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 26TH NOVEMBER 2014

ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment	Page
11-1	To receive apologies for absence	Chairman	Verbal	-
11-2	To declare interests relevant to agenda items	Chairman	Verbal	-
11-3	Minutes of the Part 1 meeting of 22nd October 2014	Chairman	1	1-9
11-4	To note progress with previous actions	Chairman	2	10-11
11-5	Chairman's report	Chairman	Verbal	-
11-6	Chief Executive's report	Chief Executive	3	12
11-7	Integrated Performance Report for October 2014	Chief Executive	4	13-25
	Additional quality items			
11-8	Clinical Quality and Patient Safety Report	Chief Nurse	5	26-35
11-9	Response to the underlying issues involved in the 'patient story' that was heard at the Oct. 2014 Board	Medical Director / Chief Nurse	6	36-37
11-10	Planned & actual ward staffing for October 2014	Chief Nurse	7	38-40
11-11	Details of the extent of the cancer-related services provided by the local voluntary/third sector	Medical Director	8	41
	Reports from Board sub-committees			
11-12	Charitable Funds Committee, 20/10/14 (incl. approval of the 2013/14 Ann. Report & Accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund)	Committee Chair	9	42-74
11-13	Quality & Safety Committee, 12/11/14	Committee Chair	10	75-76
11-14	Trust Management Executive, 19/11/14	Committee Chair	11	77
11-15	Audit and Governance Committee, 20/11/14	Committee Chair	Verbal	-
11-16	Finance Committee, 20/11/14	Committee Chair	12 (to follow)	-
	Assurance and policy			
11-17	Approval of compliance oversight self-certification	Trust Secretary	13	78-87
11-18	Ratification of Standing Fin. Instructions (ann. review)	Director of Finance	14	88-163
11-19	Review & approval of the Board's Terms of Reference	Chairman	15	164-174
11-20	**To consider any other business**			
11-21	**To receive any questions from members of the public**			
11-22	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 meetings:

- 17th December 2014, 10.30am, Academic Centre, Maidstone Hospital
- 28th January 2015, 10.30am, Education Centre, Tunbridge Wells Hospital

Anthony Jones,
Chairman

Maidstone and Tunbridge Wells NHS
NHS Trust

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 22ND OCTOBER 2014, 10.30 A.M. AT TUNBRIDGE WELLS HOSPITAL

DRAFT, FOR APPROVAL

Present:	Anthony Jones	Chairman (Chair)	(AJ)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Alex King	Non-Executive Director	(AK)
	Kevin Tallett	Non-Executive Director	(KT)
	Steve Tinton	Non-Executive Director	(ST)
	Avey Bhatia	Chief Nurse	(AB)
	Angela Gallagher	Chief Operating Officer	(AG)
	Steve Orpin	Director of Finance	(SO)
	Paul Sigston	Medical Director	(PS)
In attendance:	Paul Bentley	Director of Workforce and Communications	(PB)
	Jayne Black	Director of Strategy & Transformation	(JB)
	Kevin Rowan	Trust Secretary	(KR)
	Alan Mayhew	Patient's Relative (for item 10-8)	(AM)
	Peter Mayhew	Patient's Relative (for item 10-8)	(PM)
Observing:	Siobhan Callanan	Associate Director of Nursing for Surgery, Oncology & Support services	(SC)
	Lynn Gray	Associate Director of Nursing for emergency Services	(LG)
	Darren Yates	Head of Communications	(DY)
	Pam Croucher	Member of the public (also member of the Trust's Patient Experience Committee)	(PC)

10-1 To receive apologies for absence

Apologies were received from Sylvia Denton (SD), Non-Executive Director.

It was also noted that Sara Mumford (SM), Director of Infection Prevention and Control would not be in attendance.

AJ highlighted that this was JB's last Board meeting, as she would be leaving the Trust. AJ thanked JB for her contribution during her time at the Trust and wished her well for the future.

10-2 To declare any interests relevant to agenda items

There were no declarations of interest.

10-3 To agree the minutes of the Part 1 meeting of 24th September 2014

The minutes were agreed as a true and accurate record of the meeting subject to the following amendments:

- Item 9-8, page 6: Change "SDu referred to PS's earlier claim regarding the quality of End of Life care …." to "…SDu referred to PS's earlier comment regarding the quality of End of Life care…"
- Item 9-24, page 11: Change "…PB added that Trade Unions had given guarantees that such action would not affect clinical care..." to "…PB added that Trade Unions had given guarantees that such action would not affect urgent clinical care…"

Action: Amend the minutes of the Part 1 Trust Board meeting of 24th September 2014 (Trust Secretary, October 2014)

10-4 To note progress with previous actions

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

- **9-4: Arrange for the Board to receive details of the extent of the cancer-related services provided by the local voluntary/third sector**
  PS stated that the information would be submitted to the November 2014 Trust Board.

- **9-11: Increase the size of the "fill rate indicator return" table in future 'Planned Vs. Actual' staffing reports submitted to the Trust Board**
  AB confirmed the action had been completed, and referred to the report for agenda item 10-10.

10-5 Chairman's report

AJ reported that the Trust had a major inspection by the Care Quality Commission (CQC) over 3 days in October, involving 37 inspectors across both hospital sites. AJ continued that the inspectors had provided some feedback at the end of the 3 days, to the effect that Trust staff had been very open and welcoming. AJ added that the report of the inspection was awaited, and was likely to be published in January 2015.

10-6 Chief Executive's report

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

- The Leagues of Friends had enabled the Trust to introduce free Wi-Fi at both hospitals sites, which would be in place circa Christmas 2014. GD thanked the Leagues, and noted that accessing the Wi-Fi would require a login that would help raise the Leagues' profile
- GD had attended the Radiotherapy Unit at the Kent and Canterbury Hospital, which had some current structural problems. GD added that East Kent University Hospitals NHS Foundation Trust (EKHUFT) had been asked to resolve the problems as soon as possible

AJ commended the introduction of free Wi-Fi, and proposed that the Trust Board's gratitude be formally passed onto the Leagues of Friends This was agreed.

Action: Arrange for the Trust Board's gratitude for funding the introduction of free Wi-Fi to be formally passed on the League of Friends at both hospital sites (Trust Secretary, October 2014 onwards)

SDu asked whether the Trust had been involved in the technical considerations of the free Wi-Fi. PS confirmed that the technical issues had been reviewed by the Trust, and added he did not anticipate any significant technical problems.

AJ drew Board members' attention to the fact that the Trust was continuing to be involved in the solution to the challenges faced by Medway NHS Foundation Trust. GD confirmed that such work was continuing, and was focusing on providing Outpatient clinics for patients from the Swale area.

10-7 Integrated Performance Report for September 2014

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

- The month was very similar to the previous month
- Stroke care remained an issue, but the Trust's performance had improved
- Delayed Transfers of Care were continuing, and the inability to discharge patients was affecting the use of agency staff and other issues. GD added that this was however not unique to the Trust, and was an issue across the local health economy
- The A&E department was performing very well, given the pressures within the health economy

AJ agreed that the A&E department had performed very well.

KT asked whether the community healthcare sector was facing the same pressures as the Trust. GD replied that Kent Community Healthcare NHS Trust (KCHT) was unlikely to have the same pressures, as the underlying factor was the lack of Nursing Home capacity. GD stated that he believed that this needed to be addressed by releasing community care beds for use by acute providers.

KT commented that the Trust's partners, such as the Clinical Commissioning Group (CCG) should be applying pressure to continue with models such as that used in Romney Ward.

AB then referred to the circulated report and highlighted that complaints response times had improved for the last month, following a 4 to 5 month period where performance had been poor.

PS also highlighted that meetings regarding Stroke care were continuing, both in terms of short-term improvement and options for future service provision.

AJ commented that the performance dashboard contained very few entries within the "Bench Mark" column, and appealed for such benchmarks to be included. GD acknowledged that further work was required in relation to the inclusion of benchmarks.

SDu noted that performance on the "SHMI" indicator was rated as 'green' even though the rate was above both "Plan/Limit" and "Bench Mark". PS replied that the performance was within the agreed tolerance limits. AJ asked PS for details of such limits. PS confirmed that the tolerance limits for calendar year of 2013 were 97.8 (lower) and 106.4 (upper).

SDu also commented that the number of emergency readmissions seemed high, and asked what the "Bench Mark" level represented. PS stated that he understood the "Bench Mark" was the national average rate, and added that he did not regard the Trust's current rate to be unreasonable.

AG then referred to the circulated report and highlighted the following points:
- Elective activity was significantly below plan, and a remedial action plan was focused on reducing length of stay
- Performance on the Cancer 62-day wait (first definitive) target was below plan. AG reminded Board members that the Cancer data was always one month in arrears (i.e. the report contained the data for August)
- Issues regarding length of stay and Delayed Transfers of Care were being addressed via KCHT and Social Services

KT asked whether the elective activity situation was undermining the work to reduce the 18 week waiting list backlog. AG explained that the backlog had been reduced since May, in accordance with the Trust's plans, and was anticipated to continue to be maintained. GD clarified that elective activity had actually increased by circa 900 from 2013/14, but was below the plan for 2014/15.

AJ asked about the occurrence of the 12-hour breach ("Emergency A&E >12hr to Admission"). AG confirmed that this had occurred in May 2014.

SO then referred to the circulated report and highlighted the following points:
- There had been an in-month deficit of £0.8m against a plan of £0.5m, resulting in a year-to-date deficit of £8.7m against a planned deficit of £8.8m
- The position was affected by the aforementioned activity pressures
- Cost pressures had been affected by agency and locum staff usage
- The Cost Improvement Programme (CIP) was delivering ahead of plan, and half of the planned total had been delivered at month 6. A proportion of the CIP, equating to circa £5m, was expected to be non-recurrent, which would need to be addressed in 2015/16
- An application for additional permanent working capital support will be submitted to the Independent Trust Financing Facility in December 2014, and if successful, such support was likely to be received in February 2015. If temporary support was required prior to this, the Finance Committee would be asked to approve an application for such support

KT commended the identification of the non-recurrent CIP, and asked how this compared to the Trust's plans. SO replied that the plan was for the full CIP to be delivered recurrently. SO also emphasised that the challenge to increase the level of recurrent delivery had been acknowledged.

KT then asked for a comment on the overachievement of the CIP in July and September, when compared to plan. SO explained that the delivery for July and September included some prior-month performance, following a review of CIP schemes.

ST reported that the Finance Committee held on 20th October had heard that circa £2 to 3m of the £5m of non-recurrent CIPs had been affected by the current pressures regarding clinical activity. ST added that the Committee had also queried whether the situation represented a trend, rather than an anomaly. KT acknowledged the point, but pointed out that the £22.4m CIP was still required to be delivered, regardless, and the CIP target in future years would therefore be larger, and harder to achieve. GD agreed in part, but noted that if the trend did continue, the point would be reached at which the situation became unsustainable.

In response to a query, SO clarified that the marginal tariff for emergency admissions was currently costing the Trust circa £6m per annum.

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

- The month saw a significant reduction in the usage of temporary staff, which suggested that such usage had peaked, although it was too early to be conclusive
- Substantive recruitment had increased, as had compliance with Statutory & Mandatory training
- Sickness absence had reduced slightly, and performance was comparable with the benchmark

AJ asked whether the Trust was applying as much pressure as possible to increase substantive recruitment. PB gave assurance that the matter was receiving urgent attention, and made reference to the engagement by Senior Nursing staff, and a recent meeting with the Clinical Directors for Emergency and Speciality Medicine, to discuss options to address the recruitment challenges faced. PB added that Trust staff were currently in Glasgow, aiming to recruit more staff, and had made efforts to recruit from Spain. PB added that the recruitment of Registered Nurses in the UK was at an all-time high, which was posing a challenge across the country.

KT commented that it would be beneficial if the Workforce dashboard contained more entries within the “Plan/Limit” column. PB acknowledged the point.

AJ proposed that the next Workforce Committee focus on the recruitment of substantive staff. This was agreed.

Action: Arrange for the next meeting of the Workforce Committee to focus on the recruitment of substantive staff (Chair of Workforce Committee / Director of Workforce and Communications, December 2014)

AB then pointed out that the number of Nursing Trainees was being reduced. AJ asked what efforts were being made to address this. AB stated that she and her counterparts at other Trusts were influencing the situation as much as possible, but noted that the number of training places was commissioned by Health Education England.

Additional quality items

10-8 A patient’s experiences of the Trust’s services

AJ welcomed AM and PM to the meeting and asked them to relay their relatives’ experience to the Board. AM relayed the details of the experience of his wife, Mrs Mayhew, as follows:

- Mrs Mayhew had kidney cancer, for which she was being treated at The Royal Marsden NHS Foundation Trust.
- One day during May 2013 Mrs Mayhew woke with stomach pains. The family contacted her GP, who contacted the Tunbridge Wells Hospital, and arranged for an ambulance to take her to the A&E department at Tunbridge Wells Hospital. Mrs Mayhew was subsequently taken to the latter, on the Thursday before the early May Bank Holiday, and admitted to hospital.
- Some communication problems occurred with the doctor in training in the A&E department, which resulted in some relevant clinical information not being passed on to other staff
- Following review, the Consultant in charge of Mrs Mayhew’s care stated that he believed she could go home within a couple of days.
- During her time at the hospital, no-one carried out a physical examination of Mrs Mayhew, although a Consultant did visit Mrs Mayhew for a few minutes every day
- Mrs Mayhew deteriorated gradually over the next few days. AM made efforts to obtain assistance but the staff that were approached made it known that they were very busy

- Eventually, one doctor that was approached recognised that Mrs Mayhew had deteriorated markedly, and admitted her to the Intensive Care Unit (ICU)
- The care in ICU was excellent, but the deterioration continued, and Mrs Mayhew passed away
- The family felt that the availability of medical staff over the Bank Holiday weekend was poor, and therefore made a complaint
- The Trust's response to the complaint was not satisfactory, until, some months later, a meeting was offered, with PS

PM then highlighted the points from which the Trust could learn from the experience, as follows:

- The continuity of care was poor. There did not appear to be any one person allocated to oversee Mrs Mayhew's care, and there was therefore no consistency in such care. The continuity situation worsened significantly over the Bank Holiday weekend
- Because the family was ever present at Mrs Mayhew's bedside, the Nurses seemed to rely on the family to notify them of any concerns (though Nurses did attend when requested to do so). The presence of relatives should not detract from the level of nursing care provided to a patient.
- At one point, Mrs Mayhew was prescribed medication, but staff stated that the Pharmacy was closed on a Bank Holiday weekend
- Staff did not always demonstrate an awareness that patients react to situations differently, based on their generation and culture
- When the complaint was made, the Trust reacted defensively, and appeared to be fearful of legal action. Arranging a meeting took a long time. The family took great care in making the point that there was no intention to pursue legal action, but it was disappointing that such efforts had to be made. The Trust should therefore recognise that not every complainant wished to pursue legal action.

AJ asked for details of the timings involved. AM replied that Mrs Mayhew passed away in May 2013, and it was several months before a complaints resolution meeting was offered. It was noted that the meeting was eventually held on 21st March 2014.

AJ apologised to the family on behalf of the Trust for the problems that had arisen, and asked PS and AB to comment on the case.

PS stated that his conclusion was that the clinical staff involved had missed the point, and had not recognised that Mrs Mayhew's condition had deteriorated. PS continued that an important learning point was in recognising that it was more productive to meet with the family rather than continue with written replies to the complaint. PS added that since that time, the Trust's complaints process had improved.

AJ asked for clarification that the complaints responses from the Trust did not address all the issues raised in the complaint. AM agreed this was a fair reflection, and added that the Trust's letters of response had asserted that everything that was meant to happen with Mrs Mayhew's care had happened.

SDu gave her condolences for AM and PM's loss, and asked for an explanation of the action taken by staff to recognise patients that were deteriorating. AB explained that the Trust deployed a Patient At Risk (PAR) scoring system, which involved the taking of key observations (such as pulse, blood pressure and respiratory rate), and review by staff if the PAR score reached a certain level. AB also noted that there was a Critical Care outreach service in place, which was now available at weekends. AB continued that hourly checks by Nursing staff, which should require a Nurse to enter a patient's room, had been introduced because of the single room environment at Tunbridge Wells Hospital, and acknowledged that further action was required to reinforce this.

AB also acknowledged that the Trust's cultural response to many of the complaints it received was to consider how to defend the Trust's position, and added that although this culture was starting to change, further work was required. AB also noted that complaints resolution meetings were offered earlier in the complaints process than had previously been the case.

KT expressed surprise that the Pharmacy was closed over the Bank Holiday weekend. AJ asked for confirmation that there was an on-call Pharmacist available to obtain medication over Bank

Holiday weekends. AG and PS confirmed this was the case. GD added that ensuring this arrangement was understood by all staff, including temporary staff, was however a key lesson.

AJ stated that he would like the Trust Board to reflect on the underlying issues raised, and proposed that PS and AB bring a considered response to a future Board meeting. This was agreed.

Action: Submit a report to the Trust Board containing a response to the underlying issues involved in the 'patient story' that was heard at the October 2014 Board meeting (Medical Director / Chief Nurse, November 2014 onwards)

AJ asked AM and PM whether they wished to add anything further. AM commended the offer of a meeting with complainants, noting that although such meetings were labour intensive, complainants most likely wanted to hear that the issues they were raising would be acted upon. AM added that providing early personal contact with complaints, and being completely open, were key aspects of the complaints process.

PM emphasized that the standard of care received in ICU was very good.

AM also commented that doctors needed training in providing reassurance to family members, and commented that the Consultant providing care to Mrs Mayhew at the Bank Holiday weekend would have benefited from such training, as they had stated that they were 'just the weekend Consultant'. AJ agreed and noted that asking questions about medical staff's interaction with patients formed part of the interview process for new Consultant appointments.

AJ again apologised for the Trust's failings, and thanked AM and PM for attending the Trust Board.

[At this point, AM and PM left the meeting]

SDu commented that having a patient attend the Board was far more powerful than receiving a written story. AJ agreed

10-9 Initial findings from the CQC inspection, October 2014

It was noted that this was covered by AJ under item 10-5.

10-10 Planned and actual ward staffing for September 2014

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

- The format had been amended to enable the information to be read more easily
- John Day and the Stroke Ward at Maidstone Hospital were regularly using more staff at night than had been planned. Plans were therefore in place to increase their establishments.
- Several other areas had used more staff than planned, and some areas had used less than plan. The latter included the ICU at Maidstone Hospital, but this pattern of usage triangulated with the recent reduced acuity and dependency within the ICU

AJ asked why the levels of Clinical Support Worker (Care staff) were below the plan/fill rate to the extent reported. AB replied that using Care Staff via an agency was expensive, and therefore if a shift was unable to be filled by a person from the Bank, a judgement was often made as to whether it would be more advantageous to book another trained nurse (from the Bank), rather than have a Clinical Support Worker from an agency. AJ acknowledged the point, but suggested that manpower planning therefore needed to be reviewed. The point was acknowledged,

PS highlighted that ICU had defined ratios of nurses to patients, which may explain why the staffing in ICU would vary more than some other areas.

Reports from Board sub-committees

10-11 Quality & Safety Committee, 29/09/14

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

- The Committee expected a correlation to be in place between clinical excellence and the receipt of a Clinical Excellence Award

- The Committee recommended that the Board receive a report, to be received annually, on clinical outcomes

AJ referred to the latter point, and asked why June 2015 had been identified as the date for the Board report. SDu stated that this date allowed time for further engagement with Consultant staff in relation to the use of the 'Dr Foster' data.

KT gave assurance, based on his own involvement in the Clinical Excellence Awards process, that the principle that such awards should not be given to clinicians who are not 'clinically excellent', was already incorporated.

10-12 Trust Management Executive, 15/10/14

GD referred to the circulated report and highlighted that the Trust's response to the Ebola outbreak had been discussed.

SDu commented that there was nothing on the Trust's website that referred to Ebola. GD agreed that some such information should be made available via the website.

Action: Arrange for the Trust's website to contain some information for the public on the current Ebola outbreak (Director of Workforce and Communications, October 2014 onwards)

10-13 Finance Committee, 25/09/14 & 20/10/14

ST referred to the circulated reports and highlighted that

- The Full Business Case for the South Acute Programme (SAcP) was reviewed, and the Committee had concluded that the Board should be recommended to approve the Case
- CQUIN performance had been reviewed, and the "Reduction of surgical site infection" scheme had been noted, given the level of control the Trust should have on this matter.

PS gave assurance that work was taking place in Orthopaedics to reduce surgical site infection.

10-14 Charitable Funds Committee, 20/10/14

ST reported that the Committee had met on the 20th October and discussed the following:

- The message that expenditure needed to take place needed to be broadcast more widely
- The potential introduction of a fundraising function was discussed, and it was noted that further work had been requested, to enable a decision to be made

Planning and strategy

10-15 To discuss the Winter & Operational Resilience plans

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

- The plan contained details of schemes to address surges in demand, but it was more appropriately considered to be an Operational Resilience Plan than a Winter Pan, as it would not just apply to winter
- Some of the schemes were focused on the Trust's actions, but all of the schemes required the involvement of other parties within the local health economy
- Romney Ward had been included in the funding plans. Others schemes included charity funded schemes, such as "Take Home and Settle", which was aimed at patients who were not entitled to funded care packages after discharge. Liaison psychiatry was also supported, which had been a significant issue for the Trust in recent times
- A second phase of monies was now available, and the Trust had made bids against this. Such bids included the funding of the Trust's winter wards

AJ asked for an update on the second phase of monies. AG confirmed that such monies had not yet been made available to CCGs.

AJ remarked that many of the unfunded schemes were very important and asked whether these would be covered via the second phase. SO stated that there was a reasonable expectation regarding the Trust's bids for phase two, but such cases needed to be compelling.

KT then asked for details of the likely demand. AG replied that modelling had indicated that the Trust would need a further 28 beds i.e. over and above the beds currently being used.

SDu proposed that for future years, it would be advantageous for the Trust Board to receive the plan earlier in the year. AJ proposed that AG be asked to consider the point, and confirm which month in 2015 would be most appropriate for the plan to be considered. This was agreed.

Action: Consider which month in 2015 would be the most appropriate for the 'Winter & Operational Resilience plans' to be submitted to the Trust Board (Chief Operating Officer, October 2014 onwards)

ST asked for confirmation that the report was stating that all of the schemes in the plan would be introduced, but that some of these would not be funded. AJ confirmed that this was the correct interpretation of the report.

ST also asked for details of the Trust's progress with providing Flu vaccinations for staff. Assurance was given that progress was being made.

SO referred to AG's earlier point, and emphasised that the additional 28 beds that were required were not currently within the Trust's financial plan, and therefore these beds would result in a financial pressure. AJ acknowledged the point.

10-16 Full Business Case for the Southern Acute Programme (SAcP)

AG referred to the circulated report and highlighted that the Case was viewed at the Finance Committee on 20th October, with the Head of Informatics Programmes present. AG added that the Finance Committee recommended that the Trust Board give its approval for the Case.

GD noted that the Case had not been considered at the Trust Management Executive (TME). AG confirmed that the SAcP had been discussed at a TME meeting at which GD had not presided.

AJ asked whether any staff had been to see the preferred system in use in Salford. AG stated that a number of hospitals had been visited, but could not recall whether this had included Salford. PS gave assurance that the system was in use, and had been observed in use.

KT asked whether a review of the Trust's IT architecture had been undertaken as part of the process. AG confirmed this review had been undertaken.

KT then asked which party was undertaking the implementation of the system. AG confirmed that the intention was for the implementation team to be from the Trust.

ST confirmed that the Finance Committee had recommended the Case for approval on the basis that the system was required, the preferred system represented the best option available, and the Case represented the best business decision for the Trust, but added that HM Treasury expected to see wider benefits, which had not been considered in detail by the Finance Committee.

AJ referred to page 10 and the comment that a "A clinically led change programme will be established that will have the responsibility for assessing, developing and agreeing new clinical processes, clinical safety, clinical content and configuration", and asked for an explanation. AG explained that this statement recognised that the project was far more than just an IT project, and required changes in a number of areas, which would take time.

KT emphasised the difference between configuration and customisation, and noted that the latter involved a far greater challenge and a different pathway. KT therefore asked whether the intention was to configure or customise the system. PS stated that the system had been chosen on the basis that it could perform the functions required by the Trust. AG added that the service specification was developed via involvement from clinical staff.

AB commented that, based on her own previous experience, changing a Patient Administration System (PAS) was a huge undertaking which required significant clinical input. The point was acknowledged.

The Full Business Case was approved by the Trust Board.

AJ invited AG and PS to consider the comments made by the Board when the system was implemented.

10-17 Notification of changes to the Kent and Medway chemotherapy e-prescribing business case

AG referred to the circulated report and highlighted the following points:
- The costs had changed since the Outline Business Case was approved by the Board in May 2014, but were still within the tolerance limits of the Case
- The NHS Trust Development Authority (TDA) had confirmed that they had approved the Full Business Case, so the contract could now be awarded

AJ asked whether the issues regarding activity levels at EKHUFT had been resolved. AG replied that EKHUFT had been tasked with resolving the matter. GD added that the Kent Oncology Management System (KOMS) should be able to provide definitive activity data.

Assurance and policy

10-18 Review of the Board Assurance Framework, 2014/15

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

SDu commented that the issues discussed earlier in the meeting regarding the management of adult emergency activity were not reflected sufficiently in the document. It was agreed to add a further objective, to reflect the Trust's intentions regarding adult emergency care. GD suggested that the wording for objective 1.3 be used as the basis of the wording for the additional objective.

Action: Add a further objective to the Board Assurance Framework, to reflect the Trust's intentions regarding adult emergency care (Trust Secretary, October 2014 onwards)

The proposed revised wording for objectives 1.1 and 1.5 was approved.

10-19 Compliance oversight self-certification

KR referred to the circulated report and highlighted the following points:
- The compliance status was unchanged from the previous month
- Changes to the "Evidence of Trust compliance" from the previous month had been highlighted

SDu proposed that the "Evidence of Trust compliance" for Board Statement 8 be amended, to better reflect the role of the Board in the development of the Trust's plans. This was agreed.

Action: Amend the 'Evidence of Trust compliance' for Board Statement 8 within future oversight self-certification reports, to better reflect the role of the Board in the development of the Trust's plans (Trust Secretary, November 2014)

The oversight self-certification was approved, subject to the above amendment.

10-20 To consider any other business

There was no other business.

10-21 To receive any questions from members of the public

There were no questions.

10-22 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.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – November 2014

11-4 Log of outstanding actions from previous meetings — Chairman

Actions due and still 'open'

Ref.	Action	Person responsible	Deadline	Progress [1]
10-18 (Oct 14)	Add a further objective to the Board Assurance Framework, to reflect the Trust's intentions regarding adult emergency care	Trust Secretary	October 2014 onwards	The matter has been considered, and new objective is proposed, for approval, as follows: "Improve the non-elective pathway to deliver a more effective flow for emergency admissions". The Board is asked to agree the wording, or amend as it wishes. Once the objective is agreed, this will be added to the Board Assurance Framework.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
5-3 (May 14)	Arrange for the Audit and Governance Committee to further discuss the need for a Responsibility Assignment ('RACI') matrix	Trust Secretary	November 2014	This was discussed at the Audit and Governance Committee meeting in November 2014.
10-3 (Oct 14)	Amend the minutes of the Part 1 Trust Board meeting of 24th September 2014	Trust Secretary	October 2014	The minutes were amended
10-6 (Oct 14)	Arrange for the Trust Board's gratitude for funding the introduction of free Wi-Fi to be formally passed on the League of Friends at both hospital sites	Trust Secretary	October 2014	A formal letter of thanks, from the Chairman of the Trust Board, was sent on 23/10/14
9-4 (Sep 14)	Arrange for the Board to receive details of the extent of the cancer-related services provided	Medical Director	November 2014	The information has been submitted to the November 2014 Trust Board

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	by the local voluntary/third sector			
10-8 (Oct 14)	Submit a report to the Trust Board containing a response to the underlying issues involved in the 'patient story' that was heard at the October 2014 Board meeting	Medical Director / Chief Nurse	November 2014	A report has been submitted to the November 2014 Trust Board
10-12 (Oct 14)	Arrange for the Trust's website to contain some information for the public on the current Ebola outbreak	Director of Workforce and Communications	November 2014	The Trust's website has been updated to include information on Ebola (see www.mtw.nhs.uk/infection-control/ebola.asp)
10-15 (Oct 14)	Consider which month in 2015 would be the most appropriate for the 'Winter & Operational Resilience plans' to be submitted to the Trust Board	Chief Operating Officer	November 2014	The matter has been considered, and it has been agreed to schedule the 2015 plan to be received in June 2015. The has been added to the Trust Board Forward Programme
10-19 (Oct 14)	Amend the 'Evidence of Trust compliance' for Board Statement 8 within future oversight self-certification reports, to better reflect the role of the Board in the development of the Trust's plans	Trust Secretary	November 2014	The text in Board Statement 8 has been amended, and now states "The Board and its sub-committees are involved in the development of the Trust's annual plans…"

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Deadline	Progress
10-7 (Oct 14)	Arrange for the next meeting of the Workforce Committee to focus on the recruitment of substantive staff	Chair of Workforce Committee / Director of Workforce and Communications	December 2014	N/A

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - November 2014

11-6 Chief Executive's update Chief Executive

Summary / Key points

The enclosed report provides information on recent events at the Trust in November 2014.

1. I visited our Chronic Pain unit at Maidstone Hospital on 7th November as part of my regular ward and departmental visits. I found that the unit was in urgent need of upgrading and ensured it was prioritised. I was also very impressed by the staff I met for their tenacity and commitment to patient care.

2. We are now taking outpatient appointments from the Swale area as part of the wider NHS response in Kent to support Medway Maritime Hospital's improvement plan. GPs in Swale can refer patients who require a first appointment for non-urgent cardiology care, or care of the elderly, to specialists at Maidstone Hospital. This arrangement is in place for six months to help create the "headroom" Medway needs to improve.

3. An additional £300 million is being made available to the NHS to help deal with cold weather pressures. We expect to benefit from this second wave of winter monies to help maintain high standards of patient care over the coming months. The bids we have made will fund additional nurses and escalation wards. The NHS is under unprecedented extra demand, with a million more visits to A&E each year compared to 2010.

   Emergency admissions via our A&Es were 10% higher in October than a year ago. Year to date, ambulance conveyances and patient attendances are up 13% and 6.5% respectively. A&E activity at Maidstone and Tunbridge Wells has gone up 17% since 2008/9.

4. Up to 900 patients a year seeking urgent medical care at Tunbridge Wells Hospital (TWH) could avoid admission thanks to early expert assessment and diagnosis. We are fast-tracking the development of a new ambulatory unit at TWH to see emergency medical referrals from GPs, community health care providers and our own A&E department who may have otherwise been admitted on to a ward for diagnosis. This will enable GPs to continue to manage patients safely at home once a definitive diagnosis is made, and improves the patient experience by avoiding unnecessary hospital admission. We are now sending discharge information to GP practices electronically from our A&E departments, cutting processing and postal waiting times for this information by a week.

5. We have received permission from the NHS Trust Development Authority (TDA) to develop a new respiratory ward on the footprint of the current John Day and Jonathan Saunders Wards at Maidstone Hospital. We anticipate work starting on this important £3 million project over the spring/summer 2015.

6. We have seen only one case of hospital acquired Clostridium difficile in the last three months. This shows that we can keep our C. difficile levels really low, keeping our patients safer than ever.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - November 2014

11-7 Integrated Performance Report — Chief Executive

Summary of the Month

The Trust continues to provide high overall standards of care in a safe environment in line with national standards. This is evidenced by the 96.3% of patients surveyed in October who received harm free care while in hospital. This continues to be above national benchmarks.

However, October saw an increase in Pressure Ulcers and patient falls. Action is in hand on both matters however, and was discussed at the 'main' Quality & Safety Committee held on 12/11.

The A&E 4-hour waiting time target has been challenging and is now slightly below the 95% target for the year to date, at 94.9%.

The performance against the 62-day wait for Cancer also remains challenging, however an improvement plan has been agreed to enable the situation to be realigned with plans by January 2015. The investigation into the causes of the problems has been enclosed in this report.

Delayed transfers of care improved, but the situation is still not good. Concerted efforts continue to be made to improve the efficiency of the Trust's processes, to ensure patients are discharged in a timely manner, and in doing so, reduce length of stay.

Which Committees have reviewed the information prior to Board submission?

