Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD MEETING

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

10.30am – c.1pm WEDNESDAY 27TH JANUARY 2016

THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
1-1	To receive apologies for absence	Chairman	Verbal
1-2	To declare interests relevant to agenda items	Chairman	Verbal
1-3	Minutes of the Part 1 meeting of 25th November 2015	Chairman	1 and 1a
1-4	To note progress with previous actions	Chairman	2
1-5	Safety moment	Non-Executive Director	Verbal
1-6	Chairman's report	Chairman	Verbal
1-7	Chief Executive's report	Chief Executive	3
1-8	Integrated Performance Report for December 2015	Chief Executive	
	▪ Safe / Effectiveness / Caring	Chief Nurse	
	▪ Safe / Effectiveness (incl. HSMR)	Chief Nurse	
	▪ Safe (infection control)	Dir. of Infect. Prevention and Control	4
	▪ Well-Led (finance)	Director of Finance	
	▪ Effectiveness / Responsiveness (incl. DTOCs)	Chief Operating Officer	
	▪ Well-led (workforce)	Deputy Director of Workforce	
	Presentation from a Clinical Directorate		
1-9	Stoma Care Nurses at Maidstone Hospital	Stoma Care Nurses	Presentation
	Quality items		
1-10	Response to the recommendations arising from the external "Good Governance and Culture Review"	Chief Nurse	5
1-11	Quality and Patient Safety Report	Chief Nurse	6
1-12	Progress with the Quality Improvement Plan	Chief Nurse	7
1-13	Planned and actual ward staffing for Nov & Dec 2015	Chief Nurse	8
1-14	Board members' hospital visits	Trust Secretary	9
	Planning and strategy		
1-15	To approve the transfer of Crowborough Birthing Centre and High Weald Comm. Midwifery Services	Chief Operating Officer	10
	Assurance and policy		
1-16	Emergency Planning update (annual report to Board)	Chief Operating Officer	11
1-17	Approval of compliance oversight self-certification	Trust Secretary	12
1-18	Ratification of Gifts, Hospitality, Sponsorship and Interests Policy and Procedure	Trust Secretary	13
1-19	Ratification of Reservation of Powers and Scheme of Delegation (annual review)	Trust Secretary	14
	Reports from Board sub-committees (and the Trust Management Executive)		
1-20	Patient Experience Committee, 07/12/15	Committee Chairman	15
1-21	Trust Management Executive, 09/12/15 & 20/01/16	Committee Chairman	16
1-22	Quality Committee, 10/12/15, 06/01/16, and 11/01/16 (incl. SIs & approval of revised Terms of Reference)	Committee Chairman	17
1-23	Finance Committee, 12/01/16 & 25/01/16 (including approval of: the OBC for additional Radiotherapy LinAc bunker capacity at TW Hospital; and the Trust's application for a "Single Currency Interim Revenue Support Facility")	Committee Chairman	18 (to follow), 19 (to follow) and 20
1-24	**To consider any other business**		
1-25	**To receive any questions from members of the public**		
1-26	To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted	Chairman	Verbal
	Date of next meeting: 24th February 2016, 10.30am, Academic Centre, Maidstone Hospital		

Anthony Jones,
Chairman

Maidstone and Tunbridge Wells NHS
NHS Trust

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 25TH NOVEMBER 2015, 10.30 A.M. AT MAIDSTONE HOSPITAL

FOR APPROVAL

Present:	Anthony Jones	Chairman of the Trust Board	(AJ)
	Avey Bhatia	Chief Nurse	(AB)
	Sylvia Denton	Non-Executive Director	(SD)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Alex King	Non-Executive Director	(AK)
	Steve Orpin	Director of Finance	(SO)
	Paul Sigston	Medical Director (apart from item 11-12)	(PS)
	Kevin Tallett	Non-Executive Director (apart from item 11-22)	(KT)
	Steve Tinton	Non-Executive Director (apart from item 11-12)	(ST)
In attendance:	Paul Bentley	Director of Workforce and Communications	(PB)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Mark Cardnell	Deputy Director of Estates and Facilities (for item 11-15)	(MC)
	Jeanette Rooke	Director of Estates and Facilities (for item 11-15)	(JR)
	Kevin Rowan	Trust Secretary	(KR)
	Barry Boulton	Patient's relative (for item 11-8)	(BB)
	Deborah McNair	Patient's friend (for item 11-8)	(DMc)
Observing:	Jenny Davidson	Associate Director of Governance, Quality & Patient Safety	(JD)
	Christos Mikropoulos	Oncology Specialist Registrar (for items 11-1 to 11-11, & 11-15)	(CM)
	Darren Yates	Head of Communications	(DY)
	Oluwarantimi Amodele	Prospective Consultant candidate	(OA)
	David Gazet	Reporter, Kent Messenger (for items 11-1 to 11-11, & 11-15)	(DG)

[N.B. Prior to the meeting, all Trust Board Members (apart from ST) received a training session on "Health, Safety and Risk", led by the Trust's Risk and Compliance Manager. The slides from the session are available (in Attachment 1a)]

AJ reminded Trust Board Members that it had been agreed at the October 2015 'Part 2' Board meeting that lunch would no longer be provided, and it would be beneficial if Board Members visited the canteen to purchase their lunch. AJ also noted that it had been arranged for Board Members to make a brief visit to see the new John Day Ward, after the 'Part 1' meeting.

11-1 To receive apologies for absence

There were no apologies.

11-2 To declare interests relevant to agenda items

PB declared his appointment as the new Chief Executive of Kent Community Healthcare NHS Foundation Trust, from 01/03/16.

11-3 Minutes of the Part 1 meeting of 21st October 2015

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

11-4 To note progress with previous actions

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

- **Item 9-8i ("Ensure the Trust Board receives the outcome of the planned review of Medical rotas being led by the Medical Director").** PS reported that he would be unable to provide the requested information until March 2016.
- **Item 10-8i ("Arrange for "Patient Falls" to be reviewed at a future Quality Committee 'deep dive' meeting").** SDu confirmed that work to schedule a meeting was in progress.
- **Item 10-8iii ("Provide Trust Board Members with details of the local healthcare economy schemes being financed via the Better Care Fund").** SO reported that no response had yet been received, but he was meeting with representatives of the Clinical Commissioning Group (CCG) on 27/11/15.

11-5 Safety moment

AB highlighted that the Trust had seen increased capacity pressures over the previous 10 days, and some difficult decisions had had to be made regarding the placement of patients. AB continued that in addition, there was the forthcoming industrial action by Doctors in Training (Junior Doctors), the challenging financial situation, and the need to reduce reliance on temporary staff, all of which emphasised the need to maintain focus on patient safety throughout what will undoubtedly be a challenging time. The point was acknowledged.

11-6 Chairman's report

AJ reported that it had been announced that the NHS would receive some additional funding, and stated he hoped that such funding would reach front line services. AJ acknowledged the Trust had limited powers in terms of the allocation of the funding, but felt it was important to make its position clear. SO proposed that Trust Board Members be kept informed of the intended allocation of the funding. AJ confirmed this would be beneficial.

Action: Arrange for Trust Board Members to be kept informed of the intended allocation of the additional NHS funding that was announced on 24/11/15 (Director of Finance, November 2015 onwards)

11-7 Chief Executive's report

GD referred to the circulated report and highlighted that the 2015 Staff Star Awards had been appreciated by all who attended, including those who were nominated but had not won. GD added that the Awards showcased the positive aspects of the Trust, highlighted that the guest speaker, Cheryl Ferguson, was very good, and commended the Communications Team for organising the event. AJ proposed that a letter of thanks be sent from the Trust Board to the Communications Team. This was agreed.

Action: Arrange for a letter of thanks to be sent from the Trust Board to the Communications Team, in response to their organisation of the Staff Stars Awards 2015 (Trust Secretary / Chairman of the Trust Board, November 2015 onwards)

GD then continued, and highlighted that he had attended Hever Castle, which had been lit up in blue on the eve of World Diabetes Day. GD praised Dr Masud Haq for his efforts. AJ remarked that the event illustrated that Trust staff were often involved in positive initiatives about which the Trust Board was unaware.

GD then continued, and highlighted the following points:

- Crowborough Birthing Centre, and the associated Community Midwifery Service, would come under the Trust's management, which would improve the offer of services available to patients in the High Weald area, and prevent them from having to be transferred to Hastings to give birth. GD had had several meetings with the Crowborough Memorial Hospital League of Friends, who were very supportive, and who were likely to donate funds to improve the Centre
- Board Members would be impressed with the new John Day Ward at Maidstone Hospital (MH)
- The new Ward at Tunbridge Wells Hospital (TWH) was progressing well, and GD had seen this first hand, via a visit with the new Ward Manager and lead Consultant

AJ then referred to a recent visit he had made to the ICU with PS, where PS was asked who he was by a member of staff. AJ stated that this illustrated that many staff did not know the identity of Trust Board Members, nor understand their role. AJ proposed that actions to address this be considered as part of a wider communications initiative. This was agreed.

Action: Consider what actions should be taken to increase the awareness, among the Trust's staff, of Trust Board Members and their role (Director of Workforce and Communications, November 2015 onwards)

SDu suggested it would also be helpful if Trust Board Members reinforced the awareness of their roles during their Ward and Departmental visits. AJ agreed.

11-8 A patient's experiences of the Trust's services

AJ welcomed BB and DMc to the meeting, and invited BB to relay the details of his wife's experiences. BB highlighted the following points:

- BB's wife, Marie (MB), had experienced a fall at home, at circa 3.30am, and BB dialled 111
- Before the ambulance arrived, the 2 people who answered the 111 call were excellent, and this represented the start of MB's care
- MB was taken to TWH. The staff were excellent, and BB & MB were treated almost like royalty
- In due course, following an X-Ray, MB underwent a successful hip operation
- Rachel Cox was one of the staff who was excellent, and who went beyond the bounds of normal duty
- MB was eventually transferred to MH, for her rehabilitation. She was then discharged home, her staples were removed, and MB was able to undertake some walking
- However, MB then stuffed a second fall, affecting the other hip. A 111 call was again made, and an ambulance arrived and took MB to TWH
- Whilst at the Hospital, staff suspected something was wrong, and identified that MB had suffered a minor Stroke
- Despite this, MB underwent a further operation on her hip. The care was excellent, but MB's recovery was not as quick as had been the case with the previous operation
- MB was then transferred to the Stroke Unit. The staff on the Unit, which included Baska, a Polish Nurse, were also excellent
- Dr Chris Thom then identified that the two 'shadowed' areas on MB's X-Ray were indicative of Carcinoma, and therefore arranged for MB to be transferred home
- A team of Carers was organised (from Homecare Unique Limited) along with a bed & mattress
- The Carers were excellent, which included staff arriving when they were scheduled to do so
- Early on, BB was made aware of what a Do Not Resuscitate (DNR) order was, and informed that MB would not recover
- MB had not previously been in pain, but had to have a Morphine prescription earlier that week
- MB's condition was due to the excellent level of care by all staff
- In BB's view, the criticisms levelled at the NHS and TWH in particular, were totally unjustified. BB and MB had been met with courtesy, kindness, gentleness, and consideration. BB had had an operation at the old Kent and Sussex Hospital, and was therefore able to compare
- MB had had lots of visitors, given her standing in the local community, and this support had been beneficial. However the service, attention and care from the staff at TWH and MH had been of paramount importance

AJ thanked BB, and stated that it was very beneficial for Trust Board Members to hear about the positive work that took place at the Trust. AJ confirmed the individual members of staff referred to by BB would be sent letters of thanks.

Action: Arrange for letters of thanks to be sent to the individual members of staff referred to in the "patient story" that featured at the Trust Board on 25/11/15 (Trust Secretary, November 2015 onwards)

PS also thanked BB & stated that staff would no doubt have been delighted to have cared for MB.

BB then stated that he was having difficulty in obtaining the correct incontinence pads for MB. BB elaborated that had discovered the pads were supplied by 'Hartman', but he had contacted the suppliers, only to be told that although supplies were adequate, delivery was taking 6 weeks. AG

stated that the delivery of the pads would be arranged by the MB's Care agency, but stated that she would aim to resolve the delivery issues.

Action: Aim to resolve the issues regarding the delivery of incontinence pads to the patient referred to in the "patient story" that featured at the Trust Board on 25/11/15 (Chief Operating Officer, November 2015 onwards)

KT remarked that it would be useful to consider, in due course, how the impact of the messages given within the "patient stories" heard at Trust Board meetings could be used to beneficial effect among the Trust's staff. AJ asked PB to consider this.

Action: Consider how the impact of the messages given within the "patient stories" heard at Trust Board meetings could be used to beneficial effect among the Trust's staff (Director of Workforce and Communications, November 2015 onwards)

11-9 Review of the Board Assurance Framework, 2015/16

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

- The Board Assurance Framework (BAF) had been updated with each Responsible Director during November. The content of each section had been refreshed, and ratings for November had been given for the two questions requiring this
- Objective 4.a. had been reviewed at the Finance Committee on 23/11/15

ST remarked that he wished to dwell on what the BAF was stating, as a whole, given that the bulk of ratings were reported as 'amber'. ST then referred to objectives 1.a and 1.b, and asked whether it was reasonable to expect the rating to be 'green' before the end of 2015/16. GD replied that he would expect this to be the case, given the action that had been taken, and was continuing to be taken. KT challenged the text on for objectives 1.a and 1.b, in that he believed that the judgement of success should not rely on an inspection by the Care Quality Commission (CQC) inspection. AB agreed, but noted that she was giving considerable thought to the rating of the objectives.

KT then referred to objective 2.a, and stated that it was unfair to rate the objective as 'amber', given the Trust was doing everything it could to achieve the objective. GD agreed, and stated that the question posed on the BAF perhaps needed to be phrased differently.

AK stated that there was a danger in the ratings in the report that the Trust Board and Executive Team could be seen as lacking confidence. AK opined that it was better to be confident, noting that not every aspect could be controlled. ST agreed, stated that there much had been done regarding capacity, and therefore proposed that the rating be 'green'. ST added that the same could be said about the 'culture' and 'quality' objectives.

AJ stated that it was clear that consideration was required as to whether all of the actions needed had been adequately captured. GD reiterated his earlier point that the phrasing of the questions posed on the BAF probably needed to be changed. AJ also accepted that a 'green' rating in November would not automatically lead to a 'green' rating at the end of 2015/16, and emphasised that this should be accepted. ST concurred.

AB then referred back to the rating of objectives 1.a and 1.b, and explained that she had given an 'amber' rating as the wording of the objective referred to "…failure to provide care and treatment within the upper quartile (as recognised by patients, staff and the CQC)"; and therefore felt that she could not give a 'green' rating in this context. KT acknowledged the point.

AJ proposed that at the point of the next review, the ratings on the BAF accurately reflect the sentiment that a 'green' rating could legitimately be applied where the Trust was doing all it could to achieve the objective (and there was confidence that this action would lead to the objective being met). This was agreed. KR also proposed that the wording of the objectives be included in the review. AJ agreed.

Action: Ensure, at the point of the next review, that the ratings on the Board Assurance Framework accurately reflect the sentiment that a 'green' rating could legitimately be applied where the Trust was doing all it could to achieve the objective (and there was confidence that this action would lead to the objective being met) (Trust Secretary, February 2016)

11-10 Integrated Performance Report for October 2015

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

- Delayed Transfer of Care (DTOCs) were continuing, and A&E activity remained stable, but the conversion rate (to admissions) was reducing, which illustrated that fact that external pressure was relentless, but the Trust's efforts were having a positive effect. However, this was detrimental to the Trust's financial situation
- The 62-day Cancer waiting time target needed to be delivered for final quarter of the year
- There were continued successes in the recruitment of Nurses, which was important in the context of the new Wards that were opening in the near future

AJ referred to the table on page 2 of 18, and the level of DTOCs who were "Delayed by Social Services", and remarked that the data was interesting. GD agreed, but cautioned that the data did not reveal the full picture across the whole health economy.

Safe / Effectiveness / Caring

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

- The rate of falls had reduced slightly, which was positive, and patient falls would be discussed in detail at a Quality Committee 'deep dive' in January 2016
- The trial regarding the new method of responding to complaints was considered to have been successful, and was now being implemented for other Directorates
- There was evidence, via comments made to the Patient Advice and Liaison Service (PALS), of survey fatigue, particularly now that the Friends and Family Test (FFT) had been extended to Outpatients. AB would therefore undertake a review of the surveys undertaken at local level

ST noted that there had been a quantum increase in DTOCs, and asked for an update on the discussions that had been held with Social Services to ensure that patients could leave hospital once deemed to be medically fit. GD replied that the Trust was concerned at the ability of Social Services to accept transfers of patients, in terms of both financial ability, and the physical space available. GD continued that Social Services had responded to prompts for action, but this had not been sustained, and therefore further prompts were required. GD added that he was scheduled to meet with Greg Clark MP and Social Services on 29/11/15 to discuss the matter, but was deeply concerned with Kent County Council's proposals (which were currently out for consultation) to close a number of Nursing Homes by April 2016. GD stated that he understood the rationale for the closure i.e. to move towards assessing people in their own homes, but this was not yet feasible, and he did not therefore have confidence that the situation would improve. AK suggested that GD apprise himself of the full details of the settlement for Social Services within the Government's spending review. GD welcomed the suggestion, and invited AK to attend the meeting, which was being held at 9am on 29/11/15, at TWH. AK confirmed that he should be able to attend.

GD pointed out that at a previous meeting, Mr Clark had stated that he would hold GD resistible for the level of DTOCs, and pointed out that this position was supported by NHS England, who had threatened to fine NHS Trusts for DTOCs. AJ emphasised that the Trust Board would support GD in whatever action he believed was required.

GD then highlighted that the Chief Executive of Medway NHS Foundation Trust had appeared on South East TV news on 24/11/15 stating that Medway Maritime Hospital was full. GD noted that this was also the case for TWH and MH, but the difference between the two approaches was that that this Trust had planned to introduce increased capacity in the near future. GD emphasised that this was important in demonstrating that the Trust took the matter seriously, and was willing to act.

Safe / Effectiveness (incl. HSMR)

PS then referred to the circulated report and highlighted that both mortality ratios were now rated 'green', and were reducing. AJ asked PS whether he intended to work with Dr Foster to improve the use of the Trust's subscription. PS confirmed this was the case. AJ proposed that PS inform the Trust Board of the plans, in 2016. SDu stated that she was optimistic that the new Clinical Governance structure would lead to improvement in the use of Dr Foster data among Clinical

Directorates. AJ summarised that PS would work with Dr Foster and the Clinical Directors to improve the use of the clinical information within the 'Dr Foster' IT system, and proposed that PS provide an update on the latest situation to the Trust Board, in February 2016. This was agreed.

Action: Provide an update to the Trust Board, in February 2016, on the latest situation as to the extent of the use, within the Trust, of the clinical information within the 'Dr Foster' IT system (Medical Director, February 2016)

Safe (infection control)

SM then referred to the report and highlighted the following points:

- There had been no new cases of MRSA bacteraemia
- There had been 3 Clostridium difficile cases in the month, but the Trust was still under the trajectory for the year to date. Much work had been undertaken with clinicians in response to the cases that had occurred, and there had been a high level of interest, engagement and positive acceptance of the advice given by the Infection Control Team

Well-Led (finance)

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

- The Trust's position was £3.4m adverse against plan, so the year to date deficit was £12.8m
- Further action was needed to improve the position, and this had been discussed in more detail at the last meetings of the Finance Committee and Trust Management Executive (TME)
- Cost Improvement Plan (CIP) delivery remained just behind plan
- Cash would remain an issue, but the Trust's application for an Interim Revolving Working Capital Facility (IRWCF) had been approved, and the first drawdown had been made
- Capital expenditure was ahead of that for the same period in 2014/15, and there were some significant IT developments planned

GD asked whether the "Capital Expenditure" indicator within the Trust Performance Dashboard could be recalibrated, to enable the reporting of a more accurate reflection of the Trust's current performance. SO agreed to the request for future reports.

Action: Consider the recalibration of the "Capital Expenditure" indicator within the Trust Performance Dashboard, to enable the reporting of a more accurate reflection of the Trust's current performance (Director of Finance, November 2015 onwards)

ST asked whether information was available on the actual number of staff, compared to budget. SO confirmed this was available. ST asked whether this could be provided to the Trust Board. SO stated that the apex of such information was already included in the Performance Dashboard. ST clarified that he was trying to understand the overall numbers, in financial terms, as the impact on the use of Agency staff should only reflect the margin paid to Agency staff. KT expressed his support for the provision of such information. AJ stated that this subject would be discussed further in the 'Part 2' Trust Board meeting to be held later that day.

Effectiveness / Responsiveness (incl. DTOCs)

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

- A clear action plan was in place regarding the activity arriving via the A&E department, which included ambulatory performance
- Cancer waiting time performance continued to the focus of attention, and there had been 9 breaches of the 104-day waiting time target (which was a new target for 2015/16)

AJ queried the impact of the involvement of other Trusts in the breaches of the 104-day target, and asked whether any of the 9 breaches were the sole responsibility of the Trust. AG replied that 8 of the 9 breaches involved patients that originated from the Trust. AJ asked for further details. AG stated that 1 patient had delays that could have been prevented via consolidation of the pathway.

SD emphasised that the Trust was a Tertiary centre, and asked whether the data could differentiate the key issues for the Trust's own patients. GD pointed out that this distinction had already been made within the narrative in the circulated report.

AG then continued that the Discharge Team had been consolidated with Social Services, and the teams were being re-launched, to raise their profile. AG added that the formula had worked well elsewhere, and the team was being led by Dawn Hallam, whose post was a joint appointment.

AJ asked for a comment on the A&E 4-hour waiting time target performance at TWH, and asked how the new Ward would affect performance (all things being equal). AG replied that over the course of the year, the achievement of the 95% target would be supported by having an Ambulatory Unit. AG added that the Trust had strengthened its approach by joining the national Ambulatory Emergency Care Network, to learn from best practice. AG added that it was planned to meet the 95% target at TWH in Quarter 1 of 2016/17.

KT queried whether the Ambulatory Unit could be relabelled, given the expected caseload, and given the marginal rate of tariff that available for Emergency care. GD confirmed the repositioning of such care was planned as part of the future negotiations with the Commissioners.

GD then referred to Oncology fractions, and stated that although the numbers had reduced, there would be an improvement following the opening of the LA2 Linear Accelerator at Kent and Canterbury Hospital. AJ commended the coverage of the opening, which had been reported by local TV news.

Well-led (workforce)

PB then referred to the circulated report and highlighted the following points:
- Registered Nurse recruitment had been very successful, and there was a strong recruitment pipeline in the next 4 months, which continued to grow
- The Trust was also beginning to see some improvement in the recruitment of Medical staff

SDu asked for details of the current rate of uptake of influenza vaccinations among Trust staff. PB stated that he did not have figures to hand, but could provide these. SDu stated that this should be monitored, noting that some Trusts had achieved rates of 80%. PB stated that the national average for the previous year was circa 40%, and the Trust's uptake was similar to this. SDu emphasised the need to aspire to achieve higher levels. It was agreed that the vaccination uptake data should be provided for November and December 2015, along with assurance on the action being taken to increase the rate of uptake.

Action: Provide Trust Board Members with the rate of uptake of influenza vaccinations among Trust staff (as at November and December 2015), along with details of the action being taken to increase the rate of uptake (Director of Workforce and Communications, November 2015 onwards)

GD stated that prominence could be given to the issue as part of the summary of the Trust Board meeting, when this was issued to staff (as part of the Chief Executive weekly update).

SDu then referred to the "% Stillbirths Rate" and queried whether this should be rated as 'green'. GD and AB confirmed that this rating was incorrect. It was agreed it should therefore be changed.

Action: Arrange for the "% Stillbirths Rate" in the Trust Performance Dashboard for October 2015 to not be rated as 'green' (Chief Operating Officer, November 2015 onwards)

Quality items

11-11 Progress with the Quality Improvement Plan

AB referred to the circulated report and highlighted the following points:
- The 2 'amber' rated actions were Compliance Actions 6 and 17, but work was continuing to enable these to be rated 'green'
- Many of the 'green' rated actions were likely to be rated 'blue' in the near future

PS remarked that other data that was available showed a substantial fall in admissions to ICU over the last 12 months. AJ acknowledged the point, and queried whether PS had really stated at the Trust Board meeting on 21/10/15 that the Trust's ICUs were the best performing in the country. PS confirmed this was the case. AJ asked that PS circulate the data showing this to all Trust Board Members.

Action: Circulate, to Trust Board Members, the data that showed that the Trust's Intensive Care Units were the best performing in the country (Medical Director, November 2015 onwards)

SD also proposed that a letter be sent from the Trust Board to the staff in the ICUs, acknowledging their performance. This was agreed.

Action: Arrange for a letter to be sent from the Trust Board to the staff in the Trust's Intensive Care Units, acknowledging their performance as the best in the country (Trust Secretary / Chairman of the Trust Board, November 2015 onwards)

11-12 Clinical Quality and Patient Safety Report

AB referred to the circulated report and highlighted that the key issue was Pressure Ulcers, as there had been some Grade 3 and 4 Ulcers. AB added that efforts had been made to establish the occurrence at other local Trusts, and although there were differences in how Pressure Ulcer data was collected, it had been confirmed that Grade 3 and 4 Ulcers had occurred at other Trusts.

AJ commended the work to provide the benchmarking data in the circulated report.

11-13 Staffing (planned & actual ward staffing for Oct '15; and 6-monthly review of Ward and non-Ward areas)

AB referred to the circulated report (Attachment 8) and highlighted the following points:

- The 'planned and actual' Ward staffing data was presented in the usual report format
- The report aimed to fulfil several purposes, including trying to assure the Board that staffing levels were safe, but also show where areas had used more staff than they had planned
- In terms of overall safety, 2 Wards were subject to overall improvement plans, but there was an better overall picture than had been the case in previous reports

SDu challenged the meaningfulness of the report, and stated that it would be beneficial to have a view of the Trust's position in relation to the latest national direction i.e. which did not require absolute adherence to a 1:8 Nurse:patient ratio. SDu added that as a lay person, there had been difficulty in interpreting patients' acuity. AB replied that the format of the circulated report was prescribed, and although the previous method of reporting acuity & dependency had been beneficial, the format of the report enabled useful comparison over time. AB continued, accepted that the Nurse:patient ratio was often a misleading indicator, & highlighted that this point had been acknowledged nationally, as was evident from the letter that had been submitted for item 11-14.

SD asked how often acuity and dependency was assessed. AB confirmed that this was assessed every day, and added that decisions regarding patient need were informed by such assessments. SD queried whether the Trust had 'floaters' i.e. Nurses who were able to transfers to other Wards, as the need arose. AB confirmed this was the case, and confirmed that staff were regularly transferred between areas. It was also noted that site meetings were held 4 times a day.

AB then referred to Attachment 9, and emphasised that there were no concerns regarding safe staffing levels, and therefore no need for immediate action, so any proposed increases would be subject to the usual business case process.

SDu referred to a query that had been held at the Finance Committee on 23/11/15, regarding the fact that the A&E Department was not included in the 'planned and actual' data, and asked why the A&E Department had not been included in the Ward staffing review. AB provided an explanation of the rationale for the review of each area.

11-14 'Safe staffing and efficiency' letter from the NHS TDA etc. (and Trust response)

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

- The Trust undertook the steps referred to in the letter
- The Nurse:patient ratio at the Trust ranged from 1:1 in ICU, through to 1:9 in Romney Ward, but the average was 1:5

- The letter emphasised the need to consider roles for other professionals, for example, enhanced Clinical Support Workers, and the Trust needed to give this matter some thought

SD emphasised the robustness of the Trust's aforementioned methods for assessing acuity and dependency.

Assurance and policy

11-15 The Computer Aided Facilities Management system

AJ welcomed JR and MC to the meeting, and explained that the Computer Aided Facilities Management (CAFM) had been commended by the CQC in their latest MH inspection report as an "area of outstanding practice". JR then gave a presentation highlighting the following points:

- CAFM was the support of facilities management information by Information Technology. It provided software and systems that helped the Trust improve long-term planning of the estate, spaces, facilities, maintenance and service requirements against budgets, to ensure alignment with core business needs and also legislation
- CAFM was designed with 5 key categories: 1: Learning and Development tool; 2: Data storage and signpost; 3: Monitoring program; 4: A legal reference guide; and 5: Auditing assistance tool
- The 'Learning Zone' within the program provided direct access to over 125 websites, which included (but was not limited to): 'How healthcare was set up'; 'Business Continuity Institute'; the CQC; the Health & Safety Executive; BSRIA (best practice information); YouTube links (displaying how technical equipment operated); Healthcare Building Notes; Healthcare Technical Memorandum; and International Standards Organisation (ISO)
- The CAFM worked in 2 ways: by using picture signposting to make record keeping & retrieval quick and structured; and via formatted spreadsheets, to manage the organisation's assets
- The system gave access to over 62,753 records, which included Legal compliance documentation, reports, minutes, external and internal audits/inspection, photographs, training records, project information, reference materials, ISO structures and safe systems of work
- Data inserted into the program that was required to be updated or reviewed was electronically monitored by using 'conditional formatting'
- The CAFM also provided up to date and easily accessible links to relevant guidance, legislation and external portals which enabled informed decisions and cost effective measures to be made
- In addition, the CAFM provided a 'one-stop shop' to evidence information to support external and internal audits. This instilled confidence in operational management, systems and processes, and reduced the 'downtime' of employees supporting auditors and reporting
- The recent CQC inspection regarding water hygiene management noted the CAFM as an "outstanding piece of work"
- CAFM was now embedded as a constructive, easy and effective tool and continued to be enhanced to cover all services within the Directorate (as it had no limitations)
- A member of the senior management team would also be undertaking audits, and these would be uploaded to the CAFM system
- CAFM was used as part of the evidence for the Directorate's accreditations i.e. OHSAS 18001, ISO 22301, and ISO 14001, and the system had been of great benefit to achieving these

AJ asked for details of how the system was developed. JR replied that this involved many hours of work. AJ also asked whether staff were using the system regularly. JR confirmed this was the case, and MC added that there was now nearly 78,000 pieces of information on the system.

KT commended the simple approach, but challenged the assertion that the system had "no limitations", as such limitations were likely, given the system was based on a spreadsheet. KT added that it may be beneficial for JR and MC to explore the "Watson Analytics" system, noting that this was an intelligent machine, & free trials were available. JR acknowledged the suggestion.

KT then queried whether the data in the system was 'backed up'. MC confirmed the data was backed up to two network drives. JR added that discussions were being held with a software developer regarding the development of the system. KT cautioned against the simplicity of the system being lost through such a venture. JR acknowledged the point.

11-16 Fit & Proper Persons' (Directors) Regulations update

KR referred to the circulated report and highlighted the following points:
- Progress on implementing the Trust's response to the Fit & Proper Persons' (Directors) Regulations (FPPR) had been provided to each Trust Board meeting since December 2014, as part of the evidence in the monthly "Oversight Self-Certification" reports
- However, in October 2015, the Board agreed that the status of the Disclosure and Barring Scheme (DBS) checks being undertaken for Trust Board Members should be clarified
- The report therefore provided a comprehensive update on the implementation of the Trust's response to the FPPR, including the outcome; and information on the national situation regarding the FPPR
- In summary, no concerns have been identified thus far

Questions or comments were invited. None were received.

11-17 Approval of compliance oversight self-certification

KR referred to the circulated report and highlighted the following points:
- There were 4 changes in compliance status proposed from that approved in October 2015, which related to Conditions G5 ("Monitor guidance"); P1 ("Recording of Information (about costs) to support the Monitor pricing function by the prompt submission of information"); P2 ("Provision of information"); & P3 ("Assurance report on submissions to Monitor")
- It was proposed that the Trust change its compliance status, and declare "Yes" for compliance with all of these Conditions
- For completeness, the report now also included details of all License Conditions, including those for which the Trust was exempt (i.e. G1, G2, G3, G9, CoS1 to CoS7, and FT1 to FT4)

The compliance status of each Condition and Board Statement was approved as circulated.

11-18 Ratification of Standing Fin. Instructions (ann. review)

KT referred to the circulated report and highlighted the following points:
- The revised document had been "approved" at the Audit and Governance Committee on 04/11/15, and was being submitted to the Trust Board for "ratification"
- The Scheme of Delegation and Standing Orders would be submitted to future Board meetings, to balance their submission to the Board

The Standing Financial Instructions were ratified as circulated.

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

11-19 Charitable Funds Committee, 19/10/15 (incl. approval of the 2014/15 Ann. Report and Accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund)

SDu referred to the circulated report and highlighted that the Annual Accounts required very little changes following the independent examination by the External Auditors.

The 2014/15 Annual Report and Accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund were approved as circulated.

11-20 Audit and Governance Committee, 04/11/15

KT referred to the circulated report and highlighted the following points:
- The appointment of the Committee as the Trust's "Auditor Panel" was proposed
- Revised Terms of Reference were agreed, and had been submitted for approval

The Committee's revised Terms of Reference were approved as circulated.

The Trust Board also approved the Audit and Governance Committee's appointment as the Trust's "Auditor Panel" (and that the Committee's Terms of Reference be further amended accordingly).

11-21 Quality Committee, 11/11/15 (including SIs)

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

- The quorum requirements had not been met for part of the meeting, so the Trust Board was asked to the ratify decisions made, as detailed in the report
- An improved level of engagement had been demonstrated at the meeting

The Committee's decisions, as detailed in the report, were duly ratified.

AJ then referred to the Stroke improvement in Appendix 1, & asked when the next Sentinel Stroke National Audit Programme (SSNAP) data would be available. AG answered that this would be in February or March 2016. AJ commended the improvement, & asked that this be passed on to the team. SDu noted that the team had already been commended at the Quality Committee meeting.

11-22 Trust Management Executive, 18/11/15

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

- The meeting had operated as a de facto 'shadow' of the new Committee structure arrangements, and there had been positive engagement of Clinical Directors
- The December Trust Management Executive (TME) meeting would focus on financial issues

11-23 Finance Committee, 23/11/15 (incl. OBC for adoption of GS1 and implementation of PEPPOL)

ST referred to the circulated report (Attachment 18) and invited comments or queries. None were received. AJ noted that there would be a further discussion on finance at the 'Part 2' Board meeting scheduled for later that day.

ST then referred to Attachment 19 & stated that the Outline Business Case (OBC) for the adoption of GS1 & implementation of PEPPOL had been reviewed at the Finance Committee on 23/11/15, and was supported. GD added that the OBC had also been reviewed, and supported, by the TME.

The Outline Business Case for the adoption of GS1 and implementation of PEPPOL was approved as circulated.

Other matters

11-24 Stroke Therapy Assisted Discharge Service: Approval

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

The Trust Board gave its support to the proposal, pending completion of a business case; and supported the recruitment of staffing on a temporary contract initially until 31/03/16, and thereafter until 31/03/17, pending further CQUIN funding from West Kent CCG.

11-25 To consider any other business

There was no other business.

11-26 To receive any questions from members of the public

There were no questions.

11-27 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.

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RISK MANAGEMENT AT MTW

FOR MEMBERS OF THE TRUST BOARD AND SENIOR MANAGERS

JEFF HARRIS. C.Chem FRSC. CMIOSH

TRUST RISK MANAGER

Revised November 2015

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Objectives

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- To discuss what the HSE expects of the Board.
  - Recommendations from previous inspections
  - Workplace H&S standards
- Health and Safety Management – Guidance From HSE (PDCA)
  - Health and Safety Law
  - Health and Safety at Work Act
  - Negligence
  - Corporate manslaughter
  - Fees for intervention
  - Changes in legislation
  - Enforcing bodies

- Health and Safety Executive Programme 2015/16
- Risk Management
  - Risk Assessment
  - Risk Registers

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What would the HSE expect of the Board

To follow recommendations from previous HSE inspections and notices.

- Sept 2009 Improvement notice for inadequate training for Managers

- Board members and senior managers to have competencies to manage H&S.
  Hence regular formal training is required.
  - o Health and Safety Competences for NHS Managers published in July 2015
  - o Describes competencies required by each staff group (includes Board and Senior Managers)
  - o What the HSE will consider reasonable
  - o Undertaking a gap analysis and will report to H&S Committee.

Is 45 minutes Board Training once a year sufficient? ?

- To lead on H&S rather than the H&S committee. ✓
  Hence agree the annual programme and delegate it to the H&S Committee.

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To meet NHS Workplace Health and Safety Standards.

- **Published in July 2013 by NHS staff Council and HSE**
- **260 Standards in 28 sections**

Recently Reviewed and Trust is 96% compliant
Non-compliances are being addressed
(H&S programme and gap analysis) ✓

These standards are prescriptive (not a legal requirement).

The law requires us to do what is reasonably practicable.

Because these have been agreed by the Department of Health the HSE will consider them reasonable and we will be expected to follow them. They will be used to identify a material breach allowing charging under FFI.

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Health and Safety Management – Guidance From HSE

The HSE have published a model for Health & Safety Management (INDG 417 - PDCA).

This replaces the previous guidance HSG 65 (POPIMAR)

Any future inspections will be based on this new model.

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Health and Safety Management – Guidance From HSE

"Plan, Do, Check, Act "approach (PDCA)

The HSE's approach on managing for health and safety provides guidance to safety practitioners and directors :

- On the **core elements** of managing for health and safety.
- On **deciding** if they are doing what they need to do.
- On how to **deliver** and apply effective arrangements on their organisations.
- On how to meet the legal and moral obligations to manage the health and safety of their employees.

INDG 417 - PDCA

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PDCA cycle approach ("Plan, Do, Check, Act")

- **Plan**
  - Determine your policy
  - Plan for implementation
- **Do**
  - Profile your health and safety risks
  - Organise for health and safety
  - Implement your plan
- **Check**
  - Measure performance
  - Investigate accidents and incidents
- **Act**
  - Review performance
  - Learn lessons

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Health and Safety Law

Health and Safety at Work etc Act 1974.

The Act is short and not very prescriptive.

HSE Health & Safety Executive

Section 1, Who is Responsible for H&S – The Employer

This responsibility is delegated through the management structure to department managers

Under the Law All Managers and senior staff have employers duties. Do not need to have Manager in a job title, the higher your grade the greater the responsibility (including Doctors).

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Section 2, Employers Duties - Managers Must provide SFRP

- Safe plant and systems of work (equipment and rules)
- Safe handling, storage and transport of work articles and substances.
- Necessary information, instruction, training and supervision.
- A safe place of work, access and egress (work area and site)
- A safe working environment with adequate welfare facilities.

Section 2, Employers Duties - Absolute duty to provide

- A H&S Policy,
- A H&S Committee
- Consultation with employees

Most prosecutions are for breaching section 2 of the Act

Compliance is demonstrated through risk assessment.

Many prosecutions under section 2 are for failure to complete a suitable and sufficient risk assessment

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Section 40 HSAW

It is up to the accused to show they have acted reasonably
(Guilty until proved innocent)

Penalties

PENALTIES	SUMMARY	INDICTABLE
Sections 2-6 HSAW Act 1974	£20,000 Fine 1 years Imprisonment	Unlimited Fine 2 years Imprisonment
Failure to comply with an enforcement notice	£20,000 Fine 1 years Imprisonment	Unlimited Fine 2 years Imprisonment

£3,400 fine and costs – needle stick injury to child.
£4,000 fine – patient scalded by unguarded radiator.
£18,000 fine – employee exposed to Chemical
£20,000 fine patient fell from unrestricted window.
£37,000 fine and costs for legionella outbreak.
£90,600 fine and costs – lost radiation source.

£256,000 fine - and costs for a surgical patient burnt by a warming device MTW 2012 to 2104

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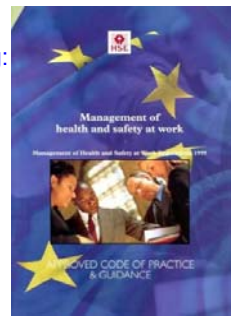
Section 15, Delegated legislation

- Allows the secretary of state to make regulations under the Act.
- There are lots of regulations

Management regulations - Requires all managers to assess and control their risks
Health, Safety and Welfare Regulations – Requires a safe workplace
RIDDOR regulations – Requires all incidents to be reported and investigated.

Other regulations require special risk assessments including:

- Moving and Handling
- Substances hazardous to health
- Work Equipment
- Fire
- Display Screens
- Asbestos
- Medical Sharps
- Electricity



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Negligence

- Common law tort of negligence
- Can also be applicable to criminal law if duty is "so far as is reasonably practical".

1. Must owe injured person a duty of care.
2. Must have been a breach in the duty of care.
3. Breach must have resulted in the harm.
4. The harm must have been foreseeable.

Examples of gross negligence would include:

- Knowingly ignoring breaches of legislation.
- Failure to act to prevent the reoccurrence of significant incidents.
- Failure to control significant hazards with foreseeable risks.
- Allowing junior managers to do the above.
- Connivance to hide or cover up the above.
- Ignoring the advice of a competant person.
- Ignoring advice from a competant organisation or regulator.

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Update on The "Corporate Manslaughter and Corporate Homicide Act"

- Act removed the need to identify a controlling mind.
- Courts are able to find the Corporate Body collectively guilty.
- The Board will be held responsible for the acts and omissions of their managers, employees and contractors.

Penalties include an Unlimited fine (percentage of turnover).

Themes

Typically small, owner managed businesses so far

Fines low because companies are small with low turnover

Fines would normally be at least 5% of turnover

No Health organisations so far

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15 Prosecutions to date – (fines plus costs)

1st	Cotswold Geotechnical	– Feb 2011 - £385,000 (£333,000 turnover)
2nd	JMW Farms	– May 2012 - £200,000
3rd	Lion Steel	- July 2012 – £560,000
4th	J Murray & Son	- Oct 2013 - £110,000
5th	Princes' Sporting Club	– Nov 2013 - £235,000 (entire assets of company)
6th	Mobile Sweepers	- Feb 2014 - £12,000
	Sole Director	- £183,000 (disqualified for 5 years)
7th	Cavendish masonry	- May 2014 - £237,000
	PS & JE Ward	- Apr 2014 - Found not guilty
	MNS mining	- Jun 2014 - Found not guilty
8th	Sterecycle	- Nov 2014 – £500,000
9th	A Diamond & Son	- Dec 2014 - £91,000
10th	G & J Crothers	- Feb 2015 - £24000
11th	Piranha Moldings	- Mar 2015 - £200,000
	Managing director	- £25,000 & 9 months imprisonment

Huntley Engineering - Nov 2014 - pending preliminary hearing
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Fee for Intervention (FFI) – 2 years on

What is FFI

- Costs recovery regime;
- HSE under a duty to recover its costs for carrying out its regulatory functions in certain instances;
- Costs recovered from those found to be in material breach of health and safety law.

Projected recovery by HSE - £37 million per year.

HSE (October 2012 – March 2015)

- FFI nationally has issued about 16,800 invoices
- Total revenue invoiced - £10,800,000 (2.5 years)
- Revenue invoiced in last year – 8,100,000
- Average invoice £650

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Changes in Legislation

- A new Memorandum of Understanding has been published between the Care Quality Commission, the Health and Safety Executive and Local Authorities in England. It is between the three bodies that can inspect and investigate incidents with regard to regulation of health and safety for patients, staff and visitors. It is required to reflect the change in regulatory powers of the CQC. The CQC will be able to issue enforcement notices and bring prosecutions.

- Construction Design and Management regulations were revised from 6th April 2015 (CDM 2015). There will be a 6 month transition.

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Enforcing Bodies

Source - Mike Walters, Principle HSE Inspector for Kent (24-4-2015)

- 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 report is late it is a 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:

Prosecuted by HSE	Prosecuted by CQC
Medical sharps (staff)	Medical sharps (patients)
Falls (staff)	Falls (patients)
Falls (visitors)	Falls from windows

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HSE Programme 2015/16

Source - Mike Walters, Principle HSE Inspector for Kent (24-4-2015)

Kent section of the HSE:

- Employs 11 staff based at Ashford.
- In 2014/15 they investigated 4 fatal accidents
- They investigated many other RIDDOR reportable incidents.
- They issued 113 improvement notices and 68 prohibition notices.
- They conducted 20 prosecutions
- Total fines £146,446 and total costs £81,052.

The MTW prosecution generated a £180,000 fine exceeding all other Kent prosecutions. This was not included in the figures because the prosecution was led Dawn Smith by who is based in Birmingham.

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HSE Programme 2015/16

The HSE have key projects and targets for 2015/16 these include:

- Late reporting under RIDDOR – they will seek information on all late reports. MTW last year had 32 RIDDORS of which 5 were late (84% compliant).

- Insufficient competent H&S assistance – There is concern that Trusts Boards do not have sufficiently qualified H&S staff to advise them. For a Trust with 2 major sites they would expect 2 advisors qualified to CMIOSH standard.

  East Kent has been issued with a notice.

  Proper funding of H&S teams is seen as evidence of commitment to H&S. They will expect senior managers to have a H&S KPI on their job description.

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HSE Programme 2015/16

The HSE have key projects and targets for 2015/16 these include:

- Safer Sharps – The HSE is gathering data from safety sharps suppliers to ascertain what proportion of their sharps are safety sharps.
  - In 2013/14 40% of MTW's sharps were safety sharps.
  - Last year this rose to 80%.
  - We can not achieve 100% as some sharps such as suture needles and scalpels do not have safety versions.
- And 4 Estates and Facilities issues: Control of Contractors, Electrical risk, Lifting equipment operations (LOLER 98) and Asbestos.

HSE Visits and Inspections

There have been no visits or inspections by HSE inspectors in the last 12 months.

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What is Risk Management ?

Risk Management is the identification, measurement and economic control of the risks which the Trust could be exposed to in the carrying out of its undertakings.

(FROM THE RISK MANAGEMENT POLICY AND STRATEGY)

- Risk Management is a culture as well as a process
- It is about shared attitudes, beliefs and behaviours at all levels of the organisation

Function of Risk Management

- Identify unwanted and uncertain future events.
- Devise strategies for dealing with those events.
- Relate them to the decision making process of the Trust.

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Who Manages Risk?

The Board is ultimately Accountable for Health, Safety and Risk.

Risk, Health and Safety are line management responsibilities.

All managers should be held responsible for the assessment and management of risks within their departments.

Advisors

Legal responsibility cannot be delegated to contractors or advisors

Ignoring the advise of Competent advisors could be considered gross negligence

Hazard - Anything that can cause harm

- Physical harm to Patients and staff
- Harm to objectives
- Organisational harm / reputational harm
- Financial harm

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Risk - The probability that harm will actually occur.

Risk Assessment - The process where hazards are identified, risks evaluated, and action plan generated to reduce impact of risks

Risk = Consequences x Likelihood.
(Severity x probability)

Use the Trusts 5x5 Risk Matrix.

The Risk score and colour is used to compare risk, set priorities and plan resources.

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RISK ASSESSMENT

Management of Health and Safety at Work Regulations 1999

Regulation 3 : "every employer to make a suitable and sufficient assessment of the health and safety risks to:
(a) His employees and
(b) Others not in his employment
to which his undertakings give rise, in order to put in place appropriate control measures".

HSE recommend a 5 step approach

Step 1 – Identify the Risk	Proactive – Risk Assessment Reactive – Incidents, Complaints & Claims
Step 2 – Analyse the Risk	Score and grade all risks using the Trust Matrix. Determines importance and priority

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Step 3 – Control the Risk

- Most Health and Safety legislation requires the employer to do what is reasonably practical:
- Do what a reasonable man or your peers would do .
- Adapt to technical progress.

Step 4 – Reduce the Risk

Risk is reduced through time based action plans.
Unresolved risk is managed through the risk register.

Step 5 – Retain / Accept the Risk

If all that all reasonably practical controls are in place and effective a risk can be accepted. Accepting a risk is a significant decision, therefore it must be:

- Made by the appropriate level of management (or by a committee)
- Justified, recorded and accountable.
- Red risks may require Board Approval

Datix

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RISK REGISTERS

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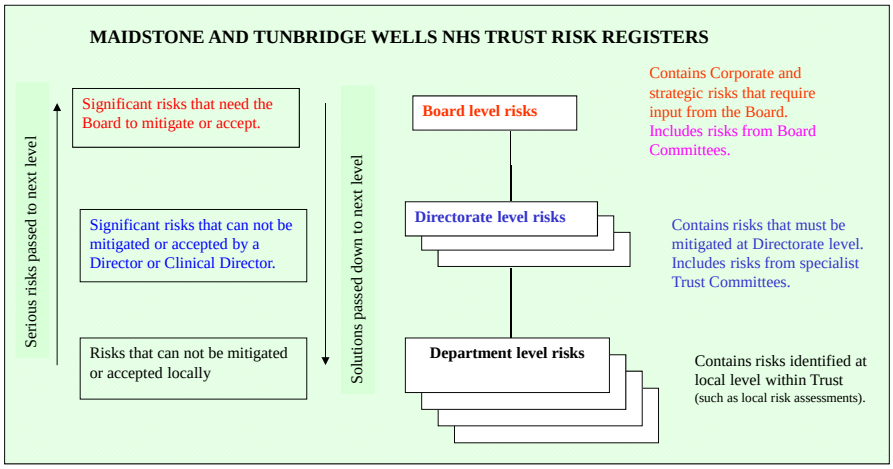
One database but different levels giving various Risk Registers



Allows risks to be managed or accepted at the correct level.

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Any Questions

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Trust Board Meeting – January 2016

1-4 Log of outstanding actions from previous meetings — Chairman

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
10-8iii (Oct 15)	Provide Trust Board Members with details of the local healthcare economy schemes being financed via the Better Care Fund	Director of Finance	October 2015 onwards	A request has been made to West Kent Clinical Commissioning Group, but a response is still awaited
11-10iv (Nov 15)	Arrange for the "% Stillbirths Rate" in the Trust Performance Dashboard for October 2015 to not be rated as "Green"	Chief Operating Officer	November 2015 onwards	A verbal update will be given at the Trust Board meeting

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
10-8i (Oct 15)	Arrange for "Patient Falls" to be reviewed at a future Quality Committee 'deep dive' meeting	Trust Secretary / Chief Nurse	January 2016	A separate meeting of the Quality Committee 'deep dive' meeting, which focused solely on patient falls, was held on 11/01/16 (the details of which are included in a summary report to the Board)
11- 6 (Nov 15)	Arrange for Trust Board Members to be kept informed of the intended allocation of the additional NHS funding that was announced on 24/11/15	Director of Finance	January 2016	Confirmation of planning guidance was issued in December, and shared with Trust Board Members. In addition, the output from various briefings (including that from NHS Providers) have been circulated to Trust Board Members by email. Additional information was included in the "business planning" update to the Finance Committee on 25/01/16 (the same report has also been submitted to the Part 2 Trust Board on 27/01/16)
11- 7i (Nov 15)	Arrange for a letter of thanks to be sent from	Trust Secretary / Chairman of the	November 2015	A letter was sent on 27/11/15 (and copied to all Trust Board

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	the Trust Board to the Communications Team, in response to their organisation of the Staff Stars Awards 2015	Trust Board		members)
11-8i (Nov 15)	Arrange for letters of thanks to be sent to the individual members of staff referred to in the "patient story" that featured at the Trust Board on 25/11/15	Trust Secretary	November 2015	3 letters were sent (to Rachel Harradine, Baska Pelc and Dr Chris Thom) on 27/11/15 (and copied to all Trust Board members)
11-8ii (Nov 15)	Aim to resolve the issues regarding the delivery of incontinence pads to the patient referred to in the "patient story" that featured at the Trust Board on 25/11/15	Chief Operating Officer	November 2015	Mr Boulton informed the Trust that a consignment of the correct incontinence pads were delivered on 26/11/15, and has confirmed that he believes that an acceptable supply position has been established
11-7ii (Nov 15)	Consider what actions should be taken to increase the awareness, among the Trust's staff, of Trust Board Members and their role	Director of Workforce and Communications	December 2015	The Communications Team are considering the ways by which Trust Board Members, and their roles, can be prompted among staff
11-8iii (Nov 15)	Consider how the impact of the messages given within the "patient stories" heard at Trust Board meetings could be used to beneficial effect among the Trust's staff	Director of Workforce and Communications	December 2015	The patient story heard at the Trust Board on 25/11/16 was shared in detail with all staff as part of the Chief Executive's weekly email update, and will be promoted further via the next Trust Newsletter. In addition, it is planned to shoot a film that could be used as a training aid for staff. Where appropriate, similar methods will be used considered for future patient stories heard at the Trust Board
11-10ii (Nov 15)	Consider the recalibration of the "Capital Expenditure" indicator within the Trust Performance Dashboard, to enable the reporting of a more accurate reflection of the Trust's current performance	Director of Finance	January 2016	The indicator has been recalibrated
11-10iii (Nov 15)	Provide Trust Board Members with the rate of uptake of influenza	Director of Workforce and Communications	January 2016	A report containing the requested information was issued to Trust Board

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	vaccinations among Trust staff (as at November and December 2015), along with details of the action being taken to increase the rate of uptake			Members via email on 08/01/16
11-11i (Nov 15)	Circulate, to Trust Board Members, the data that showed that the Trust's Intensive Care Units were the best performing in the country	Medical Director	December 2015	A report containing the relevant information (from the Intensive Care National Audit & Research Centre - ICNARC, which was submitted to the 'main' Quality Committee on 11/11/15), was emailed to all Trust Board Members on 15/12/15
11-11ii (Nov 15)	Arrange for a letter to be sent from the Trust Board to the staff in the Trust's Intensive Care Units, acknowledging their performance as the best in the country	Trust Secretary / Chairman of the Trust Board	November 2015	A letter was sent on 27/11/15 (and copied to all Trust Board members)

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
9-8i (Sep 15)	Ensure the Trust Board receives the outcome of the planned review of Medical rotas being led by the Medical Director	Trust Secretary / Medical Director	September 2015 onwards (but then extended to March 2016)	The Medical Director notified the Trust Board on 25/11/15 that he would be unable to provide the requested information until March 2016
11-9 (Nov 15)	Ensure, at the point of the next review, that the ratings on the Board Assurance Framework accurately reflect the sentiment that a 'green' rating could legitimately be applied where the Trust was doing all it could to achieve the objective (and there was confidence that this action would lead to the objective being met)	Trust Secretary	February 2016	The request will be incorporated as part of the next scheduled review of the Board Assurance Framework, in February 2016
11-10i (Nov 15)	Provide an update to the Trust Board, in February 2016, on the latest situation as to the extent of the use, within the Trust, of the clinical	Medical Director	February 2016	An agenda item has been added to the forward programme, for February 2016

Ref.	Action	Person responsible	Original timescale	Progress
	information within the 'Dr Foster' IT system			

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - January 2016

1-7 Chief Executive's report Chief Executive

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

1. Since our last Board meeting I have continued to provide support for colleagues throughout the Trust to maintain high quality standards of care in a safe environment. I have visited our clinical areas and have discussed the care we provide to aid my understanding of our performance, learn from our patients' experience, and to help identify, develop and implement ongoing improvements.

