Maidstone and Tunbridge Wells NHS
NHS Trust

Chief Executive and Chairman's Office
Maidstone Hospital
Hermitage Lane
Maidstone
Kent ME16 9QQ

Tel: 01622 226412
Fax: 01622 226416

Paul Wickenden
Overview and Scrutiny Manager
Legal and Democratic Services
Sessions House
County Hall
Maidstone
Kent ME14 1XQ

19th December 2008

Dear Paul,

Re: Health Overview and Scrutiny Committee Meetings

Further to your letter I write to provide an update with respect to the progress we have made in relation to the Hygiene code, with particular reference to core standards – C4a, C4c and C21.

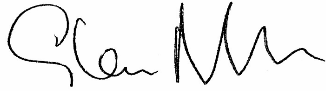
You are well aware of the issues that we have faced as a trust since the publication of the Healthcare Commission's investigation report. The trust has carried out significant work over the last year to improve the service we offer to patients in all respects, but particularly with respect to the management of infection prevention and control. We are please to be able to report, demonstrated by the evidence attached, that we have reduced the infection rates for C diff and MRSA bacteraemias significantly and are below target levels. We continue to work towards increasing standards of care and compliance with the Hygiene Code.

Attached are updates for each of the core standards you refer to.

In addition we are anticipating publication of the reports from the Healthcare Commission's Hygiene Code inspection visit and the investigation follow up visit, carried out in November, at the beginning of January. We have seen the draft reports for these and believe they provide assurance of the progress we have made with respect to the hygiene code.

My apologies that I shall not be able to attend the meeting on 9th January, however, Flo Panel-Coates, Director of Nursing and Claire Roberts, Head of Quality and Governance, will be representing me.

Yours sincerely,



Glenn Douglas
Chief Executive

Maidstone & Tunbridge Wells NHS Trust

Governance Processes

The trust has reviewed its governance processes to ensure there are clear lines of reporting and accountability. The committee structures have been reviewed in line with this (see attachment).

The DIPC provides weekly updates and monthly reports to the executive team and monthly reports to the Quality and Safety Committee and the Board – these are published on our website.

The Infection Prevention and Control Committee (IPCC) has been reconfigured and now meets monthly. This is the key committee for monitoring action plans relating to infection control issues such as the hygiene code.

Until the beginning of December meetings were held, initially weekly and then monthly to review progress against the action plan developed as a result of the Healthcare Commission Investigation report. At the beginning of December it was agreed that the few remaining actions aligned to hygiene code duties so these have now been added to the hygiene code action plan and will be reviewed by the IPCC

Core Standard C4a

The trust anticipates declaring this standard to be met for 08/09

Please see attached action plan and update from our DIPC re actions taken.

Core Standard C4c

The trust declared compliance for 07/08 but was qualified by the Healthcare Commission (HC) and found to be compliant by the end of year, not the full year.

The trust had a hygiene code inspection in October 2008 during which the HC found some areas with respect to decontamination, despite the board having received accreditation by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) in the summer. The recommendations have since been addressed and we anticipate declaring end of year compliance for 08/09.

Please see attached action plan.

The trust has recently reorganised its estates and facilities department and a new structure for the management of decontamination services has been put in place (attached). The new director of facilities is due to take up post in January 2009.

The trust is to be part of the planned Kent-wide provision of decontamination services by IHSS. This service is due to commence summer 2009. Currently internal services are compliant with required standards.

The trust is currently setting up a “Medical devices library” to enhance the management of the decontamination of reusable devices.

Core standard C21

Progress has been made with respect to this standard and we anticipate declaring it to be met for the 08/09 declaration.

Please note the attached action plan.

Challenges remain with respect to compliance with bed spacing within the hospitals. Since the investigation report, however, an external report was commissioned to review the situation and bed spacing has been increased. The Board is due to receive a further update in February regarding this issue.

In considering actions that the trust is taking to address environmental issues the development of the new hospital at Pembury is key. This hospital will have single rooms for patients and so be able to overcome the issues of both single sex accommodation and bed spacing.

A number of ward areas have successfully been upgraded. The trust is meeting its targets for the deep clean programme that is in place though out the clinical areas in the trust.

There has been a thorough review of policies and procedures with respect to cleanliness. A robust auditing system has been put in place and includes a review of compliance with the National Credits for Cleaning.

We have regular PEAT reviews and the team includes a lay representative.
Immediately after the investigation two lay people were employed to carry out cleanliness audits throughout the organisation.

Audits and inspections are reported through an identified committee structure.

Core Standard C4a infection control – Maidstone & Tunbridge Wells NHS Trust

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in Methicillin resistant *Staphylococcus aureus* (MRSA)

Core Standard Key Line of Enquiry **a. The Hygiene Code requires healthcare organisations to have in place appropriate management systems for infection prevention and control which must include the following:**								
Hygiene code duty cross reference	**Core Sub Duty**	**Assurance Statement**	**Action**	**Director Lead**	**Ops Lead**	**Review Date**	**Target**	**Progress/ Evidence**
2a	A Board level agreement outlining its collective responsibility for minimizing the risks of infection and the general means by which it prevents and controls such risks.	IPC is incorporated into all executive job descriptions with identified outcome measures	In place	CE/TC				• Letter from Chief Executive amending job descriptions and outlining executive responsibility
2a		The Chief executive, lead non-executive director and Board receive regular reports and presentations (quarterly as a minimum) from the Director of Infection Prevention and Control (DIPC)	In place	DIPC				• Infection control reports to Board incorporated inot integrated governance reports bimonthly • Weekly IC update sent to all Board members and senior managers • Annual infection control report to Board Sept 08