- Executive Team, 18/11/14
- Trust Management Executive, 19/11/14

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

Discussion and scrutiny

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

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

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

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

Responsible Committee: Quality & Safety

	Delivering or Exceeding Target
	Underachieving Target
	Failing Target

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

	Patient Safety & Quality	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
'1-01	Hospital-level Mortality Indicator (SHMI)			101.26	100.3	-0.96	0.3	*100*		100
'1-02	Standardised Mortality (Relative Risk)			91.3	91.4	0.1	-8.6	*100*		100
'1-03	Crude Mortality	1.0%	1.0%	1.2%	1.1%	-0.1%				
'1-04	Safety Thermometer % of Harm Free Care	94.7%	96.3%	94.5%	96.6%		1.6%	95.0%		0.0%
'1-05	*Rate C-Diff (Hospital only)	5.4	5.3	19.3	15.2	-4.1	-3.8	*15.7*	15.5	15.7
'1-06	Number of cases C.Difficile (Hospital)	1	1	25	20	-5.0	-5.0	*35*	35	35
'1-07	Number of cases MRSA (Hospital)	0	0	2	1	-1	0	*0*	1	
'1-08	Elective MRSA Screening	98.0%	98.0%	98.0%	98.0%		0.0%	98.0%	98.0%	
'1-09	% Non-Elective MRSA Screening	97.0%	97.0%	97.0%	97.0%		2.0%	95.0%	97.0%	
'1-10	**Rate of Hospital Pressure Ulcers	1.2	3.1	2.4	2.2	-0.2	-0.8	*3.0*	2.2	3.0
'1-11	****Rate of Total Patient Falls	6.9	6.8	7.4	6.0	-1.4	-0.7	6.75	6.0	
'1-12	****Rate of Total Patient Falls Maidstone	6.2	5.0	6.6	5.2	-1.4	-1.5	6.75	5.2	
'1-13	****Rate of Total Patient Falls Tunbridge Wells	6.5	8.4	8.1	6.6	-1.4	-0.1	6.75	6.7	
'1-14	Falls - SIs in month		4		24	24				
'1-15	MSA Breaches	0	0	10	5	-5	5	0	5	
'1-16	Total No of SIs Open with MTW	21	36			15				
'1-17	Number of New SIs in month	7	6	82	72	-10	2			
'1-18	Number of Never Events	0	0	1	2	1	2	*0*	2	
'1-19	Number of CAS Alerts Overdue	5	0			-5	0	*0*		
'1-20	*****Readmissions <30 days: Emergency	11.5%	8.9%	10.7%	11.4%	0.6%	-2.2%	*13.6%*	11.4%	14.1%
'1-21	*****Readmissions <30 days: Elective	5.3%	3.9%	5.8%	5.2%	-0.6%	-1.1%	*6.3%*	5.2%	6.8%
'1-22	***Rate of New Complaints	4.5	5.07	4.8	4.13	-0.7	-2.13	*6.26*	4.25	6.26
'1-23	% complaints responded to within target	78.4%	70.5%	57.8%	66.4%	8.6%	-8.6%	75.0%	69.9%	
'1-24	IP Resp Rate Recmd to Friends & Family	17.0%	35.0%	16.1%	44.5%	28.4%	19.5%	25%	40.3%	36.6%
'1-25	A&E Resp Rate Recmd to Friends & Family	2.6%	14.4%	2.5%	17.3%	14.7%	2.3%	15%	16.7%	19.5%
'1-26	Mat Resp Rate Recmd to Friends & Family	New	16.0%	New	19.9%	New	-0.1%	15%	19.9%	21.3%
'1-27	IP Friends & Family (FFT) Score	79	76	75	77	1	3	74	77	74
'1-28	A&E Friends & Family (FFT) Score	60	65	59	64	5	11	53	64	57
'1-29	Maternity Combined Q1 to Q4 FFT Score	New	82	New	83	New	11	72	83	66
'1-30	Five Key Questions Local Patient Survey	92.0%	91.0%			-1.0%		90%	91.0%	
'1-31	VTE Risk Assessment	95.1%	95.3%	95.2%	95.5%	0.2%	0.5%	95%	95.5%	95%
'1-32	% Dementia Screening	98.7%	98.0%	99.1%	98.9%	-0.2%	8.9%	90%	98.9%	
'1-33	% TIA with high risk treated <24hrs	50.0%	No data	59.8%	72.5%			60%	72.5%	
'1-34	% spending 90% time on Stroke Ward (Sept)	69.6%	86.2%	76.4%	81.8%	5.4%	1.8%	80%	80.1%	
'1-35	Stroke:% to Stroke Unit <4hrs (Sept)	New	37.7%	New	38.2%	New	New	75.0%	75.0%	
'1-36	Stroke: % scanned <1hr of arrival (Sept)	New	50.8%	New	46.2%	New	New	43.0%	43.0%	
'1-37	Stroke:% assessed by Cons <24hrs (Sept)	New	77.8%	New	73.9%	New	New	85.0%	85.0%	

Responsible Committee: Finance, Treasury & Investment

	Finance & Efficiency	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
3-01	Average LOS Elective	3.3	3.1	3.3	3.2	-0.1	-0.1	*3.3*	3.3	3.3
3-02	Average LOS Non-Elective	6.8	6.8	6.9	6.7	-0.2	1.0	*5.7*	6.5	5.7
3-03	New:FU Ratio	1.78	1.58	1.74	1.55	-0.19	0.03	*1.52*	1.52	
3-04	Day Case Rates	80.5%	83.4%	79.3%	83.4%	4.1%	3.4%	80.0%	80.0%	82.19%

	Finance & Efficiency	Latest Month *Plan*	Latest Month Curr Yr	Year to Date *Plan*	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan	Year End Forecast	Bench Mark
3-05	Income	33,048	40,962	224,466	230,006	6.5%	2.5%	380,768	396,746	
3-06	EBITDA	3,447	10,274	13,101	19,483	80.3%	48.7%	24,718	35,320	
3-07	Surplus (Deficit) against B/E Duty	375	7,380	(8,416)	(1,334)			(12,303)	4	
3-08	CIP Savings	1,962	2,225	11,983	13,505	48.3%	12.7%	22,400	23,018	
3-09	Cash Balance	12,984	4,170	12,984	4,170	92.2%	-67.9%	926	926	
3-10	Capital Expenditure	1,522	629	9,002	2,082	-28.7%	-76.9%	*13,516*	13,516	
3-11	**Monitor Continuity of Service Risk Rating**	New	3	2	3	New	1	2	2.5	

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

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

	Performance & Activity	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ *Limit*	Year End Forecast	Bench Mark
2-01	**Monitor Indicative Risk Rating**	**1.0**	**2.0**	**1.0**	**2.0**	**Amber/Red**		**Green**		
2-02	Emergency A&E 4hr Wait (SITREP Wks)	94.3%	93.9%	95.7%	94.9%	-0.8%	-0.1%	95%	95.0%	94.6%
2-03	Emergency A&E >12hr to Admission	0	0	0	1	1	1	0	1	
2-04	***Ambulance Handover Delays >30mins	New	No data	New	No data	New		365	0	
2-05	***Ambulance Handover Delays >60mins	New	0	New	0	New	0	0	0	
2-06	****18 week RTT - admitted patients	90.5%	95.1%	92.1%	90.6%	-1.5%	0.6%	90%	90.0%	
2-07	18 week RTT - non admitted patients	96.6%	97.5%	96.4%	96.5%	0.1%	1.5%	95%	95.0%	
2-08	18 week RTT - Incomplete Pathways	93.2%	96.0%	93.2%	96.0%	2.8%	4.0%	92%	92.0%	
2-09	18 week RTT - Specialties not achieved	3	1	22	15	-7	15	*0*	15	
2-10	18 week RTT - 52wk Waiters	0	0	0	0	0	0	*0*	0	
2-11	18 week RTT - Backlog 18wk Waiters	901	340	901	340				250	
2-12	% Diagnostics Tests WTimes <6wks	100.0%	100.00%	100.0%	99.98%	0.0%	1.0%	99.0%	99.98%	
2-13	Cancer WTimes - Indicators achieved	9	7	9	8	-1	-1	9	8	
2-14	*Cancer two week wait	98.3%	96.4%	98.3%	95.9%	-2.3%	2.9%	93%	93.0%	95.5%
2-15	*Cancer two week wait-Breast Symptoms	94.7%	95.7%	94.7%	94.5%	-0.3%	1.5%	93%	93.0%	
2-16	*Cancer 31 day wait - First Treatment	99.5%	96.6%	99.5%	98.3%	-1.3%	2.3%	96%	96.0%	98.4%
2-17	*Cancer 62 day wait - First Definitive	88.2%	79.1%	88.2%	82.2%	-6.0%	-2.8%	85%	80.0%	87.1%
2-18	Delayed Transfers of Care	4.2%	3.9%	3.3%	4.0%	0.8%	0.5%	3.5%	3.5%	
2-19	Primary Referrals	8665	9,120	55024	60,758	10.4%	10.8%	93,129	103,166	
2-20	Cons to Cons Referrals	3982	3,255	25877	23,868	-7.8%	-4.5%	42,433	40,528	
2-21	First OP Activity	12280	12,746	80789	84,673	4.8%	4.9%	135,344	143,774	
2-22	Subsequent OP Activity	24019	23,469	152226	151,754	-0.3%	2.9%	250,125	257,676	
2-23	Elective IP Activity	772	726	5305	4,600	-13.3%	-22.0%	9,584	7,811	
2-24	Elective DC Activity	3184	3,467	20232	22,123	9.3%	-4.9%	38,602	37,565	
2-25	Non-Elective Activity	4096	3,944	26948	27,833	3.3%	4.6%	*45,404*	47,472	
2-26	A&E Attendances (Calendar Mth)	10316	10,976	74399	77,716	4.5%	5.9%	*125,139*	132,553	
2-27	Oncology Fractions	6143	6,389	39320	41,207	4.8%	3.5%	67,876	70,283	
2-28	No of Births (Mothers Delivered)	470	513	3,207	3,385	5.6%	9.3%	5,310	5,803	
2-29	Midwife to Birth Ratio	New	1:28	New	1:28	New	0.00	1.28	1:28	
2-30	C-Section Rate (elective & non-elective)	25.7%	27.7%	25.9%	26.8%	0.9%	1.8%	25.0%	25.0%	
2-31	% Mothers initiating breastfeeding	83.2%	80.3%	81.8%	81.7%	-0.1%	3.7%	78.0%	81.7%	
2-32	Intra partum stillbirths Rate (%)	0.6%	0.2%	0.5%	0.1%				0.1%	

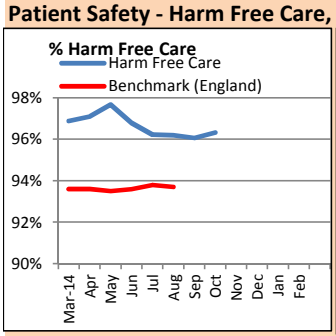
* Rate of C.Difficile per 100,000 Bed days, ** Rate of Pressure Sores per 1,000 admissions (excl Day Case), *** Rate of Complaints per 1,000 Episodes (incl Day Case), **** Rate of Falls per 1,000 Occupied Beddays, ***** Readmissions run one month behind.

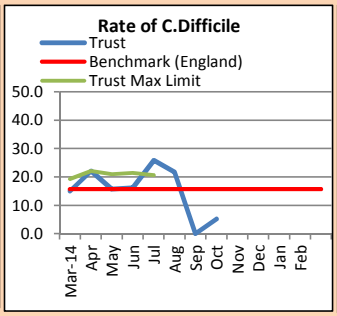
Responsible Committee: Workforce * Stroke & CWT run one mth behind, *** Ambulance Handover is unvalidated

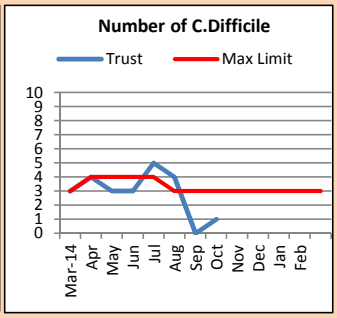
	Workforce	Latest Month Prev Yr	Latest Month Curr Yr	Year to Date Prev Yr	Year to Date Curr Yr	YTD Variance From Prev Yr	YTD Variance From Plan	Year End Plan/ Limit	Year End Forecast	Bench Mark
4-01	Establishment (Budget WTE)	5,355.7	5,421.5	5,355.7	5,421.5	1.2%	0.0%	*5,476.4*	5,476.4	
4-02	Contracted WTE	4,971.3	4,952.1	4,971.3	4,952.1	-0.4%	-4.6%	*5,257.4*		
4-03	**Contracted not worked WTE		(108.3)		(108.3)					
4-04	Locum Staff (WTE)	27.8	25.7	27.8	25.7	-7.4%				
4-05	Bank Staff (WTE)	287.1	301.3	287.1	301.3	4.9%				
4-06	Agency Staff (WTE)	148.1	186.4	148.1	186.4	25.9%				
4-07	Overtime (WTE)	58.8	78.0	58.8	78.0	32.7%				
4-08	Worked Staff WTE	5,379.1	5,453.4	5,379.1	5,453.4	1.4%	-0.5%	*5,519.7*		
4-09	Vacancies WTE	384.4	469.4	384.4	469.4	22.1%			367.1	
4-10	Vacancy %	7.2%	8.7%	7.2%	8.7%	20.6%			6.7%	
4-11	Nurse Agency Spend	(306)	(499)	(2,472)	(2,650)	7.2%			(4,471)	
4-12	Medical Locum & Agency Spend	(684)	(972)	(4,740)	(5,494)	15.9%			(9,517)	
4-13	Staff Turnover Rate	11.0%	9.4%		9.45%	-1.6%	-1.1%	*10.5%*	9.45%	8.4%
4-14	Sickness Absence	3.9%	4.4%		3.9%	0.5%	1.1%	*3.3%*	3.3%	3.7%
4-15	Statutory and Mandatory Training	86.1%	84.7%		84.7%	-1.4%	-0.3%	85.0%	85.0%	
4-16	Appraisals	82.9%	74.7%	76.3%	74.7%	-8.2%	-15.3%	90.0%	90.0%	

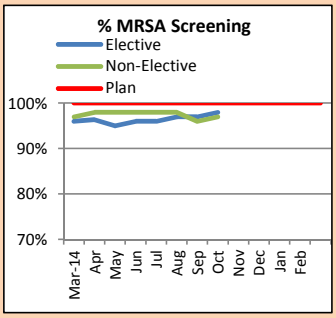
INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control

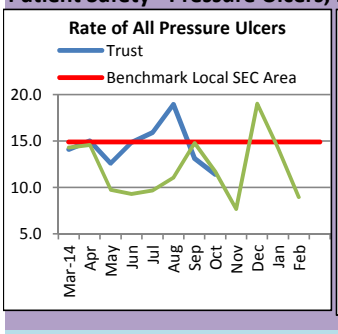


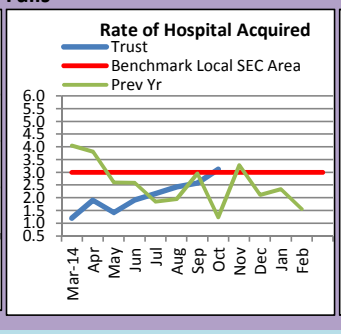


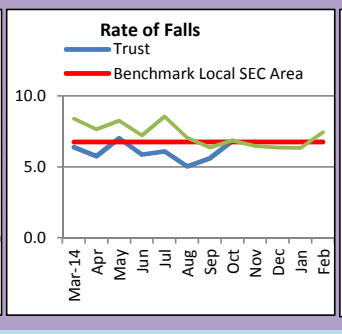


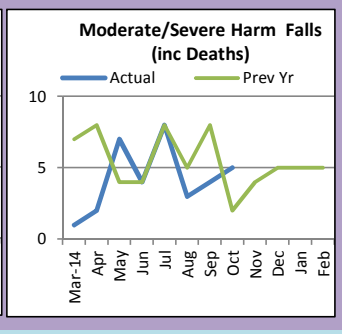


Patient Safety - Pressure Ulcers, Falls

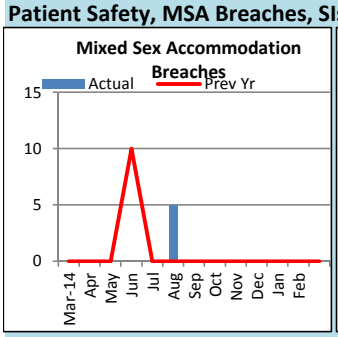


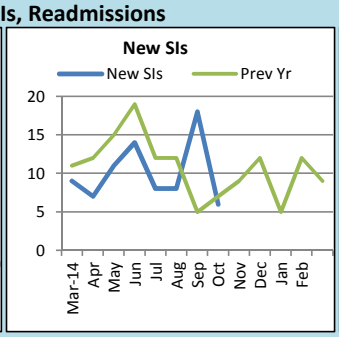


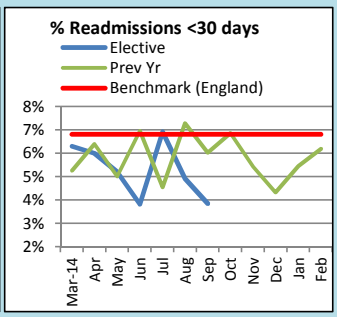


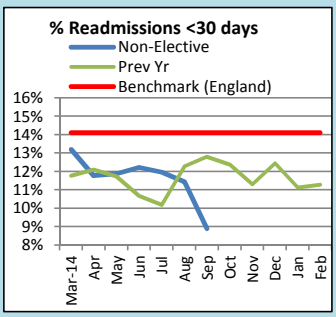


Patient Safety, MSA Breaches, SIs, Readmissions

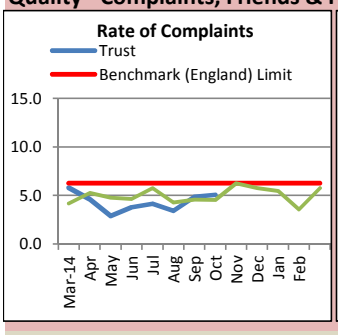


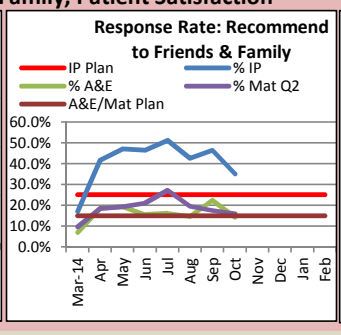


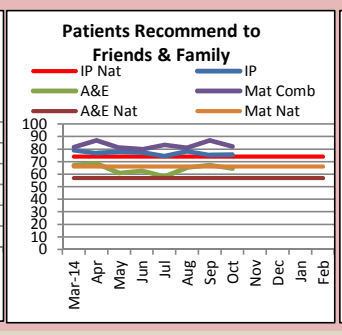


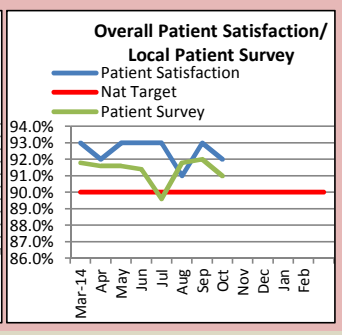


Quality - Complaints, Friends & Family, Patient Satisfaction

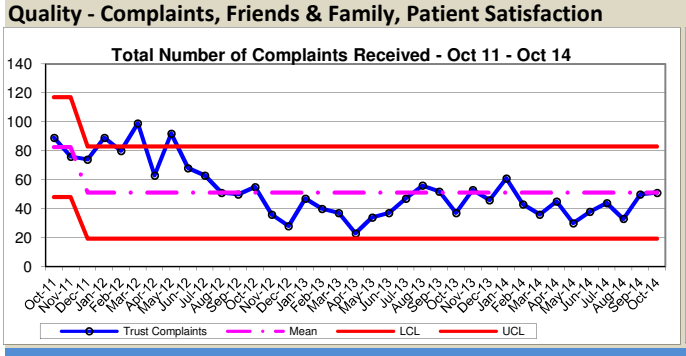


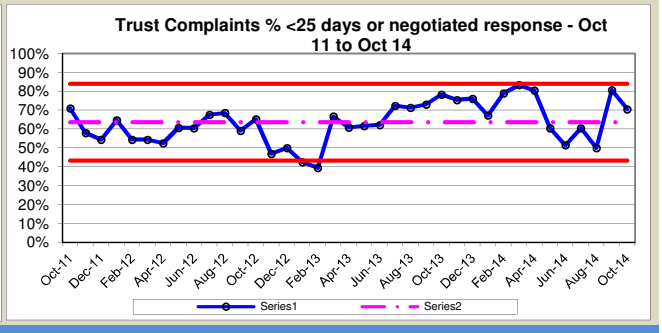




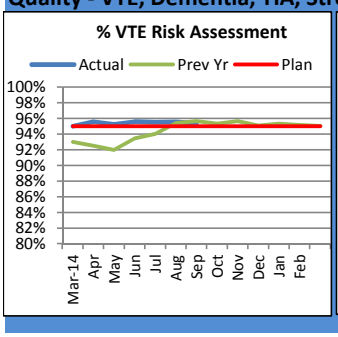


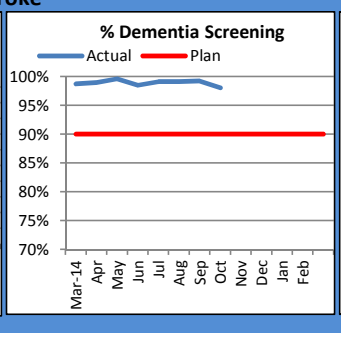
Quality - Complaints, Friends & Family, Patient Satisfaction

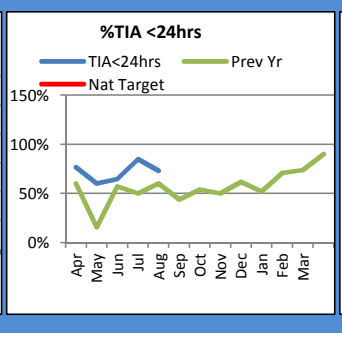


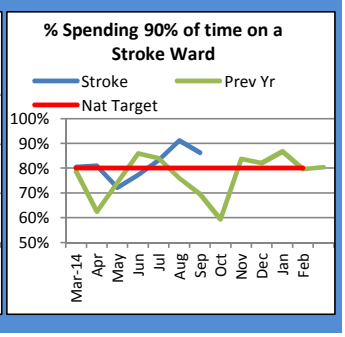


Quality - VTE, Dementia, TIA, Stroke



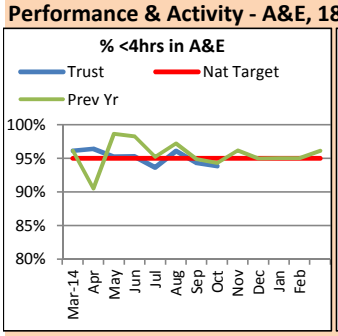


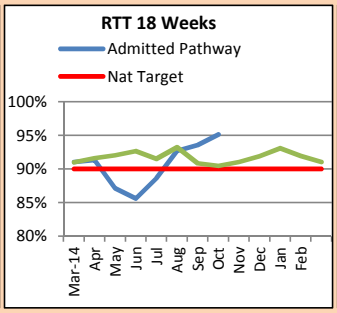


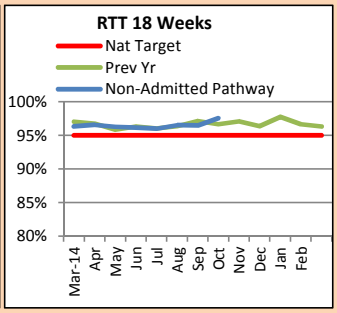


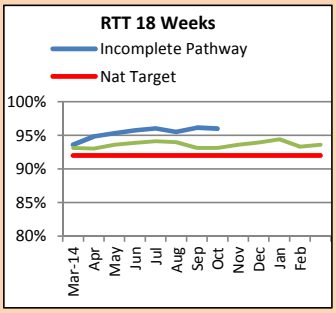
INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

Performance & Activity - A&E, 18 Weeks

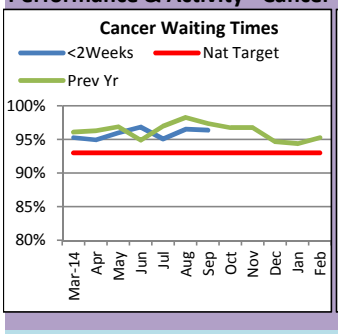


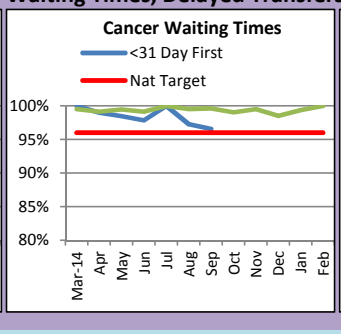


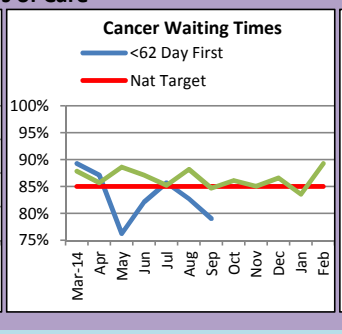


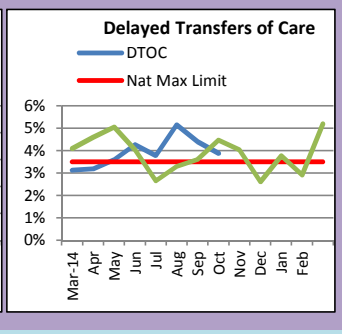


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

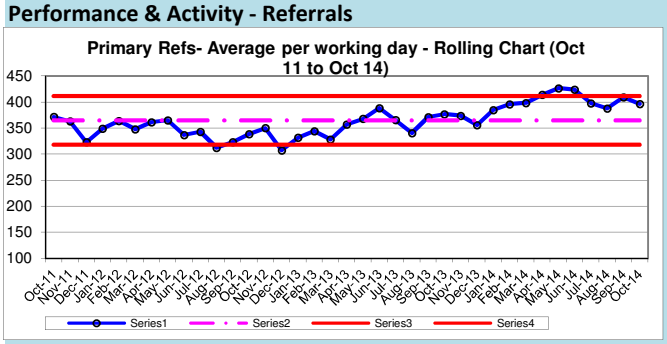


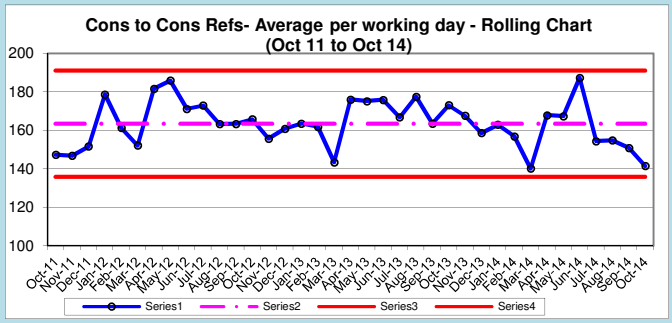




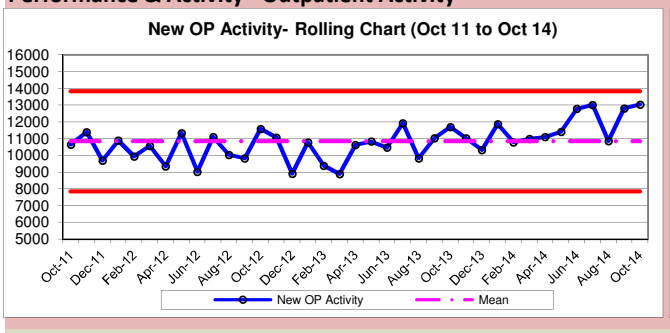


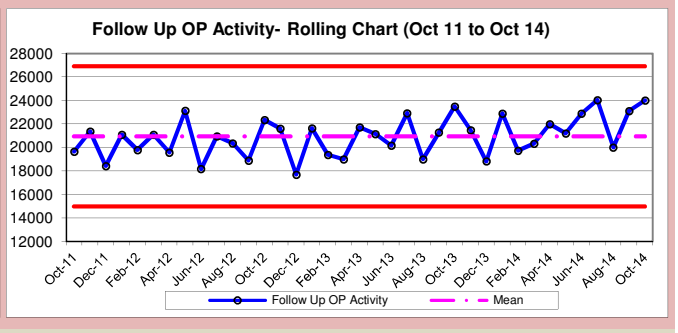
Performance & Activity - Referrals



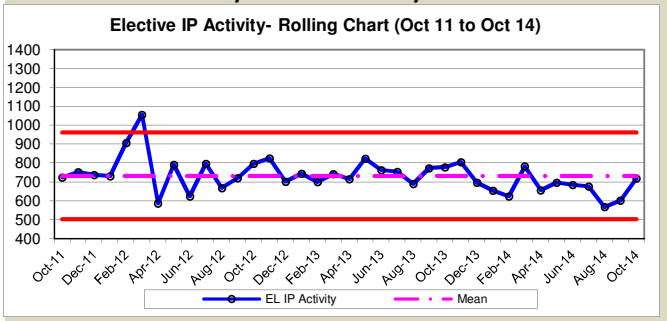


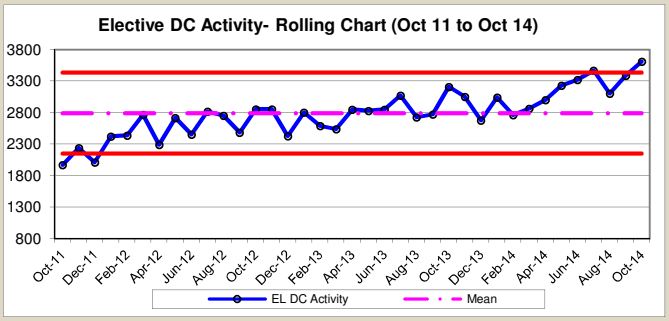
Performance & Activity - Outpatient Activity



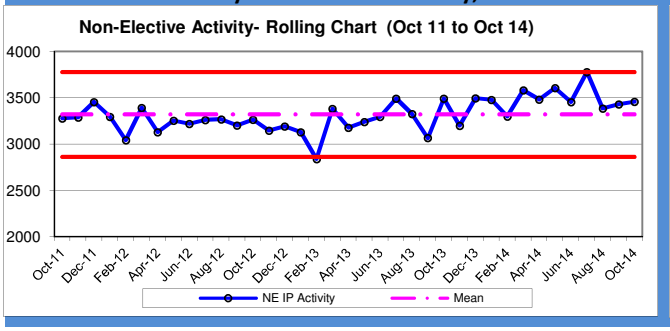


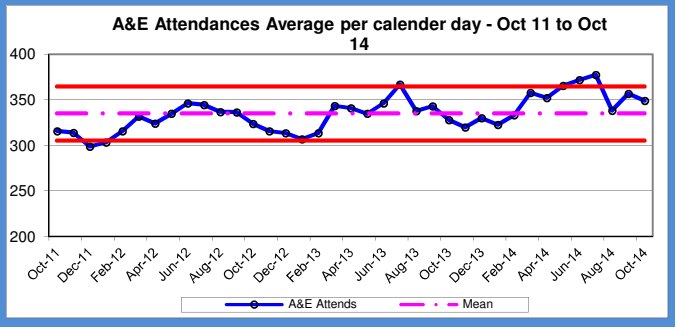
Performance & Activity - Elective Activity





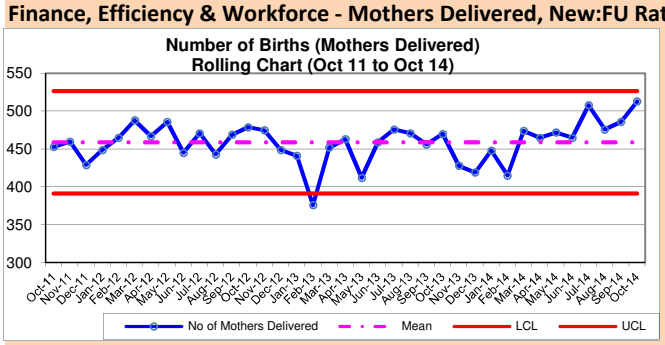
Performance & Activity - Non-Elective Activity, A&E Attendances

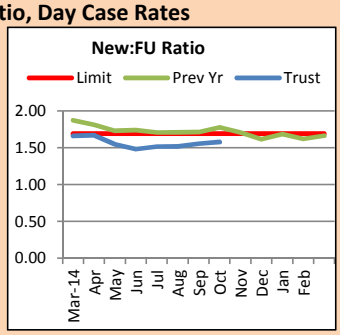


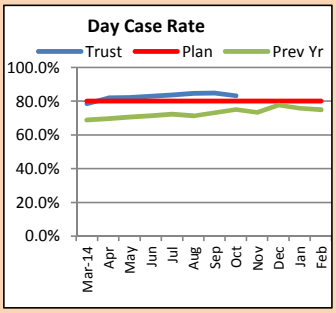


INTEGRATED PERFORMANCE REPORT ANALYSIS - FINANCE, EFFICIENCY & WORKFORCE

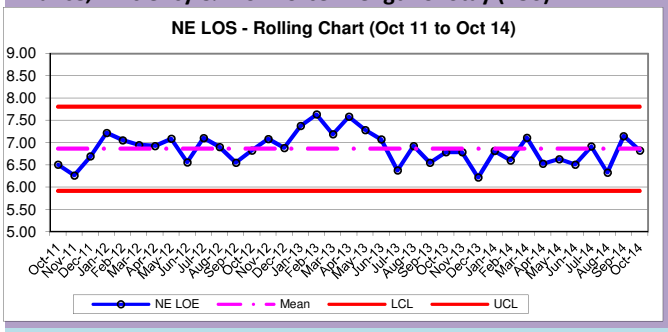
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

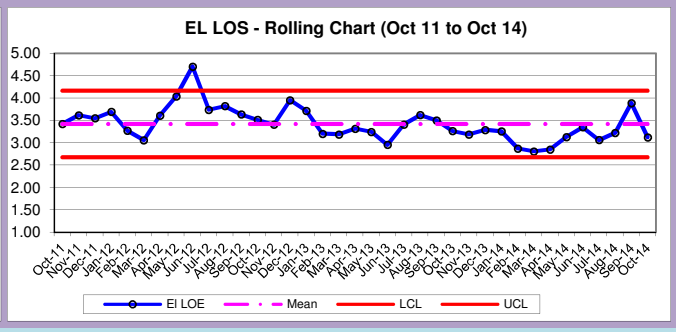




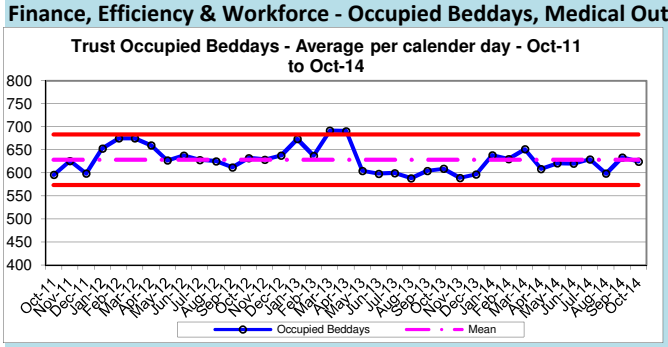


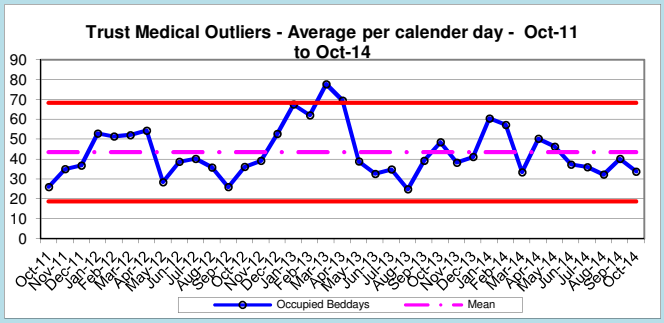
Finance, Efficiency & Workforce - Length of Stay (LOS)



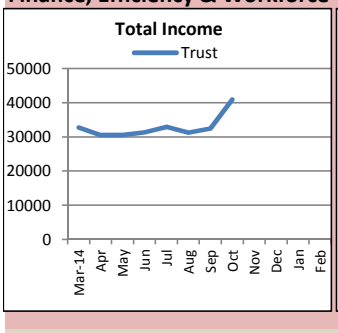


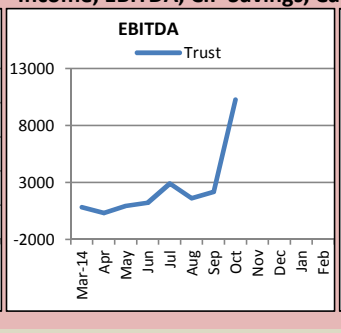
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

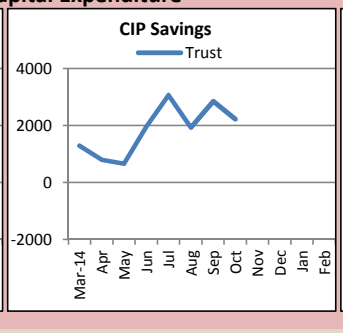


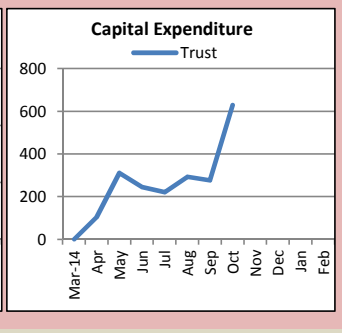


Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure

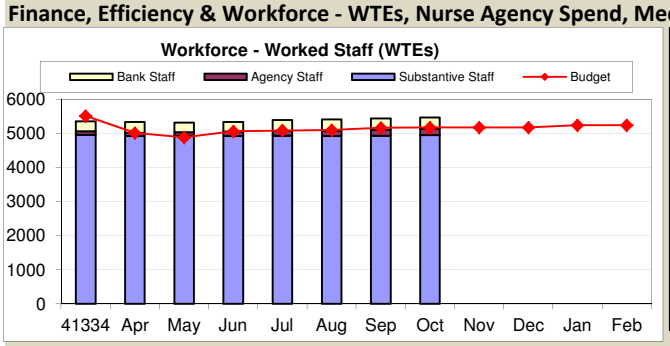


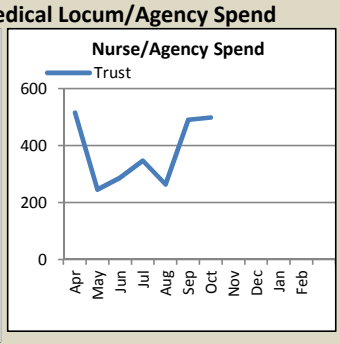


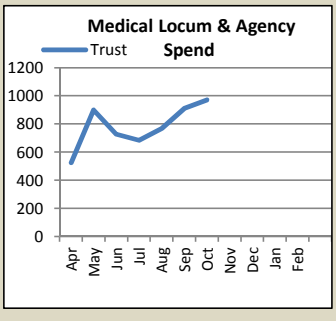




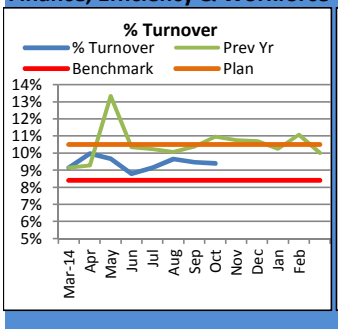
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

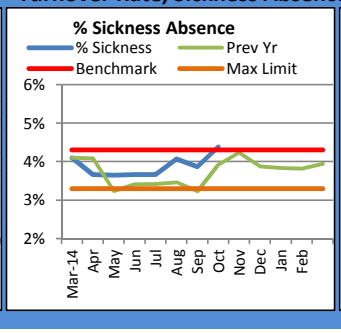


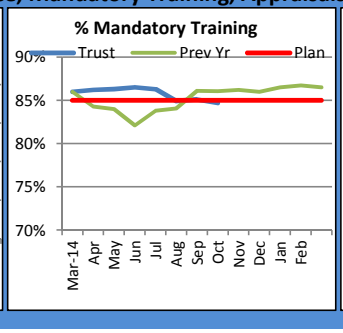


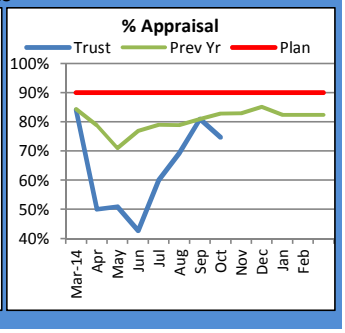


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Performance Issue
Failure to meet the 62 day cancer waiting time target.

