Between July 2016 and March 2017 there have been six allegations of assault made by patients undergoing endoscopy procedures. Three of these allegations came to light via the complaints route and three were formal safeguarding reports.

An independent internal review was undertaken by the Associate Director of Nursing for Planned Care, with support and professional advice from the Associate Director of Quality Governance and the Deputy Chief Nurse. A full Root Cause Analysis meeting was held to review all the cases collectively. These cases have been discussed in detail at the Critical Care and Specialist Medicine governance committees and the Endoscopy Users Group.

There is good oversight of the both the investigation and any emerging themes. This oversight is provided via the Learning & Improvement Panel, the Safeguarding Review Panel, the Trust's Safeguarding Adults Committee and regular joint case reviews with the Kent Safeguarding Adults Coordinator and the Designated Nurse for Safeguarding Adults.

The review process has not identified any emerging trends or themes that would give cause for concern. The cluster of cases involving the endoscopy team was identified, and links were made between those reported via the formal safeguarding reporting and those raised as more general concerns via PALS/Complaints route.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

[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 report has been prepared by John Kennedy, Deputy Chief Nurse to provide a summary of the findings from a review of a number of allegations of assault. This includes a cluster review of cases identified as part of the standard incident trend analysis, which occurred in Endoscopy.

2. Background:

Since the start of the year there has been a number of serious incidents (SI) declared that related to alleged assault to patients. The Serious Incident Reporting Framework requires any such allegation to be declared within 48hrs of becoming aware of the occurrence.

All incidents were also reported as safeguarding adult alerts in line with the requirements of the Care Act 2014 (implementation in April 2015).

The definition of an adult at risk of harm changed with the implementation of the Care Act in 2015. The definition is now broader and more inclusive than before, meaning many cases that would not have met the threshold in previous years do so now (the endoscopy unit cases would be good examples of this).

The definition of an adult at risk of harm is:

An adult who:

- Has needs for care and support (whether or not the Local Authority is meeting any of those needs) and;
- Is experiencing, or at risk of, abuse or neglect, and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Abuse or neglect may be deliberate, or the result of negligence or ignorance. Unintentional abuse or neglect may occur owing to life pressures or as a result of challenging behaviour which is not being properly addressed.

Breakdown of incidents:

The allegations can be grouped as follows:

Site	Location	Alleged victim (Adult/Child*)	Alleged perpetrator	Outcome
TWH	AMU	Adult patient	Adult patient	Partially upheld
	ED	Child patient	Staff	Partially upheld
	Endoscopy x 3^	Adult patient	Staff	Not upheld
Maidstone	ED	Adult patient	Staff	Not upheld
	ED	Adult patient	Staff	Not upheld
	Foster	Child patient	Adult patient	Upheld
	AMU	Adult patient	Adult visitor	Not upheld
	Foster x 2	Adult patient	Staff	Case open
	Endoscopy x 3^	Adult patient	Staff	Not upheld

*Child = patient up to the age of 18 years.

^ of the 6 endoscopy allegations only 3 were raised as SIs

There were two incidents of alleged patient to patient assault, and one visitor to patient assault.

Between July 2016 and March 2017 there have been six allegations of assault made by patients undergoing endoscopy procedures. Three of these allegations came to light via the complaints route and three were formal safeguarding reports.

Initially each case was reviewed and managed as it came to light. When the third formal safeguarding concern came to light, the emerging trend was reported to the Executive Team via the Learning and Improvement Panel (formally the S.I. Panel) and the Trust Clinical Governance Committee.

3. Investigation oversight:

The Trust's Learning and Improvement Panel convened a Safeguarding Review Panel to review the investigation outcomes to ensure that a robust enquiry had been undertaken and to facilitate triangulation and dissemination of any lessons learnt.

The Safeguarding review panel is chaired by the Deputy Chief Nurse and membership includes the Safeguarding Adults Matron, the Named Nurse for Safeguarding Children and the Patient Safety Manager.

The Safeguarding adult investigations are subsequently reviewed by the Safeguarding Adults Coordinator from the Local Authority (in this case Kent County Council).

In all cases the allegations were raised as safeguarding alerts and were screened by the Local Authority Central Referral Unit (CRU). Telephone triage is also undertaken with the Police either via the CRU or via the Public Protection Unit (PPU) prior to any internal investigation taking place. This is to ensure that trust staff do not inadvertently invalidate evidence prior to a police investigation should the police wish to investigate.

The endoscopy cases were subject to a review as a 'cluster'. This review was undertaken by the Associate Director of Nursing for Planned Care, with support and professional advice from the Associate Director of Quality Governance and the Deputy Chief Nurse. A full Root Cause Analysis meeting was held to review all the cases collectively. The meeting attendance included:

- Clinical Director & Consultant Gastroenterologist,
- Consultant Gastroenterologist Lead for Endoscopy
- Consultant Anaesthetist and CD for Critical Care
- Endoscopy Unit Managers for both sites
- General Manager for Critical Care
- Lead Matron for Critical Care
- Safeguarding Adults Matron

4. Investigation Methodology:

Safeguarding investigations adhere to the same principles of investigation as other incidents. This includes involvement of the patient/alleged victim where possible when drafting the terms of reference for the investigation. Reference is made to relevant national and local policy and compared with recorded and/or reported actions and intervention.

In the case of safeguarding investigations staff interviews are not commenced until a consultation with Police colleagues has been completed and the Police have confirmed that they are content for us to proceed with our internal investigation.

The investigation review of the endoscopy cluster of cases used a variety of investigatory techniques including a thematic review of the health care records, review and correlation of relevant clinical guidelines, and staff accounts related to the specific complaints and wider approaches to practice. The data had multi-disciplinary input from medical, nursing and safeguarding experts as well as managerial oversight.

Guideline and policy reviews included national and local sedation guidelines, Joint Advisory Group on GI Endoscopy (JAG), consent policy and withdrawal of consent during a produce (local peer reviewed Endoscopy guideline).

The review also considered volume of cases, case mix by age and gender as well as service user feedback and satisfaction surveys over the last year.

5. Findings:

There was some correlation between 4 of the cases (excluding the endoscopy cases) in that the patients involved all had a level of cognitive impairment, either age related, organic cause or exacerbation of a known mental health illness.
The learning from these relates to consideration of the use of enhanced care, de-escalation skills and recognition of changing behaviours. In one case the change in behaviour had been noted but the level of risk to others was not fully recognised at the time.

The child/staff case learning related to the communication challenges surrounding a child with learning difficulty who was in pain, an anxious parent and the need to apply a splint. Learning centred on how expectations are managed, and how parents and carers are engaged with the initial explanation to the patient.

Where cases have not been upheld, this has been due to lack of evidence or where descriptions of events are unable to be safely corroborated. One of these alerts was raised via a third party, on further investigation (with police involvement) the alleged victim was clear that nothing untoward had happened.

The review of the endoscopy cluster of cases considered the types of procedures, the operators, any correlation between cases for nursing and technical staff, how patients were prepared (including consent), how they were sedated and what provision was made for patients to alert the team to any significant distress or their desire for the procedure to be abandoned

Some correlation was found with route of endoscopy, with 5 of the six cases being either Upper Gastrointestinal (Upper GI) or bronchoscopy. The remaining case was a colonoscopy. This means that 5 of the 6 cases would have required the ‘scope to be passed through the throat and thence to either the bronchus or oesophagus. In either case, throat spray and light sedation would have been used to reduce the gag reflex.

There was a range of operators, and the cases were evenly split between the two sites (3 for TWH, 3 for Maidstone), therefore there investigation was unable to establish any key link or correlation between the cases.

Following review of the staff rosters there was no correlation between operators, endoscopy unit staff or location of service.

There was lengthy discussion regarding the consent process and how patient expectation was/is managed. There was debate regarding language used; for example ‘we will pass a small tube into your throat’. It was acknowledged that, at times, a more ‘positive slant’ was taken when explaining the procedure which may led to a false sense of security. There was no clear correlation between the healthcare professionals taking consent; however there was a shared understanding and agreement that often a ‘softer’ approach is taken when explaining the procedure. This is being addressed with immediate effect.

In all cases the sedation guidance was followed appropriately in line with national recommendation for Upper GI endoscopy. The Trust Adult Conscious Sedation Guidelines were first developed in 2007, and subsequently updated following a National Patient Safety Agency Rapid Response Report (2008/RRR011). The guidelines were revised again in 2010 and 2016 as further guidance became available.

It was noted that when throat spray is used many patients will cough, and report that this is unpleasant initially. This combined with sedation can make an individual disoriented to time and place.

Discussion was had about the principle of asking a patient to raise their hand if they were uncomfortable, and how this was managed when an individual’s natural instinct is to raise their hand to the their mouth to remove the cause of irritation or discomfort. It was also noted that staff will often hold a patient’s hand to reassure them and to aid any accidental knocking of the mouth guard or the scope.

The Endoscopy Unit has a guideline in place for The Withdrawal of Consent during an Endoscopic Procedure, in line with JAG accreditation requirements. The document acknowledges the dynamic nature of consent and the challenges posed to capacity to consent once sedation has been administered. The DH reference guide to Consent to Examination or Treatment is explicitly referenced here. The document recognises the need for clinical judgement to consider the balance between the level of distress being experienced by the patient and the need to complete the endoscopy at that time. ‘The endoscopist should try to establish whether the patient has capacity to withdraw a previously given consent. If capacity is lacking, it may be justified to continue in the patient’s best interest’.

The investigation also looked at overall numbers of cases undertaken (18,770 procedures for the time under review) and patient feedback.
Patient surveys recommended by JAG include questions on levels of anxiety pre and post sedation, where sedation was offered.

There were no adverse trends noted in the patient survey feedback (c600 survey returns) and no other complaints or concerns were noted with regards to levels of sedation offered or provided.

6. Actions:

The actions resulting from the endoscopy cluster was implanted during the course of the root cause analysis meeting, as the directorate governance meeting was utilised for this. Additionally these cases have been discussed by senior members of the Critical Care Directorate and the Specialist Medical Directorate.
Further review of the conscious sedation guidelines and their application to endoscopic procedures is being undertaken.

Practice and level of information given to patients is be being reviewed, with immediate effect, to ensure that information given is both realistic and tailored to the patient's need, past experience and understanding.
Wide discussion and debate is being held both locally within the Endoscopy Departments and at directorate and divisional level.

Learning from the other cases has been considered at a variety of fora, and informs the training and development programmes.

Case studies have been developed and shared as part of the Safeguarding theme for the Safety Calendar, and included in the Trust's Governance Gazette.

There has also been debate with the Kent Safeguarding Adults Coordinator and the Kent Safeguarding Adults Board in relation the thresholds for raising safeguarding alerts. There has been a rise across the County and nationally since the change in definition of an adult at risk of harm following the implementation of the Care Act (2014) which went live in April 2015.

7. Conclusion:

The change in definition of an adult at risk of harm has resulted in an increase in the number of safeguarding alerts overall. The Trust has an improving reporting culture for safeguarding concerns, and the directorate teams are seeking appropriate support to ensure robust investigations are undertaken.

There is good oversight of both the investigation and any emerging themes. This oversight is provided via the Learning & Improvement Panel, the Safeguarding Review Panel, the Trust's Safeguarding Adults Committee and regular joint case reviews with the Kent Safeguarding Adults Coordinator and the Designated Nurse for Safeguarding Adults.

The review process has not identified any emerging trends or themes that would give cause for concern. The cluster of cases involving the endoscopy team was identified, and links were made between those reported via the formal safeguarding reporting and those raised as more general concerns via PALS/Complaints route.

John Kennedy
Deputy Chief Nurse
August 2017.

Trust Board meeting - September 2017

NHS Maidstone and Tunbridge Wells NHS Trust

9-14	**ANNUAL REPORT FROM THE DIRECTOR OF INFECTION PREVENTION AND CONTROL (INCLUDING TRUST BOARD ANNUAL REFRESHER TRAINING)**	**DIRECTOR OF INFECTION PREVENTION AND CONTROL**

The enclosed report provides a summary of infection prevention and control activity in the Trust between April 2016 and March 2017.

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

This year healthcare associated infections have been sustained at previous low levels, building on previous successes over the last ten years. Infection levels have been well controlled and there have been no major outbreaks of infection.

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

This report also provides a briefing and training for Board members on the key information they need to fulfil their duties with respect to infection prevention and control.

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

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

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

Maidstone and Tunbridge Wells NHS Trust

Director of Infection Prevention and Control - Annual Report to the Board 2016/17

1. Executive Summary

This report outlines the activities of the Trust relating to infection prevention and control for the financial year 2016/17 including key achievements. It describes the Trust arrangements to allow early identification of patients with infections and measures taken to reduce the spread of infections to others.

The report also provides a briefing and training for Board members on the key information they need to fulfil their duties with respect to infection prevention and control.

Prevention and control of healthcare associated infections (HCAIs) is a key priority for Maidstone and Tunbridge Wells NHS Trust which has an infection prevention and control strategy and programme of activities including national initiatives for the reduction of infection rates.

The Infection Prevention Team (IPT) advises and co-ordinates activities to prevent and control infection; however it is the responsibility of all staff in the organisation to comply with Trust policies and implement guidelines in their local area. The IPT also works closely with other stakeholders in relation to strategies for prevention of infection including Commissioning CCGs, Public Health England and Regional Specialist Laboratories.

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

By the end of the year the Trust had maintained very low levels of MRSA and *C. difficile* infections.

Maidstone and Tunbridge Wells NHS Trust maintains compliance with CQC Outcome 8 Regulation 12 “Cleanliness and Infection Control” and the Health & Social Care Act 2008 (and its 2015 update).

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2. Our year in numbers

3. Successes

The Infection Prevention team (IPT) has had success in 2016/17, building on previous year's improvements, ensuring sustained reductions in healthcare associated infections (HCAIs) and achieving the planned reductions.

The Trust continued to sustain low levels of *C. difficile* infection. The number of cases seen was 28, exceeding the nationally set objective by one case, but achieving the rate objective at 10.4/100 000 bed days against an objective of 11.4/100 000. Overall a reduction of 95% has been seen over the last 11 years.

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

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

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

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

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

The Infection Prevention Team were awarded the Innovation Team of the Year award at the Trust Staff Star awards and also were named as Infection Prevention Society Runner-up team of the year for 2016.

The DIPC was invited to speak at the Federation of Infection Societies/Hospital Infection Society conference in November 2016 on the Trust's ten year journey from 'Zero to Hero'.

4. Structure

The Chief Nurse is the executive lead for Quality within the Trust.

Maidstone and Tunbridge Wells NHS Trust

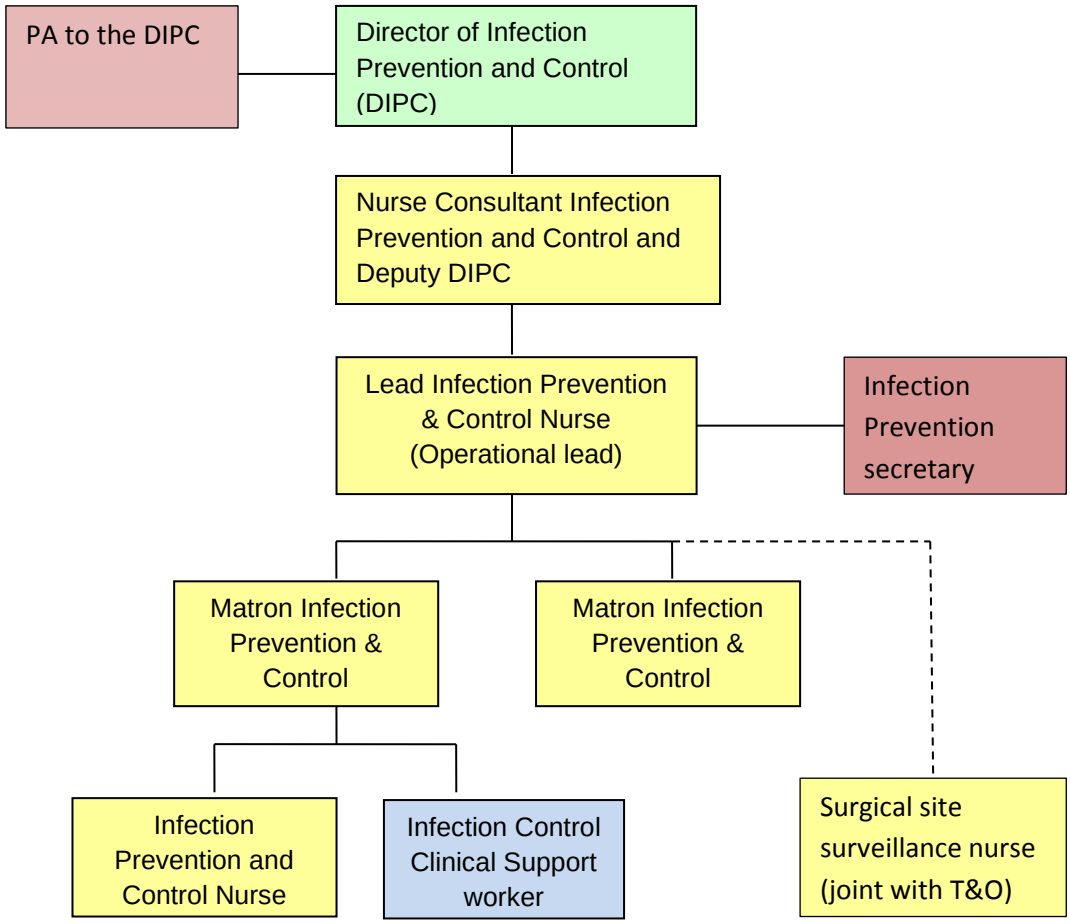
Dr Sara Mumford (consultant microbiologist) is the Director of Infection Prevention and Control (DIPC), attends the Trust Board and leads the Infection Prevention and Control strategy for the Trust, reporting to the Chief Executive Officer.

The Trust Infection Prevention and Control Committee (IPCC) is chaired by the Chief Nurse or the DIPC and meets bi-monthly. The committee has wide representation from throughout the Trust and has external representation from West Kent CCG and Public Health England. The directorates report to the IPCC on all aspects of infection prevention and antimicrobial stewardship. The IPCC reports to the Trust Clinical Governance Committee and through this committee to the Quality Committee and Trust Board.

The DIPC presents a monthly report to the Trust Management Executive.

4.1. Infection Prevention and Control Team

Fig 1: Structure of the Infection Prevention and Control Team



Our mission statement: To promote a culture whereby staff, patients, visitors, volunteers and contractors safety is ensured by the promotion of excellence in all aspects

of Infection Prevention and Control which is embedded throughout the organisation and trusted by our community.

The Infection Prevention team has remained stable throughout the year.

The surgical site surveillance post remained vacant for a long period due to difficulties in recruiting a suitable candidate, however an appointment has now been made with the development of a joint post between Trauma and Orthopaedics and Infection Prevention.

4.2. Infection Prevention and Control Committee

The IPCC reports to the Trust Clinical Governance Committee and through this committee to the Quality Committee and Trust Board. The Terms of Reference are reviewed annually.

The Chief Nurse is the Executive Director member of the committee. Prior to her retirement, Sylvia Denton was the non-executive representative on the committee.

Monitoring of antimicrobial stewardship and infection prevention practice and performance throughout the Trust, supported by triangulation audits, is reported by the directorates to the Infection Prevention and Control committee (IPCC).

The objectives of the IPCC include:

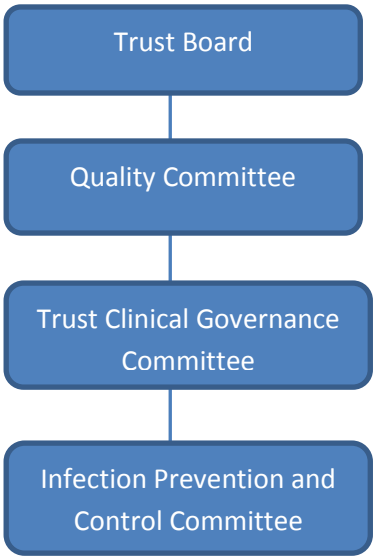
- To advise and support the Infection Prevention and Control Team.
- To provide assurance to the Trust Clinical Governance Committee with respect to infection prevention and control structure, processes and outcomes and compliance with CQC requirements as set out in the 'Hygiene Code' (The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance).
- To inform the Trust Clinical Governance Committee in a timely manner of any serious problems or hazards relating to infection control.
- To receive reports from the Infection Prevention and Control Team.
- To monitor Healthcare Associated Infection against key performance indicators including receiving reports on compliance data from Directorate representatives.
- To discuss and approve Infection Prevention and Control policies.
- To review the annual infection control programme and audit programme.
- To ensure the implementation of national guidance, and action plans arising from Patient Safety alerts relating to Infection control
- To monitor progress against CQUIN targets related to infection control

The Infection Prevention and Control Committee has no formal sub-committees. However, the Committee receives reports specifically on infection control issues from:

- Directorate Representatives (CD or Matron) from each clinical Directorate.
- The Antimicrobial Pharmacist
- The vascular access specialist practitioner
- Occupational Health Manager
- Director of Estates & Facilities (or deputy)

- Clinical Audit
- The Risk and Compliance Manager
- Learning & Development
- *C. difficile* review panel
- Others as issues arise

Fig 2: Governance structure



The IPCC is a well-attended committee with wide participation. The structured reports delivered by the directorate representatives include ward audit results, triangulation audits provided by the infection prevention team and antimicrobial audits provided by the antimicrobial pharmacist. The reports are also used to feedback to directorate clinical governance meetings on infection prevention matters.

5. What the Board needs to know in order to fulfil its responsibilities in respect of Infection Prevention and Control

5.1. History

Infection prevention and control has been an area of focus within MTW since 2006 when the Trust suffered one of the largest *C. difficile* outbreaks in the UK which was subsequently investigated by the Healthcare Commission and described in their report: *Investigation into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust*, October 2007. The report estimated that 90 deaths were directly due to C. difficile and a further 241deaths had occurred where *C. difficile* had been a contributory factor.

Crucially the report identified that management systems had failed to provide patient safety and introduced the concept of board-to-ward accountability and responsibility.

The Trust's response to the report was positive and a year later the Healthcare Commission reported that there were encouraging signs of improvement. This improvement has continued and ten years on from the publication of the report, MTW is seen as a high performing Trust for Infection Prevention and Control.

The Trust Board has recognised and agreed collective responsibility for minimising the risk of infection and has delegated responsibility for the strategic and operational leadership to the Director of Infection Prevention and Control.

5.2. Key points

- All employees of the Trust have infection control responsibility detailed within their job description
- Infection prevention and patient safety remain key priorities for the Trust
- There is wide engagement with the infection prevention agenda throughout the Trust
- A challenge culture has been encouraged within the Trust to ensure that all staff comply with infection prevention policies and processes.
- A wide range of infection prevention policies and procedures have been developed and are regularly reviewed and updated
- Emphasis has been placed on the clinical environment and cleanliness. The infection prevention team works closely with the facilities management team. The Trust has been innovative in the introduction of cleaning methods such as Hydrogen Peroxide vapour (HPV) in 2007 and UV-C light in 2016. Cleaning standards are audited regularly and reported through the Trust including to the IPCC.
- *C. difficile* has been reduced to consistently low levels across the organisation.

5.3. Hygiene Code compliance

The Health Act 2008, now superseded by the Health and Social Care Act 2013, contains a Code of Practice usually referred to as the Hygiene Code. The Code was most recently updated in 2015. The 2008 Act requires acute Trusts to comply with the Code and outlines penalties for non-compliance.

We are required by CQC to comply with Outcome 8: Cleanliness and infection control. In practice this also means that the Trust must comply with the Hygiene code.

The Trust declared compliance with the Hygiene Code in March 2009 and continues to remain compliant, maintaining evidence files and undertaking self-assessment of compliance.

The compliance criteria and some examples (not comprehensive) of how we comply are shown in the table below;

Table 1: Hygiene code compliance criteria (2015)

Compliance criteria		Examples of how we comply
1	Systems to manage and monitor the prevention and control of infection.	• Governance and reporting structure • DIPC in post - reports to CEO • Infection prevention team

Compliance criteria		Examples of how we comply
		• IPCC ToR • Annual work programme and action plan • Mandatory training • Link nurse network • Annual IC audit programme • IC policies and procedures in place • Side room management • Board level risk register • Outbreak policy • Surveillance systems • This report
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	• Director of Estates and Facilities reports to IPCC • Policies for decontamination, cleaning and laundry in place including record keeping processes • Cleaning processes agreed with Infection Prevention • Cleaning audits reported to IPCC • Deep clean programme • Hand hygiene facilities, signage and audit • JAG accreditation • Commode audits • Uniform policy
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	• Antimicrobial stewardship group meets monthly • Antimicrobial prescribing policy • Antimicrobial prescribing guidelines • Antimicrobial pharmacists in post • ASG reports to IPCC • ‘Start smart then focus’ in place • Antimicrobial training for doctors
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	• Range of information leaflets for patients and relatives • Regular communication with CCG HCAI lead • EDN • Switchboard messages on norovirus • IC messages on internet site for visitors and patients including numbers of infections • Information for patients on antimicrobials • IC information shared with GPs on case by case basis

Compliance criteria		Examples of how we comply
		• ICT attendance at daily site meetings
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	• Urgent microbiology results telephoned to clinicians • Isolation policy • Active side room management by ICT • Risk assessments carried out • Screening in place for MRSA, MSSA, GRE, CRE/CPE as appropriate • Diarrhoea policy • Reporting mechanism for notifiable disease to PHE in place
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	• Mandatory training for all staff and volunteers • Information provided to contractors • Temporary staff handbooks and competency • Bespoke training for certain groups of staff, eg porters, domestics • Handbooks for various staff groups • Exemplars of documentation provided to wards • IC resource folders on all wards – currently being converted to electronic format • Infection control responsibility included in all job descriptions
7	Provide or secure adequate isolation facilities.	• Isolation policy • Negative pressure rooms available – A&E at TWH and John Day at Maidstone • Active management of side room provision • Clear isolation signage
8	Secure adequate access to laboratory support as appropriate	• Microbiology laboratory on Maidstone site • KPIs monitored • ISO 15189 accredited • All referral labs accredited • Telepath system interfaced with ICNET
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	• Standard infection control policy • Policies for a range individual infections • Outbreak policy • Other policies in place to meet the requirements of the Code

Compliance criteria		Examples of how we comply
		• Audit programme in place to monitor compliance with policies • All policies available on Trust intranet site
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	• Immunisation of staff policy in place • All staff can access on site occupational health services • Influenza vaccination offered to all staff • Risk based screening for communicable diseases and assessment of immunity • OH arrangements in place in respect of blood borne viruses

5.4. Governance and Assurance

The Board receives assurance through the governance reporting structure, shown in fig 2, and directly from the DIPC who attends Board meetings to provide updates on infection control and new guidance relevant to the Trust.

C. difficile and MRSA bacteraemia numbers and rates are on the Board level dashboard together with MRSA screening rates.

5.5. National priorities

There are two key national priorities related to Infection Prevention and Control

- **Antimicrobial resistance** – The UK 5 year antimicrobial resistance strategy was published in 2013. This is an overarching strategy focussing activity around three strategic aims
  - To improve the knowledge and understanding of antimicrobial resistance
  - To conserve and steward the effectiveness of existing treatments
  - To stimulate the development of new antibiotics, diagnostics and novel therapies

  It lists preliminary actions for healthcare organisation, animal health organisation and the pharmaceutical industry. The actions for acute Trusts are many of the antibiotic stewardship and infection control actions that we already do plus developing an understanding of our baseline position with respect to multi-resistant organisms.

  On the back of this strategy and outbreaks in Manchester, Leeds and some of the London hospitals, Public Health England issued a patient safety alert and required Trusts to implement risk based screening for Carbapenemase-resistant organisms (CRO) by June 2014. The Trust met the deadline and further information on how this affects the Trust can be found in section 6.5.3 of this report.

Maidstone and Tunbridge Wells NHS Trust

Reduction of antimicrobial use was the subject of a CQUIN for 2016-17. The Trust met the targets and further details can be found at 7.3 in this report.

This continues to be spoken about regularly in the media and is championed by Professor Dame Sally Davies, Chief Medical Officer who is also chair of the WHO committee on antimicrobial resistance.

- **Reducing healthcare associated gram negative blood stream infections by 50% by 2020/21.**

  This was announced at the end of 2016 by the Secretary of State, Jeremy Hunt. About 35% of these infections are related to poorly managed urinary tract infections and catheter care. The target applies across the whole healthcare economy and the infection prevention and control teams across Kent and Medway, primary and secondary care, are working together to develop a strategy to reduce these infections.

  At MTW we have increased our data collection on epidemiology of these infections and active submit data to the national Public Health England database. For more information and a trend analysis see section 6.6.1 of this report.

6. Healthcare Associated Infection

6.1. HCAI action plan

A new HCAI action plan was developed in April 2016 and implemented throughout the year. The plan was monitored through the IPCC and reported to the Trust Clinical Governance committee. The 2015/16 plan was completed with outstanding actions signposted to the new action plan.

Key actions include:

- Improved monitoring of IV antimicrobial usage
- Improved understanding of baseline antimicrobial resistance data
- Achievement of antimicrobial CQUIN
- Reporting of trend analysis for MSSA bacteraemia
- Ensuring compliance with CRE/CPE screening through audit
- Ongoing compliance with NICE Quality standard for surgical site infections
- Sustaining improvement in CA-UTI incidence
- ‘Focus on’ educational programme across the Trust
- Implementation of UV-C light decontamination
- Improvement of visibility of IPC messages throughout Trust

6.2. *Clostridium difficile*

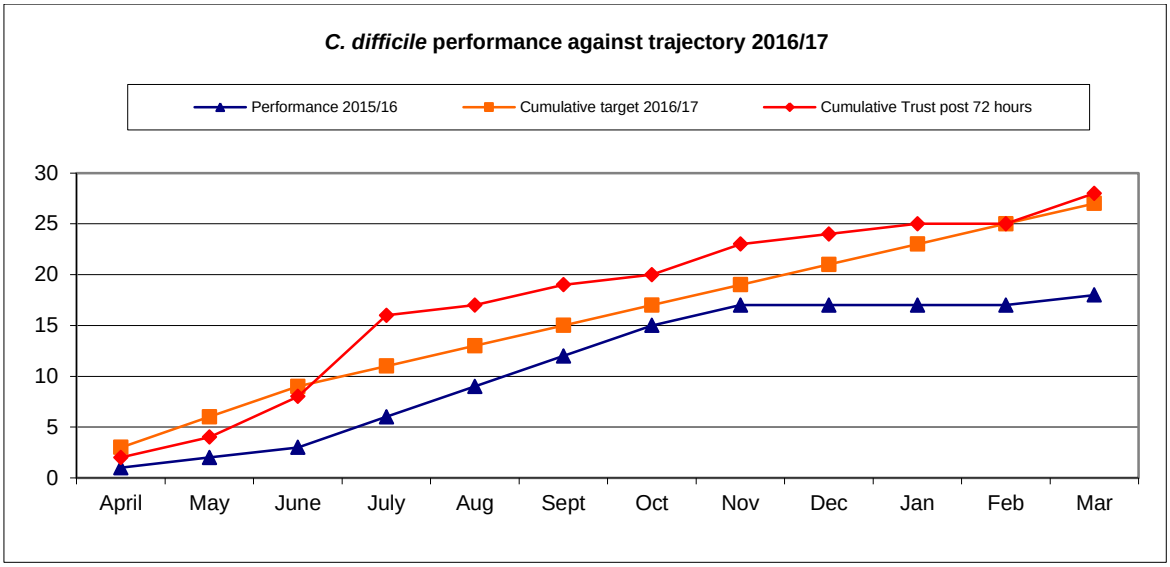
Sustaining previous improvement in *C. difficile* infection rates was one of the key objectives for the IPT throughout 2016/17

6.2.1. Rates of Infection

The Trust saw a small increase in cases of *C. difficile* infection this year. Although the nationally-set objective was exceeded by one case, the rate of infection was lower than the limit at 10.4/100 000 bed days (limit 11.4/100 000 bed days).

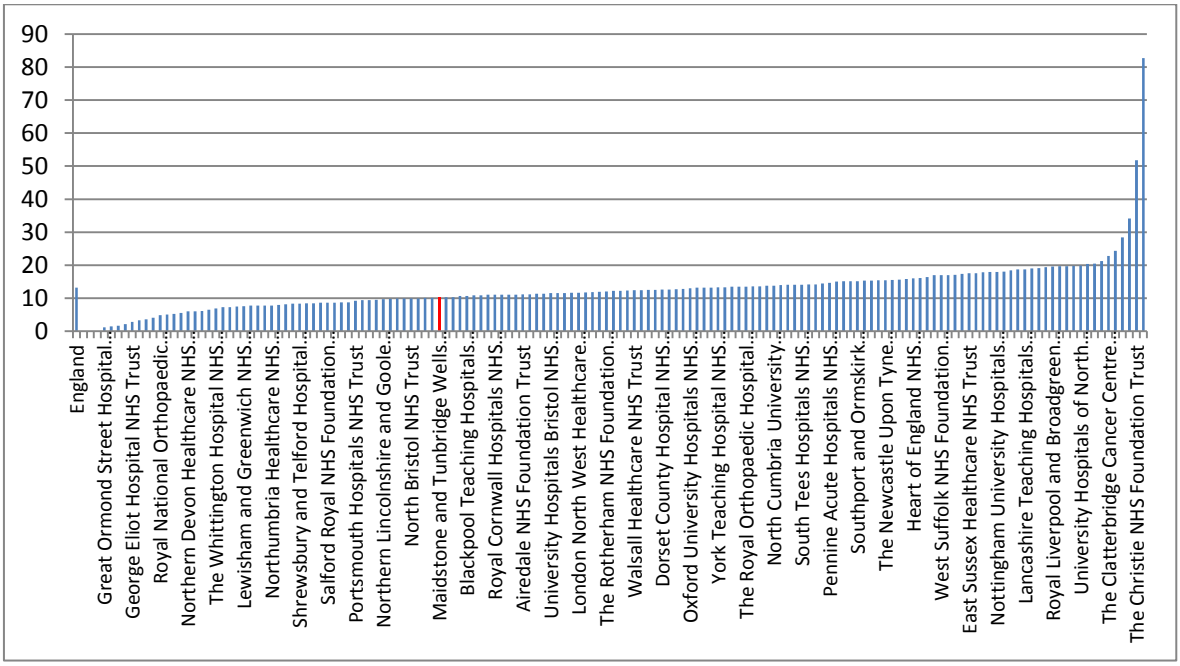
The increase in cases occurred in July when there were eight cases compared with a trajectory of two for the month (see section 10). Remedial and preventative action was taken at the time and monthly rates immediately fell back to baseline levels

Fig 3: *C. difficile* performance against trajectory



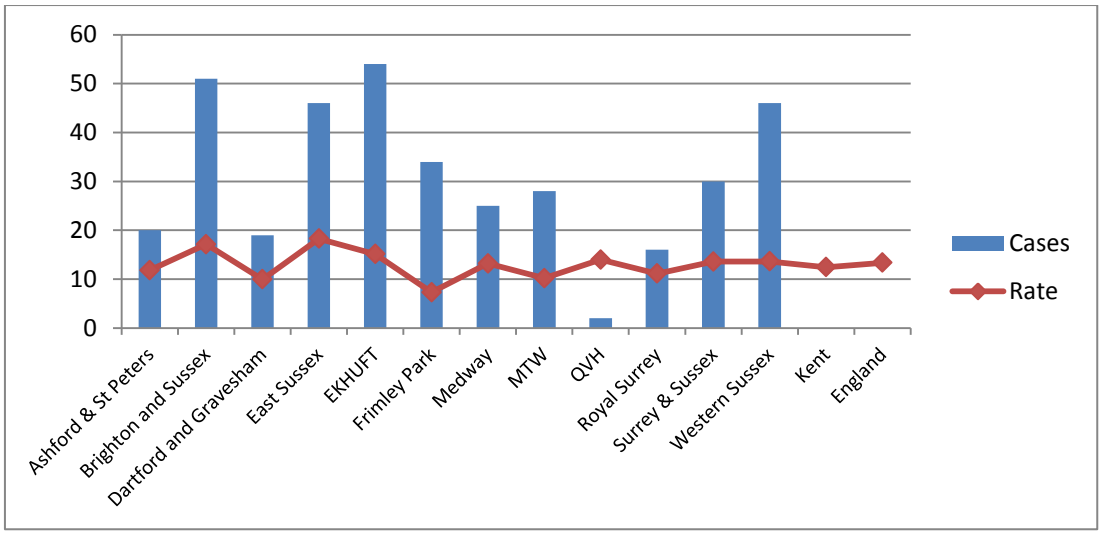
The increase in the rate of *C. difficile* infections resulted in the Trust moving out of the upper quartile compared with the rest of the Trust in England and into the second quartile.

Fig 4: Trust apportioned *C. difficile* rates for England 2016/17



The Trust continues to perform well compared with other acute Trusts in Kent, Surrey and Sussex and against the national benchmark (all England) rate of 13.35/100 000 bed days.

Fig 5. *C. difficile* cases in Kent, Surrey and Sussex



The overall reduction in cases over the last 11 years following the 2006 outbreak is 95%.

Fig 6. New cases of *C. difficile* from April 2005 to March 2017

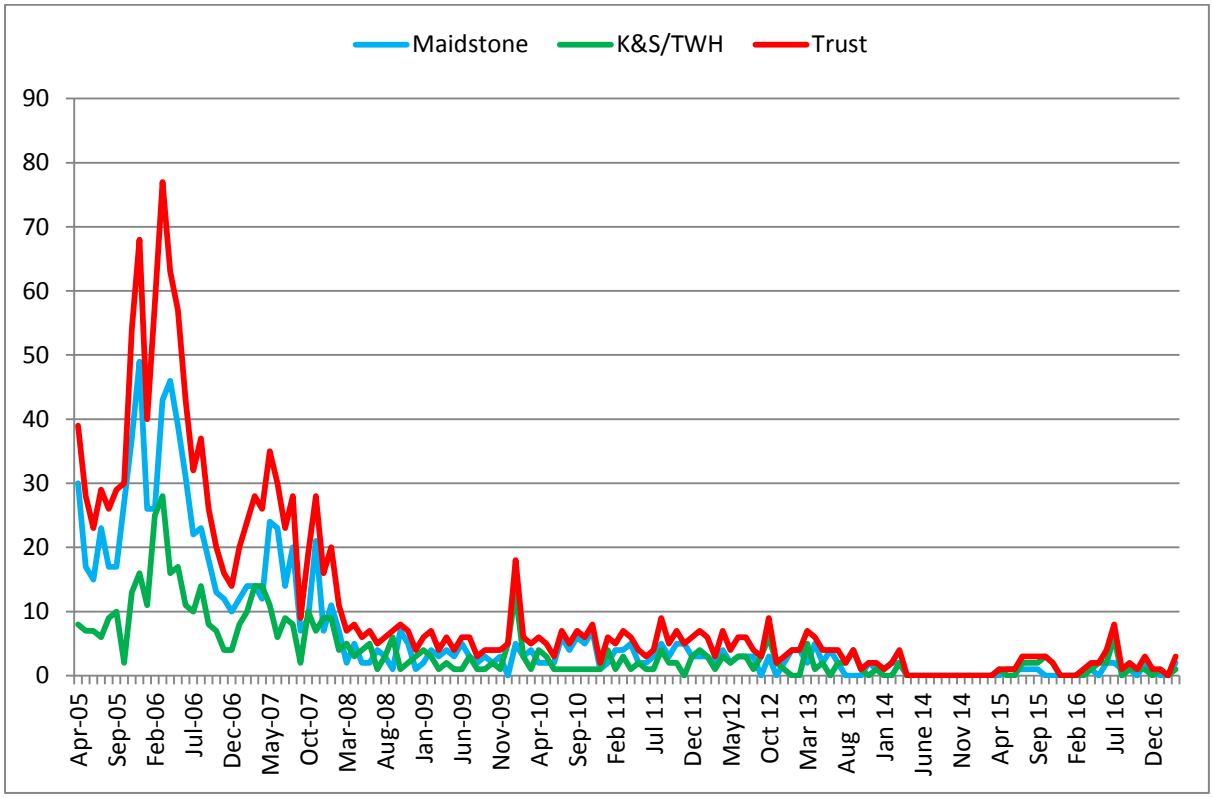
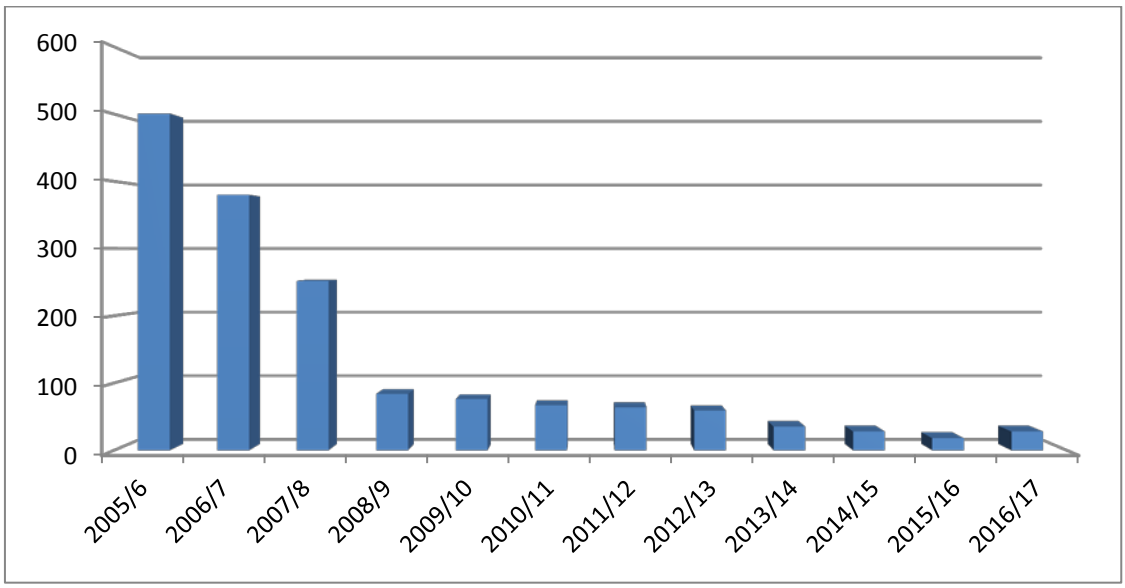


Fig 7. *C. difficile* cases by year



The Trust objective for 2017/18 was released by NHS England in February 2017. Once again, many Trusts had difficulty in achieving the 2016/17 objective so these have been carried over for the second time into 2017/18. The objective for MTW for 2017/18 is 27 cases – one case below the 2016/17 out-turn.

6.2.2. Laboratory diagnosis

During 2016/17, the microbiology laboratory processed 8916 samples for *C. difficile* on 5187 patients. Of these 1745 were GP patients, the others being inpatients in acute or community settings, MTW A&E or outpatient attenders.

157 patients were newly identified as carriers of toxigenic *C. difficile* (166 in 2015/16). A treatment algorithm is in place to enable identified carriers at high risk to be treated to avoid progression to acute infection.

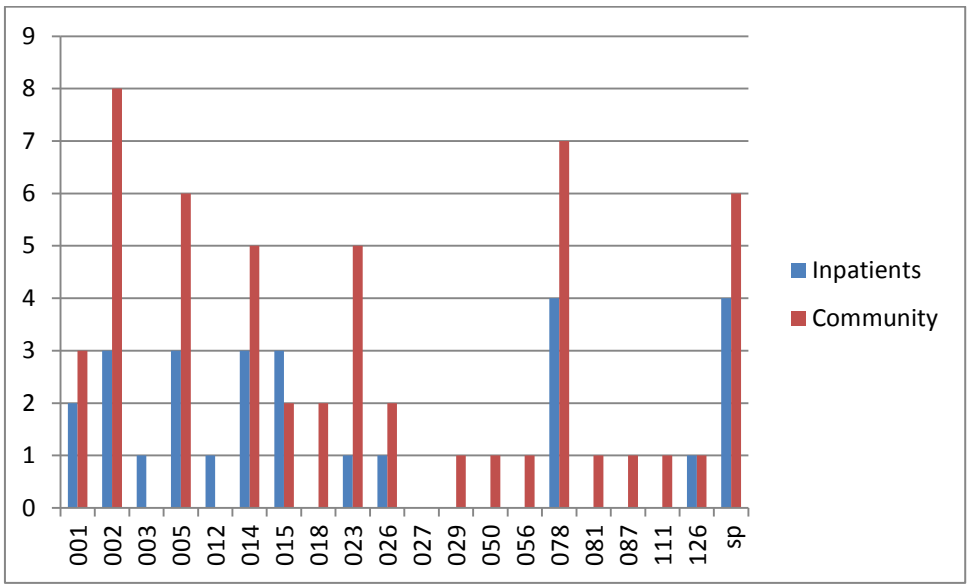
Eighty one patients were diagnosed with acute *C. difficile* infection. 28 cases were attributable to the acute Trust and 53 to the community. Of the community acquired infections, 33 were diagnosed on samples sent in by their GPs and 20 were diagnosed during the first 72 hours of their hospital admission. Four of the community cases had had recent hospital admission at MTW.

All cases are sent to the reference laboratory for ribotyping to detect any possible links between cases. Where there is suspicion of a link a request is made to the Regional Microbiologist for multi-variant loci analysis (MVLA - a type of genetic finger-printing) to confirm or rule out an association between cases. This was requested on two pairs of cases at MTW this year. (see section 10)

There are no discernible trends in the ribotypes of *C. difficile* either in the acute or primary care setting. Typing of hospital cases tends to reflect those types prevalent in the community. The 027 strain which caused the outbreak in 2005/6 has decreased in

prevalence to background levels – no cases were seen this year. The monitoring of ribotypes will continue in order to detect any trends and give an early warning of any new epidemic strains emerging.

Fig 8. Ribotyping of all *C. difficile* cases 16/17



6.2.3. Isolation

The standard within the Trust for isolation of patients with potentially infectious diarrhoea is two hours. A rapid risk assessment is in place for all patients with diarrhoea.

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

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

6.2.4. Case review

All cases of *C. difficile* infection (CDI), both community acquired and in-patient, are assessed by root cause analysis investigation. The IPT works collaboratively with the CCG infection control teams to investigate community and pre-72 hour cases.