   Similar to other hospital Trusts and healthcare providers locally, regionally and nationally, we have continued to experience high levels of demand for our services this winter, placing pressure on our emergency care services. We continue to work closely with our partners in the local health economy to reduce delayed transfers of care which remain a key challenge for our Trust and patient flows through our hospitals. This is impacting on our ability to see all of our planned patients as scheduled and has resulted in some appointments being changed to maintain patient safety. This is also having a negative impact on our financial position.
2. I have made it a priority to attend, with the Chairman of the Trust Board, and members of our Executive team, the Court case in which our Trust is charged with Corporate Manslaughter. Legal constraints restrict me from reporting further on this case, while proceedings are active. Our Trust has pleaded not guilty to this charge and will be providing evidence during the trial to support this position.
3. We have now opened our new £3 million dedicated ward for respiratory illnesses at Maidstone. John Day ward has been re-modelled and modernised to create a much-improved and impressive environment for respiratory patients. It includes an enhanced care bay for patients requiring more intensive monitoring or intervention, and a negative pressure room for patients with airborne transmitted diseases such as Tuberculosis, who require isolation. We have also opened 100 additional parking spaces at Maidstone Hospital for staff.
4. Our Research & Development leads are helping widen the boundaries of exploration into potentially lifesaving treatments for meningitis with the aid of school children from the area. Our Trust, which is hugely active in medical research, has enrolled over 1,000 school pupils in a national trial that is seeking to develop new vaccines for the potentially life-threatening disease. Researchers from our Trust have swabbed 1,114 pupils from participating schools. The research has already won a national award to recognise its initial success in involving such large numbers of people.
5. We have launched a new website for patients and visitors. The site can now be viewed on mobiles and tablets as well as computers, which means the information we provide is far more easily accessible to our users. Please do take a look - www.mtw.nhs.uk
6. We are reviewing feedback from the 2015 National Maternity Survey to support further improvements. Our survey showed that women have a high regard for their midwives and the clinical teams caring for them, with 82% reporting that they definitely have confidence and trust in local maternity services – up 12% since the last time the survey was carried out in 2013.
7. We have appointed a new Consultant Neurologist Dr Laura van der Voort specialising in MS. Our pathology laboratories have been recommended for ISO accreditation – a first in the South East. Three new inflammatory bowel disease nurse specialists will see patients on wards and in clinics from early 2016.
8. Congratulations to Christine Richards Society of Radiographers Radiographer of the Year & Kent Oncology Radiographers South East Team of the Year.

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

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

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – January 2016

1-8	Integrated Performance Report for December 2015	Chief Executive / Executive Team

The enclosed report includes:

- The 'story of the month' for December 2015, which includes the latest position on Delayed Transfers of Care (DTOCs)
- The Trust performance dashboard
- Integrated performance charts; and
- Financial performance overview.

Details on recent recruitment and retention will be provided verbally at the meeting.

Which Committees have reviewed the information prior to Board submission?

- Executive Team, 19/01/16
- Trust Management Executive, 20/01/16

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

Discussion and scrutiny

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

‘Story of the month’ for December 2015

There are three key areas of risk within clinical operations: Emergency Access & Length of Stay (LOS) and Cancer standards.

Emergency access standard & Length of Stay

A&E attendances and non-elective admissions are largely in line with the same period last year and the Emergency Access standard delivered 84.9% for the month [84.7% in December 2014]. Delayed Transfers of Care (DTOCs), which are a driver for the increased LOS increased slightly compared to November to 6.0% of all beds with the greater proportion now being patients awaiting other NHS Care. 1,203 bed days were lost to DTOC patients in December compared to 1,088 in November. Non-elective LOS has remained above 8 days in Dec which reflects a more acute patient mix as well as complex discharges. Bed occupancy has increased month-on-month and likely to continue into January. The impact of the higher occupancy and continued higher LOS is that there is much less capacity for undertaking elective work.

Count of Hospital ID	Column Labels																						
Row Labels	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Grand Total
A : Awaiting Assessment	8	6	2	3	5	7	3	2		11	17	17	15	6	15	21	15	17	15	10	5	200
B : Awaiting Public Funding		2		2	7	7	6	1		1	3	2	2		1	1	4	8	7	3	1	58
C : Awaiting Further Non-Acute NHS Care	18	38	40	46	31	33	30	25	19	21	18	28	32	34	39	48	33	30	20	6	3	592
Di : Awaiting Residential Home	2	2		9	4		1	6	10	5	3	6	18	1	11	27	28	26	22	16	21	218
Dii : Awaiting Nursing Home	3	3	2	9	2	20	13	16	8	17	12	30	40	21	38	90	57	52	56	40	73	602
E : Awaiting Care Package	2	11	9	6	8	8	13	26	15	11	18	10	7	7	20	16	27	17	32	26	43	332
F : Awaiting Community Adoptions	7	8	3	6	7	2	7	8	6	9	1	8	1	11	2	1		1	13	9	8	118
G : Patient of Family Choice	36	39	44	36	59	32	46	47	36	39	47	60	60	44	44	45	16	43	26	22	31	852
H : Disputes						1							2	1			1	3	1	1		10
I : Housing		2	6	2				2		2		1	3	4	3	1		1	13	12	9	61
Grand Total	**76**	**111**	**106**	**119**	**123**	**110**	**119**	**133**	**94**	**116**	**119**	**162**	**180**	**129**	**173**	**250**	**181**	**198**	**205**	**145**	**194**	**3043**
Trust delayed transfers of care	**3.2%**	**3.6%**	**4.3%**	**3.8%**	**5.2%**	**4.4%**	**3.9%**	**5.2%**	**3.6%**	**3.3%**	**4.3%**	**6.0%**	**5.5%**	**4.8%**	**6.8%**	**7.9%**	**7.1%**	**7.9%**	**6.6%**	**5.7%**	**6.0%**	

Cancer

The performance on Cancer targets in November (reported a month in arrears) shows a continued underperformance on the 62 day target at 76.7% and the 2 week-wait target at 89.9%. There were 8.0 breaches of the 104 day target. The 62 day position for patients managed entirely by MTW was slightly better at 80.5% for October and at 79.3% for the year to date. There are multiple causes of the underperformance which are being managed with the individual MDT leads and in November and December, patient choice, where many patients chose to delay their appointments was the main cause of the 2 week wait and breast symptoms standards.

RTT

The Referral to Treatment (RTT) performance in December dropped but remained above the target. The backlog of 18 week waiters has increased largely due to issues in 2 specialties and due to elective activity levels being affected by increased bed occupancy by emergency patients.

Quality Indicators

There were zero cases of Clostridium difficile cases in December. Year to date there have been 17 cases compared with 24 cases for the same period the previous year. There were no MRSA cases and the elective and non-elective screening remains above plan.

The rate of falls fell in December to 6.2 per 1,000 occupied beddays which is an improvement from the previous 3 months position. The rate of hospital acquired pressure for December is 2.4 per 1,000 admissions (11 pressure ulcers all grade 2) which is also an improvement from the previous 3 months.

One Never Event was declared 30th November 2015 relating to a retained specimen bag following a laparoscopic procedure. The patient was returned to theatre and bag was removed laparoscopically. The full investigation is still in progress.

The number of new complaints reduced to 39 in December which equates to a rate of 1.93 per 1,000 occupied beddays. The increasing rate in September and October has shown a downward trend in November and December. The 75% response rate continues to be achieved.

The Friends and Family positive scores and response rates for all the indicators remain above or in line with the national benchmarks

Workforce

During the month the Trust continued its recruitment performance and now employs 5,060 whole time equivalent substantive staff. This is the highest number of substantive staff employed by the Trust since reporting to the Board became the norm and represents a net increase of over 100 WTE against the same month in the previous year. The month continued to see a net increase (18 WTE) in the numbers of substantive registered nurses and a marginal increase in clinical support workers. Over the next few months the 'pipeline' of recruitment for registered nurses should enable the continued reduction in nurse vacancies with expected monthly net increases. However, despite the recruitment success the dependence upon temporary staff remained higher than planned and further work is ongoing to ensure, in line with the TDA requirements, we reduce our dependence upon expensive agency and interim workers. A task and finish group has been established to focus on medical recruitment.

Sickness absence in the month was 3.9%, representing a significant improvement on the same period last year (4.5%), and whilst not all areas of the Trust are consistently achieving the required levels of appraisal and statutory and mandatory training actions are in place to do so within the year.

TRUST PERFORMANCE DASHBOARD **Position as at:** **31 December 2015**

Governance (Quality of Service): **2.0** **Amber/Red** Based on TDA 2014/15 Methodology

Finance: **TDA** **Amber**

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 is Quarter to date, Forecast is for Quarter 4 only

	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)	19.55	0.0	14.0	9.7	-4.4	- 2.3	11.5	9.7	
1-02	Number of cases C.Difficile (Hospital)	4	0	24	17	-7	- 4	27	23	
1-03	Number of cases MRSA (Hospital)	0	0	1	1	0	1	0	1	
1-04	Elective MRSA Screening	99.0%	99.0%	99.0%	99.0%		1.0%	98.0%	99.0%	
1-05	% Non-Elective MRSA Screening	97.0%	97.0%	97.0%	97.0%		2.0%	95.0%	97.0%	
1-06	**Rate of Hospital Pressure Ulcers	1.7	2.4	2.2	2.6	0.3	- 0.4	*3.0*	2.6	3.0
1-07	***Rate of Total Patient Falls	6.4	6.2	6.2	6.8	0.6	0.6	*6.2*	6.7	
1-08	***Rate of Total Patient Falls Maidstone	3.2	5.4	5.1	6.2	1.1			6.0	
1-09	***Rate of Total Patient Falls TWells	8.5	6.9	6.9	7.1	0.2			7.1	
1-10	Falls - SIs in month		7		37	37				
1-11	Number of Never Events	1	1	2	2	0	2	*0*	2	
1-12	Total No of SIs Open with MTW	14	36			22				
1-13	Number of New SIs in month	8	12	82	78	- 4	- 12			
1-14	**Serious Incidents rate	0.39	0.59	0.48	0.44	- 0.04	0.39	*0.0506 - 0.8251*	0.44	*0.0506 - 0.8251*
1-15	Rate of Patient Safety Incidents - harmful	0.79	1.05	1.07	1.23	0.15	- 0.47	*0 - 1.698*	1.23	*0 - 1.698*
1-16	Number of CAS Alerts Overdue	0	0			0	0	*0*		
1-17	VTE Risk Assessment	96.2%	95.5%	95.6%	95.4%	-0.2%	0.4%	95.0%	95.4%	95.0%
1-18	Safety Thermometer % of Harm Free Care	96.1%	96.8%	96.3%	96.7%	0.4%	1.7%	95.0%		93.4%
1-19	Safety Thermometer % of New Harms	3.43%	1.73%	2.73%	2.43%	-0.30%	-0.57%	*3.00%*	2.43%	
1-20	C-Section Rate (non-elective)	16.1%	14.3%	15.1%	12.9%	-2.25%	-2.14%	*15.0%*	12.9%	

	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: Oct 13 to Sept 14		103.4	102.0	- 1.4	2.0	*Lower confidence limit to be <100*		100.0
2-02	Standardised Mortality (Relative Risk)	Prev Yr: Oct 13 to Sept 14		106.9	106.0	-0.9	6.0			100.0
2-03	Crude Mortality	1.1%	1.0%	1.1%	1.2%	0.0%				
2-04	****Readmissions <30 days: Emergency	11.6%	10.6%	11.6%	11.2%	-0.4%	-2.4%	*13.6%*	11.2%	14.1%
2-05	****Readmissions <30 days: All	10.9%	10.2%	10.8%	10.4%	-0.5%	-4.3%	*14.7%*	10.4%	14.7%
2-06	Average LOS Elective	3.1	3.7	3.2	3.3	0.0	0.1	*3.2*	3.2	
2-07	Average LOS Non-Elective	7.1	7.5	6.7	7.3	0.6	0.8	*6.5*	6.5	
2-08	New:FU Ratio	1.58	1.41	1.53	1.37	- 0.15	- 0.15	*1.52*	1.52	
2-09	Day Case Rates	83.6%	84.0%	83.4%	83.9%	0.5%	3.9%	80.0%	83.9%	82.2%
2-10	Primary Referrals	7,441	7,705	76,028	78,536	3.3%	1.4%	102,995	104,436	
2-11	Cons to Cons Referrals	3,235	2,613	30,838	30,534	-1.0%	2.6%	39,585	40,604	
2-12	First OP Activity	11,423	11,849	108,512	105,410	-2.9%	1.9%	137,532	140,173	
2-13	Subsequent OP Activity	20,780	22,811	194,015	195,857	0.9%	-0.2%	260,920	260,448	
2-14	Elective IP Activity	593	620	5,872	5,970	1.7%	-0.6%	7,988	7,939	
2-15	Elective DC Activity	2,851	3,140	28,188	29,535	4.8%	1.9%	38,556	39,275	
2-16	Non-Elective Activity	3,995	3,868	35,747	34,063	-4.7%	-6.1%	48,289	45,335	
2-17	A&E Attendances (Calendar Mth)	10,801	11,545	100,214	103,157	2.9%	1.0%	135,922	137,293	
2-18	Oncology Fractions	6,001	6,127	52,911	51,916	-1.9%	-3.7%	71,761	69,095	
2-19	No of Births (Mothers Delivered)	436	483	4,287	4,337	1.2%	1.3%	5,708	5,783	
2-20	% Mothers initiating breastfeeding	81.4%	No data	81.8%	78.4%	-3.4%	0.4%	78.0%	78.0%	
2-21	% Stillbirths Rate	0.9%	0.40%	0.27%	0.43%	*0.2%*	*0.0%*	*0.47%*	0.43%	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	30	0	35	0	-35	0	0	0	
3-02	*****Rate of New Complaints	1.56	1.93	3.89	2.18	-1.71128	0.86	*1.318-3.92*	2.15	
3-03	% complaints responded to within target	66.7%	75.8%	66.7%	74.6%	8.0%	-0.4%	75.0%	74.7%	
3-04	****Staff Friends & Family (FFT) % rec care	New	82.2%	New	83.0%	New	8.0%	75.0%	75.0%	79.2%
3-05	*****IP Friends & Family (FFT) % Positive	New	95.2%	New	96.5%	New	1.5%	95.0%	95.0%	95.5%
3-06	A&E Friends & Family (FFT) % Positive	New	89.7%	New	88.9%	New	1.9%	87.0%	87.0%	87.2%
3-07	Maternity Combined FFT % Positive	90.4%	96.6%	90.7%	94.9%	4.2%	-0.1%	95.0%	95.0%	94.9%
3-08	OP Friends & Family (FFT) % Positive	New	81.1%	New	79.7%	New			79.7%	

* 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.

	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	84.7%	84.9%	93.7%	87.7%	-5.9%	-7.3%	95.0%	95.0%	90.1%
4-02	Emergency A&E >12hr to Admission	0	0	2	0	-2	0	*0*	0	
4-03	Ambulance Handover Delays >30mins	New	No data	New	No data				No data	
4-04	Ambulance Handover Delays >60mins	New	No data	New	No data				No data	
4-05	18 week RTT - admitted patients	94.4%	89.7%	91.5%	90.2%	-1.3%	0.2%	90%	90.2%	
4-06	18 week RTT - non admitted patients	97.2%	97.4%	96.7%	97.8%	1.1%	2.8%	95%	97.8%	
4-07	18 week RTT - Incomplete Pathways	95.4%	93.9%	95.4%	93.9%	-1.5%	1.9%	92%	93.9%	
4-08	18 week RTT - Specialties not achieved	-	7	15	48	33	48	*0*	48	
4-09	18 week RTT - 52wk Waiters	0	0	0	5	5	5	*0*	5	
4-10	18 week RTT - Backlog 18wk Waiters	394	763	394	763				763	
4-11	% Diagnostics Tests WTimes <6wks	100.0%	99.0%	100.0%	99.0%	-1.0%	0.0%	99.0%	99.0%	
4-12	*Cancer WTimes - Indicators achieved	8	4	8	5	- 3	- 4	9	9	
4-13	*Cancer two week wait	96.7%	89.9%	96.8%	91.5%	-5.3%	-1.5%	93.0%	93.0%	
4-14	*Cancer two week wait-Breast Symptoms	96.8%	86.8%	96.9%	90.8%	-6.1%	-2.2%	93.0%	90.8%	
4-15	*Cancer 31 day wait - First Treatment	100.0%	97.4%	98.7%	96.7%	-2.0%	0.7%	96.0%	96.7%	
4-16	*Cancer 62 day wait - First Definitive	89.2%	76.7%	84.0%	74.5%	-9.6%	-10.5%	85.0%	85.0%	
4-17	*Cancer 62 day wait - First Definitive - MTW	92.1%	80.5%	89.0%	79.3%	-9.7%		85.0%		
4-18	*Cancer 104 Day wait Accountable	New	8.0	New	51.5	New	51.5	-	51.5	
4-19	Delayed Transfers of Care	3.6%	6.0%	4.1%	6.5%	2.3%	3.0%	3.5%	5.0%	
4-20	% TIA with high risk treated <24hrs	83.3%	70.4%	75.2%	70.1%	-5.0%	10.1%	60%	70.1%	
4-21	% spending 90% time on Stroke Ward	78.8%	80.5%	83.4%	83.7%	0.4%	3.7%	80%	83.7%	
4-22	Stroke:% to Stroke Unit <4hrs	30.0%	48.3%	40.0%	50.4%	10.3%	-4.6%	55.0%	55.0%	
4-23	Stroke: % scanned <1hr of arrival	30.0%	66.7%	42.1%	54.7%	12.6%	11.7%	43.0%	54.7%	
4-24	Stroke:% assessed by Cons <24hrs	78.0%	70.0%	73.8%	70.6%	-3.2%	-14.4%	85.0%	85.0%	
4-25	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	*0*	0	
4-26	Patients not treated <28 days of cancellation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*0.0%*	0.0%	

*CWT run one mth behind, YTD is Quarter to date ** Serious Incidents Rate is per 1,000 Occupied Beddays

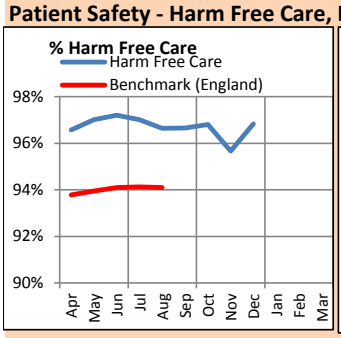
*** Contracted not worked includes Maternity /Long Term Sick **** Staff FFT is Quarterly therefore data is latest Quarter

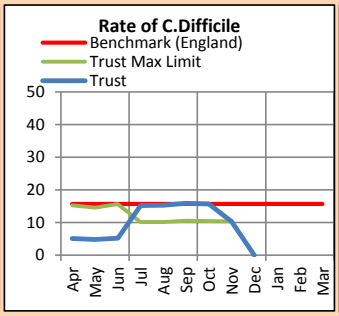
***** IP Friends and Family includes Inpatients and Day Cases ******SHMI is within confidence limit

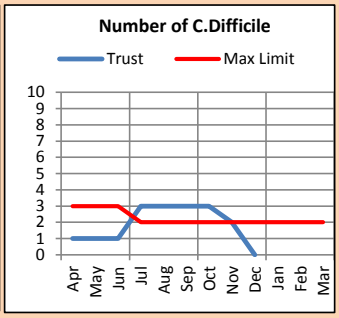
	Well-Led	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
5-01	Income	33,171	33,202	295,619	299,298	1.2%	1.7%	400,487	399,790	
5-02	EBITDA	2,740	(248)	24,844	6,464	-74.0%	-57.7%	23,821	10,218	
5-03	Surplus (Deficit) against B/E Duty	84	(2,892)	(1,500)	(18,798)			(12,132)	(23,515)	
5-04	CIP Savings	1,618	To Follow	17,505	To Follow			21,496	To Follow	
5-05	Cash Balance	6,545	4,359	6,545	4,359	-33.4%	48%	2,127	1,000	
5-06	Capital Expenditure	636	917	3,676	8,633	134.8%	-30.8%	*18,963*	14,823	
5-07	Establishment (Budget WTE)	5,423.6	5,641.2	5,423.6	5,641.2	4.0%	0.0%			
5-08	Contracted WTE	4,952.5	5,059.8	4,952.5	5,059.8	2.2%	-5.3%			
5-09	***Contracted not worked WTE	(97.7)	(104.7)	0.0	(104.7)					
5-10	Locum Staff (WTE)	38.7	50.8	38.7	50.8	31.2%				
5-11	Bank Staff (WTE)	293.3	303.9	293.3	303.9	3.6%				
5-12	Agency Staff (WTE)	205.8	260.9	205.8	260.9	26.8%				
5-13	Overtime (WTE)	73.9	59.1	73.9	59.1	-20.0%				
5-14	Worked Staff WTE	5,490.8	5,639.9	5,490.8	5,639.9	2.7%	0.0%			
5-15	Vacancies WTE	471.0	581.4	471.0	581.4	23.4%				
5-16	Vacancy %	8.7%	10.3%	8.7%	10.3%	18.7%				
5-17	Nurse Agency Spend	(763)	(716)	(3,853)	(7,562)	96.3%				
5-18	Medical Locum & Agency Spend	(1,057)	(1,094)	(7,326)	(9,147)	24.8%				
5-19	Temp costs & overtime as % of total pay bill									
5-20	Staff Turnover Rate	9.3%	10.3%		10.0%	1.0%	-0.2%	*10.5%*	10.0%	8.4%
5-21	Sickness Absence	4.5%	3.9%		3.9%	-0.5%	0.6%	*3.3%*	3.3%	3.7%
5-22	Statutory and Mandatory Training	84.2%	89.3%		89.3%	5.1%	4.3%	85.0%	85.0%	
5-23	Appraisal Completeness	75.1%	84.7%		84.7%	9.5%	-5.3%	90.0%	90.0%	
5-24	Overall Safe staffing fill rate	101.4%	99.8%	100.9%	101.3%	-1.7%		92.7%	101.3%	
5-25	****Staff FFT % recommended work	New	56.9%	New	57.7%		-1.1%	58.0%	57.7%	62.9%
5-26	***Staff Friends & Family -Number Responses	New	253	New	253					
5-27	*****IP Resp Rate Recmd to Friends & Family	New	19.7%	New	26.3%		-3.7%	30.0%	30.0%	25.1%
5-28	A&E Resp Rate Recmd to Friends & Family	New	9.7%	New	14.3%		-5.7%	20.0%	20.0%	13.6%
5-29	Mat Resp Rate Recmd to Friends & Family	17.0%	32.1%	19.5%	20.1%	0.5%	5.1%	15.0%	15.0%	22.3%

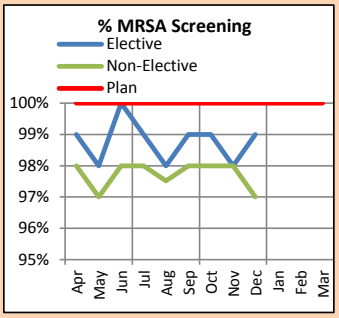
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

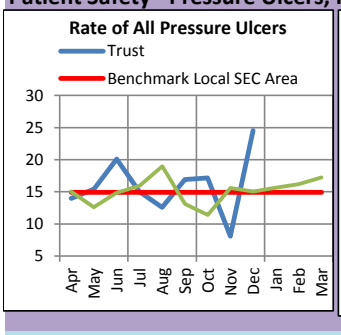


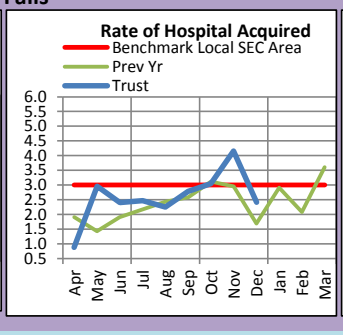


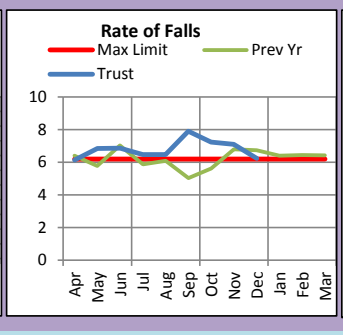


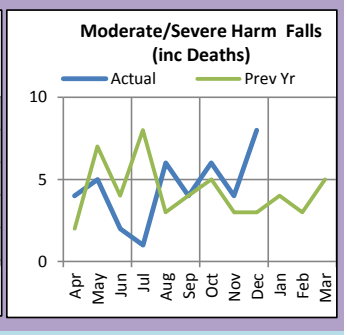


Patient Safety - Pressure Ulcers, Falls

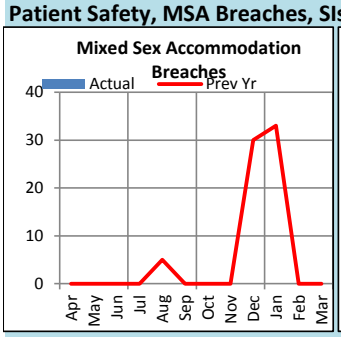


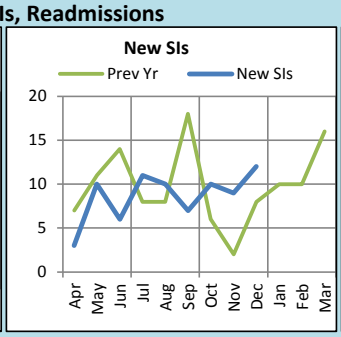


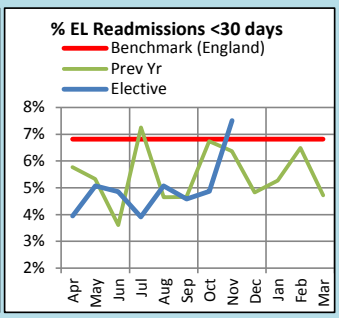


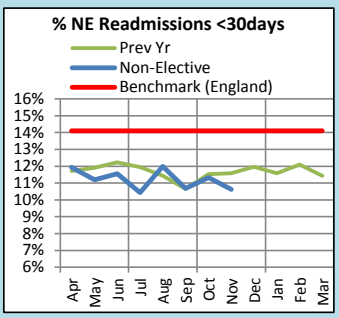


Patient Safety, MSA Breaches, SIs, Readmissions

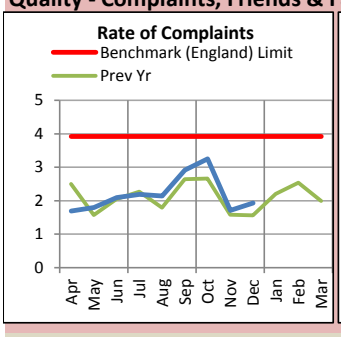


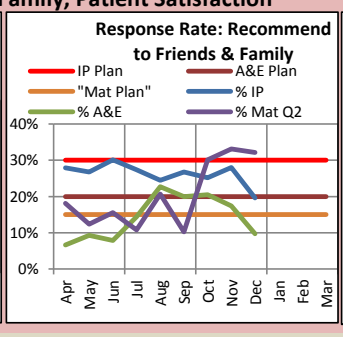


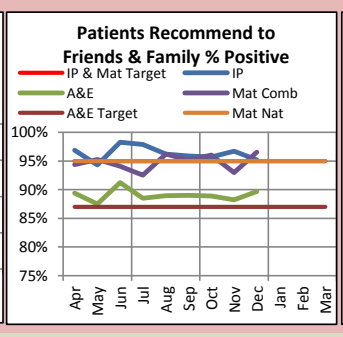


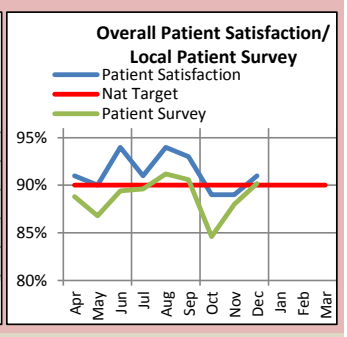


Quality - Complaints, Friends & Family, Patient Satisfaction

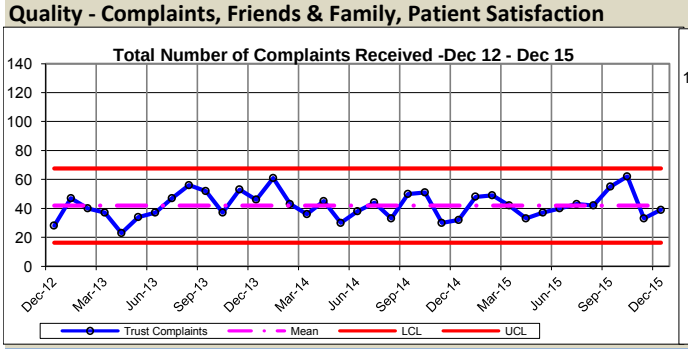


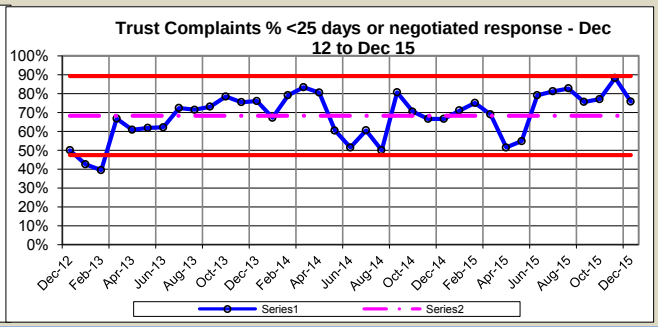




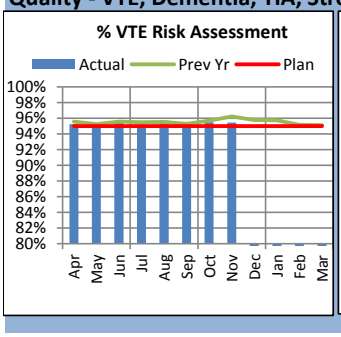


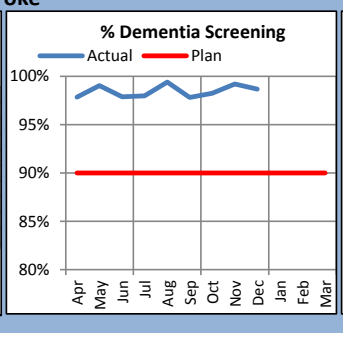
Quality - Complaints, Friends & Family, Patient Satisfaction

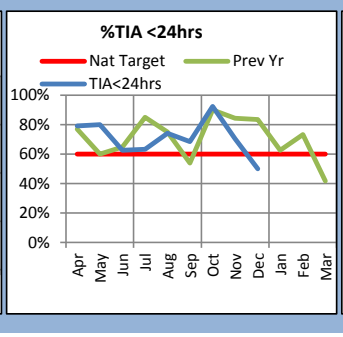


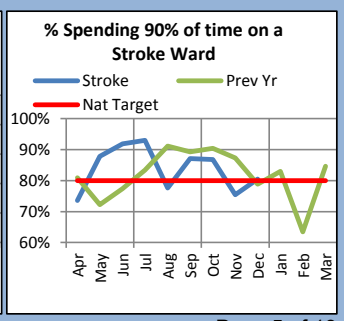


Quality - VTE, Dementia, TIA, Stroke



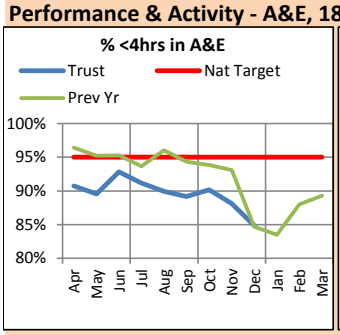


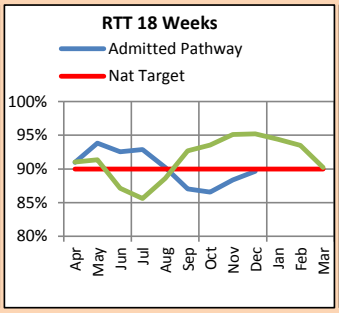


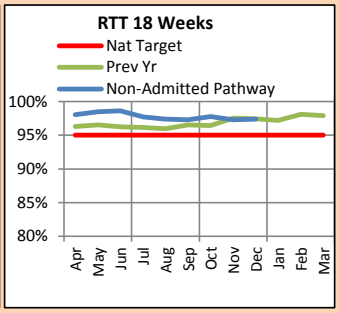


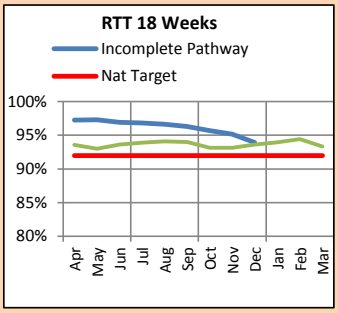
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

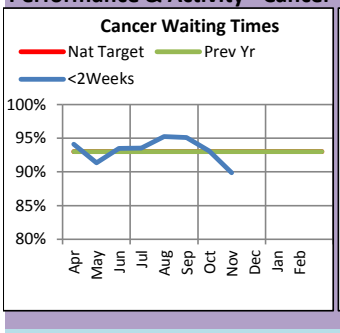


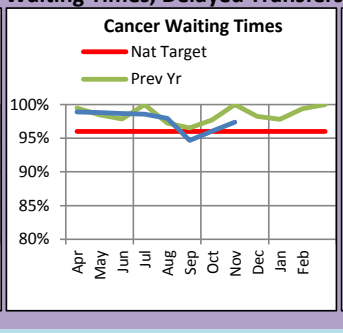


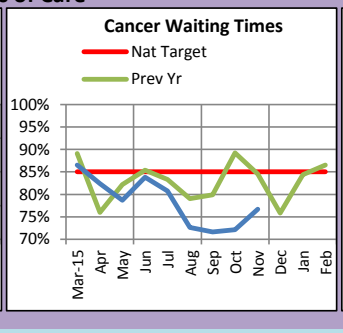


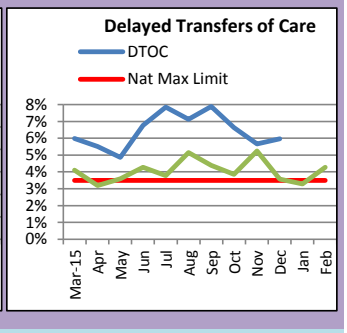


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

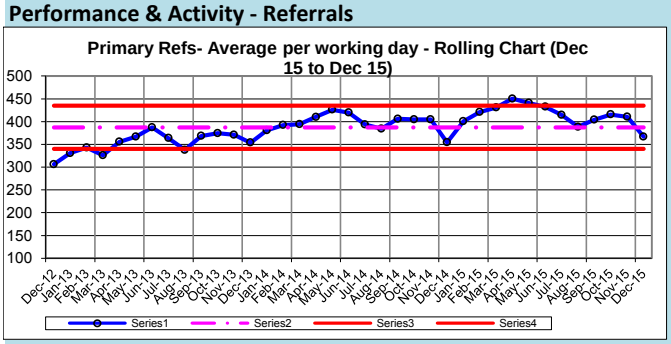


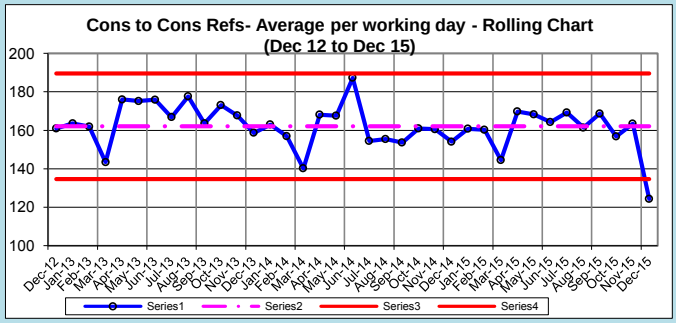




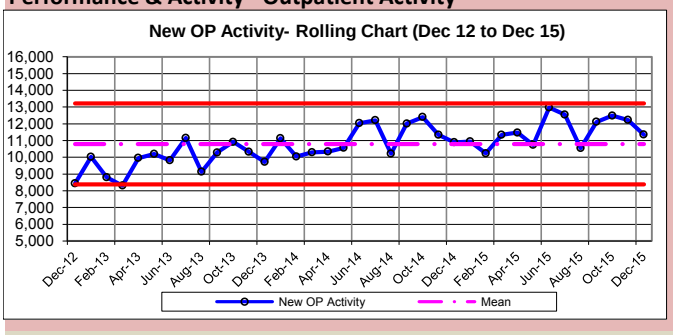


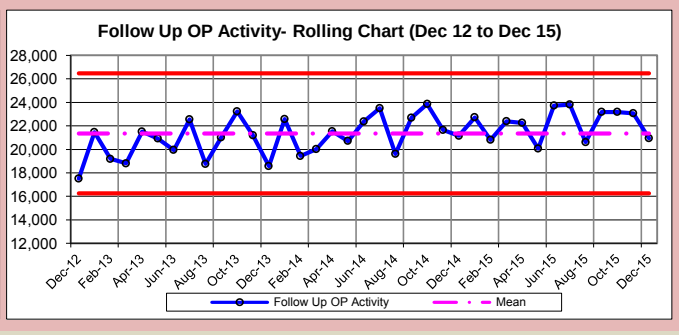
Performance & Activity - Referrals



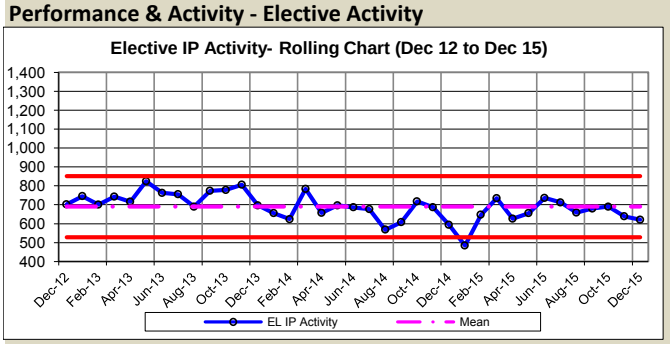


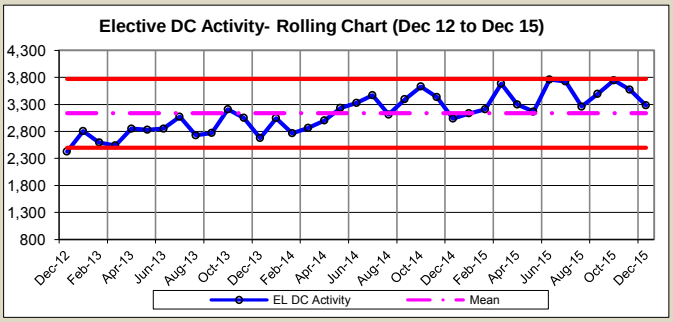
Performance & Activity - Outpatient Activity



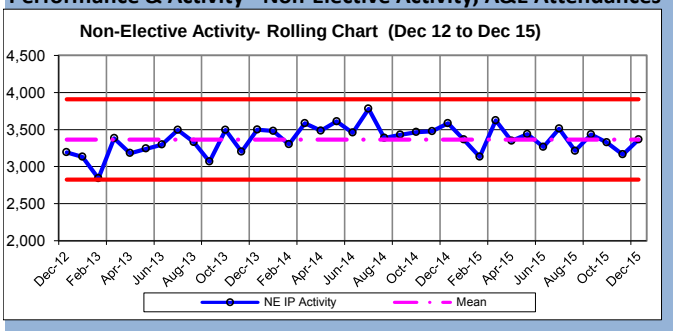


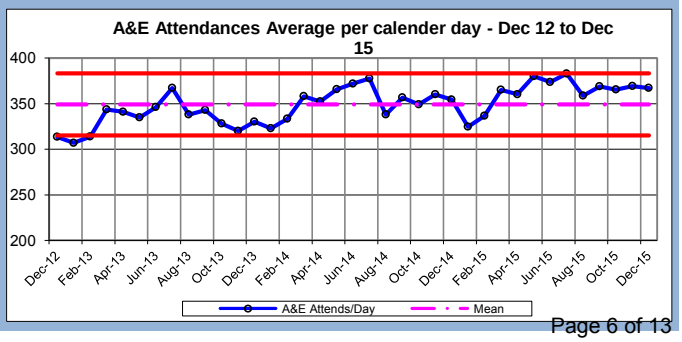
Performance & Activity - Elective Activity





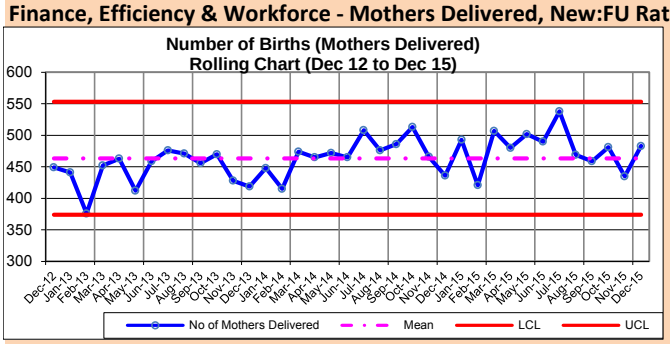
Performance & Activity - Non-Elective Activity, A&E Attendances

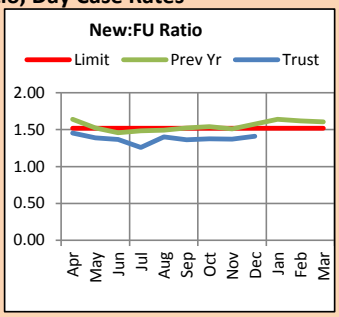


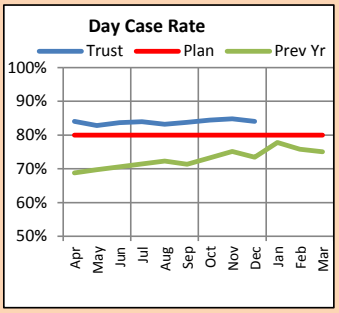


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

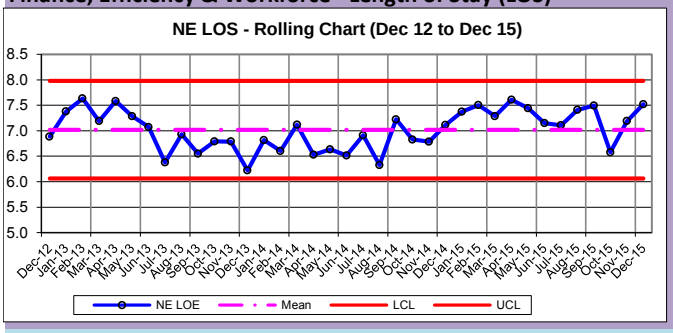
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

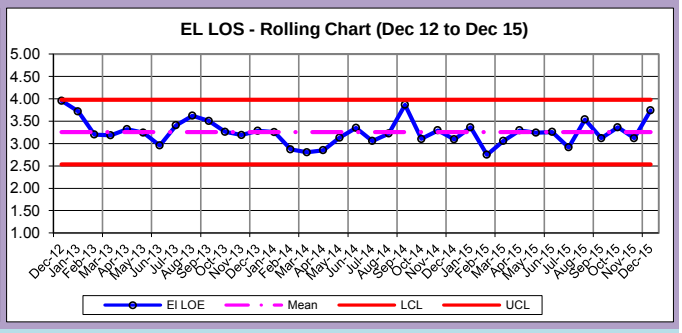




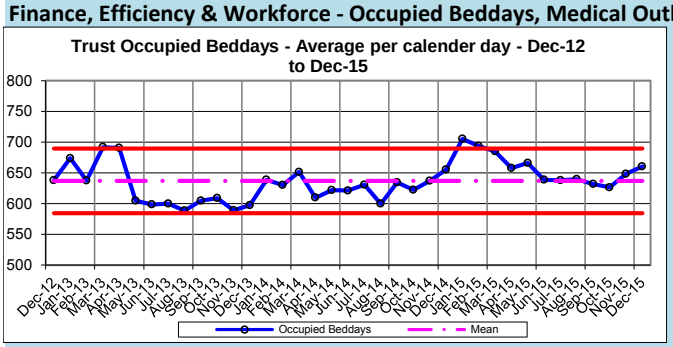


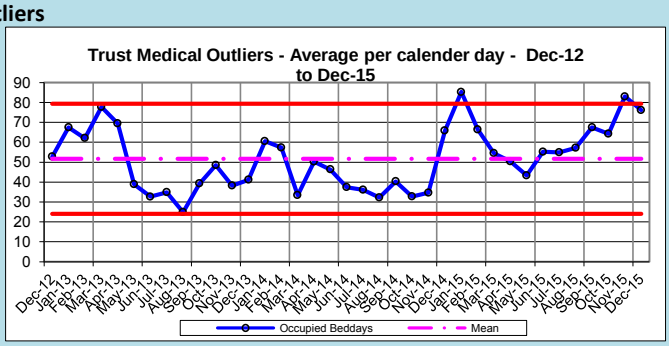
Finance, Efficiency & Workforce - Length of Stay (LOS)



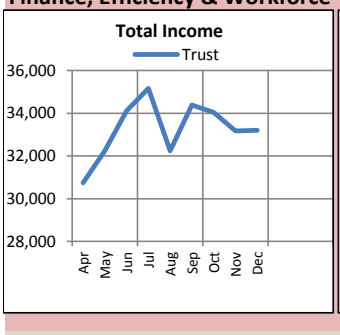


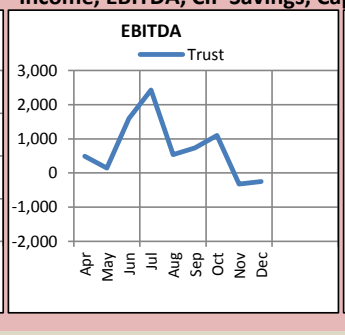
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

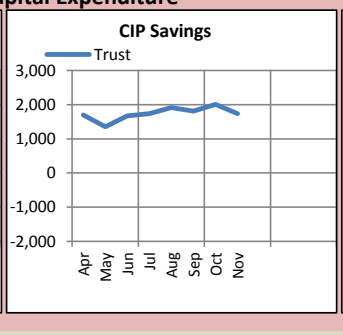


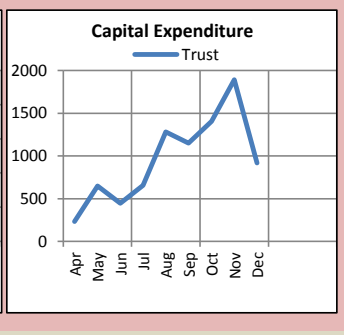


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

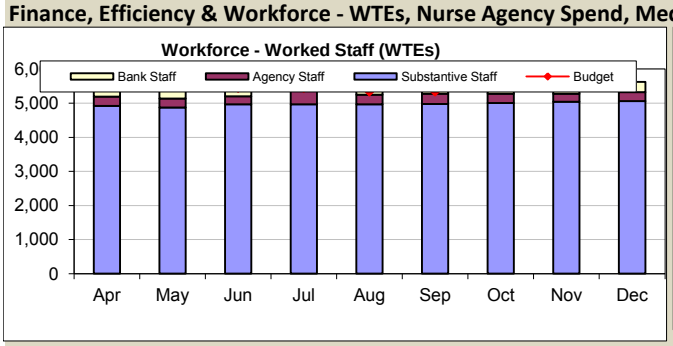


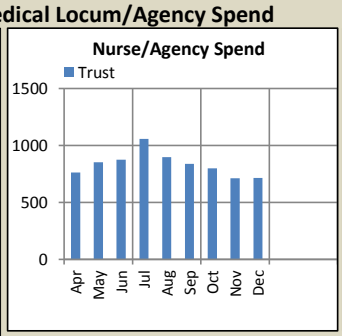


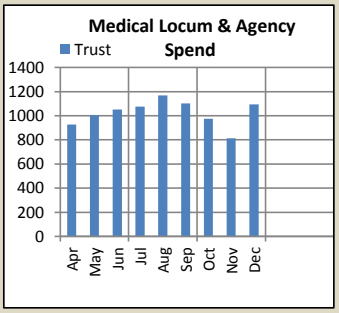




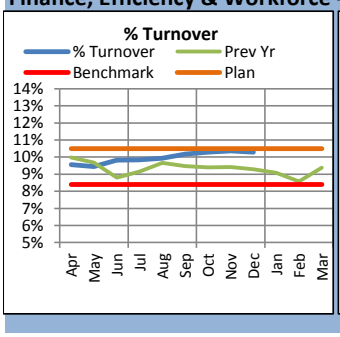
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

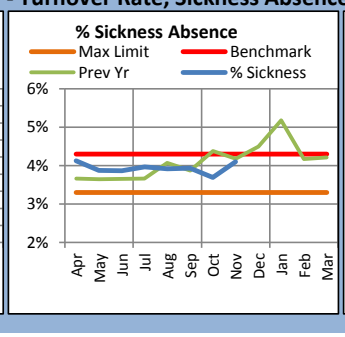


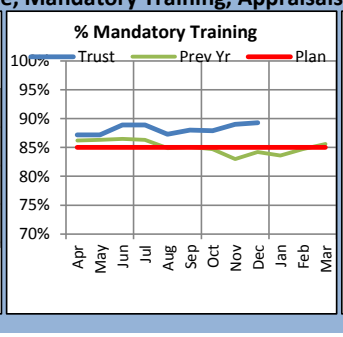


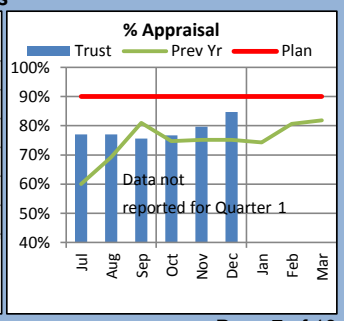


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD - JANUARY 2016

REVIEW OF LATEST FINANCIAL PERFORMANCE **DIRECTOR OF FINANCE**

Summary / Key points

- The Trust had an adverse variance against plan at the end of December 2015 of £7.11m, an increase of £1.69m in the month.
- The Trust's net deficit to date (including technical adjustments) is £18.80m against the planned deficit of £11.7m. In the month the Trust operated at a deficit of £2.89m against a plan of £1.26m deficit for December.
- There are a number of significant risks to the Trust's year end position. The risks are:
  - The Trust's ability to deliver its elective workload to planned levels and the recent trend of lower levels of SLA income performance;
  - The impact of staffing costs over plan, albeit with the plans in place to reduce agency reliance and increase substantive staffing;
  - The CCG's ability to provide the finance requested and included in the Trust's plans to support escalation capacity, winter pressure plans, CQC action plan investments (e.g. in critical care outreach) & A&E paediatric doctors;
  - Slippage on the delivery of a number of Directorate and Strategic plans intended to increase market share relating to East Sussex and Medway non elective workload, E Sussex maternity developments, areas of Best Practice Tariff and other income related CIPs. High levels of income in early months of the year previously mitigated this slippage.
- The performance in month against the forecast trajectory was slightly better than expected by £179k.
- In December the Trust operated with an EBITDA deficit of £0.25m which was £2.07m adverse to plan.
- The Trust held £4.4m of cash at the end of December, a decrease of £6.1m from the end of November.

Reason for circulation to Trust Board

To note and consider the December position and actions needed to return the Trust to plan.

Briefing paper – Trust Board

M9 Financial Performance overview

1. Overview of the Financial Position at M9 2015/16

1.1. This summary provides an overview of the financial position at M9 of 2015/16.

1.2. Under the TDA Accountability Framework the Trust is flagged as Red due to its reported financial position at month 9. The Trust moved out adversely by £1.70m against its in-month deficit plan of £1.20m resulting in a year to date deficit of £18.80m against a planned deficit of £11.70m. This is an adverse year to date variance of £7.11m. These figures include the full utilisation of reserves available for the first nine months of 2015/16.

Income

1.3. Total income for the year to date is £299.30m against a budget of £294.30m. Income for the month is £33.20m compared to the £32.38m plan for the month.

1.4. The income headlines are outlined below:

- Total income is £5.03m favourable to plan year to date.
- All applicable contractual deductions and penalties have been included and a provision has been made for challenges. A total of £5.4m provisions/deductions and £4m threshold adjustments are included in the year to date position with £7.5m provisions/deductions and another £6m threshold adjustments in the forecast outturn.
- A&E attendance activity remains higher than in the corresponding period of last year.
- The Conversion rate has increased to 26.3% in month 9 compared to the 25% experienced over the last 5 months.
- Re-chargeables on High cost drugs and devices are favourable in the month by £1m, and year to date £4.5m but these are pass through costs charged back to CCGs so there is a corresponding over-spend in the non-pay budgets.

1.5. There was a reduction in Elective inpatient and day case activity compared to last month's level (£4.6m in month 9 compared to £4.7m in month 8, with a year to date (YTD) under performance of £0.9m), including dependency on outsourced activity. Day case income is now on plan for YTD, while electives are £1m under achieved. Elective inpatients were down in month 9 as result of the high level of cancellations, which even though slightly lower than the previous month's remained high (0.7% in December vs 0.9% in November) resulting from lack of beds. The impact was most visible in T&O.

1.6. In month 9 A&E attendances remained relatively flat compared to the last 4 months' level and the conversion rate increased from 25% to 26.3%. This along with the discharge of some long stay, high acute patients has led to an increase in non-elective admissions. Overall, the level of occupied bed days remains high and has increased further in month 9 along with the conversion rate from A & E. This suggests the case mix complexity has increased, and the Trust continues to see more acute patients.

1.7. Even though NEL admissions have reduced by 5.4% YTD, the richer and more acute case-mix has resulted in longer lengths of stay and an increase in the occupied bed days (OBD). During the same comparator period between years (April to December) delayed transfers of care (DTOCs) have increased to their highest ever levels (December comparison year on year 6.5% to 4.1%, some previous months have been over 7%). The increase in OBDs has generated a 2.7% increase in income from excess bed days which are only paid beyond the relevant HRG "trim point". This suggests that whilst patient discharges are being delayed, it is not by enough to trigger a compensating excess bed day payment.