Contributory factors

The key factors have contributed to 62 day breaches position;

- delays in diagnostic pathways and
- late referrals from other providers.
- Growth in demand

These factors led to an unsustainable growth in the number of patients in the 62 backlog. There were 111 patients over 62 days at the beginning of November 2014 The backlog has reduced to >90).

Delays in histology and imaging were caused by inadequate capacity to meet the increasing demand compounded by delays in responding to that loss of capacity. The trust has seen an 11% increase in 2WW cancer referrals YTD. Capacity issues have now been resolved through a combination of new appointments of consultants and outsourcing some of the work to other providers. The improvement has resulted in more patients progressing to “decision to treat”, and as a result MTW has to treat a higher number of 62 day breaches than normal in November and December 2014. This means that MTW will not deliver the 62 day standard during these months but will deliver sustainably after this period. MTW is not anticipating meeting the 62 day target for either November or December 2014 but recover the delivery in January 2015.

About 40% of patients [84]currently in the 62 Day backlog were referred from other Trusts. 80% of the backlog patients were referred after Day 42 and about 37% of these were referred to MTW after they had breached already (after Day 62). The same proportions are reflected in the reported breaches YTD. The trust has escalated these late referrals and is working with the other providers to ensure referrals are sent as early as possible along the pathway.

Actions in place to address the current performance

- A recovery plan and trajectory has been compiled. It commenced in November and is due for completion by the end of December 2014.
- The patients waiting over 62 days will be either treated or appropriately removed from the cancer pathway by the end of December.
- The Trust is planning to increase C2WW capacity in outpatients, increase all diagnostic capacity and increase the monthly number of treatments.
- Weekly internal reporting processes within the Trust have been escalated to ensure delivery of trajectory.
- Progress reports shared at monthly performance meetings with the CCG
- The trust has escalated late referrals and is working with the other providers to ensure referrals are sent as early as possible along the pathway. January 2015

M7 Financial Performance overview

1. Overview of the Financial Position at M7 2014/15

1.1. This written summary provides an overview of the financial position at M7 of 2014/15. It should be read alongside the finance pack.

1.2. The Finance pack shows for month 7 an in month surplus of £7.4m against a plan of £0.4m (£7.0m favourable movement) resulting in a year to date deficit of £1.3m against a planned deficit of £8.4m, a favourable variance of £7.1m. There is a prudent provision for £1.0m for additional costs included within the Month 7 position.

1.3. The significant in month favourable movement of £7m relates to notification from the TDA that the Trust would receive £12m of non-recurrent deficit support funding. The £12m additional income resulted in the year to date impact of £7m; being 7/12ths of the £12m.

1.4. The Trust originally submitted its M6 reporting return to the TDA to deadline reflecting the financial position reported through the Trusts Governance structure. Following the notification of the additional £12m income the Trust was requested to resubmit the Month 6 reporting return to include the impact of 6/12ths of the £12m and to achieve the NHS breakeven duty in year. This was returned on 5th November and therefore differs from the financial position reported to the Finance Committee and Trust Board.

1.5. The total year to date total income is £230.0m against a budget of £224.5m; an overperformance of £5.5m, (£8.0m overperformance in the month). The in month 7 variable variance relates to £7.0m being 7/12ths of the £12m deficit support funding as highlighted in 1.3 above and other overperformance . The main variances on income are outlined below :

- Excluding the £7m deficit support funding, NHS Clinical income is under performing by £0.7m (overperformance of £1m in the month), but the outsourcing plan (daycases and elective inpatient) is underperforming £3.1m, therefore the SLA is still overperforming on non outsourced activity (predominantly outpatient activities) by £2.4m.
- All applicable contractual deductions and penalties have been applied and a provision has been made for challenges.
- Antiveg activity is the main over performance in other activities.
- Private Patient income is underperforming by £1.2m however this is mostly offset by NHS activity performed and by lower than planned expenditure in both pay and non-pay.

1.6. Non elective activity reduced slightly against the trend seen in previous months and is now 4.6% higher than the year to date plan (c5% higher last month). This also correlates to A&E activity reducing against the trend this month (5.9%) against the trend in previous months (6.4%). The increase above plan is mostly paid at 30% due to the threshold applied and is now 53% above plan (10% increase in the month). The threshold has not reduced in line with the activity trend as not all non elective activity is subject to the threshold and therefore this month more threshold impacting activity has occurred this month.

1.7. Elective activity increased slightly in the month. Elective activity is now 22% behind plan (2% better than last month) however 6.4% (down 1.6% in month) of the

underperformance is caused by the outsourcing plan of 445 cases with 68 cases being achieved.

1.8. Escalation bed usage remained similar to last month and this correlates to the elective and non elective activity combined remaining similar to last month (c 45 beds). Temporary nursing costs remained above trend this month but in line with the month 6 expenditure.

1.9. Operating costs are £210.5m against a plan of £212.9m, a favourable variance of £2.4m (£0.8m adverse in the month), however there is a net £1.5m of savings and reserves to be allocated which would reduce the plan to £211.4m if the whole amount was allocated to Operating expenditure.

1.10. Pay was overpsent in the month by £0.7m (for the first time this financial year following funding the workforce plan in June) and is now £0.4m underspent year to date. In actual expenditure terms the Trust experienced a further tightening in the pay position this month with the second month running pay costs being c£19.7m (£0.5m above the trend) due to the particularly high temporary staffing costs of £0.5m above the trend.

1.11. Non pay overspent by £0.8m in month and is now £2.8m underspent year to date (£2.0m last month). However, Purchase of healthcare from non NHS bodies is £3.1m underspent (£0.2m adverse in month) and is offset by underperformance in day case and elective income relating to the original plan for outsourcing activity. Non pay costs in month 7 were slightly higher than the underlying trend (£0.2m). This is made up of £1m additional cost aligned with the activity seen this month. There were however a number of additional non recurrent pressures this month which have caused a spike in expenditure and has required the release of £0.8m of the cost provision covering both pay and non pay pressures.

1.12. EBITDA is a £19.5m surplus and is now overperforming by £6.4m year to date (£6.8m in month) against the plan. This significant change is due to the inclusion of the £7m year to date impact of the £12m deficit support funding.

1.13. The financing costs including those related to the PFI and deprecation totalled £21.8m, which is now underspent against the in year plan by £1.0m (£0.2m underspent in month) due to the year to date impact of the revised calculation of PDC based on the forecast statement of financial position as opposed to the original plan and the slippage in against the capital plan reducing the depreciation cost against budget.

1.14. The year to date CIP delivery is £13.5m against a target of £12.0m and is forecast to deliver £23.0m (£22.4m last month) against the plan of £22.4m. This change in forecast of £0.6m is helping the Trust to achieve breakeven by removing the remaining deficit after the £12m funding and also covering additional cost pressures.

1.15. The I&E forecast to the end of the financial year now expects the Trust to deliver an in year breakeven position against the NHS breakeven duty, after including the £12m deficit support funding. This is against the Trusts planned deficit of £12.3m. The details of the forecast including key assumptions and risks is subject to a separate paper to the Finance Committee this month.

1.16. Cash balances of £4.2m were held at the end of M7. Discussions with NHS organisations over the settlement of 2013/14 outstanding debt are on-going, there is an expectation that this will be resolved by the end of November. The operational cash forecast has an expectation of receipt of this income circa £2.2m in December with the remaining balance £3.7m in January.

1.17. The SLA team have been in negotiations with WKCCG in respect to 14/15 contract variation which has been approved and signed increasing the baseline from £188m to £190m. An additional invoice has been raised for £1.1m to reflect the contract variation, with a cash forecast to be received in November.

1.18. 14/15 reconciliation of overperformance activity for quarter 1 is expected to be finalised by the end of November. The operational cash forecast has receipts from WKCCG £1.5m and High Weald, Lewes and Haven CCG £0.5m expected in December. Quarter 2 reconciliation of 14/15 activity is expected to be completed by the end of January, with a further cash receipt of £1m WKCCG and £0.3m from High Weald. Lewes and Haven.

1.19. The cashflow now reflects the £12m deficit support replacing the £14.3m external financing. The timings of receipt of this funding are uncertain with a cash flow working assumption of February.

1.20. The operational cash flow matches the Income and Expenditure therefore as long as both Income and Expenditure remain per forecast the £2.3m cash shorfall (£14.3m to £12m) will be planned to be managed through debt collection and minimal supplier restrictions primarily in March.

1.21. Total debtors are £56.3m (£43.2m in M6). The two largest debtors (invoiced) at the end of the period are WKCCG owing £18.7m gross and NHS England who owe £11.2m gross, primarily relating to invoices subject to year-end reconciliation. Included within the debtors balances are estimated 14/15 overperformance invoices for month's 1-5 activity of £11.8m. Within this month the contract variation for WKCCG has been approved moving the baseline from £188m to £190m. 90 day debt is £22.9m this has increased since Month 1 by £0.8m (£22.1m), but is expected to reduce significantly when the year end position agreement is reached with commissioners, along with the 14/15 quarter 1 and 2 reconciliation has been completed.

1.22. Creditors are £50.4m (£48.5m in M6). The percentage of the value of payments made within 30 days was 89% against a target of 95%, 2013/14 cumulative year end performance was 56.2%.

1.23. Capital expenditure to month 7 was £2.1m of the revised forecast expenditure £13.7m. This was £6.9m less than the planned expenditure at month 7 of £9m based on the £18.8m original plan. The plan continues to be prioritised and aligned to the Trusts strategy.

1.24. The Trust's performance against the TDA Accountability framework is Amber due to the receipt of the £12m deficit support funding.

Key Performance Indicators as at Month 7 2014/15

(A) TDA Accountability Framework and
(B) Monitor Continuity of Service Metrics

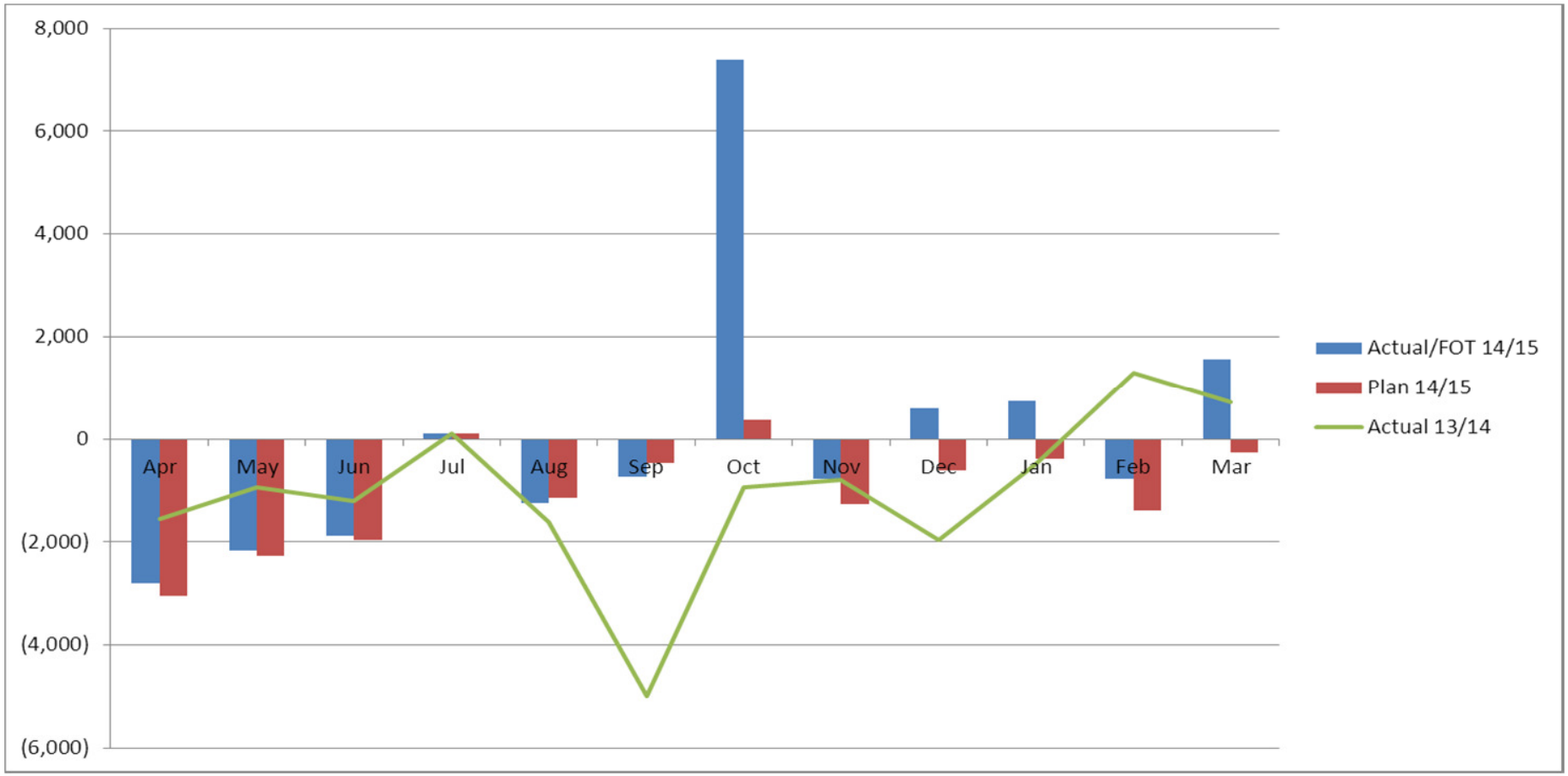
Maidstone and Tunbridge Wells NHS Trust

Key Metrics (A) Accountability Framework	Current Month Metrics: Plan (mc 01) £000s	Actual / Forecast (mc 02) £000s	Variance (mc 03) £000s	RAG Rating (mc 04)	RAG STATUS: Red	Amber	Green
NHS Financial Performance							
1a) Forecast Outturn, Compared to Plan	(12,301)	4	12,305	GREEN	A deficit position or 20% worse than plan	A position between 5% - 20% worse than plan	Within 5% or better than plan
1b) Year to Date, Actual compared to Plan	(8,416)	(1,334)	7,082	GREEN	20% worse than plan	A position between 10% - 20% worse than plan	Within 10% or better than plan
Financial Efficiency							
2a) Actual Efficiency recurring/non-recurring compared to plan -				AMBER	if either total or recurrent efficiencies are 20% worse than plan	if either total or recurrent efficiencies are between 0% and 20% of plan	If both total and recurrent efficiencies are equal to or better than plan
- Total Efficiencies for Year to Date compared to Plan	10,393	13,505	3,112				
- Recurrent Efficiencies for Year to Date compared to Plan	10,393	9,732	(661)				
2b) Actual Efficiency recurring/non-recurring compared to plan - Forecast compared to plan				RED	if either total or recurrent efficiencies are 20% worse than plan	if either total or recurrent efficiencies are between 0% and 20% of plan	If both total and recurrent efficiencies are equal to or better than plan
- Total Efficiencies for Forecast Outturn compared to Plan	22,400	23,018	618				
- Recurrent Efficiencies for Forecast Outturn compared to Plan	22,400	17,419	(4,981)				
Underlying Revenue Position							
3) Forecast Underlying surplus / (deficit) compared to Plan	(16,254)	(19,548)	(3,294)	AMBER	20% worse than plan	A position between 10% - 20% worse than plan	Within 10% or exceeding plan
Cash and Capital							
4) Forecast Year End Charge to Capital Resource Limit	13,516	13,516	0	GREEN	either greater than plan or 20% lower than plan	between 10% - 20% lower than plan	Within 10% of plan
5) Permanent PDC accessed for liquidity purposes		0		GREEN	PDC accessed	Not applicable	PDC not accessed
Trust Overall RAG Rating				AMBER	If forecast deficit position or if three or more RED in other metrics	If one or two RED or three AMBER	No RED and less than two AMBER
(B) Continuity of Service Risk Ratings							
Year to Date Rating	1.50	3.00	1.50	GREEN	If score is 2.5 or lower	Not applicable	Score of over 2.5
Fotecast Outturn Rating	2.00	2.50	0.50	GREEN	If score is 2.5 or lower	Not applicable	Score of over 2.5

I&E Monthly Position Graph as at Month 7 2014/15

Maidstone and Tunbridge Wells NHS Trust

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual/FOT 14/15	(2,805)	(2,163)	(1,882)	111	(1,242)	(734)	7,380	(778)	601	742	(776)	1,548
Plan 14/15	(3,053)	(2,261)	(1,962)	103	(1,152)	(466)	375	(1,259)	(608)	(384)	(1,382)	(254)
Actual 13/14	(1,553)	(949)	(1,201)	97	(1,616)	(4,982)	(931)	(796)	(1,968)	(480)	1,290	716



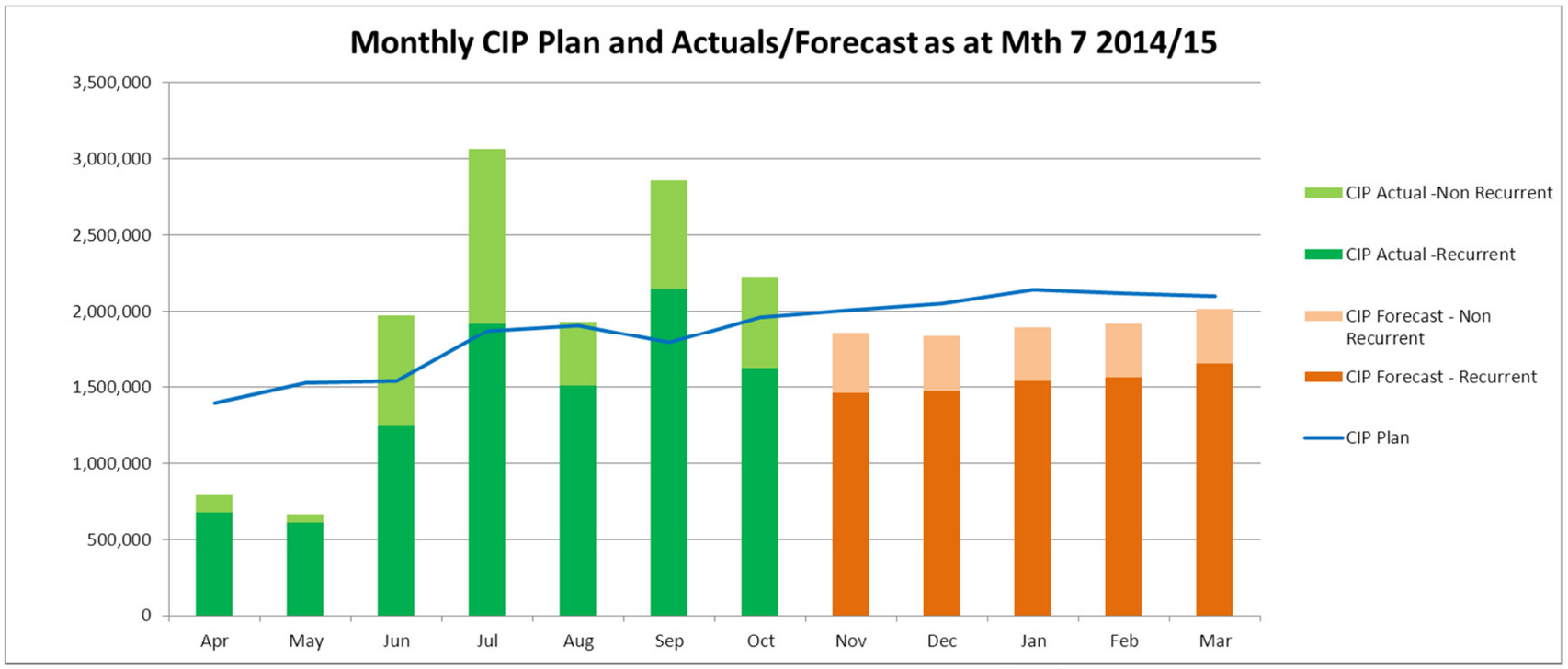
CIP Summary & Graph: as at Month 7 2014/15

Maidstone and Tunbridge Wells NHS

Maidstone and Tunbridge Wells NHS Trust

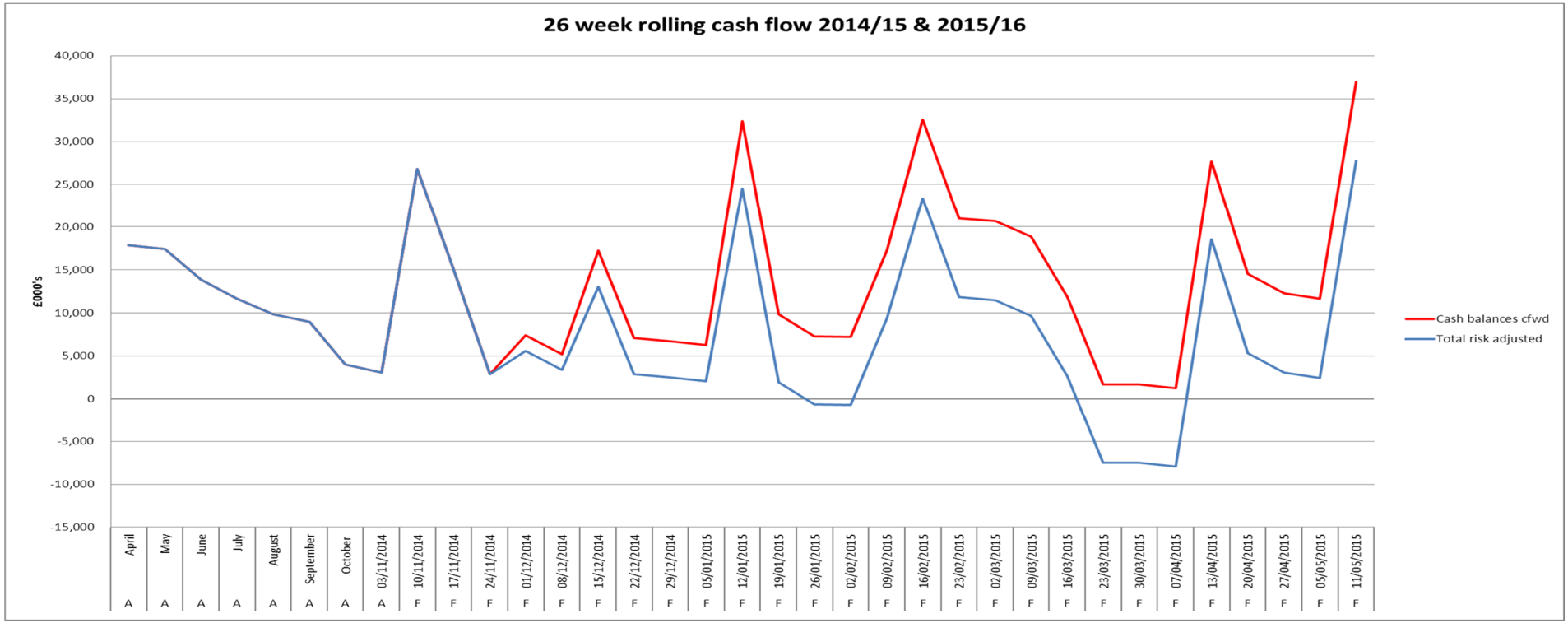
WORKSTREAMS BY DIRECTORATE BUDGET		Year To Date			Forecast		
		Plan	Actual	Variance	Plan	Actual	Variance
		£'000	£'000	£'000	£'000	£'000	£'000
Back Office	Paul Bentley	2,303	2,087	(216)	4,234	3,303	(931)
Corporate (PPU)	Angela Gallagher	171	15	(156)	385	226	(159)
Surgery	Simon Bailey	982	1,273	291	1,804	2,337	533
Surgery (Head & Neck)	Simon Bailey	537	787	250	979	1,389	410
Specialist Medicine	Clive Lawson	1,723	1,039	(684)	3,328	1,817	(1,511)
Acute Medicine/A&E	Akbar Sorma	1,305	266	(1,039)	2,264	560	(1,704)
Diagnostics & Therapies	Sarah Mumford	1,118	1,181	63	2,306	1,825	(481)
T&O	Guy Slater	628	394	(234)	1,160	762	(398)
Women's & Sexual Health	M.Wilcox	921	913	(8)	1,687	1,281	(406)
Paediatrics	Hamudi Kisat	438	300	(138)	841	482	(359)
Critical Care	Richard Leech	1,564	1,100	(464)	2,690	1,875	(815)
Cancer	Sharon Beesley	1,078	1,586	508	2,068	2,767	699
Corporate Finance		0	2,564	2,564	0	4,394	4,394
Overprogramme		(785)		785	(1,346)		1,346
Total By Directorate (includes all workstreams)		**11,983**	**13,505**	**1,522**	**22,400**	**23,018**	**618**

Recurrent v Non Recurrent Analysis	YTD £'000	FOT £'000
Recurrent	9,732	17,419
Non Recurrent	3,773	5,599
Total	**13,505**	**23,018**



26 Week graphical presentation of cash balances up to w/c 11th May 2015, actuals at 7th November 2014

Maidstone and Tunbridge Wells NHS Trust



	A	A	A	A	A	A	A	A	F	F	F	F	F	F	F	F	F	F	F
Week commencing	April	May	June	July	August	September	October	03/11/2014	10/11/2014	17/11/2014	24/11/2014	01/12/2014	08/12/2014	15/12/2014	22/12/2014	29/12/2014	05/01/2015	12/01/2015
Cash balances cfwd	**17,840**	**17,446**	**13,852**	**11,677**	**9,870**	**8,953**	**4,010**	**3,072**	**26,784**	**15,033**	**2,884**	**7,422**	**5,194**	**17,237**	**7,090**	**6,707**	**6,265**	**32,396**
13/14 o/performance	0	0	0	0	0	0	0	0	0	0	0	1,800	1,800	2,200	2,200	2,200	2,200	5,890
14/15 o/performance	0	0	0	0	0	0	0	0	0	0	0	0	0	2,000	2,000	2,000	2,000	2,000
External Financing - Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
External Financing - capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total risk adjusted	**17,840**	**17,446**	**13,852**	**11,677**	**9,870**	**8,953**	**4,010**	**3,072**	**26,784**	**15,033**	**2,884**	**5,622**	**3,394**	**13,037**	**2,890**	**2,507**	**2,065**	**24,506**

	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Week commencing	19/01/2015	26/01/2015	02/02/2015	09/02/2015	16/02/2015	23/02/2015	02/03/2015	09/03/2015	16/03/2015	23/03/2015	30/03/2015	07/04/2015	13/04/2015	20/04/2015	27/04/2015	05/05/2015	11/05/2015
Cash balances cfwd	**9,833**	**7,287**	**7,240**	**17,282**	**32,571**	**21,018**	**20,676**	**18,848**	**11,835**	**1,725**	**1,725**	**1,245**	**27,712**	**14,529**	**12,269**	**11,684**	**36,928**
13/14 o/performance	5,890	5,890	5,890	5,890	5,890	5,890	5,890	5,890	5,890	5,890	5,890	5,890	5,890	5,890	5,890	5,890	5,890
14/15 o/performance	2,000	2,000	2,000	2,000	3,300	3,300	3,300	3,300	3,300	3,300	3,300	3,300	3,300	3,300	3,300	3,300	3,300
External Financing - Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
External Financing - capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total risk adjusted	**1,943**	**-603**	**-650**	**9,392**	**23,381**	**11,828**	**11,486**	**9,658**	**2,645**	**-7,465**	**-7,465**	**-7,945**	**18,522**	**5,339**	**3,079**	**2,494**	**27,738**

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – November 2014

11-8 Clinical Quality And Patient Safety Report Chief Nurse

Summary / Key points

The attached paper provides the Board with information on the following areas:

- Actions taken to ensure focus on pressure ulcer prevention remains robust
- Trust's responsibilities in relation to Duty of Candour
- Cancer Patient Experience Survey 2014 – summary of results

Key issues for the Board to note are its statutory responsibility in ensuring Duty of Candour when significant / moderate harm has been caused to the patient. A process has been developed that includes a training programme to assist staff in delivery. The Trust is required to demonstrate compliance.

The Cancer Patient Experience survey 2014 results are overall positive and are either stable or improving in comparison to previous year.

Which Committees have reviewed the information prior to Board submission?

- Quality and Safety Committee

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

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

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

Clinical Quality and Patient Safety Report

November 2014

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 level oversight or are covered but require greater detail.

This report provides the Board with assurance on the processes in place focusing on the prevention of hospital acquired pressure ulcers, the Trust's implementation of Duty of Candour and Cancer Patient Experience Survey results and action plan.

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

Prevention of Hospital Acquired Pressure Ulcers

Over the month of October there has been an increase in the incidence of hospital acquired pressure damage. Overall number of hospital acquired damage is 15 incidents, of which 13 were category 2, and 2 ungradable. Although still small numbers and significantly below the national average the month of October had a rate of 3.1.

The location of damage is predominantly to the heels; however there has been a significant increase in the incidence of damage to ears and bridge of nose primarily as a result of prolonged oxygen therapy.

The site of pressure damage incidence is:

Site of damage	Maidstone	TWH	Total
Heels	3	4	7
Ear/Nose	1	4	5
Sacrum	1	1	2
Spine		1	1
Totals	5	10	15

Incidence by Ward:

Maidstone	Number	TWH	Number
Pye Oliver	3	11	1
Jon Saunders	1	20	3
Stroke	1	21	3
		30	1
		ITU	1
		MAU	1
Total:	5		10

The incidence is greater at the Tunbridge Wells site with 10 cases. There is no real discernable pattern of spread across the wards on either site, however it may be argued that 20 and 21 have a high potential given the age and condition profile of their case mix.

There has been wide debate within the Ward Manager cohort regarding this rise. Issues have been debated at the Friday Key Performance Indicator meetings and in other forums. The key areas of focus include the following:

Anti-slip socks

Use of anti-slips socks; the new product is a 'trainer sock' style and it was considered if staff were attempting to pull the socks up to or above the ankle thus increasing pressure to the toes and heels. An awareness campaign has been undertaken both by the Tissue Viability Nurses and the Falls Prevention Practitioner.

Nutritional support

Another consideration that generated debate was the management of patients with an elevated nutritional risk that did NOT meet the threshold for formal referral to dietician services. This has prompted a review of the snacks available at ward level. This review was undertaken by the Clinical Manager for Nutrition and Dietetic Services. The revised list has been developed with the support of the Catering team, and stock levels agreed for each ward.

Profiling beds

Further consideration has been given to the utilisation of the profiling beds, and assurance sought that beds are being 'profiled' or 'knee break' applied appropriately. Sheets were also considered, as historically there were issues with ill-fitting sheets. The Ward Mangers are not reporting any concerns with the fit of the sheets currently; however this is kept under regular review.

Mattress stock is kept under regular review, and there are no issues of concern in terms of access to AtmosAire 9000s (for high risk patients). The Trust standard mattress is an AtmosAire 4000 and is in place for patients unless clinically contraindicated.

There are no reported issues for access to powered dynamic mattresses either in or out of hours.

A full mattress stock stake is scheduled for December (this is normally undertaken annually with a small scale audit undertaken as part of the bi-annual pressure ulcer prevalence audit).

A business case is currently being developed jointly between the Tissue Viability Service and EME medical devices team for a mattress replacement programme. (The Trust currently does not have a formal on-going replacement programme in place).

Pressure ulcer awareness month

Awareness for pressure ulcer prevention has been stepped up for November, with 20th November being 'stop the pressure day'.

A number of activities are planned for this day. The Communications team are also supporting this campaign with a number of key messages being circulated via the email system, newsletters and social media.

The Trust working actively with the local health economy and is part of the Kent-wide pressure ulcer prevention group.

There is a full Trust-wide action plan for the prevention of pressure damage in place which is formally reviewed and updated every three months. The action plan is kept under weekly and monthly review for operational delivery by the Tissue Viability CNS and the Deputy Chief Nurse.

Duty of Candour

The new Duty of Candour statutory requirement responds to issues and concerns identified in a number of reviews and inquiries, including The Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Inquiry) and The Berwick Review into Patient Safety.

