

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

10.30am¹ – c.1pm WEDNESDAY 30TH NOVEMBER 2016

PENTECOST/SOUTH ROOMS, THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – P A R T 1

Ref.	Item	Lead presenter	Attachment
11-1	A patient's experiences of the Trust's services ²	Chief Nurse/Medical Director ³	Verbal
11-2	To receive apologies for absence	Chairman	Verbal
11-3	To declare interests relevant to agenda items	Chairman	Verbal
11-4	Minutes of the Part 1 meeting of 19 th October 2016	Chairman	1
11-5	To note progress with previous actions	Chairman	2
11-6	Safety moment	Chief Nurse	Verbal
11-7	Chairman's report	Chairman	Verbal
11-8	Chief Executive's report	Chief Executive	3
11-9	Review of the Board Assurance Framework, 2016/17	Trust Secretary	4
11-10	Integrated Performance Report for October 2016 <ul style="list-style-type: none"> ▪ Safe / Effectiveness / Caring ▪ Safe / Effectiveness (incl. HSMR) ▪ Safe (infection control) ▪ Well-Led (finance) ▪ Effectiveness / Responsiveness (incl. DTOCs) ▪ Well-Led (workforce) 	Chief Executive Chief Nurse Medical Director Chief Nurse Director of Finance Chief Operating Officer Director of Workforce	5
Quality items			
11-11	Supplementary Quality and Patient Safety report	Chief Nurse	6
11-12	Planned and actual ward staffing for Oct 2016	Chief Nurse	7
11-13	The "Trauma & Orthopaedics 2020" programme	Chief Operating Officer	8
11-14	Update on IT-related issues within Ophthalmology	Medical Director	9
Planning and strategy			
11-15	2016/17 Winter & Operational Resilience Plan (final)	Chief Operating Officer	10
11-16	Review of the Trust's draft Planning submissions for 2017/18 and 2018/19 (including the budgets)	Director of Finance	11
11-17	The Kent and Medway Sustainability and Transformation Plan	Chief Executive	12
Assurance and policy			
11-18	Ratification of Standing Orders, Standing Financial Instructions & Reservation of Powers & Scheme of Delegation (ann. review)	Trust Secretary / Director of Finance	13, 14 & 15
Reports from Board sub-committees (and the Trust Management Executive)			
11-19	Audit and Governance C'ttee, 03/11 (incl. approval of revised ToR)	Committee Chair	16
11-20	Quality Committee, 09/11/16 (incl. SIs)	Committee Chair	17
11-21	Trust Management Executive, 16/11	Committee Chair	18
11-22	Finance C'ttee, 28/11	Committee Chair	19 (to follow)
11-23	Charitable Funds Committee, 28/11	Committee Chair	Verbal
Other matters			
11-24	Ratification of approval of "Uncommitted Single Currency Interim Revenue Support Facility Agreement"	Trust Secretary / Director of Finance	20
11-25	To consider any other business		
11-26	To receive any questions from members of the public		
11-27	To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted	Chairman	Verbal
Date of next meeting: 21 st December 2016, 10.30am, Education Centre, Tunbridge Wells Hospital			

**Anthony Jones,
Chairman**

¹ As item 11-1 will be held in private session, the main meeting (items 11-2 onwards) will start at 11.15am

² Representatives of the press and public will be excluded from the meeting during discussion of this item by reason of the confidential nature of the business to be transacted

³ A patient will also be in attendance for this item

**MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING
(PART 1) HELD ON WEDNESDAY 19TH OCTOBER 2016, 10.30A.M AT
TUNBRIDGE WELLS HOSPITAL**

FOR APPROVAL

Present:	Anthony Jones	Chairman of the Trust Board	(AJ)
	Avey Bhatia	Chief Nurse	(AB)
	Sylvia Denton	Non-Executive Director	(SD)
	Glenn Douglas	Chief Executive	(GD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Jim Lusby	Deputy Chief Executive	(JL)
	Steve Orpin	Director of Finance	(SO)
	Paul Sigston	Medical Director	(PS)
	Kevin Tallett	Non-Executive Director	(KT)
In attendance:	Richard Hayden	Director of Workforce	(RH)
	Carole Jones	Clinical Director, Head and Neck <small>(for item 10-9)</small>	(CJ)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Kevin Rowan	Trust Secretary	(KR)
	Kym Sullivan	Associate Director of Operations, Women's, Paediatrics & Sexual Health <small>(for item 10-9)</small>	(KS)
Observing:	Annemieke Koper	Staff Side representative	(AKo)
	Darren Yates	Head of Communications	(DY)
	David East	Member of the Public	(DE)

10-1 To receive apologies for absence

Apologies were received from Angela Gallagher (AG), Chief Operating Officer; and Alex King (AK), Non-Executive Director.

10-2 To declare interests relevant to agenda items

KT reported that he continued to be engaged (via his company, Discidium Ltd) by Medway NHS Foundation Trust to deliver Programme Management Office (PMO) Services.

10-3 Minutes of the Part 1 meeting of 28th September 2016

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

10-4 To note progress with previous actions

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

- **9-8i (“Ensure the Trust Board receives the outcome of the planned review of Medical rotas being led by the Medical Director”)**. PS stated that he had no further knowledge to report regarding the new Junior Doctors contract/dispute, but the second tranche of Juniors (the Foundation Year 1 doctors) would transfer to the new contract in mid-December 2016.

AJ asked for clarification that if the implementation of the contract proceeded according to national plans, that this would be in place for all Junior Doctors by March 2017. PS clarified that full implementation would in fact take place over 18 months.

AJ then asked PS to comment on other Medical rotas. PS explained the work that was being undertaken. AJ requested that the action be kept open, and that PS give an update at each Trust Board meeting.

- **9-21ii (“Arrange for the incoming Risk and Compliance Manager to be introduced to the Trust Board after they commence in post”).** AJ proposed that the new post-holder attend a Board meeting. GD suggested the individual’s attendance could be combined with Risk Management training for the Board. KR acknowledged the suggestion, but noted that the November 2016 Board meeting took place only 2 days after the person started at the Trust.
- **9-21iii (“Circulate, to Trust Board Members, a breakdown of the reported incidents of “violence and abuse” that were referred to in the Health & Safety Annual Report for 2015/16”).** GD opined that data should be available and would have likely been reported to the Health & Safety Committee. KR agreed to liaise with AG regarding the data.

10-5 Safety moment

AB reported the following points:

- The Safety Calendar subject for October was Infection Prevention and Control, and there was a key focus on ‘back to basics’
- The Root Cause Analyses (RCAs) into recent infection cases had identified a need for more education about the timely collection of stool specimens, so work had taken place on this
- A video on commode cleaning had also been developed and issued, along with a quiz for staff

SM offered to circulate the quiz to all Trust Board Members. This was agreed.

Action: Circulate, to Trust Board Members, the Infection Prevention and Control quiz that had been issued as part of the October Patient Safety Calendar (Director of Infection Prevention and Control, October 2016)

AB continued that there was a thread on the staff forum (on the Intranet), whilst the specific focus for w/c 24/10/16 was audit, with the final week of October being concerned with promoting the use of protective equipment.

SM then added that Ultraviolet (UV)-C light decontamination had been introduced and the company providing the equipment had informed SM that the Trust was carrying out more UV light decontamination than any other Trust in the country. SM added that further work was required with the company to obtain detailed statistics on the use of the equipment, as well as have a programme for use in side-rooms and sluices, for example. AJ asked whether the equipment was just in use at Tunbridge Wells Hospital (TWH). SM confirmed that it was also in place at Maidstone Hospital (MH), albeit to a lesser extent.

AJ then noted the Trust’s previous policy regarding the prompting of visitors to clean their hands had been discussed at the Finance Committee on 17/10/16, and asked SM whether there was any further action required in relation to this. SM replied that the only concern she had regarding visitors was those attending the Trust’s hospitals with Norovirus-related symptoms. SM continued that the Trust’s main switchboard telephone message would therefore need to be changed, to emphasise the need for visitors to avoid attending the hospitals with such symptoms. AJ queried whether a statement should also be issued to the media. SM agreed this should be done.

Action: Arrange for a statement to be issued to the media emphasising the need for visitors to avoid attending the Trust’s hospitals if they had experienced Norovirus-related symptoms (Director of Infection Prevention and Control, October 2016 onwards)

10-6 Chairman’s report

AJ reported that the Trust Board supported whatever action was required to ensure the best for the patients of Kent and Medway. AJ said that there were no institutional allegiances that would lead to resistance of the actions required, as the Board was only interested in what was best for patients overall.

10-7 Chief Executive’s report

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

- The engagement process in relation to the STP had started, and some basic information had been issued to the public. The next formal STP submission was due at the end of that week, and there was an expectation that the STP document would be part of the formal Trust Board

pack of information, if not in November, then in December 2016. The STP would inevitably lead to changes as to how care was delivered, but this should be seen in a positive context

- The Trust was no longer the sole local Trust in Financial Special Measures, as some neighbouring Trusts had now been placed in that regime. At the end of 2015/16, the Trust's deficit of £23.4m was less than 16-17% of the total provider-related deficit for the whole of Kent and Medway, and the situation for 2016/17 was worse for other providers
- Winter was coming, and the physical changes required to accommodate patients during that period had started. This primarily focused on the establishment of an Orthopaedic Unit at MH, to aim to protect elective activity
- Some Trust Board Members had received flu inoculation injections, and those that had not were encouraged to do so. A proportion of the Trust's income was linked to the number of staff inoculated.

GD then continued, and reported the following points:

- GD had spent part of a recent day with Baroness Julia Cumberledge, who visited to see the Trust's Maternity pathway, which encompassed Crowborough Birthing Centre, TWH and the Maidstone Birthing Centre
- AJ had attended the 'Lung awareness day' at MH
- GD had again participated in the visit to the A&E Department from children at Oakley School in Tunbridge Wells, which was part of a programme to 'debunk' some of the myths in relation to patients with a Learning Disability. GD expressed his gratitude to Teresa Jarrett for organising the visit, and Dr Matt Milner, who was very well received by the pupils. GD encouraged Trust Board Members to attend future such events. AJ requested that Board Members be notified of any future dates. This was agreed.

Action: Arrange for Trust Board Members to be notified of the dates of any future events organised as part of the Trust's ongoing campaign to make A&E a less daunting place to individuals with a learning disability (Trust Secretary, October 2016 onwards)

10-8 Integrated Performance Report for September 2016

GD referred to the circulated report and placed the Trust's performance in the context of being at the mid-point of performance among other local providers. GD added that the Trust was managing as well as could be expected with the pressures it faced, and noted that performance on the A&E 4-hour waiting time target was being used as a bell-wether, and the Trust was performing satisfactorily. AJ noted that weekly comparative performance data for the A&E 4-hour waiting time target had been sent to AJ by GD, and GD offered to share this with all Trust Board Members. AJ confirmed this would be welcome.

Action: Arrange for Trust Board Members to be added to the circulation list for the weekly comparative performance data for the A&E 4-hour waiting time target (Trust Secretary, October 2016 onwards)

SD remarked that although there was a tendency to focus on the negative, the Trust did not control a number of the factors affecting performance, particularly, for example, in relation to access to care packages, and therefore staff should be congratulated for the work they did. GD agreed with the sentiment that access to care packages was the single biggest problem, and noted that a vast majority of such packages were provided by individuals from eastern Europe. GD added that the recent external context, including the exchange rate between Sterling and the Euro, had exacerbated the issues.

GD then invited AB to highlight any issues arising from the Integrated Performance Report.

Safe / Effectiveness / Caring

AB reported the following points:

- Progress had been made in relation to falls, and the rate of patient falls at TWH had improved, when compared to the same month in the previous year
- The 'red' area was "% complaints responded to within target", but many of the complaints had been complex, and were awaiting a response from partner organisations, despite the Trust's

response being ready (complainants preferred a single response to be sent). Performance had however also been affected by some Directorate-related issues

SDu asked whether there was any correlation between the reorganisation of the complaints process and the recent performance issues. AB replied that the reorganisation had had a very positive impact up until September, but the Directorates had been very busy in September. AB stated that she was however confident that performance would improve. GD queried whether it would be appropriate to provide a response to the complainant at the point this had been completed at the Trust, and then provide the rest of the response once the other providers involved had completed their response. GD added that having seen a number of the complex complaints, many of the issues were distinct and could therefore be responded to separately. AB agreed to consider whether the Trust's approach to responding to such complaints should be amended.

Action: Consider whether the Trust's approach to responding to complaints involving other organisations should be amended in light of the decline in performance on the “% complaints responded to within target” indicator in September 2016 (Chief Nurse, October 2016 onwards)

Safe / Effectiveness (incl. HSMR)

PS referred to the circulated report and highlighted that:

- The Summary Hospital-level Mortality Indicator (SHMI) for the “Prev Yr” “Year to Date” was not 311.7 as reported in the Dashboard
- Dr Foster had now provided a report on the Hospital Standardised Mortality Ratio (HSMR), and at present, there appeared to be no particular diagnostic groups that were of concern. However, the matter was still under investigation

AJ noted that “Crude Mortality” had remained stable. PS clarified that there had been some small changes, and this had been included in the aforementioned report he had received from Dr Foster.

KT suggested that a further report on mortality be given at the next meeting. SDu pointed out that a ‘review of mortality’ had been scheduled for a Quality Committee ‘deep dive’ on 13/12/16.

AJ then asked PS to comment on Length of Stay (LOS) performance. PS replied that this was related to the issues discussed earlier in the meeting. SM noted that as the Clinical Lead for LOS, there had been very strong engagement with all relevant staff, and although the challenge was substantial, due to the multi-factorial nature of the issue, there was cause for optimism. AJ acknowledged the complexity and the impact of external factors.

SDu then noted the recent adverse media attention regarding workload, and asked for a comment on the overall level of morale among clinical staff, and in particular whether there was a need to congratulate such efforts. AJ acknowledge the point, but stated that he believed the attitude and approach demonstrated at the Trust Management Executive (TME) meeting on 12/10/16 had been very positive. PS remarked that there was an element of stress among staff at the Trust, given the increasing activity. AJ noted that he believed the last staff survey was positive, and asked when the next survey results were due. RH replied that the results were likely to be available in February 2017, but noted that the Executive Team were continuing to engage actively with staff. SDu asked whether it was worth erecting message boards at the front entrance of the Trust's hospitals, highlighting the increased activity with which staff had to contend, and provide a context for the care being provided. GD replied that it may instead be beneficial to aim to increase the wider understanding, including within the media, of the current circumstances. SDu continued and suggested that the electronic message boards in the Outpatient waiting areas could also be utilised to provide information on the numbers of patients being seen. GD noted that there were approximately 500,000 Outpatient attendances each year. AJ agreed this was worthy of consideration, but expressed caution that the activity levels should not provide justification for providing less than optimal care. AJ therefore proposed that JL reflect on the comments and suggestions made, and submit a report to the next Trust Board meeting. This was agreed.

Action: Submit a report to the Trust Board, in November 2016, with a considered response to the suggestions made at the meeting on 19/10/16 to raise patients' and visitors'

awareness of the level of activity undertaken by the Trust (Deputy Chief Executive, October 2016 onwards)

Safe (infection control)

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

- There had been 2 cases of Clostridium difficile last month, which still left the Trust over the required trajectory
- There had still been no cases of MRSA bacteraemia
- MRSA screening showed a strong performance. SM had recently visited another Trust that had been pleased to achieve only 65% compliance

AJ asked whether the performance against the Clostridium difficile trajectory had been disrupted by the cases that occurred in July 2016. SM confirmed this was the case, and added that those cases had been felt to be due to the opening of windows during the hot weather, and not cross-infection. SM added that the advice arising from these cases was therefore to open windows prudently.

Well-Led (finance)

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

- The Trust had now agreed to the delivery of the control total with NHS Improvement (NHSI) and September was the first month this had been reflected
- NHS Constitution-related penalties had therefore been removed. If all such one-off items were excluded, the Trust was broadly performing as was expected
- Agreeing to the control total enabled the Trust to access the Sustainability and Transformation Fund (STF), although the monies for Quarter 1 of the STF were not accessible, as the Trust had not agreed to the control total during that Quarter
- The STF funding was weighted towards achievement of certain access targets
- Three other Trusts had now joined the Financial Special Measures regime: Brighton and Sussex University Hospitals NHS Trust, East Sussex Healthcare NHS Trust, and Gloucestershire Hospitals NHS Foundation Trust
- The Trust had a further review meeting with NHSI in November
- The Financial Improvement Director was on site that week
- A revised pack of information had been reviewed at the Finance Committee on 17/10/16, and weekly updates were considered at the Executive Team and within Divisions/Directorates

KT noted that there were many 'red'-rated indicators on the Performance Dashboard that related to Referral to Treatment (RTT) targets, and queried whether this was likely to lead to a form of 'RTT special measures'. GD clarified that the Trust was not in the bottom cohort of RTT performers, but acknowledged that the Trust had a problem, particularly with the size of the "RTT Incomplete Admitted Backlog". AJ queried whether the "RTT Incomplete Non-Admitted Backlog" data reported was accurate. GD explained that the data was taken at a point in time, but acknowledged that the accuracy of the data was worthy of checking.

Action: Arrange for the performance on the "RTT Incomplete Non-Admitted Backlog" indicator that was reported to the Board on 19/10/16 to be checked, to ensure the accuracy of the data (Chief Operating Officer, October 2016 onwards)

KT proposed that the Trust Board receive some further commentary on RTT performance at the next meeting. This was agreed.

Action: Include further commentary on the Trust's performance on the Referral to Treatment targets within the Integrated performance report submitted to the Trust Board in November 2016 (Chief Operating Officer, November 2016)

Effectiveness / Responsiveness (incl. DTOCs)

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

- The previous week had seen record levels of Delayed Transfers of Care (DTOCs), which had reached 9% for the first time, and which reflected a system-wide problem

- The Trust's performance on the 2-week Cancer waiting time target was close to the required level, although there were some issues relating to patient choice. However, an agreement to introduce e-referrals should address this
- The largest issue related to lower Gastrointestinal (GI) Cancer, and the Trust was preparing for an internal summit to tackle this
- A further meeting with Consultant Medical staff had been scheduled to discuss the Stroke performance

KT asked why there was "No data" reported for the "Ambulance Handover Delays >30mins" and "Ambulance Handover Delays >60mins" indicators. JL agreed to check why the data was not available, but stated that the Trust was among the better performers in the South East for Ambulance handovers. GD agreed that this had not been raised as an issue by South East Coast Ambulance Service NHS Foundation Trust.

Action: Check why there was "No data" reported for the "Ambulance Handover Delays >30mins" and "Ambulance Handover Delays >60mins" indicators within the Integrated performance report submitted to the Trust Board on 19/10/16 (Deputy Chief Executive, October 2016)

Well-led (workforce)

RH then referred to the circulated report and pointed out the following:

- Although there had been an improvement in sickness absence in the month, there had been a high level of turnover in back-office functions.
- The reported number of appraisals on the Dashboard was still not a true reflection of the appraisals that had actually occurred

AJ asked why the "Staff Turnover Rate" was rated as 'green'. RH explained that the Plan was for a rate of 10.5%. AJ acknowledged the point but noted the "Bench Mark" level was 8.4%. RH agreed to review the source and appropriateness of the "Bench Mark" percentage.

Action: Check the source and appropriateness of the "Bench Mark" percentage for the "Staff Turnover Rate" indicator within the Integrated performance report submitted to the Trust Board on 19/10/16 (Director of Workforce, October 2016)

Presentation from a Clinical Directorate

10-9 Head and Neck

AJ welcomed CJ to the meeting. CJ then gave a presentation containing the following points:

- The Directorate comprised ENT and Ophthalmology, with associated services (i.e. Audiology, Orthoptics, and Optometry).
- Ophthalmology also provided services in Medway and Swale, and both specialities also had strong community links
- There was a large dedicated Outpatients and Day Case Unit, but there was limited access to Inpatient beds
- There were 200 WTE staff, which encompassed 62 Nurses, 50 Medical staff, 61 Administrative staff, and 27 scientific staff.
- The Directorate planned to make a financial contribution of £15m for 2016/17
- In terms of current financial performance, the Directorate was on course to achieve a £240k slippage against the CIP target (25%), and was only 50% towards achieving the Financial Recovery Plan (FRP) control total
- In terms of access targets, Ophthalmology was achieving the 18-week waiting time target; Audiology had achieved the 6-week diagnostic target; and ENT was progressing to achieve 18-week wait target
- In terms of quality targets, the Directorate had a 100% performance on complaints response & Nursing audits; and the mock Care Quality Commission (CQC) inspection had been positive – the few actions that arose were focused on staff awareness of risk assessments and signage

KS then noted that there had been a capacity problem regarding Ophthalmology follow-up and macular degeneration/diabetic macular oedema treatment. AJ queried whether the condition could

be treated by GPs. CJ confirmed this was not possible. PS pointed out that only 10 years ago, it had not been possible to treat the condition at all.

CJ then continued, and highlighted the following risks that related to the Directorate:

- ENT Cancer provision involved a small number of complex treatments using different disciplines for diagnostics and treatments
- There were bed pressures for ENT admissions (there was no Inpatient ENT service at MH)
- There was acute need for high quality IT support, particularly in related to the eNotes and OpenEyes systems, and the images server

AJ noted that the Trust's IT strategy had been discussed at the Finance Committee on 17/10/16, but he did not recall any Ophthalmology issues being mentioned. KT clarified that the eNotes system had been covered at the Committee to some extent. CJ stated that there was a need for the Directorate to liaise more closely with IT, and KS added that such liaison was in development. SDu asked that an update be given to the next Board meeting on the reported IT problems. This was agreed. PS stated that he would address a report from the Director of Health Informatics.

Action: Submit a report to the Trust Board, in November 2016, on the latest situation regarding the IT-related issues within Ophthalmology that were reported at the Trust Board on 19/10/16 (Medical Director, November 2016)

CJ then continued, and highlighted the following points:

- The Directorate's challenges included Medical staffing recruitment and job design, and it was acknowledged that novel approaches were required to address such challenges
- The Directorate was developing non-medical clinicians to perform medical tasks. The Ophthalmic Nurse training scheme that had recently been re-started had resulted in a tranche of new and interested individuals and it was hoped to develop such staff
- There were a number of IT requirements to support the service and for future developments, particularly in relation to enabling access in the community, and the sharing of information
- The CIP targets were a challenge, and the Directorate was aligning with the recommendations from the Lord Carter efficiency work. The Directorate was aware it was falling short at present

KS added that the Service Line Reporting (SLR) 'deep dive' review that had been undertaken had however been positive in identifying issues for improvement.

CJ said that:

- In terms of opportunities, it was positive that there was a single provider in a growing area with a demographic profile who required the Trust's services. The Unit was also well-functioning and established, with the prospect of good community provider integration
- There was an opportunity to develop the range of specialist services provided, and there was a previous history of undertaking such development. Work was taking place on developing clinics to cross different specialties
- The Directorate was innovative in relation to IT, and there were plans for new systems for virtual clinics, to provide services more efficiently
- Future improvements including developing ways of reducing unnecessary investigations (such as a Neuro- and joint thyroid clinic); developing new models of providing care (virtual clinic, Nurse injectors); and further developing sub-specialism (cornea and oculoplastics). Some of the latter developments would involve liaison with Queen Victoria NHS Foundation Trust

PS thanked CJ for returning to the Trust and accepting the Clinical Director (CD) role. CJ emphasised the importance of KS.

KT then asked for the £15m reported contribution value to be reconciled with the findings of the aforementioned SLR 'deep dive' review. KS noted that there had been improvements since the 'deep dive', and CJ added that Theatres were not part of the Directorate (i.e. they just provided a service). KS then confirmed that the Directorate was making a positive contribution, but the aforementioned £15m was likely to be related to 2015/16 as the contribution was expected to be less for 2016/17. AJ noted the importance of contribution, but stated that fixed costs also had to be covered.

AJ asked whether East Kent Hospitals University NHS Foundation Trust (EKHUFT) provided their own Ophthalmology service. KS confirmed this was the case, and noted that EKHUFT had just issued advertisements for a further 7 Consultants. KS added that if all of these posts were filled, EKHUFT would have a higher number of Consultants than the Trust, for a smaller population. KT asked whether this would lead to a threat to the Trust's service. KS confirmed that this was not anticipated.

PS then asked for details of the Directorate's level of turnover. SO replied that income-generated income was £16.7m for the year to date. KS remarked that this explained why the Directorate had achieved their CIP target in previous years, but as income was not allowed for CIP schemes for 2016/17, the Directorate had struggled.

AJ thanked KS and CJ for their presentation.

Quality Items

10-10 Planned and actual ward staffing for September 2016

AB referred to the circulated report and highlighted that the planned staffing levels would have to be re-based in some areas, but there were no concerns she wished to raise.

10-11 Trust Board Members' hospital visits

KR referred to the circulated report and stated that the new framework for visits had replaced the previous pairing arrangements.

AJ highlighted the need for certain Board members, including himself, to undertake further visits. SD acknowledged the point, but noted that she often undertook visits as a 'mystery shopper'. SD continued that her grandson had to attend recently for treatment for a fracture, and the treatment he received was incredible. SD noted that she wished to have this acknowledged. AJ asked PS to pass on SD's thanks to the Department.

KT then asked whether the new framework applied to Non-Executive Directors (NEDs), noting that the previous pairing arrangements had included NEDs. KR confirmed the new framework did not include NEDs. AJ therefore proposed that JL, KR and himself consider what could be done to incorporate NEDs, noting that previous frameworks had had limited success.

Action: Liaise to consider how Non-Executive Directors could be incorporated into the formal framework for Ward/Departmental visits recently developed for Executive Directors (Trust Secretary / Deputy Chief Executive / Chairman of the Trust Board, October 2016 onwards)

Planning and strategy

10-12 Update on 2016/17 Winter and Operational Resilience Plan

JL referred to the circulated report and highlighted that the 'Home First' initiative was a key component, and it may be beneficial for the Board to receive a presentation on the subject. AJ agreed with the suggestion and asked KR to liaise with JL to agree the most appropriate time to schedule a presentation.

Action: Liaise to agree the most appropriate month to schedule a Trust Board presentation on the "Home First" model (Trust Secretary / Deputy Chief Executive, October 2016 onwards)

JL then continued, and highlighted the following points:

- The Trust's plan was well-organised, but stand-alone actions would be insufficient
- The Trust had taken control of the local Systems Delivery Board, which gave an opportunity to do things differently with partner organisations. There was also some cause for optimism in terms of the level of engagement with community and Social Services, although this needed to be translated into action

KT referred to "Operation Polar" on page 2, and asked whether the Trust was chairing the exercise. JL replied that although West Kent Clinical Commissioning Group (CCG) was the official lead for the exercise, the Trust was the host.

JL then referred to the bed configuration proposals and noted that these had been discussed at the last Trust Board meeting (Part 2).

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

10-13 Workforce Committee, 29/09/16 (incl. approval of revised Terms of Reference)

AJ referred to the circulated report and highlighted that:

- The Trust would lose £850k as a levy for the introduction of Apprenticeships, although this could be claimed back if the Trust established sufficient Apprenticeships. This was therefore a good opportunity to earn back the Trust's money and therefore the evolving plan would be submitted to the Committee in December
- The latest Medical Education Trainee survey showed a number of 'red flags' and the Director of Medical Education (DME) would develop a plan and submit this to the Committee

PS added that the latest GMC Trainee survey now showed the Trust to be one of the worst in the country in relation to 'red flags', but it was acknowledged that action needed to be taken. KT likened PS's remarks to those heard previously during his time as a NED. PS clarified that he did not recall the findings from previous surveys being as poor.

AJ then referred to the Terms of Reference (Appendix 1) and pointed out that the Board's approval was requested. KR proposed that in addition to the proposed changes in the report, the "Management Committee Structure" chart be removed, as such charts did not feature within the Terms of Reference of other Board sub-committees, and a Committee structure chart was maintained as a separate document. This was agreed.

The Trust Board approved the other proposed changes to the Terms of Reference as circulated.

10-14 Quality Committee, 05/10/16

RH referred to the circulated report and stated that the "Review of Women's services" was a work in progress, as the new CD had demonstrated a desire to resolve the issues, which the Trust had not effectively resolved as yet. PS acknowledged that the previous actions taken had not been effective in achieving change, but further actions were now being taken.

SDu added that the other issue explored at the meeting was compliance with the CQC domains, and it had been agreed to try and identify what external information was available on the Trust, noting that the CQC had access to a range of external information ahead of their inspections.

10-15 Trust Management Executive, 12/10/16

JL referred to the circulated report and noted that some specific actions had been agreed regarding communication.

10-16 Finance Committee, 17/10/16 (incl. approval of the Trust's Procurement Transformation Plan)

SDu referred to the circulated report (Attachment 12) and communicated the following points:

- The Director of Health Informatics had attended
- The FRP had been considered in detail, but the agenda was wide-ranging

SO then referred to Attachment 11 and noted that the Trust was required to have a Procurement Transformation Plan. SO continued that the Plan that had been developed had built on the previous work the Trust had undertaken (about which Board members were aware), and the updated version had been discussed at the Finance Committee, where it had been agreed to recommend for the Board's approval.

AJ queried whether the ratings in the "Trust Procurement Performance" indicated a high level of confidence in the achievement of the measures. SO clarified that confidence was not being measured in the rating, but the Trust was on course to deliver the Plan.

The Trust Board approved the Procurement Transformation Plan as circulated.

KR then referred to page 2 of Attachment 12, and noted that Committee had agreed that the Trust Board should be asked to consider a proposal regarding the principle that each Board sub-committee undertake an annual evaluation. KR duly proposed that the sub-committee evaluations be undertaken each year, but that the format and method be left up to the individual sub-committee, as a 'one size fits all' approach was not appropriate, given the different needs of each committee. The proposal was approved.

10-17 To consider any other business

No other business was raised.

10-18 To receive any questions from members of the public

There were no questions.

10-19 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.

Trust Board Meeting – November 2016

11-5	Log of outstanding actions from previous meetings	Chairman		
Actions due and still 'open'				
Ref.	Action	Person responsible	Original timescale	Progress ¹
9-8i (Sep 15)	Ensure the Trust Board receives the outcome of the planned review of Medical rotas being led by the Medical Director	Trust Secretary / Medical Director	September 2015 onwards (but then extended to March 2016)	The Finance Committee discussed a "Medical productivity: proposed way forward" report, at its meeting on 28/11/16, which noted the intention implement standard Rota Management processes to ensure consistency across all Divisions. It is therefore proposed that updates on that (plus the other aspects covered within the Finance Committee report) be reported to the Finance Committee in the first instance, before onward reporting to the Board (and therefore that the action as worded be closed)
9-14ii (28 th Sept 16)	Arrange for the Quality Committee to consider the findings and responses to the two Orthopaedic implant related Never Events that occurred in May 2014 and August 2016 respectively	Trust Secretary / Chief Nurse / Medical Director	September 2016 onwards	The latest Never Event had not been considered by the Learning & Improvement (SI) Panel by the time of the November 'main' Quality Committee, so the item has now been scheduled for the 'main' Quality Committee in January 2017
9-21ii (28 th Sept 16)	Arrange for the incoming Risk and Compliance Manager to be introduced to the Trust Board after they commence in post	Trust Secretary	September 2016 onwards	It is intended to introduce the individual to Trust Board Members on 30/11/16 (during the lunch break)
10-8iii (Oct 16)	Submit a report to the Trust Board, in November 2016, with a considered response to the suggestions made at the meeting on 19/10/16 to raise patients' and visitors' awareness of the level of activity undertaken by the	Deputy Chief Executive	November 2016	As the Deputy Chief Executive would not be at the Trust Board in November 2016, it was agreed to defer this to the December 2016 Board meeting

1

Not started

On track

Issue / delay

Decision required

Ref.	Action	Person responsible	Original timescale	Progress ¹
	Trust			
10-11 (Oct 16)	Liaise to consider how Non-Executive Directors could be incorporated into the formal framework for Ward/Departmental visits recently developed for Executive Directors	Trust Secretary / Deputy Chief Executive / Chairman of the Trust Board	October 2016 onwards	The matter is still under consideration (but will be concluded before the December 2016 Trust Board meeting)

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
9-13 (28 th Sept 16)	Amend the Board Assurance Framework to reflect the comments made at the Trust Board on 28/09/16	Trust Secretary	November 2016	The BAF reported to the November 2016 Board meeting reflects the requested amendments. In particular, explaining the Hilton model (for risk 2), changing the wording of risk 3 (to "The Trust does not have the <i>right correct</i> level of substantive workforce for effective delivery") and reflecting the potential impact of the Sustainability and Transformation Plan (STP) for risk 4
9-16 (28 th Sept 16)	Submit a report to the Trust Board, in November 2016, on the progress with the "Trauma & Orthopaedics 2020" programme	Chief Operating Officer	November 2016	The requested report has been submitted to the November 2016 Board
9-21iii (28 th Sept 16)	Circulate, to Trust Board Members, a breakdown of the reported incidents of "violence and abuse" that were referred to in the Health & Safety Annual Report for 2015/16	Chief Operating Officer	November 2016	The requested breakdown was circulated to Trust Board Members by email on 10/11/16
10-5i (Oct 16)	Circulate, to Trust Board Members, the Infection Prevention and Control quiz that had been issued as part of the October Patient Safety Calendar	Director of Infection Prevention and Control	October 2016	The quiz was circulated by email on 20/10/16
10-5ii (Oct 16)	Arrange for a statement to be issued to the media emphasising the need for visitors to avoid attending the Trust's hospitals if they had experienced Norovirus-related symptoms	Director of Infection Prevention and Control	November 2016	A press release has been agreed, and has been issued. The top banner on the Trust's Internet front page now includes a norovirus message, with a link to the Infection Control page (which has been updated). A Twitter alert will also be issued

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
				regularly (especially when Wards are closed to visitors).
10-7 (Oct 16)	Arrange for Trust Board Members to be notified of the dates of any future events organised as part of the Trust's ongoing campaign to make A&E a less daunting place to individuals with a learning disability	Trust Secretary	November 2016	The P.A. to the Chief Executive (who is involved in the organisation of such events) has agreed to notify Trust Board Members of any future events (which arise on an ad-hoc basis)
10-8i (Oct 16)	Arrange for Trust Board Members to be added to the circulation list for the weekly comparative performance data for the A&E 4-hour waiting time target	Trust Secretary	November 2016	The Trust Secretary has arranged to be added to the circulation list (the information is provided by NHS Improvement), and will forward these on to the Trust Board Members that are not already included as and when they are received
10-8ii (Oct 16)	Consider whether the Trust's approach to responding to complaints involving other organisations should be amended in light of the decline in performance on the "% complaints responded to within target" indicator in September 2016	Chief Nurse	November 2016	This issue has been considered, and the best guidance is clear that the complainants should be asked if they wish to receive a full or partial response (which is the Trust's practice)
10-8iv (Oct 16)	Arrange for the performance on the "RTT Incomplete Non-Admitted Backlog" indicator that was reported to the Board on 19/10/16 to be checked, to ensure the accuracy of the data	Chief Operating Officer	November 2016	The data has been checked and is accurate. There has been an increase in the RTT backlog this year mainly due to the reduction in activity in Quarter 4 of 2015/16. The Outpatient backlog has also increased in certain specialties due to issues within those specialties (e.g. Consultant vacancies leading to reduced clinics)
10-8vi (Oct 16)	Check why there was "No data" reported for the "Ambulance Handover Delays >30mins" and "Ambulance Handover Delays >60mins" indicators within the Integrated performance report submitted to the Trust Board on 19/10/16	Chief Operating Officer (originally allocated to the Deputy Chief Executive)	November 2016	The reported data is provided by South East Coast Ambulance Service NHS Foundation Trust (SECAMB) and as yet there is no mechanism for the Trust to validate this. However the un-validated data will be reported until such time as we can reconcile the information between organisations. The data is therefore included in the dashboard submitted to the November 2016 Board
10-8v (Oct 16)	Include further	Chief	November	The requested commentary has

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	commentary on the Trust's performance on the Referral to Treatment targets within the Integrated performance report submitted to the Trust Board in November 2016	Operating Officer	2016	been included within the Integrated performance report submitted to the Trust Board in November 2016
10-8vii (Oct 16)	Check the source and appropriateness of the "Bench Mark" percentage for the "Staff Turnover Rate" indicator within the Integrated performance report submitted to the Trust Board on 19/10/16	Director of Workforce	November 2016	The Bench Mark was checked, and it was discovered that the rolling 12-month average level for acute Trusts was 11.05% (not the reported 8.4%). This Bench Mark had therefore now been reflected in the Performance Dashboard
10-9 (Oct 16)	Submit a report to the Trust Board, in November 2016, on the latest situation regarding the IT-related issues within Ophthalmology that were reported at the Trust Board on 19/10/16	Medical Director	November 2016	The requested report has been submitted to the November 2016 Board
10-12 (Oct 16)	Liaise to agree the most appropriate month to schedule a Trust Board presentation on the "Home First" model	Trust Secretary / Deputy Chief Executive	November 2016	Liaison occurred, and a presentation has been scheduled for the Trust Board meeting in December 2016

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
N/A	N/A	N/A	N/A	N/A

Trust Board meeting - November 2016

11-8 Chief Executive's update

Chief Executive

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

1. All areas of our Trust (MTW) are continuing to work at pace on the development and delivery of high quality sustainable services that are better placed to meet the changing health needs of our patients both now, and in the future.

We are working closely with our clinical leads on the development of our draft two year operational plans for 2017/18 and 2018/19. Members of the Trust Board are involved in this important process that will help ensure our organisation is able to meet its primary responsibilities over the coming years, and duty of care to its patients.

It is important that our vision is closely aligned to the emerging Kent and Medway Sustainability and Transformation Plan to support the development of a truly patient-centric and cohesive countywide health service.

For the first time, all the NHS organisations in Kent and Medway, Kent County Council and Medway Council are working in partnership on plans for the future provision of health and social care services to the county's growing population of over 1.8 million people.

This gives everyone a unique opportunity to bring about positive and genuine improvement in health and social care for years to come. The aim is for patients to get one service delivered by people working together as one team, so they always see the right professional, and get care that looks at them as a whole, treating both their physical and mental health.

More effective and integrated local care will mean more frail older people are able to stay in their own homes for longer. By reducing the demand for hospital services, it will also give an opportunity to reshape the way hospital care is delivered with the NHS collaborating across Kent to improve outcomes. It is important that we make the most of these opportunities to improve patient care.

At the same time, we remain focused on our day to day priorities. We continue to address our challenging financial position, while maintaining the highest and safest standards of care for our patients. We are continuing to develop and implement our winter plan to meet our patients' increasing needs over the coming months in the expectation that we will continue to see heightened levels of demand for our services.

2. Maternity services in West Kent have been rated the best in the country following a review of nearly 200 NHS maternity services nation-wide. The data has been published as part of a transparency drive by Jeremy Hunt, the Health Secretary, in an effort to improve Britain's place in international league tables. The ratings examine stillbirth and neonatal mortality, maternal smoking at the time of delivery, women's experience of maternity services and women's choice. Results showed that 144 Clinical Commissioning Groups in the country were deemed to need improvement, a further 53 were described as performing well and just one, West Kent, was assessed as top performing. The majority of maternity services in the West Kent area are delivered by MTW.

Our maternity services have been shortlisted in the Royal College of Midwives 'Annual Midwifery Awards' 2017. MTW is one of only four organisations shortlisted in the Euroking Better Births Award for our project: 'A 'toolbox for better births for all'. The Awards are a reflection of achievement by midwifery teams across the UK, celebrating excellence across the profession. The awards are open to all midwifery teams from across the UK.

The RCM states that: 'Hard work, innovation and commitment to pushing boundaries of

excellence within the profession characterised this year's entries. The judges were impressed by this year's finalists, praising teams and organisations on their achievements.' The Awards will take place in March 2017.

3. MTW has formally renewed its partnership with iWantGreatCare (iWGC), the largest independent source of healthcare reviews. Using the iWGC service will enable all patients to leave real-time feedback about their care at our hospitals. This gives us a great source of information which will both highlight excellent care from our staff and areas where we may need to make improvements, in order to enhance the experience that patients have when they are in our care. Patients are also able to comment via other forms of social media including the Trust's own Twitter account, via NHS Choices and through our surveys.

We also routinely review our complaints and share themes with staff to aid trust-wide learning. I have helped raise several key themes with staff this month, including the need for clear communication around treatment plans between staff to avoid delay.

4. November is our 'Safety Focus Month' for falls prevention. Falls prevention is a key patient safety priority for MTW. Through the focus and hard work of all involved we are on track to remain below the falls threshold rate of 6.2 per 1000 occupied bed days.
5. The results of our second quarterly Staff Impressions Survey have now been received. 93% of staff who responded have a good impression of the Trust. 83% said they would recommend the Trust as a place to receive treatment, with quality of care being the top reason for this. 60% of staff said they would recommend the Trust as a great place to work, with job role and colleagues being the top ranking reasons for recommending.

The key themes coming out of the survey are that staff are patient-focused and caring, and colleagues are friendly and welcoming. Areas for improvement include processes and issues with IT.

6. It is important that we continue to recognise the efforts of our staff who so often go beyond the call of duty for our patients. This has never been more important as the NHS continues to see and treat record numbers of patients. Earlier this month we held our long service awards ceremony to recognise the dedication of staff who have worked for Maidstone and Tunbridge Wells NHS Trust for 15 years or more with awards being presented to staff for 15, 20, 25, 30 and 40 years' service. We also received a record number of nominations from staff and patients for this year's annual staff awards. The awards were presented earlier this month by Debbie McGee, the radio host, presenter and wife of the late Paul Daniels.

Winners and Runners-Up include the Trust's Teenage Pregnancy Midwives who provide a personalised service for young pregnant teenagers and Dr Jenny Weeks, famous for using mathematics, namely subtraction, to distract her patients undergoing stressful biopsy procedures.

Sister Sandra Wakelin, a Macmillan Lung Clinical Nurse Specialist, won the Innovation Award for her work setting up a clinic in which she sees patients and prescribes supportive medications to help them manage side effects from chemotherapy.

Winner of the Excellence Award was LA1 Oncology who were nominated by a patient who described the 'kindness, consideration and compassion' shown by the team and how 'it has been a pleasure to come every day and not a chore'.

Patient First

Runner up – Individual: Roz Barwell, Ward Manager Ward 20, TWH

Winner – Individual: Dawn Mephram, Occupational Therapist, TWH

Runner up – Team: AMU, Maidstone

Winner – Team: Teenage Pregnancy Midwives – Rachel Cant and Katie Hall, cross-site

Respect

Runner up – Individual: Dr Jenny Weeks, Breast Care department, Maidstone

Winner – Individual: Isobel Morley, AMU, Maidstone
 Runner up – Team: Pre-Assessment Nurses (Fran Staples and Karen Nightingale), Maidstone
 Winner – Team: Hedgehog Ward Nursing Team, TWH

Innovation

Runner up – Individual: Dawn Hallam, Discharge Manager, cross-site
 Winner – Individual: Sandra Wakelin, Lung Cancer CNS, Maidstone
 Runner up – Team: Inci Patel and Valerie Shield (cashier and receptionist), Maidstone
 Winner – Team: Infection Control Team, cross-site

Delivery

Runner up – Individual: Vicky Maggs, Complaints Administrator, Maidstone
 Winner – Individual: Karen Leeson, Birth Centre Manager, Crowborough
 Runner up – Team: Secondary Breast Cancer Multidisciplinary Team, Maidstone
 Winner – Team: Domestics, cross-site

Excellence

Runner up – Individual: Helen Summers, Vascular Access Nurse Specialist, cross-site
 Winner – Individual: Leon D’Cruz, Respiratory Medicine Research Associate
 Runner up – Team: Neonatal Unit, TWH
 Winner – Team: LA1 Oncology Team, Maidstone

Kent Messenger Newspaper Hospital Heroes Award

Winner: Dr Leon D’Cruz

Courier Newspaper Hospital Heroes Award

Winner: Carol Smallman

Special Recognition Award

Winner: Gnanappiragasam Sithamparapillai, Senior Biomedical Scientist

Sylvia Denton Award for Care and Compassion

Winner: Ruth Paul, Bereavement Midwife

Chairman’s Award

Winner: Kemi Adams, Traffic Officer, Security Team

Volunteer of the year

Runner Up: Anneliese Gibbs, Maidstone
 Winner: Laurie Williams, Maidstone

Employee of the year

Winner, Carol Kinsella, Out-Patient Physiotherapy Manager
 Runner Up: Matthew Hitchcock, Head Chef

Team of the Year

Runner Up: Edith Cavell Unit, Maidstone
 Winner: Cardiac Rehabilitation Volunteers, Maidstone

7. Four patients at Maidstone Hospital have been presented with awards by the Diabetes Team for managing their conditions for 50 years. The medals were presented on behalf of Diabetes UK. Dr Siva, Consultant in Diabetes, said the patients set an admirable example to others and show that normal lives can be led and much can be achieved, whilst living with diabetes.

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

Trust Board Meeting – November 2016

11-9 Board Assurance Framework (BAF) 2016/17

Trust Secretary

The management of the BAF and link with the Risk Register

The Board Assurance Framework (BAF) is the document through which the Trust Board identifies the principal risks to the Trust meeting its agreed objectives, and to ensure adequate controls and measures are in place to manage those risks. The ultimate aim of the BAF is to help ensure that the objectives agreed by the Board are met. The BAF is managed by the Trust Secretary, who liaises with each “Responsible Director” to ensure that the document is updated throughout the year. The BAF differs from the Risk Register in that the BAF should only contain a sub-set of risks on the Risk Register: those that pose a direct threat to the achievement of the Trust’s objectives.

Review by the Audit and Governance Committee

The enclosed BAF was reviewed by the Audit and Governance C’ttee on 03/11/16. Following the discussion, it was agreed to include a review of the BAF’s assurance methods as part of the annual “Assurance Framework and Risk Management” Internal Audit review in 2016/17 (and for the Director of Finance to then consider, as a result of the findings of that review, the need to allocate Internal Audit days to provide additional assurance in specific areas). The Committee also asked the Trust Secretary to consider the addition of a summary front page for the BAF, encapsulating the current status for each item. A summary has therefore been included below.

Objective	Confidence ¹
1.a. To reduce the falls rate to less than 6.2 per 1,000 occupied bed days	Green
2.a. To achieve an average maximum Length of Stay for elective care of 3.2 days	Amber Red
2.b. To achieve an average maximum Length of Stay for non-elective care of 6.8 days	Amber Red
3.a. To reduce the vacancy rate to 8.5%	Green
4.a. To maintain operational liquidity whilst reducing working capital (from the planned level for 16/17)	Amber
4.b. To improve on the Trust’s Income and Expenditure plan for 2016/17	Amber
5.a. To deliver the Trust’s 2016/17 agreed trajectory regarding the 62-day Cancer waiting time target	Green

Review by the Trust Board

This is the second time during 2016/17 that the Board has seen the populated BAF, following the review at the September 2016 Board meeting. Board members are asked to review and critique the content, by considering the following prompts:

- Are the objectives appropriately described? Should the wording of any be amended?
- Do the RAG ratings of the sufficiency of the actions taken reflect the situation as understood by the Board (and its sub-committees)?
- Do the RAG ratings of confidence that the objective will be achieved reflect the situation as understood by the Board (and its sub-committees)?
- Does any of the content require further explanation?
- Does the format of the BAF need to be amended?

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

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

Which Committees have reviewed the information prior to Board submission?

- Audit and Governance Committee, 03/11/16
- Trust Management Executive, 16/11/16
- Finance Committee, 28/11/16 (objective 4.a only)

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

Review

¹ This is the confidence of the Responsible Director that the objective will be achieved by the end of 2016/17

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

Board Assurance Framework 2016/17

What is the key risk? *Main risk*
 1 The Trust fails to improve key aspects of clinical care and safety

What does the Trust want to achieve? ³ *Objective*
 1.a To reduce the falls rate to less than 6.2 per 1,000 occupied bed days

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

What could prevent this objective being achieved? *Risks to objectives*
 1. Insufficient senior leadership and commitment
 2. Insufficient clarity of the performance required by each Ward, & the monitoring of such performance
 3. Insufficient engagement by Wards and staff
 4. The falls-related documentation not being fit for purpose

What actions have been taken in response to the above issues? *Controls*
 a. A Task and Finish group for reducing falls has been established, chaired by the Chief Nurse and supported by the Director of Infection Prevention and Control and Deputy Chief Executive (1)
 b. The Falls Review Panel has been strengthened with Executive Director leadership (Chief Nurse) (2)
 c. Individualised thresholds have been set for each Ward, and the Falls Review Panel meets with each Ward team that exceeds their threshold as part of the wider review of practice (2)
 d. The Period of Increased Incidence (PII) monitoring framework used in infection control has been revised for use in falls prevention (2)
 e. The Terms of Reference for the Slips, Trips and Falls Group have been reviewed, to engage and representation from all staff groups (3)
 f. A dashboard has been developed to enable falls data to be collated and viewed in one place (2)
 g. The Programme Management Office (PMO) is providing support to undertake data analysis (2)
 h. Nursing assessment documents for falls prevention has been reviewed (4)
 i. There is a comprehensive action plan to address the areas identified as requiring improvement from the National Falls Audit (1, 2, 3, 4)

Are the actions that had been planned for this point been taken? *Gaps in control*
 September 2016: Yes Partly No
 November 2016: Yes Partly No
 February 2017: Yes Partly No

If "Partly" or "No", please explain
 1. N/A

Where can assurance be obtained on the actions taken to date? *Sources of assurance*
 1. The Trust Performance Dashboard (which contains the "Rate of Total Patient Falls", the "Rate of Total Patient Falls Maidstone", "Rate of Total Patient Falls TWells" the number of "Falls - SIs in month") and Integrated Performance Report graphs (which shows the "Rate of Falls" graphically)
 2. Quality Accounts priorities progress reports to the Patient Experience C'ttee and Quality C'ttee
 3. The 'Quality and Governance' bi-monthly report to the Trust Clinical Governance Committee, which shows the "Rate of Patient Falls per 1,000 Occupied Beddays", and the number of Falls resulting in "No Harm", "Low Harm", "Moderate Harm", and "Severe Harm") and provides a commentary on the latest position; and also includes the falls data for each Directorate at both hospital sites

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

If "No", what other data is needed?
 1. N/A

Risk owner/s: Chief Nurse / Medical Director	Responsible Director: Chief Nurse	Main committee/s responsible for oversight: Trust Clinical Governance Committee / Quality Committee
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How confident is the Responsible Director that the objective will be achieved by the end of 2016/17?⁴
 September 2016: Yes Partly No
 November 2016: Yes Partly No
 February 2017: Yes Partly No

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
 The rate for month 6 (September) was 5.4, whilst the rate for the year to date (to month 6) was 6.0

³ In July 2016, the Trust Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance

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

How confident is the Responsible Director that the objective will be achieved by the end of 2016/17? ⁶								
September 2016			November 2016			February 2017		
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<p>Rationale for rating (including details of the further action planned for any “Amber” or “Red” ratings):</p> <ul style="list-style-type: none"> An ‘Amber/Red’ rating has been selected. The “Average LOS Elective” for the year to date at month 6, 2016/17 is 3.35 days, whilst the “Average LOS Non-Elective” for the year to date at month 6, 2016/17 is 7.5 days Ambulatory pathways were rolled out at Tun. Wells Hospital in July, led by the Directorate, but due to high escalation these have not been optimised. Pathways are in place at Maidstone but these need further embedding The actions taken and/or planned are the correct actions, and the “Home First” pathway is key to unlocking improvements. Pathways 1 & 2 will be rolled out to further Wards from December 2016 (there are 3 pathways but further work is required before Pathway 3 is ready for launch). In addition, the Clinical Director (CD) for Diagnostics & Pharmacy (D&P) will become the Trust’s named clinical lead on LOS; and a Task and Finish group led by the CD for D&P will be established to drive the completion of Electronic discharge notifications (EDNs) the day before. Clinical Leads will also be appointed at Directorate level, with additional Programmed Activity (PA) support, in order to increase clinical ‘buy in’ and leadership. There will also be an emphasis on identifying where “Day before” actions are not fully implemented, with intensive focus on those areas by SAFER team The actions taken and/or planned are therefore felt to be the correct actions required, but achieving the average LOS targets listed above may not be achieved until the end of Quarter 2, 2017/18. This level of confidence is affected by the fact that there has been no reduction in non-elective demand. Confidence would therefore be boosted by additional capacity, even if this was only short-term 								

⁶ “G”: No reason to doubt that the objective won’t be achieved; “R”: Serious doubts exist regarding achievement

Board Assurance Framework 2016/17

What is the key risk? *Main risk*
3 The Trust does not have the right level of substantive workforce for effective delivery

What does the Trust want to achieve? ⁷ *Objective*
3.a To reduce the vacancy rate to 8.5%

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

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

1. National shortage of certain staff groups	4. Inefficiency of recruitment processes
2. Lack of clarity/focus on the key actions required	5. Lack of urgency/commitment by recruiting managers
3. A lack of clarity over the performance required by each Directorate, and the monitoring of such performance	6. Uncertainty over the status of vacancies

What actions have been taken in response? *Controls*

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

Are the actions that had been planned for this point been taken? *Gaps in control*

September 2016	November 2016	February 2017									
<table border="0"> <tr> <td>Yes <input checked="" type="checkbox"/></td> <td>Partly <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> </table>	Yes <input checked="" type="checkbox"/>	Partly <input type="checkbox"/>	No <input type="checkbox"/>	<table border="0"> <tr> <td>Yes <input checked="" type="checkbox"/></td> <td>Partly <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> </table>	Yes <input checked="" type="checkbox"/>	Partly <input type="checkbox"/>	No <input type="checkbox"/>	<table border="0"> <tr> <td>Yes <input type="checkbox"/></td> <td>Partly <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> </table>	Yes <input type="checkbox"/>	Partly <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input checked="" type="checkbox"/>	Partly <input type="checkbox"/>	No <input type="checkbox"/>									
Yes <input checked="" type="checkbox"/>	Partly <input type="checkbox"/>	No <input type="checkbox"/>									
Yes <input type="checkbox"/>	Partly <input type="checkbox"/>	No <input type="checkbox"/>									

If "Partly" or "No", please explain

1. N/A

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

1. The Trust Performance Dashboard (which contains the "Vacancy %")	3. Directorate performance dashboards
2. Reports to the Workforce Committee (which includes a commentary on the latest issues regarding the vacancy rate)	4. The Chief Nurse's report to the October 2016 Trust Board regarding Nursing staffing levels

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

If "No", what other data is needed?

1. N/A

Risk owner: Director of Workforce	Responsible Director: Director of Workforce	Main committee/s responsible for oversight: Trust Management Executive / Workforce Committee / Trust Board
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How confident is the Responsible Director that the objective will be achieved by the end of 2016/17?⁸

September 2016	November 2016	February 2017									
<table border="0"> <tr> <td>Yes <input checked="" type="checkbox"/></td> <td>Partly <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> </table>	Yes <input checked="" type="checkbox"/>	Partly <input type="checkbox"/>	No <input type="checkbox"/>	<table border="0"> <tr> <td>Yes <input checked="" type="checkbox"/></td> <td>Partly <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> </table>	Yes <input checked="" type="checkbox"/>	Partly <input type="checkbox"/>	No <input type="checkbox"/>	<table border="0"> <tr> <td>Yes <input type="checkbox"/></td> <td>Partly <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> </table>	Yes <input type="checkbox"/>	Partly <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input checked="" type="checkbox"/>	Partly <input type="checkbox"/>	No <input type="checkbox"/>									
Yes <input checked="" type="checkbox"/>	Partly <input type="checkbox"/>	No <input type="checkbox"/>									
Yes <input type="checkbox"/>	Partly <input type="checkbox"/>	No <input type="checkbox"/>									

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

- The vacancy rate for the year to date (at month 6, 2016/17) is 9.3%, but the trend from previous months shows a reduction

⁷ In July 2016, the Trust Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance
⁸ "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2016/17

What is the key risk? *Main risk*
4 The Trust fails to demonstrate an ability to achieve future financial viability

What does the Trust want to achieve? ⁹ *Objective*
4.a To maintain operational liquidity whilst reducing working capital (from the planned level for 2016/17)
4.b To improve on the Trust's Income and Expenditure plan for 2016/17

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

What could prevent this objective being achieved? *Risks to objectives*
1. A lack of senior leadership and commitment
2. Poor financial controls and/or their application
3. Lack of urgency/commitment by managers
4. Lack of capability and capacity in key areas
5. If the Financial Recovery Plan (FRP) was developed without consideration of best practice elsewhere
6. NHS Improvement (NHSI) not accepting the FRP
7. The failure of the STP to have the desired effect

What actions have been taken in response? *Controls*
a. The Executive have taken urgent action to mobilise the organisation since the Trust was put into Financial Special Measures (1)
b. Control targets have been set for each Directorate to reduce their cost run rate (2)
c. A number of 'Grip and Control' measures have been implemented to ensure delivery of the Plan (e.g. increased and improved communication, increasing financial awareness, which is leading to behavioural change across the Trust)) (2, 3)
d. Launch sessions have been held along with several FRP sessions with Directorates, and a series of Executive Challenge sessions (3)
e. A new Performance Management Framework has been implemented (3)
f. A review of capacity and capability across the organisation has been undertaken, to ensure the appropriate resource (Finance, PMO, Operational teams) is in place to deliver the Plan (4)
g. The FRP has been informed by the Financial Improvement Programme Phase 1 report from KPMG LLP and by the guidance and advice from NHSI (including that from the Finance Improvement Director) (5, 6)
h. At first review meeting with NHSI, on 21/09, the Trust agreed to the control total of a £4.7m deficit for 2016/17. This agreement 'unlocked' a number of funds, including the Sustainability and Transformation Fund (STF) and also meant the Trust would not be subject to contractual penalties.

Are the actions that had been planned for this point been taken? *Gaps in control*
September 2016: Yes Partly No
November 2016: Yes Partly No
February 2017: Yes Partly No

If "Partly" or "No", please explain
1. All follow-up actions from the Financial Improvement Director's latest feedback (Oct. '16) need to be taken

Where can assurance be obtained on the actions taken to date? *Sources of assurance*
1. FRP report to Quality Committee and Trust Board, September 2016
2. Fortnightly FRP challenge sessions with the Exec.
3. Weekly FRP performance 'flash' reports to the Exec
4. Monthly financial performance (including liquidity) reports to TME, Finance Committee and Board

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

If "No", what other data is needed?
1. N/A

Risk owner: Director of Finance	Responsible Director: Director of Finance	Main committee/s responsible for oversight: Finance Committee / Trust Board
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How confident is the Responsible Director that the objective will be achieved by the end of 2016/17?¹⁰
September 2016:
November 2016:
February 2017:

Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):
▪ There remains a significant amount of risk to the delivery of the control total. The deficit to date (at month 6) was £11.4m, against a planned deficit of £11.1m i.e. £0.3m adverse to plan

⁹ In July 2016, the Trust Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance

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

Board Assurance Framework 2016/17

What is the key risk?	<i>Main risk</i>	
5 The Trust fails to maintain and improve its reputation as a Cancer provider		
What does the Trust want to achieve? ¹¹	<i>Objective</i>	
5.a To deliver the Trust's 2016/17 agreed trajectory regarding the 62-day Cancer waiting time target		
Relevant CQC domain/s:	Safe <input type="checkbox"/> Effective <input checked="" type="checkbox"/> Caring <input type="checkbox"/> Responsive <input checked="" type="checkbox"/> Well-led <input checked="" type="checkbox"/>	
What could prevent this objective being achieved?	<i>Risks to objectives</i>	
1. Insufficient engagement by clinical staff outside of the Cancer and Haematology Directorate 2. Pathways may not be optimal in relation to achieving the required performance 3. Insufficient communication of the performance required outside of the Cancer and Haematology Directorate (only 1/3 of the delivery is within the control of the Cancer and Haematology Directorate – the remainder is within Diagnostics, Surgery and Medicine)		
What actions have been taken in response?	<i>Controls</i>	
a. Two Cancer Summits, and Tumour Site-specific workshops (to focus on particular specialities) have been held (1, 3) b. The issues have been discussed in Governance meetings & the Cancer Clinical Board (1, 3) c. There are weekly Patient tracking Lists (PTLs) for each Cancer site and for other providers (3) d. Action/Recovery Plans are in place for each of the tumour sites (1, 3) e. Changes are being made to pathways (2) f. Individual Cancer pathway workshops are taking place, to focus on key issues in those specific areas (i.e. Breast, Lung, Colorectal)		
Are the actions that had been planned for this point been taken?		
<i>Gaps in control</i>		
September 2016	November 2016	
Yes <input type="checkbox"/> Partly <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> Partly <input checked="" type="checkbox"/> No <input type="checkbox"/>	
February 2017		
Yes <input type="checkbox"/> Partly <input checked="" type="checkbox"/> No <input type="checkbox"/>		
If "Partly" or "No", please explain		
1. The appointment of Clinical Nurse Specialists for the Colorectal pathway is a key enabler for that pathway. The Band 6 post has been recruited to (but the person is not yet in post), whilst the recruitment for the Band 7 post is still in process		
Where can assurance be obtained on the actions taken to date?		
<i>Sources of assurance</i>		
1. The Trust Performance Dashboard 2. Directorate reports to the Trust Clinical Governance Committee & Trust Management Executive		
Do we have all the data needed to judge performance?		
<i>Gaps in assurance</i>		
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
If "No", what other data is needed?		
1. N/A		
Risk owner: Chief Operating Officer	Responsible Director: Chief Operating Officer	Main committee/s responsible for oversight: Trust Management Executive / Trust Board
How confident is the Responsible Director that the objective will be achieved by the end of 2016/17?¹²		
September 2016	November 2016	February 2017
<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Rationale for rating (including details of the further action planned for any "Amber" or "Red" ratings):		
At month 5, 2016/17, the "Cancer 62 day wait - First Definitive" performance (overall) for the quarter to date is 73.4%, but for MTW patients only is 79.4%. This compares to the target performance of 85.2% & 85% respectively		

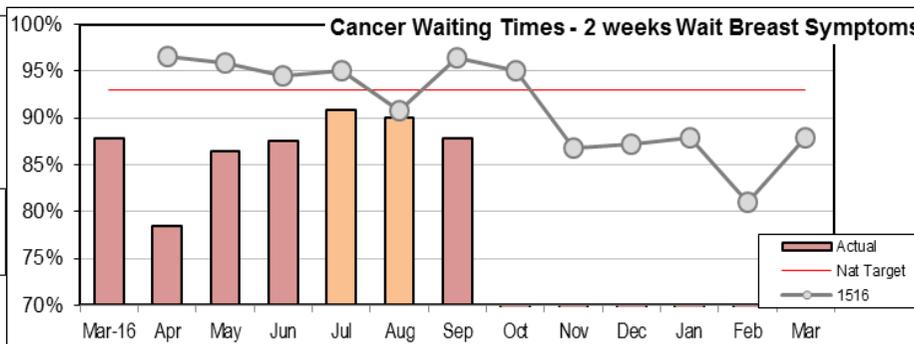
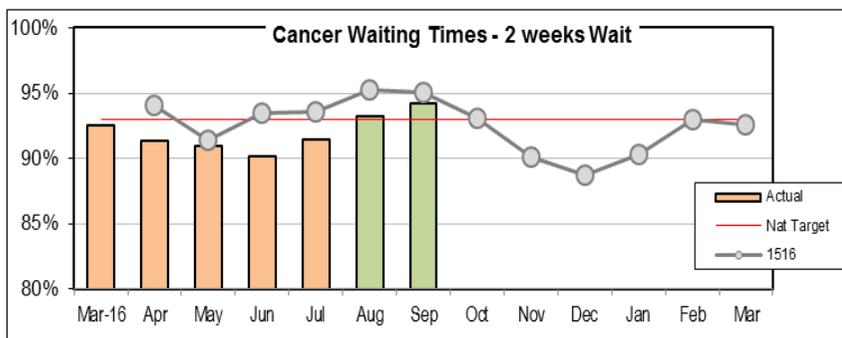
¹¹ In July 2016, the Trust Board approved the proposal to focus on a deliberately small number of higher-level objectives to act as proxy indicators (i.e. a 'litmus test') for broader performance

¹² "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Trust Board meeting – November 2016

11-10	Integrated performance report for October 2016	Chief Executive
<p>The enclosed report includes:</p> <ul style="list-style-type: none"> ▪ The 'story of the month' for October 2016 ▪ A quality exception report ▪ A Workforce update ▪ The Trust performance dashboard ▪ An explanation of the Statistical Process Control charts which are featured in the "Integrated performance charts" section ▪ Integrated performance charts 		
<p>Which Committees have reviewed the information prior to Board submission?</p> <ul style="list-style-type: none"> ▪ Trust Management Executive, 16/11/16 (performance dashboard) 		
<p>Reason for receipt at the Board (decision, discussion, information, assurance etc.) ¹</p> <p>Discussion and scrutiny</p>		

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

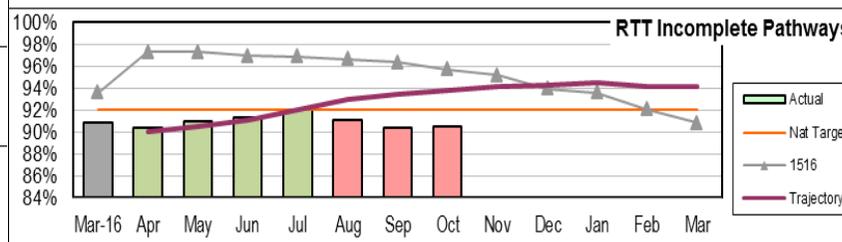
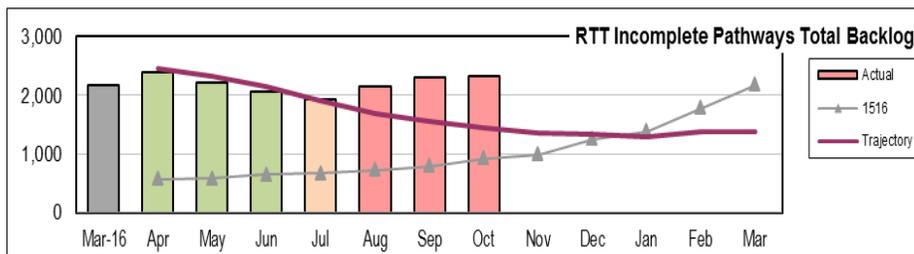


3. Cancer 62 day FDT

Performance remains off trajectory for September although the Trust has maintained a stable performance for MTW-only patients. The focus internally remains on addressing all the issues that are to do with MTW processes and clear actions have been agreed and are in place for each tumour group. The cancer delivery plan is monitored on a weekly basis with the relevant managers and clinical leads. An upgrade to the electronic patient tracking system is now available across all MDTs. A short term action plan has been compiled and the actions are being implemented and any benefits monitored. The recovery plan is focusing on the high volume tumour sites to achieve the recovery target. A revised pathway for all LGI referrals will be fully implemented as soon as the additional CNSs are in post (November – January). The revised pathway which will have intense concentration on the diagnostic period is expected reduce the overall waiting time by up to 2 weeks once fully established.

4. RTT and elective activity.

The Trust missed the agreed RTT trajectory in October, largely due to the lower than plan levels of elective activity and an increase in the outpatient waiting times in a number of outpatient specialties. There is a directorate & specialty level improvement plan in place, monitored via weekly performance meetings. The improvement in performance is dependent on treating more patients who have already waited over 18 weeks. Since the implementation of the bed configurations at the beginning of November there has been an improvement in the activity levels.



Quality Exception Report

Any matters not included within the “Quality and Patient Safety Report” will be raised by exception in the meeting.

Workforce

As at the end of October 2016, the Trust employed 5,140.7 whole time equivalent substantive staff, a modest rise on the previous month as a result of continuing recruitment activity and slightly lower turnover during the period. This has resulted in a significant reduction in the number vacancies, reducing the total by 22.1 WTE from September continuing the downward movement from August resulting in a vacancy rate of 8.9%. The Trust will continue to focus attention on recruitment, retention and establishment reviews in order to reduce the number of vacancies within the organisation further in line with achieving the 8.5% plan.

Although Bank use has reduced further in October from the September levels, dependence upon temporary staff remains higher than planned. Stated agency use has risen during October, however part of the increase is the result of a backlog of invoicing. Comparison with the same period last year shows an overall reduction in temporary staffing use as well as a shift from Agency to Bank as a result of improved agency controls. Further work is ongoing to ensure we reduce expenditure in this area.

Sickness absence in the month has increased to 4.0% during October – a targeted analysis is being prepared for review at the quarterly Workforce Committee in order to review trends and identify root causes. As the current rate is still higher than the 3.3% target, sickness absence management remains a key area of focus for the HR and operational management teams.

Statutory and mandatory training compliance has risen modestly by 1.2% from September, rising at a more significant rate than the comparator periods last year. Actions are in place to improve compliance further. Appraisal levels are reported for non-medical staff have increased significantly since September, representing a 9.6% rise as appraisals are returned and processed. Work is currently underway to provide targeted non-compliance lists to directorates and managers in order to improve return rates with specific improvements demonstrated in Urgent care over recent weeks.

TRUST PERFORMANCE DASHBOARD

Position as at:

31 October 2016

Governance (Quality of Service):

2.0

Amber/Red

Based on TDA 2014/15 Methodology

Finance:

TDA

Amber

Safe	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
	Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/Limit	Forecast	
	*Rate C-Diff (Hospital only)	15.70	4.8	11.0	13.1	2.1	2.0	11.5	
Number of cases C.Difficile (Hospital)	3	1	15	20	5	3	27	27	
Number of cases MRSA (Hospital)	0	0	1	0	-1	0	0	0	
Elective MRSA Screening	99.0%	99.0%	99.0%	99.0%		1.0%	98.0%	99.0%	
% Non-Elective MRSA Screening	98.0%	97.0%	98.0%	97.0%		2.0%	95.0%	97.0%	
**Rate of Hospital Pressure Ulcers	3.0	2.5	2.4	2.8	0.4	-0.3	3.0	2.8	
3.0									
***Rate of Total Patient Falls	7.2	5.7	6.9	5.8	-1.1	-0.4	6.20	6.20	
***Rate of Total Patient Falls Maidstone	6.7	4.7	6.1	5.1	-1.0			5.3	
***Rate of Total Patient Falls TWells	7.7	6.5	7.3	6.2	-1.2			6.9	
Falls - SIs in month	6	3	27	20	-7				
Number of Never Events	0	0	0	1	1	1	0	1	
Total No of SIs Open with MTW	22	26			4				
Number of New SIs in month	10	8	57	65	8	5			
**Serious Incidents rate	0.52	0.38	0.42	0.43	0.01	0.37	0.0584 - 0.6978	0.43	
0.0584 - 0.6978									
Rate of Patient Safety Incidents - harmful	1.17	0.77	1.33	0.64	-0.69	-0.59	0 - 1.23	0.64	
0 - 1.23									
Number of CAS Alerts Overdue	0	0			0	0	0	0	
VTE Risk Assessment	95.4%	95.3%	95.3%	95.3%	0.0%	0.3%	95.0%	95.3%	
Safety Thermometer % of Harm Free Care	96.8%	95.9%	96.8%	96.4%	-0.5%	1.4%	95.0%	93.4%	
Safety Thermometer % of New Harms	2.24%	3.98%	2.34%	3.43%	1.08%	0.4%	3.00%	3.43%	
C-Section Rate (non-elective)	12.5%	10.0%	12.5%	13.2%	0.69%	-1.8%	15.0%	13.2%	

Effectiveness	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
	Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/Limit	Forecast	
	Hospital-level Mortality Indicator (SHMI)*****	Prev Yr: Oct 13 to Sept 14		102.0	109.0	7.0	9.0	Lower confidence limit	
Standardised Mortality (Relative Risk)	Prev Yr: Oct 13 to Sept 14		103.0	109.0	6.0	9.0	to be <100	100.0	
Crude Mortality	1.1%	1.2%	1.2%	1.2%	0.0%				
****Readmissions <30 days: Emergency	10.8%	11.5%	11.5%	11.7%	0.1%	-1.9%	13.6%	11.7%	
****Readmissions <30 days: All	10.0%	10.9%	10.7%	10.9%	0.2%	-3.8%	14.7%	10.9%	
Average LOS Elective	3.37	3.41	3.17	3.34	0.17	0.13	3.20	3.20	
Average LOS Non-Elective	6.58	7.74	7.33	7.61	0.28	0.77	6.84	7.61	
*****FollowUp : New Ratio	1.26	1.32	1.27	1.55	0.29	0.03	1.52	1.55	
Day Case Rates	84.4%	84.7%	83.7%	85.0%	1.2%	5.0%	80.0%	85.0%	
Primary Referrals	9,143	8,673	62,217	63,836	2.6%	3.5%	104,825	109,125	
Cons to Cons Referrals	3,475	3,704	24,543	25,240	2.8%	2.0%	40,698	43,147	
First OP Activity	12,355	13,338	82,083	86,648	5.6%	1.5%	144,940	145,099	
Subsequent OP Activity	23,538	26,215	159,066	165,244	3.9%	0.5%	279,695	277,471	
Elective IP Activity	678	600	4,727	4,609	-2.5%	-10.4%	8,755	8,337	
Elective DC Activity	3,536	3,478	23,141	23,873	3.2%	-9.0%	44,937	41,028	
Non-Elective Activity	3,738	3,965	26,612	28,785	8.2%	6.7%	46,131	49,006	
A&E Attendances (Inc Clinics. Calendar Mth)	12,980	14,499	90,959	96,095	5.6%	0.7%	163,967	164,376	
Oncology Fractions	6,005	5,913	39,804	41,247	3.6%	-1.1%	70,642	72,617	
No of Births (Mothers Delivered)	481	520	3,419	3,570	4.4%	3.9%	5,888	6,120	
% Mothers initiating breastfeeding	79.0%	79.9%	80.7%	82.4%	1.6%	4.4%	78.0%	82.4%	
% Stillbirths Rate	0.6%	0.56%	0.43%	0.36%	-0.1%	-0.1%	0.47%	0.36%	

Caring	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
	Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/Limit	Forecast	
	Single Sex Accommodation Breaches	0	0	0	0	0	0	0	
****Rate of New Complaints	3.24	1.10	1.69	1.22	-0.5	0.10	1.318-3.92	1.24	
% complaints responded to within target	77.1%	53.8%	71.9%	67.4%	-4.4%	-7.6%	75.0%	73.6%	
****Staff Friends & Family (FFT) % rec care	82.2%	82.7%	82.7%	86.8%	4.1%	7.8%	79.0%	86.8%	
****IP Friends & Family (FFT) % Positive	95.7%	95.1%	96.5%	95.3%	-1.2%	0.3%	95.0%	95.3%	
A&E Friends & Family (FFT) % Positive	88.9%	90.9%	89.0%	90.7%	1.7%	3.7%	87.0%	90.7%	
Maternity Combined FFT % Positive	96.1%	91.6%	95.0%	93.6%	-1.4%	-1.4%	95.0%	95.0%	
OP Friends & Family (FFT) % Positive	80.0%	82.6%	79.2%	82.6%	3.3%			82.6%	

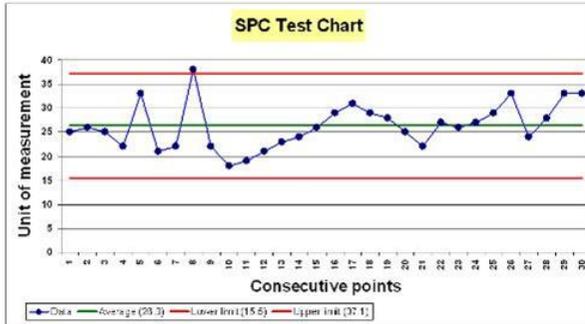
* Rate of C.Difficile per 100,000 Bed days, ** Rate of Pressure Sores per 1,000 admissions (excl Day Case), *** Rate of Falls per 1,000 Occupied Beddays, **** Readmissions run one month behind, ***** Rate of Complaints per 1,000 occupied beddays.
 ***** New :FU Ratio is only for certain specialties -plan still being agreed so currently last year plan
 ***** IP Friends and Family includes Inpatients and Day Cases *****SHMI is within confidence limit

Responsiveness	Latest Month		Year/Quarter to Date		YTD Variance		Year End		Bench Mark
	Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/Limit	Forecast	
	*****Emergency A&E 4hr Wait	91.5%	89.0%	91.8%	89.5%	-2.3%	-0.3%	95.0%	
Emergency A&E >12hr to Admission	0	0	0	0	0	0	0	0	
Ambulance Handover Delays >30mins*****	New	214 (7%)	New	1227 (5.9%)				19632 (5.9%)	
Ambulance Handover Delays >60mins*****	New	9 (0.3%)	New	139 (0.7%)				224 (0.7%)	
RTT Incomplete Admitted Backlog	671	1410	671	1410	739	446	916	916	
RTT Incomplete Non-Admitted Backlog	252	908	252	908	656	424	459	459	
RTT Incomplete Pathway	95.7%	90.5%	95.7%	90.5%	-5.3%	-3.0%	92%	92.3%	
RTT 52 Week Waiters	0	0	5	2	-3	2	0	2	
RTT Incomplete Total Backlog	923	2318	923	2318	1,395	641	1,375	1375	
% Diagnostics Tests WTimes <6wks	96.27%	99.8%	98.8%	99.8%	1.0%	0.8%	99.0%	99.0%	
*Cancer WTimes - Indicators achieved	5	3	2	3	1	-6	9	7	
*Cancer two week wait	95.1%	94.2%	94.6%	93.0%	-1.6%	0.0%	93.0%	92.3%	
*Cancer two week wait-Breast Symptoms	96.4%	87.8%	94.4%	89.6%	-4.8%	-3.4%	93.0%	93.0%	
*Cancer 31 day wait - First Treatment	94.7%	96.3%	97.1%	96.6%	-0.5%	0.6%	96.0%	96.0%	
*Cancer 62 day wait - First Definitive	71.7%	78.4%	75.2%	75.4%	0.2%	-3.7%	85.2%	80.9%	
*Cancer 62 day wait - First Definitive - MTW	77.3%	81.8%	80.7%	80.3%	-0.4%		85.0%		
*Cancer 104 day wait Accountable	9.0	6.5	28.0	53.0	25.0	53.0	0	53.0	
*Cancer 62 Day Backlog with Diagnosis	New	74	New	74					
*Cancer 62 Day Backlog with Diagnosis - MTW	New	51	New	51					
Delayed Transfers of Care	6.6%	8.0%	6.6%	6.5%	-0.1%	3.0%	3.5%	6.5%	
% TIA with high risk treated <24hrs	68.6%	85.7%	70.8%	78.6%	7.8%	18.6%	60%	78.6%	
*****% spending 90% time on Stroke Ward	87.1%	80.8%	85.0%	80.8%	-4.2%	0.8%	80%	80.8%	
*****Stroke:% to Stroke Unit <4hrs	51.7%	60.0%	51.7%	51.1%	-0.6%	-8.9%	60.0%	51.1%	
*****Stroke: % scanned <1hr of arrival	52.5%	61.8%	53.1%	54.4%	1.3%	6.4%	48.0%	54.4%	
*****Stroke:% assessed by Cons <24hrs	70.1%	61.8%	72.6%	62.3%	-10.3%	-17.7%	80.0%	62.3%	
Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	0	0	
Patients not treated <28 days of cancellation	0	5	0	18	18	18	0	18	

Well-Led	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
	Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/Limit	Forecast	
	Income	34,037	36,222	232,925	247,993	6.5%	-0.5%	440,817	
EBITDA	1,104	2,248	7,033	7,228	2.8%	-9.6%	37,717	37,178	
Surplus (Deficit) against B/E Duty	(1,698)	(542)	(12,806)	(11,942)			4,675	4,137	
CIP Savings	2,066	1,772	12,285	10,900	-11.3%	-7.6%	32,065	32,065	
Cash Balance	4,170	3,974	4,170	3,974	-4.7%	1%	1,000	1,000	
Capital Expenditure	1,403	379	5,826	1,868	-67.9%	-60.0%	15,188	6,949	
Establishment (Budget WTE)	5,643.4	5,733.1	5,643.4	5,733.1	1.6%	0.0%	5,837.3	5,837.3	
Contracted WTE	5,004.0	5,140.7	5,004.0	5,140.7	2.7%	-3.4%	5,427.1	5,427.1	
***Contracted not worked WTE	(116.5)	(120.8)	(116.5)	(120.8)	3.6%		(100.0)	(100.0)	
Bank Staff (WTE)	293.0	318.2	293.0	318.2	8.6%	20.9%	254.8	254.8	
Agency & Locum Staff (WTE)	327.2	253.3	346.7	253.3	-26.9%		155.3	155.3	
Overtime (WTE)	63.0	55.5	63.0	55.5	-11.9%		50.0	64.4	
Worked Staff WTE	5,570.7	5,646.9	5,570.7	5,646.9	1.4%	-1.5%	5,801.7	5,801.7	
Vacancies WTE	639.4	511.9	639.4	511.9	-20.0%	23.6%	408.6	408.6	
Vacancy %	11.3%	8.9%	11.3%	8.9%	-2.4%	23.6%	8.5%	8.5%	
Nurse Agency Spend	(799)	(686)	(6,079)	(5,257)	-13.5%				
Medical Locum & Agency Spend	(974)	(1,183)	(7,296)	(9,105)	24.8%				
Temp costs & overtime as % of total pay bill		15.4%		15.4%					
Staff Turnover Rate	10.3%	10.3%	9.8%	10.3%	0.0%	-0.2%	10.5%	10.3%	
Sickness Absence	3.7%	4.0%	3.9%	4.1%	0.3%	0.7%	3.3%	4.1%	
Statutory and Mandatory Training	87.9%	89.3%	87.9%	89.3%	1.4%	4.3%	85.0%	89.3%	
Appraisal Completeness	76.7%	81.8%	62.9%	81.8%	5.2%	-8.2%	90.0%	85.0%	
Overall Safe staffing fill rate	100.5%	96.9%	101.4%	99.2%	-3.6%		93.5%	99.2%	
*****Staff FFT % recommended work	56.9%	60.2%	57.4%	63.8%	6.4%	-1.8%	62.0%	63.8%	
*****Staff Friends & Family -Number Responses	253	98	1405	98	-1,307				
*****IP Resp Rate Recmd to Friends & Family	25.2%	17.1%	27.0%	22.6%	-4.4%	-2.4%	25.0%	25.0%	
A&E Resp Rate Recmd to Friends & Family	20.5%	21.8%	14.5%	15.3%	0.8%	0.3%	15.0%	15.0%	
Mat Resp Rate Recmd to Friends & Family	30.1%	34.6%	16.7%	24.1%	7.3%	-0.9%	25.0%	25.0%	

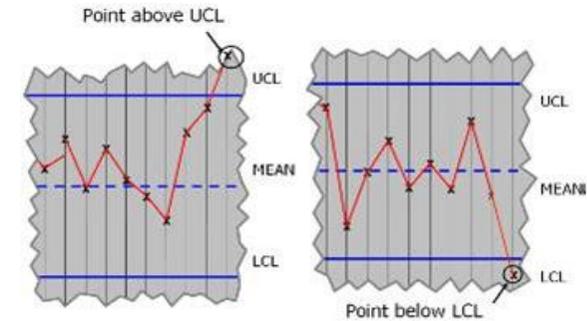
Explanation of Statistical Process Control (SPC) Charts

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

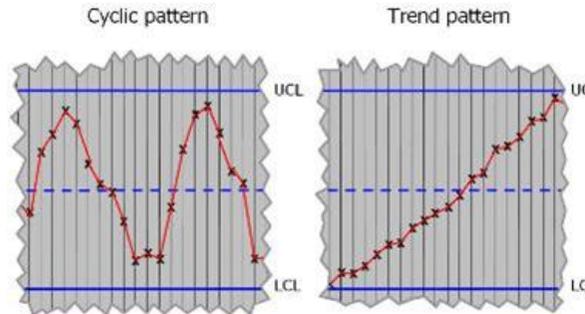


SPC is a type of charting that shows the variation that exists in the systems that are being measured. When interpreting SPC charts there are 4 rules that help to identify what the system is doing. If one of the rules has been broken, this means that 'special cause' variation is present in the system.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

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

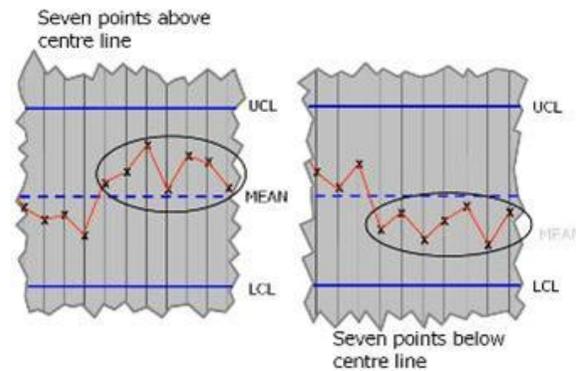


Rule 2: Any unusual pattern or trends within the cyclical pattern is seasonality but we also see it when have low numbers. To qualify as a trend there must be reasons we use SPC charts as it helps us differentiate action we have taken.