Maidstone and Tunbridge Wells NHS Trust

Root cause analysis multidisciplinary meetings are held for all hospital-attributable (post-72 hours) cases and any GP or pre-72 hour cases with recent hospital admission. This enables any lessons associated with cases arising in the community to be learned and ensures that the impact of inpatient treatment on patients is understood. Following the multidisciplinary meeting the case goes to the *C. difficile* panel where the RCA is examined by the DIPC and Chief Nurse. There is an expectation that the ward manager and consultant for the case will attend as a minimum.

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

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

Table 2: Outcomes of RCA for hospital-attributable cases April 2016-March 2017

	Unavoidable (appropriate antibiotics)	Inappropriate antibiotics	Delayed diagnosis of community acquired infection	Cross infection
C. difficile	19	5	3	1

The single case of cross infection is discussed further in Section 10.

Most (19/28) cases were judged to be due to appropriately prescribed antibiotics. It is likely that these patients were carriers of the organism and the use of antibiotics damaged the balance of their normal bacterial flora and allowed the *C. difficile* to grow and produce toxin.

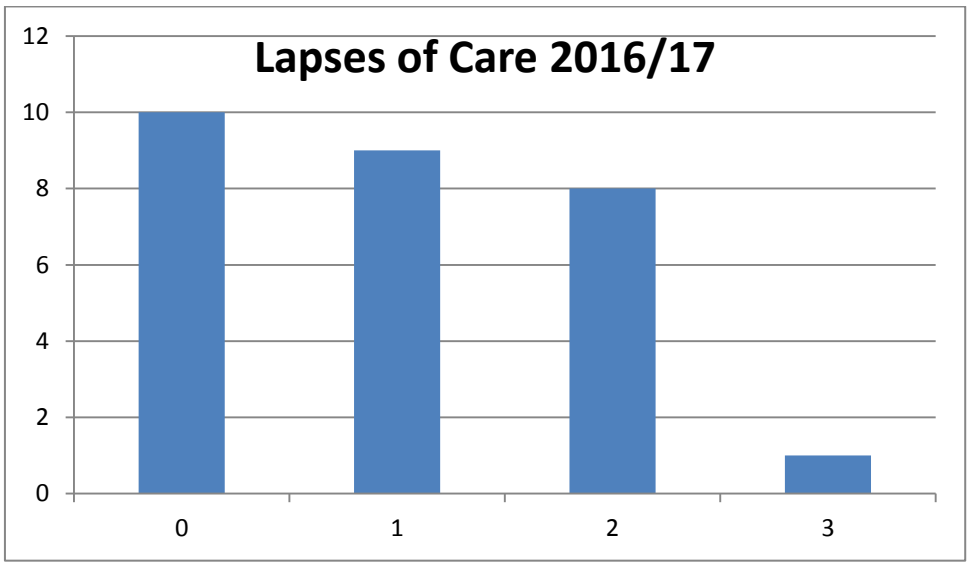
Antibiotics were considered inappropriate if they were prescribed outside the Trust guidance without agreement from a consultant microbiologist, continued for too long, or prescribed for the wrong indication.

Lapses of care are defined and standardised by a Kent and Medway-wide agreement as follows:

0 No sub-optimal care
1 Lapse of care but different management would not have made a difference to the outcome
2 Lapse of care, different management might have made a difference to the outcome
3 Lapse of care, different management would reasonably have been expected to have made a difference to the outcome

The grading of lapses of care in this way means that a finding of a lapse of care does not necessarily indicate that the case was avoidable

Fig 9. Lapses of care for hospital-attributable *C. difficile* 2016/17



Identified lapses of care included

- Delays in collection of specimen
- Inappropriate antibiotic prescribing
- Delay in isolation
- Cross infection

Potential lapses of care which were not seen in any RCA included

- Poor hand hygiene
- Cleaning standards which fell consistently below the required standard

Thirteen patients (community and hospital acquired) died during the same admission to hospital as their *C. difficile* diagnosis; however *C. difficile* was not the cause of death in any of the cases. The infection was mentioned in part 1c of the death certificate for two patients and in part 2 of the certificate for two patients.

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

Table 3: Balanced scorecard for C. *difficile* by directorate

	Acute and Specialist medicine	Surgery	Clinical Haematology	T&O	W & SH	Total
April 16	1	1				2
May 16	2					2
June 16	2	1			1	4
July 16	4	3	1			8
August 16	1					1
September 16	1	1				2
October 16				1		1
November 16	1	1	1			3
December 16			1			1
January 17	1					1
February 17						
March 17	2	1				3
Total	15	8	3	1	1	**28**

6.2.5. Periods of Increased Incidence (PII)

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

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

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

- Weekly audits of antibiotic prescribing by the antimicrobial pharmacist
- Weekly audit of the ward using the *C. difficile* High Impact Intervention audit tool until a score of >90% is achieved for three consecutive weeks and there have been no more cases during that time
- If poor audit scores are seen, an escalation meeting is held between the ward manager, matron and infection prevention to assess the need for additional support and training from the IPT
- Increased cleaning with throughout the ward with all single rooms decontaminated on discharge by either UV-C light or HPV fogging (depending on risk)
- Daily review by the infection control team
- When a PII is stepped down the ward is subject to random spot checks over the next month to ensure that improvement is sustained

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

Additional actions taken when an incident is declared include

- Multidisciplinary investigation meeting held
- Intensive infection prevention team support

During 2016/17, twenty seven PIIs were declared for *C. difficile*, ten at Maidstone and seventeen at TWH. Four wards had two PIIs during the year, two wards had three and one ward had four. The PIIs lasted an average of four weeks with the longest period being 7 weeks. This is a considerable improvement and the majority of wards will achieve the standard required in just three weeks

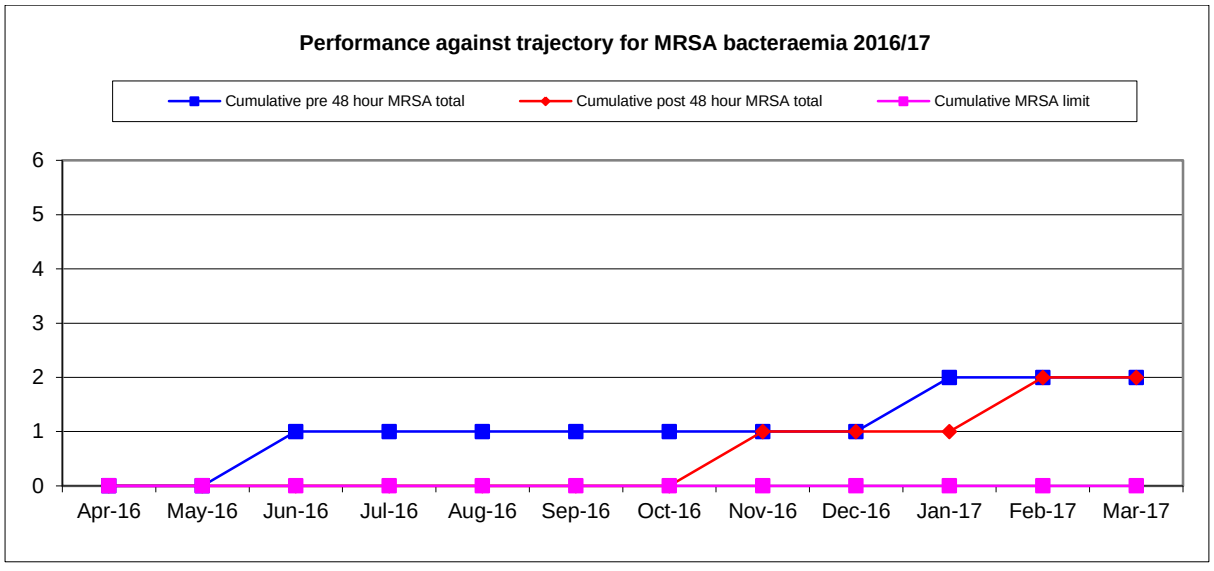
Two incidents were declared for wards where two cases occurred within 28 days. Both were in July when a general increase in incidence was seen. The PII was extended pending further investigation. On both wards the cases were of same ribotype but any link was ruled out by MVLA (genetic finger-printing). An outbreak was declared however for a case and a carrier who were linked by MVLA typing on one of the wards involved. (See section 10)

6.3. Methicillin resistant *Staphylococcus aureus* (MRSA)

6.3.1. Cases

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

Fig 10: Performance 2016/7 – Trust and Community cases

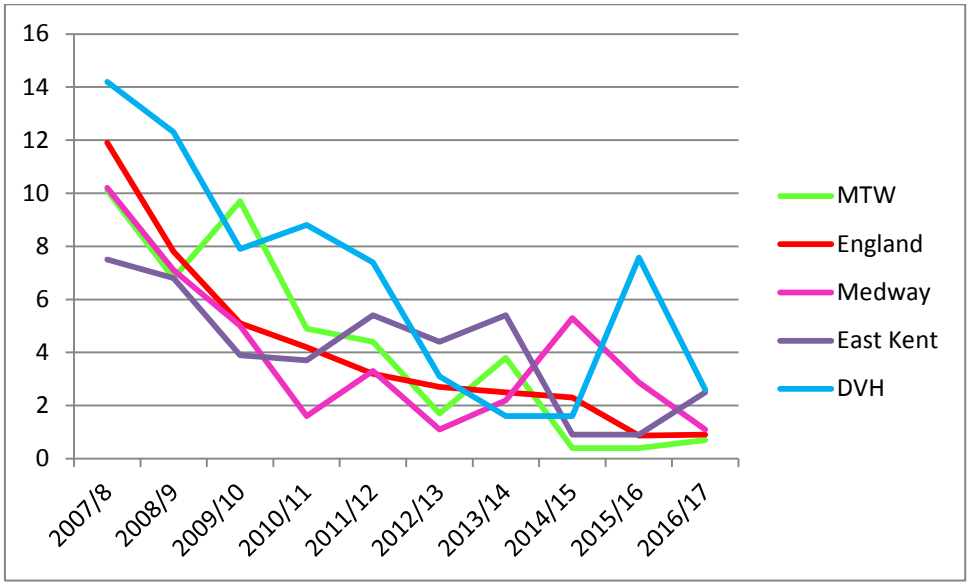


Two cases are shown for the Trust on the graph. Whilst two cases were diagnosed in inpatients more than 48 hours after admission, one of the cases was found to be unavoidable and during the Post-infection review process, NHS England assigned the case to a third party. As a result of this all published information will show only one case attribute to the Trust for the year.

Unfortunately, the Public Health England published data is for all cases diagnosed and does not reflect the assignment of cases to a third party. Consequently the PHE published Trust rate for MRSA bacteraemia is 0.7/100 000 bed days (equivalent to two cases).

Despite this the Trust benchmarks well against the other Trusts in Kent and Medway and the all England rate as shown in Fig 11.

Fig 11: MTW benchmarked against local Trusts and the national trend



Key strategies in sustaining very low rates of post 48 hour MRSA bacteraemia are:

- Dedicated vascular access specialist practitioner to provide training and competencies for junior doctors and registered nursing staff
- MRSA screening for all non-elective admissions and eligible elective admissions.
- Screening all patients prior to elective caesarean sections and other obstetric patients at 36 weeks or on admission (This has been found to be a risk factor at MTW in previous MRSA bacteraemia cases.)
- Antibiotic prophylaxis for known carriers having high risk invasive procedures (RCA has identified this as a risk factor at MTW).

6.3.2. Root Cause Analysis

All cases of MRSA bacteraemia have multidisciplinary root cause analysis completed The process usually includes colleagues from the CCG and KCHFT. A serious incident is declared for all cases of Trust-attributable cases of MRSA bacteraemia. For pre 48 hour

cases, the IPT and the relevant clinical team take part in the RCA led by the CCG. There were two community acquired MRSA bacteraemia cases diagnosed at MTW this year

The process also requires a submission to the NHS England post infection review (PIR) process which apportions responsibility for cases to the acute Trust, the CCG or a third party. The third party can be another acute Trust, a community or mental health Trust, an un-named entity, private healthcare facility or even the patient themselves. The NHS arbitration panel adjudicate the attribution of the case based on information supplied by the acute Trust and the CCG..

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

Case 1: The patient was admitted through A&E following a fall at home. Full resuscitation was required both in A&E and later on the ward, including insertion of a central line. No screening swabs were taken on admission. At RCA it was found that the need for resuscitation led to the team forgetting to take the swabs. 48 hours after the central line was removed the patient became more unwell and blood cultures taken grew MRSA. If the MRSA status had been known at the time of line removal, prophylactic antibiotics would have been given to reduce the risk of blood stream infection. Root cause – infected central line.

6.3.3. Screening

Since 2009, it has been Trust policy to screen all elective admissions (except for certain excluded groups) to comply with Department of Health policy. New guidance was published by the Department of Health in June 2014 (*Implementation of modified admission MRSA screening guidance for NHS* (2014). The guidance outlines a more focussed, cost-effective approach to MRSA screening.

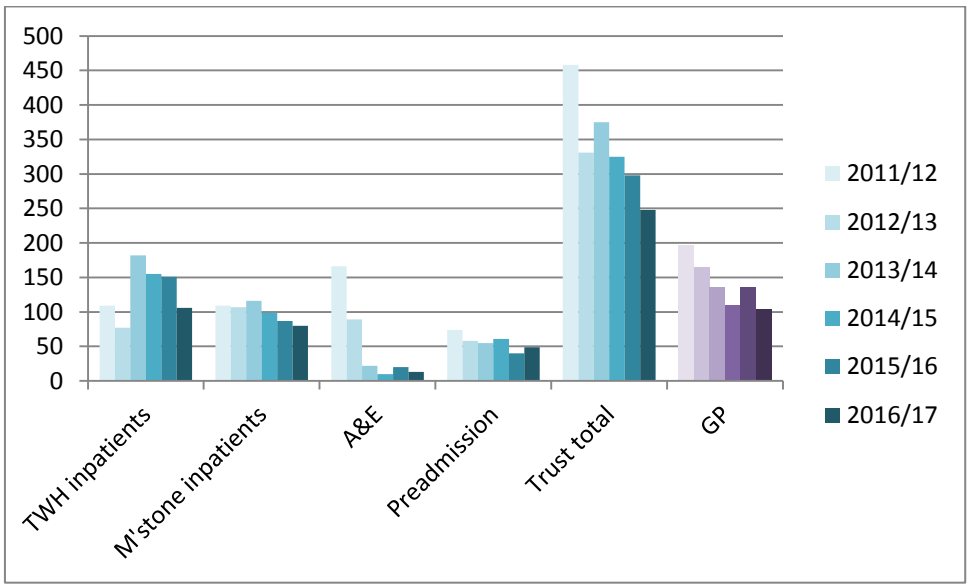
Following the publication of the guidance the screening at MTW was reviewed and revised. The revised policy was implemented in November 2014. As a consequence of this there has been no change in the incidence of MRSA bacteraemia within the Trust and further revision has not been required

New patients who are colonised are usually identified within 24 hours of admission. Advances in laboratory testing enable a positive result to be available 18 hours after the specimen arrives in the laboratory. Colonised patients are also identified as a result of clinical samples. In turn, this allows effective decolonisation of the patient to be started in a timely manner, reducing the risk of infection and spread to other patients. Patients who remain in hospital for more than a week are rescreened on a weekly basis.

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

Monthly audits of screening have shown consistent performance in line with policy standards of >97% of elective patients and >95% of non-elective patients screened

Fig 12: New MRSA colonisations 2011 - 17



A total of 87890 screens (133085 swabs) were carried out during 2016/17. 352 patients were identified as new carriers. The current new positive rate of screening swabs is 0.3%

6.3.4. Periods of Increased Incidence

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

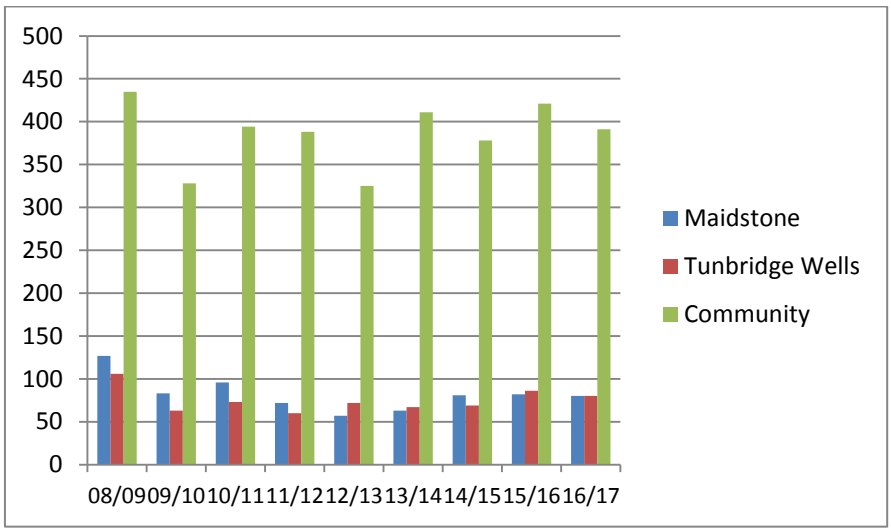
When the PII is declared the following actions are taken:

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

6.4. Extended Spectrum *Beta*-lactamase producing organisms (ESBLs)

ESBL organisms have the capability to produce enzymes which break down some of the more commonly used antibiotics. The numbers of patients developing infections with these organisms has been rising steadily over the last few years. A number of these organisms also have other mechanisms of resistance which can in some cases severely restrict the choice of antibiotic and may lead to admission to hospital for intravenous antibiotics because there are no options for oral treatment.

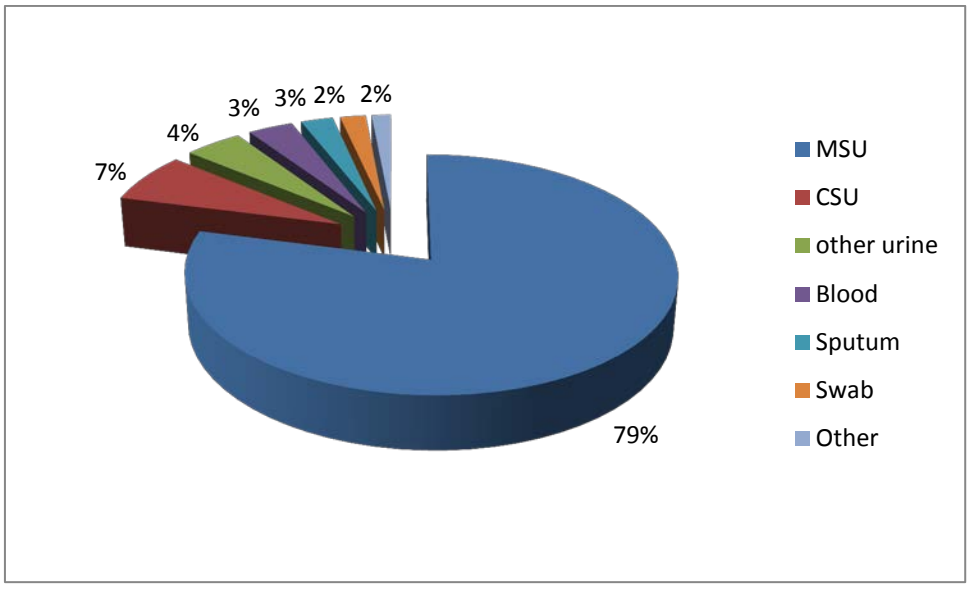
Fig 13: New ESBL isolates 2008-2017



Surveillance has been ongoing in the Trust since 2007. Earlier retrospective data shows that these organisms were seen at the Tunbridge Wells end of the Trust earlier than at Maidstone although the numbers seen at each hospital are very similar now.

There is no significant seasonal variation or trend in the number of cases seen. Most patients affected will carry the organism in their gut and as a result, urinary tract infections are the most commonly seen and account for more than three quarters of cases. Long term catheters is recognised as a risk factor for ESBL organisms, likely to be due to the treatment of recurrent infection with broad spectrum antibiotics, selecting out resistant strains which then colonise the individual's gut, forming a reservoir of infection

Fig 14: New ESBL isolates by specimen type 2016-17



6.5. Screening for other organisms

Screening for organisms other than MRSA has increased substantially over the last 2-3 years with the introduction of targeted screening programmes for various groups of patients.

6.5.1. Glycopeptide resistant Enterococci (GRE)

Glycopeptide-resistant enterococci are resistant to at least two important antibiotics widely used to treat infection in immunosuppressed patients. They are of particular concern in haematology patients who can be severely immunosuppressed as a result of both their underlying disease and chemotherapy.

Although the incidence of GRE infection has always been very low at MTW, with just two blood stream infections recorded in 2016/17, it is known that other Trusts in the region have endemic GRE and patients can acquire long-term carriage of this organism.

A screening programme amongst haematology patients was put in place in March 2014 with all haematology patients screened on admission and discharge. The carriage rate amongst this cohort of patients has remained constant at around 20%. 57 carriers of GRE were newly identified from April 2016 – March 2017. Identification of carriers enables antibiotic regimens to be tailored to individual patients depending on their carrier status.

6.5.2. Methicillin sensitive *Staphylococcus aureus* (MSSA)

MSSA has been known to be a major cause of orthopaedic surgical site infection and prosthesis infection for many years. One third of the normal population have nasal colonisation with *Staphylococcus aureus.* A screening programme for pre-operative total hip and knee patients was introduced in November 2014. Patients found to be positive on screening are treated pre-operatively with nasal antibiotic cream to reduce their risk of post-operative infection.

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

All Trusts have been required to have a screening programme for Carbapenem resistant organisms in place following a Patient Safety Alert in 2014. In 2016/17, 1633 CRE/CPE screening swabs were processed.

CPE and CRE are organisms found in the gut which are resistant to virtually every antibiotic and represent a major cross infection risk. Some organisms have the ability to transfer their resistance genes from one organism to another and even across species. Patients are identified as requiring screening by risk assessment – focussing on screening patients transferred in from healthcare abroad and patients who are transferred from (or have recently been in patients in) other UK hospitals and tertiary referral centres, including haematology patients and neonates.

Patients requiring screening are identified on or before admission and are screened by three rectal swabs on different days. Whilst awaiting the outcome of the screening swabs patients are isolated with enhanced barrier nursing precautions including the use of long-sleeved gowns. Neonates are screened by three faecal swabs, the third being at least 48 hours after transfer from another unit. These precautions inevitably put pressure on areas with limited side room provision, especially the neonatal unit, but are necessary to prevent an outbreak of these multi-resistant organisms.

One adult patient was identified as a carrier of CRE on screening. Three further adults were transferred to MTW as known carriers. Three paediatric patients transferred from London hospitals were identified as carriers of CRE or CPE on screening. All necessary precautions were implemented according to the policy and there were no episodes of cross infection.

6.6. Routine surveillance and alert organisms

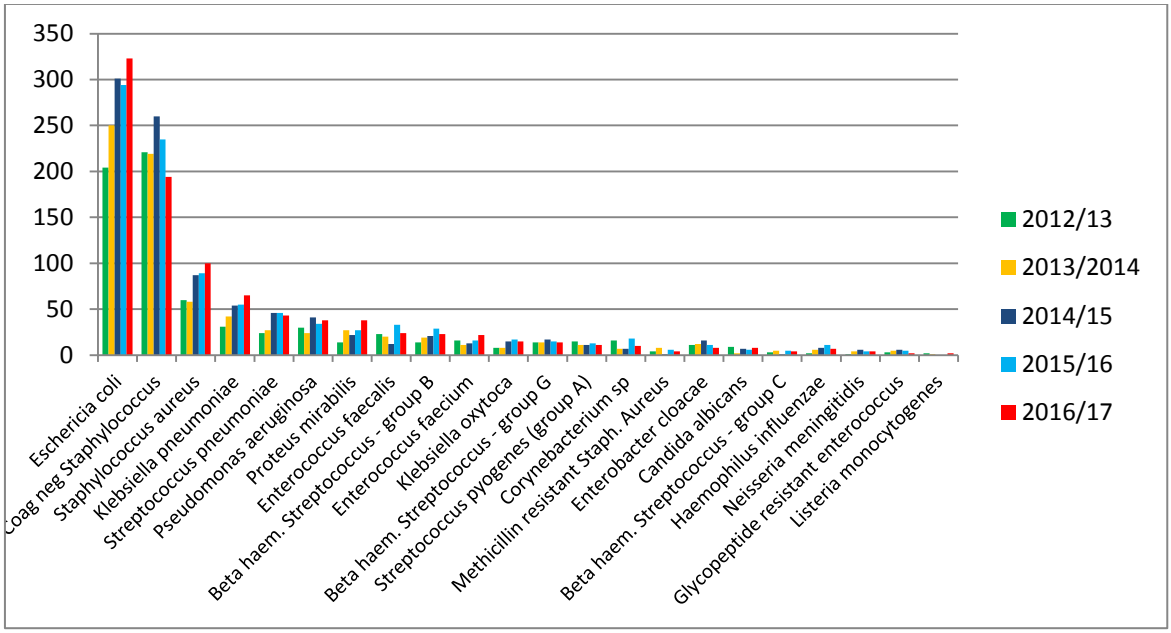
Alert organisms are those which indicate potential severe disease or, when seen in high numbers, suggest that there may be an outbreak either in the community or hospital. They often present infection control risks as they are highly infectious.

These organisms are routinely reported both to the Infection Prevention team and Public Health England as part of the national surveillance scheme

6.6.1. Blood cultures

A total of 1052 patients had positive blood cultures during 2016/17. There was a 7.5% increase in the total number of blood cultures taken (15 222) and an associated increase in the positivity rate of 11.2% (9.2% in the previous year).

Fig 15: Commonest significant isolates from Blood Cultures 2012-2017



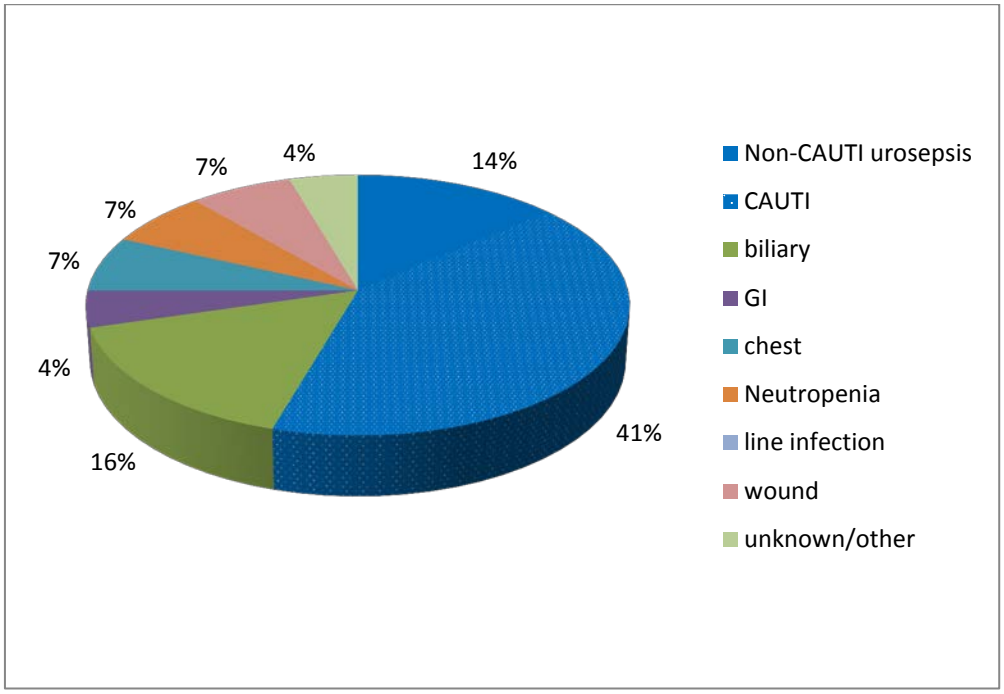
Some isolates are seen in small numbers but are highly significant for their ability to cause severe infection. These include *Neisseria meningitidis* (a cause of meningitis), *Staphylococcus aureus*, beta-haemolytic streptococci*, Listeria monocytogenes*(two infections this year after no cases in the previous three years) and S*treptococcus pneumoniae.*

Coagulase negative staphylococci may cause infection but are more likely to represent contamination of the blood culture at the time of taking the specimen. If all isolates were contaminants this would represent a contamination rate of 2%.

The commonest isolate was *E. coli* which is a gut organism, usually associated with urinary tract infection and biliary infection. Specific risk factors include extended hospital admission, urinary catheter and age over 70 years.

Gram negative (including *E. coli*) blood stream infections are the subject of a new target to reduce healthcare associated infections with these organisms across the whole healthcare economy by 50% by 2020/21. This is a challenging target and we are working with our colleagues in the CCGs and KCHFT to develop an action plan.

Fig 16: Causes of hospital acquired *E. coli* bacteraemia 2016/17



6.6.2. Methicillin sensitive *Staphylococcus aureus* (MSSA)

MSSA has been part of the mandatory surveillance for HCAI since 2010. The Trust collects epidemiological information on all cases and submits it to the national PHE database.

In 2015/16 there was a 53% increase in the number of hospital acquired cases of MSSA blood stream infection. In response to this rise, the root cause analysis of hospital acquired MSSA bacteraemia is now presented by the clinical teams at the *C. difficile*

review panel to provide additional scrutiny and enable learning to be shared across the Trust. A smaller increase (three cases) was seen for 2016/17. Actions related to the panel findings are incorporated into the HCAI action plan for 2017/18.

Sixteen cases were found to be unavoidable. The root cause of these infections includes:

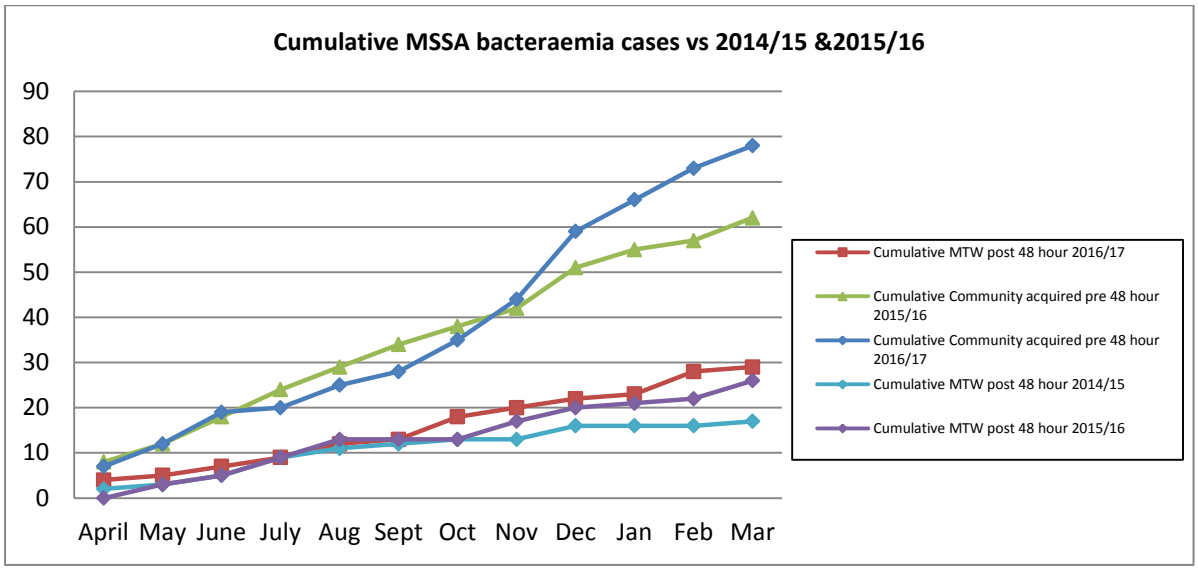
- Pre-existing skin condition
- Chronic wound colonised but appropriately treated in hospital
- Atypical presentation of septic arthritis
- Immunosuppression
- Non-surgical soft tissue infection
- Ongoing infection
- Chest infection despite all preventative care

Eight cases were found to be avoidable with lapses of care identified which may, or would have altered the outcome including:

- Abscess at ascetic tap site
- Inadequately treated infection
- Cannula site infection
- Transient bacteraemia associated with insertion/removal of PICC line
- Infection identified but untreated in chronic wounds
- Contaminated blood culture

Full trend analysis was reported to the IPCC and to the Trust Management executive for action.

Fig 17: Cumulative MSSA bacteraemia cases 2016/17 compared with 2014/15 and 2015/16



6.6.3. Invasive Group A streptococci (iGAS)

Invasive GAS (iGAS) infections are uncommon but very serious when they do occur. iGAS causes a range of diseases including necrotizing fasciitis, septic arthritis,

meningitis, pneumonia, puerperal sepsis (associated with childbirth), wound infections as well as non-focal bacteraemia.

Case fatality rates are high at approximately 15-20% within one week of diagnosis although in the national outbreak in 2009 the case fatality rate has been reported as up to 23%.
Invasive GAS infections have a seasonal pattern, with highest incidence from December to April. When a national increase in invasive GAS infection over and above the expected trend is seen, enhanced national surveillance is carried out and microbiology laboratories are required to contribute to the surveillance data. Whilst other forms of GAS infection saw an increased incidence in 2016/17 with many cases of throat infection and scarlet fever seen, there was no discernible increase in the number of iGAS infections seen at MTW.

6.6.4. Norovirus

The incidence of norovirus was very low compared with previous years. The table provides a summary of the wards affected and the associated loos of bed days.

TW AMU was the worst affected ward and infection spread more easily than it would in the rest of the hospital due to the bays rather than single rooms.

Table 4: Summary of Norovirus incidents 2016/17

Month	Ward	Patients affected	Staff affected	Bed days lost	Closure	Days closed
September 16	Chaucer	5	0	None	1 bay	3
December 16	ASU	3	1	1	1 bay	3
January 17	Edith Cavell	6	0	None	1 bay	4
January 17	TW AMU	10	8	10	4 bays	11
February 17	TW AMU	2	0	4	1 bay	4

6.6.5. *Candida auris*

Candida is a common yeast organism, best known for causing thrush infections. Occasionally it causes systemic infections in hospital patients. *Candida auris* is a new and emerging threat which is commonly resistant to first-line antifungal treatment and can develop resistance to other classes of antifungal drugs.

Sporadic cases of *C. auris* have been identified throughout England since 2013 and more recently has caused large outbreaks of infection particularly in critically ill patients and those who are immunosuppressed. Of particular concern is the organism's ability to survive in the environment.

C. auris is the subject of a level 2 Public Health England incident and enhanced surveillance is being carried out.

MTW has seen one case of *C. auris* in a patient repatriated from London. The Trust then became involved in the national incident and screening was carried out, on the advice of

Public Health England, on patients who had been in the same ward area as the index case. No secondary patients were identified and the area was deep cleaned to mitigate any potential residual risk to patients.

6.7. Water Safety

Water safety is managed through the monthly Water Hygiene Working party and the quarterly Water Steering Group.
Pseudomonas and Legionella water sampling is carried out twice yearly at TWH and Maidstone Hospital. Positive results are recorded on an action tracker and remedial work is undertaken in a timely manner.
Legionella water risk assessments have been updated and are ongoing working documents. Works identified are prioritised in order of urgency.
Pseudomonas risk assessments have been updated in line with HTM 04-01. Risk assessments are sent out to ward managers when completed.
The water hygiene policy and procedure has been updated and was ratified by the PRC in May 2017.

7. Antimicrobial Stewardship

The Trust multidisciplinary Antimicrobial Stewardship Group (ASG) is responsible for promoting and monitoring the prudent use of antimicrobials as outlined in the DoH guidance “Antimicrobial Stewardship - Start Smart then Focus” and recommendations from NICE guidelines (NG15). The ASG meets monthly to ensure the Trust antimicrobial stewardship programmes are implemented and review issues relating to antimicrobial use. The group members include consultant microbiologists, antimicrobial pharmacists, deputy chief pharmacist and WK CCG antimicrobial pharmacist. The group reports to the Drugs, Therapeutics and Medicines Management committee (DTMMC) and provides reports to the IPCC of which the antimicrobial pharmacist is a member.

The group regularly review the Trust antimicrobial guide (on the trust intranet page) to ensure it is accessible and up to data. Existing guidelines are updated and new guidance developed in consultation with the relevant lead clinicians. New and updated guidelines produced this year include:

- Teicoplanin dosing and monitoring in Adults
- Skin and soft tissue infections
- Hospital Acquired Pneumonia (HAP)
- Adult antifungal guidelines
- Malaria Treatment Guidance
- Helicobacter pylori eradication

In addition the group advised on updating the guidelines for management of infection in primary care

The group also reviews any issues arising from the daily meetings between consultant microbiologists and pharmacists and medicines incidents involving antibiotics.

This year the Trust participated in both European Antibiotic Awareness Day (EAAD) and World Antibiotics Awareness week. This helped to raise awareness amongst prescribers and nursing staff of the importance of applying stewardship to all antimicrobial prescriptions. Stalls were manned in both hospital reception areas to raise awareness with the public and encourage both staff and patients to sign-up as antibiotic guardians.

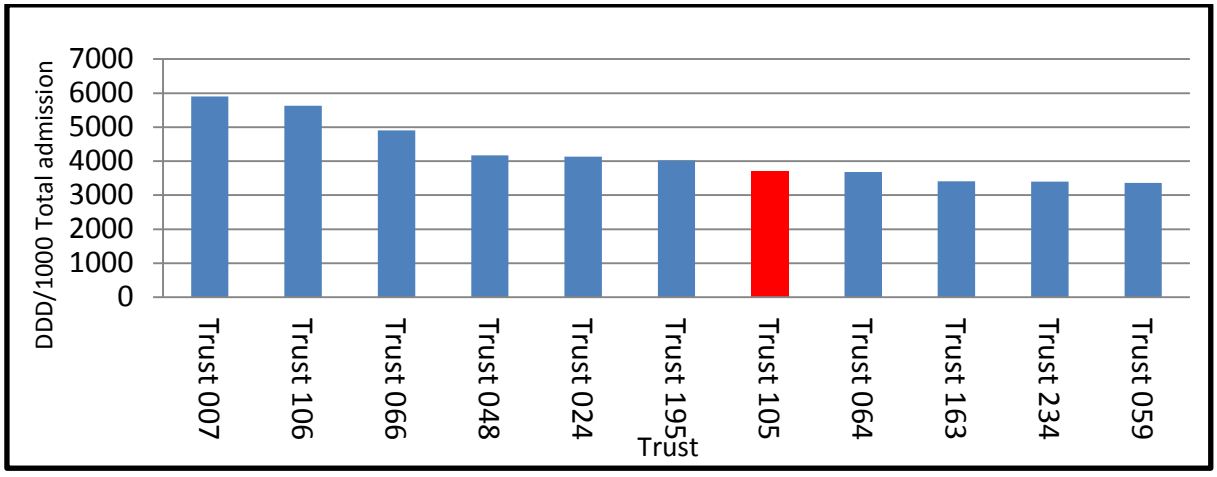
7.1. Antimicrobial usage

The antimicrobial usage data in defined daily doses (DDD) per 1000 admissions is produced monthly using the DEFINE software. This data allows the group to monitor drug usage and compare it to that of other Trusts. The usage of the following antimicrobials is reviewed and discussed at the monthly meetings:

- Total antimicrobial usage
- Piperacillin/Tazobactam & Carbapenems
- Cephalosporins, ciprofloxacin, clindamycin, co-amoxiclav and doxycycline
- Antifungals: posaconazole, ambisome, voriconazole, itraconazole, caspofungin. Fluconazole

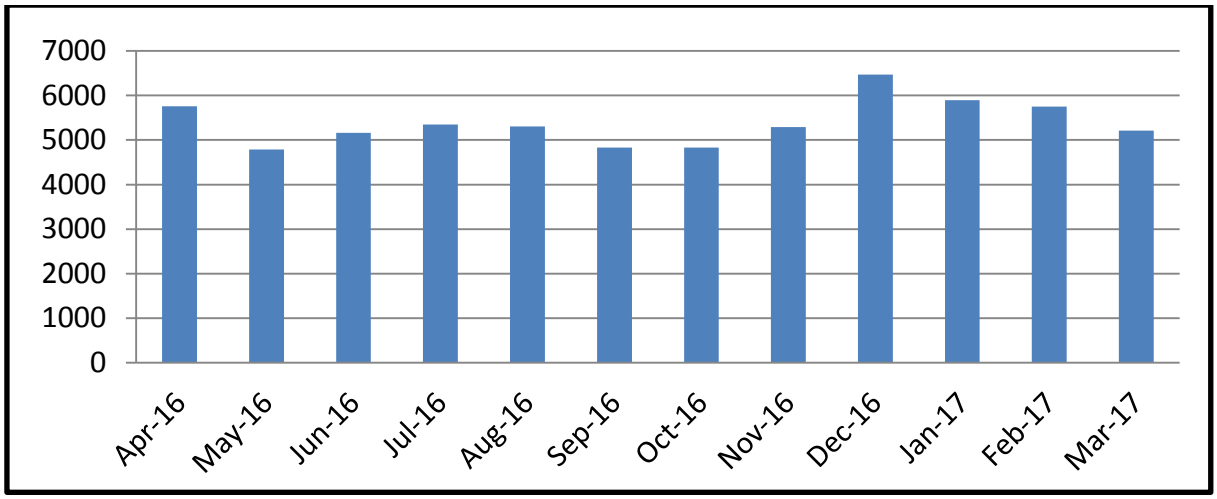
Any unusual patterns of usage are followed up with clinicians

Fig 18: Total antimicrobial usage benchmarked against similar Trusts (2016-17)



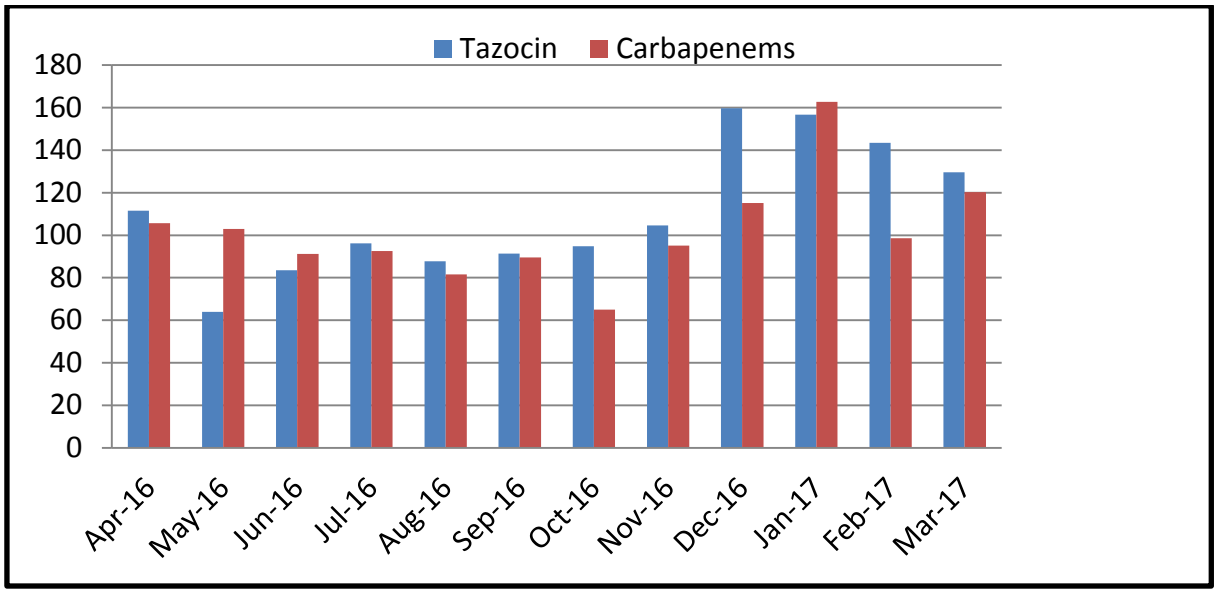
Antimicrobial usage peaks in the winter months due to the increase in respiratory infections seen at this time of year.

Fig 19: Total antimicrobial usage in defined daily doses (DDDs) per 1000 admissions



Particular interest is taken in the consumption of Piperacillin/Tazobactam and meropenem in the Trust. These are two broad spectrum antibiotics that are used in sepsis but are associated with a higher risk of *C. difficile* infection. Meropenem is also one of the Carbapenem antibiotics, resistance to which is becoming a significant problem as discussed in section 5.5 of this report.

Fig 20: Piperacillin/Tazobactam & Carbapenem usage in DDDs per 1000 admissions



7.2. Antimicrobial training and Education

A number of education sessions were delivered by the antimicrobial pharmacists and consultant microbiologists to medical staff and pharmacists. Education sessions include induction sessions for all new doctors, FY1 and FY2 teaching sessions and more advanced sessions for core medical trainees.
The team has also attended various clinical governance and directorate meetings to discuss topics including surgical prophylaxis, UTI management, audit results and the antimicrobial CQUIN.
In addition, antimicrobial information leaflets are issued to new locum doctors and FY1 as part of their induction welcome packs. An e-learning package for doctors of all grades, nurses, pharmacists and non-medical prescribers is currently under development.

7.3. Antimicrobial Audit

The pharmacists complete bi-monthly audits against the Antimicrobial prescribing policy. The audit results are reported to individual consultants, directorates and to the IPCC through the directorate triangulation reports.

In addition, weekly audits against the policy are carried out on wards where there is a PII in place.

Table 5: Trust-wide bi-monthly antimicrobial prescribing audit 2016-17

Standards	April May	June July	Aug Sept	Oct Nov	Dec Jan	Feb Mar
	(N=161)	(N=143)	(N=146)	(N=140)	(N=151)	(N=154)
% Patients with Allergy box completed	99%	99%	92%	99%	99%	99%
% Prescribed in line with guidelines	99%	98%	90%	97%	95%	93%
% with Indication documented in notes	94%	99%	89%	94%	97%	95%
% with indication documented on chart	84%	83%	74%	74%	85%	83%
% with duration documented on drug chart	79%	76%	72%	69%	73%	77%
% of Restricted antimicrobials approved by Microbiology	97%	96%	88%	96%	90%	91%
% of Patients prescribed Probiotics	81%	73%	69%	78%	77%	72%

7.4. CQUIN

This year saw the first national CQUIN for antimicrobial stewardship. The goals were as follows:

Part A –Reduction in antibiotic consumption per 1000 admissions by 1% compared with a baseline of 2013/14 data. This was further subdivided into three separate goals:

- Reduction in total antibiotic consumption by 1%
- Reduction in Carbapenem consumption by 1%
- Reduction in piperacillin/Tazobactam consumption by 1%

Actions were put in place to reduce consumption including reduction of ward stock to allow closer monitoring of consumption and to ensure senior review of all prescriptions for piperacillin/tazobactam and meropenem

The CQUIN was fully achieved with reductions in total consumption of 6.48%, piperacillin/tazobactam of 29.77% and Carbapenems of 15.93%.