1.8. From April to December 2015 the Trust reported a total of 147,616 bed days compared to the 141,612 bed days used in the corresponding period of last year, representing a 4.2% increase. Our high bed utilisation rate coupled with our inability to discharge patients quicker is increasing the level of OBDs. Between month 8 and month 9 the daily bed occupancy rate has increased by 26 resulting in a total bed utilisation of 17,399 in December (31 calendar days) compared to the 16,074 bed days in November (30 calendar days). The increase in acuity and length of stay is reducing the throughput in non-elective activity, which is further reflected in an increase in medical outliers and is adversely affecting bed capacity available for elective activity.

1.9. Outpatient activity (excluding diagnostics) is £4.7m in month 9 compared to £4.9m in the previous month. Year on year, the income from Outpatient activity is 4% higher the corresponding period of the previous financial year but is still lower than planned levels (£0.5m YTD).

1.10. Readmissions, A&E waits, RTT and other contractual penalties (relating only to incomplete pathways) were £2.9m in December compared to the £2.5m performance in November. The Readmissions, RTT and A&E penalties are calculated from Month 9 data whilst the other contractual penalties (e.g. First to Follow up OP ratios, Data quality queries) are estimates.

1.11. An 85% achievement rate for CQUINs continues to be assumed in the income position.

1.12. Non recurrent transitional support of £2.7m year to date for Cancer received from NHS England to reduce the impact of the cancer tariff in 2015-16 has been included in the position.

Outsourcing

1.13. The value of income related to outsourced activity increased to £0.27m in December from £0.25m in November with a year to date total of £2.31m. For outsourced activity the Trust pays costs that remove any contribution that it would earn from undertaking the activity in-house. Over 80% of the income for outsourced activity for the year to date relates to orthopaedic cases where there may be potential to undertake this work internally by increasing actual or productive in house capacity.

Expenditure

1.14. Operating costs are £14.8m adverse for the year to date against a planned budget of £278.1m. Pay was over plan by £1.46m in December generating a year to date adverse variance of £8.86m.

1.15. Non pay (including reserves) overspent by £1.42m in December and is £5.00m overspent year to date.

1.16. Substantive staffing is underspent for the year to date by £1.3m made up of underspending on medical posts (£0.74m), scientific posts (£0.45m) and nursing posts (£0.50m). In the month substantive pay costs overspent by £0.26m which is largely linked to further arrears of pay on medical staffing not previously notified to the Finance Managers.

1.17. The year to date major overspends on agency usage are in Nursing (£5.2m), Medical agency (£1.94m), Scientific/Therapeutic agency (£0.94) and Admin & Clerical (£0.99m). Nurse agency spend continues to fall with a £51k reduction from November's level in nurse agency spend (£716k compared with £767k). Agency costs are slightly up on last month's levels by £11k overall (£1,554k compared to £1,565k). Medical Locum costs remained high and are £0.82m overspent to date. Bank costs are over planned levels by £0.2m in the month which gives a year to date overspend of £0.6m

1.18. The trajectory plan submitted to the TDA set out a reduction in agency costs from September (for trained nursing) of £0.5m through to the end of March with an overall reduction, including additional permanent staffing, of £0.3m. In December the qualified agency nursing reduced to £693k from £734k in November. This was £222k greater than the December trajectory target which was set at £471k. The trajectory submitted to the TDA assumed that the total qualified agency nursing spend would be 8.2% by November but the Trust performance is actually 4.6% worse at 12.8%. Escalation pressures have contributed to the Trust not meeting the planned trajectory reduction.

1.19. Significant non pay overspends for the year to date are:

- Drugs and medical gases £4.81m adverse (offset in the position by the over performance in HCD income to date of £4.50m)
- Clinical Supplies is £2.4m adverse to plan – this includes cardiology devices (e.g. ICDs) that are charged back to the CCGs.
- Purchase of Healthcare from non NHS is adverse to plan by £2.6m reflecting outsourced usage to date. This is largely offset by the corresponding activity based income, though this provides no net contribution to the Trust financial position.

1.20. The main areas of under-spending in non-pay are in “other non-pay costs” which is underspent by £5.4m to date including released reserves.

1.21. Premises is £0.2m underspent to date which includes underspending on power and utilities of £0.1m.

1.22. EBITDA is a £6.5m surplus year to date and is now adverse to plan by £8.8m.

1.23. The financing costs including those related to the PFI and deprecation total £26.0m year to date which is underspent against the plan by £1.6m. The plan was agreed prior to the finalisation of the revaluation in year-end accounts, which reduced planned levels of deprecation. In addition, the in-year capital plan reprioritisation and “capping” to provide funding for the new TWH ward development has slowed down originally planned spend, and diverted it from shorter life, higher depreciating assets such as medical and IT equipment into build assets.

Forecast Outturn & Risks on delivery

1.24. The forecast out-turn and recovery plan is set out in a separate paper to the Trust Board. The performance in month against the revised forecast trajectory was slightly better than expected by £179k.

Balance Sheet & Capital

1.25. Cash balances of £4.4m were held at the end of December (£10.5m at the end of November). The Trust drew down £6.5m from the £12.1m Interim Revolving Working Capital Facility (IRWCF) in November. The Trust received £4m cash from WK CCG that has allowed the Trust to repay £2m IRWCF back to the DH in December, reducing the interest charge to be paid in March. The Trust still anticipates drawing down the full £12.1m by year end.

1.26. Total debtors are £35.6m, £1.6m lower than the reported November figure. Debt over 90 days has increased by £3.7m to £9.1m at the end of December. Debtors in excess of a £1m are;

- WKCCG £8.6m
- EK Hospitals FT £2.1m
- Medway FT £1.2m

90 day invoiced debt for private patients is currently £0.2m (£1.2m in total for all invoiced debt) with other non NHS invoiced debt over 90 days old totalling £0.3m (£1.1m in total).

1.27. Total creditors are £55.2m. Included within creditors is £18.1m deferred income of which £10.9m relates to 5 SLA advances and a further £4m from WK CCG. Payments to suppliers are currently being restricted by 25 days which means that potentially some invoices may be twenty five days past their due date when they are paid. When the invoices are paid these will adversely impact the Trust BPPC. Against the 95% target for payments made within 30 days the Trust achieved in value 85.5% in December for Trade creditors (81.3% in March 2015) and 80.6% in December for NHS creditors (66.6% in March 2015).

1.28. The pressure on the Trust's outturn position means that it will be necessary for the Trust to manage its cash through tight controls over its working capital. Increases in the Trust's forecast deficit would require consideration of further action including extending creditor terms and further restricting supplier payments. The Trust is also planning to request from the TDA a reduction in the closing cash balance held at year end from £2.1m to £1m in order to release further cash to support creditor payments.

1.29. Capital expenditure to month 9, net of donated assets, was £8.5m and is showing an underspend of £3.9m against the Trust's original plan of £12.4m for the same period. The forecast net outturn is £5.0m lower than the original plan, which is mainly accounted for by the agreement to reduce its loan request by £3m, and the decision not to proceed at this stage with the disposal of the Hillcroft residence (£0.9m, matched by reduction in spend).

1.30. The Trust previously revised its Capital Plan to the TDA in line with its Finance Improvement response, reducing its request for capital loans by £3m to £3.5m.

1.31. The Trust has submitted its application for a £3.5m capital loan or PDC and this has been supported by the TDA and is currently with the DH for approval. With the reduction in CRL from the reduced depreciation, the Trust will require the capital loan in order to stay within its capital resource limit.

2. CIP Delivery

2.1. The month 9 position shows a total CIP delivery (including full year effects) of £15.9m against the target that was included in the TDA plan of £16.1m, so under-performing by £0.2m to date.

2.2. The schemes identified are forecast to deliver £20.6m by year end which is £0.1m less than the forecast reported at month 9 due to reduced assumptions about PPU income, and leaves £0.9m of schemes that the Trust is working to identify.

2.3. Against the year to date total CIP expectation of £16.1m, shortfalls in Medical Efficiency (-£0.4m), Length of Stay (-£0.8m) and Back office (£-0.6m) are in part offset by overachievement in Contract Management (+£0.4m), Nursing and STT Efficiency (+£0.8m) and Procurement efficiencies (+£0.6m).

3. Conclusion

3.1. Elective performance remains lower than planned for this year and includes significant levels of outsourced activity, especially in orthopaedics, where the Trust does not earn a margin. Outpatient activity is higher than last year, but is also behind the plan for this year, and there are issues in ensuring outpatient clinic capacity is fully utilised while referral rates rise and waiting lists are growing. Non elective activity is lower than last year but total numbers of bed days have increased, along with delayed transfers of care. Income per spell has increased, indicating higher complexity. The increase in acuity and length of stay is reducing the throughput in non-elective activity, which is further reflected in an increase in medical outliers

and is adversely affecting bed capacity available for elective activity. The challenge for the Trust remains how to ensure maximum activity is undertaken in house to bring the Trust back to, and above, planned levels of activity whilst contributing the financial margin required.

3.2. Staffing costs remain a key area of continued focus as part of the Integrated Recovery Plan and normal day to day control. Agency costs in month are slightly above last month's levels with the majority of this being on medical agency. Pay costs remain the most significant area of pressure on the Trusts' budgets, and is currently not being covered off by income at or above planned levels.

3.3. The Trust has put in place a number of additional recovery and control measures including:

- Implement outturn recovery actions utilising Monitor Grip & Control Framework
- Issuing Directorate control totals and in the process of agreeing recovery plans with clear trajectories; fortnightly monitoring of performance to recovery plan by Executive team meeting with Directorates.
- Issuing Service Line Reporting information to focus Directorates on opportunities for increased profitability and reduced costs
- Establishment of a Task and Finish Group to identify ways to maximise day case, elective and outpatient activity and income, and to reduce waiting lists, and to review activity that is being outsourced to ensure we increase net profitability.
- Staffing Controls – maintaining focus on reduction of agency costs, interim and consultancy usage. Review by Chief Nurse of nurse rotas exceeding the 1:8 ratio.
- Restricting further use of any unspent budgets & additional procurement controls applied on areas of discretionary spend, call-off orders and large orders.
- Focusing on liquidating NHS debt to give maximum flexibility on cash and exploring all options to stretch creditors to manage outturn pressures.

3.4. The Trust Board are requested note and consider this report.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – January 2016

1-10	**Response to the recommendations arising from the external "Good Governance and Culture Review"**	**Chief Nurse**

The "Good Governance and Culture Review" was commissioned by the Chief Nurse following the publication of the Care Quality Commission (CQC) report in February 2015. The review commenced mid-April 2015 and the final report was received at the end of August 2015. The review was undertaken by Marion Smith from Marion Smith Consulting Ltd.

The report was issued to all Board members by email on 26/08/15, and then in September 2015, the Trust Board (Part 2) received the full report, and a response to the recommendations. The submitted response was discussed at length, but it was agreed that the Chief Executive coordinate a further considered response, involving the Executive Team, Trust Management Executive, Chairman of the Trust Board and others, and submit the outcome to the Trust Board in December 2015. As the December 2015 Trust Board meeting was subsequently cancelled, the response was deferred to the January 2016 Trust Board meeting.

The requested response is now enclosed, for assurance (and to provide formal closure of the "Good Governance and Culture Review" report). Much of the content (in particular the revised Committee structure) was discussed at the Trust Board 'Away Day' held on 20/11/15 (as was also discussed at the Trust Management Executive on 18/11/15).

Which Committees have reviewed the information prior to Board submission?

- Much of the content of the report (in particular the revised Committee structure) has been discussed at the Trust Management Executive (on 18/11/15), and agreed in principle at the Trust Board 'Away Day' on 20/11/15

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

"Good Governance and Culture Review": Recommendations and response

The report made 27 recommendations, each of which are listed in the table below, along with the response from the Trust.

Recommendation	Accepted?	Action taken and/or planned / reason for non- / partial- acceptance
Strategy		
1. "It is recommended that MTW Quality Strategy is updated at the earliest opportunity through a process of organisational engagement, and publicised widely across the Trust"	Yes	▪ The Quality Strategy has been reviewed recently, and has been confirmed to remain fit for purpose (much of it is still relevant and consistent with Quality Accounts priorities and Quality Improvement Plan priorities) ▪ An update/refresh will however be undertaken later in 2016 and will be integrated as part of the clinical services strategy.
Structure: Directorate Services and Governance		
2. "That the Directorate Governance structure, individual roles and responsibilities, core agenda and integrated reporting process is agreed and implemented in a consistent approach across all the Directorates"	Yes	▪ Roles and responsibilities for governance including governance facilitators) has been discussed within the Directorates and with the corporate clinical governance team, to ensure consistency ▪ Core agendas for part 1 of the Directorate Clinical Governance meetings have been in place, but more work will be undertaken to ensure consistency across all directorates. ▪ Standardised minutes and action logs from each Directorate Clinical Governance meeting are being actively promoted, via the Quality Committee and Clinical Governance Committee ▪ A central repository of all Clinical Governance meeting minutes, action logs and attendance records is received at the Trust Clinical Governance committee
3. "To enable more multi-disciplinary working through the joint planning of the clinical Governance half-day agenda and by facilitating non-medical staff to attend more often where possible"	Yes	▪ Monitoring, encouragement and facilitation of Multi professional attendance at Directorate Clinical Governance is continuing (and multi-professional attendance is improving). This will be monitored through Trust Clinical Governance Committee
4. "To introduce consistent Clinical Governance facilitation support resources across the Directorates with a quality improvement remit added to the role, enabling more effective delivery of the W2B Governance function"	Yes	▪ The Clinical Governance support for Directorates has been considered ▪ Directorate-based Governance Facilitators already provide cross-Directorate support (for example, there is a Risk and Governance Manager covering the Women's, Sexual Health and Paediatric Directorates; and a Senior Nurse for Clinical Governance covering the Cancer & Haematology, Trauma & Orthopaedics, Critical Care and Surgery Directorates) ▪ The role and responsibilities of all existing governance support posts in the Directorates will be reviewed, to ensure consistency ▪ Job Descriptions are being reviewed to ensure consistency in role and agenda
Systems and Process: Committees and Meetings		
5. "To review how the organisation and the TME engages and involves the wider senior leadership team in the oversight of Quality Governance and the operational and strategic delivery of Trust	Yes	▪ Changes have been made to the Committee structure, so that the TME becomes the 'parent' committee for the new Clinical Governance Committee. A report will then be submitted from the Clinical Governance Committee to the TME (pending approval of revised Quality Committee

Recommendation	Accepted?	Action taken and/or planned / reason for non- / partial- acceptance
services"		ToR at Trust Board in January 2016) ▪ In addition, the Directorate reporting to TME has been strengthened, and Directorates are now required to submit a brief written report, covering the key issues/risks (along with any actions planned) in relation to quality, access targets, workforce and finance
6. "To consider particularly how the Associate Director of Governance is involved in leading the delivery of Quality Governance for the Trust through the current organisational arrangements"	Yes	▪ The role of the Associate Director of Quality Governance (N.B. this is the new job title) has been reviewed, and changes have been made. ▪ This will, in addition to the changes proposed to the Committee structure, strengthen the post-holders involvement, as recommended
7. "To replace the Standards Committee with a newly convened Clinical Governance Committee with new terms of reference aligning Directorate Governance responsibilities and reporting through the new committee W2B"	Yes	▪ The Standards Committee has now been disestablished, and the newly constituted Clinical Governance Committee met for the first time in December 2015 (a report of the meeting was submitted to the 'main' Quality Committee on 06/01/16) ▪ The new Clinical Governance Committee will be a sub-committee of the TME (the Quality Committee agreed revised Terms of Reference that reflect this change, at its meeting on 06/01/16, and these have now been submitted to the Trust Board, for formal approval)
8. "To replace the existing policy ratification committee with a newly convened Trust-wide Policy Group operating as a Sub Committee of the TME to be chaired by the Trust Secretary supported by the Corporate Clinical Governance Team and to include the membership of the Trust librarian for document version control and publication purposes. To implement a clear policy approval process W2B"	In part	▪ The Policy Ratification Committee (PRC) is already a sub-committee of TME, and its membership is broad and multi-disciplinary The Trust Secretary already chairs the PRC ▪ The Clinical Governance Assistant who supports the Policy process (including the publication of Policies on Q-Pulse) has however recently been transferred under the management of the Trust Secretary (as part of the transfer of the Risk and Compliance Manager), and this will strengthen the process further ▪ The Trust librarian has joined the membership of the PRC (although they are not involved in the document version control process, which is robust) ▪ The Policy approval and ratification process is clear, and described in detail on the Trust Intranet. Awareness of the process is growing, but it is acknowledged this could be improved. However, this occur once the revised 'Policy for Policies' is finalised and publicised (see below) ▪ In addition however, a process for approving and ratifying clinical guidance (which are different from Policies) is in development led by the Associate Director of Quality Governance
9. "To develop a Trust Policy on Policies to ensure that policies are approved at Directorate Boards and relevant corporate committees prior to submission for approval to the Policy group and then for final approval to TME prior to implementation"	In part	▪ The existing Policy approval and ratification process is clear, and described in detail on the Trust Intranet. All Trust-wide Policies are approved by an appropriate Committee before being submitted for ratification (the final step before being published on the Intranet) ▪ Awareness of the process is growing, but it is acknowledged this could be improved. However, this will occur once the revised 'Policy for Policies' is finalised and publicised. This is

Recommendation	Accepted?	Action taken and/or planned / reason for non- / partial- acceptance
		scheduled for the spring of 2016
10. "The frequency of the integrated performance meeting should be increased to monthly and it is recommended that the Associate Director of Corporate Clinical Governance should be present to support the process by corporately overseeing delivery of quality Governance in the Directorates"	In part	▪ The frequency of these meetings has been reviewed, and it has been agreed to continue with quarterly meetings, but that follow-on meetings can be scheduled as required by exception. ▪ It has also been agreed the Associated Director of Quality Governance will attend if the Chief Nurse is unable to do so (and alongside where appropriate / invited)
11. "Change the Terms of Reference of the Clinical Operations committee to include Quality improvement in the title and to use this key group as a Trust-wide forum to drive quality improvement"	In part	▪ The Terms of Reference will be reviewed
Quality Committee and Patient Experience Committee		
12. "The Terms of Reference of the Quality Committee should be reviewed to include Patient Experience"	In part	▪ The Terms of Reference for the Quality Committee already include some aspects of patient experience, and a report is routinely received from the Patient Experience Committee ▪ The newly-constituted Clinical Governance Committee will receive details of Directorate's patient experience-related performance (FFT, surveys etc.), and these will then be reported to TME and the Quality Committee
13. "Whilst the CEO and Executive team are responsible for the overall oversight and assurance of Trust Governance, there is a cross-over at the present time between the role of the TME and the assurance provided by the Quality Committee for the Board. The roles of the TME and Quality Committee should be more clearly defined and it is recommended that the Quality Committee should 'hold the Executive to account' for the quality of services provided by the Trust, whilst the TME would receive a quality report from each directorate or combination of directorates to enable the Executive to be sighted and explore the major quality issues. Such an approach would require some redefinition of the membership of both groups"	In part	▪ The Terms of Reference of the Quality Committee have been revised, to make it clear that the Committee's role is to seek and obtain assurance on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care (the Quality Committee agreed revised Terms of Reference that reflect this change, at its meeting on 06/01/16, and these have now been submitted to the Trust Board, for formal approval) ▪ The change in Terms of Reference means that the Quality Committee will no longer have any sub-committees ▪ The new Clinical Governance Committee is proposed to become a sub-committee of the TME (which will be implemented if the Trust Board approved the ToR of the Quality Committee on 27/01/16)
14. "The existing Patient Experience committee should be replaced by a new Patient Experience working group established as a sub-committee of the Quality Committee"	No	▪ The Trust Board wishes for the Patient Experience Committee to continue in its present form for the time being
Health Watch		
15. "Review with Health Watch; opportunities to engage with more patient involvement activities in the Trust"	Yes	▪ Healthwatch have already been engaged in a number of ways some examples include supporting with elements of the CQC Quality Improvement Plan; being represented on the Clinical Reference Group for the new Ward at

Recommendation	Accepted?	Action taken and/or planned / reason for non- / partial- acceptance
		Tunbridge Wells Hospital; and being involved in the Stroke review engagement work ▪ In addition, the reporting of Healthwatch Kent to the Patient Experience Committee has been strengthened, and Healthwatch now submit a written report to each meeting ▪ The Patient Information and Leaflets Group (PILG) has also recently recruited additional patient representatives to review leaflets, following a request to HealthWatch volunteers
Corporate Clinical Governance team		
16. "To review how the Associate Director of Governance and central office is providing visible leadership, providing oversight of key deliverables and proactively engaging communication with Directorate staff internally to deliver the Trust key quality Governance agenda. Review opportunities and locate the team together in one location e.g. relocate one of the corporate support services to enable this"	Yes	▪ The role of the Associate Director of Quality Governance (N.B. this is the new job title) has been reviewed, and changes have been made. ▪ The central teams work closely with the Directorates and have good well established working relationships ▪ The Trust Patient Safety team has also been reviewed, and changes implemented. The Patient SafetyTeam and Complaints Teams have already been relocated (to Room 105/106 at Maidstone Hospital). Further requests to co-locate the other clinical governance teams have been submitted to Director of Estates ▪ The Complaints, Legal, Incident, PALS and Audit (CLIPA) meeting has been reinstated to proactively review and triangulate new and closed incidents. This meeting provides monthly reports to the Trust Clinical Governance Committee. ▪ A Clinical Governance Roadshow was held in November 2015, which further raised the profile of the central Governance team
Risk Management		
17. "To integrate the Trust Risk Management process from W2B and B2W with the Risk Manager and Trust Secretary working collaboratively to achieve this and with TME receiving a formal Directorate and corporate risk report on a quarterly basis from the Risk manager and the Associate Director of Governance providing interim updates to the executive on a bi -monthly basis"	In part	▪ The line-management of the Risk and Compliance Manager has been transferred to the Trust Secretary. This will enable improved links between the risk management process (which is managed by the Risk and Compliance Manager) and the Board Assurance Framework process (which is managed by the Trust Secretary) ▪ The TME already received reports on risk (including the risk register and BAF), but this process has been strengthened recently by the fact that Directorates are now required to submit a brief written report to TME, covering the key issues/risks (along with any actions planned) in relation to quality, access targets, workforce and finance ▪ A review of the risk management process is planned for later in 2016
Workforce		
18. "Consider investing in coaching skills training to build resilience and an improvement culture"	In part	▪ "Culture" was the Priority 3 of the Workforce Strategy 2015-20 that was approved by the Trust Board in September 2015. The Strategy makes a commitment to "…create a culture whereby our organisational values and behaviours support compassionate care, respect, openness and honesty" ▪ The Strategy will focus on 4 organisational

Recommendation	Accepted?	Action taken and/or planned / reason for non- / partial- acceptance
		objectives: Leadership development; Staff engagement; Talent and succession planning; and the MTW 'climate'
Serious Incidents		
19. "The presence of the clinical leader at the SI panel for the Directorate presentation is highly recommended. It is also recommended that a tracking system is implemented through a weekly meeting, Serious Event Review Group (SERG), with the purposes of a) Reviewing and updating the SI tracker and regrading current SIs b) Reviewing lessons learnt c) Identifying quality improvement actions d) Providing timely feedback to staff after an incident has been reported and investigated"	In part	▪ The Serious Incident (SI) process has been reviewed and the Board will receive a report detailing the changes. ▪ The SI panel will be changed to a Patient Safety committee that will have a reviewed membership and Terms of Reference. In addition to reviewing new and completed SI's, this committee will track action plans and testing in practice from closed SI's for assurance. ▪ SI s are under constant review in terms of new declarations, progress on those declared and being investigated and completion of action plans ▪ Efforts to improve the functionality of the Datix system will continue ▪ A DATIX app is now available on mobile devices to make reporting easier and quicker
20. "To urgently address the backlog of incidents requiring investigation"	Yes	▪ The Incident backlog is under constant review and management but remains a challenge to achieve timely closure
Openness and Transparency		
21. "Implement a tracker system to identify issues raised on the safety walkabouts to support monitoring and provide evidence of quality improvement. The Associate Directorate of Governance should have a lead role in facilitating the process W2B and B2W"	Yes	▪ Any actions required from walkabouts will be documented to ensure action and follow up by the Patient Safety Team and reported within the Patient Safety Committee, which provides a report to the Trust Clinical Governance Committee.
Shaping Culture		
22. "Consider reviewing culture and engagement through the Governance workshop planned earlier in the review"	In part	▪ "Culture" was the Priority 3 of the Workforce Strategy 2015-20 that was approved by the Trust Board in September 2015. The Strategy make a commitment to "…create a culture whereby our organisational values and behaviours support compassionate care, respect, openness and honesty" ▪ The Strategy will focus on 4 organisational objectives: Leadership development; Staff engagement; Talent and succession planning; and the MTW 'climate'
Cost Improvement		
23. "To provide assurance to the Trust Board via the quality Committee that the Directorates are adding QIA risks to their Directorate Risk Register and that this process is effectively monitored"	In part	▪ Directorates already highlight any risks associated with CIP delivery, but this process has been strengthened recently by the fact that Directorates are now required to submit a brief written report to TME, covering the key issues/risks (along with any actions planned) in relation to quality, access targets, workforce and finance (including CIP delivery) ▪ Quality Impact Assessments are reviewed and signed off by Medical Director and Chief Nurse
Business Intelligence and Measurement		
24. "To ensure appropriate core quality, performance and finance data is aligned throughout the W2B structure through an integrated	Yes	▪ A 'Proof of concept' for integrated reporting is under development for Surgery (led by IT). The model will be reviewed, and any organisation wide changes that are recommended as a result

Recommendation	Accepted?	Action taken and/or planned / reason for non- / partial- acceptance
reporting process and that quality information is being analysed to identify themes and trends for the purposes of informing continuous improvement"		will be implemented
Mortality Review Group		
25. a. "Review administrative co-ordination arrangements for the review of deaths at directorate level, apply a consistent approach across directorates and consider the role of the governance facilitator to coordinate reviews for the CD."	In part	▪ The introduction of an electronic system to support the reviewing of deaths is being explored ▪ Work is ongoing, via the Quality Committee, in relation to the increased HSMR seen in 2015 ▪ The Mortality Review process and Group has been reviewed following a recent letter from the Director of Patient Safety and National Medical Director at NHS England. The letter notes the publication of a "Mortality Governance Guide" developed by Monitor and the NHS Trust Development Authority (to help support a common and systematic approach to the issue of potentially avoidable mortality). This was noted at the 'main' Quality Committee on 06/01/16 ▪ The first new Trust Mortality Surveillance Group will meet from February 2016
b. "Implement an electronic system for reviewing all deaths"	In part	
c. "Progress review of common themes and quality improvement process and assurance"	In part	
Governance Structure		
26. "For the purposes of quality and integrated Governance, the Directorates should be rationalised into three divisional groups led by a Divisional Director, with an ADO and ADNS for each divisional group"	In part	▪ Some of the existing Directorate-based Governance Facilitators already provide cross-Directorate support (for example, there is a Risk and Governance Manager covering the Women's, Sexual Health and Paediatric Directorates; and a Senior Nurse for Clinical Governance covering the Cancer & Haematology, Trauma & Orthopaedics, Critical Care and Surgery Directorates) ▪ The role and responsibilities of all existing governance support posts in the Directorates will be reviewed, to ensure consistency ▪ Job Descriptions will be reviewed to ensure consistency and focus on priorities and core agenda; working closely with the central team ▪ The Directorate Management Structure is under review
27. "The divisions should be supported by Governance facilitators and assistants to co-ordinate delivery of complaints risk, health and safety, incidents handling, SI's and mortality reviews linked with the Corporate Clinical Governance to enable cross-Trust collaboration and learning"	In part	▪ These roles have been discussed in response to previous recommendations

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – January 2016

1-11	Quality and Patient Safety Report	Chief Nurse

The enclosed report provides information on:

- The new Serious Incident methodology
- Falls and Pressure Ulcer update
- Interpretation Services update

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

Quality Report – January 2016

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

This report is intentionally brief, highlighting only those quality indicators / areas of work which require further explanation or acknowledgement. The Board is asked to note the content of this report and make any recommendations as necessary.

The new Serious Incident methodology

The current process for Serious Incident (SI) investigation has been reviewed in light of the new NHS England recommendations within the SI framework. MTW current system relies on directorates identifying and nominating a member of staff they consider appropriate to lead the investigation of a serious incident. These staff investigate serious incidents within their own directorates or departments, a practice which can be challenged in terms of objectivity. Whilst investigation of serious incidents is within senior staff roles it is estimated an investigation can take an investigator approximately 30hrs to complete and can take them away from clinical duties.

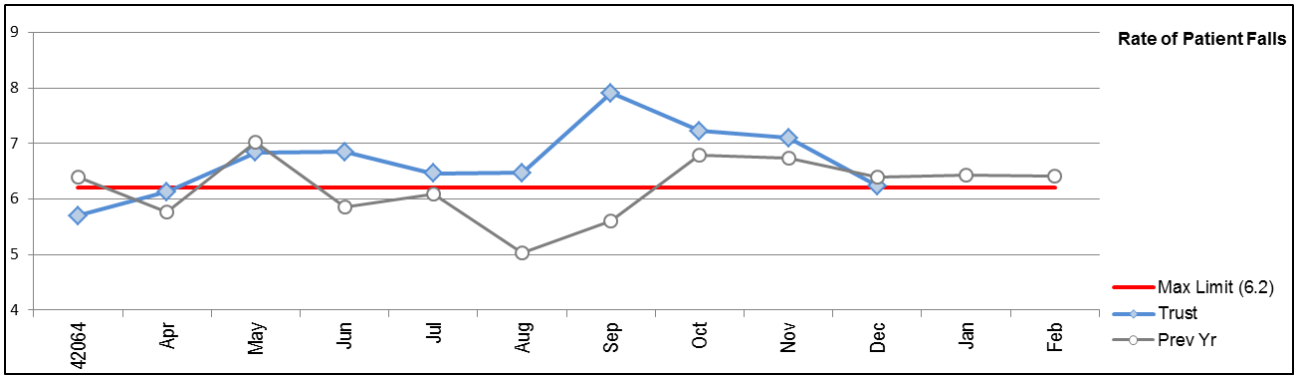
Additionally serious incidents are becoming increasingly complex with incidents occurring that involve several different directorates. It has been a challenge to ensure there is ownership and collaboration on some occasions. Additional to this the new SI framework requires more interaction and collaboration with patients and relatives affected by incidents. There is inconsistency of how this is currently achieved within the organisation, although our compliance with Duty of Candour is improving.

The patient safety team have previously offered Root Cause Analysis training, but this has been limited over the last 12 months. Finally, effecting real change has also been an area of concern; being able to evidence and assure change has occurred following an SI has been variable. The new SI system will aim to mitigate and address the current identified risks. Directorates have nominated 3 members of multidisciplinary staff each to create a central pool of highly trained and supported SI investigators. These investigators will have attended bespoke Root Cause Analysis (RCA) training which will ensure a consistency and quality of approach and standard of investigation. SI investigation methodology will be more closely monitored and evidenced.

The central patient safety team will provide help with support, organisation, co-ordination and administration of investigations. This will include a proactive approach to communication and collaboration with patients and relatives involved with serious incidents.

The central patient safety team will log all action plans centrally and review progress at each SI meeting. The SI panel will request assurance from directorate and action plan leads. Using the National Patient Safety Agency (NPSA) credibility tool an audit will be undertaken 6 months after SI investigation is complete for assurance purposes. This will ensure the action plan is completed and changes are tested in practice.

Falls update



Patient falls remain high, but have been on a downward trend over the last 3 months, following a peak in September. The rate of falls for December 2015 is 6.24 per 1,000 against a maximum Rate of 6.20 per 1,000 Occupied Bed-days.

Work continues to reduce the falls rate including continued training programme, appropriate observations and risk assessments. Additionally work has commenced on a 'Falls prevention / Patient Safety Behaviour & culture ward level high impact intervention' research project that includes elements of a successful approach seen in other NHS trusts to change the culture around falls and falls prevention. This pilot project will run for 3 months then be evaluated and reported. The Quality Committee 'Deep Dive' on 11th January focussed on falls and following this the falls group is meeting with the Chief Nurse to consider adopting a different approach to complement the work already underway.

Interpretation Services update

The Care Quality Commission (CQC) report published in February 2015 highlighted the need for staff to be provided with clear information on how to access the service. This action was taken immediately.

We decided to undertake a comprehensive review of our interpretation service and decided that we needed to update our service requirements for more effective interpretation provision for service users.

Over the last 6 months we have been working with procurement to re-tender interpretation services. This was initially delayed due to the implementation of the London Procurement Process, but we are now out for tender with the intention for the successful provider being in place by April 2016. We expect the new providers to be able to not only provide a high quality, cost effective service but also to provide data that will be helpful for future service planning.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – January 2016

1-12 CQC Quality Improvement Plan Chief Nurse

The latest monthly update on the progress to date with the Quality Improvement Plan (QIP) is enclosed.

Which Committees have reviewed the information prior to Board submission?
- Trust Management Executive, 20/01/16

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

CQC Quality Improvement Plan

Assurance Report January 2016

This report is produced to provide staff, patients, stakeholders, the CQC and the board with an assurance against the Quality Improvement Plan developed and agreed in response the CQC inspection report that was published in February 2015. This is a monthly report (commenced April 2015 onwards), following which the main Quality Improvement Plan is updated. This report is submitted to the Trust Management Executive, the Trust Board, TDA and the CQC and is shared with local commissioning groups. A summary is published on the MTW intranet and MTW website.

This report presents the progress of the Enforcement notice and Compliance actions.

Overview of progress to date

The enforcement notice was lifted by the CQC in 2015. Of those compliance actions still to be fully completed there has been reassuring progress demonstrated with some awaiting final audits to demonstrate full compliance / change in practice.

Compliance actions – Equality and Diversity

The funding for a substantive post holder for Equality and Diversity Lead has been agreed and is due to be advertised shortly with intended person in post by April 2016. This lead will undertake a comprehensive review of all existing trust practices in relation to Equality and Diversity requirements once in post.

Compliance actions – Critical care

There are continued challenges with out of hours transfers from ITU. During December 11 patients, all at TWH were transferred out of hours for clinical need. This compares with 3 in November, 4 in October, 5 in September, 1 in August and 8 in July all TWH. All mitigation is in place and each case is reviewed for learning. The opening of the new 38 bed ward in will ease capacity challenges and thus improve our ability to further reduce any discharges out of hours from ITU.

Compliance Action – Trust wide Governance

The new Governance Committee structure has been presented and agreed along with an agreed framework and process document. The Trust mortality review process is being been reviewed against the recently published NHS England guidance document for mortality surveillance.

Status of plan

Rating below relate to the progress of the enforcement/compliance action as a whole based on the date of **overall completion**. Some of the original actions, once completed have resulted in other actions being required which is simply an evolution of the situation for example compliance action 2, action 3b.

There is an element of judgment on the RAGB rating, based on the update and evidence provided and discussions.

The table below provides a summary of any issues arising.

KEY to progress rating (RAGB rating)

	Blue	Fully Assured
	Amber	Not running to time and / or more assurance required
	Green	Running to time, in progress / not running to time but sufficient assurance of progress
	Red	Not assured / actions not delivering required outcome

	Operational lead	Progress rating	Issues / Comments
Enforcement Notice – Water testing	Jeanette Rooke, Director of Estate & Facilities		Enforcement notice lifted. Completed compliance action
CA 1 - Paediatric Early Warning Scoring (PEWS) system	Jackie Tyler, Matron Children Services		PEWS in place in all required areas, training completed and rolling program for new starters. Audit of PEWS on NerveCentre due for completion January 2016.
CA 2 – ICU weekend cover	Daniel Gaughan General Manager, Critical Care		Completed compliance action
CA 3 – ICU consultant within 30mins	Daniel Gaughan General Manager, Critical Care		
CA 4 – ICU delayed admissions	Jacqui Slingsby Matron, Critical Care Directorate		Standard Operating Procedure now in place. Additional pathway for escalation areas being implemented.
CA 5 – ICU delayed discharges	Jacqui Slingsby Matron, Critical Care Directorate		
CA 6 – ICU overnight discharges	Jacqui Slingsby Matron, Critical Care Directorate		During December 11 patients, all at TWH were transferred out of hours for clinical reasons (none routine). This compares with 3 in November, 4 in October, 5 in September, 1 in August and 8 in July all TWH. ***Red over 5, Amber 5 or less. Green less than 3.***
CA 7 – Critical Care Outreach 24/7 service provision	Siobhan Callanan Associate Director of Nursing		Completed compliance action
CA 8 – ICU washing facilities	Jacqui Slingsby Matron, Critical Care Directorate		Completed compliance action
CA 9 – Cultural/linguistic needs	Richard Hayden Deputy Director of Workforce		Substantive Equality and Diversity Lead post for MTW due to be advertised shortly with intended start date April 2016.
CA 10 – CDU Privacy and dignity	Lynn Gray Associate Director of Nursing		Completed compliance action
CA 11 – Medical records	Wilson Bolsover Deputy Medical Director		Completed compliance action

	Operational lead	Progress rating	Issues / Comments
CA 12 – Security staff	John Sinclair Head of Quality, Safety, Fire and Security		Completed compliance action
CA 13 – Incident reporting	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		Patient Safety related training arranged to commence January 2016
CA 14 – Joint management of children with surgery	Hamudi Kisat / Jonathan Appleby Clinical Directors		Audit outstanding
CA 15 – Children's Clinical governance	Karen Woods Risk and Governance Manager, Children and Women's Services		Completed compliance action
CA 16 – Incident reporting + lessons learnt	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		Completed compliance action
CA 17 – Corporate clinical governance	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		Completed compliance action
CA 18 – Topical anaesthetics	Jackie Tyler, Matron Children Services		Completed compliance action

Enforcement Notice

Enforcement Action			REF	Directorate	Issue Identified	Action /s	Lead	Date to be completed	Evidence Required	Outcome/success criteria
Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – Cleanliness and Infection Control Cleanliness and infection control 12. (1) The registered person must, so far as reasonably practicable, ensure that – (a) Service users; (b) Persons employed for the purpose of the carrying on of the regulated activity; and (c) Others who may be at risk of exposure to a health care associated infection arising from the carrying on of the regulated activity, are protected against identifiable risks of acquiring such an infection by the means specified in paragraph (2). (2) The means referred to in paragraph (1) are (a) The effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection; People who use services and others were not protected against the risks associated with health care associated infections because the trust had failed to ensure that an effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of health care associated infections, with specific regard to water quality and safety and more specifically, themanagement and control of Legionella. Regulation 12(1)(a)(b)(c)(2)(a)(c).	**Executive Lead: Glenn Douglas**	**Date compliance will be achieved by: January 2015**	**EN1**	Estates and Facilities Management	The annual water sampling for legionella was six months overdue at Maidstone Hospital	1. Internal Investigation undertaken 2. External review undertaken 3. Water Hygiene Management Action Plan developed and implemented 4. Governance around water hygiene management reviewed and new system of robust Governance implemented 5. Risk Assessments and Sampling testing undertaken 6. Authorised Engineer (Water) appointed 7. Estate Management and Audit review of processes with a number of new appointments have been made within the senior team of Estates Services ensuring Authorised Persons in each technical element. The planned preventative maintenance schedule is currently being reviewed to ensure all statutory requirements are incorporated. In addition a comprehensive schedule is being developed for audit purposes. The internal auditing will be triangulated by the inspections, risk assessments and annual report undertaken and issued by the Authorised Engineer (Water) who provides the independent assurance and validation.	Jeanette Rooke	Completed 14th January 2015	Report produced outlining Governance, testing results and audit processes External review report Certificates of sampling Ongoing Agenda and Minutes of meetings	Water hygiene Management is compliant with statutory requirements with robust governance and management in place

Report submitted with all actions completed. Enforcement notice lifted; will continue to be monitored through the governance structure in place. RAGB = BLUE

Compliance action 1				CA1
Issue: *The PEWS system had not been validated and was not supported by a robust escalation protocol that was fit for purpose and was not standardised across the children's' directorate*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead:** *Jackie Tyler, Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. PEWS chart reviewed in line with tertiary referral centres (Nottingham) or PEWS from National Institute for Innovation (used in other Trusts)	New PEWS charts now in use in all paediatric areas and old charts removed	1. Validated PEWS in place. 2. Revised escalation protocol in place 3. Staff competent and consistent in using PEWS and escalation. 4. 3 monthly audit of compliance 5. Evidence of communication via meetings	30/6/15 Fully implemented 1/9/15 only audit outstanding	
2. Escalation protocol reviewed alongside the PEWS chart review	Escalation protocol approved and added to back of new PEWs charts in use			
3. Once agreed, PEWS chart and escalation protocol implemented across Children's services directorate via teaching sessions, ward level meetings, A&E and Children's services Clinical Governance meeting	Training of new starters implemented Ongoing training of staff Audits underway to provide evidence of implementation: PEWs audit Inpatients completed 25th September PEWs audit Ambulatory completed 28th September PEWS audit ED completed Nov PEWs audit to be submitted via trust audit team			
PHASE 2 Electronic solution (Nervecentre) for PEWS and escalation implemented (brought forward within existing IT plan). NB excludes paediatric A&E	All medical and nursing training completed for nerve centre. Ongoing training for new staff organised as part of induction package Audit due end of Jan 2016 (8 weeks since going live)	6. Compliance audit from Nervecenter	31/12/15 Actions completed. Audit due for completion end January 2016	
Action Plan running to time: YES				
Evidence submitted to support update (list): New PEWS Chart, audit results				
Assurance statement :				
PEWs chart in place and training implemented across all relevant departments. Nerve centre now in place across unit – to revert to paper PEWs if nerve centre fails				
Areas of concern for escalation:				
None				

Compliance action 2				CA2
Issue: *Contrary to the core standards of the Intensive Care Society: There was a lack of cover by consultants specialising in intensive care medicine at weekends; for example, one consultant covered more than 15 patients on two sites.*				
Lead: *Greg Lawton , Clinical Director*		**Operational Lead:** *Daniel Gaughan, GM*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Morning week-end ward rounds on both units implemented	Implemented and monitored on electronic rota	1. Anaesthetic electronic rota showing allocation of intensivists at weekends to site allocation 2. Business plan including risk assessment, mitigations and staffing analysis against core standards 3. TME Meeting minutes where business case considered and decision made 4. Audit of patients medical notes documenting weekend Consultant reviews	1/2/15	
2a. Second ward round at weekend is taking place at both units. Risk assessment undertaken with mitigations in place as required 2b. Second ward round at weekend in person	2a. Risk assessment undertaken with mitigation in place 2b. 1-8compliant rota in place to ensure a second ward round in person at weekend occurs.		2a. 31/3/15 2b. 1/10/15	
3a. The rota for the intensivists reviewed in line with the requirements of the ICS core standards 3b. Rota fully meeting the ICS requirements	3a. Rota reviewed 3b. Rota in line with ICS requirements now in place (1-8 compliant) Locum gaps being covered internally while recruitment of intensivist takes place. 3 fixed term generalists recruited to support theatre lists Consultant Job plans under review		3a. 31/3/15 3b. 1/10/15	
4. Business case for additional intensivists developed and considered	Agreed at TME June 2015.		17/6/15	
5. Mitigation in place for non-compliance	Mitigation part of CQC intensivist risk assessment		30/6/15	
6. Recruitment achieved	Recruitment is on-going with successful recruitment to one post in September 2015		1/4/16	
Action Plan running to time: YES				
Evidence submitted to support update (list):				
Assurance statement :				
Concerns still arise in regards to recruitment of 4 WTE suitably qualified intensivists. Further risk assessment and mitigation to be developed if recruitment campaign is ineffective.				
Areas of concern for escalation:				
Potential risk of inability to recruit suitable intensivists				

Compliance action 3				CA3
Issue: *Contrary to the core standards of the Intensive Care Society: The consultant was not always available within 30 minutes. There was only one ward round per day when there should be two to comply with core standards.*				
Lead: *Greg Lawton , Clinical Director*		**Operational Lead:** *Daniel Gaughan, GM*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Travel times & distance for each consultant being reviewed to assess compliance with 30 minutes availability for each individual consultant.	This has now been assessed by the clinical director Risk assessment completed and on risk register. New rota commenced September 2015 will have intensivists based at hospital thus ensure compliance	1. Report from Clinical Director outlining each Consultant's travel distance and confirmation of each Consultants ability to respond within 30 minutes. 2. Any delays in responding to be reported as incidents (DATIX) 3. Audit of patients medical notes documenting weekend Consultant reviews New complaint 1-8 rota implemented in September 2015	31/5/15	
2. Risk assessment to be undertaken where travel times exceed 30mins	Completed and on risk register. Following changes to the previous rota intensivists will be based on the site which is now within the 30 minute rule mitigating the risk. Risk assessment to be reviewed as now compliant.		31/5/15	
3. Ward round compliance actions in CA2	Please refer to summary in CA2		3a. 31/3/15 3b. 1/10/15	
Action Plan running to time: YES				
Evidence submitted to support update (list): Risk assessment				
Assurance statement :				
Areas of concern for escalation:				
Potential risk of inability to recruit suitable intensivists				

Compliance action 4				CA4
Issue: *Contrary to the core standards of the Intensive Care Society: Admissions were delayed for more than four hours once the decision was made to admit a patient to ICU*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Jacqui Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Consider option of ring-fencing ITU bed for admission	Discussed at Trust Management Executive: the ring-fencing of ITU bed will be implemented where possible. This has not happened consistently due to ICU bed demand; consideration is given on a daily basis at the site meetings where critical care capacity is available across the trust going into the night.	1. Minutes of TME meeting where ring-fencing option discussed 2. SOP for ITU admissions, transfers and discharges. SOP for managing critically ill patient when ITU is full 3. Site report documentation 4. Monthly performance data 5. DATIX IR1 completed for each patient who has a delayed admission to ITU due to inability to move wardable patients.	20/5/15	
2. Standard Operating Procedure developed relating to ITU admissions	SOP ratified at Standards committee in August 2015		31/5/15 New date: 31/8/15	
3. Review SOP for managing critically ill patients requiring ITU, when ITU capacity is full (for e.g. in recovery)	Pathways for patients in escalation agreed at Trust Clinical Governance meeting 15 January and being implemented.		30/4/15 New date: 30/11/15 30/1/16	
4. ITU referrals & those patients requiring ITU will be identified and discussed at each site meeting and priorities escalated as appropriate.	Attendance at each site meeting by Shift leader/matron in place. Associate Director responsible for the site ensures ITU capacity and demand is discussed at each site meeting and plans put in place with clinical teams to transfer out as appropriate. ITU referrals are consultant to consultant and raised to both the Clinical site team and Matron/Shift leader in ICU. Clinical priorities identified by the Consultant intensivist		1/4/15	
5. When no prospect of ITU capacity available on either site then arrangements for transfer to another unit will be made.	Consider escalation feasibility before any transfer. Critical care capacity within Trust reviewed before transfer outside of organisation. National Emergency bed service already in place.		1/1/15	
Action Plan running to time: YES (to new date)				
Evidence submitted to support update (list):				
Assurance statement :				
Areas of concern for escalation:				
Delay in agreement of the pathways for patients in escalation areas; further amendments required				

Compliance action 5				CA5
Issue: *Contrary to the core standards of the Intensive Care Society: Discharges from the ICU were delayed for up to a week. Of all discharges, 82% were delayed for more than 4 hours*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Jacqui Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Standard Operating Procedure to be developed relating to ITU discharges	Operational Policy which incorporates discharge policy ratified at August 2015 at Standards Committee	1. SOP for ITU admissions, transfers and discharges. 2. Site report documentation. 3. Monthly performance data 4. DATIX incident report completed for each patient who has a delayed discharge from ITU.	31/5/15 New Date: 31/8/15	
2. Transfers out of ITU to be followed up on a named patient basis at each site meeting	In place at site meetings		1/4/15	
3. To link in with Trust wide work around patient flow and delayed discharges improvement plan developed in line with D16 CQUIN and in collaboration with Chief Operating Officer and Clinical Site Management team	Monthly delayed discharge performance data captured on performance dashboard and within monthly unit reports. Performance against milestones reported at monthly CQUIN board. Incident forms completed for each delay, clinical site team identified as handlers. Trust operational plan in place to open an additional ward at TWH by Jan 2016 with the aim to ease patient flow across the trust.		30/5/15	
Action Plan running to time: completed				
Evidence submitted to support update (list):				
Assurance statement :				
Action completed				
Areas of concern for escalation:				

Compliance action 6				CA6
Issue: *Contrary to the core standards of the Intensive Care Society: Overnight discharges take place from the ICU.*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Jacqui Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. All ward fit patients to be identified to the site team at the earliest opportunity but by 1500 at the latest each day.	All patients deemed ward fit or likely to be fit are named at site meetings and entered on capacity handover form to the site team, together with any special requirements i.e. Side room needed, specialist ward etc. Displayed in site team on communications board	1. Incident (DATIX) report to be raised on all post 2000hrs transfers. Review and identification of where lessons can be learnt and improvements made	1/3/15	
2. Transfer plans to be agreed and completed by 2000 hrs at the latest. No patients to be routinely transferred from ITU after 2000.	Core standards state: *'Discharge from Critical Care should occur between 07:00hrs and 21:59hrs' (2.12)* During December 11 patients, all at TWH were transferred out of hours for clinical need. This compares with 3 in November, 4 in October, 5 in September, 1 in August and 8 in July all TWH. Incident reports were raised each time. Patients though deemed fit prior to these times were not able to be moved to a ward due to bed capacity issues. Trust operational plan in place to open an additional ward at TWH in Feb 2016 with the aim to ease patient flow across the trust.		1/3/15 (for robust patient identification and tracking New date (for new ward) 31/3/16	
Action Plan running to time: Yes (revised date)				
Evidence submitted to support update (list):				
Assurance statement :				
Areas of concern for escalation:				
Continuing issues with patient flow across the trust impacting on ICU patient discharges.				