Rules 1 and 2 are the main reason for displaying makes abnormally high or low values and trends other rules that are also used to interpret the graphs.

Rule 3: A run of seven points all above or all below This shows some longer term change in the process to perform a procedure in an outpatient setting rather points above the line then points below the line can also

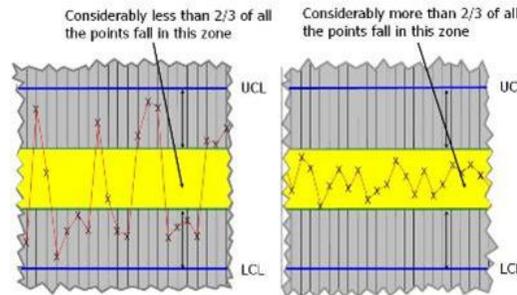


control limits. The most obvious example of a looking at daily discharges where the weekends at least 6 points in a row. This is one of the key between natural variation & variation due to some

SPC charts on our performance reports as it immediately obvious. However there are two

the centre line, or all increasing or decreasing. such as a new piece of equipment that allows us than admitting them. However alternating runs of invoke rule 3.

Rule 4: The number of points within the middle third of markedly from two-thirds of the total number of points. If controlled variation (common cause) is displayed in the which means that the variation is inherent in the process. the entire system.

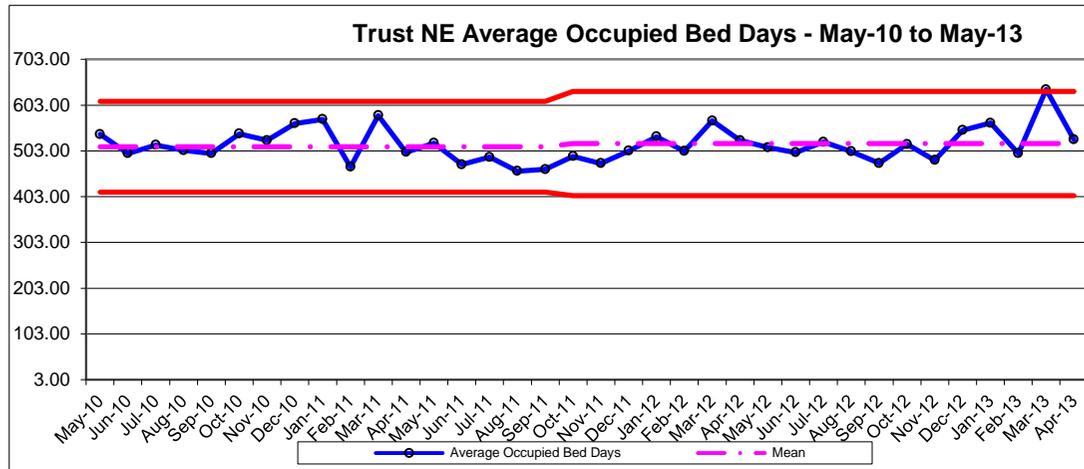


the region between the control limits differs. This gives an indication of how stable a process is. SPC chart, the process is stable and predictable, To change performance you will have to change

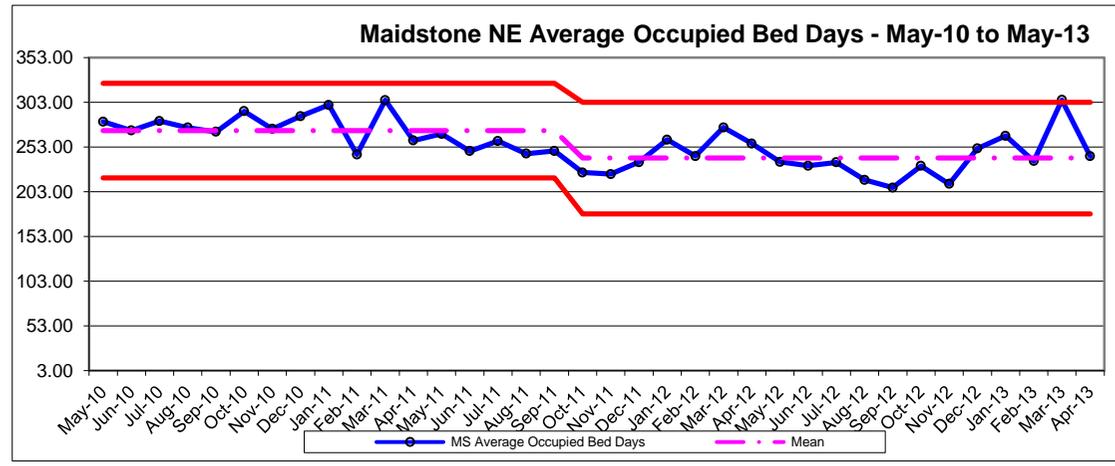
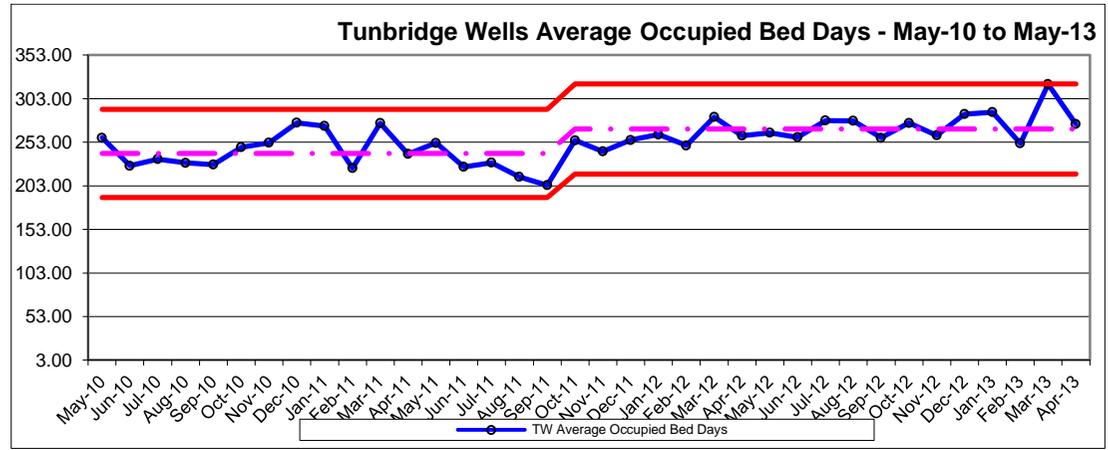
Changes to Control Lines

When there are known changes to the services we of that change. For example you will see in the graph from October 2011 onwards. This is to reflect the move of services to the new Tunbridge Wells Hospital in late September.

provide we reset the calculations as at the date below that we have re-calculated the control lines



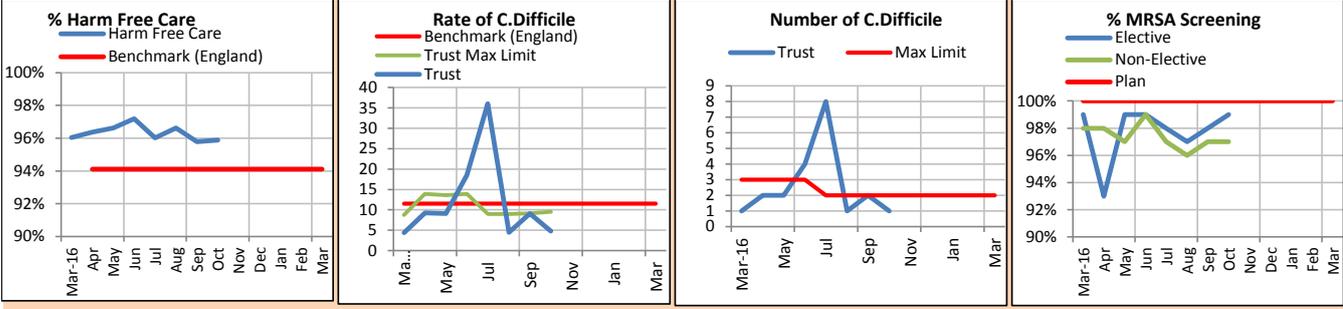
The change is not immediately obvious in the graph above if you look at just the blue line, but we know there were major changes to our inpatient beds. Looking at site level the change is more obvious:



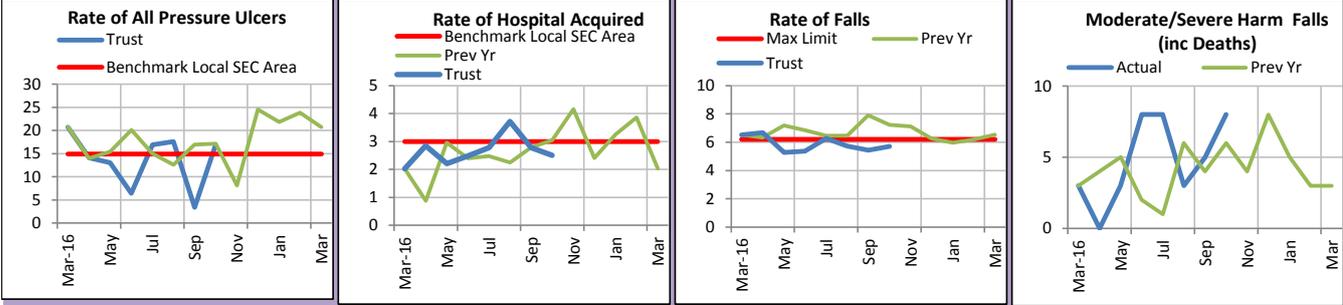
So in the examples given we have calculated a mean and control limits based on the data for May 2010 to September 2011 and then calculated them based on the period October 2011 to April 2013. The lines are all a result of the SPC calculations, only the date of the change is decided by the Information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

INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

Patient Safety - Harm Free Care, Infection Control



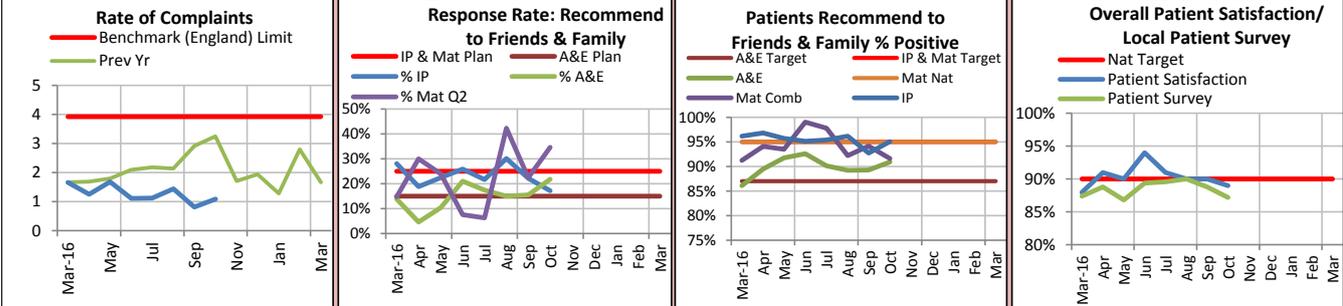
Patient Safety - Pressure Ulcers, Falls



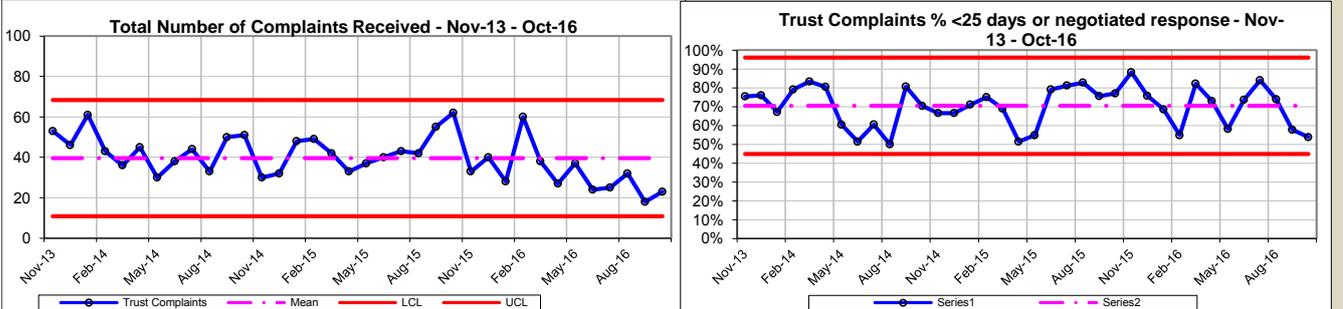
Patient Safety, MSA Breaches, SIs, Readmissions



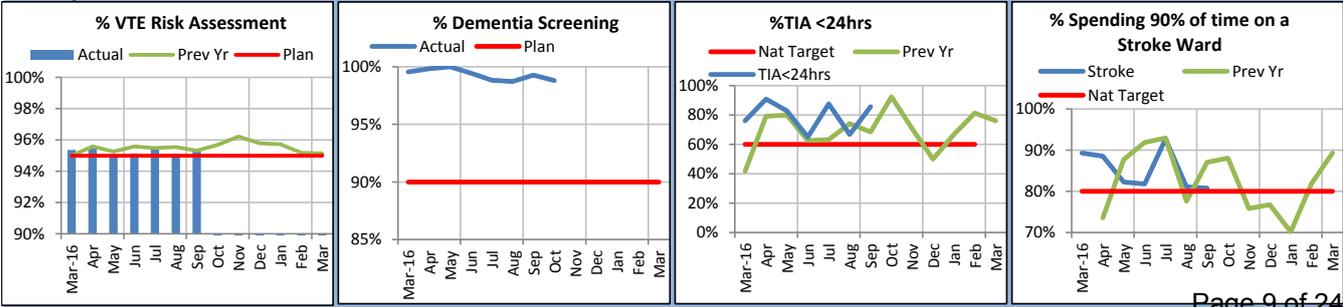
Quality - Complaints, Friends & Family, Patient Satisfaction



Quality - Complaints, Friends & Family, Patient Satisfaction

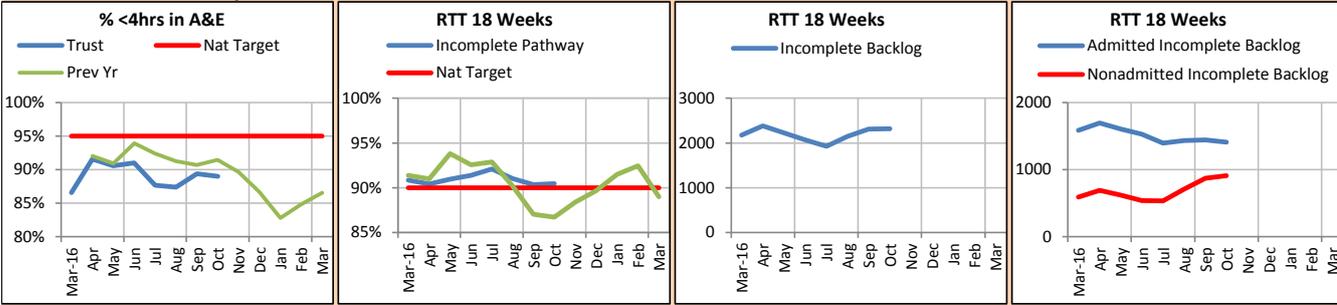


Quality - VTE, Dementia, TIA, Stroke

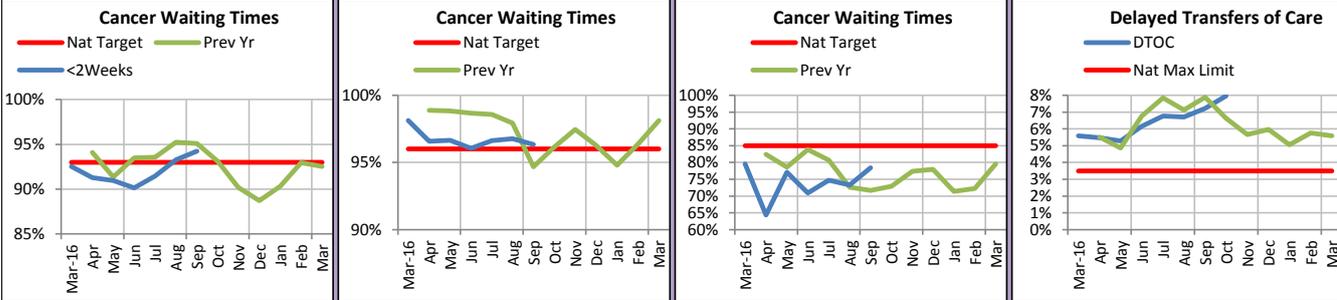


INTEGRATED PERFORMANCE REPORT ANALYSIS - PERFORMANCE & ACTIVITY

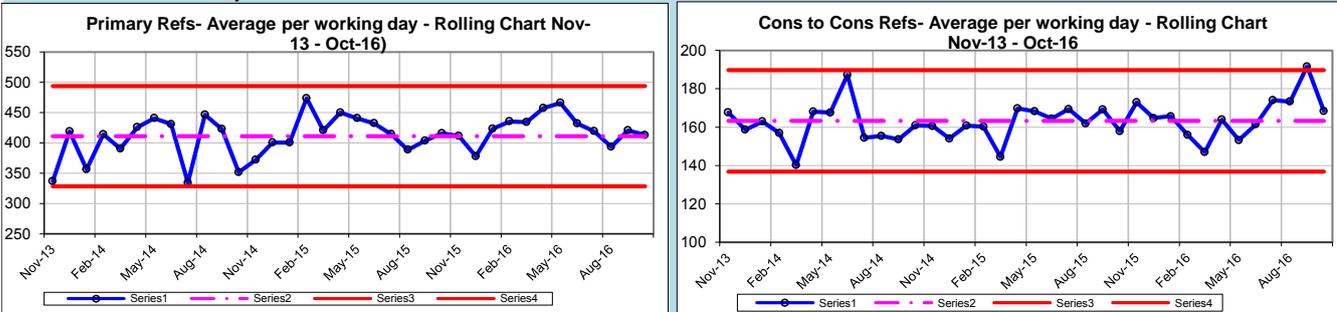
Performance & Activity - A&E, 18 Weeks



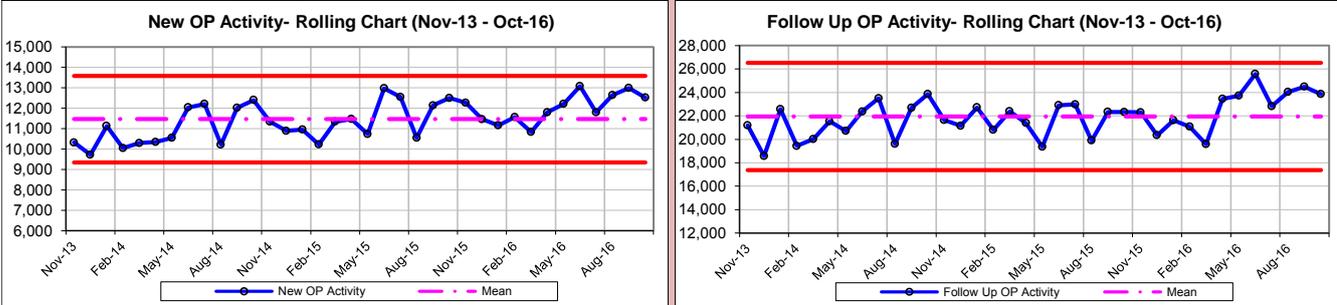
Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care



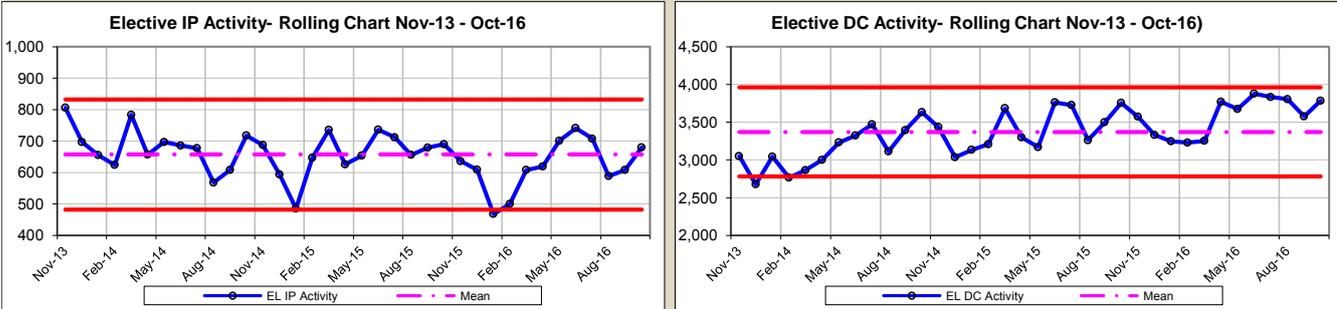
Performance & Activity - Referrals



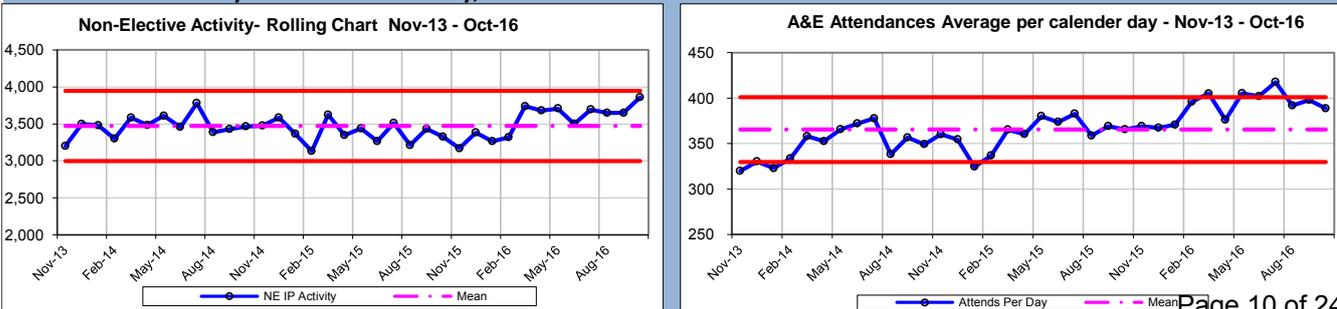
Performance & Activity - Outpatient Activity



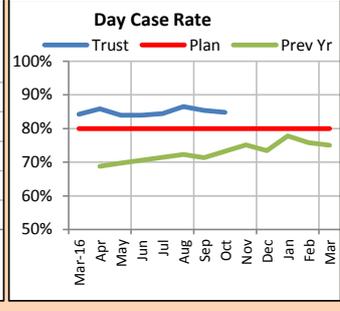
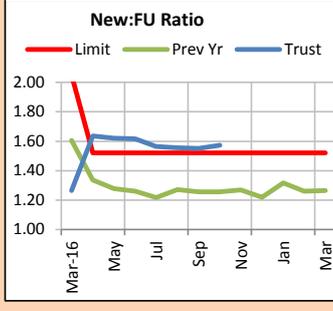
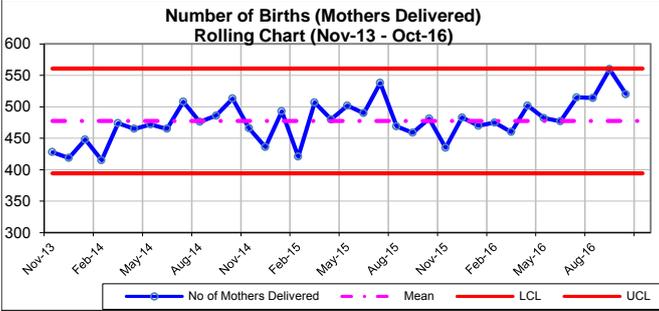
Performance & Activity - Elective Activity



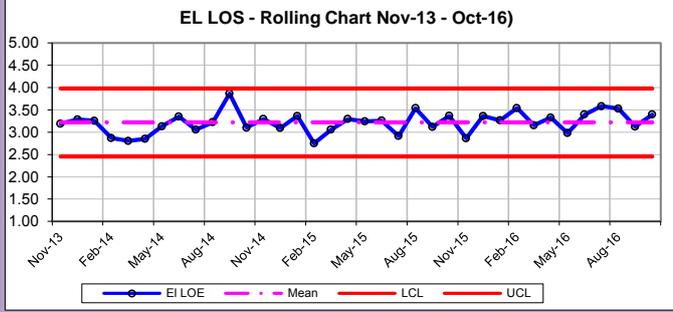
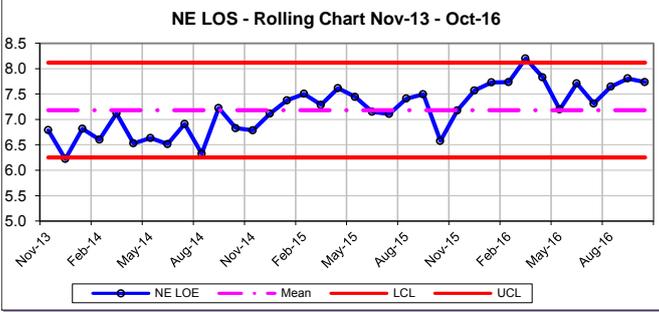
Performance & Activity - Non-Elective Activity, A&E Attendances



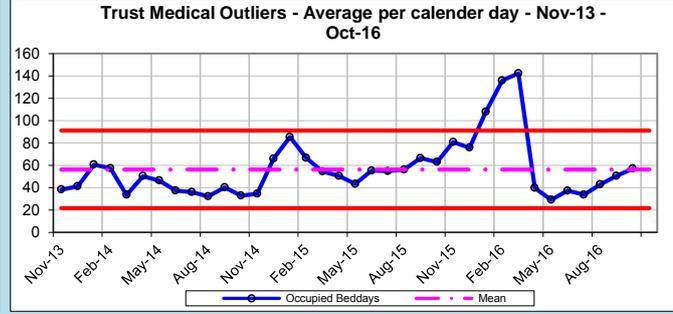
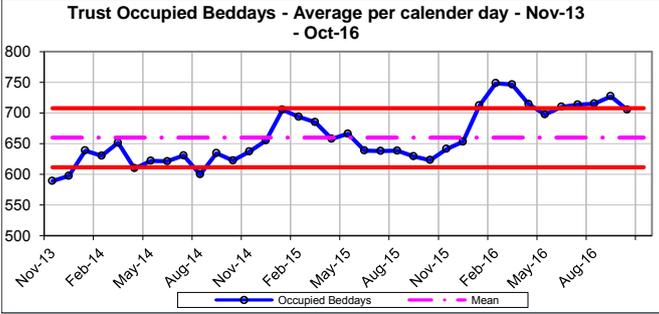
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates



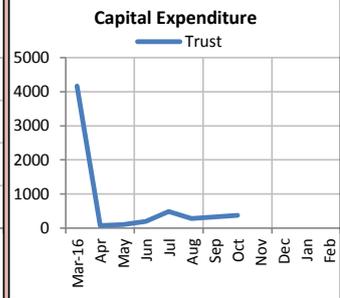
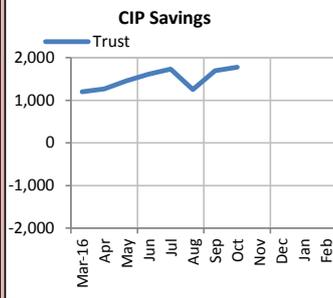
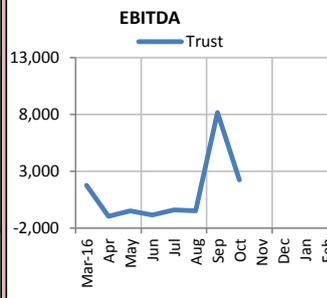
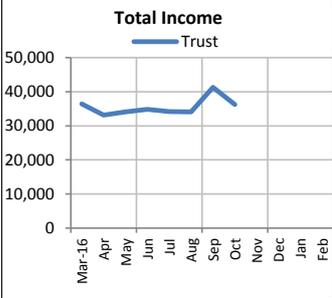
Finance, Efficiency & Workforce - Length of Stay (LOS)



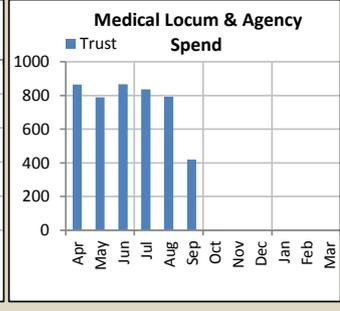
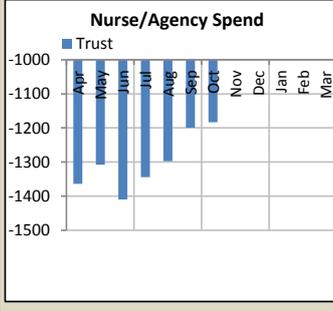
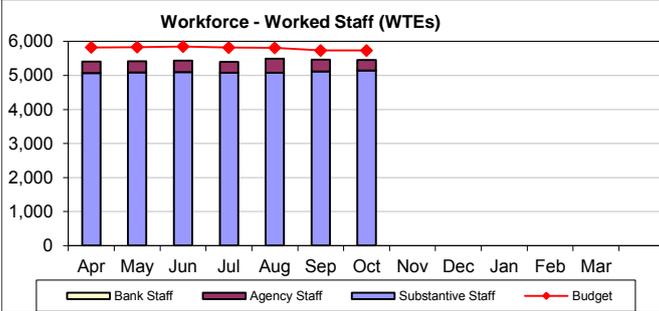
Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers



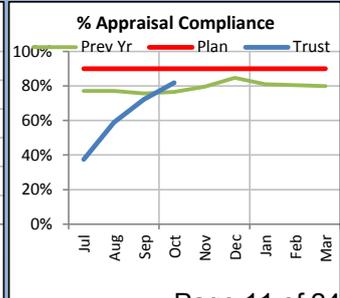
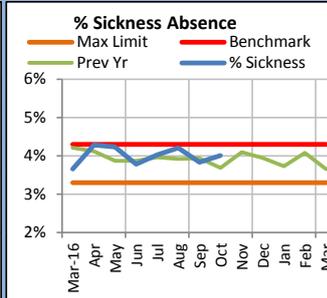
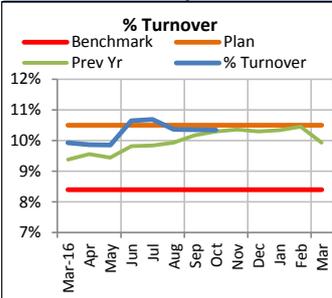
Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure



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



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



Trust Board meeting – November 2016

11-10 Review of Latest Financial Performance

Director of Finance

Summary / Key points

- The Trust had an adverse variance against plan in October 2016 of £0.2m
- The Trust's net deficit to date (including technical adjustments) is £11.9m against a planned deficit of £11.4m, therefore £0.6m adverse to plan. The driver of the adversity to plan is the Trust only achieved 85% of the STF YTD. The Trust fully achieved the element relating to financial performance and A&E performance but failed RTT and Cancer performance trajectories.
- In October the Trust operated with an EBITDA deficit of £2.2m which was £0.2m adverse to plan.
- The key drivers of the variance in the month are as follows:
 - Total income was breakeven in the month, Clinical income was £0.7m adverse in the month, £0.2m due to the Trust not achieving the full STF funding due to failure to meet RTT and Cancer trajectories agreed at the beginning of the financial year. Non Elective income net of Marginal rate was £0.6m lower than plan.
 - Pay was adverse to plan in the month by £0.2m which was due to scientific and technical staffing. Total pay spend reduced compared to the average of April to August (September excluded from trend due to incorporating YTD adjustments associated with the FRP) by £0.2m, Nursing reduced by £0.3m, Support staff by £0.1m, Medical no change and scientific and technical increased by 0.2m
 - Non Pay was underspent by £0.1m, Drugs underspent in the month by £0.2m.
- The CIP and FRP performance in October delivered efficiencies of £1.8m which was £0.8m adverse to plan. £0.6m of the slippage relates to energy and rates savings.
- The Trust held £3.9m of cash at the end of October. The Trust applied for an uncommitted loan facility at the end of October which will draw £2.7m in November.
- The Trust has agreed a control total for 2016/17 with NHSI of £4.7m surplus.

Which Committees have reviewed the information prior to Board submission?

-

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

To note the October financial position

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

Trust Board Finance Pack

Month 7
2016/17

Trust Board Finance Pack for October 2016

1. Executive Summary

- a. Executive Summary
- b. Executive Summary KPI's

2. Financial Performance

- a. Consolidated I&E

3. Expenditure Analysis

- a. Run Rate Analysis £

4. Cost Improvement Programme / Financial Recovery Plan

- a. Current Month Savings by Directorate
- b. Year to date Savings by Directorate
- c. Forecast Savings by Directorate

5. Balance Sheet and Liquidity

- a. Cash Flow
- b. Balance Sheet

6. Capital

- a. Capital Plan

1. Executive Summary

1a. Executive Summary October 2016

Key Variances £m

	October	YTD		Headlines
Total Surplus (+) / Deficit (-)	(0.2)	(0.6)	Adverse	The reported Trust position for October is a deficit of £0.5m which is £0.2m adverse to plan. The main drivers were: Clinical Income was £0.7m adverse to plan in month (£2m adverse YTD), Non Elective activity net of threshold was £0.6m adverse in the month, £0.2m adverse against Sustainability Transformation Funding (STF) due to Cancer 62 days and RTT below trajectories, £0.2m adverse relating to Out Patients partly offset by £0.4m YTD PFI indexation income. Other operating income favourable in the month by £0.5m this is mainly due to one off gains relating to COS VAT (£0.1m), HIS BI (£0.1m) and release of old year accrual (£0.1m). Pay overspent in the month by £0.2m due to increase in Scientific and Technical staffing costs, Non Pay was £0.1m favourable in the month due to underspending against drugs.
Pay	(0.2)	0.4	Favourable	Pay was £0.2m overspent in the month. The level of pay spend has reduced to month 1-5 average (Month 6 effected by non recurrent balance sheet adjustments relating to FRP) by £0.2m which was within Nursing (£0.3m) however Scientific and Technical Pay has increased by £0.1m. The increase within Scientific and Technical staffing is within Therapies (£50k), Theatres (£30k) and Cancer (£24k)
Non Elective threshold	0.6	0.6	Favourable	The non-elective threshold has been adjusted in line with the Financial Recovery plan. Negotiation and agreement with commissioners is required and therefore remains a risk to achievement of the Trust control total for 2016/17
Sustainability and Transformation Fund	(0.2)	(0.6)	Adverse	The Sustainability and Transformation fund is weighted 70% towards achieving the financial plan and 30% towards access targets (12.5% A&E, 12.5% RTT and 5% Cancer). The Trust achieved the financial plan however has not fully achieved the access targets for RTT and Cancer
CIP / FRP	(0.8)	(0.9)	Adverse	£0.6m slippage in October relates to energy and rates rebate, energy rebate now expected November 16 and rates rebate was incorporated within the September FRP.

Financial Forecast

Risks:

Unidentified FRP (£8.6m) phased from 1st January 17 equating to a reduction in budget of £3.1m per month.

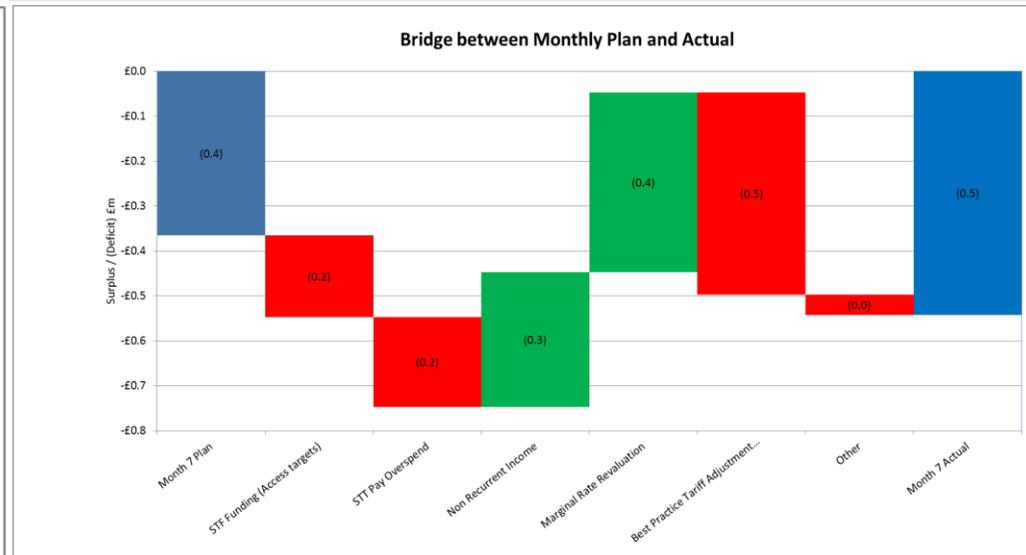
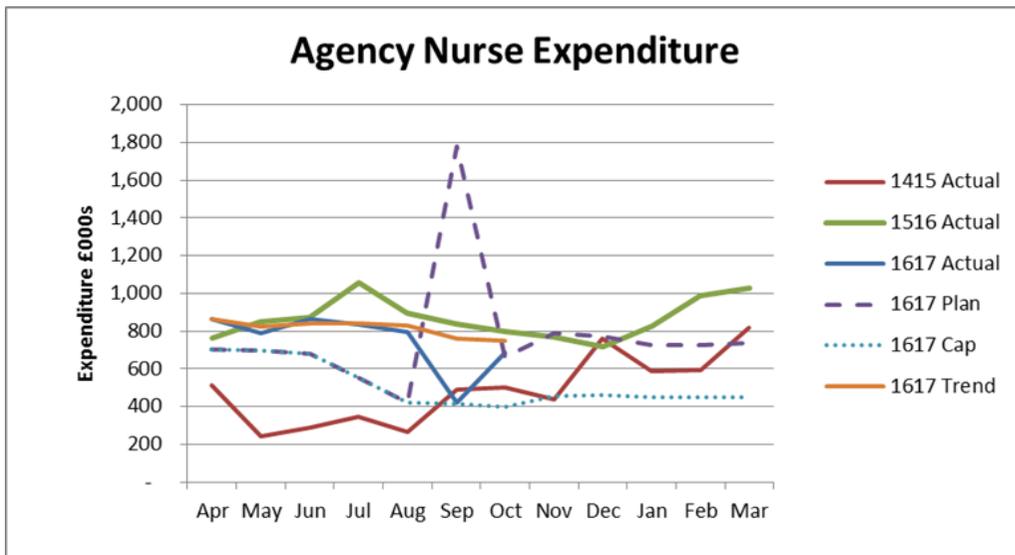
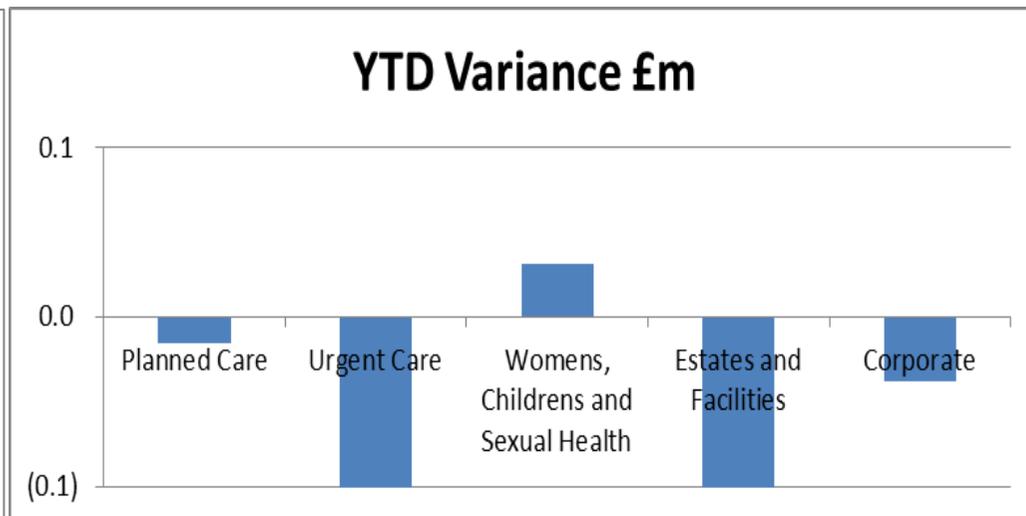
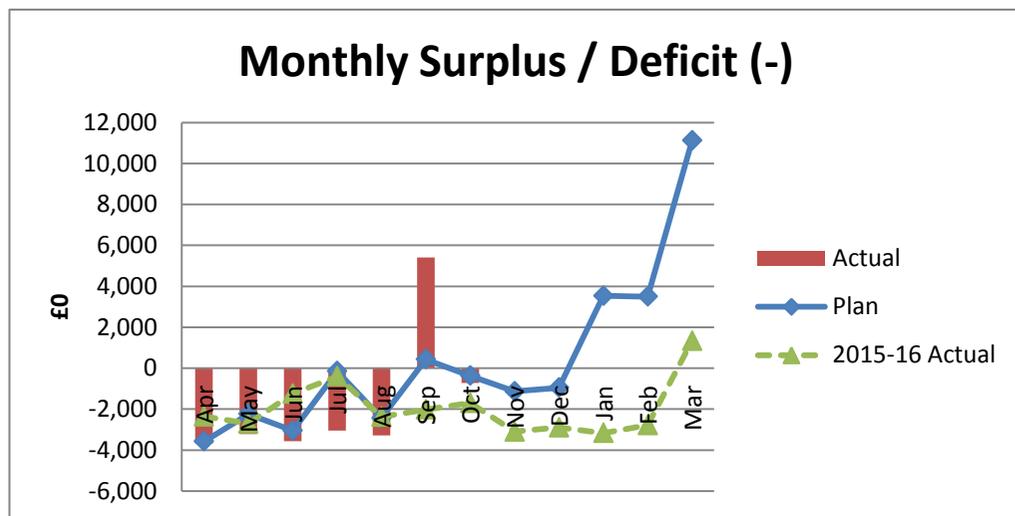
Ability to deliver elective activity due to non elective activity levels

CQUINs are finalised with the Commissioners, the main CQUINs with risk are: Flu vaccinations, Health and Well being and Antibiotic prescribing. CQUIN performance is forecasted to achieve 90% for the year.

Opportunities:

Work ongoing to identify further opportunities as part of the FRP. New FRP governance process in place. Top down savings have been developed as part of the Carter programme. These will be fast tracked over the coming months to ensure early delivery.

1b. Executive Summary KPI's October 2016



2. Financial Performance

2a. Consolidated Income & Expenditure

Income & Expenditure October 2016/17

	Current Month			Year to Date			Annual Forecast		
	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m	Forecast £m	Plan £m	Variance £m
Revenue									
Clinical Income	28.5	29.0	(0.5)	198.6	199.9	(1.4)	344.6	348.3	(3.8)
STF	0.9	1.0	(0.2)	3.6	4.2	(0.6)	6.8	9.4	(2.6)
High Cost Drugs	2.9	2.7	0.2	19.4	19.0	0.4	32.6	32.6	0
Other Operating Income	4.0	3.5	0.5	26.5	26.2	0.3	50.2	50.5	(0.3)
Total Revenue	36.2	36.3	(0.0)	248.0	249.3	(1.3)	434.1	440.8	(6.7)
Expenditure									
Substantive	(18.0)	(17.9)	(0.0)	(125.7)	(126.0)	0.2	(218.6)	(214.3)	(4.3)
Bank	(0.8)	(0.7)	(0.1)	(5.6)	(5.3)	(0.3)	(9.1)	(8.9)	(0.3)
Locum	(0.9)	(0.9)	(0.0)	(7.0)	(7.2)	0.1	(11.3)	(10.8)	(0.6)
Agency	(1.4)	(1.3)	(0.1)	(10.0)	(10.4)	0.4	(17.3)	(16.4)	(0.9)
Pay Reserves	0.0	0.0	0.0	0	0	0	0	0	0
Total Pay	(21.1)	(20.9)	(0.2)	(148.4)	(148.8)	0.4	(256.4)	(250.4)	(6.0)
Drugs & Medical Gases	(3.9)	(4.1)	0.2	(29.0)	(28.9)	(0.1)	(49.4)	(48.3)	(1.1)
Blood	(0.2)	(0.2)	0.0	(1.4)	(1.4)	0.0	(2.4)	(2.4)	0.0
Supplies & Services - Clinical	(2.7)	(2.6)	(0.1)	(18.8)	(18.2)	(0.5)	(31.3)	(30.5)	(0.8)
Supplies & Services - General	(0.5)	(0.5)	(0.1)	(3.2)	(3.2)	(0.0)	(5.4)	(5.5)	0.1
Services from Other NHS Bodies	(0.7)	(0.8)	0.1	(4.7)	(5.0)	0.3	(8.8)	(8.6)	(0.2)
Purchase of Healthcare from Non-NHS	(0.8)	(0.8)	(0.0)	(5.4)	(5.6)	0.2	(9.3)	(9.5)	0.2
Clinical Negligence	(1.5)	(1.5)	0.0	(10.6)	(10.6)	0.0	(18.3)	(18.3)	0
Establishment	(0.3)	(0.3)	(0.1)	(2.2)	(2.1)	(0.2)	(3.3)	(3.3)	0.0
Premises	(1.7)	(1.7)	0.0	(12.1)	(12.4)	0.3	(20.7)	(20.5)	(0.2)
Transport	(0.1)	(0.1)	(0.0)	(1.0)	(0.9)	(0.1)	(1.3)	(1.3)	(0.1)
Other Non-Pay Costs	(0.3)	(0.3)	(0.0)	(2.6)	(2.7)	0.1	(4.4)	(4.2)	(0.3)
Non-Pay Reserves	0.0	(0.0)	0.0	(1.3)	(1.4)	0.1	(0.3)	(0.3)	0
Total Non Pay	(12.9)	(13.0)	0.1	(92.3)	(92.5)	0.1	(155.1)	(152.7)	(2.4)
Total Expenditure	(34.0)	(33.9)	(0.1)	(240.8)	(241.3)	0.5	(411.5)	(403.1)	(8.4)
EBITDA	2.2	2.4	(0.2)	7.2	8.0	(0.8)	22.6	37.7	(15.1)
Other Finance Costs	0.0	0.0	0.0	2.9%	3.2%	58.8%	5.2%	8.6%	225%
Depreciation	(1.4)	(1.4)	0.0	(9.6)	(9.6)	0.0	(16.4)	(15.7)	(0.7)
Interest	(0.1)	(0.1)	(0.0)	(0.6)	(0.6)	(0.0)	(1.3)	(1.1)	(0.2)
Dividend	(0.3)	(0.3)	0.0	(1.9)	(1.9)	0.0	(3.1)	(3.4)	0.3
PFI and Impairments	(1.1)	(1.1)	(0.0)	(7.9)	(7.9)	(0.0)	(27.0)	(27.0)	(0.0)
Total Finance Costs	(2.9)	(2.9)	0.0	(19.9)	(20.0)	0.1	(47.9)	(47.2)	(0.6)
Net Surplus / Deficit (-)	(0.6)	(0.5)	(0.2)	(12.7)	(11.969)	(0.7)	(25.3)	(9.5)	(15.7)
Technical Adjustments	0.1	0.1	(0.0)	0.7	0.6	0.2	14.2	14.2	0
Surplus/ Deficit (-) to B/E Duty	(0.5)	(0.4)	(0.2)	(11.9)	(11.4)	(0.6)	(11.1)	4.7	(15.7)
Surplus/ Deficit (-) to B/E Duty Excl STF	(1.4)	(1.4)	0.0	(15.5)	(15.6)	0.0	(17.8)	(4.7)	(13.1)

Commentary

The Trusts deficit was £0.5m which was £0.2m adverse to plan with a YTD deficit of £11.9m (£0.6m adverse to plan).

The variance to date is due to the Trust not achieving the full STF due to the 2 performance trajectories of RTT and Cancer 62 day targets.

Non-Elective Income is adverse to plan in month by £1.2m and £1.1m year to date. The adverse movement relates to a prior period adjustment for Stroke Best Practice Tariff (£0.5m) due to a technical error in the pricing of this activity. This is offset by an improvement in the Non-Elective threshold which is £0.6m better than plan in month.

Other Operating Income benefited by one off gains relating to COS VAT (£0.1m), HIS BI income £0.1m and release of an old year accrual £0.1m.

Pay was adverse in the month by £0.2m which was within STT. The level of expenditure increased within STT by £0.1m between months, both Agency (£80k) and substantive staff (£40k) increased. The increase between months was Therapies (£50k), Critical Care (£30k) and Cancer (£24k).

Non Pay was underspent by £0.1m, £0.2m favourable within Drugs however there were overspends in Supplies and Services. Supplies and Services General increased by £130k between months, the main area of increase was within catering, impact £90k.

The main areas of overspend YTD within Supplies and Services clinical are: T&O (£278k) and Diagnostics (£124k).

The Trust is forecasting a year end deficit of £11.1m with mitigating actions of £15.6m to deliver a year end surplus including STF of £4.2m which is £0.4m adverse to plan.

3. Expenditure Analysis

3a. Run Rate Analysis

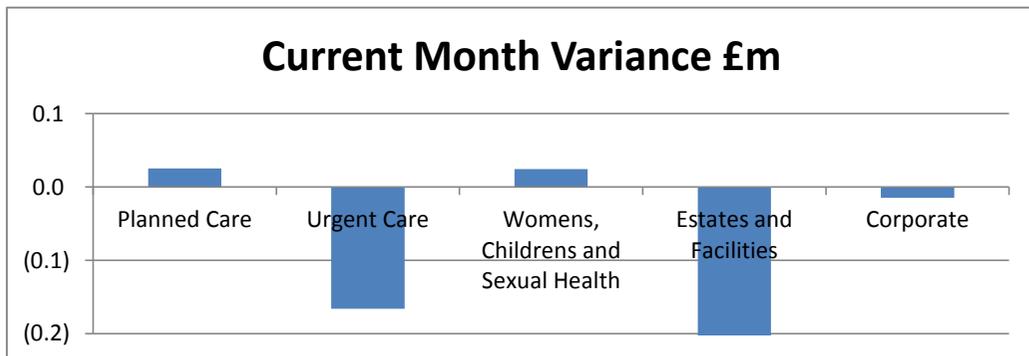
Analysis of 13 Monthly Performance (£m's)

		Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Change between Months
Revenue	Clinical Income	27.3	26.3	26.4	25.5	25.7	26.9	26.6	27.7	28.4	27.6	27.8	34.7	29.3	(5.4)
	High Cost Drugs	2.5	2.8	2.8	2.7	2.6	3.1	2.8	2.6	2.8	2.6	2.7	2.9	2.9	(0.0)
	Other Operating Income	4.3	4.1	4.0	4.0	4.6	6.5	3.8	3.8	3.6	4.0	3.6	3.7	4.0	0.3
	Total Revenue	34.0	33.2	33.2	32.2	33.0	36.4	33.2	34.1	34.8	34.2	34.1	41.3	36.2	(5.1)
Expenditure	Substantive	(17.0)	(17.5)	(17.4)	(17.3)	(17.7)	(18.1)	(17.8)	(17.9)	(18.1)	(17.9)	(17.9)	(18.1)	(18.0)	0.1
	Bank	(0.8)	(0.8)	(0.8)	(0.9)	(0.9)	(1.1)	(0.9)	(0.8)	(0.8)	(0.7)	(0.9)	(0.8)	(0.8)	(0.0)
	Locum	(0.8)	(0.6)	(0.9)	(1.0)	(0.7)	(0.6)	(1.2)	(0.9)	(1.0)	(1.1)	(1.1)	(0.8)	(0.9)	(0.1)
	Agency	(1.7)	(1.6)	(1.6)	(1.4)	(1.7)	(1.9)	(1.3)	(1.6)	(1.7)	(1.5)	(1.3)	(1.2)	(1.4)	(0.3)
	Pay Reserves	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Pay	(20.2)	(20.4)	(20.6)	(20.6)	(21.0)	(21.8)	(21.2)	(21.2)	(21.6)	(21.3)	(21.2)	(20.9)	(21.1)	(0.2)
Non-Pay	Drugs & Medical Gases	(3.7)	(4.0)	(4.1)	(4.1)	(3.9)	(4.0)	(4.3)	(4.1)	(4.4)	(3.8)	(4.0)	(4.5)	(3.9)	0.6
	Blood	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	0.0
	Supplies & Services - Clinical	(2.8)	(3.0)	(2.8)	(2.5)	(2.3)	(2.3)	(2.2)	(2.7)	(2.7)	(2.7)	(3.0)	(2.7)	(2.7)	(0.1)
	Supplies & Services - General	(0.4)	(0.5)	(0.4)	(0.6)	(0.4)	(0.7)	(0.4)	(0.5)	(0.5)	(0.4)	(0.5)	(0.4)	(0.5)	(0.1)
	Services from Other NHS Bodies	(0.4)	(0.5)	(0.6)	(0.7)	(0.6)	(0.7)	(0.7)	(0.7)	(0.8)	(0.6)	(0.6)	(0.7)	(0.7)	0.1
	Purchase of Healthcare from Non-NHS	(0.8)	(0.6)	(0.7)	(0.3)	(0.7)	(1.1)	(0.8)	(0.7)	(0.8)	(0.9)	(0.9)	(0.6)	(0.8)	(0.3)
	Clinical Negligence	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	0
	Establishment	(0.4)	(0.4)	(0.3)	(0.3)	(0.4)	(0.4)	(0.2)	(0.3)	(0.3)	(0.4)	(0.3)	(0.4)	(0.3)	0.1
	Premises	(2.0)	(1.9)	(1.8)	(1.4)	(1.0)	(1.1)	(2.1)	(1.7)	(1.9)	(1.9)	(1.7)	(1.2)	(1.7)	(0.4)
	Transport	(0.2)	(0.2)	(0.1)	(0.0)	(0.1)	(0.2)	(0.1)	(0.2)	(0.2)	(0.1)	(0.1)	(0.2)	(0.1)	0.0
	Other Non-Pay Costs	(0.4)	(0.3)	(0.4)	(0.5)	(0.8)	(0.8)	(0.2)	(0.7)	(0.6)	(0.4)	(0.2)	(0.3)	(0.3)	(0.1)
	Non-Pay Reserves	0	0	0	0	0	0	(0.2)	(0.2)	(0.4)	(0.4)	(0.4)	0.4	0.0	(0.4)
	Total Non Pay	(12.7)	(13.0)	(12.8)	(12.0)	(11.8)	(12.9)	(12.9)	(13.4)	(14.1)	(13.3)	(13.4)	(12.3)	(12.9)	(0.6)
	Total Expenditure	(32.9)	(33.5)	(33.4)	(32.6)	(32.8)	(34.7)	(34.1)	(34.6)	(35.7)	(34.6)	(34.6)	(33.1)	(34.0)	(0.8)
EBITDA	1.1	(0.3)	(0.2)	(0.4)	0.2	1.8	(1.0)	(0.5)	(0.8)	(0.4)	(0.5)	8.2	2.2	(5.9)	
Other Finance Costs	3%	-1%	-1%	-1%	1%	5%	-3%	-1%	-2%	-1%	-1%	20%	6%		
	Depreciation	(1.3)	(1.3)	(1.3)	(1.3)	(1.4)	0.9	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(0.0)
	Interest	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
	Dividend	(0.4)	(0.3)	(0.2)	(0.4)	(0.4)	0.1	(0.3)	(0.3)	(0.3)	(0.2)	(0.3)	(0.3)	(0.3)	(0.0)
	PFI and Impairments	(1.1)	(1.1)	(1.2)	(1.1)	(1.4)	(14.2)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(0.0)
	(2.9)	(2.9)	(2.8)	(2.9)	(3.2)	(13.2)	(2.9)	(2.8)	(2.8)	(2.8)	(2.8)	(2.9)	(2.9)	(0.0)	
Net Surplus / Deficit (-)	Net Surplus / Deficit (-)	(1.8)	(3.2)	(3.1)	(3.3)	(3.0)	(11.5)	(3.8)	(3.3)	(3.7)	(3.2)	(3.3)	5.3	(0.6)	(6.0)
Technical Adjustments	Technical Adjustments	0.1	0.1	0.2	0.1	0.2	12.8	0.1	0.0						
Surplus/ Deficit (-) to B/E Duty	Surplus/ Deficit (-) to B/E Duty	(1.7)	(3.1)	(2.9)	(3.2)	(2.8)	1.3	(3.7)	(3.2)	(3.6)	(3.1)	(3.3)	5.4	(0.5)	(5.9)

4. Cost Improvement Programme and Financial Recovery Plan

4a. Current month savings by Directorate

	Cost Improvement Plan			Financial Recovery Plan			Total Savings		
	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer and Haematology	0.1	0.1	0.0	0.1	0.1	0.0	0.2	0.2	0.0
Critical Care	0.1	0.1	0.0	0.0	0.0	0.0	0.1	0.1	0.0
Diagnostics	0.1	0.1	0.0	0.1	0.1	0.1	0.3	0.2	0.1
Head and Neck	0.1	0.1	(0.0)	0.0	0.0	0.0	0.1	0.1	(0.0)
Surgery	0.1	0.1	(0.0)	0.0	0.1	(0.0)	0.1	0.2	(0.0)
Trauma and Orthopaedics	0.1	0.1	(0.0)	0.0	0.0	(0.0)	0.1	0.1	(0.0)
Patient Admin	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Private Patients Unit	0.0	0.0	0.0	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Total Planned Care	0.6	0.6	(0.0)	0.3	0.2	0.0	0.9	0.9	0.0
Urgent Care	0.2	0.2	(0.0)	0.2	0.3	(0.1)	0.4	0.5	(0.2)
Womens, Childrens and Sexual Health	0.1	0.1	(0.0)	0.1	0.1	0.0	0.2	0.2	0.0
Estates and Facilities	0.1	0.7	(0.6)	0.0	0.1	(0.1)	0.1	0.8	(0.6)
Corporate	0.1	0.1	(0.0)	0.1	0.1	(0.0)	0.2	0.2	(0.0)
Total	1.1	1.7	(0.6)	0.7	0.8	(0.1)	1.8	2.5	(0.8)

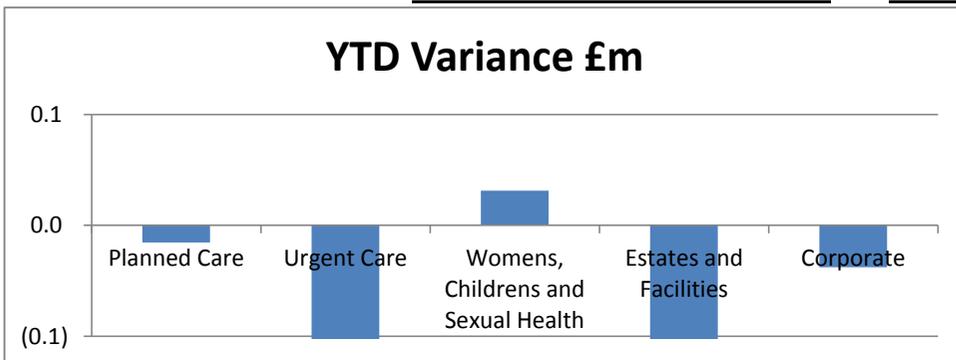


Estates and Facilities: Slippage of £0.6m relates to Energy and rates rebate. Energy rebate of £280k is forecasted to be delivered in November and the rates rebate was originally incorporated within the September FRP values.

The main area of slippage impacting the FRP relates to the nursing shift pattern review, in October this achieved 46% of the target set. Actions have been taken by the Nursing divisional teams to ensure full delivery in November.

4b. Year to Date Savings by Directorate

	Cost Improvement Plan			Financial Recovery Plan			Total Savings		
	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer and Haematology	1.6	1.6	0.0	0.1	0.1	0.0	1.7	1.7	0.0
Critical Care	0.7	0.7	0.0	0.0	0.0	0.0	0.7	0.7	0.0
Diagnostics	0.8	0.7	0.0	0.3	0.2	0.1	1.0	1.0	0.1
Head and Neck	0.5	0.5	(0.0)	0.0	0.0	0.0	0.6	0.6	(0.0)
Surgery	0.8	0.8	0.0	0.0	0.1	(0.1)	0.8	0.9	(0.1)
Trauma and Orthopaedics	0.7	0.8	(0.1)	0.0	0.0	(0.0)	0.8	0.8	(0.1)
Patient Admin	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Private Patients Unit	0.1	0.1	0.0	0.0	0.0	(0.0)	0.1	0.1	0.0
Total Planned Care	5.3	5.3	(0.0)	0.5	0.5	0.0	5.8	5.8	(0.0)
Urgent Care	2.2	2.3	(0.0)	0.2	0.3	(0.1)	2.4	2.6	(0.2)
Womens, Childrens and Sexual Health	0.6	0.6	0.0	0.2	0.1	0.0	0.7	0.7	0.0
Estates and Facilities	0.8	1.5	(0.6)	0.1	0.2	(0.1)	0.9	1.6	(0.7)
Corporate	0.6	0.6	(0.0)	0.5	0.5	(0.0)	1.0	1.1	(0.0)
Total	9.5	10.2	(0.7)	1.4	1.5	(0.2)	10.9	11.8	(0.9)



Estates and Facilities: Slippage of £0.6m relates to Energy and rates rebate. Energy rebate of £280k is forecasted to be delivered in November and the rates rebate was originally incorporated within the September FRP values. FRP Slippage relates to reduction in Taxi costs and bed hire costs.

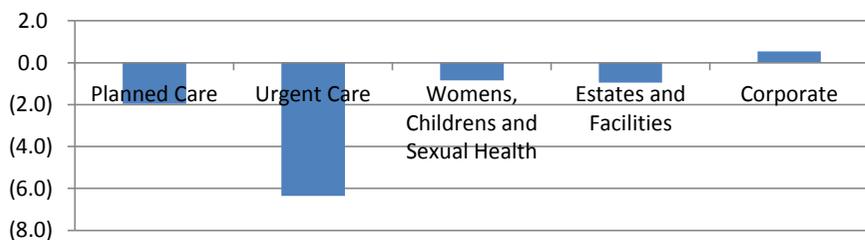
The main area of slippage impacting the FRP relates to the nursing shift pattern review, in October this achieved 46% of the target set. Actions have been taken by the Nursing divisional teams to ensure full delivery in November

4c. Forecast savings by Directorate

Directorate Performance

	Cost Improvement Plan			Financial Recovery Plan			Total Savings		
	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Cancer and Haematology	2.2	2.2	0.0	0.8	0.5	0.3	3.1	2.7	0.3
Critical Care	1.0	1.1	(0.0)	0.2	0.4	(0.1)	1.3	1.5	(0.2)
Diagnostics	1.4	1.4	0.0	1.0	1.4	(0.4)	2.4	2.8	(0.4)
Head and Neck	0.8	0.9	(0.1)	0.2	0.5	(0.3)	0.9	1.3	(0.4)
Surgery	1.2	1.2	0.0	0.4	1.0	(0.6)	1.6	2.2	(0.6)
Trauma and Orthopaedics	0.9	1.0	(0.1)	0.6	1.2	(0.7)	1.5	2.2	(0.7)
Patient Admin	0.0	0.0	0.0	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Private Patients Unit	0.2	0.2	0.0	0.0	0.0	(0.0)	0.2	0.2	0.0
Total Planned Care	7.8	8.0	(0.1)	3.2	5.0	(1.8)	11.0	13.0	(2.0)
Urgent Care	3.5	3.7	(0.2)	1.9	8.1	(6.2)	5.4	11.8	(6.4)
Womens, Childrens and Sexual Health	1.1	1.1	0.0	0.4	1.3	(0.9)	1.6	2.4	(0.8)
Estates and Facilities	1.4	2.1	(0.6)	0.9	1.2	(0.3)	2.3	3.3	(1.0)
Corporate	1.0	1.0	(0.1)	1.2	0.6	0.6	2.2	1.6	0.5
Total	14.9	15.9	(1.0)	7.6	16.2	(8.6)	22.5	32.1	(9.6)

Forecast Variance £m



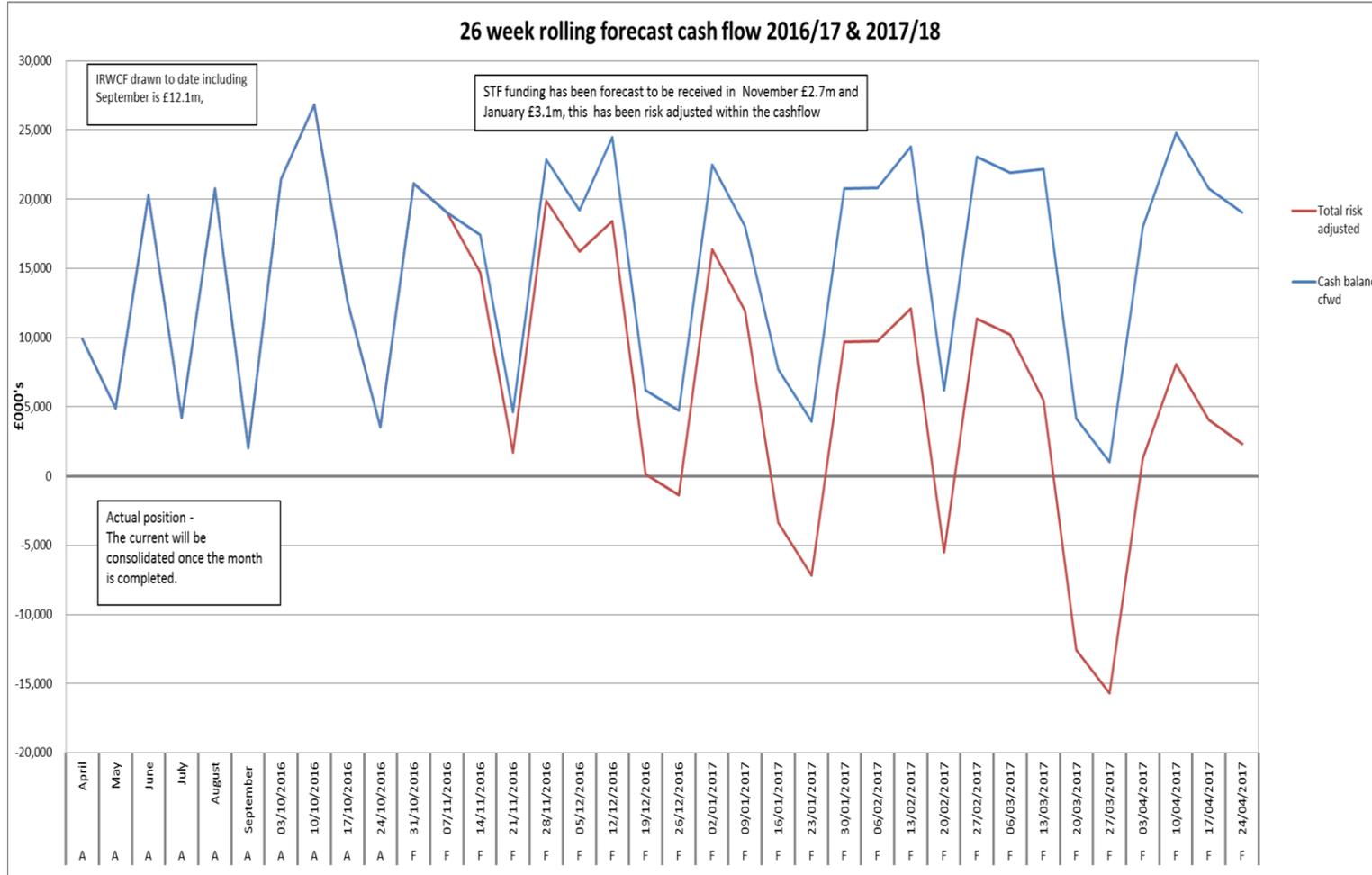
The annual savings plan for the Trust incorporating CIP and FRP equates to £32.1m for 2016/17.

The CIP forecast which was used for the resubmitted plan included savings for energy and rates. However this was not included in the I&E forecast therefore has no bottom line impact.

The current year end forecasted FRP gap is £8.6m. To deliver the control total of £4.7m surplus additional savings need to be identified.

5. Balance Sheet and Liquidity

5a. Cash Flow



Commentary

The blue line shows the Trust's cash position from the start of April, after receiving a double block from WK and Medway CCG.

In October the Trust made no capital repayment or interest payment on loan as the next loan repayment and interest payments are due in March 2017 for £1.6m.

The Trust made no payments for PDC dividend, as the next payment of £2m is due to be paid in March 2017.

For 2016/17 the Trust has IRWCF of £12.132m to assist the cash position. In October the Trust made no further withdrawals but is anticipating a withdrawal of IRWCF of £2.7m and additional support funding of £2m in mid November.

The cash forecast has been amended to reflect the I&E position after agreeing to the control totals. It assumes receiving overperformance of c£10m and receipt of STF funding of £9.4m. Both these values have been risk adjusted on the red line of the graph.

The Trust is currently paying all suppliers as authorised invoices become due. The teams are actively working on reducing the aged debtor balances, focusing on all debt balances over 90 days.

5. Balance Sheet and Liquidity

5a. Balance Sheet October 2016

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

£m's	October			September		Full year	
	Reported	Plan	Variance	Reported	Plan	Forecast	
Property, Plant and Equipment (Fixed Assets)	343.3	344.3	(1.0)	344.2	335.3	330.2	
Intangibles	2.7	1.3	1.4	2.8	1.5	2.0	
PFI Lifecycle	0.0	0.0	0.0	0.0	0.0	0.0	
Debtors Long Term	1.0	1.2	(0.2)	0.9	1.2	1.2	
Total Non-Current Assets	347.0	346.8	0.2	347.9	338.0	333.4	
Current Assets							
Inventory (Stock)	8.8	8.3	0.5	8.7	8.3	8.3	
Receivables (Debtors) - NHS	44.9	19.8	25.1	41.2	20.6	21.5	
Receivables (Debtors) - Non-NHS	13.2	7.8	5.4	12.6	10.0	9.4	
Cash	4.0	3.9	0.1	5.6	1.0	1.0	
Assets Held For Sale	0.0	0.0	0.0	0.0	0.0	0.0	
Total Current Assets	70.9	39.8	31.1	68.1	39.9	40.2	
Current Liabilities							
Payables (Creditors) - NHS	(4.4)	(5.0)	0.6	(4.4)	(5.0)	(5.0)	
Payables (Creditors) - Non-NHS	(65.5)	(32.0)	(33.5)	(65.3)	(21.8)	(21.7)	
Capital & Working Capital Loan	(2.2)	(2.2)	0.0	(2.2)	(2.2)	(2.2)	
Temporary Borrowing	0.0	0.0	0.0	0.0	0.0	0.0	
Borrowings - PFI	(4.8)	(4.8)	0.0	(4.8)	(5.1)	(5.0)	
Provisions for Liabilities and Charges	(1.9)	(2.3)	0.4	(1.9)	(1.1)	(1.0)	
Total Current Liabilities	(78.8)	(46.3)	(32.5)	(78.6)	(35.2)	(34.9)	
Net Current Assets	(7.9)	(6.5)	(1.4)	(10.5)	4.7	5.3	
Finance Lease - Non-Current	(200.2)	(200.5)	0.3	(200.6)	(198.2)	(198.2)	
Capital Loan - (interest Bearing Borrowings)	(13.4)	(13.4)	0.0	(13.4)	(16.4)	(12.4)	
Interim Revolving Working Capital Facility	(29.0)	(29.0)	0.0	(29.0)	(29.0)	(29.0)	
Provisions for Liabilities and Charges	(1.2)	(1.4)	0.2	(1.2)	(0.7)	(0.7)	
Total Assets Employed	95.3	96.0	(0.7)	93.2	98.4	98.4	
Financed By							
Capital & Reserves							
Public dividend capital	(203.3)	(203.3)	0.0	(203.3)	(203.3)	(203.3)	
Revaluation reserve	(53.8)	(53.8)	0.0	(53.8)	(53.8)	(53.8)	
Retained Earnings Reserve	161.8	161.1	0.7	163.9	158.7	158.7	
Total Capital & Reserves	(95.3)	(96.0)	0.7	(93.2)	(98.4)	(98.4)	

Commentary:

The balance sheet remains relatively constant to plan. Key movements to October are in working capital where the cash balance is decreasing from the September's position as stock, debtors and creditors are increasing. The teams are focusing on reducing the aged debtors and creditors and reviewing current processes to ensure improvement in working capital going forward.

Non-Current Assets PPE - The value of PPE continues to fall as depreciation is greater than the current capital spend, this is due to capital projects being prioritised. This is in line with plan and is not creating an unsustainable backlog of maintenance or required replacements.

Current Assets Inventory has remained consistent as the reported September position, with pharmacy stock at £3.9m, cardiology stocks £1.4m, materials management £1m and all other stock including theatres of £2.5m. Inventory reduction is a cash management and potential CIP being discussed.

NHS Receivables have increased since September and remain significantly higher than the plan value. Of the £44.7m balance, £21.0m relates to invoiced debt with £8.2m aged over 90 days, which has increased slightly from the September position of £8.1m. Due to the financial situation of many neighbouring NHS organisations regular communication is continuing and "like for like" arrangements are being actioned. An additional interim resource has been brought in on the recommendation from KMPG to assist with the reduction of debtors, working closely with the CCGs and other NHS organisations.

Trade receivables is also above plan (by £5.4m), included within this balance is trade invoiced debt of £1.4m and private patient invoiced debt of £0.8m (reduced from £0.9m in September).

Current Liabilities: NHS trade payables has remained consistent with the September reported position and is below plan. However, Non-NHS trade payables has increased and still remains significantly above plan. At present the Trust has a policy to pay approved invoices within 30 days but there are £7.4m of unapproved invoices, and £6.2m approved invoices at month end. Work is being undertaken to improve this and reduce balances over 90 days.

6. Capital

6a. Capital Programme Capital Projects/Schemes

	Year to Date			Annual Forecast			Committed
	Actual	Plan	Variance	Plan	Forecast	Variance	
	£000	£000	£000	£000	£000	£m	£000
Estates	159	1,650	1,491	9,384	2,478	6,906	890
ICT	1,465	1,811	346	2,671	2,045	626	1,546
Equipment	118	1,205	1,087	2,581	1,868	713	1,188
PFI Lifecycle (IFRIC 12)	0	0	0	553	553	0	552
Donated Assets	127	300	173	800	800	0	367
Total	1,868	4,966	3,098	15,989	7,744	8,245	4,543
Less donated assets	-127	-300	-173	-800	-800	0	-367
Contingency Against Non-Disposal	0	0	0	0	0	0	0
Adjusted Total	1,741	4,666	2,925	15,189	6,944	8,245	4,176

Commentary:

The total resource for the 2016/17 capital programme was £15.988m, including PFI lifecycle and donated assets, which had been approved by the Trust Board and prioritised by the relevant lead Directors. The Trust has proposed a Capital to Revenue transfer of £4.188m as part of its recovery plan.

A detailed review of uncommitted capital projects was undertaken by the each category lead for Estates, IT and Equipment to determine the list of projects to be deferred, in order to make it possible to reduce our outturn capital by this figure. The main project proposing to be deferred are Estates Electrical Upgrades totalling £2.7m

Given discussions with Specialist Commissioners around the Radiotherapy Development at TWH this scheme has been deferred into 17/18. It would still require approval through the NHSI process.

The Estates projects include significant investment for Backlog Maintenance of £2m, the majority of which relates to deferred 2015/16 schemes. The replacement equipment business cases were approved at the September TME meeting. The Plan of £15.988m is therefore reduced by £4.188m and £4.056m to £7.744m for 16/17.

Trust Board meeting – November 2016

11-11	Supplementary Quality and Patient Safety Report	Chief Nurse
Summary / Key points		
This report provides information on actions being taken to improve the Trust's position in regard to falls prevention, Friends & Family response rates, End of Life care and a recommendation for a change to the standard for Trust Name badges.		
Which Committees have reviewed the information prior to Board submission?		
▪ N/A		
Reason for submission to the Board (decision, discussion, information, assurance etc.) ¹		
Information, assurance, discussion and recommendations		

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

Quality Report – November 2016

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

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

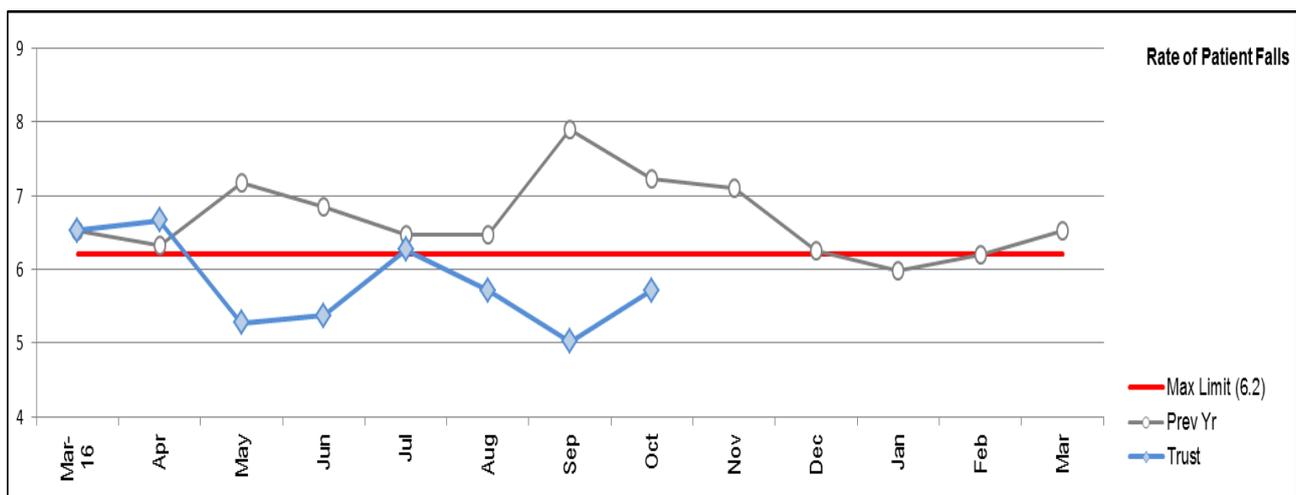
Falls prevention:

Reducing the number of patient falls has been identified as a patient safety priority this year. The focus is on ensuring falls prevention is part of all our business and to engage all staff groups in falls prevention at MTW. Our plan to reduce the rate of falls in the year to 6.2 (per 1,000 occupied bed days) has been achieved for the first 2 x quarters and as of October is 5.7 YTD. This has been with the support of the strategies listed below:-

Actions for 2016/17

- Set up Task and Finish group for reducing falls chaired by the chief nurse and supported by Director of Infection Prevention and Control and Deputy CEO.
- Review terms of reference for Slips, Trips and Falls group to engage and representation from all staff groups
- Revise the Period of increase Incidence (PII) monitoring framework for falls has been reviewed and reintroduced
- Reviewed threshold for falls number on each ward/unit and Ward Manager for any Ward exceeding threshold is supporting to bring the position back under the threshold
- Nursing assessment documents for falls prevention have been revised and falls prevention care plan is currently being trialled
- Dashboard for Falls has been established with analysis of data supported by the PMO
- National Falls Audit – Comprehensive action plan to address areas requiring improvement

Comparison of Patient Falls 2014/2015 to 2015/2016



Friends and Family (FFT)

As part of the new contract with the company IWantGreatCare (IWGC) the Trust facilitated a roadshow on both sites of the Trust with support from the company which was aimed at raising awareness among staff of the importance of obtaining the Friends and Family Test (FFT) feedback from patients as it helps us to understand more about the experience that patients have had in our care; the event also helped to promote the FFT question to patients.

A project group has been set up to monitor the Trust response rates and to address issues as they arise. The group are responsible for identifying opportunities for improvement in our current processes and to lead on improving practice specifically in relation to how we collect feedback from patients, how this is reported and importantly what actions are taken in response to patient feedback.