Part B – Empiric review of antibiotic prescriptions

Antimicrobial prescriptions were required to be reviewed within 72 hours and the outcome documented either in the notes or on the drug chart. Milestones were set with a final goal of 90% of prescriptions reviewed.

Monthly audits of compliance were carried out, the results fed back to clinical governance meetings and the general awareness of the campaign was raised by pharmacists and consultant microbiologists.

The Goal was achieved by Q4 as shown in the table below.

Table 6: Quarterly progress in compliance

CQUIN goal for 2016/17	Q1	Q2	Q3	Q4
Antimicrobial Stewardship - Percentage of antibiotic prescriptions reviewed within 72 hours- sample of 50 per month	Target 25%	Target 50%	Target 75%	Target 90%
	41%	**72%**	**85%**	91%

8. Saving Lives

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

The high impact interventions which are audited monthly are:

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

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

9. Surgical site Surveillance

Overall surgical site infections represent one fifth of all healthcare associated infections.

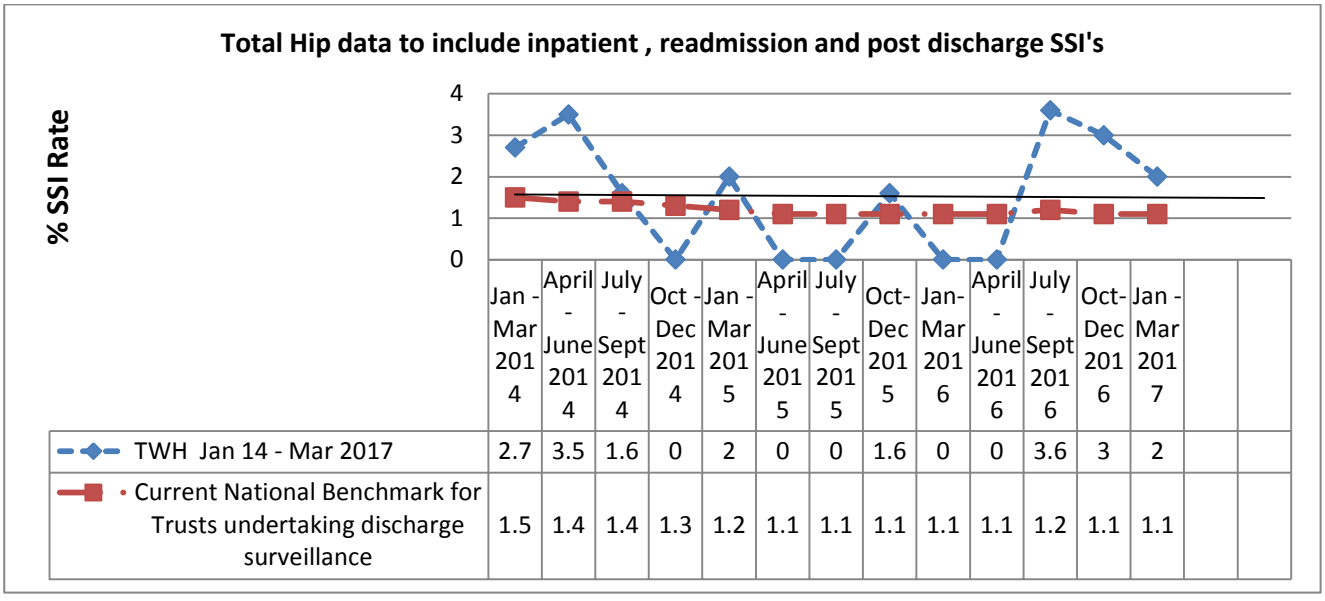
Orthopaedic surgical site infection (SSI) has been included in the mandatory healthcare associated infection surveillance system from April 2004. All NHS Trusts or facilities undertaking orthopaedic surgery must do surveillance in one or more of the orthopaedic categories - total hip replacement, hip hemi-arthroplasty, knee replacement and open reduction of long bone fracture. In any financial year, surveillance must be continued for a minimum of three consecutive months, commencing at the start of a calendar quarter.

The surveillance scheme is coordinated by the Healthcare-associated Infection and Antimicrobial Resistance (HCAI & AMR) Department of the Communicable Disease Surveillance Centre (CDSC) at the Public Health England (PHE) in Colindale.

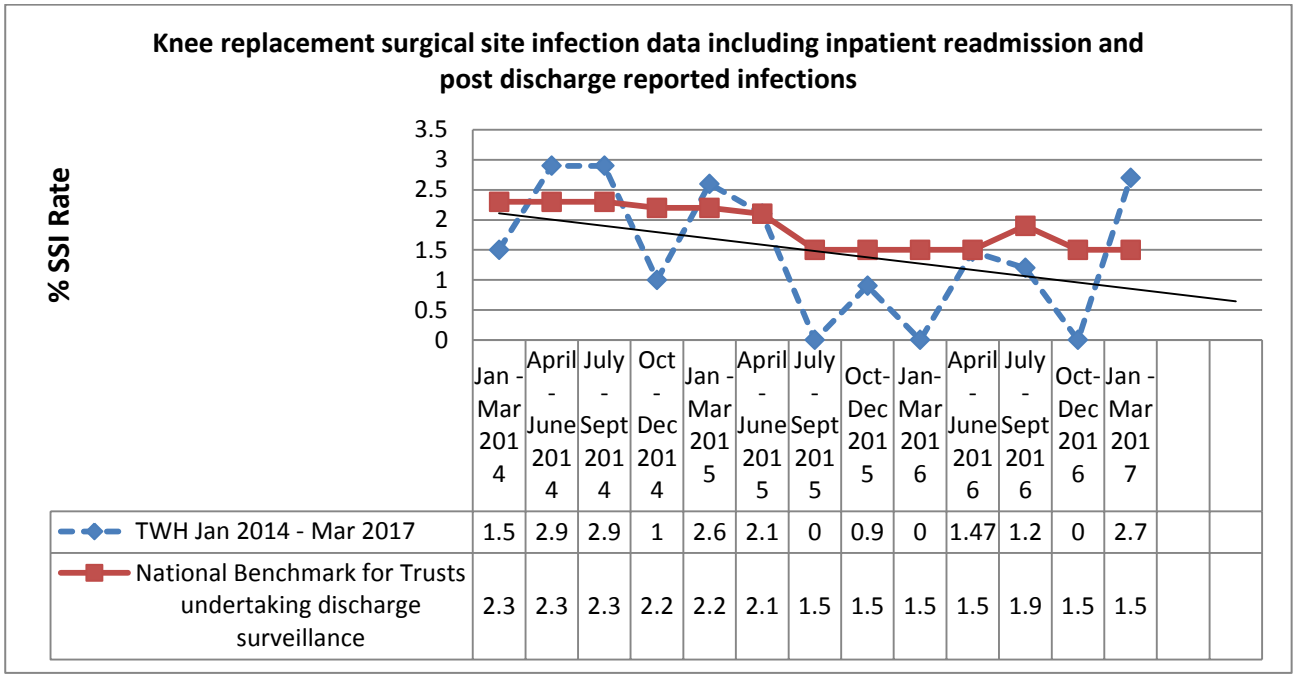
The PHE web based data capture system also collates data from a number of other categories of surgery which Trusts can complete on a voluntary basis. Due to the vacancy of the surgical site surveillance nurse the activity in this area has had to be restricted to the mandatory orthopaedic surveillance only since December 2015.

Patients are monitored for the first 60 days and infection rates monitored for up to one year post operatively. Monitoring is completed on inpatients and also by post-discharge surveillance through hospital readmission, outpatient review and patient discharge questionnaires. MTW completes the modules mandatory surveillance of elective total hip and total knee surgery, fractured neck of femur continuously throughout each year.

Fig 20: Results for elective hips and knees



	Jan - Mar 2014	April - June 2014	July - Sept 2014	Oct - Dec 2014	Jan - Mar 2015	April - June 2015	July - Sept 2015	Oct- Dec 2015	Jan- Mar 2016	April - June 2016	July - Sept 2016	Oct- Dec 2016	Jan - Mar 2017		
TWH Jan 14 - Mar 2017	2.7	3.5	1.6	0	2	0	0	1.6	0	0	3.6	3	2		
Current National Benchmark for Trusts undertaking discharge surveillance	1.5	1.4	1.4	1.3	1.2	1.1	1.1	1.1	1.1	1.1	1.2	1.1	1.1		



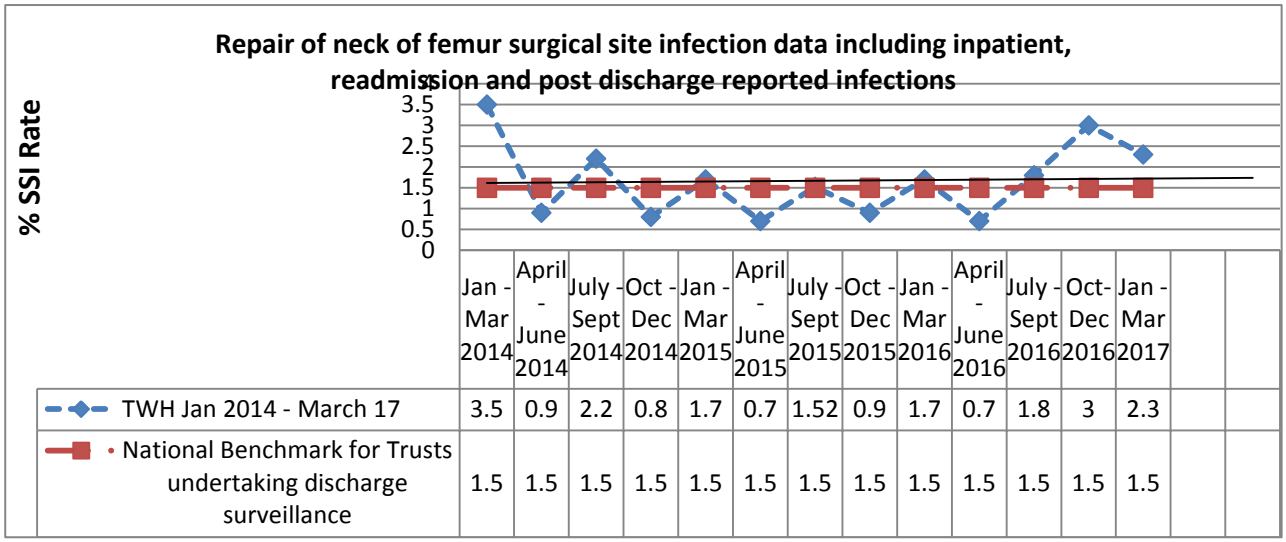
	Jan - Mar 2014	April - June 2014	July - Sept 2014	Oct - Dec 2014	Jan - Mar 2015	April - June 2015	July - Sept 2015	Oct- Dec 2015	Jan- Mar 2016	April - June 2016	July - Sept 2016	Oct- Dec 2016	Jan - Mar 2017
TWH Jan 2014 - Mar 2017	1.5	2.9	2.9	1	2.6	2.1	0	0.9	0	1.47	1.2	0	2.7
National Benchmark for Trusts undertaking discharge surveillance	2.3	2.3	2.3	2.2	2.2	2.1	1.5	1.5	1.5	1.5	1.9	1.5	1.5

Due to the low numbers of operations a single case of infection can move performance from below to above the national benchmark. For hips a peak was seen in Q2 when three infections were reported, none of which required further surgery as they were superficial in nature. Rates of infection have reduced since this peak.

For elective knees, a peak is seen for Q4, when two infections were seen, one of which required further surgery.

Further investigation is ongoing to determine if the pathway changes last year to comply with NICE guidance, which were successful in maintaining low levels of infection, are sustainably embedded

Fig 21: Results for non-elective hip surgery



	Jan - Mar 2014	April - June 2014	July - Sept 2014	Oct - Dec 2014	Jan - Mar 2015	April - June 2015	July - Sept 2015	Oct - Dec 2015	Jan - Mar 2016	April - June 2016	July - Sept 2016	Oct- Dec 2016	Jan - Mar 2017
TWH Jan 2014 - March 17	3.5	0.9	2.2	0.8	1.7	0.7	1.52	0.9	1.7	0.7	1.8	3	2.3
National Benchmark for Trusts undertaking discharge surveillance	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5

A similar pattern is seen with non-elective hip surgery with further work ongoing.

10. Incidents, Outbreaks and Serious Infections

For the period April 2016 to March 2017, the following events were investigated as infection control incidents

- TW10 - two cases of *C. difficile* within a 14 day period –no cross infection
- Trust wide increase in *C. difficile* – July 2016. Eight cases were seen during the month of July. No cross infection identified. Root cause identified as a high number of windows open during hot weather resulting in increased movement of air and potential environmental contamination. The increased cleaning levels associated with PIIs resolved the issue and infection levels returned to baseline for August.
- John Day ward – *C. difficile* cross infection identified between a carrier and a secondary case. Root cause identified as poorly closing doors in the refurbished ward. The doors failed to close properly because the automatic door closures had been disabled and there were no handles on the outside of the doors. The side rooms are located on the main corridor into the ward, an area of high traffic which also increased the risk. Enabling the door closures resolved the problem. No further cases were seen.

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

11. Training and Education

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

An on-line package is available for staff to use to fulfil the requirement for annual training. It is recommended that staff attend face to face training one year and access online training the next.

The team also participates in the induction training for junior doctors with the DIPC leading the infection control training. The consultant microbiologists provide training in antibiotic prescribing during induction training. In addition, training on infectious diseases and the use of antibiotics is provided as part of the post graduate educational programme. This year the IPT extended the face to face ward based training given to new starter nursing staff to junior doctors, proactively developing links with the junior doctors and offering support and sharing good practice with them on the wards.

Other bespoke practical training sessions have been developed to provide targeted training to facilitate learning in staff who may not have English as a first language.

A resource pack has been developed for the wards containing a wide range of handbooks for various staff groups (temporary and substantive) and exemplars of how to complete IC documentation.

Maidstone and Tunbridge Wells NHS Trust

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

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

12. Audit

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

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

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

The triangulation audits are conducted on:

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

As part of the PII process additional audits are completed on

- Ward laundry management
- Decontamination of reusable devices

Audits are reported to the IPCC

13. Innovation

Following work undertaken last year in the development of a UVC light decontamination system, the implementation phase was successfully completed. Working with colleagues from facilities, the first machines were routinely used in TWH in September. The system was later extended to Maidstone hospital.

Fig 22: The Ultra-V light stack

A total of 636 rooms were cleaned with the system from September 2016 to March 2017. The biggest advantage of the system is the time saving when compared with HPV decontamination. Until the implementation, for wards on a PII, all rooms were being decontaminated with HPV on patient discharge. This led to delays in admitting patients and caused patient flow issues in A&E. A new cleaning schedule was agreed between facilities and Infection prevention which allowed UVC decontamination except where the patient had diarrhoea or *C. difficile (*as the system is known to be less effective against *C. difficile)*. Reducing the clean time from 4 hours to under an hour has resulted in less disruption and better patient flow.
Another advantage of the system is that is can be used safely in areas where HPV cannot, such as CT and MRI scanning rooms, theatres, radiotherapy etc.

MTW is the first Trust in Kent and Medway to adopt this technology.

14. Challenges for 2017/18

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

- Sustaining the previous gains in the rate of *C. difficile* and meeting the objective
- Ensuring compliance with NICE guidance for antimicrobial stewardship
- Ensuring continued compliance with the updated Code of Practice on the prevention and control of infections and related guidance (Hygiene Code) (July 2015)
- Controlling and monitoring the development of antibiotic resistance
- Working with partners in the health economy to develop plans to reduce gram negative blood stream infections
- Working with local CCGs and NHSI to assist in peer review of other Trusts infection control
- Control use of broad spectrum antibiotics
- Support the CQUIN for antimicrobial reduction and sepsis
- Ensure the wide availability of IC resource packs on the intranet

15. Recommendation

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

Trust Board meeting - September 2017

NHS Maidstone and Tunbridge Wells NHS Trust

9-15 Planned and actual ward staffing for June and July 2017 Chief Nurse

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for the months of June and July 2017. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

Care Hours Per Patient Day

CHPPD is calculated by adding the hours of available registered nurses to the hours of available healthcare support workers during each 24 hour period and dividing the total by every 24 hours of in-patient admissions, or approximating 24 patient hours by counts of patients at midnight. NHS England have recommended the latter for the purposes of the UNIFY upload and subsequent publication.

The Carter report indicated a range for CHPPD between 6.3 and 15.48. The median was 9.13. Overall CHPPD for Maidstone has shown an increase over the last two months, being 7.7 in May, increasing to 8.1 in June and to 8.3 in July. Tunbridge Wells remained relatively static for June at 8.8 compared to 8.9 in May. However this increased to 9.2 for July. Overall the CHPPD remains within the national average range.

Planned vs. Actual

The fill rate percentage is the actual hours used compared to the hours set in the budgeted establishment. That is, the budgeted establishment sets out the numbers of Registered Nurses and Clinical Support Workers based on an average acuity and dependency (or planned case mix for elective units). When units are faced with increased acuity and/or dependency, in escalation or undergo a service change that is not currently reflected in the budget, this is represented by an 'overfill'. Financial and key nurse-sensitive indicators have also been included as an aid to triangulation of both efficient and effective use of staff.

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

Wards in this category during June were Foster Clark, Wards 2, 11, 20, and 32, and for July Wards 2, 10, 20, and 21.

All enhanced care needs are supported by an appropriate risk assessment, reviewed and approved by the Matron.

Foster Clark does not feature in the July data as the ward is closed.

Escalation areas account for over-fill on Maidstone AMU (UMAU), and TWH AMU. Short Stay Surgery also had additional staff above their plan which is not directly reflected in the fill rate. This is because the staff are 'charged' to the SSSU however they are based in the Theatre holding bay to manage the displaced day surgical activity as a result of inpatient escalation requirements.

A number of wards have a variation in RN/CSW ratios either due to lack of available bank/agency staff, or as an accepted risk based on acuity and dependency. These areas include Stroke (TWH), Pye, Wards 10, 11, 21 and 30.

Maternity manage staffing as a 'floor' with support staff moving between areas as required. Midwifery needs are assessed regularly by the Labour Ward Coordinator with midwives following women from delivery through to post-natal. This ensures that all women in established labour received 1:1 care from a Registered Midwife.

A number of wards will cross-cover each other. This enables a more efficient use of staff, and allows for safe redeployment of staff to escalated areas. For example Short Stay Surgery at Tunbridge Wells Hospital provide support to the escalated beds in Recovery. The ITUs will move staff between sites according to the acuity levels on each site.

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

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

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

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

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

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

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

RAG	Details
	Minor or No impact: Staffing levels are as expected and the ward is considered to be safely staffed taking into consideration workloads, patient acuity and skill mix. RN to patient ratio of 1:7 or better Skill mix within recommended guidance Routine sickness/absence not impacting on safe care delivery Clinical Care given as planned including clinical observations, food and hydration needs met, and drug rounds on time. OR Staffing numbers not as expected but reasonable given current workload and patient acuity.

RAG	Details
	Moderate Impact: Staffing levels are not as expected and minor adjustments are made to bring staffing to a reasonable level. OR Staffing numbers are as expected, but given workloads, acuity and skill mix additional staff may be required. Requires redeployment of staff from other wards RN to Patient ratio >1:8 Elements of clinical care not being delivered as planned
	Significant Impact: Staffing levels are inadequate to manage current demand in terms of workloads, patient acuity and skill mix. Key clinical interventions such as intravenous therapy, clinical observations or nutrition and hydration needs not being met. Systemic staffing issues impacting on delivery of care. Use of non-ward based nurses to support services RN to Patient ratio >1:9 Need to instigate Business Continuity

Which Committees have reviewed the information prior to Board submission?

- N/A

Reason for submission to 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

June'17		Day		Night		Overall Care Hours per pt day	Nurse Sensitive Indicators						Financial review		
Hospital Site name	Ward name	Average fill rate registered nurses/midwives	Average fill rate care staff (%)	Average fill rate registered nurses/midwives	Average fill rate care staff (%)		FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Overall RAG Status	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	96.7%	96.7%	99.2%	103.3%	7.8	53.3%	95.8%	4	0			132,329	126,246	6,083
MAIDSTONE	Foster Clark	114.6%	97.5%	128.9%	98.3%	7.2	24.3%	80.0%	1	1		RMN required for 26 days	0	115,715	-115,715
MAIDSTONE	Cornwallis	101.1%	98.3%	94.4%	104.5%	6.7	36.0%	87.8%	0	1			72,057	73,883	-1,826
MAIDSTONE	Coronary Care Unit (CCU)	100.0%	76.7%	100.0%	N/A	10.1	85.7%	94.4%	0	0		CSW fill rate an accepted risk, as unit is co-located on Culpepper. Staff cross-cover as required.	103,725	102,498	1,227
MAIDSTONE	Culpepper	100.0%	96.7%	100.0%	100.0%	6.8	62.7%	96.9%	0	0					
MAIDSTONE	John Day	90.5%	123.3%	100.0%	100.0%	6.9	38.5%	96.7%	5	0		RN fill rate an accepted risk. Fill rate maintained at night.	127,486	126,507	979
MAIDSTONE	Intensive Treatment Unit (ITU)	87.9%	N/A	85.4%	N/A	30.6	0.0%	0.0%	0	0		Fill rate reflects low acuity and dependency. All level 3 patients received 1:1 care, and 1:2 care provided for level 2 patients.	174,246	149,107	25,139
MAIDSTONE	Pye Oliver	92.7%	92.7%	100.0%	100.0%	6.8	44.7%	100.0%	7	1			100,557	97,887	2,670
MAIDSTONE	Chaucer	99.3%	95.8%	100.0%	100.0%	11.7	57.0%	98.4%	4	0			110,940	119,695	-8,755
MAIDSTONE	Lord North	93.3%	123.3%	94.4%	83.3%	6.8	32.3%	100.0%	1	0		Additional CSW required 1 per week to support ward attenders. Night fill rate an accepted risk based on acuity and dependency.	101,913	102,292	-379
MAIDSTONE	Mercer	108.3%	102.5%	100.0%	100.0%	6.5	50.0%	90.3%	4	0			101,227	94,343	6,884
MAIDSTONE	Edith Cavell (MOU)	104.4%	113.3%	97.8%	110.0%	5.4	50.0%	90.0%	2	0		Skill mix and fill rate reflect roster transition post ward relocation.	72,020	48,837	23,183
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	83.5%	97.3%	123.3%	203.3%	11.8	19.4%	96.2%	0	0		Bay escalated at night. Day fill rate an accepted risk to ensure cover at night.	107,935	132,154	-24,219
TWH	Stroke/W22	83.3%	98.7%	98.7%	106.7%	10.8	94.7%	100.0%	17	0		RN fill rate an accepted risk.	163,074	141,656	21,418
TWH	Coronary Care Unit (CCU)	103.1%	100.0%	111.1%	N/A	13.5	97.7%	100.0%	0	1		Additional capacity beds utilised during the month at night.	61,501	72,545	-11,044
TWH	Gynaecology/ Ward 33	97.3%	97.1%	100.0%	100.0%	9.2	49.4%	95.1%	0	0			74,602	76,917	-2,315
TWH	Intensive Treatment Unit (ITU)	99.6%	100.0%	99.6%	96.7%	30.0	0.0%	0.0%	1	1			179,243	182,056	-2,813
TWH	Medical Assessment Unit	93.7%	95.0%	119.3%	97.8%	7.6	0.0%	0.0%	6	0		Escalation over night	132,976	176,686	-43,710
TWH	SAU	98.9%	93.3%	101.7%	90.0%	11.2			1	0			54,120	62,827	-8,707
TWH	Ward 32	93.9%	94.4%	100.0%	113.3%	7.8	23.3%	100.0%	10	4		Enhanced care needs for 10 nights	122,765	128,761	-5,996
TWH	Ward 10	89.8%	95.8%	95.1%	106.3%	6.7	0.0%	0.0%	3	0		RN fill rate an accepted risk.	112,453	121,195	-8,742
TWH	Ward 11	95.7%	118.9%	95.0%	126.7%	7.0	0.0%	0.0%	3	0		Enhanced care needs for 12 days/nights	110,018	120,789	-10,771
TWH	Ward 12	84.3%	94.2%	98.9%	95.8%	6.4	32.9%	96.2%	1	1		RN fill rate an accepted risk.	122,915	110,559	12,356
TWH	Ward 20	93.3%	117.8%	100.0%	143.3%	4.2	72.2%	84.6%	10	0		Cohort nursing throughout month for falls risks and cognitive impairment.	106,506	108,932	-2,426
TWH	Ward 21	105.0%	103.3%	88.7%	156.7%	7.3	28.8%	100.0%	4	2		RN:CSW ration adverse shift an accepted risk to ensure sufficient staff on shift to respond to care needs.	133,012	124,434	8,578
TWH	Ward 2	95.0%	109.3%	101.1%	114.2%	7.7	103.3%	80.6%	9	0		16 nights needing enhanced care for falls and cognitive impairment risks.	124,028	126,425	-2,397
TWH	Ward 30	91.1%	87.5%	99.2%	105.0%	6.8	0.0%	0.0%	3	0		CSW fill rate and accepted risk.	108,041	110,841	-2,800
TWH	Ward 31	93.0%	97.9%	99.2%	91.6%	7.5	0.0%	0.0%	5	1			129,736	142,179	-12,443
Crowborough	Birth Centre	96.7%	86.7%	100.0%	86.7%				0	0		CSW fill rate an accepted risk. On-call system in place if additional support is required.	85,997	61,828	24,170
TWH	Ante-Natal	98.3%	86.7%	100.0%	86.7%	7.4	37.7%	90.7%	0	0		CSW fill rate an accepted risk. Staff move between departments, often during the course of the shift as they follow the women. Sickness rates impacted on RM fill rates. All women in established labour received 1:1 care.	615,756	662,303	-46,547
TWH	Delivery Suite	98.5%	84.4%	94.8%	101.7%	29.8			2	0					
TWH	Post-Natal	76.5%	60.0%	102.6%	67.5%	7.5			0	0					
TWH	Gynae Triage	98.3%	100.0%	100.0%	90.0%				0	0			11,974	12,338	-364
TWH	Hedgehog	96.7%	60.0%	102.0%	80.0%	9.4	19.1%	98.4%	0	0		Day unregistered fill rate an accepted risk to ensure adequate cover at night.	196,824	188,390	8,434
MAIDSTONE	Birth Centre	100.0%	100.0%	100.0%	100.0%				0	0			63,527	52,218	11,309
TWH	Neonatal Unit	102.2%	93.3%	101.7%	83.3%	14.2			0	0		Night CSW fill rate an accepted risk.	167,377	161,738	5,639
MAIDSTONE	MSSU	108.1%	100.0%	86.4%	N/A				0	0		Night RN fill rate an accepted risk. Cover provided from Peel ward when required.	40,769	39,877	892
MAIDSTONE	Peale	123.3%	53.1%	100.0%	90.0%	7.8	32.5%	100.0%	1	0		RN:CSW ratio shift to ensure appropriate headcount of staff on duty. Skill mix shift due, in part, to resolving issues of establishment review.	70,239	73,795	-3,556
TWH	SSSU	100.0%	100.0%	100.0%	100.0%	7.8	0.0%	0.0%	0	0			60,469	117,786	-57,317
MAIDSTONE	Whatman	97.8%	96.7%	100.0%	101.7%	4.5	66.7%	88.9%	9	0			90,070	85,721	4,349
MAIDSTONE	A&E	99.2%	93.3%	99.0%	96.7%		15.5%	90.7%	0	0			196,260	185,314	10,946
TWH	A&E	94.4%	95.6%	98.2%	90.0%		24.7%	93.2%	6	0			386,082	297,968	88,114
												Total Establishment Wards	**4,924,769**	**5,035,239**	**(110,470)**
												Additional Capacity beds	39,307	34,737	4,570
												Other associated nursing costs	2,601,404	2,306,599	294,805
												Total	7,565,480	7,376,576	188,904

RAG Key

Under fill

Over fill

July'17		Day		Night			Nurse Sensitive Indicators						Financial review		
Hospital Site name	Ward name	Average fill rate registered nurses/midwives	Average fill rate care staff (%)	Average fill rate registered nurses/midwives	Average fill rate care staff (%)	Overall Care Hours per pt day	FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Overall RAG Status	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	93.5%	100.8%	97.6%	104.8%	7.6	27.3%	93.3%	3	0			132,329	127,761	4,568
MAIDSTONE	Cornwallis	102.2%	100.0%	96.8%	104.8%	6.5	57.5%	93.5%	1	1			72,057	82,248	(10,191)
MAIDSTONE	Coronary Care Unit (CCU)	93.5%	100.0%	100.0%	N/A	10.4	100.0%	100.0%	0	0			114,725	107,731	6,994
MAIDSTONE	Culpepper	100.0%	98.4%	100.0%	100.0%	6.8	65.0%	96.2%	0	0					
MAIDSTONE	John Day	94.6%	121.5%	100.6%	103.2%	6.9	47.9%	91.2%	3	0		Additional CSW over 3 days to cover call bell failure (to ensure always a nurse physically in each bay).	127,486	134,768	(7,282)
MAIDSTONE	Intensive Treatment Unit (ITU)	93.5%	N/A	92.7%	N/A	27.4	0.0%	0.0%	0	0			174,246	161,189	13,057
MAIDSTONE	Pye Oliver	86.9%	89.0%	100.0%	100.0%	6.6	42.0%	88.2%	4	2		11 shifts unable to be covered by Bank or Agency.	100,557	113,853	(13,296)
MAIDSTONE	Chaucer	92.4%	97.5%	100.0%	109.7%	12.3	33.1%	97.7%	3	0			110,940	97,839	13,101
MAIDSTONE	Lord North	111.3%	100.0%	96.8%	100.0%	9.1	65.7%	95.7%	2	0		Staff member on phased return.	101,914	103,763	(1,849)
MAIDSTONE	Mercer	111.3%	100.0%	96.8%	100.0%	6.5	39.0%	91.3%	6	0		3 days of enhanced RN care need.	101,227	106,331	(5,104)
MAIDSTONE	Edith Cavell (MOU)	100.0%	101.3%	100.0%	100.0%	5.6	58.8%	90.0%	2	0			72,020	62,681	9,339
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	80.2%	98.2%	125.8%	196.8%	12.1	20.1%	98.0%	3	0		Bay escalated over night. Day RN fill rate an accepted risk to ensure cover at night.	94,435	123,216	(28,781)
TWH	Stroke/W22	84.4%	95.5%	96.8%	109.7%	9.6	105.3%	90.0%	1	1		4 shifts not covered by bank or agency.	163,074	141,790	21,284
TWH	Coronary Care Unit (CCU)	99.0%	93.5%	98.9%	N/A	10.5	76.6%	91.7%	0	0			114,725	107,731	6,994
TWH	Gynaecology/ Ward 33	98.2%	98.4%	100.0%	100.0%	7.8	11.8%	93.3%	0	0			74,602	71,203	3,399
TWH	Intensive Treatment Unit (ITU)	100.4%	100.0%	99.2%	80.6%	29.9	25.0%	100.0%	0	0		Low CSW fill rate an accepted risk.	174,246	161,189	13,057
TWH	Medical Assessment Unit	90.7%	99.2%	121.3%	98.9%	7.6	39.6%	96.6%	13	0		Bay escalated at night.	162,758	178,714	(15,956)
TWH	SAU	100.0%	100.0%	100.0%	96.8%	10.1			0	0			54,118	57,569	(3,451)
TWH	Ward 32	93.5%	92.5%	98.9%	112.1%	9.5	40.4%	91.3%	9	1		Enhanced care needs over 9 nights	122,764	138,744	(15,980)
TWH	Ward 10	88.7%	101.6%	87.9%	132.3%	6.9	69.8%	95.0%	0	0		Specials over 5 nights. RN fill rate due to vacancy and bank unable to fill.	112,453	100,032	12,421
TWH	Ward 11	95.4%	108.6%	88.7%	122.6%	6.9	48.5%	100.0%	5	0		RN:CSW ratio at night an accepted risk	110,018	111,882	(1,864)
TWH	Ward 12	90.9%	92.7%	100.0%	98.4%	6.9	37.7%	84.6%	7	1			122,915	116,441	6,474
TWH	Ward 20	98.9%	125.8%	98.9%	148.4%	5.1	24.5%	83.3%	10	0		Enhanced care for cognitive impairment and falls risk cohort throughout the month	106,507	116,410	(9,903)
TWH	Ward 21	100.5%	95.7%	96.8%	125.8%	6.7	18.2%	100.0%	11	0		Enhanced care needs over 12 nights.	133,012	123,146	9,866
TWH	Ward 2	96.0%	116.8%	98.9%	125.8%	7.8	56.7%	94.1%	11	1		20 episodes of Enhanced Care needs.	124,028	124,092	(64)
TWH	Ward 30	95.7%	87.7%	97.6%	100.0%	6.5	0.0%	0.0%	7	0		CSW fill rate an accepted risk.	108,041	120,882	(12,841)
TWH	Ward 31	95.7%	96.7%	100.0%	100.0%	7.7	52.4%	84.8%	2	1			129,736	133,338	(3,602)
Crowborough	Birth Centre	100.0%	100.0%	98.4%	100.0%				0	0			85,997	63,742	22,255
TWH	Ante-Natal	103.2%	90.3%	96.8%	87.1%	7.7	36.6%	94.3%	0	0		CSW fill rate an accepted risk.			
TWH	Delivery Suite	99.3%	88.7%	96.1%	96.8%	17.0			0	0			615,756	641,993	(26,237)
TWH	Post-Natal	98.6%	69.4%	98.4%	67.7%	8.0			0	0					
TWH	Gynae Triage	100.0%	100.0%	98.4%	100.0%				0	0			11,974	12,502	(528)
TWH	Hedgehog	95.2%	61.3%	102.6%	74.2%	9.5	2.1%	100.0%	0	0		Un-registered fill rate includes play therapy. Reduced fill rate an accepted risk.	196,824	159,196	37,628
MAIDSTONE	Birth Centre	100.0%	100.0%	100.0%	100.0%				0	0			85,997	63,742	22,255
TWH	Neonatal Unit	100.0%	109.7%	106.5%	61.3%	12.3			0	0		CSW fill rate at night an accepted risk.	167,377	169,833	(2,456)
MAIDSTONE	MSSU	115.1%	102.1%	104.8%	N/A				1	0			40,769	45,648	(4,879)
MAIDSTONE	Peale	122.6%	58.8%	101.6%	100.0%	8.0	26.8%	100.0%	1	0		RN:CSW ratio shift to ensure appropriate headcount of staff on duty. Skill mix shift due, in part, to resolving issues of establishment review.	70,239	69,298	941
TWH	SSSU	110.6%	100.0%	106.5%	100.0%				2	0		Fill rate reflected funded short stay surgery beds. Additional staff utilised to cover escalation and to support elective activity through recovery.	60,469	89,482	(29,013)
MAIDSTONE	Whatman	100.0%	124.2%	100.0%	135.5%	5.4	78.6%	90.9%	7	1		Enhanced care needs throughout the month.	90,069	92,171	(2,102)
MAIDSTONE	A&E	97.6%	74.2%	97.7%	87.1%		12.1%	91.7%	1	0		CSW fill rate an accepted risk, as bank/agency unable to fill.	205,143	175,797	29,346
TWH	A&E	90.3%	87.1%	95.9%	90.3%		10.5%	90.8%	5	0			205,143	175,797	29,346
												Total Establishment Wards	0	67,437	(67,437)
												Additional Capacity beds	**4,850,690**	**4,851,182**	**(492)**
												Other associated nursing costs	39,307	32,298	7,009
												Total	2,262,077	2,342,319	(80,242)
													7,152,074	7,225,800	(73,726)

RAG Key

Under fill

Over fill

Trust Board meeting – September 2017

NHS
Maidstone and Tunbridge Wells NHS Trust

9-18	**Health & Safety Annual Report, 2016/17 (incl. agreement of the 2017/18 programme and annual refresher training on Health & Safety, Fire safety, and Moving & Handling)**	**Chief Operating Officer / Risk and Compliance Manager**

This report has been prepared by the Trust Competent Persons for the Board.

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

- Discuss and agree the Trust's health and safety objectives
- Agree the work programme for 2017/18
- Formerly delegate the management to the Health and Safety Committee.

This annual report provides:

- A review of the Trust's Health and Safety performance for 2016/17
- Assessment against objectives and KPIs set in the previous year
- Discussion of the key health and safety issues identified within the year
- Discussion document for the Board to determine the objectives and KPIs for 2017/18
- Identifies the strategy and action plan for the next year and going forward

Our data shows that circa 46.4% of reported injuries relate to staff, contractors and visitors and 53.4% relate to patients. There are many programmes and initiatives focused on patient safety so this report concentrates on issues relating to staff safety only.

The report includes an Appendix, "What does the Board need to know?", on the basis that this provides the necessary instruction for the Trust Board i.e. above and beyond what individual Executives may be required to do, as part of their mandatory training. This covers Health & Safety, Fire safety, and Moving & Handling. The Risk and Compliance Manager will be in attendance at the Trust Board meeting to respond to any queries Board Members may have on this, or any other aspect of the report.

Which Committees have reviewed the information prior to Board submission?

- Health & Safety Committee, 07/08/17

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

1. Information and assurance
2. To approve the work programme for 2017/18

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

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Health and Safety – Annual Board Report and Programme for 2017

Requested/ Required by: Trust Board and the Trust Management Executive

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

Main author: Risk and Compliance Manager (Rob Parsons)
Contact Details: ext. 24581 rob.parsons@nhs.net

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

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

Directorate: Quality and Governance

Health and Safety – Annual Board Report and Programme for 2017

Requirement for document:	This annual report and programme is: • A review of the Trust's health and safety statistics and performance for 2016/17 • Assessment against objectives and Key Performance Indicators (KPIs) set in the previous year. • Discussion of the key health and safety issues identified within the year. • Discussion document for the Board to determine the objectives and KPIs for 2017/18. • Identifies the strategy and action plan for the next year and going forward.
Cross references:	This report is in response to key health and safety legislation enacted under the Health and Safety at Work etc Act 1974. This report is supported by the Trust's key policies and procedures: • Maidstone and Tunbridge Wells NHS Trust Health and Safety Policy. • MTW Risk Management Policy and Strategy.

Version Control:		
Issue:	**Description of changes:**	**Date:**
12	First annual Board report	May 2012
14	Second annual Board Report	May 2013
15	Third annual Board Report	May 2014
16	Fourth annual Board Report	May 2015
17	Fifth annual Board Report	July 2016
18	Sixth annual Board Report	August 2017

Contents

1. Executive Summary....4
2. Introduction....5
3. Review of Objectives and Programme set for 2016/17....5
4. Statistics for 2016/17....8
5. Benchmarking....12
6. Key Health and Safety Areas....13
7. Health and Safety Executive Inspections and Investigations in 2016/17....16
8. Health and Safety notable prosecutions and legislation changes....16
9. Summary and Conclusions....18
10. Objectives for 2017/18....19

Appendix A....25

1. Executive Summary

Introduction

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

- Discuss and agree the Trust's health and safety objectives
- Agree the work programme for 2017/18
- Formerly delegate the management to the Health and Safety Committee.

This annual report provides:

- A review of the trust's health and safety statistics and performance for 2016/17.
- Assessment against objectives and KPIs set in the previous year.
- Discussion of the key health and safety issues identified within the year.
- Discussion document for the Board to determine the objectives and KPIs for 2017/18.
- Identifies the strategy and action plan for the next year and going forward.

Staff, contractor and visitor incident statistics make up 15.6% of the total incidents reported, which is dominated by patients. There are many programmes and initiatives for patient safety so this report concentrates on staff safety only.

Highlights

- The majority of the intended programme has been completed, though there remain a number of areas where objectives have been carried over.
- Overall reporting rates have decrease by 13%, with injury rates (-7%) and near miss (-8%) reporting also down.
- The number of incidents reported under RIDDOR increased from 27 in 2016/17 to 37 in 2017/18. When combined with the drop in overall reporting rates this would indicate that there are minor incidents and near misses going unreported.
- Violence and aggression injuries saw a 12% decrease. However, this was the largest injury category with 79.
- Sharps injuries decreased by 21%, though there was an increase in eye splash incidents. There were more RIDDOR reportable dangerous occurrences from exposure to known blood borne viruses (BBV). There remains under reporting when compared with Occupational Health referrals, though the level is less than in 2015/16.
- Falls accounted for 18% of injuries with a 4% decrease.
- There has been an increase in moving and handling injuries as well as injuries as a result of collisions, traps or being struck by something.
- Occupational ill health Datix reporting has seen an increase but remains low.
- 2016 saw a significant increase in the levels of the largest fines issued to organisations for Health and Safety breaches. 19 of the 20 highest fines were over £1m.

Health and Safety Executive

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

2. Introduction

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

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

Staff, contractor and visitor incident statistics make up 15.6% of the total incidents reported. This group, however, make up 46.4% of the total injuries. These have been divided into groups based on severity:

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

The injuries have been divided into 7 types based on the categories used by the HSE in their national statistics. 97.6% of the total injuries fit into these categories. This allows for bench marking against all industry and the health sector:

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

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

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

3. Review of Objectives and Programme set for 2016/17

In September 2016 the Trust Board agreed a programme for 2016/17:

Action	Leads	Progress and Comments
Health and Safety Management		
Ensure that all Clinical and high risk departments have completed their annual review of H&S Audits.	Trust H&S advisor	Audits now included within the mock CQC inspection process.
Embed the program of audits of the documents uploaded to the H&S audit software.		Audit software is not currently fit for purpose to accurately record audits. Meeting planned with service provider to resolve.
Need to increase staff awareness of the risks posed by hot, food and drinks and kitchen equipment.	Trust H&S advisor	Catering staff briefed as part of the local staff meeting process post incident. Article highlighting risk published within the Governance Gazette.

Action	Leads	Progress and Comments
Falls (Falls Prevention Practitioner)		
Continue with awareness and training to further reduce staff falls.	Falls Prevention Practitioner	Training in Falls Handling session incorporates elements on risk factors and interventions to reduce risk of falls to heighten personal awareness for staff members.
Radiation Protection		
Control of Electromagnetic Fields at Work Regulations 2016	Radiation Protection Advisor/ EME and Technical Services Manager	A database of Trust equipment has been assembled and a risk assessment based approach developed to check EMF regulation compliance. There is a team comprising members from Medical Physics and EME who are working through the current medical equipment database.
Audit programme: Staff compliance with personal radiation dosimeter policies and procedures	Radiation Protection Advisor	A comprehensive audit of compliance was carried out between September and December 2016. The target level was set at 90% and the audit demonstrated that the compliance level was 94%. Localised non-compliance has been tackled through meetings with individuals or teams.
Violence and abuse		
Review physical restraint and CRT training for all Trust staff groups.	LSMS	Physical restraint training requires a 2 day course for staff to attend and this is not a feasible option for the Trust. The decision was taken that only blocking and breakaway techniques would be trained to Trust staff in CRT, not restraint. A new Security provider starts on 1st August 2017 with a plan to teach appropriate CRT.
Investigate trends in violence and abuse reporting to determine the reason for the increase in reported injuries.	LSMS	The Datix reports show that staff are subjected to variable levels of violence from patients with a diagnosis of dementia. Staff have been encouraged to report all assaults on Datix regardless of capacity of the patient.
Consider the provision of a secure room for patients sectioned under section 136 of the mental health Act in A&E on both sites	Head of Safety and Security	The 136 suite was not pursued. This was partly due to funding and staffing, but also due to Police protocols advising Police to escort people to mental health triage units rather than A and E's. There continues to be quiet rooms at both A and E locations for patients to be assessed in.
Support Kent police to develop a Kent wide protocol for the management of missing and mental health patients.	LSMS	This work is ongoing following some significant incidents of missing patients from MTW. The Kent wide protocol has not been ratified but there is a greater understanding between the NHS and Police on missper processes. The MTW Missing Patient policy flowchart was reviewed and amended.
Moving and Handling		
Complete the 2 year review of all patient handling generic risk assessments and safe systems of work	M&H Co-ordinator	This has been carried over for 2017/18. Ongoing rolling 3 year review of documents.
Need to continue the inclusion of spinal handling in generic risk assessments and continue the training programme.		This has been carried over for 2017/18.
Develop the in house database to adequately record training and competency evidence		Action completed. Not possible to develop the existing LMS to the extent requested. An alternative solution was agreed with Head of Compliance and Fire. Competency evidence being held by EME Services.

Action	Leads	Progress and Comments
Need to address the lack of patient canvasses resulting in an inability to follow safe practise.		This has been carried over for 2017/18. Complete.
Sharps		
The sharps task and finish group will continue to use all means to change staff attitude and the embedded medical sharps culture.	Risk and Compliance Manager	The Sharps Group has continued to meet. More work has been carried out to identify gaps in knowledge and staff attitude towards safety sharp usage.
Analyse the injury data for 2016/17 and compare with previous data set. Highlight learning.		Sharps injury numbers have continued to reduce however it remains a significant cause of injury. Incidence of exposure to known BBV is up, which is a concern.
Continue to review new safety devices in the market place across the Trust.	Vascular Access Specialist Practitioner	No new safety sharps have been identified or trialled throughout this period.
Review safety sharps training to assess if refresher training is required and how this can be delivered.	Vascular Access Specialist Practitioner	Introduction of a safety sharps questionnaire for all medical staff at induction to assess entering level of knowledge, understanding and attitudes regarding safety sharps. Same questionnaire to be sent out trust wide via survey monkey to assess knowledge, understanding and attitudes of existing staff.
Complete an options appraisal for increasing the reporting of sharps injuries by staff referring to occupational health.	Occupational Health Manager	Completed and action plan devised from this.
Develop an action plan to increase reporting	Occupational Health Manager	Action plan to increase reporting completed and implemented. All staff reporting to OH with a sharp / splash injury is told to complete an incident report and the staff member is also reported to the Health, Safety and Risk Team to ensure an entry is made under their name.
Eye Splashes (Risk Lead for Critical Care)		
The task and finish will continue with the awareness campaign through posters etc.	Risk Lead for Critical Care	Work of task and finish group to be incorporated into Sharps Working Group
Occupational Health		
Increase awareness of the need to report work place stress and other ill health events on Datix via a safety alert.	Risk and Compliance Manager	There has been an increase in reports from 2015/16 however levels remain low. A safety alert was considered but not deemed the most appropriate method of communication.
Increase awareness of the need to report work place stress and other ill health events on Datix via H&S training.	Health and Safety Advisor	This is covered generally during statutory and mandatory training with some specifics in terms of reportable disease.
Encourage staff and their managers to report work related stress and other ill health events through Datix.	Occupational Health Manager	Staff advised at the point of assessment. Managers advised to undertake stress risk assessment and follow procedure to reporting where appropriate / indicated.
Complete an options appraisal for increasing the reporting of work related stress and other ill health events through Datix.	Occupational Health Manager	Completed and action plan devised from this.
Develop an action plan to increase occupational Ill health reporting	Occupational Health Manager	Completed. Occupational ill health is reported to the Health, Safety and Risk Team by occupational health clinicians to ensure it can be assessed and reported accordingly.