2a		Monitoring of compliance and improvement plans are incorporated into the governance and performance frameworks	In place	FPC/NL				• Integrated Governance reports to Board incorporate infection control. • Annual IC report to Board Sept 08. • Weekly Exec updates sent to all Board members. • HCC and HCAI action plans. • Facilities Director appointed October 2008 (as per org chart)
2a		Monitoring, review and action to improve clinical practice and prevent and control HCAI is part of the routine business of every service area/clinical directorate	• Full implementation of Saving Lives programme. • Include Saving Lives & Hand Hygiene Audits in performance dashboard. • Saving Lives and hand hygiene audits regular agenda items at Divisional meetings and Infection Prevention and Control Committee (IPCC) • Balanced scorecard for HCAI, consultant by consultant and ward by ward reporting	JL / FP-C/SM	DD's & ADNS's		Completed 31/10/08	• Saving Lives Audit programme. (N. Drive) • Hand hygiene ward audits. • Minutes from divisional meetings to show reporting. • IPCC work to Board. • Balanced scorecard completed and circulated to divisions, IPCC and Board monthly • Annual programme agreed. • Decontamination report to the Trust Board in October 2008

2b	The designation of an individual as Director of Infection Prevention and Control (DIPC) with the role as defined in the Code and accountable directly to the Board and, from January 2008, directly to the Chief Executive	The DIPC has a job description with defined HCAI responsibilities and outcome objectives, is regularly appraised against those objectives, and reports directly to the Chief Executive and the Board	In place					• DIPC in post since Nov 2007 • DIPC job description • DIPC attends Board meetings
2c	The mechanisms by which the Board intends to ensure that adequate resources are available to secure effective prevention and control of HCAI. These should	Within the commissioning and budget setting process, resources are identified for the management if infection prevention and control. This resource allocation is regularly reviewed within the organisation	In place					• IC budget

2c	include implementing an appropriate assurance framework, infection control programme and infection control infrastructure	The infection prevention and control committee (IPCC) who reports to the DIPC and the Board agrees and reviews the HCAI programme of work and audit schedules and provides reports to the DIPC for onward communication to the Board	In place					• Annual IC programme and plan • Annual IC report to Board • IPCC annual planner • Minutes of IPCC
2c		Defined governance and performance outcomes and reporting frameworks are identified at a directorate/divisional level	Develop governance and performance outcomes and reporting frameworks within divisions.	JL/FPC	DD's & ADNS's		Completed	• Link nurse programme • Trust Assurance framework includes infection control • HCAI balanced scorecard • RCA reports • Agreed governance agenda for divisions which includes IPCC embedding as new committees
2c		The is cross representation between the Infection Prevention and Control Committee and the Drugs and Therapeutics Committee	In place					• Minutes of meetings

2c		Responsibility and accountability for infection control is clearly allocated in each clinical area (i.e. to the manager of that area)	In place					• Ward managers accountability agreement
2c		Infection prevention and control is included in the personal development plans of all infection control leads.	• Jim Lewis to write to Divisional Directors and CDs to ensure IPC included in PDP of all leads • Clarify IPC leads. • Agree role responsibilities • Confirm link nurse PDPs	Jim Lewis	DD's/ADNSs + JO		Completed 31/10/08	• Link nurse PDPs • Link nurse role description • Divisional Director JD • Clinical director JD • Letter from Medical Director
2c		The responsibilities of each member of the ICT are clearly defined and the contracted sessions of the Infection Control Doctor are defined and agreed	In place					• IC team structure • IC team job descriptions • DIPC/ICD job description and job plan

2f	A policy addressing, where relevant, admission, transfer, discharge and movement of patients between departments, and within and between health care facilities	The policy for patient movement/bed management explicitly identifies infection control risks and sets out plans for how they are to be mitigated. The policy is regularly monitored at Directorate level for compliance and fitness for purpose.	• Need to review infection control bed management. • Policies to be reviewed at Divisional level. • Audit and review	Nikki Luffingham	Gail Locock/ADNS's		30/12/08	• Bed Management Policy, • Transfer policy • Discharge/transfer forms for C.difficile patients. • Isolation ward operational policy • Admission/discharge/ transfer policy for C. difficile patients • Isolation facility audit • Review of side room provision at IPCC • Active management of side room use by infection control - twice daily reports
2f		There is regular liaison between the bed /operational manager, the ICT, ward manager and other relevant staff in respect of patient transfers within the hospital	In place					• Twice daily side room reports • infection control patients lists • ICT attends bed meeting at least once per day • outbreak policy • patient transfer policy • bed management and site sheet. • Time to isolate audit
Core Standard Key Line of Enquiry **b. The healthcare organisation should have in place appropriate management systems for infection prevention and control, including the following:**								
2c		An appropriate assurance framework	• Develop separate assurance framework for infection control	DIPC	GL/JH		31/01/09	• Infection control included in Trust assurance framework