The target for inpatient services and maternity services for the Trust has been agreed at 25% and 15% for accident and emergency services. With the new contract in place with the company there has been increased focus on the FFT response rate in the Trust which has resulted in some consistent improvements in response rates overall.

In the accident and emergency departments the response rates have been above the target of 15% since June 2016. The most recent response rate for A&E was 21.8% for October.

Maternity services have significantly increased their response rates in the past couple of months with a response rate of 34.65% for October which is excellent and well above their target.

The Inpatient response rate has fallen for the last two months with the most recent response rates for October as 17.14%. (Below target) There were some challenges in the late collection of completed Friends and Family (FFT) cards in some areas which has had an impact on overall response rates. This is now being addressed with the support and full engagement of ward managers and matrons in clinical areas.

The Trust also reports on the percentage of positive responses to the Friends and Family question. The latest results published in October indicate consistent positive feedback for inpatients with a positive score of 95.1% A&E was 90.9%, which was above target and Maternity (all 4 questions combined) was 91.6%, which was below target.

It has been considered that the reasons for this reduction in positive responses may be due to the increase in birth rates for October with an increase in staff sickness during that time. The maternity team recently had a band 7 away day and at this event there was some discussion around how the teams can impact on receiving positive feedback from women.

There has been some further analysis of the results in maternity over the past few months in an effort to understand why the positive responses are not as high as we would expect.

For maternity services women are asked about their experiences of the different aspects of the maternity care pathway. Women have the opportunity to tell us about their views on antenatal care, birthing care, postnatal care and community postnatal care. The question asked is; 'How likely are you to recommend our labour ward/birthing unit/homebirth service/postnatal ward to friends and family if they needed similar care or treatment?' There are a range of responses that a woman can select as follows:

- Extremely likely;
- Likely;
- Neither likely nor unlikely;
- Unlikely;
- Extremely unlikely and
- Don't know.

We have identified that in recent months when the positive responses have reduced in maternity services this has coincided with more women responding to the question; with a 'Don't know' response instead of ticking one of the other 5 options. The selection of the 'Don't Know' option has a negative impact on the Trust results.

The positive responses for the outpatient Friends and Family question was 82.6% in October.

Bereavement Survey:

In response to the National end of life care audit the Trust is now piloting a bereavement survey for carers. The tool which is being used is one that is used at University College Hospital London and was reviewed and approved by the Trust End of Life Care Steering group, Ethics Committee and Clinical Governance Committee. The aim of the survey is to identify opportunities for improvements in how we support carers at the end of life for their family member as well as identifying positive areas of practice.

The questionnaire and accompanying letter (attached as appendices to this paper) are given out to bereaved families/ carers when they attend the Trusts bereavement offices on each site to collect necessary paperwork following the death of their family member.

The questionnaire is posted back to the Trust Survey Lead in the Governance team, who has been collating the results. To date there have been 15 responses with some initial positive feedback which is encouraging. The pilot will continue until we have received 100 responses, at which point there will be a review of the process and the responses received at the End of Life Steering committee with the aim of embedding this survey into every day practice.

Name Badges:

The Patient Experience Committee reviewed name badges as part of feedback received from patient representatives and junior doctors. Whilst the original request was to consider different coloured badges for different disciplines, the final decision has been to maintain a single trust standard for the issue of name badges. As part of this review, opinions were sought from a wide range of staff and visitors and evidence relating to best practice was considered. The general consensus, insofar as best practice is considered, is the use of black against a yellow background is accepted as being the easiest for the majority to read at a distance.

The use of 'hello my name is...' was considered but on balance was felt to make the name badge too busy. Therefore the recommendation is that the trust standard for the issue of name badges will be black font on a yellow background (Fig 1)



Fig: 1 – LEFT: current Trust standard. RIGHT: proposed new Trust Standard.

It is anticipated that implementation will be over time, with the new standard badge being issued to new staff, and as replacement due to loss, wear and tear or change in role.

Trust Board meeting – November 2016**11-12 Safe Staffing: Planned v Actual – October 2016****Chief Nurse****Summary / Key points**

The attached paper shows the planned v actual nursing staffing as uploaded to UNIFY for the month of October 2016. This data is also published via the NHS Choices website and the Trust website as directed by NHS England and the National Quality Board.

Care Hours Per Patient Day

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

The Carter report indicated a range for CHPPD between 6.3 and 15.48. The median was 9.13. Overall CHPPD for Maidstone Hospital was 7.8. For Tunbridge Wells Hospital the overall CHPPD was 9.8.

Staffing establishments undertaken during August and September are in the process of being implemented, with full implement due from 1st November 2016. As the staffing reviews include a shift in planned skill mix, the impact on overall care hours will be minimal when viewed as an overall average across the month.

Planned vs. Actual

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

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

Wards in this category during October were Wards 10, 12, 21 and 32 which have enhanced care needs overnight. Ward 32 numbers now reflect the full range of staffing requirements following the shift between private and NHS funded beds.

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

A number of wards have variation between planned and actual due to changes in establishments mid-month. This planned number of staff has been changed as this reflects the budget for that area, however so wards have not fully implemented the revised establishments as this involves either movement of staff between wards or a shift in recruitment plan. The areas this involves includes Mercer, TWH stroke/Ward 22, Surgical Assessment Unit (SAU), Maidstone Short Stay Surgery Unit (MSSU) and Peale

Escalation areas account for the remainder of the over-fill. These areas were Maidstone AMU (UMAU), and TWH AMU.

A number of areas had a reduced fill rate, most notably CCU at Maidstone. This unit is co-located

with Culpepper Ward, and as such staff move between the two areas as required.

Maidstone Intensive Care Unit had a reduced fill rate due to reduce acuity. This was a managed reduction retaining the ability to admit to the unit if the need arose. There was a similar, though smaller, reduction in acuity in the Tunbridge Wells Intensive Care Unit, allowing for a safe reduction in the CSW hours at night.

Maternity manage staffing as a 'floor' with support staff moving between areas as required. Midwifery needs are assessed regularly by the Labour Ward Coordinator with midwives following women from delivery through to post-natal. This ensures that all women in established labour received 1:1 care from a Registered Midwife. The non-registered fill rate is anticipated to improve as all vacant post have now been appointed to, with candidates currently in the final stage of pre-employment screening.

Neonatal unit continue to have a low fill rate for non-registered staff, however this is an improved position compared to previous months with on-going recruitment to this staff group.

Accident & Emergency (A&E) Departments overall fill rates are good against planned staffing levels. Both departments had a reduced fill rate for CSWs; however this was an accepted risk and mitigated with close working between the departments and the Acute Admissions Unit with oversight from the A&E Matrons.

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

The RAG rating for the fill rate is rated as:

Green: Greater than 90% but less than 110%

Amber Less than 90% OR greater than 110%

Red Less than 80% OR greater than 130%

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

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

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

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

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

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

RAG	Details
<p>Green</p>	<p>Minor or No impact: Staffing levels are as expected and the ward is considered to be safely staffed taking into consideration workloads, patient acuity and skill mix.</p> <p>RN to patient ratio of 1:7 or better Skill mix within recommended guidance Routine sickness/absence not impacting on safe care delivery Clinical Care given as planned including clinical observations, food and hydration needs met, and drug rounds on time.</p> <p>OR</p> <p>Staffing numbers not as expected but reasonable given current workload and patient acuity.</p>
<p>Yellow</p>	<p>Moderate Impact: Staffing levels are not as expected and minor adjustments are made to bring staffing to a reasonable level.</p> <p>OR</p> <p>Staffing numbers are as expected, but given workloads, acuity and skill mix additional staff may be required.</p> <p>Requires redeployment of staff from other wards RN to Patient ratio >1:8 Elements of clinical care not being delivered as planned</p>
<p>Red</p>	<p>Significant Impact: Staffing levels are inadequate to manage current demand in terms of workloads, patient acuity and skill mix.</p> <p>Key clinical interventions such as intravenous therapy, clinical observations or nutrition and hydration needs not being met.</p> <p>Systemic staffing issues impacting on delivery of care. Use of non-ward based nurses to support services RN to Patient ratio >1:9</p> <p>Need to instigate Business Continuity</p>

Which Committees have reviewed the information prior to Board submission?

▪

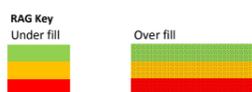
Reason for submission to the Board (decision, discussion, information, assurance etc.) ¹

Information and assurance

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

September '16		Day		Night		Overall Care Hours per pt day	Nurse Sensitive Indicators					Financial review		
Hospital Site name	Ward name	Average fill rate registered nurses/mi dwives	Average fill rate care staff (%)	Average fill rate registered nurses/mi dwives	Average fill rate care staff (%)		FFT Response Rate	FFT Score % Positive	Falls	PU ward acquired	Overall RAG Status	Comments	Budget £	Actual £
MAIDSTONE	Acute Stroke	94.2%	98.4%	108.6%	95.2%	6.7			4	0		118,482	120,791	-2,309
MAIDSTONE	Foster Clark	102.1%	104.0%	100.0%	100.0%	6.2			8	1		98,543	107,917	-9,374
MAIDSTONE	Cornwallis	116.1%	93.5%	101.1%	123.8%	6.8			2	0	Reflects changes in establishments mid-month	62,110	83,817	-21,707
MAIDSTONE	Coronary Care Unit (CCU)	69.9%	100.0%	100.0%	N/A	10.8			0	0	Accepted risk, as co-located on Culpepper	92,406	104,134	-11,728
MAIDSTONE	Culpepper	100.0%	100.0%	100.0%	100.0%	6.9			2	0				
MAIDSTONE	John Day	105.8%	87.9%	101.7%	104.8%	7.9			2	1	CSW shifts not filled by Bank	116,872	140,226	-23,354
MAIDSTONE	Intensive Treatment Unit (ITU)	92.3%	N/A	89.5%	N/A	30.4			1	0	fill rate reflects acuity. Staff moved to TWH or to wards as appropriate	169,796	149,314	20,482
MAIDSTONE	Pye Oliver	92.2%	88.8%	100.0%	97.8%	6.0			6	1	CSW shifts not filled by Bank	105,948	110,427	-4,479
MAIDSTONE	Chaucer	91.1%	98.4%	96.8%	97.8%	6.3			6	0		110,174	133,212	-23,038
MAIDSTONE	Lord North	99.4%	100.0%	101.1%	96.8%	6.8			1	0		87,269	95,387	-8,118
MAIDSTONE	Mercer	102.4%	83.1%	96.8%	100.0%	6.2			3	1	Reflects changes to establishment mid-month	95,499	101,181	-5,682
MAIDSTONE	Edith Cavell (MOU)	98.8%	95.9%	100.0%	100.0%	6.2			1	0		61,479	68,340	-6,861
MAIDSTONE	Urgent Medical Ambulatory Unit (JMAU)	86.7%	100.9%	125.1%	190.3%	12.1			2	1	Escalated over night throughout the month. RN day fill rated accepted risk to ensure nights covered	87,798	114,467	-26,669
TWH	Stroke/W22	93.5%	83.2%	98.7%	109.7%	9.9			0	0	CSW shifts not filled by Bank	172,190	149,781	22,409
TWH	Coronary Care Unit (CCU)	98.9%	78.1%	97.8%	N/A	11.5			0	0	CSW shifts an accepted risk, change in use of one room to allow for Cath Lab recovery	59,083	61,669	-2,586
TWH	Gynaecology/ Ward 33	99.1%	110.0%	100.0%	100.0%	9.3			0	0		71,115	76,494	-5,379
TWH	Intensive Treatment Unit (ITU)	96.8%	96.8%	94.4%	87.1%	32.0			0	0	11 shifts with low acuity, CSW fill rate an accepted risk. Nurse in charge supervisory.	179,175	182,137	-2,962
TWH	Medical Assessment Unit	90.7%	83.1%	133.5%	96.8%	8.0			9	0	Escalated at night	147,018	202,504	-55,486
TWH	SAU	101.6%	72.6%	106.5%	101.6%	9.6			0	0	CSW fill rate an accepted risk, reflects changes in planned establishments and relocation	86,565	89,685	-3,120
TWH	Ward 32	92.1%	97.8%	103.2%	115.7%	9.5			4	0	Enhanced care needs for 5 nights. Risk Assessments in place and reviewed by matron	115,281	118,322	-3,041
TWH	Ward 10	93.5%	103.2%	86.3%	172.6%	7.5			2	0	enhanced care needs for 29 nights (cohort of 3 pts reducing over the month). Risk assessments in place and reviewed by matron	109,717	119,257	-9,540
TWH	Ward 11	100.9%	96.8%	96.8%	108.1%	6.5			5	1		111,954	118,007	-6,053
TWH	Ward 12	88.9%	106.9%	90.2%	125.8%	6.3			18	0	4 shifts not covered (absence due to sickness) as a considered action. Shift in CSW fill rate at night reflects considered use of CSW for RN cover and revised establishments	119,124	100,087	19,037
TWH	Ward 20	92.4%	95.6%	101.8%	95.2%	6.3			13	1		112,924	131,576	-18,652
TWH	Ward 21	97.3%	93.5%	87.1%	127.4%	6.3			5	1	CSW fill rate at night reflects a considered use of CSW to cover RN absence.	126,493	126,969	-476
TWH	Ward 2	90.1%	84.8%	97.3%	101.9%	6.3			8	0	Revised establishments mid-month,	81,866	125,296	-43,430
TWH	Ward 30	91.3%	87.7%	98.4%	102.8%	6.4			3	0	Bank shifts not filled	103,381	121,225	-17,844
TWH	Ward 31	95.2%	63.8%	98.4%	98.9%	6.7			2	2	Bank shifts not filled	103,146	127,014	-23,868
Crowborough	Birth Centre	96.8%	94.9%	98.0%	93.5%				0	0		86,693	81,016	5,677
TWH	Ante-Natal	91.9%	93.5%	98.4%	71.0%				0	0	Some vacancy and sickness. CSW not covered by Bank a considered action. All women in established labour received 1:1 care	608,436	630,140	-21,704
TWH	Delivery Suite	101.4%	93.5%	95.0%	88.7%				0	0				
TWH	Post-Natal	95.2%	87.1%	99.2%	72.0%				0	0				
TWH	Gynae Triage	95.2%	96.8%	100.0%	87.1%				0	0		12,404	12,420	-16
TWH	Hedgehog	101.6%	48.4%	99.4%	112.9%	8.9			0	0	Vacancy and sickness. Day fill rate an accepted risk to ensure cover at night	207,495	185,031	22,464
TWH	Birth Centre	98.4%	96.8%	98.4%	87.1%				0	0		62,135	65,068	-2,933
TWH	Neonatal Unit	99.5%	87.1%	97.3%	80.6%	13.7			0	0	CSW rate an accepted risk, overall fill rate improving	162,821	150,642	12,179
MAIDSTONE	MSSU	115.0%	76.6%	81.0%	N/A	21.8			0	0	RN fill rate reflects changes in establishment in surgery, where staff not yet fully redeployed. Not additional staff	42,571	39,774	2,797
MAIDSTONE	Peal	102.8%	88.4%	115.5%	47.6%	8.1			0	0	Night fill rate reflects transition following establishment review.	61,121	65,078	-3,957
TWH	SSSU	109.2%	68.2%	N/A	N/A	0.0			0	0	CSW rate an accepted risk. SAU no longer co-located.	22,981	22,765	216
MAIDSTONE	Whatman	95.2%	96.8%	100.0%	103.2%	5.5			6	1		0	120,453	-137,675
MAIDSTONE	A&E	96.4%	91.9%	97.7%	52.6%				0	0		202,541	205,066	-2,525
TWH	A&E	99.7%	71.5%	99.4%	83.9%				0	0		294,413	304,938	-10,525
Total Established Wards												4,669,019	5,061,625	(409,828)
Additional Capacity beds												40,894	64,825	-23,931
Other associated nursing costs												2,854,879	2,406,413	465,688
Total												7,564,792	7,532,863	31,929

note: adjusted plan to move -£17k from whatman (FRP impact) to other associated nursing costs



Trust Board meeting – November 2016

11-13 Trauma and Orthopaedics 2020 Programme

Chief Operating Officer

Summary / Key points

The enclosed report is enclosed in response to the action agreed following a presentation by the Directorate of Trauma and Orthopaedics at the Trust Board meeting on 28/09/16 to “Submit a report to the Trust Board, in November 2016, on the progress with the “Trauma & Orthopaedics 2020” programme”

The report was noted at the Trust Management Executive (TME) Meeting on 16/11/16.

Which Committees have reviewed the information prior to Board submission?

- TME, 16/11/16

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

Review

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

Appendix 1: T&O 2020 Programme Update

1. Overview

This report provides an update on the T&O 2020 Programme, it covers the following areas:

- Bed reconfiguration – TWH ring-fencing & Maidstone Bed Allocation
- Trauma Review
- Virtual Fracture Clinic Pilot

There are weekly update meetings chaired by the Deputy Chief Executive, the meetings are attended by the CD, Director of Operations, Associate Director of Nursing, GM, Matron. Annex A is the T&O 2020 ToR and Annex B is the project plan which staff are monitored on.

The plan has been discussed at the T&O Directorate meeting in September and an away day is scheduled for the 23rd November to develop additional plans in how to improve the service and delivery. Clinical leads have been identified to support each of the key project areas.

2. Bed Reconfiguration

Tunbridge Wells Hospital

Ward 30

Prof Briggs in the GIRFT report for Orthopaedics indicated that it is essential for ring-fenced beds, laminar flow theatres and experienced orthopaedic theatre teams to improve outcomes and infection rates within Trauma and Orthopaedics.

To secure TWH activity on the 15th October there were a number of bed changes across the Trust to assist T&O in gaining ring-fenced beds on ward 30. It was agreed to secure these beds T&O beds and contract activity would move from PPU to ward 30. Also any outstanding patients from Ward 20 would be moved to ward 31.

Following the introduction we have successfully ring-fenced 10 beds. It was anticipated that we would have 15 by the end of October increasing to 20 by end of November. At this time T&O have not achieved the level of ring-fencing anticipated however this has not impacted on activity due to lack of beds.

Next steps:

- Continued communication on the types of appropriate patients for these beds (fast turnaround patients), to ensure beds for elective activity.
- Sign off of updated Escalation plan with communication of this to all staff
- Improved Trauma flows and potential ambulatory pathways reducing non-electives in elective beds

Maidstone

The opening of MOU on the 19th December will assist in the delivery of elective activity throughout the winter. At this time the business case has been signed off, activity is being mapped & staff employed.

Next steps:

- Review the Theatre Master Schedule & potential recommissioning of Theatre 5

Chaucer Update.

The reviewed and updated Chaucer Operational Policy Orthopaedic Rehabilitation Beds Chaucer document has been updated to reflect the NOF patient rehabilitation pathway as Chaucer for all patients. This went live on 17th October 2016.

Patient Pathway and Communication:

- All NOF patients are given a letter in A&E advising them of their rehabilitation pathway and this will be at Chaucer ward, Maidstone Hospital.
- Patients are then provided with a NOF Patient Pack on ward 31.

Key Issues:

Patients have refused on transferring to Chaucer. We are managing this by:

- Reviewing and updating the patient communication.
 - Patient letter
 - Introducing a patient pack on the ward.
- Implementing a clear escalation pathway for nurses when patients refuse.
- To ensure the above is delivered a bi weekly Chaucer Issues and Resolution meetings to identify and resolve issues.
- Project Review and Lessons learned - 3 month review mid January 2017

3. Trauma Review

Alongside the activity planning for MOU, trauma activity is being mapped to meet the demand 800 minutes per day weekdays. This will come into place when MOU opens. This ensures that specialist Trauma will be managed within the converted session per day and recorded accurately.

Key to the improvement of the Trauma pathway is the introduction of an end to end coordinator. The role will include the coordination of trauma patients from admittance to discharge, monitoring and identifying patients in A&E, pulling the patient through the trauma pathway. Scheduling patients for surgery, ensuring correct pre admittance advice is given and bed allocated. This role will be in place following the consultation of the Trauma Coordinators which started on the 4th November. This role mirrors the model at Royal Surrey and Sussex Hospital.

Alongside this role there will be a NOF nurse who will be the point of contact for NOF patients communicating with the patient's family, ward and theatre. They will ensure NOF patient tariffs are met.

Gold Patient.

The Gold Patient criteria draft has been agreed within the project team, the next steps are:

- Agreement of Gold Patient Criteria.
- Document Pathway
- Communication to relevant staff.
- Reporting to ensure adherence.
- Go live – To be confirmed – End of November
- Issue and resolution meeting will be arranged post go live.
- Project Review and Lessons learned - 3 month review

4. Virtual Fracture Clinic

The Virtual Fracture clinic pilot started on the 4th July and has been running for 4 months. A detailed review of the service has been undertaken and report will be distributed shortly.

It has indicated that the service is beneficial to the Trust and could make a 120k contribution. Key benefits seen so far are:

- Improving patient outcomes through fewer missed diagnosis and delayed presentations.
- On average 42% of patients can be discharged with a treatment plan from virtual Fracture clinic resulting in appropriate fracture clinic appointments with the most suitable clinician.
- Patients that need surgery have been added to the Trauma board within 4 days, some had waited over 2 weeks in the old model.
- There has been a positive impact to the volume New Fracture clinic appointments and as a result Registrars will be able to be reassigned to other activities.

The pilot has indicated that there are several areas for improvement.

- The development of a database/system to reduce the amount of manual data entry and delay in information.
- Patient telephone contact details are frequently (5-10%) incorrect so causes problems contacting these patients with their treatment plan.
- Numbers of follow-up appointments have not reduced as planned,

Next Steps:

1. Execs to review the pilot report and agreement on its viability.
2. Negotiations with the CCG for payment of the service.
3. Introduction of an IT solution to manage the VFC patients pathway and treatment plans
4. Reduce Follow-ups by introducing a process whereby if more than one follow-up is required the consultant must review.

5. MSK

Currently working with the CCG to develop referral pathways for a central clinical decision making unit. A pilot has been proposed for backs, hips and knees which timescales are being agreed. Clinical leads in place to take this forward.

Annex A

MAIDSTONE & TUNBRIDGE WELLS NHS TRUST

T&O 2020 Steering Board

Terms of Reference

1 Constitution

The T&O 2020 Steering Board operates under delegated authority of the Executive Recovery Steering Group. The purpose of the Steering Board is to oversee the improvement in T&O activity and develop a detailed workplan for T&O, against an agreed trajectory to specific timescales.

Membership

- Deputy Chief Executive (Chair)
- Clinical Director for T&O (Deputy Chair)
- Deputy Chief Operating Officer
- Associate Director Nursing Planned Care
- Consultant representation from Critical Care
- General Manager for T&O
- Matron T&O
- T&O Consultants
- Orthopaedic Geriatric Consultant
- General Manager for Theatres, Anaesthetics & Critical Care
- Information Manager
- Finance Manager
- PMO

2 Quoracy and Attendance

Meetings will be quorate when attended by no less than four members, including 1 executive and 1 consultant, are in attendance. In the absence of the chair and deputy chair, the Associate Director of Planned Care will chair the meeting.

Others may attend by the invitation of the Chair as required for specific agenda items.

5 Frequency Of Meeting

Meetings will be held on Monthly on a Wednesday.

Additional meetings will be scheduled as necessary at the request of the Chair.

6 Terms of Reference

- To ensure patient quality standards are maintained or improved via the programme of work.
- To monitor the work of the project groups against their delivery plan.
- To ensure the T&O Cost Improvement Plan for 2016/7 is met and to recommend mitigating measures if slippage occurs.
- To monitor the Key Performance Indicators for each of the programmes.
- To review and mitigate highlighted risks to the programme delivery.
- To review and/or initiate new projects related to increasing theatre utilisation.
- To act as a decision making board where projects require Executive/Consultant Input.
- The T&O 2020 group will;
 - Improve the flow of Theatre activity – elective/non elective work
 - Monitor the delivery of the bed proposal to execs
 - Match Theatre capacity with demand following an in depth review of data.
 - Identify key areas of work following review of benchmarking data (GIRFT/Model hospital)

7. Reporting

The Steering Board will report monthly to the Executive Recovery Steering Group, via the project's Executive Sponsor –The Chief Operating Officer.

The T&O 2020 project structure is contained in appendix 1.

8. Administration and Duties

The PMO will support the Steering Board by taking action points, monitoring attendance and organising the meetings.

9. Review of Terms of Reference and Monitoring Compliance

The T&O 2020 Steering Board will review its terms of reference at least annually.

Terms of reference agreed by

T&O 2020 Steering Board:

Trust Board Meeting - November 2016

11-14 Update on IT-related issues within Ophthalmology

Medical Director

Summary / key points

This report is provided in response to the agreement reached at the Trust Board meeting on 19/10/16 that the Medical Director should "submit a report to the Trust Board, in November 2016, on the latest situation regarding the IT-related issues within Ophthalmology that were reported at the Trust Board on 19/10/16".

The Clinical Director, Carole Jones, and Director of Health Informatics, Donna-Marie Jarrett have met. It was agreed that Ophthalmology has a number of issues that need support from IT and are keen to establish and maintain a strong relationship with IT in the future. In essence they want to digitise as much as possible to enable them to deliver eye care both in the hospital and community. There is the recognition that IT needs to assess ophthalmology's current environment, understand the opportunities for digitisation whilst ensuring that the data captured feeds into their mandatory regular audits. The planned outcome being a business case and project plan that includes making a case for the establishment of an Ophthalmology Systems Manager.

Immediate actions:

A workshop to capture the existing tech landscape.

A member of IT to meet with Ophthalmology on a monthly basis hereon in.

To confirm the number of desktops, laptops etc that have already been allocated as this may need to be reviewed

A member of IT to identify what is known about the current tech in Ophthalmology and so create a simple topology on the Directorate.

Which Committees have reviewed the information prior to Board submission?

- None

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

Assurance and information

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

Trust Board meeting – November 2016**11-15 2016/17 Winter & Operational Resilience Plan Chief Operating Officer**

Following the “Update on the 2016 / 17 Winter and Operational Resilience Plan” that was presented at the October 2016 Trust Board meeting, work has progressed and the final Winter Plan for 2016/17 was presented to the Trust Management Executive meeting on 16/11/16.

This report updates the Board on the work undertaken to date to give assurance that the Plan is on track to deliver its objectives. The Winter Plan for 2016/17 identifies the following key objectives:

- Maximise elective activity over this period
- Ensure delivery of A&E, RTT and Cancer standards
- Maintain quality indicators over the winter period
- Maintain the focus on financial controls and budgetary management
- Ensure patients who no longer require acute care are discharged in a safe and timely way
- Safe staffing levels are observed in all clinical areas
- Health and Social Care partners are involved in all aspects of planning
- Maximising the impact of new services and pathways developed over the past year

The Winter Planning & Resilience Programme group (WPRPG) will ensure that the plans developed will deliver operational resilience for the winter period 2016/17. The plans demonstrate provision of sufficient inpatient capacity over the winter period to meet increased service demands for both non-elective and elective patients in line with planned demand and activity, and will positively impact on the quality of care delivered and support achievement of the Trust’s operational and financial plans. MTW winter escalation period will run from 01/11/16 to 31/03/17. As part of the process to develop these plans, a detailed activity analysis has been undertaken to understand exactly what happened last year in terms of:

- Activity flow, resulting in key pressure point areas.
- The impact on clinical quality and patient safety
- The impact on our workforce and our ability to manage during this pressured period
- The financial impact to the trust through lost elective activity and the need to secure additional bank and agency staff to manage escalated areas.
- The impact on clinical and non-clinical support services

It is recognised that there is no single event which causes significant operational pressure but many factors. However the need to escalate into areas normally used for elective work is a significant factor and the plan will need to understand how best to minimise this impact. It should be noted that there will be a non-elective activity scenario in which our elective activity is again significantly compromised, even with improved flow, resulting in on-going financial pressure. The plan will identify the factors associated with this risk and impact of this occurring and identify actions to have in place to minimise the financial impact.

The four key risk areas identified in the plan include :

- Staffing vacancies (medical and nursing)
- Financial implications of delivery
- Failure to achieve A&E, RTT and Cancer standards
- Unable to undertake planned elective activity due to unplanned escalation

A number of actions and initiatives are already well established in relation to flow and capacity management and these will be reviewed further & refined as part of this planning.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 16/11/16

Reason for submission to 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

Winter Plan 2016/17 v.2

1. Introduction

This plan has been produced to ensure operational resilience for the winter period of 2016/17. Provision of sufficient inpatient bed capacity over the winter period to match fluctuations in demand for both non-elective and elective inpatients will provide a positive impact on quality, safety, and patient experience, and help the Trust deliver operational and financial plans.

The key aims of the 16/17 Winter Plan are:

- To avoid queueing ambulances where patients cannot be cared for in an Emergency Department (ED) cubicles and have to wait in the ED corridor
- To avoid cancelling elective patients who require urgent or cancer treatment
- To avoid 12 hour trolley breaches

These objectives are based on experience and learning from last year and are designed to ensure safe services are delivered throughout the winter period. Recognition has been given to the fact that last winter did not see adverse weather conditions or significant infection issues such as flu or norovirus. The Winter Plan considers that these factors may be experienced this winter.

The aims detailed above and the plan as a whole may be subject to further iterations taking into account changing situation and continuous engagement with clinical teams, local health partners in particular, Kent Community services, South East Coast Ambulance Services, Kent Mental Health services and West Kent Social Services.

This Trust plan should be read in conjunction with the following Trust plans:

- Major Incident Plan
- Pandemic Influenza Plan
- Trust Escalation policy and procedure for emergency admissions
- Business Continuity Plans

National documents supporting this plan:

- Operational Pressures Escalation Levels Framework(OPEL) , NHS England, October 2016

2. Key pressures that arise from winter

Pressures in ED at MTW are predominantly due to two factors, mismatch between demand and capacity for inpatient beds and lack of alignment of resource with demand within the Trust but also with our partners across the wider health economy, in particular Social Services, Community services, Mental Health and Ambulance Trusts. These mismatches are much more pronounced and acutely felt in the winter months because of:

- Admitted non-elective (NEL) patients are more likely to have a longer length of stay compared to the summer resulting in escalation of beds to meet demand
- Delayed discharges of medically fit patients due to lack of capacity in community / social care, access to enablement / nursing home placements
- The tendency for a more complex case mix & more demand on emergency services.
- Increased demand for acute services due to higher levels of infection within the community e.g. bronchopneumonia
- Higher levels of infection within the community with subsequent increase in demand for services, inability to discharge to community hospitals, residential or nursing homes.
- Bank holiday impact on services
- Pressure on adult critical care and paediatric high dependency capacity across the network
- Unplanned absence of staff due to seasonal illnesses e.g. flu like symptoms and winter vomiting (Norovirus)
- Adverse weather resulting in difficulty in discharging patients due to transport, domiciliary care packages etc.
- Adverse weather resulting in difficulty in getting to and from work for all staff
- Pressure on ED due to diverted demand from GPs when GPs are closed

3. Planning and Implementation

a. Maintain elective activity during the summer:

Directorates are required to plan and maintain elective activity in August and September. Robust planning of elective activity during the year is critical part of managing winter pressures proactively. Last year elective activity between August and September was more than 10% lower than in October and November. The main reason for the drop in elective activity is the unavailability of staff due to holidays. Whilst it is right that staff annual leave is accommodated, Directorates must find ways of maintaining elective activity during this period including considering annualised jobs and hiring locums staff.

b. Early winter escalation:

MTW winter escalation period will run from **02 November to 31 March 2017**, the same as last year to ensure a steady transition and to maintain patient safety and optimum patient flows. A success story of last winter was how key quality measures were maintained within acceptable standards despite the winter pressures. However some quality and patient experience measures including mortality, pressure ulcers, falls, some stroke SSNAP measures, NEL LOS and patient involvement in decisions about treatment did show deterioration in Q4. The Trust is committed to maintaining key quality and safety indicators during the winter.

c. Elective Demand Management during the winter

Predictable peaks in NEL demand due to increased admissions and delays in discharges following the seasonal holidays place substantial pressure of resources and negatively impacts patient and staff experience. Directorates are required to plan for a reduction in elective inpatient activity during critical weeks of the winter when historic data shows the ability to manage elective patients will be significantly affected.

d. Maintain patient flow during the winter:

Other than bed capacity, pressures in ED and on wards are also caused by a lack of alignment and mismatch of resource with demand, within the Trust but also with our partners across the wider health economy, in particular Social Services, Community services, Mental Health and Ambulance Trusts. Delays in discharges often occur due to pressure on medical staffing caused by a combination of increased bed base due to escalation and delays in discharging medically fit patients. Whilst it is recognised that all activities are important, there is a need to prioritise activity during this period to ensure that the hospital remains a safe environment for patients, for example by reducing scheduled outpatient clinics to support early review of sick patients on wards and facilitate discharges of those patients who no longer need acute care.

It is recognised that the opening of escalation beds will require additional staff to manage and ensure a safe care is delivered during the winter period. Recruiting Locum or Agency/Bank staff during the winter period is inefficient and ineffective as all local providers are competing for the limited resource available.

4. Demand and Capacity

i. Bed Modelling

Remodelling of "core" inpatient beds to ensure that there are enough speciality beds to meet elective and non-elective demand 85% of the time. This in turn helps ensure that patients are admitted to the right beds first time.

Fig. 1: Funded and Escalation Bed stock – Maidstone

Bed Capacity analysis - 1st Nov 2016					
Hospital - Maidstone	Ward Name	specialty	Nov-16		Physical bed baseline capacity
			Normal Beds Available	Escalation Beds Slots	
Maidstone	Whatman	medicine	28	0	28
Maidstone	Culpepper	medicine	13	0	13
Maidstone	Cornwallis	surgery	19	0	19
Maidstone	Stroke Unit	medicine	26	0	26
Maidstone	CCU	medicine	6	0	6
Maidstone	Mercer	medicine	26	0	26
Maidstone	John Day	medicine	31	0	31
Maidstone	Chaucer	ortho medical rehab	33	0	33
Maidstone	Acute Medical Unit (UMAU/MUMA)	medical	14	8	22
Maidstone	CDUM		5	0	5
Maidstone	Foster Clarke	medicine	28	0	28
Maidstone	Pye Oliver	medicine -	28	0	28
Maidstone	Short Stay Surgical Unit	surgery	0	6	6
Maidstone	Lord North	oncology	18	0	18
Maidstone	Maidstone Orthopaedic Unit	Ortho	12	0	12
Maidstone	Peale	surgery	13	0	13
Maidstone	Maidstone Cath Lab	medicine	0	3	3
Maidstone	Edith Cavell	medicine	12	10	22
		medical beds total	245	21	266
		surgical beds total	44	6	50
		oncology	18	0	18
		General	5	0	5
General & Acute (not inc ITU)			312	27	339
Maidstone			5		5
Maidstone			4		4
Critical Care			9	0	9
General & Acute (inc ITU)			321	27	348

Fig. 2: Funded and Escalation Bed stock – Tunbridge Wells

Hospital - Tunbridge Wells	Ward Name	specialty	Normal Beds Available	Escalation Beds Slots	Physical bed baseline capacity
Tun Wells	Acute Medical Unity- TAMU	medicine	22	16	38
Tun Wells	Ward 2	Elderly Care	30	0	30
Tun Wells	Ward 20	Medicine	30	0	30
Tun Wells	Ward 21	medicine (resp)	30	0	30
Tun Wells	Ward 22	stroke rehab + medicine (COE)	22	0	22
Tun Wells	Ward 12	medicine (gastro card)	30	0	30
Tun Wells	Acute Stroke Unit	medicine Acute stroke	10	0	10
Tun Wells	CCU	medicine CCU	5	0	5
Tun Wells	CCU (Cath Lab - TCCL) MRU	medicine Cath lab recov	0	0	0
Tun Wells	Ward 10	surg	30	0	30
Tun Wells	Ward 11	surg	30	0	30
Tun Wells	Ward 31	ortho	30	0	30
Tun Wells	Ward 30	ortho	30	0	30
Tun Wells	Surgical Assessment Unit (SAU)	surg	12	0	12
Tun Wells	Short Stay Surgery Unit	surg	0	11	11
Tun Wells	TW32	Medicine	20	0	20
Tun Wells	Ward 33	Female Surgical	14	0	14
Tun Wells	Hedgehog (TWHH)	paed	23	0	23
Tun Wells	The Wells Suite	pp	9	0	9
Tun Wells	Paed A.E unit	Paed	6	0	6
Tun Wells	Theatre Recovery	medicine	0	6	6
		medical beds total	199	22	221
		surgical beds total	132	11	143
		W&C	43	0	43
General & Acute (not inc ITU)			374	33	407
Tun Wells	Tun Wells	Neonatal Unit (TNNU)	18	0	18
Tun Wells	Tun Wells	ITU	7	0	7
General & Acute (inc ITU)			399	33	432

Actions: The Winter Planning & Resilience Programme Board is overseeing work to improve patient flow by reconfiguring the TWH bed base from November by:

1. Orthopaedic patients going to Ward 30 and not Ward 32. The new revised criteria for Chaucer Ward have been launched and Ward 20 will no longer be used by Orthogeriatric patients. Instead, Ward 20 will be solely used for medical patients. This will enable the Trust to have 15 dedicated beds on Ward 30 for elective orthopaedics for the rest of October rising to 20 in November.
2. The Gynae Ward at TWH has been renamed Ward 33 and while it will continue to take only female surgical patients the three postnatal rooms will be opened permanently, increasing this area to 13 beds.
3. Three outpatient rooms in the Private Patient Unit to be converted back to standard patient bedrooms. 20 beds on the PPU to become NHS medical beds.
4. Over the weekend 29th / 30th October, the Cardiac Catheter Lab recovery unit at TWH will become the new home of the Surgical Assessment Unit. Cardiac Catheter Lab patients will

be recovered in the pain room which is being redesigned to take three trollies. Three of the rooms in the Coronary Care Unit will also be changed to have 2 trolleys each, for Cardiac Catheter Lab recovery patients.

5. These changes will collectively mean that from the beginning of November the Short Stay Surgical Unit will open as a dedicated 23 hour stay day surgery unit, with an admissions lounge for all elective patients with the exception of orthopaedic inpatients initially. Interventional radiology patients will also be accommodated here.

b. Warning Escalation Indicators

Early warning indicators of pressure and / or increase in the normal activity of the Trust have been developed to identify occasions when there would cause to change the Trust status from 'business as usual' (Green) to escalation (Amber, Red and Black). At such times there is a need to manage pressure out of the system and when there is be at least one indicator identified from each category below, escalation would be considered by the Associate Director of the Day:

Fig.3: Early Warning Escalation Indicators

ED	<ul style="list-style-type: none"> >2 ambulances unable to offload for >30minutes in last 2 hours >1 patient requiring active resuscitative care > 50 patients in ED > 15 new patients per hour registering in last 2 consecutive hours Unable to create RAT capacity and >1 ambulance showing on inbound screen >2 hours to be seen by clinician Full CDU with no planned movement within 1 hour No ability to move out of RAT due to lack of Majors capacity
Bed State	<ul style="list-style-type: none"> Worse case predicted bed deficit at 09.00 >40, at 13.00 >30 and 16.30 >15 Number of allocated DTAs with no plans at 09.00 >12, 13.00 >10 and 16.30 >8 Number of critical care beds available <2 and >1 patient fit to transfer out
Outliers	<ul style="list-style-type: none"> >20 medical and placed in escalation areas >10 surgical / trauma >5 patients to return from other units
Other	<ul style="list-style-type: none"> Staffing – potentially unmanageable staffing issues likely to impact shift cover Clinical Support Services – Issues that could potentially impact on patient flow Community Hospitals – Infection control outbreaks, 100% occupancy with no expected discharges within 24 hours, staffing issues or all possible social service discharges undertaken

c. Risk/Escalation Status

MTW uses the system below to help communicate the Trust' escalation status. The Black, Red, Amber and Green (BRAG) colour code reflects the **level of risk to patient safety and the extent to which patient experience may be compromised**. This status setting applies to adult acute bed capacity (excluding paediatrics and maternity services).

Fig.4: Escalation of Risk

Escalation from one level to the next triggers actions by staff at different levels; the purpose of this is to ensure early actions to protect patient safety and experience. These actions may include deployment of senior staff to triage or assessment areas, senior doctor review of all admissions, increased speciality support in ED, increased ward rounds, deployment of non-clinical staff to support clinical staff on wards, opening of additional escalation beds, through to progressive cancellation of elective work.

The triggers help determine the escalation status & therefore, the appropriate response. The escalation status is decided by the Associate Director of the Day at 0900hrs & reviewed at 1300hrs & 1630hrs daily. When the status is determined, steps to create bed capacity are actioned. Fig. 5 & 6 below illustrate escalation actions to create bed capacity at both sites:

Fig. 6: Escalation Ladder for Tunbridge Wells Hospital

Stage	Trust Escalation Level	Clinical Area	No. of Beds to be escalated	Total Escalation beds	Triggers
Stage 1	AMBER	W10	Swing 5 beds to medicine	5	Consider moving patients with EDD's in next 48 hours to W33 to create ED flow
Stage 2	AMBER	W11	Swing 5 beds to medicine	10	
Stage 3	AMBER	W33	Swing 5 beds to medicine	15	
Stage 4	RED	W10	Swing 5 beds to medicine	20	Consider putting GP Medical Divert on to MH
Stage 5	RED	W11	Swing 5 beds to medicine	25	
Stage 6	RED	W33	Swing 5 beds to medicine	30	Move planned elective work to SSSU
Stage 7	RED	W30	Swing 5 beds to medicine	35	Move planned elective work to SSSU
Stage 7	RED	PPU	Swing 5 surgical beds to medicine	40	
Stage 8	RED	AMU / SAU	Convert 4 assessment trollies in each area to inpatient beds	48	
Stage 9	BLACK	Recovery 1	Open 6 beds for inpatients	54	
Stage 10	BLACK	Recovery 2	Open 6 beds for inpatients	60	
Stage 11	BLACK	CCU	Open 3 recovery rooms for inpatients	63	

Fig. 7: Escalation Ladder for Maidstone Hospital

Stage	Trust Escalation Level	Clinical Area	No. of Beds to be escalated	Total Escalation beds	Triggers
Stage 1	AMBER	Edith Cavell	open 5 beds including 1 side room	5	
Stage 2	AMBER	Edith Cavell	open 5 beds including 1 side room	10	
Stage 3	RED	Cornwallis / Peale	Swing 6 surgical beds to medicine	16	Identify surgical patients to go to SSU
Stage 4	RED	Cardiac Cath Lab	Open 3 beds for inpatients (on protocol)	19	Patients to be moved from Culpepper
Stage 5	RED	AMU	Convert 4 assessment trollies to inpatient beds	23	
Stage 5	RED	Cardiac Cath Lab	Open 3 beds for inpatients (on protocol)	26	
Stage 6	RED	AMU	Convert remaining 4 assessment trollies to inpatient beds	30	
Stage 7	BLACK	Cornwallis / Peale	Swing 5 surgical beds to medicine	35	Senior Management Meeting to be held (COO/Directors of Ops) to agree actions for next 24 hours
Stage 8	BLACK	Cornwallis / Peale	Swing 5 surgical beds to medicine	40	
Stage 9	BLACK	SSU	Open 6 beds for inpatients	46	

5. Risks & Contingency plans and Business Continuity

Risk Description	I	L	R A G	Key controls and assurances in place	I	L	R A G	Owner
Failure to secure nursing and medical staff in a timely manner for escalated areas	5	5	25	Work with Staff Bank to increase critical mass of staff available Review staffing at Winter Planning and Resilience Programme Group to oversee implementation and manage risks	3	4	12	Directors of Ops ADNS's
Failure to reduce the numbers DToC	4	5	20	Engagement with SS as outlined in Engagement plan below SS Winter Plans and contingency plans shared Plans tested , implementation of Home First	4	4	16	Director of Ops Urgent Care
Failure to reduce the number of MFFD patients occupying an acute bed	4	4	16	Engagement with LHE partners as outlined in Engagement plan below Implementation of Home First model SS Winter Plans and contingency plans shared Plans tested	4	3	12	Director of Ops Urgent Care
Rise in NEL admissions above plan	4	4	16	Engagement with LHE partners as outlined in Engagement plan below	4	3	12	Chief Operating Officer (COO)
Financial risk of over spend of winter plans	5	3	15	Early decision making regarding need for addition staff – aim to use Bank and avoid agencies if possible	4	3	12	Chief Operating Officer Directors of Ops
Risks to delays in completion of planned MOU refurbishment work	5	3	15	Close project management	3	2	6	Programme Board
Patient safety risks due to cancelled elective procedures	4	4	16	Plans to reduce non urgent activity during peak periods Monitor activity through remodelled bed base and identify when likely to be adverse to plan with corrective actions	4	3	12	Director of Ops Planned Care

6. Governance and Stakeholder Engagement Plan

Who?	How?	Other	Key message	Owner
Staff	Clinical Operations Group Meetings, Department & Ward meetings MTW winter planning e-mail address	Information on Intranet	Share improvement ideas Familiarise yourself with your role when in escalation Understand the agreed Annual Leave policies and plan holiday well in advance to avoid disappointment Know where to find information Get your Flu vaccination	COO GMs and Matrons
Clinical Directors Site Leads Consultants	Directorate Management meetings Clinical Governance		Involvement with escalation planning Annual Leave policies to be adhered to Flexing elective activity to match bed availability Understand actions to be taken when in escalated state	Clinical Directors
Executive Team	TME update paper		Plan, Risks and Mitigations Financial implications Recommendations/Decisions Monthly updates to TME Bi-monthly Progress updates to Board	COO
LHE partners (SS, KCHC, Mental Health, Local Hospices, SECAMB and West Kent CCG, East Sussex Healthcare NHS Trust)	A&E Delivery Board Daily Sitrep Urgent Care Board		Share learning, risks and contingency plans Shared Planned Escalation plans for the Winter - What will each partner differently this winter? - Commissioned beds, escalation beds, and staffing NWB bed capacity for East Sussex Timing of arrival of patients referred directly by GPs Test plans	COO
Patients	Trust Website	Posters Link to NHS Choices Information from NHS West Kent and Local GPs	Signposting to alternative providers Flu vaccination Visiting the hospital – Infection controls Did not attend (DNAs)	Comms teams

7. Timetable

July 2016	Paper to Trust Board outlining to Winter Plan for 16/17	Trust Board	
July 2016	Commence monthly Winter Resilience & Planning Committee meetings	COO	
August 2016	Receive plans from LHE partners	CCG	
October 2016	Test plans by holding a LHE Winter table top exercise	Director of ops Urgent Care	
October 2016	Update provided to Trust Board on progress with Winter Plan and test plan operationally	COO	
1 st November	Implement plan	COO	
November 2016	Take Winter Plan to TME	COO	
November 2016	Finalised Winter Plan to be presented at Trust Board	COO	

8. Next steps

- Further engagement with key stakeholders identified above
- Implement Action plan below
- Monthly progress reports to TME and bi-monthly assurance reports to Trust Board.

9. Draft Action Plan

Risk Description	Required Actions	Due	Owner	Progress Update	RAG
Early pressures leading to unplanned escalation if implementation of Winter plan is delayed to December.	<ul style="list-style-type: none"> a) Approval for MTW winter escalation plans to be implemented from 01 November to 28 Feb 2017 b) Use of SHREWD as a system wide escalation tool 	30/06/16	TME	Completed	
Inadequate staffing of escalation beds due to lack of available staff	c) Approve bed escalation plan for the winter	28/10/16	COO		
	d) Update the Trust Escalation policy and procedure for emergency admissions for escalation triggers to reflect learning points from 15/16 winter period and reconfiguration of beds	08/11/16	DOO UC		
Adverse weather conditions	a) Resilience tested at Winter Exercise –resulting actions being prioritised for completion	30/11/16	EP Officer/DOO UC	In progress	
	b) 4X4 vehicles available for transporting staff, patients and equipment	30/10/16	Director of Estates		
Deterioration in quality of service and patient experience caused by lack of adequate staff to support escalated demands in EDs and on wards	a) Directorates to submit revised Capacity and Demand plans for elective activity for the year, taking into account changes outlined in the winter plan.	30/08/16	GMs		
	b) Complete comprehensive staffing plan (including social services, therapies, diagnostics, pharmacy, phlebotomy, and transport) for all escalation areas - ensuring a/l is profiled to maintain capacity during December and especially first three weeks after Xmas.	30/10/16	GMs	completed	
	c) Develop operational policies for each identified escalation areas	30/11/15	Matrons		
	d) Daily matron reviews of all inpatients to be implemented	30/09/16	Matrons	In place	
	e) AD to review staffing across wards, specialties and sites	30/09/16	ADs	In place	
	f) Finalise schedule of outpatient clinics for the Winter period to support early senior review of all patients on wards including outliers	15/11/16	GMs/CDs/Out patient Manager		
	g) Review jobs plans to reduce elective admissions and maximise non-admitted activity during for Surgery during winter period	30/11/16	CDs		
	h) Consider spreading activity over seven days where possible to match elective activity with bed availability	30/10/16	GMs/CDs		
Failure to reduce the numbers DToC and failure to reduce the number of MFFD patients occupying	<p>Engagement with all health and social care partners. Specific actions include:</p> <ul style="list-style-type: none"> a) Weekly formal meeting to review all DTOC within MTW to be started from 28/10/16 with action plan in place for each patient. b) Senior sign off of weekly DTOC sitrep by MTW, KCC and East Sussex social services 	30/10/16	DOO UC	In progress	

Item 11-15. Attachment 10 - Final Winter and Operational Resilience plan

Risk Description	Required Actions	Due	Owner	Progress Update	RAG
an acute bed.	c) Begin to implement Home First model by 1 st December				
Staff absence due to flu	a) Ensure as many staff as possible take up the seasonal flu jab	31/11/16	OH	In progress	
ED pressures due to failure to direct patients to more appropriate services	Engagement with SECAMB. Specific actions include: a) Institute regular communication with HALOs and Clinical Operations Managers during the winter period to reduce inappropriate admissions / referrals to ED and maintain close working relation with SECAMB b) Implement plans to respond to any significant SECAMB handover delays of patients	30/10/16	ED GM	In progress	
Financial risk of over spend during the winter plans	a) Weekly review of all budgets to ensure early escalation of increased run rates due to impact of winter	30/10/16	DOOs		
Failure to deliver Winter plans	a) Establish Winter Planning and Resilience Programme Group to oversee implementation and manage risks	30/06/16	COO	completed	

Appendix 1: On Call Senior Managers and Directors rota 19.12.16 - 08.01.17

		On Call Manager	On Call Director
Monday	19-Dec	Siobhan Callanan	Donna Marie Jarrett
Tuesday	20-Dec	Fiona Martin	Donna Marie Jarrett
Wednesday	21-Dec	Jacqui Slingsby	Donna Marie Jarrett
Thursday	22-Dec	Daniel Gaughan	Donna Marie Jarrett
Friday	23-Dec	Sally Batley	Donna Marie Jarrett
Saturday	24-Dec	Claire Cheshire	Angela Gallagher
Sunday	25-Dec	David Fitzgerald	John Kennedy
Monday	26-Dec	Sally Foy	Claire O'Brien
Tuesday	27-Dec	Fiona Martin	Avey Bhatia
Wednesday	28-Dec	Sharon Page	Angela Gallagher
Thursday	29-Dec	Gemma Viner	Angela Gallagher
Friday	30-Dec	Kelly Cushman	Angela Gallagher
Saturday	31-Dec	Nick Sinclair	Angela Gallagher
Sunday	01-Jan	Daniel Gaughan	Paul Sigston
Monday	02-Jan	Sally Foy	Jim Lusby
Tuesday	03-Jan	Siobhan Callanan	Angela Gallagher
Wednesday	04-Jan	Kym Sullivan	Angela Gallagher
Thursday	05-Jan	Jenny Cleary	Angela Gallagher
Friday	06-Jan	Gemma Craig	Angela Gallagher
Saturday	07-Jan	Darren Palmer	Avey Bhatia
Sunday	08-Jan	Siobhan Callanan	Avey Bhatia

Trust Board meeting – November 2016

11-16	Review of the Trust's draft Planning Submissions for 2017/18 and 2018/19	Director of Finance
Summary / Key points Attached is a copy of the Trust's 2 Year Operational Plan, 2017/18 and 2018/19 which was submitted to NHS Improvement on 24/11/16.		
Which Committees have reviewed the information prior to Board submission? <ul style="list-style-type: none">▪ Finance Committee, 28/11/16		
Reason for submission to 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



**Operational Plan 2017/18- 2018/19
Maidstone and Tunbridge Wells NHS Trust**

November 2016

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Abbreviations used

ACO	Accountable Care Organisation	KPI	Key performance indicators
A&E	Accident and Emergency	LoS	Length of Stay
AHP	Allied Health Professional	LTFM	Long Term Financial Model
ATC	Adjusted Treatment Cost	MCP	Multispecialty Community Provider
BMS	Biomedical Scientist	MH	Maidstone Hospital
CAMHS	Child and Adolescent Mental Health Services	MDT	Multi-disciplinary team
CCG	Clinical Commissioning Group	MFT	Medway NHS Foundation Trust
CHPPD	Care hours Per Patient Day	MRI	Magnetic Resonance Imaging
CLIPA	Complaints, Litigation, Incidents, PALs & Audit	MTW	Maidstone and Tunbridge Wells NHS Trust
CPD	Continuous Professional Development	NHSE	NHS England
CIP	Cost Improvement Programme	NHSI	NHS Improvement
CNST	Clinical Negligence Scheme for Trusts	NICE	National Institute for Health and Care Excellence
CQC	Care Quality Commission	OP&P	Operational Productivity and Performance
DToC	Delayed Transfers of Care	OPD	Outpatient Department
ED	Emergency Department	pPCI	Primary Percutaneous Coronary Intervention
EOL	End of Life	PALs	Patient Advice and Liaison Service
EU	European Union	PFI	Private Finance Initiative
ESPs	Efficiency and Savings Plans	PMO	Programme Management Office
FFT	Friends and Family Test	PSC	Procurement Strategy Committee
FRP	Financial Recovery Plan	PTP	Procurement Transformation Programme
FYE	Full Year Effect	P2P	Procure to Pay
GIRFT	Get It Right First Time	Q	Quarter
GMS	General Medical Services	QIA	Quality Impact Assessment
GP	General practitioner	QIPP	Quality, Innovation, Productivity and Prevention
HAI	Hospital Acquired Infection	RCA	Root Cause Analysis
HEE	Health Education England	RPI	Retail Price Index
HEKSS	Health Education, Kent, Surrey & Sussex	RTT	Referral to Treatment
HIT	High impact team	SLA	Service Level Agreement
HPTP	Hospital Pharmacy Transformation Programme	SLR	Service Line Reporting
HRG	Healthcare Resource Groups	SOF	Single Oversight Framework
HR	Human Resources	STF	Sustainability and Transformation Fund
I&E	Income and Expenditure Account	STP	Sustainability and Transformation Plan
IM&T	Information Management & Technology	SS	Safe Staffing
ITU	Intensive Therapies Unit (Intensive Care Unit)	T&O	Trauma and Orthopaedics
IV	Intravenous	TDA	Trust Development Agency
KCC	Kent County Council	the Trust	Maidstone and Tunbridge Wells NHS Trust
K&M	Kent and Medway	TWH	Tunbridge Wells Hospital
KMPT	Kent and Medway Partnership Trust	WTE	Whole time equivalent

1 Activity Planning

Activity planning

The change in the national timetable for planning has required a different approach to setting baseline activity. Traditionally, activity plans have been set based on a forecast outturn usually produced at Month 8 of the current year. With the earlier start to planning, we have worked with our commissioners to model activity based on a rolling 12 months (4 months current year, 8 months previous year). To support this, the Trust has carried out detailed capacity and demand analysis to ensure that, where necessary, all gaps are identified and resolved in conjunction with the CCG and other providers.

1.1 Basis of activity planning

The Trust's activity plans for 2017/18 and 2018/19 have been developed from the following outputs:

- Detailed assessment of current capacity which has been undertaken and compared to current demand assumptions.
- Sharing of demand models with our host Commissioner, jointly discussed as part of contract negotiations, based on demographic growth and the need to maintain or improve patient access targets.
- Setting Levels of demographic growth using projections from both Kent and East Sussex County Councils to allow for a more local reflection of changes to demography. These data are based on Office for National Statistics estimates and adjusted in light of local knowledge.
- Incorporating growth and/or reduction in waiting lists during 2016/17 into the activity plans for 2017/18 to ensure the Trust manages backlogs to a sustainable level.
- Identifying additional activity to reduce waiting list backlogs to ensure that the Trust achieves the referral to treatment times (RTT) performance standard compliance both at a Trust aggregate and individual speciality level in 2017/18. This will be in line with the Sustainability and Transformation Fund (STF) criteria to meet a sustainable level of performance by March 2018.

1.2 Planning assumptions

In depth analysis of performance against plan for 2016/17, particularly for non-elective admissions, has been undertaken. This has highlighted that for 2015/16 and 2016/17 to date, activity levels were exceptionally high. The impact of this has been incorporated into plans for 2017/18 and 2018/19. Based upon the analysis and actions detailed above, the following planning assumptions have been applied to the 2017/18 and 2018/19 activity and capacity numbers:

- Elective capacity returns to steady state from April and is maintained throughout the winter period
- Demographic growth has been assumed as follows; Outpatient - 1.6%; Day Case - 1.8% and Elective - 1.6%
- The Trust will experience the same level of non-elective activity as 2015/16 and 2016/17 at the current average length of stay (LoS) and current delayed transfers of care (DToC) with demographic growth of 1.7% with a further adjustment being made for A&E growth (2.6%)
- Specialties with admitted and/or non-admitted backlogs will increase capacity and therefore activity during 2017/18 to reduce the backlog to the steady state volumes
- We expect to see an improved LOS from Q1 as the impact of Home First starts to show a sustainable benefit regarding the pathways for Medically Fit patients and DTOCs
- Productivity levels are assumed as in previous financial years with any in-year benefits identified to support the reduction in current unidentified Efficiency and Savings Plans (ESPs)
- The plan includes a significant reduction in backlog activity as per the submitted performance trajectories.
- Out-patient activity reduces in 2018/19 due to the clearance of the follow-up backlog in a number of specialties.

Figure 1 – Trust Activity

Activity	2016/17	2017/18	2018/19
	Forecast	Outturn	Plan
A&E Attendances (inc MIU)	149,681	168,162	170,548
Outpatient Appointments	544,259	575,341	564,942
Elective Day Cases	43,356	44,675	44,879
Elective In-Patients	7,877	8,117	8,017
Non-Elective In-Patients	40,935	42,014	42,803
Births	6,120	6,300	6,500

At this stage, commissioner quality, innovation, productivity and prevention (QIPP) schemes have been excluded from the Trust's plans. Further discussion is required to understand the impact on the Trust. Following this, an activity adjustment will be included in the plan based on a risk assessment and likely delivery.

1.3 Capacity

As previously stated, the Trust has undertaken detailed analysis of its current capacity and compared it to forecast demand. This includes an assessment of referral patterns which has been shared and discussed with commissioners. In conjunction with this, the lessons learned from last winter and plans for outsourcing have been incorporated into the Trust's modelling as follows:

- The need for a sustainable plan to deliver elective activity during a prolonged winter phase. To do this in 2016-17 a bed reconfiguration plan has been completed at Tunbridge Wells Hospital increasing the level of day surgery capacity and transferring a proportion of the Trauma and Orthopaedic elective work to Maidstone Hospital from the 19th December.
- Inpatient beds across both sites have been reconfigured to maximise the number of beds available to medicine from November onwards. This is now in place.
- The Winter escalation and de-escalation plan has been developed with trigger points for each stage which includes:
 - Edith Cavell ward at Maidstone, planned to increase its capacity from 12 to 22 beds to accommodate winter pressures (10 of which will be escalation beds)
 - Converting clinical areas currently using trolleys into beds.
 - Swing of surgical beds to medicine in a phased way
- The Trust continues to outsource activity to ensure performance targets are met. This will predominately be elective cases but there will be outpatients as well for Orthopaedics and Neurology.

1.4 Operational standards

In line with the National expectation regarding operational standards, the Trust plans to be sustainably compliant by the deadline of March 2018. The Trust is expecting to agree the financial control total and trajectory for compliance with the STF. This will include planned achievement of the trajectories and therefore bring the Trust in line with the mandated standards. The Trust is working closely with local commissioners to set these trajectories. The following caveats should be noted:

- Emergency Department (ED) and RTT: The actual growth in demand does not exceed the modelled volume and bed capacity is not compromised by the impact of the emergency pathway. (As per above, the Trust's reconfiguration plan is intended to mitigate this risk.)
- Cancer: Work with other partners (to improve delays in referrals to Maidstone and Tunbridge Wells NHS Trust (MTW) for treatment) continues without compromising the Trust's compliance.

2 Quality Planning

2.1 Approach to Quality Improvement

2.1.1 Context:

Quality of care is at the core of the Trust's day to day business and strategy delivery. Quality is embedded within all aspects of care, performance and development in order to meet the Trust's vision to provide the highest, consistent, quality care to our patients, whether in or outside a hospital setting. The Trust's vision, current and planned quality improvement plans are informed and directed by ongoing work from our Care Quality Commission (CQC) inspection process and through collaboration with our local CCGs and patient groups such as Healthwatch Kent.

2.1.2 Named Executive Lead:

The Executive lead for quality is the Chief Nurse.

2.1.3 Quality Improvement:

Quality improvement assurance is overseen by the Quality Committee, (a sub-committee of the Board). Quality improvement is monitored by the Trust Clinical Governance Committee and the Trust Management Executive Committee. The Trust's priorities for improvement are informed by key performance indicators (KPIs), actions and learning from our CQC process, risk registers, and feedback from the local health economy including CCG and Healthwatch Kent. Organisational service improvements are reviewed at a senior level and signed off by Executive leads. Improvement plans are supported by the Programme Management Office (PMO), as well as relevant clinical and operational managers, and are subject to a quality impact assessments (QIA) which are signed off by the Chief Nurse and Medical Director (*section 2.3 of this document*).

2.1.4 CQC Process:

Following CQC inspection (October 2014) and their report (January 2015) a quality improvement plan was developed and actions implemented. The required 18 compliance actions were completed and the enforcement notice was lifted (the Trust now has one remaining risk outstanding relating to ITU overnight unplanned discharges). Progress to eradicate this risk is being made with support of the National Commissioning for Quality and Innovation (CQUIN) [Adult Critical Care Timely Discharge]. The Quality Improvement plan was otherwise closed by the Trust Board in May 2016 with ongoing assurance via the internal surveillance inspections. These inspections, (as well as assuring consolidation and embedding of the previously identified actions), support the development of services, steering the organisation towards a 'good' and ultimately 'outstanding' CQC rating. The Trust is in the process of revising its internal inspection formula to provide each area with a rating at the end of each inspection to inspire this continuous improvement and development.

2.1.5: Quality Account:

The Trust's Quality Account provides direction for quality improvement. The 2016/17 Quality Account has been agreed with all Commissioners, with support from, Kent County Council (KCC) and HealthWatch Kent. The quality priorities were grouped into three themes: Patient Safety, Patient Experience and Clinical Effectiveness. Each theme has a key priority as follows:

- Patient Safety: To improve the dissemination of learning from serious incidents and complaints to drive improvement across the organization
- Patient Experience: To improve the use of current feedback mechanisms and provide more innovative ways to receive and act upon feedback
- Clinical Effectiveness: To improve the management of patient flow.

The Trust's top risks to quality have also been grouped into three themes: increasing rise in attendances and admissions, gaps in workforce and ability to recruit and achieving financial sustainability. These risks have been analysed and mitigated as follows:

- Increasing rise in attendances and admissions: Demand has been outstripping capacity, impacting negatively on emergency, elective and cancer pathways. Detailed assessments of current capacity have been undertaken (*as set out in section 1.1 of this document*). These have been compared to current demand assumptions to ensure that, where necessary, all gaps are identified and resolved in conjunction with the CCG and other providers.
- Gaps in our workforce and ability to recruit: (Consultant, Allied health professionals and nursing staff posts). The Trust's Workforce Plan (*section 3.3 of this document*) focusses upon achieving appropriate staffing levels to meet operational demand. Pathways for the workforce of the future are being developed in collaboration with Health Education Kent, Surrey & Sussex (HEKSS), local providers and Canterbury Christchurch University to capture how the

Item 11-16. Attachment 11 - Draft Planning Submissions for 2017-18, 18-19 health economy can integrate pathways to wrap care around the patient and provide development opportunities for our workforce.

- Achieving Financial sustainability: Service reviews are firstly considered from a quality perspective. As a Trust in financial special measures, financial recovery and stability is also an absolute focus of the Trust's strategy and is an integral part of the Trust's QIA process. Lord Carter's Review is reflective of much of the work already undertaken or identified by the Trust to maximise efficiency, reduce costs and secure reimbursement for the work we do.

2.1.6: Monitoring of Assurance Processes and Measuring Improvement:

The Trust operates integrated performance management of its quality improvement plan. As stated in section 2.1.3, the Trust's Quality Committee oversees quality assurance on behalf of the Trust Board. It undertakes a deep dive meeting on alternate months, which complements the full Committee meetings. This provides a robust focus on the metrics for quality and performance of each service area of the Trust. To support this, the scorecard from the Trust's a new Performance Management Framework, drawn from the Single Oversight Framework (SoF) monitors the key indicators from ward to board. The monthly Trust Clinical Governance Committee reviews the CLIPA report (Complaints, Litigation, Incidents, PALs and Audit) which is a 2-way process for dissemination of learning and good practice. Quality improvement is also measured by reviewing the key recommendations from the reports of the Trust's internal surveillance inspections, Executive visibility and the 6 monthly Performance and Quality Reviews undertaken with each Division (as part of the new Performance Framework).

2.1.7: Sustaining change through quality improvement capability and capacity:

For the Trust's quality improvement plan to be successful, focus has been placed upon existing skills, training requirements and the working capacity of staff to deliver their plans and any required service developments. Identification of resultant educational needs is undertaken via the Trust's appraisal system. Drawdown monies are utilized from Health Education England (HEE) for education of all staff groups, which is linked to staff appraisal, continuous professional development (CPD) and service development needs. Tracking and monitoring of the outturn and fitness of purpose of any education commissioned is undertaken to assure sound investment. Compliance with the Trust's QIA process (section 3.3) ensures adequate staffing capacity for all service changes and initiatives, with assurance that education for new roles is incorporated into start-up plans. The Trust is compliant with National Quality Board Guidance for Safe Staffing (SS) in nursing and midwifery. The SS review is reported to board twice yearly with monthly reports to the board regarding current staffing levels.

2.2: Summary of the Quality Improvement Plan (including compliance with National quality priorities)

Figure 2: Summary of Quality Improvement Plan

Priority	Summary of Key Elements of QI Initiative	Responsible Lead and Assurance Committee	National Priority Compliance	Executive Lead
Improving the Quality of Mortality Review	Maturation of the mortality review process with dissemination of key learning, extrapolated from the Directorate Clinical Governance meetings, shared across the Trust. Link to serious incident (SI) process for deceased patients. Use of Dr Foster data to add further dimension to scrutiny of clinical specialities.	Associate Director, Quality & Governance. (Clinical Governance Committee)	Keogh Mortality Review (2013)	Medical Director
Falls	Chief Nurse Chairship of Falls Committee. Maximisation of links, via the Sustainability and Transformation Plan (STP) process, to enhance falls prevention in the community. Working with community health and social care colleagues as part of the wider admission avoidance and 'near to home' care.	Deputy Chief Nurse (Patient Safety Committee)	National Patient Safety Goal (2016)/NICE CG161	Chief Nurse
Pressure Ulcers	Strengthened collaboration with partner organisations both via the Patient Safety Collaborative and Higher Education Institute to enhance workforce competence. Joint working with community and mental health teams to develop education pathways for Nursing Associates. Review of service provision for mattresses and dynamic devices.	Deputy Chief Nurse (Patient Safety Committee)	National Pressure Ulcer Advisory Panel (NPUAP)/NICE CG179	Chief Nurse
Patient Experience	Increased and better understanding of patient experience to inform clinical practice. To actively engage with Patient Representatives and external organisations including Healthwatch through listening events with better use of social media and technology. To achieve 25% response rates in the Friends and Family Test (FFT) in all adult inpatient and Maternity Services and 15% response rate for Accident and Emergency services. Action plans developed from local and national surveys.	Deputy Chief Nurse (Clinical Governance Committee/ Patient Experience Committee)	Putting Patients First 2013/Patient Experience in adult NHS services NICE CG138/NHS Outcome Framework domain 4	Chief Nurse
Endo of Life Care	Development of partnerships with external, local palliative	Deputy Chief Nurse	Transforming end	Chief Nurse

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(EOL)	care providers and commissioners. Exploration of need for 7 day palliative care service and access to care advice out of hours, and to support the patient's death in their place of choice. Individualised care plans for all patients. Learning from patient experience. Benchmark EOL care performance against national standards to inform service development.	(Clinical Governance Committee)	of life care in acute hospitals. The route to success 'how to' guide. NHSE 2015	
Safe Staffing and Care Hours per Patient Day	Twice yearly staffing reviews undertaken by the Chief Nurse with relevant Matron and Ward Manager. Service reviews by the Senior Corporate team with Chief Nurse Oversight. New electronic roster system (Allocate) to be rolled out during next two years with the ability to record patient acuity and dependency, close to real time and matched to available staff. Ensure that opportunities offered via the Apprenticeship levy are maximised to ensure safe, effective and efficient use staff.	Deputy Chief Nurse (Trust Board)	Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time- NQB 2016	Chief Nurse
Seven Day Services (4 Priority Standards)	PMO-managed programme plan, led by Medical Director. Response to 7 Day national survey findings/conclusions. Recruitment to Consultant Positions and review of Job plans/clinical pathways to support timely consultant reviews, on-going reviews and Consultant directed interventions in line with National Quality agendas & Royal College guidance to support reduction in admissions & length of stay. Recruitment to Allied Health Professional/Biomedical Scientist positions to improve access to diagnostics.	Clinical Directors (Clinical Governance Committee/Trust Management Executive)	Seven day services clinical standards in acute care – NHSE 2015	Medical Director
Maternity	1 of 7 National Pilot sites for the Choice Agenda. Working collaboratively across Kent as 'Local Maternity Systems' as link with STP. Bid submitted to improve patient safety with view to increase multi-disciplinary training. Saving Babies Lives- care bundle for reducing stillbirth by 30% by 2030 in collaboration with Public health Kent, Surrey & Sussex work plan being developed for 2016/17-18/19.	Head of Midwifery (Clinical Governance committee/Trust Management Executive)	National Maternity Review-Better Births 2016	Chief Nurse
Sepsis	Development plan to ensure compliance with National Institute for Health and Care Excellence (NICE) Guidance. Improvements to compliance with early detection and prompt administration of antibiotic therapy. Review of clinical outreach services to support initiatives.	Clinical Director, Critical Care (Clinical Governance Committee)	NICE Guidance (NG51)/Improving Outcomes for patients with sepsis, NHSE 2015	Medical Director
Mental Health/Dementia	Local collaboration with Psychiatric Liaison Service via monthly meetings (informed by clinical audit). Participation in West Kent Liaison Psychiatry Strategic Steering Group Kent & Medway Partnership Trust, (KMPT) Child and Adolescent Mental Health Services, (CAMHS), West Kent Clinical Commissioning Group (WKCCG) to work through access and waiting time standards (NHSE, 2015) and improve the quality of care provided. Delivery of full compliance for Dementia NICE Quality standards, in line with the Trust's Dementia Strategy, monitored by the Dementia steering group.	Director of Operations, Urgent Care (Clinical Governance Committee) Deputy Chief Nurse (Safeguarding Adults and Children Committee – Clinical Governance Committee)	The five year forward view for mental health, NHSE 2016 Living well with Dementia: A National dementia strategy, 2009/NICE CG103 & 42	Chief Nurse
Infection Prevention and Antimicrobial resistance	Eliminate or reduce hospital acquired infections (HAIs) to least harm and reduce LOS. Continue surveillance of alert/important organisms to identify and manage outbreaks promptly. Continue the Surgical site infection surveillance programme. Investigate any wound infections using root cause analysis (RCA). Continue antibiotic review to ensure empirical treatment advice in line with latest guidance. Collaboration with Estates and Facilities for building standards and water regulations. Improve monitoring of intravenous (IV) antibiotic usage. Assurance of good antimicrobial stewardship by implementing NICE standards and developing local quality measures. Ensure that staff has access to training in antimicrobial prescribing. Improve information on antibiotics for patients and relatives. Develop policy for providing information for patients on antimicrobials. To continue to support the PII and annual antimicrobial audits.	Director of Infection, Prevention & Control (Clinical Governance Committee)	Infection prevention and control- NICE QS 61/Antimicrobial Stewardship NICE NG15/ NHS Outcome Framework domain 5	Director of Infection, Prevention & Control

2.3: Summary of the Quality Impact Assessment (QIA) Process

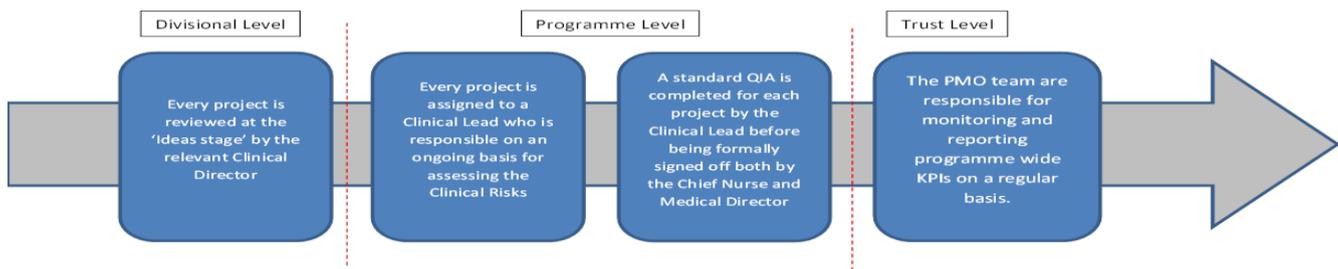
The Trust's Quality Impact Assessment (QIA) process is a well embedded and robust business as usual practice within the Trust.

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It is clearly documented in the Programme Management Office (PMO) manual, which is reviewed and updated on an annual basis to reflect any changes identified in the NHS Operational Planning and Contracting guidelines. All change, whether linked to a cost improvement or a service improvement will be subject to a QIA. With the scale of the challenge that the Trust is facing, mitigation in terms of patient quality and safety of any service change is an essential component of the Trust's assurance process. The Trust assigns a clinical lead to every project or scheme, engaged at all stages of the assessment and sign off process. The clinical lead completes the quality assessment of every project which includes:

- Identification and agreement of KPIs to provide sensitive early warning systems, which will lead to responsive and timely action as required.
- A detailed risk assessment identifying any risks to patient safety, patient experience or clinical effectiveness. This allows risks to be mitigated at the earliest possible stage.

Figure 3: QIA Process Flow



It should be noted that even if a scheme/project is in its analysis phase, a QIA will still be required to meet the NHS Operational Planning and Contracting timeline with the likely outcome that a detailed QIA will be required at the point of analysis completion or further detail available.

The QIA template incorporates all key components such as patient safety, clinical effectiveness, patient experience, staff experience, inequalities and targets/performance. The Clinical Lead completes the template with the risk rating and can allocate mitigation actions to provide a residual score. To support the National Health Service (NHS) Operational Planning and Contracting timeline, the completed QIAs are formally presented to the Medical Director and Chief Nurse as part of an agreed QIA Clinic. Notes are taken and distributed to all attendees. Any outstanding actions are managed by the Clinical Director at the Clinical Divisions' Board meetings with a follow up meeting agreed at the QIA clinic. The PMO Team is responsible for tracking and reporting KPI performance and providing a regular progress update to the Programme/Divisional Boards. All approved QIAs are formally signed by the Medical Director and Chief Nurse and scanned to provide an electronic audit trail. Any change which requires a QIA outside of the annual planning timeline will undertake the same process as noted above.

2.4: Summary of triangulation of quality with workforce and finance

To ensure triangulation of intelligence from a wide range of data sources, the Trust has developed a new performance management framework which was launched in the early Autumn of 2016. The framework is based upon the national Single Oversight Framework (SOF) and reinforces accountability for delivery at Divisional level. A ward to Board approach has been adopted, monitored through a board sign off process at Directorate, then Divisional level before presentation at the monthly Executive Performance Review meetings and ultimately, the Trust Board. A whole day each month is devoted to Trust-wide performance management, attended by all Executive Directors. The Clinical Divisions and Corporate services are accountable for the delivery of their key indicators for quality, performance, finance and workforce, together with their strategic and Trust-wide programme responsibilities. The resultant Trust Board performance dashboard provides the Board with a rich source of data intelligence which has been fully reviewed and triangulated at all levels in the organization. Every six months, a deep dive is held with the Divisions to promote further understanding of data trends and links and to provide focused challenge and support.

It is envisaged that as the process matures, the identification of the potentially less evident trends between quality, workforce and finance will become more apparent and identification of the links between areas such as lower staffing levels and quality indicators will be easier to detect. At present, peaks in indicators (for example, falls and pressure ulcers) are always checked against staffing levels through the Safer Staffing (SS) report. With the deeper analysis available to the Trust through the new performance framework and intelligence from Trust wide programmes, triangulation and comparison with more in-depth analysis is envisaged to be more accessible. Work on programmes such as the medical productivity review, analysis of unwanted variation via the seven day services programme and outputs from the recent Trust staffing review (with the validation received from the NHSI for the nurse staffing components), will all contribute to this process.

3 Workforce Planning

3.1: Workforce Strategy

A five year workforce strategy (*Workforce Strategy: Shaping Our Future Together 2015-2020*) was agreed by the Trust Board in September 2015, outlining an ambition to develop an organisation where people deliver excellence each day, feeling engaged, enabled and empowered to work for the Trust. The strategy was developed with input from clinical and corporate leaders and the Joint Consultative Forum. It comprises six workforce priorities (which link to the Trust's strategic, financial and service objectives):

- Recruitment and Retention
- Temporary Staffing
- Culture
- Health and Wellbeing
- Integrated Education
- Equality and Diversity

The Workforce Committee oversees the detailed implementation plan, assuring Board level monitoring and control. Exploring opportunities for collaborative working with partners at a local and regional level is a key aspect of the strategy, linked to the ongoing development of the STP.

3.2: Workforce Performance

As stated in section 2.4, the trust has implemented a new Performance Management Framework which is being adopted across all areas of the business. A range of workforce metrics are monitored in Divisional and Directorate operational groups. A set of KPIs are reviewed monthly by the executive directors as part of the Trust's performance dashboard. In addition, more detailed scrutiny of broader metrics, as well as targeted 'deep-dive' analysis is performed at the quarterly Workforce Committee as part of the Board assurance process. A replacement e-Rostering system (Allocate HealthRoster) has been purchased for deployment across the organisation through a two year programme. The replacement system will enable improved workforce reporting over the period, specifically in the areas of efficiency and in order to reduce agency and bank expenditure. As part of the STP footprint, the Trust is actively exploring options for shared exploitation of this tool with Medway NHS Foundation Trust (MFT) where the platform is also in use.

3.3: Workforce Planning

Workforce planning is an integrated part of the Trust's annual business planning process. Workforce plans are developed in conjunction with the organisation's strategic objectives, operational and financial plans including the Trust's Long Term Financial Model (LTFM), Cost Improvement Programme (CIP) and income forecasts. An Executive Team challenge programme of scrutiny ensures all local plans are aligned to organisational plans and objectives and have been subject to a robust QIA process. The integrated business planning process ensures that recruitment strategies, education commissioning, organisational development initiatives and workforce resource management are affordable and can be developed at a Trust-wide level and at scale. Divisional and directorate workforce plans are formally approved by the relevant clinical director (service lead) prior to review by the Trust Management Executive, Workforce Committee and Finance Committee to form a recommendation for approval or variation at the Trust Board. The Workforce Plan delivers:

- Appropriate staffing levels to meet operational demand as agreed with our commissioners and local partners
- Relevant skill-mix within clinical units to ensure the efficient, safe care of patients within the Trust
- Reduced dependence on temporary staffing (particularly high-cost agency sourcing) but protecting the ability to flex as service and contractual demands require
- An overall reduction in staffing levels as a result of increased collaboration (specifically as a result of STP back-office collaboration initiatives) with local and regional partners

Following a review of inpatient nursing staff levels, significant staffing savings were achieved across ward areas. To ensure that the delivery of safe patient care was not adversely impacted as a result of these changes, full QIAs were performed. Outcomes of the process have been shared with NHS Improvement (NHSI) and the CQC who also agreed the methodology.

Figure 4: Two-Year Workforce Plan:

Summary	Staff Classification	Oct WTE Plan	Oct WTE Wkd	Apr 17 WTE Plan
Substantive	Medical	669	637	638
	Nursing	2,109	1,970	1,963
	Other Clinical	963	956	979
	Non Clinical	1,616	1,512	1,552
Substantive Total		5,357	5,075	5,132
Agency	Medical	15	20	4
	Nursing	86	114	115
	Other Clinical	41	49	23
	Non Clinical	9	25	17
Agency Total		151	207	160
Bank	Medical	37	76	76
	Nursing	197	235	215
	Other Clinical	8	12	7
	Non Clinical	22	41	38
Bank Total		263	365	335
Grand Total		5,771	5,647	5,627

The Workforce Plan has been informed by current and future development in a number of key areas:

- Efficiencies in the delivery of corporate services across the STP footprint including exploration of the four options for consolidation and sourcing identified as part of the NHSI guidance. Specifically, the Trust is working closely with MFT as part of the A229 / A21 corridor process (*as set out in section 5.3 of this document*) to identify partnership working opportunities for Finance, HR, Procurement, Estates and Facilities, IT, Information and Legal / Governance services. A structured governance approach to this process is being adopted as part of the STP Programme.
- Improvements in medical productivity are being driven through a targeted service line reporting (SLR) review. Benchmarking against other Trusts, particularly as part of the Lord Carter model hospital framework, is currently in progress to identify areas where workforce efficiencies can be delivered.
- Support to the West Kent Clinical Commissioning Group in development and implementation of a 'virtual fracture clinic' as part of a new model of care, reducing overall workforce demand and contributing to whole system improvements;
- Work to address the implications of the Apprenticeship levy due to come into effect in April 2017, during 2017-2018. Increased opportunities for apprenticeship will be introduced for roles within Agenda for Change bands 1-4 and will primarily focus on current and new vacancies. Within 2018-2019, the scope will be increased to evaluate how apprenticeships within the professional and high banded staff groups can be introduced;
- Whilst the Trust was not successful in its application to be included in the pilot for Nurse Associates as a new healthcare role, it is expected that it will participate in the second phase of the programme. Greater use of Physician Associates will be employed at a as part of the clinical workforce to promote innovative staffing models;
- The Trust is currently undertaking a stocktake of its 7 day services programme, working closely with the Improvement Manager from the NHS England Sustainable Improvement Team. The revised programme plan is in development and is managed by the Trust's PMO, with Executive and overall clinical leadership from the Medical Director. The Trust is in tranche 3 of the national programme and is progressing along its trajectory to achieve the 4 priority standards by the March 2020 deadline. Priorities such as urgent care, medical pathways and some of the diagnostic interventions will be discussed and agreed with the host commissioner as part of this year's 7 day services annual reporting process. At present, weekend services are currently in place across a number of Allied Health Professional (AHP) disciplines (Speech and Language Therapy, Physiotherapy, Occupational Therapy) within the key areas of Stroke and Trauma and Orthopaedics. Recruitment is in place to AHP/Biomedical Scientist (BMS) positions to improve access to diagnostics. Further work on the 7-day service programme is necessary within the Trust, the outputs from which will be used to inform further workforce planning within the period.