4. Statistics for 2016/17

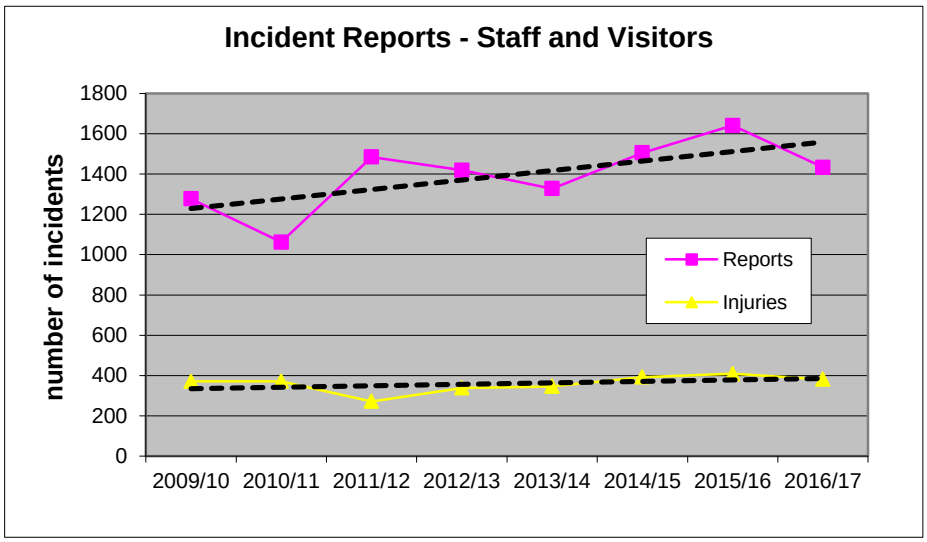
The Datix incident database was interrogated for all non-patient injuries for the period of 01/04/16-31/03/17.

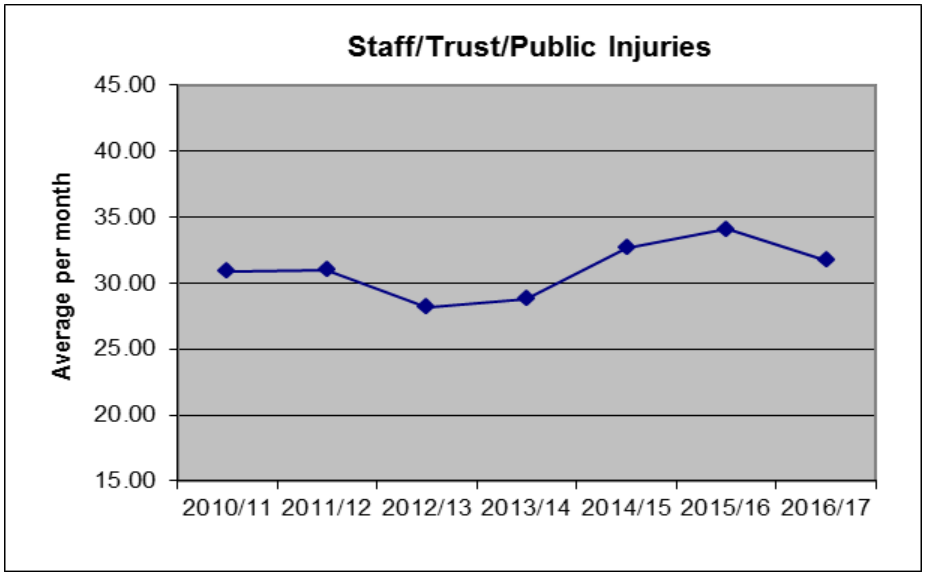
4.1. Reporting

There were 1433 non-patient incidents reported in 2016/17, which represents 15.6% of total incidents. This is a 13% decrease from 1641 the previous year and reflects a pattern of reduced reporting rates every three years.

The total number of non-patient injuries reported dropped by 7% to 381 from 409. This figure makes up 46.4% of total injuries.

The ratio of reports to injuries and decreased slightly to 3.8 reports for every injury from 4:1 in 2015/16.

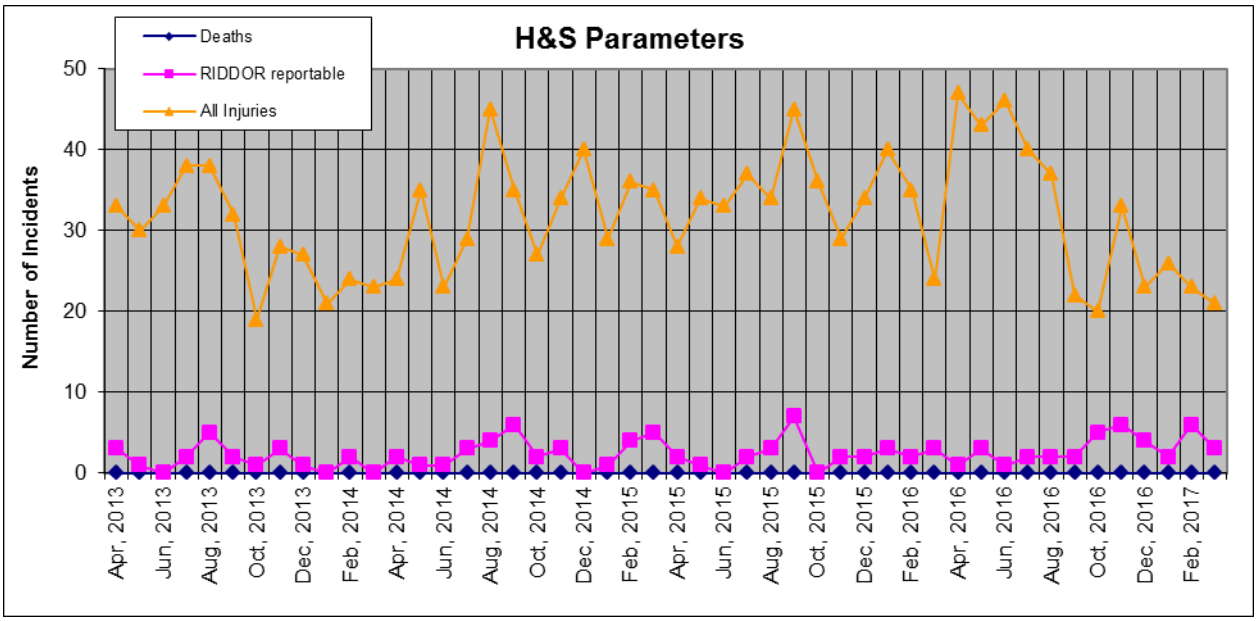




4.2. Injuries

The data for 2016/17 has been compared with the data from previous 2 years.

The Trust submitted 37 RIDDOR reports in the year at an average of 3.08 per month. This is a significant increase from 2.25 the previous year. 86.5% of RIDDOR reports were submitted on time. This is an improvement from 70% for 2015/16.



The increase in reports and timeliness of reporting would indicate that the focus on RIDDOR reporting has had an effect. However, combined with the fall in overall reporting (down 13%) and injury reporting (down 7%), reporting rates for less serious incidents and near misses (down 8%) have fallen.

RIDDOR Category	Year reported		
	2014/15	2015/16	2016/17
7 Day injury	25	16	20
Specified injury	6	10	14
Dangerous occurrences	1	1	3
Accidental death	0	0	0*
	32	**27**	**37**

There has been an increase in <u>all</u> the RIDDOR categories. Musculoskeletal injuries accounted for 45% of 7 day injuries. 100% of the specified injuries were fractures. 64% involved visitors, with 78% of these fractures to hips/femurs. All three of the dangerous occurrences were reported as exposure to known blood borne virus (BBV).

*Please note that one RIDDOR report made in 2017/18 so far relates to an accidental death which took place in 2016/17. The investigation is ongoing and this incident data will be in included in the 2017/18 annual report.

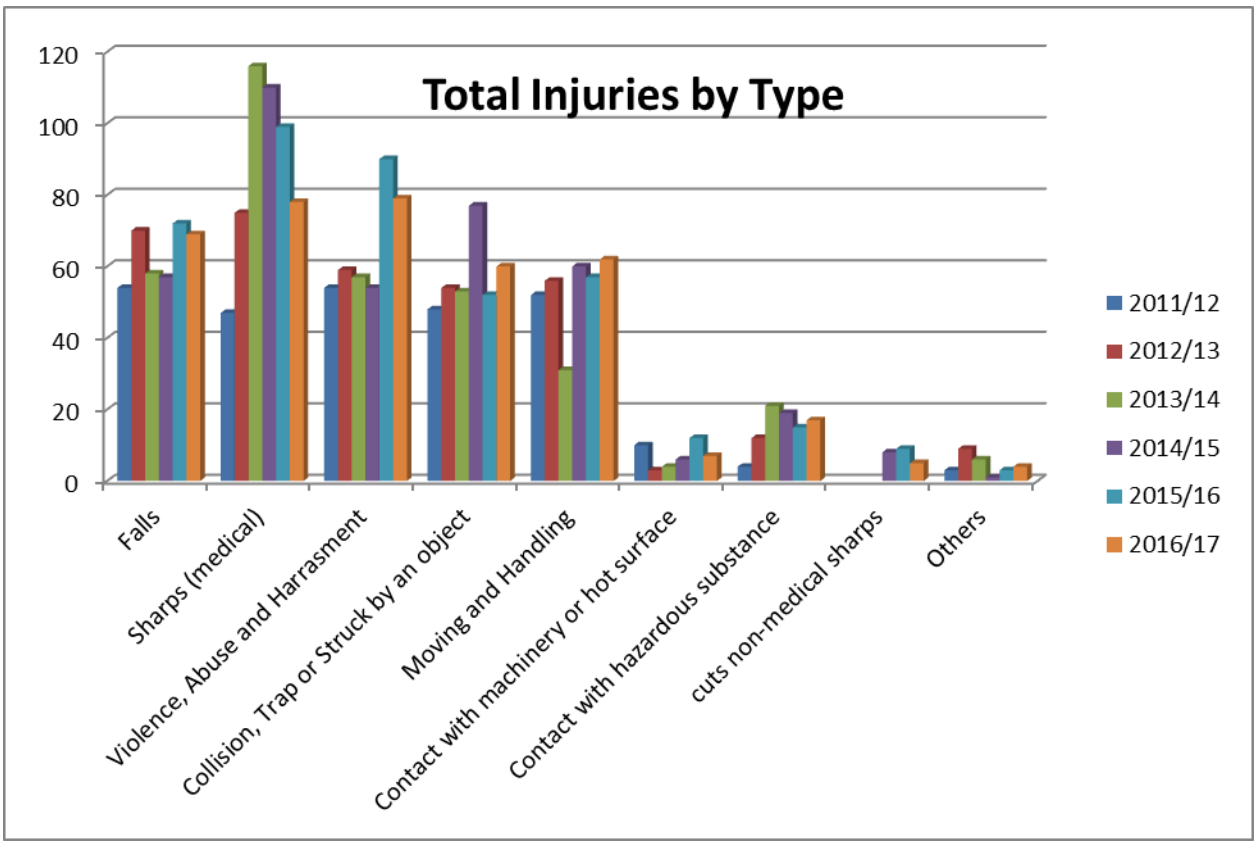
4.3. Categories of incidents resulting in injury

The seven largest categories make up 97.6% of all staff injuries. Three have increased and four have shown a decrease. The overall reduction in reporting rates (-13%) and injury rates (-7%) should also be taken into account.

	2015/16	2016/17	% of total	Change
Falls	72	69	18%	-4%
Sharps (medical)	99	78	20%	-21%
Violence, abuse and harassment	90	79	21%	-12%
Collision, trap or struck by an object	52	60	16%	+15%
Moving and handling	57	62	16%	+9%
Contact with machinery or hot surface	12	7	2%	-42%
Contact with hazardous substance	15	17	4%	+13%
Cuts non-medical sharps	9	5	1%	-44%
Others	3	4	1%	+33%
	409	**381**		

More detailed analysis is given in **Section 6** below.

The chart below compares 2016/17 injuries by type with the previous five years:



While some rates have remained steady, the most marked trend is the continued reduction in the number of medical sharps injuries, which is now close to the numbers seen in 2012/13.

4.4. Injuries by Directorate/ Specialty

The table below shows injuries by directorate/ specialty:

Directorate/ Specialty	Total Injuries	Falls	Sharps (medical)	Violence, abuse and harassment	Collision, trap or struck by an object	Moving and handling	Contact with machinery or hot surface	Contact with hazardous substances	Cuts non-medical sharps	Others
A&E	55	7	13	19	6	8	1	1		
Corporate, Clinical Governance and Nursing	26	8	2	6	3	3		1	1	2
Critical Care	24		13	1	4	2		2	1	1
Estates and Facilities	57	24	4		16	9	3	1		
Women's Children's and Sexual Health	35	4	9	6	7	6	1	2		
Surgery	31	3	13	4	4	5		2		
Head and Neck	7	1	1	1	3	1				
Cancer and haematology	15	4	3		4	3		1		
Outpatients	4	1	1			1		1		
Diagnostics and Pharmacy	27	8	3	2	2	6		2	3	1
Planned care	9	1	3	4		1				
Private patients	1					1				
Specialist Medicine and Therapies	77	6	10	36	8	14	2	1		
Trauma and Orthopaedics	13	2	3		3	2		3		
Total	**381**	**69**	**78**	**79**	**60**	**62**	**7**	**17**	**5**	**4**

The size of the respective directorates and the activities undertaken has a clear influence on the number and nature of injuries that occur. This is discussed in more detail in **Section 6** below.

4.5. Occupational ill health

Occupational ill health is identified and reported by the Occupational health department. 4 incidents of occupational ill health were reported on Datix. This is an increase on the previous three years.

Ill health	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Skin and dermatitis	3	3	1	0	0	0
Work-related stress	1	0	0	0	1	0
Occupational respiratory disease	0	0	0	0	0	1
Environmental causes of ill health	5	1	0	1	0	3
Total occupational ill health	**9**	**4**	**1**	**1**	**1**	**4**
Others (not occupational)	2	5	2	2	6	10

To raise awareness increased focus has been put on the need to report work place ill health via Datix during statutory and mandatory health and safety training. Staff are advised at the point of assessment to report occupational ill health via Datix. In addition, the Occupational Health Team liaises with the Health, Safety and Risk Team on cases of occupational ill health that require specialist advice and guidance. However, these measures alone will not significantly increase reporting and more work is required.

5. Benchmarking

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

All industries (2014/15)	Death	0.5	per 100,000 employees
Health sector (2014/15)		0	
MTW (2016/17)		0	
All industries (2015/16)	All RIDDOR injuries	274	
Health sector (2015/16)		388	per 100,000 employees
MTW (2010/11)	All RIDDOR injuries	**721**	per 100,000 employees
MTW (2011/12)		**585**	
MTW (2012/13)		**383**	
MTW (2013/14)		**232**	
MTW (2014/15)		**329**	
MTW (2015/16)		**324**	
MTW (2016/17)		**479**	

There has been an increase in the Trust RIDDOR rate per 100,000 employees in line with the increased number of RIDDOR reportable incidents and lower number of employees. The CCG has set risk levels; rates of <600 are rated as green, 600 to 660 as amber and >660 as red. **Hence MTW is rated as green.**

Further comparison data was obtained from other local Trusts. The Healthcare Risk Management Group (HMRG) has members from many Trust's in the South East.

Type of Trust	Total RIDDORs	Employees	RIDDOR Rate (per 100,000 staff)	
MTW	37	7726	479	2016/17
Health sector (HSE national data)			388	2015/16
Acute NHS Trust 1	50	5000	1000	2016/17
Acute NHS Trust 2	12	6780	177	2016/17
Acute and Community Trust 1	51	6867	743	2016/17
Acute and Community Trust 2	9	3658	246	2016/17
Community NHS Trust 1	21	5460	385	2016/17
Community NHS Trust 2	17	5556	306	2016/17
Hospices & Community Service	18	4500	400	2016/17
Private Healthcare Hospital 1	2	385	519	2016/17
Private Healthcare Hospital 2	2	1100	182	2016/17
Private Healthcare Hospital 3	4	400	1000	2016/17
Community Care	4	550	727	2016/17
Health and Education Charities	4	320	1250	2016/17
HMRG Average			478	**2016/17**

MTW's RIDDOR rate is higher than the health sector average but is almost exactly that of the HRMG average. There is a large degree of variance in directly comparable Trusts which makes comparison more difficult. Benchmarking was only possible against organisations willing to share their data.

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

6. Key Health and Safety Areas

6.1 Falls

Falls account for 18% of staff/public/Trust injuries. The number of injuries from falls this year has decreased by 4% to 69. Staff account for 65% of injuries and public 35%.

Estates and Facilities is the designated directorate/ specialty for almost 35% of slip, trip and falls injuries, with a high proportion of these involving members of the public in communal areas. Falls involving member of the public made up 64% of RIDDOR reportable specified injuries.

Falls prevention is a key patient safety agenda item for the Trust. Through this focused work has been carried out to increased staff awareness on the importance of reducing risk of falls in general. This includes environmental as well as personal risk factors.

In 2016/17 there were 7 falls incidents involving members of the public resulting in injury where a Serious Injury (SI) was declared. These incidents were investigated and presented to the Falls SI sub group. It was deemed that 6 of the 7 were unavoidable. These were presented to CCG panel and a downgrade of the SI was subsequently agreed.

6.2 Violence and Abuse

Injuries from violence accounts for 21% of all injuries and was the largest cause of injury in 2016/17 with 79 incidents. The data shows a decrease of 12% this year, close to the drop in overall reporting.

The Datix reports show that staff are subjected to variable levels of violence from patients with a diagnosis of dementia. These range from scratches and pinching to a broken nose. There has been a consolidated effort between the Dementia lead nurse and the Trust Security Manager to include dealing with challenging behaviour on their respective courses. Staff have been encouraged to report all assaults on Datix regardless of capacity of the patient.

A review of physical restraint and CRT training for all Trust staff groups was carried out. Physical restraint training requires a 2 day course for staff to attend and this is not a feasible option for the Trust. In addition physical restraint should only be used as a last resort once all other avenues have been exhausted, and in the best interests of the patient under our duty of care. An additional risk arises when a trained member of staff works alongside an untrained member of staff. The decision was taken therefore that only blocking and breakaway techniques would be trained to Trust staff in CRT, not restraint.

Following meetings and formal requests with Interserve, the current security provider, it was evident that they were not prepared to spend money on CRT for security. A new provider starts on 1st August 2017 with a plan to teach appropriate CRT.

6.3 Moving and Handling

Moving and handling incidents account for 16% of staff injuries. Last year there was a 9% increase in injuries, counter the overall trend of reduced injury rates.

A new training provider was appointed in January 2017 to deliver Trust induction and update training. Training programmes have been formulated to include recurring moving and handling issue, these being, overloading of linen bags, correct sling sizing and fitting. Initial evaluations and verbal feedback have indicated that the new trainers have been very well received by attendees.

The Moving and Handling Co-ordinator was unavailable for a large proportion of 2016/17, with no availability from November 2016 to June 2017. As a result some incomplete objectives have been carried forward to 2017/18.

6.4 Sharps

Injuries from medical sharps fell by 21% from 99 to 78. Last year there was one RIDDOR reportable sharps injury. This year there were two needle stick injuries and one eye splash where exposure to BBV was confirmed. These were reported under RIDDOR but there was no HSE follow up.

The sharps group will continue to promote sharps safety and change the embedded culture.

The Vascular Access Specialist Practitioner has continued to train all new medical staff, through induction programmes, for Blood Cultures and where appropriate in Venepuncture and Cannulation. Sharps injuries and best practice in handling medical sharps is discussed. Practical skills stations facilitate competency assessment and serve to highlight poor practice.

Nursing staff attending study days on Intravenous Therapy, Venepuncture and Cannulation and Central Venous Access Devices also receive training on sharps injuries and best practice in handling medical sharps. Staff are provided with a selection of supervised clinical skills stations with high staff to student ratios, to practise their technique in a safe and supported environment.

Every opportunity to engage company representatives in the Trust wide training of staff in the correct handling and disposal of medical sharps has been undertaken, especially coinciding with either the introduction of a new medical sharp or the change of an existing medical sharp device. Company- led Trust wide training is viewed as an essential element when considering new devices for trial and potential introduction to the Trust.

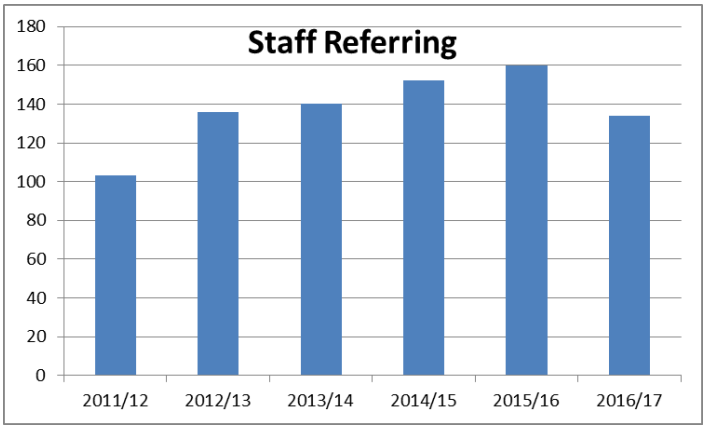
6.5 Eye Splash Injury

Including near misses and those recorded as 'No obvious harm', in 2015/16 there were 18 eye splash incidents in the Trust. This year there were also 21 eye splash incidents, including three where no bodily fluids were involved. One was reportable under RIDDOR due to exposure to known BBV. The incidents were distributed across 13 location types and 10 specialties/directorates with no clear outlier.

The work of the Eye Splash Group has been incorporated into the Sharps Working Group. There is a need to continue the awareness campaign and this will be included in the plans for the Sharps Working Group.

Sharps/ Contamination Injury Comparisons

Occupational Health reported that 134 staff had been referred following sharps/contamination injury. When the 78 sharps and 18 eye splash contamination incidents are considered this indicates 28.4% under reporting. This is approximately 10% less under reporting than in 2015/16. The programme last year had actions to encourage staff to report incidents through Datix. The occupational health data shows a decrease in injuries compared with 2015/16.



6.6 Collisions, Traps or Struck by and Object

These incidents occur when staff move around the workplace. It can be indicative of cramped conditions, bad housekeeping and rushing around. In 2015/16 there were 52 injuries. This year this has increased by 15% to 60 injuries. Estates and Facilities are the largest reporter with 27%, commonly when moving mechanical aids like cages and trolleys around the workplace and going through doorways.

Through analysis of incident data, safe systems and risk assessment, as well as an increased awareness campaign, the objective is to reduce the number of collisions, traps, and struck by type incidents in 2017/18.

6.7 Machinery, Hot Surfaces and Fluids

In 2015/16 there were 12 burns/scalds to staff. This year there was a significant decrease to 7. There was a concerted effort to reduce incident numbers. Catering staff were briefed as part of the local staff meeting process post incident. An article highlighting risk published within the Governance Gazette.

7. Health and Safety Executive Inspections and Investigations in 2016/17

7.1 Trust Inspection

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

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

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

7.2 Investigation Visits

The HSE has not visited the Trust this year to undertake investigations following RIDDOR reportable incidents.

HSE Priorities, Projects and Targets

In 2016/17 the HSE developed and began their “Helping Britain Work Well” strategy. This will continue in 2017/18.

The establishment and delivery of a comprehensive three-year Health and Work programme to reduce levels of work-related stress, musculoskeletal disorders and occupational lung disease is a key priority for 2017/18.

The HSE’s public services sector plan prioritises reducing the high levels of ill health from work-related stress and MSDs.

8. Health and Safety notable prosecutions and legislation changes

The effects of the changes in February 2016 to the sentencing guidelines for health and safety offences have been significant. In 2016 19 of the 20 highest fines handed out under the Health and Safety at Work Act or associated regulations were over £1m, compared to just three in 2015. Four of these were over £3m.

The guidelines require that the potential for harm is factored as well as any harm or disease. Two notably large penalties over £1m were for breaches where no one had been injured but a large number of workers had been exposed to risk. The Trust needs to be vigilant in ensuring risks are managed, potential for harm identified and steps taken to reduce the risk so far as is reasonably practicable.

Prosecutions of NHS Trusts generally result in lower fines due to the Public Sector reduction. Here are notable recent Health and Safety cases in health care along with lessons that can be learned from these cases for MTW:

Date	Organisation	Incident	Penalty	Learning
04/16	Morecombe Bay Foundation Trust	Failing to ensure they managed the risk of bed rails	£100,000 plus costs	*Management systems and failure to improve* This was not brought about by a single incident but a series of failings in the management of bed rails including inspection, risk assessment and maintenance.
11/16	Norfolk and Suffolk NHS Foundation Trust	78 year old patient suffering from dementia was found drowned in bath having been left unsupervised	£366,000 plus costs	*Lack of policy, procedure and suitable risk assessment* HSE investigation found insufficient policies and procedures. They had failed to complete an appropriate risk assessment.
11/16	Royal United Hospital (Bath) NHS Trust	Confused and vulnerable DoLS patient fell through a restricted window	£200,000 plus costs	*Failure to adhere to required standards, lack of suitable risk assessment* Window was fitted with one restrictor and could flex to enable gap to increase beyond 100mm standard. Trust had already received clear guidance that a single restrictor was not suitable.
06/17	Surrey and Borders Partnership NHS Foundation Trust	Patient suffering from mental-illness fell to his death from a hospital's industrial chimney	£300,000 plus costs	*Management of absconding patients and failure to learn* A series of failures to ensure the risk associated with absconding was properly managed. Inadequate communication and failure to make appropriate changes following previous incidents.

Few significant legislation changes occurred in 2016/17. There are forthcoming proposed changes. The HSE consulted on changes to the Ionising Radiation Regulations 1999 (IRR1999). The main changes are:

- Reduction in annual dose limit for exposure to the lens of the eye from 150 mSv to 20 mSv. The HSE proposes that this is introduced from January 1st 2018 as part of new guidelines.
- Introduction of a new three tiered risk based system of regulatory control so that the higher the radiation protection risk associated with the work, the greater the requirements.

9. Summary and Conclusions

- The majority of the intended programme has been completed, though there remain a number of areas where objectives have been carried over.
- The combination of a decrease in overall incident reporting rates, injury rates and near miss reports with an increase in the number of RIDDOR reports (from 27 to 37) indicates less serious incidents were going unreported in 2016/17.
- There have been efforts to raise the profile of RIDDOR requirements during 2016/17 through statutory and mandatory training, but this should not account for such an increase.
- The proportion of injuries suffered by staff, contractor and visitors is 46.4% of total. The majority of these are to staff (92%) with the remainder to the public (8%).
- However, almost a quarter of RIDDOR reportable incidents involve the public (24%) and constitute 64% of reported specified injuries. These are usually falls resulting in fractures so more work needs to be done investigating and raising awareness of slips, trips and falls in communal areas to prevent recurrence.
- Falls accounted for 18% of injuries with a 4% decrease. It remains a key focus area for the Trust.
- Violence and aggression injuries saw a 12% decrease. However, this was the largest injury category with 79. Work is ongoing to improve staff and patient security and ensure that conflict resolution training is delivered to those that need it and includes dealing with challenging conditions.
- The number of sharps incidents has decreased again, which is encouraging. However, there has been an increase in RIDDOR reportable BBV exposure incidents. Furthermore, when sharps Datix figures are compared with Occupational Health referrals there is 28.4% under-reporting. Further analysis and continued awareness, promotion of safe use of sharps and reducing the risk of eye splash incidents are required. The Sharps Working Group will take the lead in this area.
- There has been an increase in moving and handling injuries. In addition, a number of the incidents categorised under ‘collision, traps, or struck by’ also involve moving and handling activities. The unavailability of the Moving and Handling Coordinator has meant that the 2016/17 objectives have been carried over to 2017/18.
- Occupational ill health Datix reporting remains low. This is not unusual but ongoing vigilance and communication to raise reporting levels is needed.
- 2016 saw a significant increase in the levels of the largest fines issued to organisations for Health and Safety breaches. 19 of the 20 highest fines were over £1m. In addition, there were six figure penalties for NHS Trusts for failures including lack of clear policy and procedure, unsuitable risk assessments and failing to learn from previous incidents and enforcement action.

10. Objectives for 2017/18

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPIs
Health and Safety Management (Health and Safety Advisor)					
Improve the H&S audit systems in place to include active monitoring of compliance and review reminders to managers	Liaise with Synbiotix. Initial meeting in July 2017. Aug 2017: Determine system requirements. Sept and Oct 2017: Development and pilot. Nov 2017: Launch with training March and April 2018: Report on 2017/18	H&S advisor	Risk and Compliance Manager	Progress will be monitored by lead and reported to the H&S committee.	Minimum of 75% compliance with aspiration towards 85% - 90%. This takes into consideration that this will be major revision of system.
Through training and manager awareness increase the number of RIDDOR incidents reported to HSE within required timescales.	Increase reporting rate to 90% by October and achieve this for the year.	H&S advisor	Risk and Compliance Manager	Progress will be monitored by lead and reported to the H&S committee.	Aim for 90% of RIDDOR incidents to be reported on time.
Increase overall reporting rates for staff/ public/ Trust incidents on Datix following 13% decrease in 2016/17	By 31/03/18	Risk and Compliance Manager	All competent persons and risk leads	Progress will be monitored and reported to Trust Clinical Governance Committee and Health and Safety Committee	10% increase in reporting rates of staff/ public/ Trust incidents
Through analysis of incident data, safe systems and risk assessment, as well as increased awareness campaign, reduce the number of traps, struck and collision type incidents	June and July 2017: Data analysis August 2017: Article in Governance Gazette Ongoing: Statutory and Mandatory training	H&S advisor	Risk and Compliance Manager	Progress will be monitored by lead and reported to the H&S committee.	15% reduction in this category compared with 2016/17.
Falls (Falls Prevention Practitioner)					
Continue with awareness and training to further reduce staff	(The focus of the falls team is on reducing Patient falls)	Falls Prevention	Trust H&S Advisers	Continue with regular refresher	Continue with awareness and

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPIs
falls.		Practitioner / Risk Health and Safety Team		training. All falls will be investigated	training to further reduce staff falls.
Slip, trip and falls incidents involving members of public. Investigations into RIDDOR incidents to be carried out by Trust H&S Advisor wherever possible.	Throughout the year	H&S advisor	Estates and Facilities Risk Lead	Progress will be monitored by lead, through RIDDOR panels and reported to the H&S committee	Objective measure of investigation quality
Radiation Protection (Radiation Protection Advisor)					
Control of Electromagnetic Fields at Work Regulations 2016	Throughout the year	Radiation Protection Adviser / EME and Technical Services Manager	Risk and Compliance Manager	Progress will be monitored by leads and reported to the H&S committee.	Medical Equipment risk assessment database is completed, all devices have been assessed and there is a process for assessment of new devices.
Compliance with revised legislation: The Ionising Radiations Regulations 2017 and The Ionising Radiation (Medical Exposure) Regulations 2018	Throughout the year	Radiation Protection Adviser	Risk and Compliance Manager	Progress will be monitored by lead and reported to the H&S committee.	Compliance in accordance with timetable mandated by regulations when they are published
Violence and abuse (Trust Security Manager)					
To continue with the programme of access control upgrade at Maidstone Hospital	Identify areas most vulnerable and work with departmental leads. Identify funding. April 2018	Trust Security Manager	Director of E and F	Progress will be monitored by lead and reported to the H&S committee.	Additional access control in key areas and a reduction in risk and vulnerability to these areas
To continue with the programme of CCTV roll out at MGH	Areas of weakness have been identified and a roll out programme costed	Trust Security Manager	Director of E and F	Progress will be monitored by lead and reported to the	CCTV installed in areas of weakness

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPIs
				H&S committee.	
To ensure security team is fully trained in missing patient procedures, control and restraint and dementia awareness	April 2018	Trust Security Manager and Corps of Security	Director of E and F	Progress will be monitored by lead and reported to the H&S committee.	All security staff trained in areas identified
Moving and Handling (Moving and Handling Coordinator)					
Complete the 2 year review of all patient handling generic risk assessments and safe systems of work	By 31/03/2018	M&H Co-ordinator		M&H Co-ordinator to include on H&S committee report.	Continuous ongoing update programme.
Need to continue the inclusion of spinal handling in generic risk assessments and continue the training programme.	By 31/03/2018	M&H Co-ordinator	Spinal Pathway Group	To be completed as part of the 2 year review cycle. Spinal Group will review progress ST to include on H&S committee report.	Continue to deliver the monthly training sessions. L&D's completion of the additional module for AT-Learning will facilitate better identification of training needs.
Need to address the lack of patient canvasses resulting in an inability to follow safe practise	By 31/03/2018	M&H Co-ordinator	Head of Compliance and Fire	M&H Co-ordinator to include on H&S committee report.	Have sufficient canvasses across the Trust.
Improve knowledge of clinical staff for the sizing of patient hoist slings, correct fitting to the hoist sling bars, positioning of sling bar and lift strap. A proportion of hoist reported	Subject to be included in all moving and handling training sessions, specific ad-hoc training sessions and internal safety notices. Change in external Moving and Handing	Moving and Handling Co-ordinator	EME Services Manager and Trust Medical Device Safety Officer, Falls Prevention Practitioner and	Progress will be monitored by mandatory training attendance. Fewer user error EME reports.	Hoist reports no longer in the top 15 user error devices across the Trust

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPIs
jobs to EME are user errors. Hoists are continually in the top 15, number 11 2016/17, of EME no fault and user error reports. Standard training content for Liko Golvo (Trust standard hoist) and corresponding user competency assessment tool.	provider will improve training content delivery. As clinical mandatory training is every two years, it is expected that all staff will have received suitable training by April 2019		external training provider	EME identified user errors will be reported through Medical Devices Group	
Improve staff awareness of the actions to take following a patient fall, correct equipment selection for a variety of scenarios including immobilisation, correct use of individual equipment items and compatibility of items that can be used together appropriately and correctly. Documented training content for each equipment item to ensure consistent levels of training delivery and corresponding individual competency assessments to evidence training can be put into practice competent users.	Falls Handling is an optional moving and handling update, staff will attend as one of three moving and handling update sessions every two years, it is therefore expected that staff will attend within 6 years. With the current programme and venue availability it is intended that 10% of all clinical staff will receive falls handling training each year.	Moving and Handling Co-ordinator	Falls prevention practitioner and EME Services Manager and Trust Medical Device Safety Officer)	Progress will be monitored by falls training attendance. Fewer incident reports indicating manual lifting has taken place. 10% of clinical staff will return completed relevant competency assessment by April 2018 increasing to 20% in 2019 Training attendance to be monitored by At-Learning	Completed competency assessment from 10% of clinical staff by April 2018 with further 10% year on year, assuming full attendance at planned training courses.
The movement of patients with suspected or actual spinal injury is often undertaken by a multidisciplinary team or a team of handlers from different departments. It is therefore essential that a consistent	Spinal Handling is an optional moving and handling update session for clinical staff. Staff attend moving and handling updates every two years, therefore all staff should attend within 6 years.	Moving and Handling Co-ordinator	EME Services Manager and Trust Medical Device Safety Officer	Training attendance will be monitored through the AT-Learning system.	It is expected that 90% of trauma and orthopaedic staff will have attend by April 2019. An overall expectation of 7% of

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPIs
standard training is delivered to all staff likely to be involved with the care, treatment, handling an transfer of this patient group is in place and delivered every time. The training must include Miami J collar, log rolling, scoop stretcher and scoop and hoist. The standard training content and corresponding user competency assessment for the equipment and technique shall be used.	It is expected that 10% of clinical staff complete and return associated medical device competency assessments in the first year, increasing to 20% and more thereafter.				clinical staff attending every year, assuming all places are filled and suitable venue is available.
Sharps (Sharps Working Group)					
The sharps task and finish group will continue to use all means to change staff attitude and the embedded medical sharps culture	Throughout the year	H&S Advisor	Sharps Working Group	Sharps group will report to medical device and H&S committees.	Decrease sharp injuries again this year.
Analyse the injury data for 2016/17 and compare with previous data set. Highlight learning.	By August 2017	Risk and Compliance Manager	Sharps Working Group		
Continue to review new safety devices in the market place across the Trust.	Complete in 2017/18	Vascular Access Specialist Practitioner	Procurement	Sharps group will report to medical device and H&S committees.	Compliance with the H&S (Sharp Instruments in Healthcare) Regulations 2013.
Review safety sharps training to assess if refresher training is required and how this can be delivered.	Complete in 2017/18	Vascular Access Specialist Practitioner	Sharps task and finish group.	Sharps group will report to the H&S committee.	Reduce injuries as a result of lack of training

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPIs
Occupational Health (Occupational Health Manager)					
Increase awareness of the need to report work place stress and other ill health events on Datix through….	Complete throughout 2017/18	Risk and Compliance Manager	Occupational Health Manager.	Reported to H&S Committee via Occupational health report.	Comparison of numbers referred to numbers reported.
Increase awareness of the need to report work place stress and other ill health events on Datix via H&S training.	Complete throughout 2017/18	Health and Safety Advisor	Training and Development	Reported to H&S Committee via Occupational health report.	Comparison of numbers referred to numbers reported.
Encourage staff and there managers to report work related stress and other ill health events through Datix.	Complete throughout 2017/18	Occupational Health Manager	Occupational Health Department	Reported to H&S Committee via Occupational health report.	Comparison of numbers referred to numbers reported.
Review current health surveillance and its necessity undertaken by Occupational Health and other representatives in the Trust	Complete throughout 2017/18	Occupational Health Manager	Risk Lead	Reported to H&S Committee via Occupational health report.	Current health surveillance validated for its continuation, or ceased following risk assessment.
Review and raise awareness of risk assessments that do or could identify the need for health surveillance	Complete throughout 2017/18	Occupational Health Manager	Risk Lead	Reported to H&S Committee via Occupational health report.	New job roles / practices identified for health surveillance or PPE / risk avoidance where possible.

Appendix A

2017/18 Risk management training update - What does the Board need to know?

1. Health and safety

Employers have a duty under the health and safety at work act to ensure the health, safety and welfare of staff, visitors, contractors and patients so far as is reasonably practicable. The most common prosecutions brought under the Health and Safety at Work etc. 1974 (HSWA) relate to these fundamental responsibilities.

Section 37 of the HSWA imposes liability for a breach of Health & Safety legislation on certain individuals where the breach has been committed by a body corporate.

Liability arises where the offence committed by the body corporate has arisen due to the **consent** or **connivance** or has been attributable to any **neglect** on the part of the accused. The person accused in such cases is a director, manager, secretary or other similar officer or a person purporting to act in such a capacity.

Consent and connivance imply both knowledge and a decision made on such knowledge. In short, a wilful breach of legislation is evident.

Neglect does not necessarily require knowledge and culpability arises where an individual ought to have been aware of circumstances giving rise to the breach.

The potential liability does not simply arise because of the job title given to an individual within a company. It is the authority and responsibility that comes with the job which gives rise to the potential liability.

The intention is to impose liability for those who have real authority and are deemed to be the decision makers within the company having both the power and the responsibility to decide upon corporate policy and strategy.

1.1. Risk assessment

All employers must make a suitable and sufficient assessment of risks in the workplace and record the significant findings. The risk assessment must be available to staff affected. They must also be reviewed regularly and following significant incidents and change.

Improving risk assessment compliance monitoring is a key objective for the Health, Safety and Risk team in 2017/18.

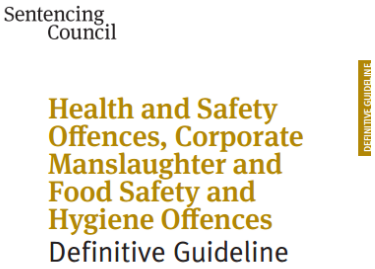
1.2. 2016 Sentencing Guidelines

The most significant change to health and safety legislation in recent years is the introduction of clear guidance on 01 February 2016 on how all health and safety cases should be sentenced. This relates to Corporate Manslaughter as well as Health and Safety and Food Safety and Hygiene Offences.

The effect of the guidance has been clear. In April 2012, Merlin Attractions Operations was fined £350,000 over the death of a 72 year old man who tripped over a parapet wall at Warwick Castle and fell head first into a dry moat. Four and a half years later in September 2016, the same firm was fined £5m over failings in the management of the Smiler rollercoaster at its theme park Alton Towers, which left 16 people injured, some seriously (Health and Safety at Work, 2016).

The introduction of the sentencing guidelines has seen the largest fines ever issued. In 2016 UK safety fines tripled. 19 of the 20 largest fines under the Health and Safety at Work Act and its associated regulations were over £1m. Four were over £3m. This compares with just three fines of over £1m in 2015 (IOSH and Osborne Clarke LLP, 2017).

The new guidelines are beginning to provide a measure of the impact that corporate manslaughter and health and safety offences can have on people and the economy. The level of these fines is also starting to reflect the economic cost to the UK of workplace illness or injury, which is reported to have been £14.1 billion in 2016 (HSE, 2016).



Under the new guidelines, courts are also starting to issue large fines to companies that have exposed workers or others to serious health and safety risks, even where an actual incident has been avoided. Two notably large penalties over £1m were for breaches where no one had been injured but a large number of workers had been exposed to risk.

1.3. How it is calculated

The court determines the offence category using **culpability:**

Very High	Deliberate breach of or flagrant disregard of the law
High	Far short of the appropriate standard, for example by: - Failing to put in place measures that are recognised standards - Ignoring concerns raised - Failing to make appropriate changes following prior incidents - Allow breaches to subsist over a long period *Serious and/ or systemic failure with the organisation to address risks to health and safety*
Medium	- Fell short of the appropriate standard between High and Low. - Systems were in place but were not sufficiently adhered to or implemented
Low	- Not far short of the standard. - Significant efforts to address risk although inadequate on this occasion. - There was no warning indicating risk to health and safety - Failings were minor and occurred as an isolated incident

And **harm**, which uses a 3x3 risk matrix to determine harm category:

		Seriousness of harm risked		
		Level A • Death • Impairment resulting in lifelong dependency • Significantly reduced life expectancy	**Level B** • Substantial effect on ability to carry out normal day-to-day activities • Progressive, permanent or irreversible condition	**Level C** • All other cases not falling within Level A or Level B
Likelihood of harm	High	Harm category 1	Harm category 2	Harm category 3
	Medium	Harm category 2	Harm category 3	Harm category 4
	Low	Harm category 3	Harm category 4	Harm category 4

Next the court must consider if the offence exposed a number of people to the risk of harm (normally it will), and whether the offence was a significant cause of actual harm.

Financial information is considered when determining the level of fine for organisations. For example, for a large organisation (turnover >£50m) fines could range from £3,000 (low culpability, harm category 4) to £10m (very high culpability, harm category 1) for an offence under the Health and Safety at Work Act. For corporate manslaughter offences, the range is £180,000 to £20m. Within each culpability/harm category range there is a starting point from which the fine can be increased due to aggravating factors or reduced due to mitigating factors.

Aggravating factors include:	Mitigating factors include:
Previous convictions Cost-cutting at the expense of safety Deliberate concealment Poor H&S record Targeting vulnerable victims Falsification of documentation or licences	No previous convictions or no relevant/ recent convictions Evidence of remedial action Cooperation with investigation Good health and safety record Effective H&S procedures

There are also guidelines for individuals, although with different sanctions (custody, community orders, fines).

Generally public sector organisations such as NHS Trusts will receive a reduction, though fines have still increased significantly since the introduction of the sentencing guidelines, as discussed in the Annual Health and Safety Report and Programme.

Organisations that focus on putting in place good health and safety policies and preventing accidents can avoid these huge fines, and can reap the rewards of having a safer and more secure working environment for their employees, as well as enjoy greater productivity and a stronger reputation (IOSH and Osborne Clarke LLP, 2017).

1.4. Health and safety summary

- Fines are increasing to reflect true cost of health and safety injury and ill-health to society

- Actual harm doesn't need to occur for large penalty to be given
- Systemic and health and safety management failings and not learning from previous incidents are factors in determining culpability

2. Moving and handling

In 2015/16, musculoskeletal disorders (MSDs) accounted for 41% of workplace ill health (HSE, 2016). Along with stress, reducing MSDs in the public sector is an area of focus for the HSE. This is unsurprising considering that health and social work is the sector with the highest rates of self-reported ill health in the UK (HSE, 2016).

Under the Moving and Handling Operations Regulations 1992 (MHOR) there is a requirement to carry out risk assessments, setting out a hierarchy of "avoid, assess, reduce" when it comes to managing the risk from moving and handling.

As well as the legal duty to undertake risk assessment, the Trust is also required to provide suitable and sufficient equipment training and supervision. Any incident that could result in harm and is found to be as a result of failure to undertake risk assessment, provide suitable and sufficient equipment or to provide training would be a found as negligent of key Health and Safety duties.

2.1. Current issues

The current key Moving and Handing issues that exist and could place the Trust at risk are as follows:-

2.1.1. Correct hoist sling sizing and fitting

A particular case in Manchester where a patient, fit for discharged was being hoisted back to bed and fell from the hoist, hitting his shoulder and head on the floor and died 5 days later with intracerebral haematoma and subsequent bronchopneumonia. No fault was found with the hoist, spreader bar or sling. The nurse had not received the practical element of moving and handling training. Root cause was defined as human error and incorrect attachment of the sling straps to the sling bar.