2d	Ensuring that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks of infection	Resources are identified and available for appropriate IC training, information and supervision	In place • Training programme currently under review					• Induction training handouts and slide presentations. • Mandatory update training resources. • Link nurse training days programme. • Protected time for link nurse training • Mandatory HCAI training - slide presentations. • Link nurse network. • E learning package
2d		Mechanisms exist to monitor compliance with the IPC training policy/plans and the outcomes are audited and incorporated into directorate and Board reports.	• Audit outcomes. • Reporting on training attendance to Divisions and Board	DIPC/TC	Gail Locock/ADNS's		30/12/08	• Attendance monitored- evidence available • Training attendance reporting in the Board performance report
2e	A programme of audit to ensure that key policies and practices are being implemented appropriately.	A balanced scorecard or equivalent framework is used to monitor compliance with statutory/mandatory/local policies and standards and is reviewed by the senior management team (SMT) and Board at least quarterly.	• Final 2009 audit plan to go to January IPCC	SM	Gail Locock/ADNS's		31/01/09	• New Committee Structure • Saving lives audits and framework • IP&CC minutes. • 2008 audit plan in place • Draft audit plan for 2009 presented at IPCC November • HCAI balanced scorecard presented monthly to divisions and bimonthly to Board

2e		Directorates review the results of compliance audits, and incorporate these into their plans for continuing improvement.	• Implement web based monitoring system for Saving lives and hand hygiene audits	SM	Gail Locock/Belinda Regan/ADNSs		31/01/09	• Clinical governance programmes i.e. balanced scorecard, RCA, saving lives • Minutes of divisional meetings and divisional ops meetings
Core Standard Key Line of Enquiry **c. The healthcare organisation assesses the risk of acquiring HCAI and takes action to reduce or control such risks. In doing so they must have:**								
3a	Made a suitable and sufficient assessment of the risks to patients in receipt of health care with respect to HCAI.	There is appropriate analysis of infection data and surveillance of alert organisms	In place					• Weekly IC reports to Board and senior management • Surveillance of alert organisms using ICNet • SSSI reports to IPCC • Root cause analysis
3a		This analysis is incorporated into the organisation's risk assessment process and is used to prioritise local and corporate action through the organisation's risk register	In place	F lo Panel-Coates	Jeff Harris/ CR			• Risk register & assurance framework. • Root cause analysis. • Minutes IPCC

3a		Infection control is incorporated into individual patient assessment and identified risks are communicated and acted upon.	In place	Flo Panel-Coates/SM	Belinda egan/ADNS's/Gail Locock		30/12/08	• C. difficile care pathway • ADLs/Care plan • Rapid risk assessment for diarrhoea
3a		National guidance and local data informs the local screening policy/guidance and mechanisms for assessing compliance are identified and implemented.	In place	Sara Mumford	Gail Locock			• MRSA Screening policy. • Compliant with national guidance • SHA monthly screening audit • Weekly monitoring reports to SHA • GRE screening giudance
3b	Identified the steps that need to be taken to reduce or control those risks.	Individual patient treatment plans reflect the outcome of HCAI risk assessment	ADLs and individual care planning to include IPC	Flo Panel-Coates	ADNS's/Matrons		Completed	• C. difficile care pathway. • Diarrhoea rapid risk assessment and pathway • ADLs. In place and monitored daily

3c	Recording its findings in relation to items a) and b)	Infection control risk assessments are a standing item on the Infection Control Committee, clinical governance/risk management/patient safety committee agenda	Risk assurance framework IPC to be included on Quality and Safety Committee agenda	Sara Mumford	Gail Locock		Completed	• Discussion of current risks at IPCC • Quality and Safety minutes – monthly report from IPCC • IPCC minutes • RCA/SUI reports
3d	Implementing the steps identified	Compliance with Infection control guidance, treatment/care plans and risks assessments are audited and monitored at directorate/divisional/ corporate level as appropriate	Develop monitoring at divisional level Framework for IPC assessments	SM/Flo Panel-Coates	Gail Locock/ADNS's		Complete	• Infection control is standing item at divisional meetings and divisional operations committee • Saving lives audits reported to divisions and IPCC. • PEAT report to IPCC • Cleaning standards audits report to divisions and IPCC • HCAI balanced scorecard • RCA as part of framework. • Final 2009 annual audit plan to be agreed at Jan 09 IPCC

3e	Appropriate methods in place to monitor the risks of infection such that it is able to determine whether further steps need to be taken to reduce or control HCAI.	Root cause analysis (RCA) is undertaken at directorate level for all patients with severe infections such as MRSA bacteraemias and *C. difficile associated infections*, and is investigated in a timely manner and the outcomes reported through local/directorate and corporate governance and performance frameworks.	Develop divisional responsibility for RCA – report to clinical governance meetings DIPC as Trust lead for HCAI RCA Draft process to go to divisions and Clinical directors	Sara Mumford/Flo Panel-Coates	DD's & ADNS's		Complete	• RCA process agreed at divisions and IPCC • DIPC is Trust lead for HCAI RCA • RCA reports reviewed at IPCC • Action plans monitored at IPCC • DIPC reports to Board.

This page is intentionally left blank

Infection Prevention and Control update for Health Overview and Scrutiny Committee – Maidstone & Tunbridge Wells NHS Trust

Key interventions 2008

Board to ward responsibility and accountability for infection prevention and control.

Zero tolerance of avoidable healthcare associated infections.

Director of Infection Prevention and Control (DIPC) reports to every Board meeting.

DIPC sends out weekly reports to all Board members and senior management.

Ward by ward and Consultant by Consultant Healthcare associated Infection (HCAI) data published.