Compliance action 7				CA7
Issue: *The outreach service does not comply with current guidelines (National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2011))*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Siobhan Callanan, ADN planned care*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Business Case approved	Approved	1. Rota showing 24 hour / 7day cover 2. Review of service and performance data via Directorate Clinical Governance meetings	27/1/15	
2. Recruitment to posts	All Band 7 posts recruited into		1/9/15	
3. Implementation of a 24 hour 7 day out-reach service which will be fully integrated with critical care service	24 hour 7 day out-reach service rota commenced		1/10/15	
Action Plan running to time: YES				
Evidence submitted to support update (list):				
Assurance statement :				
The Outreach service will be provided across the trust 24/7 from 9th October, prior to this a 24 hour service will be available over the weekends on 25th, 26th and 27th September and 2nd, 3rd and 4th October				
Areas of concern for escalation:				
None				

Compliance action 8				CA8
Issue: *Improvements are needed in relation to the environment in the Intensive Care Unit with regards to toilet/shower facilities for patients.*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Jacqui Slingsby, Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Conversion of an existing toilet to a patient toilet & bathroom facility at Tunbridge Wells Hospital	Bathroom facilities for patients have always been in place at TWH and contains a toilet within the shower room. The staff toilet which is co-located to the existing facility has been re-assigned and designated as a patient toilet, with appropriate signage	1. Photo of Toilet / shower facilities appropriate for patient use 2. Confirmation at Executive / Non Executive walkabout	1/4/15	
2. Provision of appropriate patient washing facilities within Critical Care at Maidstone Hospital	Shower room available and two designated patient toilets, one which has disabled access; all in use.		1/4/15	
Action Plan running to time: **completed**				
Evidence submitted to support update (list):				
Assurance statement :				
Photographs: Submitted with April update All areas commissioned. Executive walk round at Maidstone – Avey Bhatia & Steve Tinton 13/4/15 at Tunbridge Wells – Paul Sigston 14/4/15 Reviewed and seen on 6th July internal review – fully compliant				
Areas of concern for escalation:				

Compliance action 9				CA9
Issue: *The provider did not ensure that care and treatment was provided to service users with due regard to their cultural and linguistic background and any disability they may have*				
Lead: *Richard Hayden, Deputy Director Human Resources*	**Operational Lead:** *Richard Hayden, Deputy Director Human Resources & John Kennedy, Deputy Chief Nurse*			
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Appoint a dedicated lead for Equality and Diversity for Trust	Interim E&D Lead appointed April 2015 Funding for substantive post holder agreed, to be advertised Q4. Lead will not start until new financial year. Chief Nurse is E&D Board Lead	1. Substantive E&D Lead Appointed 2. Training records against E&D awareness programme 3. New E&D Strategy 4. Detailed action plan for improvements 5. Evaluation of changes to service and feedback from staff (staff survey), patients, Healthwatch and community groups (with actions developed and monitored as required)	1/9/15 (for interim) New date for substantive 1/04/16	
2. Develop an E&D awareness programme for all staff	E&D training 89% compliant against 85% target (April 2015). Benchmarking & intelligence from partner Trust to inform awareness programme and roll out plan that is both department specific and generic. This will be developed by the substantive E&D Lead.		1/10/15 New date 31/07/16	
3. Review and develop new E&D strategy for organisation, in collaboration with MTW staff and partner organisations	WF strategy approved June 2015. E&D priorities included & supported by project plan approved Workforce Committee September 2015 BME Forum second meeting 21/9/15. SEC BME Chair in attendance. Trust WRES data reviewed. Trust has partnered with Stonewall to support LGBT staff. Data submitted for Stonewall Equality Index		1/9/15	
4. Ensure current process for accessing translation services is communicated to all staff	Staff Communication circulated January 2015 – Recirculated July 2015. Translation service currently being re-procured		1/2/15	
5. Identify an existing NHS centre of excellence and buddy with them to ensure best practice and learning implemented in a timely fashion	Meeting and agreed contact for best practice with Leicester Partnership Trust. Work will not progress until lead is in post		1/6/15	
6. Conduct a comprehensive review of all existing Trust practices in relation to E&D requirements - for example information, translation, clinical practices, food, facilities	Under assessment with intention to commission external support Priority Plan to be finalised linked to EDS2 grading plan. WRES data presented to Board 30/9/15. Comprehensive review will be undertaken when substantive postholder in post (see 1)		1/4/16 New date 31/07/16	
7. Develop links with local support groups and communities to engage them in the improvement plan for the Trust with assistance from Healthwatch	Under assessment with patient and Carers Groups. Healthwatch will also act as final approver for EDS2		1/10/15	
8. Ensure appropriate organisational governance with assurance to Trust Board in relation to Equality and Diversity	Development of new Diversity Management Group. First meeting 30 October 2015.		1/9/15	
Action Plan running to time: YES				
Evidence submitted to support update (list): Approved business case for E&D lead				
Assurance statement :				
In progress				
Areas of concern for escalation:				

Compliance action 10				CA10
Issue: *Dignity and privacy of patients was not being met in the Clinical Decisions Unit (CDU)*				
Lead: *Akbar Soorma, Clinical Director*		**Operational Lead:** *Lynn Gray, ADN emergency*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Options appraisal for addressing existing dignity and privacy issues in CDU (2 main options are Option 1: changing function of CDU or Option 2: provision of toilet facilities)	CDU became single sexed (female) from 8th June with 2 rooms on MAU being used if required for men. SOP circulated. This has been maintained to date.	1. Options appraisal paper 2. Changes to CDU environment reviewed by link executives and reported at Standards Committee 3. Site report documentation	1/5/15	
2. Agree preferred option and implement	Long term plan has been discussed within the Directorate and two options are being scoped (AAU and MAU) to find an alternative area for CDU capacity from January 2016 once the new ward opens. Both options provide DSSA compliance.		Option 1: 1/4/16 Option 2: 1/10/15	
3. Each patient to be tracked and discussed at each site meeting to ensure timeframes met and plan for discharge / transfer in place	CDU capacity and demand continues to be discussed at each site meeting. Site report reflect s any variance from SOP over the last 24 hours (none have occurred to date).		1/4/15	
4. To link in with Trust wide work around patient flow and action TW30	Review of pathways to support the A&E flow has occurred as a result of AAU opening in May.		30/5/15	
Action Plan running to time: completed				
Evidence submitted to support update (list):				
Assurance statement :				
CDU single sex (all female). All staff aware of standard operating procedure and mandatory single sex CDU status.				
Areas of concern for escalation:				

Compliance action 11				CA11
Issue: *The provider did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.*				
Lead: *Paul Sigston, Medical Director*		**Operational Lead:** *Wilson Bolsover, Deputy Medical Director*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Reinforce requirements of Health Care Record keeping amongst multidisciplinary staff, including timely recording of actions undertaken by: 1a. Record Keeping champion for department who will be a source of information and support for record keeping standards 1b. Investigate the possibility of providing a name stamp for staff 1c. Staff involvement in record keeping audit	a) Discussed with Clinical Directors 7/10/15 b) This has been considered. Decision following audit is to not pursue this at this time c) Audit completed with staff involvement. Action plan developed	1. Minutes of Directorate Clinical Governance meetings 2. Staff audit pilot 3. Record keeping champion program and list 4. Report on name stamps for staff and recommendations 5. Induction programme for new doctors 6. Report from task and finish group on records	1a. 1/6/15 1b. 1/6/15 1c. 1/6/15 new date 1/9/15	
2. Review induction programme for new Doctors to ensure adequate training provided.	a) Induction for trainees includes legibility of notes (15.4.15) b) Clinical Tutors asked to add in requirement to avoid loose papers (7.5.15) c) College tutors to be prompted about induction for non-training grades once (b) completed.		1/5/15	
3. Multidisciplinary Task and Finish group (sub-group of health records committee) to review current notes with fresh eyes and consider where improvements can be made	a) Discussed at CD Board (6.5.15). No perceived need to change the case note records ahead of implementation of electronic records.		1/6/15	
4. Record keeping audit to be included in case reviews at Directorate CG Meetings	Underway in most Directorates with ongoing scrutiny of documentation standards		1/9/15 new date 1/12/15	
Action Plan running to time: Yes (new date)				
Evidence submitted to support update (list):				
Assurance statement :				
Audit shows reasonable compliance, however some areas for improvement. Action plan implemented.				
Areas of concern for escalation:				
None				

Compliance action 12				CA12
Issue: *Contracted security staff did not have appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs.*				
Lead: *Jeanette Rooke, Director of Estates and Facilities*		**Operational Lead***: John Sinclair, Head of Quality, Safety, Fire & Security*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Provide documentation outlining the joint partnership with our contractor in regards to the provision of training.	Completed and closed	1. Agreed documentation on joint partnership arrangements 2. Induction Attendance / compliance report on all existing security staff to Security Group 3. TNA document 4. Report on training compliance to Security Group 5. Certificates of training 6. Certificates of training	18/5/15	
2. All contractors to attend the Trust approved and agreed Induction Training and attend the Trust mandatory training	Completed		1/4/15 New date: 1/7/15	
3. Contractors to be included on the Training Needs Analysis document outlining all requirements, frequency and levels	Completed and closed		1/5/15	
4. Review compliance with all training requirements against existing security team	Completed. Security contractor has 100% compliance rate in accordance with BSIA and ACS		1/5/15	
5. The Security Manager to provide training logs for the SMART Risk Assessment Training undertaken through one to one sessions with all security officers.	Completed – evidence in the security SLA minutes		1/4/15 New date: 1/7/15	
6. All current security staff to be booked onto and attend Mental Health Awareness Training and dementia awareness training	All security staff booked on sessions		1/8/15	
Action Plan running to time: completed				
Evidence submitted to support update (list):				
Assurance statement :				
L&D have allocated all our Security Team login details for the on-line induction.				
Areas of concern for escalation:				

Compliance action 13				CA13
Issue: *The process for incident reporting did not ensure that staff were aware of and acted in accordance with the trust quality and risk policy.*				
Lead: *Avey Bhatia, Chief Nurse*		***Operational Lead:*** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	***Monthly summary update on progress***	***Evidence required***	***Action completion date***	***Rating***
1. Staff leaflet on Trust Quality and Risk Policy, including incident reporting process to be produced in collaboration with staff and distributed to existing staff and new starters at induction	Leaflet completed Distribution completed	1. Leaflet + audit of distribution and staff engagement through survey 2. fully implemented intranet and web page 3. Datix Staff survey + reporting figures / by profession 4. Education presentation + staff survey 5. Newsletter every month	1/5/15 Distribution excepted to be completed 1/9/15	
2. Governance page to be developed on the intranet and MTW website with clear signposting to Incident Reporting section	Allocated lead for this work. Intranet completed. Bolder reporting incident button already changed on intranet front page Work completed on Website		Intranet 1/6/15 Website 1/10/15 New date 1/12/15	
3. Incident reporting process currently under review, with full collaboration with clinical staff, to improve reporting process and investigate possibility of hosting reporting portal on mobile media	Datix upgrade completed. Datix review group established. Reporting page streamlined and quicker. DATIX app now loaded on the new Ipad's to be used in clinical practice		1/6/15 New date for completion of all actions: 1/8/15	
4. Education / update program on Governance, Quality and Patient Safety including incident reporting and learning lessons from incidents to be rolled out to all medical and nursing staff over next year	Identified within team and included in Governance team strategy Revised RCA training identified and planned for 18th January 2016. Incident reporting and patient safety included in induction training for new staff		1/9/15 Revised RCA training 28/2/16	
5. Continue to publish articles on Governance Gazette Newsletter relating to incident reporting and learning lessons. Encourage staff to write their own articles for publication.	Monthly articles in Governance Gazette		Monthly	
Action Plan running to time: ***Yes***				
Evidence submitted to support update (list):				
Assurance statement :				
This action plan is well underway with good progress.				
Areas of concern for escalation:				

Compliance action 14				CA14
Issue: *The clinical governance strategy within children's services did not ensure engagement and involvement with the surgical directorate*				
Lead: *Hamudi Kisat, Clinical Director & Jonathan Appleby, Clinical Director*		**Operational Lead:** *Hamudi Kisat, Clinical Director & Jonathan Appleby, Clinical Director*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Meeting between senior clinicians and managers Children's services directorate and Surgical directorates to establish clear roles and responsibilities of the care of children on the paediatric ward	Clinical Director attended surgical CG meeting to present papers	1. Minutes of joint meeting 2. Standard Operating Procedure 3. Audit of practice 4. MTW Clinical Governance Strategy 5. Agenda, Minutes and attendance records from CG meetings	1/5/15	
2. Standard Operating Procedure for care of children on surgical pathway on paediatric wards	SOP completed and circulated to staff		1/6/15 New date: 1/9/15	
3. Implementation of the SOP into routine daily practice	Patients admitted to Inpatient Ward now shared care between Paediatrics and Speciality Teams Audit planned and awaiting results		1/8/15 New date for completion of audit 1/1/16	
4. Trust to develop a consistent approach to Clinical Governance through MTW Clinical Governance Strategy developed in collaboration with internal and external stakeholders	New Governance framework developed and agreed with implementation commenced December 2015		1/9/15 New date: 1/12/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): SOP				
Assurance statement :				
Areas of concern for escalation:				
None				

Compliance action 15				CA15
Issue: *The children's directorate risk register did not ensure that risks are recorded and resolved in a timely manner.*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead:** *Karen Carter-Woods, Risk and Governance Manager*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. A full review of the directorate risks	On-going review and updating at Directorate meetings	1. Risk register shows children's section managed in a timely manner 2. Minutes of Directorate meeting / Clinical Governance meeting 3. Meeting agendas	1/5/15	
2. An update session for all senior nursing and medical staff on the purpose and process of the risk register plus induction groups	Staff updates on-going: new 'Risk Update' publication distributed		16/6/15	
3. Ensure review of risk register is standing agenda item at Directorate meetings / Clinical Governance meetings	Already standing agenda item at Directorate meetings Now standing agenda item at Paediatric Clinical Governance meeting		16/6/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): Risk update, Induction agenda's, CG agenda's				
Assurance statement :				
Work on-going within the directorate to increase staff awareness and involvement with paediatric risks				
Areas of concern for escalation:				
Nil				

Compliance action 16				CA16
Issue: *There were two incident reporting systems, the trust electronic recording system and another developed by consultant anesthetists and intensivists one for their own use. The trust could not have an overview of all incidents and potentially there was no robust mechanism for the escalation of serious incidents. Therefore opportunities were lost to enable appropriate action to be taken and learn lessons.*				
Lead: *Avey Bhatia, Chief Nurse*		**Operational Lead:** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Anaesthetic incident reporting pilot discontinued. Those involved in running this system, and other clinical staff fully engaged with the review on the DATIX system to improve reporting process	Confirmation e-mail from the lead for the anaesthetic pilot that this is discontinued. Assc. Director Quality Governance and Patient Safety attended Anaesthetic Clinical Governance meeting in May 2015 to discuss the Trust Incident reporting system in place and take questions.	1. Written Confirmation from coordinator of system 2. Leaflet audit of distribution and staff survey 3. Newsletter article 4. Increased incident reporting through single reporting system from anesthetist and intensivists	1/2/15	
2. Staff leaflet to include reminder about rationale for single reporting system	Leaflet completed, distribution due for completion 1/9/15		1/5/15	
3. Reminders in Governance Gazette and via intranet and website about the SINGLE reporting system in the Trust.	In May's edition of the Governance Gazette		1/5/15	
4. Assc. Dir. Quality, Governance and Patient Safety to attend Anaesthetic CG meeting for discussion and update on reporting system	Attended Anaesthetic Clinical Governance meeting 14th May and updated attendees on reporting system		1/5/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): e-mail confirmation + Governance Gazette + Leaflet + CG meeting minutes				
Assurance statement :				
This compliance action has been completed				
Areas of concern for escalation:				
None				

Compliance action 17				CA17
Issue: *There was a lack of engagement and cohesive approach to clinical governance. Mortality and morbidity reviews were not robust, not all deaths were discussed and there was no available documentation to support discussions.*				
Lead: *Paul Sigston, Medical Director* *Avey Bhatia, Chief Nurse*		**Operational Lead:** *Jenny Davidson, Assc Director Governance, Quality and Patient Safety*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Full review and collaborative process involving all stakeholders for developing and implementing a cohesive and comprehensive clinical governance system from ward to board	Following full collaborative process (external governance review) New Trust wide Governance framework and agreed with implementation commenced December 2015. New committee structure in place and communication with staff being rolled out January 2016	1. CG strategy including clear CG process from ward to board 2. M&M review documentation of full review process and evidence of clear discussions and shared learning 3. Update outline and attendance	1/9/15 New date: 31/12/15	
2. Development of a MTW Clinical Governance Strategy	Document on the Clinical Governance process and framework in place		1/7/15 New date: 31/12/15	
3. Mortality and morbidity review process to be reviewed in collaboration with stakeholders and developed with exploration of further use of technology and clinical governance processes to improve rigor, transparency and effectiveness	MTW mortality review process and procedure has been reviewed and developed according to new NHS England and NTDA guidance. This process needs to be adopted and embedded. New Trust Mortality Surveillance Group (formally Mortality Review Group) developed in principle with first meeting planned for February 2016 Mortality e-form solution is delayed due support for the e-Forms solution being budgeted for 2016/17. This will be re-visited April 2016		1/8/15 New date: 1/12/15	
4. Update for staff involved at directorate and Trust level on their role in the mortality & morbidity review process	Communication and engagement with senior clinicians as to roles and responsibility. Return rates for mortality reviews are average 50%.		1/10/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list):				
Assurance statement :				
Mortality review completed, however process needs to be embedded in practice.				
Areas of concern for escalation:				
Delay in e-form solution due to software costs being in 2016/17 budget planning. Revised Mortality process requires all in-hospital mortalities to be reviewed. Concerns raised about consultant SPA time in which to do this.				

Compliance action 18				CA18
Issue: *The arrangement for the management and administration of topical anaesthetics was ineffective.*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead:** *Jackie Tyler, Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Standard Operating Procedure for the administration of topical anaesthetics for children to be developed and implemented	Information regarding PGDs including Standard operating policy available on intranet Lead for ward identified – Sister Rochelle Gilder PGD now available in all areas in purple PGD folders	1. SOP for children's services. 2. Audit of prescription charts. 3. Training records of staff undertaking PGD training	1/5/15	
2. Topical anaesthetics for children prescribed in all areas of the Trust	PGD audit completed for ambulatory and inpatient areas PGD audit information currently being collated and updated with trust audit department PGD audit shows 100% compliance		1/6/15 New date 30/11/15 for audit completion	
3. A number of key staff to undertake PGD training to facilitate appropriate timeliness of prescribing.	All key staff fully trained and signed off (100%) with ongoing programme for new starters		1/7/15	
Action Plan running to time: Yes				
Evidence submitted to support update (list): audit to be submitted				
Assurance statement :				
All actions completed				
Areas of concern for escalation:				
None				

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – January 2016

1-13 Planned and actual ward staffing for Nov & Dec 2015 Chief Nurse

The enclosed report shows the planned v actual nursing staffing as uploaded to UNIFY for the months of November and December 2015. This data relates to established wards only. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

The report also includes some nurse sensitive indicators to support the professional judgement of safe delivery of care. Nurse sensitive indicators are those indicators that may be adversely impacted on if staffing levels are insufficient for the acuity and dependency of the ward. These indicators are supported by the Department of Health (2010) and latterly by the NICE review of ward staffing published in July 2014.

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'.

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. Notable in this respect during November is Pye Oliver, MOU, Ward 11 and Ward 30. In December John Day required additional staff as they had increased acuity and recently relocated into a new environment (previously housed on Foster), Ward 10 and Ward 20 had particular challenges at night, as they had two zones requiring cohort nursing. During the day this was managed by use of the communal inter-ward space, at night an increased level of supervision was required.

Escalation areas account for the remainder of the over-fill. These areas remain the same; namely UMAU, SAU and to a lesser extent MSSU. MSSU have had increased demand as much of the elective work load has been undertaken here to free beds in the main surgical wards.

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.

Fill rates below less than 90% represent a potential risk, however in some cases this is a managed risk. This may be due to decreased activity or dependency. Maidstone ICU would be an example where they are below the planned rate of 100%. However staff were redeployed to TWH ICU where acuity was higher than planned.

Maternity and Neonatal have specific challenges regarding CSW fill rates. The overall numbers are small which reflect a larger percentage number. Priority is always given to filling the night shifts as this is where the need is greatest. Maternity are actively recruiting however have a number of individuals on sick leave. This is being managed appropriately.
A number of wards have had a shift in RN:CSW ratios, notably Wards 12 and 30. In these areas this was a considered action based on professional judgement, available skill mix and patient acuity and dependency.

Financial data is included to provide potential indicators of actual spend versus planned.

Decrease in overspend is noted in a number of areas; particularly for December. Areas of particular note are Stroke (Maidstone) Romney, Coronary Care/Culpepper Mercer, Gynaecology, Ward 12 and Neonatal. This is due, in part, to the effects of recruitment initiatives starting to impact and tighter controls on the use of non-framework agencies.

As noted previously this data is for established wards. There are a number of areas that provide additional capacity or escalation. These areas include Catheter Labs on both sites, Foster Clark and Whatman. These areas are noted in the financial detail as 'additional capacity beds'. The remainder of the nursing costs related to non-ward based nurses (including specialist roles, departments and senior nurses, such as matrons).

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 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 bout below:

The key underlying reasons for amber overall ratings are vacancy resulting in an adverse shift of the RN to CSW ratios and high levels of acuity and dependency.

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.

	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

Nov'15		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 (%)	FFT Response Rate	FFT Score - % Positive	Falls	PU - ward acquired	Overall RAG Status	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	98.0%	97.5%	100.0%	106.7%	11.3%	100.0%	15	0			107,868	114,305	(6,437)
MAIDSTONE	Romney	98.9%	97.8%	98.3%	100.0%			2	0			66,973	75,606	(8,633)
MAIDSTONE	Cornwallis	94.2%	123.3%	103.3%	100.0%	15.6%	100.0%	1	0			93,342	70,658	22,684
MAIDSTONE	Coronary Care Unit (CCU)	83.3%	N/A	100.0%	N/A	56.0%	85.7%	0	0		Co-location with Culpepper allows for cross cover according to acuity. Needs were met.	104,039	102,794	1,245
MAIDSTONE	Culpepper	100.0%	88.3%	100.0%	100.0%	42.9%	100.0%	1	0		Reduced fill rate for CSWs had minimal impact.			
MAIDSTONE	Foster Clark	93.4%	113.3%	98.4%	101.7%	1.7%	100.0%	3	0			105,534	112,939	(7,405)
MAIDSTONE	Intensive Treatment Unit (ITU)	95.0%	N/A	91.3%	N/A	83.3%	100.0%	0	0			162,339	151,700	10,639
MAIDSTONE	Pye Oliver	90.7%	102.2%	98.3%	143.3%	51.3%	100.0%	6	1		12 nights required for 1:1 care/nursing presence.	95,666	115,498	(19,832)
MAIDSTONE	Chaucer	116.7%	99.2%	120.0%	133.3%	84.6%	90.9%	7	0		RMN and specials required for 24 nights	79,298	171,026	(91,728)
MAIDSTONE	Lord North	101.4%	96.0%	100.0%	106.7%	36.4%	100.0%	1	3			97,051	102,297	(5,246)
MAIDSTONE	Mercer	97.5%	114.4%	98.9%	123.3%	5.6%	33.3%	12	0		2 patients requiring additional nursing support for 4 nights and day. 6 occasions for 1 patient.	91,166	111,334	(20,168)
MAIDSTONE	MOU	82.7%	133.3%	100.0%	186.7%			2	0		24 days/nights of special/nurse presence required.	134,418	69,860	64,558
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	93.7%	102.7%	126.7%	203.3%	14.8%	98.4%	3	0		Trolleys escalated to beds over night all month	119,337	128,112	(8,775)
TWH	Acute Stroke	101.1%	96.7%	100.0%	103.3%	53.8%	100.0%	2	0			76,565	71,493	5,072
TWH	Coronary Care Unit (CCU)	97.8%	90.0%	100.6%	N/A	81.0%	97.1%	1	0			57,300	55,567	1,733
TWH	Gynaecology	104.9%	91.1%	100.0%	100.0%	25.2%	94.3%	0	0			63,360	63,922	(562)
TWH	Intensive Treatment Unit (ITU)	104.2%	100.0%	105.4%	73.3%	0.0%	NA	0	0		Additional RN cover provided by Maidstone as acuity allowed. CSW role at night was a considered reduction according to the acuity and dependency fluctuations in month.	185,375	160,512	24,863
TWH	Medical Assessment Unit	97.5%	108.1%	108.1%	109.7%	5.2%	87.5%	10	0			151,252	192,990	(41,738)
TWH	SAU	116.7%	160.0%	135.0%	180.0%			0	0		Escalated into Short Stay Surgery Unit all month	65,750	83,065	(17,315)
TWH	Ward 32	91.7%	93.3%	100.0%	100.0%	14.0%	100.0%	1	0			119,911	116,495	3,416
TWH	Ward 10	97.6%	112.5%	86.7%	156.7%	18.6%	94.7%	2	0		20 nights requiring additional CSW presence to support confused patients. Average 3 patients per night, cohort approach used. Different patients during the month. RN reduction was a considered approach based on acuity and dependency	124,165	124,406	(241)
TWH	Ward 11	99.5%	133.3%	98.3%	118.3%	50.9%	98.2%	2	0		9 patients requiring additional support due to increased dependency.	125,584	107,106	18,478
TWH	Ward 12	88.6%	93.3%	87.5%	98.3%	1.7%	100.0%	7	5		RN recruitment to manage vacancies starting to impact. RN fill rate has improved (77% for nights last month)	108,139	116,027	(7,888)
TWH	Ward 20	98.8%	109.2%	100.8%	116.7%	46.7%	57.1%	10	0		Additional requirement overnight for cohort nursing for cognitively impaired patients.	122,805	145,932	(23,127)
TWH	Ward 21	107.0%	90.0%	104.2%	100.0%	10.2%	100.0%	8	1			119,912	117,048	2,864
TWH	Ward 22	97.5%	104.4%	100.0%	100.0%	126.7%	78.9%	11	3			93,043	107,452	(14,409)
TWH	Ward 30	104.0%	96.4%	86.7%	146.7%	4.9%	100.0%	6	3		3 specials at night. Increased dependency with some shift RN shifts at night not covered by temporary staffing.	121,746	115,855	5,891
TWH	Ward 31	103.3%	102.7%	103.3%	103.3%	48.8%	95.2%	12	2			136,057	134,135	1,922
TWH	Stroke Rehab	95.6%	95.0%	98.3%	96.7%	120.0%	100.0%	2	0			57,413	59,000	(1,587)
TWH	Ante-Natal	98.3%	66.7%	100.0%	90.0%			0	0		CSW recruitment in progress. 2 in pipeline (2 started from last month) 3 wte further now in recruitment. Short fall has had some impact on emotional support. 1:1 care for established labour maintained. Post-natal and Ante-natal clinical care needs were met.	590,514	638,534	(48,020)
TWH	Delivery Suite	93.7%	85.0%	98.1%	96.7%			0	0					
TWH	Post-Natal	96.7%	89.2%	98.6%	86.7%			0	0					
TWH	Gynae Triage	100.0%	106.7%	98.3%	100.0%			0	0			11,354	11,149	205
TWH	Hedgehog	95.6%	88.2%	98.9%	101.1%	10.2%	100.0%	0	0		Minimal impact on care delivery. Recruitment plans in place to cover both vacancy and maternity leave.	183,190	183,436	(246)
TWH	Birth Centre	100.0%	100.0%	100.0%	100.0%			0	0			63,193	63,153	40
TWH	Neonatal Unit	104.4%	80.0%	99.4%	93.3%			0	0		Minimal impact on care, as good levels of RN presence.	150,643	150,295	348
TWH	MSSU	154.0%	92.9%	107.1%	N/A			0	0		Escalated/additional activity over 3 weekends.	42,528	45,167	(2,639)
TWH	Peel	93.2%	143.3%	101.1%	N/A	15.6%	100.0%	0	0			80,271	75,919	4,352
TWH	SSSU	98.4%	119.0%	N/A	N/A	0.6%	0.0%	0	0			36,096	23,743	12,353
											Total Established Wards	**4,143,197**	**4,288,528**	**(145,331)**
											Additional Capacity beds	453,403	586,817	(133,414)
											Other associated nursing costs	2,244,877	2,446,995	(202,118)
											Total Nursing Costs	6,841,477	7,322,340	(480,863)
												0	0	(0)

RAG Key

Underfill

Over fill

Dec'15		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 (%)	FFT Response Rate	FFT Score - % Positive	Falls	PU - ward acquired	Overall RAG Status	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	94.8%	99.2%	91.1%	112.9%	23.2%	84.6%	4	0		4 nights of 1:1 CSW presence required	107,868	109,401	(1,533)
MAIDSTONE	Romney	97.8%	97.8%	96.8%	103.2%			1	0			66,973	43,896	23,077
MAIDSTONE	Cornwallis	90.3%	114.5%	92.5%	106.5%	52.9%	94.0%	0	0		CSW:RN shift due to RNs being off ward for Inquest hearing for 2 days.	93,344	80,185	13,159
MAIDSTONE	Coronary Care Unit (CCU)	82.8%	N/A	100.0%	N/A	83.3%	95.0%	0	0		RN fill rate had minimal impact on care as CCU is collocated with Culpepper and staff cross cover. Reduced fill due to 16 shifts being used to cover escalation/additional capacity.	104,039	74,743	29,296
MAIDSTONE	Culpepper	100.0%	100.0%	98.4%	100.0%	45.0%	100.0%	1	0					
MAIDSTONE	John Day	97.2%	112.9%	97.3%	135.5%	0.0%	0.0%	6	0		17 episodes of care requiring 1:1 or 1:2 care/supervision.	105,534	147,583	(42,049)
MAIDSTONE	Intensive Treatment Unit (ITU)	95.2%	N/A	94.4%	N/A	50.0%	100.0%	0	0			162,340	159,556	2,784
MAIDSTONE	Pye Oliver	92.9%	109.7%	98.4%	90.3%	9.9%	100.0%	5	0			95,666	104,434	(8,768)
MAIDSTONE	Chaucer	98.1%	122.6%	96.1%	123.1%	72.5%	89.7%	13	1		17 specials/episodes of enhanced supervision	79,298	163,413	(84,115)
MAIDSTONE	Lord North	103.3%	92.1%	95.7%	100.0%	26.1%	91.7%	1	2			97,050	95,420	1,630
MAIDSTONE	Mercer	108.9%	102.2%	98.9%	100.0%	11.1%	71.4%	4	1			91,166	90,988	178
MAIDSTONE	MOU	81.2%	124.2%	100.0%	193.5%			4	1		21 specials/episodes of enhanced supervision	134,418	68,796	65,622
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	92.2%	97.4%	123.7%	183.9%	12.0%	91.8%	1	0		Escalated over night throughout the month	119,337	137,434	(18,097)
TWH	Acute Stroke	97.8%	93.5%	95.7%	103.2%	11.1%	100.0%	5	0			76,565	75,050	1,515
TWH	Coronary Care Unit (CCU)	93.5%	93.5%	92.5%	N/A	75.6%	100.0%	0	1			57,300	51,510	5,790
TWH	Gynaecology	100.0%	97.7%	100.0%	93.5%	45.4%	94.4%	0	0			66,262	64,100	2,162
TWH	Intensive Treatment Unit (ITU)	99.6%	100.0%	99.2%	N/A	0.0%	0.0%	0	0			185,376	180,179	5,197
TWH	Medical Assessment Unit	100.0%	103.2%	124.2%	103.2%	12.8%	91.7%	8	0		Increase requirement at night to support overnight care in AAU.	151,252	186,957	(35,705)
TWH	SAU	94.6%	183.9%	122.6%	177.4%			0	0		Escalated throughout the month	65,750	95,656	(29,906)
TWH	Ward 32	93.5%	96.8%	103.2%	100.0%	9.8%	100.0%	1	0			119,910	114,894	5,016
TWH	Ward 10	89.8%	121.0%	82.5%	151.6%	14.9%	93.3%	1	1		19 patients requiring additional support/enhanced supervision. Ward carrying a high number of RN vacancies. Directorate level plans in place and noted on Directorate Risk Register.	124,165	133,497	(9,332)
TWH	Ward 11	97.2%	110.8%	100.0%	96.8%	33.1%	100.0%	6	0			125,584	122,010	3,574
TWH	Ward 12	83.1%	105.4%	87.9%	125.8%	7.9%	100.0%	10	0		RN:CSW ratio a consider approach as recruitment of RN starts to impact. Number of new RNs undertaking Trust Induction and orientation.	108,139	106,460	1,679
TWH	Ward 20	99.4%	86.3%	99.2%	150.0%	41.2%	100.0%	7	1		Two cohorted areas of nursing implemented for falls prevention and cognitive impairment. Impact on fill rate shown at night, as patients cannot be nursed together at night.	122,805	139,594	(16,789)
TWH	Ward 21	95.2%	97.8%	100.8%	94.6%	2.3%	100.0%	4	0			119,912	122,457	(2,545)
TWH	Ward 22	96.8%	124.2%	96.8%	100.0%	92.9%	92.3%	9	0		Additional CSW required for 12 days during the morning for increased dependency.	93,043	102,121	(9,078)
TWH	Ward 30	99.0%	108.6%	93.5%	111.8%	1.0%	100.0%	8	0		RN: CSW ratio a considered approach. Increased dependency without increase in acuity.	121,746	137,230	(15,484)
TWH	Ward 31	99.5%	94.8%	99.2%	98.9%	11.1%	75.0%	8	1			136,057	133,914	2,143
TCH	Stroke Rehab	76.3%	124.2%	96.8%	103.2%	160.0%	100.0%	2	1		Down by 1 RN on 10 occasions. Each for the 1st half of the morning. Supported by CNS, MDT and neighbouring ward. Always 2 RNs on the ward.	57,413	55,300	2,114
TWH	Ante-Natal	98.4%	57.3%	101.6%	87.1%	32.1%	96.6%	0	0		CSW fill rate down due to: vacancy - 3 in pipeline, 1 started in month, with 2 awaiting start dates. Also have 2 on LTS 1 anticipated RTW May, other going through sickness management process. No direct clinical impact on care; however has had an impact on efficiency of moving women from Delivery to Post-Natal.	590,516	614,843	(24,327)
TWH	Delivery Suite	95.0%	87.1%	94.6%	93.8%			0	0					
TWH	Post-Natal	99.3%	81.5%	100.8%	66.9%			0	0					
TWH	Gynae Triage	100.0%	100.0%	98.4%	93.5%			0	0			11,355	10,512	843
TWH	Hedgehog	96.2%	94.2%	98.9%	88.2%	11.2%	100.0%	1	0			186,191	192,604	(6,413)
TWH	Birth Centre	100.0%	100.0%	100.0%	93.5%			0	0			65,392	63,350	2,042
TWH	Neonatal Unit	105.4%	64.5%	98.4%	93.5%			0	0		10 shifts of reduced CSWs, as a result of sickness. Priority given to ensuring cover at night.	160,644	148,825	11,819
TWH	MSSU	138.1%	85.7%	95.2%	N/A			0	0		Increased RN requirement as additional demands on Unit to cover surgical elective case load.	55,535	41,905	13,630
TWH	Peel	91.6%	135.5%	89.2%	N/A	6.7%	100.0%	0	0			80,271	78,693	1,578
TWH	SSSU	104.8%	85.7%	N/A	N/A	0.4%	100.0%	0	0			36,096	30,174	5,922
											Total Established Wards	**4,174,312**	**4,277,682**	**(103,370)**
											Additional Capacity beds	453,344	620,809	(167,465)
											Other associated nursing costs	2,206,821	2,389,390	(182,569)
											Total Nursing Costs	6,834,477	7,287,881	(453,404)

RAG Key

Underfill

Over fill

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – January 2016

1-14 Trust Board Members' hospital visits (25/09/15 to 22/01/16) Trust Secretary

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

This quarterly report therefore provides details of the hospital visits reported as being undertaken by Trust Board Members between 25th September 2015 and 22nd January 2016 (the last report submitted to the Board, in September 2015, covered visits up to 24th September).

The report includes Ward/Department visits; involvement in Care Assurance Audits; and related activity.

It should be noted however that the report does not claim to be a comprehensive record of such activity, as some Trust Board Members (most notably the Chief Executive, Chief Operating Officer, Chief Nurse, Medical Director, and Director of Infection Prevention and Control), visit Wards and other patient areas regularly, as part of their day-to-day responsibility for service delivery and the quality of care. It is not intended to capture all such routine visits within this report.

In addition, Board Members may have undertaken visits but not registered these with the Trust Management office (Board Members are therefore encouraged to register all such visits).

The report is primarily for information, and to encourage Board Members to continue to undertake visits. Board Members are also invited to share any particular observations from their visits at the Board meeting.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

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

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

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

Hospital visits undertaken by Board members, 24th September 2015 to 22nd January 2016

Trust Board Member	Areas registered with the Trust Secretary / Assistant Trust Secretary as being visited (MH: Maidstone Hospital; TW: Tunbridge Wells Hospital)	Formal feedback provided?
Chairman of Trust Board (AJ)	▪ Sexual Health Services, MH ▪ The A&E department and several Wards at both sites (on Boxing Day) ▪ Maternity, TW	-
Chief Executive (GD)	▪ ICU, TW	Yes
Chief Nurse (AB)	▪ Mercer Ward, MH	-
Chief Operating Officer (AG)	▪ Pye Oliver Ward, MH (with KT) ▪ Cornwallis Ward, MH (with KT) ▪ Foster Clarke Ward, MH (with KT) ▪ Chronic Pain Unit, MH (with KT) ▪ GUM clinic, MH (with KT) ▪ Admissions Lounge, MH (with KT) ▪ Oncology Unit, Canterbury Hospital (East Kent Hospitals University NHS Foundation Trust)	-
Deputy Chief Executive (JL)	▪ Library Services, Academic Centre, MH (with SDu) ▪ Human Resources, MH (with SDu) ▪ Chaucer Ward, MH (with SDu) ▪ Microbiology, MH (with SDu) ▪ Nutrition/Dietetics, MH (with SDu)	Yes
Director of Finance (SO)	-	-
Director of Infection Prevention and Control (SM)	-	-
Director of Workforce and Communications (PB)	-	-
Medical Director (PS)	-	-
Non-Executive Director (KT)	▪ Pye Oliver Ward, MH (with AG) ▪ Cornwallis Ward, MH (with AG) ▪ Foster Clarke Ward, MH (with AG) ▪ Chronic Pain Unit, MH (with AG) ▪ GUM clinic, MH (with AG) ▪ Admissions Lounge, MH (with AG)	-
Non-Executive Director (AK)	-	-
Non-Executive Director (SD)	-	-
Non-Executive Director (SDu)	▪ Library Services, Academic Centre, MH (with JL) ▪ Human Resources, MH (with JL) ▪ Chaucer Ward, MH (with JL) ▪ Microbiology, MH (with JL) ▪ Nutrition/Dietetics, MH (with JL)	Yes
Non-Executive Director (ST)	-	-

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – January 2016

1-15	To approve the transfer of Crowborough Birthing Centre and High Weald Community Midwifery Services	Chief Operating Officer

- This paper provides due diligence analysis on the transfer of Crowborough Birthing Centre from East Sussex Healthcare NHS Trust to Maidstone and Tunbridge Wells NHS Trust.
- Whilst the deliveries in the Crowborough Birthing Centre have been in decline the midwifery service as it stands makes a positive contribution with further opportunities for growth.
- Crowborough Birthing Centre needs a refurbishment – but is essentially safe. The Birthing Centre will be owned by NHS Property Services who will be MTW's landlords responsible for providing hard and soft FM.
- Capital developments need to go through NHS Property Services, as any investment cannot sit on MTWs asset register.
- Staffing levels are currently adequate but additional staffing is required to ensure parity with MTW staffing levels.
- Staff need to be orientated to work in MTW.
- Equipment owned and removed by ESHT will need to be replaced.
- Provision of and training in the use of mobile devices prior to April will be a necessary component of the mobilisation phase to mitigate the risk of under-recording clinical activity.
- MTW taking over the running of the Crowborough Birthing Centre has been welcomed by the Crowborough League of Friends.
- The enclosed report (apart from the Appendix) was reviewed at the Trust Management Executive on 20/01/16, and the transfer was supported
- The Finance Committee was then asked to review the financial aspects of the proposed transfer, and recommend to the Trust Board that the Trust proceed to plan for and take over the Crowborough Birthing Centre from 1st April 2016. The outcome of the Finance Committee's review will be reported verbally at the Trust Board on 27/01/16

Which Committees have reviewed the information prior to Board submission?
- Trust Management Executive, 20/01/16
- Finance Committee, 25/01/16

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
To review the enclosed report, and approve the transfer of Crowborough Birthing Centre and High Weald Community Midwifery Services

[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

The Crowborough Birthing Centre is a midwife-led service current run by East Sussex Healthcare NHS Trust. The birthing unit serves the population of the High weald in which many women regard MTW as their local obstetric unit. MTW already accept all emergency transfers from the Birth Centre as it is the nearest acute hospital and wish to be the Lead provider of choice for midwifery services at the Crowborough Birthing Centre (CBC) and the community services for Crowborough and the surrounding villages.

On 12th January, the East Sussex Hospitals Trust Board confirmed that it was prepared to transfer the Crowborough Birthing centre and Community Midwifery service to Maidstone and Tunbridge Wells NHS Trust. This paper outlines the outcome of the due diligence analysis, required to provide assurance that the proposed transfer is safe, financially viable and provides future opportunities.

2. Scope (What we are taking over)

2.1 Crowborough Birthing Centre

The Crowborough Birthing Centre (CBC) is a midwife-led service run by East Sussex Healthcare NHS Trust (ESHT). The Centre has six beds, is open 24 hours a day and is run by a dedicated team of experienced midwives. The Centre offers complete ante-natal care, screening tests (with an ultrasound scanner available), parent education classes, as well as the option of having a home birth or birth centre birth.

2.2 Staffing

The midwifery team at Crowborough provide an integrated service whereby midwives cover the Crowborough birthing centre and the Community Midwifery Service. The clinical team consists of:

- 2 (1.8 WTE) x Band 7 (+0.18 WTE vacancy)
- 13 (10 WTE) x Band 6
- 7 (5) WTE Band 2 Midwifery Support Worker

2.3 Community Midwifery service.

Antenatal/Postnatal clinics are held in the following locations.

Day	Time	Location
Monday	09.30 – 13.00	Hartfield Medical Centre
	13.00 – 16.30	Heathfield Community Health Centre
Tuesday	09.20 – 13.00	Meads Surgery, Uckfield
	13.30 – 16.00	Buxted Medical Centre, Uckfield
Wednesday	09.00 – 13.00	Bird-In-Eye Surgery, Uckfield
	0.900 – 13.00	Crowborough Birthing Centre
Thursday	09.00 - 13.00	Crowborough Birthing Centre
	09.50 – 13.00	Ticehurst Children's Centre
Friday	09.00 – 13.00	The Brook Health Centre, Crowborough

These clinics support the following GP practices:

Hartfield

- Ashdown Forest Health Centre (G81024)
- Groombridge & Hartfield Medical Group (G81614)

Heathfield

- Heathfield Surgery (G81 88)
- Manor Oak Surgery (G81097)
- Woodhill Surgery (G81097)

Uckfield

- The Meads Surgery (G81037)

- Bird-In-Eye Surgery (G81086)
- Buxted Medical Centre (G81102)

Crowborough

- Beacon Surgery (G81019)
- Saxonbury House (G81055)
- Rotherfield Surgery (G81043)

Ticehurst

- Belmont Surgery (G81030)

3. Market Opportunity (Whether there is room to grow)

3.1 Catchment Area

For the purpose of the due diligence analysis, the catchment area includes the GP surgeries supported by the Crowborough Midwifery Team as well as the local areas to which choosing Crowborough Birthing Centre is a viable option – typically within 30 minutes. This is to show the potential to increase activity within CBC. The proximity to Crowborough, total activity and MTW's market share is shown below.

					MTW	
Location	**Practice**	**Postcode**	**CBC (mins)**	**14/15**	**14/15**	**%**
Crowborough	BEACON SURGERY (G81019)	TN6	0	95	72	76%
Crowborough	SAXONBURY HOUSE SURGERY (G81055)	TN6	0	78	59	76%
Crowborough	ROTHERFIELD SURGERY (G81043)	TN6	0	69	55	80%
Forest Row	ASHDOWN FOREST HEALTH CENTRE (G81024)	RH18	18	57	14	25%
Groombridge & Hartfield	GROOMBRIDGE AND HARTFIELD MED GRP (G81614)	TN7	12	48	39	81%
Heathfield	HEATHFIELD SURGERY (G81088)	TN21	18	86	60	70%
Heathfield	MANOR OAK SURGERY (G81097)	TN21	23	28	19	68%
Mayfield	WOODHILL SURGERY (G81040)	TN20	16	17	15	88%
Uckfield	THE MEADS SURGERY (G81037)	TN22	15	103	15	15%
Uckfield	BIRD-IN-EYE SURGERY (G81086)	TN22	21	81	20	25%
Uckfield	BUXTED MEDICAL CENTRE (G81102)	TN22	13	78	22	28%
Wadhurst	BELMONT SURGERY (G81030)	TN5	16	62	51	82%
Total - Crowborough Midwifery Team				**802**	**441**	**55%**
Etchingham	FAIRFIELD SURGERY (G81052)	TN19	30	29	11	38%
Hailsham	HAILSHAM MEDICAL GROUP (G81059)	BN27	36	134	3	2%
	THE QUINTIN MEDICAL CENTRE (G81098)	BN27	32	57	11	19%
	HERSTMONCEUX HEALTH CENTRE (G81634)	BN27	35	30	4	13%
Total - Crowborough Catchment Area (Non-MTW)				**250**	**29**	**12%**
Lamberhurst	LAMBERHURST (G82170)	TN3	26	16	15	94%
Pembury	KINGSWOOD SURGERY (G82016)	TN2	21	115	112	97%
	ROWAN TREE SURGERY (G82715)	TN2	15	51	50	98%
	WATERFIELD HOUSE SURGERY (G82155)	TN2	29	42	42	100%
Southborough	CLANRICARDE MEDICAL CENTRE (G82025)	TN4	20	114	111	97%
	ST ANDREWS MEDICAL CENTRE (G82137)	TN4	28	87	85	98%
	ABBEY COURT (G82103)	TN4	21	78	75	96%
	RUSTHALL MEDICAL PRACTICE (G82152)	TN4	20	53	51	96%
Speldhurst	SPELDHURST & GREGGSWOOD MEDICAL GROUP (G820	TN3	19	67	65	97%
Tunbridge Wells	GROSVENOR MEDICAL CENTRE (G82041)	TN1	23	142	139	98%
	LONSDALE MEDICAL CENTRE (G82768)	TN1	20	95	91	96%
	ST JAMES MEDICAL CENTRE (G82075)	TN1	23	78	73	94%
	UPPER GROSVENOR ROAD SURGERY (G82692)	TN1	23	1	1	100%
Total - Crowborough Catchment Area (MTW)				**939**	**910**	**97%**
Grand Total				**1,991**	**1,380**	**69%**

Birth numbers at Crowborough Birthing Centre have been in decline. In 2014/15, there were 1,991 deliveries from the Crowborough catchment area of which only 127 (6%) were seen at CBC. In comparison, activity at Maidstone Birthing Centre (plus Homebirths) has grown and accounts for 15% of the population from Maidstone catchment area.

It is noticeable that MTW undertakes 97% of the deliveries from the West Kent CCG practices which are within 30 minutes of Crowborough Birthing Centre. These patients are generally seen in Pembury Hospital and not the Maidstone Birthing Centre which suggests there is considerable scope to grow the service.

A successful birthing unit at Crowborough will seek to increase the number of deliveries to the rate experienced in Maidstone. This will draw patients away from other delivery units, including Pembury which will either generate more income or improve cost effectiveness. The centre would also appeal to women from Lewes & East Grinstead as BSUH does not have this type of birth option.

3.2 Competitor Analysis

Maternity services in the proximity of Crowborough are provided from the following sites:

- **Conquest Hospital (ESHT) - Hastings**
  A consultant led maternity unit with a delivery suite, postnatal ward and antenatal ward.
- **Eastbourne District General Hospital (ESHT)– Eastbourne**
  Midwifery Led Unit (MLU) for women who have had an uncomplicated pregnancy and no medical problems or conditions.
- **Royal Sussex County Hospital (BSUH)– Brighton**
  Includes Neonatal Intensive Care Unit (NICU), 12 Labour rooms, 3 birth pools,
- **Princess Royal Hospital (BSUH)– Haywards Heath**
  Consultant led maternity unit with 8 labour rooms, 2 birth pools, post-natal ward
- **East Surrey Hospital (SASH)- Redhill**
  The service provides antenatal, intrapartum (labour and birth) and postnatal care, delivered by 128 midwives (full-time equivalent) and supported by a team of obstetric and gynaecological consultants.

Travel times between the catchment area identified above and competitor sites are as follows:

				Travel time							
				ESHT NHS Trust			MTW NHS Trust		BSUH NHS Trust		S&S NHS Trust
				CBC - Crowborough	Eastbourne General	Conquest - Hastings	MBC - Maidstone	TWH - Pembury	RSCH - Brighton	PRH - Haywards Heath	ESH - Redhill
	Post Code	Area	Total Deliveries	Travel Time	Travel Time	Travel Time	Travel Time	Travel Time	Travel Time	Travel Time	Travel Time
Crowborough Midwifery Service	TN20	Mayfield	17	15	39	41	48	27	60	37	66
	TN21	Heathfield	114	24	32	32	57	37	64	43	72
	TN22	Uckfield & Buxted	262	18	36	47	65	36	50	21	49
	TN5	Wadhurst	62	21	48	41	42	24	75	50	65
	TN6	Crowborough & Rotherfield	242	0	41	52	46	26	60	30	51
	TN7	Groombridge & Hartfield	48	15	51	60	55	30	50	31	41
	RH18	Forest Row	57	20	47	65	57	41	48	21	35
		Total	**802**								
Other	BN27	Hailsham	221	41	26	36	81	53	54	51	79
	TN19	Etchingham	29	35	42	25	52	30	70	49	71
		Total	**250**								
MTW	TN1	Tunbridge Wells	316	**22**	**55**	**46**	**36**	**9**	**68**	**47**	**51**
	TN2	Pembury	208	**22**	**55**	**40**	**29**	**3**	**69**	**48**	**44**
	TN3	Langton Green / Frant	83	**21**	**56**	**53**	**50**	**23**	**63**	**40**	**53**
	TN4	Southborough	332	**22**	**58**	**51**	**39**	**12**	**71**	**45**	**43**
		Total	**939**								

Grand Total	**1,991**

Closest
2nd closest
3rd closest
Furthest

This table shows how the areas covered by the Crowborough Community Midwifery team is well aligned with MTW and that there are future opportunities for growth.

4. Staffing (What the staffing issues are)

4.1 Staffing Levels

The Crowborough Midwifery team currently has 0.18 WTE clinical vacancies and 2 midwifery support workers have recently resigned. The staffing requirement to manage the current caseload has been reviewed by the MTW Midwifery team to ensure the current service is safe and identify the changes required to ensure parity with MTW staffing levels. This is as follows:

	Current		Proposed	
	WTE	**£**	**WTE**	**£**
Band 7	1.8			
Band 6	10			
Total Midwives	**11.8**	**£516,035**	**16.6**	**£734,850**
Band 2	5	£106,376	5.2	£110,631
Total MSW	**5**	**£106,376**	**5.2**	**£110,631**

The increase in staffing required is due to a number of factors as follows:

- **Community Caseload** - The recommended caseload per midwife is 120. With circa 800 cases per annum, the WTE community midwife requirement is therefore 6.7.
- **Birthing Centre Staffing** - The birthing centre requires 2 midwives during the day and 1 midwife all night to provide 24 hour cover. This equates to 8.4 WTE Band 6/7.
- **Uplift** - 22% uplift has been incorporated to cover annual, sickness and maternity leave.
- **Management Time** - Management time of 0.4 WTE Band 7 is required to support the transition and replace the management support previously provided by ESHT.
- **Midwifery Supervision** - The Nursing & Midwifery Council stipulate that all midwives are required to have a supervisor allocated to them and recommend a caseload of 15 midwives per supervisor. An additional 0.1 WTE Band 7 is therefore required to provide the requisite supervision time. As 2 of the members of the Crowborough team are supervisors, this will also help MTWs supervision team to reach this target.
- **Sonography** - 0.4 WTE Band 7 Sonography provision is required to ensure patients have access to the requisite tests. Nationally, there is a shortage of sonographers so as part of the workforce plan, community midwives are being trained to provide this service. This will help ensure tests are carried out in the community.
- **Specialist Support** – Additional 1 WTE Band 7 is required to provide the specialist services as follow:
    - Safeguarding,
    - Infant Feeding,
    - Screening
- **Midwifery Support Workers** - The increase of 0.2 WTE Band 2 Midwifery Support Workers will ensure there is a 1 band 2 available 24 hours per day.

Although there is a considerable staffing deficit which will need to be addressed, operationally, the current level is considered safe. However, the Trust we need to have clear escalation policies in place to support if activity increases quickly. Longer term, it is expected that as the birth rate increases the clinical staffing levels would be managed to increase to similar levels and structure as the Maidstone Birth Centre.

4.2 Due Diligence

As part of this process, MTW will need to review the existing staffing establishment within CBC and also risk assess what would happen should staff leave before the transfer date and any difficulties associated with recruiting into these posts. Staff will retain their contractual terms and conditions upon transfer including any local agreements, which the Trust have yet to be advised. Staff will also be governed by any of their preceding contractual policies and procedures upon transfer, which could be different to MTW's policies and procedures.

Minimal HR information has been provided to date and there is a legal requirement under TUPE regulations for due diligence information to be provided to the new provider 28 days prior to transfer. This information includes details on employees such as their pay, job role, pension information, sickness, disciplinary, grievances, etc. The Trust should also receive information relating to any reportable incidents or accidents in last 5 years or any instances where action has been taken by employees against the NHS (Tribunal or personal injury claims). Included with this information should be any outstanding or pending claims which MTW would potentially become liable for.

4.3 Mobilisation

Staff will need support during this period and will be provided the option of either being transferred across to the MTW services under TUPE conditions if they choose to work for MTW, or they could choose to stay with East Sussex and move to work at either the Hastings or Eastbourne sites. TUPE would enable the service to continue, especially the community part of the service, during the period of transition.

There are several midwives who are currently on the bank who are not part of the consultation service. These members of staff will be invited to join the MTW bank in order to ensure continuity of service.

5. Estates & Facilities

5.1 NHS Property Services

Crowborough Birthing Centre was transferred from ESHT to NHS Property Services in November 15. If the Maternity Service were to transfer to MTW, the building will remain the property of NHS Property Services and MTW will become their tenant. Based on a square meterage of 330sqm, NHS Property Services have quoted a rental fee of £57,650 per annum.

As a tenant, MTW cannot access its own capital to fund developments in Crowborough Birthing Centre. Capital spend undertaken by NHS Property Services falls into two categories:

- Landlord spend - defined as day to day maintenance of buildings in accordance with landlord obligations.
- Customer spend - defined as that which is required to fund strategic works such as major refurbishments, change of use, re-modelling of floor layouts, and new builds requested by customers.

There are different approval processes for expenditure in each of these categories.

5.2 Soft FM – Crowborough Birthing Centre

Soft FM is provided by ESHT who are commissioned by NHS property Services. Soft FM provided by ESHT is charged to NHS Property Services who will recharge Soft FM costs back to MTW as part of the rental agreement.

The cost of soft FM has been benchmarked by NHS Property Services at £10,982 per annum.

5.3 Hard FM – Crowborough Birthing Centre

Hard FM is provided by Sussex Community Trust who are commissioned by NHS Property Services. Hard FM provided by SCT is charged to NHS Property Services who recharges back to MTW as part of the rental agreement.

The Hard FM services included are:

- Building and fabric maintenance both planned and reactive
- Energy and water management.
- Building management systems; boiler, heating, air con etc

The cost of hard FM (which includes Rates and Utilities) is expected to cost £34,000 per annum.

5.4 Maintenance of Crowborough Birthing Centre

The Estates & Facilities department has visited the Crowborough Birthing Centre and have identified the following issues which require urgent attention:

- Delivery room has a bath and not birthing pool compromising Moving & Handling processes.
- Plant room has a fire risk.
- Skirting Boards presenting an infection control risk.

These concerns are considered Landlord schemes. The approval process for Landlord schemes is led by NHS Property Services with a degree of local and regional delegation depending on the size of the scheme, as follows:

- Under £75,000: local office approval
- £75,000 - £250,000: regional office approval
- £250,000 - £500,000: Executive Director approval
- £500,000 and above: Asset and Investment Committee approval

The premises audit has been sent to NHS Property Services to confirm the process for undertaking the remedial work.

5.5 Strategic Development of CBC

Longer-term, there needs to be some investment in the facilities currently offered at Crowborough to bring the service up to the same standard as that provided at the 2 MTW sites- e.g. single rooms with ensuite facilities. This will improve the appeal of the centre to increase the number of patients. This would need to be reviewed in terms of estate requirement and funding options although the Crowborough Hospital League of Friends has agreed to provide some financial support.

Strategic developments are considered Customer Capital Schemes. All schemes are led by commissioners and the role of NHS Property Services is to work with them on those schemes that NHS England has placed in its pipeline, in order provide assurance on the following points:

- Statutory and technical compliance
- It is in line with NHS guidance
- Functionality (and sizing)
- Buildings are fully utilised
- Affordability (in line with the customer's affordability limit)
- Value for money
- Cost neutral: all the costs are being covered by tenancies or underwritten by a customer organisation.

To ensure this happens consistently the company's internal governance process is followed, using the same approval limits as for Landlord Capital. Any schemes over £3m will go to the NHS Property Services Board for final approval.

5.6 Community Clinics

In addition to CBC, the midwifery service operates from:

- Hartfield Medical Centre
- Heathfield Community Health Centre
- Meads Surgery – Uckfield
- Buxted Medical Centre - Uckfield
- Bird-in-Eye Surgery - Uckfield
- The Brook Health Centre - Crowborough
- Ticehurst Children's Centre
- Uckfield Community Centre

For clinics which operate from privately owned GP Surgeries, the working assumption is that these will continue without charge. The Surgeries concerned will be notified of the change in provider as part of the Communications plan.

Heathfield Community Centre is a site owned by NHS Property Services who have been informed of the Crowborough development. It is assumed that existing service locations will continue to be used as they are currently for the foreseeable future and a small provision has been included in the costings.