4 Financial planning

4.1 Financial forecasts and modelling

The financial plan has been modelled using a consistent and integrated approach with the activity and workforce models. The plan has used the starting point of the forecast outturn for 2016/17 as at month 4. This underpins the Trust's Financial Recovery Plan (FRP) for this financial year. The Trust has then applied a number of assumptions to this, these include:

- Price changes using the application of the draft 2017/18 tariffs, equating to a 2.1% tariff uplift plus specific Clinical Negligence Schemes for Trust (CNST) impact on the Healthcare Resource Groups (HRGs) (net impact circa 0.1%); the suspension of fines due to agreement to the control total and performance trajectories in place and agreed with the CCGs.
- The efficiency programme impacts on costs for pay and non-pay, inclusive of this is the impact on planned workforce changes agency, agency reduction to ensure the Trust deliver the specified agency cap (£13.6m) and the Carter efficiency implementation plan
- Inflation assumptions for the published pay and price levels, notified CNST premium and the forecast retail price index (RPI) on the PFI contract
- A 0.5% contingency reserve (£2.1m)
- Clinical activity volume changes, mainly relating to demographic changes

A series of high level assumptions have been applied to collate the 2018/19 financial plan. These assumptions mainly relate to inflation and any known changes planned in the next two years.

The Finance, Information, Workforce and PMO teams have worked together to collate the plan, ensuring that assumptions made in the plan are applied consistently to all relevant matrix.

The Trust is planning a 2017/18 deficit of £4.5m pre STF and a surplus of £6.7m post STF. The table below shows the income and expenditure position for 2016/17 to 2018/19.

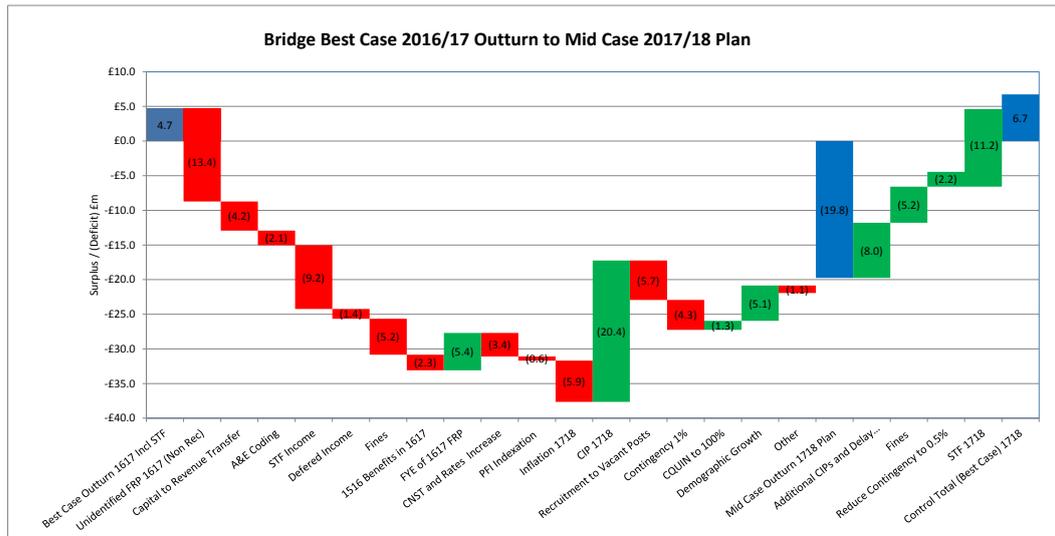
Figure 5: I&E Position 2016/17 to 2018/19

	2016/17 Control Total (£m)	2017/18 Best Case (£m)	2018/19 Best Case (£m)
Income	440.8	440.5	448.1
Pay	-250.7	-251.5	-251.8
Non Pay	-152.4	-149.8	-151.2
EBITDA: Surplus / (Deficit)	37.7	39.3	45.1
Depreciation and Other	-15.7	-15.3	-16.6
Impairment of Fixed Assets	-13.5	-1.0	-1.0
Other Finance Costs	-14.6	-14.9	-14.9
PDC Dividend	-3.4	-2.4	-2.4
Total	-47.2	-33.6	-34.9
Surplus / (Deficit) before Technical Adj:	-9.5	5.7	10.2
Technical Adjustments	14.2	1.0	1.0
Net Surplus / (Deficit) Post Technical	4.7	6.7	11.2
Control Target Excl STF	-4.5	-4.5	0.0
Variance to Control Target	0.0	0.0	0.0

It should be noted at this stage the Trust is working with commissioning partners to agree contracts for 2017/18 & 2018/19. At this stage no specific QIPP schemes have been agreed or included in the activity or financial modelling. The income plan includes penalties for readmissions and new to follow up ratios. The Trust has not included any provisions for performance penalties within the overall financial plan on the basis that STF will be available.

The main changes between the 2016/17 forecast outturn position and the 2017/18 plan are set out in the bridge below.

Figure 6: Changes Between 2016/17 Forecast Outturn Position and 2017/18 Plan



The Trust has included a 0.5% contingency reserve (£2.1m) to provide for any risk management required during the financial year. The Trust has highlighted the following risks as part of the business planning process.

Figure 7: Business Planning Risks

Risk	Mitigating Actions
CIP gap	There is currently an unidentified gap of £16.3m. The Trust has RAG rated all schemes, however at this stage the identified value has not been risk adjusted. The Trust has developed top down saving opportunities to mitigate the current gap. This has been discussed at Board as part of the sign off process for the 2017/18 two year plan. These will now be developed at pace prior to the final submission in December
Recruitment	Delivery of a number of pay savings will be reliant on a continuous recruitment strategy, which in some cases may rely on overseas recruitment. Agency usage is at the specified cap level of £13.6m
Ability to manage within the non-elective bed base	The Trust is also opening the Maidstone Orthopaedic Unit (MOU) at Maidstone site to ensure that during the winter months the Trust is able to maintain elective activity levels, in particular T&O at the required income plan, therefore also reducing the risk of over reliance on outsourcing patients. A ward reconfiguration has also taken place at TWH to ensure we maintain flow
Contract negotiations	Negotiations are currently on-going. There is a gap in the views of the individual organisations, however at this stage the Trust is not expecting to require mediation

4.2 Efficiency Savings for 2017/18 to 2018/19

The Trust has undertaken a robust planning process for two year operational plan, with an efficiency target of 6% in 2017/2018 and 4% in 2018/2019. The Trust has been clear in the local guidance issued to Divisions that the efficiency programme needs to focus on cost reduction. The Divisions have presented their draft business plans to the Executive on two occasions. These meetings have taken place in the form of an executive challenge session. Through this process the Divisions have identified schemes that delivery efficiency, productivity and /or service redesign. The table below provides a summary of the Divisional savings plans.

Figure 8: Divisional Savings Plans - Summary

Division	Identified				Target £000	Variance £000
	Green £000	Amber £000	Red £000	Total £000		
Corporate	528	302	30	860	1,639	-779
Estates and Facilities	0	72	150	222	2,490	-2,268
Planned Care	2,202	1,322	1,285	4,809	12,784	-7,975
Urgent Care	999	838	3,297	5,135	7,598	-2,464
Womens, Childrens and Sexual Health	76	268	7	350	3,189	-2,838
Total	3,804	2,802	4,769	11,375	27,700	-16,325

The PMO team is working with the Divisions to assure the Trust's efficiency programme:

- Development of Divisional Project initiation documentation and plans are in progress to support the identified schemes
- Divisional QIAs have been reviewed and signed off by the Chief Nurse and Medical Director
- Unidentified schemes are phased from May 17
- Schemes identified as high risk continue to be subject to ongoing validation to convert to medium and low risk and assure delivery
- The top down initiatives that have been developed will reduce the value classified as unidentified

4.2.1: Lord Carter provider productivity work programme

The Trust has a clear work programme and governance structure for driving through the efficiencies identified as part of the Carter programme. The Trust has recently re-launched SLR within the Trust and is providing a monthly report to Divisions. In addition to this the Trust is carrying out "deep dives" of the ten specialties identified by the national Carter team as above the national benchmarked data. The high level findings of these reviews are incorporated within the top down savings identified to bridge the current gap.

Key deliveries against the Operational Productivity & Performance (OP&P) requirements are:

- Hospital Pharmacy Transformation Programme (HPTP)
 - Draft Plan submitted on 31st October, as planned
- Resource Deployment Analysis – Care Hours Per Patient Day (CHPPD)
 - Reduction in Nursing Headroom by 1% implemented
 - Reduction in Nursing establishment based upon detailed ward by ward review
- Procurement Transformation Programme (PTP)
 - Purchase Price Index Benchmarking (PPIB) monthly returns produced
 - Efficiency Savings of minimum 10% savings factored into 17/18 & 18/19 CIP plans
- Get it Right First Time (GIRFT)
 - Review of Orthopedics – Cemented / Uncemented and opportunities
 - Spinal Surgery

The Trust continually works with NHSI in terms of the Model Hospital Dashboard and guidance to ensure that we continually support the OP&P Programme and deliver efficiencies.

4.2.2: Agency Rules

The Temporary Staffing Workstream, which is led by our Chief Operating Officer, will continue to monitor and control the temporary staffing usage, which will comply with the agency spending rules issued on 17th October 2016.

The Trust has completed and will be submitting the agency self-certification checklist on 30th November and continues to report on a weekly basis the breakglass submission, incorporating the additional reporting requirements in terms of agency usage which breach the hourly and daily rate. The Temporary Staffing group, meet on a weekly basis to review usage in excess of the

Item 11-16. Attachment 11 - Draft Planning Submissions for 2017-18, 18-19 divisional and directorate agency ceiling caps, which equates to the Trusts total ceiling cap of £13.6m and monitor / challenge recovery plans to ensure delivery against the ceiling cap for all clinical staffing groups. The key reasons for temporary staffing usage are monitored and reviewed in terms of recruitment pipeline, sickness management and rota management to ensure that the agency ceiling reduction trajectory is on target.

The Trust has seen continual improvement in reducing the reliance upon temporary staff for nursing and will replicate the process undertaken for Medical and Other clinical staffing groups.

The temporary staffing group consists of

- Directors of Operations
- Associate Director of Nursing
- HR – Recruitment / Staff Bank
- Procurement Manager
- Finance Manager
- Head of PMO

4.2.3: Procurement

MTW’s Procurement Department has transformed over the last two years. It is now structured to take a category management approach that looks strategically at spend to identify opportunities that are greater than compliance with European Union (EU) procurement regulations and instead supports the Trust to be an intelligent client/buyer of goods and services. The approach focuses on delivering savings through tendering or renegotiations and demand management; and it has structured the teams to take a strategic, tactical and operational approach to procurement which reflects the ideal model proposed by the NHSI report entitled ‘Leading practice guidance for corporate services’, published in September 2016.

The Procurement Strategy Committee (PSC) was established in 2015 to have an overview and scrutiny role in relation to the Procurement Transformation Programme. The programme focuses on transforming people and processes and the PSC reports into the Finance Committee to provide assurance about progress. The PSC currently has oversight on the Trust’s move from Marrakech to Integra 2 so that we have a seamless Procure to Pay (P2P) system that reduces buyer intervention, as well as oversight in relation to the Trust introducing an electronic inventory management system.

In 16/17, the Procurement Department is supporting the Trust in relation to financial special measures by introducing a discretionary spend policy. It has also stretched its CIP target from £4.1 million to £4.3 million. Over the last two years (14/15 and 15/16), the team has delivered savings of £1.2 million and £1.6 million. This year, the department is on track to deliver £4.3 million of savings. The Procurement Department is identifying savings for the 2 year plan and is working with departments to find a minimum of £5.3 million of opportunities.

The Department has reviewed the Carter report and undertaken a self-assessment with the findings below shared in the Trust’s Procurement and Transformation Plan.

Figure 9: Self Assessment – Procurement Plan (Carter)

MEASURES		PERFORMANCE			COMMENTARY
		SEPTEMBER 2016	TARGET SEPT 2017	TARGET SEPT 2018	
1	Monthly cost of clinical and general supplies per ‘WAU’	£2,921,030	£ target TBC	£ target TBC	Target for Sept 17 will be completed once the Model hospital data has been refreshed.
2	Total % purchase order lines through a catalogue (target 80%)	60%	70%	80%	The current position provided covers the Purchase order not purchase order lines. This is not previously measured within the Trust but will be measured from now on.

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3a	Total % of expenditure through an electronic purchase order (target 80%) up to and including PO issue	43%	60%	80%	The Trust has a No PO no Pay policy and this is being strictly applied across all Directorates. The embedding of this policy will significantly improve the Trust position by enforcing proper procurement process.
3b	Total % of transactions through an electronic purchase order (target 80%) up to and including PO issue	74%	80%	80%	
3c	Total % of expenditure through an electronic purchase order (target 80%) from requisition through to and including payment	5%	50%	80%	Whilst the ordering and finance process is electronic, the current payment system is not completely electronic with the majority of invoices coming into the Trust as hard copy.
3d	Total % of transactions through an electronic purchase order (target 80%) from requisition through to and including payment	63%	70%	80%	
4	% of spend on a contract (target 90%)	61%	75%	90%	The Trust is reviewing this area and where there is no contract in place, this will form part of the 2017/18 work plan. There has already been a significant improvement in this area due to the 3 year procurement transformation programme.
5a	Inventory Stock Turns -static	Days	Days	Days	The Trust has begun the implementation of an inventory management system which will be captured under this section of the report in the future.
5b	Inventory Stock Turns -dynamic	Days	Days	Days	
6	NHS Standards Self-Assessment Score (average total score out of max 3)	1.16	1.47	1.67	Level has been achieved. Awaiting peer review to complete accreditation.
7	Purchase Price Benchmarking Tool Performance	TBC	TBC	TBC	To be completed using the recently released tool

¹ RAG Rating Definitions:

Green = better than the Lord Carter or Trust target
 Amber = Up to 10% less than Carter target
 Red = More than 10% below Carter target

4.2.4: Partnerships and collaboration

The Kent and Medway Heads of Procurement: Medway Foundation Trust, Dartford and Gravesham NHS Trust, East Kent Hospitals University NHS Foundation Trust and Maidstone and Tunbridge Wells NHS Trust have agreed next steps for working together as a region in relation to strategic procurement. The Heads of Procurement meet every month to discuss opportunities for collaboration.

This group meets monthly, and currently has no terms of reference but has, through continued dialogue completed the following collaborative procurements:

- (1) Total Waste Management Contract – Awarded 1 Sept 2016, saving Kent & Medway STP £1.4m over 5 years.
- (2) Agency – Market Management and controls to NHSI Cap Rates currently in progress

The Heads of Procurement are taking a strategic approach to mutual areas of interest. The strategic approach will rationalise effort across Kent and Medway by identifying a Category Lead for areas of spend (or suppliers) that would benefit from taking a Kent and Medway approach.

4.3: Capital planning

The Trust is planning a five year capital programme of total value £74m (excluding donated assets) which is entirely focussed on delivering the clinical strategy, driving access and operational performance improvements and reducing backlog and clinical risk to ensure appropriate patient safety and experience within an efficient environment.

The programme reflects plans for essential improvements in backlog estates (£11m), Tunbridge Wells Hospital lifecycle (£3.7m), plus an additional electrical substation at the Maidstone site which has reached maximum electrical load (£2.5m), and capital associated with an Energy Performance contract that the Trust plans to seek through Salix funding (£4m). It includes necessary replacement equipment provision of c. £17m including linear accelerators for the Cancer Centre, along with £4m of associated estates work, and an Information Management and Technology (IM&T) modernisation programme (£5.3m). Strategically, the Trust is planning the replacement of the Theatre complex at Maidstone Hospital (£15m), the development of radiotherapy services at the Tunbridge Wells Hospital to provide additional bunker capacity (c £7m), and additional magnetic resonance imaging (MRI) capacity (£2.5m) to reduce reliance on outsourced private sector capacity.

The primary source of capital funding is internally generated cash through depreciation and capital receipts received on the planned sale of assets, net of repayments of principal on the existing capital loans, PFI lease repayments and PFI lifecycle repayments. The Trust has reprioritised and scaled down its capital programme in the light of the constraints on external capital, the new approach to accounting for PFI capital repayments, and also to reflect its stretching of the existing asset base (e.g. linac operational lives have been increased to 13 years from 10 to reflect actual usage) and the impact of valuation impairments. The Trust plans to continue accessing charitable funding to support its capital investment, particularly in cardiology and oncology, and also considering other approaches to managing its resource requirement e.g. the use of managed service arrangements (currently used for instance in laboratory services).

The scale of required estate renewal, and operational pressures, means that the Trust has planned for capital investment loans to support its strategic needs to increase diagnostic capacity (£2.5m MRI build/equipment in 2018/19), its development of a satellite radiotherapy facility at TWH (£7.3m across 2018/19 and 2019/20) and the theatre renewal at Maidstone requiring a new build (£15m across 2018/19 and 2019/20).

The Trust is planning to dispose of two adjacent residential properties next to the TWH site. The capital receipts are planned within the programme to help finance the estates developments in 2017/18.

5: Links to Emerging Sustainability and Transformation Plan

5.1 Case for Change: The Kent and Medway health and social care system is developing its case for change, with an intention to publish this in February 2017. This will outline a range of challenges that are being faced by health and social care that are driving the transformation of care being pursued by the STP (as summarised below).

Health and wellbeing

- **Population growth:** Projected to grow by c5% (~ 89,000 people) over the next five years, with uneven growth across the patch putting pressures on some parts of the system
- **Ageing population:** Largest age group growth is in demographic of 85+ years bringing increased needs for health and social care
- **Health inequality:** Range of life expectancies for both men and women related to deprivation exist, with the main causes of death being from preventative interventions and the gap has not closed over the last 10 years
- **Housing growth:** Kent and Medway earmarked for significant housing growth e.g. Ebbsfleet, adding to the demand for health and care services

Quality of Care

- **Stresses in the system:** Services close to capacity across the patch with acute occupancy over 90%; a number of providers in special measures; a high ratio of patients to GPs and a number of GPs giving up general medical services (GMS) contracts or retiring
- **Delivery of constitutional targets:** Delayed transfer of care, A&E targets, RTT, cancer targets, ambulance response times and other services pressures (e.g. stroke) continue to be an ongoing issue
- **Workforce issues:** Significant workforce issues around recruitment, rotas and maintaining a viable workforce impacting health and social care

Sustainability

- **Financial sustainability:** 15/16 deficit of £109m forecast to rise to £434m by 20/21 in a 'do nothing' scenario (this excludes social care budget pressures (KCC £45m, Medway Council £7m).
- **Clinical sustainability:** Growing reliance on agencies due to workforce issues around unsustainable rotas, recruitment and retention.

The challenges outlined above are already being experienced by the Trust as outlined in this document, characterised by an increased demand for services due to changes in the population and increased challenges in delivering constitutional targets and maintaining expenditure within control totals. The STP is a complex change programme and aims to transform the way we delivery care against four key themes:

5.2 Four Key STP Themes/Workstreams:

Figure 10 – Current Position - Four Key STP Themes/Workstreams

	STP Position	Operational Plan Reference
i. Care transformation	Transforming our care for patients, moving to a model which prevents ill health, intervenes earlier, and delivers excellent, integrated care closer to home. This clinical transformation will be delivered on four key fronts: <ul style="list-style-type: none"> • Local care (Out-of-hospital care) • Hospital transformation • Mental health • Prevention 	DN – to add detail to Dec 23 rd OP draft - following further K&M wide discussions in Nov & Dec
ii. Productivity and Modelling	We will undertake a programme to identify, quantify and deliver savings through collaborative provider productivity addressing the following areas: <ul style="list-style-type: none"> • CIPs and QIPP delivery (ref: sections 2 and 3 of this plan) • Shared back office and corporate services (e.g. finance, payroll, HR, legal) – the trust is leading on this for the Kent and Medway STP • Shared clinical services (e.g. pathology integration) • Procurement and supply chain • Prescribing 	DN – to add detail to Dec 23 rd OP draft - following further K&M wide discussions in Nov & Dec
iii. Strategic enablers	We need to develop three strategic priorities to enable the delivery of our transformation: <ul style="list-style-type: none"> • Workforce • Digital • Estates 	DN – to add detail to Dec 23 rd OP draft - following further K&M wide discussions in Nov & Dec
iv. System leadership	A critical success factor of this programme will be system leadership and system thinking. We have therefore mobilised dedicated programmes of work to address:	DN – to add detail to Dec 23 rd OP draft - following further K&M wide discussions in Nov & Dec

	<ul style="list-style-type: none"> • Commissioning transformation - enabling profound shifts in the way we commission care • Communications and engagement - ensuring consistent communications and inclusive engagement 	
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5.3 Local Care: Out-of-hospital care needs to rapidly move from a service provided by a large number of smaller businesses and services, working and governed independently of each other, into consolidated arrangements that support the delivery of integrated and coordinated care, through multispecialty community provider (MCP) type arrangements, and, potentially, into a small number of larger accountable care organisation (ACO) type arrangements that would also hold commissioning budgets. This change will not be undertaken for the sake of the change but because the coming together of existing primary care with the services already provided outside of hospital will mean patients can remain in their own homes for longer, active 'well-health' management for the population will be the goal.

Our out-of-hospital care model needs to enable to us to potentially care for a significant number of individuals who are currently cared for in the acute sector. These arrangements are also the vehicle that will allow us to integrate health and local authority provision and local commissioning. This potentially enables the development of a wide spectrum of integrated provision arrangements (e.g. therapy led enablement services and nurse-led home care models). Although working to a similar design across Kent and Medway, implementation of new models of out-of-hospital care will be locally developed to meet the differing needs of local people and the differing workforce constraints across Kent and Medway

5.4 Hospital Care: In relation to the hospital workstream of the STP, we are building on the strategic direction outlined in the NHS England Urgent and Emergency Care Review and consolidating services to create emergency hospital centres with specialist services and separate emergency hospital centres. Alongside these we are looking to better separate planned and unplanned activity through the establishment of specialist planned care hospital centres, including the further development of Kent's cancer centre at Maidstone Hospital. The develop of emergency hospital centres with more specialist services will be achieved through the further consolidation and co-location of specialist services such as primary percutaneous coronary intervention (pPCI); vascular, renal, head and neck; urology; hyper-acute stroke; haemat-oncology and gynae-oncology in patient services. We are also exploring the development of more complex / specialised services in a shared care model with London providers.

To support the delivery of the strategic direction outlined in the STP, the boards of Medway Foundation NHS Trust and MTW have agreed to a short process to complete primary objectives by the end of 2016, covering:

- The development of a single draft document setting out the strategic direction of acute services
- The identification of opportunities for consolidation and greater efficiency in back office services
- A coherent shared strategy for planned care, most likely taking the shape of a single shared centre

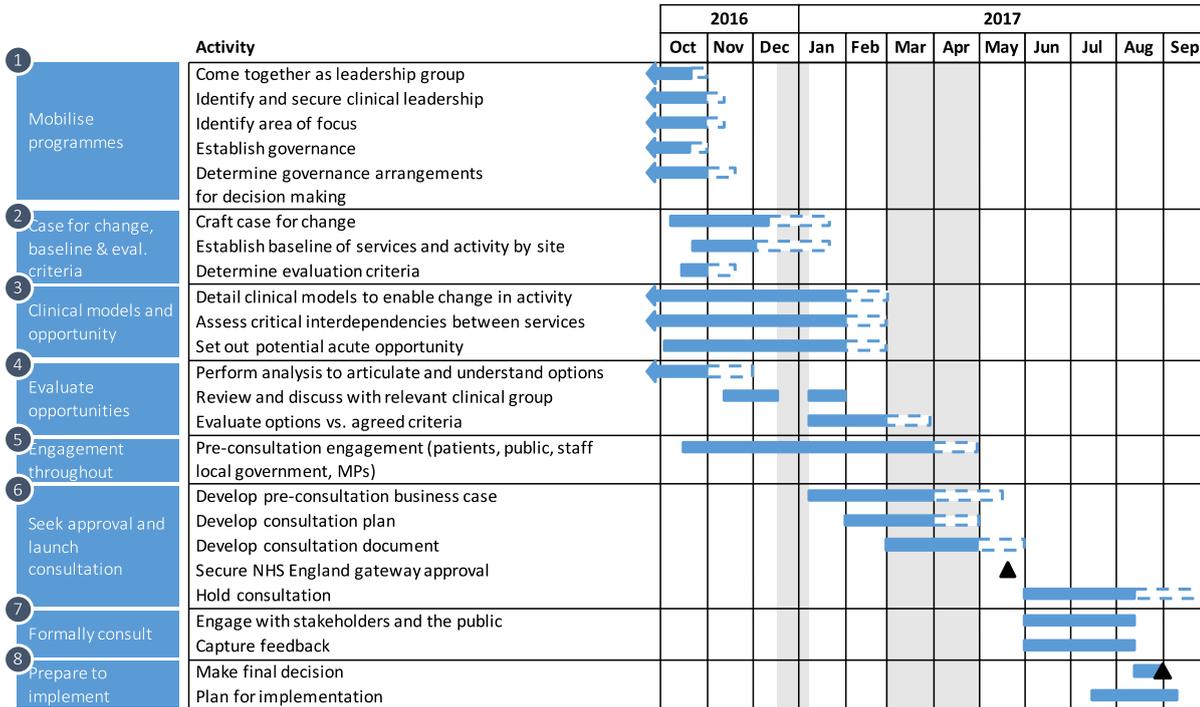
The Trust is also working with the STP enabler workstreams, aligned to our own internal priorities as outlined in this plan:

5.5 Enabler Workstreams:

Workforce <i>Developing a workforce strategy to deliver the transformation required in K&M</i>	Estates <i>Establishing a single, K&M-wide view of estate held by health and care organisations (including LAs)</i>	Digital <i>Delivering the digital capabilities that are necessary to underpin and facilitate the STP</i>
<p>Key objectives:</p> <ul style="list-style-type: none"> • Develop a fit for purpose infrastructure for workforce scheduling and planning assurance across K&M, particularly to support new care models • Undertake an Organisational Design (OD) programme of work to ensure system leadership and talent management is in place to support the STP • Analyse demand and projection of supply to support potential safe service and rota arrangements in K&M • Develop a K&M Medical School for both undergraduate and post-graduate education • Increase supply and develop specific roles in K&M proactively e.g. paramedic practitioners; dementia care workforce; pharmacy in community and primary care physicians assistants 	<p>Key objectives:</p> <ul style="list-style-type: none"> • Establish a K&M-wide view of estate held by health and care organisations and develop a long-term estates plan to enable the transformation required in K&M • Establish and maintain the baseline metrics for the estate, covering: land ownership, running costs, condition, suitability and occupancy • Implement an estate efficiency savings programme through: optimising asset utilisation and occupancy; overall management of the estate; consolidation of support services; and realisation of surplus assets across the common estate. • Redesign and align the estate footprint to support new care models , including the disposal of estates asset and exploring funding models 	<p>Key objectives:</p> <ul style="list-style-type: none"> • Provide all STP workstreams with the Information Management and Technology capabilities necessary to deliver the transformation required • Design and deliver a universal care record across K&M • Ensure universal clinical access – facilitating effective and efficient care so that patients can get the right care in the right place by professionals with the right information the first time • Establish universal transactional services and shared management information systems • Improve communications and networking of clinical and non-clinical services across K&M • Facilitate self-care by harnessing technology such as wearable devices and patient-centric monitoring

STP High Level Timeline

Figure 11 – STP Timeline



Trust Board meeting – November 2016

11-17 The Kent and Medway Sustainability and Transformation Plan Chief Executive

The draft Sustainability and Transformation Plan (STP) for Kent and Medway was published on 23/11/16, and is enclosed. The Plan has been developed by NHS, Social care and public health leaders in Kent and Medway. It is the first time these parties have all worked together in this way and it gives a unique opportunity to bring about positive and genuine improvement in health and social care delivery over the next 5 years.

The draft Plan builds on conversations held over several years with local people about the care they want and need, and has the patient at its heart. However, it is work in progress - concrete proposals are not being put forward at this stage.

The Trust Board is therefore asked to support the 'direction of travel' described in the STP, noting that the Plan is work in progress.

A summary document, "Transforming health and social care in Kent and Medway" has also been updated and published. Both documents, plus some further information, are available on the Trust's website (www.mtw.nhs.uk/about-us/transforming-health-social-care-in-kent-medway/).

In the New Year, along with more detailed information about the STP, a timetable for engaging with the public in Kent and Medway in 2017 will be published.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

The Trust Board is asked to support the 'direction of travel' described in the STP

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



Transforming health and social care in Kent and Medway

Sustainability and Transformation Plan

21st October 2016

Work in progress

Transforming Health and Social Care in Kent and Medway

Kent and Medway, like other parts of England, have the challenge of balancing significantly increasing demand, the need to improve quality of care and improve access all within the financial constraints of taxpayer affordability over the next five years. Health and social care, with partners, have come together to develop this Sustainability and Transformation Plan. We have a track record of working well together and, increasingly, of integrating our approach to benefit our population by achieving more seamless care, and workforce and financial efficiencies.

This is an exciting opportunity to change the way we deliver prevention and care to our population. We are working in new ways to meet people's needs and aspirations, ensuring an increased quality of support by a flexible NHS and social care provision.

Our main priority is to work with clinicians and the public to transform Local Care through the integration of primary, community, mental health and social care and re-orientate some elements of traditional acute hospital care into the community. This allows patients to get joined-up care that considers the individual holistically – something patients have clearly and consistently told us they want.

We believe the way to achieve this is to enhance primary care by wrapping community services around a grouping of GP practices, to support the communities they serve, and to commission and manage higher-acuity and other out-of-hospital services at scale, so that we are able to:

- meet rising demand, including providing better care for the frail elderly, end of life patients, and other people with complex needs, who are very clear that they want more joined-up care;
- deliver prevention interventions at scale, improve the health of our population, and reduce reliance on institutional care; done well this will:
- enable us to take forward the development of acute hospital care (through reducing the number of patients supported in acute hospitals and supporting these individuals in the community).

Clinical evidence tells us that many patients, particularly the elderly frail, who are currently supported in an acute hospital are better cared for in other settings. Changing the setting of care for these individuals will be truly transformational. We know it is possible to deliver this change and already have local examples to build upon where this new approach is being delivered (such as the Encompass Vanguard comprising 16 practices (170,000 patients) in east Kent who are operating as a multi-specialty community provider (MCP), providing a wide range of primary care and community services).

We also need to focus more on preventing ill-health and promoting good health and our Local Care model needs to deliver population-level outcomes through delivery at scale. This is needed to support individuals in leading healthy lives, as well as reduce demand and costly clinical interventions. We also need a disproportionate focus on the populations where health outcomes are the poorest.

In response to this, acute care will need to change to improve patient experience and outcomes; achieve a more sustainable workforce infrastructure; and make best use of our estate, reducing our environmental impact and releasing savings. We want to continue to create centres of acute clinical expertise that see a greater separation between planned and unplanned care. This would end the current pattern of much-needed surgery being delayed because of pressure on beds for non-elective patients. Through this we will deliver referral to treatment time (RTT) targets; improve workforce rotas, retention and morale; and release significant savings, alongside investment in Local Care.

This is an ambitious plan of work and we are committed to progressing it for the benefits of the people we serve.

Glenn Douglas
Senior Responsible Officer
Kent and Medway Sustainability and Transformation Plan

Executive summary (1/2)

- The Kent and Medway health and care system is seeking to deliver an integrated health and social care model that focuses on delivering high quality, outcome focused, person centred, coordinated care that is easy to access and enables people to stay well and live independently and for as long as possible in their home setting
- More than that, the system will transform services to deliver proactive care, and ensure that support is focused on improving and promoting health and wellbeing, rather than care and support that is solely reactive to ill health and disease
- Core to the model is the philosophy of health and care services working together to promote and support independence, utilising statutory, voluntary and where appropriate the independent sector to deliver the right care, in the right place, at the right time
- Our transformation plan will bring a profound shift in where and how we deliver care. It builds on conversations held with local people about the care they want and need and has the patient at its heart:
 - Our first priority is developing **Local Care**, building on local innovative models that are delivering new models of care, which brings primary care general practices into stronger clusters, and then aggregating clusters into multispecialty community provider (MCP) type arrangements, and, potentially, into a small number of larger accountable care organisation (ACO) type arrangements that hold capitated budgets
 - Local Care will enable services to operate at a scale where it will be possible to bring together primary, community, mental health and social care to develop truly integrated services in the home and in the community
 - This model will manage demand for acute services, enabling significant reductions in acute activity and length of stay which amount to ~£160m of net system savings by 2020/21 and relieve pressure on our bed base
 - We have also therefore committed to a Kent and Medway-wide strategy for **Hospital Care**, which will both ensure provision of high-quality specialist services at scale and also consider opportunities to optimise our service and estate footprint as the landscape of care provision becomes more local
 - Work is ongoing to surface potential opportunities and evaluate them ahead of public consultation from June 2017

Executive summary (2/2)

- Over the last year we have built the new working relationships and launched the discussions which enable us to work at a greater scale and level of impact than before.
- In recent months we have made dramatic improvements in our STP, moving from a fragmented and unsustainable programme to one which has a truly transformational ambition, engages health and social care leaders from across the footprint, has robust governance oversight, and brings the system back towards sustainability.
- Our plan aims for a radical transformation in our population's health and wellbeing, the quality of our care, and the sustainability of our system by targeting interventions in four key areas:

Care Transformation

Preventing ill health, intervening earlier and bringing excellent care closer to home

Productivity

Maximising synergies and efficiencies in shared services, procurement and prescribing

Enablers

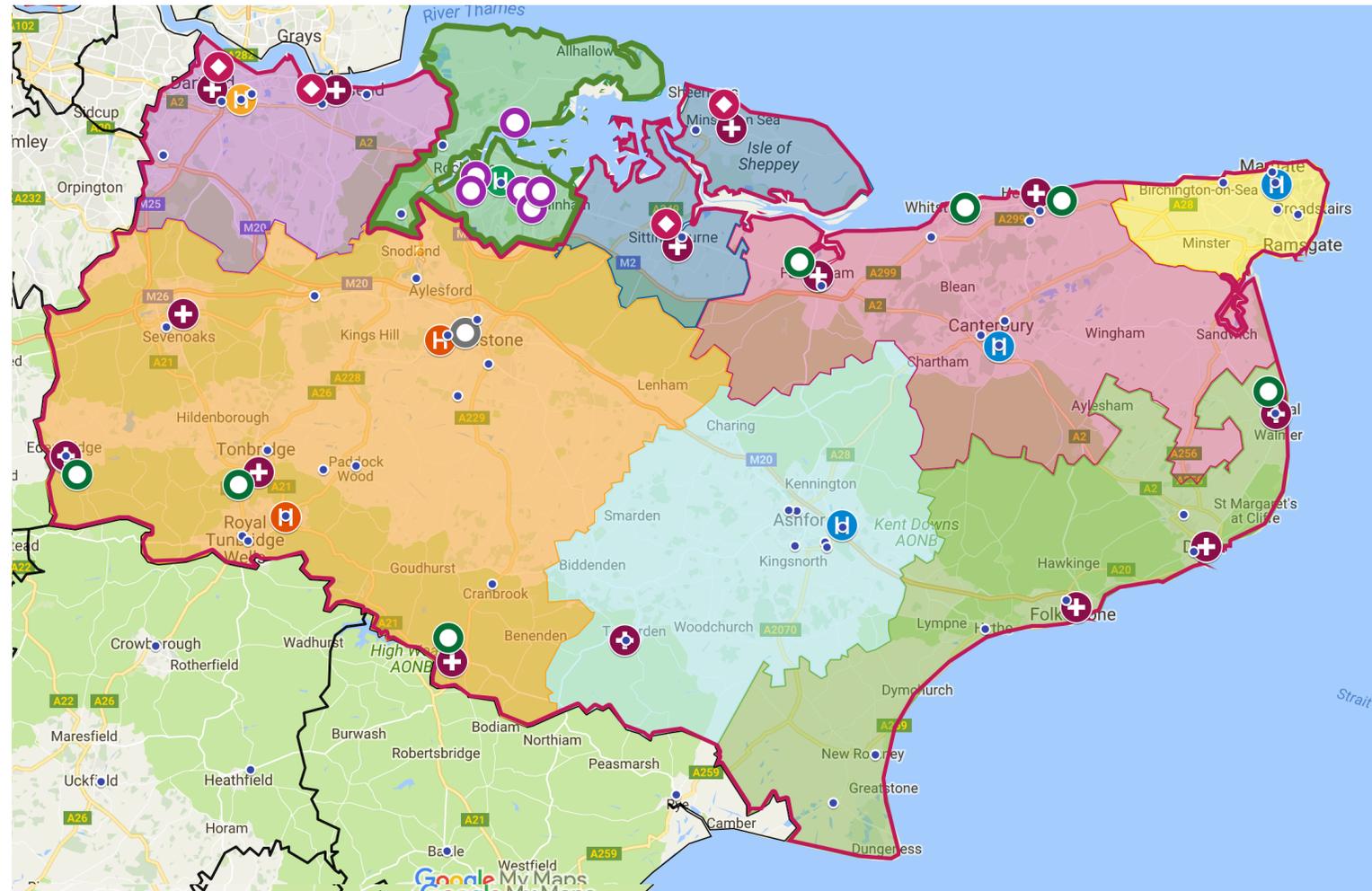
Investing in estates, digital infrastructure and the workforce needed to underpin a high-performing system

System Leadership

Developing the commissioner and provider structures which will unlock greater scale and impact

- Our financial strategy now directs the system back to sustainability, closing a £486m do-nothing financial challenge (including social care pressures) to a remaining £29m challenge in 2020/21. The remaining £29m challenge is associated to financial pressures that arise as a result of the Ebbsfleet Health New Town Development.
- Working with health and social care professionals, patients and the public, we are continuing to develop our plan and design the transformation programme which will deliver it
- We anticipate that some elements of the core transformation will influence 2017/18 operational planning and that a first wave of holistic transformation will launch in 2018

We are eight CCGs, 7 NHS providers and two local authorities, joining together with other partners, to transform health and care in Kent & Medway



Since June we have made great strides in strengthening our change programme and raising our joint ambition

Previous position

How we are strengthening the programme

Programme development

- Programme lacked a robust and active set of workstreams aligned with strategic priorities
- No PMO to drive progress

- ✓ Workstreams mobilising around core priorities, with SROs now all in place and PIDs being completed
- ✓ PMO established with interim external support

Financial sustainability

- Plan did not balance, leaving a £196m NHS gap before STF allocation

- ✓ Analytical work undertaken across Kent and Medway has indicated significantly higher potential to transform the way we deliver health and care
- ✓ Our financial framework is now close to balance

System leadership and relationships

- Two-speed programme with little strategic work completed across Kent and Medway
- Insufficient governance

- ✓ Commitment from leaders across the STP footprint to work together and drive further, faster
- ✓ Alignment around joint consultation timeline
- ✓ Strengthened governance arrangements in place

Communication

- Varying levels of communication with wider stakeholders beyond senior system leaders

- ✓ Consensus across all organisations around STP
- ✓ STP rationale and benefits communicated to staff, public, stakeholders and media in letter signed by leaders
- ✓ Comprehensive communications and engagement plan in place to March 2017 (incl. key stakeholders and timing)

We believe that health and care in Kent and Medway needs to change

Case for change

Our ambition

Health and wellbeing

- Our population is expected to **grow by 90,000 people** (5%) over the next five years; 20,000 of these people are in the new town in Ebbsfleet. Growth in the number of over 65s is **over 4 times greater** than those under 65; an aging population means **increasing demand for health and social care**.
- There are **health inequalities** across Kent & Medway; in Thanet, one of the most deprived areas of the county, a woman living in the best ward for life expectancy can expect to live **almost 22 years longer** than a woman in the worst. The main causes of early death are **often preventable**.
- Over **500,000 local people live with long-term health conditions**, many of which are preventable. And many of these people have multiple long-term health conditions, dementia or mental ill health.

- Create services which are able to meet the needs of our changing population
- Reduce health inequalities and reduce death rates from preventable conditions
- More measures in the community to prevent and manage long-term health conditions

Quality of care

- There are many people who are **in hospital beds who could be cared for nearer to home**. Being in a hospital bed **for too long is damaging for patients** and increases the risk of them ending up in a care home.
- We are **struggling to meet performance targets** for cancer, dementia and A&E. This means people are not seen as quickly as they should be.
- Many of our local hospitals are in 'special measures' because of **financial or quality pressures** and numerous local nursing and residential homes are **rated 'inadequate' or 'requires improvement'**.

- Make sure people are cared for in clinically appropriate settings
- Deliver high quality and accessible social care across Kent and Medway
- Reduce attendance at A&E and onward admission at hospitals
- Support the sustainability of local providers

Sustainability

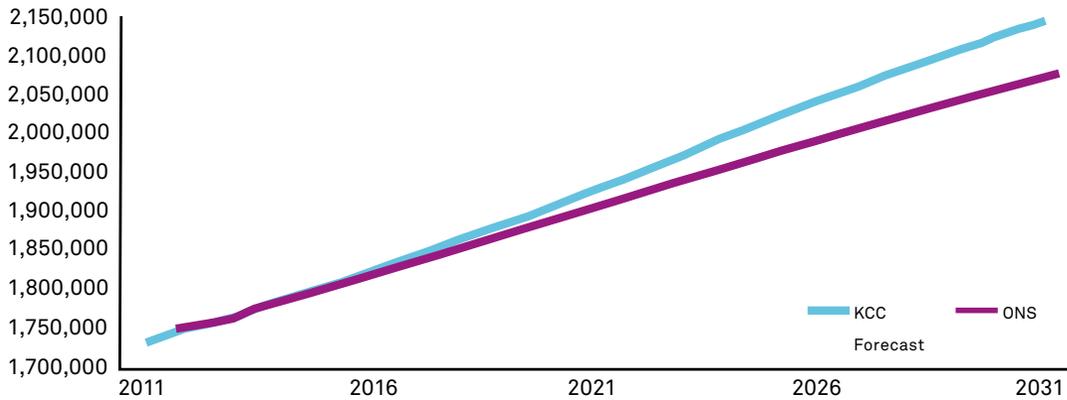
- We are **£109m 'in the red'** and this will rise to **£486m by 20/21** across health and social care if we do nothing.
- Our **workforce is aging** and we have difficulty recruiting in some areas. This means that **senior doctors and nurses are not available** all the time.

- Achieve financial balance for health and social care across Kent and Medway
- To attract, retain and grow a talented workforce

Kent and Medway population is set to grow rapidly, faster than ONS projections

Housing developments will bring a higher population than ONS projections

Population growth forecast, Kent, KCC estimate vs. ONS



- Kent and Medway has planned significant housing growth (aimed at commuters and new families)
- The Kent and Medway Growth and Infrastructure Framework (KMGIF) has projected 188,200 new homes and 414,000 more people incremental to ONS projections
- Expected that the new population will place pressure on paediatric and maternity care especially

Ebbsfleet Health Garden City brings an additional pressure

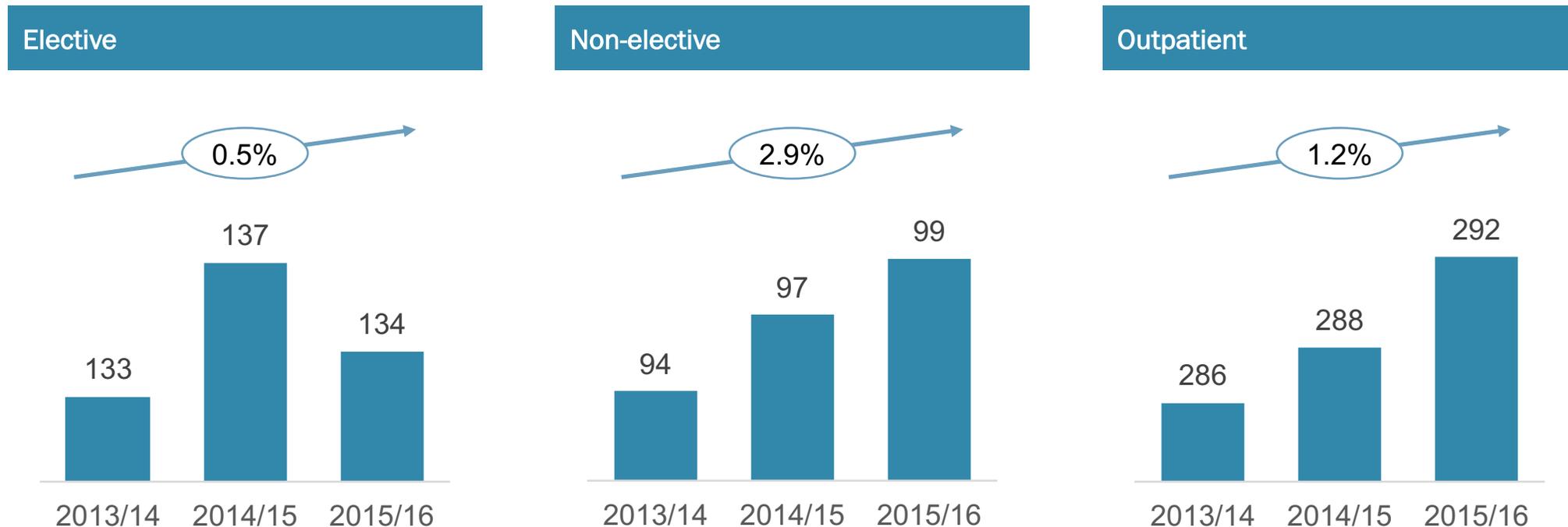


- Ebbsfleet Healthy Garden City and wider local housing developments will grow Dartford, Gravesham and Swanley CCG population especially
- Population expected to grow by 21,000 by 2020/21
- Work by local NHS organisations suggests £28m health care commissioner pressure and £75m provider capital needs

The rate at which our growing population uses services is also rising, placing further pressure on services

Example: Acute activity per 1,000 population, Kent and Medway

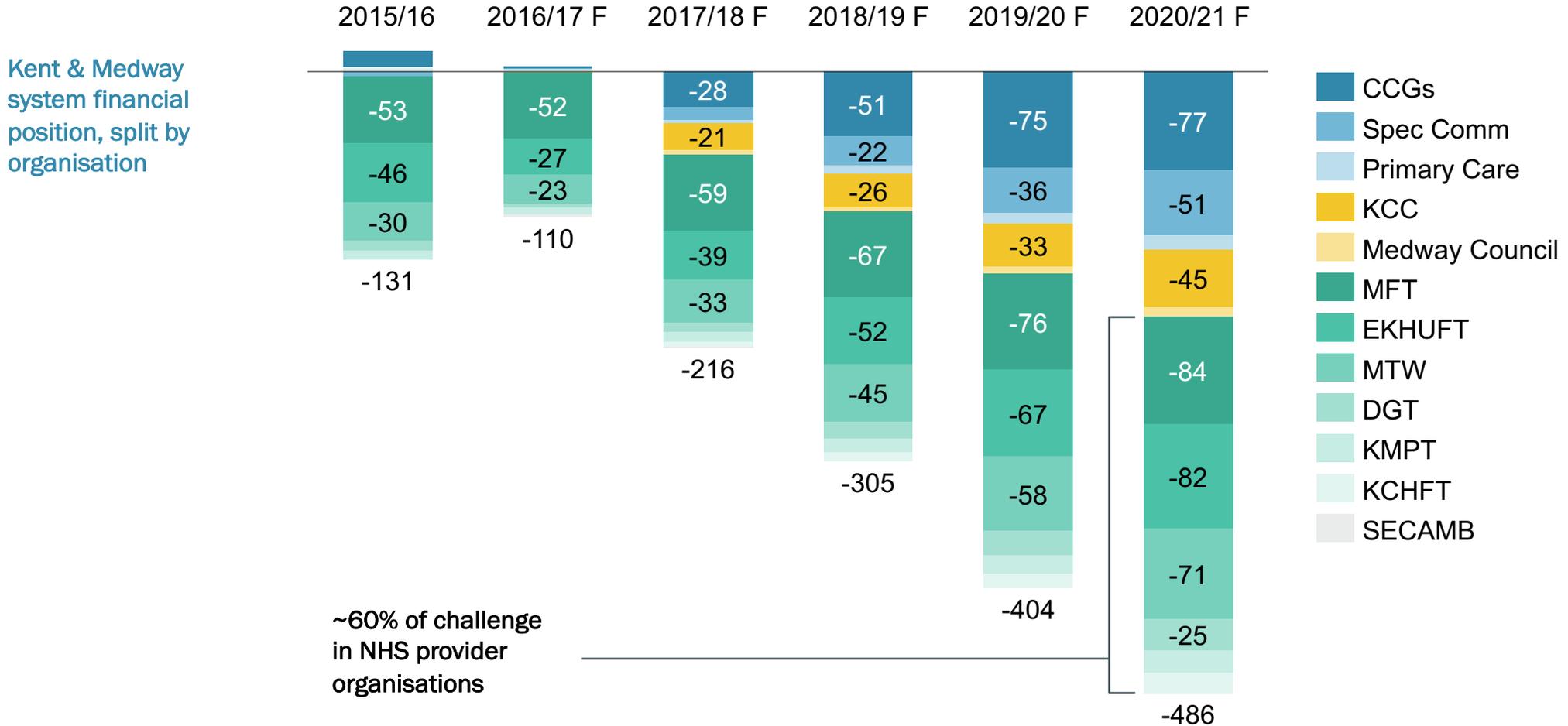
- CAGR, %



Notes: 1 Right Care peers for each K&M CCG selected and peer activity data aggregated, weighting by population
Source: MAR Data, Carnall Farrar analysis

Increasing demand is set to widen a £110m system deficit in 2016/17 into a £486m financial challenge by 2020/21 if nothing is done

£ Millions, health and social care system surplus/deficit, assuming ONS population growth



Note: 'No nothing' scenario is hypothetical; local authorities in particular confirm their statutory obligation and commitment not to run a deficit
 Source: Kent and Medway STP Finance Group

We are pursuing transformation around four themes to tackle these challenges

Care Transformation

We are transforming our care for patients, moving to a model which prevents ill health, intervenes earlier, and delivers excellent, integrated care closer to home.

This clinical transformation will be delivered on four key fronts:

- **Prevention:** Enlisting public services, employers and the public to support health and wellbeing, with efforts to tackle the future burden of cardiovascular disease and diabetes
- **Local care:** A new model of care closer to home for integrated primary, acute, community, mental health and social care
- **Hospital transformation:** Optimal capacity and quality of specialised, general acute, community and mental health beds
- **Mental health:** Bringing parity of esteem, integrating physical and mental health services, and supporting people to live fuller lives

Productivity

We can achieve more collectively than we can as individual organisations.

This applies most immediately for Providers in Kent & Medway as they look to realise efficiencies and productivity improvements in non-clinical settings.

Learning the lessons from the Carter Review, we will undertake a programme to identify, quantify and deliver savings through collaborative provider productivity addressing the following areas:

- **CIPs and QIPP delivery**
- **Shared back office** and corporate services (e.g., Finance, Payroll, HR, Legal)
- **Shared clinical services** (e.g. Pathology integration)
- **Procurement** and supply chain
- **Prescribing**

Enablers

We need to develop three strategic priorities to enable the delivery of our transformation:

- **Workforce:** Transforming our ability to recruit, inspire and retain the skilled health and care workers we need to deliver high-quality services – including partnership with local universities to develop a medical school
- **Digital:** Unifying four local digital roadmaps within a single Kent and Medway digital framework, which both informs and is informed by the strategic clinical models we are implementing
- **Estates:** Achieving 'One Public Estate' by working across health organisations and local authorities to find efficiencies, deliver new models of care, and develop innovative ways of financing a step change in our estate footprint

System Leadership

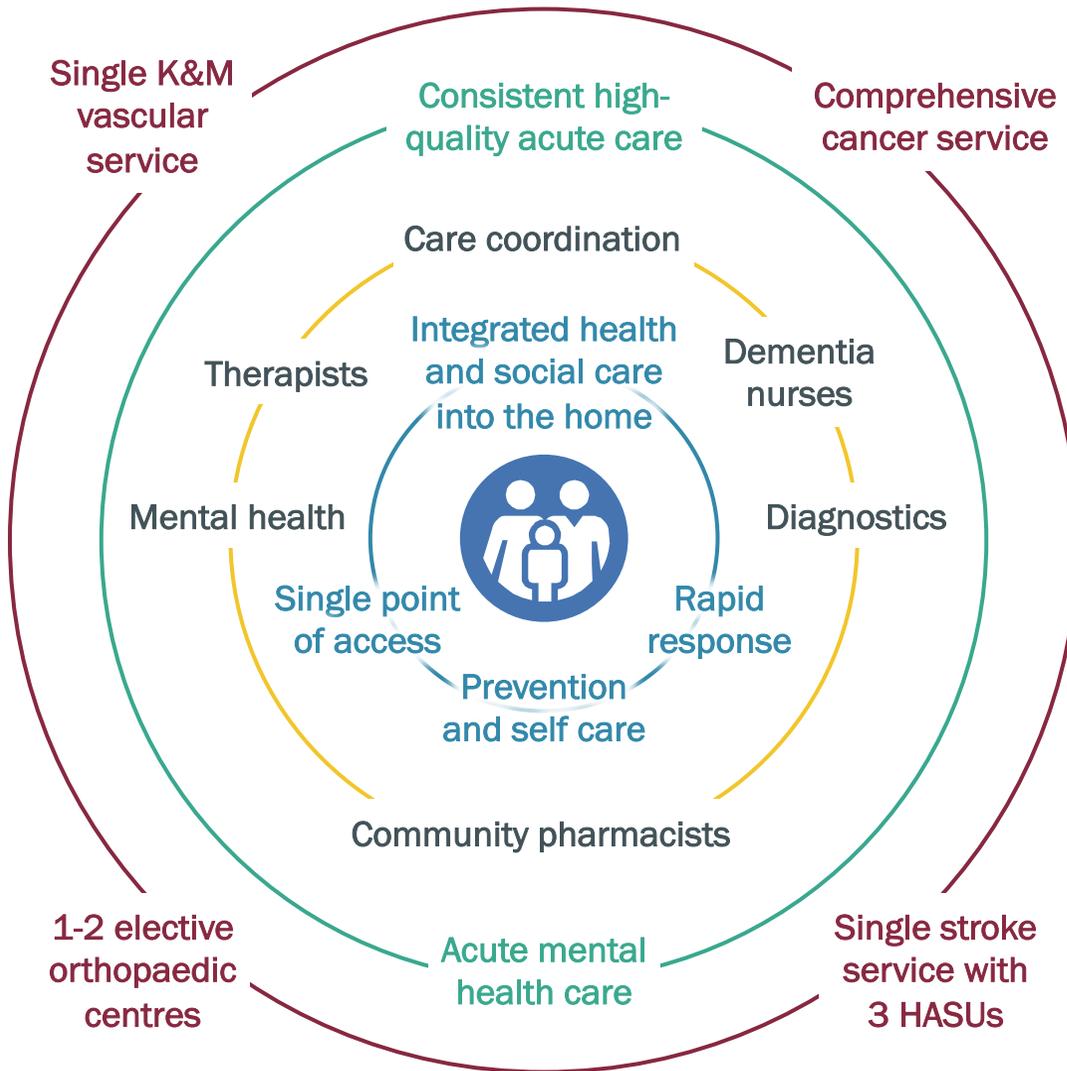
A critical success factor of this programme will be system leadership and system thinking. We have mobilised dedicated programmes of work to address:

- **Commissioning transformation:** Enabling plans for the future to be shaped by health and social care professionals, the public, patients, carers and stakeholders in an open and honest way, and responding to concerns
- **Communications and engagement:** Ensuring consistent communications and inclusive engagement which inform and include all key stakeholders in the design and development of the STP

We are currently designing a workstream to consider provider organisational form and develop the strategy to sustaining innovative provider models of care, including Accountable Care Organisations (ACOs).

Our vision for care has the patient at its core

Kent and Medway Future Care Model



How health and care services will work for patients

- Your own bed is the best bed: only the most seriously injured or ill will ever spend more than a few days in an acute hospital due to their need to be under the care of a consultant
- Teams will support frail older people and people with complex needs, including those reaching the end of their lives at home whenever possible to maximise their quality of life
- Health and social care teams will support people at home, providing care, treatment and support round-the-clock, including in a crisis – and will be based in GP practices and community hubs
- People in Kent and Medway will take good care of themselves and of each other – taking charge of their health and wellbeing, avoiding preventable illnesses, and being experts on their own health, knowing when they can manage and when they need to contact a professional
- People will have planned surgery under conditions that maximise their recovery, including improved health before their operation

We are enlisting the whole Kent and Medway community in improving health and wellbeing through our prevention programme

Our vision

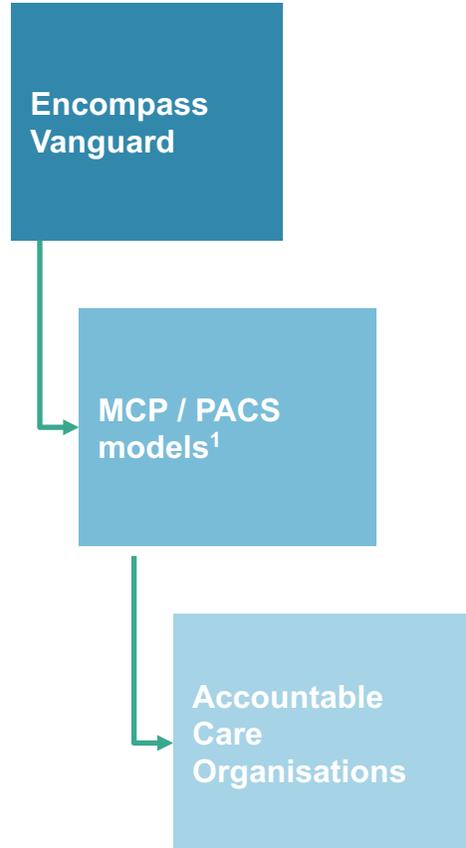
- Improve health and wellbeing for our population, reducing their need for health and care services
- We aim to make this vision the responsibility of all health and social care services, employers and the public
- We will achieve this by:
 - delivering workplace health initiatives, aimed at improving the health of staff delivering services;
 - industrialising clinical treatments related to lifestyle behaviours and treat these conditions as clinical diseases;
 - treating both physical and mental health issues concurrently and effectively; and
 - concentrating prevention activities in four key areas

Our prevention priorities

- **Obesity and Physical Activity:** ‘Let’s Get Moving’ physical activity pathway in primary care at scale across Kent and Medway. Increase capacity in Tier 2 Weight Management Programmes from 2,348 to 10,000
- **Smoking Cessation and Prevention:** Acute trusts becoming smoke-free with trained advisors, tailored support for the young and youth workers, pregnant and maternal smokers and people with mental health conditions.
- **Workplace Health:** Working with employers on lifestyle interventions and smoking and alcohol misuse, providing training programmes for improved mental health and wellbeing in the workplace
- **Reduce Alcohol-Related Harms in the Population:** ‘Blue Light initiative’ addressing change-resistant drinkers. ‘Identification and Brief Advice’ (IBA) in hospitals (‘Healthier Hospitals initiative’) and screening in GPs. Alcohol health messaging to the general population

Local Care aims to improve health, support independence and reduce reliance on hospitals through transformational, integrated health and social care

Our journey



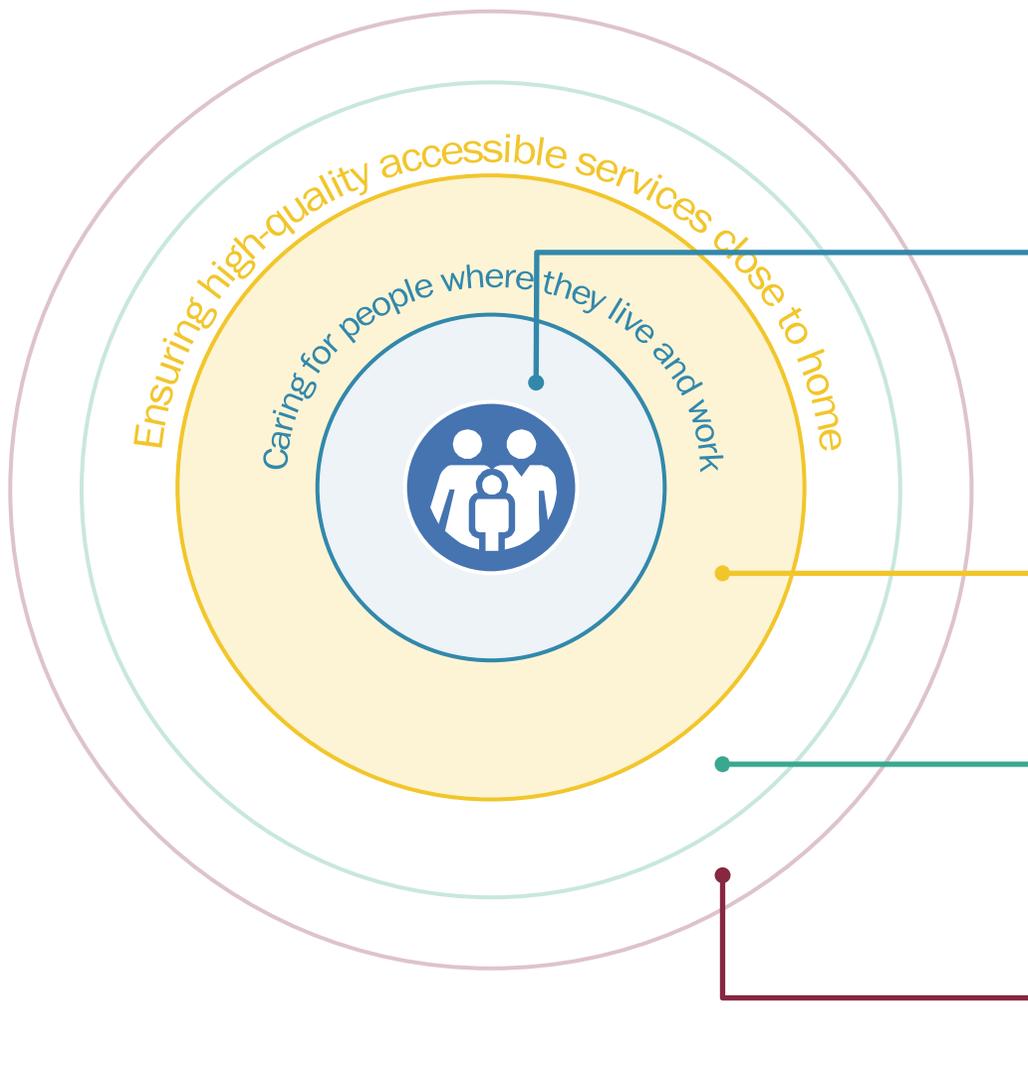
Our aspirations

- Identify patients’ healthcare needs and provide integrated treatment which encompasses all of them
- Empower patients through person centered, proactive support
- Ensure increased patient participation in their own care
- Enable proactive care that supports improving and promoting health and wellbeing, supporting patients ability to live independently
- Facilitate clear signposting to the most relevant service that is driven by a ‘community first’ philosophy
- Utilise coordinated statutory, voluntary and where appropriate the independent sector services including: primary, community, secondary, social care, mental health and voluntary services that are wrapped around defined GP populations
- Provide a range of out of hospital services through Local Care hubs (incl. community hospitals) facilitating increased local accessibility
- Enable innovation in coordinated care provision

How we will deliver our vision



Our Local Care model will be delivered across Kent and Medway through a series of strategic interventions both close to home and beyond



Key interventions

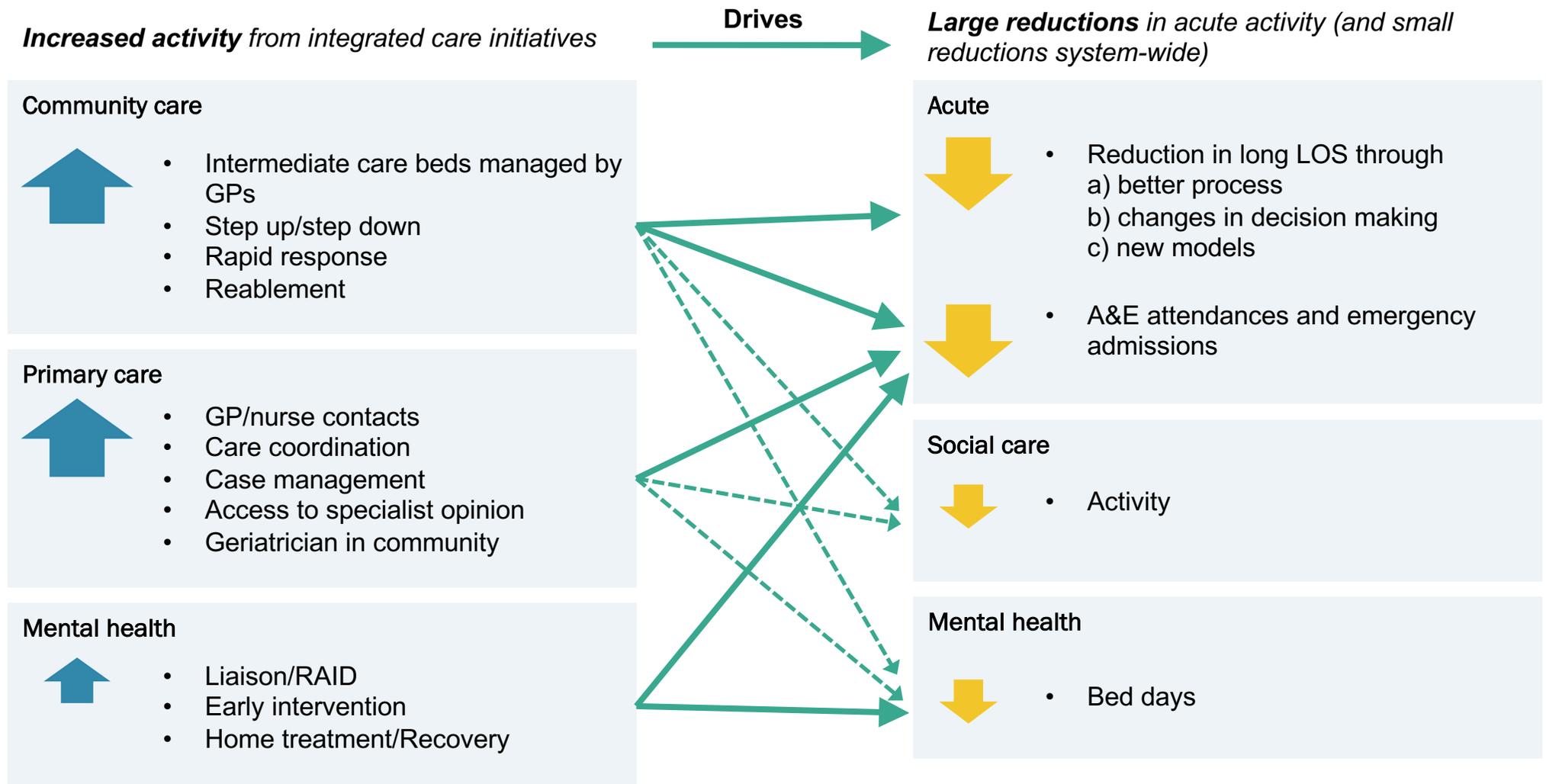
- 1 Support people and their carers to improve and maintain health and wellbeing by building knowledge and changing behaviours
- 2 Bring integrated health and social care into the home
- 3 Provide rapid response service to get a community nurse to home within 2 hours and avoid ambulance or admission
- 4 Provide single point of access to secure any community and social care package
- 5 Care coordination, planning and management around GP practices and community services
- 6 Access to expert opinion without referral for outpatient appointment, including making use of GPSI and advanced nurse and therapist roles
- 7 Facilitation of transitions of care incl. discharge planning
- 8 Mental health liaison

Innovative interventions are also being developed and delivered locally to meet population needs

Selection of local interventions

<p>Swale integrated care teams</p>	<p>Integrated care teams made up of community nurses and social care practitioners have been introduced and attached to General Practice clusters. Further supported by the successful procurement of adult community services, this has allowed us to move at pace to integrated new models of care (done jointly with DGS).</p>	<p>Thanet IACO</p>	<p>The vision for integrated health and social care in Thanet is being delivered via a MCP operating as an Integrated Accountable Care Organisation (IACO). The IACO has just won National Association of Primary Care provider development of the year.</p>
<p>Dartford, Gravesham and Swanley new town</p>	<p>Having successfully won healthy new town status following a competitive process linked to the North Kent and specifically Ebbsfleet Garden City Development, significant focus is on reduction of health inequalities through new models of care.</p>	<p>Encompass Vanguard CHOCs</p>	<p>Community Hub Operating Centres (CHOCs) have developed an Integrated Case Management (ICM) model to deliver community based integrated assessment, care planning and service delivery for people who are at risk of hospital admission.</p>
<p>Dartford, Gravesham and Swanley integrated commissioning</p>	<p>DGS has established an integrated commissioning team jointly with Kent Council Council for children's, Learning Disabilities and Mental Health services, including joint governance arrangements and full time posts.</p>	<p>Encompass Vanguard social prescribing</p>	<p>The Encompass MCP Vanguard has partnered with Red Zebra Community Solutions and now uses a web-based tool for NHS professionals and social prescribing services in the community to refer people to a range of local, non-clinical support. This has resulted in improved social, emotional or practical wellbeing for patients.</p>
<p>Medway and Swale collaboration</p>	<p>Medway and Swale CCG, MFT and Medway Council have collectively created a whole system improvement collaborative called MASCOE to drive key components of delivery within the new models of care.</p>	<p>Canterbury and Coastal paramedics</p>	<p>Paramedic practitioners attached to General practices doing visits with the GP EPR. This has resulted in faster response rates, better patient satisfaction and a reduction in inappropriate admissions to hospitals. A similar initiative has been subsequently developed in Swale.</p>
<p>Herne Bay 7-day access</p>	<p>7-day access to a range of urgent and outreach services, including diagnostics have resulted in better patient experience and reduced acute admissions and A&E attendances.</p>	<p>South Kent Coast</p>	<p>SKC are undertaking a Rheumatology pilot, delivering rheumatology care closer to home, supporting self-care, increasing capacity and primary care skill/knowledge. Potential savings of 30% against tariff. Ongoing work to replicate in cardiology and respiratory care.</p>

Growing our Local Care model will enable a change in care setting and drive large reductions in acute activity



We are delivering Local Care by scaling up primary care into clusters and hub-based Multispeciality Care Provider models

Local Care infrastructure

Description

Population served

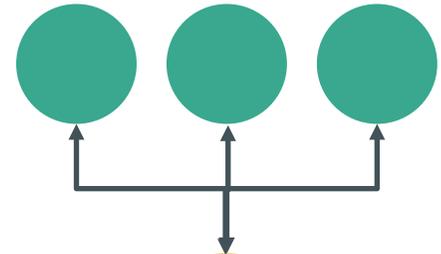
GP practices



- Individual GP practices providing limited range of services
- Many working well at scale, others struggling with small scale and related issues incl. workforce

- Various

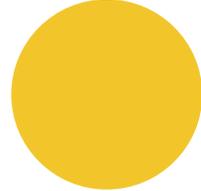
Tier 1
Extended Practices with community and social care wrapped around



- Larger scale general practices or informal federations
- Providing enhanced in-hours primary care and enable more evening and weekend appointments.

- 20 – 60k

Tier 2
MCPs/PACS based around community hubs



- Multi-disciplinary teams delivering physical and mental health services locally at greater scale
- Seven day integrated health and social care

- 50 – 200k

Our local implementation of the Kent and Medway model varies to meet the needs of our populations

Summary of Local Care models across Kent and Medway

	Ashford	Canterbury & Coastal	DG&S	Medway	Thanet	Swale	South Kent Coastal	West Kent
Population	129,000	220,000	261,000	295,000	144,000	110,000	202,000	479,000
No. GP practices	14	21	34	53	17	19	30	62
Average list size	9,200	10,500	7,700	5,600	8,500	5,800	6,700	7,700
Extended practices	3	5	TBC	9	4	TBC	4	9
Population	30 – 60 k	30 – 60 k	20 – 40k	30 k	30 – 60 k	20 – 40k	30 – 60 k	TBC
Hubs	1	1	5	3	1	2	1	3 – 5
Population	129,000	220,000	50 k	100 k	144,000	50 k	202,000	TBC
Chair	Navin Kumta	Sarah Phillips	Elizabeth Lunt	Peter Green	Tony Martin	Fiona Armstrong	Jonathan Bryant	Bob Bowes
AO	Simon Perks	Simon Perks	Patricia Davies	Caroline Selkirk	Hazel Carpenter	Patricia Davies	Hazel Carpenter	Ian Ayres

Notes: Whitstable Vanguard represents 4 of the 5 hubs in Canterbury and Coast CCG. Ashford, Canterbury & Coastal, South Kent Coast and Thanet have no extended practices; practices grouped directly into hubs.

Source: CCG returns, September 2016

We are investing in key initiatives which will enable our Local Care transformation and improve the way we commission and deliver health and care

Our vision

1 Pursue single shared record

- Provide health and care professionals with immediate access to all relevant information about a patient's care, treatment, diagnostics and previous history for all patients across Kent and Medway
-

2 Industrialise the Kent Integrated Dataset

- Enable information flow to support targeting, care delivery, planning, performance and payment by leveraging the unique KID dataset
-

3 Develop capitated payment models

- Enable the pooling of resource across health and social care
 - Breakdown silos to allow delivery of integrated care
 - Facilitate the development of accountable care organisations that support delivery of our vision
-

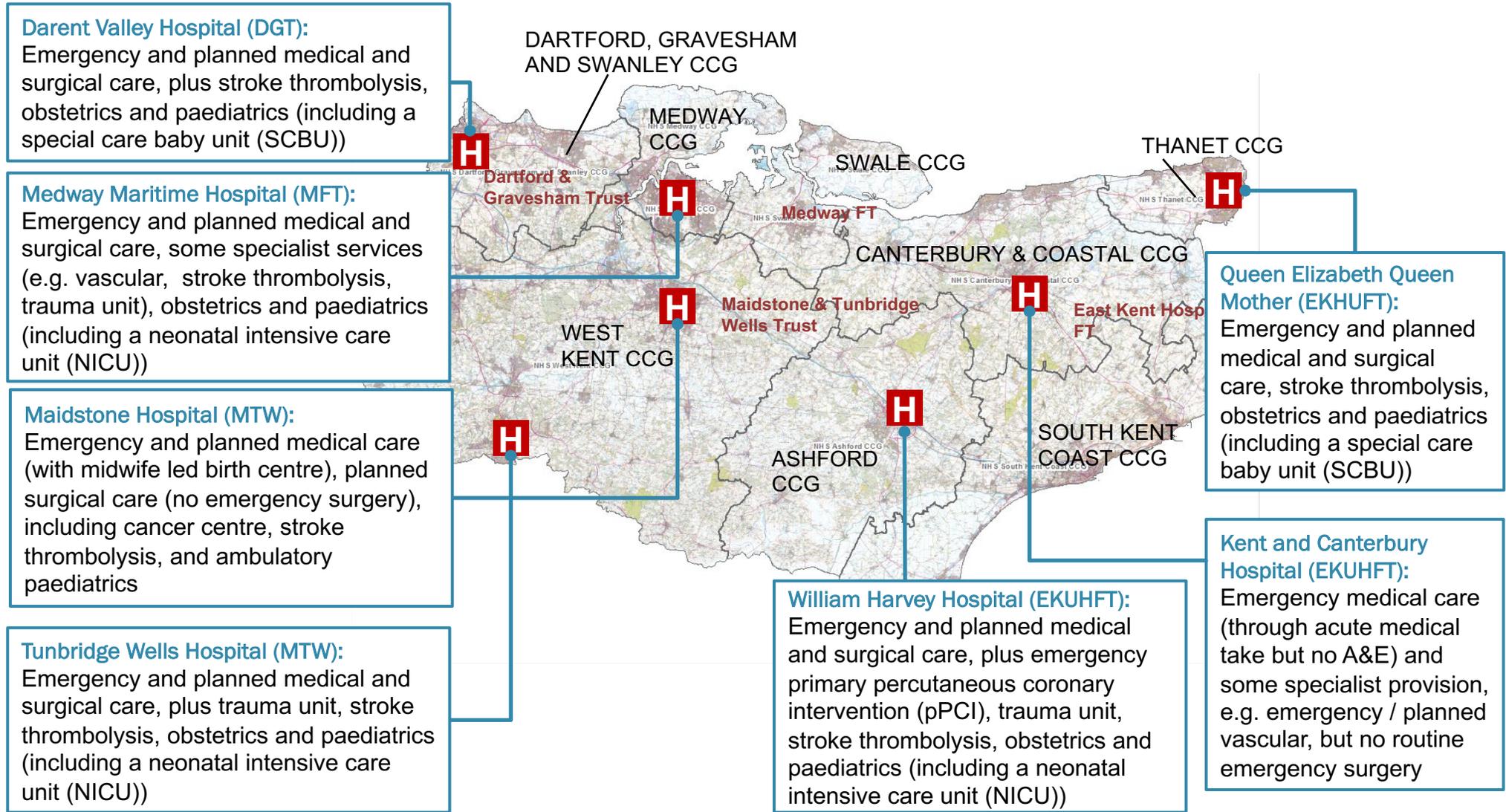
4 Maximise value of one public estate

- Release capacity that is surplus to needs from reduction in beds and release of unnecessary estate and invest in housing and community facilities
 - Maximise colocation of professionals in hubs to facilitate multidisciplinary working, extended hours and extended range of services available to patients
 - Make use of flexibilities from Local Authority to invest in one public estate
-

5 Commissioning transformation

- Develop single strategic commissioning across Kent and Medway to create the capability and capacity to drive the update of new information and payment models and secure the release of value from the estate

Our Acute Care model is partially consolidated, but is still largely based on historic dispersal of services



Progress has been made in the re-design of acute services across Kent and Medway

K&M strategic priorities: Consolidation of emergency and elective services

- Creation of emergency hospital centres with specialist services and separate emergency hospital centres;
- Establishment of specialist planned care hospital centres;
- Further consolidation and co-location of specialist services such as pPCI; vascular, renal, head and neck; urology; hyper-acute stroke; haemat-oncology and gynae-oncology in patient services;
- Further development of Kent's cancer centre;
- 10 clinical standards for urgent care being met;
- Exploration of more complex services in a shared care model between London and local providers;
- Development of new and innovative models of care;
- Agreement to widespread shared service arrangements with appropriate specialist service providers

East Kent

- EKHUFT has modelled the shift in activity and capital requirements for a range of acute configuration options, together with a significant and safe shift to local care models with potential activity savings worth at least 300 acute beds
- These options include the “as is” model, alongside an option that sees the closure of one site and the creation of a single site option
- EK's initial thinking sees the creation of one emergency hospital centre with specialist services¹ and a trauma unit for a natural catchment of over 1.5m
- This site will be supported by a further emergency hospital centre and a planned care hospital, supported by rehabilitation services and a primary care led urgent care centre
- Emerging model has potential to deliver over £90m efficiencies in EKHUFT

Medway, North Kent and West Kent

- The boards of MFT and MTW have agreed to a short process to complete primary objectives by the end of 2016:
 - The development of a single draft document setting out the strategic direction of acute services
 - The identification of opportunities for consolidation and greater efficiency in back office services
 - A coherent shared strategy for planned care, most likely taking the shape of a single shared centre
- A collaboration between DGT and GSTT to develop a Foundation Healthcare Group model

Investment in our Local Care model should enable ~£210m gross spend reduction in the acute sector by 2020/21

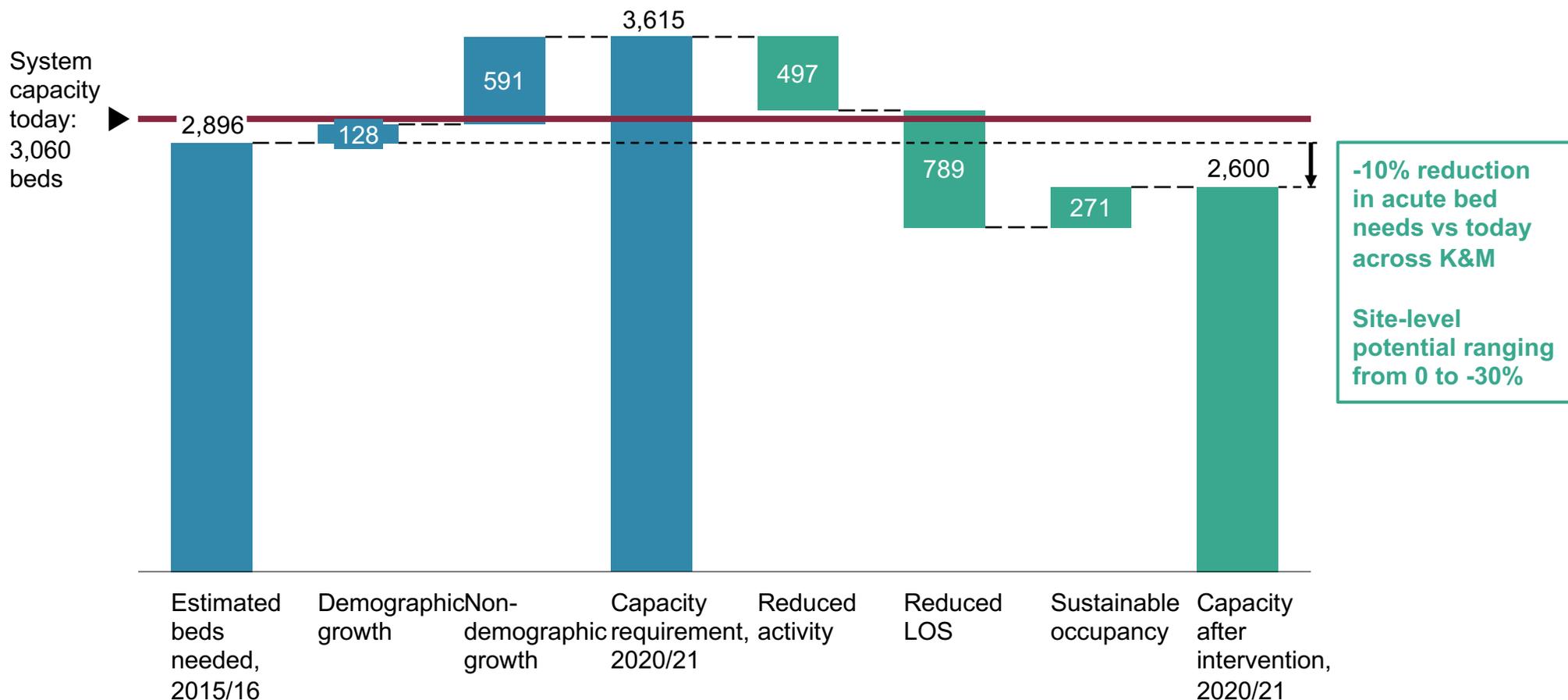
System savings, 2020/21, £ Millions

	Key enablers	Opportunity	Gross	Net ⁵
1 Avoid emergency admissions through more proactive and coordinated care	<ul style="list-style-type: none"> Care coordinators Rapid response 	<ul style="list-style-type: none"> Internal and external activity benchmarking¹ suggests opportunity to reduce acute activity: <ul style="list-style-type: none"> Non-elective: -13% A&E: -16% 	71	46
2 Reduce avoidable non-elective inpatient length of stay	<ul style="list-style-type: none"> Effective discharge planning Rapid response Domiciliary care package Single point of assessment 	<ul style="list-style-type: none"> Significant numbers of elderly patients in beds who are medically fit for discharge Limiting non-elective stays by over-70s to 10 days would yield a ~27% bed day reduction² 	64	48
3 Optimise elective pathway	<ul style="list-style-type: none"> MDT clinic Preoperative assessment Consultant level feedback Effective planning for discharge 	<ul style="list-style-type: none"> Activity benchmarking¹ suggests opportunity to reduce elective volume by ~14% Limiting 3-9 day elective stays to 3 days would yield a ~17% bed day reduction³ 	53	49
4 Optimise outpatient pathway	<ul style="list-style-type: none"> Expert first point of contact Qualified referrals Diagnostic protocols Non-medical support and education 	<ul style="list-style-type: none"> Internal and external activity benchmarking¹ suggests opportunity to reduce outpatient activity by ~12% 	26	22
Total			214	165

Notes: 1 Internal benchmarking between GP practices and external benchmarking vs. Right Care peers of each Kent and Medway CCG 2 258k bed days, 830 beds vs. 2020/21 position after admission avoidance intervention. 3 16k bed days, 53 beds. Further potential to increase theatre throughput. 4 Not quantified 5 Reinvestment rates for activity reduction: NEL: 35%, EL: 5%, AE: 35%, OP: 35% first and 5% for follow-up; 25% for length of stay reduction

Improved Local Care could relieve pressure on acute capacity

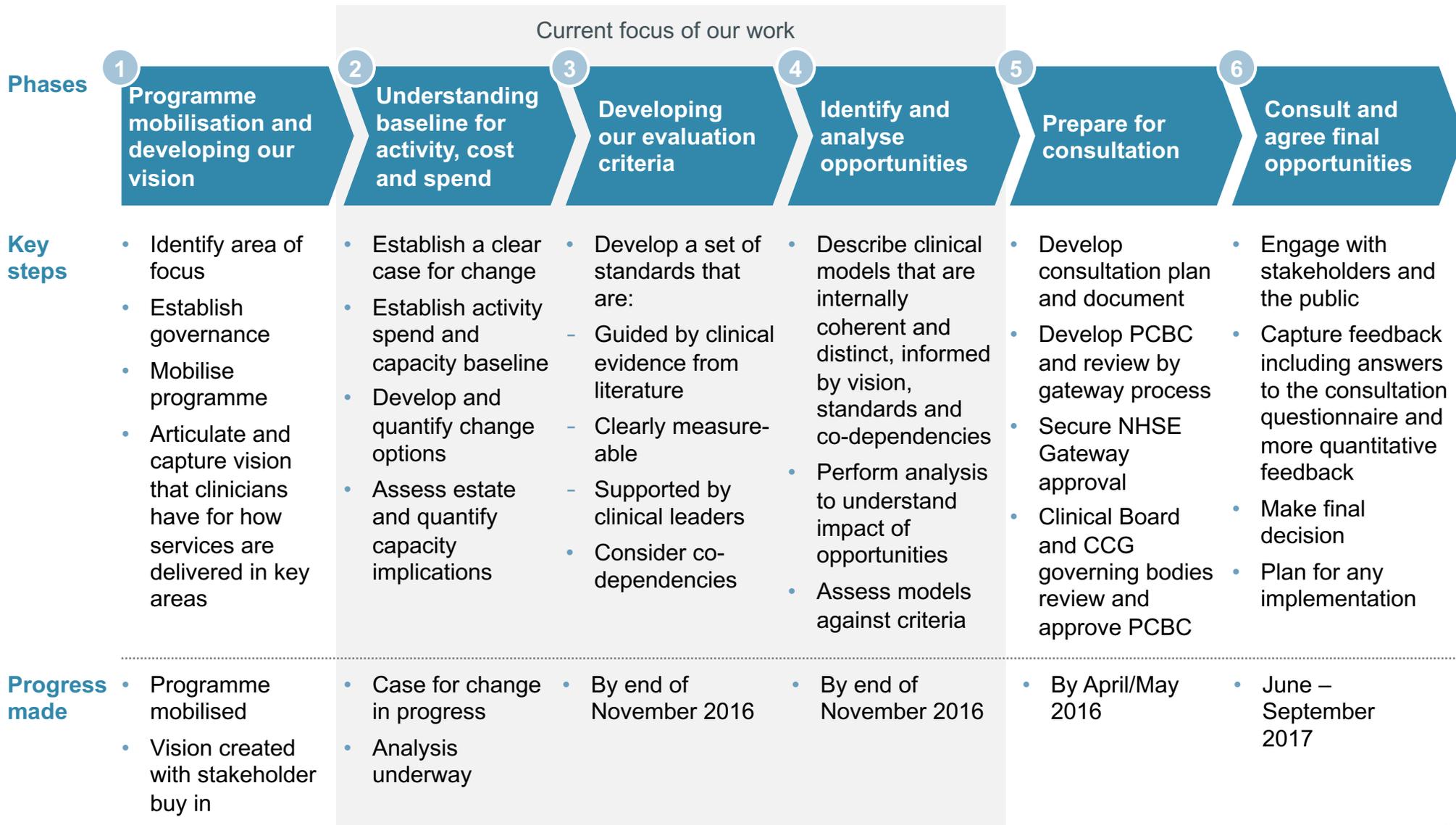
Acute bed requirements to support elective and non-elective activity



Note: Assumed occupancy rates: DGT: 99%, MTW: 94%, MFT: 99%, EKHUFT: 91%. 'Sustainable occupancy' lever estimates the impact of reducing acute bed occupancy levels to 85% across the Kent and Medway system.