The new statutory duty requires the Trust to inform patients when significant harm to them has occurred, provide an explanation of what went wrong and offer an apology. It is clear that being open and honest when incidents occur is not only highly desired by patients but also demonstrates the value we place on safe, quality care and learning from when things don't go as expected. It is important to acknowledge that this occurs daily already however the documentation of these discussions and written communication

The roll out for Duty of Candour includes a training presentation that will be used at Trust level, directorate level and team level meetings over October and November. This will also be available for new staff as part of induction and for new doctors on rotation. We have developed posters and postcards for staff to provide written support for their duty of candour requirements and template letters will be used for the written communication with patients or patient relatives. A rolling audit will be implemented in December. All material stated above is available on request.

Cancer Patient Survey Results 2014

The National Cancer Patient Survey included 63 Trusts and MTW was ranked within the top third of these Trusts for patient satisfaction. The results from the survey have been analysed in order to see which areas MTW did well at and which areas nationally had room for service improvement. The action plan details the scores against these questions for 2013 and 2014.

MTW scored in the top 20% of the country for the following questions:

1. Patients were able to get understandable answers to important questions all/ most of the time.
2. Patients were given written information about their side effects.
3. Patients were given easy to understand written information about tests.
4. Staff explained completely what would be done during the test.
5. GP given enough information about patient`s condition and treatment

MTW were ranked in the bottom 20% of the country for the following 5 questions:

1. Staff gave a complete explanation of the purpose of the test.
2. Patients have taken part in cancer research.
3. Doctors did not always talk in front of patients as if they were not there.
4. Patients were not always given enough privacy when discussing their condition.
5. Patients were not always given enough privacy when examined or treated.

To compare this to other Trusts it should be noted that:

- Barts Health NHS Trust (London), 57 of the 69 questions were below the national average.
- Dartford Trust, 15 out of 69 questions were below the national average
- Brighton Trust, 22 out of 69 questions were below the national average
- For MTW, 5 of the 69 questions asked were below the national average.

An action plan has been developed to address all of the above issues (appendix 1). The criterion that was used for the action plan where the following:

- Any area were the Trust scored the national average or less
- Any area were the Trust scored above the national average however the national average was still very low and this area would benefit from service improvement

There was also a section on the questionnaire for patients to write in their own comments. The Trust received 117 pages of patient comments and the majority of these were very complimentary. The 3 questions were:

Q1. Was there anything particularly good about your NHS cancer care?

The key themes from the patients' responses were:

- "Superb nursing care."
- "From first being told that I had cancer I had excellent care at all levels"
- "Care excellent at Maidstone and Pembury Hospital"
- "My Consultant is very approachable and has a kind and caring attitude. I feel that she is very approachable."
- "Excellent care been given, I cannot fault it."

Q2. Was there anything that could have been improved?

- "More Doctors on duty at the weekends."
- "Only appointment time"
- "Waiting times for drugs to be released from Pharmacy and dispensed"
- "Availability and cost of car parking"
- "A&E pathways: length of time to be seen and bed availability"

Q3. Any other comments?

- "More dietary advice please"
- "I did not realise I could claim exemption from prescription charges as a cancer patient, someone outside of the Hospital told me this."
- "Lack of information re financial help."
- "I would and have recommended Maidstone Hospital to others"
- "I think you could say I am a very happy customer and so glad to be alive.

The last question of the National Cancer Patient Survey asked would patient rate their care as Excellent or Very Good and **90%** of patients agreed that their care was excellent or very good.

CLINICAL AUDIT ACTION PLAN AUDIT ID:

Audit Title: National Cancer Patient Experience Survey Programme 2014

Auditor(s) Cancer Services Directorate

- *Ensure that the recommendations detailed in this action plan mirror those recorded in the "Recommendations" section of the report.*
- *The "Actions required" should specifically state what needs to be done to achieve the recommendations. A recommendation may require more than one action to achieve the desired outcome.*
- *All updates on the action plan should be included in the "Comments" section*

Consultant / Supervisor (Audit Lead)	Name: Dr Sharon Beesley	Title: Consultant Oncologist	Contact: 25026
General Manager	Name: Helen Bennett	Spec: Oncology	Contact: 28650
Forum where audit presented and action plan agreed:	Patient Experience Committee	Date of discussion:	

Methodology:

1. All questions where year on year performance decreased by 5% or more.
2. All questions where MTW performed lower than the national percentage scores.
3. Areas where the MTW team would like to improve as a service improvement to patients.

Key areas for improvement	Action	Lead person responsible	Date
Q11 Patient told they could bring a friend when first told they had cancer Trust score 2013 65% Trust score 2014 72% National score 2014 75%	Discuss with patient experience committee whether or not all Trust letters should explicitly state that the patient is welcome to bring someone with them to all appointments. • Review current information given to new patients (clinic letters and information leaflets). • Implement posters around the Trust • Communicate with GP's • Update all Trust websites e.g. KOC and MTW	Matron McMillan Information Manager McMillan Information Manager General Manager McMillan Information Manager	Jan 2015

Key areas for improvement	Action	Lead person responsible	Date
Q14 Patients given written information about the type of cancer they had Trust score 2014 74% Trust score 2013 71% National 72%	• Cancer Directorate to review Directorates literature. • CNS staff to ensure literature is given out • Review of literature in the Macmillan Information Centre • Posters informing patients of the information service available at the MacMillan Information Centre to go up around the Hospitals • Develop a leaflet on the McMillan Information Centre to give to all patients • Scope having volunteers at TWH to offer services cross site.	Matron CNS staffs McMillan Information Manager McMillan Information Manager McMillan Information Manager McMillan Information Manager	Jan 2015
Q16 Patients views definitely taken into account by Doctors and Nurses discussing treatment Trust score 2014 70% Trust score 2013 71% National 71%	• Reminder from Directorates to all clinical teams to include the views of the patients.	General Manager	Jan 2015
Q17 Possible side effects explained in an understandable way Trust score 2014 77% Trust score 2013 78% National 75%	• Review current information given to patients regarding side effects. • Develop a future side effects patient information leaflet.	McMillan Information Manager Matron	Jan 2015
Q19 Patient definitely told about treatment side effects that could affect them in the future Trust score 2014 58% Trust score 2013 57% National 56%	• See above, Q17 action.		Jan 2015
Q20 Patient definitely involved in decisions about care and treatment Trust score 2014 74% Trust score 2013 73% National 72%	• Discuss with Directorate clinical teams issue and implement ideas for improvement.	General Manager	Jan 2015

Key areas for improvement	Action	Lead person responsible	Date
Q27 Hospital staff gave information on getting financial help Trust score 2014 48% Trust score 2013 47% National 54%	• MTW will provide 1 days' worth of financial advice per week from mid November onwards. • This will be publicised using posters, word of mouth, Trust website, etc. • McMillan Information Manager to cascade train as many staff as possible (CNS's, Volunteers, Unit and Ward staff) to increase the number of people who can help patients with their finances.	McMillan Information Manager	Jan 2015
Q28 Hospital staff told patient they could get free prescriptions Trust score 2014 71% Trust score 2013 70% National 78%	• Review current patient literature packs to include advice on free prescriptions. • Posters on free prescriptions and financial help to be displayed prominently and refreshed in ward areas, clinics, etc across the Trust. • Produce a leaflet to be included in every patients TTO drugs. • Update the KOC website and the Trust website with this information.	McMillan Information Manager McMillan Information Manager Pharmacy Manager McMillan Information Manager	Jan 2015
Q29 patient has seen information about cancer research in the hospital Trust score 2014 83% Trust score 2013 81% National 86%	• Implement a Research Trials Notice board within the KOC informing patients of ongoing trials and the outcomes. • Poster campaign across the Trust in waiting room areas.	KOC Research Nurse McMillan Information Manager	Jan 2015
Q30 Taking part in cancer research discussed with patient Trust score 2014 25% Trust score 2013 29% National 31%	• Raise awareness with Clinicians of the results of this survey (Clinical Governance sessions, Cancer Board, 1 to 1's. • Change the Electronic Action Sheet on KOMS to have a tick box to ask the clinician whether or not a clinical trial was appropriate (can't move on until they've acknowledged the question). • Reinforce with the clinician the importance of informing the patient if their case is not suitable for any research trials. • Resolve the staffing issues within the Research team (has been difficult to attract candidates to posts).	General Manager General Manager Oncology Clinical Director General Manager	Jan 2015
Q31 Patient has taken part in cancer research Trust score 2014 54% Trust score 2013 64% National 63%	• Review the number of trials currently on offer. • Explore the feasibility of what would be required to increase this. • Review the process for recruiting patients.	KOC Research Nurse	Jan 2015

Key areas for improvement	Action	Lead person responsible	Date
Q37 Patients received understandable answers to important questions all/ most of the time Trust score 2014 79% Trust score 2013 81% National 83%	• All Directorates to be reminded to speak to patients jargon free and ensure that the patient fully understands what they have been told. • Share the findings of this survey with the clinical teams (as per earlier)	General Manager	Jan 2015
Q38 Patient had confidence and trust in all doctors treating them Trust score 2014 82% Trust score 2013 86% National 85%	• All Directorates to discuss this finding at clinical governance meetings. • Further survey/analysis required of why patients lack confidence in some of the Doctors treating them.	Oncology Clinical Director/ Matron/ GM	Jan 2015
Q39 Doctors did not talk in front of patients as if they were not there Trust score 2014 78% Trust score 2013 82% National 84%	• Review how many of the teams have been on advanced communications skills. • Launch mini ”refresher” sessions to remind staffs of previous learning. • Share findings of this survey with all directorates.	Oncology Clinical Director/ Matron/ GM	Jan 2015
Q40 Patients family definitely had opportunity to talk to the doctor Trust score 2014 66% Trust score 2013 63% National 67%	• All Directorates to discuss this finding at clinical governance meetings. • Directorates to review availability of clinical teams. • Further survey/analysis required of why patients lack confidence in some of the Doctors treating them.	Oncology Clinical Director/ Matron/ GM	Jan 2015
Q44 Always / nearly always enough nurses on duty Trust score 2014 67% Trust score 2013 56% National 62%	• Safe staffing levels agreed and implemented across all Directorates.	Matron	Jan 2015
Q47 All staff asked patients what name they prefer to be called by? Trust score 2014 52% Trust score 2013 50% National 60%	• All Directorates to discuss this finding at clinical governance meetings. • Remind all staff to discuss with the patient what name they would like to be called and if appropriate document.	General Manager Matron	Jan 2015
Q48 Always given enough privacy when discussing condition or treatment Trust score 2014 82% Trust score 2013 83% National 85%	• All Directorates to discuss this finding at clinical governance meetings. • All staff to ensure patient is satisfied with level of privacy offered / provided prior to any examination / discussion • Encourage staff to sign up to Dignity in Care – Dignity Champion • Review availability of quiet or private rooms to have discussions	General Manager Clinical staff Ward Manager/Matron Matron	Jan 2015

Key areas for improvement	Action	Lead person responsible	Date
Q49 Always given enough privacy when being examined or treated Trust score 2014 92% Trust score 2013 91% National 95%	• See above.		Jan 2015
Q50 Patient was able to discuss worries or fears with staff during visit Trust score 2014 66% Trust score 2013 57% National 65%	• Staff to promote listening culture by undertaking additional training so they feel able to support patients (e.g. basic counselling skills) • All Directorates to discuss this finding at clinical governance meetings.	Matron	Ongoing Jan 2015
Q55 Family definitely given all information need to help care at home Trust score 2014 60% Trust score 2013 56% National 60%	• Notice board to go up in the KOC with information for family and services available/ contact numbers. • Leaflet to be developed to go in the patient's information pack.	McMillan Information Manager	Jan 2015
Q58 Staff definitely did everything to control side effects of chemotherapy Trust score 2014 79% Trust score 2013 78% National 81%	• Emergency chemotherapy phone to be re-launched (this will allow a patient to go through to the relevant person for help) • Re training of staff competencies • Full review of documentation given to patients		Jan 2015
Q68 Patient offered written assessment and care plan Trust score 2014 20% Trust score 2013 24% National 22%	• All Directorates to discuss this finding at clinical governance meetings. • Task and finish group for the oncology department to review the best way to issue the patient with a written assessment and care plan using KOMS.		Jan 2015

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – November 2014

11-9	**Response to the underlying issues involved in the 'Patient Story' that was heard at the October 2014 Board**	**Medical Director / Chief Nurse**

Summary / Key points

The report provides a response to the underlying issues involved in the 'patient story' that was heard by the October 2014 Board:

Reflection on the patient story presented at the October Board

The family of a lady who died within our Trust kindly presented their reflections on the care that she had received and also their reflections on the interaction that had occurred since they had made contact with our complaints team.

In a brief summary, Mrs M was suffering from a tumour of her kidney and was undergoing palliative chemotherapy at the Royal Marsden, with an unusual drug. She was admitted over a long weekend in early 2013 and saw several different consultants. After the weekend, she deteriorated and required emergency surgery, was admitted to ITU and did not recover.

I will highlight different sections of their comments, in order that we, as a Board, can reflect on the issues.

Continuity of care

Several different consultants were in charge of this patient's care, there seemed to be difficulty in noticing her clinical deterioration and a comment was made regarding inadequate examination.

- Different consultants will be required over a weekend, and in this instance, there were concerns raised by the family probably exacerbated by some inappropriate comments from the specific consultants. A full handover is required and in this instance, investigation does not show any lack of appropriate handover.
- This patient gradually deteriorated and this was not apparent to the clinical team.
- A consultant saw this patient every day.
- A full examination did not occur each day.
- There may be 70-90 surgical patients on any day.
- 7 day outreach is now in place.
- Introduction of electronic "trigger" tools.
- In May 2013 a large number of junior surgical staff were temporary (following new rotation form 1st April).

Staffing levels

The family thought that there was inadequate staffing over the long weekend, though there is no evidence to show this – on one shift, there was a request for an additional member of staff, but this request could not be filled.

Pharmacy closed at weekends

The family appeared to have been informed that a reason for not dispensing a drug was that pharmacy was closed. We have always had 24 hour on call availability of Pharmacists, but this comment does suggest that the perception is different on the wards. We now have seven day pharmacy opening. In actual fact, the drug prescribed was available on another ward in the hospital.

Complaint
The family put forward a very detailed clinical complaint. This appears to have caused a defensive (though not incorrect) response, which in fact, was not the issue that concerned the family. With such a complex issue, it would have been much more appropriate to have arranged a meeting with the family. Unfortunately, the family dynamics meant that any meeting took many months to arrange. Our complaints systems are much better at picking out the issues where a meeting will bring greater understanding.

Conclusion
As team, we need to reflect on all of the issues brought up by the family. Some of these will require examination of the clinical care we deliver and others relate to our complaint response.

I would like to formally thank the family for agreeing to share their reflections with us.

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
To provide a response and follow up background information.

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board – November 2014

11-10 Safe Staffing: Planned V Actual – October 2014 Chief Nurse

Summary / Key points

The attached paper is a copy of the planned v actual nursing staffing as uploaded to UNIFY and published via NHS Choices on the Trust website for the month of October 2014.

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

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

ICU – Maidstone site: at 82 – 85% across both registered and un-registered staff. This was sufficient to meet the needs of the patients on the unit at that time. Additional staff were re-deployed to Tunbridge Wells ICU where acuity and dependency was higher.

Hedgehog: Clinical Support Worker fill rate was 53% for day shift and 80% for night shift. The overall Registered Nurse (Child) fill rate was within acceptable tolerances maintaining sufficient skilled staff to provide the care required safely. Key issues for decrease in fill rates relate to the need to escalate Woodland, which results in an overall dilution of support workers.
The focus is kept on ensuring RN (Child) shifts are covered.

MAU: Clinical Support Worker fill rate was 78% during the day. However there was sufficient Registered Nurse cover to meet the needs of patients. Whilst the reduction in Clinical Support Worker resulted on reactive care rather than proactive care for 5 shifts, there were no increases noted in key nurse sensitive indicators (falls, pressure ulcers).

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

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

UMAU – increased requirement met for staff at night.

Surgical Short Stay – TWH: This unit was used for escalation, primarily overnight.

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

Jonathan Saunders: increased requirement for clinical support workers, particularly at night to manage a noro-virus outbreak. This additional support was required to ensure patients hydration and hygiene needs were being adequately met

Ward 10 had an increased nursing requirement due to increased acuity and dependency,
with one patient requiring a nursing presence overnight on 13 nights and one patient requiring a nursing presence for 2 nights. All these patients are ‘named’ and a matron level review of requirement.

Ward 11 had an increased requirement for nursing presence for 14 nights due to increased acuity and dependency. Additional requirements were put in place following a matron level review as with Ward 10.

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

John Day required additional Clinical Support Workers at night to manage a number of patients with increased dependency. These patients had significant confusional states, as well as geographical layout and location increasing risk for absconding as one bay has an emergency exit directly from the bay. This bay is not directly visible from the rest of the ward. This additional requirement was put in place following a matron level review of need.

The attached appendix gives the break down by ward.

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

Reason for receipt at the Board.
Assurance

Ward name	Main 2 Specialties on each ward		Day		Night	
	Specialty 1	Specialty 2	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Acute Stroke	300 - GENERAL MEDICINE	430 - GERIATRIC MEDICINE	100.0%	104.0%	98.9%	112.9%
Romney	314 - REHABILITATION	300 - GENERAL MEDICINE	98.9%	100.0%	100.0%	96.8%
Cornwallis	100 - GENERAL SURGERY	101 - UROLOGY	97.8%	114.5%	111.8%	
Coronary Care Unit (CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	95.7%		100.0%	
Culpepper	320 - CARDIOLOGY	300 - GENERAL MEDICINE	98.4%	100.0%	98.4%	100.0%
Foster Clark	340 - RESPIRATORY MEDICINE	300 - GENERAL MEDICINE	92.3%	111.8%	99.2%	109.7%
Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		85.1%	82.6%	82.3%	
John Day	301 - GASTROENTEROLOGY	300 - GENERAL MEDICINE	80.0%	106.5%	97.8%	200.0%
Jonathan Saunders	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	96.8%	106.5%	98.9%	148.4%
Lord North	370 - MEDICAL ONCOLOGY	800 - CLINICAL ONCOLOGY	100.6%	106.5%	97.8%	100.0%
Mercer	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	98.4%	98.9%	94.6%	129.0%
Pye Oliver	100 - GENERAL SURGERY	101 - UROLOGY	112.4%	137.1%	117.2%	109.7%
Urgent Medical Ambulatory Unit (UMAU)	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	96.6%	96.5%	124.7%	183.9%
Acute Stroke	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	100.0%	100.0%	96.8%	112.9%
Coronary Care Unit (CCU)	320 - CARDIOLOGY	300 - GENERAL MEDICINE	98.9%	112.9%	98.9%	
Gynaecology	502 - GYNAECOLOGY		104.8%	97.8%	100.0%	100.0%
Intensive Treatment Unit (ITU)	192 - CRITICAL CARE MEDICINE		102.0%	96.8%	102.8%	35.5%
Medical Assessment Unit	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	106.7%	78.3%	101.7%	84.4%
SDU	100 - GENERAL SURGERY	101 - UROLOGY	114.8%	111.1%	133.9%	154.8%
Ward 32	110 - TRAUMA & ORTHOPAEDICS	100 - GENERAL SURGERY	100.0%	100.0%	100.0%	100.0%
Ward 10	100 - GENERAL SURGERY		95.4%	104.8%	96.0%	114.5%
Ward 11	100 - GENERAL SURGERY		96.8%	104.3%	100.0%	127.4%
Ward 12	320 - CARDIOLOGY	301 - GASTROENTEROLOGY	98.1%	92.5%	87.8%	127.4%
Ward 20	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	97.2%	118.5%	92.7%	132.3%
Ward 21	340 - RESPIRATORY MEDICINE	302 - ENDOCRINOLOGY	115.2%	108.6%	117.4%	117.7%
Ward 22	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	96.8%	103.2%	102.2%	96.8%
Ward 30	110 - TRAUMA & ORTHOPAEDICS		96.7%	109.5%	100.0%	103.2%
Ward 31	110 - TRAUMA & ORTHOPAEDICS		116.7%	91.0%	124.2%	116.1%
Stroke Rehab	430 - GERIATRIC MEDICINE	300 - GENERAL MEDICINE	99.1%	100.0%	100.0%	100.0%
ante-natal	501 - OBSTETRICS		103.2%	93.5%	98.4%	93.5%
delivery suite	501 - OBSTETRICS		97.5%	93.5%	90.0%	96.8%
post-natal	501 - OBSTETRICS		100.7%	99.2%	97.6%	96.0%
Gynae Triage	502 - GYNAECOLOGY		100.0%	96.8%	98.4%	100.0%
Hedgehog	420 - PAEDIATRICS		96.1%	53.7%	107.5%	80.6%
Birth Centre	501 - OBSTETRICS		101.7%	86.7%	100.0%	100.0%
Neonatal Unit	420 - PAEDIATRICS		102.2%	87.1%	98.9%	87.1%
MSSU	100 - GENERAL SURGERY		101.2%	106.3%	119.4%	

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – November 2014

11-11	Cancer Related Services Provided By The Local Voluntary/Third Sector	Medical Director

Summary / Key points

It was agreed at the September Trust Board to arrange for the Board to receive details of the extent of the cancer-related services provided by the local voluntary/third sector. Information on a number of the voluntary services available is detailed below.

Voluntary sector Oncology related services

A wide portfolio of services are provided to patients that is in addition to care provided by the NHS. Some examples are given below:-

- **Hospices**: There are two hospices within our area, the Heart of Kent (Preston Hall) and the Hospice in the Weald (Pembury). The majority of their funding comes from charitable donations. Both of these hospices provide many services, that are in addition to the traditional inpatient care.

- **Macmillan**:

    - Macmillan volunteer service West Kent - provides befriending and practical help to people affected by cancer in West Kent.
    - Macmillan volunteer service East Kent - provides befriending and practical help to people affected by cancer in East Kent.
    - Macmillan East Kent Benefits advice service.
    - The Macmillan Carers support service East Sussex.
    - Macmillan benefits advice service East Sussex.
    - Medway Macmillan Benefits advice Service.
    - We have 5 Information Centre volunteers who support people attending the Kent Oncology Macmillan Information Centre. They also support patients on wards and in chemo unit.

- **Pickering** cancer drop in centre, Tunbridge Wells.

- 3 centre volunteers also help to run the **Look Good Feel better** make up workshops we run once a month in conjunction with the Look Good Feel Better Charity. They help with admin, booking in ladies, and running the workshops.

- 3 **British Red Cross** volunteers provide hand and arm massage on the chemo units at Maidstone and Pembury Hospital.

- 1 **Volunteer** does admin work for planning and scheduling department in radiotherapy.

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

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

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - November 2014

11-12	**Charitable Funds Committee, 20/10/14 (incl. approval of the 2013/14 Ann. Report & Accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund)**	**Committee Chair (Non-Executive Director)**

Summary / Key points

A verbal summary of the Charitable Funds Committee meeting held on 20th October was provided to the October Trust Board.

One of the main matters considered at the Committee was the 2013/14 Annual Report and Accounts of Maidstone and Tunbridge Wells NHS Trust Charitable Fund. The draft Annual Report and Accounts were discussed and agreed, subject to some minor amendments. It was further agreed that the Trust Board should be recommended to approve the Annual Report and Accounts, and the Management Representation Letter. To this end, the following information is enclosed:

- The draft Annual Report and Accounts for 2013/14 (including the Independent Auditor's report). This incorporates the amendments agreed at the Charitable Funds Committee on 20/10/14
- The draft Management Representation Letter

Maidstone and Tunbridge Wells NHS Trust is the sole corporate Trustee for Maidstone and Tunbridge Wells NHS Trust Charitable Fund. Best practice guidance from the Charity Commission on the governance of NHS Charities is that even if oversight of the Charitable Fund is delegated to a Charitable Funds Committee, the corporate trustee (which is represented by the Trust Board) should maintain direct control over certain aspects of such oversight. Approval of the Annual Report and Accounts is considered to be a key indicator of the maintenance of such control, and reflects the duties of the trustee. The Annual Accounts of the Fund are legally required to be submitted to the Charity Commission within 10 months from the financial year-end (i.e. by the end of January 2014). The Trust Board is therefore asked to approve the enclosed documents, to enable the required submission to take place.

Which Committees have reviewed the information prior to Board submission?

- Charitable Funds Committee, 20/10/14

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

- Information and assurance
- To approve the 2013/14 Annual Report and Accounts for Maidstone and Tunbridge Wells NHS Trust Charitable Fund

[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 Charitable Fund

Charity Number 1055215

Annual Report and Accounts for the year ended 31st March 2014

Contents

Annual Report for the year ended 31 March 2014

The Corporate Trustee (Trustee) presents the Maidstone and Tunbridge Wells NHS Trust Charitable Funds ("the Charity's") annual report and the audited financial statements for the year ended 31 March 2014.

The financial statements set out on pages 18 to 29 comply with the charity's trust deed, applicable Accounting Standards in the United Kingdom and the Statement of Recommended Practice (SORP) "Accounting and Reporting by Charities" issued in October 2005, and the Charities Act 2011.

Trustee Statement

The generosity of the many people who have raised funds, given donations and made provisions in their will, is recognised by both the Trustee and staff particularly in the current financial climate. The Trustee and the staff, would like to express their sincere gratitude to all those who have made a contribution which has enabled the Charity to enhance the standard of care, services and facilities provided by the Maidstone and Tunbridge Wells NHS Trust to patients, their relatives, visitors and staff.

Information about the Charity

The Maidstone and Tunbridge Wells NHS Trust ('the Trust') is the Corporate Trustee of the charitable fund under paragraph 16c of Schedule 2 of the NHS and Community Care Act 1990. The Charity is constituted by a Trust Deed and registered with the Charity Commissioners under charity number 1055215, and includes funds in respect of the Hospitals of the Maidstone and Tunbridge Wells NHS Trust.

During the year the Charity was situated on two main sites at Maidstone and Pembury in Kent. These are Maidstone Hospital and The Tunbridge Wells Hospital at Pembury.

The Charity is a 'NHS Umbrella Charity' under which there are individual sub-funds that are held for administrative purposes, principally to respect the wishes of the donors.

Within the Umbrella there were a total of 162 individual funds at the 31st March 2014 with a total value of £1,094k. The number of funds in each category is as follows:-

- 85 restricted funds.
- 2 endowment funds (capital in perpetuity) - only the net income to be spent, whilst the capital remains invested.
- 75 unrestricted or designated Funds created for donations received for use by hospitals, wards and departments to reflect donors' wishes. These do not form a binding trust.

The major funds within each of these categories are disclosed in Note 8 in the accounts.

The Corporate Trustee

Maidstone and Tunbridge Wells NHS Trust is the Corporate Trustee of the Charity.

The Trust Board effectively adopts the role of Trustee as defined by the Charity Commission (it is considered to be the agent of the Trustee). Individual members of the Board are not trustees under Charity Law.

Details of appointments and terminations within the financial year are tabled below:

Executive Directors	Non-Executive Directors	Other Directors
Glenn Douglas – Chief Executive	Anthony Jones – Chairman of Trust Board	Sara Mumford – Director of Infection Prevention and Control
John Headley – Finance Director (to 27th October 2013)	Steve Tinton – Chair of Charitable Funds Committee for 2013/14	Jayne Black – Director of Transformation (joined September 2013)
Ian Miller – Interim Director of Finance (from 1st November 2013)	Phil Wynn-Owen (Chair of Charitable Funds Committee) (left Board on 30th December 2013)	Terry Coode – Director of Corporate Affairs
Paul Sigston – Medical Director	Sarah Dunnett (joined Board in January 2014)	Paul Bentley – Director of Strategy and Workforce
Angela Gallagher – Chief Operating Officer	Kevin Tallett	
John Kennedy – Interim Director of Nursing (left 30 June 2013)	Sylvia Denton	
Avey Bhatia – Chief Nurse (joined Board on 1st July 2013)	Beverley Evans (left 3rd April 2013)	Stephen Smith (Associate Non-Executive Director)

None of the Board Directors have received any remuneration from the Charity in this financial year for work relating to their responsibilities for the Charity as agent of the Corporate Trustee. (2012/13 none)

The principal office of the Charity is:

Trust Headquarters
Maidstone and Tunbridge Wells NHS Trust
Maidstone Hospital
Hermitage Lane
Maidstone
Kent ME16 9QQ

Principal advisors:

External Auditor Grant Thornton UK LLP Grant Thornton House Melton Street London NW1 2EP	Bankers Citibank Citibank NA, London Branch 25 Canary Wharf London E14 5LB
Solicitors Brachers Solicitors Somerfield House 59 London Road Maidstone Kent ME16 8JH	Bankers National Westminster Bank Kent Corporate Business Centre PO Box 344 Maidstone Kent ME14 1AT
Investment Managers Charities Aid Foundation 25 Kings Hill Avenue Kings Hill West Malling Kent ME19 4TA	Bankers Lloyds TSB 2nd Floor 11 Earl Grey Street Edinburgh EH3 9BN
	Bankers Santander Business Banking Bridle Road Bootle Merseyside L30 4GB
	Bankers Clydesdale Bank 6/8 London Road Unit 5 Peveril Court Crawley RH10 8JB

Governance and Management of the Charity

Governance

The Board of the Maidstone and Tunbridge Wells NHS Trust became responsible for the funds with effect from the 1 April 2000, following the merger of the Kent and Sussex Weald NHS Trust, which was based at Tunbridge Wells and the Mid Kent Healthcare Trust, which was located at Maidstone. The Board delegates the daily stewardship of the funds to the Charitable Funds Committee of the Trust, which within its annual programme of meetings, includes relevant training and updates as required to assist in the performance of its role as Trustee.

The Charitable Funds Committee plans to meet at least three times a year.

The proceedings and decisions of the committee are recorded. The minutes of each meeting are formally agreed by the Chairman of the Committee and circulated to all members.

Recruitment and Training of Board and Committee Members

All Board and committee members undertake a two day induction programme within the Trust upon joining. They are also able to focus on a particular area of the Trust in which they have a special interest or concern.

Management of the Charity

The Charitable Funds Committee has a tightly controlled scheme of authorisation in place in order to spend the funds. This is achieved by delegating the day to day expenditure to the duly authorised fund holders. The fund holders consist mainly of ward managers, senior medical staff or senior department managers. Each individual fund holder is approved by the general manager or Clinical Director of the Directorate, and also made aware of the Trust's Standing Orders and Standing Financial Instructions, that apply to Charitable Funds. Each fund holder receives a detailed financial statement of the fund each month.

Risk Management

The major risks to the Charity have been assessed, and in the Board's opinion, all necessary action has been taken and procedures have been put in place to minimise those risks wherever possible. The risk policies and financial controls of the Trust also apply to the Charitable Funds. The Corporate Trustee has identified that the only major area of financial risk for the Charitable Funds is the performance of the investments.

To mitigate the risk of investment performance the Corporate Trustee has adopted a relatively low risk policy, but 50% of funds will remain exposed to those risks normally associated with investing in stocks and shares and regarded as medium to long term investment. The cash balances will be invested in bank accounts which have a low credit risk (a minimum rating of 'Fitch AA-'/ 'Moody's AA3') and covered by the Financial Services compensation scheme up to a maximum of £85,000 per 'authorised institution'. The maximum investment in each banking institution will be £100,000 and therefore the maximum risk on each investment is £15,000.

Investment Powers

The investment powers of the charitable fund are stated in the Declaration of Trust registered with the Charity Commission, which provides for the following:

''*to invest the trust fund and any part thereof in the purchase of or at interest upon the security of such stocks, funds, securities or other investments of whatsoever nature and where so ever situate as the trustee in their discretion think fit but so that the trustee:*

a) shall exercise such power with the care that a prudent person of business would in making investments for a person for whom he felt morally obliged to provide;

b) shall not make any speculative or hazardous investment (and, for the avoidance of doubt, this power to invest does not extend to the laying out of money on the acquisition of futures and traded options);

c) shall not have power under this clause to engage in trading ventures; and

d) shall have regard to the need for diversification of investments in the circumstances of the Charity and to the suitability of proposed investments.''

Investment strategy

The investment strategy of the charity is defined, by the charitable fund committee on behalf of the corporate trustee as follows:

"*to maximise total returns whilst minimising any risk to the total value of the fund in both the short to medium term.*"

The strategy identifies the current preferred investment mix for the charity as:

- 50% Cash;
- 25% Equities; and
- 25% Bonds.

The Charitable Funds Committee monitors the performance of the investments on a regular basis.

Professional Advisors

The External Audit is performed by Grant Thornton UK LLP. In addition, TIAA, the internal auditors of the Trust, review on a planned basis the systems and procedures put in place by the Corporate Trustee.

Aims and Objectives for the Public Benefit

The key objective of the Trustee of the Maidstone and Tunbridge Wells NHS Charity is to ensure that donations and legacies received are used in accordance with the wishes of the donor and the aims of the Trust.

The Corporate Trustee confirms that the guidance provided by the Charity Commission has been referred to with regard to the need for public benefit when reviewing their aims and objectives and future activities.

The purpose of the Charity is to provide benefit to the public by supporting the prevention and treatment of illness in all its forms and to promote research and education in healthcare through:

- Improving the patient and carer experience;
- Improving healthcare facilities and equipment;
- Facilitating high quality research programmes;
- Encouraging and supporting innovation in the development of services; and
- Supporting the training, personal development and welfare of staff.

The objects of the umbrella Charity are stated in the Trust deed as follows:-

"*The Trustee shall hold the trust fund upon trust to apply the income, and at their discretion, so far as may be permissible, the capital, for such purposes relating to Hospital Services (including Research); or to any other part of the Health Service associated with any hospital as the Trustee think fit.*"

The restricted funds have individual specified purposes that govern their use, in conjunction with the objects of the umbrella Charity.

Strategy for Achieving its Objectives

The Charitable Funds are used to support the overall objectives of the Trust, and include the provision of a wide range of equipment and facilities for both patients and staff. This allows the Trust to develop its services through new equipment and facilities and to provide training for staff which enhances their skills and knowledge allowing them to improve their contribution to the provision of its services to the public benefit.

The development of the Trust's services may be dependent on both the Charitable Funds and the funds received from the Exchequer. This interdependency provides opportunities for the Charity to contribute to services which make a greater impact than the cash sum would make on its own.

Reserves and Commitments

Charity Reserves as defined under SORP 2005 (GL51) are those funds which become available to the charity to be spent at the Trustee's discretion in furtherance of the charity's objectives, excluding funds which are spent or committed or could only be realised through the disposal of fixed assets. These are therefore classified as 'free'.

The Corporate Trustee has not made any changes to policies during the year and still requires that commitments against each fund are made only when the resources needed are available.