6. IT

There will be a requirement to replace or add to the existing IT equipment at CBC. An initial review has identified that staff following MTW processes will be required to enter more records electronically than at present which will necessitate additional computer access, for example in consulting rooms used for antenatal appointments. The need for improved IT is evidenced in paragraph 8.2. The capital cost of the IT requirement is estimated as follows:

Item	Cost
PC/Phones	£9,000
Nursing Obs (Nervecentre)	£10,000
Build	£6,000
Community Midwives Tablets	£6,000
Infrastructure Network	£13,000
Total	**c£44,000**

An element of the IT capital costs relate to Infrastructure. As this work will be undertaken in a building that does not belong to MTW, these changes will require approval of NHS Property Services and will not begin until April at the earliest. To mitigate against no having IT access, Community midwives based at Crowborough will require mobile tablet devices in order to support remote access to trust systems and facilitate data entry of maternity records at the point of care. This approach will provide consistency with the community midwives at MTW.

Telephone numbers which are well known and published within the community will be retained, although new equipment will be provided to support them as necessary.

7. Equipment

There will be a requirement to replace or add to the equipment in the Crowborough Birthing Centre. It is currently not clear what equipment is being retained by ESHT and what is being left at CBC. This is in part due to the equipment purchases funded by Crowborough League of Friends.

In order to estimate the equipment costs, the equipment purchased as part of the Maidstone Birthing Centre has been reviewed. A provision of £40k has therefore been incorporated within the costings.

8. Finance

8.1 National tariff

The national tariff for the maternity pathway provides a payment structure as follows[2]:

Delivery Phase

With complications and co-morbidities	£2,641
Without complications and co-morbidities	£1,795

Non-Delivery Phase

	Standard	Intermediate	Intensive
Antenatal Phase	£1,161	£1,857	£3,091
Postnatal Phase	£274	£346	£930

[2] 2015/16 prices incl. MFF

8.2 Expected Income

Assuming the Crowborough population has the same proportional split between standard, intermediate and intensive care as MTW, from the updated Maternity system, the expected income has been reviewed by the SLA team and is expected to be as follows:

			Standard	Intermediate	Intensive	Total
Income - Non-Delivery Phase						
Tariff						
	Antental		£1,161	£1,857	£3,091	
	Postnatal		£274	£312	£839	
MTW Split						
	Antenatal	No.	3,800	1,863	588	6,250
		%	61%	30%	9%	
	Postnatal	No.	3,463	2,210	128	5,800
		%	60%	38%	2%	
Crowborough						
	Antenatal	No.	525	258	81	864
		£	£610,045	£479,854	£251,104	£1,341,004
	Postnatal	No.	479	306	18	802
		£	£131,190	£95,335	£14,803	£241,328
Total Income - Non-delivery Phase						***£1,582,332***
Income - Delivery Phase						
Tariff						
	Without complications & co-morbidities					£1,795
	No. Deliveries - CBC				127	
	No. Deliveries - Home				19	
	Total No. deliveries					146
Total Income - Delivery Phase						***£262,515***
GRAND TOTAL						***£1,844,847***

The SUS data provided by HWLH CCG relating to antenatal and postnatal activity is considerably lower than would be expected with only 521 patients having antenatal appointments and 153 patients having postnatal appointments. This suggests data entry is a key issue within the Midwifery team which will need to be closely monitored and supported.

8.3 Expected Expenditure

The estimated expenditure associated with the Crowborough Maternity service, were it to open on 1st April 2016, is as follows:

Expenditure - Revenue						
		Current	**Additional**	**Total**		
Expenditure - Pay		**WTE**	**WTE**	**WTE**	**£**	
Band 7	Midwife	1.8		1.8	£90,346	
	Specialist		1	1	£50,192	
	Midwifery Supervision (0.1)		0.1	0.1	£5,019	
	Sonographer (0.4)		0.4	0.4	£20,077	
	Community Team Leader Mgmt		0.4	0.4	£20,077	
	Total	**1.80**	**1.90**	**3.70**	**£185,711**	
Band 6	Midwife	10	2.9	12.9	£549,139	
	Total	**10**	**2.9**	**12.9**	**£549,139**	
Band 2	Midwifery Support Worker	5	0.2	5.2	£110,631	
	Total	**5**	**0.2**	**5.2**	**£110,631**	
Total Pay Costs						**£845,481**
Expenditure - Non-Pay						
	Rent - CBC				£57,650	
	Rent - Other Clinics				£5,000	
	Service Charge (Rates, Utilities and Hard FM)				£34,000	
	Soft FM (Cleaning etc..)				£10,982	
	Consumables				£45,018	
	IT				£13,301	
	EME				£10,000	
	Transport				£0	
	Pathology				£15,000	
	Imaging				£0	
	Other				£10,000	
Total Non-Pay Costs						**£200,951**
TOTAL EXPENDITURE - REVENUE						**£1,046,432**
Expenditure - Capital						
	Non-recurrent Equipment (Based on MBC)				£42,000	
	IT Costs				£43,049	
TOTAL EXPENDITURE - CAPITAL						**£85,049**

This costing schedule incorporates the assumptions outlined in sections 4 – 7 within this paper on HR, Estates & Facilities, IT and Equipment.

8.4 Net I&E

Based on the assumptions outlined within this paper and assuming that equipment is purchased capital funds, the net contribution of this service is £798k

8.5 Conclusion

Provisional analysis indicates that the running the Crowborough Birthing Centre and Community Midwifery Service would make a positive contribution. However, there is opportunity to improve the contribution further by increasing the rate at which the birthing centre is used, taking patients away from more expensive delivery units at TWH and other maternity providers. This could be achieved through the

refurbishment and reconfiguration of the Crowborough Birthing Centre which be subject to a separate business case worked up in conjunction with the CCG.

9. Operational

9.1 Integrated Service

By MTW operating Crowborough Birthing Centre, women will have the choice to have all their care with one provider – MTW, an integrated service with community and the acute Trust – rather than the current situation of a potential of a fragmented service for some women. The integrated services will consist of:

- Local Booking appointment with a named midwife
- Women can be referred to the same provider if they are experiencing any issues during the early part of their pregnancy
- Local scanning facilities to provide more local scans in the future (further work and development will be required for this service)
- 20 week scan
- Screening support services – including blood tests and analysis
- Continuity of Community midwifery
- A seamless pathway to Obstetric care for women who need or wish to choose it
- Midwifery led intra partum care in a midwifery led unit
- Quick and easy access to obstetric or neonatal care if complications arise during labour
- The same computerized notes throughout and seamless administration pathways
- Continuity of post-natal care
- Breast feeding support
- 24 hour helpline and drop in facility
- Support for staff – training and career opportunities
- Safeguarding
- Bereavement
- Infant feeding

The key operational issues are outlined below.

9.2 Staffing

In order to manage the transition and replicate the recommended caseload per midwife used by MTW, which would be necessary to reduce the risk of closing the unit, operationally the service requires an additional 4.8 band 6/7 midwives and 0.2 band 2 midwife support worker. This will provides 2 midwives and a midwife support worker during the daytime and 1 midwife and 1 midwifery support worker at night.

9.3 Estates & Facilities

Clarity is required with regard to contact points and process with regard to Hard and Soft FM issues. Operationally, the delivery room has a bath and not a birthing pool which makes it more difficult lifting women out of the bath. The birthing centre also has skirting boards which are not ideal for infection control. However, the birthing centre has been operational for numerous years in this form and so is not expected to present material operational risks.

9.4 IT

Access to IT to facilitate data entry is central to the viability of the Crowborough service. Training in the use of mobile devices prior to April will be a necessary component of the mobilisation phase.

9.5 Operational Policies

The following operational policies have been reviewed:

- Transfer policy
- Escalation to close
- Pathway
- Criteria
- Business Continuity
- Safeguarding

Whilst these differ to the operational policies adopted by MTW, and that MTW would seek to harmonise the policies at the earliest opportunity, the existing policies are considered to be safe. However, the Safeguarding and Escalation policies will need to be updated prior to 1st April with appropriate contact names and details.

10. Political

10.1 NICE guidance

The National Institute for Health and Care Excellence (NICE) recently published an updated version of the guideline Intrapartum care: Care of healthy women and their babies during birth (NICE, December 2014). In this guideline NICE recommends that all women with an uncomplicated pregnancy should be given the option of giving birth in a midwifery led unit (Birth Centre) as well as in hospital or at home, citing evidence from the Birth Place in England study (2011). This land mark study (which studied a total of 64,000 women), found that, for low risk women, birth is as safe for babies in a Birth Centre or at home as it is in hospital, with the added benefit of reduced intervention for the mother, including lower rates of caesarean, instrumental birth and episiotomy.

10.2 Lessons from Maidstone Birthing Centre

Clinical outcomes for women starting labour at the Maidstone Birth Centre are consistently excellent, with more than 88% of women having a normal birth during the last year. Transfer rates for women who develop problems in labour compare favourably with those in the Birth Place study. There are safe systems and processes in place to ensure that appropriate women use the Centre and that the service maintains a high standard of clinical governance.

Results from the Friends and Family test consistently rate the Birth Centre as excellent and usually place the Birth centre as the highest scoring area for the whole of Maidstone and Tunbridge wells NHS Trust. Breast feeding rates are also high.

10.3 Patient View

Women have stated that “Proximity/location” is the overwhelming driver of choice to help them decide where to have their baby. Whilst Crowborough is a well-regarded service, rated as “Excellent” in the friends & family test, the number of deliveries as a percentage of births in the Crowborough catchment area is low.

By contrast the number of deliveries at the Maidstone Birthing Centre as a percentage of births in the Maidstone catchment area is high and as many women in High Weald regard Pembury as their local obstetric unit MTW is well placed to replicate the service at Crowborough.

Local support for the unit indicated by Chantal Wilson, Chairman, Friends of Crowborough Hospital, who said:

> *“The Friends of Crowborough Hospital are delighted with the in-principle decision to move the management of High Weald maternity services (including Crowborough Birthing Centre) to Maidstone and Tunbridge Wells Trust. This means that women who give birth at Crowborough will have their care overseen by Pembury, which is a much more natural focus than Hastings which currently runs the service as part of East Sussex Healthcare Trust. In this new arrangement, the Friends look forward to enhanced maternity services for north Weald women, including being*

able to have scans and blood tests at Crowborough, This is altogether excellent news for Crowborough!"

The Maternity Services will work closely with the local community to ensure that they are involve with the new designs of the upgraded facilities as well as planning for the whole services for the future. GPs also need to be informed of any such changes and also invited to be involved in the future developments of the service.

There needs to be a clear communication plan to raise awareness of the plans for the service; the need for a temporary period of closure for refurbishment and regular updates throughout this period. This will involve a variety of mediums- open meetings, workshops press releases, Trust website, and letters to women. Clear communication with all stakeholders is vital for the success of this project

11. Risks

The risks associated with this proposal include:

- Adoption of 3-part national tariff – The costing model has assumed the adoption of the 3-part national tariff for Antenatal, Delivery and Postnatal care. A finance schedule provided by ESHT indicate that an element of income was paid on a block contract which MTW would want to avoid.

- Activity data capture – Assuming the 3-part national tariff is adopted, it is essential that the Trust is able to capture and submit activity data, in particular the non-delivery phase. Data provided by HWLH CCG suggests that non-delivery phase activity (for Antenatal and Postnatal care) was understated with, for example, only 156 post-natal cases for 800 births.

- Increase in demand – Numbers of deliveries at the Crowborough Birthing Centre have been in decline and the centre has been staffed accordingly. If demand were to increase, the Trust would need to respond appropriately.

12. Governance

A Project Steering Group has been established to "To manage the smooth transition of the Crowborough War Memorial Hospital, Birthing Unit and local Community Midwifery services from East Sussex Healthcare NHS Trust (ESHT) to Maidstone and Tunbridge Wells NHS Trust. To be operational by the 1st April 2016". The Terms of Reference are enclosed at Appendix 1.

Appendix 1: Crowborough War Memorial Hospital Birthing Unit - Terms of Reference and Membership of the Project Steering Group

1. **Project brief** :

To manage the smooth transition of the Crowborough War Memorial Hospital, Birthing Unit and local Community Midwifery services from East Sussex Healthcare NHS Trust (ESHT) to Maidstone and Tunbridge Wells NHS Trust. To be operational by the 1st April 2016

2. Project Objectives:

- Undertake a due diligence assessment for MTW to take on the birthing unit at Crowborough hospital, along with the associated community maternity service.
- Develop the necessary business case to identify all necessary costs including project cost, to enable appropriate budgets to be set.
- Ensure that the new service is operational and clinically safe from the 1st April 2016 (or in line with the agreed date identified in the project plan)
- Ensure that all policies and procedures are in place for the new unit covering all clinical, administrative, hard and soft FM services .
- All Staff affected, both administrative and clinical have been TUPE'd across to MTW in a timely way and to meet the project brief. They are fully engaged and are prepared to work to new policies, procedures and management structure, in line with MTW ways of working. Any staff vacancies have been identified and a[appointed to.
- Ensure that all MTW IT systems are in place and fully operational to capture, monitor activity and help with clinical decision making.
- Ensure that all necessary equipment has been purchased, tested, staff trained and operationally ready, in line with the go live date.
- Ensure that all patients are fully aware of the new service and there is excellent local communication concerning access and service delivery for both patients, local Gp's, plus all other affected clinicians.
- Ensue that the physical environment is appropriate to meet the needs of the patients and staff.
- ALL necessary Service Level Agreements are in place covering the maternity service along with agreed contract activity levels and KPI's

3. Context

The Crowborough Birthing Centre is a dearly cherished local service, providing women in the High Weald and adjacent parts of West Kent with the choice of a high quality, midwife-led service. Consensus has grown during the last couple of years that the clearest relationship with hospital-based maternity services is with the service based at Tunbridge Wells Hospital. This would provide the opportunity to replicate the successful service model developed in Maidstone for the benefit of expectant mothers and their families in and around Crowborough and Tunbridge Wells.

East Sussex Healthcare NHS Trust (ESHT) currently provides the midwife-led service at Crowborough, along with community midwifery. It has now indicated its intention to cease providing these services in the future. Agreement has, therefore, been reached between MTW,ESHT and East Sussex CCGs that the services should move to MTW in their entirety.

This is a positive development for local patients and intensive work will now be necessary to put the foundations in place to support a successful and sustainable transfer of the services

The work required will be focused on the most appropriate service model and this will form the basis of the contractual agreement that will facilitate the transfer. The agreement in principle that has been reached is a significant step forward and provides clarity around the direction of travel.

Under the proposed model women will have the option of receiving all their care from a single, integrated provider.

This would consist of:

- A local booking appointment with a named midwife
- Choice of being referred to the same provider in the event of problems early in pregnancy
- Local scanning facilities
- Screening support services
- 20 week scan
- Continuity of community midwifery
- A seamless pathway to obstetric care where appropriate
- Midwife-led intra partum care in a midwife-led unit
- Good access to obstetric or neonatal care where appropriate
- Single set of (computerised) notes and joined up administration
- Continuity of post natal care
- Breast feeding support
- 24 hour helpline and drop in facility
- Support for staff

The opportunity to significantly enhance patients' experience of care is self-evident. The challenge now for MTW is to secure sufficient assurance through a process of due diligence to support contract signature.

4. Project Delivery Structure

The project will be delivered through a Steering Group chaired by the Chief Operating Officer and a Clinical Reference group reporting into it, chaired by the Head of Midwifery Women's and children's Health service . This governance structure will deliver the project objectives. A schematic of the proposed membership is shown as Fig 1 attached

5. Role of Steering group

The Steering group takes full responsibility for the governance of the Project . The key roles and responsibilities of the steering group in respect of governance are:-

- To drive the project forward and deliver the objectives and benefits of the Project as identified in the business case. Ensure the project is delivered on time and within budget;

- Test that Project objectives are appropriately defined and owned consistently throughout the delivery structure and that those objectives remain aligned to the Trust's strategic objectives;

- To direct , develop , agree, monitor and maintain a clear plan of action and delivery via the Clinical Reference group, reporting into it;
- Agree the governance structure, terms of reference and membership;
- Ensure that required resources are committed to the project;
- Ensure the project remains within any constraints;
- Approve project documentation, including the Project Mandate, Deployment Plan Document, Risks and Issues log and End Project Report;
- Agree the project plan, time frames and potential constraints. Ensure that the Project is monitored, timetables are managed and that obstacles are removed that may delay its delivery;
- Ensure that Risks and Issues are managed appropriately identify mitigating actions, with all significant red risks being identified to the TME.
- Ensure that a full Quality Impact assessment has been undertaken and supported by all parties prior to implementation.
- Establish the Clinical Reference Group and any working groups as required to enable progression of the project;
- Ensure that the needs of stakeholders are appropriately represented throughout the delivery structure;
- Receive and consider progress reports from the Clinical Reference Group and act, when required, upon its recommendations;
- Make recommendations to TME on the information needed by them, to provide the necessary assurances that the Project will deliver as planned;

The project Steering group reports into the TME through regular progress reports against the agreed project plan identifying any key risks and decision points.

Through the ESHT representative, progress reports will be shared with ESHT board

The Project Steering group will monitor and delivery the changes on behalf of TME. They will act on its behalf within the limits of its authority as laid out in the Trust's Standing Orders and Standing Financial Instructions and via the Chief Operating officers Executive powers, who Chairs the steering group.

6. Membership

The core membership of the Crowborough birthing unit Steering group includes:

Chair - COO, Angela Gallagher
Clinical Reference group chair – Jenny Cleary
ESHT representative –Michele Small GM Women's & Children
HR lead – Richard Haden

Estates Lead - Jeanette Rooke
IT lead - Donna Jarrett
Consultant Obstetrician
GP – representative
Business / contracting /strategic lead – Steve Williams
Programme manager – Steve Jones
Project manager – Susan Powley
Admin support –

Other persons may be co-opted on to the steering group depending on the business to be discussed

7. Meeting structure

The steering group will have two parts:

Part A - Work with ESHT to allow the smooth transition of services.
Part B- Any commercial issues only affecting MTW

8. Frequency of Meetings

The Steering group will meet monthly or as frequently as the chair requires.

9. Term

The Crowborough birthing unit steering group and its supporting delivery structure will remain in place until the Project is formally closed by the TME.

10. Quorum

The Crowborough birthing unit Steering group will be quorate when the chair is present with at least 3 other members at the meeting.

Members may request a deputy to attend meetings in their place providing the deputy has been agreed in advance. Such deputy will count towards the quoracy of the meeting.

11. Administration and Duties

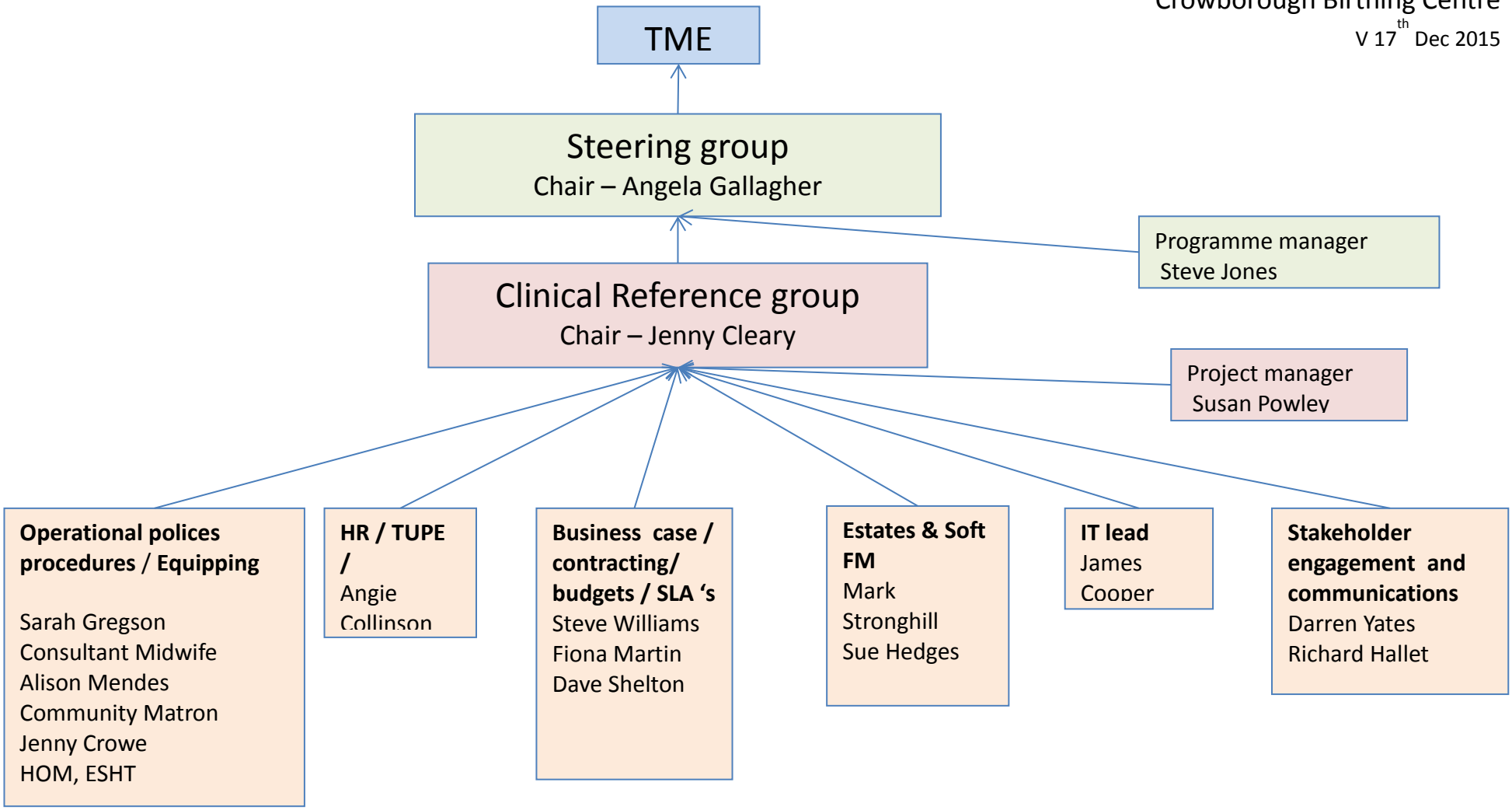
The PA to COO (Steering group Chair) with the the support of the project manager will be responsible for:

- Calling, collating and circulating the papers for the meeting
- Drafting the meeting agenda
- Take the minutes
- Record and monitor attendance
- Plan the meeting dates for the year and book rooms.

12. Audit Arrangements

The minutes and reports will be available for review by any audit process.

Crowborough Birthing Centre
V 17th Dec 2015



Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - January 2016

1-16 Emergency Planning update (annual report to Board) Chief Operating Officer

Summary

The enclosed report is the Annual Report to Board on Emergency Planning it summarises key aspects of preparedness for 2015.

- The Trust is a statutory responder under the Civil Contingencies Act with key responsibilities
- The Emergency Planning Team provide expert guidance and training in preparing the organisation
- The Trust is regarded as a leader in the field of Emergency Planning and is recognised for its good practice
- The report summarises the work to ensure preparedness during the last twelve months

Which Committees have reviewed the information prior to Board submission?

- Resilience Committee

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

For discussion, assurance & 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

mtw.nhs.uk
Emergency Planning and Response

Maidstone and Tunbridge Wells NHS Trust

Emergency Planning, Response & Recovery Annual Report 2015

taking pride

Patient First · Respect · Innovation · Delivery · Excellence

1 Introduction

1.1 This report summarises the work of the Emergency Planning Team, key aspects of the organisations emergency preparedness over the past year and how the Trust maintains its readiness to prepare, respond and recover from both emergencies and disruptive challenges.

1.2 The Trust as a Category One responder under the Civil Contingencies Act 2004 has specific statutory duties in relation to emergency planning and response. In addition the organisation has other obligations as required by contracts and performance standards set by NHS England.

1.3 Throughout the year a continuous process of exercising, testing, training, assurance has taken place.

1.4 This year the Trust has enjoyed a student working with the team allowing the team to shape future talent and the next generation of emergency planning professionals.

1.5 The Trust continues to work with other NHS Organisations and this has started closer working with East Kent Hospitals University Foundation Trust along with existing work with Dartford & Gravesham and Surrey & Sussex Health NHS Trust.

2. Incidents

2.1 On June 10th thirteen vehicles were involved in a collision with a heavy goods vehicle in Tunbridge Wells. The South East Coast Ambulance Service initially declared a Major Incident and alerted the Trust accordingly. The Switchboard activated the major Incident plan in accordance with their standing instructions. The Ambulance Service once a more thorough assessment of the scene was possible then stood the Incident down. This gave the Trust the opportunity to test its Communications Cascades for real. It was a good reminder to staff to make sure all contact details are kept up to date with the Switchboard.

2.2 During the last week of December 2014 and into the first week of January 2015 Business Continuity arrangements were tested as an unprecedented surge in admissions to the hospitals meant additional response arrangements had to be put in place. The Trust responded well and staff were commended for their commitment to care under significant pressure.

2.3 On 29th April there was an IT failure at Tunbridge Wells Hospital resulting in Business Continuity Arrangements being activated. This was followed on May 4th with a Power Failure at Maidstone Hospital also requiring Business Continuity Arrangements to be put in place. Investigations and Action Plans have been completed through the Resilience and Health and Safety Committees.

2.4 On April 9th a vulnerable patient went missing from the Maidstone Hospital requiring a multi-agency response and the opening of an Incident Command Centre. The patient was found safe and well. The Incident allowed the Trust to test its new missing persons policy which was updated following a multi-agency debrief.

2.5 In the first part of 2015 Industrial Action was called by a number of unions representing staff working in the NHS. Business Continuity Arrangements were considered but not needed however considerable work was completed in order to get the necessary Situation Reports to the Department of Health on time. Later junior doctors announced a series of periods of Industrial Action requiring additional planning.

2.6 Throughout the summer the Emergency Planning Team were involved in looking at the issues facing the Trust from the prolonged use of Operation Stack on the M20. Additional contingency planning became necessary as new operational responses were needed on the ground very quickly by Kent Police and other partner agencies especially during hot weather.

2.7 In July the Met Office issued a Level 3 Heatwave requiring activation of short term Heatwave Response Plans.

2.8 In November, Business Continuity Plans were activated when boilers at the Trust Laundry failed. The plans put in place enabled no loss of service to patients and staff.

2.9 On the 24th of November Virgin Media cut through a major incoming phone cable resulting in loss of phone services. This required activation of business continuity plans to ensure that key responses remained operational. Plans were able to be activated quickly and enabled critical communications to be maintained.

3. Training & Exercises

3.1 Exercise Carbine was the Trust's major tabletop exercise this year held on June 25th involving all areas of the Trust. This involved Kent Police and South East Coast Ambulance Service working through a firearms scenario testing all areas of the Major Incident Response.

3.2 Exercise Paratum Communitas held in April was regional exercise held by NHS England and the Trust was represented by a number of staff to work through scenarios with other agencies including the Military, Blue light services and Trauma Networks.

3.3 The Trust also conducted a Communications Exercise on November 13th

3.4 Exercise Polar – this tabletop looked at Winter Resilience Plans for the organisation in conjunction with West Kent CCG, out of hours providers and SECAMB.

3.5 Exercise Neptune was carried out in October which tested the Business Continuity plans relating to Pathology and Blood Transfusion Services.

3.6 The Trust hosted a major workshop in November for all Trusts in Kent & Medway to examine acute hospital evacuation plans in conjunction with partner agencies including Police, Fire & Rescue, Local Authorities and SECAMB.

3.7 In February the Trust was took part in an exercise to examine plans for a Flu Pandemic in conjunction with NHS England, CCGs, Public Health England and other NHS organisations.

3.8 In April various exercises examined plans to look at relocation of the Emergency Departments to other parts of the estate in the event of an internal emergency allowing services to continue.

3.9 In July the Trust took part in a tabletop exercise with partners in the Mental Health Trust to test their plans for Priority House adjacent to the Maidstone Hospital Site.

4. Command Accreditation Scheme

4.1 Following on from the success of the pilot command training courses which the Trust ran last year. The majority of Tactical Level Command managers have completed this essential training and sessions are now being rolled out for Operational Command Level Managers.

4.2 The Resilience Committee have approved a Command Accreditation Scheme so that all managers who are likely to have to manage incidents are accredited to do so by completing a set standard of training and take part in Exercises.

4.3 Following training managers are issued with a portfolio which contains National Occupational standards relating to their role and how they meet those standards. It also allows managers at appraisal sessions to identify training needs and compliance with the standard.

4.4 The team in conjunction with the Communications Team have also provided Emergency media training in two parts so all mangers in charge of an incident can work with the media appropriately. This also includes the use of Social Media in emergencies.

5. Command Support Team

5.1 The Emergency planning Team have set up a Command Support Team allowing those staff with skills but not a primary role to engage in emergency response by supporting the Command Teams in the Hospital Incident Command Centre. This has been popular with the first 12 staff members already completing training.

6. Public Safety and Partnerships

6.1 LHRP

The Trust continues to be represented at the Local Health Resilience Partnership (LHRP) with other parts of the Kent & Medway Health Economy contributing where required.

6.2 LRF

The Trust continues to support the activities of the Kent Local Resilience Forum (LRF) through membership of sub groups and working groups to support multi agency planning, training and response.

6.3 SAG

The trust continues to represent the NHS on local authority safety advisory groups in Sevenoaks District Council, Tonbridge & Malling, Maidstone and Tunbridge Wells Borough Councils. These groups contribute to community safety by screening licensing for large public events allowing the NHS to monitor medical provision and crowd welfare and thus reduce the potential affects to A&E as well as other admission avoidance measures such as recommending on site pharmacy provision or inclement weather precautions. This year has been busy with high profile events such as the Elton John Concert and Social Festival requiring additional planning with colleagues in other agencies.

8.4 Emergency Planning Leads Group

The trust continues to meet and engage with other NHS emergency planning teams across Kent, London and East Sussex. It also remains part the NHS Kent & Medway emergency planning group. It is also an active member of the National Performance Advisory Group for NHS Resilience.

8.5 Railcare

The team has continued to support Railcare Volunteers in their work to provide support to the NHS in a railway incident. These are staff volunteers from the Railway Industry who can respond to hospitals and other locations to assist hospital staff and emergency services in providing support and resources to help those affected.

8.6 **Trauma Network**

Emergency Planning remain a core member of the Trust Trauma Board and also work with the Trauma Network. An excellent relationship with Emergency Planning Staff at Kings College Hospital has led to the establishment of South East London, Kent & Medway Trauma Network Emergency planning Committee which allows the whole network to look at seamless planning and response across the network including London Ambulance Service and South East Coast Ambulance Service along with all the Acute NHS Trusts in the Network.

8.7 **Emergency Services**

The team continue to work closely with both Kent and East Sussex Emergency Services in training, exercising, planning and response. This year with the emergence of MERS in parts of the world the Trust collaborated with Public Health England and South East Coast Ambulance to give additional training to Paramedics to avoid the need for patients to have to go to the Emergency Department for testing.

Additional work has been undertaken with all emergency service partners during the last twelve months to ensure the Trust remains a key player in local resilience planning.

8.8 **Helipad**

The team continue to manage the helipad plan as required under the Department of Health HTM and work with Kent Surrey and Sussex Air Ambulance, RAF, HM Coastguard and other providers such as the Children's Air Ambulance to ensure safe use of the landing points in the trust. This year with the opening of the new HM Coastguard Search & Rescue base at Lydd Airport in Kent the Trust were the first in the South East to engage with them in training of their staff and to familiarise Trust staff including critical care staff, security, Porters and managers with the special arrangements for their helicopters. Since the base has opened both Maidstone and Tunbridge Wells Hospitals have seen them landing and have a very good relationship. The Trust will also be working to provide training for the flight paramedics at Search & Rescue Bases across the South of England next year and working in partnership to train hospital staff in helicopter transfers. The team have worked with our helicopter providers to produce a DVD to highlight the safety procedures during helicopter operations which is available on our You Tube channel.

9. Assurance

9.1 CCG Assessment of Emergency Planning & Response Arrangements

The Commissioning Support Unit audited the Trust against the National Core standards and has reported that the Trust is fully compliant with the standards and has formally reported the same to NHS England and the CCG. The report is enclosed (Appendix 1).

9.2 Following the Attacks in Paris, NHS England wrote to all Trusts asking them for further assurance on a number of elements. This is enclosed at Appendix 2.

10. New Policies

10.1 During the year the team updated or provided new policies for:

- Site Lockdown
- Management of VIP and protected persons
- Emergency Planning Policy
- Flu Pandemic response

12 CBRN/Hazmat Team

12.1 The Trust has had a Chemical, Biological, Radiological and Nuclear (CBRN)/ hazardous materials (Hazmat) team for over twelve years trained to deal with hazardous incidents. Training is on going and the team can respond and work across West Kent. Considerable time is spent ensuring that this team receive quality training and that the approach is safe.

12.2 It is extremely important that the Emergency Departments take time to ensure all ED staff are booked on to the training and that this is planned throughout the year. The Emergency Planning Team will continue to recruit staff from outside the ED and managers are asked to continue to support releasing staff to attend training.

12.3 This year the Trust ran a Kent & Medway wide study day with aim of standardising the approach in the county.

13. Business Continuity

13.1 During the year considerable investment in Business Continuity led to the Estates & Facilities Directorate gaining the ISO standard 22301 in Business Continuity – only the second Trust in the UK to achieve it. This represents a major achievement.

13.2 During the summer the Trust undertook various support to Medway NHS Foundation Trust as part of Operation Indigo while improvements and training were undertaken at that site.

13 Conclusion

13.1 The Trust remains well prepared for emergencies.

13.2 The Board is asked to support the concept that staff must be released for training and attendance at training is regarded as a key priority.

13.3 The Trust remains in strong position but can only maintain this with continued adequate funding and commitment from the Directorate Senior Management teams. Directorates need to ensure that Business Continuity and Resilience is high up on their Directorate Work plans.

NHS

South East
Commissioning Support Unit

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

EPRR Assurance Audit Report

September 2015

SOUTH EAST/CSU

Date	Version	Author	Notes
10.09.15	1	Josh Tarling SECSU	

Contents

Assurance Visit 3
Audit Details 3
Areas investigated 3
Audit Results 4
Audit Narrative 5

Assurance Visit

South East CSU Business Resilience Team conducted a visit to Maidstone and Tunbridge Wells NHS Trust to conduct an audit of their Emergency Planning Response and Recovery (EPRR) preparedness against the NHS England EPRR Core Standards. The purpose of the visit was to enable the trust to provide assurance to their commissioner as to the level of their preparedness

Audit Details	
Date of audit	09 September 2015
Location of Audit	Pembury Hospital
Auditors	Josh Tarling (SECSU) on behalf of West Kent CCG
Provider representatives	John Weeks, Julie Elphick

Areas Investigated

The audit looked for evidence against the cores standards identified by NHS England as being required to be in place by Acute Healthcare Providers. The four investigated areas were:

- EPRR Core Standards
- Pandemic Influenza “deep dive” additional standards
- HazMat/ CBRN Core Standards
- HazMat/ CBRN Equipment Checklist

Audit Results

MTW were able to provide evidence to demonstrate the following rates of compliance:

	Green (full compliance)	Amber (plans to address gaps on annual work programme)	Red (significant gaps with no plans to address)
EPRR Core Standards	33/33	0/33	0/33
Pandemic Flu Deep Dive standards	4/4	0/4	0/4
Hazmat/ CBRN Standards	13/13	0/13	0/13
Hazmat/ CBRN equipment check	32/32	0/32	0/32

Full audit results are appended to this report.

Based on the NHS England levels of assurance below we conclude that Maidstone and Tunbridge Wells NHS Trust meets the requirements for full compliance.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

Audit Narrative

MTW continue to demonstrate among the highest levels of compliance across the providers in Kent. The Commissioner can be assured that the trust has in place all necessary and reasonable measures to respond appropriately to both external major incidents and internal business continuity and service disruptions.

In addition to this assurance process MTW were recently subject to a CQC audit which focused heavily on emergency preparedness. The CQC report identified high levels of competency and staff awareness as well as up to date procedures and extensive training.

The commissioner should also be aware that MTW demonstrates good practice in a number of EPRR related area including;

- Developing Strategic and Tactical hospital commander courses in collaboration with NHS England
- Leading multi-agency work around hospital evacuation
- Providing CBRN training services to other hospital trusts
- On track to achieve ISO 22301 Business Continuity Accreditation for their Estates functions.

	Please provide assurance that:	Assurance Level	Please provide details
All Trusts	You have reviewed and tested your cascade systems to ensure that they can activate support from all staff groups, including doctors in training posts, in a timely manner including in the event of a loss the primary communications system;	Assured	Communications Exercise Carried out on November 11 2015. If primary fails we can use social media and the media to assist. This worked well in the recent cumbria floods.
All Trusts	You have arrangements in place to ensure that staff can still gain access to sites in circumstances where there may be disruption to the transport infrastructure, including public transport where appropriate, in an emergency;	Assured	The Trust will during an incident the Trust will seek assistance from multi agency Partners via NHS Gold to the Strategic Co-ordination Group. The Trust has a staff bus that goes between sites that can help. There are arrangements with multi agency partners at TWH called OPERATION RADIATE & OPERATION WHEEL
All Trusts	Plans are in place to significantly increase critical care capacity and capability over a protracted period of time in response to an incident, including where patients may need to be supported for a period of time prior to transfer for definitive care;	Assured	Plans drawn up in the Flu Pandemic to expand Critical care capacity have been kept up to date.
All Trusts	You have given due consideration as to how the trust can gain specialist advice in relation to the management of a significant number of patients with traumatic blast and ballistic injuries.	Assured	Plans already exist for clinicans to get advice from the Duty major Trauma Consultant via the Trauma Network and Burns & plastics advice from the Burns Network
SECAMB only	Ensure that the Marauding Terrorism and Firearms, Hazardous Area Response Team, Chemical, Biological, Radiological and Nuclear capacity and capability is declared live in Proclus and updated a minimum of every 12 hours.		Not Applicable

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – January 2016

1-17 Oversight Self-Certification, Month 9, 2015/16 Trust Secretary

As the Trust Board did not meet during December, to consider the self-certification for month 8, the certification submitted to the TDA for that month mirrored that for month 7 (i.e. the certification approved by the Board in November 2015). This approach was agreed with the Chairman of the Trust Board and Chief Executive.

The enclosed schedule sets out the proposed oversight self-certification submission for month 9, 2015/16, based on performance as at 31st December. This submission must be sent to the NHS Trust Development Authority (TDA) by the end of January (i.e. by 29th).

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

1. The NHS Provider licence conditions (although NHS Trusts are exempt from the requirement to hold an NHS Provider license); and
2. Board statements

The Trust is not required to provide supporting evidence (as listed in the "Evidence of Trust compliance" columns), and is just required to respond to each statement with "Yes" (i.e. compliant), "No" (i.e. not compliant) or "Risk" (i.e. at risk of non-compliance). If "No" or "Risk" is selected, a commentary on the actions being taken, and a target date for completion (in dd/mm/yyyy format), is required in order for the submission to be made.

The proposed self-assessment (and responses where required) for the latest submission are included in the "Latest assessment – Compliant?" column. The evidence has been refreshed and updated from that reviewed at the October 2015 Board meeting. Additions are highlighted, whilst deletions are shown as ~~struckthrough~~.

There are no changes in compliance status proposed from that agreed by the Trust Board in November 2015.

For completeness, the report also includes details of all License Conditions, including those for which the Trust is exempt (i.e. G1, G2, G3, G9, CoS1 to CoS7, and FT1 to FT4).

Which Committees have reviewed the information prior to Board submission?

- N/A

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

The Board is asked to:

1. Review the evidence presented to support the self-assessment (and amend if required); and
2. Approve the "Latest assessment – Compliant?" status for the forthcoming submission to the TDA

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

Oversight Self Certification – NHS Provider Licence Conditions

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
General Condition 1 (G1 - "Provision of information") This condition contains an obligation for all licensees to provide Monitor with any information they require for their licensing functions	The NHS Trust Development Authority does not require the Trust to submit a compliance position regarding this Condition, as it only applicable to those with NHS Provider licenses (NHS Trusts are exempt from the requirement to hold such a license)	
General Condition 2 (G2 - "Publication of information") This licence condition obliges licensees to publish such information as Monitor may require.	The NHS Trust Development Authority does not require the Trust to submit a compliance position regarding this Condition, as it only applicable to those with NHS Provider licenses (NHS Trusts are exempt from the requirement to hold such a license)	
General Condition 3 (G3 - "Payment of fees to Monitor") The Act gives Monitor the ability to charge fees and this condition obliges licence holders to pay fees to Monitor if requested.	The NHS Trust Development Authority does not require the Trust to submit a compliance position regarding this Condition, as it only applicable to those with NHS Provider licenses (NHS Trusts are exempt from the requirement to hold such a license)	
General Condition 4 (G4 - "Fit and proper persons as Governors and Directors") This licence condition prevents licensees from allowing unfit persons to become or continue as governors or directors (or those performing similar or equivalent functions).	All Trust Directors are "fit and proper" persons; confirmed through appointment process. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were approved by Parliament on 6th November 2014. The Regulations introduced a new requirement that Directors (or equivalent) of health service bodies be "fit and proper persons". Specifically, Directors should not be "unfit", which equates to not being an undischarged bankrupt; not having sequestration awarded in respect of their estate; not being the subject of a bankruptcy restrictions order; not being a person to whom a moratorium period under a debt relief order applies; not having made a composition or arrangement with, or granted a trust deed for, creditors; not being included in the children's barred list or the adults' barred list; and not being prohibited, by or under any enactment, from holding their office or position, or from carrying on any regulated activities[2]. In addition Directors need to be "of good character"[3], and have the health,	Yes

[2] Regulated activities are listed in Schedule 1 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They are: 'Personal care'; 'Accommodation for persons who require nursing or personal care'; 'Accommodation for persons who require treatment for substance misuse'; 'Treatment of disease, disorder or injury'; 'Assessment or medical treatment for persons detained under the Mental Health Act 1983'; 'Surgical procedures'; 'Diagnostic and screening procedures'; 'Management of supply of blood and blood-derived products etc'; 'Transport services, triage and medical advice provided remotely'; 'Maternity and

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
	qualifications, skills and experience to undertake the role. Finally, Directors should not have "been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity…". This latter restriction enables a judgement that a person is not fit to be a Director on the basis of any previous misconduct or incompetence in a previous role for a service provider. This would be the case even if the individual was working in a more junior capacity at that time (or working outside England). The Regulations apply to all Directors and "equivalents", which will include Executive Directors of NHS Trusts and Foundation Trusts. It is the responsibility of the provider and, in the case of NHS bodies, the chair, to ensure that all Directors meet the fitness test and do not meet any of the 'unfit' criteria. The Chair of a provider's board will need to confirm to the CQC that the fitness of all new Directors has been assessed in line with the new regulations; and declare to the CQC in writing that they are satisfied that they are fit and proper individuals for that role. The CQC may also ask the provider to check the fitness of existing Directors and provide the same assurance to them, where concerns about such Director come to the CQC's attention. It is proposed that the process agreed by the Board be formalised by being incorporated into the Trust's Standing Orders, which have been revised to this effect, and will be submitted for ratification to the Trust Board in February 2016. A report on the latest position regarding implementation of the approved approach was ~~has also been~~ submitted to the November 2015 Trust Board meeting.	
General Condition 5 (G5 - "Monitor guidance") This licence condition requires licensees to have regard to any guidance that Monitor issues.	The Trust has due regard to the relevant guidance issued by Monitor, which includes "Approved costing guidance" (which: sets out costing principles and standards, and guidance for both reference costs and PLICS collections for the year; explains the approach to costing and cost collection that Monitor are encouraging providers of NHS services to adopt; tells providers how to comply with the pricing conditions of Monitor's provider licence that relate to recording of costs; and supports the continuous improvement of costing processes in the NHS), and guidance relating to the national tariff (such guidance is often issued jointly with NHS England).	Yes
General Condition 6 (G6 - "Systems for compliance with licence conditions and related obligations)	The NHS Trust Development Authority does not require the Trust to submit a compliance position regarding this Condition, as it only applicable to those with NHS Provider licenses (NHS Trusts are exempt from the requirement to hold such a license)	

midwifery services'; 'Termination of pregnancies'; 'Services in slimming clinics'; 'Nursing care'; and 'Family planning services'. Any provider carrying on any of these activities in England must register with the Care Quality Commission.

[3] In determining whether a Director is "of good character", consideration should be given as to whether the person has been convicted in the UK of any offence; or whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
This licence condition requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements.		
General Condition 7 (G7 - "Registration with the Care Quality Commission") This licence condition requires providers to be registered with the CQC (if required to do so by law) and to notify Monitor if their registration is cancelled.	The Trust has full registration with the CQC. The Trust is registered to deliver the following regulated activities at both main hospital sites: 'Treatment of disease, disorder or injury'; 'Surgical procedures'; 'Diagnostic and screening procedures'; 'Maternity and midwifery services' and 'Family planning'. In addition, the Trust is registered to undertake 'Termination of pregnancies' at Tunbridge Wells Hospital. The Trust has also made a recent application to have the Regulated Activity of "Assessment or medical treatment for persons detained under the Mental Health Act 1983" added to its registration, following a review of the CQC's latest "The scope of registration" guidance (March 2015). The Trust is not a provider of Mental Health services, but sometimes, the Trust's patients are detained under the Mental Health Act (i.e. on the Trust's acute hospital sites), in order for assessment and/or treatment by staff from the local Mental Health Trust (Kent and Medway NHS and Social Care Partnership Trust). It has been noted that other local acute NHS providers have added "Assessment or medical treatment for people detained under the Mental Health Act 1983)" to their Registration, to ensure that the assessment of such patients is covered via their registration, and the Trust wishes to do the same. CQC assessors visited the Trust in October to consider the Trust's application, and in November the CQC confirmed that the application had been accepted. This is therefore now reflected in the Trust's CQC Registration. As noted in the Chief Executive's report that was submitted to the November 2015 Trust Board, the Trust will need to apply to the CQC to have the Crowborough Birthing Centre added to the Trust's list of "Locations" on its CQC Registration. This application has now been made (pending the Trust Board's approval of the transfer, which is scheduled for the January 2016 Board meeting).	Yes
General Condition 8 (G8 - "Patient eligibility and selection criteria") This condition requires licence holders to set transparent eligibility and selection criteria for patients and to apply these in a transparent manner	The Referral and Treatment Criteria (RATC) which apply from 1st April 2015 are published on the West Kent CCG website ("Kent and Medway clinical commissioning groups' (CCGs') schedule of policy statements for health care interventions, and referral and treatment criteria").	Yes
General Condition 9 (G9 - "Application of Section 5 (Continuity of Services)") This condition applies to all licence holders. It sets out the conditions under which a	The NHS Trust Development Authority does not require the Trust to submit a compliance position regarding this Condition, as it only applicable to those with NHS Provider licenses (NHS Trusts are exempt from the requirement to hold such a license)	

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
service will be designated as a Commissioner Requested Service. If a licensee provides any Commissioner Requested Services, all the Continuity of Services Conditions apply to the licence holder.		
Pricing condition 1 (P1 - "Recording of Information") Under this licence condition, Monitor may oblige licensees to record information, particularly information about their costs, in line with guidance to be published by Monitor.	The Trust records information regarding its costs in accordance with Monitor's "Approved costing guidance".	Yes
Pricing condition 2 (P2 - "Provision of information") Having recorded the information in line with Pricing condition 1 above, licensees can then be required to submit this information to Monitor	The Trust submits the relevant information regarding its costs to Monitor, in accordance with Monitor's "Approved costing guidance".	Yes
Pricing condition 3 (P3 - "Assurance report on submissions to Monitor") When collecting information for price setting, it will be important that the information submitted is accurate. This condition allows Monitor to oblige licensees to submit an assurance report confirming that the information they have provided is accurate.	The Trust's methodologies and approaches taken in the compilation of the mandatory submission Reference Cost submission is reviewed and approved by the Finance Committee. The latest approval took place in June 2015. In addition, the Trust has been selected for audit as part of Monitor's 2015/16 Reference Costs Assurance Programme. The audit will be undertaken by PricewaterhouseCoopers LLP (PwC), on behalf of Monitor, and will assess whether the Trust's Reference Cost submissions have been prepared in accordance with Monitor's costing guidance. The audit will take place between October and December 2015. Following completion of the audit, PwC will prepare a draft report for Monitor which will be sent to the Trust to comment on its factual accuracy and to enable the Trust to produce an action plan to address any issues and risks identified. The Audit and Governance Committee will oversee the audit, and the response.	Yes
Pricing condition 4 (P4 - "Compliance with the national tariff") The Health and Social Care Act 2012 requires commissioners to pay providers a price which complies with, or is determined in accordance with, the National Tariff for	The Trust is compliant with the national tariff and where local tariffs are applied, are subject to negotiation and agreement with the CCG/Commissioners.	Yes

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
NHS health care services. This licence condition imposes a similar obligation on licensees, i.e. the obligation to charge for NHS health care services in line with the National Tariff.		
Pricing condition 5 (P5 - "Constructive engagement concerning local tariff modifications") The Act allows for local modifications to prices. This licence condition requires licence holders to engage constructively with commissioners, and to try to reach agreement locally, before applying to Monitor for a modification.	The Trust is compliant with the national tariff and where local tariffs are applied, are subject to negotiation and agreement with the CCG/Commissioners.	Yes
Competition condition 1 (C1 - "Patient choice") This condition protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider. This condition applies wherever patients have a choice of provider under the NHS Constitution, or where a choice has been conferred locally by commissioners.	The Trust complies with the philosophy of patient choice, with regards to choice of provider. The Trust has not taken any actions to inhibit patient choice.	Yes
Competition condition 2 (C2 - "Competition oversight") This condition prevents providers from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users. It also prohibits licensees from engaging in other conduct which has the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	The Trust does not seek to inhibit competition.	Yes
Integrated care condition 1 (C3 - "Provision of integrated care")	The Trust does nothing to inhibit integration and positively advocates it where integration is in the patient's best interests.	Yes

Condition	Evidence of Trust compliance / Commentary	Latest assessment – Compliant?
The Integrated Care Condition applies to all licence holders. The Integrated Care Condition is a broadly defined prohibition: the licensee shall not do anything that could reasonably be regarded as detrimental to enabling integrated care. It also includes a patient interest test. The patient interest test means that the obligations only apply to the extent that they are in the interests of people who use health care services.		
Continuity of Services Conditions (CoS1 to CoS7) The Continuity of Services Conditions allow Monitor to protect and promote patients' interests by ensuring that vital services continue to operate if a provider becomes financially distressed or insolvent.	The NHS Trust Development Authority does not require the Trust to submit a compliance position regarding these Conditions, as they are only applicable to those with NHS Provider licenses (NHS Trusts are exempt from the requirement to hold such a license)	
NHS Foundation Trust Conditions (FT1 to FT4) The NHS foundation trust licence conditions translate the well-established core of Monitor's previous oversight of NHS foundation trust governance into Monitor's licence-based system of regulation.	The NHS Trust Development Authority does not require the Trust to submit a compliance position regarding these Conditions, as they are only applicable to those with NHS Provider licenses (NHS Trusts are exempt from the requirement to hold such a license)	

Oversight Self Certification – Board Statements

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
For clinical quality, that: 1. the Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	▪ The Trust's integrated performance dashboard is reviewed monthly and includes the TDA's "routine quality & governance indicators" ▪ A "~~Clinical~~ Quality & Patient Safety Report" report is submitted to the Trust Board every other meeting ▪ The Quality Committee, and its sub-committees, provides a focus on quality issues arising from Directorates. A summary of each Quality Committee meeting is reported to the Board ▪ The Patient Experience Committee provides a patient	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	perspective and input, and a summary of each Patient Experience Committee meeting is reported to the Board ▪ The Chief Nurse, a Board member, is accountable for quality ▪ There are dedicated complaints and Serious Incidents (SI) management functions ▪ Ongoing conduct of Family and Friends Test is reported through the Trust performance dashboard ▪ Patient stories are heard at Trust Board meetings ▪ Board member visits to wards and departments enable triangulation of quality and other performance indicators. Pairings of NED and Executive Board members, to further promote such visits, have now been issued. Board members also participate in the conduct of Care Assurance Audits ▪ Systems investment (e.g. Q-Pulse, Symbiotix, Dr Foster) supports effective quality information/data management ▪ Quality Accounts have been developed in liaison with stakeholders ▪ Quality Impact Assessments conducted on all CIP initiatives ▪ Priority of patient care reflected in Trust values & embedded in staff appraisal ▪ The Trust has commissioned an external review of "Good Governance and Culture", the findings of which were discussed by the Board in September 2015. It was agreed at the Board meeting the Chief Executive should "Coordinate a considered response to the recommendations arising from the external "Good Governance and Culture Review" (involving the Executive Team and Trust Management Executive), and submit the outcome to the Trust Board". This response ~~is in process (the report was reviewed and discussed at the Trust Management Executive on 18/11/15), and a report is scheduled to be submitted to the Trust Board in December 2015.~~ has been submitted to the January 2016 Trust Board meeting. The final report of the Trust's inspection by the Care Quality Commission in October 2014 was published in February 2015,	

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	and confirms that Trust's overall rating as 'Requires Improvement'. A Quality Improvement Plan has been developed in response, and has been submitted to the CQC. It is monitored via monthly reports to the Trust Management Executive and Trust Board. In October 2015, the CQC published a further "Quality Report" for Maidstone Hospital, following the inspection visit on 30th June 2015. The report confirmed that Maidstone Hospital was now compliant with the warning notice served on 16th November 2014 relating to water quality.	
For clinical quality, that: 2. the board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements	The Trust has full registration with the CQC. The Trust is registered to deliver the following regulated activities at both main hospital sites: 'Treatment of disease, disorder or injury'; 'Surgical procedures'; 'Diagnostic and screening procedures'; 'Maternity and midwifery services'; 'Family planning'; and "Assessment or medical treatment for persons detained under the Mental Health Act 1983". In addition, the Trust is registered to undertake 'Termination of pregnancies' at Tunbridge Wells Hospital. The final report of the Trust's inspection by the Care Quality Commission in October 2014 was published in February 2015, and confirms that Trust's overall rating as 'Requires Improvement'. A Quality Improvement Plan has been developed in response, and has been submitted to the CQC. It is monitored via monthly reports to the Trust Management Executive and Trust Board. In October 2015, the CQC published a further "Quality Report" for Maidstone Hospital, following the inspection visit on 30th June 2015. The report confirmed that Maidstone Hospital was now compliant with the warning notice served on 16th November 2014 relating to water quality. An in-house process to monitor ongoing compliance is in development.	Yes
For clinical quality, that: 3. the board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on	The Medical Director is the responsible officer for medical practitioner revalidation. The May 2015 Trust Board received the 2014/15 Annual Report from the Responsible Officer, and	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
behalf of the trust have met the relevant registration and revalidation requirements.	approved a 'statement of compliance' confirming that the Trust, as a designated body, was in compliance with the regulations governing appraisal and revalidation.	
For finance, that: 4. the board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time	The Trust continues to operate as a going concern, and the 2014/15 financial accounts were prepared on this basis. The External "Audit Findings" report for 2014/15 stated that "We have reviewed the Directors' assessment and are satisfied with managements assessment that the going concern basis is appropriate for the 2014/15 financial statements". The Trust achieved a small surplus in 2014/15, and the Trust Board approved the 2014/15 Accounts in May 2015.	Yes
For governance, that 5. the board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times	The NTDA accountability framework aims to ensure that Trusts have a real focus on the quality of care provided. Under this framework, quality focus is achieved through: (i) Planning – the Trust conducts an annual process of service and budget planning and the Board reviews and agrees the Plan (ii) Oversight – the Trust participates fully in the oversight model (self-certification, review meetings) (iii) Escalation – The Trust welcomes support from the TDA and will cooperate fully with escalation decisions (iv) Development – the Trust will embrace the development model as appropriate (v) Approvals – the Trust is fully engaged in the FT application process and is awaiting dialogue with the TDA on the timetable towards authorisation. Trust values and priorities mirror the TDA's underpinning principles: ▪ local accountability – e.g. liaison with CCGs, Patient Experience Committee, patient satisfaction monitoring, whistleblowing & complaints management ▪ openness and transparency – e.g. embedded in Trust value on respect; duty of candour in Board Code of Conduct; open approach to Public Board meetings (which take place each month) and both external &, internal communications	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	channels; a growing Membership ▪ making better care easy to achieve – the Trust's stated priority, above all things, is the provision of high quality & safe care to patients (Patient First). ▪ an integrated approach to business – the Trust has adopted an integrated governance approach including an integrated performance dashboard.	
For governance, that: 6. all current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.	See 5 above. In addition: ▪ The Trust monitors performance each month in accordance with the TDA Quality and Governance indicators. A Board Assurance Framework and risk register, supported by an overall Risk Management Policy, are established and scrutinised by various Committees ▪ Risks receive regular scrutiny and assurance ▪ Mitigating actions have agreed dates for delivery ▪ An annual Internal Audit plan is agreed and focuses on areas of key risk ▪ A professional Trust Secretary is employed ▪ A dedicated Risk Manager is employed ▪ The Trust fully participates in the TDA Oversight process ▪ The Trust was recently evaluated against the Well-Led Framework via an external Governance Adviser (see Statement 1 above)	Yes
For governance, that: 7. the board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance	See Statement 6 above. In addition: All risks are RAG rated according to severity and likelihood; mitigating actions are monitored and reported. Key risks to the Trust's agreed objectives are reported via the Board Assurance Framework (BAF). The format of the BAF was revised for 2015/16, and was reviewed by the Board in July, September, and November 2015. The BAF is also reviewed by the Audit and Governance Committee and Trust Management Executive.	Yes
For governance, that: 8. the necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating	The Board and its sub-committees are involved in the development of the Trust's annual plans, including specific aspects as required (financial, winter pressures, infection control, health and safety etc.). Key risks to the Trust's agreed	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	objectives are reported via the Board Assurance Framework. The Audit and Governance Committee, like all Board committees, provides a report to the Board following each meeting which is presented by the Committee Chairman (a NED). The Board is fully engaged with the development of the IBP and the Clinical Strategy that underpins it.	
For governance, that: 9. an Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	The Annual Governance Statement 2014/15 was approved by the Trust Board in May 2015.	Yes
For governance, that: 10. the Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward	The Trust Board monitors compliance with existing targets, and actions to address any issues, at each meeting, primarily via the integrated performance report.	Yes
For governance, that: 11. the trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit	The Trust achieved IG toolkit level 2 for 2014/15 against all Requirements. The submission was approved by the Trust Board in March 2015	Yes
For governance, that: 12. the board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.	A Trust Board Code of Conduct is in place which confirms the requirement to comply with the Nolan principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership. A register of Directors' interests is maintained and Board members are invited to declare any interests relevant to the agenda at the beginning of each Board meeting, and each Board sub-committee. The Register of Directors' Interests was refreshed in March/April 2015, and features within the Annual Report for 2014/15, which the Trust Board approved in May 2015. The Trust's revised "Gifts, Hospitality, Sponsorship and Interests Policy and Procedure" (which strengthens the Trust's	Yes

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	processes for monitoring interests) has been submitted to the TME for approval, and has been ~~will be~~ submitted to the Trust Board, for ratification, in ~~December 2015~~ January 2016. All formal Board positions are filled substantively.	
For governance, that: 13. the board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	▪ The Remuneration Committee reviews the performance of Executive Directors. ▪ The TDA conducted a review of the Trust Board in 2013/14 ▪ The Trust continues to adhere to the Oversight process ▪ A proposed approach to the new 'fit and proper persons' Regulations was approved at the December 2014 Trust Board, and implementation has commenced (refer to General Condition 4 above).	Yes
For governance, that: 14. the board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan	▪ All Executive Director (and Clinical Director) positions are filled. ▪ The objectives of Executive Directors cascade from the Trust's corporate objectives which are agreed by the Trust Board.	Yes

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – January 2016

1-18	**Ratification of Gifts, Hospitality, Sponsorship and Interests Policy and Procedure**	**Trust Secretary**

A review of the Trust's existing policies regarding gifts, sponsorship and interests has been undertaken, and the draft revised Policy and Procedure is enclosed, for ratification.