Source: Kent and Medway provider length of stay data; NHSE KH03 occupancy data, 2015/16; Carnall Farrar analysis

Work is ongoing to surface potential opportunities to improve the financial and clinical sustainability of hospital-based care



Our Mental Health programme will delivery parity of esteem, promote health and wellbeing, integrate physical and mental health services and improve crisis care

Our vision

We will ensure that our Mental Health provision delivers parity of esteem for any individual with a mental health condition

Our vision is to ensure that within Kent and Medway we create an environment where mental health is everyone's business, where every health and social care contact counts where we all work together to encourage and support children, their parents, young people and adults of all ages with a mental health problem or at risk of developing one to live in their own community, to experience care closer to or at home and to stay out of hospital and lead a meaningful life.

Local Care:

- Promoting wellbeing and reducing poor health
- Delivering integrated physical and mental health services

- 1 **Live well service:** Cross-sector partnership to strengthen wellbeing by increasing access to wellbeing navigators and community link works and investing in training
- 2 **Open Dialogue Pilot:** Investing in holistic family intervention in first episode of psychosis to reduce admission by training more staff and peers in the approach
- 3 **Encompass MCP Vanguard:** Ensure MH professionals are an integral part of the model, with integrated care plans for individuals with LTC and MH comorbidity
- 4 **Single point of access:** Dedicated, clinically-led MH screening, assessment and signposting 24/7 linked to NHS 111, SECAMB, acute and primary care
- 5 **Complex needs:** Reviewing patients with complex needs in out-of-area specialist placements and seeking to repatriate; refining out-of-area placement process

Acute Care:

- Delivering improved care for people and their carers when in a crisis

- 1 **Improved patient flow:** Reach zero private beds by December 2016, implement alternative models of care to prevent admission and actively manage DToCs
- 2 **Therapeutic staffing and peer support:** Implementation of Therapeutic Staffing model on acute wards, with reduced LOS and use of temporary staff
- 3 **Liaison Psychiatry:** Implement Core 24 model in all acute EDs by 2018 and partner w. acute providers for Medically Unexplained Symptoms outpatient service
- 4 **Personality disorder pathway:** Implement NICE-compliant pathway ensuring effective prevention, community-based treatment and acute crisis response
- 5 **Single point of access:** Linked point of access, also providing tele-triage psychiatric assessments for people presenting in crisis

We are undertaking an ambitious programme to deliver efficiencies and productivity improvements through collaboration

Where are we today?

- Significant opportunities exist to design and deliver efficient and effective non-clinical services collaboratively
- In the first instance, we are focusing on the opportunity to consolidate corporate services between NHS provider organisations to both improve quality whilst driving down cost
- Furthermore, we will explore opportunities with local authorities where collaboration would make sense: predominantly in IT, estates and facilities, but potentially other areas in addition
- The services in scope of the initial wave of redesign programme are:
 - Finance
 - HR
 - Procurement
 - Legal services
 - IM&T
 - Estates & facilities
 - Governance & risk

What are our plans for the future?

- Our vision for the future of corporate services in Kent and Medway:
 - Tasks and resources are not duplicated between individual organisations
 - Standardisation of approach and process enables economies of scale to be delivered
 - Outsourcing of services is chosen where it provides the best route for service delivery at scale
 - Alternative methods and approaches are considered and where individual organisations work collaboratively for the greater benefit of all, balancing issues of sovereignty with issues of cost and efficiency
- The corporate services consolidation project has been incorporated in the STP financial plan with a target saving of **£39m by 2021**
- We intend to therefore undertake a larger-scale productivity programme to deliver collaborative savings in **networked clinical services, shared clinical support services and collaborative prescribing** as well as shared corporate services/back office

What are our design principles?

- In each area a consistent process will be followed to design a new shared model:
 1. Conduct a rapid review to understand the opportunity
 2. Complete a full benchmark to assess potential savings
 3. Define the collaborative strategy and identify the key initiatives through a hypothesis-driven approach
 4. Define the most appropriate sourcing strategy, e.g. in house/outsource
 5. Define the target operating model for the services
 6. Transition: establish the shared service, including organisation, people, process and technology
 7. Establish service and operating level arrangements
 8. Define supplier management arrangements:
 - A. Sourcing; scenario planning and options analysis
 - B. Procurement strategy including competitive dialogue and managing the procurement process

We have mobilised Enabler groups to deliver our transformation

Workforce

Developing a workforce strategy to deliver the transformation required in K&M

Key objectives:

- Develop a fit for purpose infrastructure for workforce scheduling and planning assurance across K&M, particularly to support new care models
- Undertake an Organisational Design (OD) programme of work to ensure system leadership and talent management is in place to support the STP
- Analyse demand and projection of supply to support potential safe service and rota arrangements in K&M
- Develop a K&M Medical School for both undergraduate and post-graduate education
- Increase supply and develop specific roles in K&M proactively e.g. paramedic practitioners; dementia care workforce; pharmacy in community and primary care, physicians assistants

Estates

Establishing a single, K&M-wide view of estate held by health and care organisations (including LAs)

Key objectives:

- Establish a K&M-wide view of estate held by health and care organisations and develop a long-term estates plan to enable the transformation required in K&M
- Establish and maintain the baseline metrics for the estate, covering: land ownership, running costs, condition, suitability and occupancy
- Implement an estate efficiency savings programme through: optimising asset utilisation and occupancy; overall management of the estate; consolidation of support services; and realisation of surplus assets across the common estate.
- Redesign and align the estate footprint to support new care models , including the disposal of estates asset and exploring funding models

Digital

Delivering the digital capabilities that are necessary to underpin and facilitate the STP

Key objectives:

- Provide all STP workstreams with the Information Management and Technology capabilities necessary to deliver the transformation required
- Design and deliver a universal care record across K&M
- Ensure universal clinical access – facilitating effective and efficient care so that patients can get the right care in the right place by professionals with the right information the first time
- Establish universal transactional services and shared management information systems
- Improve communications and networking of clinical and non-clinical services across K&M
- Facilitate self care by harnessing technology such as wearable devices and patient-centric monitoring

We are innovating how patients experience care through digital initiatives

	Our vision	Progress across Kent and Medway
Universal patient record	<ul style="list-style-type: none"> Health and care professionals have immediate access to all relevant information about a patient’s care, treatment, diagnostics and previous history, for all patients across Kent; with each digital footprint area determining their own delivery approach. 	<ul style="list-style-type: none"> West Kent currently implementing a solution across major providers; other areas working to identify preferred solution.
Universal clinical access	<ul style="list-style-type: none"> Health and care professionals can operate in the same way independent of their geographic location 	<ul style="list-style-type: none"> No firm plans yet across KEM, although discussions are taking place with potential providers.
Universal transactional services	<ul style="list-style-type: none"> Health and care professionals can access a common directory of services and make arrangements for the appropriate referral to the next stage of the care pathway 	<ul style="list-style-type: none"> Across KEM there are plans to expand the use of eRS.
Shared management information	<ul style="list-style-type: none"> Health and care professionals have the management information they require to run an efficient and effective service for patients e.g. details of bed occupancy and compliance with targets. 	<ul style="list-style-type: none"> Most provider organisations in Kent have deployed Shrewd to gather KPIs. Core business intelligence under procurement jointly by KEM CCGs
Online patient services	<ul style="list-style-type: none"> Patients can access their medical and social care records online and use other online services e.g. book a GP appointment or ask a clinician a question 	<ul style="list-style-type: none"> Patients access GP records provided through the GP system in most parts of KEM. Ongoing work to develop online patient portals
Expert systems	<ul style="list-style-type: none"> Health and care professionals and patients have access to knowledge bases to support the care processes 	<ul style="list-style-type: none"> Limited community wide expert systems exist. Needs further definition to develop requirements
Personal digital healthcare	<ul style="list-style-type: none"> Patients can use personal technology to support their healthcare e.g. a device can automatically send data to alert their GP. This can be collated and used to inform population health management 	<ul style="list-style-type: none"> Limited facilities in place at present and needs further definition

We are pursuing ACO arrangements and strategic commissioning and have agreed a series of next steps for our Commissioning Transformation workstream

Future of commissioning

ACOs and strategic commissioning

- Pursuing the potential for commissioning to move into new care models operating in ACO-type arrangements
- Strategic commissioning will need to be undertaken at a greater scale, across a wider geography, with focus on:
 - Defining and measuring outcomes
 - Putting in place capitated budgets
 - Appropriate incentives for providers to deliver outcomes
 - Longer-term contracts extending over five to ten years

Benefits

- Reduce transaction costs and free up resources to invest in improving health and care.
- Generate opportunities to bring together the current dispersed approach to enabling infrastructure
- Support streamlining of back office overheads to ensure that resources are focused on front line delivery.
- Drive integration of health and social care at all levels and support new care models to be implemented at pace and scale

Impacts to consider

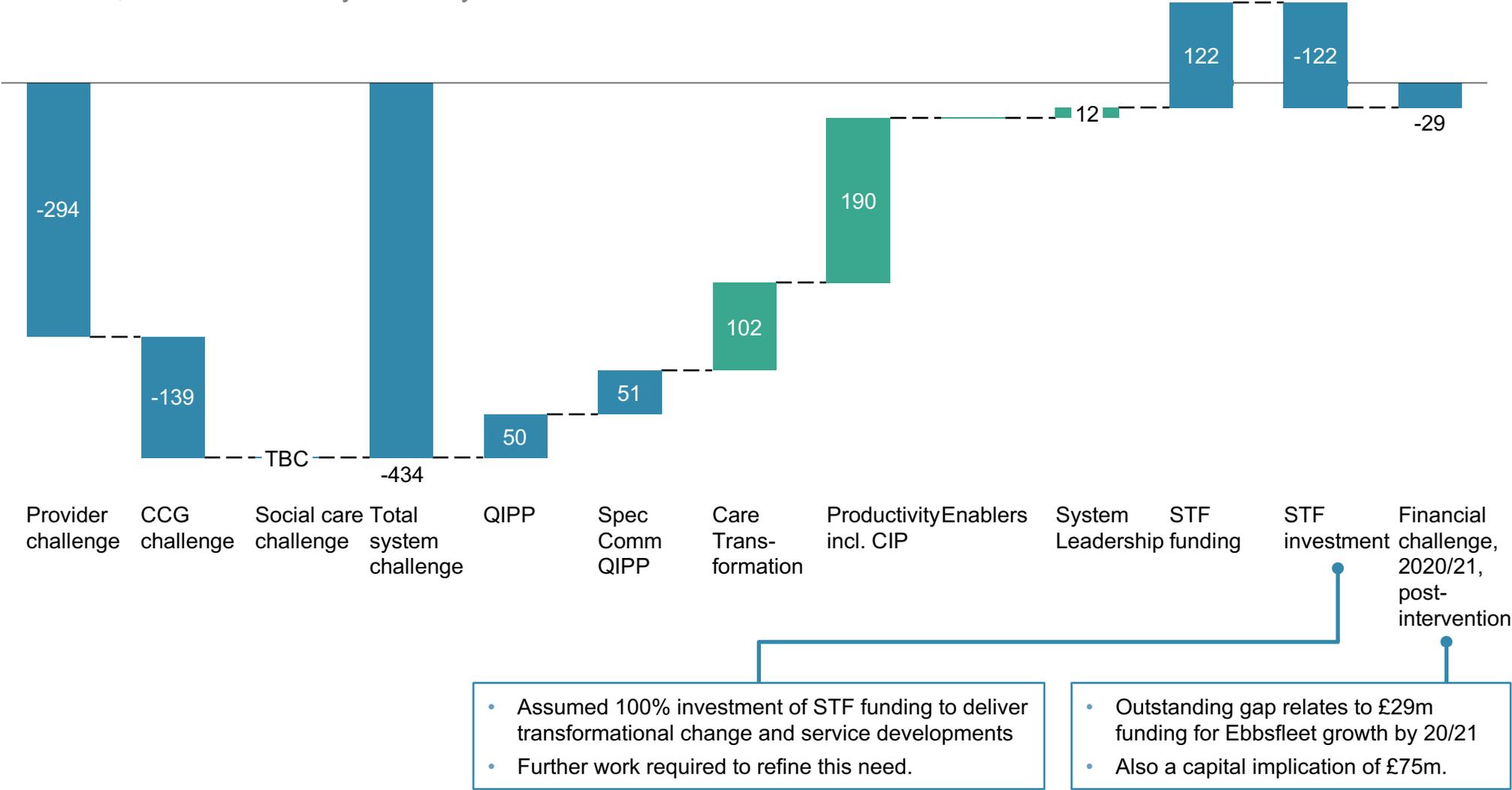
- Understand new contracting models to allow ACOs as lead providers to be commissioned to provide appropriate outcomes for defined populations with minimal transactional bureaucracy
- Understand evolution of CCGs and NHSE commissioning and impacts on form and function of CCGs

Next steps

- Reset the K&M leadership coalition for change (executives, practitioners and politicians)
- Develop and agree a more compelling case for change across K&M with absolute buy-in from all organisations
- Develop transformation plan to address the case for change which binds K&M together – story + numbers
- Clarify what model(s) are to be pursued for ACO/MCP/PACS and what will deliver
- Develop options and decide scale and subsidiarity
 - What to do at K&M and different levels?
 - What to do locally and what to aggregate up?
- Resourcing plan of money and people to deliver plans – put forward best people to drive. Build on existing success and deprioritise other things.

Our financial plan brings the system close to balance

£ Millions, Kent and Medway health system



Notes: 1 Includes 7 day services, GP forward view, increased capacity for CAHMS and eating disorders, implementing mental health task force and cancer task force, maternity review, digital road maps, investment in prevention.

Source: STP financial template

STP NHS financial submission

Healthcare financial forecast, 'do nothing'

£m	15/16	16/17	17/18	18/19	19/20	20/21
Commissioner						
Income	2,850	2,937	3,019	3,102	3,190	3,327
Spend						
Secondary Care	1,631	1,652	1,704	1,751	1,801	1,867
Admin	39	40	41	41	42	43
Other	525	559	590	619	650	683
Primary Medical Care	221	228	239	249	259	273
Specialised	424	455	487	521	558	601
NR Spend - Transformation	0	0	0	0	0	0
Total	2,841	2,934	3,060	3,182	3,310	3,467
Commissioner Surplus (Deficit)	9	3	(41)	(80)	(120)	(139)
Provider						
Income (inc. Non-Footprint)	1,888	1,940	1,996	2,043	2,114	2,190
Spend						
Pay	1,263	1,280	1,329	1,377	1,438	1,502
Non-Pay	765	773	818	862	922	982
NR Spend- Transformation	0	0	0	0	0	0
Total	2,028	2,053	2,147	2,239	2,359	2,484
Provider Surplus (Deficit)	(140)	(112)	(151)	(195)	(246)	(294)
Indicative STF Allocation 2020/21	0	0	0	0	0	0
Footprint Surplus (Deficit)	(131)	(109)	(191)	(276)	(365)	(434)

Impact of interventions

15/16	16/17	17/18	18/19	19/20	20/21
0	0	0	0	0	0
0	0	0	0	0	0
0	0	(25)	(79)	(110)	(147)
0	0	0	(5)	(6)	(6)
0	0	(8)	(10)	(12)	(12)
0	0	0	0	0	0
0	0	(10)	(22)	(36)	(51)
0	0	0	0	0	61
0	0	(43)	(117)	(163)	(216)
0	0	43	117	163	216
0	0	(24)	(75)	(103)	(137)
0	0	0	0	0	0
0	0	(48)	(114)	(174)	(232)
0	0	(22)	(48)	(70)	(93)
0	0	0	0	0	61
0	0	(70)	(162)	(244)	(264)
0	0	46	87	141	127
0	0	34	34	0	122
0	0	89	204	304	343

'Do something', base case

15/16	16/17	17/18	18/19	19/20	20/21
2,850	2,937	3,019	3,102	3,190	3,327
1,631	1,652	1,679	1,671	1,690	1,719
39	40	41	36	37	37
525	559	582	609	638	671
221	228	239	249	259	273
424	455	477	499	522	550
0	0	0	0	0	61
2,841	2,934	3,017	3,064	3,147	3,311
9	3	2	37	43	16
1,888	1,940	1,972	1,968	2,011	2,053
1,263	1,280	1,281	1,263	1,263	1,271
765	773	796	814	852	888
0	0	0	0	0	61
2,028	2,053	2,077	2,077	2,116	2,220
(140)	(112)	(105)	(108)	(105)	(167)
0	0	34	34	0	122
(131)	(109)	(68)	(38)	(62)	(29)

Capital implications are being assessed and outline capital requirements are detailed in the financial return. Lack of access to capital is potentially a significant barrier to change (including to support transformation but also to support smaller schemes to enable operational delivery, e.g. endoscopy). It is inevitable that transformation of the care model will require a re-profiling of estate and we are working with KCC, who are leading on estates for the STP, to identify innovative solutions. As part of this we are looking to work with NHS I, NHS E and NHS Property Services to develop a business case to reinvest receipts from disposals to enable transformation.

Sensitivity analysis on STP financial submission

Health system impact, £ Millions

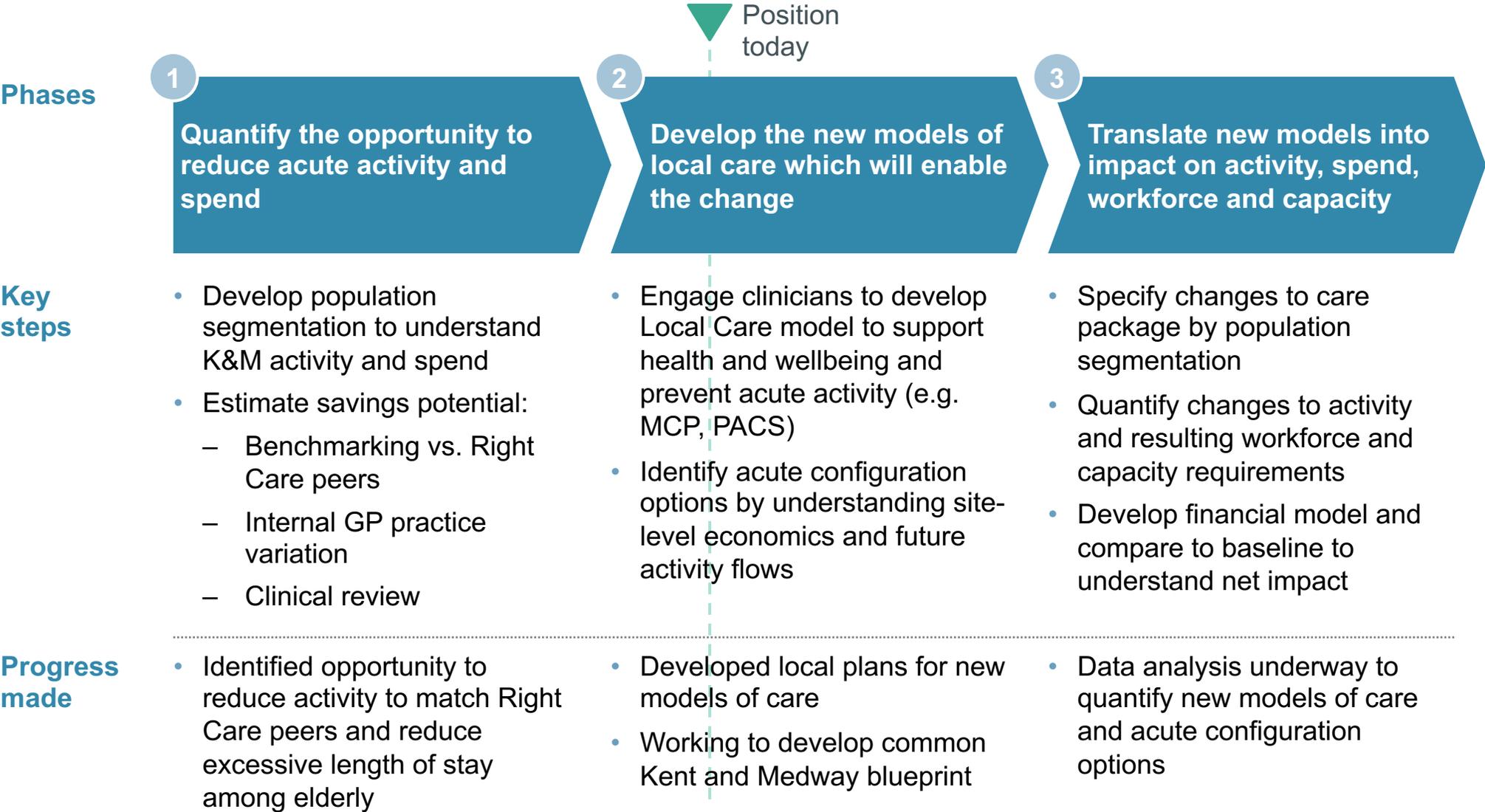
	Upside	Base case	Downside
20/21 challenge, 'do nothing'	(434)	(434)	(434)
CCG QIPP	50	50	25
NHSE QIPP	51	51	25
Care Transformation			
Secondary to out-of-hospital care	74	33	10
Primary Prevention	22	22	11
RightCare Savings	46	46	23
Total	141	102	44
Productivity			
Cross Organisational Savings	39	39	20
Delivery of Provider BAU CIP	151	151	75
Total	190	190	95
Enablers			
TBC			
System Leadership			
Reconfiguration of Commissioners	6	6	3
Reconfiguration of Providers	6	6	3
Total	12	12	6
Service Developments cost more/less than £122m	70	0	(35)
Variance on 16/17 Position	0	0	(108)
Ebbsfleet Additional Growth	28	0	0
Total	126	0	(143)
Grand Total	110	(29)	(382)

Emerging analytical insights suggest a stretch target, validating the opportunity for our Care Transformation programme to enable financial sustainability

Workstream	Net impact, base case, 2020/21, £M	Key assumptions
Local Care / Hospital Care	156	<ul style="list-style-type: none"> • Acute activity reductions to match Right Care peer or internal GP top decile level: NEL 13%, A&E 16%, EL 15%, OP 12% • Acute reduction in avoidable inpatient length of stay <ul style="list-style-type: none"> – Non-elective stays by over-70s limited to 10 days yielding 27% bed day reduction – Elective stays in key specialisms reduced (TBC) yielding a 17% bed day reduction • Aggregate reinvestment rate of 22% to enable new Local Care model, integrating primary, community, social, mental health and acute care • Impact on bed-based community care not yet quantified • Impact beyond activity/LOS reductions enabled by Local Care model not yet quantified
Mental Health	20	<ul style="list-style-type: none"> • Shift in care delivery model from inpatient admissions to community contacts to match top quartile delivery cost performance among peer CCGs with comparable population complexity • Assuming £375 cost per OBD and £125 cost per contact (NHS Benchmarking national averages) • However, additional cost pressure (not quantified) may exist incremental to assumed financial challenge to deliver the Five Year Forward View for mental health
Prevention	21	<ul style="list-style-type: none"> • TBC
Total	197	

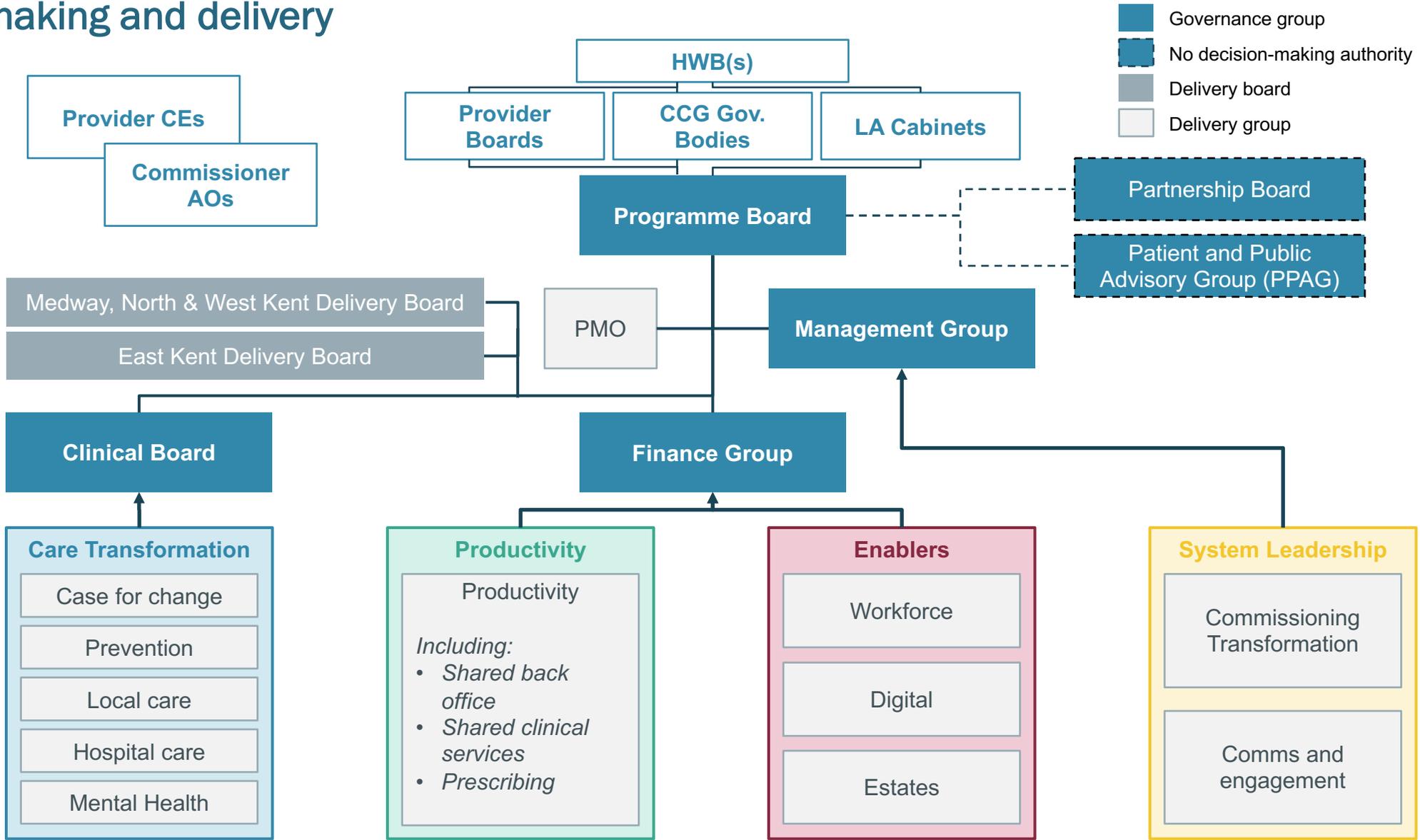
Source: Carnall Farrar analysis

We are moving next to quantify bottom-up the impact of the Kent and Medway local care model which will enable this financial transformation



Source: Carnall Farrar methodology

We have strengthened our STP governance arrangements to accelerate decision-making and delivery



Source: Kent and Medway STP PMO – emerging recommendations following STP Governance Workshop, 17 October 2016

We have mobilised Oversight Groups to steer and oversee the transformation

	Role	Membership
Programme Board	<ul style="list-style-type: none"> Provides collective leadership to drive development and implementation of STP Ultimately responsible for design and delivery Ensures programme keeps to time and focus and that it delivers the outcomes required 	<ul style="list-style-type: none"> Independent Chair: Ruth Carnall Glenn Douglas, STP SRO Michael Ridgwell, STP Programme Director CCG AOs Trust Chief Executives Chief Executives of KCC and Medway Council NHSE and NHSI Regional Directors Chairs of Clinical Board Chair of Finance Group Chair of Patient and Public Advisory Group Comms and engagement lead
Management Group	<ul style="list-style-type: none"> Supports Programme Board to ensure efficient and effective oversight of programme Drives programme delivery to ensure on track Oversees PMO and work of System Leadership workstreams 	<ul style="list-style-type: none"> Chair: Glenn Douglas Michael Ridgwell Ian Ayres (nominated by CCGs) Matthew Kershaw Paul Bentley Helen Greatorex Ian Sutherland, Medway Council Kent County Council rep. (TBC) Phil Cave, Finance Group Chair Chairs of Clinical Board Comms and engagement lead
Clinical Board	<ul style="list-style-type: none"> Provides clinical leadership to programme Leads development of strategy's clinical content and oversees work of clinical workstreams Advises Programme Board on all clinical matters 	<ul style="list-style-type: none"> Co-chairs: TBC Clinical Chairs of CCGs Trust Medical Directors Directors of Public Health Senior Social Care professionals from Adults' and Children's services Nursing and Allied Health Professional representatives
Finance Group	<ul style="list-style-type: none"> Provides financial leadership and oversees of the Enabler and Productivity workstreams Provides strategic advice and guidance for STP delivery and development Ensures the plan makes best use of available resources for K&M population 	<ul style="list-style-type: none"> Chair: Phil Cave All Chief Finance Officers from CCGs All NHS and NHS Foundation Trust Finance Directors NHS England specialised commissioning finance lead NHSE primary care commissioning finance lead KCC Finance Lead MUA Finance Lead

Our workstreams are mobilising at pace to detail our strategy

R Red A Amber G Green

	Workstream	SRO	Status
Care Transformation	Case for change	<ul style="list-style-type: none"> Co-chairs of Clinical Board 	G
	Prevention	<ul style="list-style-type: none"> Andrew Burnett (Dir. Public Health, MUA) Andy Scott-Clark (Dir. Public Health, KCC) 	G
	Hospital Care	<ul style="list-style-type: none"> Glenn Douglas (CE, MTW) 	R
	Local care	<ul style="list-style-type: none"> Caroline Selkirk (AO, Medway CCG) 	R
	Mental Health	<ul style="list-style-type: none"> Helen Greatorex (CE, KMPT) 	A
Productivity	Provider productivity including shared back office, shared clinical services and prescribing	<ul style="list-style-type: none"> Steve Orpin (DoF, MTW) 	A
Enablers	Workforce	<ul style="list-style-type: none"> Hazel Carpenter (AO, SKC & Thanet CCGs) 	R
	Digital	<ul style="list-style-type: none"> Susan Acott (CE, DGT) 	A
	Estates	<ul style="list-style-type: none"> Rebecca Spore (Dir. Of Infrastructure, KCC) 	A
System Leadership	Commissioning transformation	<ul style="list-style-type: none"> Felicity Cox (NHS England), supported by Ian Ayres as Lead (AO, West Kent CCG) 	A
	Communications and engagement	<ul style="list-style-type: none"> Michael Ridgwell (STP Programme Director) 	A

Mobilisation and next steps

- Each workstream has:
 - An assigned SRO; and
 - completed a Project Initiation Documents (PID)
- Workstreams are at different stages of development as a result of the programme being stood up at pace
- During the next 3 months, all workstreams will undertake a consistent and detailed planning and design process through facilitated workshops – this will ensure consistent planning assurance and governance reporting
- The STP PMO will provide the structures, processes and template materials to enable the workstreams to plan and deliver projects effectively and in a consistent approach
- Workstreams will routinely report to their corresponding Oversight Group

We are pressing ahead to meet key programme milestones

Design Oct – Dec 2016

- **Oct 2016:** Programme governance arrangements agreed; PMO, workstreams and Oversight Groups mobilised
- **Oct 31 2016:** Clinical model evaluation criteria agreed at Programme Board
- **Nov 2016:** Initial clinical model options set out
- **Nov 2016:** Local Care and Hospital transformation modelling completed
- **Nov 2016:** Initiate pre-consultation engagement
- **Dec 2016:** Clinical Board and Programme Board review case for change
- **Dec 2016:** Organisations develop Operational Plans for FY17/18

Note: though this is not the direct responsibility of the STP, the STP will track progress and hold peers to account

Prepare for consultation 2017

- **Jan 2017:** Case for change published
- **Feb 2017:** Critical workforce analysis completed
- **Feb 2017:** Clinical model options evaluated against agreed criteria
- **March 2017:** Formal sign off of agreed clinical model
- **April 2017:** Pre-Consultation Business Case developed
- **April 2017:** Consultation document developed
- **May 2017:** CCG governing bodies approve PCBC, consultation document and consultation plan
- **May 2017:** NHS gateway approval secured
- **June 2017:** Consultation begun
- **Aug 2017:** Review responses
- **Dec 2017:** Final consultation decision made
- **Dec 2017:** Implementation plan developed

Implement 2018 – 2020

- **Implementation of overall programme, based on output of previous phases**
 - Implementation plans identified to be rolled out in waves to ensure delivery
 - Wave durations vary by workstream (between 3-6 months)
- **STP PMO to remain in place to monitor and ensure effective implementation of programme**
 - Phased transition of oversight and monitoring from the STP PMO after wave 1, to ensure ownership by relevant stakeholders

Development of our case for change is an immediate priority to be overseen by the Clinical Board

Agreed approach by end of 2016

1
Develop the case for change using existing data

Key steps

- **Establish the Clinical Board:** confirm the terms of reference and membership. Convene first Board meeting. Confirm specific contributions required from members. Review and confirm results from analysis in 1:1 discussion with key individuals.
- **Capture and distil an agreed crisp and compelling case for change** in a written prose and brief PowerPoint.

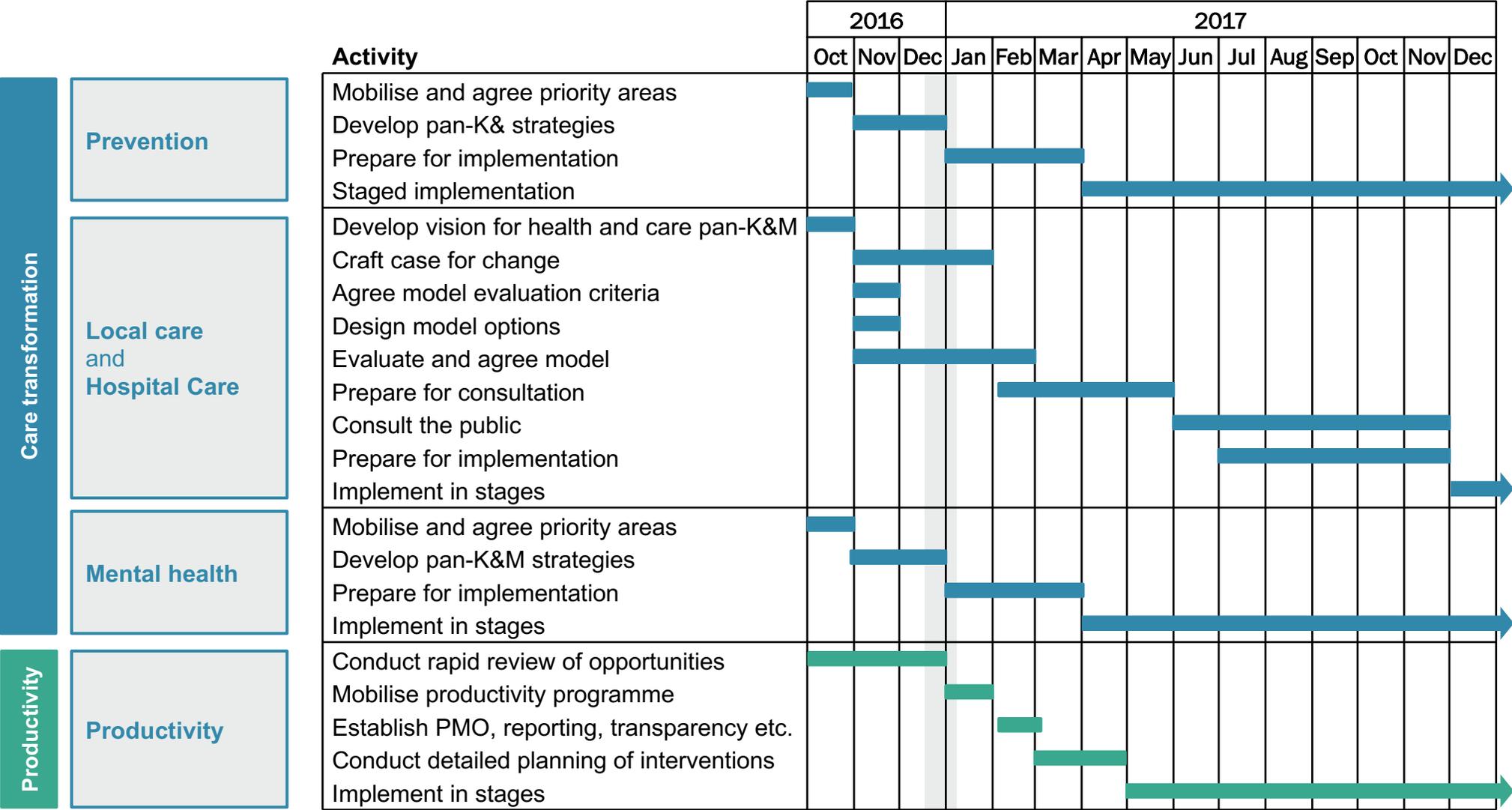
2
Undertake additional data collection

-
- **Collect and review local, bespoke data** relating to:
 - Self-assessment against quality standards
 - Acuity audit across acute and community hospital beds
 - Drivers of the commissioning and provider deficits
 - Number of lives lost through weekend working
 - Workforce (vacancies, turnover, sickness)
 - Local success stories
 - Utilisation of community hospitals

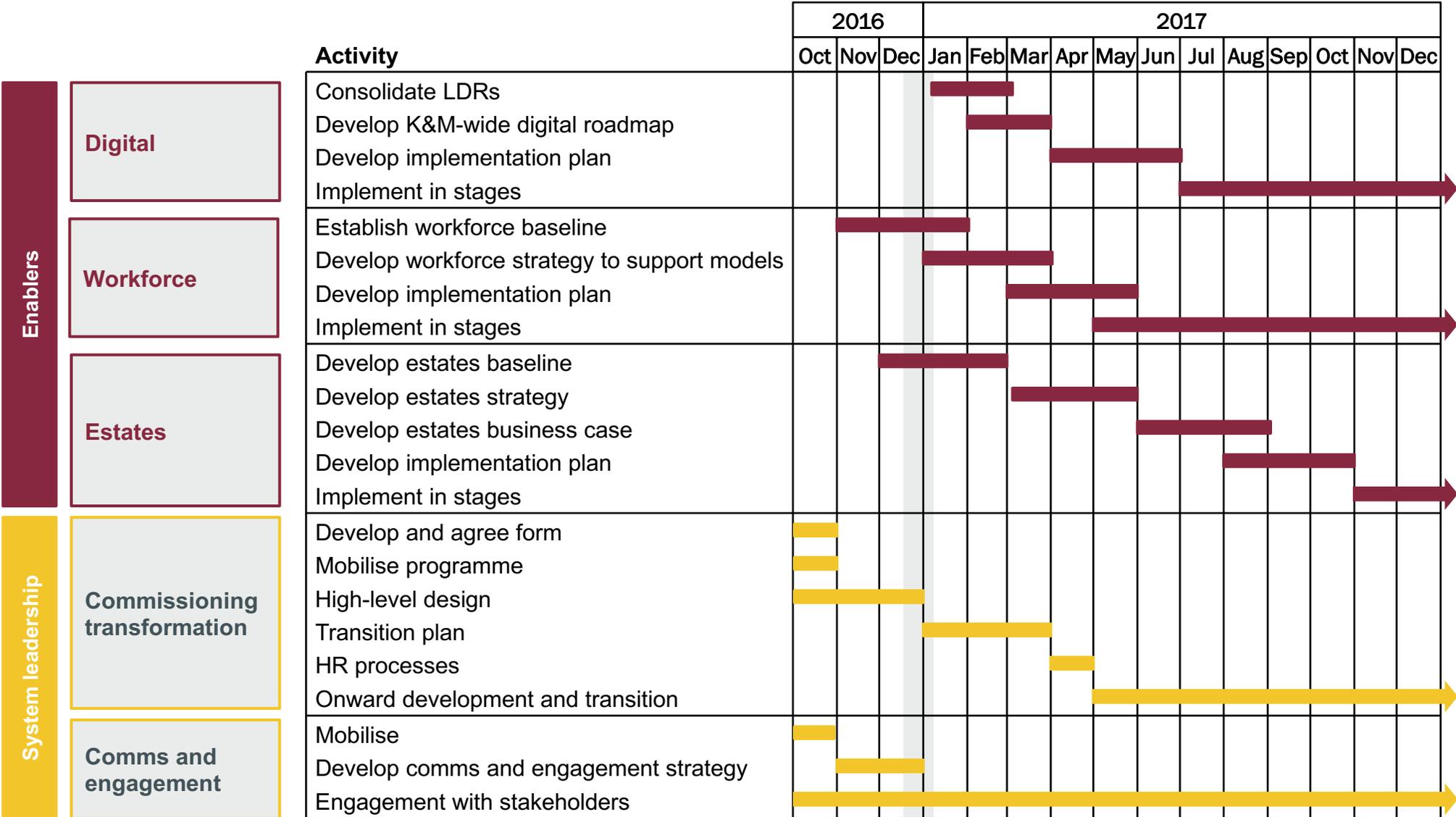
Approach

- Assess existing case for change
 - Work with Clinical Board to discuss and seek contributions
 - Perform and review targeted analysis
 - Synthesise key themes
 - Review with the Clinical Board
 - Approval by the Clinical Board
-
- Draft data collection instrument
 - Meet with Medical Directors to discuss data collection requirements, expected inputs and outputs
 - Data collection, analysis and presentation
 - Review with key individuals
 - Review with the Clinical Board
 - Support Medical Directors in their communication to senior colleagues the steps being taken

K&M STP overarching programme timeline (1 of 2)



K&M STP overarching programme timeline (2 of 2)



Source: Kent and Medway STP PMO

In the interests of transparency this submission remains unaltered from the version submitted to NHS England and NHS Improvement on the 21st October 2016 – the following lists changes that have been made to this submission since it's publication

- Slide 9 - footnote on should refer to “do nothing scenario” not ”no nothing scenario”
- Slide 11 references 3 HASUs (hyper acute stroke units) and 1to 2 elective orthopaedic centres, the development of these would be subject to public consultation (with regard to the development of orthopaedic centres this is just one example of how the separation of planned and unplanned care could be supported and different approaches are being considered in different areas and would be subject to consultation if required)
- Slide 15 should say Ashford Rural 6-day service not Herne Bay 7-day service
- Slide 21 references that in East Kent the options modelled include an “as is” model, alongside an option that sees the closure of one site and the creation of a single site option; these represent a number of the options alongside a range of other options representing varying degrees of potential change that have been modelled
- Slide 25 should indicate that the open dialogue intervention will be used across diagnoses (rather than the first episode of psychosis as it currently reads)
- Slide 28 reference KEM – this should refer to Kent and Medway
- Slide 36 references KCC and Medway Council chief executives would sit on the programme board this should indicate that senior officer representation, chair of health and wellbeing boards and directors of public health from the two councils would sit on the group.

Trust Board meeting – November 2016**11-18 Ratification of Standing Orders (annual review)****Trust Secretary**

The Trust's Standing Orders (SOs) are due their routine annual review. Having been reviewed a number of changes are proposed.

The SOs are directly linked to the Standing Financial Instructions and Reservation of Powers and Scheme of Delegation, which are featured as separate agenda items / reports at the November Board meeting.

A revised document was issued for consultation on 13/10/16. The Finance Committee was also formally apprised of the main finance-related proposed changes at its meeting on 19/10/16.

The majority of the proposed changes reflect national changes (i.e. the establishment of NHS Improvement) as well as local 'housekeeping' (changes of job titles, refection of the introduction of Divisions, dissolution of the KMHS etc.). However, the main proposed changes of note are:

- Format/style changes (although the page numbering listed in the table of contents will however only be corrected once the 'tracked' changes are accepted)
- Removal of the Foundation Trust Committee. This had been 'dormant' since 2013. The Chairman of the Trust Board (who chairs that Committee) has confirmed he is content with the proposal, on the basis that the Foundation Trust Committee would be reconstituted as and when required in the future
- Removal of details in relation to interests that is already contained within the Gifts, hospitality, sponsorship and interests policy and procedure
- Inclusion of a definition of the role of Senior Independent Director (a role which is currently held by the Vice Chairman of the Trust Board)

All of the proposed changes are 'tracked' in the enclosed document.

The Audit and Governance Committee reviewed and "approved" the revised Standing Orders at its meeting on 03/11/16. The Trust Board is therefore asked to "ratify" the document.

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 17/10/16 (summary of proposed changes only)
- Audit and Governance Committee, 03/11/16

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

Ratification

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

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Standing Orders

Requested/ Required by:	Audit and Governance Committee and Trust Board (Required by NHS Code of Accountability for NHS Boards)
Main author:	Trust Secretary
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Document lead:	Director of Finance
Supersedes:	Standing Orders (v <u>54.03</u>)
Reviewed by:	Audit and Governance Committee, 6th August 2015
Approved by:	Audit and Governance Committee, <u>3rd 4th</u> -November 201 <u>65</u>
Ratified by:	Trust Board, <u>3024th November</u> February 2016
Review date:	<u>November</u> February 2017

With effect from November~~February~~ 2016

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The master copy is held on Q-Pulse Document Management System
This copy – REV5.0

Document history

Requirement for document:	<ul style="list-style-type: none"> • Code of Conduct / Code of Accountability in the NHS (NHS Appointments Commission / Department of Health)
Cross References / (external documents): Associated Documents: <i>(List all best practice documents supporting this document)</i>	<ul style="list-style-type: none"> • Accountable Officer Memorandum for Trust Chief Executives • Anti-Fraud, Bribery and Corruption Policy and Procedure [RWF-OPPPCS-NC-WF48] • Bribery Act 2010 • Capital Regime and Investment Business Case Approvals Guidance for NHS Trusts (NHS Trust Development Authority) • Code of Conduct / Code of Accountability in the NHS (NHS Appointments Commission / Department of Health) • Code of Practice on openness in the NHS (Department of Health) • Data Protection Act 1998 • Disciplinary Policy and Procedure [RWF-OPPPCS-NC-WF10] • Freedom of Information Act 2000 Code of Conduct for NHS Managers (Department of Health 2002) • Gifts, hospitality, sponsorship and interests policy and procedure [RWF-OPPPCS-NC-TM48] • Health and Social Care Act 2012 • International Financial Reporting Standards • Managing Public Money (HM Treasury) • Model Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions, Department of Health (2006) • National Health Service Act 2006 • National Health Service and Community Care Act 1990 • NHS Trust Chair Role and behaviours & Framework (NHS Trust Development Authority) • NHS Trust NED Role and behaviours & Framework Jan 15 (NHS Trust Development Authority) • Nolan Standards of Public Life • Practice Guide 8: Execution of Deeds (Land Registry) • Removing or suspending from office – chairs and non-executive directors of NHS trusts and NHS charity trustees (NHS Trust Development Authority) • Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England (Professional Standards Authority) • Standards of Business Conduct for NHS staff (HSG (93)5) • Standing Financial Instructions [RWF-OPPPCS-NC-TM22] Reservation of Powers and Scheme of Delegation [RWF-OPPPCS-NC-TM21] • Terms of Reference for the Trust Board and its sub-committees

	<ul style="list-style-type: none"> • The Accountability Framework for NHS Trust Boards (NHS Trust Development Authority) • The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 • The Healthy NHS Board 2013 (NHS Leadership Academy) • The National Health Service Trusts (Membership and Procedure) Regulations 1990 (and subsequent amendments) • The Public Bodies (Admission to Meetings Act) 1960
<u>Associated documents (internal documents)</u>	<ul style="list-style-type: none"> • Anti-Fraud, Bribery and Corruption Policy and Procedure [RWF-OPPPCS-NC-WF48] • Disciplinary Policy and Procedure [RWF-OPPPCS-NC-WF10] • Gifts, hospitality, sponsorship and interests policy and procedure [RWF-OPPPCS-NC-TM48] • Reservation of Powers and Scheme of Delegation [RWF-OPPPCS-NC-TM21] • Standing Financial Instructions [RWF-OPPPCS-NC-TM22] • Terms of Reference for the Trust Board and its sub-committees

Version Control:		
Issue:	Description of changes:	Date:
1.0	Standing Orders (with effect from 1 April 2008)	February 2008
2.0	Standing Orders (with effect from 1 April 2009)	February 2009
3.0	Standing Orders (with effect from 1 April 2010)	March 2010
4.0	Standing Orders (with effect from 1 April 2011)	March 2011
4.1	Standing Orders (with effect from July 2012)	July 2012
4.2	Standing Orders (With effect from September 2013)	August 2013
4.3	Added note to front page (November 2014)	November 2014
5.0	Revised, to incorporate the following changes: <ul style="list-style-type: none"> ▪ Strengthened and expanded “Definitions” section, including “The Executive Team” and the formal introduction of the concept of a “Parent Committee” ▪ Removal of detailed descriptions of the role of Trust Board sub-committees (cross-reference to the Terms of Reference is made instead) ▪ Inclusion of the Trust’s arrangements regarding the “Fit and Proper Persons” Regulations (FPPR) ▪ Cross reference to the Trust’s Gifts, hospitality, sponsorship and interests policy and procedure ▪ Refining of the arrangements for use of the Trust’s Seal (including the introduction of a formal request process) ▪ Inclusion of a requirement that uses of the Trust’s Seal are reported to the Finance Committee ▪ Extension of the list of “Notifiable Interests”, to 	February 2016

	match those in the Gifts, hospitality, sponsorship and interests policy and procedure	
<u>6.0</u>	<u>Revised to incorporate the following changes:</u> <ul style="list-style-type: none"> ▪ <u>Removal of the Foundation Trust Committee (this had been 'dormant' since 2013)</u> ▪ <u>Housekeeping changes (job titles etc.)</u> ▪ <u>Removal of details in relation to interests that is already contained within the Gifts, hospitality, sponsorship and interests policy and procedure</u> 	<u>November 2016</u>

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Section A - Interpretation and definitions for Standing Orders and 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”. For this Trust it shall be the Chief Executive.

“ADO / ADNS” means Associate Director of Operations (ADO) or Associate Director for Nursing Services (ADNS). [These roles work at Divisional level.](#)

“Associate Non-Executive Director” means a person appointed to advise the Trust Board, in a similar role to that of a Non-Executive Director, but for which the role carries no formal position on the Trust Board. Therefore, although an Associate Non-Executive Director can attend Board meetings and contribute fully to the issues being considered, they are not able to vote on any matters, should this be required.

“Attest” means the formal action of bearing witness. In the context of these Standing Orders, attestation is required when the Trust Seal is affixed to a document. Affixing the Seal to a document has the effect of the document being signed by the Trust. Attestation involves bearing witness to the use of that Seal, and to the validity of that use, and involves signing the document that has been Sealed. Attesting the use of the Seal does not make that individual a party to the document Sealed.

“Budget” means a resource, expressed in financial terms, for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

“Budget holder”, “Budget Manager” or “Cost Centre 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” means the person presiding over a Committee and/or Group. The term “Chairman” is a generic term, and not intended to indicate the gender of the person presiding. The use of the term “Chairman” reflects the use of the generic term in the primary and secondary legislation pertaining to NHS Trusts (including the National Health Service and Community Care Act 1990 and The National Health Service Trusts (Membership and Procedure) Regulations 1990).

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

“Chief Executive” 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. A Committee can be a “Parent Committee” or a “Sub-Committee” (see below)

“Committee members” means persons formally appointed to sit on or to chair specific committees. The members of a Committee should be those required to be present at meetings of that Committee.

“Contracting and procuring” 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.

“Deed” means a written legal instrument which passes, affirms or confirms an interest, right, or property. Deeds are required for certain legal transactions (primarily those relating to land and/or property), but can be used in other situations (Local Authority contracts are often executed as Deeds, and a Deed may be used to amend a previous contract if the amendments appear to be to the advantage of only one of the parties). Unlike most non-Deed contracts, which are only enforceable if something (i.e. money, goods or services) transfers between the parties, this is not the case for Deeds, and parties sometimes therefore wish to have their contracts executed as Deeds to avoid uncertainty as to whether such transfer has occurred. In addition, the time limit for bringing a claim under a deed is 12 years (for a non-Deed contract, this is 6 years), so some parties execute their contracts as Deeds to take advantage of this longer period of limitation. To be a Deed, a document must: be in writing; make clear on its face that it is intended to be a Deed by the person making it or the parties to it (this can be done by the document describing itself as a Deed or expressing itself to be

executed as a deed 'or otherwise'); and be validly executed as a Deed by the person making it or one or more of the parties to it.

“Director” means Executive or Non-Executive Director of the Board as the context permits. -The inclusion of the word “Director” in a staff member’s job title does not mean that they automatically meet the definition of being a “Director” for the context of these Standing Orders.

“Directorate” means one of the major units of operations in the Trust. Each Directorate functions separately, with a separate management team, governance arrangements, budget and performance monitoring data/processes. Directorates can be “Clinical” (for which the management team is headed by a “Clinical Director”) or non-clinical. Non-clinical Directorates are usually corporate-based functions, such as IT, Human Resources, Finance and Clinical/Quality Governance.

“Division” means a grouping of two or more “Clinical Directorates” into a single operating unit, for the purposes of oversight.

“Director of Finance” means the Chief Financial Officer of the Trust.

“Establishment Order” means The Maidstone and Tunbridge Wells National Health Service Trust (Establishment) Order 2000.

“Director of Operations” means the officer/s of the Trust who oversee performance at Divisional level. There are currently Director of Operations for “Planned Care” and “Urgent Care”.

“Executive Director” means a member of the Trust Board who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) of The National Health Service Trusts (Membership and Procedure) Regulations 1990. Executive Directors are expected to be present at, and participate in, meetings of the Trust Board.

“Executive Team” means the group of employees who collectively have managerial control over the major activities of the Trust, and who influence the operations of the Trust as a whole rather than the decisions of individual Directorates or departments. For this Trust, this will be the Chief Executive, the Deputy Chief Executive, the Chief Nurse, the Chief Operating Officer, the Director of Finance, the Director of Workforce ~~and Communications~~ and the Medical Director.

“Fit and Proper Persons: Directors” Regulations (FPPR) means the sections of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that relate to “Fit and proper persons: directors”.

“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 and Procedure Regulations” means The National Health Service Trusts (Membership and Procedure) Regulations (SI 1990/2024) and subsequent amendments.

“Motion” means a formal proposition to be discussed and voted on during the course of a meeting.

“NHS Improvement (NHSI)” means [the operational name given to the organisation responsible for overseeing foundation trusts and NHS trusts.](#)

“Nominated officer” means an officer charged with the responsibility for discharging specific tasks within Standing Orders and/or Standing Financial Instructions.

“Non-Executive Director” means a member of the Trust Board who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1(3) of the Membership and Procedure Regulations. All non-Executive Directors have voting rights at the Trust Board, but Non-Executive Director posts are public appointments and not jobs and are therefore not subject to the provisions of employment law.

“Non-voting Board Member” means a Trust Board Member who is not entitled to exercise voting rights at the Trust Board.

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

“Papers” means reports that are formally submitted to Trust Board and/or Committees.

“Parent Committee” means a Committee that sits directly above another Committee in the Trust’s Committee structure (the Trust Board is therefore the Parent Committee to its sub-committees, as listed in SO 4.8). A Parent Committee would generally be expected to have a broader scope and have more authority than its sub-committees. The Parent Committee should determine how (including how often) it wishes to receive reports of the output from its sub-committees. This should include provision for escalating matters of urgency/importance in between the agreed reporting frequencies. If a Parent Committee determines that a matter reported to it is important enough for it to report on, to its own Parent Committee, it should be able to do so, via the reporting arrangements that exist between it and its Parent. The Parent Committee may also wish to approve the Terms of Reference of its sub-committees. Each Committee can only have one Parent Committee (however, it is possible for the output from a committee to be reported to multiple committees, if this is considered to be required).

“Part 1 meeting” means the Trust Board meeting held in public session, under The Public Bodies (Admission to Meetings Act) 1960.

“Part 2 meeting” means the Trust Board meeting held in private session, subject to resolution (see SO 3.17).

“Scheme of Delegation” means the Reservation of Powers and Scheme of Delegation, which states which decisions will be reserved to the Trust Board only, and which decisions will be delegated (and to whom).

“Senior Manager” means an officer holding a senior managerial or senior clinical role with management responsibilities. For this Trust this includes [“Directors”](#), [Directors of Operations](#), and Associate Directors and their direct reports and Clinical Directors and Consultants. However, please note that for the purposes of reporting “Senior Managers” remuneration (In accordance with Section 234b and Schedule 7a of the Companies Act, as required by NHS Bodies), a “Senior Manager” is considered to be defined as “Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual [Directorates](#) or departments”. For this Trust, and for this purpose, the definition of “Senior Manager” only applies to Trust Board Members.

“SD” means Scheme of Delegation

“Senior Independent Director (SID)” means [one of the independent Non-Executive Directors appointed by the Board, to be available to listen to concerns which contact through the normal channels of the Chairman, Chief Executive or Director of Finance has failed to resolve or for which such contact is inappropriate.](#)

“SFIs” means Standing Financial Instructions.

“SOs” means Standing Orders.

“Standing Orders Set” means the Standing Orders, Standing Financial Instructions and Reservation of Powers and Scheme of Delegation. Unlike NHS Foundation Trusts, NHS Trusts do not have a “Constitution”, but the “Standing Orders Set” can be considered as the closest equivalent to such a Constitution.

“Sub-Committee” means a Committee that sits directly below a Parent Committee in the Trust’s Committee Structure. The Terms of Reference of a Sub-Committee can be set (and amended) by the Parent Committee, should the latter wish to exercise this right. The reporting requirements of a Sub-Committee to its Parent Committee should be determined by the Parent Committee. The Parent Committee should also determine a route for the escalation of matters of urgency/importance in between the agreed reporting frequencies. Each Sub-Committee can only have one Parent Committee, but the output of the Sub-Committee’s work may be reported to other Committees, as required.

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

“TME” means the Trust Management Executive which is the senior management committee of the Trust.

“the Trust” means Maidstone and Tunbridge Wells NHS Trust.

“Trust Board” means the Chairman, Executive and Non-Executive Directors of the Trust collectively as a body.

“Trust Board Member” (or “Board Member”) means an individual regarded as being a member of the Trust Board. The influence (or potential influence) exerted by the individual is the key determinant, rather than their ability to vote at Board meetings. Trust Board members are those that are expected to be at each Board meeting (and sit at the Board table), and contribute fully to each agenda item. For this Trust, Trust Board Members comprise the Chairman of the Trust Board, Non-Executive Directors, the Executive Team, and the Director of Infection Prevention and Control. Please note however that the provisions in these Standing Orders relating to voting (SO 3.12) only apply to “Voting Board Members” (see below).

“Trust Secretary” means a person appointed to act independently of the 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” means the Non-Executive Director appointed to take on the duties of the Chairman of the Trust Board if the Chairman is absent for any reason.

“Voting Board Member” means a Trust Board Member who is entitled to exercise voting rights at the Trust Board.

Section B – Standing Orders

1. Introduction

1.1 Statutory Framework

The Maidstone and Tunbridge Wells NHS Trust (the Trust) is a statutory body which came into existence on 14th February 2000 under The Maidstone and Tunbridge Well NHS Trust (Establishment) Order 2000 No 237, (the “Establishment Order”).

- 1.1.1 The principal places of business of the Trust are: Maidstone Hospital, Hermitage Lane, Maidstone, Kent ME16 9QQ and ~~the~~ Tunbridge Wells Hospital at Pembury, Tonbridge Road, Pembury, Tunbridge Wells, Kent TN2 4QJ.
- 1.1.2 NHS Trusts are governed by Acts of Parliament, mainly the National Health Service and Community Care Act 1990 , National Health Service Act 2006 and Health and Social Care Act 2012. The functions of the Trust are conferred by this legislation.
- 1.1.3 As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.
- 1.1.4 The Trust also has statutory powers under Section ~~7~~ of the National Health Service Act 2006, to fund projects jointly planned with local authorities, voluntary organisations and other bodies.
- 1.1.5 The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of the Standing Orders Set, outlining the responsibilities of individuals.
- 1.1.6 The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 NHS Framework

- 1.2.1 In addition to the statutory requirements, the Secretary of State through the Department of Health issues further directions and guidance. These are normally issued under cover of a circular or letter.
- 1.2.2 The Code of Accountability requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior Executives (a Scheme of Delegation). The Code also requires the establishment of Audit and Remuneration Committees with formally agreed

Terms of Reference. The Code of Conduct makes various requirements concerning possible conflicts of interest of Board Members.

- 1.2.3 The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS.

1.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to “make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct”. Delegated Powers are covered in a separate document (Reservation of Powers and Scheme of Delegation). That document has effect as if incorporated into the Standing Orders and Standing Financial Instructions (all 3 documents comprise the “Standing Orders Set”).

2. The Trust Board: Composition of membership, tenure and role of Members

2.1 Composition of the Membership of the Trust Board

In accordance with the Membership and Procedure Regulations, and the Establishment Order, the composition of the Trust Board shall be:

- 2.1.1 The Chairman of the Trust Board (Appointed by the [TDA-NHSI](#) Appointments function);
- 2.1.2 Up to 5 Non-Executive Directors (appointed by the [TDA-NHSI](#) Appointments function);
- 2.1.3 Up to 5 officer Executive Directors with voting rights (but not exceeding the number of Non-Executive Directors). For this Trust this currently includes:
- the Chief Executive
 - the Chief Nurse (who must be a registered nurse or registered midwife as defined in section 10(7) of the Nurses, Midwives and Health Visitors Act 1979(10)¹)
 - The Chief Operating Officer
 - The Director of Finance;
 - The Medical Director (who must be a medical practitioner¹)

¹ As per The National Health Service Trusts (Membership and Procedure) Regulations 1990
Standing Orders
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The Trust shall have not more than 11 and not less than 8 Voting Board Members (unless otherwise determined by the Secretary of State for Health and set out in the Trust's Establishment Order or such other communication from the Secretary of State).

- 2.1.4 Other non-voting Executive Directors as the [Chairman of the Trust Board Trust](#) will determine (currently the Director of Workforce ~~and Communications~~ and Deputy Chief Executive).
- 2.1.5 Other non-voting positions as the [Chairman of the Trust Board Trust](#) will determine (currently the Director of Infection Prevention and Control).
- 2.1.6 The Trust may confer on staff the title "Director" as an indication of their corporate or senior leadership responsibility within the Trust, but such titles do not automatically mean that the post is either an Executive Director, or a member of the Executive Team.
- 2.1.7 The Trust may appoint Associate Non-Executive Directors, in a non-voting capacity, to provide additional expertise to the Trust Board.

2.2 Appointment of Chairman and Non-Executive Directors of the Trust Board

- 2.2.1 Paragraph 4 of Schedule 5A to the 1977 Act, as inserted by the Health Act 1999, provides that the Chairman of the Trust Board is appointed by the Secretary of State, but otherwise the appointment and tenure of office of the Chairman and Non-Executive Directors are set out in the Membership and Procedure Regulations.

2.3 Terms of Office of the Chairman and Non-Executive Directors of the Trust Board

- 2.3.1 The regulations setting out the period of tenure of office, and the arrangements for the termination or suspension of office of the Chairman and Non-Executive Directors are contained in Sections 2 to 4 of the Membership and Procedure Regulations.
- 2.3.2 The NHS Trust Development Authorities' guidance "Removing or suspending from office – chairs and non-executive directors of NHS trusts and NHS charity trustees" should be consulted, should circumstances demand.

2.4 Appointment and Powers of Vice-Chairman

- 2.4.1 Subject to Standing Order 2.4.2) below, the Chairman and Non-Executive Directors of the Trust Board may appoint a Non-Executive Director to be Vice-Chairman, for such period, not exceeding the remainder of his term as a Non-Executive Director, as they may specify on appointing him.
- 2.4.2 Any member so appointed may at any time resign from the office of Vice-Chairman by giving notice in writing to the Chairman of the Trust Board. The

Chairman and Non-Executive may thereupon appoint another member as Vice-Chairman in accordance with the provisions of Standing Order 2.4 (1).

- 2.4.3 Where the Chairman of the Trust Board has died or has ceased to hold office, or where they have been unable to perform their duties as Chairman owing to illness or any other cause, the Vice-Chairman shall act as Chairman of the Trust Board until a new Chairman is appointed or the existing Chairman resumes their duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform those duties, be taken to include references to the Vice-Chairman.

2.5 Joint Members

- 2.5.1 Where more than one person is appointed jointly to a post mentioned in regulation 2(4)(a) of the Membership and Procedure Regulations those persons shall count for the purpose of Standing Order 2.1 as one person.
- 2.5.2 Where the office of a member of the Board is shared jointly by more than one person:
- (a) either or both of those persons may attend or take part in meetings of the Board;
 - (b) if both are present at a meeting they should cast one vote if they agree;
 - (c) in the case of disagreements no vote should be cast;
 - (d) the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.11 (Quorum).

2.6 Public involvement and consultation

- 2.6.1 Section 242 of the National Health Service Act 2006 requires NHS organisations to make arrangements to involve and consult patients and the public in:
- (a) planning of the provision of services.
 - (b) the development and consolidation of proposals for changes in the way those services are provided, and
 - (c) decisions to be made by the NHS organisation affecting the operation of services.
- 2.6.2 The Trust will work with relevant partners to meet the legal requirements set out above, but the Patient Experience Committee will act as the forum by which the Trust will involve and consult with its patients and public.

2.7 Role of the Trust Board

The Trust Board will function as a corporate decision-making body, Executive and Non-Executive Directors will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and

managerial issues facing the Trust in carrying out its statutory and other functions.

2.7.1 Executive Directors

Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

2.7.2 Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the Accountable Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

2.7.3 Director of Finance

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

2.7.4 Non-Executive Directors

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as Non-Executive Directors or when Chairing a committee of the Trust which has delegated powers.

2.7.5 Chairman of the Trust Board

The Chairman of the Trust Board shall be responsible for the operation of the Trust Board and chair all Board meetings when present. The Chairman has certain delegated executive powers. The Chairman must comply with the terms of appointment and with these Standing Orders.

The Chairman shall liaise with the [TDA-NHSI](#) Appointments function over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

2.8 Corporate role of the Trust Board

- 2.8.1 All business shall be conducted in the name of the Trust.
- 2.8.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.
- 2.8.3 The powers of the Trust established under statute shall be exercised by the Trust Board meeting in public session except as otherwise provided for in Standing Order No. 3.
- 2.8.4 The Trust Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

2.9 Schedule of Matters reserved to the Board and Scheme of Delegation

- 2.9.1 The Trust Board has resolved that certain powers and decisions may only be exercised by the Trust Board in formal session. These powers and decisions are set out in the “Reservation of Powers and Scheme of Delegation” and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.10 Lead Roles for Trust Board Members

- 2.10.1 The Chairman will ensure that the designation of Lead roles or appointments of Trust Board Members as required by the Department of Health or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc.). A record of these lead roles will be maintained by the Trust Secretary.

2.11 Response to the “Fit and Proper Persons: Directors” Regulations

The Trust will apply the procedures outlined in Appendix Four.

3. Meetings of the Trust Board

3.1 Calling meetings

- 3.1.1 Ordinary meetings of the Trust Board shall be held at regular intervals at such times and places as the Trust Board may determine.
- 3.1.2 The Chairman of the Trust Board may call a meeting of the Board at any time.
- 3.1.3 One third or more members of the Trust Board may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.2 Notice of Meetings and the Business to be transacted

- 3.2.1 Before each meeting of the Board, a notice (agenda) specifying the business proposed to be transacted shall be delivered to every member by electronic transmission, or sent by post to the usual place of residence of each member, so as to be available to members at least three clear [calendar](#) days before the meeting. The notice shall be signed by the Chairman or by an officer authorised by the Chairman to sign on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting.
- 3.2.2 In the case of a meeting called by members in default of the Chairman calling the meeting, the notice shall be signed by those members.
- 3.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.
- 3.2.4 A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman of the Trust Board at least 10 clear [calendar](#) days before the meeting. -The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 [calendar](#) days before a meeting may be included on the agenda at the discretion of the Chairman [of the Trust Board](#).
- 3.2.5 Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)). For this Trust, posting the notice on the Trust's Internet site shall be considered to fulfil this requirement.

3.3 Agenda and Supporting Papers

- 3.3.1 The Agenda will be sent to members at least 5 [calendar](#) days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, unless there are extenuating circumstances.

3.4 Petitions

- 3.4.1 Where a petition has been received by the Trust the Chairman of the Trust Board shall include the petition as an item for the agenda of the next meeting.

3.5 Notice of Motion

- 3.5.1 Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to Rescind a Resolution', a member of the Board wishing to move a motion shall send a written or electronic transmission notice to the Trust Secretary who will ensure that it is brought to the immediate attention of the Chairman.

3.5.2 The notice shall be delivered at least 5 clear [calendar](#) days before the meeting. The Trust Secretary shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

3.6.1 Subject to the agreement of the Chairman, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a member of the Board may give written or electronic transmission notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman of the Trust Board's decision to include the item shall be final.

3.7 Motions: Procedure at and during a meeting

3.7.1 Who may propose

A motion may be proposed by the Chairman of the meeting or any member present. It must also be seconded by another member.

3.7.2 Contents of motions

The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Trust Board;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put

3.7.3 Amendments to motions

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.7.4 Rights of reply to motions

a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive/original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.7.5 Withdrawing a motion

A motion, or an amendment to a motion, may be withdrawn.

3.7.6 Motions once under debate

a) When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' committee to deal with a specific item of business;
- that a member/director be not further heard;
- a motion under Section I (2) or Section I (8) of the Public Bodies (Admissions to Meetings) Act 1960 resolving to exclude the public, including the press (see Standing Order 3.17).

b) In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

c) If a motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motion to Rescind a Resolution

3.8.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which

notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

- 3.8.2 When any such motion has been dealt with by the Trust Board it shall not be competent for any director/member other than the Chairman to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Chairman of meeting

- 3.9.1 At any meeting of the Trust Board the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Vice-Chairman if present, shall preside.
- 3.9.2 If the Chairman and Vice-Chairman are absent, another Non-Executive Director present at the meeting shall choose who shall preside.

3.10 Chairman's ruling

- 3.10.1 The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum

- 3.11.1 No business shall be transacted at a Trust Board meeting unless at least one-third of the whole number of the Chairman and members (including at least one Executive Director and one Non-Executive Director) is present.
- 3.11.2 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum at Trust Board meetings.
- 3.11.3 If the Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.12 Voting

- 3.12.1 Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.14 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of Voting Board Members present and voting on the question. In the case of an equal

vote, the person presiding (i.e.: the Chairman of the meeting) shall have a second, and casting vote.

- 3.12.2 At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.
- 3.12.3 If at least one third of the Voting Board Members present so request, the voting on any question may be recorded so as to show how each Member present voted or did not vote (except when conducted by paper ballot).
- 3.12.4 If a Voting Board Member so requests, their vote shall be recorded by name.
- 3.12.5 In no circumstances may an absent Voting Board Member vote by proxy. Absence is defined as being absent at the time of the vote.
- 3.12.6 A manager who has been formally appointed to act up for an Executive Director with voting rights during a period of incapacity or temporarily to fill a vacancy for an Executive Director with voting rights shall be entitled to exercise the voting rights of that Executive Director.
- 3.12.7 A manager attending the Trust Board meeting to represent an Executive Director with voting rights during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.
- 3.12.8 For the voting rules relating to joint members see Standing Order 2.5.

3.13 Suspension of Standing Orders

- 3.13.1 Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the voting Board Members are present (including at least one Executive Director and one Non-Executive Director) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.
- 3.13.2 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and Trust Board Members.
- 3.13.3 No formal business may be transacted while Standing Orders are suspended.
- 3.13.4 The Audit and Governance Committee shall review every decision to suspend Standing Orders.

3.14 Variation and amendment of Standing Orders

- 3.14.1 These Standing Orders shall not be varied except in the following circumstances:
- upon a notice of motion under Standing Order 3.5;
 - upon a recommendation of the Chairman or Chief Executive included on the agenda for the meeting;
 - that two thirds of the Voting Board Members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive Directors vote in favour of the amendment;
 - providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.15 Record of Attendance

- 3.15.1 The names of the Chairman and ~~Trust Board Members~~ Directors present (and in attendance) at the meeting shall be recorded.

3.16 Minutes

- 3.16.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it. In practical terms, the approved minutes will be signed soon after the meeting at which they were approved.
- 3.16.2 No discussion shall take place upon the minutes except upon their accuracy, the actions arising, or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.17 Admission of public and the press

3.17.1 Admission and exclusion on grounds of confidentiality of business to be transacted

The public and representatives of the press may attend all meetings of the Trust Board, but shall be required to withdraw upon the Trust Board request as follows:

- 'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

3.17.2 General disturbances

The Chairman (or Vice-Chairman) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements

for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'.

Section 1(8) Public Bodies (Admissions to Meetings) Act 1960.

3.17.3 **Business proposed to be transacted when the press and public have been excluded from a meeting**

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in (i) and (ii) above, shall be confidential to the members of the Board.

Board Directors and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked "Confidential" outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports/papers.

3.17.4 **Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust Board.

3.18 **Observers at Trust meetings**

The Trust Board will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

4. Appointment of Committees and Sub-Committees

4.1 Appointment of Committees

Subject to such directions as may be given by the Secretary of State for Health, the Trust Board may appoint committees of the Trust.

The Trust shall determine the membership and Terms of Reference of committees and sub-committees, and shall if it requires to, receive and consider reports of such committees.

4.2 Joint Committees

4.2.1 Joint committees may be appointed by the Trust by joining together with one or more other Trust or health service organisation. This may comprise Board members or other officers from the respective organisations.

4.2.2 Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the Trust or other health bodies in question, appoint sub-committees consisting wholly or partly of Board members, officer, or other representatives as agreed by the respective organisations.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any sub-committees established by the Trust Board. In which case the term "Chairman" is to be read as a reference to the Chairman of other committee as the context permits, and the term "member" is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

4.4 Terms of Reference

4.4.1 Each such committee shall have such Terms of Reference and powers and be subject to such conditions (as to reporting back to the Trust Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such Terms of Reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

4.6 Approval of Appointments to Committees

The Trust Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Appointments for Statutory functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

4.8 Sub-Committees established by the Trust Board

The principal sub-committees constituted by the Board are listed below.

The membership, role, authority and duties of each Committee are stated within their Terms of Reference (see SO 4.4), which shall be reviewed (and revised if necessary) and agreed annually, and formally approved by the Trust Board. The final version of each sub-committee's Terms of Reference will be held by the Trust Secretary.

- Audit and Governance Committee
- Remuneration and Appointments Committee
- Charitable Funds Committee
- Finance Committee
- Quality Committee
- Workforce Committee
- Patient Experience Committee
- ~~Foundation Trust Committee~~

4.8.1 Other Committees

The Board may constitute such other committees as required to discharge the Trust's responsibilities.