Isolation wards on both Maidstone and Kent and Sussex sites. The ward on the Maidstone site is specifically for C. difficile patients.

Patients with C. difficile in Kent and Sussex hospital are transferred to the Maidstone Isolation ward.

Development of a C. difficile integrated care pathway.

Multidisciplinary rounds on C. difficile isolation ward.

Twenty four hour per day cleaning on Maidstone and Kent and Sussex sites and available if required on Pembury site.

Strict antibiotic policy.

Every C. difficile infection and MRSA or Glycopeptide resistant enterococcal blood stream infection has full root cause analysis with action plans. Implementation of action plans is monitored by the Infection Prevention and Control Committee.

Infection Control team expanded with recruitment of two senior matrons.

Implementation of ‘Bare below the Elbows’ across the Trust.

Mandatory 20 minute training session for every member of staff on hand hygiene and the saving lives programme.

Responsibility for infection control is included in the job description of every member of staff.

Strict policy in place for the management of patients with diarrhoea.

The link nurse network has been strengthened with ring-fenced time for training.

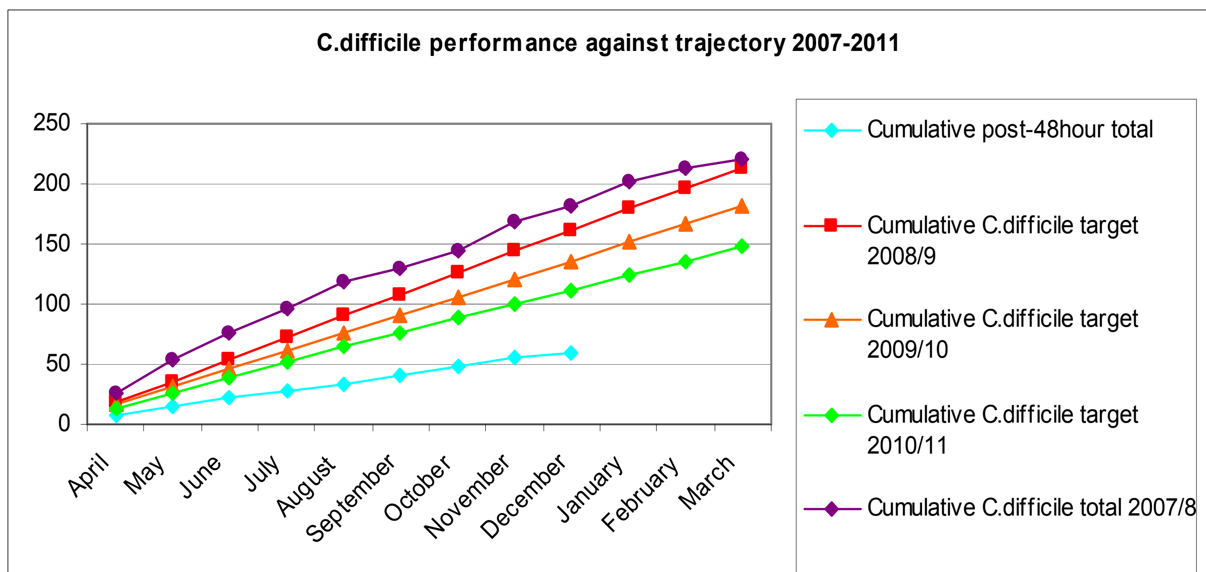
Improved laboratory testing for C. difficile with twice daily testing during the week and once daily at weekends.

All inpatients with diarrhoea are tested up to three times per week for C. difficile to ensure that cases are not missed.

Use of hydrogen peroxide fogging to enhance cleaning following C. difficile outbreaks/incidents.

Data

C. difficile



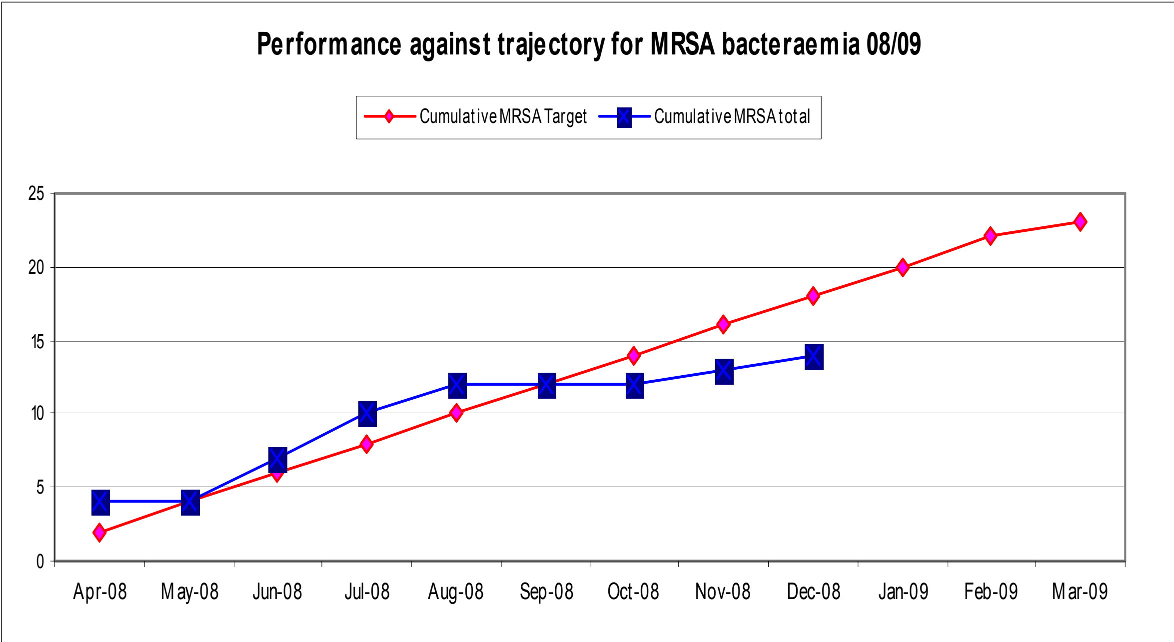
Numbers of C. difficile are well below the SHA stretch target as shown above. For the first half of 2008/9 there were 57 C. difficile infections diagnosed in inpatients (40 of which were post 48 hours) compared with 160 diagnoses in inpatients for the same period of 2007/8, a reduction of 64% year on year. This reduction is continuing and the Trust currently has the lowest rate of C. difficile infection in the South East Coast SHA.