The enclosed Policy will replace the Trust's current "Standards of Conduct Policy and Procedure", and complement the guidance within the Trust's Standing Orders.

In drafting the document, the aim has been to ensure the Policy…

- Is the definitive source of guidance on such matters
- Clarifies exactly what is expected of staff
- Reflects the latest accepted best practice (including the Policies of other acute NHS Trusts)
- Is proportionate
- Is based on a principles approach, but provides instruction where necessary
- Does not introduce any radical new requirements

The initial draft Policy was reviewed at the Audit and Governance Committee in August 2015. Amendments were made, and the Policy was then issued for a full consultation (which included the Local Counter Fraud Specialist, Internal Audit, and all Consultants). The Policy was then reviewed and approved at the Trust Management Executive in November 2015. Ordinarily, the Policy would then be submitted to the Policy Ratification Committee (PRC) for ratification, but when the Finance Committee reviewed the proposed changes to the Standing Financial Instructions, Scheme of Delegation and Standing Orders, in September 2015, it was agreed that the Trust Board should be asked to "ratify" the Policy. When the PRC therefore reviewed the Policy, on 15/01/16, it "recommended the Policy for ratification by the Trust Board".

If the Policy is ratified, the creation of on-line forms will be pursued, to make it easier for staff to complete the required declarations.

Which Committees have reviewed the information prior to Board submission?

- Audit and Governance Committee, 06/08/15
- Trust Management Executive, 18/11/15 (which "approved" the Policy")
- Policy Ratification Committee, 15/01/16 (which "recommended the Policy for ratification by the Trust Board")

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

Ratification

[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

Gifts, Hospitality, Sponsorship and Interests Policy and Procedure

Requested/ Required by:	Department of Health
Main author:	Trust Secretary
Contact details:	kevinrowan@nhs.net
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Document lead:	Director of Finance
Directorate:	Trust Management
Specialty:	Trust Management
Supersedes:	Standards of Conduct Policy and Procedure [Version 3.0: February 2013]
Approved by:	Trust Management Executive, 18th November 2015
Ratified by:	Trust Board, 27th January 2016 (having been reviewed by the Policy Ratification Committee, 15th January 2016)
Review date:	January 2019

Document history

Requirement for document: (*Why is this document necessary?)*	The document sets out the expected behaviour and process to be followed to ensure the Trust complies with the principles within, among other things, the Department of Health Circular HSG (93) 5 (Standards of Business Conduct for NHS Staff); and the Bribery Act 2010.
Cross references: *(List all best practice documents supporting this document)*	Department of Health Circular HSG (93) 5 (Standards of Business Conduct for NHS Staff)
Associated documents: *(List all documents associated with this document)*	This Policy / procedure should be read in accordance with the following Trust policies, procedures and guidance. • Anti Fraud, Bribery and Corruption Policy and Procedure [RWF-OPPPCS-NC-WF48] • Disciplinary Policy and Procedure [RWF-OPPPCS-NC-WF10] • Medical Devices Policy and Procedure [RWF-OPPPCS-NC-EST2] • Medical Staff Leave (Annual Leave and Public Holidays / Study and Professional Leave) Policy and Procedure [RWF-OPPPCS-NC-WF42] • Medicines Policy and Procedure [RWF-OPPPCSS-C-PHAR1] • Policies and procedures for Charitable funds [RWF-OPPCS-NC-TM47] • Reservation of Powers and Scheme of Delegation [RWF-OPPCS-NC-TM21] • Standing Orders [RWF-OPPCS-NC-TM23] • Standing Financial Instructions [RWF-OPPCS-NC-TM22] This Policy / procedure should be read in accordance with the following external documents: • The Blue Guide: Advertising and promotion of medicines in the UK (the Medicines and Healthcare products Regulatory Agency) • Conflicts of interest (Report by the Comptroller and Auditor General, 2015) • Financial and commercial arrangements and conflicts of interest (General Medical Council) • The National Health Service Trusts (Membership and Procedure) Regulations 1990 (and subsequent amendments)

Version Control: *Details of approved versions*		
Issue:	**Description of changes:**	**Date:**
1.0	New Policy which… ▪ replaces the Standards of Conduct Policy and Procedure ▪ clarifies and strengthens the process for monitoring the receipt of gifts, sponsorships and interests ▪ introduces an upper limit (over £25) for the acceptance of gifts ▪ extends the list of Notifiable Interests	November 2015

Policy statement for

Gifts, Hospitality, Sponsorship and Interests Policy

This Policy gives clear direction to all staff (including Non-Executive Directors) on:

- The consideration of offers of gifts, including when declarations are required
- The management of offers of hospitality from external organisations, including when declarations are required
- The management of offers of sponsorship from external organisations, including when declarations are required
- The management, and declaration, of interests, including potential conflicts

Gifts, Hospitality, Sponsorship and Interests Procedure

Contents **Page**

1.0 Introduction, scope and underlying principles 5

2.0 Definitions 7

3.0 Duties 10

4.0 Training / competency requirements 11

5.0 Procedure 12

5.2 Procedures relating to offers of Gifts, Hospitality & related matters 12

5.2 Procedures relating to the declaration of interests 15

5.3 Procedures relating to Sponsorship 16

6.0 Access to the Registers of Interests 17

7.0 Monitoring and audit 17

Appendix One: Process requirements 19

Appendix Two: Consultation table 20

Appendix Three: Equality Impact Assessment 21

Further Appendices

Appendix Four: Gifts, Hospitality and Sponsorship Form 22

Appendix Five: Declaration of Officers' Interests Form 22

Appendix Six: Declaration of Trust Board Members' Interests Form 22

Appendix Seven: Examples of specific issues that may arise, and associated guidance 22

Appendix Eight: Flowcharts to assist in decision-making 22

Appendix Nine: The Nolan Committee's seven principles of public life 22

1.0 Introduction, scope and underlying principles

1.1 Introduction

There may be occasions when Trust staff (including Non-Executive Directors) are offered gifts, hospitality or sponsorship.

Staff may also hold interests which could, or appear to, conflict with those of the Trust.

It is important that the management of these circumstances adheres to the framework established by this Policy, to protect individual employees, and the Trust as a whole, from allegations of fraud and/or corruption; and to reduce the risk of legal challenge of decisions made by the Trust (if a decision-maker has a conflict of interest then the decision is potentially vulnerable and could be overturned on Judicial Review[1]).

It is an offence under the Bribery Act 2010[2] for an employee to corruptly accept any reward or inducement for doing, or refraining from doing, anything, in his or her official capacity, or corruptly showing favour, or disfavour to any organisation or person.

The Trust has a zero tolerance of bribery and corruption. Breaches of this Policy will be investigated according to the Disciplinary Policy and Procedure, and disciplinary action, including dismissal, may be taken.

The relevant declarations should be made to the Trust Secretary, as outlined below.

1.2 Scope and exclusions

The Policy applies to all employees and workers including Bank and temporary staff. The Policy also applies to the Trust's Non-Executive Directors.

This Policy does not cover:

- The provision of hospitality by the Trust; or
- Payment/s to a member of staff that amounts to remuneration for the delivery of a service, e.g. receiving a fee for providing a lecture
- Conflicts of interest relating to the clinical care and treatment of individual patients. Guidance on such conflicts is available from professional bodies (including the General Medical Council)

In addition, the Policy does not generally apply to conflicts of interests held by non-staff (i.e. external) personnel undertaking consultancy work for the Trust.

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[1] Article 6 of the European Convention on Human Rights and Articles 41 and 47 of the EU Charter of Fundamental Rights enshrine the principle that decisions should be made free from actual and apparent bias

[2] The Bribery Act 2010 contains 2 general criminal offences that apply to individuals, covering the offering, promising or giving of a bribe (active bribery) and the requesting, agreeing to receive or accepting of a bribe (passive bribery). The Act also sets out two further offences which specifically address commercial bribery. One of these (a so-called 'section 7' offence) creates a form of corporate liability for failing to prevent bribery on behalf of a commercial organisation (which includes NHS organisations).

However, any potential conflicts of interest should be identified during the decision to engage (by the person engaging that consultant). If the consultant is engaged, all potential conflicts of interest should be explicitly declared in any reports issued by the consultant.

1.3 Underlying principles

Public sector bodies, which include the NHS, must be impartial and honest in the conduct of their business, and their employees should remain beyond suspicion. This is a key tent of the Nolan Committee's seven principles of public life (see Appendix Nine [RWF-XXXXXXX]). In keeping with this, the following underlying principles are paramount:

1. Staff must not encourage patients (or their friends or relatives) to give, lend or bequeath money or gifts or make donations that will, or appear to, directly or indirectly be of benefit to them

2. Staff must decline gifts and/or hospitality of any kind which might reasonably be perceived to…
   a. compromise their personal judgment or integrity
   b. be an abuse of trust
   c. exert undue influence
   d. obtain preferential consideration
   e. bring their own professional reputation, or the reputation of the Trust, into disrepute
   f. result in them or the Trust receiving adverse publicity and/or public criticism

3. Staff must ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties. Conflicts of interest are not confined to financial interests, and may also include other personal interests

2.0 Definitions

Benefit:	Extra money or other non-monetary compensation that is received in addition to salary
Bequest:	A legacy, a thing left by a person in their last Will
Bribery:	The practice by which a person who can take a decision or action on behalf of others by virtue of their authority or position is influenced by paying or offering monetary benefits for influencing them to take an action or decision which they would not have done otherwise
Business conduct:	The standards of behaviour expected when involved in commercial or business activity in the name of the Trust
Cash:	Currency, coins, postal orders, cheques
Direct cash equivalents:	"Stored value" products (such as gift certificates / cards / vouchers) whose value can be guaranteed to match that of the funds (i.e. cash) used to pay for the product
Conflict of interest:	A set of circumstances that creates a risk that an individual's ability to apply judgement or act in one role is, or could be, impaired or influenced by a secondary interest. A conflict can occur in any situation where an individual or organisation can exploit a professional or official role for personal or other benefit. Often the perception of conflict alone is enough to cause concern

Discount: A reduction in the usual price of something

Gift: Something that is given to somebody from an individual (i.e. not an organisation), usually in order to provide pleasure or to show gratitude

For ease of reference, "Gift" will be used throughout this document to refer to a "gift", "benefit", and/or "gratuity"

"Gifts" also include those left via a patient's bequest

Gratuity: A small gift, usually given to somebody as a token of thanks

Hospitality: The business of entertaining existing or potential clients, conference delegates, or other officials. Hospitality is by definition offered on behalf of an organisation and includes a broad spectrum of activities, including:

- Food and/or drink
- Costs associated with meetings (including meeting room hire)
- Entertainment
- Attendance at training events / conferences
- Hotel and transport costs (including trips abroad)
- Expense paid trips etc.

In some circumstances the terms "Hospitality" and "Sponsorship" may be used interchangeably. This is not problematic, but for the purposes of distinction, "Hospitality" should be regarded as the item being offered, whilst "Sponsorship" should describe the funding associated with such "Hospitality". In this sense, an employee may be in receipt of funding (i.e. "Sponsorship") to attend a conference (which represents the "Hospitality")

Inducement: A thing that persuades or leads someone to do something

Lavish or excessive: Hospitality and/or Sponsorship that would not be regarded as normal and reasonable in the circumstances, or would not be similar to the scale of hospitality which the Trust as an employer would be likely to offer

Lottery tickets These are "stored value" products whose value cannot be guaranteed to match that of the funds used to pay for the product (i.e. so that the value could exceed the value paid, by potentially significant amounts). This would include tickets for entry into lottery competitions (e.g. the National Lottery, local lotteries, and other nationwide lottery schemes), lottery 'scratchcards' and raffle tickets.

Non-Executive Director: A member of the Trust Board who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1(3) of the Membership and Procedure Regulations. All non-Executive Directors have voting rights at the Trust Board, but Non-Executive Director posts are public appointments and not jobs and are therefore not subject to the provisions of employment law. For the purposes of this Policy, "Non-Executive Director" includes "Associate Non-Executive Directors" (refer to the Trust's Standing Orders for further details)

Non-Trust premises Premises other than those operated by, booked by, and/or funded by, the Trust

Notifiable Interest: Any interest that is held by Trust staff that meets the criteria for inclusion on the Trust's Register of Interests. Specifically the interests that are required to be declared are those which are "relevant and material" i.e.:

a. Directorships, including Non-Executive Directorships held in private companies or Public Limited Companies (PLCs) (with the exception of those of dormant companies)
b. Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c. Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS
d. A position of authority in an organisation in the field of health and social care (i.e. separate to any position held at the Trust)
e. Any connection with an organisation that could be viewed as a direct competitor to the Trust in the field of health and social care
f. Any connection with a voluntary or other organisation contracting for NHS services (this would include being a minority shareholder in such organisations)
g. Research funding/grants that may be received by an individual or their department
h. Interests in pooled funds that are under separate management
i. Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks
j. Appointment to a public office which may result in the individual's association with the Trust being made public. This could include, for example, election to a Parish Council
k. Political affiliation which may result in the individual's association with the Trust being made public. This could include, for example, being a spokesperson for a political party

The influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest.

Officer: An employee of the Trust or any other person holding a paid appointment or office with the Trust.

Pecuniary interest Interests relating to or consisting of money. Subject to the exceptions set out in the Trust's Standing Orders, a person shall be treated as having an indirect pecuniary interest in a contract if:
a) he/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or
b) he/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same

Sponsorship: The provision of funding, or a non-fee service from an external (i.e. non-Trust) source. Sponsorship covers a broad spectrum of activities, such as providing all or part of the costs of employing a member of staff, NHS research, equipment, the provision of non-fee services (speakers, buildings, premises etc.); attendance at training events / conferences; Hotel and transport costs (including trips abroad) etc.

In some circumstances the terms "Hospitality" and "Sponsorship" may be used interchangeably. This is not problematic, but for the purposes of distinction, "Hospitality" should be regarded as the item being offered, whilst "Sponsorship" should describe the funding associated with such "Hospitality". In this sense, an employee may be in receipt of funding (i.e. "Sponsorship") to attend a conference (which represents the "Hospitality")

Staff: Persons employed by the Trust, including those employed part-time, full-time, on substantive terms, on temporary terms (including 'interims'). For the purposes of this Policy, the term "staff" includes Non-Executive Directors

Supplier An organisation that provides, or could provide in the future, a service to

	the Trust under contract. This includes Pharmaceutical companies.
Trust Board Member	An individual regarded as being a member of the Trust Board. The influence (or potential influence) exerted by the individual is the key determinant, rather than their ability to vote at Board meetings. Trust Board members are those that are expected to be at each Board meeting (and sit at the Board table), and contribute fully to each agenda item. For those currently regarded as Trust Board Members, please refer to the Standing Orders
Trust premises	Premises operated by, booked by, and/or funded by, the Trust

3.0 Duties

All employees (and Non-Executive Directors):

- To be impartial and honest in the conduct of their official business
- To ensure they do not use their official position for personal gain or advantage, whether directly or indirectly (i.e. through any private business or other interests)
- To consider, when gifts are offered, whether they can be received without contravening this Policy
- To seek appropriate advice and guidance before accepting any gifts that they may be offered (if in any doubt)
- To politely decline any personal offers of cash, regardless of value, and to formally declare such offers (by completing the "Gifts, Hospitality and Sponsorship Form" – See Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet)
- To ensure that any personal offers of non-cash gifts over £25 are politely declined, and formally declared (by completing the "Gifts, Hospitality and Sponsorship Form" – See Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet)
- To declare any "Notifiable Interest", using the "Declaration of Officers' Interests Form" (See Appendix Five, and also on the Trust's Intranet)
- To carefully consider the implications of accepting any offers of Hospitality that takes place on Non-Trust premises
- To formally declare any offers of Hospitality to take place on Non-Trust premises (by completing the "Gifts, Hospitality and Sponsorship Form" – See Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet)
- To carefully consider the implication of accepting offers of Sponsorship
- To ensure that any offers of Sponsorship are formally declared(by completing the "Gifts, Hospitality and Sponsorship Form" – See Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet)
- To declare any "Notifiable Interest" that they hold
- To ensure that they remove themselves from any decision-making process that is, or could be perceived to be, related to any "Notifiable Interest" that they hold
- To report any instances of bribery, or suspected bribery, to their line manager

N.B. Any member of staff who believes that any colleague/s may have been offered gifts, hospitality or sponsorship that is eligible to be declared; or hold notifiable interests, but which has not been declared, should raise their concerns with the Trust Secretary in the first instance (for advice).

Line Managers:

- To ensure their staff are aware of this Policy and when they need to make a declaration of the offer of a Gift, Hospitality, Sponsorship, or the existence of a "Notifiable Interest"
- To be aware of the "Notifiable Interests" held by their staff
- To investigate any breaches of this Policy

- To respond to any reports of bribery, or suspected bribery in accordance with the Trust's Anti Fraud, Bribery and Corruption Policy and Procedure

General Managers:
- To consider and authorise any offers to fund entire posts via external Sponsorship

Medical Education department:
- To provide the Trust Secretary with details of any requests for Study Leave made in accordance with the Trust's Medical Staff Leave Policy and Procedure where it has been confirmed that external funding/sponsorship has been provided

Trust-employed organisers of on-site Hospitality funded via external Sponsorship:
- To consider whether on-site Hospitality could, in the judgement of any reasonable person, be considered lavish or excessive; and if so, declare any lavish or excessive on-site Hospitality using the Trust's "Gifts, Hospitality and Sponsorship Form" (See Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet)

Consultants requesting addition of new medicines to the Trust's Formulary:
- To formally declare any interests they may have in the new medicine, using the "Request form for the addition of a new drug to the Trust formulary" (available from the Trust's Pharmacy Department)

Staff requesting the introduction of new medical devices:
- To adhere to the Trust's Procurement processes (further details can be obtained from the Procurement Department)
- To ensure compliance with the Trust's Medical Devices Policy and Procedure

All Trust Board Members (in addition to the duties for 'All employees'):
- To abide by the Code of Conduct for NHS Boards (see Appendix Ten [RWF-XXXXXXX])

Trust Secretary:
- To maintain the "Register of Gifts, Hospitality and Sponsorship", and provide appropriate reports on the register
- To maintain the "Register of Board Members' Interests", and provide appropriate reports on the register
- To maintain the "Register of Officers' Interests", and provide appropriate reports on the register
- To provide reports on declarations made to the Audit and Governance Committee (for Gifts, Hospitality and Sponsorship) and Trust Board (for Interests)
- To issue a twice-yearly reminder to staff regarding the need to make the declarations referred to in this Policy (see below)
- To coordinate the processes for the annual staff declarations required by this Policy
- To review details of any requests for Study Leave made in accordance with the Trust's Medical Staff Leave Policy and Procedure where it has been confirmed that external Sponsorship has been provided, to ensure that a declaration of such Sponsorship has been made
- To consider any requests for exceptional circumstances, in accordance with this Policy

4.0 Training / competency requirements

This Policy and Procedure is considered to be a reference document. Staff need to be aware of its existence, but should consult its content as and when required. For this reason, it is not considered that formal training is needed. However, the Trust Secretary is available to respond to any queries regarding the Policy.

The Policy will be made available on the Trust's Intranet. In addition, the Trust Secretary will arrange for an 'all users' email to be issued on two occasions during the year:

1. In early December (ahead of Christmas, at which there is likely to be an increase in the offer of Gifts and Hospitality); and
2. At the start of each financial year (in April)

The email will remind staff of the existence of the Policy, and of the need to make appropriate declarations.

5.0 Procedure

5.1 Procedures relating to offers of Gifts, Hospitality & related matters

5.1.1 Gifts

a. Staff must not, under any circumstances, accept gifts of cash offered to them personally, regardless of the value involved. If such gifts are offered, staff should ask those making the offer if they would instead like to make a donation to the appropriate charitable fund. For advice on this, staff should contact the Financial Services Department (or refer to the Policies and procedures for Charitable funds)

b. If gifts of cash are made via non-personal means (e.g. via the post), efforts should be made (by the person to whom the gift was offered) to contact the person making the gift, to politely explain that the cash cannot be accepted, and either make arrangements for the money to be returned (ideally in person, or if this is not possible, via recorded postal delivery), or to seek the consent for the money to be donated to the Maidstone and Tunbridge Wells NHS Trust Charitable Fund. If efforts to contact the person are unsuccessful, the money should be donated to the Maidstone and Tunbridge Wells NHS Trust Charitable Fund

c. Any offers of cash (regardless of value) should be declared to the Trust by the intended recipient, via completion of the "Gifts, Hospitality and Sponsorship Form" (see Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet)

d. It is acceptable for offers of gifts of cash to Wards/Departments to be regarded as a donation to the relevant designated charitable fund. For advice on this, staff should contact the Financial Services Department (or refer to the Policies and procedures for Charitable funds)

e. Staff may accept non-cash gifts offered to them personally, provided they are not (nor appear to be) valued at above £25. Generally, such offers do not need to be declared (though certain exceptions apply – see h. and i. below)

f. All offers of non-cash gifts above the value of £25 must be politely declined, and declared to the Trust, via completion of the "Gifts, Hospitality and Sponsorship Form" (see Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet). This Form should be submitted within 10 working days of the offer. It is the offer that is being declared

g. If staff are genuinely unaware of the value of any offers of gifts, they should make a reasonable assessment, and seek the advice of their line manager. The Trust Secretary is also able to advise in the event of any uncertainty

h. If several gifts below the value of £25 are offered from the same (or related) sources within a 12-month period, the offer of such gifts should be politely declined at the point that the £25 threshold is exceeded. At that point, the offer should also be declared, via the

"Gifts, Hospitality and Sponsorship Form" (see Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet). This step has been included to protect staff from appearing to be taking advantage of the £25 threshold, by accepting several gifts that are below this amount individually, but which over a period of time, may equate to a greater amount

i. If gifts below the £25 threshold are offered to different staff members (individually) from the same source, at the same time, and the collective value of such gifts exceeds the £25 threshold, such staff members are free to accept the offer, but a single declaration should be made, via the "Gifts, Hospitality and Sponsorship Form" (see Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet) that covers the collective value of the offers and the intended recipients. The Manager of the Staff is responsible for ensuring the declaration is made

j. If an offer of a non-cash gift/s above the value of £25 is made to a Ward/Department as a whole i.e. with the intention of the gift being received by more than one individual, the decision whether to accept the gift should be made by the Ward Manager/Head of Department. The decision should take into account whether the Gift is lavish or excessive, and also whether the acceptance accords with the underlying principles in section 1.3. The £25 threshold for individual gift acceptance should also be used to inform the decision. In any case, the offer should be declared by the Ward Manager/Head of Department, via completion of the "Gifts, Hospitality and Sponsorship Form" (see Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet)

k. Offers of "direct cash equivalents" can be accepted, providing the value does not exceed £25. If the value is £25 or below, the offer can be accepted, and does not need to be declared. If the value is above £25, the offer should be politely declined, and declared by the intended recipient, via completion of the "Gifts, Hospitality and Sponsorship Form" (see Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet)

l. Offers of Lottery tickets should be politely declined, and declared by the intended recipient, via completion of the "Gifts, Hospitality and Sponsorship Form" (see Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet). If such offers are made via non-personal means (e.g. via the post), efforts should be made to contact the person making the offer, to politely explain that the gift cannot be accepted, and make arrangements for the tickets to be returned (ideally in person, or if this is not possible, via recorded postal delivery). If efforts to contact the person are unsuccessful, the lottery tickets should be provided to the Trust Finance Department. Any winnings arising from the tickets will be donated to the Maidstone and Tunbridge Wells NHS Trust Charitable Fund. N.B. To guard against accusations of fraud, the Finance Department will photograph the ticket/s on receipt (to record the serial numbers), and for lottery scratchcards, two members of the Department will undertake to 'scratch' the cards in each other's' presence.

5.1.2 Hospitality

a. As a general principle, staff should not accept any offers of individual items from a Supplier. Staff may however accept Gratuities (small

gifts) without formal declaration. Such Gratuities may include items such as calendars, diaries, pens and other stationery

b. If Suppliers offer hospitality on Non-Trust premises and staff have a legitimate reason to attend in a professional capacity, such hospitality can be accepted, provided the acceptance accords with the underlying principles listed in section 1.3. Recipients of such offers should make it clear that such acceptance would not influence any future decision regarding the continued or future engagement of the Supplier. Recipients of such offers must also complete and submit the Trust's "Gifts, Hospitality and Sponsorship Form" (see Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet). This Form should be submitted within 10 working days of the receipt of such hospitality
c. Hospitality provided via Sponsorship on Trust premises does not need to be routinely declared, as, in general, such Hospitality would not be considered lavish or excessive. However, if such Hospitality could, in the judgement of any reasonable person, be considered lavish or excessive, the organiser of such Hospitality must make a declaration, using the "Trust's Gifts, Hospitality and Sponsorship Form" (see Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet). This Form should be submitted within 10 working days of the receipt of such hospitality
d. The acceptance of any goods or services offered from Suppliers on a trial basis, for no payment, should be declared, via the "Trust's Gifts, Hospitality and Sponsorship Form" (see Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet). Acceptance of such goods or services must not lead to the circumvention of, or prejudice to, the proper completion of the Trust's procurement processes
e. Visits to supplier's premises involving overnight accommodation and travel, as part of a product research or evaluation should generally be at the Trust's expense

5.1.3 Discounts from local or national businesses

a. Trust staff are free to accept any discount offered by a local or national business that is available to them because of their employment either within the NHS, or because of their employment by the Trust, providing that a) such discounts are available to all Trust employees, and b) the acceptance of such discounts accords with the underlying principles listed in section 1.3. The offer and use of such discounts does not need to be declared
b. The Trust's allowance of the acceptance of discounts should not be used as a way of circumventing the processes in relation to the acceptance of Gifts and Hospitality, outlined above. For example, individual staff members would not be expected to accept a Supplier's offer of a 99.9% discount on a large value item. Adherence to the underlying principles stated in section 1.3 of this Policy should always be expected

5.1.4 Trade or discount schemes

a. Offers of trade or discount schemes, by which personal benefit is obtained from the Trust's purchase of goods or services at a reduced price are should be politely declined and/or returned to the sender
b. The exceptions to this are benefits negotiated by the Trust for use by its staff (for which the above guidance relating to "Discounts from local or national businesses" applies)

5.1.5 Awards or prizes

a. If staff are offered an award or prize from an external agency in connection with their official duties, they will be allowed to accept it in the Trust's name, provided that:
   - The offer has been made as a result of personal (or team) achievement related to the staff members' expected duties; and
   - The acceptance accords with the principles listed in section 1.3

5.1.6 Gifts bequeathed in patients' wills

a. Staff must not encourage patients to bequeath money or gifts in their Wills
b. It is however recognised that patients may wish to make such bequeaths, and if undertaken via the correct legal procedures (the Will's executors will determine the legality of the will, and seek to resolve any contested bequeaths), staff would be free to accept these, providing that such acceptance does not conflict with the underlying principles stated in section 1.3 of this Policy
c. Any staff that are aware that they will be the beneficiary of such bequests should declare this (regardless of the value of the bequest), using the Trust's "Gifts, Hospitality and Sponsorship Form" (see Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet). Such declarations should be made as soon as the Staff member becomes aware of the bequest (this may be before the patient's death)
d. Such declarations are not required for patients who are related to staff members

5.1.7 Exceptional circumstances

a. If any member of staff feels there are exceptional circumstances why an offer prohibited by this Policy should be accepted, then full supporting details should be provided on the "Trust's Gifts, Hospitality and Sponsorship Form" (see Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet) before acceptance. The completed form should be forwarded to the Trust Secretary, who will discuss the matter with the Director of Finance, and will confirm in writing if approval to accept the offer is to be given

5.1.8 Annual reminder to declare gifts, hospitality and sponsorship

a. Staff are expected to declare relevant offers of Gifts, Hospitality and Sponsorship within 10 working days of such offers being made. However, as an aide memoire to staff that have omitted to make relevant declarations within the year, senior managerial and clinical staff will be invited to make an annual declaration of any gifts, hospitality and sponsorship received in-year. This declaration process will be organised by the Trust Secretary
b. A positive nil-declaration is not required, and it will be assumed that staff that have not submitted an annual declaration by the required deadline do not have any relevant declarations to make
c. Staff who have omitted to make in-year declarations may be contacted by the Trust Secretary to ascertain the reason/s for such omission. Any issues of concern will be discussed with the Trust's Director of Finance

Appendix Seven provides examples of issues that may arise, with associated guidance. Appendix Eight provides some flowcharts to assist in decision-making.

5.2 Procedures relating to the declaration of interests

The Trust needs to be made aware of all cases where an employee, or his or her close relative or associate, has a controlling and/or significant financial interest in a business (including a private company, public sector organisation, other NHS employer and/or voluntary organisation), or in any other activity or pursuit, which may compete for an NHS contract to supply either goods or services to the employing authority.

All Trust staff should therefore declare such interests, on starting employment and/or on acquisition of the interest. The interests that are "Notifiable" and that should be declared are outlined in the 'definitions' section above.

A nil declaration is not required by staff, but Trust Board Members are required to make a positive declaration on appointment, and annually thereafter, even if no interests are held. The Form at Appendix Six should be used for this purpose.

5.2.1 Annual reminder to staff declare interests

a. Staff are expected to declare relevant interests on appointment, or at the point they arise. However, as an aide memoire to staff that have omitted to make relevant declarations within the year, senior managerial and clinical staff will be invited to make an annual declaration of any, such interests. This declaration process will be organised by the Trust Secretary
b. A positive nil-declaration is not required, and it will be assumed that staff that have not submitted an annual declaration by the required deadline do not have any interests to declare
c. This assumption does not apply to Trust Board Members, who are required to complete a declaration even if no interests are held

5.2.2 Annual refresh of Trust Board Members' interests

a. Trust Board Members are also expected to declare relevant interests on appointment, or at the point they arise. However, a formal refresh of Trust Board Members' Interests will be undertaken annually, at the end of each financial year. This process will be organised by the Trust Secretary
b. An annual declaration is required even if no interests are held

5.2.3 Declaration of interests in relation to requests for new medicines

a. If a Consultant wishes for a new medicine to be added to the Trust's Formulary, a specific declaration of any interests in the new medicine must be made
b. This declaration should be made using the "Request form for the addition of a new drug to the Trust formulary", which is available from the Trust's Pharmacy Department. Such interests will be considered by the Drugs and Therapeutics Committee in deciding whether to approve the new medicine
c. The Drugs and Therapeutics Committee will also ensure that any relevant interests are declared at each meeting of the Committee

5.2.4 Declaration of interests in relation to requests for new medical devices

a. Medical devices are expected to be introduced following adherence to the Trust's procurement processes, which includes the declaration of relevant interests. Further details can be obtained from the Procurement Department
b. All newly delivered medical equipment even those given free of charge must comply with standards for use of new equipment outlined in the Trust's Medical Devices Policy and Procedure

5.2.5 Declaration of interests at the start of meetings

a. The Trust Board and its sub-committees will invite those present at its meetings "To declare interests relevant to agenda items" at the start of proceedings
b. Such declarations should be made verbally, to enable these to be formally recorded in the minutes of the meeting
c. The Chairman of the meeting should determine whether any declarations made require the individual to be excluded from the Committee's proceedings

Appendix Seven provides examples of issues that may arise, with associated guidance. Appendix Eight provides some flowcharts to assist in decision-making.

5.3 Procedures relating to Sponsorship

Offers of Sponsorship are acceptable, but only when:

a. There is an obvious and genuine benefit to a department and/or the Trust as a whole (the benefit can be related to education, training or research and development, for example); and
b. Impartiality can be assured i.e. there are no genuine or perceived incentives or expectations to prescribe or use more of any particular treatment or product as a result of the Sponsorship; and
c. There is no indication that the Sponsorship offered differs significantly from that offered to other individuals or organisations

Acceptance of such Sponsorship must not lead to the circumvention of, or prejudice to, the proper completion of the Trust's Procurement processes.

The procedure for declaring Sponsorship is the same as that for Gifts, and all offers must be declared by completing the "Trust's Gifts, Hospitality and Sponsorship Form" (See Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet).

5.3.1 Sponsorship of entire posts

a. The Trust recognises that it may receive offers for entire posts (i.e. employed positions) to be funded via external organisations. Such offers may be connected to particular research trials, and may be funded by Pharmaceutical and/or medical equipment companies. Such offers are acceptable, provided they do not lead to conflict with the underlying principles stated in section 1.3 of the Policy, and provided that impartiality can be assured. Specifically, the following arrangements should be in place:
    - All such arrangements should be declared, using the "Gifts, Hospitality and Sponsorship Form" (See Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet)
    - There should be no incentive or expectation to prescribe or use more of any particular treatment or product other than in

accordance with the peer-reviewed and mutually agreed protocol for the specific research intended
- The Offer to fund the post should be considered and authorised by the General Manager (or equivalent) for the area concerned

Appendix Seven provides examples of issues that may arise, with associated guidance. Appendix Eight provides some flowcharts to assist in decision-making.

6.0 Access to the Registers of Interests

6.1 Trust Board Members

- The Register of Board Members' Interests is available to staff and members of the public, on request from the Trust Secretary
- Trust Board Members' declared interests will be published in the Trust's Annual Report. The interests to be published will be those declared at the end of the relevant financial year

6.2 Officers

- The Trust Board will be notified of the interests declared by Officers, via an annual report from the Trust Secretary
- Officers are entitled to see the declarations they have made which are recorded in the Register of Officers' Interests
- The content of declarations made by Officers may be shared with members of Trust staff that are involved in the award of contracts to suppliers, to ensure that the staff members holding the declared interests are prohibited from being involved in the decision-making process

7.0 Monitoring and audit

The Policy will be monitored via the following methods:

- The Trust Secretary will submit a report of "Gifts, hospitality and sponsorship declared" to the Audit and Governance Committee (at a frequency determined by the Committee)
- The Trust Secretary will submit a report to the Trust Board once a year of the interests declared by Officers
- The Trust Secretary will submit a report to the Trust Board once a year of the interests declared by Trust Board Members
- The Trust Secretary will review details of any requests for Study Leave made in accordance with the Trust's Medical Staff Leave Policy and Procedure where it has been confirmed that external Sponsorship has been provided, to ensure that a declaration of such Sponsorship has been made

APPENDIX ONE

1.0 Implementation and awareness

The Policy will be implemented via the Trust Secretary, and be incorporated into the forward planning of the Audit and Governance Committee and Trust Board.

- Once ratified the author will submit this policy/procedural document to the Clinical Governance Assistant who will activate it on the Trust document management database on the intranet, under “Policies & Q-Pulse”.
- A monthly publications table is produced by the Clinical Governance Assistant which is published on the Trust intranet under “Policies”; 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.
- In addition, the Trust Secretary will make efforts to promote the existence of the Policy among all staff (particularly Consultants)

2.0 Review

The Policy will be reviewed every three years, or as and when changes are required (e.g. due to external requirements, including changes in legislation).

3.0 Archiving

The Trust intranet retains all superseded files in an archive directory in order to maintain document history.

APPENDIX TWO

CONSULTATION ON: Gifts, hospitality, sponsorship and interests policy and procedure
Please return comments to: *Kevin Rowan, Trust Secretary (kevinrowan@nhs.net)*
By date: 30/09/15

Job title: *List staff to be included in the consultation. See Section 5.5 of the "Production, Approval and Implementation of Policies and Procedures" policy and procedure for guidance.*	**Date sent dd/mm/yy**	**Date reply received**	**Modification suggested? Y/N**	**Modification made? Y/N**
The following staff MUST be included in ALL consultations:				
Local Counter Fraud Specialist	28/08/15			
Clinical Governance Assistant	28/08/15	16/09/15	Y	Y
Chief Pharmacist	28/08/15			
Please list key staff whose reply is compulsory before approval can be granted:				
Chief Executive	27/07/15 & 28/08/15			
Director of Finance	27/07/15 & 28/08/15			
Chief Operating Officer	27/07/15 & 28/08/15			
Director of Workforce and Communications	27/07/15 & 28/08/15			
Deputy Chief Executive	27/07/15 & 28/08/15			
Chief Nurse	27/07/15 & 28/08/15			
Medical Director	27/07/15 & 28/08/15	02/09/15	N	N/A
Director of Infection Prevention and Control	27/07/15 & 28/08/15			
Deputy Director of Finance (Financial Governance)	27/07/15 & 28/08/15			
Head of Financial Services	27/07/15 & 28/08/15			
Director of Medical Education	28/08/15	01/09/15	N	N/A
Chair of Finance Committee	28/08/15	01/09/15	Y	Y
Other Non-Executive Directors	28/08/15			
Please list other staff to be included in the consultation but whose reply is not compulsory:				
Senior Managers	28/08/15			
Consultants	28/08/15			
Joint Consultative Forum				
Audit and Governance Committee	06/08/15			
The following staff have consented to include their name in the policy and appendices:				
Kevin Rowan (Trust Secretary)	28/08/15			
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Title of policy or practice	Gifts, hospitality, sponsorship and interests policy and procedure
What are the aims of the policy or practice?	To give clear guidance to all Staff on the acceptance of gifts, benefits, gratuities and hospitality; and outlines the circumstances when gifts, gratuities, benefits and/or hospitality may be accepted or must be declined, when a declaration must be made
Identify the data and research used to assist the analysis and assessment	
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no). If yes give details.**
Males or Females	**No**
People of different ages	**No**
People of different ethnic groups	**No**
People of different religious beliefs	**No**
People who do not speak English as a first language	**No**
People who have a physical disability	**No**
People who have a mental disability	**No**
Women who are pregnant or on maternity leave	**No**
Single parent families	**No**
People with different sexual orientations	**No**
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	**No**
People in deprived areas and people from different socio-economic groups	**No**
Asylum seekers and refugees	**No**
Prisoners and people confined to closed institutions, community offenders	**No**
Carers	**No**
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	
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 Three of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust polices, procedures and leaflets'.

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 (Trust policies, procedures and leaflets):

No.	Title	Unique ID
Appendix Four	Gifts, Hospitality and Sponsorship Form	[RWF-XXXXXXX]
Appendix Five	Declaration of Officers' Interests form	[RWF-XXXXXXX]
Appendix Six	Declaration of Trust Board Members' Interests Form	[RWF-XXXXXXX]
Appendix Seven	Examples of issues that may arise, and associated guidance	[RWF-XXXXXXX]
Appendix Eight	Flowcharts to assist in decision-making	[RWF-XXXXXXX]
Appendix Nine	The Nolan Committee's seven principles of public life	[RWF-XXXXXXX]
Appendix Ten	Code of Conduct for NHS Boards	[RWF-XXXXXXX]

Gifts, hospitality and sponsorship form

Name:	
Job title	
Extension / bleep no.:	
Department / Directorate:	
Please give details of the Gift / Hospitality / Sponsorship offered:	
Who gave the Gift / Hospitality / Sponsorship? (please state the name and address, if known)	
Please outline the reason/s for the Gift / Hospitality / Sponsorship:	
Amount / value:	

Have you accepted or declined the offer?	Accepted ☐	Declined ☐

This form should be submitted within 10 working days of the offer of any gifts, hospitality or sponsorship.

When completed, please return this form to:
The Trust Secretary, Trust Management Office, Maidstone Hospital

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Please note, an electronic version of this form is available on the Intranet, at www.tbc.nhs.uk

Maidstone and Tunbridge Wells NHS
NHS Trust

Declaration of officers' interests form

Name:	
Job title	
Extension / bleep no.:	
Department / Directorate:	

I confirm I have the following notifiable [1] interests which may conflict or impact on my role as an Officer [2] of Maidstone and Tunbridge Wells NHS Trust.

When completed, please return this form to:
The Trust Secretary, Trust Management Office, Maidstone Hospital

Please note, an electronic version of this form is available on the Intranet, at www.tbc.nhs.uk

[1] Interests which should be regarded as "relevant and material" are: a) Directorships including Non-Executive Directorships held in private companies or Public Limited Companies (with the exception of those of dormant companies); b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS; c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS; d) A position of authority in an organisation in the field of health and social care (i.e. separate to any position held at the Trust); e) Any connection with an organisation that could be viewed as a direct competitor to the Trust in the field of health and social care; f) Any connection with a voluntary or other organisation contracting for NHS services (this would include being a minority shareholder in such organisations); g) Research funding/grants that may be received by an individual or their department; h) Interests in pooled funds that are under separate management; i) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks; j) Appointment to a public office which may result in the individual's association with the Trust being made public; k) Political affiliation which may result in the individual's association with the Trust being made public. This could include, for example, being a spokesperson for a political party.

[2] An 'officer' is an employee of the Trust or any other person holding a paid appointment or office with the Trust.

Maidstone and Tunbridge Wells NHS
NHS Trust

Declaration of Trust Board Members' Interests Form

Name:	

Job title	

I confirm I have the following notifiable [1] interests which may conflict or impact on my role as a Trust Board Member at Maidstone and Tunbridge Wells NHS Trust (if none, please state "None").

Date:

Signed:

When completed, please return this form to:
The Trust Secretary, Trust Management Office, Maidstone Hospital

[1] Interests should include a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies); b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS; c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS; d) A position of Authority in a charity or voluntary organisation in the field of health and social care; e) Any connection with an organisation that could be viewed as a direct competitor to the Trust in the field of health and social care; f) Any connection with a voluntary or other organisation contracting for NHS services; g) Research funding/grants that may be received by an individual or their department; h) Interests in pooled funds that are under separate management; i) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks; j) Appointment to a public office which may result in the individual's association with the Trust being made public; k) Political affiliation which may result in the individual's association with the Trust being made public.

Examples of specific issues that may arise, and associated guidance

Issue / Situation	Guidance
A Supplier offers to provide training for Trust staff	▪ The offer is acceptable, providing the training covers practices expected of its staff by the Trust. ▪ The details of the training should be declared using the "Gifts, Hospitality and Sponsorship Form" (See Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet) ▪ Staff should not be expected to alter their own activity to accord with the suppliers' wishes, if these do not accord with those of the Trust. ▪ Acceptance of the offer should not impact on any future decisions regarding the Suppliers products or services
A manufacturer of ostomy equipment offers to sponsor the funding of a Stoma Nurse post in the Trust	▪ The offer is acceptable provided… o it does not require the Stoma Nurse to recommend the sponsor's products in preference to other clinically appropriate appliances o it does not require the Trust to recommend patients to use a particular dispensing service or withhold information about other products o accepting the offer does not compromise (or appear to compromise) the Trust's impartiality in relation to current or future equipment purchases ▪ The offer needs to be considered and authorised by a General Manager (or equivalent)
A manufacturer of a particular type of Nicotine Replacement Therapy offers to provide their product at a reduced rate to the Trust	▪ This arrangement is acceptable provided that there is a clear clinical view that these products are appropriate to particular patients and there is no obligation to also prescribe these products to other patients for whom an alternative product would be at least as beneficial. ▪ The offer should be declared using the "Gifts, Hospitality and Sponsorship Form" (See Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet)
A pharmaceutical company offers to provide 'starter packs' at a discounted price	▪ This offer is acceptable, but should be declared using the "Gifts, Hospitality and Sponsorship Form" (See Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet) ▪ Subsequent prescribing should not be influenced by the provision of such 'starter packs'.
A catering company offers to provide discounted products to Trust employees	▪ The offer is acceptable, provided the same offer is available to all Trust employees. ▪ The offer does not need to be declared
A patient offers £20 cash to a Nurse who	▪ The offer should be politely declined, and the person making the offer should be asked if they would instead like to make a

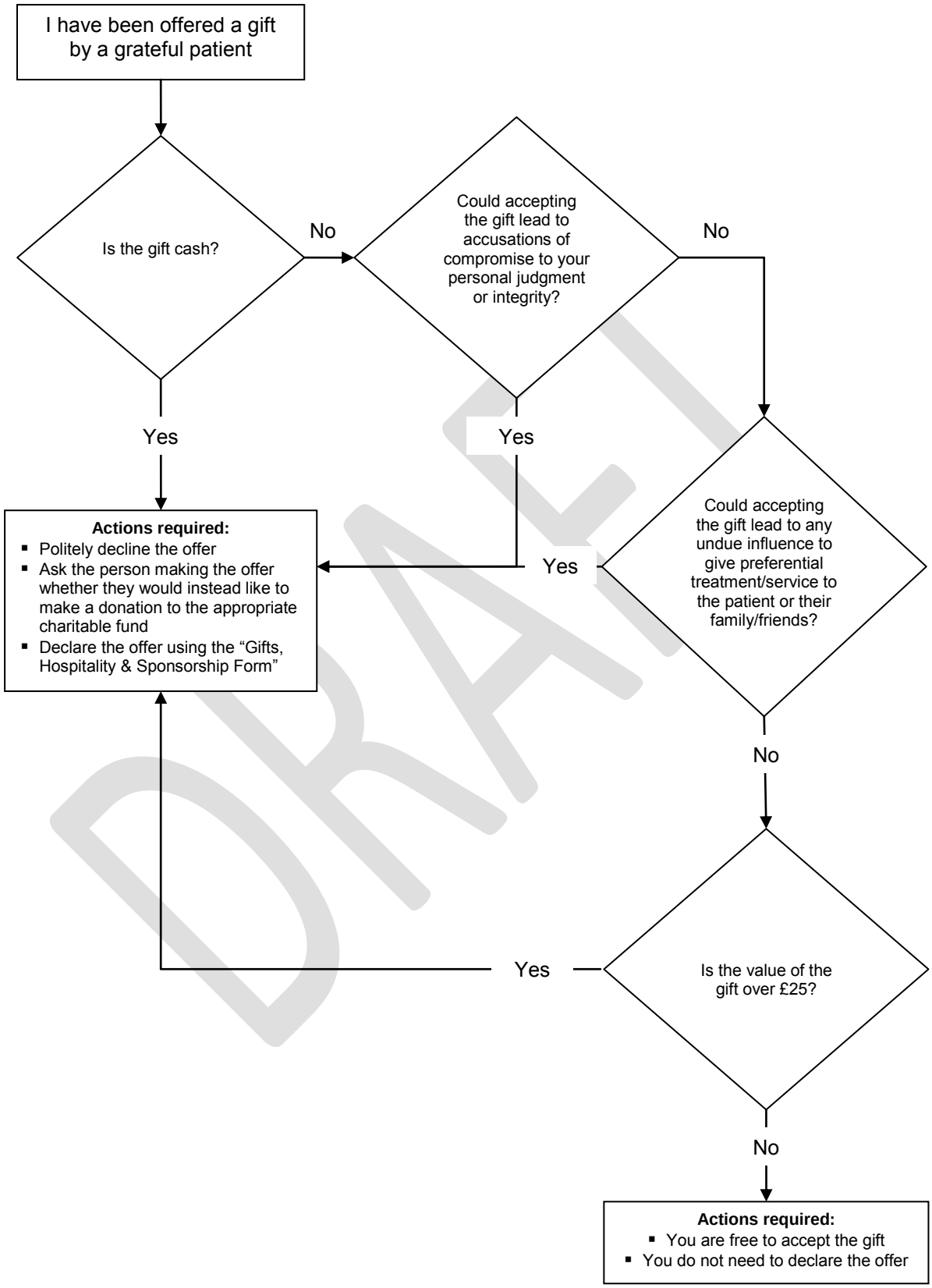
Issue / Situation	Guidance
has cared for him/her whilst he/she has been an inpatient	donation to the appropriate charitable fund. Staff should contact the Financial Services Department (or refer to the Policies and procedures for Charitable funds) for further advice ▪ The offer should be declared using the "Gifts, Hospitality and Sponsorship Form" (See Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet)
A patient offers a watch, believed to be worth £50, to a Clinical Support Worker (CSW) who has cared for him/her whilst he/she has been an inpatient	▪ The offer should be politely declined, as this exceeds the £25 threshold allowed by the Trust ▪ The offer should be declared using the "Gifts, Hospitality and Sponsorship Form" (See Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet)
A patient sends £25 in cash in an envelope to a doctor who has cared for her whilst she has been an inpatient	▪ Efforts should be made to contact the patient, to politely explain that the money cannot be accepted, and either make arrangements for the money to be returned to the patient, or seek the patient's consent for the money to be donated to the Maidstone and Tunbridge Wells NHS Trust Charitable Fund; ▪ The offer should be declared using the "Gifts, Hospitality and Sponsorship Form" (See Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet); ▪ If the patient is insistent, they should be politely informed that the money will be donated to the Maidstone and Tunbridge Wells NHS Trust Charitable Fund
A patient sends a £25 gift card / voucher to a Clinical Support Worker who has cared for him/her whilst he/she has been an inpatient	▪ The gift can be accepted ▪ The gift does not need to be declared, as it is not above £25
A patient offers a £10 gift card / voucher to a Clinical Support Worker (who has cared for him/her whilst he/she has been an inpatient) 11 months after they have offered a £20 gift to the same Clinical Support Worker	▪ The offer of the second gift should be politely declined, as this would mean the staff member has exceeded £25 threshold allowed by the Trust during a 12 month period ▪ The offer of the second gift should also be declared, via the "Gifts, Hospitality and Sponsorship Form" (see Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet), and the form should explain the circumstances i.e. that although the individual offer is below the £25 threshold, it exceeds the threshold when combined with a previous gift
A patient offers 3 members of staff individuals gifts of £10 each, and at least one staff member is aware of the offers	▪ The staff members are free to accept the gifts ▪ As the collective value of such gifts exceeds the £25 threshold, a single declaration should be made, via the "Gifts, Hospitality and Sponsorship Form" (see Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet) that covers the collective value of the offers.