The Trust Management Executive (TME) is not a sub-committee of the Trust Board, but it is the senior management committee within the Trust. Its purpose is to oversee and direct: the effective operational management of the Trust; the delivery of safe, high quality, patient-centred care; the development of Trust strategy, culture and policy; and the identification, mitigation and escalation of assurance and risk issues. [The Trust Management Executive will operate in accordance with Terms of Reference](#)

which shall be approved by the TME. The final version of the TME's Terms of Reference will be held by the Trust Secretary.

4.8.2 Deputising Officers

An Officer in attendance for an Executive Director may count towards the quorum at sub-committees of the Trust Board, if the Chairman of the Committee is advised and agrees in advance of the commencement of the meeting. It will be recorded in the minutes of the meeting that the Officer is deputising for the Executive Director and forms part of the committee's quorum for that meeting only.

4.8.3 Confidential Proceedings

A Director or officer of the Trust shall not disclose a matter considered by the Trust Board or a Committee in confidence without its permission until the Board or Committee has considered the matter in public or has resolved to make the matter public.

5. Arrangements for the exercise of Trust functions by delegation

5.1 Delegation of Functions to Committees, Officers or other bodies

5.1.1 Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.1.2 Section 16B of the NHS Act 1977 allows for regulations to provide for the functions of Trust's to be carried out by third parties. In accordance with The Primary Care Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 the functions of the Trust may also be carried out in the following ways:

- (i) by another Trust;
- (ii) jointly with any one or more of the following: NHS trusts, [TDA-NHSI](#) or CCG;
- (iii) by arrangement with the appropriate Trust or CCG, by a joint committee or joint sub-committee of the Trust and one or more other health service bodies;
- (iv) in relation to arrangements made under S63(1) of the Health Services and Public Health Act 1968, jointly with one or more [TDA-NHSI](#), NHS Trusts or CCG.

5.1.3 Where a function is delegated by these Regulations to another Trust, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place. In other situations, i.e. delegation to committees,

sub-committees or officers, the Trust delegating the function retains full responsibility.

5.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman of the Trust Board after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Trust Board in public session (Part 1) for formal ratification.

5.3 Delegation to Committees

5.3.1 The Trust Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and Terms of Reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

5.3.2 When the Trust Board is not meeting as the Trust in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Trust in public session.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

5.4.2 The Chief Executive shall ensure a Scheme of Delegation is prepared which shall be considered and approved by the Trust Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Trust Board.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance to provide information and advise the Board in accordance with statutory or Department of Health requirements. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Trust Board and Scheme of Delegation of powers

- 5.5.1 The arrangements made by the Trust Board as set out in the “Reservation of Powers and Scheme of Delegation” shall have effect as if incorporated in these Standing Orders.

5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders 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 Trust Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive and Trust Secretary as soon as possible.

6. Overlap with other trust policy statements / procedures, regulations and the Standing Financial Instructions

6.1 Policy statements: general principles

The Trust Board will from time to time agree Policy statements/ procedures which will apply to all or specific groups of staff employed by Maidstone and Tunbridge Wells NHS Trust. The decisions to agree such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's financial governance documents incorporating the Standing Orders, Standing Financial Instructions and Reservation of Powers.

6.2 Specific Policy statements

Notwithstanding the application of SO 6.1 above, these Standing Orders must be read in conjunction with the following Trust documents:

- Standing Financial Instructions (SFIs) [RWF-OPPCS-NC-TM22]
- Reservation of Powers and Scheme of Delegation [RWF-OPPCS-NC-TM21]
- Gifts, hospitality, sponsorship and interests policy and procedure [RWF-OPPCS-NC-TM48]
- Board of Directors Code of Conduct
- Disciplinary Policy and Procedures [RWF-OPPPCS-NC-WF10]

6.3 Review of Standing Orders

Standing Orders shall be reviewed annually. The requirement for review extends to all documents having the effect as if incorporated into the

Standing Orders i.e. the Standing Financial Instructions and Scheme of Delegation.

6.4 Specific guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997
- Human Rights Act 1998
- Freedom of Information Act 2000
- Code of Conduct for NHS Managers 2002
- Data Protection Act 1998
- Bribery Act 2010

6.5 Circulation of Standing Orders

It is the duty of the Director of Finance (supported by the Trust Secretary) to ensure that existing Directors, Officers and all new appointees are notified of and understand their responsibilities within Standing Orders (SOs), Standing Financial Instructions (SFIs), Reservation of Powers and Scheme of Delegation. The latest version shall be made available to all staff, via the Trust intranet.

7. Duties and obligations under these Standing Orders

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and applicability to Board Members

- i) The NHS Code of Accountability requires Trust Board Members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests, as and when they arise, to the Trust Secretary. Any Board members appointed subsequently should do so on appointment, and as and when they arise (to the Trust Secretary).
- ii) In addition, Trust Board Members should declare any interests they may have in agenda items on particular Board meetings, at the start of such meetings (see SO 7.1.4).

[III\) Full details of the specific requirements can be found in the Gifts, hospitality, sponsorship and interests policy and procedure.](#)

7.1.2 Interests which are relevant and material

(i) ~~Interests which should be regarded as "relevant and material" are:~~

- ~~a) Directorships, including Non-Executive Directorships held in private companies or Public Limited Companies (PLCs) (with the exception of those of dormant companies);~~
 - ~~b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;~~
 - ~~c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;~~
 - ~~d) A position of Authority in an organisation in the field of health and social care (i.e. separate to any position held at the Trust);~~
 - ~~e) Any connection with an organisation that could be viewed as a direct competitor to the Trust in the field of health and social care~~
- ~~Any connection with a voluntary or other organisation contracting for NHS services (this would include being a minority shareholder in such organisations);~~
- ~~Research funding/grants that may be received by an individual or their department;~~
- ~~Interests in pooled funds that are under separate management.~~
- ~~Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.~~
- ~~Appointment to a public office which may result in the individual's association with the Trust being made public. This could include, for example, election to a Parish Council.~~
- ~~Political affiliation which may result in the individual's association with the Trust being made public~~
- Full details of Interests which are relevant and material can be found in the Gifts, hospitality, sponsorship and interests policy and procedure.

(ii) ~~Any Trust Board Member who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, shall declare his/her interest by giving notice in writing of such fact to the Trust Secretary as soon as practicable.~~

7.1.3 Advice on Interests

If Trust Board Members have any doubt about the relevance of an interest, this should be discussed with the Chairman of the Trust Board or with the Trust Secretary.

International Financial Reporting Standard No 24 (issued by the International Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.1.4 Recording of Interests in Trust Board minutes

Trust Board Members' interests in the agenda item/s of particular Board meetings should be declared at the start of the relevant meeting, and should be recorded in the minutes.

7.1.5 **Publication of declared interests in Annual Report**

Trust Board Members' declared interests should be published in the Trust's Annual Report. The interests to be published will be those declared at the end of the relevant financial year.

7.1.6 **Conflicts of interest which arise during the course of a meeting**

During the course of a Trust Board meeting, if a conflict of interest is established, the Trust Board Member concerned should withdraw from the meeting and play no part in the relevant discussion or decision (see overlap with SO 7.3). [The Chairman of the Trust Board \(advised by the Trust Secretary\) will make the final determination on such circumstances.](#)

7.2 **Register of Trust Board Members' Interests**

- 7.2.1 The Chief Executive will ensure that a Register of Trust Board Members' Interests is established to record formally declarations of interests of Trust Board Members. In particular the Register will include details of all directorships and other relevant and material interests (as defined in SO 7.1.2) which have been declared.
- 7.2.2. These details will be kept up to date by the Trust Secretary, by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.
- 7.2.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.
- 7.2.4 The Trust Secretary will hold and maintain the Register of Interests.

7.3 **Exclusion of Chairman and Members in Proceedings on account of pecuniary interest**

7.3.1 **Definition of terms used in interpreting 'Pecuniary' interest**

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

- (i) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(ii) “contract” shall include any proposed contract or other course of dealing.

(iii) “Pecuniary interest”

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

- a) he/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or
- b) he/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

iv) Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:-

- a) neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or
- b) any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or
- c) those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2 (ii).

7.3.2 Exclusion in proceedings of the Trust Board

- (i) Subject to the following provisions of this Standing Order, if the Chairman of the Trust Board or a Trust Board Member has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it. [The Chairman of the Trust Board \(advised by the Trust Secretary\) will make the final determination on such circumstances.](#)

- (ii) The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed. (See SO 7.3.3 on the 'Waiver' which has been approved by the Secretary of State for Health).
- (iii) The Trust Board may exclude the Chairman or a Trust Board Member from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.
- (iv) Any remuneration, compensation or allowance payable to the Chairman or a Member by virtue of paragraph 11 of Schedule 5A to the National Health Service Act 1977 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this Standing Order.
- (v) This Standing Order applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Trust and applies to a member of any such committee or sub-committee (whether or not he/she is also a member of the Trust) as it applies to a member of the Trust Board.

7.3.3 Waiver of Standing Orders made by the Secretary of State for Health

(1) Power of the Secretary of State to make waivers

Under regulation 11(2) of the NHS (Membership and Procedure Regulations SI 1999/2024, there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a chairman or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver has been agreed in line with sub-sections (2) to (4) below.

(2) Definition of 'Chairman' for the purpose of interpreting this waiver

For the purposes of paragraph 7.3.3.(3) (below), the "relevant chairman" is

- (a) at a meeting of the Trust, the Chairman of that Trust;
- (b) at a meeting of a Committee –
 - (i) in a case where the member in question is the Chairman of that Committee, the Chairman of the Trust [Board](#);

- (ii) in the case of any other member, the Chairman of that Committee.

(3) Application of waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest.

It will apply to:

- (i) A member of the Maidstone and Tunbridge Wells NHS Trust (“the Trust”), who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of –
 - (a) services under the National Health Service Act 1977; or
 - (b) services in connection with a pilot scheme under the National Health Service Act 1997;

for the benefit of persons for whom the Trust is responsible.

- (ii) Where the ‘pecuniary interest’ of the member in the matter which is the subject of consideration at a meeting at which he is present:-
 - (a) arises by reason only of the member’s role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;
 - (b) has been declared by the relevant chairman as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:-
 - (i) are members of the same profession as the member in question,
 - (ii) are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(4) Conditions which apply to the waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

- (a) the member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

- (b) the relevant chairman must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.3.3 (2) (b) above, except where that member is the Chief Executive;
- (c) in the case of a meeting of the Trust:
 - (i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;
 - (ii) may not vote on any question with respect to it.
- (d) in the case of a meeting of the Committee:
 - (i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;
 - (ii) may vote on any question with respect to it; but
 - (iii) the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

7.4 Standards of Business Conduct

7.4.1 Trust Policy and National Guidance

All Trust staff and members of the Trust Board must comply with the Trust's Gifts, hospitality, sponsorship and interests policy and procedure, the national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff' (see Appendix Six) ,and the Bribery Act 2010.

A Board of Directors Code of Conduct has been established to promote the highest possible standards of conduct and behaviour in all matters pertaining to the Board. This code explicitly refers to the Nolan Standards of public life (www.public-standards.gov.uk)

7.4.2 Interests of Officers

- i) The arrangements relating to interests of Trust Officers are covered via the Gifts, Hospitality, Sponsorship and Interests Policy and Procedure [RWF-OPPCS-NC-TM48]

7.4.3 Canvassing of and Recommendations by Trust Board Members in Relation to Appointments

- i) Canvassing of Trust Board Members or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall

disqualify the candidate for such appointment. -The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

- ii) Trust Board Members shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.
- iii) Informal discussions outside appointment panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

7.4.4 **Relatives of Members or Officers**

- i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.
- ii) The Chairman and every member of the Trust Board shall disclose to the Trust Secretary any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Trust Secretary to report to the Trust Board any such disclosure made.
- iii) On appointment, (and prior to acceptance of an appointment in the case of Executive Directors) Trust Board Members should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.
- iv) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Exclusion of Chairman and members in proceedings on account of pecuniary interest' (SO 7.3) shall apply.

7.5 **Acceptance of gifts by staff**

7.5.1 The Director of Finance (supported by the Trust Secretary) shall ensure that all staff are made aware of the Trust "Gifts, hospitality, sponsorship and interests policy and procedure". This policy follows the guidance contained in the Department of Health circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' (Annex B) and also takes into account the requirements of the Bribery Act 2010 and associated Government guidance.

8. Custody of Seal, Sealing of documents and signature of documents

8.1 Custody of Seal

The common Seal of the Trust shall be kept by the Trust Secretary in a secure place.

8.2 Sealing of Documents

8.2.1 For NHS Trusts, the arrangements for the use of Seals is primarily guided by the National Health Service Act 2006. Affixing the Trust Seal is required in order for certain legal documents to be properly executed. Generally, the use of the Seal is reserved for Deeds. Requests for documents to have the Trust Seal affixed should be made to the Trust Secretary, using a Form that the Trust Secretary designs for that purpose. The Form will outline the purpose of the document, the financial values involved (if any) and the implications for the Trust.

8.2.2 If, following review of the Form referred to in 8.2.1, the Trust Secretary confirms that it is necessary for the document to be Sealed, the Seal shall be affixed in the presence of the Trust Secretary, and one member of the Executive Team, and shall be attested by them. The member of the Executive Team should not be from the department from which the document arises. 8.2.3. If the Trust Secretary is not available, and the Seal needs to be affixed to the document before they become available, the Seal can be affixed in the presence of two members of the Executive Team, who can then attest the document.

8.2.4. The requirements regarding the use of the Seal should be applied in addition to any requirements regarding the authorisation of contracts / Service Level Agreements, based on their value. For authorisation limits, please refer to the Reservation of Powers and Scheme of Delegation [RWF-OPPCS-NC-TM21].

8.2.5 Details of the documents where the Seal has been affixed shall be reported to the next available meeting of the Finance Committee, by the Trust Secretary.

8.3 Register of Sealing

The Trust Secretary shall keep a register in which he/she, shall enter a record of the Sealing of every document, and of those attesting.

8.4 Signature of documents

8.4.1 Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any member of the Executive Team.

- 8.4.2 The Chief Executive, Director of Finance or other member of the Executive Team shall be authorised, by resolution of the Trust Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a Deed, for which the Trust Seal is required – see 8.2), the subject matter of which has been reviewed by the person signing, and determined to be appropriate. This provision should be applied in addition to any requirements regarding the authorisation of contracts / Service Level Agreements, based on their value. For authorisation limits, please refer to the Reservation of Powers and Scheme of Delegation [RWF-OPPCS-NC-TM21].
- 8.4.3 In land transactions, the signing of certain supporting documents will be delegated to Senior Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a Deed, for which the Trust Seal is required – see 8.2).

9. Miscellaneous

9.1 Joint Finance Arrangements (see overlap with SFI No. 12.3)

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 28A of the NHS Act 1977. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999.

APPENDIX ONE

Process Requirements

1.0 Implementation and Awareness

- 1.1 ~~Once approved the Author will send this document to the Clinical Governance Assistant who will publish it on the Trust intranet~~ Once ratified the PRC Chairman will email this policy/procedural document to the Clinical Governance Assistant (CGA) who will activate it on the Trust approved document management database on the intranet, under 'Policies & Q-Pulse'.
- 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 COMMS team. A monthly publications table is produced by the CGA which is published on the Trust intranet under 'Policies & Q-Pulse'; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter~~
- 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. On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications~~

2.0 Review

The Standing Orders will be reviewed annually.

3.0 Archiving

~~The Trust intranet retains all superseded files in an archive directory in order to maintain document history. Reference should be made to the Records Management Policy and Procedure [OPPCS-NC-TM1]~~ The Trust approved document management database on the intranet, under 'Policies & Q-Pulse', retains all superseded files in an archive directory in order to maintain document history

APPENDIX TWO**CONSULTATION ON:** Standing Orders

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: The Trust Secretary (kevinrowan@nhs.net)

By date: 12th-24th October 2016

Name:	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Clinical Governance Assistant	13/10/16			
Chief Pharmacist	13/10/16			
Staff-Side Chair	13/10/16			
Emergency Planning team	13/10/16	14/10/16	N	N/A
Head of Staff Engagement & Equality	13/10/16			
Health Records Manager	13/10/16			
Local Counter Fraud Specialist	13/10/16			
Chief Internal Auditor	13/10/16			
Director of Finance	13/10/16			
Deputy Directors of Finance	13/10/16			
The Executive Team	13/10/16			
Non-Executive Directors	13/10/16			
Risk Manager				
Head of Information Governance	13/10/16			
Assoc. Director, Quality Governance	13/10/16			
Dir. of Operations, Planned Care	13/10/16	13/10/16	Y	Y
Dir. of Operations, Urgent Care	13/10/16			
Deputy Director of Finance (Financial Governance)	13/10/16			
Deputy Director of Finance (Financial Performance)	13/10/16			
Associate Director of Nursing, Planned Care	13/10/16			
Associate Director of Nursing, Urgent Care	13/10/16			
Head of Midwifery/Professional Lead, Paediatrics, Women's & Sexual Health	13/10/16			
Associate Director of Operations, Women's, Paeds & Sexual Health	13/10/16			
Director of Health Informatics	13/10/16			
Director of Estates and Facilities	13/10/16			
Head of Perf. & Delivery, Urgent Care	13/10/16			
Assistant Director of Business Intelligence	13/10/16			
Deputy Chief Nurses	13/10/16			
Director of Medical Physics	13/10/16			
General Managers	13/10/16			
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 (EIA) 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 EIA must also be placed on the Trust's intranet. This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development and approval process. Please note that completion is mandatory for all policy and procedure development exercises**~~

Title of policy or practice	Standing Orders
What are the aims of the policy or practice?	To specify the powers and authority that are reserved for the Trust Board and which have been delegated
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	No
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	Is there an adverse impact or potential discrimination (yes/no). If yes give details.
Gender identity	No
People of different ages	No
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language	No
People who have a physical or mental disability or care for people with disabilities	No
Women who are pregnant or on maternity leave	No
Sexual orientation (LGBT)	No
Marriage and civil partnership	No
Gender reassignment	
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 EqlA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.

APPENDIX FOUR

Procedures to be applied in response to the “Fit and Proper Persons: Directors” Regulations

1. Each Director should be asked to sign a declaration covering the specific aspects of the FPPR (verbatim), as listed in Appendix Five.

The declaration will form part of the application process for new Executive Directors (the application process for new Non-Executive Directors is operated by the NHS Trust Development Authority), and will be then re-affirmed on appointment (for all Directors), and annually thereafter (again, for all Directors). The latter two stages should be scheduled to be undertaken at the same time as the annual declaration of Board Members’ interests.

If an individual is unable to sign the declaration, the reasons should be discussed with the Chairman of the Trust Board (the Trust Secretary will also be available for an initial discussion). For Executive Directors, the discussion should involve the Chief Executive. This discussion may result in the declaration being amended to reflect the specific circumstances of that individual. For example, they may have been convicted in the UK of a minor offence, which would prevent them from the signing the declaration, but which, in the judgement of the Chairman, would not mean that they were not of “good character”. In this case, the declaration form would be amended to enable the individual to sign it, and a record would be kept (by the Trust Secretary) of the reasons why the declaration form was amended.

2. An “Enhanced with list checks” Disclosure and Barring Service (DBS) check should be undertaken for each Member of the Trust Board (the “Enhanced with list checks” check includes a check of the DBS barred lists, which is one of the FPPR criteria for being “unfit”).

The Trust will apply the “DBS update” process to all Members of the Trust Board (this enables (for an annual fee, which will be paid by the Trust) employers to be notified of any changes to an individual’s DBS status proactively i.e. without the need to undertake a new check.

If the DBS check identifies any convictions that have not been declared (see step 1 above), the Chairman of the Trust Board will discuss the findings of the check with the individual (and the Chief Executive, for an Executive Director), and instigate appropriate action.

3. The Trust Secretary should undertake ‘due diligence’ checks for each Director, to support the declarations in step 1 i.e. to determine whether the individual:
 - is an undischarged bankrupt
 - has had sequestration awarded (which has not been discharged) in respect of their estate
 - is the subject of a bankruptcy restrictions order, or an interim bankruptcy restrictions order, or an order to like effect made in Scotland or Northern Ireland
 - is a person to whom a moratorium period under a debt relief order applies (under Part VIIA (debt relief orders) of the Insolvency Act 1986(b))
 - has made a composition or arrangement with, or granted a trust deed for, creditors (and not been discharged in respect of it)
 - Is not prohibited, by or under any enactment, from holding their office or position, or from carrying on any regulated activities
 - has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals

- has 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

Such 'due diligence' checking should also incorporate any specific qualification requirements for Executive roles (e.g. that the Director of Workforce ~~and Communications~~ be a member of the Chartered Institute of Personnel and Development), and will include (but not be limited to) publicly available registers, such as:

- the Individual Insolvency Register (IIR)
- the Companies House database of disqualified directors (under the Company Directors Disqualification Act 1986)
- the Insolvency Service's register of Directors they got disqualified
- the List of Registered Medical Practitioners
- Nursing and Midwifery Council (NMC) register
- Other professional registers
- Publicly available investigation reports of failings within health and social care provision

Such checks will be undertaken on appointment, and annually thereafter. Ad-hoc checks will also be undertaken if any information is received that warrants such checks being made.

If these checks identify any issues of concern in relation to the FPPR, the Trust Secretary will raise these concerns with the Chairman of the Trust Board, who will in turn discuss the concerns with the individual, and instigate appropriate action.

4. The annual appraisal process for all Trust Board members should incorporate a formal review and confirmation that the individual:
 - continues to have the qualifications, competence, skills and experience which are necessary for the work to be performed by them; and
 - continues to be able by reason of their health (after reasonable adjustments are made) of properly performing tasks which are intrinsic to the work for which they are employed

These aspects should be part of the formal documentation for such appraisals.

Obviously, this step is not intended to prevent any changes in an individual's circumstances being reviewed and responded to at the time such changes occur (i.e. relevant action should not be deferred until an individual's annual appraisal).

5. The contracts of employment for all officer Members of the Trust Board should take into account the fact that an individual cannot continue within the role should they meet any of the criteria for being "unfit".

The above 5 steps will be applied routinely. However, if an allegation is made that a specific Trust Board Member is in breach of the FPPR, the Trust Secretary will oversee an investigation into the circumstances of the allegation, and ensure the findings of the investigation are provided to the Chairman of the Trust Board, for consideration.

APPENDIX FIVE

'Fit and proper person' declaration for Trust Board Members

In accordance with [The Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2014](#), which requires that Directors (or equivalent) of health service bodies be "fit and proper persons", I hereby declare that...

- (a) I have the qualifications, competence, skills and experience which are necessary for the work for which I am employed / relevant office or position for which I am appointed
- (b) I am able by reason of my health (after reasonable adjustments are made) of properly performing tasks which are intrinsic to the work for which I am employed / office or position for which I am appointed
- (c) I have not 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 activity² or providing a service elsewhere which, if provided in England, would be a regulated activity
- (d) I am not "unfit". In this regard...
 - ... I am not an undischarged bankrupt
 - ... I have not had sequestration awarded (which has not been discharged) in respect of my estate
 - ... I am not the subject of a bankruptcy restrictions order, or an interim bankruptcy restrictions order, or an order to like effect made in Scotland or Northern Ireland
 - ... I am not a person to whom a moratorium period under a debt relief order applies (under Part VIIA (debt relief orders) of the Insolvency Act 1986(b)).
 - ... I have not made a composition or arrangement with, or granted a trust deed for, creditors (and not been discharged in respect of it)
 - ... I am not included in the children's barred list or the adults' barred list, maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
 - ... I am not prohibited, by or under any enactment, from holding my office or position, or from carrying on any regulated activities²
- (e) I am of "good character". In this regard...
 - ... I have not been convicted in the UK of any offence, or been convicted elsewhere of any offence which, if committed in any part of the UK, would constitute an offence
 - ... I have not been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

Signed:

Name
Job title

Date:

Please direct any queries towards the Trust Secretary

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

Standing Orders

Written by: Trust Secretary

Review date: ~~November~~February 2017

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Standards of Business conduct for NHS staff (reproduced from HSG (93)5)

N.B. Parts C (“Action checklist for NHS Managers”) and D (“Short guide for staff”) have not been reproduced

Part A: Brief summary of the main provisions of the Prevention of Corruption Acts 1906 and 1916

Acceptance of gifts by way of Inducements or rewards

1. Under the Prevention of Corruption Acts, 1906 and 1916, it is an offence for employees corruptly to accept any gifts or consideration as an inducement or reward for:

- Doing, or refraining from doing, anything in their official capacity; or
- Showing favour or disfavour to any person in their official capacity.

2. Under the Prevention of Corruption Act 1916, any money, gift or consideration received by an employee in public service from a person or organisation holding or seeking to obtain a contract will be deemed by the courts to have been received corruptly unless the employee proves the contrary.

Part B: General policy guidelines

Introduction

1. These guidelines, which are intended by the NHSME to be helpful to all NHS employers (I) and their employees, re-state and reinforce the guiding principles previously set out in Circular HM (62) 21 (now cancelled), relating to the conduct of business in the NHS.

Responsibility of NHS employers

2. NHS employers are responsible for ensuring that these guidelines are brought to the attention of all employees; also that machinery is put in place for ensuring that they are effectively implemented.

Responsibility of NHS staff

3. It is the responsibility of staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties. This primary responsibility applies to *all NHS Staff*, i.e. those who commit NHS resources directly (e.g. by the ordering of goods) or those who do so indirectly (e.g. by the prescribing of medicines). A further example would be staff who may have an interest in a private nursing home and who are involved with the discharge of patients to residential facilities.

Guiding principle in conduct of public business

4. It is a long established principle that public sector bodies, which include the NHS, must be impartial and honest in the conduct of their business, and that their employees should remain beyond suspicion. It is also an offence under the Prevention of Corruption Acts 1906 and 1916 for an employee corruptly to accept any inducement or reward for doing, or refraining from doing anything, in his or her official capacity, or corruptly showing favour, or disfavour, in the handling of contracts (see Part A).

Staff will need to be aware that a breach of the provisions of these Acts renders them liable to prosecution and may also lead to loss of their employment and superannuation rights in the NHS

Principles of conduct in the NHS

5. NHS staff are expected to:

- Ensure that the interest of patients remains paramount at all times;
- be impartial and honest in the conduct of their official business;
- use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.

6. It is also the responsibility of staff to ensure that they do **not**:

- abuse their official position for personal gain or to benefit their family or friends;
- seek to advantage or further private business or other interests, in the course of their official duties.

Implementing the guiding principles

Casual gifts

7. Casual gifts offered by contractors or others, e.g. at Christmas time, may not be in any way connected with the performance of duties so as to constitute an offence under the Prevention of Corruption Acts. Such gifts should nevertheless be politely but firmly declined. Articles of low intrinsic value such as diaries or calendars, or small tokens of gratitude from patients or their relatives, need not necessarily be refused. In cases of doubt staff should either consult their line manager or politely decline acceptance.

Hospitality

8. Modest hospitality provided it is normal and reasonable in the circumstances, e.g. lunches in the course of working visits, may be acceptable, though it should be similar to the scale of hospitality which the NHS as an employer would be likely to offer.

9. Staff should decline all other offers of gifts, hospitality or entertainment. If in doubt they should seek advice from their line manager.

Declaration of interests

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

11. All NHS staff should therefore declare such interests to their employer, either on starting employment or on acquisition of the interest, in order that it may be known to and in no way promoted to the detriment of either the employing authority or the patients whom it serves.

12. One particular area of potential conflict of interest that may directly affect patients is when NHS staff hold a self-beneficial interest in private care homes or hostels. While it is for staff to declare such interests to their employing authority, the employing authority has a responsibility to introduce whatever measures it considers necessary to ensure that its interests and those of patients are adequately safeguarded. This may for example take the form of a contractual obligation on staff to declare any such interests. Advice on professional conduct issued by the General Medical Council recommends that when a doctor refers a patient to a private care home or hostel in which he or she has an interest, the patient must be informed of that interest before referral is made.

Standing Orders

Written by: Trust Secretary

Review date: ~~November~~February 2017

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13. In determining what needs to be declared, employers and employees will wish to be guided by the principles set out in paragraph 5 above.

14. NHS employers should:

- ensure that staff are aware of their responsibility to declare relevant interests (perhaps by including a clause to this effect in staff contracts)
- consider keeping registers of all such interests and making them available for inspection by the public.
- develop a local policy, in consultation with staff and local staff interests, for implementing this guidance. This may include the disciplinary action to be taken if an employee fails to declare a relevant interest, or is found to have abused his or her official position, or knowledge, for the purpose of self-benefit, or that of family or friends.

Preferential treatment in private transactions

15. Individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of their NHS employer. (This does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised staff interests on behalf of all staff – for example, NHS staff benefits schemes.)

Contracts

16. All staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign Purchase Orders, or place contracts for goods, materials or services, are expected to adhere to professional standards of the kind set out in the Ethical Code of the Institute of Purchasing and Supply (IPS), reproduced at Part E.

Favouritism in awarding contracts

17. Fair and open competition between prospective contractors or suppliers for NHS contracts is a requirement of NHS Standing Orders and of EC Directives on Public Purchasing for Works and Supplies. This means that:

- no private, public or voluntary organisation or company which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors, whether or not there is a relationship between them and the NHS employer, such as a long-running series of previous contracts.
- each new contract should be awarded solely on merit, taking into account the requirements of the NHS and the ability of the contractors to fulfil them.

18. NHS employers should ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant managerial capacity. Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff that are known to have a relevant interest play no part in the selection.

Warnings to potential contractors

19. NHS employers will wish to ensure that all invitations to potential contractors to tender for NHS business include a notice warning tenderers of the consequences of engaging in any corrupt practices involving employees of public bodies.

Outside employment

20. NHS employees are advised not to engage in outside employment that may conflict with their NHS work, or be detrimental to it. They are advised to tell their NHS employing authority if they think they may be risking a conflict of interest in this area: the NHS employer will be responsible for judging whether the interests of patients could be harmed, in line with the principles in paragraph 5 above. NHS employers may wish to consider the preparation of local guidelines on this subject.

Private practice

21. Consultants (and associate specialists) employed under the Terms and Conditions of Service of Hospital Medical and Dental Staff are permitted to carry out private practice in NHS hospitals subject to the conditions outlined in the handbook "A Guide to the Management of Private Practice in the NHS". (See also PM (79) 11). Consultants who have signed new contracts with Trusts will be subject to the terms applying to private practice in those contracts.

22. Other grades may undertake private practice or work for outside agencies, providing they do not do so within the time they are contracted to the NHS, and they observe the conditions in paragraph 20 above. All hospital doctors are entitled to fees for other work outside their NHS contractual duties under "Category 2" (paragraph 37 of the TCS of Hospital Medical and Dental staff), e.g. examinations and reports for life insurance purposes. Hospital doctors and dentists in training should not undertake locum work outside their contracts where such work would be in breach of their contracted hours. Career grade medical and dental staff employed by NHS Trusts may agree terms and conditions different from the National Terms and Conditions of Service.

Rewards for Initiative

23. NHS employers should ensure that they are in a position to identify potential intellectual property rights (IPR), as and when they arise, so that they can protect and exploit them properly, and thereby ensure that they receive any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by their employees in the course of their NHS duties. Most IPR are protected by statute; e.g. patents are protected under the Patents Act 1977 and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. To achieve this, NHS employers should build appropriate specifications and provisions into the contractual arrangements that they enter into *before* the work is commissioned, or begins. They should always seek legal advice if in any doubt in specific cases.

24. With regard to patents and inventions, in certain defined circumstances the Patents Act gives *employees a right* to obtain some reward for their efforts, and employers should see that this is effected. Other rewards may be given voluntarily to employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.

25. In the case of collaborative research and evaluative exercises with manufacturers, NHS employers should see that they obtain a fair reward for the input they provide. If such an exercise involves additional work for an NHS employee outside that paid for by the NHS employer under his or her contract of employment, arrangements should be made for some share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties. Care should however be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer.

Commercial Sponsorship for attendance at courses and conferences

Standing Orders

Written by: Trust Secretary

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26. Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses is acceptable, but only where the employee seeks permission in advance and the employer is satisfied that acceptance will not compromise purchasing decisions in any way.

27. On occasions when NHS employers consider it necessary for staff advising on the purchase of equipment to inspect such equipment in operation in other parts of the country (or exceptionally, overseas), employing authorities will themselves want to consider meeting the cost, so as to avoid putting in jeopardy the integrity of subsequent purchasing decisions.

Commercial sponsorship of posts "linked deals"

28. Pharmaceutical companies, for example, may offer to sponsor, wholly or partially, a post for an employing authority. NHS employers should not enter into such arrangements, unless it has been made abundantly clear to the company concerned that the sponsorship will have no effect on purchasing decisions within the authority. Where such sponsorship is accepted, monitoring arrangements should be established to ensure that purchasing decisions are not, in fact, being influenced by the sponsorship agreement.

Under no circumstances should employers agree to "linked deals" whereby sponsorship is linked to the purchase of particular products or to supply from particular sources.

"Commercial in-confidence"

29. Staff should be particularly careful of using, or making public, internal information of a "commercial in-confidence" nature, particularly *if its disclosure would prejudice the principle of a purchasing system based on fair competition. This principle applies whether private competitors or other NHS providers are concerned*, and whether or not disclosure is prompted by the expectation of personal gain (see paragraphs 16 and 18 above and Part E).

30. However, NHS employers should be careful about adopting a too restrictive view on this matter. It should certainly not be a cause of excessive secrecy on matters which are not strictly commercial per se. For example, the term "commercial in confidence" should not be taken to include information about service delivery and activity levels, which should be publically available. Nor should it inhibit the free exchange of data for medical audit purposes, for example, subject to the normal rules governing patient confidentiality and data protection. In all circumstances the overriding consideration must be the best interests of patients.

Part E: Institute of Purchasing and Supply - Ethical Code (Reproduced by kind permission of IPS)

Introduction

1. The code set out below was approved by the Institute's Council on 26 February 1977 and is binding on IPS members.

Precepts

2. Members shall never use their authority or office for personal gain and shall seek to uphold and enhance the standing of the Purchasing and Supply profession and the Institute by:

- a) maintaining an unimpeachable standard of integrity in all their business relationships both inside and outside the organisations in which they are employed;
- b) fostering (the highest possible standards of professional competence amongst those for whom they are responsible;

- c) optimising the use of resources [or which they are responsible to provide the maximum benefit to their employing organisation;
- d) complying both with the letter and the spirit of;
 - i. the law of the country in which they practise;
 - ii. such guidance on professional practice as may be issued by the Institute from time to time;
 - iii. contractual obligations;
- e) ejecting any business practice that might reasonably be deemed improper.

Guidance

3. In applying these precepts, members should follow the guidance set out below:
- a) Declaration of interest. Any personal interest that may impinge or might reasonably be deemed by others to impinge on a member's impartiality in any matter relevant to his or her duties should be declared.
 - b) Confidentiality and accuracy of information. The confidentiality of information received in the course of duty should be respected and should never be used for personal gain; information given in the course of duty should be true and fair and never designed to mislead.
 - c) Competition. While bearing in mind the advantages to the member's employing organisation of maintaining a continuing relationship with a supplier, any relationship which might, in the long term, prevent the effective operation of fair competition, should be avoided.
 - d) Business Gifts. Business gifts other than items of very small intrinsic value such as business diaries or calendars should not be accepted.
 - e) Hospitality. Modest hospitality is an accepted courtesy of a business relationship. However, the recipient should not allow him or herself to reach a position whereby he or she might be deemed by others to have been influenced in making a business decision as a consequence of accepting such hospitality; the frequency and scale of hospitality accepted should not be significantly greater than the recipient's employer would be likely to provide in return.
 - f) when it is not easy to decide between what is and is not acceptable in terms of gifts or hospitality, the offer should be declined or advice sought from the member's superior.

Trust Board meeting – November 2016

11-18	Ratification of Standing Financial Instructions (annual review)	Trust Secretary/Director of Finance
<p>The Trust has committed to reviewing the Standing Financial Instructions (SFIs) each year. The document has therefore been reviewed, and a number of revisions are proposed.</p>		
<p>The revised SFIs were circulated widely by email on 05/10/16, for consultation. The Finance Committee was also formally apprised of the main finance-related proposed changes at its meeting on 19/10/16. The revised document was then reviewed at the Audit and Governance Committee on 03/11/16, where it was “approved”. However, since the Audit and Governance Committee, the need for a number of additional amendments has been identified. These amendments are included in the list below.</p>		
<p>The full SFI document is enclosed, with all proposed changes shown as ‘tracked’. However, the major proposed changes to the SFIs are summarised below (please note that the page numbers in the contents page will be out of synchronisation at this stage with the contents as the track changes and the amendments alter the paging. This will be finalised when the review is completed. Cross referencing below is therefore by paragraph number):</p>		
<ul style="list-style-type: none"> ▪ Formalisation of the Audit and Governance Committee’s role in the appointment of the Trust’s External Auditor [2.1.3] ▪ Updating of the sections relating to Hosting of services to take account of the dissolution of the Health Informatics Service. [2.7] ▪ Amendment of the wording to change from review/approval of “Annual Plans” to “plans for the forthcoming year/s” [4.1.1] ▪ Amended wording to enable greater flexibility in relation to imposing further restrictions in-year for situations such as financial special measures without requiring the SFIs to be amended [4.1.1(c)] ▪ Clarification that the approval of the capital and revenue schemes relates to the business case that involves the expenditure commitment (which may not necessarily be the Full Business Case) [4.3.2(l)] ▪ Updating of the regulatory guidance to recognise the establishment of NHS Improvement (NHSI) as the single regulator including issued guidance e.g. the Single Oversight Framework [sundry] ▪ Amendment of commitment to undertake competitive tenders of the Trust’s commercial banking arrangements (i.e. excluding the Government Banking Service) “periodically”, rather than “at least every five years” given the negligible use of commercial banking accounts [6.4.2] ▪ Clarification that the Director of Finance is responsible for “procedures for the use of agreed debit/credit card machines, and the safe storage of the Trust’s official credit card” [7.4.1(c)] ▪ The removal of “approved contractors”, on the basis of good Procurement practice and the Trust’s existing process [8.6] ▪ Incorporation of the Trust new e-procurement system as part of the tender process. [8.6.1(iv)] ▪ Clarification that the national guidance relating to Consultancy spending applies to the “Personnel and agency or temporary staff contracts” [8.12] ▪ Inclusion of text under the “Disposals” section that “Proposals to sell assets must seek as far as possible to obtain best value and to avoid unplanned losses” [8.14.2] ▪ Formalisation of the “No purchase order, No Pay policy” that was introduced in-year [12.2.3] ▪ Clarification that “Purchases from petty cash” can be used for “other emergency circumstance agreed by the Director of Finance” (in addition to existing defined uses) [12.2.8] ▪ Extension of the annual housekeeping exercise of the asset register to include “...reviewing the appropriateness of asset lives” [15.4.10] ▪ Strengthening of the wording relating to Patients’ Property liability remaining with patients. [19.2] ▪ Restriction of the authorisation of a) orders, tenders and competitive quotations and b) 		

contracts and SLAs, from £50,000 up to £249,999 to the Director of Finance and one of either the Chief Executive or Deputy Chief Executive (rather than just any member of the Executive Team) [Annex B 8.8.1]

- Post-Audit and Governance Committee amendment: Removal of the role of the Trust Management Executive in approving Business Cases (following the amended Business Case process that was agreed by the Executive Team) [4.3.2 (h)]
- Post-Audit and Governance Committee amendment: Increasing the limit for which Business Cases for capital expenditure require the approval of NHSI, from £5m to £15m (following guidance issued by NHSI since the Audit and Governance Committee) [15.1.2] N.B. NHSI reserves the right to reduce the latter limit if a Trust enters the 'Special Measures' regimes, or fails to achieve other agreed performance requirements.

The Trust Board is asked to review and "ratify" the SFIs.

It should however be noted that the establishment of the NHS Improvement as the single regulator is likely to lead to further in-year guidance being issued e.g. updated Capital and Business Case guidance is anticipated. This may require an in-year variation to be made to SFIs as appropriate.

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 17/10/16 (summary of proposed changes only)
- Audit and Governance Committee, 03/11/16

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

Ratification

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

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Standing Financial Instructions (SFIs)

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
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Approved by:	Audit and Governance Committee, <u>34rd</u> November 201 <u>65</u>
Ratified by:	Trust Board, <u>30²⁵</u> th November 201 <u>65</u>
Review date:	November 2016

With Effect from November 20165

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Cross references:	<ul style="list-style-type: none"> Department of Health's Commercial Sponsorship – Ethical standards in the NHS Records Management: NHS Code of Practice Code Of Conduct/ Code of Accountability in the NHS (NHS Appointments' Commission / Department of Health) Bribery Act 2010 Standards of Business Conduct for NHS Staff(HSG (93)5) Data Protection Act 2010 International Financial Reporting Standards Capital Regime and Investment Business Case Approvals Guidance for NHS Trusts (NHS Trust Development Authority) NHS Audit Committee Handbook (2014) Managing Public Money (HM Treasury) The Accountability Framework for NHS Trust Boards (NHS Trust Development Authority) Single Oversight Framework (formerly the Accountability Framework of NHS Trust Boards) Strengthening Financial Performance and Accountability in 2016/17 Model Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions, Department of Health (2006) NHS Trust Development Authority consultancy spending controls guidance NHS Protect Standards for Providers
Associated documents:	<ul style="list-style-type: none"> Maidstone and Tunbridge Wells NHS Trust. <i>Standing Orders</i> [RWF-OPPCS-NC-TM23] Maidstone and Tunbridge Wells NHS Trust. <i>Reservation of Powers and Scheme of Delegation</i> [RWF-OPPCS-NC-TM21] Maidstone and Tunbridge Wells NHS Trust. <i>Procurement Strategy</i> Maidstone and Tunbridge Wells NHS Trust. <i>Anti-Fraud, Bribery and Corruption Policy and Procedure</i> [RWF-OPPPCS-NC-WF48] Maidstone and Tunbridge Wells NHS Trust. <i>Overpayments Policy and Procedure</i> [RWF-OPPPCS-NC-WF74] Maidstone and Tunbridge Wells NHS Trust. <i>Code of Conduct for NHS Board</i> [RWF-OWP-APP536] Maidstone and Tunbridge Wells NHS Trust. <i>Standards of Conduct Policy and Procedure</i> [RWF-OPPPCS-NC-WF32] Maidstone and Tunbridge Wells NHS Trust. <i>Patient Property Policy & Procedure</i> [RWF-OPPPCS-NC-NUR1] Maidstone and Tunbridge Wells NHS Trust. <i>Charitable funds, Policies and procedures for</i> [RWF-OPPPCS-NC-TM47] Maidstone and Tunbridge Wells NHS Trust. Gifts, hospitality, sponsorship and interests policy and procedure [RWF-OPPPCS-NC-TM48] Maidstone and Tunbridge Wells NHS Trust. Expenses Policy and Procedure [RWF-OPPPCS-NC-WF63] Maidstone and Tunbridge Wells NHS Trust. Changes, Payments and Leavers Policy and Procedure RWF-OPPPCS-NC-WF67 Maidstone and Tunbridge Wells NHS Trust. Overpayments Policy and Procedure [RWF-OPPPCS-NC-WF74]

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5.0	Standing Financial Instructions updated (with effect from	Nov 2015

Version control:		
Issue:	Description of changes:	Date:
	November 2015	
6.0	Standing Financial Instructions updated (with effect from November 2016)	Nov 2016

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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 Financial Instructions (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 ([specifically including the National Health Service Act 2006 and Health and Social Care Act 2012](#)) or in the Financial Regulations made under the Acts shall have the same meaning in these 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. For this Trust it shall be the Chief Executive.

"ADO / ADNS" means [Associate Director of Operations \(ADO\) or Associate Director for Nursing Services \(ADNS\)](#). [These roles work at Divisional level.](#)

"Associate Non-Executive Director" means a person appointed to advise the Trust Board, in a similar role to that of a Non-Executive Director, but for which the role carries no formal position on the Trust Board. Therefore, although an Associate Non-Executive Director can attend Board meetings and contribute fully to the issues being considered, they are not able to vote on any matters, should this be required.

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

"Chief Executive" 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. The members of a committee should be those required to be present at meetings of that committee

"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.

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

"Establishment Order" means The Maidstone and Tunbridge Wells National Health Service Trust (Establishment) Order 2000.

"Executive Director" means a member of the Trust Board who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) of The National Health Service Trusts (Membership and Procedure) Regulations 1990 (i.e. the Chairman of the Trust or any person nominated by such a Committee for appointment as a Trust Board member). Executive Directors are expected to be present at, and participate in, meetings of the Trust Board.

"Executive Team" means the group of employees who collectively have managerial control over the major activities of the Trust, and who influence the operations of the Trust as a whole rather than the decisions of individual directorates or departments. For this Trust, this will be the Chief Executive, the Deputy Chief Executive, the Chief Nurse, the Chief Operating Officer, the Director of Finance, the Director of Workforce ~~and Communications~~ and the Medical Director.

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

"NHSI" means NHS Improvement which is the regulatory body for NHS Trusts and Foundation Trusts, comprising the former TDA and Monitor.

"Nominated officer" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and/or 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, but Non-Executive Director posts are public appointments and not jobs and are therefore not subject to the provisions of employment law.

“Non-voting Board Member” means a Trust Board Member who is not entitled to exercise voting rights at the Trust Board.

“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.

“Scheme of Delegation” means the Reservation of Powers and Scheme of Delegation, which states which decisions will be reserved to the Trust Board only, and which decisions will be delegated (and to whom).

“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. However, please note that for the purposes of reporting “Senior Managers” remuneration (In accordance with Section 234b and Schedule 7a of the Companies Act, as required by NHS Bodies), a “Senior Manager” is considered to be defined as “Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments”. For this Trust, and for this purpose, the definition of “Senior Manager” only applies to Trust Board Members.

“SD” means Scheme of Delegation

“Senior Independent Director (SID)” means one of the independent Non-Executive Directors appointed by the Board, to be available to listen to concerns which contact through the normal channels of the Chairman, Chief Executive or Director of Finance has failed to resolve or for which such contact is inappropriate.

“SFIs” means Standing Financial Instructions.

“SLA” means Service Level Agreements

“SOs” means Standing Orders.

“Standing Orders Set” means the Standing Orders, Standing Financial Instructions and Reservation of Powers and Scheme of Delegation. Unlike NHS Foundation Trusts, NHS Trusts do not have a “Constitution”, but the “Standing Orders Set” can be considered as the closest equivalent to such a Constitution.

“STP” means the “Sustainability and Transformation Plan” which sets out an integrated five year plan for how all health and care services will develop for a given local population, or “footprint” e.g. Kent and Medway.

"TDA" means the former NHS Trust Development Authority, which monitors and regulates the performance of NHS Trusts. This is now part of NHS Improvement (NHSI) which combines the TDA and Monitor bodies. ~~and supports their journey towards Foundation Trust status~~

"TME" means the Trust Management Executive which is the senior management committee of the Trust.

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

"Trust Board" means the Chairman, Executive Directors and Non-Executive Directors collectively as a body.

"Trust Board Member" (or "Board Member") means an individual regarded as being a member of the Trust Board. The influence (or potential influence) exerted by the individual is the key determinant, rather than their ability to vote at Board meetings. Trust Board members are those that are expected to be at each Board meeting (and sit at the Board table), and contribute fully to each agenda item. For this Trust, Trust Board Members comprise the Chairman of the Trust Board, Non-Executive Directors, the Executive Team, and the Director of Infection Prevention and Control. Please note however that the provisions in these Standing Orders relating to voting (SO 3.12) only apply to "Voting Board Members" (see below).

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

"Voting Board Member" means a Trust Board Member who is entitled to exercise voting rights at the Trust Board.

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 Trust 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 Trust 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 The Audit and Governance Committee will act as the Trust's Auditor Panel for External Audit appointments (refer to the Terms of Reference of the Audit and Governance Committee for further details).

2.1.43 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 of the Trust Board 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 Auditors were previously appointed by the Audit Commission. With its abolition from 1st April 2015, arrangements have been put into place to transfer its functions. The management of the existing audit contracts have transferred to Public Sector Audit Appointments Ltd as a transitional body prior to the establishment of Local Auditor Panels who will in future advise on auditor appointments. ~~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 PSAA Ltd if the issue cannot be resolved~~

2.4.2 Health bodies will move to the new audit framework in 2017/18 under the Local Audit and Accountability Act 2014. NHS Trusts will select and appoint their own auditors and directly manage their contracts for the audits for the financial year starting 1st April 2017, with the legislation requiring that the auditors are appointed by 31st December 2016. The Audit and Governance Committee has been established as the Auditor Panel for the recommendation of the appointment to the Trust Board.~~must ensure a cost-efficient service.~~

~~2.4.3~~ 2.4.32 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 (LCFS) 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 Kent & Medway Health Informatics Service (KMHS)

2.7.1 ~~Following the change in status of the HIS so that it is no longer a separate hosted service, the HIS Management Board is a normal part of the Trust's corporate management structure and is therefore subject to all the standard requirements of the Trust. The KMHS service formerly hosted by the Trust was dissolved on the 31st March 2016.~~

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 for the coming year or years. The APlan 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.

(c) whatever content is required by NHS Improvement as regulated by its planning guidance

(d) details of how the Plan links to the local Sustainability and Transformation Plan (STP) and any critical dependencies

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 Trust Board. Such budgets will:

- (a) be in accordance with the aims and objectives set out in the APPlan
- (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 Finance Committee and Trust 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.

4.1.7 The Director of Finance will publish annually a budget holder guidance manual to ensure all budget holders understand their responsibilities and to provide practical guidance.

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 Finance Committee and Trust Board in a form approved by the Finance Committee and 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 12.2.5 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) All developments, services changes, investments (revenue, capital or funded through charitable funds), or other proposals that increase the Trust's costs or incomes must be tested and approved through the Trust's business case process. This includes adherence to the relevant delegated limits which are currently:
 - a. Cases up to £250,000 require approval by one of the Director of Finance or Deputy Chief Executive
 - ~~a.b.~~ Cases up to £500,000 require approval by the Chief Executive TME
 - ~~b.c.~~ Cases of £500,000 or over require approval by the Trust Finance Committee
 - ~~e.d.~~ Cases of £1,000,000 or over require Trust Board Approval
 - ~~d.e.~~ Cases of £15,000,000 or over require Trust Development Authority NHSI approval for capital investments, or equivalent managed service or leased equipment, IT or Property arrangements (where the whole life cost is the determinant).
- (i) 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.
- (j) 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
- (k) Adhere to Trust procurement policies in respect to non-pay purchases including those outlined in Section 8 of this document.
- (l) The limits described above relate to the approval of the stage of the Business Case in which the commitment to undertake expenditure is made. In some circumstances, this may be at the Outline Business Case (OBC) stage, rather than the Full Business Case (FBC) stage.

~~(k)~~(m) _____

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 HM~~ 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 for 2016/17 must be audited by an auditor appointed by the Audit Commission or successor body (see 2.4.1). For 2017/18 onwards the Trust will be appointing its Auditor through an approved process. The Auditor must be recognised as licenced by a Regulatory Supervised Body. 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 Group Accounting Manual

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~~ Improvement (TDANHSI) published cash management guidance, Trusts should minimize the use of commercial bank accounts and utilise Government Banking Service accounts for the majority of banking services.
- 6.1.2 The Trust 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:
- bank accounts and Government Banking Service (GBS) accounts;
 - establishing separate bank accounts for the Trust's non-exchequer funds;
 - ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;
 - reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.
 - monitoring compliance with ~~TDA~~ NHSI cash management guidance on the level of cleared funds in commercial accounts.

6.3 Banking arrangements

- 6.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts, which must include:
- the conditions under which each bank and GBS account is to be operated;
 - 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~~ periodically. The results of the tendering exercise should be reported to the Finance Committee and Trust 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 [MonitorNHSI](#)'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 [MonitorNHSI](#)/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 Appendix 6 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; [procedures for the use of agreed debit/credit card machines, and the safe storage of the Trust's official credit card.](#)

(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 Cash receipts over £1,000 must receive authority from the [Finance Department](#) prior to their acceptance in order to reduce risk of accepting fraudulent currency or potentially supporting money laundering.

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](#) or other authorised 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

8.3 Reverse e-auctions 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 [NHS Trust Development Authority](#) 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 with [the Trust Development Authority](#) [NHS](#) guidance on Consultancy spending controls to NHS Trusts (see Annex C)

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);
- ~~f~~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) , London Procurement Partnership (LPP), 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. Any such arrangements must comply with [TDA-NHSI](#) and Trust guidance if the payment arrangement is 'off payroll'.
- (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 suggests 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, **B**udget 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 recorded in an appropriate Trust record and reported to the next available Audit and Governance Committee.

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. All procurement instigated Tenders will be issued via the electronic tendering system administered by the London Procurement Partnership (LPP) ‘Due North’ or Crown Commercial Solutions (CCS). All bid submissions will be submitted via these systems with no manual tenders accepted.

(iv) It is important to note that from October 2018 it is mandatory for all procurement communication to be conducted electronically and therefore written tenders will not be permitted.

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

~~(iv)~~(vi) 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 – P21+, Scape, 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

All procurement generated tenders are received via the electronic portal and cannot be accessed until the deadline for receipt has passed. For manual 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, the electronic portal will be accessed by

nominated officers within the procurement team who will download all tenders received within the deadline. For manual 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 Associate Director of Procurement or their nominated deputy

- (ii) The electronic tendering portal closes at the deadline and will not accept any attempt to file a tender after this deadline. For manual tenders 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.
- (v) 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.
- (vi) Every tender received via the electronic tendering portal shall be automatically marked with the date of opening and who has accessed the tender. For manual tenders these will be initialled by those present at the opening.
- (vii) The system will hold a full record of all tender activity for electronic tenders. For manual tenders, 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 suppliers invited or expressed an interest;
 - the names of suppliers from which tenders have been received and those that have opted out;
 - the date the tenders were received;
 - the date the tenders were opened and for manual tenders, the persons present at the opening;
 - for manual tenders, the price shown on each tender;
 - for manual tenders, a note where price alterations have been made on the tender.
 - for manual tenders, each entry to this register shall be signed by those present.
 - for manual tenders, 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 will not be permitted by the electronic system., but for manual tenders, 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) The electronic tendering system will not allow late submission of any tender under any circumstances. Written 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 written 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 of the Trust Board. In all cases the Reservation of Powers and Scheme of Delegation should be consulted in relation to the value of waiving of quotation or single tender action required to be approved by the Trust Board.

8.6.8 ~~List of approved firms (see SFI No. 8.5.3 Building and Engineering construction works)-Use of Approved Contractor lists~~

Under Procurement legislation there is no reference to Approved Contractor lists. Tenders and quotes should be advertised in accordance with Procurement legislation to anyone in the UK or the European Union. Where recognised frameworks are used these will restrict competition or selection of contractors to those contractors duly accepted onto the frameworks.

Trust procurement processes via tendering or use of recognised frameworks will ensure through appropriate Pre-qualification questionnaires (PQQs) and evaluation processes that competing suppliers fulfil technical, clinical, employment, and any other applicable statutory or regulatory requirements for the provision of the relevant goods or services. In addition the Trust will ensure that appropriate evaluation of financial standing and competence is undertaken prior to the award of any contract.

~~(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. For tenders managed via the electronic tendering process the approved supplier framework forms part of the tendering portal.~~

~~(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. For tenders managed via the electronic tendering process the approved supplier framework forms part of the tendering portal.~~
- ~~(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 Act 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 to be completed and authorised in line with the Scheme of Delegation. These should be reported to the next Audit and Governance Committee.

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

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~~-NHSI and Department of Health guidance. When the Trust 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 Trust 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; and with the [Trust Development Authority NHSI](#) guidance on Consultancy spending controls to NHS Trusts (see Annex C)
- (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. Procurements in this category must adhere to the Trust and [Trust Development Authority NHSI \(TDA\)](#) guidance on Consultancy spending controls and Agency spending and price capping controls and Trust off payroll guidance where applicable. Any Consultancy contracts which exceed the maximum of £50,000 p.a or exceed the day rate caps implemented by NHSI must seek approval from NHSI for such contracts to be awarded.

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 ([as amended](#)) 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 [accordance](#) 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~~-NHSI 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~~Head of Financial Services. In the event that a loss on disposal is expected, this must be approved by the Director of Finance prior to disposal. Proposals to sell assets must seek as far as possible to obtain best value and to avoid unplanned losses.

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 to Funds 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. [This includes arrangements with Commissioning bodies \(e.g. CCGs\), provider Trusts, other public sector bodies \(e.g. Local Authorities\) and other private bodies.](#)

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~~ [NHSI Single Oversight](#) Framework;
- Information Governance requirements;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways.

9.1.2 The ~~Finance~~ Director [of Finance](#) will ensure that all SLAs will be reviewed annually to ensure that they remain fit for purpose taking into consideration any notice periods for changes.

9.1.3 All SLAs must be signed by all parties.

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 ensure that regular reports are provided to the Board detailing actual and forecast income from commissioner— SLAs through the finance reporting. 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 and acted upon by the Director of Finance. 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 Trust 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 no hosted service to which 9.5.1 and 9.5.2 apply.
- 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 Trust 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 and Appointments Committee”.
- 11.1.2 The Committee’s duties, membership and authority will be described in Terms of Reference, which will be reviewed annually, and approved by the Trust Board (also annually). This will include the requirement to review the appointment of Executive Directors and other staff appointed on Very Senior Manager (VSM) contracts, to ensure such appointments have been undertaken in accordance with Trust Policies
- 11.1.3 The Committee shall record in writing the basis for its decisions. The Trust Board shall however remain accountable for the Committee’s decisions on the remuneration and terms of service covered under its Terms of Reference
- 11.1.4 The Trust 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 and Appointments 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:
- within their approved budget and funded establishment,
 - authorised to do so by the Chief Executive via the Sscheme of Ddelegation and in accordance with the agreed approval process (e.g. Recruitment panel authorisations); ~~and~~
 - booked/managed through the Trust’s recruitment or staff bank departments;
 - compliant with DH, TDA-NHSI or other relevant regulatory guidance.
- 11.3.2 The Remuneration and Appointments 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 ~~All 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 Trust 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 and Appointments 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 and Appointments Committee and will require additional approval from the ~~Trust Development Authority~~ NHSI's Remuneration and Appointments Committee, ~~in accordance with the TDA 2015-16 Accountability Framework.~~

11.6.3 All contractual severance payments to the Chief Executive or Executive Directors shall be approved by the Trust's Remuneration and Appointments Committee and the NHSI's ~~Trust Development Authority's~~ Remuneration Committee.

11.6.4 All non-contractual severance payments will require HM Treasury approval in addition to that of Trust and ~~TDA~~ NHSI Remuneration Committees.

11.6.5 In the event that severance payments are considered to include "novel or unusual" elements. These will normally require HM Treasury approval, in addition to the Trust and ~~TDA~~ NHSI Remuneration Committees.

11.7 Agency procurement

11.7.1 The use of agency staffing should be kept to the minimum required to maintain agreed operational capacity. Any agency requests must be made in accordance with Trust procedures and using recognised framework agencies via the staff bank.

11.7.2 Agency procurement must comply with nationally published regulations eg. Guidance from ~~the Trust Development Authority~~ NHSI on agency caps and frameworks.

12. NON-PAY EXPENDITURE

12.1 Delegation of authority

12.1.1 The Trust 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.

(c) additional non-pay spending controls applied in specific circumstances e.g. if the Trust enters financial special measures (see NHSI guidance "Strengthening financial performance and accountability in 2016/17").

(d) additional financial restrictions including discretionary spend areas and non-stock items purchased.

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 The Trust has in place a No purchase order, No Pay policy which has been communicated to all Trust suppliers. Any invoices received where no purchase order has been raised will be returned to managers who will be required to justify the reason for the expenditure and why a purchase order was not raised.

~~12.2.2~~ 12.2.4 A list of any authorised exceptions to the requirement to raise a purchase order is held within the procurement department

~~12.2.3~~ 12.2.5 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 and delegated officers (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. 12.2.6 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 to less than £25.00 per claim unless advance authority is given by the [Financial Services Team Head of Financial Services](#). There are also restrictions in respect of the type of purchase and Petty cash may be used for specified or emergency use only subject to the following:-

~~a. — minor emergency purchases approved in advance by procurement~~

~~b.a.~~ Emergency spending as part of the Emergency planning and business continuity standards authorised by the Emergency Planning team or other emergency circumstance agreed by the Director of Finance

~~e.b.~~ reimbursement of Patient travel

~~d.c.~~ reimbursement of small balances of patient monies (see patient property policy)

~~e.d.~~ no reimbursement of expenses for staff (including uniforms) or volunteers may be made from petty cash under any circumstances

~~f.e.~~ no reimbursement for any electronic or electrical items may be made from petty cash as these items could form a health and safety risk if procured outside official channels

Instances where expenditure has been split to fall below petty cash thresholds will be reported to the Director of Finance.

~~F~~ failure to adhere to the requirements of section 12.2.8 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 [Trust—Development AuthorityNHSI](#) guidance on Consultancy spending controls to NHS Trusts.
- (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. 7.4 and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff" (SO Appendix 6) 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) Where orders are amended, authorisation at the appropriate level must be sought in advance of the amended order being issued
- (j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;
- (k) changes to the list of employees and officers authorised to certify invoices are held in an appropriate record.

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, FINANCING AND INTERIM SUPPORT

13.1 Borrowing and interim support

- 13.1.1 The Director of Finance will advise the Trust 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 or interim support, whether Capital Support Loan, Revolving Working Capital Support Facility, or Interim Revenue Support Loan, within the borrowing limits set by the [Trust Development Authority \(TDA\)NHSI](#) and the Department of Health (DH). The Director of Finance is also responsible for reporting periodically to the Finance Committee and Trust Board concerning the PDC debt and all loans, support 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 / or the Director of Finance.
- 13.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for interim support 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-NHSI](#) and Department of Health.
- 13.1.5 Any short-term borrowing drawdown must be with the authority of two members of an authorised panel, one of which must be the Director of Finance or authorised deputy. The Revolving Working Capital Facility must be set up in accordance with the requirements of the [TDA-NHSI and the DH](#). The Finance Committee and Trust Board must be made aware of all short term borrowings at their next - available meetings.
- 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 AuthorityNHS Improvement](#) and [the](#) 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 Trust Board on investments and shall report periodically to the Finance Committee and Trust 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; and
- (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 HM Treasury Green book, International Financial Reporting Standards, ~~TDA~~ NHSI 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 Trust Management Executive, Finance Committee and/or Trust Board has approved the business case in accordance with delegated limits after suitable review and challenge;
- (c) that any other external requirements have been fulfilled e.g. NHS Improvement ~~TDA~~ authorisation limits including temporary changes to delegated limits;
- (d) for projects over £500k the relevant Business Case requires Finance Committee approval; Trust Board approval is required for projects of £1million and over; for projects over £15m ~~Trust Development Authority~~ NHSI approval is required (N.B. NHSI reserves the right to reduce the latter limit if a Trust enters the 'Special Measures' regimes, or fails to achieve other agreed performance requirements).

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 capital 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 ~~S~~cheme of ~~D~~elegation for capital investment management in accordance with "Estatecode" guidance, ~~TDA~~ [NHSI](#) 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:
- specific authority to commit expenditure;
 - authority to proceed to tender (see overlap with SFI No. 8.5);
 - 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 ~~Following the [dissolution of the HIS in March 2016](#) this section is no longer used. ~~change in arrangements regarding the status of the HIS as a "hosted" service within MTW, it will now be subject to the same process of capital bidding, review, prioritisation and approval processes as any other Directorate within the Trust. 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 as part its business planning submission within the Trust overall process.~~~~
- 15.2.2 ~~Before work can commence on any HIS project the Director will ensure that:~~
- ~~Capital and revenue funding has been fully agreed by the Trust and SLA partners as appropriate;~~
 - ~~Where assets are to be procured and owned, a business case must be submitted in accordance with the Trust policies for approval in the agreed format. Approval will be in accordance to the Trust and TDA delegated limits (see 15.1.2(d))~~

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:
- 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.
 - 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 Trust 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-NHSI](#).
- 15.4.8 The value of each asset shall be depreciated using appropriate methods and rates with reference to Department of Health and [TDA-NHSI](#) 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-NHSI](#).
- 15.4.10 An annual housekeeping exercise of the asset register should be undertaken in respect of fully depreciated assets and in reviewing the appropriateness of asset lives.

15.5 Security of assets

- 15.5.1 The overall control of Trust assets is the responsibility of the Chief Executive
- 15.5.2 Each department and ward is responsible for establishing and maintaining registers of its high risk and business critical assets under £5,000 in value, and periodically reviewing and updating the records. Evidence of these

registers and the processes of maintaining them will be required to comply with the requirements of the Standards for Providers (Security Management).

- 15.5.3 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.
 - (h) all disposals or losses of assets must be recorded and reported in line with the requirements set out in SFI section 17.
- 15.5.4 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.
- 15.5.5 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.
- 15.5.6 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) subject to annual stock take processes; and
- (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; and
- (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 Director of Finance or Deputy Directors of Finance of all the details relating to the loss. 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 Specialist 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 (in the reasonable judgment of the Director of Finance), the Director of Finance must immediately notify:

- (a) the Trust Board (at its next available meeting), and
- (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 Compensation payments to Chief Executives or Directors reporting to the Chief Executive require approval of the Trust's Remuneration and Appointments' Committee and ~~the Trust Development Authority~~ [NHS Improvement](#)'s Remuneration Committee. In the event the payment includes novel or unusual elements it may require [HM](#) 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 Trusts in the [TDA Southlocal](#) area 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 a 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; and
- (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 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. They will be informed 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~~ Patients or their guardians will be asked to sign appropriate disclaimers and indemnities in accordance with the Trust's Patients' Property Policy.

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.
- (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.
- (4) All Fund Holders are required to comply with the Charitable Fund Policy and Procedure.

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 Gifts, hospitality, sponsorship and interests policy and procedure and SO No. 7, SO Appendix 6

21.1 Detailed guidance on the acceptance of gifts by staff is contained in the Trust Gifts, hospitality, sponsorship and interest's policy and procedure (~~see Annex D~~)

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 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.23.4 - Detail shall be maintained of records destroyed.

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 Policy and framework, in accordance with current Department of Health assurance framework requirements, ~~which must be approved and monitored by the Trust Board.~~

The ~~programme of risk management~~ Policy and framework 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~~ Policy and framework.

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 Trust Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority ([NHSLA](#)) or self-insure for some or all of the risks covered by the risk pooling schemes. If the Trust 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 Trust 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 Trust 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.

Procedures supporting the Standing Financial Instructions

**CE= Chief Executive; DoF= Director of Finance; DoWG=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.	DoWG
11.4.2 (h)	Procedures for payment by cheque, bank credit or cash	DoWG/DoF
11.4.2 (i)	Procedure for the recall of cheques and bank credits	DoWG/DoF
11.4.5	Payroll: audit review procedures	DoWG/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)	Instructions restrictions of purchases from petty cash in terms of value and by type of purchase.	DoF
12.3.1	Payments to local authorities and 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	DoF

Paras.	Procedure	Lead
	records for receipt of goods, issues, and returns to stores, and losses.	
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	£
4.3.2(h)	For revenue developments over £500k the relevant Business Case requires Finance Committee approval. Trust Board approval is required for cases of £1million and over. For revenue developments or investments over £1.5m whole life costs involving managed service or lease arrangements (for equipment, IT, property), the relevant Business Case requires the approval of the Trust Development Authority <u>NHSI (N.B. NHSI reserves the right to reduce the latter limit if a Trust enters the 'Special Measures' regimes, or fails to achieve other agreed performance requirements)</u>	<u>Up to £250,000 one of Director of Finance or Deputy Chief Executive</u> Up to £ 500,000 <u>Chief Executive TME</u> £500,000 and over FC £1,000,000 and over Trust Board £15,000,000 and over <u>TDA-NHSI</u>
8.9	Local procurement procedures will operate 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 exc VAT
8.7.1	Three 3 Written quotations are required where intended expenditure/income is reasonably expected to be between	10,001 and 49,999 exc VAT
8.5.3 (a)	Formal tendering is required if income or expenditure is reasonably expected to exceed	49,999 exc VAT
8.8.1	Authorisation of Tenders or Competitive quotations Head Associate Director of Procurement and one of Deputy Director of Finance Above plus one Executive Director <u>of Director of Finance, Deputy CEO, or CEO</u> Above plus Chief Executive or Trust Board	(exc VAT) 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 <u>(TDA)NHSI</u> 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 NHSI 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-NHSI <u>Remuneration and Appointments'</u> Committees as above and will require <u>HM</u> 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%
12.2.8	Purchases from petty cash are restricted in per claim unless advance authority is given by the Financial Services Team	25.00
15.1.2d	For projects over £500k the relevant Business Case requires Finance Committee approval; if £1million or over Trust Board	£500,000 and over FC £1,000,000 and over

Section B Para.	Limit	£
	approval is required.	Trust Board
15.1.2 (d)	For projects over £15m the relevant Business Case requires the approval of the Trust Development Authority NHSI. (N.B. NHSI reserves the right to reduce the latter limit if a Trust enters the 'Special Measures' regimes, or fails to achieve other agreed performance requirements)	<u>£15,000,000</u>
19.6.1	Value above which probate or Letters of Administration required if patient property held exceeds	5,000
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

TDA (now NHSI) consultancy spending controls: Executive Summary (July 2015)

Spending by NHS providers on management consultants was £420 million in 2014/15 and given the current level of provider deficits the NHS cannot continue to spend on this scale without getting maximum value for money. The TDA are therefore putting in place support and controls at a national level to ensure that only good value for money consultancy is commissioned and, where, possible generic technical advice is widely shared within the NHS.

Effective 2nd June 2015, NHS Trusts are required to secure advance approval from the NHS TDA before:

- Signing new revenue contracts for consultancy projects over £50,000 including irrecoverable VAT and expenses; this includes contracts where contractual negotiations were in place prior to 2nd June. These controls do not currently apply to capital contracts, interim management and day rate contractors.
- Extending or varying existing revenue contracts or incurring additional expenditure to which they are not already committed (where the total contract value exceeds £50,000 including irrecoverable VAT and expenses).

Important notes:

- Consultancy is as defined in the NHS Manual for Accounts (see overleaf)
- Interim management and day rate contractors are currently outside these controls but in accordance with Agency controls contractors must be procured from a 'framework' agency.
- Under HMRC current guidance, VAT is recoverable on the professional services of managers, advisers, experts, specialists and consultants for advice or information on how to affect something but not on the implementation of the new process / initiative. Contracts that include research / information gathering / provision of advice or recommendations AND support in implementing those regulations are not VAT recoverable. It is important that contracts and project specifications only claim implementing if they are really going to affect something. If they are in an advisory or supportive capacity but not implementing this changes the VAT treatment under current guidance.
- During 2015/16, the NHS TDA will collect detailed financial data on consultancy contract procurement as part of the regular collection process.
- NHS Trusts are expected to comply with this controls process. A failure to do so may indicate to the NHS TDA that a trust does not have adequate expenditure controls in place which may result in the TDA requesting that the NHS Trust obtains prior approval before committing to other discretionary expenditure items.
- Evidence suggesting organisations are seeking to avoid these controls through splitting contracts, manipulating contract scope or substituting contracts with high cost interims or secondees from consultancies will be subject to follow up by the TDA.

Approval process – for revenue contracts over £50,000 (including irrecoverable VAT and expenses)

NHS Trusts must complete the TDA business case approval form, available from Procurement, which will allow the NHS TDA Consultancy Control panel to assess each case.

The key areas of focus for the template are:-

- Ambition to deliver something of value, importance and relevance that supports the trust's strategic and operational objectives
- Clear scope developed with engagement with patients, clinicians, commissioners and suppliers
- Robust contract management – that the Trust can manage supplier, control spend and ensure VFM
- Capacity for the Trust to implement findings / recommendations
- Timeline of work – with details on when expected outcomes will be delivered
- Robust implementation review proposal – focus on benefits and value added
- Value on price – options appraisal, evidence of sourcing best value supplier
- Wider use of findings – expectation that the results will be made available for wider benefit of NHS, particularly if technical advice which is likely to be generic; right of access to be written into contracts.

On completion of approved consultancy projects, NHS Trusts will be required to submit to the NHS TDA a report detailing benefits of the work and value added.

Extract from draft NHS Manual for Accounts 2015-16: Consultancy (chapter 4 annex 5)

The provision to management of objective advice and assistance relating to strategy, structure, management or operations of an organisation, in pursuit of its purposes and objectives. Such assistance will be provided outside the “business as usual” (BAU) environment when in-house skills are not available and will be of no essential consequence and time-limited. Services may include the identification of options with recommendations and/or assistance with (but not delivery of) the implementation of solutions.

The consultancy category will include areas such as:

- **Strategy:** The provision of objective advice and assistance relating to corporate strategies, appraising business structures, value for money reviews, business performance measurement, management services, product design and process and production management
- **Finance:** The provision of objective advice and assistance relating to corporate financing structures, accountancy, control mechanisms and systems. This does not include “auditor’s remuneration”, this is reported separately. It will include:
 - Strategic Finance: Providing specialist services and support in the form of financial, legal, insurance advice to develop a Public Private partnership/Private Finance Initiative deal for procurement requirement.
 - Operational Finance: Procurement advice on risk management and internal control systems including audit arrangements. Advice on the commercial viability of grant recipients, suppliers and partners; solvency checks

- **Organisation and change management:** Provision to management of objective advice and assistance relating to the strategy, structure management and operations of an organisation in pursuit of its purposes and objectives. Long range planning, re-organisation of structure, rationalisation of services, general business appraisal of organisation
- **IT/IS:** The provision of objective advice and assistance relating to IT/IS systems and concepts, including strategic studies and development of specific projects. Defining information needs, computer feasibility studies and making computer hardware evaluations. Including consultancy related to e-business
- **Property and construction:** The provision of specialist advice relating to the design, planning and construction, tenure, holding and disposal strategies. This can also include the advice and services provided by surveyors and architects
- **Procurement:** the provision of objective advice and assistance when establishing procurement strategies
- **Legal services:** The provision of external specialist legal advice and opinion in connection with the policy formulation and strategy development particularly on commercial and contractual matters
- **Marketing and communication:** The provision of objective advice, assistance and support in the development of publicising and the promotion of the entity's Business Support programmes, including advice on design, programme branding, media handling and advertising
- **Human resource, training and education:** The provision of objective advice and assistance in the formulation of recruitment, retention, manpower planning and HR strategies and advice and assistance relating to the development of training and education strategies
- **Programme and project management:** The provision of advice relating to ongoing programmes and one-off projects. Support in assessing, managing and or mitigating the potential risks involved in a specific initiative; work to ensure expected benefits of a project are realised
- **Technical:** The provision of applied technical knowledge. This can be sub-divided into:
 - Technical studies: Research based activity including studies, prototyping and technical demonstrators.
 - Project support: Project based activities including technical consultancy, concept, development and in-service support activities.
 - Engineering support: Task based support including Post Design Services, repair, calibration, analysis testing and integration.

Annex D

Gifts, Hospitality, Sponsorship and Interests Policy and Procedure

~~Policy subject to agreement~~

APPENDIX ONE

Process requirements

1.0 Implementation and awareness

- Once ratified the document lead or author will submit this policy/procedural document to the Clinical Governance Assistant who will activate it on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.
- A monthly publications table is produced by the Clinical Governance Assistant which is published on the Trust intranet under "Policies"; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.

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: kate.lawrence3@nhs.net

By date: Friday 21st October 2016

Name:	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Clinical Governance Assistant	5.10.16	15.10.16	N	N
Chief Pharmacist (if pharmacy/prescribing issues are included in the document)	5.10.16			
Staff-Side Chair (if Workforce / HR issues are included in the document)	5.10.16			
Emergency Planning team (a vast majority of Policies have some form of Emergency Planning aspect, even if this is only minor)	5.10.16	6.10.16	N	N
Head of Staff Engagement and Equality (Equality & Diversity agenda must be considered within all policies)	5.10.16			
Health Records Manager (if the document contains any mention of patient record keeping and documentation)	5.10.16			
All individuals listed on the front page of this document	5.10.16			
Local Counter Fraud Specialist	5.10.16			
Chief Internal Auditor	5.10.16	21.10.16	Y	Y
Director of Finance	5.10.16			
Deputy Director of Finance (Performance)	5.10.16	7.10.16	N	N
Deputy Director of Finance (Governance)	5.10.16	7.10.16	Y	Y
Executive Directors	5.10.16			
Non-Executive Directors	5.10.16			
Risk Manager	5.10.16	Vacant post		
Head of Information Governance	5.10.16			
Human Resources Business Partners	5.10.16	27.10.16	N	N
Head of Employee Services	5.10.16	27.10.16	Y	Y
Head of Employee Relations	5.10.16	27.10.16	Y	Y
Head of Finance Systems	5.10.16	27.10.16	Y	Y
Head of SLA & Income	5.10.16			
Head of Financial Management	5.10.16	27.10.16	Y	Y

Name:	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Associate Director of Procurement	5.10.16	5.10.16	Y	Y
Financial Services Manager	5.10.16	7.10.16	Y	Y
Contracts Manager	5.10.16	27.10.16	N	N
Deputy and Associate Directors	5.10.16			
Head of R&D	5.10.16			
Associate Director, Quality Governance	5.10.16			
EME Services Manager	5.10.16			
Capital Planning Manager	5.10.16	5.10.16	Y	Y
Local Security Management Specialist	5.10.16			
Staff Side representative	5.10.16			
Trust Secretary	5.10.16	5.10.16	Y	Y
General Managers / Heads of Department	5.10.16			
Director of Estates and Facilities	5.10.16			
Director of Health Informatics	5.10.16			
Assistant Director of Business Intelligence	5.10.16	27.10.16	N	N

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.
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	No
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	Is there an adverse impact or potential discrimination (yes/no). If yes give details.
Gender identity	No
People of different ages	No
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language	No
People who have a physical or mental disability or care for people with disabilities	No
Women who are pregnant or on maternity leave	No
Sexual orientation (LGBT)	No
Marriage and civil partnership	No
Gender reassignment	
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?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.

Trust Board meeting – November 2016

11-18	Ratification of Reservation of Powers and Scheme of Delegation (annual review)	Trust Secretary/Director of Finance
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The Trust's Reservation of Powers and Scheme of Delegation are due their routine annual review. Following that review, a number of changes are proposed.

The proposed changes primarily reflect those that have already been proposed as part of the revised Standing Orders and Standing Financial Instructions, which are featured as separate agenda items/reports at the Trust Board. Any de facto changes in practice that are not reflected in the document have also been included.

The document was issued for wide consultation on 05/10/16. The Finance Committee was also formally apprised of the main finance-related changes at its meeting on 19/10/16. The Audit and Governance Committee then reviewed and "approved" the Reservation of Powers and Scheme of Delegation at its meeting on 03/11/16. However, since the Audit and Governance Committee, the need for a number of additional amendments has been identified. Most of these amendments are included in the list below, though some further amendments are required (this is explained below).

All proposed changes are 'tracked' in the enclosed document, but the main proposed changes of note are as follows:

- Formatting / style changes (although the page numbering listed in the table of contents will however only be corrected once the 'tracked' changes are accepted)
- Acknowledgement and clarification that modifications to the corporate organisational structure of the Trust are not approved by the Board (but that changes to Trust Board sub-committees are), and that the Chief Executive is authorised to approve the organisational / management structure of the Trust and of any modifications
- Synchronising the previously-agreed requirement that the Board's approval is required for expenditure (capital and revenue) in excess of £1,000,000 (and that the Finance Committee's approval is required for such expenditure of £500,000 and above)
- Restricting the approval of expenditure (capital and revenue) of less than £500,000 to the Director of Finance and one of either the Chief Executive or Deputy Chief Executive (rather than just any member of the Executive Team)
- Clarification that the approval of the capital and revenue schemes referred to above relates to the business case that involves the expenditure commitment (which may not necessarily be the Full Business Case)
- Amendment of the wording to change from review/approval of "Annual Plans" to "plans for the forthcoming year/s"
- Inclusion of Divisional authorisation (to reflect the new organisational structure)
- Formalisation of the Audit and Governance Committee's role in the appointment of the Trust's External Auditor
- Amendment of the values of contract limits to match those within the latest version of the Official Journal of European Union
- Incorporation of the Trust new e-procurement system as part of the tender process.
- Restriction of the authorisation of a) orders, tenders and competitive quotations and b) contracts and SLAs, from £50,000 up to £250,000 to the Director of Finance and one of either the Chief Executive or Deputy Chief Executive (rather than just any member of the Executive Team)
- Restriction of the authorisation of orders, tenders and competitive quotations by the Chief Executive to £500,000, and allocation of authorisations from £500,000 up to £1,000,000 to the Finance Committee (with authorisation £1,000,000 and above to the Trust Board)
- Removal of the requirement for a Review of Partnerships to be received at the Audit and Governance Committee
- Post-Audit and Governance Committee amendment: Increasing the limit for which Business

Cases for capital expenditure require the approval of NHSI, from £5m to £15m (following guidance issued by NHSI since the Audit and Governance Committee). N.B. NHSI reserves the right to reduce the latter limit if a Trust enters the 'Special Measures' regimes, or fails to achieve other agreed performance requirements.

- Post-Audit and Governance Committee amendment: Clarification that capital and revenue cases up to the value of £250,000 are required to be authorised by one of the Director of Finance or Deputy Chief Executive; and for cases between £250,000 and £500,000 to be authorised by the Chief Executive
- Post-Audit and Governance Committee amendment: Removal of the "Above Plus..." principle relating to the authorisation of orders, tenders and competitive quotations (i.e. so that the individual with the most senior authorisation powers is the only person listed in the relevant section) N.B. This does not preclude the ultimate authoriser from seeking appropriate assurance from the individuals below their own level of authority
- Post-Audit and Governance Committee amendment: Section 3.5 (Engagement of Staff not on the establishment). Listing of "Executive Vacancy Panel" as the authoriser for "Estates and other project consultancy staff"
- Post-Audit and Governance Committee amendment: Changes to the authorisation of the "Booking of bank, locum or agency staff"

As noted above, some further amendments are still required. These relate to the "Waiving of quotation or single tender action" (3.3.4 c)); "Authorisation or Orders, tenders and competitive quotations" (3.3.4 f)); and "Approval of Contracts and SLAs" (3.3.4 g)) sections (all highlighted in yellow), and reflects the need for further consideration as to what the most appropriate governance arrangement should be (i.e. in terms of balancing the need for control against the need to support speed of decision-making). The Trust Secretary and Deputy Director of Finance (Financial Governance) have commenced work to establish the processes in place at other NHS Trusts, to inform future proposals on these sections. In the meantime, the wording is proposed to be left as currently stated (with the exception of 'housekeeping' changes).