MRSA

At the end of March 2008 the Trust achieved the national target of a 50% reduction in MRSA bacteraemia (blood stream infection).

Against the current year trajectory the number of cases seen in the trust is 14 (YTD target 18) – see graph below.

The trust has increased MRSA screening to all elective cases to comply with DoH guidance and will be further increasing screening over the next year to eighteen months to achieve universal admission screening.



Sara Mumford
DIPC
18 December 2008

This page is intentionally left blank

Core Standards C4c Decontamination – Reporting & Learning – Action Plan – Maidstone & Tunbridge Wells NHS Trust

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.

Element:

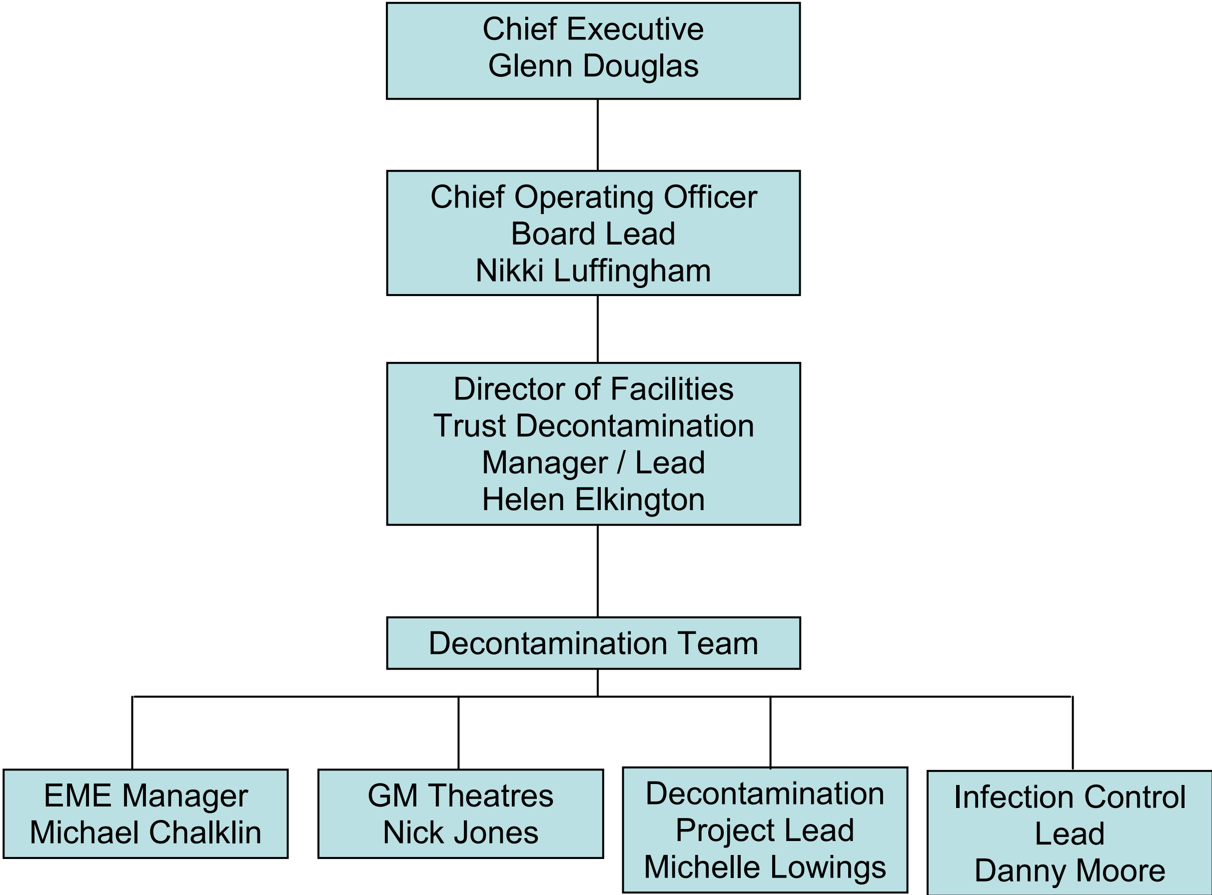
	Line of Enquiry	Action	Success Criteria	Review Date	Lead	Update & Evidence
a	The healthcare organisation has designated a lead manager for decontamination of reusable medical devices used for treatment	Post to be appointed	Director of Facilities briefed on decontamination issues	January 2009	Director of Facilities	Post commencement January 2009
b	The healthcare organisation must, with a view to minimising the risk of HCAI, ensure that there are effective arrangements, including a decontamination programme for the appropriate decontamination of reusable medical devices.	Update policies Medical Devices Decontamination Policy Review Medical Devices Policy Liaison between infection control team and medical devices committee and decontamination project lead Expand maintenance	Policy implementation Policy implementation Monitoring of	Monthly January	Infection control committee Infection control committee S Smith M Lowings M Chalklin	Written policies and procedures Draft awaiting approval December 08 Draft awaiting approval December 08 Minutes of meetings from infection control committee, medical devices committee, decontamination project Maintenance plan to