Issue / Situation	Guidance
A pharmaceutical company offers to fund a Consultant to attend a conference in Madrid	▪ This arrangement is acceptable provided that… o There is an obvious and genuine benefit to a department and/or the Trust as a whole in the Consultant's attendance; and o There is no obligation to prescribe the company's products as a result o There is no indication that the Sponsorship offered differs significantly from that offered to other individuals o Acceptance does not conflict with the underlying principles stated in Section 1.3 of this Policy ▪ The offer should be declared using the "Gifts, Hospitality and Sponsorship Form" (See Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet)
A pharmaceutical company offers to pay for catering for an educational event being held at one of the Trust's hospitals	▪ The offer is acceptable provided that… o There is no obligation to prescribe the company's products; and o Acceptance does not conflict with the underlying principles stated in Section 1.3 of this Policy ▪ The offer does not need to be declared, unless it is felt that, in the judgement of any reasonable person, such hospitality could be considered lavish or excessive (in which case the organiser of the event should make a declaration, using the "Gifts, Hospitality and Sponsorship Form" (See Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet).
A Consultant owns some shares in a pharmaceutical company	▪ The ownership of the shares should be declared, using the "Declaration of Officers' Interests Form" (even though minority shareholders will not generally have influence over a company's activities, they would likely benefit from any business such companies would receive from NHS clients)
An employee has been elected as a local Parish Councillor	▪ The appointments should be declared, using the "Declaration of Officers' Interests Form"
An employee has shares in a Limited Liability Partnership (LLP) that provides independent sector (i.e. non-NHS) healthcare	▪ The ownership of the shares should be declared, using the "Declaration of Officers' Interests Form"
A Consultant undertakes private practice for a non-NHS organisation (under an employer-employee relationship)	▪ Consideration should be given as to whether the private practice is covered under the notifiable interest of "Any connection with an organisation that could be viewed as a direct competitor to the Trust in the field of health and social care"; and/or "Any connection with a voluntary or other organisation contracting for NHS services (this would include

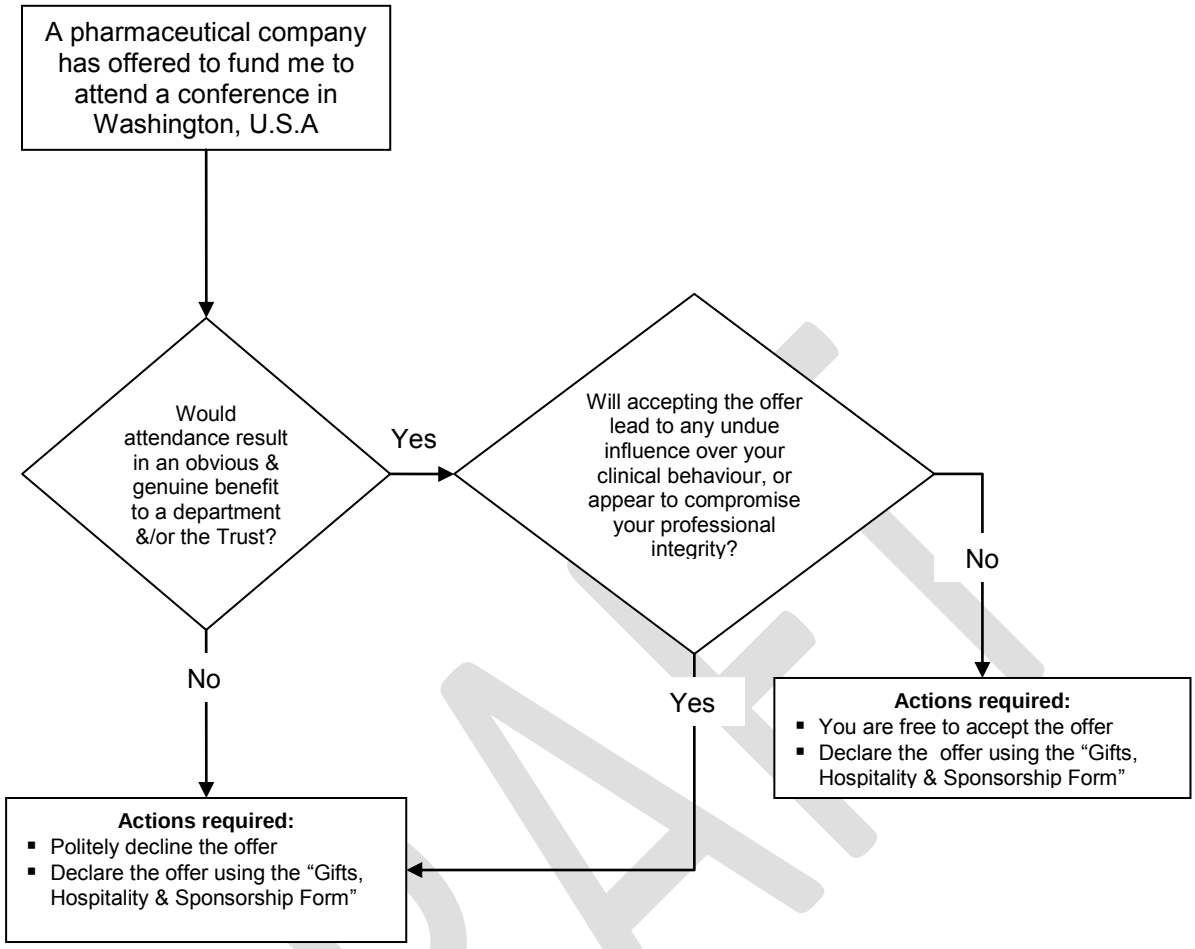
Issue / Situation	Guidance
	being a minority shareholder in such organisations)". ▪ If the private practice is considered to be covered, the employer-employee relationship should be declared, using the "Declaration of Officers' Interests Form" ▪ If there is any doubt, the advice would always be to make a declaration.
A grateful patient gives 40 National Lottery tickets to a Ward Manager, to distribute to all the Nurses on the Ward	▪ The offer should be politely declined, and declared by the intended recipient, via completion of the "Gifts, Hospitality and Sponsorship Form" (see Appendix Four [RWF-XXXXXXX], and also on the Trust's Intranet). ▪ If the offer is made via non-personal means (e.g. via the post), efforts should be made to contact the person making the offer, to politely explain that the gift cannot be accepted, and make arrangements for the tickets to be returned (ideally in person, or if this is not possible, via recorded postal delivery). ▪ If efforts to contact the person are unsuccessful, the lottery tickets should be provided to the Trust Finance Department. Any winnings arising from the tickets will be donated to the Maidstone and Tunbridge Wells NHS Trust Charitable Fund. N.B. To guard against accusations of fraud, the Finance Department will photograph the ticket/s on receipt (to record the serial numbers), and for lottery scratchcards, two members of the Department will undertake to 'scratch' the cards in each other's' presence.

Flowcharts to assist in decision-making

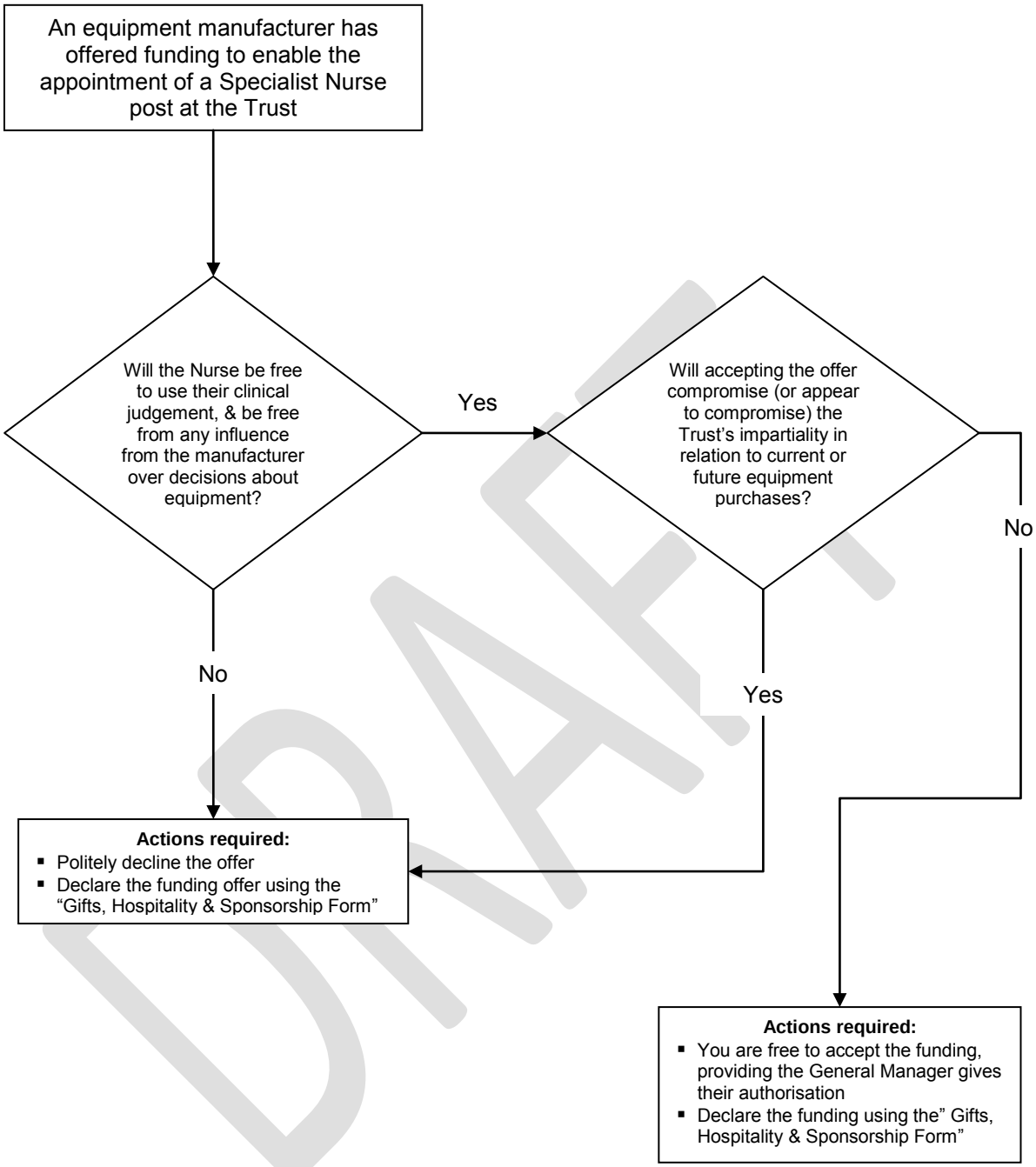
Flowchart 1: Gifts



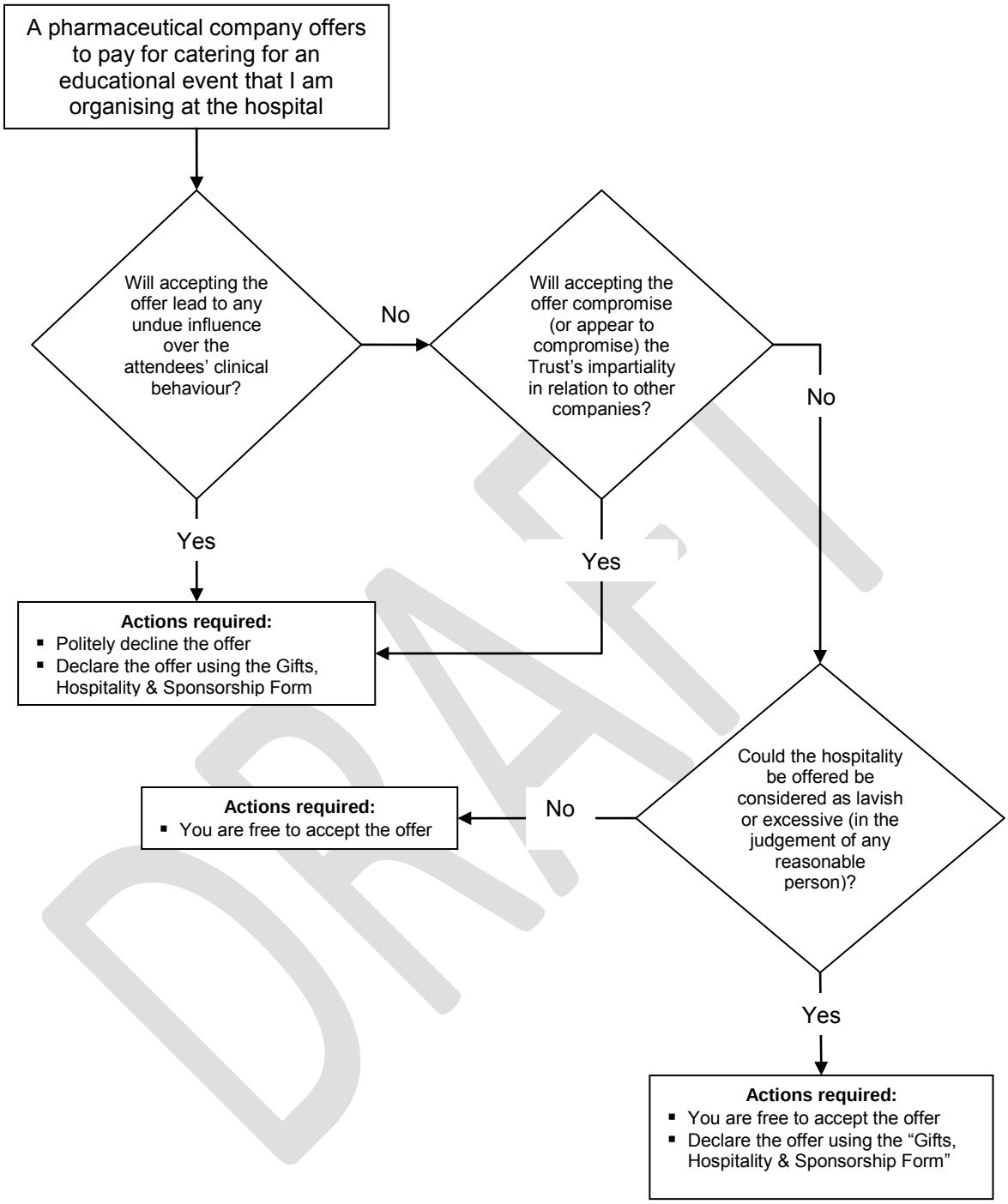
Flowchart 2: Sponsorship (to attend a conference / event)



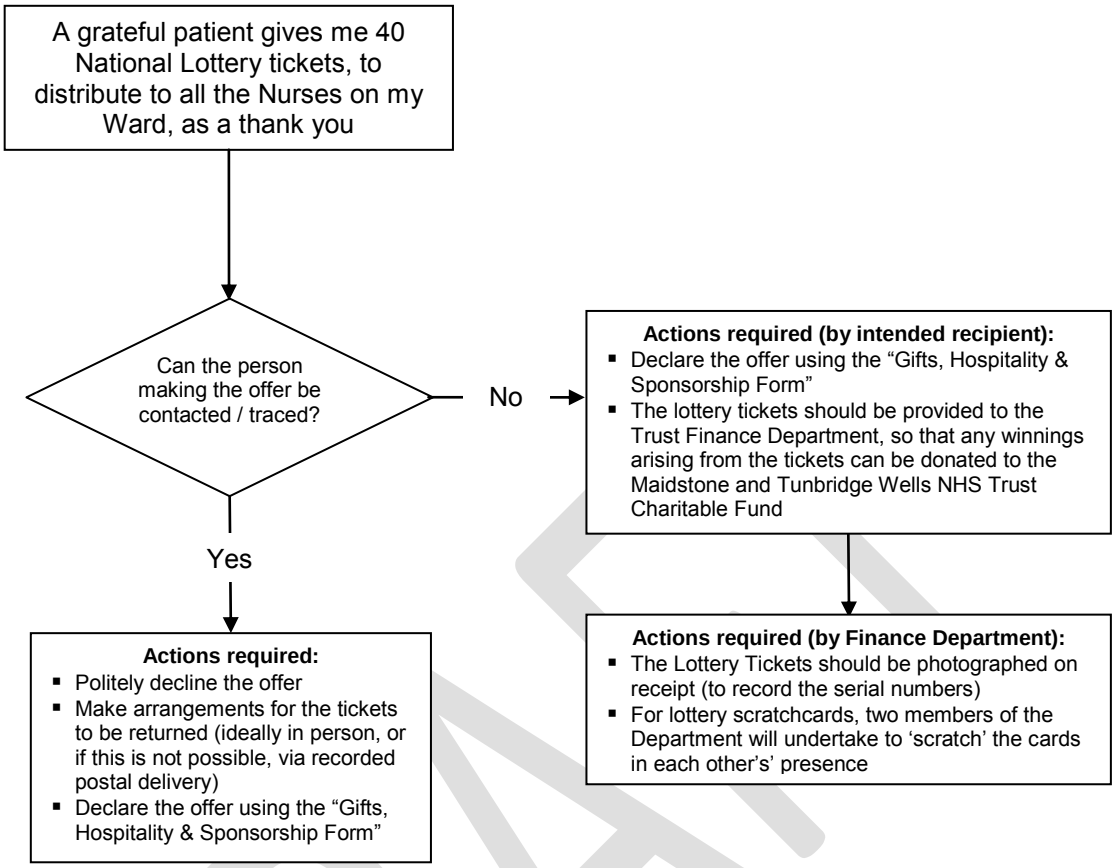
Flowchart 3: Sponsorship (to fund a post)



Flowchart 4: Sponsorship (event catering)



Flowchart 5: Lottery tickets



The Nolan Committee's seven principles of public life

The Trust endorses the principles set out by the Nolan Committee for those who serve the public. These principles shall apply to all Trust staff.

Selflessness

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness

Holders of public office should be as open as possible about all the decisions and action that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

Holders of public office should promote and support these principles by leadership and example.

Code of Conduct for NHS Boards

GUIDING PRINCIPLE IN THE CONDUCT OF PUBLIC BUSINESS

1.1 **Public Service Values.** Public service values must be at the heart of the National Health Service. High standards of corporate and personal conduct, based on recognition that patients come first, have been a requirement throughout the NHS since its inception. Moreover, since the NHS is publicly funded, it must be accountable to Parliament for the services it provides and for the effective and economical use of taxpayers' money.

1.2 **General Principles**. Public service values matter in the NHS and those who work in it have a duty to conduct NHS business with probity. They have a responsibility to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

The success of this Code depends on a vigorous and visible example from Boards and the consequential influence on the behaviour of all those who work within the organisation. Boards have a clear responsibility for corporate standards of conduct and acceptance of the Code should inform and govern the decisions and conduct of all Board members.

1.3 **Public Business and Private Gain**. No one should use their public position to further their private interests.

Where there is a potential for private interests to be material and relevant to NHS business, the relevant interests should be declared and entered into a register, which is available to the public.

1.4 **Hospitality and Other Expenditure**. The use of NHS monies for hospitality and entertainment, including hospitality at conferences or seminars, should be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector.

1.5 **Relations with Suppliers**. Suppliers should be selected on the basis of quality, suitability, reliability and value for money.

1.6 **Staff.** NHS Boards should ensure that staff have a proper and widely publicised procedure for voicing complaints or concerns about misadministration, breaches of this Code and other concerns of an ethical nature. The Board and non-executive directors in particular must establish a climate that enables staff to have confidence in the fairness and impartiality of procedures for registering their concerns.

1.7 **Compliance**. Board members should satisfy themselves that the actions of the Board and its members in conducting Board business fully reflect the values in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon. All Board members of NHS Authorities and Trusts are required, on appointment, to subscribe to the Code of Conduct.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – January 2016

1-19 Reservation Of Powers And Scheme Of Delegation (Revised) Trust Secretary

The Trust's Reservation of Powers and Scheme of Delegation are due their routine (annual) review, following which a number of changes are proposed.

The proposed changes primarily reflect those that have already been proposed as part of the revised Standing Orders and Standing Financial Instructions (SFIs). All three documents were reviewed and approved at the Audit and Governance Committee on 04/11/15. The SFIs were then ratified[1] at the Trust Board on 25/11/15, and the Standing Orders are scheduled to be ratified at the Board in February 2016.

Any de facto changes in practice that were not reflected in the existing document have also been included (for example, in the approval of complaints and disciplinary procedures).

The proposed changes are 'tracked' in the enclosed document.

Which Committees have reviewed the information prior to Board submission?

- Audit and Governance Committee, 06/08/15 (first revised draft) & 04/11/15 (at which the revised document was approved)

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

Ratification

[1] In accordance with the Trust's process for dealing with Trust-wide Policies, all such documents are subject to a two-stage ratification process. The first stage is "approval", whilst the final stage is "ratification". Ordinarily, "ratification" would be undertaken by the Trust's Policy Ratification Committee, but for certain documents, ratification is more appropriately undertake by the Trust Board. As the Standing Orders, Scheme of Delegation and Standing Financial Instructions in effect form the Trust's 'constitutional' documents, the Trust Board is asked to ratify these.

[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

Maidstone and Tunbridge Wells NHS
NHS Trust

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Reservation of Powers and Scheme of Delegation

Requested/ Required by:	Trust Board
Main author:	Trust Secretary
	Contact Details: 01622 228 698
Other contributors:	Consultation list contributors (Appendix Two)
Document lead:	Director of Finance
Supersedes:	Reservation of Powers and Scheme of Delegation (with effect from September 2013)
Reviewed by:	Audit and Governance Committee, 6th August 2015
Approved by:	Audit and Governance Committee, 4th November 2015
Ratified by:	Trust Board, 27th January 2016
Review date:	January 2017

With Effect from January 2016

Document history

Requirement for document:

- Code of Conduct / Code of Accountability in the ~~for~~ NHS ~~Boards~~ (NHS Appointments Commission / Department of Health)
  ~~Trust (Functions) Directions 2000 issued by the Secretary of State~~

Cross References / Associated Documents:

- Standing Financial Instructions [RWF-OPPCS-NC-TM22]
- Standing Orders [RWF-OPPCS-NC-TM23]
- Cash management procedures / GBS Mandate
- Medicines Policy and Procedure [RWF-OPPPCSS-C-PHAR1]
- Medical Devices ~~and Equipment~~ Policy and Procedure [RWF-OPPPCS-NC-EST2]
- DoH Losses and compensations guidance
- ~~Fraud Policy~~Anti Fraud, Bribery and Corruption Policy and Procedure [RWF-OPPPCS-NC-WF48]
- ~~Response Plan~~
- ~~Whistle Blowing Policy~~Speak Out Safely (SOS) Policy and Procedure (formerly Whistle Blowing) [RWF-OPPPCS-NC-WF33]
- Research and Development Policies (MANY)
- Security Policy
- Patient Property Policy [RWF-OPPPCS-NC-NUR1]
- Patient Transport Policy
- DoH HTCS regulations
- ~~Code of Conduct Policy~~
- Board of Directors Code of Conduct ~~Policy~~
- Human Resources Policies and Guidelines (MANY)
- Mobile Phone policy and procedure [RWF-OWP-PP-COR-NC-HI5]
- BNF and NICE Guidance
- DoH Commercial sponsorship – ethical standards in the NHS guidance
- ~~Complaints Procedure~~Policy and Procedure for Management of Concerns and Complaints [RWF-OPPPCS-NC-CG31]
- Infection Control Policy
- Patient Access Policy
- Data Protection Act 1998
- Freedom of Information Act 2000
- Freedom of Information Policy

Version Control:

Issue:	Description of changes:	Date:
0.0	Scheme of Delegation (with effect from 1 April 2008)	February 2008
1.0	Scheme of Delegation (with effect from 1 April 2009)	March 2009
2.0	Scheme of Delegation (with effect from 1 April 2010)	March 2010
3.0	Scheme of Delegation (with effect from 1 April 2011)	March 2011
3.1	Scheme of Delegation (with effect from July 2012)	July 2012
3.2	Scheme of Delegation (with effect from September 2013)	Sept 2013
3.3	Added note to front page (November 2014)	November 2014
3.4		March 2015
4.0	Revised to ensure synchronicity with the revised Standing Orders and Standing Financial Instructions (including standardised terminology)	January 2016

Contents Page

1.0 Reservation of powers to the Board of Directors and delegation of powers 5
2.0 Functions which are reserved for decision by the Board 6
3.0 Scheme of Delegation
3.1 Planning and budgetory control 9
3.2 Banking and gbs accounts 10
3.3 Non pay revenue and capital expenditure 11
3.4 Setting of fees and charges 15
3.5 Engagement of staff not on the establishment 16
3.6 Charitable funds 16
3.7 Agreements licences (property only) 17
3.8 Condemning and disposal 17
3.9 Losses, writeoffs and compensation 17
3.10 Reporting incidents to local counter fraud service 19
3.11 Reporting incidents to the police 19
3.12 Petty cash disbursements 20
3.13 Gifts and rewards 20
3.14 Implementation of audit recommendations 21
3.15 Maintain and update financial policies 21
3.16 Workforce and pay 21
3.17 Authorisation of new drugs 26
3.18 Authorisation of sponsorship deals 26
3.19 Authorisation of research and development projects 26
3.20 Authorisation of clinical trials 26
3.21 Insurance policies and risk management 26
3.22 Multi user clinical products review 26
3.23 Patients and relatives complaints 26
3.24 Relationship with press 26
3.25 Infectious diseases and notifiable outbreaks 27
3.26 Extended role activities 27
3.27 Patient services 27
3.28 Facilities for staff not employed by the trust to gain practical experience or undertake remunerated work on Trust premises 28

3.29 Fire regulations 28
3.30 Health and Safety 28
3.31 Review of medicines inspectorate regulation 28
3.32 Environmental regulations 29
3.33 Review of Trust's compliance with the Data Protection Act 29
3.34 Monitor proposals for contractual arrangements between the Trust and outside bodies 29
3.35 Review the Trust's compliance with Access to Records Act 29
3.36 Review the Trust's compliance with Code of Practice for handling confidential information 29
3.37 Declaration of interests register 29
3.38 Hospitality register 29
3.39 Trust seal 29
3.40 Retention of records 30
3.41 Clinical governance 30
3.42 Serious ~~untoward~~ Incident reporting 30
3.43 Management of medical devices 30
3.44 Review of partnerships 30
3.45 Freedom of Information 30
4.0 Glossary of terms and abbreviations 31

Appendices

Appendix 1: Process Requirements 33
1.0 Implementation and Awareness 33
2.0 Review 33
3.0 Archiving 33
Appendix 2: Consultation 34
Appendix 3: Equality Impact Assessment 35

1.0 Reservation of powers to the Board of Directors and delegation of powers

1.1 Introduction

The Code of Accountability for NHS Boards requires the Board of Directors to draw up a schedule of decisions reserved to the Trust Board only and to ensure that management arrangements are in place to enable the clear delegation of its other responsibilities.

This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation, including financial limits and approval thresholds. However, the Board of Directors remains accountable for all of its functions, including those, which have been delegated and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

All powers of the Trust, which have not been retained as reserved by the Board of Directors or delegated to a Board sub-cCommittee, shall be exercised on behalf of the Board of Directors by the Chief Executive. The Scheme of Delegation identifies any functions, which the Chief Executive shall perform personally and those delegated to other Ddirectors or Oofficers. All powers delegated by the Chief Executive can be reassumed by him/her should the need arise.

Caution over the Use of Delegated Powers.

Powers are delegated to Ddirectors and Oofficers on the understanding that they would not exercise delegated powers in a matter which in their judgement was likely to be a cause for public concern.

Absence of Director or Officer to whom Powers have been delegated.

In the absence of a Ddirector or Oofficer to whom powers have been delegated, those powers shall be exercised by that Ddirector's or Oofficer's superior, unless alternative arrangements have been approved by the Trust Board. If the Chief Executive is absent, powers delegated to him/her may be exercised by the Chairman of the Trust Board, after taking appropriate advice from the Director of Finance.

References to Eexecutive Ddirectors within thisese documents include all Eexecutive Ddirectors who attend the Board including those without voting rights.

2.0 Functions which are reserved for decision by the Trust Board

2.1 General Enabling Provision

The Trust Board may determine any matter it wishes, in full session, within its statutory powers.

2.2 Regulation and Controls

- Approval, suspension, variation or amendment of Standing Orders, schedule of matters reserved to the Trust Board and Standing Financial Instructions for the regulation of its proceedings and business.
- Approval of Reservation of Powers and Scheme of Delegation and from the Trust Board to Oofficers.
- Requiring and receiving the declaration of Trust Board Membersdirectors' interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration.
- Requiring and receiving the declarations of interests from Oofficers, which may conflict with those of the Trust.?
- Disciplining Directors who are in breach of Statutory Requirements or Standing Orders.
- ~~Approval of the disciplinary procedure for officers of the Trust.~~
- ~~Approval of the arrangements for dealing with complaints.~~
- Adoption of the corporate organiszational structure of the Trust and to agree any modification there to. For clarity this would comprise details of the structure of the Board and its sub-committees and the Directorate structure of the Trust. —Organisational structures below Executive and Clinical Director are the responsibility of the Chief Executive.
- To receive reports from committees including those which the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action thereon.
- To confirm the recommendations of the Trust Board's sub-committees.
- To establish Tterms of Rreference and reporting arrangements of all Trust Board sub-committees (and other committees if required).
- Ratification of any urgent decisions taken by the Chairman of the Trust Board in accordance with Standing Orders.
- Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.
- Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.
- ~~Approval of the Trust's Major Incident Plan.~~
- ~~Specification of Financial and Performance reporting arrangements~~

2.3 Appointments

- The appointment and dismissal of Trust Board sub-committees.
- The appointment of the Vice Chairman of the Trust Board.
- Though the Remuneration and Appointments Committee, the appointment, appraisal, disciplining and dismissal of Eexecutive directors.
- The appointment of members of any sub-committee of the Trust Board.
- The appointment appraisal, disciplining and dismissal of the Secretary (where the appointment of a Secretary is required under SOs)

2.4 Policy Determination

The approval and ratification of the Trust's ~~management policies, including Human Resources policies, which incorporate the arrangements for the appointment, removal and remuneration of staff~~ Standing Orders, Standing Financial Instructions and Reservation of Powers and Scheme of Delegation.

2.5 Strategy and Business Plans and Budgets

- Definition of the strategic aims and objectives of the Trust.
- Approval ~~annually~~ of ~~5 year~~ lintegrated Bbusiness Pplan (IBP) and annual planning submissions to the NHS Trust Development Authority (~~financial plan~~ in respect of the application of available financial resources).

2.6 General Matters

- Acquisition, disposal or change of use of land and/or buildings, involving capital expenditure in excess of £~~750~~500,000
- The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £~~750~~500,000
- ~~To agree action on litigation against or on behalf of the Trust over £50,000~~
- ~~Approval of appointment of Investment managers for funds held on trust and approval of the Trust Investment Policy~~

2.7 Financial and Performance Reporting Arrangements

- Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from Ddirectors, sub-committees, ~~associate directors~~ and officers of the Trust.
- Approval of the opening or closing of any bank or investment accounts.

- Consideration and approval of the Trust's Annual Report and ~~including the A~~annual A~~a~~ccounts, prior to submission to the Department of Health.

2.8 Audit Arrangements

- To ~~approve audit arrangements (including arrangements for the separate audit of funds held on trust) and to~~ receive reports of the Audit and Governance Committee meetings and take appropriate action.
- The receipt of the A~~a~~nnual Management Letter received from the external auditor and agreement of action on the recommendation where appropriate of the Audit and Governance Committee.
- ~~The receipt of the annual report received from the internal auditor and the agreement of action on the recommendation where appropriate of the Audit Committee~~

3.0 Scheme of Delegation

The delegation shown in the tables below is the lowest level to which authority is delegated.

Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning finance must be carried out in accordance with Standing Financial Instructions (SFI), Standing Orders (SO), Financial Policies and Procedures.

Delegated matter	Authority delegated to	Key reference documents
3.1 Planning and Budgetary Control		SFI sections 4 and 12
a) Prepare and submit an Annual ~~Financial~~ Plan for Trust Board approval	Chief Executive	
b) Prepare and submit income and expenditure budgets for Trust Board approval	Director of Finance	
c) Delegation of the management of all budgets	Chief Executive	
d) Responsibility of keeping within budget		
• for totality of services	Chief Executive	
• Clinical Directorates	Chief Operating Officer	
• Corporate Directorates	Relevant Executive Director	
• ~~at Divisional level~~	~~Divisional Director/ADO/ADNS~~	
• at Directorate level	CD/General Manager/Matron	
• at cost centre level	Budget Holder	

Delegated matter	Authority delegated to	Key reference documents
e) Non-Budgeted Expenditure. Any proposed expenditure, including overspending, which has not been provided for in an approved budget requires the following authorisation: • Up to £100,000 • From £100,001 to £200,000 • Over £200,000	 Director of Finance Chief Executive Trust Board	
f) Capital Expenditure • Prepare and submit capital budgets (Capital Programme) for Board Approval • Authorisation of changes to the Capital Programme • Approval of Emergency Capital Expenditure	Director of Finance Trust Board Director of Finance plus one other Executive Ddirector	
3.2 Banking and GBS Accounts		
a) Maintenance and operation of bank and GBS accounts in the name of the Trust	Director of Finance	SFI section 6
b) Cheque and BACS Payments	Finance Department designated signatories	Cash Management procedures
c) CHAPS or 3 day BACS payments (via internet banking) <£5,000 CHAPS or 3 day bacs payments (via internet banking) >£5,000	Authorised on line by one bank mandate signatory Authorised on line by one bank mandate signatory PLUS further bank mandate signatory to countersign paperwork	GBS Mandate

Delegated matter	Authority delegated to	Key reference documents
3.3 Non Pay Revenue and Capital Expenditure – Requisitioning of Goods and Services		SFI sections 8,12 and 15
3.3.1 Authorisation of Orders		
a) Overall responsibility for requisitioning/ordering of all goods and services	Director of Finance	
b) Non-Stock requisitions < £10,000 > £10,001	 Budget Holder in accordance with Authorised Signatories Register In accordance with the limits in 3.3.4(f)	
c) Stock requisitions < £10,000 > £10,001	 Budget Holder in accordance with Authorised Signatories Register In accordance with the limits in 3.3.4(f)	
d) Pharmacy orders – (approved medicines only) <£99,999 >£100,000	 Chief Pharmacist or nominated deputy In accordance with limits in section 3.3.4(f)	Medicines policy set by the Medicines Management Committee
e) Medical Equipment < £10,000 > £10,001	Purchases must be in line with key reference document. Budget Holder in accordance with Authorised Signatories Register In accordance with the limits in 3.3.4(f)	Medical Devices and Equipment policy

Delegated matter	Authority delegated to	Key reference documents
3.3.2 Authorisation of Invoices		
a) < £10,000	Budget Holder in accordance with Authorised Signatories Register	SFI sections 8,12 and 15
b) > £10,001	In accordance with the limits in 3.3.4(f)	
3.3.3 Approval of Business cases **Values over duration of business case ~~excl. VAT~~**		SFI sections 8,12 and 15 and Capital Investment Manual
a) Capital Investment, including equipment and estates expenditure		
Investment less than £~~750~~500,000 (full business case)	Director of Finance and one Executive Director	SFI 15.1.2 (d)
Investment ~~greater than~~ £~~750~~500,000 and above (full business case)	Finance Committee ~~and Trust Board~~	
Investment £1,000,000 and above (full business case)	Trust Board	
b) Planned Service Developments/Revenue cases (e.g. consultant appointments)		SFI 4.3.2 (h)
Investment up to £~~750~~500,000 – full business case	Director of Finance and one Executive Director	
Investment of £500,000 and above	Finance Committee	
Investment of £1,000,000 and above	Trust Board	
~~c) Service Developments between £750,000 and £5m – full business case~~	~~Trust Board~~	

Delegated matter	Authority delegated to	Key reference documents
~~d)~~c) All cases with capital investment greater than £5m – require NHS TDA approval. Require SOC, OBC and FBC, as directed by the NHS TDA	Trust Board prior to submission to NHS TDA	NHS TDA Capital Regime and Investment Business case approvals guidance
3.3.4 Quotations, Tendering, Leasing and Contract Procedures **Costs over total life of contract – values excl. VAT**		SFI sections 8,12 and 15, Capital Investment Manual and Procurement Policy
a) Quotations and Tendering Limits: • Obtain a non-competitive quotation for goods/services up to £10,000 (exc VAT) • Obtain 3 written competitive quotations for goods/services from £10,001 to £49,999 (Exc VAT) • Obtain competitive tenders for goods/services above £50,000 (Exc VAT)	Budget Holder in liaison with Procurement Dept Budget Holder in liaison with Procurement Dept Budget holder in liaison with Procurement Dept	
b) Compliance with the directives from the Council of the European Union and notified limits equal and greater than: • Supplies Contracts £~~113,057~~111,676 • Service Contracts £~~173,934~~111,676 • Works Contracts £~~4,348,350~~ 4,322,012	~~Head of Procurement~~Associate Director of Procurement and Director of Estates and Facilities	Published by Official Journal of European Union every 2nd January (~~Next update January 2014~~correct at 01/01/14)

Delegated matter	Authority delegated to	Key reference documents
c) Waiving of quotation or single tender action: • From £10,001 to £49,999 • From £50,000 to £249,999 • From £250,000 to £749,999 • More than £750,000	Deputy Director of Finance Director Of Finance Chief Executive Trust Board	
d) Receipt and safe custody of quotations and tender: • Quotations • Tenders	Procurement Dept Chief Executive	
e) Opening of tenders:	One Senior Member of staff designated by the Chief Executive, not associated with the Tender PLUS Head of Procurement or nominated deputy. Where tenders include in-house submissions non-exec should sit on evaluation team if spend exceeds £~~750~~500,000	

Delegated matter	Authority delegated to	Key reference documents
f) Authorisation of Orders, tenders and competitive quotations: • up to £49,999	Budget Holder to the limit as recorded in Authorised Signature Register and Associate Director if over limit (plus Head of Procurement for tenders only)	
• From £50,000 up to £249,999	Above PLUS one Executive Director	
• From £250,000 to £749,999	Above PLUS Chief Executive	
• Over £750,000	Trust Board – Note if expenditure approved as Business case to Trust Board further authorisation will only be required if value exceeds approved business case. If consistent with Business case ~~Finance~~ Director of Finance and Chief Executive will authorise.	
g) Approval of Contracts and SLAs (value for contract duration excl. VAT): • up to £49,999	Budget Holder to the limit as recorded in Authorised Signature Register and Associate Director if over limit plus Head of Procurement	
• From £50,000 up to £249,999	Above PLUS one Executive Director	
• From £250,000 to £749,999	Above plus Chief Executive or Director of Finance	SFI 8.8.1
• Over £750,000	Trust Board – Note if expenditure approved as Business case to Trust Board further authorisation will only be required if value exceeds approved business case. If consistent with Business case ~~Finance~~ Director of Finance and Chief Executive will authorise.	

Delegated matter	Authority delegated to	Key reference documents
h) Maintenance of the Tender Register	~~Head~~ Associate Director of Procurement and Director of Estates and Facilities	
3.4 Setting of Fees and Charges		SFI sections 7 and 9 and Private Patient policy
a) Service Agreements for the provision of services to patients	Chief Executive in conjunction with Director of Finance	
b) All other charges including Private patients, overseas visitors, income generation and other related services	Director of Finance	
3.5 Engagement of Staff not on the establishment Values include all on costs		SFI section 8
a) Estates and other project consultancy staff: • < £20,000 • > £20,000	One Executive Director Director of Finance plus One executive Director	
b) All Management Consultancy	Chief Executive	
c) Engagement of Trust's solicitors	Any of: Executive Director, Associate Director of Governance, Quality & Patient Safety, Head of Quality and Governance, Legal Service Manager, Trust Secretary	
d) Booking of bank, locum or agency staff: • Medical Locums • Others All signed requests require submission to and approval of the Temporary Staffing Panel	Clinical ~~Divisional~~ Director Associate Director / ADNS	

Delegated matter	Authority delegated to	Key reference documents
3.6 Charitable Funds		SFI section 20 and Charitable Funds policies
a) Authorise revenue expenditure (excl. VAT) (N.B. Capital expenditure is authorised in accordance with the Trust's capital authorisation process):		
• Up to £1,000	Fund Holder	
• £1,001 to £5,000	Fund Holder + Divisional Director or Executive Director	
• £5,001 to £50,000	Above plus Director of Finance ~~Director~~ or Deputy	
• £50,001 to £100,000	Charitable Fund Committee	
• Over £100,000	Trust Board	
b) Investment of Funds	Charitable Funds Committee	
3.7 Agreements / Licences (Property only)		
a) Preparation and signature of all new tenancy agreements/licences for all staff subject to Trust Policy on staff accommodation	Accommodation Officer in conjunction with Director of ~~Strategy and~~ Workforce and Communications	
b) Extensions to existing leases	Director of Finance	
c) Letting of premises to outside organisations	Director of Finance	
d) Approval of rent based on professional assessment	Director of Finance	
3.8 Condemning and Disposal **Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively (including x-ray films, mechanical and engineering plant):** **All Medical devices condemnations must be via E.M.E. Services**		SFI sections 17 and 8 Medical Devices and equipment Policy
a) with current estimated book value less than £10,000	Department Manager and Deputy Director of Finance	

Delegated matter	Authority delegated to	Key reference documents
b) with current estimated book value from £10,000 to £50,000	Department Manager plus ADO and Director of Finance	
c) with current estimated book value greater than £50,000	Chief Executive	
3.9 Losses, Write-offs and Compensation		SFI section 17 and DoH Losses and Compensations guidance
a) Cash Losses (theft, fraud, salary, overpayments, loss of cash), Bad Debts and Abandoned Claims • Up to £5,000 • From £5,001 to £50,000 • Above £50,000	 Deputy Director of Finance Director of Finance Trust Board ~~of Directors~~	
b) Fruitless Payments (including abandoned capital schemes) • Up to £5,000 • From £5,001 to £50,000 • From £50,001 to £100,000 • Above £100,000	 Deputy Director of Finance Director of Finance Chief Executive Trust Board ~~of Directors~~	
c) Loss or Damage to buildings, property, equipment and stock • Up to £100,000 • Above £100,000	 Director of Finance Trust Board ~~of Directors~~	
d) Compensation under legal obligation • Up to £10,000 • Above £10,000	 Director of Finance Trust Board ~~of Directors~~	

Delegated matter	Authority delegated to	Key reference documents
Personal Injuries • Up to £10,000 • Above £10,000 Medical Negligence • From £10,000 to £100,000 • Above £100,000	Director of Finance Trust Board ~~of Directors~~ Chief Executive Trust Board ~~of Directors~~	
e) Extra Contractual Payments to Contractors • up to £10,000 • above £10,000	Director of Finance Trust Board ~~of Directors~~	
f) Ex-gratia payments to patients and staff for loss of personal effects • Up to £1,000 • From £1,001 to £5,000 • From £5,001 to £10,000 • Above £10,000	Executive Director Director of Finance Chief Executive Trust Board ~~of Directors~~	
g) Extra statutory and extra regulatory payments, and payments relating to maladministration	Trust Board ~~of Directors~~	
3.10 Reporting of Incidents to the Local Counter Fraud Service		
In all cases	Director of Finance has overall responsibility, however in accordance with key reference documents, Incidents can be reported by ALL individuals	Fraud Policy, Response Plan, Whistle Blowing Policy Research Misconduct and Fraud Policy and Procedure 2012

Delegated matter	Authority delegated to	Key reference documents
3.11 Reporting of Incidents to the Police		Fraud Policy, Response Plan, Security Policy
a) Where a criminal offence is suspected	Clinical Site Manager plus Executive Director in conjunction with Local Security Management Specialist. In accordance with key reference documents, Incidents can be reported by ALL individuals	
b) Where a fraud is involved	Director of Finance in conjunction with the Local Counter Fraud Specialist In accordance with key reference documents, Incidents can be reported by ALL individuals	
3.12 Petty Cash Disbursements		
Reimbursement via cashier of; a) Expenditure items (>£25.00 requires authorisation from Financial Services) b) Patients monies c) patients fares	Budget Holder per authorised signatory register and Financial Services if >£25.00 Cashier (confirmed with patient officer records) Cashier in accordance with patient transport policy and DH HTCS (Hospital Travel Costs Scheme) regulations	SFI sections 12 and 19, patient property policy, patient transport policy and DH HTCS regulations
3.13 Gifts and Rewards **Receipt or Provision of Hospitality and Gifts – Applies to both individual and collective hospitality offered, received or provided.** Refer to Gifts, Hospitality, Sponsorship and Interests Policy and Procedure for full guidance		SO Section 7.5 SFI Section 21 ~~Code of Conduct policy~~ Gifts, Hospitality, Sponsorship and Interests Policy and Procedure ~~Board Code of Conduct policy~~

Delegated matter	Authority delegated to	Key reference documents
~~Gifts/Rewards provided to employees not included in terms and conditions of employment~~ • ~~Gift or Hospitality Received over £25.00 (Over £25 HMRC personal taxation may apply and is responsibility of recipient)~~ • ~~Hospitality Provided - Hospitality offered as part of a legitimate working event~~ • ~~Hospitality Provided - Extraneous Hospitality offered~~ • ~~Gifts/rewards offered to employees by the Trust for innovative work~~ ○ ~~Up to £25~~ ○ ~~Over £25~~	~~Declaration required in Trust's Hospitality Register (Complete Trust hospitality register form Appendix 5 Standards of Conduct policy) **NB declaration required even if refused**~~ ~~Prior approval by Executive Director or Clinical Governance Manager~~ ~~Prior approval by Executive Director~~ ~~One of: ADO/ADN/Divisional Director~~ ~~Director of Finance~~	
3.14 Implementation of Internal and External Audit Recommendations	Director of Finance	SFI section 2
3.15 Maintain and Update Financial Policies	Director of Finance	SFI section 1
3.16 Workforce and Pay		
a) Authority to fill funded posts on the establishment	Recruitment Panel with Director of Finance plus one Executive Director - Consultants and Senior Managers must be authorised by Chief Executive	SFI section 11 Human Resources Policies and Guidelines
b) Authority to fill funded post not on the establishment (i.e. increasing revenue cost	Recruitment Panel with Director of Finance plus one Executive Director - Consultants and Senior	Temporary Staffing

Delegated matter	Authority delegated to	Key reference documents
to the Trust)	Managers must be authorised by Chief Executive	Procedures and control policy
c) Authority to employ bank/agency staff	Either of ADO/ADN~~/Divisional Director~~	SFI sections 11 and 8
d) The granting of additional increments to staff within budgets and regulations	Employing Director	
e) All requests for upgrading/regrading (All requests shall be dealt with in accordance with Trust procedures)	Executive Director has responsibility however Key reference document allows manager discretion to regrade following AfC evaluation process	Agenda for change job evaluation policy
f) Additional staff to the agreed establishment with specifically allocated finance, all staff grades	Short term - Recruitment Panel with Director of Finance plus one Executive Director	
g) Pay:		Recruitment, Selection and Employment Checks Policy and Procedure
I. Authority to complete standing data (payroll) forms effecting pay, new starters, variations and leavers.	Recruitment Team for starters Departmental Managers - variations in pay and leavers	
II. Authority to complete and authorise absence reporting forms.	Departmental Manager	
III. Authority to authorise overtime.	Departmental Manager plus either of ADO/ADNs~~/Divisional Director~~	
IV. Authority to authorise travel and subsistence expenses.	Departmental Manager	Travel and Expenses policy
V. Authority to authorise Change of Circumstance forms - no financial implication	Departmental Manager	
VI. Authority to authorise Change of Circumstance form – below £5,000 per	One of Budget Holder (If sufficient authority), ADO/ADNS~~/Divisional Director~~	

Delegated matter	Authority delegated to	Key reference documents
annum full year effect		
VII. Authority to authorise change of Circumstance form – above £5,000 per annum full year effect	One of Budget Holder (If sufficient authority), PLUS ADO/ADNS~~/Divisional Director~~	
h) Annual Leave:		
I. Approval of annual leave	Departmental Manager	
II. Approval of annual leave – carry forward up to 1 weeks contracted hours	One of - ~~Divisional Director/~~ADO/ADNS	
III. Approval of annual leave – carry forward of more than 1 weeks contracted hours	NOT ALLOWED	Annual Leave and public holidays policy
i) Compassionate and Special Leave:		
I. Compassionate leave up to 5 days	Departmental Manager	
II. Compassionate leave over 5 days	One of - ~~Divisional Director/~~ADO/ADNS	Other leave information policy
III. Special leave arrangements up to five day (with pay)	Employing Director	
j) Unpaid Leave	Departmental Manager	
k) Sick Leave		
I. Authorisation of sick leave	Departmental Manager in conjunction with Directorate HR Business Partner	
II. Return to work part-time or otherwise restricted duties on full pay to assist recovery	Departmental Manager in conjunction with Directorate HR Business Partner	
III. Any extension of sick leave over employee	Employing Director	Standards of Conduct Policy

Delegated matter	Authority delegated to	Key reference documents
conditions of service		
l) Study Leave		
I. All study leave outside the UK including CME/professional leave	Chief Executive and Medical Director in conjunction with the ADO and Divisional Director	
II. Medical Staff CME/Professional study leave (UK)	Divisional Director in conjunction with the ADO and Divisional Director	Standards of Conduct Policy
III. Junior medical staff in training	Divisional Director in conjunction with Clinical Director	
IV. All other study leave (UK)	Departmental Manager	
m) Relocation Expenses		
Authorisation of payment of relocation expenses incurred by officers taking up new appointment		Relocation expenses policy and procedure
• Up to maximum claim of £3,000	Associate Director of Workforce	
n) Grievance Procedure		
All grievance cases must be dealt with strictly in accordance with the Trust Grievance Procedure and the advice of Human Resources must be sought	Director of Strategy and Workforce has overall responsibility, cases dealt with by the Human Resources team	Grievance and Disputes policy and procedure
o) Disciplinary Procedure		
All disciplinary cases must be dealt with strictly in accordance with the Trust Disciplinary Procedure and the advice of	Director of Strategy and Workforce has overall responsibility, cases dealt with by the Human Resources team	Disciplinary

Delegated matter	Authority delegated to	Key reference documents
Human Resources must be sought		policy and procedure
p) Authorised Car and Mobile Phone Users		
I. Requests for new post to be authorised as regular car users	One of : ~~Divisional Director/~~ADN/ADO	
II. Re-designation of existing posts as authorised car user	One of : ~~Divisional Director,~~ ADN/ADO	Mobile phone policy and procedure
III. Requests for authorised mobile phone user status	One of : ~~Divisional Director,~~ ADN/ADO	
q) Renewal of Fixed Term Contract within funded establishment (if outside of establishment see 19b above)	Short term - Recruitment Panel Recruitment Panel	
r) Staff Retirement Policy Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances	Chief Executive Remuneration Committee	Flexible retirement policy
s) Contractual Redundancy		
I. up to £100,000	Trust Board Remuneration Committee and NHS TDA Remuneration Committee	
II. All packages within range of £50,000 and £100,000 to be reported to Remuneration Committee	Remuneration Committee, NHS TDA Appointments and Remuneration Committee, Treasury Approval	
III. Packages in excess of £100,000	Refer to Treasury	DH Losses and Compensations Guidance
IV. In relation to Chief Executive or direct reports to be approved by;	To be considered by the Remuneration Committee and will require Treasury approval	
V. Payments of a novel or unusual nature		

Delegated matter	Authority delegated to	Key reference documents
VI. NHS bodies must obtain Treasury's explicit permission before making any staff severance payments that exceed legal or contractual obligations.	There is no delegated authority to make any such payments, whatever the value	
t) Ill Health Retirement Decision to pursue and authorise retirement on the grounds of ill health	Director of Strategy and Workforce has overall responsibility, Cases dealt with by Occupational Health and Human Resources teams	Managing attendance policy
u) Dismissal/Suspension	Director of Strategy and Workforce, Executive Director and designated Senior Managers	
3.17 Authorisation of New Drugs	Medical Director and Director of Finance, Chief Pharmacist, Drugs and Therapeutics Committee	BNF NICE
3.18 Authorisation of Sponsorship Deals a) General Sponsorship	Chief Executive, Medical Director and Director of Finance	SFI section 7 and DoH commercial sponsorship – ethical standards in the NHS guidance
b) Research and Development Sponsorship	Medical Director in liaison with Deputy Director of Finance	Research and Development Policies
3.19 Authorisation of Research and Development Projects	Research and Audit Manager, R and D Management Committee	Research and Development Policies
3.20 Authorisation of Clinical Trials	Research and Audit Manager, R and D Management Committee	Research and Development Policies
3.21 Insurance Policies and Risk Management	Chief Nurse	SFI section 24 and Risk Management Strategy and Policy

Delegated matter	Authority delegated to	Key reference documents
3.22 Multi-User Clinical Products Review	R and D Management Committee	Research and Development Policies
3.23 Patients and Relative's Complaints		
a) Overall responsibility for ensuring that all complaints are dealt with effectively	Chief Executive	Complaints Procedure
b) Responsibility for ensuring complaints relating to a Directorate are investigated thoroughly	Chief Operating Officer and Complaints Officer	
c) Effective management of medical legal complaints	Patient Safety and Risk Manager	
3.24 Relationship with Press		
a) Within office hours	Head of Communications/Communications Manager	
b) Outside office hours	Executive Director on-call and Clinical Site Manager in liaison with the On Call Communication Manager	
3.25 Infectious Diseases and Notifiable Outbreaks		
• Overall responsibility for ensuring that there are effective arrangements for infection control within the Trust	Chief Executive	Infection Control Policy
• Ensure effective steps are taken so that all staff adheres to the Infection control policy and the guidelines and protocols which underpin it.	Director of Infection Prevention and Control	
• Prepare and present the Annual Infection Control report to the Trust Board and Governance and Risk Committee.	Director of Infection Prevention and Control	
3.26 Extended Role Activities		
Approval of staff to undertake extended professional clinical roles	Medical Director and Chief Nurse for nursing and midwifery staff and healthcare	

Delegated matter	Authority delegated to	Key reference documents
	support workers	
3.27 Patient Services a) Variation of operating and clinic sessions within existing resources b) All proposed changes in bed allocation and use: • Temporary change • Permanent change	Chief Operating Officer Chief Operating Officer or Executive Director on call (out of hours) Chief Executive	Patient Access Policy
3.28 Facilities for Staff not Employed by the Trust to gain Practical Experience or undertake remunerated work on Trust premises a) Professional recognition, honorary contracts and insurance of medical staff b) Work experience students c) Volunteers	Director of Strategy and Workforce Director of Strategy and Workforce Chief Nurse	
3.29 Fire Regulations a) Overall responsibility for review of all statutory compliance with Fire Regulations b) Effective management of fire precautions to meet regulations	Chief Executive Fire Safety Officer	
3.30 Health and Safety a) Overall responsibility for review of all statutory compliance legislation and Health and Safety	Chief Executive	

Delegated matter	Authority delegated to	Key reference documents
requirements, including Control of Substances Hazardous to Health (COSHH) b) Effective management of compliance issues to meet legislation	 Head of Clinical Governance and Risk/Risk Manager	
3.31 Review of Medicines Inspectorate Regulation	Medical Director in conjunction with Chief Pharmacist (with GM of Diagnostic Directorate)	
3.32 Environmental Regulations a) Overall responsibility for review of compliance with environmental regulations, (e.g. clean air, waste disposal) b) Effective management of compliance issues to meet legislation	Chief Executive after consultation with Director of Estates and Facilities Director of Estates and Facilities	
3.33 Review of Trust's Compliance with the Data Protection Act	Director of ICT (Trust's Data Protection Officer)	DPA 1998
3.34 Monitor proposals for contractual arrangements between the Trust and outside bodies	Director of Finance and other appropriate Executive Director	
3.35 Review the Trust's compliance with Access to Records Act	Director of ICT (Trust's Data Protection Officer)	DPA 1998
3.36 Review of the Trust's compliance with the Code of Practice for handling confidential information in the contracting environment and compliance with "Safe Haven" per EL(92)60	Medical Director	
3.37 The keeping of a Declaration of Interest Register	~~Director of Corporate Affairs~~Trust Secretary	Standing Orders / Gifts, Hospitality, Sponsorship and Interests Policy and Procedure

Delegated matter	Authority delegated to	Key reference documents
3.38 The keeping of a hospitality Register	~~Director of Corporate Affairs~~Trust Secretary	Standing Orders / Gifts, Hospitality, Sponsorship and Interests Policy and Procedure
3.39 Trust Seal		
a) Attestation of sealing in accordance with Standing Orders	The Trust Secretary, and one member of the Executive Team (not from the department from which the document arises). In the absence of the Trust Secretary, two members of the Executive Team can attest. ~~Chief Executive and Director of Corporate Affairs In the absence of either of the two officers, the Chairman (or another Director duly authorised by the Chairman) may attest the use of the seal.~~	Standing Orders
b) Keep seal in a safe place and maintaining a Register of Sealing	~~Director of Corporate Affairs~~Trust Secretary	Standing Orders
3.40 Retention of Records	Director of Finance	
3.41 Clinical Governance	Chief Executive, Medical Director and Chief Nurse	
3.42 Serious ~~Untoward~~ Incident Reporting	Chief Nurse	
3.43 Management of Medical Devices	Estates and Facilities Director	Medical Devices and equipment Policy
3.44 Review of Partnerships a) Annual review of partnerships b) Ensuring partnership agreements are in place and monitored c) Review of the financial standing of partners	Deputy Director of Finance	SFI section 9
3.45 Freedom of Information	~~Finance~~ Director of Finance	FOIA 2000, FOI Policy

4.0 Glossary of terms and abbreviations (refer to Standing Orders for full list of definitions)

Term or abbreviation	Meaning for the purposes of this document
SOs	Standing Orders
SFIs	Standing Financial Instructions
Budget Holder	The Ddirector or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.
Departmental Manager	AfC band 7 and above manager with staffing and budget responsibility
ADO	Associate Director of Operations – includes Associate Directors in Corporate areas
ADN	Associate Director of Nursing
CD	Clinical Director
GM	General Manager
Senior Nurse	Nurse Consultants, Matrons, Ward Sisters, Specialist Nurses
~~DD~~	~~Divisional Director~~
SOC	Strategic Outline Case
OBC	Outline Business Case
FBC	Full Business case
NHS TDA	NHS Trust Development Authority
OJEU	Official Journal of European Union
FOI (A)	Freedom of Information (Act)
DPA	Data Protection Act
HTCS	Hospital Travel Costs Scheme (DH)
Officer	An employee of the Trust or any other person holding a paid appointment or office with the Trust.
Chairman of the Trust Board"	The person appointed by the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "Chairman of the Trust Board" shall be deemed to include the Vice-Chairman of the Trust Board if the Chairman is absent from the meeting or is otherwise unavailable.
Chief Executive	the chief officer of the Trust
Director	Executive or Non-Executive Director of the Board as the context permits. The inclusion of the word "Director" in a staff member's job title does not mean that they automatically meet the definition of being a "Director" for the context of these Standing Orders.
Director of Finance	The Chief Financial Officer of the Trust.
Executive Director	A member of the Trust Board who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) of The National Health Service Trusts (Membership and Procedure) Regulations 1990. Executive Directors are

Term or abbreviation	Meaning for the purposes of this document
	expected to be present at, and participate in, meetings of the Trust Board.
Executive Team	The group of employees who collectively have managerial control over the major activities of the Trust, and who influence the operations of the Trust as a whole rather than the decisions of individual directorates or departments. For this Trust, refer to the Standing Orders for the up to date list of relevant persons.
Non-voting Board Member	A Trust Board Member who is not entitled to exercise voting rights at the Trust Board.
Senior Manager	An officer holding a senior managerial or senior clinical role with management responsibilities. For this Trust this includes Directors and Associate Directors and their direct reports and Clinical Directors and Consultants. However, please note that for the purposes of reporting "Senior Managers" remuneration (In accordance with Section 234b and Schedule 7a of the Companies Act, as required by NHS Bodies), a "Senior Manager" is considered to be defined as "Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments". For this Trust, and for this purpose, the definition of "Senior Manager" only applies to Trust Board Members.
Trust Board	The Chairman, Executive and Non-Executive Directors of the Trust collectively as a body.
Trust Board Member (or Board Member)	An individual regarded as being a member of the Trust Board. The influence (or potential influence) exerted by the individual is the key determinant, rather than their ability to vote at Board meetings. Trust Board members are those that are expected to be at each Board meeting (and sit at the Board table), and contribute fully to each agenda item. For this Trust, Trust Board Members comprise the Chairman of the Trust Board, Non-Executive Directors, the Executive Team, and the Director of Infection Prevention and Control. Please note however that the provisions in these Standing Orders relating to voting (SO 3.12) only apply to "Voting Board Members" (see below).
Voting Board Member	A Trust Board Member who is entitled to exercise voting rights at the Trust Board.