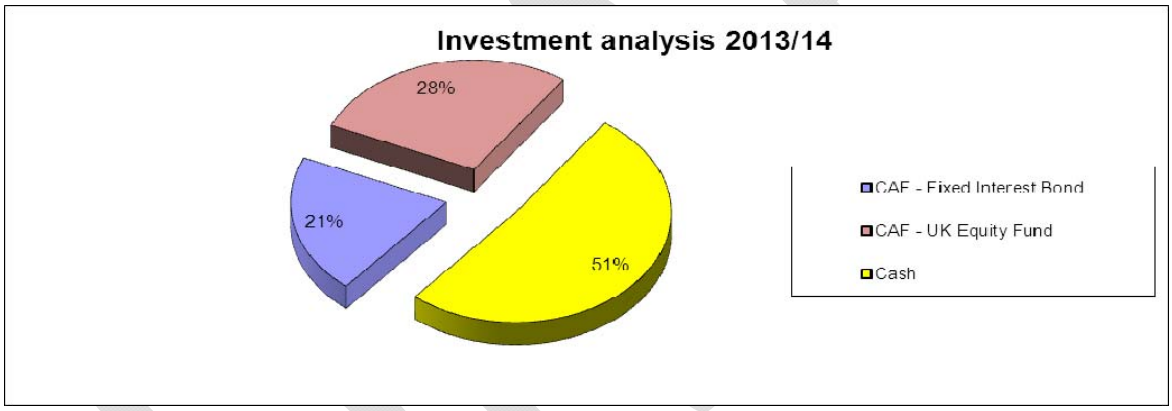
Major items of expenditure for both goods and services are agreed in advance in order that the necessary liquid resources can be released from the Investment Managers on a planned and timely basis. None of the funds held by the Investment Managers are committed on a long term basis as the Corporate Trustee has a policy to put the funds to the best possible use as quickly as is reasonably possible, taking into consideration any particular restrictions imposed by individual donors.

Investment Performance

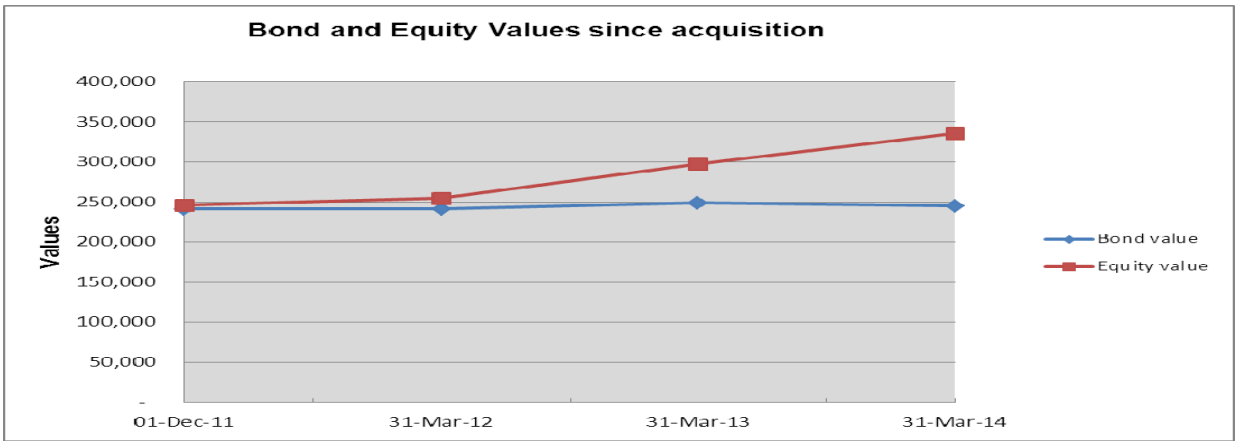
Investment income for the year was £25k (2012/13 £24k). In the current economic climate this is considered to indicate an acceptable performance for an investment strategy based on a low risk portfolio of investments. The total performance return on the portfolio of the investments (equity and bond) was £6k which equates to a 1.12% on the opening portfolio value (2012/13 2.49%).

The value of equities and bonds varies according to market forces with the CAF bonds and equities portfolio increasing in market value to £581k at 31 March 2014 (£547k at 31 March 2013). The cash investment at 31 March 2014 was £613k (£520k at 31 March 2013).

The current asset portfolio of cash and investment allocation totalling £1,194k at 31.03.14 is shown in the following graph:



Although the cash allocation at 51% is broadly in line with the strategy of Cash 50%, Bonds 25%, Equities 25%, the mix of bonds (21%) and equities (28%) is not completely in line due to the fact that the equity investments have performed better over time. The graph below demonstrates the performance of the bonds and equities since their purchase in December 2011.

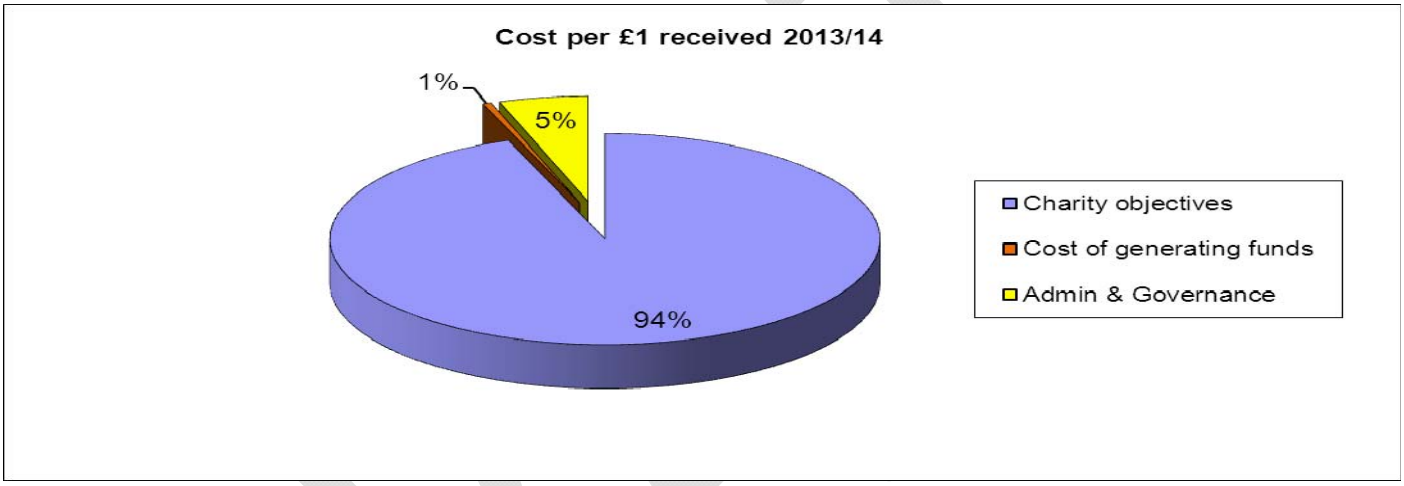


Performance of the portfolio is monitored and reviewed on a quarterly basis by the Charitable Funds Committee.

Achievement of public benefit

The Trust has achieved its objectives to enhance services and amenities for the public both as patients and visitors as well as staff through the purchase of equipment and support for projects.

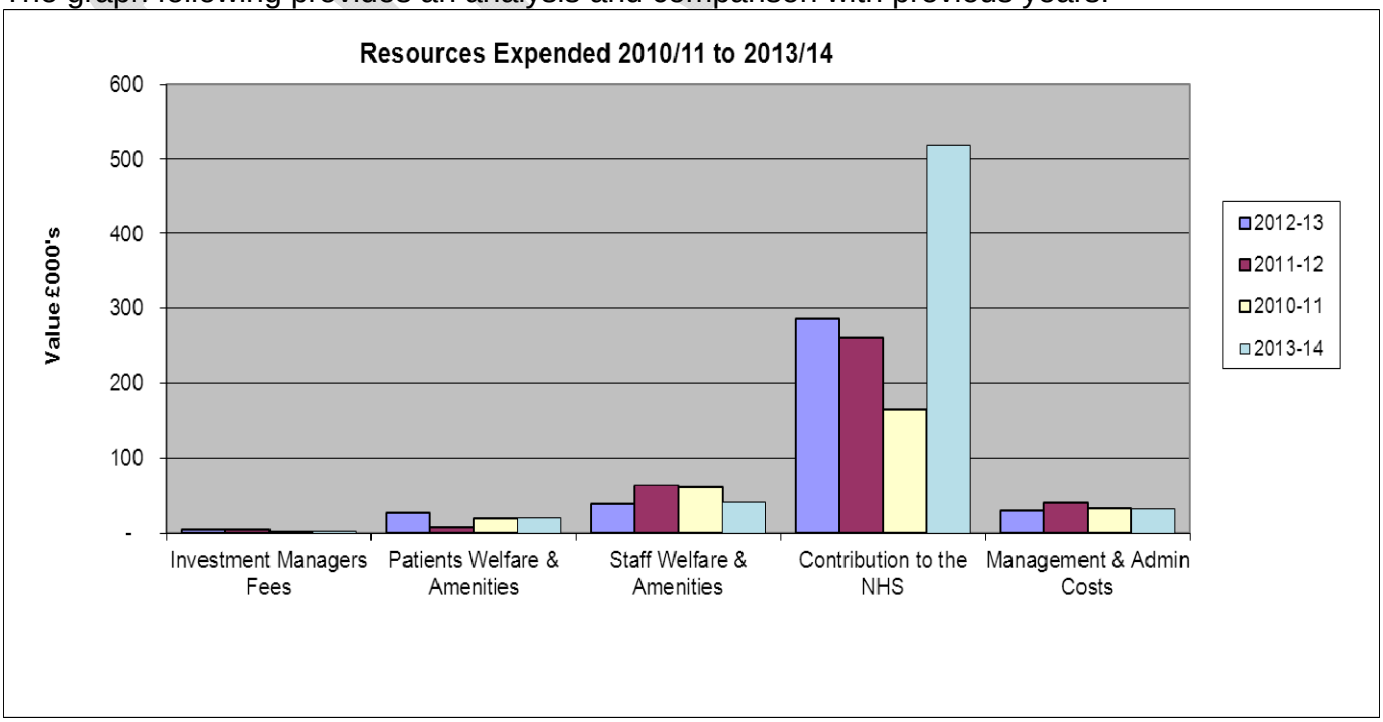
The graph below shows that in this financial year for every £1 raised, 94pence was spent in achieving the objectives of the charity. Although a 'cost-per-pound' raised ratio can be misleading as many factors can affect the analysis, it can be a useful guide to both donors and the corporate trustee.



Expenditure

Total resources expended by the Charity within this financial year were £613k (2012/13 £386k), of which £578k (94%) was a direct contribution to the Trust (2012/13 £351k 91%).

The graph following provides an analysis and comparison with previous years:



Charitable expenditure for the year is detailed below.

Medical Equipment – Total spend £429k (2012/13 £221k)

Medical equipment has been purchased within the reporting year to provide additional resources to enhance the quality of treatment, services and amenities within the Trust.

The most significant purchases were:

- Echogastroscope (£86k) to replace the existing oesophageal EUS scope which is over 6 years old.
- Purchase of a replacement ultrasound machine for the breast care unit at Maidstone Hospital to support the development of new and improved techniques around the treatment for breast care patients (£83k).
- Trolley Life Guards (£37k) to replace 15 patient trolleys at a cost of £2,500 each.
- BodyBox – Lung Function Machine (£27k) ensuring non-urgent lung function tests are carried out within 2 weeks.

Other Direct Contributions to the NHS – Total spend £41k (2012/13 £65k)

Expenditure in this category includes fixtures and fittings, production of a video for the birthing centre patients and nursing staff to provide additional support for the Oncology Department on a pilot basis to establish if the additional resourcing improved the patient experience. The pilot was deemed successful and the additional support has been funded from Trust exchequer funds for 2014/15.

Information Technology – Total spend £48k (2012/13 £0)

Expenditure supported the implementation of ‘Patient Knows Best’ web services.

Patient Welfare and amenities – Total spend £20k (2012/13 £26k)

90% (£18k) of the expenditure in this category provides complementary physiotherapy service for patients with multiple sclerosis to enable patients to maintain higher levels of ability.

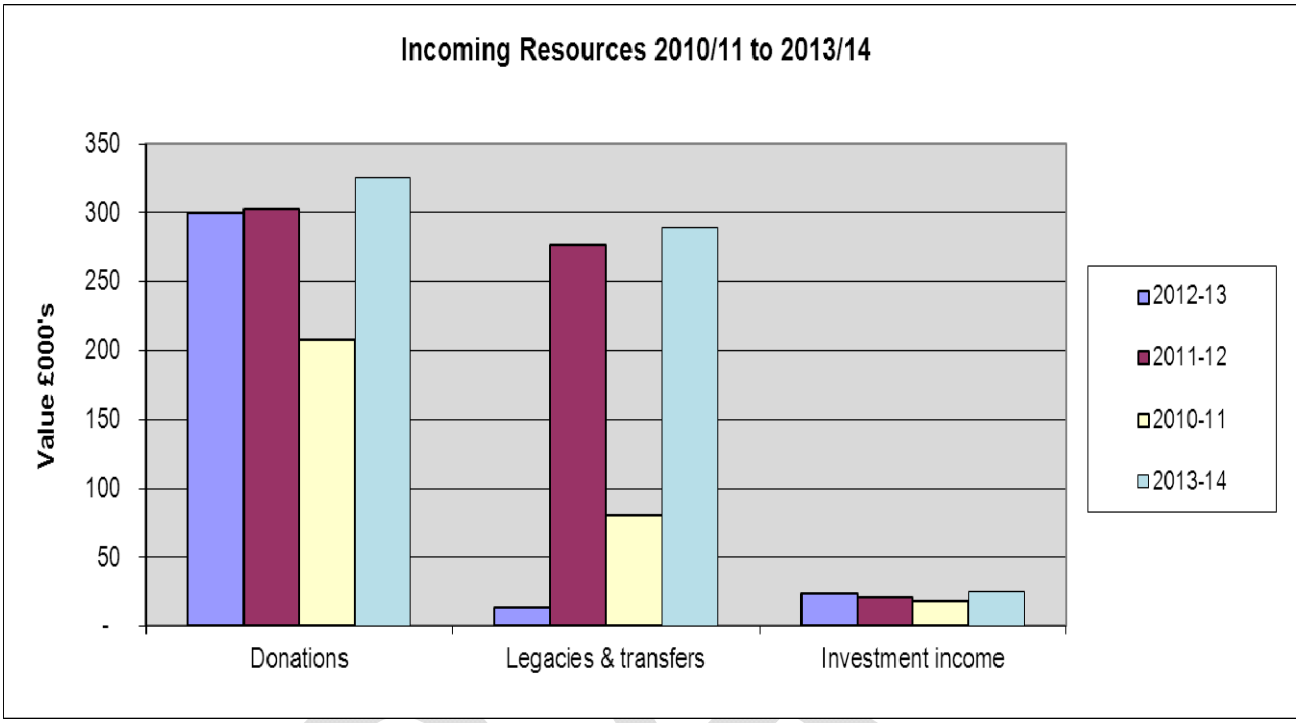
Staff Amenities and Welfare – Total spend £40k (2012/13 £39k)

Staff throughout the Trust ‘go the extra mile’ to ensure the best quality of care for patients. The corporate Trustee recognises this commitment and the hard work and care given to patients and to those who visit the Trust.

63% of expenditure in this category is as support for additional training, allowing staff to develop within their roles and allowing them to enhance patient care and experience.

Income

The graph below shows an analysis of income sources for the current and two previous financial years:



The majority of income received by the Charity is from grateful patients and relatives who wish to support the Trust in appreciation of the work and care provided by the Trust staff.

The total voluntary income received from all sources was £615k. A total of £326k was received from donations and £289k from legacies.

The Trust received the following significant donations (over £10k) during the year:

	£000's
Peggy Wood Foundation – To purchase an Ultrasound machine for the Breast care Unit at Maidstone Hospital	83
Peggy Wood Foundation – To purchase an EBUS Scope for the Endoscopy Unit at Maidstone Hospital	59
Merck Serono Ltd – To support complimentary therapy for Multiple Sclerosis patients	20
Peggy Wood Foundation – To purchase a Microscope and Camera System for the Breast care Unit at Maidstone Hospital	12

Southborough Rotary Club donations funded a new sensory room the children's ward at Tunbridge Wells Hospital.

Gary Batchelor who took part in the Paris marathon to raise £800 for the Neonatal Unit at Tunbridge Wells Hospital

Legacies

Legacies were received from the estates of the following:

	£000's
The late Ruth Green for the Maidstone Hospital Medical Equipment fund	261
The late John Lockhart for the Maidstone Hospital Oncology ward funds	11
The Late Frances Maynard for the Upper Gastrointestinal fund of Maidstone Hospital	10
The Late Jean Gravenell for the Maidstone Hospital Oncology ward funds	5
The Late Leonard Petch for the Oncology wards of the Maidstone and Tunbridge Wells NHS Trust	2

The Trust holds no material assets bequeathed to the charity but subject to a life tenancy interest held by a third party.

The Corporate Trustee is most appreciative of every gift and sends thanks to all who have supported the Trust in this way.

Fundraising

The Trust has an active 'just giving' page that received donations of £19k this year compared to £4k last year.

Gift Aid is being encouraged and staff are reminded to ask donors to use the donation and gift aid forms to increase their donation.

Intangible Income

The Statement of Financial Activity does not include any estimation of intangible income in respect of volunteers' services or the free use of Trust premises.

Looking Forward

The Trustee is dedicated to strengthening the long term viability of the Charity, working in partnership with the Trust to achieve their aim to deliver a first class healthcare service for our patients.

The Trust is a member of the Association of NHS Charities and continues to work with colleague organisations to ensure best practice in the Charity's activities.

Additionally the Trust commissioned a consultant to advise on fundraising opportunities for the Trust and the Trustee will be considering this report in 2014/15.

Making donations

There are several ways that the generosity of those wishing to donate to our funds can be enhanced through tax saving schemes such as Gift Aid and through the internet on www.justgiving.com.

We hope that you will continue to support the Trust as it seeks to enhance patient care and support staff in delivering a first class service to patients, relatives and visitors.

If you would like to find out more about the work of the Charity, make a donation, or raise funds, please contact the Trust at the principal office (details on page 3), via our website at www.mtw.nhs.uk or complete the attached form at the end of the report and send it to us.

The following pages show the financial accounts for the year ended 31 March 2014.

Statement of Trustee responsibilities in respect of the Trustee annual report and the financial statements

Under charity law, the Corporate Trustee is responsible for preparing the Annual Report and the financial statements for each financial year which show a true and fair view of the state of affairs of the Charity and of the financial position at the end of the year.

In preparing these financial statements, generally accepted accounting practice entails that the trustee:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether the recommendations of the Statement of Recommended Practice have been followed, subject to any material departures disclosed and explained in the financial statements;
- state whether the financial statements comply with the trust deed, subject to any material departures disclosed and explained in the financial statements;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue its activities.

The trustee is required to act in accordance with the trust deed of the charity, within the framework of trust law. They are responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the charity at that time, and to enable the trustee to ensure that, where any statements of accounts are prepared by them under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision.

They have general responsibility for taking such steps as are reasonably open to them to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

As far as the trustee is aware, there is no relevant audit information of which the charity's auditors are unaware and the trustee confirms that they have met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 18 – 19 attached have been compiled from and are in accordance with the financial records maintained by the trustee.

By Order of the Trustee

Signed:

Anthony Jones,
Chairman of Trust Board
Maidstone and Tunbridge Wells NHS Trust

Date: ……

Independent auditor's report to the Trustee of Maidstone and Tunbridge Wells NHS Charity

We have audited the financial statements of Maidstone and Tunbridge Wells NHS Trust Charitable Fund for the year ended 31 March 2014 which comprise the statement of financial activities, the balance sheet and related notes. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

This report is made solely to the Charity's trustees, as a body, in accordance with Section 154 of the Charities Act 2011. Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and its trustees as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of trustees and auditor
As explained more fully in the Trustees' Responsibilities Statement set out on page 16 the trustees are responsible for the preparation of financial statements which give a true and fair view. We have been appointed as auditor under section 149 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's (APB's) Ethical Standards for Auditors.

Scope of the audit of the financial statements
A description of the scope of an audit of financial statements is provided on the APB's website at www.frc.org.uk/apb/scope/private.cfm.

Opinion on financial statements
In our opinion the financial statements:
- give a true and fair view of the state of the charity's affairs as at 31 March 2014, and of its incoming resources and application of resources, for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

Matters on which we are required to report by exception
We have nothing to report in respect of the following matters where the Charities Act 2011 requires us to report to you if, in our opinion:
- the information given in the Trustees' Annual Report is inconsistent in any material respect with the financial statements; or
- sufficient accounting records have not been kept; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit.

Grant Thornton UK LLP
Statutory Auditor, Chartered Accountants
Grant Thornton House, Melton Street, Euston Square, London, NW1 2EP
Date:

Statement of Financial Activities for the year ended 31 March 2014

					2013/14	2012/13
	Note	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds £000	**Total Funds £000**	Total Funds £000
Incoming resources	2					
Donations		69	257	0	**326**	300
Legacies		10	279	0	**289**	13
Total Donations and Legacies		**79**	**536**	**0**	**615**	313
Investment income		5	20	0	**25**	24
Total incoming resources		**84**	**556**	**0**	**640**	337
Resources expended	3					
Costs of generating funds	3.1	(1)	(2)	0	**(3)**	(5)
Charitable Activities						
Activities in furtherance of Charity's objectives	3.2	(81)	(497)	0	**(578)**	(351)
Governance and administration	3.3	(7)	(25)	0	**(32)**	(30)
Total resources expended		**(89)**	**(524)**	**0**	**(613)**	(386)
Net incoming / (outgoing) resources		**(5)**	**32**	**0**	**27**	(49)
Gains / (losses) on revaluation and disposal	4	7	23	0	**30**	51
Net movement in Funds	4	**2**	**55**	**0**	**57**	2
Fund Balances brought forward at 31 March 2013		275	753	9	**1037**	1037
Fund balances carried forward at 31st March 2014		**277**	**808**	**9**	**1094**	

The notes at pages 20 to 29 form part of these financial statements

Balance Sheet as at 31 March 2014

					2013/14	2012/13
	Note	**Unrestricted Funds £000**	**Restricted Funds £000**	**Endowment Funds £000**	**Total Funds £000**	Total Funds £000
Fixed Assets	5					
Investments	5.1	149	432	0	581	558
Total Fixed Assets		**149**	**432**	**0**	**581**	558
Current Assets	6					
Cash at bank and in hand	6.1	154	450	9	613	520
Debtors due within one year	6.2	1	0	0	1	74
Total current Assets		**155**	**450**	**9**	**614**	594
Creditors due within one year	7.1	(27)	(74)	0	(101)	(115)
Net Current Assets / (Liabilities)		**128**	**376**	**9**	**513**	479
Total Net Assets		**277**	**808**	**9**	**1094**	1037
Funds of the Charity	8					
Endowment Funds					9	9
Restricted Funds					808	753
Unrestricted Funds					277	275
Total Funds					**1094**	1037

For purposes of splitting assets / liabilities by category, endowment funds are categorised as cash, restricted and unrestricted by transaction where available, otherwise apportioned by fund category balance.

The notes at pages 20 to 29 form part of these financial statements

Signed on behalf of the Trustee:

Anthony Jones,
Chairman of Trust Board
Maidstone and Tunbridge Wells NHS Trust

Date:

Notes to the financial statements for the year ended 31 March 2014

1. Principal accounting policies

1.1. Accounting Convention

The financial statements have been prepared in accordance with applicable Accounting Standards in the United Kingdom and the Statement of Recommended Practice (SORP) "Accounting and Reporting by Charities" published in March 2005 and the Charities Act 2011. A summary of the principal accounting policies, which have been applied consistently, are set out below.

Basis of preparation

The financial statements are prepared in accordance with the historical cost convention, except for Investments, which are included at market value. During the year, the Charity reviewed its accounting policies and made no changes.

1.2. Incoming Resources

Donations, grants, legacies and gifts in kind (voluntary Income)
Donations and grants are credited to revenue on a receivable basis. It is not the Charity's policy to defer income even where a pre-condition for use is imposed.

Legacies are accounted for upon receipt.

Incoming resources from Capital Endowments are placed into an income fund when received. Income will be placed into funds in accordance with donors' wishes, but without forming a binding trust, unless a signed document is received and approved by the Trustee.

Gifts in kind are valued at a reasonable estimate of their value to the Charity.

Gifts donated for resale are included as income when they are sold.

Intangible Income
Intangible income, which comprises donated services or use of Trust property, is included in income at a valuation which is an estimate of the financial cost borne by the donor where such a cost is material, quantifiable and measurable. No income is recognised when there is no financial cost borne by a third party.

Investment Income
Investment Income and gains and losses on investments are credited / charged to the funds quarterly using the average fund balance to apportion the gain / loss.

1.3. Resources expended

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to the category. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party. Overheads have been allocated pro rata to the value of the individual funds on a quarterly basis.

Exceptional Items
Exceptional Items are shown on the face of the Sofa under the category to which they relate with further detail, where appropriate, provided in the notes.

Costs of generating funds
The costs of generating funds are the costs associated with generating income for the funds held on trust. This will include the costs associated with Investment Managers and other promotional and fundraising events including any trading activities.

Charitable Activities
Expenditures are given as grants made to third parties (including NHS bodies) in furtherance of the charitable objectives of the funds. They are accounted for on an accruals basis, in full, as liabilities of the Charity when approved by the Trustee and accepted by the beneficiaries.

Governance and administration
These are accounted for on an accruals basis and are recharges of appropriate proportions of the staff costs and overheads from Maidstone and Tunbridge Wells NHS Trust. These costs are calculated on an average fund balance of the individual funds and allocated on a quarterly basis. Administration and Governance costs are submitted to the Charitable funds Committee for approval. Governance costs include audit fees.

Irrecoverable VAT
Any irrecoverable VAT is charged to the Statement of Financial Activities.

Recognition of liabilities
Liabilities are recognised as and when an obligation arises to transfer economic benefits as a result of past transactions or events.

1.4. Structure of funds

Unrestricted funds are general funds, which are available for use at the discretion of the Trustee in furtherance of the objectives of the Charity. Funds which are not legally restricted but which the Trustee has chosen to earmark for set purposes are designated funds.

Where there is a legal restriction or a binding agreement with a donor, on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. There are a number of funds currently classified as restricted where there is no evidence to support this classification. The Trust is continuing its work, in conjunction with the auditors to correct this classification where appropriate.

Endowment Funds are funds that hold capital in perpetuity. Investment income resulting from these capital holdings may be utilised in accordance with the donor's wishes.

Transfers between funds are made at the discretion of the Trustee, taking account of any restrictions imposed by the donor.

The purposes of each fund with a balance in excess of £10,000 at the year-end are set out in note 8.1 to the financial statements.

1.5. Finance and Operating Leases
The Charity has no finance or operating leases

1.6. Fixed Assets

Tangible Fixed Assets
The Charity held no tangible fixed assets during the year.

Investments Fixed Assets
Investments held by the Trustee's investment advisers are included at closing market value at the balance sheet date. Any realised and unrealised gains and losses on revaluation or disposal are combined in the Statement of Financial Activities. All investments held are pooled across all of the funds.
Please see investment strategy on page 8 for further information.

Investment properties
The Charity held no investment properties during the year

1.7. Stocks

The Charity held no stocks during the year

1.8. Gains and losses

Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later).

Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later). Investment income and gains/losses are allocated quarterly according to the average fund balance, to the appropriate fund and included within the Statement of Financial Activities.

1.9. Cash and Cash equivalents

Operational cash is represented by the balance on the charity bank accounts at the balance sheet date. Cash investments are the deposits in interest bearing accounts that are readily convertible to cash with no risk of change in value.

The Charitable Fund qualifies as a small entity and as a consequence, it is exempt from the requirement to publish a cash flow statement under Financial Reporting standard 1 (revised) Cash Flow Statements.

1.10. Pensions

The Charity has no employees.

1.11. Prior Year Adjustments

There has been no change to the accounts of the prior years.

2. Incoming Resources

				2013/14	2012/13
Voluntary Income	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds £000	**Total Funds £000**	Total Funds £000
Donations	69	257	0	**326**	300
Legacies	10	279	0	**289**	13
Total Donations and Legacies	**79**	**536**	**0**	**615**	**313**
Investment income					
Dividends from investment portfolio	1	5	0	**6**	6
Interest from investment portfolio	4	14	0	**18**	18
Bank Interest	0	1	0	**1**	0
Total Investment income	**5**	**20**	**0**	**25**	**24**
Total incoming resources	**84**	**556**	**0**	**640**	**337**

3. Resources Expended

3.1. Cost of generating funds	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds	**2013/14 Total Funds £000**	2012/13 Total Funds £000
Investment managers fees	(1)	(2)	0	**(3)**	(5)
Total cost of generating funds	**(1)**	**(2)**	**0**	**(3)**	(5)

3.2. Charitable Activities	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds	**2013/14 Total Funds £000**	2012/13 Total Funds £000
Patients welfare and amenities					
Hospitality	(1)	(1)	0	**(2)**	(5)
Other	0	0	0	**0**	0
Complimentary Therapies	(18)	0	0	**(18)**	(21)
Total patients welfare and amenities	**(19)**	**(1)**	**0**	**(20)**	(26)
Staff welfare and amenities					
Training	(12)	(13)	0	**(25)**	(29)
Hospitality	(0)	(7)	0	**(7)**	(3)
Christmas Events	(4)	(3)	0	**(7)**	(5)
Other	(1)	(0)	0	**(1)**	(2)
Total staff welfare and amenities	**(17)**	**(23)**	**0**	**(40)**	(39)
Contributions to the NHS					
Medical and Rehabilitation Equipment	(37)	(392)	0	**(429)**	(221)
Furniture and Fittings	(7)	(3)	0	**(10)**	(54)
Other	(1)	(19)	0	**(20)**	(11)
IT	0	(48)	0	**(48)**	0
Nursing Staff Salary Support	(0)	(11)	0	**(11)**	0
Total contribution to Maidstone and Tunbridge Wells NHS Trust	**(45)**	**(473)**	**0**	**(518)**	(286)

3.3. Governance & Administration Costs	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds £000	**2013/14 Total Funds £000**	2012/13 Total Funds £000
Governance – Salaries and overheads	(6)	(21)	0	**(27)**	(27)
Governance – Audit Fees (external)	(1)	(4)	0	**(5)**	(3)
Total governance & admin costs	**(7)**	**(25)**	**0**	**(32)**	(30)
Total resources expended	**(89)**	**(524)**	**0**	**(613)**	(386)

3.4. Employee Information

The Charity does not employ any staff directly, although members of the finance team support the administration function of the Charity. Their costs have been included in note 3.3.

During the year none of the members of the NHS Trust Board or senior NHS staff or parties related to them were beneficiaries of the Charity. Neither the Corporate Trustee nor any member of the NHS Trust Board has received honoraria, emoluments, or expenses in the year and the Corporate Trustee has not purchased trustee indemnity insurance.

4. Net Movements in Funds

				2013/14	2012/13
	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds £000	**Total Funds £000**	Total Funds £000
Net Incoming/(outgoing) resources before other recognised gains and losses	(5)	32	0	27	(49)
Gains/Losses on Investments	7	23	0	30	51
Total net movement in funds	**2**	**55**	**0**	**57**	2
Fund balances at 1 April 2013	275	753	9	1037	1037
Fund balances carried forward at 31 March 2014	**277**	**808**	**9**	**1094**	

5. Analysis of Movement of Fixed Asset Investments

5.1. Investments	Carrying value at 01/04/13 £000	Additions to investment at cost £000	Disposals at carrying value £000	Net gain / (loss) on revaluation £000	**Carrying value at 31/03/2014 £000**
Schroder Alternative Diverse Fund LE Units (UK)	11	0	(7)	(4)	**0**
CAF Bond Income Fund (UK)	249	0	0	(4)	**245**
CAF Equity Growth Fund (UK)	298	0	0	38	**336**
Total Fixed Asset Investments	**558**	**0**	**(7)**	**30**	**581**

6. Current Assets

6.1. Cash and cash investments	2013/14	2012/13
	Total Funds £000	Total Funds £000
Cash Investments:		
Santander	**80**	80
Clydesdale	**82**	80
Lloyds	**0**	85
CAF	**80**	80
Operational Bank Accounts:		
Nat West	**85**	85
GBS bank account	**189**	76
Nat West bank account	**97**	34
Total Cash and Cash Investments	**613**	520

6.2. Debtors	2013/14	2012/13
	Total Funds £000	Total Funds £000
Amounts falling due within one year	**1**	74
Total Debtors due within one year	**1**	74

7. Current Liabilities

7.1. Creditors	2013/14	2012/13 *
	Total Funds £000	Total Funds £000
Amounts falling due within one year		
Trade Creditors	**(57)**	(77)
Other Creditors	**(6)**	(15)
Owed to Maidstone and Tunbridge Wells NHS Trust	**(30)**	(20)
Accruals	**(8)**	(3)
Total Creditors due within one year	**(101)**	(115)

* 2012/13 Comparators restated to provide additional analysis

8. Details of Funds

	Balance 1 April 2013	Incoming resources	Resources Expended	Gain & (losses) on revaluation & disposal of investment assets	Balance 31 March 2014
	£000	£000	£000	£000	£000
Permanent Endowment Funds					
Endowment Funds (2 funds)	9	0	0	0	9
Total Endowment Funds	9	0	0	0	9
Restricted Funds					
DGH General Fund (Maidstone)	48	17	(61)	1	5
DGH Patients Amenity Fund	11	0	0	0	11
Medical Equipment Fund (M/S)	0	264	(237)	4	31
CT Scanner Pembury	13	0	0	0	13
Haematology Fund	25	2	(1)	1	27
Stroke Unit Fund (M/S)	8	4	(1)	0	11
Oncology Equipment Fund	261	4	(7)	7	265
Medical Imaging Ultrasound	16	6	(2)	0	20
Gynaecology Oncology	11	0	0	0	11
CT Scanning Fund Maidstone	23	10	(4)	1	30
Pierre Fabre Grant Fund	79	2	(14)	2	69
Cellular Pathology Fund	24	0	(1)	1	24
Cardio Respiratory Fund	20	0	0	0	20
Diabetes Centre Fund	53	6	(6)	1	54
Oncology Centre Fund	10	66	(8)	2	70
Other Restricted Funds (closing balance <£10,000 70 funds)	151	175	(182)	3	147
Total Restricted Funds	753	556	(524)	23	808
Unrestricted Funds					
Lung Function Fund	15	0	0	0	15
Haematology Development Fund	18	0	(2)	0	16
Special Care Baby Unit TWH	16	22	(16)	0	22
Pembury General Fund	11	0	0	0	11
Neurology Fund	55	20	(19)	1	57
Gastrointestinal Fund	2	10	0	0	12
Other Unrestricted Funds (closing balance < £10,000 69 funds)	158	32	(52)	6	144
Total Unrestricted Funds	275	84	(89)	7	277
Total Funds	1037	640	(613)	30	1094

8.1. Nature and Purpose of Material Funds (Closing balance > £10,000)

Restricted Funds	**Nature and purpose of Fund**
DGH Patients Amenity Fund	Supports Maidstone Hospital.
Medical Equipment Maidstone	Supports Maidstone Hospital
CT Scanner Tunbridge Wells	Supports the CT Scanning Department Tunbridge Wells Hospital
Haematology Fund	Supports the Haematology Department at Maidstone Hospital
Oncology Equipment Fund	Supports the Oncology Centre for the purchase of Equipment.
Stroke Unit Maidstone Fund	Supports the Stroke Unit at Maidstone Hospital
Medical Imaging Ultrasound	Supports the Medical Imaging and Ultrasound Department at Maidstone Hospital.
Gynaecology Oncology Fund	Supports the Gynaecology Oncology Department at Maidstone Hospital
CT Scanner Fund Maidstone	Supports the CT Scanning Department at Maidstone.
Pierre Fabre Grant Fund	Supports the Oncology Department at Maidstone Hospital with specialist procedures.
Gastrointestinal Fund	Supports the Gastrointestinal Unit at Maidstone Hospital
Cellular Pathology Fund	Supports the Cellular Pathology Unit at Maidstone Hospital
Oncology Centre Fund	Supports the Oncology Centre at Maidstone Hospital
Cardio Respiratory Fund	Supports the Cardio Respiratory Unit at the Tunbridge Wells Hospital
Diabetes Centre Fund	Supports the Diabetes Centre based at Tunbridge Wells Hospital for patients with diabetes and associated conditions.
Unrestricted Funds	
Lung Function Fund	Supports the Lung Function Clinic at the Tunbridge Wells Hospital
Haematology Department Fund	Supports the development of Haematology across all sites of the Trust
Special Care Baby Unit Fund	Supports the Special Care Baby Unit at Tunbridge Wells Hospital
Neurology Fund	Supports the Neurology Department at Tunbridge Wells Hospital
Pembury General Fund	Supports Tunbridge Wells Hospital at Pembury

9. Charity Tax

Maidstone and Tunbridge Wells NHS Trust Charity is considered to pass the tests set out in Paragraph 1 Schedule 6 Finance Act 2010 and therefore it meets the definition of a charitable trust for UK income tax purposes. Accordingly, the charity is potentially exempt from taxation in respect of income or capital gains received within categories covered by Part 10 Income Tax Act 2007 or Section 256 of the Taxation of Chargeable Gains Act 1992, to the extent that such income or gains are applied exclusively to charitable purposes.