		year plan	decontamination programme Concise plan of events for decontamination	2009		be review January 2009
c	The healthcare organisation should ensure that decontamination services are provided by an agency that accords with MDD 93/42 and that are registered with an MHRA approved notified body.	Ensure standards of decontamination services meets requirements Work to quality monitoring systems as provided by external bodies (IHSS) Complete national online training	Audit of sterile services Report to In health sterile services technical group Certification for all staff	February 2009 Ongoing review	M Lowings M Lowings	Audit March 08 Action Plan completed and reviewed November 08 Minutes of technical group meetings twice monthly Ongoing for all sterile services staff Technical group sign off on completion expect March 08
d	When commissioning services, the healthcare organisation should satisfy itself that contractors have appropriate systems in place to keep patients, staff and visitors safe from healthcare associated infection, so far as reasonably practicable	External provider vetted and agreed by Trust board New services endorsed by infection control Trust Board final agreement and sign	Service contract agreed Infection control agreement Agreement to readiness by	April 2008 January 2009 June/July 2009	Chief Executive Director of infection control Chief Executive	Contract agreed April 2008 Plans endorsed and signed ongoing signatures required at different phases of the project to be complete by May 2009 External provider commences service in

		off readiness to transfer document	Project Lead, GM Theatres, Directors and Trust Board			July 2009
e	Re-useable medical devices (apart from flexible endoscopes) should be decontaminated in a suitable sterile services environment.	Infection control audit of sterile services Evaluation of existing services Transition to new external services	March 2008 Audit by DOH representative(initial review) 2nd Visit to establish readiness Transfer of services July 2009 national decontamination project (Kent Cluster)	November 2008 November 2008 February 2009 June/July 2009	Daniel Moore M Lowings M Lowings Nick Jones (GM for Theatres) & M Lowings	Audit plan reviewed Nov 2008 all actions completed where feasible remaining actions not addressed due to services going to off site provider July 2009 Audit and action plan review by technical group December 2008 Ongoing reviews of new services Minutes of meetings: (once fortnightly) Project Board: Transition Management Team: Joint Management Board: Technical Group: HR Group: Local Implementation Group:
f	Flexible endoscopes should have their own dedicated area for decontamination as outlined in	Current review of existing environment for decontamination	Service developments achieved in line	November 2008 & Ongoing	D Gaughan	Minutes of meetings held 4th/5th November 2008

	medical devices agency bulletin DB 2002(05)	of endoscopes following HCC visit November 2008	with healthcare commissions recommendations			Relevant departmental changes to take place scheduled for completion by March 2009.
		Staff updates and equipment training from company to ensure correct use of decontamination equipment	Washer disinfector/ steriliser training for all endoscopy staff and external users: areas selected staff trained urology investigations unit: Intensive care: Theatres:	December 2008		Company approved Certification December 2008

Decontamination Responsibility – Maidstone & Tunbridge Wells NHS Trust



This page is intentionally left blank

Core Standard C21 clean, well designed environments – Reporting & Learning – Action Plan Exec Lead. Estates Director – Maidstone & Tunbridge Wells NHS Trust

Statement: Healthcare services are provided in environments, which promote effective care and optimise health outcomes by being well designed and well maintained, with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.

Element 1: The healthcare organisation has taken steps to provide care in well designed and well maintained environments including in accordance with Building Notes and Health Technical Memorandum, the *Disability Discrimination Act 1995* and the *Disability Discrimination Act 2005* and associated code or practice.

	Line of Enquiry	Action	Success Criteria	Review Date	Lead	Update & Evidence
C21	The healthcare organisation should have taken steps to provide care in environments that are well designed and well maintained. In taking these steps the organisation should have taken into account the guidance and recommendations from *Developing an estates strategy*, *Estatecode: essential guidance on estates and facilities management*, *A risk based methodology for establishing* and *Managing backlog* and the *NHS Environmental assessment tool*. (please see point of information below for details of each piece of guidance)	The Trust holds a comprehensive library of design information and complies with NHS Guidance, HTM and HBN documents where appropriate. Backlog is assessed and managed in line with the risk based methodology.	No issues raised by patients, visitors and staff.	Ongoing	Phil Marsden	Library and design documentation available.
	The healthcare organisation should also be complying with the Disability	Comprehensive reports have been	No issues raised by patients,	Ongoing	Phil Marsden	DDA reports available