APPENDIX ONE

Process Requirements

1.0 Implementation and Awareness

1.1 Once approved the Document Lead or Author will send this document to the Clinical Governance Assistant who will publish it on the Trust intranet.

1.2 All staff will have access to a copy of the document through the Trust's intranet site. A monthly table of Trust publications will be produced by the Clinical Governance Assistant; this will be published on the Bulletin Board (Trust intranet) under "Trust Publications", and a notification email circulated Trust wide by the COMMS team.

1.3 On receipt of the Trust wide Bulletin Board notification all managers should ensure that their staff members are aware of the new publications.

2.0 Review

The Reservation of Powers and Scheme of Delegation instructions will be reviewed annually.

3.0 Archiving

The Trust intranet retains all superseded files in an archive directory in order to maintain document history.

Maidstone and Tunbridge Wells NHS
NHS Trust

APPENDIX TWO

CONSULTATION ON: Reservation of powers and scheme of delegation

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Head of Financial Services (wmaher2@nhs.net)___

By date: Friday 6th September 2013

Name:	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Local Counter Fraud Specialist	~~09/08/2013~~ 06/08/15 & 04/11/15			
Chief Internal Auditor	~~09/08/2013~~ 06/08/15 & 04/11/15	~~06/09/13~~	~~Y~~	~~Y~~
Director of Finance	~~09/08/2013~~ 06/08/15 & 04/11/15	~~10/09/13~~	~~N~~	~~N~~
Deputy Director of Finance	~~09/08/2013~~ 06/08/15 & 04/11/15	~~12/09/13~~	~~N~~	~~N~~
Executive Directors	~~09/08/2013~~ 06/08/15 & 04/11/15	~~TC 28/08/13~~	~~Y~~	~~Y~~
Non Executive Directors	~~09/08/2013~~ 06/08/15 & 04/11/15	~~ST 05/09/13~~	~~N~~	~~N~~
Risk Manager	~~09/08/2013~~			
Head of Information Governance	~~09/08/2013~~			
Human Resources Business Partner	~~09/08/2013~~	~~12/09/13~~	~~Y~~	~~Y~~
Head of Finance Systems	~~09/08/2013~~	~~12/09/13~~	~~N~~	~~N~~
Head of SLA and Income	~~09/08/2013~~	~~12/09/13~~	~~N~~	~~N~~
Head of Financial Management	~~09/08/2013~~	~~12/09/13~~	~~N~~	~~N~~
Head of Procurement	~~09/08/2013~~			
Financial Services Manager	~~09/08/2013~~	~~11/09/13~~	~~N~~	~~N~~
Financial Accountant	~~09/08/2013~~	~~11/09/13~~	~~N~~	~~N~~
Technical Team Leader	~~09/08/2013~~	~~11/09/13~~	~~N~~	~~N~~
Debt Management Team Leader	~~09/08/2013~~	~~11/09/13~~	~~N~~	~~N~~
Payables Team Leader	~~09/08/2013~~	~~11/09/13~~	~~N~~	~~N~~
Associate Directors	~~09/08/2013~~	~~SC 19/08/13~~	~~N~~	~~N~~
HIS Managing Director	~~09/08/2013~~			
Head of R and D – CLRN	~~09/08/2013~~			
Head of Quality and Governance	~~09/08/2013~~			
EME Services Manager	~~09/08/2013~~			

Capital Planning Manager	~~09/08/2013~~	~~12/09/13~~	~~N~~	~~N~~
Local Security Management Specialist	~~09/08/2013~~			
Staff side representative	~~09/08/2013~~			
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

Maidstone and Tunbridge Wells NHS
NHS Trust

APPENDIX THREE

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of Policy or Practice	Reservation of powers and Scheme of delegation
What are the aims of the policy or practice? Identify the data and research used to assist the analysis and assessment	Financial Governance document
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no). If yes give details.**
Males or Females	No
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak english as a first language	Yes (May have difficulty in understanding document, support / interpretation can be provided on request
People who have a physical disability	Yes (Sight impaired may have difficulty in reading document, a braille version can be provided on request)
People who have a mental disability	Yes (May have difficulty in understanding document, support can be provided on request)
Women who are pregnant or on maternity leave	No
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	N/A
When will you monitor and review your EqIA?	At the same time as the Reservation of powers and scheme of delegation document (annually)
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix Three~~3~~ of the Reservation of powers and scheme of delegation document on the Trust Intranet

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – January 2016

1-20	**Summary report from the Patient Experience Committee meeting, 07/12/15**	**Committee Chairman (Non-Executive Director)**

A Patient Experience Committee meeting was held on 7th December 2015. The issues covered, and the actions agreed, were as follows:

- A report on the CIP workstream on **cancelled and missed appointments** was discussed, and assurance was given that progress had been made, but more was needed to improve effectiveness. It was agreed that an update should be provided to the June 2016 meeting
- An **update on translation services** was given, and the Chief Nurse was asked to submit a report to the March 2016 Committee on the Trust's new translation service
- An **update on Stroke Services** was given (via the same report that had been submitted to the 'main' Quality Committee on 11/11/15), and it was agreed to receive a further update at the March 2015 Patient Experience Committee meeting
- The latest **Complaints and PALS contacts data** was reviewed, and it was noted that the Trust intended to undertake the complaints survey in-house (the Patients Association was currently engaged to undertake the survey)
- An update on the latest activity of **Healthwatch Kent** was given by the Healthwatch representative. The update included the intention to undertake an 'Enter and View' visit to the Outpatient department in 2016.
- Progress on the **Quality Accounts priorities for 2015/16** was reported, and suggestions for the 2016/17 priorities were encouraged. It was agreed to discuss what the 2016/17 priorities should be at the March 2016 meeting (for inclusion in the 2015/16 Quality Accounts)
- Progress with the implementation of the action plan relating to the latest **Patient Led Assessments of the Care Environment (PLACE)** was reported, which led to a discussion of the cessation of the 'red tray' alert system at Maidstone Hospital (which related to the introduction of new mealtime serving trollies). It was agreed to submit a report to the March 2016 Committee on the mealtime support being given to patients, in the light of this change
- The representative from **West Kent Clinical Commissioning Group** gave an update on current activities; and the usual update on **Communications and Membership** was given
- **Planned and recent service changes** were reported, which included the new John Day Ward at Maidstone Hospital (MH); the development of a PET/CT fixed unit at MH; the Future Ward and Theatre upgrade programme; the potential Macmillan Centre on the MH site; the changes to the Minty suite in Outpatients; the new inpatient Ward at Tunbridge Wells Hospital (TWH); the Crowborough Birthing Centre, and related community care; the appointment of new Inflammatory Bowel Disease Nurse Specialists; the plans for the dedicated Paediatric Emergency Department at TWH; & the new GP primary care service in the Emergency Dept.
- The latest findings from the **local patient survey (incl. Friends and Family)** were discussed, which highlighted that overall satisfaction had decreased in October (which was associated with a corresponding increase in the number of patient complaints/concerns for the same month). However, it was too early to consider whether this should be a cause of concern, in terms of a long terms trend. Other findings showed that satisfaction with involvement in care and decisions and standards of cleaning remained stable; and call bell response times remain good overall (however patient perception of response times has deteriorated).
- The summary reports of the last 3 meetings of the **Quality Committee** were received
- A report was received from the **Patient Information and Leaflets Group (PILG)** (the Committee's only sub-committee), which noted that an advert in the 'Patient First' magazine and a request to Healthwatch had led to the successful recruitment of additional patient representatives to undertake review of leaflets
- A **Junior Doctor** gave their observations on their time at the Trust. It was agreed to submit a report to the March 2016 Committee in response to the issues they raised, which included the isolation experienced by patients at TWH, the number of Ward outliers, the difficulty relatives had in identifying staff members' profession, & the support available to dementia patients

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – January 2016

1-21	Summary of the Trust Management Executive (TME) meetings, 09/12/15 & 20/01/16	Chief Executive / Deputy Chief Executive

The TME has met twice since the last Trust Board meeting, on 09/12/15 and 20/01/16.

The meeting on 09/12/15 did not cover the usual standing items/reports but instead focused on the following three key areas:

- **Financial recovery and Service Line Reporting (including Directorate views on SLR)**. The Director of Finance gave a presentation highlighting the key financial challenges faced by the Trust, for 2015/16 and beyond, which highlighted the following points:
  - The Trust's recovery actions would be set against a small number of overarching headings, to create a simple and understandable message: "Control totals and recovery plans"; "Service Line Reporting and increased profitability"; "Income"; "Staffing Controls"; "Unspent budgets and discretionary spend"; and "Innovation Fund"
  - The Trust would be implementing the methods included in Monitor's "Grip and Control Framework" document
  - Each Directorate had been set a control total for the remainder of the financial year, and been asked to construct a plan that would achieve their total (and to be clear on the consequences of that plan, to enable the associated risks to be assessed). This process would be applied to all Clinical and Corporate Directorates
  - Initial Service Line Reporting (SLR) data, based on the 2014/15 financial year, was presented and Clinical Directors shared their initial observations regarding such data, and its future use. The data would be refreshed, for the first 6 months of 2015/16 by the end of December 2015
  - The need to make short-term improvements, and focus on current clinical activity, rather than solely focus on costs was emphasised, along with the point that any improvement would be beneficial, no matter how small
- **Clinical Strategy**
  - The Deputy Chief Executive and Head of Strategy gave a presentation outlining the current strategic thinking, and the work that had been undertaken to identify the Trust's existing strengths, and most likely areas for future development.
  - The presentation included the work that had been undertaken thus to review ways to improve the Trust's financial viability (in the light of the current financial position).
  - There was a good level of engagement from the Clinical Directors
- **Follow-up of the issues discussed at the TME 'away seminar', 18/03/15**
  - The Director of Workforce and Communications led a discussion focusing on the challenges faced by Clinical Directors in balancing their responsibilities to manage the 'here and now' with the need to consider the future strategy of their Directorates
  - The challenges discussed focused on the time available to step back from day to day duties and consider longer-term matters
  - Although a number of proposals to assist were considered, such as the rescheduling of some corporate processes, to avoid clashes (e.g. between the appraisal and business planning cycles); and further externally-facilitated development work, it was agreed that no immediate action was required

The key items covered at the meeting on 20/01/16 were as follows:

- In the **safety moment**, the Chief Operating Officer highlighted the current inpatient capacity pressures, & the large number of outliers (from patients' speciality, and from inpatient areas)
- The key issues highlighted via the **reports from the Clinical Directors** were as follows:
  - Staffing issues were again were a theme for several Directorates, in relation to recruitment to specific posts and/or the continued usage of temporary staff. Trauma and Orthopaedics reported that the Junior Doctor rota continued to raise concerns, but it was noted that the business case to introduce Physician Associate posts needed further development, as the reported costs in creating the posts was more than the costs of the current situation. It was noted that the Clinical Director would meet with the Chief Operating Officer and Director of Finance to discuss the case further

  - Performance against key access targets continued to be a challenge, but there was a commitment to continue with efforts to resolve the current obstacles
  - The Clinical Directors present also acknowledged the financial challenges they faced, particularly in relation to the achievement of their Cost Improvement Plans (CIPs)
  - CT and MRI reporting was acknowledged to be much improved, and the "Kent Transforming Pathology Service" project was noted to be underway, with facilitation from Specialist Projects team and partnership with East Kent Hospitals University NHS Foundation Trust. The project aims to identify a third party partner to invest in both Trusts' Pathology services
- The latest **performance, for month 9**, 2015/16 was reported, which included the latest **financial performance**. The latest position regarding **infection prevention and control** was also discussed, which included a recent increase in the use of Tazocin
- The latest update on progress in implementing **the Quality Improvement Plan** developed in response to the findings from the CQC's inspection was reported, and an update on the implementation of two priorities for 2015/16 made in the **Quality Accounts 2014/15**. It was agreed to consider whether the patient safety film that was intended to be made as part of the "Initiatives for further action for 2015/16" could be made using in-house resources (as the cost of having the film made externally was reported as being prohibitive)
- The Director of Finance gave an update on **business planning, 2016/17**, which included a discussion of the latest guidance issued from the NHS Trust Development Authority and Monitor
- A report containing the outcome of the due diligence that had been undertaking regarding the **transfer of Crowborough Birthing Centre & High Weald Community Midwifery Services** was received, and the Committee confirmed its support to the transfer
- A presentation on the development of the **Clinical Strategy** was intended, but did not occur due to time constraints. The presentation slides were instead circulated to all Committee members
- A report outlining the Implementation of the **South Acute Programme (SAcP)** i.e. the replacement PAS+ was received, and the Committee supported the proposed timings in relation to the development of a business case to assess the feasibility and affordability of purchasing and implementing of an Electronic Patient Record (EPR) solution, called 'Sunrise' (as this would involve significant additional cost to that already committed). It was noted that the Finance Committee & Trust Board would be asked to review the case as part of the Trust's usual process
- A report on the **Future estate development** was received, which highlighted the proposed timing for the development of a new theatre complex on the Maidstone Hospital site. The Committee supported the development of a Strategic Outline Case (SOC) in the first instance, but acknowledged that the availability of external funding was severely constrained
- The **business cases** that had been recently-approved by the Investment Appraisal Group and/or Executive Team were noted. An update was also given on the development of the Outline Business Case **(OBC) for additional Radiotherapy LinAc bunker capacity at Tunbridge Wells Hospital**. It was noted that the OBC was being finalised, with the aim to submit for review at the Finance Committee on 25/01/16 (and approval by the Trust Board on 27/01/16)
- Two **replacement Consultant posts** were approved (for an Anaesthetist with a specialist interest in chronic pain management; & an Orthopaedic surgeon with a specialist interest in knee surgery)
- The **Board Assurance Framework** received at the November Board was reviewed, as was the latest version of the **Trust Risk Register**
- An update on the **Internal Audit reviews** within the 2015/16 plan was provided, and updates were received on the work of the **TME's sub-committees** (Capital meetings; Procurement Strategy Committee; Clinical Operations and Delivery Committee; Policy Ratification Committee; and Informatics Steering Group)
- The **Patient Access to Treatment Policy and Procedure (RTT 18 weeks)** was approved

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

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

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – January 2016

1-22	Summary report from the Quality Committee meetings, 10/12/15, 06/01/15 & 11/01/16 (incl. approval of revised ToR)	Committee Chairman (Non-Exec. Director)

The Quality Committee has met three times since the last Trust Board meeting. 'Deep dive' meetings were held on 10/12/15 and 11/01/16, whilst a 'main' meeting was held on 06/01/16.

The 'deep dive' meeting held on 10/12 was unfortunately not quorate, as there was only one Non-Executive Director present. This summary should therefore be regarded as a request to ratify the decisions made. The following issues were covered:

- The Trust Lead Cancer Clinician attended to give an **update on Cancer Multidisciplinary Team (MDT) meetings**. It was reported that the situation had improved since the report given to the Committee in August 2015. Specifically, a 'Cancer of Unknown Primary' MDT meeting had now been established, and the efficiency of MDT meetings was being reviewed, with the intention of making improvements. Key priorities to achieve and sustain the 62-day Cancer waiting time target were being addressed, and the awareness of Cancer access targets had been raised among the MDT leads
- An update was given on the latest situation regarding **Women's Services**, and it was agreed that a further update should be provided at the 'Part 2' Trust Board meeting in January 2016
- A **review of plans for 7-day services** was undertaken, via review of the Trust's submission of a national "Seven Day Service Self-Assessment Tool" (7DSAT), which had been developed to help organisations to plan for implementing 7 day services. The results showed that the Trust was broadly similar, and in some places better, than peers, but the Committee heard that a further audit would be undertaken in March 2016, via a review of Healthcare Records. It was felt that the next submission would demonstrate an even more favourable situation
- The Chief Pharmacist then attended for a **review of Pharmacy**, although the focus was on the recently-introduced 7 day Pharmacy service. The new weekend service started in September 2015, and operates from 9am to 4pm on Saturdays, and from 10am to 4pm on Sundays. The service had been in place for 3 months, and the main benefit had been the ability to discharge patients at weekends, instead of them having to stay in hospital until Monday. From a safety perspective, medical reconciliation rates had also improved, which benefitted patients.

The following issues were covered at the 'main' meeting held on 06/11/16:

- **Revised Terms of Reference** (ToR) were agreed, to reflect the proposed changes in the Clinical Governance Committee Structure (which will mean that the Quality Committee will not have any sub-committees). The Terms of Reference are enclosed at Appendix 1, for the Trust Board's approval. The proposed changes are 'tracked', and should be self-explanatory.
- The latest **Stroke care performance** was reported. The report that was received is enclosed at Appendix 2, and has been included as a result of a previous request from the Board. The **Kent & Medway Stroke Review** was also discussed, and it was agreed that the Chief Operating Officer would submit a report to the 'main' Quality Committee in March 2016 on the outcome of a forthcoming meeting with the Programme Director for that Review
- The **Clinical Directorates** presented their reports. The key issues raised were as follows:
  - **Surgery** reported that the Directorate remained in escalation; a joint Clinical Governance meeting with Critical Care would discuss pre-operative fasting; Nurse vacancies were improving (but there was high spending on medical staff); & the 62-day wait Cancer target was still failing, but the risk had reduced from 'red', as improvements had been seen
  - **Women's & Sexual Health** reported that a clinical audit of 500 sets of Healthcare records was scheduled for the end of February; the positive results from the National Maternity Survey had been welcomed; Caesarean section rates were close to planned levels; there had been two cases of Venous thromboembolism (VTE), and work was ongoing to address the issues; and there had been two unavoidable Clostridium difficile cases
  - **Trauma & Orthopaedics** reported that the rate of return for the mortality review process

was improving; a major risk regarding the bed state was raised (and the Chief Operating Officer acknowledged that the non-elective pathway was currently the major risk being faced by the Trust); a Grade 3 Pressure Ulcer had occurred; and the Junior Doctor rota remained a problem (although there were medium & long term solutions being progressed). Following some critical comments regarding the business case process (which was one of the solutions referred to), it was agreed to arrange for a review of the Trust's business case process to be undertaken at the Finance Committee

- **Emergency & Medical Services** reported that operational pressures and staffing challenges continued; falls had reduced, and there had been one case of Clostridium difficile. Friends and Family Test response rates had also reduced, but the Net Promoter Score was good (4.72 out of 5).
- **Diagnostics, Therapies & Pharmacy** reported that Cellular Pathology reporting had reduced over the Christmas period (and a particular issue had been identified regarding the transfer of specimens arising from theatre); Radiology reporting times had however improved; the action plan in response to the recent Medicines and Healthcare products Regulatory (MHRA) inspection of blood transfusion had now been accepted by the MHRA, and the focus was now on implementing the actions. One specific issue raised was that Wards were not regularity 'fating' their transfusions (i.e. to record the actual end-point destination of the blood) and Matrons were asked to ensure that this took place. The recent blood transfusion-related Never Event was also highlighted.
- **Critical Care** reported on the recent Never Event involving a retained specimen bag; the challenges of delayed discharges; and the fact that a recent advert for Intensivists had no suitable candidates (so a further advert would be issued in Quarter 1 of 2016/17). The occurrence of some Diathermy burns was also reported, and it was stated that on investigation the incidents were related to human error (rather than equipment errors). There had also been one closed Serious Incident (SI), relating to a Colonoscopy
- **Children's Services** reported that work was continuing on the conversion of the Ambulatory unit to the Paediatric Unit at Tunbridge Wells Hospital, and this was expected to be open in February 2016. In addition, staffing challenges remained; and there had been two minor (i.e. no harm) medication-related errors
- **Cancer & Haematology** reported that there were no red risks, and no recent SIs, and the main performance issue related to access targets, including 62-day waiting time target

It was highlighted that if the revised ToR were approved, **Clinical Directorates would not submit routine reports at future Quality Committee meetings**, and would instead provide a detailed report to the Clinical Governance Committee (who would in turn provide a report to the Quality Committee)

- The Head of Performance & Information attended, to **update on progress with addressing the clinical and non-clinical issues discussed at the Quality Committee 'deep dive' meeting on Hospital Standardised Mortality Ratio** (HSMR) on 05/10/15. The Committee was not assured by the information presented, as there appeared to be a discrepancy between the data originally presented by Dr Foster and that which was reported to the meeting. It was therefore agreed that a further report should be submitted to the 'main' Quality Committee in March 2016
- The latest situation regarding **Catheter Associated Urinary Tract Infections** was reported, and assurance was given that the CQUIN was fully expected to be achieved at year-end
- The latest **SIs** were considered, and the intended move towards having the investigation led by someone from outside of the Directorate in which the SI occurred was noted. The intention to involve family members of the patient throughout the SI process was also reported. It was highlighted that the highest number of declared SIs related to fractures following falls.
- The Complaints and PALS Manager gave an **update on complaints** (for Q 1 & 2, 2015/16), & reported that the 252 complaints received was a rise on the same period the previous year. The Chief Nurse acknowledged the increase, and confirmed that this was being investigated.
- Reports on the latest findings from relevant **Internal Audit reviews**, and latest media coverage/**reputational risk** issues were noted.
- The minutes of the **Quality Committee 'deep dive' held on 10/12/15** were received, along with a report from the **Patient Experience Committee** held on 07/12/15

- The last reports were also received from the latest meetings of the Quality Committee's current **sub-committees** i.e. Mortality Review Group, Safeguarding Adults, Infection Prevention & Control, Patient Environment Steering Group, and Safeguarding Children. A report was also given from the first meeting of the new **Clinical Governance Committee**, which has formed by joining the previous Clinical Governance and Standards Committees.

The 'deep dive' meeting held on 11/01/16 focused on a review of the actions being taken regarding **Patient Falls**. The meeting was also unfortunately not quorate, as there was only one Executive Director present. This summary should therefore also be regarded as a request to ratify the decisions made. The following issues were covered:

- The Head of Nursing-Patient Safety and Quality; and Deputy Chief of Safety; from **Brighton and Sussex University Hospitals NHS Trust** (BSUH) attended the meeting, to describe the approach taken at their Trust. The Trust's own Falls Team were also present.
- The meeting heard that the monthly **falls rate** (per 1000 bed days) at the Trust increased by 60% from September 2011 (from circa 5 to 8), following the opening of the new Tunbridge Wells Hospital and the resulting service relocation. There was then a 23% reduction in falls between 2012/13 (8.0) and 2014/15 (6.16), but a slight increase since (to 6.5 - 6.6)
- The Falls Team also highlighted that the Trust performed well on the Organisational component of the Royal College of Physicians' **National Audit of Inpatient Falls 2015**, and the only gap was the lack of an audit of bed rail use. For the clinical component of the audit, there were significant gaps in the assessment of individual patients (though this was comparable to other sites). Four domains were better than average, with 3 worse
- The Committee was informed that a **range of actions had been taken**, including the introduction of blue wristbands, non-slip socks, and falls alarms. In 2013/14 and 2014/15 there was a local CQUIN target in place. In addition, monthly "FALLSAFE" audits were undertaken by Wards; Falls Link Nurses had been established; the Policy and Procedure for the Management of Slips, Trips and Falls was updated in September 2013; and Periods of Increase Incidence (PII) were applied to areas experiencing higher numbers of falls. Other actions have been considered, including the use of Hip Protectors, which aimed to reduce the consequences of falls, but these had not been introduced
- The Committee then heard that 5 years ago, BSUH had experienced a **falls-related SI**, involving a serious head injury. The Trust's Chief of Safety met with the patient's family, and made a commitment to reduce the falls rate at the Trust. A series of actions were then developed and agreed, following a campaign launch event, and although there was an initial reduction in falls, this then stalled. A CQUIN target was then agreed, which led to increased interest from the Board
- The circumstances that occurred at Winterbourne View hospital then had an impact, in that this demonstrated that junior members of staff were able to set the **culture** in a hospital. BSUH therefore considered whether this could be engineered in reverse i.e. could staff exhibiting 'falls safe' behaviours spread such behaviours to other staff. A Project Lead was duly appointed
- The Project that followed focused on 8-10 wards, and one of the tools used was **After Action Reviews** (AAR), which involved a debrief in the immediate aftermath of a fall, held in the spirit of learning, and not blaming. An 'emergent design' approach was also used, in which the actions were not designed in advance, but adjusted to the circumstances as they developed
- There was a deliberate attempt to mine the **ideas that arose from front-line staff**, rather than impose management ideas
- The sole focus of the Head of Nursing-Patient Safety and Quality and Deputy Chief of Safety's **time**, for the duration of the project (a period of several months), was on patient falls. All of their other duties were dispensed
- The **falls rate at BSUH** was 6.22 in 2010, and (generally) there had been a decrease each year, although it had now plateaued (at 3.4). The approach was not grandiose, and was not based on large scale learning, but on focusing on learning following each incident, in terms of what could have been done differently
- It was agreed that the Chief Nurse should reflect, with the Falls Team, on the discussion at the meeting, and submit a **report to the March 2016 meeting of the 'main' Quality Committee**, outlining the next steps to be taken.

- The Committee also agreed that the **February 2016 'deep dive' meeting** would review "Findings from the National Clinical Audits relating to Cancer" and "Review of compliance with the statutory Duty of Candour"; the **April 2016 'deep dive' meeting** would review "Critical Care"; and the **June 2016 'deep dive' meeting** would review "Paediatric care (with a focus on the non-elective pathway for children at both hospital sites)"

Which Committees have reviewed the information prior to Board submission?

- N/A

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

1. Information and assurance
2. To approve the Committee's revised Terms of Reference (Appendix 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

Appendix 1: Revised Terms of Reference (for approval)

QUALITY COMMITTEE

TERMS OF REFERENCE

1. Purpose

The Quality Committee is constituted at the request of the Trust Board to seek and obtain assurance ~~oversee the implementation and management within the Trust of~~ on the effectiveness of the Trust's structures, systems and processes to enable delivery of the Trust's objectives relating to quality of care.

2. Membership

- Non-Executive Director (Chair) *
- Non-Executive Director (Vice Chair) *
- Chief Operating Officer *
- Chief Nurse *
- Medical Director *
- Director of Infection Prevention & Control (if not represented via a Clinical Director)
- Associate Director for Quality Governance~~, Quality and Patient Safety~~ *
- Risk and Compliance Manager
- Clinical Directorate representation – Clinical Directors (CD) or designated deputy (General Manager (GM) or Matron)

* Denotes those who constitute the membership of the 'deep dive' meeting (see below)

Members are expected to attend all relevant meetings, but will be required to attend at least 4 of the 'main' Quality Committee meetings (those who are also members of the 'deep dive' meeting will be required to attend at least 3 such meetings). Failure of a committee member to meet this obligation will be referred to the Chair of the Quality Committee for action.

3. Quorum

The Committee will be quorate when the following members are present:

- The Chair or Vice~~Deputy~~ Chair of the Quality Committee
- 1 other Non-Executive Director
- 2 Executive Directors
- 7 Clinical Directorate Representatives (i.e. CD, Matron or GM)
- 1 member of the MTW Governance Team

The 'deep dive' meeting (see below) will be quorate when the following members are present:

- The Chair or Vice Chair of the Quality Committee
- 1 other Non-Executive Director
- 2 Executive Directors

4. Attendance

The following are invited to attend each 'main' meeting

- Internal Audit
- Complaints & PALS Manager
- The Chief Nurse from West Kent Clinical Commissioning Group (CCG) (or Deputy Chief Nurse in their absence)

Other staff may be invited to attend, as required, to meet the Committee's purpose and duties.

All other Non-Executive Directors (including the Chairman of the Trust Board) and Executive Directors (i.e. apart from those listed in the "Membership") are entitled to attend any meeting of the Committee.

5. Frequency of Meetings

Meeting will be generally held every month, but will operate under two different formats. The meeting held on alternate months will be a 'deep dive' meeting, which will enable detailed scrutiny of a small number of issues/subjects For clarity, the other meeting will be referred to as the 'main' Quality Committee.

Additional meetings will be scheduled as necessary at the request of the Chair.

6. Duties

6.1 To seek and obtain ~~receive~~ assurance on the delivery of quality of care across the Trust

6.2 To seek and obtain assurance on ~~monitor~~ the mitigations for significant risks relating to quality

6.3 To seek and obtain assurance ~~ensure~~ that the Trust Risk Management Strategy and Policy is implemented consistently across the Trust, in relation to quality issues~~.~~

6.4 To seek and obtain assurance ~~approve, review and monitor~~on the implementation of relevant policies and procedures~~.~~

6.5 To monitor the effectiveness of quality systems at a Corporate and Directorate level, and seek and obtain assurance~~ensure~~ that appropriate actions are taken.

6.6 To seek and obtain assurance ~~ensure~~ that Directorates are identifying and managing their own quality issues effectively~~.~~

6.7 To receive details~~reports~~ about complaints, claims and inquests, and the Trust's response.

6.8 To receive ~~reports~~ details of Serious Incidents, and the Trust's response.

6.9 To seek and obtain assurance ~~receive progress reports~~ on the Trust's compliance with the Fundamental Standards (as defined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014~~.~~

6.10 To seek and obtain assurance ~~ensure~~ that the Trust and its officers are working in partnership with external agencies for the effective management of risk across the health economy~~.~~

6.11 To seek and obtain assurance on the appropriateness of ~~oversee~~ action taken in response to specific adverse circumstances (e.g. outbreaks of infection)

7. Parent committees and reporting procedure

The Quality Committee is a sub-committee of the Trust Board. The Committee Chair~~man~~ will report activities to the Trust Board to next Trust Board meeting following each Quality Committee meeting.

Any relevant feedback and/or information from the Trust Board will be reported by Executive and Non-Executive members to each meeting of the Committee, by exception.

The Committee's relationship with the Clinical Governance and Patient Experience Committee~~s~~ is covered separately, below.

8. Sub-committees and reporting procedure

The Committee has no sub-committees.
~~The following Committees report to the Quality Committee through their respective chairs or representatives following each meeting. The frequency of reporting will depend on the frequency of each of the sub-committees:~~

- ~~Clinical Governance Committee~~
- ~~Infection Prevention and Control Committee~~
- ~~Mortality Review Group~~
- ~~Patient Environment Steering Group~~
- ~~Safeguarding Adults Committee~~
- ~~Safeguarding Children Committee.~~
- ~~Standards Committee~~

The Committee may however ~~also~~ establish ~~constitute~~ 'Task & Finish' Groups to assist it in meeting its duties.

9. Clinical Governance Committee

The Clinical Governance Committee will provide regular reports to the Quality Committee, which will include details of the activities of the Clinical Governance Committee, and the status of any issues related to the Quality Committee's duties.

The Quality Committee may also commission the Clinical Governance Committee to review a particular subject, and provide a report.

10~~9~~. Patient Experience Committee

The Quality Committee may commission the Patient Experience Committee to review a particular subject, and provide a report. Similarly, the Patient Experience Committee may request that the Quality Committee undertake a review of a particular subject, and provide a report.

The Patient Experience Committee should also receive a summary report of the work undertaken by the Quality Committee, for information/assurance (and to help prevent any unnecessary duplication of work). The summary report submitted from the Quality Committee to the Trust Board should be used for the purpose. Similarly, a summary report of the Patient Experience Committee will be submitted to the Quality Committee.

11~~0~~. Administration

The minutes of the Committee will be formally recorded and presented to the following meeting for agreement and the review of actions

The Trust Secretary will ensure that each committee is given appropriate administrative support and will liaise with the Committee Chair on:

- The Committee's Forward Programme, setting out the dates of key meetings & agenda items
- The meeting agenda
- The meeting minutes and the action log

12~~1~~. Emergency powers and urgent decisions

The powers and authority of the Quality Committee may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least two Executive Director members. The exercise of such powers by the Committee Chair shall be reported to the next ~~formal~~ meeting of the Quality Committee, for formal ratification.

13. Review of Terms of Reference

These Terms of Reference will be agreed by the Quality Committee and approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

- Agreed by Quality and Safety Committee: 13 March 2013
- Approved by the Board: March 2013
- Agreed by the Quality & Safety Committee 'deep dive' meeting: 25th April 2014
- Terms of Reference (amended) agreed by the Quality & Safety Committee: 9th May 2014
- Approved by the Board: May 2014
- Terms of Reference (amended) agreed by the Quality & Safety Committee: 21st January 2015 (to remove reference to the Health & Safety Committee, which is a sub-committee of the Trust Management Executive)
- Revised Terms of Reference agreed by the Quality & Safety Committee, 13th May 2015
- Revised Terms of Reference approved by the Trust Board, 27th May 2015
- Revised Terms of Reference agreed by the Quality Committee, 6th January 2016
- Revised Terms of Reference approved by the Trust Board, 27th January 2016

Appendix 2: Stroke care update report received at the 'main' Quality Committee on 06/01/16

Maidstone and Tunbridge Wells NHS
NHS Trust

QUALITY COMMITTEE - JANUARY 2016

1-6	**UPDATE ON STROKE CARE PERFORMANCE**	**CLINICAL DIRECTOR, EMERGENCY AND MEDICAL SERVICES**

The enclosed report provides information on:

- Current stroke performance against national benchmarks
- Actions being taken to maintain and further improve standards

Reason for receipt at the Quality Committee (decision, discussion, information, assurance etc.)
Information and assurance

1. Introduction

Following the initial Quality & Safety Committee's 'Deep Dive' into the Trust Stroke services in July 2014, updates have been requested and produced for presentation at each Quality Committee. This provides both an update on the transformation of stroke services across the Trust in addition to regional benchmarking. The paper also allows assurance on the quality of care being delivered within the Trust. As from May 2015, a more compact report showing Stroke headlines was requested to replace the full paper. This is the fourth short headline paper to be presented to the Quality Committee.

2. Performance Standards

Information is now collected monthly by the Trust to give internal assurance about delivery against the Sentinel Stroke National Audit Programme (SSNAP). The Trust has also recently reviewed its own targets to continue to drive improvements within stroke care, adhere to national standards and drive excellence in stroke care.

2.1 CT scan performed in under an hour:

- November data for scanning within 1 hour has continued to be successful with Tunbridge Wells Hospital (TWH) scanning 57.7% within the hour and Maidstone (MH) scanning 60%. The national average remains static at 47.4% with a SSNAP "A" Level requiring 48% of patients to be scanned with an hour. Both sites are significantly above this target.
- 12 hour scanning indicates a slight deterioration with TWH scanning 84.6% within 12 hours and MH remaining more consistent at 97.1%. National average currently sits at 91%, with a Level A consisting of 95% of patients being scanned within 12 hours.
- SSNAP results covering data collected July-September 2015 has now been reported. Both sites obtained a Level "A" which is highly commendable.

2.2 Proportion of all stroke patients given thrombolysis (all stroke types) and 2.3 Percentage of thrombolysed patients with a door-to-needle time <60mins is as follows:

- November data indicates that there was an encouraging 11.5% of patients' thrombolysed at TWH. The month saw 2/3 patients (67%) thrombolysed within 60 minutes.
  - At MH a low 2.9% of patients were thrombolysed, which equated to 1 patient, which achieved the 60 minute target.
- Thrombolysis rates and the 60 minute door to needle target consistently remains a challenge with fluctuating results. However, December has shown an increase in thrombolysed patients cross site, and shall be reviewed when the Trust's data is available.
- SSNAP Results covering data from July – September 2015 shows consistency at TWH, again achieving a level "C" due to numbers of patients thrombolysed in addition to achieving the mean time to thrombolysis of 55 minutes. MH however, did see an improvement from last quarter's level "E" to a "D" for multiple domain factors.

2.4 Proportion of Patients admitted to the stroke unit within four hours:

- November data within this performance indicator shows that MH admitted 55.9% of stroke patients to the stroke unit within 4 hours. TWH showed a drop to 38.5% due to a higher than average number having their strokes within a few days of one another and not having the available stroke beds to meet the 4 hour admission criteria. SSNAP data however showed a stable picture at TWH in regards to achieving the 4 hour target. Comparatively MH site also showed a steady performance by remaining a level "C".

2.5 Assessment by a stroke physician within 24 hours:

- Monthly data from November indicates specialist assessments were completed within 24 hours in 65.5% of cases at TWH and 54.3% at MH, which shows a drop in performance at TWH due there not being a locum stroke physician in post, with a static performance at MH. A vacancy still remains open at TWH for a stroke physician despite advertising.

2.6: Current 80/90 Performance

- November data is currently 75.4% with a current year to date (YTD) performance of 83.7%. The national average for this indicator has increased from 84% to 86.1%. It is expected that December data will show a reduction in 80/90 stay at TWH due to the numbers admitted in a short time frame.

2.7: CQUIN achievement for 15-16

- The new CQUIN for 15-16 has been agreed which is focused upon Early Supported Discharge (ESD) use to reduce Length of stay (LOS). A working party has been formed to identify steps to assist in achieving the required outcome.

3. Conclusion

Data has generally remained static with some encouraging improvements and areas for focus. Work continues locally with site specific action plans and meetings taking place to improve performance and drive up standards of care. The Kent Stroke Review continues to progress, with both nursing and medical clinical leads in addition to a strategic representative attending the Clinical Reference group to represent the Trust. Options are currently being identified and presented to the CCG's which may result in public consultation by March/April 2016. SSNAP results for July-September 2015 have shown once again a small improvement at TWH with almost achieving a Level C (missing this by 1.1 points) after a deduction of points for a Level B within audit compliance. MH has maintained a "C" rating as expected.

Below shows Kent's SSNAP results for April – June 2015 and July - September 2015 which is encouraging for benchmarking. This placed MH and TWH as the third and fourth highest performing units in Kent just under Queen Elizabeth and the William Harvey with TWH close to entering the SSNAP Level C band (60 points required).

April – June 2015

- Queen Elizabeth SSNAP Level C (64.1 points)
- Maidstone SSNAP Level C (63.7 points)
- Darenth Valley SSNAP Level C (62.3 points)
- William Harvey SSNAP Level C (60.8 points)
- TWH SSNAP Level D (57.9 points)
- Kent and Canterbury SSNAP Level D (47 points)
- Medway Maritime SSNAP Level D (43.7 points0

July – September 2015

- William Harvey SSNAP Level B (70.3 points)
- Queen Elizabeth SSNAP Level C (68.4 points)
- Maidstone SSNAP Level C (63.7 points)
- TWH SSNAP Level D (58.9 points)
- Darenth Valley SSNAP Level D (57 points)
- Kent and Canterbury SSNAP Level D (55.6 points)
- Medway Maritime SSNAP Level D (46.5 point)

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – January 2016

1-23	**Finance Committee, 25/01/16 (Approval of application for a "Single Currency Interim Revenue Support Facility")**	**Chairman of Finance Committee / Director of Finance**

The Finance Committee reviewed (and supported) the Trust's application for a "Single Currency Interim Revolving Working Capital Support Facility" (IRWCF), for £12.132m, on 19/10/15. The application was then approved for submission by the Trust Board on 21/10/15, and the Department of Health (DH) subsequently approved the application (on 28/10/15).

Drawdowns on the facility have been made by the Trust since, but the NHS Trust Development Authority then wrote to the Trust on 04/01/16, suggesting an application be made to convert the IRWCF to an alternative financial vehicle i.e. a "Single Currency Interim Revenue Support Facility" (the new Facility has more favourable terms than the IRWFC). The table below compares the key aspects of the two Facilities.

Existing (Single Currency Interim Revolving Working Capital Support Facility)	**New (Single Currency Interim Revenue Support Facility)**
▪ Incurs interest at 3.5%	▪ Incurs interest at 1.5%
▪ The repayment date is 12/10/20 (although the expectation was that the Facility was to be repaid or converted within 2 years)	▪ The repayment date is 18/02/19 (as the Agreement covers a 3 year period, set to start from the date of the first expected draw)
Additional Terms and Conditions: "Deficit Targets and Capital Controls" (Schedule 8) ▪ "The Borrower must not exceed Deficit Target and / or Capital Control Limits set by the Lender. Limits may be adjusted by the lender from time to time in consultation with the relevant supervisory body. Performance against these limits will be monitored by the relevant supervisory body. For avoidance of doubt, as at the date of this agreement, the deficit target limit is £12,132,000 and the Capital Control Limit is not applicable".	Additional Terms and Conditions: "Surplus/Deficit and Capital Limits" (Schedule 8) ▪ "The Lender has set a Surplus/Deficit Limit and/or a Capital Limit for the Borrower in consultation with the relevant Supervisory Body. These Limits reflect the aggregate of Voted Funds available to the Lender at the date of this Agreement ▪ 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 ▪ 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 ▪ 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 ▪ 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) ▪ Limits may be adjusted by the Lender from time to time in consultation with the relevant Supervisory Body ▪ Performance against Limits will be monitored by the relevant Supervisory Body ▪ For the avoidance of doubt, as at the date of this Agreement and for the financial year to which this agreement relates, the Surplus/Deficit Limit is (£12,132,000) and the Capital Limit is not applicable

The loan Agreement for the new Facility is enclosed. As with the original application for the IRWCF, a Trust Board resolution is required as part of the application process, along with the signing of a new Direct Debit (DD) Mandate.

The Trust Board resolution must include the following (see Schedule 1 of the Agreement):
(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" (for the IRWCF, the Director of Finance was authorised)
(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 (for the IRWCF, the Director of Finance and the Deputy Directors of Finance were authorised)
(D) Confirming the Borrower's undertaking to comply with the Additional Terms and Conditions"

The "Additional Terms and Conditions" referred to in Resolution (D) above are contained in Schedule 8 of the enclosed Agreement.

The Agreement must be signed in blue ink by the officer named in part (B) of the resolution

For the IRWCF, the Trust Board approved the proposal that the DD Mandate be signed by two signatories from the current Authorised Signatory panel held by the DH Cash funding team (i.e. the Chief Executive, Director of Finance, Deputy Directors of Finance, Head of Financial Services, and the Head of Financial Systems).

The Trust requested the DH to reduce the minimum cash balance held to £1m, from the £2.1m suggested by the DH in the original financing documentation. This has now been approved and the enclosed Agreement (and letter from the DH) reflects this reduced minimum balance.

On 25/01/16, the Finance Committee was asked to review the enclosed Agreement and agree to recommend that the Trust Board (on 27/01/16):

- Approves the resolution above
- Authorises the Director of Finance to execute the Finance Documents on its behalf
- Authorises, on its behalf, the Director of Finance and Deputy Directors of Finance to sign and/or despatch all documents and notices and to be signed and/or despatched by it under or in connection with the Finance Documents
- Authorise the signing of the Direct Debit Mandate by two signatories from the current Authorised Signatory panel held by the DH Cash funding team (i.e. the Chief Executive, Director of Finance, Deputy Directors of Finance, Head of Financial Services, and the Head of Financial Systems)
- Confirm the undertaking to comply with the Additional Terms and Conditions (as listed in Schedule 8)
- Approves the amendment to the minimum cash balance (as listed in the enclosed letter from the DH)

The outcome of the Finance Committee's review will be reported verbally at the Board on 27/01/16.

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 25/01/16

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

- To approve the resolution above
- To authorise the Director of Finance to execute the Finance Documents on behalf of the Trust Board
- To authorise, on its behalf, the Director of Finance and Deputy Directors of Finance to sign and/or despatch all documents and notices and to be signed and/or despatched by it under or in connection with the Finance Documents
- To authorise the signing of the Direct Debit Mandate by two signatories from the current Authorised Signatory panel held by the DH Cash funding team (i.e. the Chief Executive, Director of Finance, Deputy Directors of Finance, Head of Financial Services, and the Head of Financial Systems)
- To confirm the undertaking to comply with the Additional Terms and Conditions (as listed in Schedule 8)
- To approve the amendment to the minimum cash balance (as listed in the enclosed letter from the DH)

[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

DATED 2016

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
(as Borrower)

and

THE SECRETARY OF STATE FOR HEALTH
(as Lender)

£12,132,000

SINGLE CURRENCY INTERIM REVENUE SUPPORT

FACILITY AGREEMENT

REF NO: DHPF/ISWBL/RWF/2015-12-16/A

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	8
6.	PAYMENTS AND REPAYMENT	10
7.	PREPAYMENT AND CANCELLATION	10
8.	INTEREST	11
9.	INTEREST PERIODS	11
10.	PREPAYMENT AMOUNT	12
11.	INDEMNITIES	12
12.	MITIGATION BY THE LENDER	13
13.	COSTS AND EXPENSES	13
14.	REPRESENTATIONS	14
15.	INFORMATION UNDERTAKINGS	16
16.	GENERAL UNDERTAKINGS	18
17.	COMPLIANCE FRAMEWORK	20
18.	EVENTS OF DEFAULT	21
19.	ASSIGNMENTS AND TRANSFERS	23
20.	ROLE OF THE LENDER	24
21.	PAYMENT MECHANICS	25
22.	SET-OFF	26
23.	NOTICES	27
24.	CALCULATIONS AND CERTIFICATES	28
25.	PARTIAL INVALIDITY	28
26.	REMEDIES AND WAIVERS	28
27.	AMENDMENTS AND WAIVERS	28
28.	COUNTERPARTS	28
29.	GOVERNING LAW	28
30.	DISPUTE RESOLUTION	28
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) **MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST** of**, Maidstone Hospital, Hermitage Land, Maidstone, Kent, ME16 9QQ** (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 Interim Support facility made available under this Agreement as described in Clause 2 (*The Facility*).

"Facility Amount" means £12,132,000 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 18/02/2019.

"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.

"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 £1,000,000;

"**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 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 either the NHS Trust Development Authority and/or 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 a sterling interim support facility in an aggregate amount equal to the Facility Amount.

2.2 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 be obliged to 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

£000	Q1	Q2	Q3	Q4	TOTAL
2015-16	0	0	0	12,132	**12,132**
TOTAL					**12,132**

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 February 2019	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. These Limits reflect the aggregate of Voted Funds available to the Lender at the date of this Agreement.

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.

1.8. For the avoidance of doubt, as at the date of this Agreement and for the financial year to which this agreement relates, the Surplus/Deficit Limit is (£12,132,000) and the Capital Limit is not applicable.

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 MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

By:

Name:

Position:

Address: Maidstone Hospital
Hermitage Land
Maidstone
Kent
ME16 9QQ

Email: stephen.orpin@nhs.net

Attention: Stephen Orpin

Lender

The Secretary of State for Health

By:

Name:

Address: Department of Health,
4th Floor,
Skipton House,
80 London Road,
London SE1 6LH

Email: dhloanscentralinbox@dh.gsi.gov.uk

Department of Health

Provider Finance
Quarry House
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LS2 7PD
dhloanscentralinbox@dh.gsi.gov.uk
www.dh.gov.uk

Stephen Orpin
Maidstone and Tunbridge Wells NHS Trust
Hermitage Lane
Maidstone
Kent

ME16 9QQ

21/01/2016

By email stephen.orpin@nhs.net

Dear Stephen

Single Currency Interim Working Revenue Support Facility Agreement between Maidstone and Tunbridge Wells NHS Trust and the Secretary of State for Health reference DHPF/ISRWF/RWF/2015-10-02/A and dated 28/10/2016 (the "Agreement")

1. This notice is supplemental to the Agreement. The terms within this letter shall have the same meaning as those defined within the Agreement.

2. A variation is proposed to the Minimum Cash Balance within the Agreement such that Schedule 3: Defined Facility Limits shall be amended as follows:

SCHEDULE 3: DEFINED FACILITY LIMITS

Defined Term	Amount
Facility Amount	£12,132,000
Minimum Cash Balance	£1,000,000
Maximum Cash Balance	£10,159,000

3. An additional variation is also proposed to the Agreement such that existing Schedule 8: Additional Terms and Conditions shall be substituted by the revised schedule set out in Annex 1 of this letter
4. Please sign the attached copy of this letter to signify your agreement, on behalf of Maidstone and Tunbridge Wells NHS Trust to the terms of this agreement as set out above.

Yours sincerely

For and on behalf of The Secretary of State for Health

Name:

For and on behalf of Maidstone and Tunbridge Wells NHS Trust