It should also be noted that the establishment of the NHS Improvement as the single regulator is likely to lead to further in-year guidance being issued e.g. updated Capital and Business Case guidance is anticipated. This may require an in-year variation to be made to SFIs as appropriate

The Trust Board is therefore asked to "ratify" the document, noting that the aforementioned further amendments will be submitted at a later date.

Which Committees have reviewed the information prior to Board submission?

- Finance Committee, 17/10/16 (summary of proposed changes only)
- Audit and Governance Committee, 03/11/16

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

Ratification

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

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Reservation of Powers and Scheme of Delegation

Requested/ Required by:	Trust Board
Main author:	Trust Secretary Contact Details: 01622 228 698
Other contributors:	Consultation list contributors (Appendix Two)
Document lead:	Director of Finance
Supersedes:	Reservation of Powers and Scheme of Delegation (with effect from September 2013 6)
Reviewed by:	Audit and Governance Committee, 3rd November 2016 ^{6th August 2015}
Approved by:	Audit and Governance Committee, 3rd November 2016 ^{4th November 2015}
Ratified by:	Trust Board, 30th November 2016 ^{27th January 2016}
Review date:	January 2017 ^{November 2017}

With Effect from ~~January 2016~~^{November 2016}

Disclaimer: Printed copies of this document may not be the most recent version.
The master copy is held on Q-Pulse Document Management System
This copy – REV~~4~~⁵.0

Document history

Requirement for document:	<ul style="list-style-type: none"> • Code of Conduct / Code of Accountability in the NHS -(NHS Appointments Commission / Department of Health)
Cross References (external documents)/ Associated Documents:	<ul style="list-style-type: none"> • Anti-Fraud, Bribery and Corruption Policy and Procedure [RWF-OPPPCS-NC-WF48] • BNF and NICE Guidance • Board of Directors Code of Conduct • Cash management procedures / Government Banking Service (GBS) Mandate • Data Protection Act 1998 • Department of Health (DH) Healthcare Travel Costs Scheme (HTCS) regulations • Department of Health Losses and compensations guidance • Department of Health Commercial sponsorship – ethical standards in the NHS guidance • Freedom of Information Act 2000 • Freedom of Information Policy • Human Resources Policies and Guidelines (MANY) • Infection Control Policy • Medical Devices Policy and Procedure [RWF-OPPPCS-NC-EST2] • Medicines Policy and Procedure [RWF-OPPPCSS-C-PHAR1] • Mobile Phone policy and procedure [RWF-OWP-PP-COR-NC-HI5] • Patient Access Policy • Patient Property Policy [RWF-OPPPCS-NC-NUR1] • Patient Transport Policy • Policy and Procedure for Management of Concerns and Complaints [RWF-OPPPCS-NC-CG31] • Research and Development Policies (MANY) • Security Policy • Speak Out Safely (SOS) Policy and Procedure (formerly Whistle Blowing) [RWF-OPPPCS-NC-WF33] • Standing Financial Instructions [RWF-OPPCS-NC-TM22] • Standing Orders [RWF-OPPCS-NC-TM23]
Associated Documents (internal documents)	<ul style="list-style-type: none"> • Annual Leave and Public Holiday Policy and Procedure [RWF-OPPPCS-NC-WF38] • Anti-Fraud, Bribery and Corruption Policy and Procedure [RWF-OPPPCS-NC-WF48] • Archiving Clinical Trial Documentation Policy and Procedure [RWF-OPPPCS-NC-CG40] • Board of Directors Code of Conduct • Charitable funds, Policies and procedures for [RWF-OPPCS-NC-TM47] • Code of Conduct for NHS Board [RWF-OWP-APP536] • Concerns and Complaints, Policy and Procedure for Management of [RWF-OPPPCS-NC-CG31] • Disciplinary Policy and Procedure [RWF-OPPPCS-NC-WF10] • Financial Management and Accounting Policy and Procedure, Research and Development [RWF-OPPPCS-NC-CG33] • Flexible retirement policy and procedure [RWF-OPPPCS-NC-WF66] • Freedom of Information Act 2000 Policy and Procedure [RWF-OPPCS-NC-

TM2]

- [Gifts, hospitality, sponsorship and interests policy and procedure \[RWF-OPPCS-NC-TM48\]](#)
- [Grievance and Disputes Policy and Procedure \[RWF-OPPPCS-NC-WF27\]](#)
- [Infection Control Policy and Procedure \[RWF-OPPPCSS-C-PATH15\]](#)
- [Job Evaluation Policy and Procedure \(AFC\) \[RWF-OPPPCS-NC-WF36\]](#)
- [Managing Attendance at Work \(formerly Sickness Absence\) Policy and Procedure \[RWF-OPPPCS-NC-WF5\]](#)
- [Medical Devices Policy and Procedure \[RWF-OPPPCS-NC-EST2\]](#)
- [Medicines Policy and Procedure \[RWF-OPPPCSS-C-PHAR1\]](#)
- [Patient Access to Treatment Policy and Procedure \[RWF-OPPPCS-C-TM2\]](#)
- [Patient Property Policy & Procedure \[RWF-OPPPCS-NC-NUR1\]](#)
- [Patient Transfer Policy and Procedure \[RWF-OPPPCS-C-TM3\]](#)
- [Private Patients Services Policy and Procedure \[RWF-OPPP-PP-NC2\]](#)
- [Recruitment, Selection and Employment Checks Policy and Procedure \[RWF-OPPPCS-NC-WF47\]](#)
- [Relocation Expenses Policy and Procedure \[RWF-OPPPCS-NC-WF62\]](#)
- [Research Adverse Event and Safety Reporting Policy and Procedure \[RWF-OPPPCS-NC-CG36\]](#)
- [Research and Development Strategy \[RWF-OPPPCS-NC-CG39\]](#)
- [Research and Development, Approval Policy and Procedure for \[RWF-OPPPCS-NC-CG35\]](#)
- [Research Misconduct and Fraud Policy and Procedure \[RWF-OPPPCS-NC-CG37\]](#)
- [Security Policy and Procedure \[RWF-OPPPCS-NC-FH3\]](#)
- [Speak Out Safely \(SOS\) Policy and Procedure \(formerly Whistle Blowing\) \[RWF-OPPPCS-NC-WF33\]](#)
- [Special Leave and Other Leave Policy and Procedure \[RWF-OPPPCS-NC-WF69\]](#)
- [Standing Financial Instructions \[RWF-OPPCS-NC-TM22\]](#)
- [Standing Orders \[RWF-OPPCS-NC-TM23\]](#)
- [Temporary staff \(including Bank\) usage policy and procedure \[RWF-OPPPCS-NC-WF75\]](#)

Version Control:

Issue:	Description of changes:	Date:
0.0	Scheme of Delegation (with effect from 1 April 2008)	February 2008
1.0	Scheme of Delegation (with effect from 1 April 2009)	March 2009
2.0	Scheme of Delegation (with effect from 1 April 2010)	March 2010
3.0	Scheme of Delegation (with effect from 1 April 2011)	March 2011
3.1	Scheme of Delegation (with effect from July 2012)	July 2012
3.2	Scheme of Delegation (with effect from September 2013)	Sept 2013
3.3	Added note to front page (November 2014)	November 2014
3.4		March 2015
4.0	Revised to ensure synchronicity with the revised Standing Orders and Standing Financial Instructions (including standardised terminology)	January 2016
<u>5.0</u>	<u>Annual review - reformatted to enable easier reading; amendment of authorisation levels to match the changes within the Standing Financial Instructions and Standing</u>	<u>November 2016</u>

Version Control:

Issue: **Description of changes:**

Date:

| [Orders](#)

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

1.1 Introduction

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

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

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

Caution over the Use of Delegated Powers.

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

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

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

~~References to Executive Directors within this document include all Executive Directors who attend the Board including those without voting rights.~~

2.0 Functions which are reserved for decision by the Trust Board

2.1 General Enabling Provision

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

2.2 Regulation and Controls

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

2.3 Appointments

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

2.4 Policy Determination

The approval and ratification of the Trust's Standing Orders, Standing Financial Instructions and Reservation of Powers and Scheme of Delegation.

2.5 Strategy and Business Plans and Budgets

- ~~Approval Definition~~ of the strategic aims and objectives of the Trust.
- Approval of ~~Integrated Business Plan (IBP) and annual future~~ planning submissions to ~~NHS Improvement the NHS Trust Development Authority (in respect of the application of available financial resources).~~

2.6 General Matters

- Acquisition, disposal or change of use of land and/or buildings, involving capital expenditure in excess of ~~£500,000~~ £1,000,000
- The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £500,000

2.7 Financial and Performance Reporting Arrangements

- Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from Directors, sub-committees, and officers of the Trust.
- Approval of the opening or closing of any bank or investment accounts.
- Consideration and approval of the Trust's Annual Report and Annual Accounts, prior to submission to the Department of Health.

2.8 Audit Arrangements

- To receive reports of the Audit and Governance Committee meetings and take appropriate action.
- The receipt of the Annual Management Letter received from the external auditor and agreement of action on the recommendation where appropriate of the Audit and Governance Committee
- To approve the appointment of the Trust's External Auditor, following a recommendation from the Audit and Governance Committee as Auditor Panel (and following due procurement process)

3.0 Scheme of Delegation

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

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

Delegated matter	Authority delegated to	Key reference documents
3.1 Planning and Budgetary Control		SFI sections 4 and 12
a) Prepare and submit plans for the forthcoming year/san Annual Plan for Trust Board approval	Chief Executive	
b) Prepare and submit income and expenditure budgets for Trust Board approval	Director of Finance	
c) Delegation of the management of all budgets	Chief Executive	
d) Responsibility of keeping within budget		
<ul style="list-style-type: none"> for totality of services 	Chief Executive	
<ul style="list-style-type: none"> Clinical Directorates 	Chief Operating Officer	
<ul style="list-style-type: none"> Corporate Directorates 	Relevant member of the Executive Team	
<ul style="list-style-type: none"> At Divisional level 	The relevant Director of Operations	
<ul style="list-style-type: none"> at Directorate level 	Clinical Director / General Manager / Matron	
<ul style="list-style-type: none"> at cost centre level 	Budget Holder	
e) Non-Budgeted Expenditure. Any proposed expenditure, including overspending, which has not been provided for in an approved budget requires the following authorisation:		
<ul style="list-style-type: none"> Up to £100,000 	Director of Finance	
<ul style="list-style-type: none"> From £100,001 to £200,000 	Chief Executive	
<ul style="list-style-type: none"> Over £200,000 	Trust Board	
f) Capital Expenditure		
<ul style="list-style-type: none"> Prepare and submit capital 	Director of Finance	

Delegated matter	Authority delegated to	Key reference documents
budgets (Capital Programme) for Board Approval		
<ul style="list-style-type: none"> • Authorisation of changes to the Capital Programme 	Trust Board	
<ul style="list-style-type: none"> • Approval of Emergency Capital Expenditure 	Director of Finance plus one other member of the Executive Director Team	
3.2 Banking and Government Banking Service (GBS) Accounts		
a) Maintenance and operation of bank and GBS accounts in the name of the Trust	Director of Finance	SFI section 6
b) Cheque and Bankers' Automated Clearing Services (BACS) Payments	Finance Department designated signatories	Cash Management procedures
c) CHAPS or 3 day BACS payments (via internet banking) <£5,000	Authorised on line by one bank mandate signatory	GBS Mandate
CHAPS or 3 day BACS payments (via internet banking) >£5,000	Authorised on line by one bank mandate signatory PLUS further bank mandate signatory to countersign paperwork	
3.3 Non Pay Revenue and Capital Expenditure – Requisitioning of Goods and Services		SFI sections 8,12 and 15
3.3.1 Authorisation of Orders		
a) Overall responsibility for requisitioning/ordering of all goods and services	Director of Finance	
b) Non-Stock requisitions		
< £10,000	Budget Holder in accordance with Authorised Signatories Register	
> £10,001	In accordance with the limits in 3.3.4(f)	
c) Stock requisitions		
< £10,000	Budget Holder in accordance with Authorised Signatories Register	

Delegated matter	Authority delegated to	Key reference documents
> £10,001	In accordance with the limits in 3.3.4(f)	
d) Pharmacy orders – (approved medicines only) <£99,999	Chief Pharmacist or nominated deputy	Medicines policy and procedure set by the Medicines Management Committee
>£100,000	In accordance with limits in section 3.3.4(f)	
e) Medical Equipment < £10,000	Purchases must be in line with key reference document. Budget Holder in accordance with Authorised Signatories Register	Medical Devices Policy and Procedure Equipment policy SFI 15.1.2 (d) re capital investments
> £10,001	In accordance with the limits in 3.3.4(f)	
3.3.2 Authorisation of Invoices		
a) < £10,000	Budget Holder in accordance with Authorised Signatories Register	SFI sections 8,12 and 15
b) > £10,001	In accordance with the limits in 3.3.4(f)	
3.3.3 Approval of Business cases		
Values over duration of business case		SFI sections 8,12 and 15 and Capital Investment Manual
a) Capital Investment, including equipment and estates expenditure Investment <u>of</u> less than £ 250 500,000 (<u>in relation to the full business case that involves the expenditure commitment</u>)	<u>One of</u> Director of Finance <u>and one other member of</u> <u>Deputy Chief Executive</u> the Executive Team	SFI 15.1.2 (d)
<u>Investment of over £250,000 up to £500,000</u>	<u>Chief Executive</u>	
Investment <u>of</u> £500,000 and above (<u>in relation to the full business case that involves the expenditure</u>)	Finance Committee	

Delegated matter	Authority delegated to	Key reference documents
commitment Investment of £1,000,000 and above (in relation to the full business case that involves the expenditure commitment)	Trust Board	
b) Planned Service Developments/Revenue cases (e.g. consultant appointments) Investment up to £ 250 500,000 (in relation to the — full business case that involves the expenditure commitment)	One of Director of Finance and one Deputy Chief Executive other member of the Executive Team	SFI 4.3.2 (h)
Investment of over £250,000 up to £500,000	Chief Executive	
Investment of £500,000 and above	Finance Committee	
Investment of £1,000,000 and above	Trust Board	
c) All cases with capital investment greater than £15m – require NHS Improvement TDA approval. (R requires Strategic Outline Case, Outline Business Case and Full Business Case , as directed by the NHS Improvement TDA) (N.B. NHSI reserves the right to reduce the latter limit if a Trust enters the 'Special Measures' regimes, or fails to achieve other agreed performance requirements)	Trust Board prior to submission to NHS Improvement TDA	NHS Improvement TDA Capital Regime and Investment Business case approvals guidance
3.3.4 Quotations, Tendering, Leasing and Contract Procedures Costs over total life of contract – values excl. VAT		SFI sections 8,12 and 15, Capital Investment Manual and Procurement Policy
a) Quotations and Tendering Limits: <ul style="list-style-type: none"> Obtain a non-competitive quotation for goods/services up to £10,000 (excl. VAT) 	Budget Holder in liaison with Procurement Department	
<ul style="list-style-type: none"> Obtain 3 written competitive quotations for goods/services from £10,001 up to £50,000 49,999 (excl. VAT) 	Budget Holder in liaison with Procurement Department	
<ul style="list-style-type: none"> Obtain competitive tenders for goods/services above £50,000 	Budget holder in liaison with Procurement	

Delegated matter	Authority delegated to	Key reference documents
(E excl. VAT)	Department	
b) Compliance with the directives from the Council of the European Union and notified limits equal and greater than: <ul style="list-style-type: none"> Supplies Contracts £<u>111,676,106,047</u> Service Contracts £<u>111,676,106,047</u> Works Contracts £<u>4,322,0124,104,394</u> 	Associate Director of Procurement and Director of Estates and Facilities Management	Published by Official Journal of European Union every 2 nd January (correct at 01/01/1 <u>64</u>)
c) Waiving of quotation or single tender action: <ul style="list-style-type: none"> From £10,001 to £49,999 	Deputy Directors of Finance	
<ul style="list-style-type: none"> From £50,000 to £249,999 	Director Of Finance	
<ul style="list-style-type: none"> From £250,000 to £749,999 	Chief Executive	
<ul style="list-style-type: none"> More than £750,000 	Trust Board	
d) Receipt and safe custody of quotations and tender: <ul style="list-style-type: none"> Quotations 	Procurement Department	
<ul style="list-style-type: none"> Tenders 	Chief Executive	
e) Opening of tenders:	All tenders should be electronic via the Trust e-procurement system by January 2017. All procurement tenders are now electronic and opening the tenders on the system is only permitted once the tender is closed. For any paper based tenders, One-one Senior Member of staff designated by the Chief Executive, not associated with the Tender PLUS the Associate Director Head of Procurement or	

Delegated matter	Authority delegated to	Key reference documents
	nominated deputy. Where tenders include in-house submissions non-exec should sit on evaluation team if spend exceeds £500,000	
<p>f) Authorisation of Orders, tenders and competitive quotations:</p> <ul style="list-style-type: none"> up to £49,999 	Budget Holder to the limit as recorded in Authorised Signature Register and Deputy/Associate Director if over limit (plus Associate Director/Head of Procurement for tenders only)	
<ul style="list-style-type: none"> From £50,000 up to £249,999 	Above PLUS one member of the Executive Team	
<ul style="list-style-type: none"> From £250,000 to £749,999 	Above PLUS Chief Executive	
<ul style="list-style-type: none"> Over £750,000 	Trust Board – Note if expenditure is approved as a Business case to Trust Board, further authorisation will only be required if value exceeds the approved Business Case. If it is consistent with the Business Case, the Director of Finance and Chief Executive will authorise.	
<p>g) Approval of Contracts and SLAs (value for contract duration excl. VAT):</p> <ul style="list-style-type: none"> up to £49,999 	Budget Holder to the limit as recorded	SFI 8.8.1

Delegated matter	Authority delegated to	Key reference documents
	in Authorised Signature Register and Deputy/Associate Director if over limit plus Associate Director/Head of Procurement	
<ul style="list-style-type: none"> From £50,000 up to £249,999 	Above PLUS one member of the Executive Team	
<ul style="list-style-type: none"> From £250,000 to £749,999 	Above plus Chief Executive or Director of Finance	
<ul style="list-style-type: none"> Over £750,000 	Trust Board – Note if expenditure approved as Business Case to Trust Board further authorisation will only be required if value exceeds approved business case. If consistent with Business case Director of Finance and Chief Executive will authorise.	
h) Maintenance of the Tender Register	Associate Director of Procurement and Director of Estates and Facilities Management	
3.4 Setting of Fees and Charges		SFI sections 7 and 9 and Private Patient Services Policy and Procedure
a) Service Agreements for the provision of services to patients	Chief Executive in conjunction with Director of Finance	
b) All other charges including Private patients, overseas visitors, income generation and other related services	Director of Finance	
3.5 Engagement of Staff not on the establishment Values include all on costs		SFI section 8
a) Estates and other project consultancy staff: <ul style="list-style-type: none"> < £20,000 	One member of the	

Delegated matter	Authority delegated to	Key reference documents
	Executive Team Executive Vacancy Panel authorisation	
<ul style="list-style-type: none"> • > £20,000 	Director of Finance plus one member of the Executive Team Executive Vacancy Panel authorisation	
b) All Management Consultancy	Chief Executive (and NHSI if over £50,000)	
c) Engagement of external Trust's legal representations solicitors	Any of: a member of the Executive Team; Associate Director, of Quality Governance ; Quality & Patient Safety, Trust Head of Quality and Governance ; Solicitor ; Legal Service Manager; Trust Secretary	
d) Booking of bank, locum or agency staff:		
<ul style="list-style-type: none"> • Medical Locums (within NHSI Agency Cap) 	General Manager or Clinical Director	
<ul style="list-style-type: none"> • Medical Locums (above NHSI Agency Cap) 	Chief Executive	
<ul style="list-style-type: none"> • Others (within NHSI Agency Cap) 	Associate Director / ADNS General Manager or Matron	
<ul style="list-style-type: none"> • Others (above NHSI Agency Cap) 	Chief Executive	
All signed requests require submission to and approval of the Temporary Staffing Panel		
3.6 Charitable Funds		SFI section 20 and Policies and Procedures for Charitable Funds policies
a) Authorise revenue expenditure (excl. VAT) (N.B. Capital expenditure is authorised in accordance with the Trust's capital authorisation process):		

Delegated matter	Authority delegated to	Key reference documents
<ul style="list-style-type: none"> Up to £1,000 	Fund Holder	
<ul style="list-style-type: none"> £1,001 to £5,000 	Fund Holder & Clinical Director or member of the Executive Team	
<ul style="list-style-type: none"> £5,001 to £50,000 	Above plus Director of Finance or <u>a Deputy Director of Finance</u>	
<ul style="list-style-type: none"> £50,001 to £100,000 	Charitable Fund Committee	
<ul style="list-style-type: none"> Over £100,000 	Trust Board	
b) Investment of Funds	Charitable Funds Committee	
3.7 Agreements / Licences (Property only)		
a) Preparation and signature of all new tenancy agreements/licences for all staff subject to Trust Policy on staff accommodation	Accommodation Officer in conjunction with Director of Workforce and <u>Communications</u>	
b) Extensions to existing leases	Director of Finance	
c) Letting of premises to outside organisations	Director of Finance	
d) Approval of rent based on professional assessment	Director of Finance	
3.8 Condemning and Disposal Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively (including x-ray films, mechanical and engineering plant):		SFI sections 17 and 8
All Medical devices condemnations must be via E.M.E. Services		Medical Devices and equipment Policy <u>and Procedure</u>
a) with current estimated book value less than £10,000	Department Manager and <u>a</u> Deputy Director of Finance	
b) with current estimated book value from £10,000 to £50,000	Department Manager plus ADO and <u>the</u> Director of Finance	
c) with current estimated book value greater than £50,000	Chief Executive	
3.9 Losses, write-offs and compensation		SFI section 17 and DeH Losses and Compensations guidance
a) Cash Losses (theft, fraud, salary, overpayments, loss of cash), Bad Debts and Abandoned Claims		

Delegated matter	Authority delegated to	Key reference documents
<ul style="list-style-type: none"> Up to £5,000 	A Deputy Director of Finance	
<ul style="list-style-type: none"> From £5,001 to £50,000 	Director of Finance	
<ul style="list-style-type: none"> Above £50,000 	Trust Board	
b) Fruitless Payments (including abandoned capital schemes) <ul style="list-style-type: none"> Up to £5,000 	A Deputy Directors of Finance	
<ul style="list-style-type: none"> From £5,001 to £50,000 	Director of Finance	
<ul style="list-style-type: none"> From £50,001 to £100,000 	Chief Executive	
<ul style="list-style-type: none"> Above £100,000 	Trust Board	
c) Loss or Damage to buildings, property, equipment and stock <ul style="list-style-type: none"> Up to £100,000 	Director of Finance	
<ul style="list-style-type: none"> Above £100,000 	Trust Board	
d) Compensation under legal obligation <ul style="list-style-type: none"> Up to £10,000 	Director of Finance	
<ul style="list-style-type: none"> Above £10,000 	Trust Board	
Personal Injuries <ul style="list-style-type: none"> Up to £10,000 	Director of Finance	
<ul style="list-style-type: none"> Above £10,000 	Trust Board	
Medical Negligence <ul style="list-style-type: none"> From £10,000 to £100,000 	Chief Executive	
<ul style="list-style-type: none"> Above £100,000 	Trust Board	
e) Extra Contractual Payments to Contractors <ul style="list-style-type: none"> up to £10,000 	Director of Finance	
<ul style="list-style-type: none"> above £10,000 	Trust Board	
f) Ex-gratia payments to patients and staff for loss of personal effects <ul style="list-style-type: none"> Up to £1,000 	Member of the Executive Team	
<ul style="list-style-type: none"> From £1,001 to £5,000 	Director of Finance	
<ul style="list-style-type: none"> From £5,001 to £10,000 	Chief Executive	
<ul style="list-style-type: none"> Above £10,000 	Trust Board	
g) Extra statutory and extra regulatory payments, and payments relating to maladministration	Trust Board	
3.10 Reporting of Incidents to the Local Counter Fraud Service		
In all cases	Director of Finance has overall responsibility,	Anti-Fraud, Bribery and Corruption

Delegated matter	Authority delegated to	Key reference documents
	however in accordance with key reference documents, Incidents can be reported by ALL individuals	Policy, Response Plan , Speak Out , Safely Whistle Blowing Policy, Research Misconduct and Fraud Policy and Procedure 2012
3.11 Reporting of Incidents to the Police		Anti-Fraud , Bribery and Corruption Policy and Procedure, Response Plan , Security Policy and Procedure
a) Where a criminal offence is suspected	Clinical Site Manager plus a member of the Executive Team in conjunction with Local Security Management Specialist (LSMS). In accordance with key reference documents, Incidents can be reported by <u>all</u> ALL individuals	
b) Where a fraud is involved	Director of Finance in conjunction with the Local Counter Fraud Specialist In accordance with key reference documents, Incidents can be reported by <u>all</u> ALL individuals	
3.12 Petty Cash Disbursements		
Reimbursement via cashier of; a) Expenditure items (>£25.00 requires authorisation from Financial Services)	Budget Holder per authorised signatory register and Financial Services if >£25.00	SFI sections 12 and 19, patient property policy, Patient Transfer Policy and Procedure patient transport policy and DH Healthcare Travel Costs Scheme (HTCS) regulations
b) Patients monies	Cashier (confirmed with patient officer records)	
c) patients fares	Cashier in accordance with	

Delegated matter	Authority delegated to	Key reference documents
	patient transport policy and DH HTCS (Hospital Travel Costs Scheme) regulations	
<p>3.13 Gifts, <u>hospitality</u> and <u>sponsorship</u> Rewards</p> <p>Receipt or <u>provision</u> of <u>hospitality</u>, <u>sponsorship</u> and <u>gifts</u> – Applies to both individual and collective hospitality offered, received or provided.</p> <p>Refer to Gifts, Hospitality, Sponsorship and Interests Policy and Procedure for full guidance</p>		<p>SO Section 7.5</p> <p>SFI Section 21</p> <p>Gifts, Hospitality, Sponsorship and Interests Policy and Procedure</p>
<p>3.14 Implementation of Internal and External Audit Recommendations</p>	Director of Finance	SFI section 2
<p>3.15 Maintain and Update Financial Policies</p>	Director of Finance	SFI section 1
<p>3.16 Workforce and Pay</p>		
<p>a) Authority to fill funded posts on the establishment</p>	<p><u>Vacancy Control Recruitment</u> Panel with Director of Finance plus one member of the Executive Team - Consultants and Senior Managers must be authorised by Chief Executive</p>	<p>SFI section 11 <u>Human Resources Policies and Guidelines</u></p>
<p>b) Authority to fill funded post not on the establishment (i.e. increasing revenue cost to the Trust)</p>	<p><u>Vacancy Control Recruitment</u> Panel with Director of Finance plus one member of the Executive Team - Consultants and Senior Managers must be authorised by Chief Executive</p>	<p><u>Staff Bank and Temporary Staff (including Bank) Usage Policy and Procedure</u></p>
<p>c) Authority to employ Bank staff</p>	<p>In general terms, the Ward Manager, but please refer to the Staff Bank and Temporary Staff Usage Policy and</p>	<p><u>Staff Bank and Temporary Staff (including Bank) Usage Policy and Procedure</u></p>

Delegated matter	Authority delegated to	Key reference documents
	Procedure for more specific guidance	
d) Authority to employ Agency staff	general terms, the Matron/Site Practitioner (for Framework Agencies) and Associate Director/member of Executive Team (for non-Framework Agencies), but please refer to the Staff Bank and Temporary Staff Usage Policy and Procedure for more specific guidance Associate Director / member of Executive Team	Staff Bank and Temporary Staff (including Bank) Usage Policy and Procedure
e) The granting of additional increments to staff within budgets and regulations	Employing member of the Executive Team Director	SFI sections 11 and 8
f) All requests for upgrading/regrading (All requests shall be dealt with in accordance with Trust procedures)	A member of the Executive Team has responsibility however Key reference document allows manager discretion to regrade following AfC evaluation process	Agenda for change Job Evaluation policy and procedure (AfC)
g) Additional staff to the agreed establishment with specifically allocated finance, all staff grades	Short term - Vacancy Control Recruitment Panel with Director of Finance plus one member of the Executive Team	
h) Pay: I. Authority to complete standing data (payroll) forms effecting pay, new starters, variations and leavers.	Recruitment Team for new starters and changes as a result of the recruitment process . Budget	Recruitment, Selection and Employment Checks Policy and Procedure

Delegated matter	Authority delegated to	Key reference documents
	holders for variations in hours and leavers. Departmental Managers- variations in pay and leavers	
II. Authority to complete and authorise absence reporting forms	Departmental Manager	
III. Authority to authorise overtime.	Departmental Manager plus either of ADO/ADNs	
IV. Authority to authorise travel and subsistence expenses	Departmental Manager	
V. Authority to authorise Change of Circumstance forms - no financial implication	Departmental Manager	
VI. Authority to authorise Change of Circumstance form – below £5,000 per annum full year effect	One of Budget Holder (If sufficient authority), ADO/ADNS	
VII. Authority to authorise change of Circumstance form – above £5,000 per annum full year effect	One of Budget Holder (If sufficient authority), PLUS ADO/ADNS	
i) Annual Leave: I. Approval of annual leave	Departmental Manager	Annual Leave and Public Holidays Policy and Procedure
II. Approval of annual leave – carry forward up to 1 weeks contracted hours	One of- ADO/ADNS General Manager/Matron or equivalent (but final sign-off is by Human Resources)	
III. Approval of annual leave – carry forward of more than 1 weeks' contracted hours	NOT ALLOWED Only allowed for Staff on long-term sick leave and maternity leav HR have to sign off all carry over as the final sign off (refer to Annual Leave and Public Holiday Policy and	

Delegated matter	Authority delegated to	Key reference documents
	Procedure)	
j) Compassionate and Special Leave:		Special Leave and Other Leave information Policy and Procedure
I. Compassionate leave up to 5 days	Departmental Manager	
II. Compassionate leave over 5 days	One of - ADO/ADNS	
III. Special leave arrangements up to five day (with pay)	Employing member of the Executive Team Director	
k) Unpaid Leave	Departmental Manager	
l) Sick Leave:		
Authorisation of sick leave	Departmental Manager in conjunction with Directorate HR Business Partner	
I. Return to work part-time or otherwise restricted duties on full pay to assist recovery	Departmental Manager in conjunction with Occupational Health Directorate HR Business Partner	
II. Any extension of sick leave over employee conditions of service	Employing member of the Executive Team Director	
m) Study Leave:		
I. All study leave outside the UK including CME/professional leave	Chief Executive and Medical Director in conjunction with the ADO and Clinical Director	
II. Medical Staff CME/Professional study leave (UK)	Director of Medical Education Clinical Director in conjunction with the ADO and Clinical Director	
III. Junior medical staff in training	Director of Medical Education Clinical Director in conjunction with the Clinical Director	

Delegated matter	Authority delegated to	Key reference documents
IV. All other study leave (UK)	Departmental Manager / Budget Holder	
n) Relocation Expenses: Authorisation of payment of relocation expenses incurred by officers taking up new appointment <ul style="list-style-type: none"> Up to maximum claim of £3,000 	Associate Director of Workforce Head of Employee Relations or Head of Employee Services	Relocation expenses policy and procedure
o) Grievance Procedure: All grievance cases must be dealt with strictly in accordance with the Trust Grievance Procedure and the advice of Human Resources must be sought	Director of Workforce and Communications has overall responsibility, cases dealt with by the Human Resources team	Grievance and Disputes policy and procedure
p) Disciplinary Procedure: All disciplinary cases must be dealt with strictly in accordance with the Trust Disciplinary Procedure and the advice of Human Resources must be sought	Director of Workforce and Communications has overall responsibility, cases dealt with by the Human Resources team	Disciplinary policy and procedure
q) Authorised Car and Mobile Phone Users: I. Requests for new post to be authorised as regular car users	One of:- Director of Operations / ADN/ADO	Mobile phone policy and procedure
II. Re-designation of existing posts as authorised car user	One of:- Director of Operations / ADN/ADO	
I. Requests for authorised mobile phone user status	One of:- Director of Operations/ADN/AD O	
r) Renewal of Fixed Term Contract within funded establishment (if outside of establishment see 19b above):	Short term - Vacancy Control Recruitment Panel	
s) Authorisation of extensions of contract beyond normal retirement	Short term - Vacancy	Flexible retirement policy

Delegated matter	Authority delegated to	Key reference documents
age in exceptional circumstances:	Control Recruitment Panel	and procedure
t) Contractual Redundancy I. up to £100,000	Chief Executive and Remuneration and Appointments Committee	DH Losses and Compensations Guidance
II. All packages within range of £50,000 and £100,000 to be reported to Remuneration and Appointments Committee	Remuneration and Appointments Committee , Trust Board, Remuneration and Appointments Committee and NHS Improvement FDA Remuneration Committee	
III. Packages in excess of £100,000	Remuneration and Appointments Committee, NHS Improvement FDA Appointments and Remuneration Committee, and HM Treasury Approval	
IV. In relation to Chief Executive or direct reports to be approved by;	Refer to HM Treasury	
V. Payments of a novel or unusual nature	To be considered by the Remuneration and Appointments Committee and will require HM Treasury approval	
VI. NHS bodies must obtain Treasury's explicit permission before making any staff severance payments that exceed legal or contractual obligations.	There is no delegated authority to make any such payments, whatever the value	
u) Ill Health Retirement Decision to pursue and authorise retirement on the grounds of ill health	Director of Workforce and Communications has overall responsibility, Cases dealt with by	Managing Attendance at Work (formerly Sickness Absence) Policy and Procedure

Delegated matter	Authority delegated to	Key reference documents
	Occupational Health and Human Resources teams	
v) Dismissal/Suspension	Director of Workforce and Communications , members of the Executive Team and designated Senior Managers	
3.17 Authorisation of New Drugs	Medical Director and Director of Finance, Chief Pharmacist, Drugs and Therapeutics Committee	BNF NICE
3.18 Authorisation of Sponsorship Deals		SFI section 7 and DeH commercial sponsorship – ethical standards in the NHS guidance
a) General Sponsorship	Chief Executive, Medical Director and Director of Finance	
b) Research and Development Sponsorship	Medical Director in liaison with Deputy Director of Finance	Research and Development Approval Policies and Procedure for
3.19 Authorisation of Research and Development Projects	Research and Audit Manager, Research and Development Management Committee	
3.20 Authorisation of Clinical Trials	Research and Audit Manager, Research and Development Management Committee	
3.21 Insurance Policies and Risk Management	Chief Nurse	SFI section 24 and Risk Management Strategy and Policy
3.22 Multi-User Clinical Products Review	Research and Development Management Committee	Research and Development Approval Policies and Procedure for
3.23 Patients and Relative's Complaints		

Delegated matter	Authority delegated to	Key reference documents
a) Overall responsibility for ensuring that all complaints are dealt with effectively	Chief Executive	Policy and Procedure for the
b) Responsibility for ensuring complaints relating to a Directorate are investigated thoroughly	Chief Operating Officer and Chief Nurse	Management of Concerns and Complaints Procedure
c) Effective management of medical legal complaints	Trust Solicitor Patient Safety and Risk Manager	
3.24 Relationship with Press a) Within office hours	Head of Communications / Communications Manager	
b) Outside office hours	Executive Director on-call and Clinical Site Manager in liaison with the On Call Communication Manager	
3.25 Infectious Diseases and Notifiable Outbreaks • Overall responsibility for ensuring that there are effective arrangements for infection control within the Trust	Chief Executive	Infection Control Policy and Procedure
• Ensure effective steps are taken so that all staff adheres to the Infection control policy and the guidelines and protocols which underpin it.	Director of Infection Prevention and Control	
• Prepare and present the Annual Infection Control report to the Trust Board and Trust Clinical Governance Committee.	Director of Infection Prevention and Control	
3.26 Extended Role Activities • Approval of staff to undertake extended professional clinical roles	Medical Director and Chief Nurse for nursing and midwifery staff and healthcare support workers	
3.27 Patient Services a) Variation of operating and clinic sessions within existing resources	Chief Operating Officer	Patient Access to Treatment Policy and Procedure

Delegated matter	Authority delegated to	Key reference documents
b) All proposed changes in bed allocation and use: <ul style="list-style-type: none"> • Temporary change 	Chief Operating Officer or Executive Director on call (out of hours)	
<ul style="list-style-type: none"> • Permanent change 	Chief Executive	
3.28 Facilities for Staff not Employed by the Trust to gain Practical Experience or undertake remunerated work on Trust premises		
a) Professional recognition, honorary contracts and insurance of medical staff	Director of Workforce and Communications	
b) Work experience students	Director of Workforce and Communications	
c) Volunteers	Chief Nurse	
3.29 Fire Regulations		
a) Overall responsibility for review of all statutory compliance with Fire Regulations	Chief Executive	
b) Effective management of fire precautions to meet regulations	Fire Safety Officer Head of Compliance and Fire	
3.30 Health and Safety		
a) Overall responsibility for review of all statutory compliance legislation and Health and Safety requirements, including Control of Substances Hazardous to Health (COSHH)	Chief Executive	
b) Effective management of compliance issues to meet legislation	Chief Nurse / Associate Director, Quality Governance	
3.31 Review of Medicines Inspectorate Regulation	Medical Director in conjunction with Chief Pharmacist (with GM of Diagnostics Directorate)	
3.32 Environmental Regulations		
a) Overall responsibility for review of	Chief Executive	

Reservation of Powers and Scheme of Delegation

Written by: Trust Secretary

Review date: January [November](#) 2017Document Issue No. [4.05.0](#)

Delegated matter	Authority delegated to	Key reference documents
compliance with environmental regulations, (e.g. clean air, waste disposal)	after consultation with Director of Estates and Facilities Management	
b) Effective management of compliance issues to meet legislation	Director of Estates and Facilities Management	
3.33 Review of Trust's Compliance with the Data Protection Act	Director of Health Informatics (Trust's Data Protection Officer)	DPA 1998
3.34 Monitor proposals for contractual arrangements between the Trust and outside bodies	Director of Finance and other appropriate member of the Executive Team	
3.35 Review the Trust's compliance with Access to Records Act	Director of Health Informatics (Trust's Data Protection Officer)	DPA 1998
3.36 Review of the Trust's compliance with the Code of Practice for handling confidential information in the contracting environment and compliance with "Safe Haven" per EL(92)60	Medical Director	
3.37 The keeping of a Declaration of Interest Register	Trust Secretary	Standing Orders / Gifts,
3.38 The keeping of a hospitality Register	Trust Secretary	Hospitality, Sponsorship and Interests Policy and Procedure
3.39 Trust Seal a) Attestation of Sealing in accordance with Standing Orders	The Trust Secretary and one member of the Executive Team (not from the department from which the document arises). In the absence of the Trust Secretary, two members of the Executive Team can attest.	Standing Orders

Delegated matter	Authority delegated to	Key reference documents
b) Keep seal in a safe place and maintaining a Register of Sealing	Trust Secretary	
3.40 Retention of Records	Director of Finance	
3.41 Clinical Governance	Chief Executive, Medical Director and Chief Nurse	
3.42 Serious Incident Reporting	Chief Nurse	
3.43 Management of Medical Devices	Director of Estates and Facilities Management Director	Medical Devices and equipment Policy and Procedure
3.44 Review of Partnerships a) Annual review of partnerships b)a) Ensuring partnership agreements are in place and monitored e)b) Review of the financial performance standing of partners	Deputy —Director of Finance	SFI section 9
3.445 Freedom of Information	Medical Director Director of Finance	Freedom of Information Act OIA 2000, FOI Policy and Procedure
3.45 Organisational / management structure		
Approval of the organisational / management structure of the Trust and of any modifications	Chief Executive	

4.0 Glossary of terms and abbreviations (refer to Standing Orders for full list of definitions)

Term or abbreviation	Meaning for the purposes of this document
SOs	Standing Orders
SFIs	Standing Financial Instructions
Budget Holder	The Director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.
Departmental Manager	AfC band 7 and above manager with staffing and budget responsibility
ADO	Associate Director of Operations (These roles work at Divisional level) – includes Associate Directors in Corporate areas
ADN	Associate Director of Nursing. These roles work at Divisional level.
CD	Clinical Director
GM	General Manager
Senior Nurse	Nurse Consultants, Matrons, Ward Sisters, Specialist Nurses
SOC	Strategic Outline Case
OBC	Outline Business Case
FBC	Full Business case
NHSI-TDA	NHS Trust Development Authority Improvement. This is the operational name given to the organisation responsible for overseeing Foundation Trusts and NHS Trusts.
OJEU	Official Journal of European Union
FOI (A)	Freedom of Information (Act)
DPA	Data Protection Act
HTCS	Hospital Travel Costs Scheme (DH)
Officer	An employee of the Trust or any other person holding a paid appointment or office with the Trust.
Chairman of the Trust Board	The person appointed by the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression “Chairman of the Trust Board” shall be deemed to include the Vice-Chairman of the Trust Board if the Chairman is absent from the meeting or is otherwise unavailable.
Chief Executive	T the chief officer of the Trust
Director	Executive or Non-Executive Director of the Board as the context permits. The inclusion of the word “Director” in a staff member’s job title does not mean that they automatically meet the definition of being a “Director” for the context of these Standing Orders.
Director of Finance	The c Chief f Financial o fficer of the Trust.
Director of Operations	The officer/s of the Trust who oversee performance at Divisional level. There are currently Director of Operations for

Term or abbreviation	Meaning for the purposes of this document
	“Planned Care” and “Urgent Care” .
Directorate	One of the major units of operations in the Trust. Each Directorate functions separately, with a separate management team, governance arrangements, budget and performance monitoring data/processes. Directorates can be “Clinical” (for which the management team is headed by a “Clinical Director”) or non-clinical. Non-clinical Directorates are usually corporate-based functions, such as IT, Human Resources, Finance and Clinical/Quality Governance
Division	A grouping of two or more “Clinical Directorates” into a single operating unit, for the purposes of oversight
Executive Director	A member of the Trust Board who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) of The National Health Service Trusts (Membership and Procedure) Regulations 1990. Executive Directors are expected to be present at, and participate in, meetings of the Trust Board.
Executive Team	The group of employees who collectively have managerial control over the major activities of the Trust, and who influence the operations of the Trust as a whole rather than the decisions of individual directorates or departments. For this Trust, refer to the Standing Orders for the up to date list of relevant persons.
Non-voting Board Member	A Trust Board Member who is not entitled to exercise voting rights at the Trust Board.
Senior Manager	An officer holding a senior managerial or senior clinical role with management responsibilities. For this Trust this includes “Directors” , Directors of Operations , and Associate Directors and their direct reports, and Clinical Directors and Consultants. However, please note that for the purposes of reporting “Senior Managers” remuneration (In accordance with Section 234b and Schedule 7a of the Companies Act, as required by NHS Bodies), a “Senior Manager” is considered to be defined as “Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual Directorates or departments”. For this Trust, and for this purpose, the definition of “Senior Manager” only applies to Trust Board Members.
Trust Board	The Chairman, Executive and Non-Executive Directors of the Trust collectively as a body.
Trust Board Member (or Board Member)	An individual regarded as being a member of the Trust Board. The influence (or potential influence) exerted by the individual is the key determinant, rather than their ability to vote at Board meetings. Trust Board members are those that are expected to be at each Board meeting (and sit at the Board table), and contribute fully to each agenda item. For this Trust, Trust

Term or abbreviation	Meaning for the purposes of this document
	Board Members comprise the Chairman of the Trust Board, Non-Executive Directors, the Executive Team, and the Director of Infection Prevention and Control. Please note however that the provisions in these Standing Orders relating to voting (SO 3.12) only apply to "Voting Board Members" (see below).
Voting Board Member	A Trust Board Member who is entitled to exercise voting rights at the Trust Board.

Process Requirements

1.0 Implementation and Awareness

~~1.1—Once ratified the PRC Chairman will email this policy/procedural document to the Clinical Governance Assistant (CGA) who will activate it on the Trust approved document management database on the intranet, under 'Policies & Q-Pulse'. Once approved the Document Lead or Author will send this document to the Clinical Governance Assistant who will publish it on the Trust intranet.~~

A monthly publications table is produced by the CGA which is published on the Trust intranet under 'Policies & Q-Pulse'; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.

~~1.2—All staff will have access to a copy of the document through the Trust's intranet site. A monthly table of Trust publications will be produced by the Clinical Governance Assistant; this will be published on the Bulletin Board (Trust intranet) under "Trust Publications", and a notification email circulated Trust wide by the COMMS team.~~

On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications

~~1.3—On receipt of the Trust wide Bulletin Board notification all managers should ensure that their staff members are aware of the new publications.~~

2.0 Review

The Reservation of Powers and Scheme of Delegation instructions will be reviewed annually.

3.0 Archiving

The Trust approved document management database on the intranet, under 'Policies & Q-Pulse', retains all superseded files in an archive directory in order to maintain document history.~~The Trust intranet retains all superseded files in an archive directory in order to maintain document history.~~

APPENDIX TWO**CONSULTATION ON:** Reservation of powers and scheme of delegation

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: [Trust Secretary](mailto:Trust_Secretary@nhs.net) [Head of Financial Services](mailto:Head_of_Financial_Services@nhs.net)
[\(kevinrowan@nhs.net\)](mailto:kevinrowan@nhs.net)

By date: [21st October 2016](#)

Name:	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Clinical Governance Assistant	06/10/16	15/10/16	Y	Y
Chief Pharmacist	06/10/16			
Staff-Side Chair	06/10/16			
Emergency Planning team	06/10/16			
Head of Staff Engagement and Equality	06/10/16			
Health Records Manager	06/10/16			
Local Counter Fraud Specialist	06/10/16			
Chief Internal Auditor	06/10/16			
Director of Finance	06/10/16			
Deputy Director of Finance	06/10/16			
The Executive Team	06/10/16			
Non-Executive Directors	06/10/16			
Risk Manager				
Head of Information Governance	06/10/16			
Assoc. Director, Quality Governance	06/10/16	27/10/16	Y	Y
Dir. of Operations, Planned Care	06/10/16			
Dir. of Operations, Urgent Care	06/10/16			
Deputy Director of Finance (Financial Governance)	06/10/16			
Deputy Director of Finance (Financial Performance)	06/10/16			
Assoc. Director of Nursing, Planned Care	06/10/16			
Assoc. Director of Nursing, Urgent Care	06/10/16			
Head of Midwifery/Professional Lead, Paediatrics, Women's & Sexual Health	06/10/16			
Associate Director of Operations, Women's, Paeds & Sexual Health	06/10/16			
Director of Health Informatics	06/10/16			
Dir. of Estates and Facilities Management	06/10/16			
Head of Perf. & Delivery, Urgent Care	06/10/16			
Head of Employee Relations	06/10/16	27/10/16	Y	Y
Head of Employee Services	06/10/16	27/10/16	Y	Y
HR Business Partner	06/10/16	27/10/16	Y	Y
Assistant Director of Business Intelligence	06/10/16			
Deputy Chief Nurses	06/10/16			
Director of Medical Physics	06/10/16			
General Managers	06/10/16			
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**

~~This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development and approval process. Please note that completion is mandatory for all policy and procedure development exercises. In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality. The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.~~

~~Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.~~

Title of policy or practice	Reservation of powers and scheme of delegation
What are the aims of the policy or practice?	To specify the powers and authority that are reserved for the Trust Board and which have been delegated
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	No
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	Is there an adverse impact or potential discrimination (yes/no). If yes give details.
Gender identity	No
People of different ages	No
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language	No
People who have a physical or mental disability or care for people with disabilities	No
Women who are pregnant or on maternity leave	No
Sexual orientation (LGBT)	No
Marriage and civil partnership	No
Gender reassignment	
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?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.

Trust Board meeting – December 2016

**11-19 Summary report from Audit and Governance Committee,
03/11/16 (incl. approval of revised Terms of Reference)**

Trust Secretary

The Audit and Governance Committee met on 3rd November 2016. Immediately after the ‘main’ meeting, the Committee reconvened as the “Auditor Panel” (to consider the recommendation to appoint an External Auditor from 2017/18). A summary report and recommendation from the “Auditor Panel” has been submitted to the ‘Part 2’ Board, due to commercial confidentiality.

1. The key matters considered at the ‘main’ meeting were as follows:

- Revised Terms of Reference were agreed (as part of their annual review), and are submitted to the Board for approval (see Appendix 1 – with proposed changes ‘tracked’)
- The Board Assurance Framework (BAF) was reviewed prior to this being reviewed at the Trust Board in November, & a discussion ensued on how the Committee should use the BAF to achieve assurance, as distinct from its routine review by the Trust Board
- A Counter Fraud update was reviewed, and a theme around lack of appropriate checks and controls was identified. This led to the agreement to ask the Workforce Committee to review the compliance of the Trust’s payroll provider with its contractual requirements
- An update on progress with the Internal Audit plan for 2016/17 (incl. progress with actions from previous Internal Audit reviews was reported). The list of recent Internal Audit reviews are shown below (in section 2). The status of outstanding recommendations was reviewed, and the number relating to Outstanding Transferred Kent and Medway HIS Audit Recommendations noted. A discussion was also held on how Client Briefings from both the Internal and External Auditors were processed and managed within the Trust, and the Director of Finance agreed to develop a process to keep track of such briefings (as notified by Internal and External Audit) and to ensure that matters arising from such reports were identified and referred for appropriate scrutiny within the Trust as required
- A ‘Progress and emerging issues report’ was received from External Audit and no matters of significance were reported. The Committee noted that the Trust would be under ongoing scrutiny from a financial perspective, and noted the importance of lessons learnt from its period in Financial Special Measures
- The Director of Finance provided a verbal summary of the latest financial situation
- The latest losses & compensations data was reviewed, which showed an increase in value of claims, but a reduction in cases, compared with the same period in the previous year
- The latest single tender waivers data was reviewed, which showed an increase in volume & a decrease in value of waivers compared with the same period in the previous year
- A report detailing gifts, hospitality and sponsorship declared since the last meeting was considered, along with a review of the ongoing consultation by NHS England on conflicts of interest within the NHS, and the key issues which might affect the Trust
- Revised Standing Orders, Standing Financial Instructions (SFIs) and Reservation of Powers and Scheme of Delegation were reviewed and approved.
- The Committee agreed the method and timing by which it would undertake its next self-assessment (in early 2017)

2. The Committee received details of the following Internal Audit reviews:

- “Health Records” (which received a “Limited Assurance” conclusion)
- “Pharmacy” (which received a “Limited Assurance” conclusion)
- “NHS In-House Information Governance Toolkit: Training Material Checklist (which received a “(Fully Comprehensive – NHS Connecting for Health rating)” conclusion)

3. The Committee was also notified of the following “high” priority outstanding actions from Internal Audit reviews:

- “Data Quality of KPIs” (2 outstanding actions)
- “Retrospective Never Events” (1 outstanding action)

- “Additional Consultant Payments” (1 outstanding action)

The Committee was also notified of the following “urgent” priority outstanding actions from Outstanding Transferred Kent and Medway HIS Audit Recommendations:

- “KMH1415” Follow up” (1 outstanding action)
- “IT Controls Assurance – Active Directory Security Controls Review” (1 outstanding action)
- “Business Intelligence System” (1 outstanding action)

4. The Committee agreed that (in addition to any actions noted above):

- The Owner of the 2 Outstanding Audit Recommendations for the “Data Quality of KPIs” Internal Audit review, and the Director of Health Informatics should be asked to attend the next meeting, to discuss the implementation of their respective Recommendations (but the invitations should be withdrawn if these were completed by mid-January 2017)
- The Internal Audit Manager should include a review of the BAF’s assurance methods as part of the annual “Assurance Framework and Risk Management” Internal Audit review in 2016/17, and the Director of Finance should consider the need to allocate Internal Audit days to provide additional assurance against specific areas of the BAF, arising from the above review by Internal Audit
- The addition of a summary front page for the BAF, encapsulating the current status for each item, should be considered (by the Trust Secretary), and further consideration should be given to how the Committee should use the Board Assurance Framework (i.e. to ensure a distinction from the role of Trust Board)
- The management arrangements relating to (Counter Fraud) Investigation 16/17.0032SERT/16/00056, should be reviewed to ensure that decision making occurred at an appropriately senior level
- A system of more regular / routine reporting of (patient property) losses data should be implemented at local level, and more detail on the 2 “Transport” waivers in the next Single Tender Waivers Report should be provided at the next meeting
- The Workforce Committee should review the process relating to the management and authorisation of Study Leave by Trust staff
- The circumstances of the (gifts, hospitality and sponsorship) declaration relating to specific member of Trust staff should be explored to establish if the associated event incurred any cost to the Trust (in terms of back-filling staff), and the Trust Secretary should investigate if the principle existed within the Trust that hosting of external courses/events on Trust premises should incur no expense to the Trust
- The definition for “Senior Independent Director” should be included in the “Interpretation and definitions” for Standing Orders and SFIs, and the listing for “Associate Director of Operations” should be re-inserted in the “Interpretation and definitions” for SFIs. Section 3.44 of the Reservation of Powers and Scheme of Delegation should also reflect the content of section 9.4 of the SFIs (in relation to the review of key partnerships)

5. The issues that need to be drawn to the attention of the Board are as follows:

- The Committee acknowledged the efforts that had resulted in the “Fully Comprehensive – NHS Connecting for Health conclusion” for the Internal Audit review of “NHS In-House Information Governance Toolkit: Training Material Checklist
- The Committee has requested a review of Medical Productivity by the Finance C’ttee and have scheduled this to be reported to the Audit and Governance C’ttee in February 2017
- The revised Terms of Reference are enclosed for approval by the Board

Which Committees have reviewed the information prior to Board submission?

N/A

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

1. Information and assurance; and
2. To approve the revised Terms of Reference for the Audit and Governance Committee

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

AUDIT AND GOVERNANCE COMMITTEE

TERMS OF REFERENCE

Constitution / Purpose

- 1.1 The Audit and Governance Committee has been established by the Trust Board as a non-executive committee of the Board. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.
- 1.2 The Committee supports the Trust Board by critically reviewing the governance and assurance processes on which the Board places reliance. This therefore incorporates reviewing Governance, Risk Management and Internal Control (including the Board Assurance Framework); oversight of the Internal and External Audit, and Counter Fraud functions.
- 1.3 The Committee also undertakes detailed review of the Trust's Annual Report and Accounts.
- 1.4 The Trust Board has also appointed the Audit and Governance Committee as the Trust's Auditor Panel, in accordance with Schedule 4, Paragraph 1 of the Local Audit and Accountability Act 2014. The Auditor Panel will advise the Trust Board on the selection, appointment and removal of external auditors (for appointments for 2017/18), and on the maintenance of independent relationships with such auditors.

Authority

- 2.1 The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
- 1.5 The Committee is authorised to undertake all relevant actions to fulfil its role as the Trust's Auditor Panel.

Membership

- 3.1 The Committee shall be appointed by the Trust Board from amongst the Non-Executive Directors of the Trust (other than the Chairman of the Trust Board), and shall consist of not less than three members. A Non-Executive Director ~~Chairman~~ of the Committee will be appointed by the Trust Board, together with a Vice-Chair~~man~~. If a Non-Executive Director member is unable to attend a meeting they will be responsible for finding a replacement to ensure quoracy for the meeting. The Chair~~man~~ and Vice-Chair~~man~~ of the Committee will also act as Chair~~man~~ and Vice-Chair~~man~~ (respectively) of the Auditor Panel.
- 3.2 Other individuals may be co-opted to attend to address issues of specific concern at the discretion of the Committee Chair~~man~~.
- 3.3 When undertaking the role of the Auditor Panel, the membership shall comprise the entire membership of the Audit and Governance Committee, with no additional appointees. This means that all members of the Auditor Panel are independent, Non-Executive Directors.
- 3.4 Conflicts of interests relevant to agenda items must be declared and recorded at the start of each meeting (including meetings of the Auditor Panel). If a conflict of interest arises, the Chair~~man~~ may require the affected ~~Auditor Panel~~ member to withdraw at the relevant discussion or voting point.

Quorum

- 4.1 The Committee shall be quorate when two Non-Executive members are present (including either the Chairman or Vice Chairman).
- 4.2 However, when the Committee is undertaking the role of the Trust's "Auditor Panel", the Committee shall be quorate when three Non-Executive members are present (including either the Chairman or Vice Chairman)².

Attendance

- 5.1. The following will routinely attend meetings of the Committee (but will not be members):
 - Director of Finance
 - Deputy Director of Finance (Financial Governance)
 - Head of Internal Audit and/or other appropriate representatives
 - External Audit Engagement Lead and/or other appropriate representatives
 - Local Counter Fraud Specialist
 - Trust Secretary
- 5.2 Members (listed above) are expected to attend all meetings of the Committee
- 5.3 The Chief Executive and other members of the Executive Team will be invited to attend when the Committee is discussing areas of risk or assurance that are the responsibility of that Director and it is felt that their attendance is necessary to fully understand or address the issues
- 5.4 The Chief Executive may be invited to attend to discuss the process for assurance that supports the Annual Governance Statement; and the agreement of the Internal Audit annual plan. The decision as to whether to invite the Chief Executive for these items rests with the Chairman.
- 5.5 The Committee will meet privately with the External and Internal Auditors regularly, at the start of each meeting.
- 5.6 The Trust Secretary will provide appropriate support to the Chairman and Committee members, and will be responsible for the administration of the Committee (see section 10).
- 5.7 The Chairman may also invite others to attend when the Committee is meeting as the Auditor Panel. These invitees are not members of the Auditor Panel

6. Frequency of meetings

- 6.1 Meetings shall be held not less than four times a year. The Chairman of the Committee will have the discretion to agree additional meetings in order to adequately meet the objectives of the Committee.
- 6.2 The External Auditor or Head of Internal Audit may request an additional meeting if they consider that one is necessary. Any member of the Trust Board may put a request in writing to the Chairman of the Committee for an additional meeting, stating the reasons for the request. The decision whether or not to arrange such a meeting will be at the sole discretion of the Chairman of the Committee.
- 6.3 As a general rule, the Auditor Panel will meet on the same day as the Audit and Governance Committee. However, Auditor Panel business shall be identified ~~via a clearly and separately on the~~ agenda, and Audit and Governance Committee members shall deal with these matters as Auditor Panel members, not as Audit and Governance Committee members. The Auditor Panel's Chairman shall formally state (and this shall be formally recorded) when the Auditor Panel is meeting in that capacity.

² Independent members of the Auditor Panel must be in the majority and there must be at least two independent members present or 50% of the auditor panel's total membership, whichever is the highest

7 Duties

7.1 The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

7.2 The Committee shall 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.

7.3 In particular, the Committee will review the adequacy of:

7.3.1 All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit [Opinionstatement](#), external audit opinion or other appropriate independent assurances, prior to endorsement and/or approval by the Trust Board

7.3.2 The underlying assurance process that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

7.3.3 The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification.

7.3.4 The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Protect.

7.4 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from member of the Executive Team and managers, as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

7.5 This will be evidenced through the Committee's use of an effective Board Assurance Framework (BAF) to guide its work and that of the audit and assurance functions that report to it.

7.6 As part of its integrated approach, the Committee will have effective relationships with other key committees, so that it understands processes and linkages. However, these other committees must not usurp the Audit and Governance Committee's role.

Internal Audit

7.7 The Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Trust Board.

This will be achieved by:

7.6.1 Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

7.6.2 Review and approval of the Internal Audit Charter, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework

7.6.3 Consideration of the major findings of Internal Audit work (and management's response), and ensure co-ordination between the Internal and External auditors to optimise audit resources

7.6.4 Ensuring that the Internal Audit Function is adequately resourced and has appropriate standing within the organisation

7.6.5 Carrying out an annual review of the effectiveness of Internal Audit

External Audit

7.8 The Committee shall review the work and findings of the Trust's External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy
- Discussion with the External Auditors of their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review all External Audit reports, including the report to those charged with governance, agreement of the Annual Audit Letter (before submission to the Trust Board) and any work carried outside the annual audit plan, together with the appropriateness of management responses
- Ensuring that there is in place a clear framework for the engagement of external auditors to supply non audit service

Other Assurance Functions

- 7.9 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation, in so far as they affect the Trust's agreed objectives. These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

Counter Fraud

- 7.10 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud that meet NHS Protect's standards and shall review the outcomes of Counter Fraud work.

Management

- 7.11 The Committee shall request and review reports and positive assurances from members of the Executive Team and managers on the overall arrangements for governance, risk management and internal control.
- 7.12 They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Annual Report and Financial Reporting

- 7.13 The Committee shall monitor the integrity of the financial statements of the Trust and the formal announcements relating to the Trust's financial performance.
- 7.14 The Committee should ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.
- 7.15 The Committee shall review the Annual Report and Financial Statements before submission to the Trust Board, focusing particularly on:
- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
 - Changes in, and compliance with, accounting policies and practices
 - Unadjusted mis-statements in the financial statements
 - Significant judgements in preparation of the financial statements
 - Significant adjustments resulting from the audit
 - The letter of Management Representation
 - Explanations for significant variances
 - Qualitative aspects of financial reporting

Whistleblowing ("Speaking Out Safely")

- 7.16 The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety

matters and ensure that any such concerns are investigated proportionately and independently. [The usual method of meeting this duty would be to commission an Internal Audit review of the arrangements.](#)

Auditor Panel

- 7.17 As the Auditor Panel, the Committee shall advise the Trust Board on the selection and appointment of the Trust's External Auditor. This includes:
- agreeing and overseeing a robust process for selecting the External Auditors in accordance with the Trust's normal procurement rules
 - making a recommendation to the Trust Board as to who should be appointed (ensuring that any conflicts of interest are dealt with effectively)
 - Advise the Trust Board on the maintenance of an independent relationship with the appointed External Auditor
 - Advise (if asked) the Trust Board on whether or not any proposal from the External Auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable
 - Advise on (and approve) the contents of the Trust's policy on the purchase of non-audit services from the appointed External Auditor
 - Advise the Trust Board on any decision about the removal or resignation of the External Auditor

8. Parent committee and reporting procedure

- 8.1 The committee is a sub-committee of the Trust Board.
- 8.2 The minutes of Committee meetings shall be formally recorded by the Trust Secretary. The [Chairman](#) of the Committee shall also provide a brief written report to the Trust Board, summarising the issues covered at the meeting and drawing to the attention of the Board any issues that require disclosure to the full Board, or require executive action.
- 8.3 The Committee will report to the Trust Board annually (via a written Annual Report) on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and embeddedness of risk management in the organisation, and the integration of governance arrangements. The Annual Report should also describe how the Committee has fulfilled its Terms of Reference, and give details of any significant issues that the Committee considered in relation to the financial statements, and how these were addressed. [The work of the Committee as the Trust's Auditor Panel should also be included.](#)
- 8.4 The Committee shall undertake an annual self assessment to ensure the objectives of the Terms of Reference are being met.
- 8.5 The [Chairman](#) must report to the Trust Board on how the Auditor Panel has discharged its responsibilities.
- 8.6 The [Chairman](#) must draw to the attention of the Trust Board any issues that require disclosure to the Board in relation to Auditor Panel duties.

9. Sub-committees and reporting procedure

- 9.1 The Committee has no sub-committees.

10. Administrative arrangements

- 10.1 The Committee shall be supported administratively by the Trust Secretary, whose duties in this respect will include:
- Maintenance of a forward programme of work, setting out the dates of planned meetings and key agenda items
 - Agreement of agenda for next meeting with [Chairman](#), allowing adequate notice for reports to be prepared which adequately support the relevant agenda item.

- Collation and distribution of agenda and reports one week before the date of the meeting
- Ensuring the minutes are taken and that a record is kept of matters arising and issues to be carried forward
- Advising the Committee on all pertinent areas

11. Emergency powers and urgent decisions

- 11.1 The powers and authority which the Trust Board has delegated to the Audit and Governance Committee may, when an urgent decision is required between meetings, be exercised by the Chairman of the Committee, after having consulted at least two Non-Executive Director members. The exercise of such powers by the Committee Chairman shall be reported to the next formal meeting of the Audit and Governance Committee, for formal ratification.

12. Review of Terms of Reference and Monitoring Compliance

- 12.1 These Terms of Reference will be agreed by the Audit and Governance Committee and approved by the Trust Board. They will be reviewed annually or sooner if there is a significant change in the arrangements.

Terms of Reference agreed by Audit and Governance Committee: April 2013

Terms of Reference approved by the Board: May 2013

Terms of Reference agreed by the Audit and Governance Committee, November 2014

Terms of Reference approved by the Trust Board, December 2014

Terms of Reference agreed by the Audit and Governance Committee, November 2015

Terms of Reference approved by the Trust Board, November 2015

Terms of Reference agreed by the Audit and Governance Committee, February 2016 (N.B. the Board had already authorised the Audit and Governance Committee to agree changes in relation to the Committee's role as Auditor Panel)

Terms of Reference agreed by the Audit and Governance Committee, November 2016

Trust Board Meeting - November 2016**11-20 Summary report from Quality Committee, 09/11/16****Committee Chair (Non-Executive Director)**

The Quality Committee met on 9th November 2016. It was 'main' meeting.

The key matters considered at the meeting were as follows:

- The Chief Nurse was invited to raise any **quality matters arising from the Financial Recovery Plan (FRP)** (the Finance Committee had agreed that this should be discussed at the Quality Committee). It was reported that some Quality Impact Assessment (QIA) clinics had been held, to consider proposed schemes, and it was noted that the QIA process involved allocating a score to each scheme, and identifying any mitigating actions that were intended. It was reported that the only scheme resulting in concerns was the Nursing staffing scheme which had been discussed at various forums (including the Trust Board). When asked, the Chief Nurse confirmed that the Committee could take assurance that any actions arising from FRP schemes that had been subject to a full QIA thus far would not affect the quality of care.
- The **latest Stroke care performance** was reported. The report that was received is enclosed at Appendix 1 (following a previous request from the Board). It was noted that there had been further improvement on the Sentinel Stroke National Audit Programme (SSNAP) indicators, and Maidstone Hospital was now rated (overall) as the top local provider on the SSNAP. It was also noted that there had been some direction from the Kent and Medway Stroke review and Sustainability and Transformation Plan, but there was a consensus among the Trust's Stroke teams that it was best to continue working from the Trust's 2 hospital sites until the outcome of the wider reviews was clear
- The Chief Nurse submitted the report following a **review of Nursing documentation**, which had been requested following the discussion of the findings from national clinical audits at a previous Committee meeting. It was noted that a large range of documentation was in place, and the intention was to reduce the number requiring fee-text documenting of Care Plans. The Committee also heard that Falls-related documentation had been streamlined, to make the assessment & Care Plan more useful. It was however noted that the volume of documentation required, and the need for this to be entered contemporaneously was challenging, and it could take up to 1 hour to complete the required documentation for each patient admission.
- The latest situation regarding **Cancer waiting time target performance** was reported by the Chief Operating Officer. It was noted that despite the struggle to achieve the 2-week and 62-day waiting time targets over the past year, there had been 2 months of delivering the 2-week wait target. The risks to the 62-day first definitive treatment target were reported, and although it was noted that there had been improvements in the Breast and Lung Tumour Groups, improvement was still required in Colorectal. It was however highlighted that a Workshop was planned to be held to focus on the new actions required, a Clinical Nurse Specialist (CNS) had been appointed, and funding had also been obtained from Macmillan for a further CNS. The Committee also heard that despite the need to improve, it remained the case that there were no adverse outcomes reported for Colorectal patients
- The assurance report from the **Trust Clinical Governance Committee** was reviewed. The Chair of that Committee (the Medical Director) introduced the key issues, which included the view that the Committee was becoming more embedded. In response to a query, the Medical Director stated that the evidence indicated that Sepsis care at the Trust was adequate.
- The Clinical Directors, Matrons and/or General Managers were then invited to report any issues from the Directorate sections of the report. The key points reported were as follows:
 - Mortality reviews were an area of high risk for Specialist Medicine & Therapies, as these were only being undertaken sporadically
 - The main concern for Acute and Emergency was recruitment and retention, particularly for the A&E at Tunbridge Wells Hospital (TWH). However, it was noted that increasing patient demand was now reflected in a new establishment/rota, which had been agreed by the Executive Team. The General Manager for the Directorate expressed confidence that the

plan was robust, and would reduce Locum expenditure. It was noted that all posts were anticipated to be filled by March or April 2017.

- For Surgery, it was noted that reconfiguration of beds had now occurred
- Head & Neck reported that there had been 3 cases of endophthalmitis following intravitreal injection, but following investigation, only 1 was found to be infectious, which was within the national rate (endophthalmitis was recognised as a potential complication of intravitreal injection). It was also noted that an intravitreal injection checklist was being developed (which was similar to the WHO surgical checklists)
- Trauma & Orthopaedics acknowledged the need to improve the completion of Mortality reviews, but highlighted that Ward 32 had been identified as having the lowest amount of falls at the Trust. The Clinical Director also reported that an implant company had issued a Field Safety Notice regarding Femoral Heads, and the relevant implants had been removed from the Trust's stock. It was noted that the records of any patients that had already received the implants would be reviewed to consider whether any action was required.
- Critical Care reported that Theatre vacancies were their main problem, particularly at TWH, though a significant amount of work was being done, including overseas recruitment
- Cancer and Haematology highlighted that it had now been agreed to relocate breach risks regarding Cancer targets, but further education was required with the other Trusts that referred patients to the Trust. It was also noted that Oncology Consultant recruitment remained an issue, but active recruitment was underway. The Medical Director also pointed out that Haematology needed to improve the completion of Mortality reviews
- Diagnostics & Pharmacy reported that Histopathology turnaround times continued to improve, and performance on the antibiotic-related CQUIN targets was going well, but the required level of performance for Quarter 4 would be challenging
- Women's & Sexual Health reported that there were concerns about Sonography capacity, due to staff leaving to go on maternity leave and retirement, and a possible increase in demand. Concern regarding Waiting times for Gynaecology patients was also expressed, but it was noted that extra clinics and Theatre sessions were being planned
- For Children's services, the lack of Paediatric Nurses in the Paediatric A&E was noted to be a concern, but it was reported that it was intended that Nurses would rotate to the A&E from Paediatrics, as the latter department did not have any vacancies. It was also reported that 4 extra inpatient beds were being created on Hedgehog Ward (by relocating a treatment room and the 'den' that was used by teenage patients). The Clinical Director was also commended for the Directorate's efforts in overcoming the recruitment challenges it had faced, but in ensuring discussion, the recent problems the Directorate had faced in obtaining approval from the Recruitment Panel to extend the term of some existing posts was noted. It was agreed that the issue be raised at the Trust Board, as part of this summary report from the Committee.
- The summary report from the **Patient Experience Committee** held on 06/09/16; and the unapproved minutes of the **Quality Committee 'deep dive' meeting** of 05/10/16; were noted
- An update on **Serious Incidents** (SIs) was given, and queries were raised regarding some of the cases. The Chief Nurse also noted that the Learning and Improvement (SI) Panel had met earlier that day, and the most recent Never Event had been reviewed in detail (a more detailed review of this is scheduled for the 'main' Quality Committee in January 2017)
- An update was given on the outcome of the **Internal Audit advisory review regarding Never Events** (which had been commissioned following the Safety Moment at May 2016 Board meeting). It was noted that the review concluded that adequate processes in place to minimise the risk of all but one of the 13 relevant Never Events occurring, but the full review report, with the full response, would be submitted to the 'main' Quality Committee in January 2017
- The Chief Operating Officer gave a **report on the work being done to reduce Length of Stay** and emphasised that the SAFER bundle was a key aspect of the work being undertaken, but it was highlighted that there was a lead-in time before compliance became embedded
- Finally, the Committee was notified that an **evaluation survey** would be issued, which would provide Committee members with an opportunity to identify for any areas of improvement

1. The Committee agreed that (in addition to any actions noted above):

- An “update report on the work to reduce Length of Stay” should be scheduled for each future meeting of the ‘main’ Quality Committee

2. The issues that need to be drawn to the attention of the Board are as follows:

- It was agreed to highlight to the Board the concerns raised by the Clinical Director for Children’s Services regarding the appropriateness of the Trust Recruitment Panel’s response to the Directorate’s requests to extend the term of some fixed-term Medical posts

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

Appendix 1: Update on Stroke care performance reported to 'main' Quality Cttee on 09/11/16

QUALITY COMMITTEE - NOVEMBER 2016

11-6	UPDATE ON THE LATEST STROKE CARE PERFORMANCE	CLINICAL DIRECTOR, SPECIALIST MEDICINE AND THERAPIES
<p>The enclosed report provides information on:</p> <ul style="list-style-type: none">▪ Current stroke performance against national benchmarks▪ Actions being taken to maintain and further improve standards		
<p>Reason for receipt at the Quality Committee (decision, discussion, information, assurance etc.) Information and assurance</p>		

1. Introduction

Following the initial Quality & Safety Committee's 'Deep Dive' into the Trust Stroke services in July 2014, updates have been requested and produced for presentation at each Quality Committee. This provides both an update on the transformation of stroke services across the Trust in addition to regional benchmarking. The paper also allows assurance on the quality of care being delivered within the Trust. As from May 2015, a more compact report showing Stroke headlines was requested to replace the full paper. This is the ninth short headline paper to be presented to the Quality Committee.

2. Performance Standards

Information is now collected monthly by the Trust to give internal assurance about delivery against the Sentinel Stroke National Audit Programme (SSNAP). The Trust continues to review its own targets to continue to drive improvements within stroke care, adhere to national standards and drive excellence in stroke care.

2.1 CT scan performed in under an hour:

- Data for scanning in September within 1 hour has continued to perform well. Tunbridge Wells Hospital (TWH) scanned 61.5% within an hour and Maidstone Hospital (MH) scanned 59.3% of patients within 1 hour. This indicated that both units were scanning within the top quartile and effectively achieving an equivalent of a SSNAP "A" Level, which requires 48% of patients to be scanned within an hour.
- 12 hour scanning also showed a static position with TWH scanning 88.5% of patients within 12 hours and Maidstone scanning 88.9%.
- SSNAP data for the period April – July 2016 to be working at a SSNAP level "B". This is a static position for TWH but a drop for Maidstone which was expected due to the dip in performance in May as outlined in Septembers quality and safety report.
-

2.2 Proportion of all stroke patients given thrombolysis (all stroke types) and 2.3 Percentage of thrombolysed patients with a door-to-needle time <60mins is as follows:

- September data indicates that there was a mixed picture in regards to thrombolysed patients with an increase at TWH to 11.5%. Of these patients' thrombolysed at TWH 67% were thrombolysed within 60 minutes. This equated to 2/3 patients.
- At MH September data showed 3.7% of patients were thrombolysed, although August had a better picture at 8%. In September this equated to 1 patient, who was not thrombolysed within an hour. Nationally the average percentage of patients' thrombolysed is 11.9%. As mentioned within previous reports, monthly clinical governance has not indicated that any eligible patients were not thrombolysed for any reason other than medical contra indications.

2.4 Proportion of Patients admitted to the stroke unit within four hours:

- September data within this performance indicator shows that MH admitted an astounding 70.4% of stroke patients to the stroke unit within 4 hours, which has significantly increased from previous poor performance in June at 34.6%. This is thought to be due to the re confirmation with action plan meetings, discussion with site practitioners and Junior Dr's and CNS team working "bank" to support the direct transfers. This however, is not consistent and sustainable as previously mentioned – Nurses have felt more constraint on their time, releasing a nurse from the ward has become more difficult, and once released were unable to pull the patient to CT, and ultimately to the stroke unit as needed to return to the stroke unit early as are often also in charge of the ward and needing to support a very junior team. ASU and Ward 22 at TWH continue to have a significant number of medical inliers, making access to the stroke beds difficult. The new pathway commenced in September and appears to be working well but needs to continue to have the ring fenced beds protected.

2.5 Assessment by a stroke physician within 24 hours:

- Monthly data from July indicates specialist assessments were completed within 24 hours in 46.2% of cases at TWH due the only stroke consultant being on leave for 3/5. However, experienced senior stroke Dr's were available to assess them. The lack of a stroke consultant has been raised as a patient safety concern due to acute strokes being admitted to TWH with no stroke consultant available for a significant period of time. MH had 62.3% assessed within 24 hours which has very much remained the same since the start of the new financial year. The national average for this indicator is 80.5%. The indicator is heavily reliant upon a 7 day consultant service.

2.6: Current 80/90 Performance

Year to date for 16/17 commencing April 2016 has a current performance of 85.4%. Care must continue to be taken to monitor capacity at Maidstone, as stroke diverts have been placed to divert the stroke service from TWH to Maidstone due to a lack of stroke trained nurses to hold the bleep. This has meant an increase in flow to Maidstone's stroke unit and patients being removed from their stroke pathway to outlying medical wards to free up ring fenced stroke beds.

2.7: CQUIN achievement for 15-16

- ***The new CQUIN for 15-16 has been agreed which is focused upon Early Supported Discharge (ESD) use to reduce Length of stay (LOS).***

An audit regarding the health and social care documentation has been completed, with an action plan ready for submission to the CCG.

The stroke bi yearly SSNAP organisational audit has been completed and the outcomes will be reported at the next Q&S committee.

3. Conclusion

Data has been varied with peaks dips in performance cross site over the month of September

Local improvements and contingency plans continue to be in place to mitigate against the risks, in the form of SECAMB diverts where required, and support of cross site nursing team. Nursing options have been escalated up within the directorate to address the significant nursing challenges. A risk summit has also been held where a consensus was met which agreed to continue to provide stroke services cross site in the short-medium term. A paper will be written to present to TME with proposal and investment required.

The

Below is an update of Kent's SSNAP results for April – June 2015, July - September 2015, October – December 2015, January – March 2016 and most recently April 2016-July 2016 which places Maidstone as the highest performing unit in Kent. TWH were 4th, and missed out on a "C" grade due to being penalised for poor audit compliance. The audit compliance primarily addresses key stroke assessments such as the NIHSS being completed on admission.