	Discrimination Act 1995. The Disability Discrimination Act 1995 makes discrimination on the grounds of disability, unlawful in respect of, amongst other things, access to goods, facilities, services and premises. The healthcare organisation should ensure that the design and maintenance of its premises do not 'make it impossible or unreasonably difficult for disabled persons to make use of' their services. The organisation should have considered its environment with regards to access to and use of services, and suitability of accommodation and facilities for disabled people.	completed for all our sites identifying DDA issues, these have been reviewed and actions taken where appropriate. All new schemes are design to ensure where possible DDA compliance. Improvement to DDA issues will be taken forward with the opening of the new hospital at Pembury and the development of the estate strategy at Maidstone.	visitors and staff.			
	The Healthcare organisation should be 'able to demonstrate that wards and departments are kept clean'	Quality Audits	Quality audits are programmed to be undertaken in accordance with the NSC risk categories.	Ongoing	Sue Hedges	Quality audits are available to be reviewed. Quality audits are reported quarterly to the IPCC committee. (All evidence is available in a hard copy file which is kept in the facilities office)

	The healthcare organisation should: • Have identified cleaning outcomes based on the national specifications • Have planned cleaning procedures based on levels of risk and priority • Have a system of technical and managerial audits in place to monitor cleanliness levels.	Quality Audits	Quality audits are programmed to be undertaken in accordance with the NSC risk categories.	Ongoing	Sue Hedges	Quality audits are available to be reviewed. Quality audits are reported quarterly to the IPCC committee.
		Domestic staff work schedules.	Work is monitored in additional to the audit programme.	Ongoing	Sue Hedges	Work schedules and rectification sheets.
		Draft Operational Cleaning policy		Under review	Jim Scott	Draft Operational cleaning policy
		The National Specifications for Cleanliness in the NHS: A Framework for setting and measuring performance Operational Plan		Board approved September 2007	Jim Scott	The National Specifications for Cleanliness in the NHS: A Framework for setting and measuring performance Operational Plan (All evidence is available in a hard copy file which is kept in the facilities office)

	The organisation should have in place clear local policies, which include cleaning methods and frequencies, risk protocols and local service level agreements for each functional area	Infection Control policy and procedures.	Reduced infection rates.	Ongoing	Sue Hedges	Policy and Procedure
		BICSc methods for cleaning.	Improved standards	Ongoing	Sue Hedges	Training records
		Frequencies are based on NSC guidelines.	Improved standards	Ongoing	Sue Hedges	NSC Guidelines (All evidence is available in a hard copy file which is kept in the facilities office)
		Service level agreements not yet in place.		March 2009	Sue Hedges	
	The healthcare organisation should have adopted the commitments of 'A matron's charter'. This document 'sets out 10 broad commitments that should be adopted everywhere in the NHS' The document states that the commitments should be used as a basis for discussion, as a spur to teams to audit their practice, as a foundation for developing service ideals and as a tool to enable local targets for improvement to be set.	Facilities Manager Soft FM attends the weekly Site meetings to update ward managers and matrons on any cleaning related issues.	Improved communication	Ongoing	Sue Hedges	Meeting Minutes
		All ward managers and matrons receive copies of audit reports.	Improved understanding of cleaning issues.	Ongoing	Sue Hedges	Audit reports
		Patient Environment Strategy Group	High level group allowing any specific issues to be raised to Board level.	Ongoing	Jim Scott	Meeting Minutes

		National Standards of Cleanliness operational group	Review trends and highlight areas of concern to feed into the PESG group	Ongoing	Sue Hedges	Meeting Minutes (All evidence is available in a hard copy file which is kept in the facilities office)
	Revised guidance on contracting for cleaning states that the organisation should have systems in place to assess the effectiveness of its cleaning programmes and should have benchmarked its performance and outcomes against other healthcare organisations of a similar type and size.	ERIC reports PEAT Assessments	 Continued improvements in scores	Ongoing Ongoing	Sue Hedges Jim Scott	ERIC Data PEAT Scores (All evidence is available in a hard copy file which is kept in the facilities office)

This page is intentionally left blank

Maidstone & Tunbridge Wells NHS Trust

Trust Management Structure

Chief Executive
G Douglas

- Director of Infection Prevention and Control, S Mumford
  - Infection Control
- Chief Operating Officer, N Luffingham
  - Operational Estates Facilities
  - ICT Director
    - ICT Directorate
  - Innovations Team
  - Divisional Director of Cancer Support Services, S Coltart
    - Associate Director of Operations, C Donnelly
    - Cancer
    - Imaging
    - Therapies
    - Pathology
    - Pharmacy
    - Infection Control
  - Divisional Director of Women's and Children's Services, W Bolsover
    - Associate Director of Operations, M Harvey
    - Associate Director of Nursing, G Duffey
    - Obstetrics and Genecology
    - Paediatrics
    - Sexual Health
  - Divisional Director of Planned Services, P Sigson
    - Associate Director of Operations, D deRozarieux
    - Associate Director of Nursing, S Callanan
    - T&O, Planned Care and Outpatients
    - Surgery and Urology
    - Head and Neck
    - Theatres, ITU and Outreach
  - Divisional Director of Emergency Services, J Webb
    - Associate Director of Operations, M Tunbridge
    - Associate Director of Nursing, L Summerfield
    - Acute and Emergency Medicine Maidstone.
    - Acute and Emergency Medicine K&S
    - Specialist Medicine 1
    - Specialist Medicine 2
- Finance Director, P Turner
  - Strategic Finance
  - Service Agreements
  - Financial services
  - Financial systems
  - Management Accounts
- New Hospital Development Director, G Goddard
  - PFI
- Human Resources Director, T Coode
  - Occupational Health
  - HR Business Partnering
  - Learning and Development
  - HR Shared Services
- Medical Director, J Lewis (interim)
  - Director of Medical Education
  - Head of Quality and Governance (dotted line)
- Director of Nursing, F Panel-Coates
  - Head of Quality and Governance
    - Quality & Patient Safety Manager
      - Complaints, Claims and Patient Safety Teams
    - Risk Manager
      - H&S, Fire, Moving & Handling, Risk and Incident Databases
    - Audit and Research Manager
      - Audit and Research Teams
- Corporate Development Director, F Sims
  - Strategic Estates
  - Business Planning Team
  - Information Team