MTW currently has 130 patient hoists and stand-aids to manage manual handling risk with approximately 750 fabric slings and accessories, held within the medical device libraries, available for use with these hoists. EME services receive regular hoist reports from wards that result in no fault being found. Some of these reports involve connecting the sling to the sling bar, poor positioning of the sling bar and poor positioning of the lift strap. These types of reports are user errors which have, as yet, not resulted in such a terrible outcome.

The previous contracted external trainers were incorrectly delivering slings sizing and fitting training. This has been rectified, a new training provider is in place, additional ad-

hoc training sessions delivered, including sling sizing and fitting within other practical handling sessions and periodic internal safety notices. Sling sizing and fitting remains an essential training element for all clinical staff.

2.1.2. Falls handling training

Falls Handling training has been very well attended and covers falls prevention, the fallen person and safer moving of a fallen person with and without injury.

The Trust has a provision of suitable equipment to encourage immobilisation (scoops) when required and to move a fallen person from the floor, in a variety of scenarios, to avoid hazardous manual lifting. There have been several occasions where staff have immobilised the fallen person but then have not known how to use compatible equipment to safely move the scoop from the floor.

It is essential that all clinical staff attend Falls Handling training to be able to utilise equipment safely and correctly, prevent risk of injury to staff, exacerbation of injury to patients and minimise risk to the organisation.

2.1.3. Overloading linen bags

Ward staff continue to overload a large proportion of linen bags with dirty linen, this makes the bags very heavy and present a risk to facilities staff. This has been added to classroom training programmes, internal safety alerts and sampling by Facilities Zone Managers.

2.1.4. Training and competency evidence

To ensure consistent levels of training to all staff and to evidence learning has taken place, standard training content and medical device competencies should be prepared and used for all patient handling aids.

3. Fire safety update

3.1. Grenfell Tower fire

In the wake of the Grenfell Tower fire, a national safety operation is under way to identify buildings with cladding akin to that used on the Grenfell Tower.

Current building regulations stipulate what cladding can be used and where. Fire rated cladding/Fire stopping systems should be used above 18 meters. Several cladding returns have been completed for our sites, Maidstone and Pembury, between June and August 2017 to NHSI, The Cabinet office and the local council regarding the coverings and building types. These returns have been completed to enable the authorities to highlight and prioritise those Hospitals that may be at risk.

Maidstone and Pembury have not been subjected to any further requirement to test or supply any further information with regards to what can be considered at risk cladding.

One of the precautions that other NHS sites have employed is 24hr Fire Wardens. Our Security Officers already conduct this function as part of their duties. A refresher Toolbox talk was delivered to our Security Supervisors to be cascaded to all our Security Officers.

3.2. Fire drills

In the last 3 years, the Trust has been averaging 92 False Fire Alarm activations per year.

The Trust Fire Safety Officer has been working with the Emergency Planning Team and recently Kent Fire & Rescue on the feasibility of clinical and non-clinical fire drill exercises.

Practice fire drills will be done as a simulated exercise in conjunction with the Ward/Department's Fire Risk Assessment.

A fire drill can consist of a talk-through fire drill which will be undertaken during Fire Evacuation Marshal training. The frequency of the drills will be annual, 2 per site, and simulate actual site conditions.

In the event of an inability to carry out an evacuation due to the clinical needs of the patients the Trust Fire Safety Officer will ensure that all staff are walked through the procedure, this can also be conducted after a False Fire Alarm Activation if the Trust Fire Officer deems appropriate.

Once the decision has been made as to the level of the Fire drill to be carried out, the Trust Fire Safety Officer will arrive unannounced and start the drill. This will be recorded on the Fire Drill form. From this recommendations will be made and will be taken to the next meeting of the Trust Health & Safety Committee (or Trust Resilience Committee, depending on schedule) where an action plan will be agreed. The action plan will be presented by the Trust Fire Officer to the Trust Health & Safety Committee (or Trust Resilience Committee) until completion of the action plan.

The completed action plan will then be retained by the Trust Fire Officer with the DP154 Fire Drill Audit Checklist. A record of all fire drills undertaken is held with the Trust Fire Officer.

The Trust's Fire policy is currently being reviewed, and it is intended to amend the current section on fire drills, to train Fire Evacuation Marshals with the emphasis on Evacuation during a Fire Emergency. Appendix 2 of the policy will contain an outline regarding this.

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Trust Board meeting – September 2017

NHS Maidstone and Tunbridge Wells NHS Trust

9-19 Ratification of revised Risk Management Policy and Procedure — Trust Secretary

The revised "Risk Management Policy and Procedure" is enclosed. The current "Risk Management Policy and Strategy" was due to be reviewed March 2016. This review was delayed until the appointment of the new Risk and Compliance Manager, but has now been reviewed and revised. The following revisions have been made:

- Change in name to "Risk Management Policy and Procedure"
- Inclusion of description of the Trust's approach to "Risk Appetite"
- Greater description of the risk management roles of the Trust's key Committees
- The streamlining, re-ordering and restructuring of the document, including replacing repetition with references to relevant Trust documents

The revised Policy and Procedure was issued for consultation between 02/05/2017 and 25/05/2017. All suggested amendments were made with one exception, which related to the Trust's Risk Grading Matrix. Where risk is calculated as Likelihood (L) x Severity (S) = Risk Rating (R) i.e. L x C = R, it is possible for a score of 10 to have a 'green' rating (5L x 2S) or an 'amber' rating (2L x 5C), and also possible for a score of 15 to have an 'amber' rating (5L x 3C) or a 'red' rating (3L x 5C). The feedback was that this could lead to confusion. The greater weight given to severity over likelihood in determining risk levels is unusual but not unique to the Trust. However, given the number of interrelated policies, procedures and systems (including the Datix IT system), that utilise the risk matrix as it is currently established, it would be impractical to change this quickly. It should also be noted that the current matrix has been in place for several years. It is however intended to re-examine this issue when the "Risk Assessment Policy and Procedure" is reviewed.

After the consultation, a statement that regular reviews of risks should take place, and that the frequency of these reviews should be associated with the level of risk (i.e. so higher-rated risks are reviewed more frequently) has been added, to make this previously implicit point clearer.

Ordinarily, policies are "approved"[1] by the relevant committee, then submitted for "ratification"[2] by the Policy Ratification Committee (PRC). However, the Trust's process allows for certain policies to be ratified by the Trust Board, if the importance of the policy warrants this. Given the importance of the Risk Management framework across the Trust, the Risk Management Policy and Procedure has been deemed suitable for ratification by the Board. The Policy was therefore approved by the Trust Management Executive (TME) on 21st June 2017, and then reviewed at the PRC on 11th August 2017 (at which the policy was recommended for ratification by the Trust Board).

Once ratified, the policy will be uploaded to the Q-Pulse document management system, where it will be available to all staff.

Which Committees have reviewed the information prior to Board submission?

- Audit and Governance Committee, 04/05/17 (as part of the policy consultation)
- Trust Management Executive (TME), 21/06/17 (where the policy was approved)
- Policy Ratification Committee, 11/08/17 (where the policy was recommended for Board ratification)

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [3]

Review and ratification

[1] "Approval" is official agreement by an appropriate Committee that the content of a policy and procedure meets the required standards, is fit for purpose, and is suitable to be submitted for ratification. Approval is the penultimate step before a policy and procedure is issued for use. Approval can only be given by the appropriate formal Trust Committee.

[2] "Ratification" is final authorisation for use within the Trust.

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

Maidstone and Tunbridge Wells NHS Trust

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Risk Management Policy and Procedure

Target audience:	All Trust staff
Main author:	Rob Parsons, Risk and Compliance Manager **Contact details:** rob.parsons@nhs.net
Other contributors:	Trust Secretary Associate Director, Quality Governance
Executive lead:	Chief Nurse
Directorate:	Corporate
Specialty:	Corporate (Corporate Risk)
Supersedes:	Risk Management Policy and Strategy (Version 8.0, March 2014)
Approved by:	Trust Management Executive, 21st June 2017
Ratified by:	Trust Board, 7th September (having been reviewed by the Policy Ratification Committee, 11th August 2017)
Review date:	September 2020

Maidstone and Tunbridge Wells NHS Trust

Document history

Requirement for document:	This policy is a statement of managerial intent to effectively manage risk within the Trust and support the Trust's Health and Safety Policy and Procedure. To state the Trust's commitment to: • A risk awareness culture and shared beliefs • An integrated risk management system • Risk assessment and control • Learning from the investigation of adverse incidents through a culture of openness
Cross references (external):	1. The Health and Safety at Work etc. Act 1974 2. The Health and Social Care Act 2012 3. Management of Health and Safety at Work Regulations 1999 4. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 5. Ionising Radiation Regulations 1999 6. Ionising Radiation (Medical Exposure) Regulations 2000 7. Department of Health (2003). Building the Assurance Framework: A Practical Guide for NHS Boards 8. Good Governance Institute (2012). GGI Board Briefing: Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, January 2012. 9. Good Governance Institute (2016). The new Integrated Governance Handbook 2016: developing governance between organisations (GBO) 10. HM Treasury (2014) Assurance Frameworks, January 2014 11. Institute of Risk Management (2016) About Risk Management: What is Risk Management? Available at: www.theirm.org/the-risk-profession/risk-management.aspx [Accessed 24 March 2017] 12. Medicines and Healthcare products Regulatory Agency (MHRA) (2015) Lasers, Intense Light Source Systems and LEDs – Guidance for Safe Use in Medical, Surgical, Dental and Aesthetic Practices, September 2015 13. Scally G and Donaldson LJ (1998) Clinical governance and the drive for quality improvement in the new NHS in England. *British Medical Journal,* 317(7150) 4 July pp.61-65
Associated documents (internal):	• Health and Safety Policy and Procedure [RWF-OPPPCS-NC-CG1] • Risk Assessment Policy and Procedure [RWF-OPPPCS-NC-CG6] • Guidance on Risk Register Administration and Review [RWF-OPPPCS-NC-CG14] • Incident Management Policy and Procedure [RWF-OPPPCS-NC-CG22] • Serious Incidents (SI) Policy and Procedure [RWF-OPPPCS-NC-CG23] • Core Statutory and Mandatory Training Policy and Procedure [RWF-OPPPCS-NC-WF22] • Major Incident Plan [RWF-OPPP-CS-NC1] • Appraisal Policy and Procedure for Non-Medical Staff [RWF-OPPPCS-NC-WF17] • Appraisal and Revalidation of Medical Staff Policy and Procedure [RWF-OPPPCS-NC-WF16] • Policy and Procedure on Being Open / Duty of Candour [RWF-OPPPCS-NC-CG2] • Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures [RWF-OPPPCS-NC-CG25] • Information Lifecycle Management Policy and Procedure [RWF-IMT-CIN-POL-1] • Waste, Policy and Procedure for the Management of Healthcare [RWF-OPPPCS-NC-FH6]

Maidstone and Tunbridge Wells NHS Trust

Keywords:	Board Assurance Framework	Red Risk	Risk
	Risk Appetite	Risk Assessment	Risk Management
	Risk Mitigation	Risk Register	

Version control:		
Issue:	**Description of changes:**	**Date:**
1.0	Major rewrite of Trust's Risk Strategy	September 2006
2.0	Policy updated with minor changes	July 2007
3.0	Policy and strategy combined and updated	February 2009
4.0	Policy and Strategy updated	February 2010
5.0	Policy and Strategy updated to include Tunbridge Wells Hospital	January 2011
5.1	Updated ToR appendices	November 2011
6.0	Policy updated with minor changes.	January 2012
6.1	Minor changes made following HSE Inspection and advise	May 2012
7.0	Reviewed - minor changes made following organisational restructure.	March 2013
8.0	Reviewed - minor changes made following organisational restructure.	March 2014
9.0	Reviewed – Document name change. Introduction of risk appetite. Revision of committee structure. Re-ordering and restructuring of the policy and procedure document.	July 2017

Maidstone and Tunbridge Wells NHS Trust

Policy statement for

Risk Management Policy

Maidstone and Tunbridge Wells NHS Trust (the Trust or MTW) will provide and promote:

- High standards of safe clinical care
- An environment which is safe for patients, visitors, staff, contractors and volunteers
- The health, safety and wellbeing of its staff

This is achieved through a robust risk management framework and process and a culture in which all staff are risk aware. All risks will be systematically identified, either proactively through risk assessment, or reactively through the reporting and investigation of adverse incidents. Risks can then be escalated to the Trust's Risk Register to be effectively managed through time-based action plans. This policy and procedure describes the Trust's risk management framework, and how this functions.

The Trust seeks to deliver good quality healthcare in all aspects of its services to patients, local community, visitors and staff. Therefore, the Trust has a duty to limit the potential impact of a wide variety of risks. By minimising risks, the Trust seeks to protect the quality of services provided and the Trust's reputation and also maximises the resources available for patient services and care.

The Trust accepts that not all risks can be eliminated. An acceptable risk is one which has been appropriately assessed and the risk reduced so far as is reasonably practical. A balance is made between the risk and the resources needed in time and money to further reduce the risk.

The Trust's appetite for risk will be assessed for each risk (including business risk). The appetite will be expressed as a target risk score which can be understood by all staff through the Risk Categorisation Matrix.

Maidstone and Tunbridge Wells NHS Trust

Risk Management Procedure

1.0 Introduction and scope 6

2.0 Definitions / glossary 7

3.0 Duties 10

4.0 Training / competency requirements 22

5.0 Procedure 23

6.0 Risk management procedure 25

APPENDIX 1 32

APPENDIX 2 34

APPENDIX 3 35

FURTHER APPENDICES 36

Maidstone and Tunbridge Wells NHS Trust

1.0 Introduction and scope

1.1 Introduction

Risk management is the culture, processes and structures that are directed towards the effective management of potential opportunities and threats. It is supported by shared attitudes and beliefs at all levels of the organisation (see section 2.1 for definition).

The Institute of Risk Management (IRM) describes risk management as *"understanding, analysing and addressing risk to make sure organisations achieve their objectives"* (IRM, 2016).

The Trust is committed to an integrated risk management system, covering both clinical and non-clinical activities, which will support the Trust in meeting its business objectives.

1.2 Benefits of effective risk management

Risk management is a dynamic process that results in changes to the Trust's processes, procedures and environment and also to the way staff work and learn. It is an integral element of the Trust's risk and control framework and provides a structured approach to encourage:

- Accountability at all levels of the organisation
- A high standard of patient focused service, increasing user involvement when planning/changing service
- Creativity and innovation in management practice and healthcare delivery
- Improved organisational morale
- More efficient management and transparent decision making
- The effective and efficient delivery of health services
- Improved patient and staff safety by addressing systematic failures

And:

- To develop the capacity to learn from failures
- To ensure risk management is an integral part of the organisational culture
- To ensure employees and management are accountable for managing risks
- To re-engineer and improve processes through patient focused care
- To foster an environment of continuous improvement through self-assessment
- To harness and maximise the resources available
- To encourage identification and acknowledgement of good practice
- To encourage employee involvement by identifying and prioritising risks and opportunities

1.3 Function of risk management

Good risk management awareness and practice at all levels is crucial to the success of any organisation. Risk is inherent in everything that the Trust does and it is essential that it is managed in a systematic and consistent manner throughout the organisation.

The function of risk management is to:

- Identify opportunities and threats and consider their impact on the Trust, its patients, staff and other persons affected by our undertakings
- Devise strategies for managing/mitigating those events and evaluate their costs
- Relate the points above to the decision-making process of the Trust

This is achieved by:

- Putting patient safety and care at the forefront of all the Trust does
- Ensuring that the environment in which healthcare is delivered is safe as is reasonably practicable
- Identifying, through risk assessment, what could go wrong and why
- Minimising risks, by ensuring that all staff are appropriately skilled and aware of their respective roles and responsibilities
- Compliance with Statutory Instruments and best practice standards
- Encouraging comprehensive reporting of adverse events and near misses
- Learning lessons from adverse incidents and ensuring action is taken to prevent recurrence
- Making appropriate changes through time based action plans
- Monitoring and auditing the effectiveness of any measures introduced to control risk
- Having robust communication systems between staff and with those using our services

2.0 Definitions / glossary

2.1 Adverse incident (adverse event / near miss / patient safety incident)

Adverse incident is the general term given to adverse events and near misses. It refers to any event or circumstance that did lead, or could have led to, unintended or unexpected harm, loss or damage to people or property.

An adverse event is an incident where harm, loss or damage did occur.
A near miss is an incident where harm, loss or damage could have occurred.

A patient safety incident is an adverse event or near miss which occurs at any point during diagnosis, treatment or care (pathway of care) of a patient. This was formerly referred to as a clinical incident. For further guidance see the Incident Management Policy and Procedure.

2.2 Board Assurance Framework (BAF)

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

2.3 Clinical governance

Clinical governance is “a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (Scally and Donaldson, 1998).

2.4 Current risk score

As actions are completed and new controls introduced the likelihood and severity of the outcome may reduce, in turn reducing the risk score. The current risk score reflects the present situation between the initial and target risk scores.

2.5 Datix

Datix is the risk management information system used by the Trust to manage incidents, complaints, claims as well as the Trust risk register.

2.6 Hazard

A hazard is something that has the potential to cause harm, loss, damage or other unwanted outcomes to individuals, services, the organisation or the environment.

2.7 Health and Safety at Work etc. Act 1974 (HSWA)

The HSWA is the primary piece of legislation covering occupational health and safety in the UK.

2.8 Health and Safety Executive

The Health and Safety Executive (HSE) is the national independent enforcement agency for work-related health, safety and illness. It acts in the public interest to reduce work-related death and serious injury across the UK's workplaces.

2.9 'Red risk'

A risk which is rated within the 'red' category using the Trust's Risk Categorisation Matrix is classified as a 'Red Risk'. Red risks represent a significant threat to the Trust and immediate senior management attention and/or action is required.

2.10 Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

RIDDOR require employers, the self-employed and controllers of premises to report specific types of incidents to the HSE.

2.11 Risk

Risk is the likelihood that a hazard will cause harm, loss, damage or other unwanted outcome.

The risks faced by the Trust are numerous and varied. There are many types and sources of risk (See **Appendix 5**). They include:

- Patient safety (includes patient safety incidents and near misses)
- Health, safety and fire (includes accidents, damage incidents and near misses)
- Failure to meet objectives, standards and targets (internal and external)
- Financial risks
- Business interruption and emergency situations (civil contingency)
- Security, fraud and data protection
- Staff recruitment, retention, competency, training and skill mix
- Prosecution and litigation
- Reputation of the Trust

This list is not exhaustive as there are many other sources of risk.

2.12 Risk appetite

"Risk is unavoidable, and every organisation needs to take action to manage risk in a way that it can justify to a level which is tolerable. The amount of risk that is judged to be tolerable is the risk appetite." (Good Governance Institute, 2012)

In Maidstone and Tunbridge Wells NHS Trust (MTW) the risk appetite is the level of risk the Trust is willing to accept for each identified risk (see 'Target risk score' below).

2.13 Risk Categorisation Matrix

The matrix provides statements which can be used as guidance to determine the likelihood and severity of the outcome on a 1 to 5 scale. The risk score can be determined from these scores.

2.14 Risk management

Risk management is the identification, measurement and control of the risks which the Trust could be exposed to in the carrying out of its undertakings.

2.15 Risk rating (risk score)

Risk is made up of two components; the severity of the outcome (consequence) and the probability it will occur (likelihood). These components are each scored on a scale of 1 to 5 as described in the Trust's Risk Categorisation Matrix (Appendix 4). The risk rating is defined as the consequence multiplied by the likelihood.

The risk rating determines the importance and priority given to the risk. Full details of risk rating and assessment are given in the Trust's Risk Assessment Policy and Procedure.

2.16 Risk Register

The Risk Register is a record of information about identified risks. The Trust's Risk Register is recorded using the Datix IT system and contains information about unresolved risks as well as closed risks.

2.17 Serious incident (SI)

Some incidents need to be declared as an SI. For further guidance, definitions and the Procedure for managing SIs see the Serious Incidents Policy and Procedure.

2.18 Target risk score

The Risk Categorisation Matrix can be used to determine an acceptable level of risk. This is the target risk score and reflects the risk appetite. The risk appetite, and therefore the target risk score, can change over time and be influenced by internal and external factors.

There is no 'zero' risk score. A residual risk will remain even after control measures are put into place. A decision needs to be made as to what is reasonable and when a risk can be accepted. Health and safety legislation, for example, accepts this and requires the employer to reduce reasonably foreseeable risks, so far as is reasonably practicable. This is defined as when the cost of an additional control measure is grossly disproportionate to the risk reduction that will result from that additional control.

Target risk scores should be at as high as can be tolerated.

2.19 Unmitigated risk

An unmitigated risk is where control measures have not been introduced and the risk rating is unacceptably high. Risks are identified using a systematic approach and assessed using the Trust's Risk Categorisation Matrix (Appendix 4).

3.0 Duties

3.1 Executive and management responsibilities

3.1.1 Duties of the Trust Board

Authority and responsibility for governance and for establishing, supporting and evaluating this policy and procedure rests with the Trust Board. The Trust Board remains the primary point of assurance on risk.

The Board will ensure risks to the Trust's key objectives are identified and included in the BAF.

There are many types and sources of risk throughout the Trust and these are managed through a committee structure that ensures all types of risks are identified and managed effectively. The committee structure is available at **Appendix 6.**

3.1.2 Executive accountabilities

The **Chief Executive**, as the Trust's Accountable Officer, carries overall responsibility for risk management and governance and is responsible for ensuring that risk management systems are in place and functioning effectively. They are also required to sign the Annual Governance Statement to be published annually in the Trust's Annual Report.

Responsibilities for specific areas of risk management have been delegated to **members of the Executive Team** and through them, to managers.

- The **Medical Director** and the **Chief Nurse** both take the lead for clinical governance.
- The **Chief Nurse** leads on quality, which includes risk management.
- The **Medical Director** is the Trust's Caldicott Guardian and is responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.
- The **Chief Nurse** through the **Director of Health Informatics** takes the lead for information governance, including the Data Protection Act, the Freedom of Information Act, patient and staff confidentiality and the security of records.
- The **Chief Operating Officer** takes the lead for Health and Safety.
- The Board-level director with fire safety and emergency planning and resilience responsibility is the **Chief Operating Officer.**
- The **Security Management Director** is responsible for providing a safe environment and fire prevention systems. At MTW this is the **Chief Operating Officer**.
- The **Director of Infection Prevention and Control (DIPC)** is responsible for infection prevention and control.
- The **Director of Finance** takes the lead for making arrangements for effective systems of financial controls and financial assurance processes. The **Director of Finance** ensures that the proper arrangements for financial controls exist in terms of appropriate recording of financial transactions, financial reporting, financial performance, financial planning and in securing value for money.

- The **Director of Workforce** takes the lead for workforce planning, staffing issues, Trust-wide education, training, learning, and the provision of sufficient Occupational Health Services.

3.1.3 Trust Secretary

The **Trust Secretary** is responsible for the management of the BAF and the Risk Register.

3.1.4 Departmental Managers

Risk, health, safety and welfare of staff and others, are line management responsibilities (Health and Safety at Work etc. Act (HSWA), 1974; Management of Health and Safety at Work Regulations (MHSWR), 1999). Although the Chief Executive has ultimate accountability, all managers will be held responsible for managing the risks in their department. Key staff are trained to assist managers in completing their statutory duties but not legally responsible for ensuring their completion.

Department managers should ensure that they have key staff in place and they are fully trained to undertake their roles.

Managers will identify their risks and record them on the Risk Register. They will be supported by their Directorate Risk Lead. The manager will then manage their risks through time-based action plans to introduce controls.

3.2. All staff

All staff are expected to be risk aware at all times and ensure that their line managers are notified of hazards and risks that they see in the workplace. All staff must cooperate with the Trust and their line managers and comply with all Trust policies and procedures. All staff must accept personal responsibility for maintaining a safe environment and safe systems of work. This is a legal duty under Health and safety legislation (HSWA, 1974; MHSWR, 1999).

All employees of the Trust are responsible for participating and cooperating in investigations and risk assessments as well as completing all mandatory and statutory training as required.

The Trust promotes a fair blame policy and all employees are encouraged to learn from incidents and implement actions. Only in certain circumstances will disciplinary action be considered.

If an issue of individual competency is identified, staff will be managed using the appraisal process and individual performance review.

3.3. Arrangements at Tunbridge Wells Hospital

Tunbridge Wells Hospital is operated under a project agreement between the Trust and the Kent and East Sussex Weald Hospital Limited (KESWHL). KESWHL (through “Interserve”, its contractor) is responsible for:

1. Building maintenance and the life cycle of the estate.
2. Grounds and gardens
3. Utilities
4. Fire detection systems and alarms

Both KESWHL and MTW have a duty to cooperate and coordinate its health, safety and risk arrangements. This is achieved through weekly interface meetings and a monthly

liaison meeting. The “Informed client” and “Trust representative” are members of these committees and the Trust Health and Safety committee; see section 3.7.17.

Employees of KESWHL and Interserve are also expected to comply with Trust policy, procedures and safe systems of work.

3.4 Clinical risk management

3.4.1. Clinical Directors

Clinical Directors are responsible for patient safety, staff safety and risk within their directorate. Clinical Directors are supported in this role by other senior managers with various titles. These are given in the ‘Directory of local key staff and managers’ (**Appendix 7**). The Clinical Director and their Senior Managers are responsible for patient safety, staff safety and risk within their directorate.

Clinical Directors will nominate a senior member of their staff to be the **Directorate Risk Lead** (often a Senior Manager or Matron). Clinical Directors will notify the Risk and Compliance Manager (see section 3.5.1) of the identity of their risk leads. The Directorate Risk Leads are identified in the ‘Directory of local key staff and managers’ (**Appendix 7**).

Clinical Directors will ensure the implementation of this policy and procedure and other associated policies and procedures within their directorate.
The Clinical Directors will:

- Work with all key stakeholders to develop and improve the directorate activities to ensure that services are safe, effective, caring, responsive and well-led
- Lead on service planning for their clinical area with the Senior Managers, and ensure associated risks are identified, assessed and managed
- Support the evaluation and further developments of systems of clinical governance within their directorate
- Ensure clinical standards of patient care are kept under constant review
- Ensure the implementation of clinical information and risk management systems to ensure the cost effective delivery of care consistent with patient, workload and dependence

3.4.2. Medical Clinical Governance Leads

Each directorate will have a Clinical Governance Lead who will:

- Arrange clinical governance meetings and ensure attendance by a multi-disciplinary team; they must complete a report after each meeting
- Lead the discussions in the meeting
  - Quality of care (e.g. deaths, complications, adverse incidents, access, readmission and length of stay)
  - Complaints (response time, actions and learning)
  - Clinical risks, incidents and SIs (response times, actions and learning)
- Monitor clinical governance action plans
- Report to the directorate committees

3.5. Non-clinical risk management

The Trust has staff that specialise in the management of non-clinical risk.

3.5.1. Non-clinical specialties (directorates)

The non-clinical specialties within the Trust are divided into directorates each lead by a Director who is responsible for patient safety, staff safety and risk within their directorate.

Directorate management teams will nominate a senior member of their staff to be the **Directorate Risk Lead.** Directorate management teams will notify the Risk and Compliance Manager (see section 3.5.1) of the identity of their risk leads. The Directorate Risk Leads are identified in the 'Directory of local key staff and managers' (**Appendix 7**).

Directorate management teams will ensure the implementation of this policy and procedure and associated policies and procedures within their Directorate.

3.5.2. Directorate Risk Leads

Each Directorate will have a Directorate Risk Lead. They must be a senior member of the Directorate's staff. This role is in addition to their function and will appear in their job description.

The Directorate Risk Lead will advise their Director and Senior Managers, if required, of their risk management responsibilities. This will include ensuring the implementation of this policy and procedure and associated policies and procedures.

The Directorate Risk Lead will ensure that Senior Managers and Clinical Directors are kept fully informed of all risks and incidents.

The Trust employee known as the "Informed Client" will act as the Risk Lead for the project agreement between the Trust and the Kent and East Sussex Weald Hospital Limited (KESWHL). The "Informed Client" will coordinate the two organisations' health and safety arrangements.

The Directorate Risk Lead may nominate local Risk Co-ordinators to support them.

A 'Directory of local key staff and managers' is published as **Appendix 7** of this policy and can be accessed through Q-Pulse.

The Directorate Risk Lead, on behalf of their Director and Senior Managers will:

- Raise risk issues and report on performance to Directorate Management Meetings. The report should include the Directorate risk assessment programme, adverse incidents and the Directorate risk register.
- Ensure that all departments complete their risk assessment programmes according to the Risk Assessment Policy and Procedure.
- Ensure that generic risk assessments that are applicable to other wards and departments within the directorate are identified and pooled.
- Ensure that time based action plans for the mitigation of risk are prepared, implemented and completed on a regular basis.
- Review Directorate risk register and ensure that it is managed effectively.
- Ensure key documents and evidence are collected immediately after an incident.
- Highlight possible SIs and incidents reportable to external bodies such as the Health and Safety Executive (i.e. under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)).
- Ensure timely investigation of all adverse incidents. Incidents must be investigated and closed within 45 working days (9 weeks).

- Co-ordinate and monitor the investigation of incidents.
- Support investigators to undertake root cause analysis of red and amber rated incidents.
- Ensuring appropriate risk assessments are reviewed or completed after an investigation.
- Ensure that recommendations are implemented from investigations through time based action plans.
- Ensure that incident closure reports are completed and shared.
- Ensure the incident reporter and department/ward staff have received feedback on investigation findings, recommendations and action plans. If required arrange debriefing for staff involved in incidents.
- Review incident investigations and trends.
- Share learning from adverse incident investigations with other Directorate leads.
- Ensuring six monthly workplace health and safety inspections are completed and results passed to the directorate committees.
- Ensure all department health and safety audits are completed and recorded on the Health & Safety module of the Synbiotix IT audit and compliance system.
- Ensure that suitable and sufficient numbers of key staff are nominated and trained to fulfil the key risk management functions within all departments throughout the Directorate. The key staff includes Risk Assessors and Incident Investigators.
- Ensure that the Risk and Compliance Manager (see section 3.5.1) is informed of the identities of key staff.

The Directorate Risk Lead will lead on the Directorate Risk Register and:

- Be trained by the Datix Facilitator or the Risk and Compliance Manager
- Administer and maintain the Directorate Risk Register
- Add and update assessed risks to the Risk Register
- Provide regular reports/data for Managers and local committees
- Liaise with others ensuring the continual development of the Directorate risk register
- Report to the Health and Safety Committee on their risks 3 times per year

The Directorate Risk Lead should immediately bring to the attention of their Director, General Manager, the Health, Safety and Risk Team and the Patient Safety Manager:

- Significant adverse incidents e.g. Those that are red rated or reportable to the Health and Safety Executive (HSE)
- Possible SIs
- Risks that require action across directorates or across the Trust
- Any identified learning that applies across directorates or across Trust sites

3.6. Key staff

The Trust has key staff that are specifically trained to undertake risk management functions. A 'Directory of local key staff and managers' is published as **Appendix 7** of this policy and held on the risk page on the Trust's Intranet.

3.6.1. Risk assessors

Directorates need to appoint an appropriate number of risk assessors supported by adequate resources. The number required will depend on the size and complexity of the directorate. Every department should have the services of at least one risk assessor.

The risk assessor will be trained to carry out the risk assessments required within their department. They must complete the risk assessment training including the competency assessment as described in the Core Statutory and Mandatory Training Policy and Procedure.

The risk assessor will:

- Advise the departmental manager on what assessments are required.
- Assist the manager in completing the risk assessment programme.
- Complete the required risk assessment paperwork.
- Undertake a 6 monthly workplace inspection with the department manager, passing the results to the Risk Lead.
- Undertake or facilitate risk assessments in response to concerns raised by staff.
- Review risk assessments as required in legislation.
- Assist the Risk Lead in identifying and pooling generic risk assessments that are applicable to other wards and departments within the directorate.

The risk assessor, on behalf of the manager will:

- Share the outcome of risk assessments with the Directorate Risk Lead.
- Share the outcome of risk assessments with all relevant staff and ensuring the completion of signatory charts.
- Assist the Directorate Risk Lead to put any unresolved risks, resulting from assessments, on to the Risk Register.
- Communicate the outcome of red- and amber-rated risks to the department manager and the Risk Lead as appropriate.

3.6.2. Internal Audit

Internal Audit, in conjunction with the Audit and Governance Committee will undertake an annual review of Trust's Assurance Framework and Risk Register.

3.7. Competent persons

All organisations must appoint adequate numbers of 'competent persons' to assist in undertaking the measures necessary to comply with health and safety legislation (HSWA, 1974; MHSWR, 1999). These are individuals with specialist skills, knowledge and qualifications that are assessed by external bodies such as the Institute for Occupational Safety and Health (IOSH). They are available to advise managers and employees on all aspects of health, safety and risk.

The competent persons will:

- Provide advice and guidance on risk management including policy development
- Provide reports as required to managers and committees
- Promote risk management
- Identify new legislation and guidance and review related policies and procedures
- Serve on Trust committees and advise on risk issues
- Act as key contact with enforcing officers from regulatory bodies

Competent persons are not employed to manage risk within the Trust but to advise and support managers to carry out their duties. Risk remains a line management responsibility. Ignoring the advice of competent persons could be interpreted as gross negligence.

The Trust's competent persons will identify hazards within their area of expertise. They undertake Trust-wide risk assessments for these hazards. The results of these assessments will be incorporated into policies and procedures that are implemented Trust-

wide. Significant assessments are added to the risk register as closed risks (archived but accessible to staff). Some assessments will be appended to policies and procedures.

3.7.1. The Risk and Compliance Manager

The Risk and Compliance Manager will:

- Act as the competent person advising all levels of management on their responsibilities under health and safety legislation
- Advise managers, members of the Executive Team and the Trust Board of changes in health and safety legislation
- Prepare the draft annual Health and Safety report for the Trust Board
- Lead on the risk management process for the Trust including the provision of advice on the identification, analysis and control of risks
- Facilitate the management of corporate risk by members of the Executive Team through the Trust's Risk Register
- Providing reports on risk management issues to committees
- Lead on the development of risk policies and procedures, including this policy
- Review and validate, with the relevant Directorate Risk Lead, the Trust's Risk Register entries for Red Risks

3.7.2. Patient Safety Lead

The Patient Safety Lead will:

- Be a source of competent advice and assistance in the management of patient safety and clinical risk.
- Advise managers on investigations and the identification of remedial actions for clinical risk.
- Quality assures the investigation of patient safety incidents and reports to appropriate committees.
- Be a source of competent advice on the investigation and reporting of SIs.
- Lead on the administration of the Department of Health Central Alerting System (CAS) on behalf of the Trust for Patient Safety Alerts.

3.7.3. Health and Safety Advisor

The Trust's Health and Safety Advisor will:

- Be a source of competent advice and assistance in the management of health and safety.
- Advise managers and staff on health and safety legislation, practice and the development of safe systems of work following risk assessment or incident investigation.
- Lead on the development of health and safety policies and procedures.
- Ensure that all health and safety incidents reportable to an external agency have been investigated.
- Ensure that all RIDDOR reportable adverse events are reported to the HSE.
- Act as point of contact with HSE Inspectors
- Be the responsible person for the production, delivery and evaluation of the Trust's health and safety and risk management training programmes.
- Quality assure the investigation of staff, public and Trust safety incidents and make reports to appropriate committees.

3.7.4. Moving and Handling Co-ordinator

The Moving and Handling Co-ordinator will:

- Be the Trust's competent person for assessment, advice, training and the development of safe systems of work relating to the moving and handling of people and loads.
- Lead on policy development for manual handling operations and equipment.
- Advise the Trust on appropriate moving and handling training interventions, including induction and refresher training, for all staff, students and managers.
- Investigate and advise on adverse incidents involving manual handling operations that are reportable to an external agency.
- Act as point of contact with the HSE Inspectors.
- Lead on the development of moving and handling policy.

3.7.5. Fire Safety Officer (Head of Compliance and Fire)

The Fire Safety Officer will:

- Ensure that the Trust has a full range of authoritative technical and practical guidance for a comprehensive fire risk assessment programme.
- Provide suitable and sufficient training to all staff on all matters relating to fire safety in Trust premises.
- Report and make recommendations to the Trust on all identified deficits which compromise the Trust's ability to comply with fire safety legislation.
- Be the key contact for external enforcing agencies such as the Fire Authority.
- Investigate and advise on all adverse events where fire is a component part.

3.7.6. Radiation Protection Adviser (RPA)

The RPA is the Trust's competent person to be consulted for advice about matters related to the safe use of ionising radiation (x-rays and radioactive materials), as required by Regulation 13 of the Ionising Radiations Regulations 1999. The RPA must be consulted by the Trust for advice on a range of matters that include:

- The implementation of ionising radiation requirements in controlled and supervised areas, including engineering controls, safe systems of work, and personal protective equipment.
- The prior examination of plans for installations and the acceptance into service of new or modified sources of ionising radiation in relation to any engineering controls, design features, safety features and warning devices provided to restrict exposure to ionising radiation.
- Regular calibration of equipment provided for monitoring levels of ionising radiation and regular checking that such equipment is serviceable and correctly used.
- The periodic examination and testing of engineering controls, design features, safety features and warning devices and regular checking of systems of work provided to restrict exposure to ionising radiation.
- Giving advice regarding radiation risks as part of the investigations into adverse incidents involving ionising radiation.
- Advising Members of the Executive Team and the Trust Board of changes in legislation.
- Leading on policy development for radiation protection.

- Acting as the key Trust contact for external bodies such as the HSE and Environment Agency for matters concerning the use of ionising radiation at work.

3.7.7. Medical Physics Experts (MPEs)

The MPEs are the Trust's competent persons to be consulted for expert advice about clinical risk matters related to the safe use of ionising radiation (x-rays and radioactive materials) for the medical exposure of patients and other persons. MPEs are a requirement of Regulation 9 of the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). Speciality and department documentation should detail the scope of involvement of the MPE. This will include:

- Involvement in any investigations if medical exposures are greater than intended. Additionally, in Radiotherapy, they should be consulted in investigations where target doses are less than intended.
- Acting as the key Trust contact for reporting IR(ME)R incidents to external bodies such as the CQC.

3.7.8. Laser Protection Adviser (LPA)

The LPA is the Trust's competent person to be consulted for advice about matters related to the safe use of Class 3B and Class 4 lasers, as well as certain applications of other classes, required by Section 3.3 of the document Lasers, Intense Light Source Systems and LEDs – Guidance for Safe Use in Medical, Surgical, Dental and Aesthetic Practices.

The LPA must be consulted for advice on a range of matters that include:

- The implementation of laser requirements as to controlled areas, including engineering controls, safe systems of work, and personal protective equipment.
- The prior examination of plans for installations and the acceptance into service of new or modified lasers in relation to any engineering controls, design features, safety features and warning devices provided to restrict exposure to laser radiation.
- Giving advice regarding laser radiation risks as part of the investigations of adverse incidents involving lasers.

3.7.9. The Director of Infection Prevention and Control (DIPC)

The DIPC will:

- Be the Trust's competent advisor in all matters relating to infection prevention and control.
- Lead the Infection Prevention and Control Team.
- Develop infection prevention and control policies and procedures.

And ensure that:

- Investigation and advice is given on all infection prevention and control risks that are reported
- Inspections and audits are carried out across Trust sites.
- Infection prevention and control training is delivered as identified by risk assessment, training needs analysis and Department of Health guidance.

3.7.10. Local Counter Fraud Specialist (LCFS)

The LCFS investigates all alleged fraud and corruption. In this Trust, the LCFS is provided by TIAA Ltd. The LCFS reports to the Director of Finance.

The LCFS provides a comprehensive programme to:

- Create a strong anti-fraud culture within the Trust
- Deter and prevent incidents of fraud
- Investigate and detect all reported cases of fraud
- Apply the correct sanctions and redress when cases are proven.

3.7.11. Local Security Management Specialist (LSMS)

The LSMS assists and advises on security issues and breaches including:

- Physical assaults on staff
- Harassment and verbal abuse.
- Theft of Trust assets and criminal damage to Trust property
- Anti-social behaviour in and around the work place

The LSMS is responsible for:

- Acting as the competent person advising management of their security responsibilities, ensuring compliance with the relevant external standards for providers.
- Tackling violence against all staff working in the Trust by investigation and prosecution of assailants. Applying a wide range of sanctions against those responsible, e.g. seeking criminal, civil and/or disciplinary measures as appropriate.
- Creating a pro-security culture within the Trust.
- Prevention, deterrence, detection and investigation of all security breaches.
- Seeking redress for losses suffered through the criminal and civil justice systems against offenders.
- Being the key contact for external enforcing agencies such as the Police
- Advising members of the Executive Team and the Trust Board of changes in legislation with respect to security issues.

3.7.12. Occupational Health Service

The Occupational Health Service will:

- Provide competent advice and clinical practice to all levels of staff.
- Contribute to the prevention of ill health and disease associated with work and aim to optimise staff health in the workplace.
- Ensure that any occupational diseases referred are reported under the RIDDOR regulations as required.
- Provide health surveillance to ‘at-risk’ staff.
- Provide advice on health surveillance associated with the Control of Substances Hazardous to Health Regulations.
- Provide advice to staff returning to work after illness or an accident.
- Provide an immunisation service to staff.
- Provide pre-employment medicals if required.
- Facilitate the provision of eyesight and hearing testing if required.
- Provide advice to management on medical legislation and health surveillance.
- Provide health education and support e.g. diet, smoking, stress management.

The Occupational Health Manager and Consultant will:

- Be the Trust’s competent persons for occupational health advice and training.
- Be the key contacts for external enforcing officers such as the Employment Medical Advisory Service (EMAS).

- Lead on policy development for occupational health.

3.7.13. Caldicott Guardian

The Medical Director has been appointed Caldicott Guardian. The Guardian will:

- Ensure that the Trust satisfies the highest practical standards for handling patient identifiable information;
- Facilitate and enable appropriate information sharing and make decisions on behalf of the Trust following advice on options for lawful and ethical processing of information, in particular in relation to disclosures;
- Represent and champion Information Governance requirements and issues at Board level;
- Ensure that confidentiality issues are appropriately reflected in organisational strategies, policies and working procedures for staff; and
- Oversee all arrangements, protocols and procedures where confidential patient information may be shared with external bodies both within, and outside, the NHS.

3.7.14. Senior Information Risk Owner (SIRO)

In this Trust the **Chief Nurse** is the SIRO. The SIRO will:

- Take overall ownership of the Trust's Information Lifecycle Management Policy and Procedure;
- Act as champion for information risk on the Board; and
- Provide written advice to the Accountable Officer (Chief Executive) on the content of the Trust's Annual Governance Statement in regard to information risk.
- Understand how the strategic business goals of the Trust and how other NHS organisations' business goals may be impacted by information risks, and how those risks may be managed.
- Implement and lead the NHS Information Governance (IG) risk assessment and management processes within the Trust and advise the Board on the effectiveness of information risk management across the organisation
- Receive training as necessary to ensure they remain effective in their role as SIRO.

3.7.15. Head of Quality, Safety, Fire and Security

The Head of Quality, Safety, Fire and Security:

- Provides specialist health, safety and risk advice specific to the needs of the Estates and Facilities Directorate.
- Promotes a risk aware culture within the Estates and Facilities Directorate.
- Assists in the management of risk for the directorate including the provision of advice on the identification, analysis and control of risks.
- Assists in the development of risk, health and safety policies, strategies and procedures for the directorate and where it may also impact Trust wide.

3.7.16. Dangerous Goods Safety Advisor (DGSA)

In this Trust the DGSA is provided by an external provider who:

- Provides advice and assistance in the disposal of waste and dangerous goods.
- Carries out inspections and audits across Trust sites.
- Assists in the development of waste policy and procedures, including the Policy and Procedure for the Management of Healthcare Waste.

3.7.17. Emergency Planning Officer

The Trust's Emergency Planning Officer will:

- Be a source of competent advice and assistance in the management of major incidents and emergencies within the Trust and the community.
- Lead on meeting the requirements of the Civil Contingencies Act.
- Lead on the development of the Trust's emergency plans, policies and procedures.
- Lead the Emergency Planning Team.
- Lead on hazardous material and helicopter incidents. Take the overall lead in liaison with other Category 1 responders including emergency services, military and local authorities.

3.7.18. "Informed Client" and "Trust Representative"

Tunbridge Wells Hospital is operated under a project agreement between the Trust and the KESWHL. The "Informed client" and "Trust representative" cooperate and coordinate the health and safety arrangements between the two organisations.

This is achieved through weekly interface meetings and a monthly "Programme Liaison Committee". The "Informed Client" is a member of the Liaison Committee and the Trust Health and Safety Committee.

3.7.19. Chief Pharmacist

The Chief Pharmacist will:

- Be the Trust's competent person for assessment, advice, training and the development of safe systems of work relating to the management of medicines.
- Lead on policy development for the management of medicines.
- Investigate and advise on adverse incidents involving medication errors.
- Be the key contact for external enforcing agencies such as the Medicines and Healthcare Products Regulatory Agency (MHRA) for medication incidents.

3.7.20. Electro-Medical Engineering (EME) Services and Technical Services Manager

The EME Services and Technical Services Manager will:

- Be the Trust's competent person for assessment, advice, training and the development of safe systems of work relating to the purchase and implementation of medical devices.
- Lead on policy development for the management of medical devices.
- Investigate and advise on adverse incidents involving medical devices.
- Be the key contact for external enforcing agencies such as the MHRA for medical device incidents.

3.7.21. Vascular Access Specialist Practitioner

The Vascular Access Specialist Practitioner will:

- Be the Trust's competent person for assessment, advice, training and the development of safe systems of work relating to the purchase and implementation of medical sharps.

- Lead on policy and development for the management of medical sharps (In collaboration with the Infection Control Team and occupational health)
- Investigate and advise on adverse incidents involving medical sharps.
- Lead on training for the use of medical sharps.

4.0 Training / competency requirements

4.1. Trust Board

The Risk and Compliance Manager will provide training for Trust Board Members every year as part of the annual Health and Safety Board Report.

4.2. Manager training

The Risk and Compliance Manager will provide specialist training for all managers in the Trust. This is delivered as part of a new manager's course. All managers should receive this training once.

4.3. Training for all Trust employees

All staff will receive appropriate training as a minimum at the following intervals:

- On induction training is given to all new staff through the Trust's online induction. Local managers are responsible for providing additional health, safety and risk management training to all staff through local induction programmes.
- This should be refreshed every 3 years as part of mandatory refresher courses.