10. Related Parties

The Charity is established to hold the charitable funds of the Maidstone and Tunbridge Wells NHS Trust.

During the year none of the NHS Trust Board or members of key management staff or parties related to them has undertaken any material transactions with the Maidstone and Tunbridge Wells NHS Trust.

The Charity has made revenue and capital payments, in the form of grants, to the Maidstone and Tunbridge Wells NHS Trust, the Corporate Trustee of the charity. In addition £27k (2012/13 £27k) was payable by the Charity to the Trust in respect of contribution to salaries and overheads to support the administration of the Charity. The amount due at the balance sheet date to Maidstone and Tunbridge Wells NHS Trust was £30k.

	2013/ 2014	**2013/ 2014**	**2012/ 2013**	**2012/ 2013**
	Turnover of connected Organisation	Net Profit / (Loss) for the connected Organisation*	Turnover of connected Organisation	Net Profit / (Loss) for the connected Organisation
	£000	£000	£000	£000
Maidstone and Tunbridge Wells NHS Trust	**375,714**	**(12,374)**	**367,391**	**129**

*Based on NHS breakeven duty performance.

11. Events after the reporting year

The charity has identified £15k, included in the reported balances, that is to be transferred to Kings College Hospitals in 2014/15.

Maidstone and Tunbridge Wells NHS
NHS Trust

Maidstone and Tunbridge Wells NHS Trust Charity Donation Form
Registered Charity Number 1055215

Name: _____

Address: _____ Post Code: _____

Email: _____

PURPOSE OF DONATION
Whilst recognising that this does not form a binding trust I request that my donation of

£…… Is to be used for: (please delete as applicable)

Wherever it will be most useful

Patients and staff at the Maidstone Hospital / Tunbridge Wells Hospital (Pembury)

The following specific purpose/department ……

Payment Methods

1 Cheques made payable to **Maidstone and Tunbridge Wells NHS Trust**
2 Standing Order -Please call us on 01622 224500 and ask for Sue Osborne
3 Make A Donation By Phone – If you would prefer to make a donation over the phone, please call us on 01622 224500. If you have an email address, we can send you bank details for electronic payments. We will require a remittance advice to enable us to receipt your donation. We currently accept the following cards: Maestro UK; MasterCard; Solo; Visa;
4 Visit our 'just giving' page www.justgiving.com

Gift Aid

If you are a UK taxpayer the Maidstone and Tunbridge Wells NHS Trust Charity (MTW) can reclaim the tax you have paid on every donation you make. You must have paid sufficient UK income or capital gains tax to cover the claim. For every £1 you give we can claim 25p back from the HM Revenue & Customs at no extra cost to you.

……..YES, I am a UK taxpayer and would like MTW to reclaim tax on this and any future donations I may make.

Date ...../……. /……. Signature……

……..Please tick here if you DO NOT wish the Maidstone and Tunbridge Wells NHS Trust Charity to contact you by phone or post about our work

……Please tick here if you DO NOT wish the Maidstone and Tunbridge Wells NHS Trust Charity to contact you by email.

Please return to:
Maidstone and Tunbridge Wells NHS Trust, Financial Services, Maidstone Hospital, Hermitage Lane, Maidstone, Kent ME16 9QQ Telephone 01622 224500 www.mtw.nhs.uk

THANK YOU FOR YOUR SUPPORT

Maidstone and Tunbridge Wells NHS
NHS Trust

Grant Thornton UK LLP
The Explorer Building
Fleming Way
Manor Royal
Crawley RH10 9GT

Trust Management
Maidstone and Tunbridge Wells NHS Trust
Maidstone Hospital
Hermitage Lane
Maidstone
Kent ME16 9QQ

26th November 2014

Dear Sirs

MAIDSTONE AND TUNBRIDGE WELLS NHS CHARITABLE FUND FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2014

This representation letter is provided in connection with the audit of the financial statements of Maidstone and Tunbridge Wells NHS Charitable Fund for the year ended 31 March 2014 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with Section 154 of the Charities Act 2011.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Financial Statements

i. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated 6 October 2014, for the preparation of the financial statements in accordance with the Charities Act 2011, and the Statement of Recommended Practice 'Accounting and Reporting by Charities (revised 2005) ('SORP'), issued by the Charity Commission for England and Wales and any subsequent amendments or variations to this statement., in particular the financial statements give a true and fair view in accordance therewith.

ii. We acknowledge our responsibility for the design and implementation of internal control to prevent and detect error and fraud.

iii. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

iv. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of Statement of Recommended Practice 'Accounting and Reporting by Charities (revised 2005) ('SORP'), issued by the Charity Commission for England and Wales and any subsequent amendments or variations to this statement.

v. All events subsequent to the date of the financial statements and for which Statement of Recommended Practice 'Accounting and Reporting by Charities (revised 2005) ('SORP'), issued by the Charity Commission for England and Wales and any subsequent amendments or variations to this statement require adjustment or disclosure have been adjusted or disclosed.

vi. We have adjusted all misstatements brought to our attention. The financial statements are free of material misstatements, including omissions.

vii. We can confirm that:

a. all income has been recorded;
b. the restricted funds have been properly applied;
c. constructive obligations for grants have been recognized; and
d. the trustees consider there to be appropriate controls in place to ensure overseas payments are applied for charitable purposes.

Information Provided

viii. We have provided you with:
a. access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
b. additional information that you have requested from us for the purpose of your audit; and
c. unrestricted access to persons within the entity from whom you determine it necessary to obtain audit evidence.

ix. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

x. All transactions have been recorded in the accounting records and are reflected in the financial statements.

xi. We have disclosed to you our knowledge of fraud or suspected fraud affecting the entity involving:
a. management;
b. employees who have significant roles in internal control; or
c. others where the fraud could have a material effect on the financial statements.

xii. We have disclosed to you our knowledge of any allegations of fraud, or suspected fraud, affecting the entity's financial statements communicated by employees, former employees, analysts, regulators or others.

xiii. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

xiv. We have disclosed to you the identity of the entity's related parties and all the related party relationships and transactions of which we are aware.

xv. We confirm that we have reviewed all correspondence with regulators, which has also been made available to you, including, in England and Wales, the serious incident report guidelines issued by the Charity Commission (updated in 2010). We also confirm that no serious incident reports have been submitted to the Charity Commission, nor any events considered for submission, during the year or in the period to the signing of the balance sheet.

Yours faithfully

Glenn Douglas
Chief Executive
(Signed on behalf of the Trust Board)

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - November 2014

11-13	Summary report from the Quality & Safety Committee meeting, 12/11/14	Committee Chair (Non-Executive Director)

Summary / Key points

The 'main' Quality & Safety Committee met on 12th November, and covered the following issues:

- **'Out of Hours Treat and Transfer':** The latest position on the transfer of patients from Maidstone Hospital (MH) to Tunbridge Wells Hospital (TWH) and vice versa, for 01/07 to 30/09. It was agreed to receive a further update in March 2015.
- **Protection of elective Trauma and Orthopaedic beds:** An update was received on the latest position, which had been agreed at the Clinical Operations and Delivery Group. It was agreed to receive a further update at the next 'main' Committee, in January 2015
- **Stroke care performance:** The latest performance indicator data was discussed, as reported by the Sentinel Stroke National Audit Programme (SSNAP). It was noted that for the "CT Scan performed in under an hour" indicator, TWH performance was in the upper quartile and MH also performed well, as a result of efforts regarding the pathway & communication. However, performance on the "Proportion of all stroke patients given thrombolysis" and "Percentage of thrombolysed patients with a door-to-needle time <60mins" indicators were below the national average. In summary, there had been some recent improvement, but there was much still to be done. It was agreed to continue to receive the data at future meetings.
- **Child and Adolescent Mental Health Services (CAMHS):** It was noted that the service still had some issues, but assurance was provided that efforts were being made to address these.
- **Reputational risk issues:** A written report was received on the latest media coverage
- **Clinical governance committee structure:** The committee was notified that the Trust's Clinical Governance committee structure was currently being reviewed, with particular emphasis on the functioning of the Quality & Safety Committee, the Standards Committee and Clinical Governance Committee. Formal proposals are not yet ready for discussion however.
- **Quality & Safety Committee 'deep dive' meeting, 29/09/14:** The minutes were received.
- **Quality & Governance report:** The key issues highlighted were the findings from the third (draft) Intelligent Monitoring report from the CQC; and the recent increase in hospital acquired Pressure Ulcers (though the Trust remains below the national average). Urinary Tract Infections (UTIs) and patient falls were also discussed, and it was agreed to submit reports to the next Committee on both issues.
- The latest **Serious Incidents** were considered
- An update on **complaints (for quarters 1 & 2, 2014/15)** was received, and it was agreed to receive a report every 6 months
- The Committee received an update on the work of the **Patient Safety Think Tank**
- Details of the latest **visits from external agencies** were reported
- The recent findings from relevant **Internal Audit reviews** were received
- The **"Aggregation, analysis and learning from incidents, complaints and claims**

procedure" was approved

- All the **Directorates** presented their usual reports. The key issue raised were:
  - **Cancer and Haematology** were not achieving the target for "% of Adult Inpatients that have a VTE Risk Assessment". It was agreed the findings from the current investigation should be reported at the next meeting. It was also agreed that a summary of the 2014 National Cancer Patient Experience Survey (and the action plan/response) should be included in the next Cancer & Haematology Directorate report
  - **Children's service**s continue to face workforce challenges
  - **Critical Care** noted that all unplanned returns to Theatre were now being recorded via Datix and forwarded to relevant Directorates for review and action plan, if necessary
  - **Diagnostics, Therapies & Pharmacy** reported that Cellular pathology reporting had improved over the last 2 months, and Radiology reporting delays were reducing, with the use of locums
  - **Emergency & Medical Services** reported that the A&E 4-hour waiting time target had not been met for quarter 2, but performance was on trajectory for quarter 3. The successful Trauma Unit assessment from the South East Trauma Network was also noted.
  - Complaint response times for **Surgery** remain a concern, as the Directorate had failed to meet the Trust standard for 2 months
  - For **Trauma & Orthopaedics**, the mortality rate in hip fracture patients remained a concern, and action was being taken. It was also reported that for Surgical Site Infections, a Task and Finish group, chaired by the Clinical Director (CD) had been established. In addition, investigation was continuing as to the reasons for the Patient Reported Outcome Measures (PROMs) data for knee replacements being below the national average
  - For **Women's and Sexual Health**, the external review was awaited regarding Consultant team working relationships; & the continuing staffing issues in Colposcopy were reported
  - It was also noted that a recurring theme in all the Directorate reports was poor performance on the survey question "Did a member of staff tell about medication side effects to watch for when you went home?". It was noted that this had been a long standing issue, but efforts were being made to address this
- **Sub-committee reports:** Reports were received from the latest meetings of the Standards Committee, the Infection Prevention & Control Committee (which had discussed changes to the Trust's MRSA screening programme, to make such screening more targeted); the Safeguarding Children Committee; the Clinical Governance Committee; and the Patient Environment Steering Group

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 - November 2014

11-14	Summary of the Trust Management Executive (TME) meeting, 19/11/14	Committee Chair (Chief Executive)

This report provides information on the TME meeting held on the 19th November. The key points from the meeting were as follows:

- **CQC inspection**, October 2014: The latest information was reported, and the need to be ready to respond to the report, once received, was emphasised
- The latest position on the situation re **Medway NHS Foundation Trust** was discussed. It was noted that the focus of the Trust has been on the feasibility of supporting Swale Clinical Commissioning Group (CCG), by taking new GP referrals from the Swale area, for a 6 month period in three specialties: Elderly Care, Respiratory and Cardiology. It was reported that local assessment of capacity had been undertaken within these specialities and specific arrangements have been agreed with Swale CCG lead officers
- Updates were received on the establishment of an **Ambulatory Unit at Tunbridge Wells**, the **bed reconfiguration plans for Maidstone** Hospital; the plans for **implementation of the SAcP** (replacement PAS+); and the implementation of **Chemotherapy eprescribing**
- The **integrated performance report for month 7** (including quality, activity, finance and workforce) was discussed
- The Medical Director gave an update on the plans regarding the future options for **Stroke** care
- Updates were also given on the **business planning process** for 2015/16 and 2016/17, and the continued development of the Trust's **clinical strategy**
- The **Directorate reports** identified the following issues:
  - Workforce challenges continue to be experienced in a number of Directorates, which was resulting in increased expenditure on locum and agency staff
  - The very poor state of the fabric at Kent and Canterbury is delaying the commissioning of the new Linear Accelerator (LINAC);
  - Reporting times for Radiology had continued to improve, and the Cellular Pathology reporting improvement had been maintained
  - The response to the identified concerns regarding fractured neck of femur mortality was continuing, supported by the Medical Director and Chief Nurse
- The Chief Pharmacist gave the first report of what will be a standing agenda item at the meetings. The report focused on the efforts being made to increase reporting of **medicine-related incidents**. It was noted that the Trust was a relatively low reporter of such incidents, and there had therefore been a CQUIN target set to improve levels of reporting.
- The **recently-approved business cases** were noted
- Approval was granted to appoint a **replacement Clinical Oncologist** (Breast and Lung)
- The latest update of the **Trust Risk Register** was discussed
- An update on the progress with the **Internal Audit plan for 2014/15** was received (this was a new report to the TME)
- Updates were received on the work of the **TME's sub-committees** (Capital Prioritisation Group; Clinical Operations & Delivery Group; Health & Safety Committee and the Policy Ratification Committee)
- Assurance was given on the continuity plans in place for the **industrial action** scheduled for 24/11/14

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive

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

- Information and assurance

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – November 2014

11-17 Oversight Self-Certification, Month 7, 2014/15 Trust Secretary

The enclosed schedule sets out the proposed oversight self-certification submission for month 7, based on performance as at 31s October 2014. This submission must be sent to the NHS Trust Development Authority (TDA) by the end of November (i.e. by 28th).

Significant changes from the previous report and submission, which was agreed at the Board meeting in October 2014, are highlighted.

As Board members are aware, each month the Trust Board is required self-assess against the questions contained in two self-certification documents under the TDA oversight process:
1. Monitor licence conditions; and
2. Board statements

The Trust is not required to provide supporting evidence (as listed in the "Evidence of Trust compliance" columns), and is just required to respond to each statement with "Yes" (i.e. compliant), "No" (i.e. not compliant) or "Risk" (i.e. at risk of non-compliance). If "not compliant" or "at risk of non-compliance" is selected, a commentary on the actions being taken, and a target date for completion (in dd/mm/yyyy format), is required in order for the submission to be made. The proposed self-assessment (and responses where required) for the latest submission are included in the compliance column. The "Evidence of Trust Compliance" document has incorporated amendments agreed at previous Trust Board meetings.

In relation to the Monitor licence conditions, there are some items which, as an aspirant Trust, the Board does not need to consider at the present time. These will however need to be understood and implemented as part of the trajectory to submit a Foundation Trust (FT) application. As with the previous month's self-assessment, and as was agreed at the Board Forum meeting in February 2014, it is proposed that, where appropriate, where the Trust continues to declare non-compliance, and that the date by which the Trust will become compliant should be listed as 31st March 2016.

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
The Board is asked to:
- Review the evidence presented to support the self-assessment (and amend if required);
- Consider whether the "latest assessment" accurately reflects the current situation regarding compliance;
- Approve the self-assessment for the forthcoming submission to the TDA

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

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

General conditions

Condition	Evidence of Trust compliance / Commentary	Latest assessment
G4 – Fit and proper persons as Governors and Directors No unfit persons – undischarged bankrupts – imprisoned during last 5 years – disqualified Directors	All Trust Directors are "fit and proper" persons; confirmed through appointment process. ~~From October 2014, subject to parliamentary approval, Directors of NHS providers must meet a 'fit and proper person test'.~~ The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were approved by Parliament on 6th November 2014. These are the Regulations that will introduce a new requirement that Directors (or equivalent) of health service bodies be "fit and proper persons". The Care Quality Commission (CQC) will be able to insist on the removal of Directors that fail this test. ~~The test is being introduced as part of the fundamental standard requirements for all providers.~~ 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 ~~to the usual requirements of~~ Directors need to be "of good character"[3], and have the health, 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…". ~~, the regulation goes further by barring individuals who are prevented from holding the office (for example, under a Directors' disqualification order) and significantly, excluding from office people who: "have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider".~~ This latter restriction will enable the CQC to decide that a person is not fit to be a Director on the basis of any previous misconduct or incompetence in a previous role for a service	Compliant

[2] Regulated activities are listed in Schedule 1 of the 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 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
	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 ~~It will~~ apply to all directors and "equivalents", which will include Executive Directors of NHS Trusts and Foundation Trusts. It will be the responsibility of the provider and, in the case of NHS bodies, the chair, to ensure that all Directors meet the fitness test and do not meet any of the 'unfit' criteria. The Chair of a provider's board will need to confirm to the CQC that the fitness of all new Directors has been assessed in line with the new regulations; and declare to the CQC in writing that they are satisfied that they are fit and proper individuals for that role. The CQC may also ask the provider to check the fitness of existing Directors and provide the same assurance to them, where concerns about such Director come to the CQC's attention. ~~The Trust will obviously monitor the approval of the Regulations carefully, and respond to the requirements by adapting its processes accordingly.~~ Although the Regulations will not, strictly speaking, be applied retrospectively, the Trust will likely need to ensure current Board members meet the Regulations' requirements for being "fit and proper". The Trust Secretary is currently liaising with the Chairman and the Human Resources team to consider how best to respond to the new requirements.	
G5 – Having regard to Monitor guidance – guidance exists or is being developed on: ▪ Monitors enforcement ▪ Monitors collection of cost information ▪ Choice and competition ▪ Commissioners rules ▪ Integrated Care ▪ Risk Assessment ▪ Commissioner requested services ▪ Operation of the risk pool	Monitor guidance is at varying degrees of progress through the consultation process. Trust response: **As an aspirant Trust, the guidance has not yet been fully reviewed and embedded. However the Trust will receive a summary of Monitor guidance requirements so that it can ensure compliance at a time appropriate to its foundation trust application trajectory.**	Not Compliant Compliant by 31/03/16
G7 – Registration with the Care Quality Commission	The Trust has full registration with the CQC. The Trust is registered to deliver the following regulated activities: (i) treatment of disease, disorder and injury; (ii) surgical procedures; (iii) diagnostic screening procedures; (iv) maternity and midwifery services; (v) termination of pregnancy; (vi) family planning. A recent application had been made to the CQC to amend the Trust's registration to reflect the fact that all these activities occur at both of the Trust's hospital sites (at present, (v) and (vi) do not apply to Maidstone Hospital. This application resulted in the CQC undertaking a site visit to Maidstone Hospital on 10th September. Following discussion with the CQC team on the day, it was agreed that the Trust would withdraw its request to register "Termination of Pregnancies" (this was always understood as an anticipated outcome, and does not cause any problems, as this service can still continue to be provided	Compliant

Condition	Evidence of Trust compliance / Commentary	Latest assessment
	at Tunbridge Wells Hospital). For the "Family Planning" registration, the main CQC assessor will assemble his report alongside his two colleagues and progress with the application. The Trust has provided all information requested by the CQC regarding the application, and a decision is ~~now~~ still awaited from the CQC.	
G8 – Patient eligibility and selection criteria (for services and accepting referrals) ▪ Criteria are transparent ▪ Criteria are published	The Referral and Treatment Criteria (RATC) which apply from 1st April 2014 are published on the West Kent CCG website ("Kent and Medway clinical commissioning groups' (CCGs') [sic] schedule of policy statements for health care interventions, and referral and treatment criteria").	Compliant

Pricing conditions

Condition	Evidence of Trust compliance	Latest assessment
P1 – Recording of Information (about costs) to support the Monitor pricing function by the prompt submission of information	Trust response: **As an aspirant Trust, the requirement has not yet been fully reviewed and embedded. However the Trust will receive a summary of the Monitor pricing condition so that it can ensure compliance at a time appropriate to its foundation trust application trajectory** An action plan is required to ensure readiness to comply with all Monitor Pricing conditions at the required time (the Director of Finance will be responsible for leading on this).	Not Compliant *Compliant by 31/03/16*
P2 – **Provision of information** to Monitor about the cost of service provision	Trust response: **As an aspirant Trust, the requirement has not yet been fully reviewed and embedded. However the Trust will receive a summary of the Monitor information condition so that it can ensure compliance at a time appropriate to its foundation trust application trajectory**	Not Compliant Compliant by *31/03/16*
P3 – Assurance report on submissions to Monitor. To ensure that information is of high quality, Monitor may require Trusts to submit an assurance report	Trust response: **As an aspirant Trust, the requirement has not yet been fully reviewed and embedded. However the Trust will receive a summary of the Monitor assurance reporting condition so that it can ensure compliance at a time appropriate to its foundation trust application trajectory**	Not Compliant Compliant by *31/03/16*
P4 – Compliance with the national tariff (or to agree local prices in line with rules contained in the National tariff)	The Trust is compliant with the national tariff and where local tariffs are applied, are subject to negotiation and agreement with the CCG/Commissioners.	Compliant
P5 – Constructive engagement concerning local tariff modifications The aim is to encourage local agreement between commissioners and providers	The Trust is compliant with the national tariff and where local tariffs are applied, are subject to negotiation and agreement with the CCG/Commissioners.	Compliant

Condition	Evidence of Trust compliance	Latest assessment
where it is uneconomical to provide a service at national tariff; thereby minimising Monitors need to set a modified tariff.		

Competition conditions

Condition	Evidence of Trust compliance	Latest assessment
C1 – Right of patients to make choices Providers must notify patients when they have a choice of provider, make information about services available, and not offer gifts/inducements for patient referrals. Choice would apply to both nationally determined and locally introduced patient choices of provider.	The Trust complies with the philosophy of patient choice, with regards to choice of provider. The Trust has not taken any actions to inhibit patient choice. The development of private patient services, the development of a birthing centre and the response to the KIMS private hospital are examples where the Trust has increased patient choice.	Compliant
C2 – Competition Oversight Providers cannot enter into agreements which may prevent, restrict or distort competition (against the interests of healthcare users).	The Trust does not seek to inhibit competition.	Compliant

Integrated care conditions

Condition	Evidence of Trust compliance	Latest assessment
IC1 – Provision of Integrated Care Trusts are prohibited from doing anything that could be regarded as detrimental to enabling integrated care. Actions must be in the best interests of patients.	The Trust seeks to become an integrated care provider and is in discussion with the CCG about integration initiatives. The Trust does nothing to inhibit integration and positively advocates it where integration is in the patient's best interests.	Compliant

Oversight Self Certification – Board Statements

Statement	Evidence of Trust compliance	Latest assessment
For clinical quality, that: 1. the Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	▪ The Trust's integrated performance dashboard is reviewed monthly and includes the TDA's "routine quality & governance indicators" ▪ A "Clinical Quality & Patient Safety Report" report is submitted to the Trust Board ▪ The Quality & Safety Committee, and its sub-committees, provides a focus on quality issues arising from Directorates. A summary of each Quality & Safety Committee meeting is reported to the Board ▪ The Patient Experience Committee provides a patient perspective and input ▪ The Chief Nurse, a Board member, is accountable for quality ▪ There are dedicated complaints and Serious Incidents (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 ▪ SI report summaries are circulated to all Board members ▪ Board member visits to wards and departments enable triangulation of quality and other performance indicators. Pairings of NED and Executive Board members, to further promote such visits, have now been issued. Board members also participate in the conduct of Care Assurance Audits ▪ Systems investment (e.g. Q-Pulse, Symbiotix, Dr Foster) supports effective quality information/data management ▪ Quality Accounts have been developed in liaison with stakeholders ▪ Quality Impact Assessments conducted on all CIP initiatives ▪ Priority of patient care reflected in Trust values & embedded in staff appraisal The independent assessment of the Trust's Quality Governance Framework has largely endorsed the Trust's self-assessment and gave a validated score of 3.5; an action plan has been drafted to achieve further improvements. Further improvements include: - strengthening the processes through which learning is shared and embedded has been recognised, and - developing further benchmarks to support the assurance & target setting process CQC intelligent monitoring assessment updated in July 2014 rated the Trust as "3" (with 6 being the highest/best score). The next Intelligence Monitoring data will be published by the CQC in December 2014.	Compliant

Statement	Evidence of Trust compliance	Latest assessment
For clinical quality, that: 2. the board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements	The Trust has full registration with the CQC. The Trust is registered to deliver the following regulated activities: (i) treatment of disease, disorder and injury; (ii) surgical procedures; (iii) diagnostic screening procedures; (iv) maternity and midwifery services; (v) termination of pregnancy; (vi) family planning. A recent application had been made to the CQC to amend the Trust's registration to reflect the fact that all these activities occur at both of the Trust's hospital sites. This application is being considered by the CQC at present. A CQC inspection of Tunbridge Wells Hospital reported in January 2014 concluded 'moderate concerns' about the Management of Medicines and Staffing outcomes. Actions are underway to address the areas of concern identified by the inspection, and the latest position was reported to the Trust Management Executive on 17th September. A Care Quality Commission inspection of Maidstone Hospital was undertaken in February 2014. Actions are underway to address the areas of concern identified by the inspection, and the latest position was reported to the Trust Management Executive on 17th September. The outcome of the inspection by the CQC's Chief Inspector of Hospitals in October 2014 is awaited.	Compliant
For clinical quality, that: 3. the board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	The Medical Director is the responsible officer for medical practitioner revalidation. The Trust Board in May 2014 received the 2013/14 Annual Report from the Responsible Officer, and approved a 'statement of compliance' confirming that the Trust, as a designated body, was in compliance with the regulations governing appraisal and revalidation.	Compliant
For finance, that: 4. the board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time	Trust response: The Trust reported a deficit for 2013/14 and the financial situation is under ongoing review with the TDA. However, the Trust continues to operate as a going concern.	Compliant
For governance, that 5. the board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times	The NTDA accountability framework aims to ensure that Trusts have a real focus on the quality of care provided. Under this framework, quality focus is achieved through: (i) Planning – the Trust conducts an annual process of service and budget planning and the Board reviews and agrees the IBP	Compliant

Statement	Evidence of Trust compliance	Latest assessment
	(ii) Oversight – the Trust participates fully in the oversight model (self-certification, review meetings) (iii) Escalation – The Trust welcomes support from the TDA and will cooperate fully with escalation decisions. The Trust, has fully engaged with a risk summit of performance issues (c.diff, surgical trainees, A&E) (iv) Development – the Trust will embrace the development model as appropriate. The Trust has committed to development programmes for (i) Board members; (ii) Executive team, (iii) Clinical Directors and (iv) General Managers/Matrons. (v) Approvals – the Trust is fully engaged in the FT application process and is awaiting dialogue with the TDA on the timetable towards authorisation. Trust values and priorities mirror the TDA's underpinning principles: ▪ local accountability – e.g. liaison with CCGs, Patient Experience Committee, patient satisfaction monitoring, whistleblowing & complaints management ▪ openness and transparency – e.g. embedded in Trust value on respect; duty of candour in Board Code of Conduct; open approach to Public Board meetings (which now take place each month) and both external &, internal communications channels; a growing membership ▪ making better care easy to achieve – the Trust's stated priority, above all things, is the provision of high quality & safe care to patients (Patient First). ▪ (d) an integrated approach to business – the Trust has adopted an integrated governance approach including an integrated performance dashboard.	
For governance, that: 6. all current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.	See 5 above. In addition: ▪ The Trust monitors performance each month in accordance with the TDA Quality and Governance indicators. A Board Assurance Framework and Board level risk register, supported by an overall Risk management Policy, are established and scrutinised by accountable Executive Directors, and reported ▪ Risks receive ~~are assigned to Committees for~~ ongoing scrutiny and assurance. ▪ Mitigating actions have agreed dates for delivery. ▪ An annual Internal Audit plan is agreed and focuses on areas of key risk. ▪ A professional Trust Secretary is employed. ▪ A dedicated Risk Manager is employed. ▪ The Trust fully participates in the TDA Oversight process. ▪ The independent assessment of the BGAF & QGF was conducted in July 2013 and the positive results reported to the Trust Board in September 2013; a follow up review conducted in December 2103 re-affirmed the assessment.	Compliant

Statement	Evidence of Trust compliance	Latest assessment
For governance, that: 7. the board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance	See 6 above. In addition: All risks are RAG rated according to severity and likelihood; mitigating actions are monitored and reported. Key risks to the Trust's agreed objectives are reported via the Board Assurance Framework. The Trust Management Executive (EDs and CDs) is the designated risk management committee of the Trust and reports to the Trust Board.	Compliant
For governance, that: 8. the necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	The Board and its sub-committees are involved in ~~informed of the progress with~~ 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 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 Chair (a NED). The Board is fully engaged to the development of the IBP and the Clinical Strategy that underpins it.	Compliant
For governance, that: 9. an Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	The Annual Governance Statement 2013/14 was agreed by the Trust Board in May 2014.	Compliant
For governance, that: 10. the Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward	Quality and governance indicators are monitored by the Board each month through the integrated performance dashboard. The Board is committed to achieving all targets and has set the vision of being in the best 20% of acute trusts nationally. The Trust is currently performing against the requirements of the NTDA oversight model.	Compliant
For governance, that: 11. the trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit	The Trust has achieved IG toolkit level 2 for 2013/14	Compliant

Statement	Evidence of Trust compliance	Latest assessment
For governance, that: 12. the board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.	A Trust Board Code of Conduct is in place which confirms the requirement to comply with the Nolan principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership. A register of interests is maintained and Board members are invited to declare any interests relevant to the agenda at the beginning of each Board meeting, and each Board sub-committee. A new Non-Executive Director commenced in September 2014, which means that all formal Board positions are now filled substantively.	Compliant
For governance, that: 13. the board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	▪ The composition and operation of the Board has been debated in Board development activity and a paper produced to enable the further review of Board composition when vacancies occur. ▪ A launch session for the Board development programme for 2014 took place in December 2013, facilitated by Hay Group; this will synchronise with separate Executive Director, Clinical Director, General Manager/Matron development programmes. ▪ The Remuneration Committee reviews the performance of Executive Directors. ▪ The TDA has conducted a review of the Trust Board. ▪ The Trust continues to adhere to the Oversight process.	Compliant
For governance, that: 14. the board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan	▪ All Executive Director (and Clinical Director) positions are filled. ~~▪ A new position of Director of Strategy & Transformation has been created.~~ ▪ The objectives of Executive Directors cascade from the Trust's corporate objectives which are agreed by the Trust Board. The Trust Board agreed the Trust's objectives for 2014/15 in September 2014, and agreed that these objectives should also apply for the 2015/16 year (subject to minor amendments regarding specific targets)	Compliant

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - November 2014

11-18	Ratification of Standing Financial Instructions (annual review)	Director of Finance / Trust Secretary

The Standing Financial Instructions (SFIs) are due their annual review, and therefore been duly reviewed. A number of changes have been made. These changes had been discussed briefly at the Audit and Governance Committee on 20/11/14, where approval was granted, subject to further discussion at the Finance Committee. Such discussion occurred at the Finance Committee on the same day, and some further minor changes were agreed.

The revised SFIs, incorporating all the agreed changes, are enclosed. A full „track changes' version is available on request from the Trust Secretary, for those Board members not present at the Audit and Governance Committee or Finance Committee.

Many of the changes relate to titles, NHS bodies (e.g. TDA), updated document references and formats. The key changes worthy of note include:

- Updated definitions of Executives, Board and inclusion of SIRO (Section A)
- 6.1.2 – clearer role for Finance Committee in relation to Banking arrangement changes
- 7.3.3 – strengthened requirements for notifying salary overpayments
- 7.4.2 – clarified statement on receipt of cash/cheques, including charitable funds
- 8.6.7 – defined statement of who can request Tender reports to the Board
- 8.15.2/15.2.2/15.2.6 inter alia – reduction of previous threshold of £750k to £500k relating to:
    1) Threshold for investment cases requiring Finance Committee/Board sign off
    2) Threshold for NED involvement in tender evaluations
    3) Threshold for HIS capital approvals & HIS Management Board delegated authority
- 9.5.4 – Clarification that Trust services hosted by another Trust will be subject to host Trust SO/SFIs (applicable to KPP)
- 11.1 – revised wording around Remuneration Committee role. This aspect in particular was discussed in detail at the Finance Committee on 20/11/14
- 11.6 – revised severance thresholds and governance (per NHS Trust Development Authority (TDA) Accountability Framework)
- 12.1.1 – definition of non pay scope to clarify it includes revenue, capital and charitable funds
- 12.2.2/3 – clarifications of purchase ordering control
- 12.2.8 & ff – new section on petty cash strengthening controls
- 15.4.5 – insertion of clear requirement to raise a VAT compliant sales invoice for all disposals
- 17.2.5 – clarification of losses sign off via AC
- 18.1 & 18.2 – SIRO role defined generically, update on FoI publication scheme requirements
- Annex B – limits updated as changed within SFIs e.g. £750k reduction to £500k

The SFIs is one of a very small number of documents that the Board is asked to ratify. The others include the "Reservation of Powers and Scheme of Delegation" and "Standing Orders", which, together with the SFIs represent the Trust's constitutional framework. The latter two documents will be reviewed and revised within the next three months. If the SFIs are ratified, any changes to authorisation limits will be included in the "Reservation of Powers and Scheme of Delegation" at the point at which these are revised.