Revised October 2008

Maidstone & Tunbridge Wells NHS Trust

Management Committee Structure

TRUST BOARD

Joint Strategic Programme Board
Chaired by CEO

Audit Committee
(Bi-monthly)
Chaired by NED

Audit committee oversees the activities of all the Committees

Human Resources Committee
Chaired by NED

- **Education & Training Committee**
- **Occupational Health**

Executive Team
(Fortnightly)
Chaired by CEO

Remuneration Committee
Chaired by NED

Finance & Charitable Funds Committee
Chaired by NED

Patient Experience Committee
Chaired by NED

- Patient Information

Quality and Safety Committee
(Monthly)
Chaired by NED

Divisional Operational Committee
(Monthly)
Chaired by Chief Operating Officer

Health & Safety Committee
(bimonthly)
Chief Operating Officer

- Security Group
- Waste Group
- Interventional Procedure (ad hoc) Chaired by Medical
- Medical Devices
- Local & specialist H&S committees, site panels and Patient Environmental Action Group
- Health, Safety & risk Reports from Directorates and specialists

Standards Committee
(monthly)
Medical Director

- Ethics
- Resuscitation
- Medicines Management
- Drugs and Therapeutics
- Transfusion
- Research & Development
- Interventional Procedures
- Clinical Governance Leads group

Infection Control Committee
(monthly)
DIPC

CLIP Group
(monthly)
Director of Nursing

Safeguarding Children & Adults
(TBA)
TBA

Information Governance / ICT
(monthly)
ICT Director

Cancer and Support Services Divisional Meeting
(Monthly)

Directorate meeting

- Cancer
- Imaging
- Therapies
- Pathology
- Pharmacy
- Infection control

Women's & Children's Services Divisional Meeting
(Monthly)

Directorate meetings

- Obstetrics and Genecology
- Paediatrics

Directorates meet monthly Chaired by Divisional Director

Planned Services Divisional Meeting
(Monthly)

Directorate meetings

- T&O, Planned Care and Outpatients
- Surgery and Urology
- Head & Neck
- Theatres, ITU and Outreach

Emergency Services Divisional Meeting
(Monthly)

Directorate meetings

- Acute and Emergency Medicine Maidstone
- Acute and Emergency Medicine K&S
- Specialist Medicine 1
- Specialist Medicine 2

THICK ARROWS INDICATE INFORMATION FLOWS

Blood Transfusion Comm

Maidstone & Tunbridge Wells NHS Trust

Governance Structure

TRUST BOARD

Audit Committee (Bi-monthly)

Audit committee oversees the activities of all the Committees

Remuneration & Appointment Committee Chaired by NED

Human Resources Committee Chaired by NED

- Education & Training Committee Chaired by HR Director
- Occupational Health Risk

Quality and Safety Committee (Monthly) Chaired by NED

Divisional Operational Committees (Monthly) Chaired by Chief Operating Officer

Patient Experience Committee (monthly) Chaired by NED

- Patient Information and Letters Group

Finance & Charitable Funds Committee

- Financial Risks

Infection Control Committee (monthly) Chaired by DIPC

Health & Safety Committee (bimonthly) Chaired by Chief Operating Officer

- Specialist H&S committees E.g.: Radiation Protection Laboratories etc
- Local H&S committees, Site based panels and Patient Environmental Action Group
- Medical Devices Committee (monthly) Chaired By Consultant Nurse
- Security Group (bimonthly) Chaired By LSMS
- Resilience Committee (bimonthly) Chaired by TBA
- Waste Group (6 weekly) Chaired By Facilities Manager
- Health, Safety & Risk Reports from Directorates and specialists such as Fire and Moving and Handling

Information Governance/ICT (bimonthly) Chaired by ICT Director

CLIP Group (monthly) Chaired by Director of Nursing

Standards Committee (monthly) Chaired by Medical Director

- Medicines Management Committee (bimonthly) Chaired by Chief Pharmacist
- Resuscitation Committee (bimonthly) Chaired By Consultant for Critical Care
- Research & Development Committee (Quarterly) Chaired by Trust Research Lead
- Clinical Governance Leads Group (Quarterly) Chaired by Medical Director
- Ethics Committee (bimonthly) Chaired By Medical Director
- Drugs and Therapeutics Committee (6 weekly) Chaired by Consultant Physician
- Blood Transfusion Committee (bimonthly) Chaired By Divisional Director for Planned Care
- Interventional Procedures Committee (ad hoc) Chaired by Medical Director

Safeguarding Children & Adults (TBA) Chaired by TBA

THICK ARROWS INDICATE INFORMATION FLOWS

Revised October 2008

This page is intentionally left blank