The Trust's Competent Persons will provide specialist training such as:

- Manual handling and patient handling training
- Fire training
- Training to address the risks associated with violence and abuse
- Infection prevention and control training
- Other specialist risk and clinical governance training as required

Full details of training courses are given in the Trust's training prospectus and Core Statutory and Mandatory Training Policy and Procedure.

The Trust's Learning & Development Department will monitor the uptake of mandatory health and safety training within directorates and provide reports to relevant committees. The Workforce Committee will monitor and review the training programme and training uptake across the Trust and provide assurance to the Trust Board.

4.3.1. Training for key staff

The identified key personnel who are required to undertake the role of Risk Lead, Risk Assessor and Incident Investigation Facilitator will already possess sound knowledge, skills and experience appropriate to their sphere of responsibility.

The Trust's Competent Persons will provide:

- Specialist training for Directorate Risk Leads to enable them to carry out their roles. The Risk and Compliance Manager ensures they receive training and follows up non-attendance.
- The Health, Safety and Risk Team will provide risk assessor training to all staff nominated to carry out risk assessments.
- The Patient Safety Team will provide incident management training to all staff nominated as incident investigators.

5.0 Procedure

Trust Committee Structure for Managing Risk

There are many types and sources of risk throughout the Trust and these are managed through a committee structure that ensures all types of risks are managed effectively. The committee structure is displayed in charts in **Appendix 6.**

5.1 The Trust Board

The Trust Board (either directly or through its sub-committees) will:

- Ensure the safe delivery of healthcare, within available financial and other resource limits
- Ensure integration of risk management into the business planning and performance management arrangements
- Ensure risks are identified and assessed and included in the BAF and/or the Risk Register.
- Receive assurance that the risks associated with the Trust's objectives are being managed.
- Ensure timely investigation of serious adverse incidents and SIs.
- Achieve a balance between the mitigation of risk and the required resources.
- Receive reports and act upon risk-related recommendations from appropriate committees.
- Receive assurance from Internal Audit and the Audit and Governance Committee that the risk processes and structures are fit for purpose.

Each year the Board will receive an annual Health and Safety Report which will include:

- Health and safety statistics and performance
- Suggested Key Performance Indicators (KPIs) and targets
- A draft plan for health and safety
- Clear ownership of objectives and KPIs

The Trust Board will discuss and modify the KPIs, targets and plan. The Board will be asked to delegate the monitoring and implementation of the plan to the lead director (Chief Operating Officer) for Health and Safety and the Health and Safety Committee.

5.2 Trust Management Executive (TME)

The TME is the senior management committee within the Trust. Its purpose is to oversee and direct:

- The effective operational management of the Trust, including achievement of standards, targets and other obligations
- The delivery of safe, high quality, patient-centred care
- The development of Trust strategy, culture and policy
- The identification, mitigation and escalation of assurance and risk issues

The TME has specific duties with respect to risk management and internal control to:

- Ensure that robust risk management policies and processes are in place
- Ensure that all key assurance and risk issues are identified and recorded
- Oversee the management of the highest-rated risks
- To escalate any risks of corporate significance or seriousness to the Trust Board, for consideration and/or action

- To review and endorse the Trust's Annual Governance Statement, prior to this being considered at the Audit and Governance Committee and Trust Board
- Undertake regular review of red risks, and the action/s being taken to mitigate (and ideally reduce) such risks

5.3 Quality Committee

The Quality Committee will set the strategic direction for quality, governance and risk management within the Trust.

The Quality Committee will:

- Receive reports and act upon recommendations from the Trust Clinical Governance Committee.
- Receive reports and act upon recommendations from the Clinical Directors which will include significant issues raised at Directorate Committees.
- Make recommendations to the Trust Board.

Reports from the Quality Committee contribute to the Chief Executive's assessment of the effectiveness of the system of internal control as required in the Annual Governance Statement.

5.4 Trust Clinical Governance Committee

The Trust Clinical Governance Committee is a sub-committee of the TME.

The committee oversees many of the clinical governance functions within the Trust. It ratifies decisions being made by the reporting committees as well as producing a steer on national requirements. It receives performance reports from the Directorates on clinical governance and risk.

5.5 Health and Safety Committee

The Health and Safety Committee is a sub-committee of the TME.

The key function of the committee is to co-ordinate the operational elements of the risk management agenda and is a requirement under the HSWA. The membership represents this operational function in that it includes Directorate Risk Leads, Union Representatives and competent persons and is a key element in the Trust's communication with employees of health and safety issues.

The Health and Safety Committee receives reports about key issues arising from specialist sub-committees concerned with the management of health, safety and risk. The committee receives reports from Directorate Risk Leads on Directorate performance and key issues raised at Directorate meetings.

The committee influences and monitors the annual health and safety KPIs, targets and plan. It implements the annual health and safety plan.

5.6 Finance and Performance Committee

The Finance Committee is a sub-committee of the Trust Board and oversees the finance-related aspects of the BAF and Risk Register.

5.7 Audit and Governance Committee

The Audit and Governance Committee is a sub-committee of the Trust Board and has the responsibility for ensuring effective internal control. It does so through scrutiny of the Trust's systems and processes to ensure that all controls are in place and effective.

In this way the committee provides assurance to the Board regarding its controls systems and supports the Annual Governance Statement.

The committee will, in conjunction with Internal Audit, oversee risk management across the Trust. An annual report from the committee will be submitted to the Trust Board.

5.8 Other specialist risk committees

The full committee structure is complex and includes many specialist groups which report in to the above committees. The membership of each committee is such that it includes the staff with the appropriate competence, knowledge and authority to manage the risks they represent. The full committee structure is given in **Appendix 6.**

The specialist groups have a duty to ensure that risks identified by them are included, where appropriate on the Trust's Risk Register. Responsibilities assigned to individuals for the management of the risks must be agreed with and accepted by the individual.

5.9 Directorate committees

Risks identified locally through risk assessment or incident investigation will be raised and discussed at directorate management meetings by departmental managers. These will be collated by the Directorate Risk Lead to comprise the Directorate risk register.

The Directorate Risk Lead will provide assurance to the Health and Safety Committee on directorate performance on managing risks and incidents.

The Directorate Risk Lead will report to the directorate committee on risk matters which will include:

- Reports from department committees on issues raised and decisions made.
- The Directorate risk register.
- The directorate's risk assessment programme.
- Review of adverse incidents and trends.
- Directorate performance on managing the Directorate risk register.
- Directorate performance in the management of adverse incidents.
- Directorate performance in the management of complaints.
- Feedback from the Health and Safety Committee.
- Feedback from the Trust Clinical Governance Committee.
- The Health and Safety Committee
- The Trust Clinical Governance Committee
- The Quality Committee
- Other specialist risk committees
- The Trust Board

5.10 Local committees

The Trust has numerous other committees and groups at department level. These report to their Directorate committees thus allowing issues to be escalated from Ward to Board.

6.0 Risk management procedure

Risk management is the identification, measurement and control of the risks which the Trust could be exposed to in the carrying out of its undertakings. Hazards need to be identified, risks assessed and controls introduced to reduce the risk to an acceptable risk score.

6.1 Risk identification

It is important that hazards and risks are identified at all levels of the organisation. This could be proactively through risk assessment or reactively from adverse incidents and complaints.

This includes all sources of risk as indicated in **Appendix 5**. These include:

- Health and safety risks
- Clinical risks
- Unforeseen potential future risks
- Risks to quality standards
- Risks to objectives and targets
- Financial risk
- Information governance
- Corporate risk (to organisation)
- Workforce risks (Human Resources)
- Risk of prosecution and litigation
- Risk to the reputation of the Trust
- All other activities and undertakings

6.1.1 Local hazard identification and risk assessment

Most risks are identified at local level and initially managed by department managers. All managers can identify risk and add to the risk register. These risks can then be either managed locally or escalated through the committee structure.

All managers have to undertake an annual review of their risk assessments which includes a review of their “hazard profile checklist”. This document lists all the possible hazards their staff could face. Where policies, procedures or assessments exist they are hyperlinked to the hazard profile checklist and hence shared with local managers.

All managers carry out local health and safety inspections during which they may identify further hazards. Adverse incident reporting and management will also identify unforeseen hazards.

6.1.2 Trust-wide hazard identification and risk assessment

The Trust’s competent persons will identify hazards within their area of expertise. They undertake Trust wide “generic” risk assessments for these hazards. The results of these assessments will be incorporated into policies and procedures that are implemented Trust wide. Significant assessments are added to the risk register as closed risks (archived but accessible to staff). Some assessments will be appended to policies and procedures.

The Trust’s competent persons view all adverse incidents in their areas of expertise. They sit on Trust committees so are able to identify or indicate hazards around the Trust.

Business cases should identify any hazards and risks. These should be included in the decision making process. It is a requirement under financial standards that all business decisions are risk assessed.

Each year the Trust Board will set the key objectives for the Trust. The risks to meeting these objectives will be included in the BAF.

6.2 Risk assessment

All risks will be identified, analysed and controlled in accordance with the Trust's Risk Assessment Policy and Procedure and guidance documents.

All risks are graded for their potential impact and likelihood of harm using the Trust's Risk Categorisation Matrix (**Appendix 4**). Numbers and colour indicate the weighting of risk and allows priorities and resources to be proportionate to the risk. The matrix allows different types of risk to be compared.

The risk score may determine the priority, response and level of management required to manage the risk.

RISK RATING	PRIORITY	RESPONSE	LEVEL OF ACTION
Blue (1-4)	Low	None/ long term	Departmental
Green (5-10)	Low / Medium	Medium term	Departmental
Amber (10-15)	Medium / High	Short term	Directorate
Red (15-25)	High	Immediate	Directorate / higher tier committee (N.B Risk Register entries for Red Risks must be reviewed and validated by the Risk and Compliance Manager, with the relevant Directorate Risk Lead)

6.3 Risk appetite

Risk appetite is the level of the risk the Trust will accept for a particular type of risk. When a risk is assessed the uncontrolled risk score is determined. It is important to consider what a satisfactory situation would be and also determine the target risk score. The target risk score will be the risk appetite and should be as high as can be tolerated.

RISK RATING	APPETITE
Blue (1-4)	No work or resources need to be committed to reduce the risk further.
Green (5-10)	Little time and resource needs to be committed. Action will be taken only if cheap and easy to do. Risks are usually accepted and closed when they are reduced to green.
Amber (10-15)	Action needs to be taken. Actions can be planned and completed in the medium term. Resources and time can be balanced against the harm. Some risks are accepted and closed when amber if balanced against other risks or requires excessive resources.
Red (15-25)	Action needs to be considered and/or taken immediately. Significant time and resources should be committed. Red Risks can only be accepted by the Executive Team, but efforts should continue to be made to reduce the risk rating

The Risk Categorisation Matrix has columns for different categories of risk. For each type there are statements used to indicate how the severity would be graded. The detail of these statements sets the organisations risk appetite. For each individual risk the target risk score is a direct result of the application of these statements.

6.4 Risk mitigation

Once a risk is identified, controls need to be introduced that will reduce the likelihood of the risk and, in certain cases, the severity of the risk. Action plans must be developed and unresolved risk added to the risk register.

The risk and action plan must be regularly reviewed by a relevant management group or committee. As the likelihood and/ or severity are reduced the current risk score will fall. When the actions are complete the current risk score will reach the target risk score and the risk can be closed.

Legislation states that risks must be reduced "so far as is reasonably practicable" (SFRP). In deciding what is reasonable a balance has to be made between the risk score, and the resources required to mitigate the risk further. Accepting a risk must be an informed decision and therefore must be made by the appropriate level of management. The decision should be justified, recorded in the Risk Register and be accountable to an individual or committee.

6.5 Role of managers

Risk management is a line management responsibility and **all** managers are responsible for managing the risks in their departments or areas of responsibility.

Every manager in the Trust has a legal duty to manage their risks. They each have the duty and authority to:

- Identify risks by:
  - Undertaking risk assessment, safety audits and inspections.
  - Investigating all adverse incidents and complaints.
- Mitigate risks to prevent harm by:
  - Undertaking immediate actions.
  - Seeking advice from competent staff (see section 3.5).
  - Adding unresolved risks to the local risk register.
  - Developing time based action plans.
  - Undertaking planning to implement longer term solutions.
  - Accepting blue and green risks where the target risk score has been achieved and the residual risk is reasonable.
- Escalate risks that cannot be mitigated locally by:
  - Raising risks to directorate level.
  - Ensuring Directorate Risk Leads raise issues at directorate committees.
- Feedback information to staff so that:
  - They are aware of hazards and risks.
  - They are aware of risk assessments.
  - They are aware of actions taken.
  - They are encouraged to report risks and incidents.

Failure to act on identified risk, failure to escalate significant red and amber risks, and failure to engage in the risk management process will be viewed as serious dereliction of duty.

Managers can be advised by risk assessors who have been trained in risk assessment. For green risks a formal risk assessment is not required. For more complex risks a written assessment would be required (see table below). Risks should be mitigated and accepted

before work begins or a service opens. The table below is a guide only as each risk is unique and must be considered fully. Some red risks will be simple and require simple management whereas some amber risks will be complex and affect other departments.

Risk score	Manager	Risk assessment	Monitoring committee	Reporting
1 to 10 (Blue & Green)	Department manager	Informal investigation (dynamic risk assessment).	Local management team (Ward level).	Findings shared with staff.
10 to 15 (Amber)	Department manager advised by a trained risk assessor.	Formal risk assessment and entry on the risk register.	Directorate management committee. specialist Trust risk committee.	Written risk assessment shared with staff.
15 to 20 (Red)	Department manager advised by a trained risk assessor, the Directorate Risk Lead and Health, Safety and Risk Team.	Formal risk assessment, entry on the risk register and discussion at directorate management meetings. N.B. Risk Register entries for Red Risks must be reviewed and validated by the Risk and Compliance Manager, with the relevant Directorate Risk Lead.	Directorate management committee. specialist Trust risk committee. Board sub-committee.	Written risk assessment and findings shared across the Trust.

Managers are also responsible for including Trust wide risk assessments within their department's risk arrangements and share them with staff. All health, safety and risk responsibilities should be included in job descriptions. Objectives and targets should be included in the annual appraisal process.

6.6 Risk escalation

Many risks are identified at local level and initially managed by department managers. These departmental level risks are often mitigated locally if the actions required are within the remit of the manager responsible. Managers complete local action plans and these are discussed at local management meetings.

The Datix Risk Management software requires the risk to be assigned a 'level'. This identifies at which management level the risk is being managed and provides an escalation route. Risk should be escalated to the next management level in agreement with the Directorate Risk Lead when the risk:

- Requires action outside the remit of the responsible manager
- Has wider reaching effect than the locality (department)
- Is outside the financial capability of the department
- May affect the strategic direction of locality (department or directorate etc.)

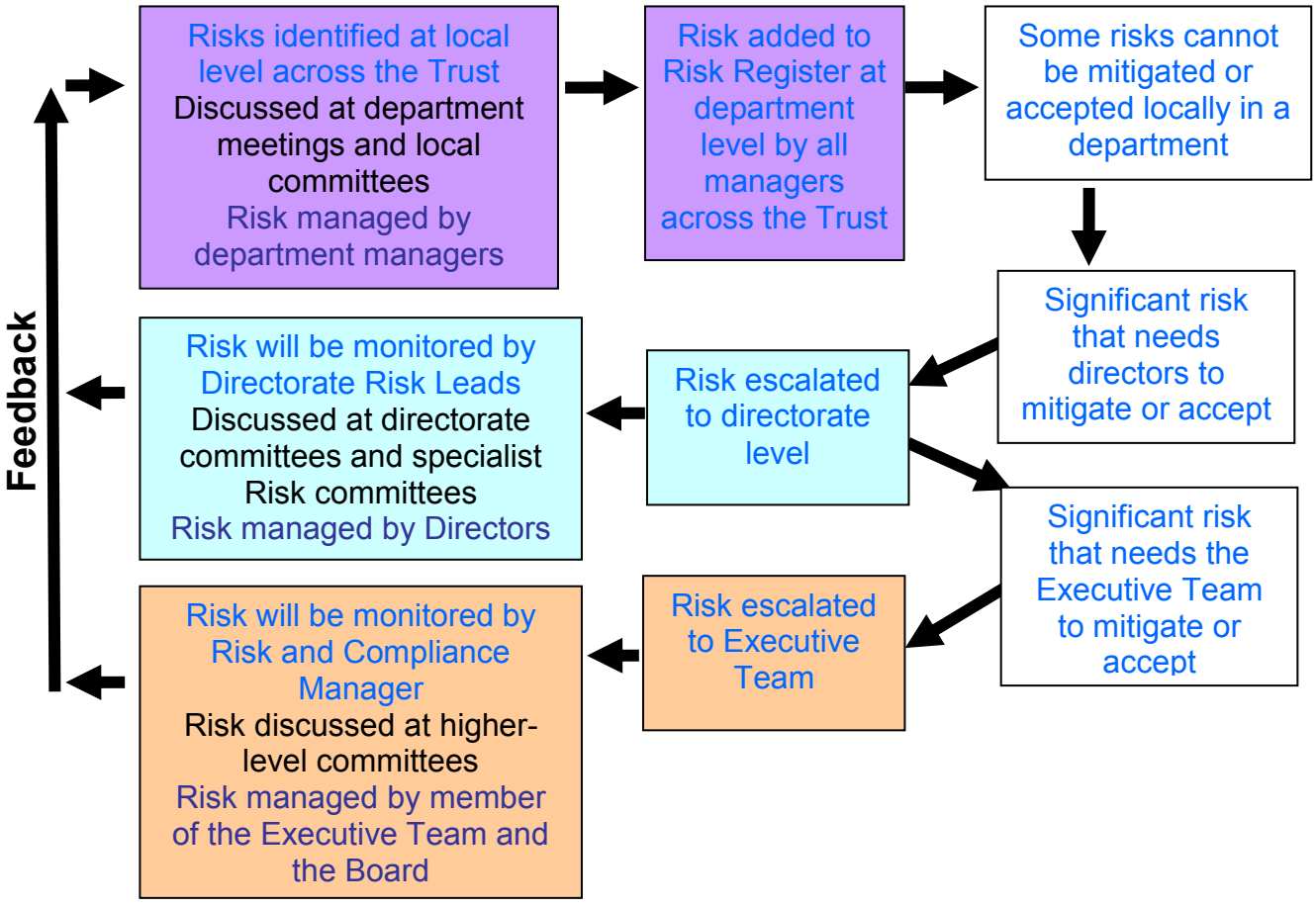
They are first raised to Directorate-level risk. They will be monitored by the Directorate Risk Lead and be discussed by the directorate committees. These may also be discussed at specialist risk committees if the expertise of competent persons is required.

Where risks cannot be mitigated at directorate level they will be raised to a higher tier committee and managed through members of the Executive Team and the Risk and Compliance Manager. The higher tier committee will be asked to either:

- Be aware of a risk and its action plan.
- Undertake an action to mitigate the risk.
- Or accept the risk on behalf of the Trust.

At which ever level the risk is mitigated or accepted at it is essential that the results are fed back to the original department and reporter. The results should be recorded on the Risk Register and the risk closed. The successful completion of the action plan should be reported to all relevant committees.

Risks identified in departments can be escalated to higher committees. Risks identified at higher level can also be delegated through the committee structure to local management committees.



6.7 Risk Register

The Trust's Risk Register is held within the Datix system in a Risk Register module. Risks are held in a single database but reports can be generated based on level, speciality, rating etc. Therefore Directorate Risk Leads can generate their Directorate Risk Register.

Where a risk is assessed as, or escalated to, a 'Red Risk' an appropriate level of consultation must take place to ensure that the assessment has been made in accordance

with this policy. Initially this may be through discussion with the Risk and Compliance Manager or other suitable competent person. At the earliest opportunity the risk should be discussed at a relevant directorate and/or specialist committees to determine its current status and any further mitigation.

All risks should be managed in accordance with the principles of risk assessment, risk mitigation and risk appetite outlined in this policy. This includes regular reviews, which should take place with increasing frequency commensurate with increasing level of risk.

Trust-wide risks and 'Red Risks' are reviewed by members of the Executive Team and Risk and Compliance Manager at regular meetings. In addition, the Risk and Compliance Manager produces reports to higher tier committees which are reviewed and discussed at that level.

The full Risk Register contains all open risks and is published and shared with members of the Executive Team and directorates every 2 months.

More information is available in Guidance on Risk Register Administration and Review.

6.8 Board assurance framework (BAF)

The BAF is the document through which the Trust Board identifies the principal risks to the Trust meeting its agreed objectives, and to ensure adequate controls and measures are in place to manage those risks. The ultimate aim of the BAF is to help ensure that the objectives agreed by the Board are met. The BAF is managed by the Trust Secretary, who liaises with each "Responsible Director" to ensure that the document is updated throughout the year. The BAF differs from the Risk Register in that the BAF should only contain a sub-set of risks on the Risk Register: those that pose a direct threat to the achievement of the Trust's objectives.

7.0 Adverse incident management

7.1 Adverse incident reporting

All adverse incidents will be reported and managed in accordance with the Trust's Incident Management Policy and Procedure.

Maidstone and Tunbridge Wells NHS Trust

APPENDIX 1

Process requirements

1.0 Implementation and awareness

- Once ratified at Board, the Policy Ratification Committee (PRC) Chair will email this policy/procedural document to the Corporate Governance Assistant (CGA) who will activate it on the Trust approved document management database on the intranet, under 'Policies & Q-Pulse'.
- A monthly publications table is produced by the CGA which is published on the Trust intranet under 'Policies & Q-Pulse'; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.
- The establishment of a risk management culture within the Trust is dependent on this strategy being successfully implemented. It is important that the strategy is implemented from the top down to show management commitment and demonstrate an appropriate level of priority and importance.
- This policy must be ratified by the Trust Board
- This policy will be bought to the attention of all staff via the email system of dissemination.
- Implementation will be progressed through a process of continuous improvement. This will continue to ensure that once an acceptable standard is reached, it is maintained and improved. The KPI's and targets used will be set by the relevant committees.

2.0 Monitoring compliance with this document

- Minor changes to this policy and strategy will be noted by the Risk and Compliance Manager and included in the regular review. Major changes will be agreed by the TME and the policy and procedure revised. All changes to the policy and procedure, between full reviews, must be approved by the Board.
- Trust performance with respect to the implementation of this policy and procedure will be overseen by the Trust Health and Safety Committee and the Trust Management Executive.
- The Risk and Compliance Manager will undertake monitoring of the Trust's performance in risk management and risk assessment.
- The Patient Safety Lead will undertake monitoring of the Trust's performance in incident reporting and investigation.
- Regular reports will be sent to the Directorate Risk Leads for discussion at directorate meetings. The Directorate Risk Leads attend the Health and Safety Committee and will provide assurance reports on to account for their performance. The Risk and Compliance Manager will also provide regular risk reports to the Health and Safety Committee.

3.0 Review

This policy and procedure and all its appendices will be reviewed at a minimum of once every 3 years, following the procedure set out in the 'Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures' [RWF-OPPPCS-NC-CG25].

If, before the document reaches its review date, changes in legislation or practice occur which require extensive or potentially contentious amendments to be made, a full review, approval and ratification must be undertaken.

If minor amendments are required to the policy and procedure between reviews these do not require consultation and further approval and ratification. Minor amendments include changes to job titles, contact details, ward names etc.; they are 'non-contentious'. For a full explanation please see the 'Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures' [RWF-OPPPCS-NC-CG25]. The amended document can be emailed to the CGA for activation on the Trust approved document management database on the intranet, under 'Policies & Q-Pulse'. Similarly, amendments to the appendices between reviews do not need to undergo consultation, approval and ratification.

4.0 Archiving

The Trust approved document management database on the intranet, under 'Policies & Q-Pulse', retains all superseded files in an archive directory in order to maintain document history.

Maidstone and Tunbridge Wells NHS Trust

APPENDIX 2

CONSULTATION ON: Risk Management Policy and Procedure
Consultation process – Use this form to ensure your consultation has been adequate for the purpose.
Please return comments to: Rob Parsons, Risk and Compliance Manager
By date: 25/05/17

Job title:	**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:				
Clinical Governance Assistant ruthdickens@nhs.net	02.05.17	09.05.17	Y	Y
Chief Pharmacist and Formulary Pharmacist mildred.johnson@nhs.net	02.05.17			
Staff-Side Chair annemieke.koper@nhs.net	02.05.17	02.05.17	N	
Emergency Planning Team Epo.mtw@nhs.net	02.05.17			
Head of Staff Engagement and Equality jo.petch@nhs.net	02.05.17	03.05.17	Y	Y
Health Records Manager di.peach@nhs.net	02.05.17			
All individuals listed on the front page of this document	02.05.17			
All members of the approving committee: Trust Management Executive	02.05.17			
Directorate Risk Leads	02.05.17			
Competent Persons (see Section 3.5)	02.05.17	24.05.17	Y	N
Members of the Trust Clinical Governance Committee	02.05.17			
Members of the Health and Safety Committee	02.05.17	03.05.17	Y	Y
Other individuals the author believes should be consulted:				
Trust Secretary	02.05.17			
Associate Director Quality and Governance	02.05.17			
Chief Nurse	02.05.17			
The following staff have given consent for their personal names to be included in this policy and its appendices:				
Ruth Dickens, Mildred Johnson, Amanda LePage, Annemieke Koper, Jo Petch, Di Peach, Rob Parsons				

Maidstone and Tunbridge Wells NHS Trust

APPENDIX 3

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development and approval process. **Please note that completion is mandatory for all policy and procedure development exercises.**

Title of policy or practice	Risk Management Policy and Procedure
What are the aims of the policy or practice?	Describe commitment to and processes for the management of risk throughout the Trust
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	
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.**
Gender identity	No
People of different ages	No
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language (but excluding Trust staff)	Yes. Some safety documentation must be provided in different languages if staff require a translation
People who have a physical or mental disability or care for people with disabilities	Yes. If specific risks are identified then risk assessment should be undertaken. Failure to undertake risk assessment where need identified or risk assessment which is not suitable and sufficient could give rise to potential discrimination.
People who are pregnant or on maternity leave	Yes. Risk assessment must be undertaken in line with Management of Health and Safety at Work Regulations 1999. Failure to undertake risk assessment or risk assessment which is not suitable and sufficient could give rise to potential discrimination.
Sexual orientation (LGB)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	Yes
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 Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.

Maidstone and Tunbridge Wells NHS Trust

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust approved document management database on the intranet, under 'Policies & Q-Pulse':

No.	Title	Unique ID	Title and unique id of policy that the appendix is primarily linked to
4	Risk Categorisation Matrix	RWF-OWP-APP51	Risk Assessment Policy and Procedure [RWF-OPPPCS-NC-CG6]
5	Types and sources of risk used to populate the Risk Register	RWF-OWP-APP452	Risk Register Administration and Review, Guidance on [RWF-OPPPCS-NC-CG14]
6	Trust governance committee structure chart	RWF-OWP-APP2	Health and Safety Policy and Procedure [RWF-OPPPCS-NC-CG1]
7	Directory of local key staff and managers	RWF-OWP-APP678	Health and Safety Policy and Procedure [RWF-OPPPCS-NC-CG1]

Trust Board meeting - September 2017

NHS Maidstone and Tunbridge Wells NHS Trust

9-20	**Approval of Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment**	**Chief Operating Officer**

The enclosed spreadsheet provides information on the organisations compliance and self-assessment against the NHS England Core Standards for Emergency Planning Response & Recovery.

- The Trust has assessed itself against the 45 Core standards and is fully compliant with 45
- The Trust Board will receive a full annual report into preparedness at the Trust in January.
- This year a deep dive self-assessment into governance has revealed the Trust is fully compliant
- A further assessment into Chemical Biological Radiological and Nuclear preparedness revealed the Trust is fully compliant.

  The self-assessment endorses the report received in January that indicated a good level of preparedness at the Trust

  The self-assessment was conducted with the Commissioning Support Unit on the 22 of August 2017 on behalf of the CCG who agreed with our self-assessment having looked at the evidence.

Which Committees have reviewed the information prior to Board submission?
- Resilience Committee

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
To approve the Emergency Preparedness, Resilience and Response (EPRR) Core Standards self-assessment

[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

NHS England Core Standards for Emergency preparedness, resilience and response

v5.0

The attached EPRR Core Standards spreadsheet has 6 tabs:

EPRR Core Standards tab: with core standards nos 1 - 37 (green tab)

Governance tab:-with deep dive questions to support the EPRR Governance'deep dive' for EPRR Assurance 2017 -18(blue) tab)

HAZMAT/ CBRN core standards tab: with core standards nos 38- 51. Please note this is designed as a stand alone tab (purple tab)

HAZMAT/ CBRN equipment checklist: designed to support acute and ambulance service providers in core standard 43 (lilac tab)

MTFA Core Standard: designed to gain assurance against the MTFA service specification for ambulance service providers only (orange tab)

HART Core Standards: designed to gain assurance against the HART service specification for ambulance service providers only (yellow tab).

This document is V50. The following changes have been made :

• Inclusion of EPRR Governance questions to support the 'deep dive' for EPRR Assurance 2017-18

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																			
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	• Ensuring accountaable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergeny Preparedness Resilience and Response, and Business Continuity Management agendas				
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	• Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an appropriate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.				
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y					
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y					
Duty to assess risk																			
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages;	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages				
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.	• surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites) There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency as well as external risks eg. Flooding, COMAH sites etc.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed				
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
Duty to maintain plans – emergency plans and business continuity plans																			
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity.	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.				
9		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
10		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y	Y	Y			Y	Y	Y	Y	Y			Y					
11	Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Severe Weather (heatwave, flooding, snow and cold weather)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
12		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y					
13		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Y	Y	Y			Y		Y	Y				Y					
14		Mass Casualties	Y	Y	Y			Y		Y	Y				Y					
15		Fuel Disruption	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
16		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y					
17		Infectious Disease Outbreak	Y	Y	Y			Y	Y	Y	Y	Y		Y	Y					
18		Evacuation	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y					
19		Lockdown	Y	Y	Y			Y	Y					Y	Y					
20		Utilities, IT and Telecommunications Failure	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y					
21		Excess Deaths/ Mass Fatalities	Y	Y	Y					Y	Y				Y					
22		having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab			Y															
23		firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab			Y															
24	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • Contact details of key personnel and relevant partner agencies • Plan maintenance procedures (Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).				
25	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.				
26	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
27	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management	Y	Y	Y			Y	Y											
28	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Specifiy who has been consulted on the relevant documents/ plans etc.				
29	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold) at the end of an incident.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
Command and Control (C2)																			
30	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	Explain how the emergency on-call rota will be set up and managed over the short and longer term.				
31	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England publised competencies are based upon National Occupation Standards .	Y	Y	Y		Y	Y	Y	Y	Y	Y			Y	Training is delivered at the level for which the individual is expected to operate (ie operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.				
32	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and scope of the organisation.	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/co0ordination centre and manage any events required.				
33	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
34	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.		Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y					
35	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials	Y		Y															
36	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident	Y		Y															
Duty to communicate with the public																			
37	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	Y	Y	Y			Y	Y	Y	Y	Y			Y	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.				

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
38	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.				
Information Sharing – mandatory requirements																				
39	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). • Social networking tools may be of use here.				
Co-operation																				
40	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		Y	Y	Y			Y	Y	Y	Y	Y		Y	Y	• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and memebership is quorat.				
41	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	• Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups				
42	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	NB: mutual aid agreements are wider than staff and should include equipment, services and supplies.	Y	Y	Y			Y	Y	Y	Y	Y		Y	Y	• Taking lessons learned from all resilience activities				
43	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.				Y						Y	Y			Y	• Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements				
44	Arrangements outline the procedure for responding to incidents which affect two or more regions.				Y						Y				Y	• Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues • Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area				
45	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.	Y	Y	Y				Y	Y			Y		Y					
46	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared										Y									
47	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months									Y	Y									
48	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y	Y	Y			Y	Y	Y		Y			Y					
Training And Exercising																				
49	Arrangements include a curent training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • A training needs analysis undertaken within the last 12 months • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate • Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective • Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs.				
50	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. • If possible, these exercises should involve relevant interested parties. • Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidentshave been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at least every three years				
51	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		Y	Y	Y			Y	Y	Y	Y	Y			Y					
52	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		Y	Y	Y		Y	Y	Y	Y	Y	Y			Y					

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
2017 Deep Dive																			
DD1	The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a public Board/Governing Body meeting for sign off within the last 12 months.	• The organisation has taken the LHRP agreed results of their 2016/17 NHS EPRR assurance process to a public Board meeting or Governing Body, within the last 12 months • The organisations can evidence that the 2016/17 NHS EPRR assurance results Board/Governing Body results have been presented via meeting minutes.	Y	Y	Y	Y	Y	Y	Y		Y	Y			Y	• Organisation's public Board/Governing Body report • Organisation's public website				
DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	• There is evidence that the organisation has published their 2016/17 assurance process results in their Annual Report	Y	Y	Y	Y	Y	Y	Y			Y			Y	• Organisation's Annual Report • Organisation's public website				
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	• The organisation has an identified Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio. • The organisation has publicly identified the Non-executive Director/Governing Body Representative that holds the EPRR portfolio via their public website and annual report • The Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio is a regular and active member of the Board/Governing Body • The organisation has a formal and established process for keeping the Non-executive Director/Governing Body Representative briefed on the progress of the EPRR work plan outside of Board/Governing Body meetings	Y	Y	Y	Y	Y	Y	Y		Y	Y			Y	• Organisation's Annual Report • Organisation's public Board/Governing Body report • Organisation's public website • Minutes of meetings				
DD4	The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function	• The organisation has an internal group that meets at least quarterly that agrees the EPRR work priorities and oversees the delivery of the organisation's EPRR function.	Y	Y	Y	Y	Y	Y	Y		Y	Y			Y	• Minutes of meetings				
DD5	The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group	• The organisation's Accountable Emergency Officer is a regular attendee at the organisation's meeting that provides oversight to the delivery of the EPRR work program. • The organisation's Accountable Emergency Officer has attended at least 50% of these meetings within the last 12 months.	Y	Y	Y	Y	Y	Y	Y			Y			Y	• Minutes of meetings				
DD6	The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings	• The organisation's Accountable Emergency Officer is a regular attendee at Local Health Resilience Partnership meetings • The organisation's Accountable Emergency Officer has attended at least 75% of these meetings within the last 12 months.	Y	Y	Y	Y	Y	Y	Y	Y		Y			Y	• Minutes of meetings				

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental Health care providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**						**Evidence of assurance**				
	Preparedness											
53	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Y	Y	Y	Y	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control				
54	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	Y	Y	Y	Y	Y	• Site inspection • IT system screen dump				
55	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	Y	Y	Y	Y	Y	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)				
56	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		Y		Y			• Resource provision / % staff trained and available • Rota / rostering arrangements				
57	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	Y	Y	Y	Y	Y	• Provision documented in plan / procedures • Staff awareness				
	Decontamination Equipment											
58	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	Y	Y	Y	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))				
59	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017	Y		Y							
60	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place	Y		Y							
61	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment		Y		Y							
62	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)	Y		Y							
	Training											
63	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training		Y		Y							
64	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	Y	Y	Y	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme				
65	The organisation has sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		Y		Y							
66	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)	Y	Y	Y	Y	Y					

HAZMAT CBRN equipment list - for use by Acute and Ambulance service providers in relation to Core Standard 43.

No	Equipment	Equipment model/ generation/ details etc.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.
	EITHER: Inflatable mobile structure		
E1	Inflatable frame		
E1.1	Liner		
E1.2	Air inflator pump		
E1.3	Repair kit		
E1.2	Tethering equipment		
	OR: Rigid/ cantilever structure		
E2	Tent shell		
	OR: Built structure		
E3	Decontamination unit or room		
	AND:		
E4	Lights (or way of illuminating decontamination area if dark)		
E5	Shower heads		
E6	Hose connectors and shower heads		
E7	Flooring appropriate to tent in use (with decontamination basin if needed)		
E8	Waste water pump and pipe		
E9	Waste water bladder		
	PPE for chemical, and biological incidents		
E10	The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable).		
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme		
	Ancillary		
E12	A facility to provide privacy and dignity to patients		
E13	Buckets, sponges, cloths and blue roll		
E14	Decontamination liquid (COSHH compliant)		
E15	Entry control board (including clock)		
E16	A means to prevent contamination of the water supply		
E17	Poly boom (if required by local Fire and Rescue Service)		
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)		
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)		
E20	Waste bins		
	Disposable gloves		
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe		
E22	FFP3 masks		
E23	Cordon tape		
E24	Loud Hailer		
E25	Signage		
E26	Tabbards identifying members of the decontamination team		
E27	Chemical Exposure Assessment Kits (ChEAKs) (via PHE): should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support.		
	Radiation		
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)		
E29	Hooded paper suits		
E30	Goggles		
E31	FFP3 Masks - for HART personnel only		
E32	Overshoes & Gloves		

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations have an MTFA capability at all times within their operational service area.	• Organisations have MTFA capability to the nationally agreed safe system of work standards defined within this service specification. • Organisations have MTFA capability to the nationally agreed interoperability standard defined within this service specification. • Organisations have taken sufficient steps to ensure their MTFA capability remains complaint with the National MTFA Standard Operating Procedures during local and national deployments.			Y													
2	Organisations have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability.	• Deployment to the Home Office Model Response sites must be within 45 minutes.			Y													
3	Organisations have the ability to ensure that ten MTFA staff are released and available to respond to scene within 10 minutes of that confirmation (with a corresponding safe system of work).	• Organisations maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA capability matrix. • Organisations ensure that, as part of the selection process, any successful MTFA application must have undergone a Physical Competence Assessment (PCA) to the nationally agreed standard. • Organisations maintain the minimum level of training competence among all operational MTFA staff as defined by the national training standards. • Organisations ensure that each operational MTFA operative is competent to deliver the MTFA capability. • Organisations ensure that comprehensive training records are maintained for each member of MTFA staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the MTFA skill sets.			Y													
4	Organisations ensure that appropriate personal equipment is available and maintained in accordance with the detailed specification in MTFA SOPs (Reference C).	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable. • All MTFA equipment is maintained to nationally specified standards and must be made available in line with the national MFTA 'notice to move' standard. • All MTFA equipment is maintained according to applicable British or EN standards and in line with manufacturers' recommendations.			Y													
5	Organisations maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability.	• Organisations ensure that Control rooms are compliant with JOPs (Reference B). • With Trusts using Pathways or AMPDS, ensure that any potential MTFA incident is recognised by Trust specific arrangements.			Y													
6	Organisations have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.				Y													
7	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.				Y													
8	Organisations maintain an appropriate register of all MTFA safety critical assets.	• Assets are defined by their reference or inclusion within the National MTFA Standard Operating Procedures. • This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).			Y													
9	Organisations ensure their operational commanders are competent in the deployment and management of NHS MTFA resources at any live incident.				Y													
10	Organisations maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
11	In any event that the organisations is unable to maintain the MTFA capability to the interoperability standards, that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
12	Organisations support the nationally specified system of recording MTFA activity which will include a local procedure to ensure MTFA staff update the national system with the required information following each live deployment.				Y													
13	Organisations ensure that the availability of MTFA capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
14	Organisations maintain a set of local MTFA risk assessments which are compliment with the national MTFA risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
15	Organisations have a robust and timely process to report any lessons identified following an MTFA deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
16	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
17	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.				Y													
18	FRS organisations that have an MTFA capability the ambulance service provider must provide training to this FRS	Training to include: • Introduction and understanding of NASMed triage • Haemorrhage control • Use of dressings and tourniquets • Patient positioning • Casualty Collection Point procedures.			Y													
19	Organisations ensure that staff view the appropriate NARU training and briefing DVDs	• National Strategic Guidance - KPI 100% Gold commanders. • Specialist Ambulance Service Response to MTFA - KPI 100% MTFA commanders and teams. • Non-Specialist Ambulance Service Response to MTFA - KPI 80% of operational staff.			Y													

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations maintain a HART Incident Response Unit (IRU) capability at all times within their operational service area.	• Organisations maintain the four core HART capabilities to the nationally agreed safe system of work standards defined within this service specification. • Organisations maintain the four core HART capabilities to the nationally agreed interoperability standard defined within this service specification. • Organisations take sufficient steps to ensure their HART unit(s) remains complaint with the National HART Standard Operating Procedures during local and national deployments. • Organisations maintain the minimum level of training competence among all operational HART staff as defined by the national training standards for HART. • Organisations ensure that each operational HART operative is provided with no less than 37.5 hours protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven week period). • Organisations ensure that all HART operational personnel are Paramedics with appropriate corresponding professional registration (note s.3.4.6 of the specification). • As part of the selection process, any successful HART applicant must have passed a Physical Competence Assessment (PCA) to the nationally agreed standard and the provider must ensure that standard is maintained through an ongoing PCA process which assesses operational staff every 6 months and any staff returning to duty after a period of absence exceeding 1 month. • Organisations ensure that comprehensive training records are maintained for each member of HART staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets.			Y												
2	Organisaions maintain a HART Urban Search & Rescue (USAR) capability at all times within their operational service area.				Y													
3	Organisations maintain a HART Inland Water Operations (IWO) capability at all times within their operational service area.				Y													
4	Organisations maintain a HART Tactical Medicine Operations (TMO) capability at all times within their operational service area.				Y													
5	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	• Four HART staff must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. Note: This standard does not apply to pre-planned operations or occasions where HART is used to support wider operations. It only applies to calls where the information received by the provider indicates the potential for one of the four HART core capabilities to be required at the scene. See also standard 13. • Organisations maintain a minimum of six competent HART staff on duty for live deployments at all times. • Once HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations can ensure that six HART staff are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. • Organisations maintain a HART service capable of placing six competent HART staff on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). Competence is denoted by the mandatory minimum training requirements identified in the HART capability matrix. • Organisations maintain any live (on-duty) HART teams under their control maintain a 30 minute 'notice to move' to respond to a mutual aid request outside of the host providers operational service area. An exception to this standard may be claimed if the live (on duty) HART team is already providing HART capabilities at an incident in region.			Y												
6	Organisations maintain a criteria or process to ensure the effective identification of incidents or patients at the point of receiving an emergency call that may benefit from the deployment of a HART capability.				Y													
7	Organisations ensure an appropriate capital and revenue depreciation scheme is maintained locally to replace nationally specified HART equipment.	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should have processes in place to use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable.			Y												
8	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.				Y													
9	Organisations ensure that the HART fleet and associated incident technology are maintained to nationally specified standards and must be made available in line with the national HART 'notice to move' standard.				Y													
10	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.				Y													
11	Organisations maintain an appropriate register of all HART safety critical assets. Such assets are defined by their reference or inclusion within the National HART Standard Operating Procedures. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).				Y													
12	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the HART estate specification.				Y													
13	Organisations ensure their incident commanders are competent in the deployment and management of NHS HART resources at any live incident.				Y													
14	In any event that the provider is unable to maintain the four core HART capabilities to the interoperability standards,that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
15	Organisations support the nationally specified system of recording HART activity which will include a local procedure to ensure HART staff update the national system with the required information following each live deployment.				Y													
16	Organisations maintain accurate records of their compliance with the national HART response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
17	Organisations ensure that the availability of HART capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
18	Organisations maintain a set of local HART risk assessments which compliment the national HART risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
19	Organisations have a robust and timely process to reportany lessons identified following a HART deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
20	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
21	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.				Y													

Trust Board Meeting – September 2017

NHS Maidstone and Tunbridge Wells NHS Trust

9-21	**Summary report from Finance and Performance C'ttee, 21/08 (incl. quarterly progress update on Procurement Transformation Plan and approval of "Uncommitted Single Currency Interim Revenue Support Facility Agreement")**	**Committee Chair (Non-Exec. Director)**

The Finance Committee met on 21st August 2017.

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

- The actions from previous meetings were reviewed
- Under the "Safety Moment", it was reported that August's theme was Naso-Gastric Tube Safety
- An update on the Workforce Transformation Programme noted that implementation was underway; negotiations were in progress with the preferred supplier of job planning software; and job planning documentation was due to be considered at the meeting of the Joint Medical Consultative Committee on 24/08/17. The Committee agreed that quarterly update reports should be received with effect from November 2017
- The Month 4 financial position was reviewed and discussed in detail. Key risks to the position reported, which included settlement with West Kent Clinical Commissioning Group (CCG) for 2016/17. It was hoped to agree a view with the CCG on underlying activity for the year very shortly. One of the key issues in dispute was the in-year change in A&E clinical coding by the Trust. The CCG and the Trust had agreed to prepare a joint statement to crystallise each party's position, which could also be used in the event of formal mediation / arbitration (although this eventuality was considered unlikely). It was noted that the aligned incentives contract for 2017/18 should preclude such issues
- As part of the review of the Month 4 financial position, it was also agreed the Director of Finance would:
  - Provide more clarity on the composition of "Total Temporary Medical Staffing Expenditure" before the next meeting
  - Review the workforce graphs to ensure key messages are communicated to committee members
- An update was given on the 2017/18 Cost Improvement Programme (CIP), which highlighted the differences in phasing between the original agreed plan and the live plan and outlined the position of the key divisions. As part of the review of the CIP, the Director of Finance agreed to provide more detail on the composition of the "Pay (WTE reductions)" figure in the CIP Financial Analysis Trust summary before the next meeting
- The proposed submission for the next Financial Special Measures Review Checkpoint Meeting with NHS Improvement (NHSI) on 30/08/17 was considered in detail, and it was agreed to review the information presented in the light of the suggestions made at the meeting, in time for submission to NHSI prior to the meeting (on 29/08/17)
- The Trust's response to the letter from the National Urgent and Emergency Care Director about preparation for winter 2017/18 was noted, with particular focus on ensuring sufficient capacity and reducing bed occupancy to 92% or less
- The month 4 non-financial performance was considered and the latest position in relation to the A&E 4-hour; Delayed Transfers of Care (DTOCs); 62-day Cancer waiting time and Referral to Treatment (RTT) waiting time targets was reviewed. It was agreed that clarification of the operational issues challenging Trauma & Orthopaedics performance in the light of apparently low activity levels at Maidstone Hospital was required
- The usual monthly update on the Lord Carter efficiency review was discussed, and positive feedback given about a recent meeting on Clinical Workforce Development, between the Medical Director, Deputy Director of Finance (Financial Performance) and the National Director of Workforce Efficiency, NHSI. It was reported that the Trust had been invited to be involved in the 2nd wave of the National Job Planning Programme and had also joined the Carter ambassadors group as a prime user of the Model Hospital portal
- A quarterly update on progress with the Procurement Transformation Plan was reported (the same report has been submitted to the Trust Board, in Appendix 2). The Director of Finance agreed to review the feasibility of using external catalogue management for Trust

procurement

- The 6-monthly report describing the post-project reviews of approved Business Cases was received, which reported the outcome of the review of a business case for the Recruitment of 4 x hybrid – Paediatric consultants to provide A&E Consultant cover at Tunbridge Wells Hospital
- A proposal to approve the investment of £50k for a diagnostic/scoping exercise for the establishment of a wholly owned Trust subsidiary was considered. The Committee agreed that an application should be made for the provision of £50k Sustainability and Transformation Partnership (STP) funding for use towards a targeted scoping exercise to determine the case for the establishment of a Trust subsidiary (on the basis that the findings would be applicable and available to other parties within the Kent and Medway STP)
- The Director of Finance reported on the guidance recently issued by NHSI / Care Quality Commission (CQC) on the Use of Resources Assessment Framework. It was agreed that a first view of the Trust's position against the Framework should be reported to the next meeting
- The usual monthly report on breaches of the external cap on the Agency staff pay rate was noted

2. In addition the agreements referred to above, the Committee agreed that:

- N/A

3. The issues that need to be drawn to the attention of the Board are as follows:

- A request for an uncommitted loan facility (in advance of Sustainability and Transformation Fund (STF) payments) was considered and it was agreed to submit a recommendation to the Trust Board that it approves the proposed advance funding application for the Quarter 1 STF payment in 2017/18 (£1.677m) and the application for future potential loan facilities to advance against the STF payments to a maximum value of £7.265m, with reference to points 1-7 of Appendix 1

Which Committees have reviewed the information prior to Board submission?