Which Committees have reviewed the information prior to Board submission?

- Audit and Governance Committee, 20/11/14
- Finance Committee, 20/11/14

Reason for receipt at 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

Standing Financial Instructions

Requested/ Required by:	Trust Board
Main author:	Head of Financial Services
Other contributors:	Consultation list contributors (Appendix Two)
Document lead:	Director of Finance Contact Details: 01622 226422
Supersedes:	Standing Financial Instructions (with effect September 2013)
Approved by:	Audit and Governance Committee, November 2014
Ratified by:	Trust Board, November 2014
Review date:	September 2015

With Effect from November 2014

Document History

Requirement for document:	• Trust (Functions) Directions 2000 issued by the Secretary of State • Code of Accountability • Bribery Act 2010 and associated Government guidance
Cross References / Associated Documents:	• Standing Orders • Reservation of Powers and Scheme of Delegation • Department of Health's Commercial Sponsorship – Ethical standards in the NHS • Records Management: NHS Code of Practice • Trust Procurement Strategy • Code Of Conduct • Board Code of Conduct • Bribery Act 2010 • Standards of Business Conduct for NHS Staff • Data Protection Act 2010 • International Financial Reporting Standards • British Standard Code of Practice • Overpayments Policy • Anti Fraud, Bribery and Corruption Policy • NHS Audit Committee Handbook (2014) • Managing Public Money guidance • The NHS Trust Development Authority 2014-15 Accountability Framework

Version Control:		
Issue:	**Description of changes:**	**Date:**
1.0	Standing Financial Instructions (with effect from 1 April 2008)	February 2008
2.0	Standing Financial Instructions (with effect from 1 April 2009)	March 2009
3.0	Standing Financial Instructions (with effect from 1 April 2010)	March 2010
4.0	Standing Financial Instructions (with effect from 1 April 2011)	March 2011
4.1	Standing Financial Instructions (with effect from July 2012)	July 2012
4.2	Standing Financial Instructions (with effect from Sept 2013)	Sept 2013
4.3	Standing Financial Instructions (with effect from November 2014 – Definitions amended to ensure consistency, and to more accurately describe the circumstances at the Trust; authority of Remuneration Committee amended to accord with current practice)	November 2014

SECTION A

INTERPRETATION AND DEFINITIONS FOR STANDING FINANCIAL INSTRUCTIONS

Save as otherwise permitted by law, at any meeting the Chairman of the Trust Board shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Trust Secretary).

Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

"Accountable Officer" means the NHS Officer responsible and accountable to parliament for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets in accordance with the requirements of HM Treasury guidance Managing Public Money (July 2013). For this Trust it shall be the Chief Executive.

"Board" means the Chairman, Executive Directors and Non-Executive Directors collectively as a body. Any person that is expected to be present at, and participate in, meetings of the Trust Board, as a matter of routine, should be regarded as being a part of the Board. However, only those persons with voting rights will be regarded as a formal member of the Trust Board.

"Budget" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"Budget holder", or "Budget Manager" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

"CCG" means Clinical Commissioning Group, responsible for commissioning many NHS funded services under the Health and Social Care Act 2012

"Chairman of the Board" is 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 "the Chairman of the Board" shall be deemed to include the Vice-Chairman of the Board if the Chairman is absent from the meeting or is otherwise unavailable.

"Chief Executive" means the chief officer of the Trust.

"Commissioning" means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

"Committee" means a committee or sub-committee created and appointed by the Trust.

"Committee members" means persons formally appointed by the Board to sit on or to chair specific committees.

"Contracting and procurement" means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

"Director" means an 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 SFIs.

"Executive Director" means a senior Officer of the Trust who is expected to be present at, and participate in, meetings of the Trust Board. The Board contains both voting and non-voting Executive Directors (the latter of which are not formal members of the Board, and will regarded as being „in attendance' at Board meetings).

"Director of Finance" means the Chief Financial Officer of the Trust.

"Funds held on trust" shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

"Membership, Procedure and Administration Arrangements Regulations" means The National Health Service Trusts (Membership and Procedure) Regulations (SI 1990/2024) and subsequent amendments.

"Nominated officer" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"Non-Executive Director" means a formal member of the 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, Procedure and Administration Arrangements Regulations. All non-Executive Directors have voting rights at the Trust Board.

"Associate Non-Executive Director" means a person who is not an officer of the Trust and who is expected to undertake the role of a Non-Executive Director, but who is not a formal member of the Board, and who does not have voting rights at the Board. Associate Non-Executive Directors will be regarded as being „in attendance' at Trust Board meetings.

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

"Senior Information Risk Owner (SIRO)" is an Executive Director or Senior Management Board Member who will take overall ownership of the

Organisation's Information Risk Policy, act as champion for information risk on the Board and provide written advice to the Accounting Officer on the content of the Organisation's Statement of Internal Control in regard to information risk. The SIRO implements and leads the Information Governance (IG) risk assessment and management processes within the Organisation and advises the Board on the effectiveness of information risk management across the Organisation. The SIRO for this Trust is the Chief Nurse.

"Senior Manager" means an officer holding a senior managerial or senior clinical role with management responsibilities. For this Trust this includes Directors and Associate / Deputy / Assistant Directors and their direct reports, and Clinical Directors and Consultants.

"SD" means Scheme of Delegation

"SFIs" means Standing Financial Instructions.

"SLA" means Service Level Agreements

"SOs" means Standing Orders.

"**TDA"** means the NHS Trust Development Authority, which monitors the performance of NHS Trusts and supports their journey towards Foundation Trust status

"the Trust" means Maidstone and Tunbridge Wells NHS Trust.

"Trust Secretary" means a person appointed to act independently of the Trust Board to provide advice on corporate governance issues to the Board and the Chairman, and monitor the Trust's compliance with the law, Standing Orders, and Department of Health guidance.

"Vice-Chairman of the Board" means the Non-Executive Director appointed by the Chairman to take on the Chairman's duties if the Chairman is absent for any reason.

SECTION B - STANDING FINANCIAL INSTRUCTIONS

1. INTRODUCTION

1.1 General

1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

1.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Reservation of Powers and Scheme of Delegation adopted by the Trust.

1.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Hosted Services. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

1.1.5 **The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.**

1.1.6 Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit and Governance Committee for referring action or ratification. **All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.**

1.1.7 The Director of Finance shall ensure that detailed procedures and systems are prepared and maintained relating to all sections of these SFIs. These procedures, in effect form part of these Standing Financial Instructions.

1.1.8 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other directors or employees who have been duly authorised to represent them, except in respect of Banking Arrangements (See section 6)

1.1.9 Wherever the term „employee' is used, and where the context permits, it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.2 Responsibilities and Delegation

1.2.1 The Trust Board

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

1.2.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Trust's Reservations of Matters Reserved to the Board. All other powers have been delegated to such other committees as the Trust has established.

1.2.3 **The Chief Executive and Director** of Finance

The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control. However, the financial performance of the Trust is a key objective for all senior managers, including clinicians, and forms part of the Trust's performance management processes to ensure formal and effective accountability for delivery of budgets.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall responsibility for the Trust's activities; is responsible to the Chairman and the Trust Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.4 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

1.2.5 **The Director** of Finance

The Director of Finance is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control, including ensuring that detailed financial procedures and systems incorporating

the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:

(d) the provision of financial advice to other members of the Board and employees;

(e) the design, implementation and supervision of systems of internal financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.2.6 Trust **Board Members and Employees**

All members of the Trust Board and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.2.7 **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.2.8 For all members of the Trust Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance and in line with the Records Management: NHS code of Practice.

2. AUDIT

2.1 Audit and Governance Committee

2.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit and Governance Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2014), which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(c) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) reviewing and approving schedules of losses, write offs and compensations, and making recommendations to the Board, as required;

(f) Reviewing the arrangements in place to support the Board Assurance Framework process and advising the Board accordingly.

2.1.2 Where the Audit and Governance Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit and Governance Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health (and if so, to the Director of Finance in the first instance).

2.1.3 It is the responsibility of the Director of Finance to ensure an adequate Internal Audit service is provided and the Audit and Governance Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

2.2 Director of Finance

2.2.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the Public Sector Internal Audit Standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(d) ensuring that an annual Internal Audit report is prepared for the consideration of the Audit and Governance Committee. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;

(ii) major internal control weaknesses discovered;

(iii) progress on the implementation of internal audit recommendations;

(iv) progress against plan over the previous year;

(v) strategic audit plan covering the coming three years;

(vi) a detailed plan for the coming year.

2.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;
(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.

2.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.3.3 The Head of Internal Audit will normally attend Audit and Governance Committee meetings and has a right of access to all Audit and Governance Committee members, the Chairman and Chief Executive of the Trust.

2.3.4 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit and Governance Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every three years.

2.4 External Audit

2.4.1 The External Auditor is appointed by the Audit Commission (until April 2015 when functions will be taken over by the National Audit Office and NHS England) and paid for by the Trust. The Audit and Governance Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the Audit Commission if the issue cannot be resolved.

2.4.2 Prior approval must be sought from the Audit and Governance Committee for each discrete piece of additional work awarded to the external auditors.

2.5 Fraud and Corruption

2.5.1 In line with their responsibilities, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance with the NHS Standard Contract regarding the implementation and maintenance of appropriate counter fraud, bribery and corruption arrangements.

2.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

2.5.3 The Local Counter Fraud Specialist shall report to the Trust Director of Finance and shall work with staff in NHS Protect in accordance with the Department of Health Fraud and Corruption Manual.

2.5.4 The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust.

2.6 Security Management

2.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

2.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

2.6.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS). For this Trust the SMD is the Chief Operating Officer.

2.7 Health Informatics Service (HIS)

2.7.1 In respect of the operations of the HIS, the HIS Management Board is responsible to the Trust's Audit and Governance Committee, for establishing the Audit arrangements for the purpose of receiving audit reports on the operations of the HIS, and overseeing appropriate corrective action for any weaknesses identified by those reports. The Management Board will ensure that the HIS Partnership Board is kept informed of any audit weaknesses identified and the progress in addressing them.

2.7.2 As part of the wider controls assurance framework, the HIS Management Board will ensure the status of audits on HIS operations is reported to the Trust Audit and Governance Committee and Chief Executive, at least once a year, to enable the Chief Executive to sign the Governance Statement in the Trust's annual report and accounts.

2.7.3 Any failure by, or inability of, the HIS management to take appropriate corrective action on a matter that will have an impact on the Trust's accounts and cash flow must be reported to the Director of Finance at the earliest opportunity.

2.7.4 When so directed by the Trust's Audit and Governance Committee, the HIS Management Board must take corrective action to ensure that the Trust's financial system and accounts are not adversely affected by any issue of the HIS operations identified by the external auditors.

3. SECTION NOT USED

4. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

4.1 Preparation and Approval of Plans and Budgets

4.1.1 The Chief Executive will compile and submit to the Board an Annual Plan (AP) which takes into account financial targets and forecast limits of available resources. The AP will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

4.1.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the AP

(b) accord with workload and workforce plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds;

(e) identify potential risks.

4.1.3 The Director of Finance shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

4.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

4.1.5 All budget holders will ensure that they understand their allocated budgets and raise any issues immediately on receipt of new financial year allocations. If no issues are raised then budgets will be deemed to be accepted by the budget holder.

4.1.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their allocations successfully.

4.2 Budgetary Delegation

4.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;

(b) the purpose(s) of each budget heading;

(c) individual and group responsibilities;

(d) authority to exercise virement;

(e) achievement of planned levels of service;

(f) the provision of regular reports.

4.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

4.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

4.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

4.3 Budgetary Control and Reporting

4.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(ii) Movements in cash and capital;

(iii) capital project spend and projected outturn against plan;

(iv) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and workforce budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

(f) holding a record of authorised budget holders (see section 12.2.4 d(i))

4.3.2 Each Budget Holder is responsible for ensuring that they:

(a) Participate fully in the Business and Financial planning process

(b) Review, understand and validate the financial position of the Trust for their specific area of responsibility on a monthly basis

(c) Ensure that they operate within their agreed budgets

(d) Ensure any potential or actual variation to plan including overspending or reduction of income is notified to the Board via delegated authority.

(e) The above (d) includes ensuring all potential or actual financial risks are identified to the Directorate Management Team and to Finance Managers in advance of them arising, or as soon as the Budget Holder becomes aware of the issue, whether this is on potential overspending or income shortfall. This may include the financial

aspects of issues relating to patient safety or quality of service as highlighted to the appropriate executive officer and committee.

(f) Ensure the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised

(g) Ensure all changes to workforce are in line with Section 11 of this document

(h) Ensure that a Business Case is submitted and subsequently approved in line with Trust requirements, before any additional expenditure not identified during the Business Planning process, is incurred.

(i) Respond on a timely and appropriate basis to all queries raised on financial performance and monitoring. This includes attendance at review meetings, providing or validating documentation and any other reasonable requests

(j) Adhere to Trust procurement policies in respect to non pay purchases including those outlined in Section 8 of this document.

4.3.3 Budget Holders are reminded of the requirement to adhere to the SFIs and the duty to disclose non-compliance – See SFI reference 1.1.5 and 1.1.6

4.3.4 The Chief Executive is responsible for identifying and implementing a financial recovery plan, including cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

4.3.5 The Cost Improvement Programme (CIP) will go through a quality impact assessment process in order to ensure any issues around patient safety and / or quality of service are understood and agreed by the relevant committee.

4.4 Capital Expenditure

4.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure (the particular applications relating to capital are contained in SFI 15).

4.4.2 Capital Assets should not be purchased from revenue funding

4.5 Monitoring Returns

4.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation, in accordance with the timetable set.

5. ANNUAL ACCOUNTS AND REPORTS

5.1 **The Director** of Finance, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the Trust's accounting policies, and International Financial Reporting Standards (IFRS);

(b) prepare and submit annual financial reports to the Department of Health certified in accordance with current guidelines;

(c) submit financial returns to the Department of Health for each financial year in accordance with the timetable prescribed.

5.2 The Trust's annual accounts must be audited by an auditor appointed by the Audit Commission (see 2.4.1). The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

5.3 The Trust will publish an Annual Report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health's Manual for Accounts.

6. BANK AND GOVERNMENT BANKING SERVICE

6.1 General

6.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Department of Health. In line with NHS Trust Development Authority (TDA) published cash management guidance, Trusts should minimize the use of commercial bank accounts and consider using Government Banking Service accounts for all banking services.

6.1.2 The Board shall approve the banking arrangements, following a recommendation from the Finance Committee.

6.2 Bank and Government Banking Service

6.2.1 The Director of Finance is responsible for:

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

(e) monitoring compliance with TDA cash management guidance on the level of cleared funds in commercial accounts.

6.3 Banking Procedures

6.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts, which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

6.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated

6.4 Tendering and Review

6.4.1 The Director of Finance will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business. The exception is where Government Banking Service is used for the majority of services and the charges levied by commercial banking providers are well within the tender threshold.

6.4.2 Competitive tenders, where required under 6.4.1, should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

7. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.1 Income Systems

7.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

7.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

7.2 Fees and Charges

7.2.1 The Trust shall follow the Department of Health's and Monitor's established costing guidance in setting prices for NHS service level agreements.

7.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Monitor/NHS England jointly published national tariffs or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Trust code of Conduct Policy and the Department of Health's Commercial Sponsorship – Ethical standards in the NHS shall be followed(see also Annex B of Standing Orders)

7.2.3 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

7.3 Debt Recovery

7.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

7.3.2 Any income not received should be dealt with in accordance with losses procedures.

7.3.3 All overpayments of salary should be identified by the Manager or Employee and notified to the Trust immediately. Failure to do so could constitute Fraud. When identified recovery will be initiated immediately in line with the Trust overpayment policy.

7.4 Security of Cash, Cheques and other Negotiable Instruments

7.4.1 The Director of Finance is responsible for:

(a) approving the form of all receipts, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

7.4.2 All Official Trust cash or cheques, Revenue and Charitable, received within any Ward or Department, must be passed intact to the Trust cashiers for banking at the earliest opportunity. Subsequent expenditure must follow Trust policy (refer section 12).

7.4.3 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

7.4.4 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

7.4.5 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

8. TENDERING AND CONTRACTING PROCEDURE

8.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied) and the Procurement strategy. All tendering and quotation procedures shall be administered by the Trust procurement department.

8.2 EU Directives Governing Public Procurement

Directives by the Council of the European Union, issued by the Department of Health (DH) governing procedures for awarding all forms of contracts, shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions (for limits see Annex B)

8.3 Reverse eAuctions and other e procurement techniques

The Trust should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions and other "e" procurement techniques. For further guidance on Reverse eAuctions refer to the Cabinet Office website.

8.4 Capital Investment Manual and other Department of Health Guidance

The Trust shall comply, as far as is practicable with the requirements of the Department of Health „Capital Investment Manual', „Estatecode' and the NHSTDA Capital Regime and Investment Business case approvals guidance' in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health guidance "The Procurement and Management of Consultants within the NHS".

8.5 Formal Competitive Tendering

8.5.1 General Applicability

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, including equipment and consumables;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens);
- for disposals.

8.5.2 Health Care Services

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 9 and No. 10

8.5.3 Exceptions and instances where formal tendering need not be applied

Formal tendering procedures need not be applied where:

(a) expenditure or income does not, or is not reasonably expected to, exceed £49,999 excluding VAT

(b) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with;

c) regarding disposals as set out in Standing Financial Instructions No. 17

d) Formal tendering procedures **may be waived** in the following circumstances:

- in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;
- where the requirement is covered by an existing contract;
- where Crown Commercial Services (CCS) , or other approved national/regional contracts or NHS Supply Chain framework agreements are in place;
- where a consortium or partnership arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium or partner members;
- where the timescale genuinely precludes competitive tendering, but failure to plan the work properly would not be regarded as a justification for a single tender;
- where specialist expertise is required and is genuinely available from only one source; This would include specialist original equipment manufacturer (OEM) parts, maintenance and repairs.
- there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
- where the market has been tested and insufficient number of tenders have been received;
- using clinicians currently employed by the Trust for initiatives such as waiting list reduction or Trust private patient work due to the benefits that entails, however the Trust should still ensure that value for money is being received in these arrangements.

(e) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

(f) where allowed and provided for in the Capital Investment Manual.

8.5.4 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultancy originally appointed through a competitive procedure unless meeting the criteria of 8.5.3(a).

8.5.5 Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the next available Audit and Governance Committee.

8.5.6 Fair and Adequate Competition

Where the exceptions set out in SFI No. 8.5.3 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required. Practically, to ensure three returns, best practice suggest inviting at least five bidders to tender.

8.5.7 Building and Engineering Construction Works

Competitive Tendering may only be waived in accordance with the criteria set out in 8.5.3.

8.5.8 Items which subsequently breach thresholds after original approval

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record. The budget holder is required to advise the Procurement department, in writing where this is the case and the Procurement department will include in reporting to the Audit and Governance Committee

8.5.9 Splitting Orders

Orders may not be split for administrative or other purposes to avoid the tendering thresholds. The requirement for quotation or tender should be based, in all cases for the life of the arrangement as proposed at the outset. When determining the value of the expenditure, Budget holders must consider the aggregation of entire spend of the arrangement, as planned, which may cover more than one financial year

Contracts for equipment maintenance and repair would generally be viewed as an annual contract due to potential changes to service requirements and would not be viewed as a split order.

Orders which, following investigation are found to have been split to avoid tendering processes shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

8.6 Contracting/Tendering Procedure

8.6.1 Invitation to tender

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(ii) All written invitations to tender shall state that no tender will be accepted unless:

(iii) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word “tender” followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager; (b) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer. In the case of eTenders issued via an electronic tendering system, all bid submissions will be submitted via the system ePortal. This eliminates the manual opening procedures.

(iv) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable

(v) Every tender for building or engineering works shall embody or be in the terms of the current edition of one of the recognised forms of contract relevant to the scope of works being undertaken.

E.g. Construction works - National Engineering Contracts (NEC3) or Joint Contract Tribunal (JCT) suites of documents. Engineering plant - Institution of Mechanical Engineers, The Institution of Electrical Engineers and the Association of Consulting Engineers (Form MF/1).Civil engineering work- the General Conditions of contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors (GC works 1).

These documents shall be modified in accordance with Department of Health guidance and, in minor respects, to cover special features of individual projects. Tender based on other forms of contract may be used only after prior consultation with the Director of Estates & Facilities Management.

8.6.2 Receipt and safe custody of tenders

The Chief Executive, or his nominated representative not from the originating department, will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

8.6.3 Opening tenders and Register of tenders

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the Chief Executive and not from the originating department. One of these senior officers should be the Head of Procurement or their nominated deputy

(ii) The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.

(iii) The „originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(iv) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

(vi) All Members of the Board and the Trust Secretary will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

(vii) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(vii) A register shall be maintained by a person authorised by the Chief Executive' to show for each set of competitive tender invitations despatched:

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(viii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (SFI No. 8.6.5 below).

8.6.4 Admissibility

i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive

(ii) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

8.6.5 Late tenders

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

8.6.6 Acceptance of formal tenders

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

(ii) The lowest tender that meets the specified requirements, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

(v) All tenders should be treated as confidential and should be retained for inspection.

8.6.7 Tender reports to the Trust Board

Reports to the Trust Board will be made on an exceptional circumstance basis only, prompted by a request from the Director of Finance, Chief Executive or Chairman.

8.6.8 List of approved firms (see SFI No. 8.5.3 Building and Engineering construction works.

(a) Responsibility for maintaining list

A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All firms must be made aware of the Trust's terms and conditions of contract.

(b) Approved list of contractors

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction.

ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970 (amended 2003), the Sex Discrimination Act 1975 (amended 2003), the Race Relations Act 1976 (amended 2000), and the Disability Discrimination Acct 1995 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the

appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

c) **Financial Standing and Technical Competence of Contractors**

The Director of Finance may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

8.6.9 Exceptions to using approved contractors

If in the opinion of the Chief Executive and the Director of Finance or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list

8.7 Quotations: Competitive and non-competitive

8.7.1 General Position on quotations

Written quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £10,000, but not exceed £49,999 excluding VAT. Where three written quotations cannot be obtained then a single tender waiver form will be required.

8.7.2 Competitive Quotations

(i) Written quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust. Practically, to ensure three returns, best practice suggests inviting at least five bidders to provide written quotations.

(ii) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(iii) A quotation should be treated as confidential and must be retained for inspection.

(iv) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or

the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

8.7.3 Non-Competitive Quotations

Competitive quotation procedures may be waived in the circumstances set out in section 8.5.3(d) but must be supported by a non-competitive quotation in writing and a single tender waiver.

8.7.4 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance.

8.8 Authorisation of Tenders and Competitive Quotations

8.8.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the officers detailed in the scheme of delegation (annex B).

8.8.2 These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's Scheme of Delegation.

8.8.3 Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

8.9 Instances where formal competitive tendering or competitive quotation is not required

Where competitive tendering or a competitive quotation is not required where expenditure is genuinely expected to be below £10,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance. Designated Budget Managers are expected to secure value for money.

8.10 Private Finance for capital procurement (see overlap with SFI No. 15)

The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a major capital procurement, or as in accordance with current TDA and Department of Health guidance. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

8.11 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the Capital Investment Manual, Estatecode and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

8.12 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

8.13 Healthcare Services Agreements (see overlap with SFI No. 9)

8.13.1 Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a Public Benefit Corporation, is a legal document and is enforceable in law.

8.13.2 The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with the Trust's agreed policy.

8.14 Disposals (See overlap with SFI No. 17)

8.14.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the procurement strategy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £10,000 this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH and TDA guidance has been issued but subject to compliance with such guidance.

8.14.2 Prior to any decision on disposal the book value of the asset should be obtained from the Financial Services Department. In the event that a loss on disposal is expected, this must be approved by the Director of Finance prior to disposal

8.14.3 Disposals of fixed assets, whether by sale, exchange, scrapping, loss or otherwise, shall be notified to the Director of Finance as soon as they take place and must follow the arrangements set out in Section 17 of the SFIs.

8.15 In-house Services

8.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine that in-house services should be market tested periodically by competitive tendering.

8.15.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a procurement officer and a Director of Finance Representative. For services having a likely contract expenditure exceeding £500,000, a non-Executive Director should be a part of the evaluation team.

8.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

8.15.4 The evaluation team shall make recommendations to the Board.

8.15.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

8.16 Applicability to Trust and Fund held on Trust and Other Private Resources

These Instructions shall apply to Exchequer funds and to works, services and goods purchased from the Maidstone and Tunbridge Wells NHS Trust Charitable fund and other private resources.

9. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES (see overlap with SFI No. 8.13)

9.1 Service Level Agreements (SLAs)

9.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

All SLAs should aim to implement the agreed priorities contained within the Annual Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the NHS TDA Accountability Framework;
- Information Governance requirements;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways.

9.2 Involving Partners and jointly managing risk

A good SLA will result from a dialogue with clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

9.3 Reports to Board on SLAs

The Chief Executive as the Accountable Officer will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.

9.4 Partnerships

The Director of Finance is responsible for ensuring that any partnerships that the Trust may have are identified through an annual review and that partnership agreements are put in place reflecting the arrangements. These arrangements should be routinely monitored by senior management to ensure they are operating as intended and meeting their objectives. The Director of Finance will maintain a register of partnerships, which will be reviewed by the Audit and Governance Committee annually. The financial

performance of partnerships will be monitored by the Director of Finance and the results shared with partners and acted upon.

9.5 Hosting of Services

9.5.1 The Director of Finance will ensure a business case is prepared, for review by the Finance Committee, and approval by the Board, to support any proposed hosting of services to other organisations. The business case should include a cost benefit analysis and identify financial and operational risks to Maidstone and Tunbridge Wells NHS Trust, together with any legal implications. Following approval, hosted services should only be provided once a signed Service Level of Agreement is in place with all member organisations. All costs incurred by the Trust in hosting a service shall be recoverable from member organisations, including corporate overhead.

9.5.2 The hosted service(s) should fully comply with the Trust's Standing Financial Instructions/Standing Orders and other core procedures established within the Trust unless specifically agreed in writing by the Trust Chief Executive. Contracts will be signed with other organisation members of the hosted service(s) which should stipulate the members financial and other responsibilities/commitments, both whilst a member of the hosted service(s) and if they leave following termination of the agreement.

9.5.3 The Trust currently has the following hosted service to which 9.5.1 and 9.5.2 apply:-

- Health Informatics Service (HIS)

9.5.4 Services used by the Trust but hosted by another body will follow the Standing Financial Instructions / Standing Orders and other procedures as set by the host body.

10 SECTION NOT USED

This section is not currently applicable to Maidstone and Tunbridge Wells NHS

11. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

11.1 Remuneration and Terms of Service (see overlap with SO No. 4 appointment of committees and sub committees)

11.1.1 In accordance with Standing Orders the Board shall establish a committee to consider remuneration and terms of service, with clearly defined Terms of Reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. For this Trust this is the "Remuneration Committee".

11.1.2 The Committee will:

(a) approve remuneration and terms of service for the Chief Executive and Executive Directors including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(b) approve the remuneration and terms of service for the Chief Executive and Executive Directors to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements where appropriate;

(c) monitor and evaluate the performance of the Chief Executive and Executive Directors;

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

11.1.3 The Committee shall record in writing the basis for its decisions. The Board shall however remain accountable for the Remuneration Committee's decisions on the remuneration and terms of service covered under 11.1.2.

11.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee (and which are not covered by nationally agreed Terms and Conditions.

11.1.5 The Trust will pay allowances to the Chairman and non-officer members of the Board in accordance with instructions issued by the Secretary of State for Health.

11.2 Funded Establishment

11.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

11.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive via delegated authority.

11.3 Staff Appointments

11.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless:

(a) within their approved budget and funded establishment,

(b) authorised to do so by the Chief Executive via the scheme of delegation and in accordance with the agreed approval process (e.g. Recruitment panel authorisations); and

c) managed through the Trust's recruitment or staff bank departments

11.3.2 The Remuneration Committee will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

11.4 Processing Payroll

11.4.1 **The Director of Workforce and Communications** is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

(e) Appropriate (contracted) terms and conditions

11.4.2 **The Director of Workforce and Communications in conjunction with the Director of Finance** will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque, bank credit, or cash to employees and officers;

(i) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

(n) ensuring that pay information is accurately reflected in the financial records of the Trust.

11.4.3 **Appropriately nominated managers** have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with local instructions and in the form prescribed by the Director of Workforce and Communications**;**

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Workforce and Communications must be informed immediately.

(d) see overlap with budget holder responsibilities SFI section 4.3.

11.4.4 **Individual Employees / Officers** have responsibility for checking their payslips and ensuring that any discrepancies of over or underpayment are reported to their line manager immediately. See also section 7.3.3

11.4.5 Regardless of the arrangements for providing the payroll service, **the Director of Workforce and Communications in conjunction with the Director of Finance** shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangement are made for the collection of payroll deductions and payment of these to appropriate bodies.

11.5 Contracts of Employment

11.5.1 The Board shall delegate responsibility to the Director of Workforce and Communications for:

(a) ensuring that all employees are issued with a Contract of Employment in a form which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

11.6 Redundancy and Early Retirements

11.6.1 The Remuneration Committee will approve individual non Board redundancy packages up to £100,000. Approval must be sought prior to any formal communication being made with an employee.

11.6.2 Individual non Board redundancy packages in excess of £100,000 will be approved by the Trust Remuneration Committee and will require additional

approval from the Trust Development Authority's Remuneration Committee in accordance with the TDA 2014-15 Accountability Framework.

11.6.3 All contractual severance payments to the Chief Executive or Executive Directors shall be approved by the Trust's Remuneration Committee and the NHS Trust Development Authority's Remuneration Committee.

11.6.4 All non contractual severance payments will require Treasury approval in addition to that of Trust and TDA Remuneration Committees.

11.6.5 In the event that severance payments are considered to include "novel or unusual" elements. These will normally require Treasury approval, in addition to the Trust and TDA Remuneration Committees.

12. NON-PAY EXPENDITURE

12.1 Delegation of Authority

12.1.1 The Board will approve the level of non-pay expenditure (Revenue, Capital and Charitable Funds) on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

12.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to approve requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for approval above that level.

12.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

12.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 8)

12.2.1 Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed), shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's procurement department or other specialist advisor (e.g. IT or estates) shall be sought.

12.2.2 All purchases (NHS and trade) should have a purchase order made with the formal involvement of the Procurement Department (for goods and services), the Estates Department (for specialised maintenance and services and capital items), Chief Pharmacist for Pharmacy supplies and the Human Resources department for Agency staff and other recruitment related expenditure.

12.2.3 A list of any authorised exceptions to the requirement to raise a purchase order is held within the procurement department

12.2.4 System of Payment and Payment Verification

The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

12.2.5 The Director of Finance will:

(a) agree with the Trust Board the thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) Authorised Signatory Register - A list of Board Directors and budget holders (including specimens of their signatures) authorised to approve orders and certify invoices. See overlap with SD section 3.3.4(f)

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 12.2.5 below.

12.2.6 Prepayments

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).

(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time

during the course of the prepayment agreement unable to meet his commitments;

(c) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

12.2.7 Official orders

Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

12.2.8 Purchases from Petty Cash

Purchases from petty cash are restricted in value and by type of purchase and may be used for specified or emergency use only subject to the following:-

(a) minor emergency purchases approved in advance by procurement

(b) reimbursement of Patient travel

(c) reimbursement of small balances of patient monies (see patient property policy)

(d) reimbursement of expenses for staff or volunteers may not be made from petty cash

(e) failure to adhere to the requirements of section 12.2.7 may result in claims being refused

12.2.9 Duties of Managers and Officers

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement (see section 8.2)

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with „The procurement and Management of Consultants' guidance issued by the Department of Health;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Order No. 7 and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff" (SO Annex B) and the Bribery Act 2010 and associated Government guidance); More detailed guidance is available in the Trust Code of Conduct policy.

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract or purchases from petty cash (see k below);

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order at the earliest opportunity and clearly marked "Confirmation Order";

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds or delegated limits See overlap with section 8.5.9;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of employees and officers authorised to certify invoices are notified to the Director of Finance;

12.2.10 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within Estatecode and other Department of Health Guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

12.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with Standing Order No. 9.1)

12.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid

down by the Director of Finance which shall be in accordance with these Acts. (See overlap with Standing Order No. 9.1)

13. EXTERNAL BORROWING

13.1 Borrowing

13.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital; and likewise its ability to repay principal and interest on any proposed new borrowing, whether Capital Investment Loan or Working Capital Loan, within the borrowing limits set by the Trust Development Authority (TDA) and the Department of Health (DH). The Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

13.1.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Director of Finance.

13.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

13.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cashflow position, represent good value for money, and comply with the latest guidance from the TDA and Department of Health.

13.1.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Director of Finance. The Board must be made aware of all short term borrowings at the next Board meeting.

13.1.6 All long-term borrowing must be consistent with the plans outlined in the current Annual Plan and be approved by the Trust Board, and meet the requirements as currently set out by the Trust Development Authority and Department Health.

13.2 Investments

13.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

13.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

13.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained

14. SECTION NOT USED

15. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

15.1 Capital Investment

15.1.1 The Chief Executive

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) shall ensure that the capital investment is not undertaken without confirmation of commissioner(s) support, where applicable, and the availability of resources to finance all revenue consequences, including capital charges.

15.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the regulatory guidance contained within the Capital Investment Manual, the Treasury Green book, International Financial Reporting Standards, TDA Capital Regime and Investment Business Case Approvals Guidance for NHS Trusts and other applicable guidance) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(ii) appropriate project management and control arrangements;

(b) that the Executive Team has approved the business case after suitable review and challenge;

(c) that any other external requirements have been fulfilled e.g. NHS TDA authorisation limits

15.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of “Estatecode”.

15.1.4 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

15.1.5 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised budget.

15.1.6 The approval of a capital programme shall not constitute approval for expenditure on any specific scheme.

15.1.7 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance, TDA Capital Regime and Investment Business Case Approvals Guidance for NHS Trusts and the Trust’s Standing Orders.

15.1.8 The Chief Executive shall issue through delegation to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with SFI No. 8.5);

(c) approval to accept a successful tender (see overlap with SFI No. 8.8).

15.1.9 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

15.1.10 Prioritisation of the capital programme will take account of the Trust's commitment to the sustainable use of resources and look favourably on any plans that reduce the use of energy and other natural resources, minimise the production of waste and contribute to the sustainable development of the wider community.

15.2 HIS Capital Projects

15.2.1 The Managing Director of the HIS will be responsible for ensuring that a project programme incorporating HIS's capital expenditure requirements is drawn up each year for agreement by the HIS Management Board. The programme will be included in the annual business plan, which will be subject to overall approval by the HIS Partnership Board. HIS members will be responsible for purchasing capital equipment from their own resources. Where a potential capital asset purchase/investment will benefit and provide services to more than one HIS member, the business case will be prepared identifying how the asset will be funded. The business case, and the responsibilities associated with the revenue and capital consequences, must be agreed by the HIS Partnership Board and the host organisation. If agreed and unless agreed otherwise, the asset will be placed on the hosts asset register. Under no circumstances will the host be responsible for any future risk in respect of the shared element of the asset. Contracts agreed with members must stipulate the on-going financial and other commitments/obligations should they leave the HIS.