- N/A

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

1. Information and assurance
2. To approve the proposed advance funding application for the Quarter 1 Sustainability and Transformation Fund (STF) payment in 2017/18 (£1.677m) and the application for future potential loan facilities to advance against the STF payments to a maximum value of £7.265m, with reference to points 1-7 of the "Request to approve an "Uncommitted Single Currency Interim Revenue Support Facility Agreement"" (see Appendix 1)
3. To note the quarterly progress update on the Procurement Transformation Plan (see Appendix 2)

Appendix 1: Request to approve an "Uncommitted Single Currency Interim Revenue Support Facility Agreement"

On 21/08/17, the Finance and Performance Committee agreed to recommend the approval of a request for an uncommitted loan facility (in advance of Sustainability and Transformation Fund (STF) payments) by the Trust Board at its meeting on 07/09/17.

The background to this request, as considered by the Finance and Performance Committee, and the terms of the Committee's recommendation are detailed below:

Background:

The Trust's prior year Income and Expenditure deficits have required working capital support to ensure cash liquidity. In 2015/16 the DH consolidated prior financing into a revenue support loan of £16.9m (1.5% per annum), and in 2016/17 the Trust made use of its Interim Revolving Working Capital Facility to the agreed level of £12.132m (3.5% interest per annum) to support the cash implications of the planned deficit. In addition, during the year, DH agreed that providers could apply for financing to advance the cash for expected Sustainability and Transformation (STF) payments given the significant time lag between accrual and actual cash settlement. The Trust took advantage of this option for the Quarter 3 STF payment in 2016/17 (£2.458m) with the actual STF payment not being made until April 2017. As a result of the Trust being in financial special measures, the financing for the advance was made as an uncommitted term loan at 6% interest rate.

The Trust's submitted financial plan for 2017/18 did not include any additional working capital financing to support the recovery plan and agreed control total. It did include assumptions about the payment of STF funding comprising:

- Qtr 1 STF £1.677m
- Qtr 2 STF £2.235m
- Qtr 3 STF £3.353m
- Qtr 4 STF £3.912m (cash expected in 2018/19 if STF payment earned)
- Total £11,177m

2017/18 STF Payments

The Trust has assessed that it expects a STF payment of £1.677m in line with plan for the first quarter of 2017/18. This payment will require authorisation through the NHS England/Department of Health process and is therefore not likely to be cash settled until November. NHSI has sent out guidance indicating that Trusts who have signed up to their control totals are able to access financing to advance the STF payments where there is a cash lag.

The next draw down date for financing is 11/09/17. The Trust submitted a cashflow by 10/08/17 to NHS Improvement (NHSI) indicating that it was seeking an advance in September. The Trust has been issued with a provisional template for an "uncommitted single currency interim revenue support facility agreement" (see annex 1) at 1.5% interest rate. Given the Trust is in Financial Special Measures this interest rate may be varied to 3.5% (for Trusts in special measures but with an agreed recovery plan on track) or 6% (no agreed recovery plan or not achieving the current plan). Assuming the two month period of advance before repayment for the Quarter 1 STF payment, the interest incurred is estimated below for the range of possible interest rates:

- £4,411 at 1.5%
- £10,292 at 3.5%
- £17,643 at 6.0%

In order to avoid repeating this approach for future potential advances of STF in the year, NHSI have recommended that a Board resolution is passed to cover the maximum amount of STF funding likely to be advanced in the year in cash terms (which would be the first three quarters in the year) and then arrange the uncommitted loans on the authority of the Board resolution. If the subsequent quarter STF payments are not earned through meeting the relevant criteria, the advances in the form of the loans will not be sought or approved by NHSI.

The agreement document includes the “additional terms and conditions” in schedule 8 which have been common to all the financing agreements in the last three years, and to which the Trust has already signed up on each previous financing loan agreement.

Recommendation:

The Finance and Performance Committee has recommended that the Trust Board approves the proposed advance funding application for Quarter 1 STF payment in 2017/18 (£1.677m) and to the approach that requests of the Trust Board:

1. Approval of the financing proposed via the loan agreement template and the Board Resolution as set out below, in line with the enclosed Schedule 1 of the Loan facility documentation (“Conditions Precedent).
2. Approval that the loan facility can be signed by the Director of Finance under delegated authority
3. Resolution to approve the applications for loan facilities to advance against STF payments to a maximum value of £7.265m, being the total of the first three quarters in 2017/18, actual and planned.
4. Agreement to the terms of and the transactions contemplated by the attached loan subject to DH finalising the exact value and confirmation of financing product as a result of special measures regime
5. Authorisation of the Director of Finance as the nominated officer to execute the agreement (“the Finance Documents”)
6. Authorisation of the Director of Finance to manage the agreement i.e. to sign and/or despatch all documents and notices including any Utilisation Requests required under the agreement.
7. Agreement to the additional terms and conditions set out in the relevant schedule of the facility agreement (schedule 8)

Annex 1 - Uncommitted single currency interim revenue support facility agreement

Annex 1

DATED 2016

[ ]
(as Borrower)

and

THE SECRETARY OF STATE FOR HEALTH
(as Lender)

£[ ]

UNCOMMITTED SINGLE CURRENCY INTERIM REVENUE SUPPORT FACILITY AGREEMENT

REF NO: DHPF/ISUCL/]

TABLE OF CONTENTS

Clause	Headings	Page
1.	DEFINITIONS AND INTERPRETATION	2
2.	THE FACILITY	8
3.	PURPOSE	8
4.	CONDITIONS OF UTILISATION	8
5.	UTILISATION	9
6.	PAYMENTS AND REPAYMENT	10
7.	PREPAYMENT AND CANCELLATION	10
8.	INTEREST	11
9.	INTEREST PERIODS	12
10.	PREPAYMENT AMOUNT	12
11.	INDEMNITIES	12
12.	MITIGATION BY THE LENDER	13
13.	COSTS AND EXPENSES	14
14.	REPRESENTATIONS	14
15.	INFORMATION UNDERTAKINGS	17
16.	GENERAL UNDERTAKINGS	18
17.	COMPLIANCE FRAMEWORK	21
18.	EVENTS OF DEFAULT	21
19.	ASSIGNMENTS AND TRANSFERS	23
20.	ROLE OF THE LENDER	24
21.	PAYMENT MECHANICS	25
22.	SET-OFF	27
23.	NOTICES	27
24.	CALCULATIONS AND CERTIFICATES	28
25.	PARTIAL INVALIDITY	28
26.	REMEDIES AND WAIVERS	28
27.	AMENDMENTS AND WAIVERS	29
28.	COUNTERPARTS	29
29.	GOVERNING LAW	29
30.	DISPUTE RESOLUTION	29
SCHEDULE 1: CONDITIONS PRECEDENT		30
SCHEDULE 2: UTILISATION REQUEST		31
SCHEDULE 3: NOT USED		32
SCHEDULE 4: ANTICIPATED DRAWDOWN SCHEDULE		33
SCHEDULE 5: DISPUTE RESOLUTION		34
SCHEDULE 6: REPAYMENT SCHEDULE		37
SCHEDULE 7: PERMITTED SECURITY – EXISTING SECURITY		38

THIS AGREEMENT is dated 2016 and made between:

(1) **[ ]** of**, XXX** (the **"Borrower" which expression shall include any successors in title or permitted transferees or assignees**); and

(2) **THE SECRETARY OF STATE FOR HEALTH** as lender (the **"Lender" which expression shall include any successors in title or permitted transferees or assignees**).

IT IS AGREED as follows:

1. DEFINITIONS AND INTERPRETATION

1.1 Definitions

In this Agreement:

"Account" means the Borrower's account held with the Government Banking Service.

"Act" means the National Health Service Act 2006 as amended from time to time.

"Additional Terms and Conditions" means the terms and conditions set out in Schedule 8.

"Agreed Purpose" means working capital expenditure for use only if it has insufficient working capital available as set out under the Terms of this Agreement, to maintain the provision of the Borrower's services in its capacity as an NHS Body. For the purposes of this agreement, working capital expenditure shall include repayment of outstanding loans under any working capital facility provided by the Lender to the Borrower.

"Authorisation" means an authorisation, consent, approval, resolution, licence, exemption, filing, notarisation or registration.

"Available Facility" means the Facility Amount less:

(A) all outstanding Loans; and

(B) in relation to any proposed Utilisation, the amount of any Loan that is due to be made on or before the proposed Utilisation Date.

"Availability Period" means two years from and including the date of this Agreement. The Availability Period may be extended, at the Borrower's option, subject to no outstanding Event of Default. Any extension can be for a period of up to twelve months, subject to the Availability Period expiring no later than the Final Repayment Date.

"Business Day" means a day (other than a Saturday or Sunday) on which banks are open for general banking business in London.

"Capital Limit" means the overall maximum net inflow/outflow from investing activities incurred by the Borrower as set by the Lender for any relevant financial year

"Cash Balance" means the Borrower's available cash balances, whether held within the Government Banking Service or otherwise, on the Utilisation Date to the Monday preceding the 18th day of the following Month.

"Cashflow Forecast" means the Borrower's current rolling 13 week cashflow forecast in a form to be agreed with the Lender from time to time (and as prepared on behalf of the Borrower's Board). The forecast must include all utilisations and proposed utilisations under any agreement with the Lender for the relevant period.

"Compliance Framework" means the relevant Supervisory Body's frameworks and/or any replacement to such frameworks for monitoring and assessing NHS Bodies and their compliance with any consents, permissions and approvals.

"Dangerous Substance" means any natural or artificial substance (whether in a solid or liquid form or in the form of a gas or vapour and whether alone or in combination with any such other substance) capable of causing harm to the Environment or damaging the Environment or public health or welfare including any noxious, hazardous, toxic, dangerous, special or controlled waste or other polluting substance or matter.

"Default" means an Event of Default or any event or circumstance specified in Clause 18 (*Events of Default*) which would (with the expiry of a grace period, the giving of notice, the making of any determination under the Finance Documents or any combination of any of the foregoing) be an Event of Default.

"Default Rate" means the official bank rate (also called the Bank of England base rate or BOEBR) plus 300 basis points per annum.

"Deficit Limit" means the Surplus/Deficit outturn for the Borrower set by the Lender for any relevant financial year before impairments and transfers.

"Environment" means the natural and man-made environment and all or any of the following media namely air (including air within buildings and air within other natural or man-made structures above or below ground), water (including water under or within land or in drains or sewers and inland waters), land and any living organisms (including humans) or systems supported by those media.

"Environmental Claim" means any claim alleging liability whether civil or criminal and whether actual or potential arising out of or resulting from the presence at on or under property owned or occupied by the Borrower or presence in or escape or release into the environment of any Dangerous Substance from any such property or in circumstances attributable to the operation of the Borrower's activities or any breach of any applicable Environmental Law or any applicable Environmental Licence.

"Environmental Law" means all statutes, instruments, regulations, orders and ordinances (including European Union legislation, regulations, directives, decisions and judgements applicable to the United Kingdom) being in force from time to time and directly enforceable in the United Kingdom relating to pollution, prevention thereof or protection of human health or the conditions of the Environment or the use, disposal, generation, storage, transportation, treatment, dumping, release, deposit, burial, emission or disposal of any Dangerous Substance.

"Environmental Licence" shall mean any permit, licence, authorisation, consent or other approval required by any Environmental Law or the Planning (Hazardous Substances) Act 1990.

"Event of Default" means any event or circumstance specified as such in Clause 18 (*Events of Default*).

"Facility" means the uncommitted interim support facility made available under this Agreement as described in Clause 2 (*The Facility*).

"Facility Amount" means £[ ] at the date of this Agreement and thereafter that amount to the extent not cancelled, reduced or transferred by the Lender or the Borrower (as may be amended by the Lender from time to time).

"Final Repayment Date" means [ ].

"Finance Documents" means:

(A) this Agreement; and

(B) any other document designated as such by the Lender and the Borrower.

"Financial Indebtedness" means any indebtedness for or in respect of:

(A) moneys borrowed;

(B) any amount raised by acceptance under any acceptance credit facility;

(C) any amount raised pursuant to any note purchase facility or the issue of bonds, notes, debentures, loan stock or any similar instrument;

(D) the amount of any liability in respect of any lease or hire purchase contract which would, in accordance with any applicable Audit Code for NHS Bodies, any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies, be treated as a finance or capital lease;

(E) receivables sold or discounted (other than any receivables to the extent they are sold on a non-recourse basis);

(F) any amount raised under any other transaction (including any forward sale or purchase agreement) having the commercial effect of a borrowing;

(G) any derivative transaction entered into in connection with protection against or benefit from fluctuation in any rate or price (and, when calculating the value of any derivative transaction, only the marked to market value shall be taken into account);

(H) any counter-indemnity obligation in respect of a guarantee, indemnity, bond, standby or documentary letter of credit or any other instrument issued by a bank or financial institution; and

(I) the amount of any liability in respect of any guarantee or indemnity for any of the items referred to in paragraphs (A) to (H) above.

"Government Banking Service" means the body established in April 2008 being the banking shared service provider to government and the wider public sector incorporating the Office of HM Paymaster General (OPG).

"Interest Payment Date" means the last day of an Interest Period.

"Interest Period" means, in relation to a Loan, the period determined in accordance with Clause 9 (*Interest Periods*) and, in relation to an Unpaid Sum, each period determined in accordance with Clause 8.3 *(Default interest).*

"**Interest Rate**" means 1.5% per annum, or other applicable interest rate that shall be notified by the Lender to the Borrower in respect of each Loan upon Utilisation.

"Licence" means the licence issued by Monitor to any person who provides a health care service for the purposes of the NHS.

"Limits" means the Deficit Limit and/or the Capital Limit where set out in the Finance Document

"Loan" means a loan made or to be made under the Facility or the principal amount outstanding for the time being of that loan.

"Material Adverse Effect" means a material adverse effect on:

(A) the business or financial condition of the Borrower;

(B) the ability of the Borrower to perform any of its material obligations under any Finance Document;

(C) the validity or enforceability of any Finance Document; or

(D) any right or remedy of the Lender in respect of a Finance Document.

"Minimum Cash Balance" means £[ ];

"**Monitor**" means the sector regulator for health care services in England or any successor body to that organisation

"Month" means a period starting on one day in a calendar month and ending on the numerically corresponding day in the next calendar month, except that:

(A) (subject to paragraph (C) below) if the numerically corresponding day is not a Business Day, that period shall end on the next Business Day in that calendar month in which that period is to end if there is one, or if there is not, on the immediately preceding Business Day;

(B) if there is no numerically corresponding day in the calendar month in which that period is to end, that period shall end on the last Business Day in that calendar month; and

(C) if a period begins on the last Business Day of a calendar month, that period shall end on the last Business Day in the calendar month in which that period is to end,

provided that the above rules will only apply to the last Month of any period.

"NHS Body" means either an NHS Trust or an NHS Foundation Trust , or any successor body to that organisation**.**

"NHS Improvement" means the body incorporating the roles of Monitor and the NHS Trust Development Authority and acting as the health sector regulator providing healthcare transformation, regulatory and patient safety expertise.

"NHS Trust Development Authority" means the body responsible for monitoring the performance of NHS Trusts and providing assurance of clinical quality, governance and risk in NHS Trusts, or any successor body to that organisation;

"Original Financial Statements" means a certified copy of the audited financial statements of the Borrower for the financial year ended 31st March 2015.

"Participating Member State" means any member state of the European Communities that adopts or has adopted the euro as its lawful currency in accordance with legislation of the European Community relating to Economic and Monetary Union.

"Party" means a party to this Agreement.

"Permitted Security" means:

(A) normal title retention arrangements arising in favour of suppliers of goods acquired by the Borrower in the ordinary course of its business or arising under conditional sale or hiring agreements in respect of goods acquired by the Borrower in the ordinary course of its business;

(B) liens arising by way of operation of law in the ordinary course of business so long as the amounts in respect of which such liens arise are not overdue for payment;

(C) any existing Security listed in Schedule 7;

(D) any Security created or outstanding with the prior written consent of the Lender; and

(E) any other Security securing in aggregate not more than £150,000 at any time.

"Relevant Consents" means any authorisation, consent, approval, resolution, licence, exemption, filing, notarisation or registration of whatsoever nature necessary or appropriate to be obtained for the purpose of entering into and performing the Borrower's obligations under the Finance Documents.

"Relevant Percentage" means in respect of each Repayment Date, the percentage figure set opposite such Repayment Date in the Repayment Schedule.

"Repayment Dates" means the repayment dates set out in the Schedule 6 (Repayment Schedule).

"Repayment Instalment" means each instalment for the repayment of the Loan referred to in Clause 6.2.

"Repayment Schedule" means the repayment schedule set out in Schedule 6 (*Repayment Schedule*).

"Repeating Representations" means each of the representations set out in Clause 14 (*Representations*) other than those under Clauses 14.9, 14.10, 14.12.2 and 14.16.2.

"Security" means a mortgage, charge, pledge, lien or other security interest securing any obligation of any person or any other agreement or arrangement having a similar effect.

"Supervisory Body" means NHS Improvement, incorporating and representing both of the bodies previously known as the NHS Trust Development Authority and Monitor..

"Tax" means any tax, levy, impost, duty or other charge or withholding of a similar nature (including any penalty or interest payable in connection with any failure to pay or any delay in paying any of the same).

"Tax Deduction" means a deduction or withholding for or on account of Tax from a payment under a Finance Document.

"Test Date" means the Utilisation Date and each Interest Payment Date.

"Unpaid Sum" means any sum due and payable but unpaid by the Borrower under the Finance Documents.

"Utilisation" means a utilisation of the Facility.

"Utilisation Date" means the date of a Utilisation, on which a drawing is to be made under the Facility, such date to be the Monday preceding the 18th day of any month.

"Utilisation Request" means a notice substantially in the form set out in Schedule 2 (*Utilisation Request*).

"VAT" means value added tax as provided for in the Value Added Tax Act 1994 and other tax of a similar nature, whether imposed in the UK or elsewhere.

1.2 **Construction**

1.2.1 Unless a contrary indication appears, any reference in any Finance Document to:

(A) the **"Lender"**, the **"Borrower"** the **"Supervisory Body"** or any **"Party"** shall be construed so as to include its successors in title, permitted assigns and permitted transferees;

(B) **"assets"** includes present and future properties, revenues and rights of every description;

(C) a **"Finance Document"** or any other agreement or instrument is a reference to that Finance Document or other agreement or instrument as amended or novated;

(D) **"indebtedness"** shall be construed so as to include any obligation (whether incurred as principal or as surety) for the payment or repayment of money, whether present or future, actual or contingent;

(E) a **"person"** includes any person, firm, company, corporation, government, state or agency of a state or any association, trust or partnership (whether or not having separate legal personality) or two or more of the foregoing;

(F) a **"regulation"** includes any regulation, rule, official directive, request or guideline (whether or not having the force of law) of any governmental, intergovernmental or supranational body, agency, department or regulatory, self-regulatory or other authority or organisation;

(G) **"repay"** (or any derivative form thereof) shall, subject to any contrary indication, be construed to include **"prepay"** (or, as the case may be, the corresponding derivative form thereof);

(H) a provision of law is a reference to that provision as amended or re-enacted;

(I) a time of day is a reference to London time; and

(J) the word **"including"** is without limitation.

1.2.2 Section, Clause and Schedule headings are for ease of reference only.

1.2.3 Unless a contrary indication appears, a term used in any other Finance Document or in any notice given under or in connection with any Finance Document has the same meaning in that Finance Document or notice as in this Agreement.

1.2.4 A Default (other than an Event of Default) is **"continuing"** if it has not been remedied or waived and an Event of Default is **"continuing"** if it has not been waived or remedied to the satisfaction of the Lender.

1.3 **Third party rights**

1.3.1 Except as provided in a Finance Document, the terms of a Finance Document may be enforced only by a party to it and the operation of the Contracts (Rights of Third Parties) Act 1999 is excluded.

1.3.2 Notwithstanding any provision of any Finance Document, the Parties to a Finance Document do not require the consent of any third party to rescind or vary any Finance Document at any time.

2. THE FACILITY

2.1 Subject to the terms of this Agreement, the Lender makes available to the Borrower an uncommitted sterling interim support facility in an aggregate amount equal to the Facility Amount under the terms of which the Lender may, in its sole and absolute discretion, provide Loans to the Borrower from time to time, unless the Lender, in its sole and absolute discretion, has previously notified the Borrower of the termination of the Facility.

2.2 This agreement is not, nor shall it be deemed to constitute, a commitment on the part of the Lender to make any extension of credit to or for the account of the borrower and may not be relied upon by the Borrower for any financing.

2.3 The Lender reserves the right to revoke or withdraw this agreement and the facility in its sole and absolute discretion at any time.

2.4 The Facility shall be utilised by the Borrower for the purposes of and/or in connection with its functions as an NHS Body.

3. PURPOSE

3.1 Purpose

The Borrower shall apply all Loans towards financing or refinancing the Agreed Purpose.

3.2 Pending application

Without prejudice to Clause 3.1 *(Purpose)*, pending application of the proceeds of any Loan towards financing or refinancing the Agreed Purpose, the Borrower must deposit such proceeds in the Account.

3.3 Monitoring

The Lender is not bound to monitor or verify the application of any amount borrowed pursuant to this Agreement.

4. CONDITIONS OF UTILISATION

4.1 Initial conditions precedent

The Borrower may not deliver the first Utilisation Request unless the Lender has received all of the documents and other evidence listed in Schedule 1 (*Conditions precedent*) in form and substance satisfactory to the Lender or to the extent it has not received the same, it has waived receipt of the same. The Lender shall notify the Borrower promptly upon being so satisfied.

4.2 Further conditions precedent

The Lender will only comply with a Utilisation Request if on the date of the Utilisation Request and on the proposed Utilisation Date:

4.2.1 No Event of Default might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware;

4.2.2 the Repeating Representations to be made by the Borrower with reference to the facts and circumstances then subsisting are true in all material respects; and,

4.2.3 the Borrower has provided to the Lender its most recent 13 week cash flow forecast, together with any other information that may from time to time be required.

5. UTILISATION

5.1 Utilisation

5.1.1 The Borrower may take Loans from time to time hereunder, subject to receipt by the Lender from the Borrower, of a Utilisation Request in accordance with this Agreement and an appropriate Cashflow Forecast.

5.1.2 The Utilisation Request must be for an amount not greater than the amount specified under Clause 5.4.2

5.1.3 Where agreed by the Lender, the proceeds of a Utilisation may be used to repay outstanding loans under any working capital facility between the Lender and the Borrower provided that:

(A) Such agreement is granted by the Lender;

(B) any request is included in the Cashflow Forecast; and

(C) that such repayment is received by the Lender on the same working day as the Utilisation.

5.2 Delivery of a Utilisation Request

The Borrower may utilise the Facility by delivery to the Lender of a duly completed Utilisation Request not later than 11.00 a.m. five Business Days before the proposed Utilisation Date unless otherwise agreed.

5.2.1 The Borrower may only issue one Utilisation Request per Month unless otherwise agreed.

5.3 Completion of a Utilisation Request

The Utilisation Request is irrevocable and will not be regarded as having been duly completed unless:

(A) the proposed Utilisation Date is a Business Day within the Availability Period; and

(B) the currency and amount of the Utilisation comply with Clause 5.4 (*Currency and amount*).

5.4 Currency and amount

5.4.1 The currency specified in the Utilisation Request must be sterling.

5.4.2 The amount of each proposed Loan must be an amount which is not more than the amount required to maintain a Cash Balance equivalent to the Minimum Cash Balance for a period from the Utilisation Date to the Monday preceding the 18th day of the following Month

5.4.3 The amount of each proposed Loan must be an amount which is not more than the Available Facility and which is a minimum of £150,000 or, if less, the Available Facility.

5.5 **Payment to the Account**

The Lender shall pay each Loan:

5.5.1 by way of credit to the Account and so that, unless and until the Lender shall notify the Borrower to the contrary, the Lender hereby consents to the withdrawal by the Borrower from the Account of any amount equal to the relevant Loan provided that any sums so withdrawn are applied by the Borrower for the purposes for which the relevant Loan was made;

5.5.2 if the Lender so agrees or requires, on behalf of the Borrower directly to the person to whom the relevant payment is due as specified in the relevant Utilisation Request; or

5.5.3 in such other manner as shall be agreed between the Lender and the Borrower.

6. PAYMENTS AND REPAYMENT

6.1 **Payments**

6.1.1 The Borrower shall make all payments payable under the Finance Documents without any Tax Deductions, unless a Tax Deduction is required by law.

6.1.2 The Borrower shall promptly upon becoming aware that it must make a Tax Deduction (or that there is any change in the rate or the basis of a Tax Deduction) notify the Lender accordingly.

6.1.3 If a Tax Deduction is required by law to be made by the Borrower, the amount of the payment due from the Borrower shall be increased to an amount which (after making any Tax Deduction) leaves an amount equal to the payment which would have been due if no Tax Deduction had been required.

6.1.4 If the Borrower is required to make a Tax Deduction, the Borrower shall make that Tax Deduction and any payment required in connection with that Tax Deduction within the time allowed and in the minimum amount required by law.

6.1.5 Within thirty days of making either a Tax Deduction or any payment required in connection with that Tax Deduction, the Borrower shall deliver to the Lender evidence reasonably satisfactory to the Lender that the Tax Deduction has been made or (as applicable) any appropriate payment paid to the relevant taxing authority.

6.2 **Repayment**

The Borrower shall repay the aggregate value of all outstanding Loans drawn under the Facility in full on or before the last day of the current Availability Period as set out in Schedule 6 *(Repayment Schedule)*.

6.3 **Reborrowing**

The Borrower may not reborrow any part of the Facility which is repaid or prepaid.

7. PREPAYMENT AND CANCELLATION

7.1 **Illegality**

If it becomes unlawful in any applicable jurisdiction for the Lender to perform any of its obligations as contemplated by this Agreement or to fund or maintain all or any part of the Loans:

7.1.1 the Lender shall promptly notify the Borrower upon becoming aware of that event;

7.1.2 upon the Lender notifying the Borrower, the Available Facility will be immediately cancelled; and

7.1.3 the Borrower shall repay such Loans on the last day of the Interest Period for Loans occurring after the Lender has notified the Borrower or, if earlier, the date specified by the Lender in the notice delivered to the Borrower (being no earlier than the last day of any applicable grace period permitted by law).

7.2 **Voluntary cancellation**

The Borrower may, if it gives the Lender not less than seven days' (or such shorter period as the Lender may agree) and not more than fourteen days' prior notice, cancel the whole or any part (being a minimum amount of £100,000) of the Facility Amount.

7.3 **Voluntary prepayment of Loans**

The Borrower may, if it gives the Lender not less than seven days' (or such shorter period as the Lender may agree) and not more than thirty days' prior notice, prepay the whole or any part of any Loan (but, if in part, being an amount that reduces the amount of the Loan by a minimum amount of £250,000).

7.4 **Restrictions**

7.4.1 Any notice of cancellation or prepayment given by any Party under this Clause 7 shall be irrevocable and, unless a contrary indication appears in this Agreement, shall specify the date or dates upon which the relevant cancellation or prepayment is to be made and the amount of that cancellation or prepayment.

7.4.2 Any prepayment under this Agreement shall be made together with accrued interest on the amount prepaid without premium or penalty and applied against the outstanding Repayment Instalments in inverse order of maturity.

7.4.3 The Borrower shall not repay or prepay all or any part of the Loan or cancel all or any part of the Available Facility except at the times and in the manner expressly provided for in this Agreement.

7.4.4 No amount of the Available Facility cancelled under this Agreement may be subsequently reinstated.

7.5 **Automatic Cancellation**

At the end of the Availability Period the undrawn part of the Available Facility will be cancelled.

8. INTEREST

8.1 **Calculation of interest**

The rate of interest on each Loan for each Interest Period is the Interest Rate.

8.2 **Payment of interest**

The Borrower shall pay accrued interest on each Loan on the last day of each Interest Period.

8.3 **Default interest**

8.3.1 If the Borrower fails to pay any amount payable by it under a Finance Document on its due date, interest shall accrue on Unpaid Sums from the due date up to the date of actual payment (both before and after judgment) at the Default Rate. Any interest

accruing under this Clause 8.3 shall be immediately payable by the Borrower on demand by the Lender.

8.3.2 Default interest (if unpaid) arising on an overdue amount will be compounded with the overdue amount at the end of each Interest Period applicable to that overdue amount but will remain immediately due and payable.

9. INTEREST PERIODS

9.1 Interest Payment Dates

The Interest Period for each Loan shall be six Months, provided that any Interest Period which begins during another Interest Period shall end at the same time as that other Interest Period (and, where two or more such Interest Periods expire on the same day, the Loans to which those Interest Periods relate shall thereafter constitute and be referred to as one Loan).

9.2 Shortening Interest Periods

If an Interest Period would otherwise overrun the relevant Repayment Date, it shall be shortened so that it ends on the relevant Repayment Date.

9.2A Payment Start Date

Each Interest Period for a Loan shall start on the Utilisation Date or (if already made) on the last day of its preceding Interest Period.

9.3 Non-Business Days

If an Interest Period would otherwise end on a day which is not a Business Day, that Interest Period will instead end on the next Business Day in that calendar month (if there is one) or the preceding Business Day (if there is not).

9.4 Consolidation of Loans

If two or more Interest Periods end on the same date, those Loans will be consolidated into and be treated as a single Loan on the last day of the Interest Period.

10. PREPAYMENT AMOUNT

10.1.1 If all or any part of the Loans are subject to a voluntary prepayment pursuant to Clause 7.3 (*Voluntary prepayment of Loans*), the Borrower shall pay to the Lender on the relevant prepayment date the Prepayment Amount in respect of the same.

10.1.2 For as long as the Secretary of State for Health remains the Lender, the Lender will consider waiving the Prepayment Amount in cases where the Borrower can demonstrate to the Lender's satisfaction that the voluntary prepayment results from the Borrower's proper use of genuine surplus funds resulting from a sale of assets or trading activities.

11. INDEMNITIES

11.1 Currency indemnity

11.1.1 If any sum due from the Borrower under the Finance Documents (a **"Sum"**), or any order, judgment or award given or made in relation to a Sum, has to be converted from the currency (the **"First Currency"**) in which that Sum is payable into another currency (the **"Second Currency"**) for the purpose of:

(A) making or filing a claim or proof against the Borrower;

(B) obtaining or enforcing an order, judgment or award in relation to any litigation or arbitration proceedings,

the Borrower shall as an independent obligation, within five Business Days of demand, indemnify the Lender against any cost, loss or liability arising out of or as a result of the conversion including any discrepancy between (A) the rate of exchange used to convert that Sum from the First Currency into the Second Currency and (B) the rate or rates of exchange available to that person at the time of its receipt of that Sum.

11.1.2 The Borrower waives any right it may have in any jurisdiction to pay any amount under the Finance Documents in a currency or currency unit other than that in which it is expressed to be payable.

11.2 **Other indemnities**

The Borrower shall, within five Business Days of demand, indemnify the Lender against any cost, loss or liability incurred by the Lender as a result of:

11.2.1 the occurrence of any Event of Default;

11.2.2 a failure by the Borrower to pay any amount due under a Finance Document on its due date;

11.2.3 funding, or making arrangements to fund, all or any part of the Loans requested by the Borrower in a Utilisation Request but not made by reason of the operation of any one or more of the provisions of this Agreement (other than by reason of default or negligence by the Lender alone); or

11.2.4 the Loans (or part of the Loans) not being prepaid in accordance with a notice of prepayment given by the Borrower.

11.3 **Indemnity to the Lender**

The Borrower shall promptly indemnify the Lender against any cost, loss or liability incurred by the Lender (acting reasonably) as a result of:

11.3.1 investigating any event which it reasonably believes is a Default; or

11.3.2 acting or relying on any notice, request or instruction which it reasonably believes to be genuine, correct and appropriately authorised.

11.4 **Environmental indemnity**

The Borrower shall promptly indemnify the Lender within five Business Days of demand in respect of any judgments, liabilities, claims, fees, costs and expenses (including fees and disbursements of any legal, environmental consultants or other professional advisers) suffered or incurred by the Lender as a consequence of the breach of or any liability imposed under any Environmental Law with respect to the Borrower or its property (including the occupation or use of such property).

12. MITIGATION BY THE LENDER

12.1 **Mitigation**

12.1.1 The Lender shall, in consultation with the Borrower, take all reasonable steps to mitigate any circumstances which arise and which would result in any amount becoming payable under or pursuant to, or cancelled pursuant to Clause 7.1

(Illegality) including transferring its rights and obligations under the Finance Documents to another entity owned or supported by the Lender.

12.1.2 Clause 12.1.1 does not in any way limit the obligations of the Borrower under the Finance Documents.

12.2 **Limitation of liability**

12.2.1 The Borrower shall indemnify the Lender for all costs and expenses reasonably incurred by the Lender as a result of steps taken by it under Clause 12.1 (Mitigation).

12.2.2 The Lender is not obliged to take any steps under Clause 12.1 (Mitigation) if, in its opinion (acting reasonably), to do so might be prejudicial to it.

13. COSTS AND EXPENSES

13.1 **Enforcement costs**

The Borrower shall, within three Business Days of demand, pay to the Lender the amount of all costs and expenses (including legal fees) incurred by the Lender in connection with the enforcement of, or the preservation of any rights under, any Finance Document.

14. REPRESENTATIONS

The Borrower makes the representations and warranties set out in this Clause 14 to the Lender on the date of this Agreement.

14.1 **Status**

14.1.1 It is an NHS Body in accordance with the provisions of the Act.

14.1.2 It has the power to own its assets and carry on its business as it is being conducted.

14.2 **Binding obligations**

The obligations expressed to be assumed by it in each Finance Document are legal, valid, binding and enforceable obligations.

14.3 **Non-conflict with other obligations**

The entry into and performance by it of, and the transactions contemplated by, the Finance Documents to which it is party do not and will not conflict with:

14.3.1 any law or regulation applicable to it;

14.3.2 its constitutional documents; or

14.3.3 any agreement or instrument binding upon it or any of its assets.

14.4 **Power and authority**

It has the power to enter into, exercise its rights under, perform and deliver, and has taken all necessary action to authorise its entry into, performance and delivery of, the Finance Documents to which it is a party and the transactions contemplated by those Finance Documents.

14.5 **Validity and admissibility in evidence**

All Authorisations required:

14.5.1 to enable it lawfully to enter into, exercise its rights and comply with its obligations in the Finance Documents to which it is a party; and

14.5.2 to make the Finance Documents to which it is a party admissible in evidence in its jurisdiction of incorporation,

have been obtained or effected and are in full force and effect.

14.6 **Relevant Consents**

14.6.1 All Relevant Consents which it is necessary or appropriate for the Borrower to hold have been obtained and effected and are in full force and effect.

14.6.2 There exists no reason known to it, having made all reasonable enquiries, why any Relevant Consent might be withdrawn, suspended, cancelled, varied, surrendered or revoked.

14.6.3 All Relevant Consents and other consents, permissions and approvals have been or are being complied with.

14.7 **Governing law and enforcement**

14.7.1 The choice of English law as the governing law of the Finance Documents will be recognised and enforced by the courts of England and Wales.

14.7.2 Any judgment obtained in England in relation to a Finance Document will be recognised and enforced by the courts of England and Wales.

14.8 **Deduction of Tax**

It is not required to make any deduction for or on account of Tax from any payment it may make under any Finance Document.

14.9 **No filing or stamp taxes**

It is not necessary that the Finance Documents be filed, recorded or enrolled with any court or other authority in any jurisdiction or that any stamp, registration or similar tax be paid on or in relation to the Finance Documents or the transactions contemplated by the Finance Documents.

14.10 **No default**

14.10.1 No Event of Default might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware.

14.10.2 No other event which constitutes a default under any other agreement or instrument which is binding on it or to which its assets are subject which might have a Material Adverse Effect might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware.

14.11 **No misleading information**

14.11.1 All factual information provided by or on behalf of the Borrower in connection with the Borrower or any Finance Document was true and accurate in all material respects as at the date it was provided or as at the date (if any) at which it is stated.

14.11.2 Any financial projections provided to the Lender by or on behalf of the Borrower have been prepared on the basis of recent historical information and on the basis of reasonable assumptions.

14.11.3 Nothing has occurred or been omitted and no information has been given or withheld that results in the information referred to in Clause 14.12.1 being untrue or misleading in any material respect.

14.12 **Financial statements**

14.12.1 Its financial statements most recently delivered to the Lender (being on the date of this Agreement, the Original Financial Statements) were prepared in accordance with any applicable Audit Code for NHS Bodies, any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies and/or any other guidance with which NHS Bodies are (or in the case of the Original Financial Statements were) required to comply.

14.12.2 Its financial statements most recently delivered to the Lender (being on the date of this Agreement, the Original Financial Statements) fairly represent its financial condition and operations during the relevant financial year.

14.12.3 There has been no material adverse change in the business or financial condition of the Borrower since the date to which its financial statements most recently delivered to the Lender were made up.

14.13 **Ranking**

Its payment obligations under the Finance Documents rank at least pari passu with the claims of all its other unsecured and unsubordinated creditors, except for obligations mandatorily preferred by law.

14.14 **No proceedings pending or threatened**

No litigation, arbitration or administrative proceedings of or before any court, arbitral body or agency which, if adversely determined, might reasonably be expected to have a Material Adverse Effect have (to the best of its knowledge and belief) been started or threatened against it.

14.15 **Environmental Matters**

14.15.1 It is and has been in full compliance with all applicable Environmental Laws and there are, to the best of its knowledge and belief after reasonable enquiry, no circumstances that may prevent or interfere with such full compliance in the future, in each case to the extent necessary to avoid a Material Adverse Effect and the Borrower has not other than in the ordinary course of its activities placed or allowed to be placed on any part of its property any Dangerous Substance and where such Dangerous Substance has been so placed, it is kept, stored, handled, treated and transported safely and prudently so as not to pose a risk of harm to the Environment.

14.15.2 It is and has been, in compliance in all material respects with the terms of all Environmental Licences necessary for the ownership and operation of its activities as presently owned and operated and as presently proposed to be owned and operated.

14.15.3 It is not aware, having made reasonable enquiries, of any Environmental Claim.

14.16 **Repetition**

The Repeating Representations are deemed to be made by the Borrower by reference to the facts and circumstances then existing on the date of each Utilisation Request and on the first day of each Interest Period.

15. INFORMATION UNDERTAKINGS

The undertakings in this Clause 15 remain in force from the date of this Agreement for so long as any amount is outstanding under the Finance Documents or any part of the Facility is available for utilisation.

15.1 Financial statements

The Borrower shall supply to the Lender its audited financial statements for each financial year and its financial statements for each financial half year (including any monitoring returns sent to the appropriate Supervisory Body), in each case when such statements are provided to the appropriate Supervisory Body.

15.2 Requirements as to financial statements

15.2.1 Each set of financial statements delivered by the Borrower pursuant to Clause 15.1 (Financial statements) shall be certified by a director of the Borrower, acting on the instructions of the board of directors of the Borrower, as fairly representing its financial condition as at the date as at which those financial statements were drawn up.

15.2.2 The Borrower shall procure that each set of financial statements delivered pursuant to Clause 15.1 (Financial statements) is prepared in accordance with any applicable Audit Code for NHS Bodies and any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies or in the case of the Original Financial Statements in accordance with such guidelines with which NHS Bodies are required to comply.

15.3 Information: miscellaneous

The Borrower shall supply to the Lender:

15.3.1 copies or details of all material communications between the Borrower and the relevant Supervisory Body, including all relevant official notices received by the Borrower promptly after the same are made or received and, upon the Lender's request, any other relevant documents, information and returns sent by it to the appropriate Supervisory Body;

15.3.2 copies or details of all material communications between the Borrower and its members or its creditors (or in each case any class thereof), including all official notices received by the Borrower promptly after the same are made or received and upon the Lender's request any and all other documents dispatched by it to its members or its creditors (or in each case any class thereof), promptly after they are sent to such members or creditors;

15.3.3 details of any breaches by the Borrower of the Compliance Framework;

15.3.4 details of any breaches by the Borrower of the Licence or the terms of their Licence;

15.3.5 details of any other financial assistance or guarantee requested or received from the Secretary of State for Health other than in the ordinary course of business promptly after the same are requested or received;

15.3.6 upon the Lender's request, information regarding the application of the proceeds of the Facility;

15.3.7 promptly upon becoming aware of them, the details of any litigation, arbitration and/or administrative proceedings which are current, threatened or pending against the Borrower which would reasonably be expected to have a Material Adverse Effect;

15.3.8 promptly, such further information regarding the financial condition, business and operations of the Borrower as the Lender may reasonably request to the extent the same are relevant to the Borrower's obligations under this Agreement or otherwise significant in the assessment of the Borrower's financial performance and further to the extent that the disclosure of information will not cause the Borrower to be in breach of any obligation of confidence owed to any third party or any relevant data protection legislation; and

15.3.9 any change in the status of the Borrower after the date of this Agreement

15.4 **Notification of default**

15.4.1 The Borrower shall notify the Lender of any Default (and the steps being taken to remedy it) promptly upon becoming aware of its occurrence.

15.4.2 Promptly upon a request by the Lender, the Borrower shall supply a certificate signed by two of its directors (acting on the instructions of the board of directors of the Borrower) on its behalf certifying that no Default is continuing (or if a Default is continuing, specifying the Default and the steps, if any, being taken to remedy it).

15.5 **Other information**

The Borrower shall promptly upon request by the Lender supply, or procure the supply of, such documentation and other evidence as is reasonably requested by the Lender (for itself or on behalf of a prospective transferee) in order for the Lender (or such prospective transferee) to carry out and be satisfied with the results of all necessary money laundering and identification checks in relation to any person that it is required to carry out pursuant to the transactions contemplated by the Finance Documents.

16. GENERAL UNDERTAKINGS

The undertakings in this Clause 16 remain in force from the date of this Agreement for so long as any amount is outstanding under the Finance Documents or any part of the Facility is available for utilisation.

16.1 **Authorisations**

The Borrower shall promptly:

16.1.1 obtain, comply with and do all that is necessary to maintain in full force and effect; and

16.1.2 supply certified copies to the Lender of any Authorisation required under any law or regulation of its jurisdiction of incorporation to enable it to perform its obligations under the Finance Documents and to ensure the legality, validity, enforceability or admissibility in evidence in England of any Finance Document.

16.2 **Compliance with laws**

The Borrower shall comply in all respects with all laws to which it may be subject, if failure so to comply would materially impair its ability to perform its obligations under the Finance Documents and shall exercise its powers and perform its functions in accordance with its constitutional documents.

16.3 **Negative pledge**

16.3.1 The Borrower shall not without the prior written consent of the Lender (such consent not to be unreasonably withheld or delayed) create or permit to subsist any Security over any of its assets save for any Permitted Security.

16.3.2 The Borrower shall not:

(A) sell, transfer or otherwise dispose of any of its assets on terms whereby they are or may be leased to or re-acquired by it;

(B) sell, transfer or otherwise dispose of any of its receivables on recourse terms;

(C) enter into any arrangement under which money or the benefit of a bank or other account may be applied, set-off or made subject to a combination of accounts; or

(D) enter into any other preferential arrangement having a similar effect,

in circumstances where the arrangement or transaction is entered into primarily as a method of raising Financial Indebtedness or of financing the acquisition of an asset.

16.4 **Disposals**

16.4.1 The Borrower shall not in a single transaction or a series of transactions (whether related or not) and whether voluntary or involuntary sell, lease, transfer or otherwise dispose of any material asset without the prior written consent of the Lender.

16.4.2 Clause 16.4.1 does not apply to:

(A) any sale, lease, transfer or other disposal where the higher of the market value or consideration receivable does not (in aggregate) in any financial year exceed 10% of the total net assets of the Borrower as at the end of the most recent financial year end for which audited financial statements have been published.

(B) any sale, lease, transfer or other disposal expressly identified in Schedule 8..

16.5 **Merger**

Without prejudice to Clause 16.4 (disposals) the Borrower shall not, without the prior written consent of the Lender, enter into nor apply to the relevant Supervisory Body (including pursuant to Section 56 of the Act) to enter into any amalgamation, demerger, merger or corporate reconstruction.

16.6 **Guarantees**

The Borrower will not, without the prior written consent of the Lender, give or permit to exist any guarantee or indemnity by it of any obligation of any person, nor permit or suffer any person to give any security for or guarantee or indemnity of any of its obligations except for guarantees and indemnities:

16.6.1 made in the ordinary course of the Borrower's business as an NHS Body ; and

16.6.2 which when aggregated with any loans, credit or financial accommodation made pursuant to Clause 16.7 (*Loans*) do not exceed £1,000,000 (or its equivalent in any other currency or currencies) in aggregate in any financial year.