15.2.2 The programme will reflect national and local priorities and steps necessary to meet delivery targets. It must, also, reflect any additional funding available through central programmes for IT, by CCGs and other capital funds that may be made available by HIS partners from their own capital resources. All proposed spending reported made through the Host must be agreed by the Host Director of Finance to be capable of being financed within the Host annual capital resource limit, and must be planned in sufficient time to allow it to be incorporated in the annual TDA planning submissions.

The necessary business cases must be presented through the Host capital approval arrangements for Executive Team approval, and as applicable approval by the Trust Finance Committee and Trust Board (schemes of £500k and above).

15.2.3 Before work can commence on any HIS project the Director will ensure that:

a) Capital and revenue funding has been fully agreed by members and the host organisation

b) Where assets are to be Host procured and owned, a business case must be submitted to the Host Executive Team for approval in the agreed format. For schemes over £500k the business case will need Host Trust Finance Committee and Board approval;

c) for projects valued at more than £5m where assets are to be Host procured and owned, a business case will need to be made in addition to the NHS TDA for approval under the current delegated capital limits

d) Where assets are client procured and owned, the HIS Management Board will need to accord to the capital investment procedures relevant to the client organisation and be able to demonstrate this has been done to the Host Trust organisation and its auditors

The Director may delegate these responsibilities to a nominated Project Director.

15.2.4 Once a project has been formally approved by the HIS Management Board, the Project Director may commit expenditure to it, provided that any necessary Host Trust, Client Trust, TDA or National approvals have also been given and funding has been agreed by the members and host organisation.

15.2.5 Powers to approve expenditure on particular projects may be delegated to project and programme boards established to oversee the implementation of specific projects and programmes. However, such delegation may not exceed the limits sanctioned by the HIS Management Board.

15.2.6 Should it become necessary during the course of the year to introduce a new project, which has not been included in the business plan, the HIS Management Board will have delegated powers from the HIS Partnership Board to approve projects up to a value of £500,000. These powers are subject to there being agreement of the funding on the part of the host organisation and HIS Partner, production of relevant business cases, and available capital resource to finance the spend. For projects valued at more than £500,000 the approval of the HIS Partnership Board, and as appropriate the client or Host organisation (and if relevant the NHS TDA) must be obtained before work on the project can commence. Such approval can be given by a majority of the members of the HIS Partnership Board individually in writing.

15.3 Private Finance (see overlap with SFI No. 8.10)

15.3.1 The Trust should normally test for PFI when considering major capital procurement, or as directed by current Department of Health guidance. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

(a) The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health or in line with any current guidelines.

(c) The proposal must be specifically approved by the Board.

15.4 Asset Registers

15.4.1 The Trust's asset register is an integral part of the Trust's asset management information and along with relevant financial information will be used in actively managing the asset base of the Trust. The Chief Executive is responsible for the maintenance of up to date registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical verification of assets against the asset register to be conducted once a year.

15.4.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the guidance issued by the Department of Health.

15.4.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and timesheets for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

15.4.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

15.4.5 A sales invoice must be raised in respect of all disposals by sale, to ensure correct VAT accounting

15.4.6 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

15.4.7 The value of each asset shall be indexed, if appropriate, to represent current values in accordance with guidance issued by the Department of Health and TDA.

15.4.8 The value of each asset shall be depreciated using appropriate methods and rates with reference to Department of Health and TDA guidance.

15.4.9 The Director of Finance of the Trust shall calculate and pay capital charges as specified in guidance issued by the Department of Health and TDA.

15.5 Security of Assets

15.5.1 The overall control of Trust assets is the responsibility of the Chief Executive.

15.5.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, remaining useful life, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

15.5.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

15.5.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

15.5.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

Where practical, assets should be marked as Trust property

16. STORES AND RECEIPT OF GOODS

16.1 General position

16.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take processes;

(c) valued at the lower of cost and net realisable value.

16.2 Control of Stores, Stocktaking, condemnations and disposal

16.2.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

16.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as Trust property.

16.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

16.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store, that are classified as „stock', at least once a year, in accordance with agreed processes.

16.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

16.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 17 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

16.3 Goods supplied by NHS Supply Chain

16.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note notifying Procurement of any discrepancies.

16.4 Consignment Stock

16.4.1 Consignment Stocks are those items that remain the property of the supplier until used, but that are available on site for practical reasons

16.4.2 Any consignment stock held must have been approved in accordance with the delegation of authority and must be kept to an agreed minimum level. Consignment stock held must not be included in the Trust's stock values but separate detailed records must be kept

16.4.3 it is the responsibility of the Clinical Director to ensure that SFI 16.4.2 is followed.

17. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS (see overlap with SFI 8 and SFI 2.5 Fraud & Corruption)

17.1 Disposals and Condemnations

17.1.1 Procedures

The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

17.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate and the net book value at the time of proposed disposal.

17.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

17.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

17.2 Losses and Special Payments

17.2.1 Procedures

The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

17.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the relevant Local Counter Fraud Service in accordance with Secretary of State for Health's Directions.

17.2.3 The Director of Finance must notify the Local Counter Fraud Specialist and the External Auditor of all frauds.

17.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

(a) the Board,

(b) the External Auditor.

17.2.5 Within limits delegated to it by the Department of Health, the Audit and Governance Committee shall approve the writing-off of losses on behalf of the Board.

17.2.6 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations

17.2.7 For any loss, the Director of Finance should consider whether any insurance claim can be made.

17.2.8 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

17.2.9 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

17.2.10 Compensations payments to Chief Executives or Directors reporting to the Chief Executive require approval of the Trust's Remuneration Committee and the Trust Development Authority's Remuneration Committee. In the event the payment includes novel of unusual elements it may require Treasury approval. (see SFI 11.6)

17.2.11 All losses and special payments must be reported periodically to the Audit and Governance Committee.

18. INFORMATION TECHNOLOGY

18.1 Responsibilities and duties of the Senior Information Risk Owner (SIRO)

18.1.1 The Senior Information Risk Owner, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's financial data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

18.1.2 The Senior Information Risk Owner shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

18.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

18.2.1 In the case of computer systems which are proposed for general applications and those applications which the majority of Trust's in the South East Authority wish to sponsor jointly, all responsible directors and employees will send to the Trust's Director of Health Informatics for submission and approval by the ICT Steering Group the following:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

18.2.2 The Director of Health Informatics shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority and compliance to this is a statutory requirement. It describes the classes or types of information about our Trust that we make publicly available.

18.3 Contracts for Computer Services with other health bodies or outside agencies

18.3.1 The Director of Health Informatics shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

18.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Health Informatics shall periodically seek assurances that adequate controls are in operation.

18.4 Risk Assessment

The Director of Health Informatics shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

18.5 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Health Informatics Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Director of Finance staff have access to such data;

(b) such computer audit reviews as are considered necessary are being carried out.

18.6 Standard of Non-Financial Records

The Director of Health Informatics shall be responsible for ensuring that non-financial records are adequate for contractual and management purposes.

18.7 Security and Integrity of Records

The Director of Health Informatics shall be responsible for implementing all necessary systems to ensure the security and integrity of the records in which this data (Financial and Non-Financial) is held. Records will be maintained in accordance with the Records Management: NHS Code of Practice.

19. PATIENTS' PROPERTY

19.1 Safe Custody of Patients' Property

The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

19.2 Liability for Patients' Property

The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; (notices are subject to sensitivity guidance)
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

19.3 Procedures for Patients' Property

19.3.1 The Chief Nurse must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

19.3.2 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients

19.4 Bank accounts for Patients' Property

Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

19.5 Restricted Use of Patients' Property

Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19.6 Deceased Patients

19.6.1 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the

property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

19.6.2 Where a patient, dying intestate and without lawful kin, leaves property in the hands of the Trust, the Director of Finance shall report the facts to the Treasury Solicitor. Where the net estate after payment of all known liabilities and collection of all known assets amounts to £200 or less, the money can be retained as a contribution towards expenses. The Trust will not accept responsibility for any assets in the hands of any other person or organisation.

19.6.3 The burial or cremation of deceased patients for whom no other arrangements are possible shall be undertaken by the Trust and the cost thereof recovered as a first charge against the patient's property, if any.

20. FUNDS HELD ON TRUST (INCLUDING CHARITABLE FUNDS)

20.1 Corporate Trustee

(1) Standing Order No. 2.8 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, along with SO 4.8.3 that defines the need for compliance with Charity Commission latest guidance and best practice.

(2) The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

(3) The Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

20.2 Accountability to Charity Commission and Secretary of State for Health

(1) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

(2) The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

20.3 Applicability of Standing Financial Instructions to funds held on Trust

(1) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No 8.16).

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

21. ACCEPTANCE OF GIFTS BY STAFF (see overlap with Trust Code of Conduct Policy and SO No. 7, SO Annex B and SFI No. 12.2.6 (d))

21.1 Detailed guidance on the acceptance of gifts by staff is contained in the Trust Code of Conduct Policy

21.2 **Improper Gifts and Hospitality** – A Director or employee of the Trust shall not in any circumstances solicit, proposition or agree to receive from any third party any form of gift, hospitality or other benefit in return for doing or not doing anything in relation to the discharge of their duties and responsibilities on the half of the Trust or for showing or not showing any favour in relation to such duties and responsibilities

21.3 **Other Gifts and Hospitality** – It is accepted that in some circumstances (Outside of those mentioned in 21.2 above), that it may be perfectly appropriate for a Director or employee of the Trust to agree to receive modest gifts and / or hospitality from third parties. E.g. the receipt of items such as pens or calendars from organisations with which the Trust does business or the acceptance of hospitality which arises out of normal Trust business and where this can reasonably be regarded as being in the Trust's best interests.

The test that needs to be applied in all such situations is whether a fair minded member of the public, knowing the facts of the matter, would see anything improper or suspicious in the receipt of the gift and / or hospitality.

21.4 **Registration of gifts and Hospitality with a value greater than £25.00**

If a Director or employee of the Trust proposes to accept a gift or hospitality offer (of the type mentioned in 21.3 above) which can be reasonably regarded as having a monetary value of more than £25.00 then the Director or employee must follow the guidance set out in the Code of Conduct policy. This requires that approval to accept the gift or hospitality is sought from an Executive Director (Reservation of Powers and Scheme of delegation section 3.13). A gifts and hospitality declaration needs to completed by the recipient and forwarded promptly (via the approving Director) for inclusion in the Trust Gift and Hospitality register. The register will be periodically presented to the Trust's Audit and Governance Committee.

21.5 **Refusal of Gift or Hospitality**

In the interests of transparency, all gifts or Hospitality over £25.00 should be declared even if refused.

22. SECTION NOT USED

23. RETENTION OF RECORDS

23.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

23.2 The records held in archives shall be capable of retrieval by authorised persons.

23.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

23.4 Information Asset Owners, as delegated by the Chief Executive, are responsible for ensuring the appropriate retention and subsequent disposal of records in line with Records Management: NHS Code of Practice.

24. RISK MANAGEMENT AND INSURANCE

24.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured;

g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make the Annual Governance Statement that is published with the Annual Report and Accounts as required by current Department of Health guidance.

24.2 Insurance: Risk Pooling Schemes administered by NHSLA

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical,

property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

24.3 Insurance arrangements with commercial insurers

24.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

(1) Trust's may enter commercial arrangements for insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;

(2) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and

(3) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Director of Finance should consult the Department of Health.

24.4 Arrangements to be followed by the Board in agreeing Insurance cover

(1) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Nurse shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Nurse shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Nurse shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Nurse will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the „deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Annex A

Procedures supporting the Standing Financial Instructions
CE= Chief Executive DoF= Director of Finance **HRD=Director of Workforce and Communications CN=Chief Nurse**

Paras.	Procedure	Lead
1.2.5 (b)	Ensuring detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions.	DoF
6.3.1	Prepare detailed instructions on the operation of bank and GBS accounts	DoF
7.3.2	Bad Debts to be dealt with in accordance with Losses and Special payments procedures	DoF
7.4.1.(c)	The security of keys, and for coin operated machines;	DoF
7.4.1 (d)	Prescribing systems and procedures for handling cash and negotiable securities	DoF
Section 8	Tendering and Contracting	DoF
9.4	Development and maintenance of a register to monitoring Partnerships	DoF
9.5	Development of a Business case supporting any proposed hosting of services provided to other organisations	DoF
11.3.2	Determination of starting pay rates, condition of service, etc, for employees.	HRD
11.4.2 (h)	Procedures for payment by cheque, bank credit or cash	HRD/DoF
11.4.2 (i)	Procedure for the recall of cheques and bank credits	HRD/DoF
11.4.5	Payroll: Audit Review Procedures	HRD/DoF
12.1.3	Professional Advice for the supply of goods and services	DoF
12.2.4	Instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds	DoF
12.2.4 (d) (iv)	Instructions to employees regarding the handling and payment of accounts within the Finance Department	DoF
12.2.7.(k)	Restrictions of purchases from petty cash in terms of value and by type of purchase.	DoF
12.3.1	Payments to Local Authorities & Voluntary Organisations under Section 28A	DoF
13.1.3	Applications for loans and overdrafts.	DoF
13.2.3	The operation of investment accounts and on the records to be maintained.	DoF
15.1.3	Capital Projects: Stage payments	CE
15.1.5	Regular reporting of Capital expenditure and commitment against authorised expenditure	DoF
15.1.6	Issue a scheme of delegation for capital investment management	CE
15.1.9	The financial management, including variations to contract, of capital investment projects and valuation for accounting purposes	DoF
15.4.5	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers	DoF
15.5.2	Asset Control	DoF
15.5.3	Reporting of breaches of agreed security practices	DoF
16.2.3	Set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.	DoF

16.2.6	Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.	DoF
17.1.1	Detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers	DoF
17.2.1	Prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers	DoF
18.1.1 (a)	Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's financial data, programs and computer hardware	CN
19.3.1	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises)	CN
19.4	Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under agreed arrangements.	DoF
24.4.(1)	Use the risk pooling schemes administered by the NHS Litigation Authority	CN
24.4 (2)	Management of any claims arising from third parties and payments in respect of uninsured	CN
24.4 (3)	Ensure documented procedures to cover the management of claims and payments below the deductible in risk pooling schemes	DoF

NB: "1.1.7 The Director of Finance shall ensure that detailed procedures and systems are prepared and maintained relating to all sections of these SFIs. These in effect form part of these Standing Financial Instructions."

Annex B

Financial Limits contained within the Standing Financial Instructions

Section B Para.	Limit	£ (excl. VAT)
8.9	Local procurement procedures will operates for items requisitioned and expected to be below £10,000 (Purchase Orders required for all purchases see para. 12.2). Designated Budget Managers are expected to secure value for money	10,000
8.7.1	3 Written Quotations are required where intended expenditure/income is reasonably expected to be between	10,001 and 49,999
8.5.3 (a)	Formal Tendering is required if income or expenditure is reasonably expected to exceed	49,999
8.8.1	Authorisation of Tenders or Competitive quotations Head of Procurement and one of Associate Director of Finance /DDoF Above plus one Executive Director Above plus Chief Executive or Trust Board	Up to 49,999 50,000 – 249,999 250,000 – 500,000 Greater than 500,000
8.14.1 (c)	Competitive Tendering not required if income from disposal is expected to be less than	10,000
8.15.2 (c)	Where tenders include in-house submissions, Non-Executive Director should sit on evaluation teams if contract expenditure is likely to exceed	500,000
11.6.1	The Trust Remuneration Committee approve individual non Board contractual redundancy packages up to	100,000
11.6.2	Trust Remuneration Committee and Trust Development Authority (TDA) Remuneration Committee to approve individual non Board redundancy packages in excess of	100,000
11.6.3	All contractual severance payments to the Chief Executive or Executive Directors must be approved by the Trust's Remuneration Committee and the NHS Trust Development Authority's Remuneration Committee.	
11.6.4/5	Non contractual severance payments and payments of a novel or unusual nature require the approval of the Trust and TDA Remuneration Committees as above and will require Treasury approval.	
12.2.5	Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate	NLF + 2%
15.2.2	HIS business cases must be presented through the Host capital approval arrangements for Executive Team approval, and as applicable approval by the Trust Finance Committee and Trust Board if schemes is likely to exceed	500,000
15.2.3 (b)	Business case to be submitted to Host Trust Finance Committee and Host Trust Board Approval if expenditure is likely to exceed	500,000
15.2.3 (c)	Host procured and owned HIS Projects require a business case to be submitted and require NHS TDA approval if expenditure is likely to exceed	5,000,000
15.2.6	Approval Limits for HIS Management Board for new in year HIS projects.	Up to 500,000
15.2.6	HIS Partnership Board, Host organisation (or Client) and NHS TDA if appropriate, must approve in year projects in excess of	500,000
19.6.1	Value above which Probate or Letters of Administration required if patient property held exceeds	5,000

Section B Para.	Limit	£ (excl. VAT)
19.6.1	Forms of indemnity required if deceased patients property fall below	5,000
19.6.2	A contribution to expenses not exceeding £200 may be retained in cases where a patient, dying intestate and without lawful kin, leaves property in the hands of the Trust	200.00
21.4	A Director or employee must follow the guidance set out in the code of conduct policy if accepting a gift or hospitality more than	25.00
21.5	Refused gifts / Hospitality should be declared if over	25.00

APPENDIX ONE

Process Requirements

1.0 Implementation and Awareness

1.1 Once approved the Document Lead or Author will send this policy/procedural document to the Clinical Governance Assistant who will publish it on the Trust intranet.

1.2 All staff will have access to a copy of the policy and procedure 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 Communications 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 Standing Financial 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.

APPENDIX TWO

CONSULTATION ON: Standing Financial Instructions

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 7th November 2014

Name: Name: *List key staff appropriate for the document under consultation. Select from the following:*	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Local Counter Fraud Specialist	09/10/14	10/10/14	Y	Y
Chief Internal Auditor	09/10/14	28/10/14	Y	Y
Director of Finance	09/10/14	29/10/14	Y	Y
Deputy Director of Finance	07/10/14	07/10/14	Y	Y
Executive Directors	09/10/14			
Non-Executive Directors	09/10/14	04/11/14 (2)	Y	Y
Risk Manager	09/10/14			
Head of Information Governance	09/10/14	12/11/14	Y	Y
Human Resources Business Partner	09/10/14	07/11/14	Y	Y
Head of Finance Systems	09/10/14	14/10/14	Y	Y
Head of SLA & Income	07/10/14	07/10/14	Y	Y
Head of Financial Management	07/10/14	07/10/14	Y	Y
Head of Procurement	08/10/14	08/10/14	Y	Y
Financial Services Manager	09/10/14	06/11/14	Y	Y
Service agreements manager	09/10/14			
Technical Team Leader and team	09/10/14	07/11/14	Y	Y
Debt Management Team Leader and team	09/10/14	06/11/14	Y	Y
Payables Team Leader and team	09/10/14	07/11/14	Y	Y
Associate Directors	09/10/14			
HIS Managing Director	09/10/14			
Head of R&D	09/10/14			
Head of Quality and Governance	09/10/14			
EME Services Manager	09/10/14			
Capital Planning Manager	09/10/14	13/10/14	Y	Y
Local Security Management Specialist	09/10/14	13/10/14	N	N
Staff side representative	09/10/14			
Trust Secretary	09/10/14	11/11/14	Y	Y
General Managers / Heads of department	09/10/14			
Head of Estates	08/10/14	08/10/14	Y	Y
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.

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	**Standing Financial Instructions**
What are the aims of the policy or practice?	The Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust.
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	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 Standing Financial Instructions document (annually)
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of the Standing Financial Instructions document on the Trust Intranet

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - November 2014

11-19 Trust Board Terms of Reference — Chairman of Trust Board

The Terms of Reference for the Trust Board were last reviewed in July 2013, and are therefore due their routine annual review.

The Trust Secretary has reviewed the Terms of Reference, and proposes a number of changes. None of the changes are significant, and represent 'housekeeping' i.e. to reflect the actual current practise in operation.

The revised Terms of Reference are enclosed, in two versions: a 'clean' version (with the proposed changes made), and a 'track changes' version, showing the proposed changes.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Approval

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board

Terms of Reference

Purpose and duties

1. The Trust exists to „provide goods and services for any purposes related to the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health'.

2. The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf, but the Board may delegate any of those powers to a committee of Directors or to an Executive Director. The Board consists of a Chairman (Non-Executive), five other Non-Executive Directors (voting members), the Chief Executive, and four Executive Directors (voting members). Other Directors (non-voting) also attend the Board, and contribute to its deliberations and decision-making.

3. The Board leads the Trust by undertaking three key roles:
   3.1. Formulating strategy;
   3.2. Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable;
   3.3. Shaping a positive culture for the Board and the organisation.

4. The general duty of the Board and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the patients and communities served and members of the organisation.

5. The practice and procedure of the meetings of the Board – and of its Committees – are not set out here but are described in the Board's Standing Orders and Code of Conduct.

<u>General responsibilities</u>

6. The general responsibilities of the Board are:
   6.1. To work in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, accessible, effective and well governed services for patients and carers;
   6.2. To ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity;
   6.3. To exercise collective responsibility for adding value to the Trust by promoting its success through the direction and supervision of its affairs in a cost effective manner.

7. In fulfilling its duties, the Board will work in a way that makes the best use of the skills of Non-Executive and Executive Directors.

<u>Leadership</u>

8. The Board provides active leadership to the organisation by:
   8.1. Ensuring there is a clear vision and strategy for the Trust that is implemented within a framework of prudent and effective controls which enable risks to be assessed and managed;
   8.2. Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.

<u>Strategy</u>

9. The Board:
   9.1. Sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;

9.2. Monitors and reviews management performance to ensure the Trust's objectives are met;
9.3. Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
9.4. Develops and maintains an annual plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders;
9.5. Ensure that national policies and strategies are effectively addressed and implemented within the Trust.

Culture

10. The Board is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Board is entirely consistent with those values.

11. A Board Code of Conduct has been developed to guide the operation of the Board and the behaviour of Board members.

Governance

12. The Board:
12.1. Ensures that the Trust has comprehensive governance arrangements in place that ensures that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
12.2. Ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe services taking account of patient and carer experiences;
12.3. Ensures compliance with the principles of corporate governance and with appropriate codes of conduct, accountability and openness applicable to Trusts;
12.4. Formulates, implements and reviews Standing Orders and Standing Financial instructions as a means of regulating the conduct and transactions of Trust business;
12.5. Ensures that the statutory duties of the Trust are effectively discharged;
12.6. Acts as the agent of the corporate trustee for the Maidstone and Tunbridge Wells NHS Trust Charitable Fund. This includes approving the Annual Report and Accounts of the Charitable Fund.

Risk Management

13. The Board:
13.1. Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
13.2. Ensures that there are sound processes and mechanisms in place to ensure effective patient and carer involvement with regard to the development of care plans, the review of quality of services provided and the development of new services;
13.3. Ensures there are appropriately constituted appointment arrangements for senior positions such as Consultant medical staff and Directors.

Ethics and integrity

14. The Board:
14.1. Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of Trust business;
14.2. Ensures that Directors and staff adhere to any codes of conduct adopted or introduced from time to time.

Sub-Committees

15. The Board is responsible for maintaining committees of the Board with delegated powers as prescribed by the Trust's Standing Orders and/or by the Board from time to time

Communication

16. The Board:
    16.1. Ensures an effective communication channel exists between the Trust, staff and the local community;
    16.2. Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
    16.3. Ensures that those Board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website;
    16.4. Approves the Trust's Annual Report and Annual Accounts.

Quality Success and Financial success

17. The Board:
    17.1. Ensures that the Trust operates effectively, efficiently, economically;
    17.2. Ensures the continuing financial viability of the organisation;
    17.3. Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
    17.4. Ensure that the Trust achieves the targets and requirements of stakeholders within the available resources;
    17.5. Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

Role of the Chairman

18. The Chairman is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole;

19. The Chairman is responsible for the effective running of the Board and for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives;

20. The Chairman is the guardian of the Board's decision-making processes and provides general leadership of the Board.

Role of the Chief Executive

21. The Chief Executive reports to the Board Chairman and to the Board directly.

Board Membership

22. The Board will comprise of the following persons:
    22.1. A Non-Executive Chairman
    22.2. Non-Executive Directors (5). One of these will be designated as Vice Chairman
    22.3. The Chief Executive
    22.4. The Director of Finance
    22.5. The Medical Director
    22.6. The Chief Nurse
    22.7. The Chief Operating Officer

Quorum

23. The Board will be quorate when four of the membership including at least the Chairman (or Non-Executive Director nominated to act as Chairman), one other Non-Executive Director, the Chief Executive (or Executive Director nominated to act as Chief Executive), and one other Executive Director (member) are in attendance.

Attendance

24. The Trust Secretary will attend each meeting.

25. Other staff members and external experts may be attend the Board to contribute to specific agenda items, at the discretion of the Chairman

Frequency of meetings

26. The Board will sit formally at least ten times each calendar year. Other meetings of the Board will be called as the need arises and at the discretion of the Chair.

Board development

27. The Chairman in consultation with the Trust Board will review the composition of the Board to ensure that it remains a “balanced board” where the skills and experience available are appropriate to the challenges and priorities faced;

28. Board members will participate in Board development activity designed to support shared learning and personal development.

Sub-committees and reporting procedure

29. The Board has the following sub-committees
    29.1. The Quality & Safety Committee
    29.2. The Patient Experience Committee
    29.3. The Audit and Governance Committee
    29.4. The Finance Committee
    29.5. The Workforce Committee
    29.6. The Trust Management Executive
    29.7. The Foundation Trust Committee
    29.8. The Finance Committee
    29.9. The Remuneration Committee

30. A summary report from each meeting will be provided to the Trust Board (by the chair of that meeting) in a timely manner

31. The Terms of Reference for each sub-committee will be approved by the Trust Board. The Terms of Reference will be reviewed annually, agreed by each sub-committee, and approved by the Trust Board.

Administration

32. The Board shall be supported administratively by the Trust Secretary whose duties in this respect will include:
    32.1. Agreement of the agenda for Board meetings with the Chairman and Chief Executive;
    32.2. Collation of reports for Board meetings;
    32.3. Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward on an action log;
    32.4. Advising the Board on governance matters.

33. A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in Standing Orders to all Directors and others as agreed with the Chair and Chief Executive from time to time.

Review

34. These Terms of Reference will be reviewed at least every 12 months.

Approved by the Trust Board, November 2014

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board

Terms of Reference

~~This document~~

~~1. These terms of reference describe the role and working of the Board and are for the guidance of the Board, for the information of the Trust as a whole. They also serve as the basis of the terms of reference for the Board's own committees.~~

~~Role and~~ Purpose and duties

~~2.~~1. The Trust exists to „provide goods and services for any purposes related to the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health' ~~[HEALTH & SOCIAL CARE ACT 2012].~~

~~3.~~2. The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf, but the Board may delegate any of those powers to a committee of Directors or to an Executive Director. The Board consists of ~~Executive Directors, one of whom is the Chief Executive, and Non-Executive Directors, one of whom is the Chair.~~a Chairman (Non-Executive), five other Non-Executive Directors (voting members), the Chief Executive, and four Executive Directors (voting members). Other Directors (non-voting) also attend the Board, and contribute to its deliberations and decision-making.

~~4.~~3. The Board leads the Trust by undertaking three key roles:

~~4.1.~~3.1. Formulating strategy;

~~4.2.~~3.2. Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable;

~~4.3.~~3.3. Shaping a positive culture for the Board and the organisation.

~~5.~~4. The general duty of the Board and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the patients and communities served and members of the organisation.

~~6.~~5. The practice and procedure of the meetings of the Board – and of its Committees – are not set out here but are described in the Board's S~~s~~tanding O~~o~~rders and C~~c~~ode of C~~c~~onduct.

General r~~R~~esponsibilities

~~7.~~6. The general responsibilities of the Board are:

~~7.1.~~6.1. To work in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, accessible, effective and well governed services for patients and carers;

~~7.2.~~6.2. To ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity;

~~7.3.~~6.3. To exercise collective responsibility for adding value to the Trust by promoting its success through the direction and supervision of its affairs in a cost effective manner.

~~8.~~7. In fulfilling its duties, the Board will work in a way that makes the best use of the skills of Non-Executive and Executive Directors.

Leadership

~~9.~~8. The Board provides active leadership to the organisation by:

~~9.1.~~8.1. Ensuring there is a clear vision and strategy for the Trust that ~~people know about and that~~ is ~~being~~ implemented within a framework of prudent and effective controls which enable risk~~s~~ to be assessed and managed;

~~9.2.~~8.2. Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.

Strategy

~~10.~~9. The Board:

~~10.1.~~9.1. Sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;

~~10.2.~~9.2. Monitors and reviews management performance to ensure the Trust's objectives are met;

~~10.3.~~9.3. Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;

~~10.4.~~9.4. Develops and maintains an annual ~~business~~ plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders;

~~10.5.~~9.5. Ensure that national policies and strategies are effectively addressed and implemented within the Trust.

Culture

~~11.~~10. The Board is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Board is entirely consistent with those values.

~~12.~~11. A Board Code of Conduct has been developed to guide the operation of the Board and the behaviour of Board members.

Governance

~~13.~~12. The Board:

~~13.1.~~12.1. Ensures that the Trust has comprehensive governance arrangements in place that ensures that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;

~~13.2.~~12.2. Ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe services taking account of patient and carer experiences;

~~13.3.~~12.3. Ensures compliance with the principles of corporate governance and with appropriate codes of conduct, accountability and openness applicable to Trusts;

~~13.4.~~12.4. Formulates, implements and reviews ~~s~~Standing Oorders and ~~s~~Standing Ffinancial instructions as a means of regulating the conduct and transactions of Trust business;

~~13.5.~~12.5. Ensures that the statutory duties of the Trust are effectively discharged;

~~13.6.~~12.6. Acts as the agent of the corporate trustee for the Maidstone and Tunbridge Wells NHS Trust Charitable Fund~~Trust's charitable funds~~. This includes approving the Annual Report and Accounts of the Charitable Fund.

Risk Management

~~14.~~13. The Board:

~~14.1.~~13.1. Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;

~~14.2.~~13.2. Ensures that there are sound processes and mechanisms in place to ensure effective patient and carer involvement with regard to the development of care plans, the review of quality of services provided and the development of new services;

~~14.3.~~13.3. Ensures there are appropriately constituted appointment arrangements for senior positions such as Cconsultant medical staff and ~~Executive~~ Directors.

Ethics and integrity

~~15.~~14. The Board:

~~15.1.~~14.1. Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of Trust business;

~~15.2. Establishes appeals panels as required by employment policies particularly to address appeals against dismissal and final stage grievance hearings;~~

~~15.3.~~14.2. Ensures that Directors and staff adhere to any codes of conduct adopted or introduced from time to time.

Sub-Committees

~~16.~~15. The Board is responsible for maintaining committees of the Board with delegated powers as prescribed by the Trust's Sstanding Oorders and/or by the Board from time to time

Communication

~~17.~~16. The Board:

~~17.1.~~16.1. Ensures an effective communication channel exists between the Trust, staff and the local community;

~~17.2.~~16.2. Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;

~~17.3.~~16.3. Ensures that those Board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website;

~~17.4.~~16.4. Approves ~~Publishes an~~ the Trust's A~~a~~nnual R~~r~~eport and A~~a~~nnual A~~a~~ccounts.

Quality Success and Financial success

~~18.~~17. The Board:

~~18.1.~~17.1. Ensures that the Trust operates effectively, efficiently, economically;

17.2. Ensures the continuing financial viability of the organisation;
~~18.2.~~17.3. Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;

~~18.3.~~17.4. Ensure that the Trust achieves the targets and requirements of stakeholders within the available resources;

~~18.4.~~17.5. Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

Role of the Chairman

~~19.~~18. The Chairman is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole;

~~20.~~19. The Chairman is responsible for the effective running of the Board and for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives;

~~21.~~20. The Chairman is the guardian of the Board's decision-making processes and provides general leadership of the Board.

Role of the Chief Executive

~~22.~~21. The Chief Executive ~~(CEO)~~ reports to the Board Chairman and to the Board directly. ~~All members of the management structure report either directly or indirectly, to the CEO~~

~~23. The CEO is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board;~~

~~24. The CEO is responsible for implementing the decisions of the Board and its committees, providing information and support to the Board.~~

Board Membership

~~25.~~22. The Board will comprise

~~25.1.~~22.1. A Non-Executive Chairman
~~25.2.~~22.2. Non-Executive Directors (5). One of these will be designated as Vice Chairman
~~25.3.~~22.3. The Chief Executive
~~25.4.~~22.4. The Director of Finance
~~25.5.~~22.5. The Medical Director

25.6.22.6. Director of NursingThe Chief Nurse
25.7.22.7. The Chief Operating Officer

Quorumacy

26.23. The Board will be quorate when four of the membership including at least the Chairman (or Non-Eexecutive Director nominated to act as Chairman), one other Non-Eexecutive Director, the Chief Executive (or Executive Director nominated to act as Chief Executive), and one other Executive Director (member) are in attendance.

Attendance

24. In attendance:
Other Executive Directors (Non-Voting) The Trust Secretary will attend each meeting.

- Associate Non-Executive Directors operating in an advisory capacity

25. By invitation as required Other staff members and external experts may be attend the Board to contribute to specific agenda items at the discretion of the Chairman

Frequency of meetings

27.26. The Board will sit formally at least six ten times each calendar year. of which at least four times shall be in public. Other meetings of the Board will be called as the need arises and at the discretion of the Chair.

Board development

28.27. The Chairman in consultation with the Trust Board will review the composition of the Board to ensure that it remains a “balanced board” where the skills and experience available are appropriate to the challenges and priorities faced;

28. Board members will participate in Board development activity designed to support shared learning and personal development.

Sub-committees and reporting procedure

29. The Board has the following sub-committees
29.1. The Quality & Safety Committee
29.2. The Patient Experience Committee
29.3. The Audit and Governance Committee
29.4. The Finance Committee
29.5. The Workforce Committee
29.6. The Trust Management Executive
29.7. The Foundation Trust Committee
29.8. The Finance Committee
29.9. The Remuneration Committee

30. A summary report from each meeting will be provided to the Trust Board (by the chair of that meeting) in a timely manner

31. The Terms of Reference for each sub-committee will be approved by the Trust Board. The Terms of Reference will be reviewed annually, agreed by each sub-committee, and approved by the Trust Board.

~~Other Matters~~Administration

29.32. The Board shall be supported administratively by the Trust Secretary whose duties in this respect will include:

29.1.32.1. Agreement of the agenda for Board meetings with the Chairman and Chief Executive;

29.2.32.2. Collation of reports ~~and papers~~ for Board meetings;

29.3.32.3. Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward on an action log;

29.4.32.4. Advising the Board on governance matters.

30.33. A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in S~~s~~tanding O~~o~~rders to all Directors and others as agreed with the Chair and Chief Executive from time to time.

Review

31.34. These T~~t~~erms of R~~r~~eference ~~for the Board~~ will be reviewed at least every 12 months.