16.7 **Loans**

The Borrower will not make any investment in nor make any loan or provide any other form of credit or financial accommodation to, any person except for investments, loans, credit or financial accommodation:

16.7.1 made in the ordinary course of the Borrower's business as an NHS Body ;

16.7.2 made in accordance with any investment policy or guidance issued by the relevant Supervisory Body; and

16.7.3 which when aggregated with any guarantees or indemnities given or existing under Clause 16.6 (*Guarantees*) do not exceed £1,000,000 (or its equivalent in any other currency or currencies) in aggregate in any financial year.

16.8 **Consents**

The Borrower must ensure that all Relevant Consents and all statutory requirements, as are necessary to enable it to perform its obligations under the Finance Documents to which it is a party, are duly obtained and maintained in full force and effect or, as the case may be, complied with.

16.9 **Activities**

The Borrower will not engage in any activities other than activities which enable it to carry on its principal purpose better, if to do so may, in the Lender's opinion, have a Material Adverse Effect.

16.10 **Environmental**

The Borrower shall:

16.10.1 obtain, maintain and comply in all material respects with all necessary Environmental Licences in relation to its activities and its property and comply with all Environmental Laws to the extent necessary to avoid a Material Adverse Effect;

16.10.2 promptly upon becoming aware notify the Lender of:

(A) any Environmental Claim current or to its knowledge threatened;

(B) any circumstances likely to result in an Environmental Claim; or

(C) any suspension, revocation or notification of any Environmental Licence;

16.10.3 indemnify the Lender against any loss or liability which:

(A) the Lender incurs as a result of any actual or alleged breach of any Environmental Law by any person; and

(B) which would not have arisen if a Finance Document had not been entered into; and

16.10.4 take all reasonable steps to ensure that all occupiers of the Borrower's property carry on their activities on the property in a prudent manner and keep them secure so as not to cause or knowingly permit material harm or damage to the Environment (including nuisance or pollution) or the significant risk thereof.

16.11 **Constitution**

The Borrower will not amend or seek to amend the terms of its authorisation as an NHS Body or the terms of its constitution without the prior written consent of the Lender, in each case if to do so would be reasonably likely to have a Material Adverse Effect.

16.12 **The relevant Supervisory Body**

The Borrower will comply promptly with all directions and notices received from the relevant Supervisory Body to the extent failure to do so might have a Material Adverse Effect and will, upon the Lender's request, provide reasonable evidence that it has so complied.

16.13 **Additional Terms and Conditions**

The Borrower will comply promptly with the Additional Terms and Conditions.

17. COMPLIANCE FRAMEWORK

17.1 **Compliance**

The Borrower shall ensure at all times that it complies with its Licence and/or any other terms and conditions set by the relevant Supervisory Body.

17.2 **Advance Notification**

Without prejudice to the Borrower's obligations under Clause 17.1 (*Compliance*), if the Borrower becomes aware at any time after the date of signing of the Agreement that it is or is likely to breach any of the terms referred to in Clause 17.1 and/or a material failure under the requirements of the Compliance Framework is likely, it shall immediately notify the Lender of the details of the impending breach.

18. EVENTS OF DEFAULT

Each of the events or circumstances set out in this Clause 18 is an Event of Default.

18.1 **Non-payment**

The Borrower does not pay on the due date any amount payable pursuant to a Finance Document at the place at and in the currency in which it is expressed to be payable unless:

18.1.1 its failure to pay is caused by administrative or technical error; and

18.1.2 payment is made within two Business Days of its due date.

18.2 **Compliance Framework and Negative Pledge**

Any requirement of Clause 17 (*COMPLIANCE FRAMEWORK*) or Clause 16.3 (*Negative Pledge*) is not satisfied.

18.3 **Other obligations**

18.3.1 The Borrower does not comply with any term of:

(A) Clause 15.5 (*Notification of default*); or

(B) Clause 16 (*General Undertakings*).

18.3.2 The Borrower does not comply with any term of any Finance Document (other than those referred to in Clause 18.1 (*Non-payment*), Clause 18.2 (*Compliance Framework and Negative Pledge*) and Clause 18.3.1(*Other obligations*) unless the failure to comply is capable of remedy and is remedied within ten Business Days of the earlier of the Lender giving notice or the Borrower becoming aware of the failure to comply.

18.4 **Misrepresentation**

Any representation or statement made or deemed to be made by the Borrower in any Finance Document or any other document delivered by or on behalf of the Borrower under or in connection with any Finance Document is or proves to have been incorrect or misleading in any material respect when made or deemed to be made.

18.5 **Cross default**

18.5.1 Any Financial Indebtedness of the Borrower is not paid when due nor within any originally applicable grace period.

18.5.2 Any Financial Indebtedness of the Borrower is declared to be or otherwise becomes due and payable prior to its specified maturity as a result of an event of default (however described).

18.5.3 Any commitment for any Financial Indebtedness of the Borrower is cancelled or suspended by a creditor of the Borrower as a result of an event of default (however described).

18.5.4 Any creditor of the Borrower becomes entitled to declare any Financial Indebtedness of the Borrower due and payable prior to its specified maturity as a result of an event of default (however described).

18.5.5 No Event of Default will occur under this Clause 18.5 if the aggregate amount of Financial Indebtedness or commitment for Financial Indebtedness falling within Clauses 18.5.1 to 18.5.4 is less than £250,000 (or its equivalent in any other currency or currencies).

except that for as long as the Secretary of State for Health remains the Lender, the provisions of Clause 18.5 relate to Financial Indebtedness owed to any party but do not apply to amounts owed to other NHS bodies in the normal course of business where a claim has arisen which is being disputed in good faith or where the Borrower has a valid and contractual right of setoff.

18.6 **Insolvency**

18.6.1 The Borrower is unable or admits inability to pay its debts as they fall due, suspends making payments on any of its debts or, by reason of actual or anticipated financial difficulties, commences negotiations with one or more of its creditors with a view to rescheduling any of its indebtedness.

18.6.2 A moratorium is declared in respect of any indebtedness of the Borrower.

18.7 **Insolvency proceedings**

Any corporate action, legal proceedings or other procedure or step is taken:

18.7.1 in relation to a composition, assignment or arrangement with any creditor of the Borrower; or

18.7.2 in relation to the appointment of a liquidator, receiver, administrator, administrative receiver, compulsory manager or other similar officer in respect of the Borrower or any of its assets; or

18.7.3 in relation to the enforcement of any Security over any assets of the Borrower,

or any analogous action, proceedings, procedure or step is taken in any jurisdiction.

18.8 **Appointment of a Trust Special Administrator**

An order, made as required under The Act for the appointment of a Trust Special Administrator.

18.9 **Creditors' process**

Any expropriation, attachment, sequestration, distress or execution affects any asset or assets of the Borrower having an aggregate value of £250,000 and is not discharged within ten Business Days.

18.10 **Repudiation**

The Borrower or any other party to a Finance Document repudiates any of the Finance Documents or does or causes to be done any act or thing evidencing an intention to repudiate any Finance Document.

18.11 **Cessation of Business**

Other than with the prior written approval of the Lender, the Borrower ceases, or threatens to cease, to carry on all or a substantial part of its business or operations.

18.12 **Unlawfulness**

It is or becomes unlawful for the Borrower or any other party to a Finance Document to perform any of its obligations under any Finance Document.

18.13 **Material adverse change**

Any event or circumstance or series of events or circumstances occurs which, in the reasonable opinion of the Lender, has or is reasonably likely to have a Material Adverse Effect.

18.14 **Additional Terms and Conditions**

In the reasonable opinion of the Lender, the Borrower fails to make reasonable efforts to comply with the Additional Terms and Conditions.

18.15 **Acceleration**

On and at any time after the occurrence of an Event of Default which is continuing the Lender may by notice to the Borrower:

18.15.1 cancel the Facility whereupon it shall immediately be cancelled; and/or

18.15.2 declare that all or part of the Loans, together with accrued interest, and all other amounts accrued or outstanding under the Finance Documents be immediately due and payable, whereupon they shall become immediately due and payable; and/or

18.15.3 declare that all or part of the Loans be payable on demand, whereupon they shall immediately become payable on demand by the Lender.

19. ASSIGNMENTS AND TRANSFERS

19.1 **Assignments and transfers by the Lender**

Subject to this Clause 19, the Lender may:

19.1.1 assign any of its rights; or

19.1.2 transfer by novation any of its rights and obligations,

to another entity owned or supported by the Lender or to a bank or a financial institution or to a trust, fund or other entity which is regularly engaged in or established for the purpose of

making, purchasing or investing in loans, securities or other financial assets (the **"New Lender"**).

19.2 **Conditions of assignment or transfer**

19.2.1 The consent of the Borrower is required for an assignment or transfer by the Lender, unless:

(A) the assignment or transfer is to an entity owned or supported by the Lender; or

(B) a Default is continuing.

19.2.2 The consent of the Borrower to an assignment or transfer must not be unreasonably withheld or delayed. The Borrower will be deemed to have given its consent twenty Business Days after the Lender has requested it unless consent is expressly refused (and reasons for such refusal are given) by the Borrower within that time.

provided that nothing in this Clause shall restrict the rights of the Secretary of State for Health to effect a statutory transfer.

19.3 **Disclosure of information**

The Lender may disclose to any person:

19.3.1 to (or through) whom the Lender assigns or transfers (or may potentially assign or transfer) all or any of its rights and obligations under the Finance Documents;

19.3.2 with (or through) whom the Lender enters into (or may potentially enter into) any transaction under which payments are to be made by reference to, any Finance Document or the Borrower;

19.3.3 to whom, and to the extent that, information is required to be disclosed by any applicable law or regulation;

19.3.4 which are investors or potential investors in any of its rights and obligations under the Finance Documents and only to the extent required in relation to such rights and obligations;

19.3.5 which is a governmental, banking, taxation or other regulatory authority and only to the extent information is required to be disclosed to such authority,

any information about the Borrower and/or the Finance Documents as the Lender shall consider appropriate if, in relation to Clauses 19.3.1, 19.3.2 and 19.3.4 the person to whom the information is to be given has agreed to keep such information confidential on terms of this Clause 19.3 provided always that the Lender shall comply with any relevant data protection legislation.

19.4 **Assignment and transfer by the Borrower**

The Borrower may not assign any of its rights or transfer any of its rights or obligations under the Finance Documents.

20. ROLE OF THE LENDER

20.1 **Rights and discretions of the Lender**

20.1.1 The Lender may rely on:

(A) any representation, notice or document believed by it to be genuine, correct and appropriately authorised; and

(B) any statement made by a director, authorised signatory or authorised employee of any person regarding any matters which may reasonably be assumed to be within his knowledge or within his power to verify.

20.1.2 The Lender may engage, pay for and rely on the advice or services of any lawyers, accountants, surveyors or other experts.

20.1.3 The Lender may act in relation to the Finance Documents through its personnel and agents.

20.1.4 Notwithstanding any other provision of any Finance Document to the contrary, the Lender is not obliged to do or omit to do anything if it would or might in its reasonable opinion constitute a breach of any law or a breach of a fiduciary duty or duty of confidentiality.

20.2 **Exclusion of liability**

20.2.1 Without limiting Clause 20.2.2, the Lender will not be liable for any omission or any act taken by it under or in connection with any Finance Document, unless directly caused by its gross negligence or wilful misconduct.

20.2.2 The Borrower may not take any proceedings against any officer, employee or agent of the Lender in respect of any claim it might have against the Lender or in respect of any act or omission of any kind by that officer, employee or agent in relation to any Finance Document and any officer, employee or agent of the Lender may rely on this Clause. Any third party referred to in this Clause 20.2.2 may enjoy the benefit of or enforce the terms of this Clause in accordance with the provisions of the Contracts (Rights of Third Parties) Act 1999.

20.2.3 The Lender will not be liable for any delay (or any related consequences) in crediting an account with an amount required under the Finance Documents to be paid by the Lender if the Lender has taken all necessary steps as soon as reasonably practicable to comply with the regulations or operating procedures of any recognised clearing or settlement system used by the Lender for that purpose.

20.2.4 The Lender shall not be liable:

(A) for any failure by the Borrower to give notice to any third party or to register, file or record (or any defect in such registration, filing or recording) any Finance Document; or

(B) for any failure by the Borrower to obtain any licence, consent or other authority required in connection with any of the Finance Documents; or

(C) For any other omission or action taken by it in connection with any Finance Document unless directly caused by its gross negligence or wilful misconduct.

21. PAYMENT MECHANICS

21.1 **Payments**

21.1.1 The Borrower shall receive notification 10 working days prior to each payment required under a Finance Document, the Borrower shall make the same available to the Lender (unless a contrary indication appears in a Finance Document) for value on the due date at the time and in such funds specified by the Lender as being customary

at the time for settlement of transactions in the relevant currency in the place of payment.

21.1.2 Payment shall be collected through Direct Debit from a Borrower's account with the Government Banking Service.

21.2 **Distributions to the Borrower**

The Lender may (with the consent of the Borrower or in accordance with Clause 22 (*Set-off*)) apply any amount received by it for the Borrower in or towards payment (on the date and in the currency and funds of receipt) of any amount due from the Borrower under the Finance Documents or in or towards purchase of any amount of any currency to be so applied.

21.3 **Partial payments**

If the Lender receives a payment that is insufficient to discharge all the amounts then due and payable by the Borrower under the Finance Documents, the Lender shall apply that payment towards the obligations of the Borrower in such order and in such manner as the Lender may at its discretion decide.

21.4 **No set-off**

All payments to be made by the Borrower under the Finance Documents shall be calculated and be made without (and free and clear of any deduction for) set-off or counterclaim.

21.5 **Business Days**

21.5.1 Any payment which is due to be made on a day that is not a Business Day shall be made on the next Business Day in the same calendar month (if there is one) or the preceding Business Day (if there is not).

21.5.2 During any extension of the due date for payment of any principal or Unpaid Sum under this Agreement, interest is payable on the principal or Unpaid Sum at the rate payable on the original due date.

21.6 **Currency of account**

21.6.1 Subject to Clauses 21.6.2 to 21.6.5, sterling is the currency of account and payment for any sum due from the Borrower under any Finance Document.

21.6.2 A repayment of the Loan or Unpaid Sum or a part of the Loan or Unpaid Sum shall be made in the currency in which the Loan or Unpaid Sum is denominated on its due date.

21.6.3 Each payment of interest shall be made in the currency in which the sum in respect of which the interest is payable was denominated when that interest accrued.

21.6.4 Each payment in respect of costs, expenses or Taxes shall be made in the currency in which the costs, expenses or Taxes are incurred.

21.6.5 Any amount expressed to be payable in a currency other than sterling shall be paid in that other currency.

21.7 **Change of currency**

21.7.1 Unless otherwise prohibited by law, if more than one currency or currency unit are at the same time recognised by the central bank of any country as the lawful currency of that country, then:

(A) any reference in the Finance Documents to, and any obligations arising under the Finance Documents in, the currency of that country shall be translated into, or paid in, the currency or currency unit of that country designated by the Lender (after consultation with the Borrower); and

(B) any translation from one currency or currency unit to another shall be at the official rate of exchange recognised by the central bank for the conversion of that currency or currency unit into the other, rounded up or down by the Lender (acting reasonably).

21.7.2 If a change in any currency of a country occurs, this Agreement will, to the extent the Lender (acting reasonably and after consultation with the Borrower) specifies to be necessary, be amended to comply with any generally accepted conventions and market practice in the London interbank market and otherwise to reflect the change in currency.

22. SET-OFF

The Lender may set off any matured obligation due from the Borrower under the Finance Documents against any matured obligation owed by the Lender to the Borrower, regardless of the place of payment, booking branch or currency of either obligation. If the obligations are in different currencies, the Lender may convert either obligation at a market rate of exchange in its usual course of business for the purpose of the set-off.

23. NOTICES

23.1 Communications in writing

Any communication to be made under or in connection with the Finance Documents shall be made in writing and, unless otherwise stated, may be given in person, by post, fax or by electronic communication.

23.2 Addresses

The address and fax number (and the department or officer, if any, for whose attention the communication is to be made) of each Party for any communication or document to be made or delivered under or in connection with the Finance Documents is:

23.2.1 in the case of the Borrower, that identified with its name below; and

23.2.2 in the case of the Lender, that identified with its name below,

or any substitute address, email address, fax number or department or officer as the Borrower may notify to the Lender by not less than five Business Days' written notice.

23.3 Delivery

23.3.1 Any communication or document made or delivered by one person to another under or in connection with the Finance Documents will only be effective:

(A) if by way of fax, when received in legible form; or

(B) if by way of letter, when it has been left at the relevant address or five Business Days after being deposited in the post postage prepaid in an envelope addressed to it at that address,

and, if a particular department or officer is specified as part of its address details provided under Clause 23.2 (*Addresses*), if addressed to that department or officer.

23.3.2 Any communication or document to be made or delivered to the Lender will be effective only when actually received by the Lender and then only if it is expressly marked for the attention of the department or officer identified with the Lender's signature below (or any substitute department or officer as the Lender shall specify for this purpose).

23.4 **Electronic communication**

23.4.1 Any communication to be made between the Borrower and the Lender under or in connection with this Agreement and any other Finance Document may be made by electronic mail or other electronic means, if the Borrower and the Lender:

(A) agree that, unless and until notified to the contrary, this is to be an accepted form of communication;

(B) notify each other in writing of their electronic mail address and/or any other information required to enable the sending and receipt of information by that means; and

(C) notify each other of any change to their address or any other such information supplied by them.

23.4.2 Any electronic communication made between the Borrower and the Lender will be effective only when actually received in readable form and only if it is addressed in such a manner as the Borrower and the Lender, as the case may be, specify for this purpose.

24. CALCULATIONS AND CERTIFICATES

24.1 **Accounts**

In any litigation or arbitration proceedings arising out of or in connection with a Finance Document, the entries made in the accounts maintained by the Lender are *prima facie* evidence of the matters to which they relate.

24.2 **Certificates and Determinations**

Any certification or determination by the Lender of a rate or amount under any Finance Document is, in the absence of manifest error, conclusive evidence of the matters to which it relates.

24.3 **Day count convention**

Any interest, commission or fee accruing under a Finance Document will accrue from day to day and is calculated on the basis of the actual number of days elapsed and a year of 365 days or, in any case where the practice in the London interbank market differs, in accordance with that market practice.

25. PARTIAL INVALIDITY

If, at any time, any provision of the Finance Documents is or becomes illegal, invalid or unenforceable in any respect under any law of any jurisdiction, neither the legality, validity or enforceability of the remaining provisions nor the legality, validity or enforceability of such provision under the law of any other jurisdiction will in any way be affected or impaired.

26. REMEDIES AND WAIVERS

No failure to exercise, nor any delay in exercising, on the part of the Lender, any right or remedy under the Finance Documents shall operate as a waiver, nor shall any single or partial

exercise of any right or remedy prevent any further or other exercise or the exercise of any other right or remedy. The rights and remedies provided in this Agreement are cumulative and not exclusive of any rights or remedies provided by law.

27. AMENDMENTS AND WAIVERS

Any term of the Finance Documents may only be amended or waived in writing.

28. COUNTERPARTS

Each Finance Document may be executed in any number of counterparts, and this has the same effect as if the signatures on the counterparts were on a single copy of the Finance Document.

29. GOVERNING LAW

This Agreement shall be governed by and construed in accordance with English law.

30. DISPUTE RESOLUTION

The Parties agree that all disputes arising out of or in connection with this Agreement will be settled in accordance with the terms of Schedule 5.

This Agreement has been entered into on the date stated at the beginning of this Agreement.

SCHEDULE 1: CONDITIONS PRECEDENT

1. Authorisations

1.1 A copy of a resolution of the board of directors of the Borrower:

(A) approving the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;

(B) authorising a specified person or persons to execute the Finance Documents to which it is a party on its behalf; and

(C) authorising a specified person or persons, on its behalf, to sign and/or despatch all documents and notices (including, if relevant, any Utilisation Request and) to be signed and/or despatched by it under or in connection with the Finance Documents to which it is a party.

(D) Confirming the Borrower's undertaking to comply with the Additional Terms and Conditions

1.2 A certificate of an authorised signatory of the Borrower certifying that each copy document relating to it specified in this Schedule 1 and provided to the Lender is correct, complete and in full force and effect as at a date no earlier than the date of this Agreement.

2. Financial Information

Updated financial statements of the Borrower unless otherwise available.

3. Finance Documents

3.1 This Agreement (original).

3.2 The original or certified copy (as the Lender shall require) of any Finance Document not listed above.

4. General

4.1 A copy of any other Authorisation or other document, opinion or assurance which the Lender considers to be necessary or desirable in connection with the entry into and performance of the transactions contemplated by any Finance Document or for the validity and enforceability of any Finance Document.

4.2 Evidence that the fees, costs and expenses then due from the Borrower pursuant to Clause 13 (*Costs and expenses*) have been paid or will be paid by the first Utilisation Date.

SCHEDULE 2: UTILISATION REQUEST

From:[ ]

To: The Secretary of State for Health

Dated:

Dear Sirs

[ ] – £
dated [ ] (the "Agreement")

1. We refer to the Agreement. This is a Utilisation Request. Terms defined in the Agreement have the same meaning in this Utilisation Request unless given a different meaning in this Utilisation Request.

2. We wish to borrow a Loan on the following terms:

Proposed Utilisation Date:	[ ] (or, if that is not a Business Day, the next Business Day)
Amount:	[ ] or, if less, the Available Facility
Payment Instructions:	[*Relevant account to be specified here*]

3. We confirm that each condition specified in Clause 4.2 (Further conditions precedent) is satisfied on the date of this Utilisation Request.

4. We represent and warrant that the Loan will be applied solely towards working capital requirements of the Borrower in its requirement as an NHS Trust/NHS Foundation Trust.

5. This Utilisation Request is irrevocable.

Yours faithfully

……
authorised signatory for and on behalf of the Board of Directors
[ ]

SCHEDULE 3: NOT USED

SCHEDULE 4: ANTICIPATED DRAWDOWN SCHEDULE

NOT USED.

SCHEDULE 5: DISPUTE RESOLUTION

1. NEGOTIATION

If any claim, dispute or difference of whatsoever nature arising out of or in connection with this Agreement ("**Dispute(s)**") arises, the Parties will attempt in good faith to settle it by negotiation. Each Party will nominate at least one management representative ("**Authorised Representative**") who shall attend and participate in the negotiation with authority to negotiate a solution on behalf of the Party so represented.

2. MEDIATION

It shall be a condition precedent to the commencement of reference to arbitration that the Parties have sought to have the dispute resolved amicably by mediation as provided by this paragraph 2.

2.1 Initiation of Mediation Proceeding

(A) If the Parties are unable to settle the Dispute(s) by negotiation in accordance with paragraph 1 within 15 days, either Party may by written notice upon the other initiate mediation under this paragraph 2. The notice initiating mediation shall describe generally the nature of the Dispute.

(B) Each Party's Authorised Representative nominated in accordance with paragraph 1 shall attend and participate in the mediation with authority to negotiate a settlement on behalf of the Party so represented.

2.2 Appointment of Mediator

(A) The Parties shall appoint, by agreement, a neutral third person to act as a mediator (the "Mediator") to assist them in resolving the Dispute. If the Parties are unable to agree on the identity of the Mediator within 10 days after notice initiating mediation either party may request the Centre for Effective Dispute Resolution ("CEDR Solve") to appoint a Mediator.

(B) The Parties will agree the terms of appointment of the Mediator and such appointment shall be subject to the Parties entering into a formal written agreement with the Mediator regulating all the terms and conditions including payment of fees in respect of the appointment. If the Parties are unable to agree the terms of appointment of the Mediator within 10 days after notice initiating mediation either Party may request CEDR Solve to decide the terms of appointment of the Mediator

(C) If the appointed Mediator is or becomes unable or unwilling to act, either Party may within 10 days of the Mediator being or becoming unable or unwilling to act follow the process at paragraph 2.3 to appoint a replacement Mediator and paragraph 2.4 to settle the terms of the appointment of the replacement Mediator.

2.3 Determination of Procedure

The Parties shall, with the assistance of the Mediator, seek to agree the mediation procedure. In default of such agreement, the Mediator shall act in accordance with CEDR Solve's Model Mediation Procedure and Agreement. The Parties shall within 10 days of the appointment of the Mediator, meet (or talk to) the Mediator in order to agree a programme for the exchange of any relevant information and the structure to be adopted for the mediation.

2.4 **Without Prejudice/Confidentiality**

All rights of the Parties in respect of the Dispute(s) are and shall remain fully reserved and the entire mediation including all documents produced or to which reference is made, discussions and oral presentations shall be strictly confidential to the Parties and shall be conducted on the same basis as "without prejudice" negotiations, privileged, inadmissible, not subject to disclosure in any other proceedings whatever and shall not constitute any waiver of privilege whether between the Parties or between either of them and a third party. Nothing in this paragraph 2.4 shall make any document privileged, inadmissible or not subject to disclosure which would have been discloseable in any reference to arbitration commenced pursuant to paragraph 3.

2.5 **Resolution of Dispute**

If any settlement agreement is reached with the assistance of the Mediator which resolves the Dispute, such agreement shall be set out in a written settlement agreement and executed by both parties' Authorised Representatives and shall not be legally binding unless and until both parties have observed and complied with the requirements of this paragraph 2.5. Once the settlement agreement is legally binding, it may be enforced by either party taking action in the High Court.

2.6 **Failure to Resolve Dispute**

In the event that the Dispute(s) has not been resolved to the satisfaction of either Party within 30 days after the appointment of the Mediator either party may refer the Dispute to arbitration in accordance with paragraph 3.

2.7 **Costs**

Unless the Parties otherwise agree, the fees and expenses of the Mediator and all other costs of the mediation shall be borne equally by the Parties and each Party shall bear their own respective costs incurred in the mediation regardless of the outcome of the mediation.

3. **ARBITRATION**

3.1 If the Parties are unable to settle the Dispute(s) by mediation in accordance with paragraph 2 within 30 days, the Dispute(s) shall be referred to and finally determined by arbitration before an Arbitral Tribunal composed of a single Arbitrator.

3.2 Any reference of a Dispute to arbitration shall be determined in accordance with the provisions of the Arbitration Act 1996 and in accordance with such arbitration rules as the Parties may agree within 20 days after notice initiating arbitration or, in default of agreement, in accordance with the Rules of the London Court of International Arbitration which Rules are deemed to be incorporated by reference into this clause.

3.3 London shall be the seat of the arbitration.

3.4 Reference of a Dispute to arbitration shall be commenced by notice in writing from one Party to the other Party served in accordance with the provisions of Clause 23 (Notices).

3.5 The Arbitral Tribunal shall be appointed as follows.

(A) Within 14 days of receipt of any notice referring a Dispute to arbitration the Parties shall agree the identity of the person to act as Arbitrator. In default of agreement or in the event the person so identified is unable or unwilling to act, either party shall be

entitled to request the President for the time being of the Chartered Institute of Arbitrators to appoint an Arbitrator for the Dispute and the parties shall accept the person so appointed.

(B) If the Arbitrator becomes unwilling or unable to act, the procedure for the appointment of a replacement Arbitrator shall be in accordance with the provisions of paragraph 3.5(A).

3.6 The language of the arbitration shall be English.

SCHEDULE 6: REPAYMENT SCHEDULE

Repayment Date	Relevant Percentage
18th July 2020	100%

SCHEDULE 7: PERMITTED SECURITY – EXISTING SECURITY

NONE

SCHEDULE 8: ADDITIONAL TERMS AND CONDITIONS

1. Surplus/Deficit and Capital Limits

1.1. The Lender has set a Surplus/Deficit Limit and/or a Capital Limit for the Borrower in consultation with the relevant Supervisory Body.

1.2. The Borrower understands and accepts these Limits in the recognition that any net expenditure in excess of the relevant Limit(s) cannot be funded by the Lender based upon the assumptions made by the Lender at the date of this Agreement.

1.3. The Borrower undertakes not to put forward any Utilisation Requests on this or any other Facility with the Lender that would result in Limits being exceeded by the Borrower without the explicit agreement of the Lender.

1.4. In the event that a utilisation is likely to lead to a Limit being exceeded, the Borrower shall inform the Lender two calendar months before any such utilisation may be submitted.

1.5. The Borrower will make no assumptions in any financial planning in relation to any financial support from the Lender beyond financing previously agreed to support the relevant Limit(s).

1.6. Limits may be adjusted by the Lender from time to time in consultation with the relevant Supervisory Body.

1.7. Performance against Limits will be monitored by the relevant Supervisory Body.

2. Nursing agency expenditure:

2.1. The Borrower undertakes to comply with nursing agency spending rules as set out in the letter of 1 September 2015 from David Bennett and Robert Alexander to NHS Foundation Trust and Trust Chief Executives as may be updated from time to time. In particular, the Borrower undertakes to:

2.1.1. Procure all nursing agency staff through approved frameworks unless such action is otherwise authorised by the relevant Supervisory Body.
2.1.2. Implement an annual maximum limit for agency nursing expenditure as a percentage of the total nursing staff budget as set out in the letter of 01 September 2015 or as otherwise notified by the relevant Supervisory Body.
2.1.3. Implement any additional controls as may be required by the relevant Supervisory Body in relation to the planned introduction of price caps.

2.2. The Borrower additionally undertakes to Implement the NHS Employers Five High Impact Actions

3. Professional Services Consultancy Spend

3.1. The Borrower will not enter into any contract for the procurement of professional consultancy services with a value in excess of £50,000 without the prior approval of the relevant Supervisory Body. The value of multiple contracts issued in respect similar Terms of Reference will be aggregated, as though a single contract had been issued, in respect of the application of this clause.

4. VSM Pay Costs

4.1. Where the borrower is authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the views of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500.

4.2. Where the borrower is not authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the approval of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500.

4.3. The Borrower undertakes to implement the requirements in respect of the treatment of "off - payroll" workers included in the letter from David Nicholson to Chairs and Chief Executives of 20th August 2012, or any subsequent guidance issued by the Lender.

4.4. The Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England to all newly appointed VSMs except where existing statutory terms take precedence. In addition the Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England for existing VSMs where Section 16 is referenced in their contracts of employment.

5. Estate Costs

5.1. The Borrower undertakes to examine the overall running costs of Estates and Facilities against a benchmark group of similar NHS Trusts within 3 months from the date of this Agreement. Where higher than average costs are identified, and there is no valid reason for this, the Borrower will put in place an action plan to reduce these costs to match the agreed benchmark level. DH will need to satisfy itself that the benchmark is reasonable and plan is deliverable.

6. Surplus Land

6.1. The Borrower shall ensure that it has in place an up to date estates strategy covering a period at least 3 years from the date of this Agreement. The estates strategy should be informed by discussions with commissioners about clinical service requirements and consider options for rationalising the estate and releasing surplus land.

6.2. The report required in clause 6.1 shall identify surplus land and potentially surplus land to be released during the period from the date of this Agreement date to 31 March 2020.

6.3. The Borrower shall provide the Lender with a copy of its estate strategy within 6 weeks of the date of this Agreement or at a date otherwise agreed with the Lender. The Lender will need satisfy itself that the strategy is complete and deliverable for this condition to be satisfied.

7. Procure21

7.1. The Borrower will use the P21+ Procurement Framework for all publicly funded capital works, unless otherwise agreed with the relevant Supervisory Body.

7.2. Where the Borrower proposes to use an alternative procurement route, the Borrower will submit a business case to the relevant Supervisory Body for approval demonstrating that an alternative procurement route offers better Value for Money than the P21+ Procurement Framework.

8. Finance and Accounting and Payroll

8.1. The Borrower undertakes to commission NHS Shared Business Services to complete a baseline assessment of the Borrower's finance and accounting and payroll services to assess the benefit of the use, or increased use, of an outsourced service provider. The Borrower will provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement.

8.2. Where the assessment by NHS Shared Business Services supports the case for the use, or increased use, of an outsourced service provider, the Borrower will undertake an appropriate market testing exercise or use existing Government Framework Agreements to procure an outsourced service provider within a timescale to be agreed with the Lender.

9. Bank Staffing

9.1. The Borrower will undertake an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency to assess the benefit of the use, or increased use of an Outsourced Staff Bank provider. The Borrower commits to provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement.

9.2. Where an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency supports the case for the use of Outsourced Staff Bank provider, the Borrower will undertake an appropriate market testing exercise or use an existing Government Framework Agreement to procure an Outsourced Staff Bank provider within a timescale to be agreed with the Lender.

10. Procurement

10.1. The Borrower shall provide third party non-pay spend to the lender in a format specified by the Lender, within 6 months of the date of this Agreement, and at least annually thereafter, on the request of the Lender,

10.2. The Borrower shall test the savings opportunities of increasing usage of the NHS Supply Chain and future editions and/or replacements of the NHS Catalogue within 6 months of the date of this Agreement and at least annually thereafter, on the request of the Lender,

10.3. Any savings identified through the process set out in 10.2 will be pursued by the Borrower. Any identified savings which the Borrower does not intend to pursue must be notified to the Lender along with the reasons for not doing so.

10.4. The Borrower will provide the Lender with current copies of its medical capital equipment asset register, medical equipment maintenance schedule, and capital medical equipment procurement plans within 6 months of the date of this Agreement, and at least annually thereafter on the request of the Lender.

11. Crown Commercial Services ("CCS")

11.1. The Borrower undertakes to test the scope of savings opportunities from CCS within 6 months of the date of this Agreement, subject to appropriate CCS resources being available to support this undertaking. Any savings identified as part of this process which the Borrower does not intend to pursue must be notified to the Lender with the reasons for not doing so.

11.2. The Borrower additionally undertakes to provide details of its relevant requirements in support of all future collaborative procurements including e-auctions.

12. EEA and non-EEA Patient Costs Reporting

12.1. The Borrower undertakes to:

12.1.1. Become a member of the EEA portal and actively report EHIC and S2 patient activity on the portal

12.1.2. Provide an overview of the patient identification, billing and costs recovery systems in place with any planned improvements (for EEA and non-EEA patients)

12.1.3. Participate and collaborate with local/national commissioners in the development of the new ""risk sharing"" model for non-EEA chargeable patients.

13. On request of the Lender, the Borrower agrees to provide timely information and enable appropriate access to parties acting on behalf of the Lender for the purposes of appropriate tracking and reporting of progress delivering the conditions set out within this Schedule.

SIGNATORIES

Borrower

For and on behalf of [ ]

By:

Name:

Position:

Address:

Email:

Attention:

Lender

The Secretary of State for Health

By:

Name:

Address: Department of Health,
2nd Floor
Quarry House,
Quarry Hill,
Leeds, LS2 7UE

Email: dhloanscentralinbox@dh.gsi.gov.uk

FINANCE AND PERFORMANCE COMMITTEE – AUGUST 2017

NHS Maidstone and Tunbridge Wells NHS Trust

8-14	QUARTERLY PROGRESS UPDATE ON PROCUREMENT TRANSFORMATION PLAN	DIRECTOR OF FINANCE

Executive summary

The Procurement Transformation Plan (PTP) was approved by the Trust Board on the 19th October 2016 and submitted to NHSI by the deadline of 31st October 2016.

It was a requirement that every Trust should have a Procurement Transformation Plan. The PTP is a document which outlines the procurement function within the Trust and the key actions to deliver the Lord Carter targets set within the document.

The Trust submits a monthly upload of the PTP metrics. We have requested feedback on the metrics but have not received anything to date.

This is the third quarterly report to the Finance Committee about progress against the PTP.

Reason for circulation to Finance and Performance Committee

Review - the Finance Committee approved the Procurement Transformation Plan that was submitted to NHSI in October 2016 and asked for regular updates about progress against the Carter metrics and the action plan within the Plan.

1. INTRODUCTION

1.1 The Procurement Transformation Plan (PTP) was approved by the Trust Board on the 19th October 2016 and then submitted to NHS Improvement by the 31st October 2016, which was the deadline for Board approved submissions.

1.2 The PTP guidance from NHSI requires that Trusts provide regular progress updates on their PTPs to their Trust's board and NHS Improvement on a quarterly basis.

2. DETAIL AND BACKGROUND

Background

2.1 The Procurement Transformation Plan was approved by the Trust Board on the 19th October 2016 and then submitted to NHSI by the 31st October, which was the deadline for Board approved submissions.

2.2 The Programme Lead – Carter Procurement has been reviewing the submitted plans and will provide feedback to individual trusts. To date the Trust has not received any feedback.

2.3 The Associate Director of Procurement has been attending the meetings of the National Health Service Procurement Alliance. Invitations to this meeting are based on Trusts submitting their PTP and confirming agreement to the Nationally Contract Products Programme. The purpose of this meeting is to bring together procurement leaders from across England at regular intervals to discuss and agree joint strategies for improvement in operations and value for money. In doing so the Alliance is expected to support delivery of Lord Carter's recommendations 2016, the national e-procurement strategy and Get it Right First Time (GIRFT). These meetings have been held monthly since January.

2.4 There is the expectation that the Procurement Alliance will focus on the changes of the Future Operating model coming into place in 2018. This will have a significant impact on the way local procurement team purchase clinical products.

Carter Metrics

2.5 The table, overleaf, is an update on the metrics reported to the Committee in October 2016.

METRICS		PERFORMANCE				COMMENTARY
		ACTUAL			TARGET	
		SEPTEMBER 2016	JUNE 2017	SEPTEMBER 2017	SEPTEMBER 2018	
1	Monthly cost of clinical and general supplies per 'WAU' (Weighted Activity Unit)	£339 per WAU	£280.99 per WAU	TBC by NHSI	TBC by NHSI	The model hospital data will be updated in December 2017.
2	Total % **purchase order lines** through a catalogue (target 80%)	60%	97.8%	72%	80%	This metric relates to the proportion of Integra POs that utilise the approved e-catalogues.
3a	Total % of **expenditure** through an electronic purchase order (target 80%) up to and including PO issue	43%	44%	60%	80%	The Trust has a No PO no Pay policy and this is strictly applied across the Trust. This has significantly improved the Trust's position in relation to the coverage of transactions. The Trust PFI is now covered by a PO with effect from August 2017. This will significantly impact on the level of PO coverage
3b	Total % of **transactions** through an electronic purchase order (target 80%) up to and including PO issue	74%	88.91%	80%	80%	

[1] The information related to WAU is based on the spend in 2015/16 and is a figure derived from the "Model Hospital" work by the Carter team.

METRICS		PERFORMANCE				COMMENTARY
		ACTUAL		TARGET		
		SEP 2016	JUNE 2017	SEPTEMBER 2017	SEPTEMBER 2018	
3c	Total % of expenditure through an electronic purchase order (target 80%) from requisition through to and including payment	11.74%	62.38%	50%	80%	The current payment system is not completely electronic with a number of invoices coming into the Trust as hard copy though in turn these may be processed using OCR technology. This indicator includes data from EME from shires as well as the data from Integra. The level of POs have increased as all Omnicell orders are covered by a PO now as well. There are currently a small number of large transactions that are not covered by a PO.
3d	Total % of transactions through an electronic purchase order (target 80%) from requisition through to and including payment	63%	70.64%	70%	80%	
4	% of spend on a contract (target 90%)	61%	63.36%	81%	90%	The Trust performance is improving in this area. Work is also being undertaken to negotiate with suppliers to tie them into a fixed term contract.
5a	Inventory Stock Turns-static	Days	22.39 Days	Days	Days	The Trust is implementing an inventory management system which has supported getting this data. No target has been set by NHSI for this indictor.
5b	Inventory Stock Turns-dynamic – stock managed through a system eg. Omnicell	Days	Days	Days	Days	
6	NHS Standards Self-Assessment Score (average total score out of max 3)	1.16	1.16	2	2	Peer review was due in June 2017. Procurement have chased for an update on the peer review but have been told there are currently no reviewers

METRICS	PERFORMANCE	COMMENTARY

		ACTUAL		TARGET		
		SEPTEMBER 2016	JULY 2017	SEPTEMBER 2017	SEPTEMBER 2018	
7	NHSI's Purchase Price Index Benchmarking (PPIB) Tool	N/A[2]	Variance to median[3] £655,235	TBC	TBC	A full review of the PPIB data has been completed. £655,235 opportunity out of £25.5million spend has been identified as potential opportunity. This is being reviewed in detail.

[2] PPIB tool was not published at this time. Please note that the PPIB tool currently relates to data from acute trusts only.
[3] Based on £20.7million of spend with 949 suppliers for 12000 products

RAG Rating Definitions:
Green = At, or better, than the target
Amber = Up to 10% less than target
Red = More than 10% below target

Action plan

2.6 A review of the action plan is in appendix one of the document. The action plan is confirmed below.

Procurement objective	Action
Procurement strategy	Staff qualifications. An internal target has been set for 50% of procurement team qualified. 100% of staff are qualified within category management, however there are 3 vacancies within the team.
Procurement workplan	Completion of 2017/18 and 2018/19 procurement workplan. These workplans will cover tail spend and improve the trust position on contract spend. Procurement are looking at current tail end spend for efficiencies through rationalising the supplier base.
Procurement Savings	Target set of £5.3 million 2017/18 CIP.
Communication strategy	There has been wider engagement with divisions and procurement. Procurement is present at all division CIP meetings now. Communication to internal and external stakeholders. Focus on Trust policy to ensure adherence to spend restrictions as well as improved compliance. This is a key objective within the procurement strategy.
Policies, processes and systems	Policies are reviewed and updated annually or at times of significant change.
Spend controls	Percentage of invoiced expenditure captured electronically through Purchase orders (P2P systems).

Procurement objective	Action
	Re-launch of the Trust 'No Purchase Order, No Pay' policy.
People and Organisation	Achievement of the procurement standard level 1 and training programme to support level 2.
Collaboration	50% of expenditure on goods and services is channelled through collaborative arrangements by 2017/18, rising to 60% by 2019.
	Alignment of procurement work plans across the region
	Review of external options for transactional procurement
	Integra financial system – working groups for agreement and alignment for the use of the system
	Market management engagement – 2 supplier events per year.
	Shared learning and collaboration of the FOM across the region
	2 supplier surveys per year to be sent to support the review of the team's engagement with the market

3. Risks and issues

3.1 The previous report noted the risk of a shortage of procurement skills within the region. There are 3 vacancies within the category management team and a fourth will arise in September with the departure of the Head of Category Management. This is a key risk to the delivery of the CIP saving for 17/18. The team have recruited 2 interims to support the CIPs plan but this is only short term solution.

The Associate Director is working with an agency to support permanent recruitment to these roles as the numerous adverts for these roles have been unsuccessful. The Associate Director of Procurement has established regular meetings with the Heads of Procurement from the acute trusts in the STP footprint. This meeting has now widened to include the Heads of Procurement from non-acute trusts.

These meetings have led to seven areas of collaboration being agreed so that the skills and expertise across the region are focused for the benefit of all. This approach has proved to be helpful to the Trust given the recent resignation of a Category Manager and the unsuccessful recruitment campaigns to replace this officer, because the work that has been commenced by the current post holder can be continued when he moves to another Trust within the STP footprint.

Work is being undertaken on a joint catalogue system across the region to pool resources and negotiate with suppliers on behalf of the STP.

An apprentice role has also been appointed to the team. This role is focused on supporting the systems team and documenting the team processes. The role will also negotiate with local suppliers to support the transactional team.

4. RECOMMENDATION

4.1 It is recommended that the Finance Committee note and review the information in the report.

Appendix 1: Update about the action plan

Procurement objective	Action	Update
Procurement strategy	Staff qualifications. An internal target has been set for 50% of procurement team qualified. Training matrix has been pulled together to identify the training requirements of all staff and link this to their role. This will support the Trust in achieving the level 2 procurement standard.	The procurement team has 40% of its staff with CIPS qualifications. The category management team is 100% CIPS qualified.
Procurement workplan	Completion of 2017/18 and 2018/19 procurement workplan. These workplans will cover tail spend and improve the trust position on contract spend.	The Purchasing team has a workplan that commenced in January 2017.This has not progressed as quickly as anticipated but is continuing through the summer. The annual spend between these suppliers ranges from over £22,000 to £200,000 and a total spend of £3.77 million.
Procurement Savings	Target of £5.3m 2017/18 CIP	The detailed plans for the CIP which is £5.3 million of non-pay are being developed with directorates. The biggest area of support is planned care where their procurement saving alone is over £4,000,000. Seven areas of collaboration with STP partners have been identified and currently in progress.
Communication strategy	Communication to internal and external stakeholders. Focus on Trust policy to ensure adherence to spend restrictions as well as improved compliance. This is a key objective within the procurement strategy.	Planned actions for 2016/17 have been completed. Further communications plans for 2017/18 are set out in the sections below.
Policies, processes and systems	Policies are reviewed and updated annually or at times of significant change.	Policies and processes are being reviewed and these will be captured in a procurement manual. . The manual will be finalised by an intern over the summer following workshops with all three teams within the Department. Interviews for the intern take place on 18 May.
Spend controls	Percentage of invoiced expenditure captured electronically through Purchase orders (P2P systems). Re-launch of the Trust No Purchase Order, No Pay policy.	Integra is now live and supporting the re-launch of the Trust's No PO, No Pay policy.
People and Organisation	Achievement of the procurement standard level 1 and training programme to support level 2.	The Trust has invested in the procurement team to support achieving level 2. A peer review has been requested for June 2017. The

Procurement objective	Action	Update
		associate director has followed up regarding the review but the current feedback is that there are no assessors to undertake the review.
Collaboration	50% of expenditure on goods and services is channelled through collaborative arrangements by 2016, rising to 60% by 2019.	52% of the Trust's spend is through collaborative arrangements.
	Alignment of procurement work plans across the region	This is being progressed for 2017/18. The STP HoPs have all shared work plans and identified areas of duplication and assigned a lead for the STP to progress the work.
	Review of external options for transactional procurement	This is part of the STP corporate services work stream.
	Integra financial system – working groups for agreement and alignment for the use of the system	This is part of the STP corporate services work stream.
	Market management engagement – 2 supplier events per year.	A supplier event is planned for the first 6 months of the financial year. Once was planned for April but smaller events are being held with suppliers for the seven areas of STP collaboration. These events will be more focused on the specific category of spend.
	Shared learning and collaboration of the FOM across the region	Part of the National Health Service Procurement Alliance, they will be looking at how we can work together to deliver greater savings in advance of the FOM, with the expectation that the learning is taken back to respective STPs. Both MTW and East Kent Foundation Trust have attended the Alliance. The meetings are held monthly in London.
	2 supplier surveys per year to be sent to support the review of the team's engagement with the market	A supplier survey and Trust survey is planned for September 2017.