April – June 2015

- Queen Elizabeth SSNAP Level C (64.1 points)
- Maidstone SSNAP Level C (63.7 points)
- Darent Valley SSNAP Level C (62.3 points)
- William Harvey SSNAP Level C (60.8 points)
- TWH SSNAP Level D (57.9 points)
- Kent and Canterbury SSNAP Level D (47 points)
- Medway Maritime SSNAP Level D (43.7 points)

July – September 2015

- William Harvey SSNAP Level B (70.3 points)
- Queen Elizabeth SSNAP Level C (68.4 points)
- Maidstone SSNAP Level C (63.7 points)
- TWH SSNAP Level D (58.9 points)
- Darent Valley SSNAP Level D (57 points)
- Kent and Canterbury SSNAP Level D (55.6 points)
- Medway Maritime SSNAP Level D (46.5 point)

October – December 2015

- Queen Elizabeth Hospital SSNAP Level A (86 points)
- Maidstone Hospital SSNAP Level B (71 points)
- William Harvey Hospital SSNAP Level D (59.8 points)
- Kent and Canterbury Hospital SSNAP Level D (50.4 points)
- Tunbridge Wells Hospital SSNAP Level D (50.3 points)
- Medway Maritime Hospital SSNAP Level D (46.5 points)
- Darent Valley Hospital SSNAP Level D (37.6 points)

January – March 2016

- Queen Elizabeth Hospital SSNAP Level A (88 points)
- Maidstone Hospital SSNAP Level B (75 points)
- William Harvey Hospital SSNAP Level B (70 points)
- Tunbridge Wells Hospital SSNAP Level D (58.9)
- Kent and Canterbury Hospital SSNAP Level D (47.7 points)
- Medway Maritime Hospital SSNAP Level D (47.5)
- Darent Valley Hospital SSNAP Level D (41.5 points)

April – July 2016

- Maidstone Hospital SSNAP Level B (70 points)
- William Harvey Hospital SSNAP Level C (68 points)
- Queen Elizabeth Hospital SSNAP Level C (64.6 points)
- Tunbridge Wells Hospital SSNAP Level D (58.8 points)
- Kent and Canterbury Hospital SSNAP Level D (56 points)
- Darent Valley Hospital SSNAP Level D (43.3 points)
- Medway Maritime Hospital SSNAP Level D (42.3 points)

Trust Board meeting – November 2016

11-21 Summary of the Trust Management Executive (TME) meeting, 16/11

Deputy Chief Executive

The TME has met once since the last Board meeting. The key items covered were as follows:

- Proposals for **revised functioning and Terms of Reference (ToR)** were discussed, & approved. The main change is that Clinical Directors will no longer be required to submit a report to TME on their Directorates, as the minutes from the Divisional Board meetings will now serve the purpose of reporting issues (from the 3 clinical Divisions). The revised ToR (with the changes ‘tracked’) are enclosed in Appendix 1 (for information)
- In the **safety moment**, the Chief Nurse reported the action being taken to prevent falls, which was the key patient safety priority for November. The need for medication to be constantly reviewed was highlighted, as this was a key factor for falls
- The key issues highlighted via the **reports from the Clinical Directors (CD)** were as follows:
 - Cancer and Haematology: As part of the national replacement programme for Linear Accelerators (LinAcs), NHS England had offered to fund 1 LinAc in 2016/17, 2 LinAcs in 2017/18, and 1 LinAc for 2018/19. Liaison was also continuing with other local providers in relation to the Cancer Service Level Agreements (SLAs), and the Deputy Chief Executive had issued a letter to such providers.
 - Children’s Services: The Trust’s Tongue-tie service had been suspended (following an incident). Referrals were continuing to be received, but these were being directed to King’s College Hospital NHS Foundation Trust. It was confirmed that there had been no significant concern raised as a result of the suspension
 - Critical Care: Obstetric anaesthetic provision had been subject to a gap analysis, and the additional provision required had been calculated. The pre-assessment service was also in need of review, following some recent issues (the Chief Operating Officer agreed to liaise with the CD for Critical Care to aim to address the situation)
 - Diagnostics & Pharmacy: There had been difficulty in appointing a Breast Consultant Radiologist, and although the service was coping, via the engagement of Locum staff, the service was precarious
 - Acute and Emergency: The Acute Medical Unit (AMU) was under a period of increased incidence (PII) for falls. Collaboration between Acute and Emergency and Women’s and Children’s services was also continuing, now that the Paediatric A&E was in place, and it had been agreed to second Paediatric Nurses from the Paediatrics department (in response to recent staffing issues), and to swap some roles across the Directorates. It was also noted that the Urgent Care Division had the largest number of vacancies in the Trust, and in response, a stand had been purchased at the forthcoming ‘Acute & General Medicine’ conference being held at the ExCeL in London
 - Specialist Medicine and Therapies: Staffing gaps continued in certain specialities, although there had been an improvement compared to the previous year
 - Surgery: The Directorate had taken possession of new Surgical Assessment Unit (SAU), and the Unit was currently full, the Chief Operating Officer expressed confidence that the new Unit would function as intended in the future
 - Head and Neck: Access issues continued in relation to follow-up appointments, particular for Oculoplastics. Staffing issues also remained, and there was a focus to improve the quality of the posts, to increase their attractiveness to prospective candidates. The Medical Director also confirmed that the Trust’s Endophthalmitis rate was in accordance with national levels (there had been some recent cases of Endophthalmitis associated with intravitreal injections)
 - Trauma & Orthopaedics: The Directorate’s new General Manager, Jan Edmondson, started in post on 21/11. An update on the “Trauma & Orthopaedics 2020” programme was also given.
 - Women’s and Sexual Health: Staffing was the largest issue of concern, particularly in relation to Anaesthetic provision on the Labour Ward, and there was recognition of the need to expedite the issue. It was also noted that the Inquest into the death of Mrs Cappuccini would

take place in January 2017

- The Director of Finance reported on progress **against the Financial Recovery Plan**
- The **performance for month 7**, 2016/17 was discussed (which included a detailed report on Cancer waiting times)
- The latest position regarding **infection prevention and control** was reported, & it was noted that there had been an MRSA bacteraemia case in November. It was also noted that there was now a target to reduce E. coli bacteraemia by 50% across the entire health economy by 2020.
- The latest report from the **Trust Clinical Governance Committee** was noted
- An update on the **Kent and Medway Sustainability and Transformation Plan (STP)** was given
- The Director of Finance gave an update on **business planning for 2017/18 & 2018/19**, which noted that the Trust's control total for 2017/18 had been set as a deficit of no more than £4.5m
- The Chief Operating Officer reported the final outcome of the current **review of bed configuration/capacity**, and it was noted that the changes had been implemented from 01/11/16
- The Chief Operating Officer also reported on the final version of the **Winter and Operational Resilience Plan**
- An update on the planned **implementation of the SAcP (replacement PAS+)** was given, which included the latest on the 3 key reasons for the delay (Order Communications, the Contract Data Set File, and training). It was noted that liaison was continuing with Allscripts, but the Trust's PAS would not be changed until early March 2017
- The **Business Cases** that had been approved since the last TME meeting were noted, and 2 **replacement Consultant posts were approved** (for a Consultant Ophthalmologist with interest in Oculoplastics; and a Consultant Rheumatologist)
- The **Board Assurance Framework for 2016/17** was received, and an update on the **Internal Audit plan for 2016/17** (including outstanding actions) was noted
- Formal updates were received on the work of the TME's main **sub-committees** (Health & Safety Committee, Clinical Operations & Delivery Committee, Information Governance Committee, Informatics Steering Group, Policy Ratification Committee, and MTW Programme Committee).
- Under Any Other Business, it was noted that a **bed audit** would take place on 22/11/16, which related to STP planning, and similar audits would take place at all local Trusts on the same day. It was also highlighted that 2 senior members of the Trust's staff (Helen Burn and Gemma Craig) had been awarded **scholarships from the Florence Nightingale Foundation**

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

Appendix 1: Revised Terms of Reference for TME (for information)

TRUST MANAGEMENT EXECUTIVE (TME)

TERMS OF REFERENCE

1. Purpose

- 1.1. The Trust Management Executive (TME) is the senior management committee within the Trust. Its purpose is to oversee and direct:
 - 1.1.1 The effective operational management of the Trust, including achievement of standards, targets and other obligations
 - 1.1.2 The delivery of safe, high quality, patient-centred care
 - 1.1.3 The development of Trust strategy, culture and policy
 - 1.1.4 The identification, mitigation and escalation of assurance and risk issues

2. Membership

- 2.1. The membership of the TME is as follows:
 - 2.1.1. [Deputy](#) Chief Executive (Chair)
 - 2.1.2. Medical Director
 - 2.1.3. Chief Nurse
 - 2.1.4. Director of Finance
 - 2.1.5. Chief Operating Officer
 - 2.1.6. Director of Workforce ~~and Communications~~
 - 2.1.7. ~~Deputy~~ Chief Executive (Vice-Chair)
 - 2.1.8. Clinical Directors (x ~~8~~10)
 - 2.1.9. Director of Infection Prevention Control (if not already represented under 2.1.8)
 - 2.1.10. Chief Pharmacist
 - ~~2.1.11.~~ [Trust Lead Cancer Clinician](#)
 - ~~2.1.12.~~ [Director of Operations, Planned Care](#)
 - ~~2.1.13.~~ [Director of Operations, Urgent Care](#)
 - ~~2.1.11.~~~~2.1.14.~~ [Associate Director of Operations, Women's, Paediatrics and Sexual Health](#)
- 2.2. Members should send appropriate deputies, when they are unable to attend in person

3. Attendance and quorum

- 3.1. Others may attend by the invitation of the Chair for specific agenda items.
- 3.2. Meetings will be quorate when attended by no less than ~~6~~8 members which includes a minimum of 3 Executive Directors (2.1.1 to 2.1.7 above, one of whom will Chair the meeting), ~~and 4~~3 Clinical Directors, ~~and 1 Director of Operations or Associate Director of Operations.~~

4. Frequency of meetings

- 4.1. Meetings will be generally held monthly, usually on the third Wednesday of the month.
- 4.2. Additional meetings will be scheduled as necessary at the request of the Chair.
- 4.3. The Trust Secretary will ensure that appropriate secretarial support is provided. This will include agreement of the agenda with the Chair, collation of [report papers](#), taking meeting minutes and keeping a record of agreed actions.

5. Sub-committees and reporting procedure

- 5.1. The following sub-committees report to the TME through their respective Chairs or representatives following each meeting. The frequency of reporting will depend on the frequency of each of the sub-committees:
 - 5.1.1. Capital Programme Meetings (x 3 - for Estates, IT and Equipment)
 - 5.1.2. Clinical Directors' Committee
 - 5.1.3. Clinical Operations & Delivery Committee

- 5.1.4. Health & Safety Committee
- 5.1.5. Information Governance Committee
- 5.1.6. Informatics Steering Group
- 5.1.7. MTW Programme Committee
- 5.1.8. Nursing, Midwifery and AHP Committee
- 5.1.9. Patient Environment Committee
- 5.1.10. Policy Ratification Committee
- 5.1.11. Private Patient Committee
- 5.1.12. Procurement Strategy Committee
- 5.1.13. Sustainable Development & Environment Committee
- 5.1.14. Trust Clinical Governance Committee

The Terms of Reference of TME sub-committees are not required to be approved by the ~~TMErust Management Executive~~ as a matter of routine. However such approval will be required if so determined by the Chair. Such approval will be required for sub-committees that have been established at the specific request of the TME.

6. Parent Committee and reporting procedure

- 6.1 The TME has no parent committee, but will provide a summary report to the Trust Board (and to appropriate Board sub-Committees where required) on its activities / decisions

7. Duties

Strategy ~~and plans and objectives~~

- 7.1 Develop and agree proposals for submission to the Trust Board on the Trust's strategy, vision, aims, objectives and values
- 7.2 Discuss proposals for submission to the Trust Board on the Trust's annual plan/s, including the revenue and capital budgets / plans.
- 7.3 Oversee the implementation of the annual plan/s

Finance

- 7.4 Oversee the annual ~~business~~ planning process, including budget setting, to ensure that financial plans are cohesive and deliverable and appropriately reflect (i) agreed service developments, (ii) activity projections, (iii) contract agreement and (iv) resourcing plans
- 7.5 To monitor monthly financial performance and forecasts (including capital) to aim to ensure that the Trust's annual financial plan is delivered

Performance ~~management~~

- 7.6 Review the Trust's overall performance, including review of the Trust Performance Dashboard
- 7.7 ~~Monitor compliance with relevant standards, targets and other obligations, and agree actions and responsibilities to address shortcomings or the development requirements identified~~
- 7.8 Agree actions and responsibilities in relation to key performance issues escalated from Performance Review meetings with ~~Directorates Divisions-~~
- 7.9 ~~Challenge progress against key performance indicators~~

Risk management and internal control

- 7.10 Ensure that robust risk management ~~strategies,~~ policies and processes are in place
- 7.11 Ensure that all key assurance and risk issues are identified and recorded
- 7.12 Oversee the management of the highest-rated risks
- 7.13 To escalate any risks of corporate significance or seriousness to the Trust Board, for consideration and/or action
- 7.14 To review and endorse the Trust's Annual Governance Statement, prior to this being considered at the Audit and Governance Committee and Trust Board

Quality

- 7.15 Review compliance with the national "fundamental standards", and agree and monitor action plans to address weaknesses in compliance or assurance

- 7.16 Oversee the effective delivery of safe, high quality, patient-centred care through monitoring integrated performance reports [and progress with Quality Accounts priorities](#), agreeing remedial actions where issues are identified, and monitoring implementation of such actions
- 7.17 The items in 7.15 and 7.16 will mainly be achieved through reporting from the Trust Clinical Governance Committee, although specific items may be brought directly to the TME with the agreement of the respective Chairs.

IT and Information Governance

- 7.18 Oversee the resolution of any IT-related operational issues. This will mainly be achieved through exception reporting from the Informatics Steering Group, although specific items may be brought directly to the TME with the agreement of the respective Chairs.
- 7.19 Review and endorse the draft Information Governance Toolkit year-end return for submission to the Trust Board
- 7.20 Oversee the implementation of effective arrangements for information governance. This will mainly be achieved through exception reporting from the Information Governance Committee, although specific items may be brought directly to the TME with the agreement of the respective Chairs.

Estates

- 7.21 Oversee strategic estates issues and ensure that the requirements of clinical services, and the need for the effective use of resources, are delivered through the investment in, and utilisation of, the Trust's buildings and sites. This will mainly be achieved through reporting from the MTW Programme Committee, although specific items may be brought directly to the TME with the agreement of the respective Chairs.

Workforce

- 7.22 Review and endorse workforce planning proposals to ensure that workforce projections meet current and future service delivery requirements
- 7.23 Monitor compliance with key workforce metrics, and ensure that effective actions are being taken to meet Trust targets
- 7.24 Review the annual national (and local) staff satisfaction surveys and agree actions and approaches to further improve levels of satisfaction and motivation and address any issues identified

Business cases

- 7.25 ~~Review and approve Business Cases (once such Cases have been considered by the Investment Appraisal Group), within the Committees' designated level of authority under the Trust's Standing Orders and Standing Financial Instructions. To note Business Cases approved by the Executive Members of the Investment Appraisal Group (IAG)~~
- 7.26 Review Business Cases [required to be approved by the Finance Committee and/or Trust Board](#), prior to review by the Finance Committee and/or Trust Board, and support / make recommendations, as required
- 7.27 Review and approve requests for replacement Consultant posts

8. Emergency powers and urgent decisions

- 8.1 The powers and authority of the TME may, when an urgent decision is required between meetings, be exercised by the Chair of the Committee, after having consulted at least two Executive Director members. The exercise of such powers by the Committee Chair shall be reported to the next formal meeting of the TME, for noting.
- 8.2 If the Chair agrees, a decision on an item can be made via 'virtual' means. In such circumstances, all TME members will be emailed the details of the proposed decision, and offered the opportunity to object, by a given date (this would be at least 2 working days from the date of issue of the email). If no objections are received, the proposal will be considered to be approved. If objections are received, the Chair will determine whether to a) defer the decision to a formal meeting (to enable discussion to occur) or b)

overrule the objection/s. If the latter is determined, an explanation will be provided to the next formal meeting.

9. Review

- 9.1 The ~~TME~~[Trust Management Executive](#) will review (and approve) its Terms of Reference at least annually
-

History

- Agreed by the Trust Management Executive, 22/01/14
- Approved by Trust Board, January 2014
- Amendments agreed by the Trust Management Executive, 23/04/14
- Approved by Trust Board, May 2014
- Amended following decision by Trust Board, November 2014 that the Trust Management Executive should no longer be a sub-committee of the Trust Board
- Amendments approved by the Trust Management Executive, 15/04/15 (annual review)
- Approval of addition of "Procurement Strategy Committee" as a formal sub-committee, November 2015
- [Amendments approved by the Trust Management Executive, 17/02/16 \(addition of several sub-committees, and refining of described processes to match actual practices\)](#)
- [Amendments approved by the Trust Management Executive, 16/11/16 \(to reflect new Divisional structure and changes to TME's functioning\)](#)

Trust Board Meeting – November 2016**11-22 Summary report from Finance Committee, 28/11/16****Committee Chair (Non-Executive Director)**

The Finance Committee met on 28th November 2016.

1. The key matters considered at the meeting were as follows:

- Under the “Safety Moment”, the Trust Secretary noted that the safety calendar theme for November was Falls prevention
- An update on progress in implementing the Financial Recovery Plan (FRP) was given, following the second review meeting with NHS Improvement (NHSI) on 23/11. The month 7 financial performance for 2016/17 was also reviewed
- The Deputy Chief Executive submitted a report on the proposed way forward for improving Medical productivity, and it was agreed that an update item/report should be scheduled for each Committee meeting from December onwards
- The financial aspects of the Trust’s draft Planning submissions for 2017/18 and 2018/19 were reviewed, noting that the Plans had been submitted to NHSI on 24/11
- The Deputy Director of Finance (Financial Performance) gave an update on the national planning initiatives/focus areas; and Lord Carter efficiency review, and it was agreed that similar reports should be submitted to each Committee meeting from December onwards
- The “Uncommitted Single Currency Interim Revenue Support Facility Agreement” that was approved by the Trust Board under its “Emergency powers and urgent decisions” provisions in November was received and noted
- A report of a post-project review of the Business Case for the Crowborough Birth Centre was reviewed, but it was noted that further work was required, and it was therefore agreed to consider the full review report in January 2017. A report was also received on the process for undertaking post-project review of Business Cases, and it was agreed to schedule 6-monthly reports on this subject, from February 2017
- The financial aspects of the Board Assurance Framework (BAF) were reviewed, and some changes to the content were agreed. It was also agreed that the Trust Secretary should arrange for the Trust Board to be asked to approve the Committee’s proposal to replace current objective 4.b with an alternative objective (see below)
- A briefing report was received on the PFI contract for Tun. Wells Hospital and it was agreed that the Deputy Chief Executive should liaise with representatives of the PFI Project Company, to assess the level of interest in exploring a potential extension to the term of the Project Agreement. The Director of Finance was also asked to provide further information in relation to a comment within the report. It was further agreed that the latest monthly report of the performance of the Project Company should be circulated to Committee members.
- The self-assessment against the Agency self-certification checklist required to be submitted to NHSI was reviewed, and recommended to the Board for approval. It was noted the Trust Board would be asked to approve the content on 30/11/16 (within the ‘Part 2’ meeting)
- The usual report on breaches of the external cap on the Agency staff pay rate was noted
- The Director of Finance reported on the outcome of the review the contract for the Financial Improvement Programme work undertaken by KPMG LLP
- The Deputy Chief Executive reported that NHS England Specialised Commissioning had offered to fund the replacement of the oldest Linear Accelerator (LinAc) at Maidstone Hospital, & that the Trust would be submitting the required expression of interest on 28/11. The potential to receive funding for a further 3 replacement LinAcs was also noted
- The Director of Finance informed the Committee of his intention to submit a report, for consideration at the Committee (and Board) in December 2016 regarding the potential disposal of the ‘Hillcroft’ and ‘The Springs’ properties held by the Trust

2. In addition the agreements referred to above, the Committee agreed that:

- The Director of Finance would provide an update to the Trust Board on 30/11/16 on the latest position regarding the 2016/17 contract negotiations with West Kent Clinical Commissioning Group (this update is expected to be given with the 'Part 2' Board meeting)

3. The issues that need to be drawn to the attention of the Board are as follows:

- The Committee felt that objective 4.b within the BAF ("To improve on the Trust's Income and Expenditure plan for 2016/17") should be replaced with an alternative objective, "To deliver the control total for 2016/17"
- The self-assessment against the Agency self-certification checklist required to be submitted to NHSI was reviewed, and the content was recommended for approval by the Board

Which Committees have reviewed the information prior to Board submission?

- N/A

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

- Information and assurance

Trust Board meeting – November 2016

11-24	Ratification of approval of “Uncommitted Single Currency Interim Revenue Support Facility Agreement”	Trust Secretary / Director of Finance
<p>On 07/11/16, the Trust Board was asked to use its “Emergency powers and urgent decisions” provisions, to approve the arrangement of an uncommitted loan facility.</p>		
<p>The specific terms of these provisions are as follows:</p>		
<ol style="list-style-type: none"> 1. “The powers which the Board has reserved to itself within the Standing Orders Set may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman of the Trust Board after having consulted at least two Non-Executive Directors”. 2. “The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Trust Board in public session (Part 1) for formal ratification”. 		
<p>Approval was duly granted, and the agreement was signed by a representative of the Secretary of State for Health at the Department of Health (with the agreement date being 08/11/16).</p>		
<p>In order to fulfil point 2. listed above, the decision to approve is required to be formally ratified. The Agreement has therefore been enclosed, and the Board is ask to ratify the decision.</p>		
<p>Which Committees have reviewed the information prior to Board submission?</p>		
<ul style="list-style-type: none"> ▪ N/A 		
<p>Reason for submission to the Board (decision, discussion, information, assurance etc.) ¹</p>		
<p>Formal ratification</p>		

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

DATED 8th November 2016

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
(as Borrower)

and

THE SECRETARY OF STATE FOR HEALTH
(as Lender)

£2,708,000

UNCOMMITTED SINGLE CURRENCY INTERIM REVENUE SUPPORT
FACILITY AGREEMENT

REF NO: DHPF/ISUCL/RWF/2016-11-04/A

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THIS AGREEMENT is dated 8th November 2016 and made between:

- (1) MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST of, Maidstone Hospital, Hermitage Land, Maidstone, Kent, ME16 9QQ (the "Borrower" which expression shall include any successors in title or permitted transferees or assignees); and
- (2) THE SECRETARY OF STATE FOR HEALTH as lender (the "Lender" which expression shall include any successors in title or permitted transferees or assignees).

IT IS AGREED as follows:

1. DEFINITIONS AND INTERPRETATION

1.1 Definitions

In this Agreement:

"Account" means the Borrower's account held with the Government Banking Service.

"Act" means the National Health Service Act 2006 as amended from time to time.

"Additional Terms and Conditions" means the terms and conditions set out in Schedule 8.

"Agreed Purpose" means working capital expenditure for use only if it has insufficient working capital available as set out under the Terms of this Agreement, to maintain the provision of the Borrower's services in its capacity as an NHS Body. For the purposes of this agreement, working capital expenditure shall include repayment of outstanding loans under any working capital facility provided by the Lender to the Borrower.

"Authorisation" means an authorisation, consent, approval, resolution, licence, exemption, filing, notarisation or registration.

"Available Facility" means the Facility Amount less:

(A) all outstanding Loans; and

(B) in relation to any proposed Utilisation, the amount of any Loan that is due to be made on or before the proposed Utilisation Date.

"Availability Period" means two years from and including the date of this Agreement. The Availability Period may be extended, at the Borrower's option, subject to no outstanding Event of Default. Any extension can be for a period of up to twelve months, subject to the Availability Period expiring no later than the Final Repayment Date.

"Business Day" means a day (other than a Saturday or Sunday) on which banks are open for general banking business in London.

"Capital Limit" means the overall maximum net inflow/outflow from investing activities incurred by the Borrower as set by the Lender for any relevant financial year

"Cash Balance" means the Borrower's available cash balances, whether held within the Government Banking Service or otherwise, on the Utilisation Date to the Monday preceding the 18th day of the following Month.

"Cashflow Forecast" means the Borrower's current rolling 13 week cashflow forecast in a form to be agreed with the Lender from time to time (and as prepared on behalf of the Borrower's Board). The forecast must include all utilisations and proposed utilisations under any agreement with the Lender for the relevant period.

"Compliance Framework" means the relevant Supervisory Body's frameworks and/or any replacement to such frameworks for monitoring and assessing NHS Bodies and their compliance with any consents, permissions and approvals.

"Dangerous Substance" means any natural or artificial substance (whether in a solid or liquid form or in the form of a gas or vapour and whether alone or in combination with any such other substance) capable of causing harm to the Environment or damaging the Environment or public health or welfare including any noxious, hazardous, toxic, dangerous, special or controlled waste or other polluting substance or matter.

"Default" means an Event of Default or any event or circumstance specified in Clause 18 (*Events of Default*) which would (with the expiry of a grace period, the giving of notice, the making of any determination under the Finance Documents or any combination of any of the foregoing) be an Event of Default.

"Default Rate" means the official bank rate (also called the Bank of England base rate or BOEBR) plus 300 basis points per annum.

"Deficit Limit" means the Surplus/Deficit outturn for the Borrower set by the Lender for any relevant financial year before impairments and transfers.

"Environment" means the natural and man-made environment and all or any of the following media namely air (including air within buildings and air within other natural or man-made structures above or below ground), water (including water under or within land or in drains or sewers and inland waters), land and any living organisms (including humans) or systems supported by those media.

"Environmental Claim" means any claim alleging liability whether civil or criminal and whether actual or potential arising out of or resulting from the presence at on or under property owned or occupied by the Borrower or presence in or escape or release into the environment of any Dangerous Substance from any such property or in circumstances attributable to the operation of the Borrower's activities or any breach of any applicable Environmental Law or any applicable Environmental Licence.

"Environmental Law" means all statutes, instruments, regulations, orders and ordinances (including European Union legislation, regulations, directives, decisions and judgements applicable to the United Kingdom) being in force from time to time and directly enforceable in the United Kingdom relating to pollution, prevention thereof or protection of human health or the conditions of the Environment or the use, disposal, generation, storage, transportation, treatment, dumping, release, deposit, burial, emission or disposal of any Dangerous Substance.

"Environmental Licence" shall mean any permit, licence, authorisation, consent or other approval required by any Environmental Law or the Planning (Hazardous Substances) Act 1990.

"Event of Default" means any event or circumstance specified as such in Clause 18 (*Events of Default*).

"Facility" means the uncommitted interim support facility made available under this Agreement as described in Clause 2 (*The Facility*).

"Facility Amount" means £2,708,000 at the date of this Agreement and thereafter that amount to the extent not cancelled, reduced or transferred by the Lender or the Borrower (as may be amended by the Lender from time to time).

"Final Repayment Date" means 18/11/2019.

"Finance Documents" means:

- (A) this Agreement; and
- (B) any other document designated as such by the Lender and the Borrower.

"Financial Indebtedness" means any indebtedness for or in respect of:

- (A) moneys borrowed;
- (B) any amount raised by acceptance under any acceptance credit facility;
- (C) any amount raised pursuant to any note purchase facility or the issue of bonds, notes, debentures, loan stock or any similar instrument;
- (D) the amount of any liability in respect of any lease or hire purchase contract which would, in accordance with any applicable Audit Code for NHS Bodies, any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies, be treated as a finance or capital lease;
- (E) receivables sold or discounted (other than any receivables to the extent they are sold on a non-recourse basis);
- (F) any amount raised under any other transaction (including any forward sale or purchase agreement) having the commercial effect of a borrowing;
- (G) any derivative transaction entered into in connection with protection against or benefit from fluctuation in any rate or price (and, when calculating the value of any derivative transaction, only the marked to market value shall be taken into account);
- (H) any counter-indemnity obligation in respect of a guarantee, indemnity, bond, standby or documentary letter of credit or any other instrument issued by a bank or financial institution; and
- (I) the amount of any liability in respect of any guarantee or indemnity for any of the items referred to in paragraphs (A) to (H) above.

"Government Banking Service" means the body established in April 2008 being the banking shared service provider to government and the wider public sector incorporating the Office of HM Paymaster General (OPG).

"Interest Payment Date" means the last day of an Interest Period.

"Interest Period" means, in relation to a Loan, the period determined in accordance with Clause 9 (*Interest Periods*) and, in relation to an Unpaid Sum, each period determined in accordance with Clause 8.3 (*Default interest*).

"Interest Rate" means 1.5% per annum, or other applicable interest rate that shall be notified by the Lender to the Borrower in respect of each Loan upon Utilisation.

“Licence” means the licence issued by Monitor to any person who provides a health care service for the purposes of the NHS.

“Limits” means the Deficit Limit and/or the Capital Limit where set out in the Finance Document

“Loan” means a loan made or to be made under the Facility or the principal amount outstanding for the time being of that loan.

“Material Adverse Effect” means a material adverse effect on:

- (A) the business or financial condition of the Borrower;
- (B) the ability of the Borrower to perform any of its material obligations under any Finance Document;
- (C) the validity or enforceability of any Finance Document; or
- (D) any right or remedy of the Lender in respect of a Finance Document.

“Minimum Cash Balance” means £1,000,000;

“Monitor” means the sector regulator for health care services in England or any successor body to that organisation

“Month” means a period starting on one day in a calendar month and ending on the numerically corresponding day in the next calendar month, except that:

- (A) (subject to paragraph (C) below) if the numerically corresponding day is not a Business Day, that period shall end on the next Business Day in that calendar month in which that period is to end if there is one, or if there is not, on the immediately preceding Business Day;
- (B) if there is no numerically corresponding day in the calendar month in which that period is to end, that period shall end on the last Business Day in that calendar month; and
- (C) if a period begins on the last Business Day of a calendar month, that period shall end on the last Business Day in the calendar month in which that period is to end,

provided that the above rules will only apply to the last Month of any period.

“NHS Body” means either an NHS Trust or an NHS Foundation Trust , or any successor body to that organisation.

“NHS Improvement” means the body incorporating the roles of Monitor and the NHS Trust Development Authority and acting as the health sector regulator providing healthcare transformation, regulatory and patient safety expertise.

“NHS Trust Development Authority” means the body responsible for monitoring the performance of NHS Trusts and providing assurance of clinical quality, governance and risk in NHS Trusts, or any successor body to that organisation;

“Original Financial Statements” means a certified copy of the audited financial statements of the Borrower for the financial year ended 31st March 2015.

“Participating Member State” means any member state of the European Communities that adopts or has adopted the euro as its lawful currency in accordance with legislation of the European Community relating to Economic and Monetary Union.

"Party" means a party to this Agreement.

"Permitted Security" means:

- (A) normal title retention arrangements arising in favour of suppliers of goods acquired by the Borrower in the ordinary course of its business or arising under conditional sale or hiring agreements in respect of goods acquired by the Borrower in the ordinary course of its business;
- (B) liens arising by way of operation of law in the ordinary course of business so long as the amounts in respect of which such liens arise are not overdue for payment;
- (C) any existing Security listed in Schedule 7;
- (D) any Security created or outstanding with the prior written consent of the Lender; and
- (E) any other Security securing in aggregate not more than £150,000 at any time.

"Relevant Consents" means any authorisation, consent, approval, resolution, licence, exemption, filing, notarisation or registration of whatsoever nature necessary or appropriate to be obtained for the purpose of entering into and performing the Borrower's obligations under the Finance Documents.

"Relevant Percentage" means in respect of each Repayment Date, the percentage figure set opposite such Repayment Date in the Repayment Schedule.

"Repayment Dates" means the repayment dates set out in the Schedule 6 (Repayment Schedule).

"Repayment Instalment" means each instalment for the repayment of the Loan referred to in Clause 6.2.

"Repayment Schedule" means the repayment schedule set out in Schedule 6 (*Repayment Schedule*).

"Repeating Representations" means each of the representations set out in Clause 14 (*Representations*) other than those under Clauses 14.9, 14.10, 14.12.2 and 14.16.2.

"Security" means a mortgage, charge, pledge, lien or other security interest securing any obligation of any person or any other agreement or arrangement having a similar effect.

"Supervisory Body" means NHS Improvement, incorporating and representing both of the bodies previously known as the NHS Trust Development Authority and Monitor..

"Tax" means any tax, levy, impost, duty or other charge or withholding of a similar nature (including any penalty or interest payable in connection with any failure to pay or any delay in paying any of the same).

"Tax Deduction" means a deduction or withholding for or on account of Tax from a payment under a Finance Document.

"Test Date" means the Utilisation Date and each Interest Payment Date.

"Unpaid Sum" means any sum due and payable but unpaid by the Borrower under the Finance Documents.

"Utilisation" means a utilisation of the Facility.

"Utilisation Date" means the date of a Utilisation, on which a drawing is to be made under the Facility, such date to be the Monday preceding the 18th day of any month.

"Utilisation Request" means a notice substantially in the form set out in Schedule 2 (*Utilisation Request*).

"VAT" means value added tax as provided for in the Value Added Tax Act 1994 and other tax of a similar nature, whether imposed in the UK or elsewhere.

1.2 Construction

1.2.1 Unless a contrary indication appears, any reference in any Finance Document to:

- (A) the **"Lender"**, the **"Borrower"** the **"Supervisory Body"** or any **"Party"** shall be construed so as to include its successors in title, permitted assigns and permitted transferees;
- (B) **"assets"** includes present and future properties, revenues and rights of every description;
- (C) a **"Finance Document"** or any other agreement or instrument is a reference to that Finance Document or other agreement or instrument as amended or novated;
- (D) **"indebtedness"** shall be construed so as to include any obligation (whether incurred as principal or as surety) for the payment or repayment of money, whether present or future, actual or contingent;
- (E) a **"person"** includes any person, firm, company, corporation, government, state or agency of a state or any association, trust or partnership (whether or not having separate legal personality) or two or more of the foregoing;
- (F) a **"regulation"** includes any regulation, rule, official directive, request or guideline (whether or not having the force of law) of any governmental, intergovernmental or supranational body, agency, department or regulatory, self-regulatory or other authority or organisation;
- (G) **"repay"** (or any derivative form thereof) shall, subject to any contrary indication, be construed to include **"prepay"** (or, as the case may be, the corresponding derivative form thereof);
- (H) a provision of law is a reference to that provision as amended or re-enacted;
- (I) a time of day is a reference to London time; and
- (J) the word **"including"** is without limitation.

1.2.2 Section, Clause and Schedule headings are for ease of reference only.

1.2.3 Unless a contrary indication appears, a term used in any other Finance Document or in any notice given under or in connection with any Finance Document has the same meaning in that Finance Document or notice as in this Agreement.

1.2.4 A Default (other than an Event of Default) is **"continuing"** if it has not been remedied or waived and an Event of Default is **"continuing"** if it has not been waived or remedied to the satisfaction of the Lender.

1.3 Third party rights

1.3.1 Except as provided in a Finance Document, the terms of a Finance Document may be enforced only by a party to it and the operation of the Contracts (Rights of Third Parties) Act 1999 is excluded.

1.3.2 Notwithstanding any provision of any Finance Document, the Parties to a Finance Document do not require the consent of any third party to rescind or vary any Finance Document at any time.

2. THE FACILITY

- 2.1 Subject to the terms of this Agreement, the Lender makes available to the Borrower an uncommitted sterling interim support facility in an aggregate amount equal to the Facility Amount under the terms of which the Lender may, in its sole and absolute discretion, provide Loans to the Borrower from time to time, unless the Lender, in its sole and absolute discretion, has previously notified the Borrower of the termination of the Facility.
- 2.2 This agreement is not, nor shall it be deemed to constitute, a commitment on the part of the Lender to make any extension of credit to or for the account of the borrower and may not be relied upon by the Borrower for any financing.
- 2.3 The Lender reserves the right to revoke or withdraw this agreement and the facility in its sole and absolute discretion at any time.
- 2.4 The Facility shall be utilised by the Borrower for the purposes of and/or in connection with its functions as an NHS Body.

3. PURPOSE

3.1 Purpose

The Borrower shall apply all Loans towards financing or refinancing the Agreed Purpose.

3.2 Pending application

Without prejudice to Clause 3.1 (*Purpose*), pending application of the proceeds of any Loan towards financing or refinancing the Agreed Purpose, the Borrower must deposit such proceeds in the Account.

3.3 Monitoring

The Lender is not bound to monitor or verify the application of any amount borrowed pursuant to this Agreement.

4. CONDITIONS OF UTILISATION

4.1 Initial conditions precedent

The Borrower may not deliver the first Utilisation Request unless the Lender has received all of the documents and other evidence listed in Schedule 1 (*Conditions precedent*) in form and substance satisfactory to the Lender or to the extent it has not received the same, it has waived receipt of the same. The Lender shall notify the Borrower promptly upon being so satisfied.

4.2 Further conditions precedent

The Lender will only comply with a Utilisation Request if on the date of the Utilisation Request and on the proposed Utilisation Date:

- 4.2.1 No Event of Default might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware;
- 4.2.2 the Repeating Representations to be made by the Borrower with reference to the facts and circumstances then subsisting are true in all material respects; and,

- 4.2.3 the Borrower has provided to the Lender its most recent 13 week cash flow forecast, together with any other information that may from time to time be required.

5. UTILISATION

5.1 Utilisation

- 5.1.1 The Borrower may take Loans from time to time hereunder, subject to receipt by the Lender from the Borrower, of a Utilisation Request in accordance with this Agreement and an appropriate Cashflow Forecast.
- 5.1.2 The Utilisation Request must be for an amount not greater than the amount specified under Clause 5.4.2
- 5.1.3 Where agreed by the Lender, the proceeds of a Utilisation may be used to repay outstanding loans under any working capital facility between the Lender and the Borrower provided that:
- (A) Such agreement is granted by the Lender;
 - (B) any request is included in the Cashflow Forecast; and
 - (C) that such repayment is received by the Lender on the same working day as the Utilisation.

5.2 Delivery of a Utilisation Request

The Borrower may utilise the Facility by delivery to the Lender of a duly completed Utilisation Request not later than 11.00 a.m. five Business Days before the proposed Utilisation Date unless otherwise agreed.

- 5.2.1 The Borrower may only issue one Utilisation Request per Month unless otherwise agreed.

5.3 Completion of a Utilisation Request

The Utilisation Request is irrevocable and will not be regarded as having been duly completed unless:

- (A) the proposed Utilisation Date is a Business Day within the Availability Period; and
- (B) the currency and amount of the Utilisation comply with Clause 5.4 (*Currency and amount*).

5.4 Currency and amount

- 5.4.1 The currency specified in the Utilisation Request must be sterling.
- 5.4.2 The amount of each proposed Loan must be an amount which is not more than the amount required to maintain a Cash Balance equivalent to the Minimum Cash Balance for a period from the Utilisation Date to the Monday preceding the 18th day of the following Month
- 5.4.3 The amount of each proposed Loan must be an amount which is not more than the Available Facility and which is a minimum of £150,000 or, if less, the Available Facility.

5.5 Payment to the Account

The Lender shall pay each Loan:

- 5.5.1 by way of credit to the Account and so that, unless and until the Lender shall notify the Borrower to the contrary, the Lender hereby consents to the withdrawal by the Borrower from the Account of any amount equal to the relevant Loan provided that any sums so withdrawn are applied by the Borrower for the purposes for which the relevant Loan was made;
- 5.5.2 if the Lender so agrees or requires, on behalf of the Borrower directly to the person to whom the relevant payment is due as specified in the relevant Utilisation Request; or
- 5.5.3 in such other manner as shall be agreed between the Lender and the Borrower.

6. PAYMENTS AND REPAYMENT

6.1 Payments

- 6.1.1 The Borrower shall make all payments payable under the Finance Documents without any Tax Deductions, unless a Tax Deduction is required by law.
- 6.1.2 The Borrower shall promptly upon becoming aware that it must make a Tax Deduction (or that there is any change in the rate or the basis of a Tax Deduction) notify the Lender accordingly.
- 6.1.3 If a Tax Deduction is required by law to be made by the Borrower, the amount of the payment due from the Borrower shall be increased to an amount which (after making any Tax Deduction) leaves an amount equal to the payment which would have been due if no Tax Deduction had been required.
- 6.1.4 If the Borrower is required to make a Tax Deduction, the Borrower shall make that Tax Deduction and any payment required in connection with that Tax Deduction within the time allowed and in the minimum amount required by law.
- 6.1.5 Within thirty days of making either a Tax Deduction or any payment required in connection with that Tax Deduction, the Borrower shall deliver to the Lender evidence reasonably satisfactory to the Lender that the Tax Deduction has been made or (as applicable) any appropriate payment paid to the relevant taxing authority.

6.2 Repayment

The Borrower shall repay the aggregate value of all outstanding Loans drawn under the Facility in full on or before the last day of the current Availability Period as set out in Schedule 6 (*Repayment Schedule*).

6.3 Reborrowing

The Borrower may not reborrow any part of the Facility which is repaid or prepaid.

7. PREPAYMENT AND CANCELLATION

7.1 Illegality

If it becomes unlawful in any applicable jurisdiction for the Lender to perform any of its obligations as contemplated by this Agreement or to fund or maintain all or any part of the Loans:

- 7.1.1 the Lender shall promptly notify the Borrower upon becoming aware of that event:

7.1.2 upon the Lender notifying the Borrower, the Available Facility will be immediately cancelled; and

7.1.3 the Borrower shall repay such Loans on the last day of the Interest Period for Loans occurring after the Lender has notified the Borrower or, if earlier, the date specified by the Lender in the notice delivered to the Borrower (being no earlier than the last day of any applicable grace period permitted by law).

7.2 Voluntary cancellation

The Borrower may, if it gives the Lender not less than seven days' (or such shorter period as the Lender may agree) and not more than fourteen days' prior notice, cancel the whole or any part (being a minimum amount of £100,000) of the Facility Amount.

7.3 Voluntary prepayment of Loans

The Borrower may, if it gives the Lender not less than seven days' (or such shorter period as the Lender may agree) and not more than thirty days' prior notice, prepay the whole or any part of any Loan (but, if in part, being an amount that reduces the amount of the Loan by a minimum amount of £250,000).

7.4 Restrictions

7.4.1 Any notice of cancellation or prepayment given by any Party under this Clause 7 shall be irrevocable and, unless a contrary indication appears in this Agreement, shall specify the date or dates upon which the relevant cancellation or prepayment is to be made and the amount of that cancellation or prepayment.

7.4.2 Any prepayment under this Agreement shall be made together with accrued interest on the amount prepaid without premium or penalty and applied against the outstanding Repayment Instalments in inverse order of maturity.

7.4.3 The Borrower shall not repay or prepay all or any part of the Loan or cancel all or any part of the Available Facility except at the times and in the manner expressly provided for in this Agreement.

7.4.4 No amount of the Available Facility cancelled under this Agreement may be subsequently reinstated.

7.5 Automatic Cancellation

At the end of the Availability Period the undrawn part of the Available Facility will be cancelled.

8. INTEREST

8.1 Calculation of interest

The rate of interest on each Loan for each Interest Period is the Interest Rate.

8.2 Payment of interest

The Borrower shall pay accrued interest on each Loan on the last day of each Interest Period.

8.3 Default interest

8.3.1 If the Borrower fails to pay any amount payable by it under a Finance Document on its due date, interest shall accrue on Unpaid Sums from the due date up to the date of actual payment (both before and after judgment) at the Default Rate. Any interest

accruing under this Clause 8.3 shall be immediately payable by the Borrower on demand by the Lender.

8.3.2 Default interest (if unpaid) arising on an overdue amount will be compounded with the overdue amount at the end of each Interest Period applicable to that overdue amount but will remain immediately due and payable.

9. INTEREST PERIODS

9.1 Interest Payment Dates

The Interest Period for each Loan shall be six Months, provided that any Interest Period which begins during another Interest Period shall end at the same time as that other Interest Period (and, where two or more such Interest Periods expire on the same day, the Loans to which those Interest Periods relate shall thereafter constitute and be referred to as one Loan).

9.2 Shortening Interest Periods

If an Interest Period would otherwise overrun the relevant Repayment Date, it shall be shortened so that it ends on the relevant Repayment Date.

9.2A Payment Start Date

Each Interest Period for a Loan shall start on the Utilisation Date or (if already made) on the last day of its preceding Interest Period.

9.3 Non-Business Days

If an Interest Period would otherwise end on a day which is not a Business Day, that Interest Period will instead end on the next Business Day in that calendar month (if there is one) or the preceding Business Day (if there is not).

9.4 Consolidation of Loans

If two or more Interest Periods end on the same date, those Loans will be consolidated into and be treated as a single Loan on the last day of the Interest Period.

10. PREPAYMENT AMOUNT

10.1.1 If all or any part of the Loans are subject to a voluntary prepayment pursuant to Clause 7.3 (*Voluntary prepayment of Loans*), the Borrower shall pay to the Lender on the relevant prepayment date the Prepayment Amount in respect of the same.

10.1.2 For as long as the Secretary of State for Health remains the Lender, the Lender will consider waiving the Prepayment Amount in cases where the Borrower can demonstrate to the Lender's satisfaction that the voluntary prepayment results from the Borrower's proper use of genuine surplus funds resulting from a sale of assets or trading activities.

11. INDEMNITIES

11.1 Currency indemnity

11.1.1 If any sum due from the Borrower under the Finance Documents (a "**Sum**"), or any order, judgment or award given or made in relation to a Sum, has to be converted from the currency (the "**First Currency**") in which that Sum is payable into another currency (the "**Second Currency**") for the purpose of:

(A) making or filing a claim or proof against the Borrower:

- (B) obtaining or enforcing an order, judgment or award in relation to any litigation or arbitration proceedings,

the Borrower shall as an independent obligation, within five Business Days of demand, indemnify the Lender against any cost, loss or liability arising out of or as a result of the conversion including any discrepancy between (A) the rate of exchange used to convert that Sum from the First Currency into the Second Currency and (B) the rate or rates of exchange available to that person at the time of its receipt of that Sum.

- 11.1.2 The Borrower waives any right it may have in any jurisdiction to pay any amount under the Finance Documents in a currency or currency unit other than that in which it is expressed to be payable.

11.2 Other indemnities

The Borrower shall, within five Business Days of demand, indemnify the Lender against any cost, loss or liability incurred by the Lender as a result of:

- 11.2.1 the occurrence of any Event of Default;
- 11.2.2 a failure by the Borrower to pay any amount due under a Finance Document on its due date;
- 11.2.3 funding, or making arrangements to fund, all or any part of the Loans requested by the Borrower in a Utilisation Request but not made by reason of the operation of any one or more of the provisions of this Agreement (other than by reason of default or negligence by the Lender alone); or
- 11.2.4 the Loans (or part of the Loans) not being prepaid in accordance with a notice of prepayment given by the Borrower.

11.3 Indemnity to the Lender

The Borrower shall promptly indemnify the Lender against any cost, loss or liability incurred by the Lender (acting reasonably) as a result of:

- 11.3.1 investigating any event which it reasonably believes is a Default; or
- 11.3.2 acting or relying on any notice, request or instruction which it reasonably believes to be genuine, correct and appropriately authorised.

11.4 Environmental indemnity

The Borrower shall promptly indemnify the Lender within five Business Days of demand in respect of any judgments, liabilities, claims, fees, costs and expenses (including fees and disbursements of any legal, environmental consultants or other professional advisers) suffered or incurred by the Lender as a consequence of the breach of or any liability imposed under any Environmental Law with respect to the Borrower or its property (including the occupation or use of such property).

12. MITIGATION BY THE LENDER

12.1 Mitigation

- 12.1.1 The Lender shall, in consultation with the Borrower, take all reasonable steps to mitigate any circumstances which arise and which would result in any amount becoming payable under or pursuant to, or cancelled pursuant to Clause 7.1

(Illegality) including transferring its rights and obligations under the Finance Documents to another entity owned or supported by the Lender.

12.1.2 Clause 12.1.1 does not in any way limit the obligations of the Borrower under the Finance Documents.

12.2 Limitation of liability

12.2.1 The Borrower shall indemnify the Lender for all costs and expenses reasonably incurred by the Lender as a result of steps taken by it under Clause 12.1 (Mitigation).

12.2.2 The Lender is not obliged to take any steps under Clause 12.1 (Mitigation) if, in its opinion (acting reasonably), to do so might be prejudicial to it.

13. COSTS AND EXPENSES

13.1 Enforcement costs

The Borrower shall, within three Business Days of demand, pay to the Lender the amount of all costs and expenses (including legal fees) incurred by the Lender in connection with the enforcement of, or the preservation of any rights under, any Finance Document.

14. REPRESENTATIONS

The Borrower makes the representations and warranties set out in this Clause 14 to the Lender on the date of this Agreement.

14.1 Status

14.1.1 It is an NHS Body in accordance with the provisions of the Act.

14.1.2 It has the power to own its assets and carry on its business as it is being conducted.

14.2 Binding obligations

The obligations expressed to be assumed by it in each Finance Document are legal, valid, binding and enforceable obligations.

14.3 Non-conflict with other obligations

The entry into and performance by it of, and the transactions contemplated by, the Finance Documents to which it is party do not and will not conflict with:

14.3.1 any law or regulation applicable to it;

14.3.2 its constitutional documents; or

14.3.3 any agreement or instrument binding upon it or any of its assets.

14.4 Power and authority

It has the power to enter into, exercise its rights under, perform and deliver, and has taken all necessary action to authorise its entry into, performance and delivery of, the Finance Documents to which it is a party and the transactions contemplated by those Finance Documents.

14.5 Validity and admissibility in evidence

All Authorisations required:

14.5.1 to enable it lawfully to enter into, exercise its rights and comply with its obligations in the Finance Documents to which it is a party; and

14.5.2 to make the Finance Documents to which it is a party admissible in evidence in its jurisdiction of incorporation,

have been obtained or effected and are in full force and effect.

14.6 Relevant Consents

14.6.1 All Relevant Consents which it is necessary or appropriate for the Borrower to hold have been obtained and effected and are in full force and effect.

14.6.2 There exists no reason known to it, having made all reasonable enquiries, why any Relevant Consent might be withdrawn, suspended, cancelled, varied, surrendered or revoked.

14.6.3 All Relevant Consents and other consents, permissions and approvals have been or are being complied with.

14.7 Governing law and enforcement

14.7.1 The choice of English law as the governing law of the Finance Documents will be recognised and enforced by the courts of England and Wales.

14.7.2 Any judgment obtained in England in relation to a Finance Document will be recognised and enforced by the courts of England and Wales.

14.8 Deduction of Tax

It is not required to make any deduction for or on account of Tax from any payment it may make under any Finance Document.

14.9 No filing or stamp taxes

It is not necessary that the Finance Documents be filed, recorded or enrolled with any court or other authority in any jurisdiction or that any stamp, registration or similar tax be paid on or in relation to the Finance Documents or the transactions contemplated by the Finance Documents.

14.10 No default

14.10.1 No Event of Default might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware.

14.10.2 No other event which constitutes a default under any other agreement or instrument which is binding on it or to which its assets are subject which might have a Material Adverse Effect might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware.

14.11 No misleading information

14.11.1 All factual information provided by or on behalf of the Borrower in connection with the Borrower or any Finance Document was true and accurate in all material respects as at the date it was provided or as at the date (if any) at which it is stated.

14.11.2 Any financial projections provided to the Lender by or on behalf of the Borrower have been prepared on the basis of recent historical information and on the basis of reasonable assumptions.

14.11.3 Nothing has occurred or been omitted and no information has been given or withheld that results in the information referred to in Clause 14.12.1 being untrue or misleading in any material respect.

14.12 Financial statements

14.12.1 Its financial statements most recently delivered to the Lender (being on the date of this Agreement, the Original Financial Statements) were prepared in accordance with any applicable Audit Code for NHS Bodies, any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies and/or any other guidance with which NHS Bodies are (or in the case of the Original Financial Statements were) required to comply.

14.12.2 Its financial statements most recently delivered to the Lender (being on the date of this Agreement, the Original Financial Statements) fairly represent its financial condition and operations during the relevant financial year.

14.12.3 There has been no material adverse change in the business or financial condition of the Borrower since the date to which its financial statements most recently delivered to the Lender were made up.

14.13 Ranking

Its payment obligations under the Finance Documents rank at least pari passu with the claims of all its other unsecured and unsubordinated creditors, except for obligations mandatorily preferred by law.

14.14 No proceedings pending or threatened

No litigation, arbitration or administrative proceedings of or before any court, arbitral body or agency which, if adversely determined, might reasonably be expected to have a Material Adverse Effect have (to the best of its knowledge and belief) been started or threatened against it.

14.15 Environmental Matters

14.15.1 It is and has been in full compliance with all applicable Environmental Laws and there are, to the best of its knowledge and belief after reasonable enquiry, no circumstances that may prevent or interfere with such full compliance in the future, in each case to the extent necessary to avoid a Material Adverse Effect and the Borrower has not other than in the ordinary course of its activities placed or allowed to be placed on any part of its property any Dangerous Substance and where such Dangerous Substance has been so placed, it is kept, stored, handled, treated and transported safely and prudently so as not to pose a risk of harm to the Environment.

14.15.2 It is and has been, in compliance in all material respects with the terms of all Environmental Licences necessary for the ownership and operation of its activities as presently owned and operated and as presently proposed to be owned and operated.

14.15.3 It is not aware, having made reasonable enquiries, of any Environmental Claim.

14.16 Repetition

The Repeating Representations are deemed to be made by the Borrower by reference to the facts and circumstances then existing on the date of each Utilisation Request and on the first day of each Interest Period.

15. INFORMATION UNDERTAKINGS

The undertakings in this Clause 15 remain in force from the date of this Agreement for so long as any amount is outstanding under the Finance Documents or any part of the Facility is available for utilisation.

15.1 Financial statements

The Borrower shall supply to the Lender its audited financial statements for each financial year and its financial statements for each financial half year (including any monitoring returns sent to the appropriate Supervisory Body), in each case when such statements are provided to the appropriate Supervisory Body.

15.2 Requirements as to financial statements

15.2.1 Each set of financial statements delivered by the Borrower pursuant to Clause 15.1 (Financial statements) shall be certified by a director of the Borrower, acting on the instructions of the board of directors of the Borrower, as fairly representing its financial condition as at the date as at which those financial statements were drawn up.

15.2.2 The Borrower shall procure that each set of financial statements delivered pursuant to Clause 15.1 (Financial statements) is prepared in accordance with any applicable Audit Code for NHS Bodies and any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies or in the case of the Original Financial Statements in accordance with such guidelines with which NHS Bodies are required to comply.

15.3 Information: miscellaneous

The Borrower shall supply to the Lender:

15.3.1 copies or details of all material communications between the Borrower and the relevant Supervisory Body, including all relevant official notices received by the Borrower promptly after the same are made or received and, upon the Lender's request, any other relevant documents, information and returns sent by it to the appropriate Supervisory Body;

15.3.2 copies or details of all material communications between the Borrower and its members or its creditors (or in each case any class thereof), including all official notices received by the Borrower promptly after the same are made or received and upon the Lender's request any and all other documents dispatched by it to its members or its creditors (or in each case any class thereof), promptly after they are sent to such members or creditors;

15.3.3 details of any breaches by the Borrower of the Compliance Framework;

15.3.4 details of any breaches by the Borrower of the Licence or the terms of their Licence;

15.3.5 details of any other financial assistance or guarantee requested or received from the Secretary of State for Health other than in the ordinary course of business promptly after the same are requested or received;

15.3.6 upon the Lender's request, information regarding the application of the proceeds of the Facility;

15.3.7 promptly upon becoming aware of them, the details of any litigation, arbitration and/or administrative proceedings which are current, threatened or pending against the Borrower which would reasonably be expected to have a Material Adverse Effect;

15.3.8 promptly, such further information regarding the financial condition, business and operations of the Borrower as the Lender may reasonably request to the extent the same are relevant to the Borrower's obligations under this Agreement or otherwise significant in the assessment of the Borrower's financial performance and further to the extent that the disclosure of information will not cause the Borrower to be in breach of any obligation of confidence owed to any third party or any relevant data protection legislation; and

15.3.9 any change in the status of the Borrower after the date of this Agreement

15.4 Notification of default

15.4.1 The Borrower shall notify the Lender of any Default (and the steps being taken to remedy it) promptly upon becoming aware of its occurrence.

15.4.2 Promptly upon a request by the Lender, the Borrower shall supply a certificate signed by two of its directors (acting on the instructions of the board of directors of the Borrower) on its behalf certifying that no Default is continuing (or if a Default is continuing, specifying the Default and the steps, if any, being taken to remedy it).

15.5 Other information

The Borrower shall promptly upon request by the Lender supply, or procure the supply of, such documentation and other evidence as is reasonably requested by the Lender (for itself or on behalf of a prospective transferee) in order for the Lender (or such prospective transferee) to carry out and be satisfied with the results of all necessary money laundering and identification checks in relation to any person that it is required to carry out pursuant to the transactions contemplated by the Finance Documents.

16. GENERAL UNDERTAKINGS

The undertakings in this Clause 16 remain in force from the date of this Agreement for so long as any amount is outstanding under the Finance Documents or any part of the Facility is available for utilisation.

16.1 Authorisations

The Borrower shall promptly:

16.1.1 obtain, comply with and do all that is necessary to maintain in full force and effect; and

16.1.2 supply certified copies to the Lender of any Authorisation required under any law or regulation of its jurisdiction of incorporation to enable it to perform its obligations under the Finance Documents and to ensure the legality, validity, enforceability or admissibility in evidence in England of any Finance Document.

16.2 Compliance with laws

The Borrower shall comply in all respects with all laws to which it may be subject, if failure so to comply would materially impair its ability to perform its obligations under the Finance Documents and shall exercise its powers and perform its functions in accordance with its constitutional documents.

16.3 Negative pledge

16.3.1 The Borrower shall not without the prior written consent of the Lender (such consent not to be unreasonably withheld or delayed) create or permit to subsist any Security over any of its assets save for any Permitted Security.

16.3.2 The Borrower shall not:

- (A) sell, transfer or otherwise dispose of any of its assets on terms whereby they are or may be leased to or re-acquired by it;
- (B) sell, transfer or otherwise dispose of any of its receivables on recourse terms;
- (C) enter into any arrangement under which money or the benefit of a bank or other account may be applied, set-off or made subject to a combination of accounts; or
- (D) enter into any other preferential arrangement having a similar effect,

in circumstances where the arrangement or transaction is entered into primarily as a method of raising Financial Indebtedness or of financing the acquisition of an asset.

16.4 Disposals

16.4.1 The Borrower shall not in a single transaction or a series of transactions (whether related or not) and whether voluntary or involuntary sell, lease, transfer or otherwise dispose of any material asset without the prior written consent of the Lender.

16.4.2 Clause 16.4.1 does not apply to:

- (A) any sale, lease, transfer or other disposal where the higher of the market value or consideration receivable does not (in aggregate) in any financial year exceed 10% of the total net assets of the Borrower as at the end of the most recent financial year end for which audited financial statements have been published.
- (B) any sale, lease, transfer or other disposal expressly identified in Schedule 8..

16.5 Merger

Without prejudice to Clause 16.4 (disposals) the Borrower shall not, without the prior written consent of the Lender, enter into nor apply to the relevant Supervisory Body (including pursuant to Section 56 of the Act) to enter into any amalgamation, demerger, merger or corporate reconstruction.

16.6 Guarantees

The Borrower will not, without the prior written consent of the Lender, give or permit to exist any guarantee or indemnity by it of any obligation of any person, nor permit or suffer any person to give any security for or guarantee or indemnity of any of its obligations except for guarantees and indemnities:

- 16.6.1 made in the ordinary course of the Borrower's business as an NHS Body ; and
- 16.6.2 which when aggregated with any loans, credit or financial accommodation made pursuant to Clause 16.7 (*Loans*) do not exceed £1,000,000 (or its equivalent in any other currency or currencies) in aggregate in any financial year.

16.7 Loans

The Borrower will not make any investment in nor make any loan or provide any other form of credit or financial accommodation to, any person except for investments, loans, credit or financial accommodation:

- 16.7.1 made in the ordinary course of the Borrower's business as an NHS Body ;

16.7.2 made in accordance with any investment policy or guidance issued by the relevant Supervisory Body; and

16.7.3 which when aggregated with any guarantees or indemnities given or existing under Clause 16.6 (*Guarantees*) do not exceed £1,000,000 (or its equivalent in any other currency or currencies) in aggregate in any financial year.

16.8 Consents

The Borrower must ensure that all Relevant Consents and all statutory requirements, as are necessary to enable it to perform its obligations under the Finance Documents to which it is a party, are duly obtained and maintained in full force and effect or, as the case may be, complied with.

16.9 Activities

The Borrower will not engage in any activities other than activities which enable it to carry on its principal purpose better, if to do so may, in the Lender's opinion, have a Material Adverse Effect.

16.10 Environmental

The Borrower shall:

16.10.1 obtain, maintain and comply in all material respects with all necessary Environmental Licences in relation to its activities and its property and comply with all Environmental Laws to the extent necessary to avoid a Material Adverse Effect;

16.10.2 promptly upon becoming aware notify the Lender of:

- (A) any Environmental Claim current or to its knowledge threatened;
- (B) any circumstances likely to result in an Environmental Claim; or
- (C) any suspension, revocation or notification of any Environmental Licence;

16.10.3 indemnify the Lender against any loss or liability which:

- (A) the Lender incurs as a result of any actual or alleged breach of any Environmental Law by any person; and
- (B) which would not have arisen if a Finance Document had not been entered into; and

16.10.4 take all reasonable steps to ensure that all occupiers of the Borrower's property carry on their activities on the property in a prudent manner and keep them secure so as not to cause or knowingly permit material harm or damage to the Environment (including nuisance or pollution) or the significant risk thereof.

16.11 Constitution

The Borrower will not amend or seek to amend the terms of its authorisation as an NHS Body or the terms of its constitution without the prior written consent of the Lender, in each case if to do so would be reasonably likely to have a Material Adverse Effect.

16.12 The relevant Supervisory Body

The Borrower will comply promptly with all directions and notices received from the relevant Supervisory Body to the extent failure to do so might have a Material Adverse Effect and will, upon the Lender's request, provide reasonable evidence that it has so complied.

16.13 Additional Terms and Conditions

The Borrower will comply promptly with the Additional Terms and Conditions.

17. COMPLIANCE FRAMEWORK

17.1 Compliance

The Borrower shall ensure at all times that it complies with its Licence and/or any other terms and conditions set by the relevant Supervisory Body.

17.2 Advance Notification

Without prejudice to the Borrower's obligations under Clause 17.1 (*Compliance*), if the Borrower becomes aware at any time after the date of signing of the Agreement that it is or is likely to breach any of the terms referred to in Clause 17.1 and/or a material failure under the requirements of the Compliance Framework is likely, it shall immediately notify the Lender of the details of the impending breach.

18. EVENTS OF DEFAULT

Each of the events or circumstances set out in this Clause 18 is an Event of Default.

18.1 Non-payment

The Borrower does not pay on the due date any amount payable pursuant to a Finance Document at the place at and in the currency in which it is expressed to be payable unless:

18.1.1 its failure to pay is caused by administrative or technical error; and

18.1.2 payment is made within two Business Days of its due date.

18.2 Compliance Framework and Negative Pledge

Any requirement of Clause 17 (*COMPLIANCE FRAMEWORK*) or Clause 16.3 (*Negative Pledge*) is not satisfied.

18.3 Other obligations

18.3.1 The Borrower does not comply with any term of:

(A) Clause 15.5 (*Notification of default*); or

(B) Clause 16 (*General Undertakings*).

18.3.2 The Borrower does not comply with any term of any Finance Document (other than those referred to in Clause 18.1 (*Non-payment*), Clause 18.2 (*Compliance Framework and Negative Pledge*) and Clause 18.3.1 (*Other obligations*)) unless the failure to comply is capable of remedy and is remedied within ten Business Days of the earlier of the Lender giving notice or the Borrower becoming aware of the failure to comply.

18.4 Misrepresentation

Any representation or statement made or deemed to be made by the Borrower in any Finance Document or any other document delivered by or on behalf of the Borrower under or in connection with any Finance Document is or proves to have been incorrect or misleading in any material respect when made or deemed to be made.

18.5 Cross default

- 18.5.1 Any Financial Indebtedness of the Borrower is not paid when due nor within any originally applicable grace period.
- 18.5.2 Any Financial Indebtedness of the Borrower is declared to be or otherwise becomes due and payable prior to its specified maturity as a result of an event of default (however described).
- 18.5.3 Any commitment for any Financial Indebtedness of the Borrower is cancelled or suspended by a creditor of the Borrower as a result of an event of default (however described).
- 18.5.4 Any creditor of the Borrower becomes entitled to declare any Financial Indebtedness of the Borrower due and payable prior to its specified maturity as a result of an event of default (however described).
- 18.5.5 No Event of Default will occur under this Clause 18.5 if the aggregate amount of Financial Indebtedness or commitment for Financial Indebtedness falling within Clauses 18.5.1 to 18.5.4 is less than £250,000 (or its equivalent in any other currency or currencies).

except that for as long as the Secretary of State for Health remains the Lender, the provisions of Clause 18.5 relate to Financial Indebtedness owed to any party but do not apply to amounts owed to other NHS bodies in the normal course of business where a claim has arisen which is being disputed in good faith or where the Borrower has a valid and contractual right of setoff.

18.6 Insolvency

- 18.6.1 The Borrower is unable or admits inability to pay its debts as they fall due, suspends making payments on any of its debts or, by reason of actual or anticipated financial difficulties, commences negotiations with one or more of its creditors with a view to rescheduling any of its indebtedness.
- 18.6.2 A moratorium is declared in respect of any indebtedness of the Borrower.

18.7 Insolvency proceedings

Any corporate action, legal proceedings or other procedure or step is taken:

- 18.7.1 in relation to a composition, assignment or arrangement with any creditor of the Borrower; or
- 18.7.2 in relation to the appointment of a liquidator, receiver, administrator, administrative receiver, compulsory manager or other similar officer in respect of the Borrower or any of its assets; or
- 18.7.3 in relation to the enforcement of any Security over any assets of the Borrower,

or any analogous action, proceedings, procedure or step is taken in any jurisdiction.

18.8 Appointment of a Trust Special Administrator

An order, made as required under The Act for the appointment of a Trust Special Administrator.

18.9 Creditors' process

Any expropriation, attachment, sequestration, distress or execution affects any asset or assets of the Borrower having an aggregate value of £250,000 and is not discharged within ten Business Days.

18.10 Repudiation

The Borrower or any other party to a Finance Document repudiates any of the Finance Documents or does or causes to be done any act or thing evidencing an intention to repudiate any Finance Document.

18.11 Cessation of Business

Other than with the prior written approval of the Lender, the Borrower ceases, or threatens to cease, to carry on all or a substantial part of its business or operations.

18.12 Unlawfulness

It is or becomes unlawful for the Borrower or any other party to a Finance Document to perform any of its obligations under any Finance Document.

18.13 Material adverse change

Any event or circumstance or series of events or circumstances occurs which, in the reasonable opinion of the Lender, has or is reasonably likely to have a Material Adverse Effect.

18.14 Additional Terms and Conditions

In the reasonable opinion of the Lender, the Borrower fails to make reasonable efforts to comply with the Additional Terms and Conditions.

18.15 Acceleration

On and at any time after the occurrence of an Event of Default which is continuing the Lender may by notice to the Borrower:

18.15.1 cancel the Facility whereupon it shall immediately be cancelled; and/or

18.15.2 declare that all or part of the Loans, together with accrued interest, and all other amounts accrued or outstanding under the Finance Documents be immediately due and payable, whereupon they shall become immediately due and payable; and/or

18.15.3 declare that all or part of the Loans be payable on demand, whereupon they shall immediately become payable on demand by the Lender.

19. ASSIGNMENTS AND TRANSFERS

19.1 Assignments and transfers by the Lender

Subject to this Clause 19, the Lender may:

19.1.1 assign any of its rights; or

19.1.2 transfer by novation any of its rights and obligations,

to another entity owned or supported by the Lender or to a bank or a financial institution or to a trust, fund or other entity which is regularly engaged in or established for the purpose of

making, purchasing or investing in loans, securities or other financial assets (the "New Lender").

19.2 Conditions of assignment or transfer

19.2.1 The consent of the Borrower is required for an assignment or transfer by the Lender, unless:

- (A) the assignment or transfer is to an entity owned or supported by the Lender; or
- (B) a Default is continuing.

19.2.2 The consent of the Borrower to an assignment or transfer must not be unreasonably withheld or delayed. The Borrower will be deemed to have given its consent twenty Business Days after the Lender has requested it unless consent is expressly refused (and reasons for such refusal are given) by the Borrower within that time.

provided that nothing in this Clause shall restrict the rights of the Secretary of State for Health to effect a statutory transfer.

19.3 Disclosure of information

The Lender may disclose to any person:

- 19.3.1 to (or through) whom the Lender assigns or transfers (or may potentially assign or transfer) all or any of its rights and obligations under the Finance Documents;
- 19.3.2 with (or through) whom the Lender enters into (or may potentially enter into) any transaction under which payments are to be made by reference to, any Finance Document or the Borrower;
- 19.3.3 to whom, and to the extent that, information is required to be disclosed by any applicable law or regulation;
- 19.3.4 which are investors or potential investors in any of its rights and obligations under the Finance Documents and only to the extent required in relation to such rights and obligations;
- 19.3.5 which is a governmental, banking, taxation or other regulatory authority and only to the extent information is required to be disclosed to such authority,

any information about the Borrower and/or the Finance Documents as the Lender shall consider appropriate if, in relation to Clauses 19.3.1, 19.3.2 and 19.3.4 the person to whom the information is to be given has agreed to keep such information confidential on terms of this Clause 19.3 provided always that the Lender shall comply with any relevant data protection legislation.

19.4 Assignment and transfer by the Borrower

The Borrower may not assign any of its rights or transfer any of its rights or obligations under the Finance Documents.

20. ROLE OF THE LENDER

20.1 Rights and discretions of the Lender

20.1.1 The Lender may rely on:

- (A) any representation, notice or document believed by it to be genuine, correct and appropriately authorised; and
- (B) any statement made by a director, authorised signatory or authorised employee of any person regarding any matters which may reasonably be assumed to be within his knowledge or within his power to verify.

20.1.2 The Lender may engage, pay for and rely on the advice or services of any lawyers, accountants, surveyors or other experts.

20.1.3 The Lender may act in relation to the Finance Documents through its personnel and agents.

20.1.4 Notwithstanding any other provision of any Finance Document to the contrary, the Lender is not obliged to do or omit to do anything if it would or might in its reasonable opinion constitute a breach of any law or a breach of a fiduciary duty or duty of confidentiality.

20.2 Exclusion of liability

20.2.1 Without limiting Clause 20.2.2, the Lender will not be liable for any omission or any act taken by it under or in connection with any Finance Document, unless directly caused by its gross negligence or wilful misconduct.

20.2.2 The Borrower may not take any proceedings against any officer, employee or agent of the Lender in respect of any claim it might have against the Lender or in respect of any act or omission of any kind by that officer, employee or agent in relation to any Finance Document and any officer, employee or agent of the Lender may rely on this Clause. Any third party referred to in this Clause 20.2.2 may enjoy the benefit of or enforce the terms of this Clause in accordance with the provisions of the Contracts (Rights of Third Parties) Act 1999.

20.2.3 The Lender will not be liable for any delay (or any related consequences) in crediting an account with an amount required under the Finance Documents to be paid by the Lender if the Lender has taken all necessary steps as soon as reasonably practicable to comply with the regulations or operating procedures of any recognised clearing or settlement system used by the Lender for that purpose.

20.2.4 The Lender shall not be liable:

- (A) for any failure by the Borrower to give notice to any third party or to register, file or record (or any defect in such registration, filing or recording) any Finance Document; or
- (B) for any failure by the Borrower to obtain any licence, consent or other authority required in connection with any of the Finance Documents; or
- (C) For any other omission or action taken by it in connection with any Finance Document unless directly caused by its gross negligence or wilful misconduct.

21. PAYMENT MECHANICS

21.1 Payments

21.1.1 The Borrower shall receive notification 10 working days prior to each payment required under a Finance Document, the Borrower shall make the same available to the Lender (unless a contrary indication appears in a Finance Document) for value on the due date at the time and in such funds specified by the Lender as being customary

at the time for settlement of transactions in the relevant currency in the place of payment.

21.1.2 Payment shall be collected through Direct Debit from a Borrower's account with the Government Banking Service.

21.2 Distributions to the Borrower

The Lender may (with the consent of the Borrower or in accordance with Clause 22 (*Set-off*)) apply any amount received by it for the Borrower in or towards payment (on the date and in the currency and funds of receipt) of any amount due from the Borrower under the Finance Documents or in or towards purchase of any amount of any currency to be so applied.

21.3 Partial payments

If the Lender receives a payment that is insufficient to discharge all the amounts then due and payable by the Borrower under the Finance Documents, the Lender shall apply that payment towards the obligations of the Borrower in such order and in such manner as the Lender may at its discretion decide.

21.4 No set-off

All payments to be made by the Borrower under the Finance Documents shall be calculated and be made without (and free and clear of any deduction for) set-off or counterclaim.

21.5 Business Days

21.5.1 Any payment which is due to be made on a day that is not a Business Day shall be made on the next Business Day in the same calendar month (if there is one) or the preceding Business Day (if there is not).

21.5.2 During any extension of the due date for payment of any principal or Unpaid Sum under this Agreement, interest is payable on the principal or Unpaid Sum at the rate payable on the original due date.

21.6 Currency of account

21.6.1 Subject to Clauses 21.6.2 to 21.6.5, sterling is the currency of account and payment for any sum due from the Borrower under any Finance Document.

21.6.2 A repayment of the Loan or Unpaid Sum or a part of the Loan or Unpaid Sum shall be made in the currency in which the Loan or Unpaid Sum is denominated on its due date.

21.6.3 Each payment of interest shall be made in the currency in which the sum in respect of which the interest is payable was denominated when that interest accrued.

21.6.4 Each payment in respect of costs, expenses or Taxes shall be made in the currency in which the costs, expenses or Taxes are incurred.

21.6.5 Any amount expressed to be payable in a currency other than sterling shall be paid in that other currency.

21.7 Change of currency

21.7.1 Unless otherwise prohibited by law, if more than one currency or currency unit are at the same time recognised by the central bank of any country as the lawful currency of that country, then:

- (A) any reference in the Finance Documents to, and any obligations arising under the Finance Documents in, the currency of that country shall be translated into, or paid in, the currency or currency unit of that country designated by the Lender (after consultation with the Borrower); and
- (B) any translation from one currency or currency unit to another shall be at the official rate of exchange recognised by the central bank for the conversion of that currency or currency unit into the other, rounded up or down by the Lender (acting reasonably).

21.7.2 If a change in any currency of a country occurs, this Agreement will, to the extent the Lender (acting reasonably and after consultation with the Borrower) specifies to be necessary, be amended to comply with any generally accepted conventions and market practice in the London interbank market and otherwise to reflect the change in currency.

22. SET-OFF

The Lender may set off any matured obligation due from the Borrower under the Finance Documents against any matured obligation owed by the Lender to the Borrower, regardless of the place of payment, booking branch or currency of either obligation. If the obligations are in different currencies, the Lender may convert either obligation at a market rate of exchange in its usual course of business for the purpose of the set-off.

23. NOTICES

23.1 Communications in writing

Any communication to be made under or in connection with the Finance Documents shall be made in writing and, unless otherwise stated, may be given in person, by post, fax or by electronic communication.

23.2 Addresses

The address and fax number (and the department or officer, if any, for whose attention the communication is to be made) of each Party for any communication or document to be made or delivered under or in connection with the Finance Documents is:

23.2.1 in the case of the Borrower, that identified with its name below; and

23.2.2 in the case of the Lender, that identified with its name below,

or any substitute address, email address, fax number or department or officer as the Borrower may notify to the Lender by not less than five Business Days' written notice.

23.3 Delivery

23.3.1 Any communication or document made or delivered by one person to another under or in connection with the Finance Documents will only be effective:

- (A) if by way of fax, when received in legible form; or
- (B) if by way of letter, when it has been left at the relevant address or five Business Days after being deposited in the post postage prepaid in an envelope addressed to it at that address,

and, if a particular department or officer is specified as part of its address details provided under Clause 23.2 (*Addresses*), if addressed to that department or officer.

23.3.2 Any communication or document to be made or delivered to the Lender will be effective only when actually received by the Lender and then only if it is expressly marked for the attention of the department or officer identified with the Lender's signature below (or any substitute department or officer as the Lender shall specify for this purpose).

23.4 Electronic communication

23.4.1 Any communication to be made between the Borrower and the Lender under or in connection with this Agreement and any other Finance Document may be made by electronic mail or other electronic means, if the Borrower and the Lender:

- (A) agree that, unless and until notified to the contrary, this is to be an accepted form of communication;
- (B) notify each other in writing of their electronic mail address and/or any other information required to enable the sending and receipt of information by that means; and
- (C) notify each other of any change to their address or any other such information supplied by them.

23.4.2 Any electronic communication made between the Borrower and the Lender will be effective only when actually received in readable form and only if it is addressed in such a manner as the Borrower and the Lender, as the case may be, specify for this purpose.

24. CALCULATIONS AND CERTIFICATES

24.1 Accounts

In any litigation or arbitration proceedings arising out of or in connection with a Finance Document, the entries made in the accounts maintained by the Lender are *prima facie* evidence of the matters to which they relate.

24.2 Certificates and Determinations

Any certification or determination by the Lender of a rate or amount under any Finance Document is, in the absence of manifest error, conclusive evidence of the matters to which it relates.

24.3 Day count convention

Any interest, commission or fee accruing under a Finance Document will accrue from day to day and is calculated on the basis of the actual number of days elapsed and a year of 365 days or, in any case where the practice in the London interbank market differs, in accordance with that market practice.

25. PARTIAL INVALIDITY

If, at any time, any provision of the Finance Documents is or becomes illegal, invalid or unenforceable in any respect under any law of any jurisdiction, neither the legality, validity or enforceability of the remaining provisions nor the legality, validity or enforceability of such provision under the law of any other jurisdiction will in any way be affected or impaired.

26. REMEDIES AND WAIVERS

No failure to exercise, nor any delay in exercising, on the part of the Lender, any right or remedy under the Finance Documents shall operate as a waiver, nor shall any single or partial

exercise of any right or remedy prevent any further or other exercise or the exercise of any other right or remedy. The rights and remedies provided in this Agreement are cumulative and not exclusive of any rights or remedies provided by law.

27. AMENDMENTS AND WAIVERS

Any term of the Finance Documents may only be amended or waived in writing.

28. COUNTERPARTS

Each Finance Document may be executed in any number of counterparts, and this has the same effect as if the signatures on the counterparts were on a single copy of the Finance Document.

29. GOVERNING LAW

This Agreement shall be governed by and construed in accordance with English law.

30. DISPUTE RESOLUTION

The Parties agree that all disputes arising out of or in connection with this Agreement will be settled in accordance with the terms of Schedule 5.

This Agreement has been entered into on the date stated at the beginning of this Agreement.

SCHEDULE 1: CONDITIONS PRECEDENT

1. Authorisations

1.1 A copy of a resolution of the board of directors of the Borrower:

- (A) approving the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;
- (B) authorising a specified person or persons to execute the Finance Documents to which it is a party on its behalf; and
- (C) authorising a specified person or persons, on its behalf, to sign and/or despatch all documents and notices (including, if relevant, any Utilisation Request and) to be signed and/or despatched by it under or in connection with the Finance Documents to which it is a party.
- (D) Confirming the Borrower's undertaking to comply with the Additional Terms and Conditions

1.2 A certificate of an authorised signatory of the Borrower certifying that each copy document relating to it specified in this Schedule 1 and provided to the Lender is correct, complete and in full force and effect as at a date no earlier than the date of this Agreement.

2. Financial Information

Updated financial statements of the Borrower unless otherwise available.

3. Finance Documents

3.1 This Agreement (original).

3.2 The original or certified copy (as the Lender shall require) of any Finance Document not listed above.

4. General

4.1 A copy of any other Authorisation or other document, opinion or assurance which the Lender considers to be necessary or desirable in connection with the entry into and performance of the transactions contemplated by any Finance Document or for the validity and enforceability of any Finance Document.

4.2 Evidence that the fees, costs and expenses then due from the Borrower pursuant to Clause 13 (*Costs and expenses*) have been paid or will be paid by the first Utilisation Date.

SCHEDULE 2: UTILISATION REQUEST

From: []

To: The Secretary of State for Health

Dated:

Dear Sirs

[] - £
dated [] (the "Agreement")

1. We refer to the Agreement. This is a Utilisation Request. Terms defined in the Agreement have the same meaning in this Utilisation Request unless given a different meaning in this Utilisation Request.

2. We wish to borrow a Loan on the following terms:

Proposed Utilisation Date: [] (or, if that is not a Business Day, the next Business Day)

Amount: [] or, if less, the Available Facility

Payment Instructions: [Relevant account to be specified here]

3. We confirm that each condition specified in Clause 4.2 (Further conditions precedent) is satisfied on the date of this Utilisation Request.

4. We represent and warrant that the Loan will be applied solely towards working capital requirements of the Borrower in its requirement as an NHS Trust/NHS Foundation Trust.

5. This Utilisation Request is irrevocable.

Yours faithfully

.....
authorised signatory for and on behalf of the Board of Directors
[]

SCHEDULE 3: NOT USED

SCHEDULE 4: ANTICIPATED DRAWDOWN SCHEDULE

NOT USED.

SCHEDULE 5: DISPUTE RESOLUTION

1. NEGOTIATION

If any claim, dispute or difference of whatsoever nature arising out of or in connection with this Agreement ("**Dispute(s)**") arises, the Parties will attempt in good faith to settle it by negotiation. Each Party will nominate at least one management representative ("**Authorised Representative**") who shall attend and participate in the negotiation with authority to negotiate a solution on behalf of the Party so represented.

2. MEDIATION

It shall be a condition precedent to the commencement of reference to arbitration that the Parties have sought to have the dispute resolved amicably by mediation as provided by this paragraph 2.

2.1 Initiation of Mediation Proceeding

- (A) If the Parties are unable to settle the Dispute(s) by negotiation in accordance with paragraph 1 within 15 days, either Party may by written notice upon the other initiate mediation under this paragraph 2. The notice initiating mediation shall describe generally the nature of the Dispute.
- (B) Each Party's Authorised Representative nominated in accordance with paragraph 1 shall attend and participate in the mediation with authority to negotiate a settlement on behalf of the Party so represented.

2.2 Appointment of Mediator

- (A) The Parties shall appoint, by agreement, a neutral third person to act as a mediator (the "**Mediator**") to assist them in resolving the Dispute. If the Parties are unable to agree on the identity of the Mediator within 10 days after notice initiating mediation either party may request the Centre for Effective Dispute Resolution ("**CEDR Solve**") to appoint a Mediator.
- (B) The Parties will agree the terms of appointment of the Mediator and such appointment shall be subject to the Parties entering into a formal written agreement with the Mediator regulating all the terms and conditions including payment of fees in respect of the appointment. If the Parties are unable to agree the terms of appointment of the Mediator within 10 days after notice initiating mediation either Party may request CEDR Solve to decide the terms of appointment of the Mediator
- (C) If the appointed Mediator is or becomes unable or unwilling to act, either Party may within 10 days of the Mediator being or becoming unable or unwilling to act follow the process at paragraph 2.3 to appoint a replacement Mediator and paragraph 2.4 to settle the terms of the appointment of the replacement Mediator.

2.3 Determination of Procedure

The Parties shall, with the assistance of the Mediator, seek to agree the mediation procedure. In default of such agreement, the Mediator shall act in accordance with CEDR Solve's Model Mediation Procedure and Agreement. The Parties shall within 10 days of the appointment of the Mediator, meet (or talk to) the Mediator in order to agree a programme for the exchange of any relevant information and the structure to be adopted for the mediation.

2.4 Without Prejudice/Confidentiality

All rights of the Parties in respect of the Dispute(s) are and shall remain fully reserved and the entire mediation including all documents produced or to which reference is made, discussions and oral presentations shall be strictly confidential to the Parties and shall be conducted on the same basis as "without prejudice" negotiations, privileged, inadmissible, not subject to disclosure in any other proceedings whatever and shall not constitute any waiver of privilege whether between the Parties or between either of them and a third party. Nothing in this paragraph 2.4 shall make any document privileged, inadmissible or not subject to disclosure which would have been discloseable in any reference to arbitration commenced pursuant to paragraph 3.

2.5 Resolution of Dispute

If any settlement agreement is reached with the assistance of the Mediator which resolves the Dispute, such agreement shall be set out in a written settlement agreement and executed by both parties' Authorised Representatives and shall not be legally binding unless and until both parties have observed and complied with the requirements of this paragraph 2.5. Once the settlement agreement is legally binding, it may be enforced by either party taking action in the High Court.

2.6 Failure to Resolve Dispute

In the event that the Dispute(s) has not been resolved to the satisfaction of either Party within 30 days after the appointment of the Mediator either party may refer the Dispute to arbitration in accordance with paragraph 3.

2.7 Costs

Unless the Parties otherwise agree, the fees and expenses of the Mediator and all other costs of the mediation shall be borne equally by the Parties and each Party shall bear their own respective costs incurred in the mediation regardless of the outcome of the mediation.

3. ARBITRATION

3.1 If the Parties are unable to settle the Dispute(s) by mediation in accordance with paragraph 2 within 30 days, the Dispute(s) shall be referred to and finally determined by arbitration before an Arbitral Tribunal composed of a single Arbitrator.

3.2 Any reference of a Dispute to arbitration shall be determined in accordance with the provisions of the Arbitration Act 1996 and in accordance with such arbitration rules as the Parties may agree within 20 days after notice initiating arbitration or, in default of agreement, in accordance with the Rules of the London Court of International Arbitration which Rules are deemed to be incorporated by reference into this clause.

3.3 London shall be the seat of the arbitration.

3.4 Reference of a Dispute to arbitration shall be commenced by notice in writing from one Party to the other Party served in accordance with the provisions of Clause 23 (Notices).

3.5 The Arbitral Tribunal shall be appointed as follows.

(A) Within 14 days of receipt of any notice referring a Dispute to arbitration the Parties shall agree the identity of the person to act as Arbitrator. In default of agreement or in the event the person so identified is unable or unwilling to act, either party shall be

entitled to request the President for the time being of the Chartered Institute of Arbitrators to appoint an Arbitrator for the Dispute and the parties shall accept the person so appointed.

- (B) If the Arbitrator becomes unwilling or unable to act, the procedure for the appointment of a replacement Arbitrator shall be in accordance with the provisions of paragraph 3.5(A).

3.6 The language of the arbitration shall be English.

SCHEDULE 6: REPAYMENT SCHEDULE

Repayment Date	Relevant Percentage
18th November 2019	100%

SCHEDULE 7: PERMITTED SECURITY – EXISTING SECURITY

NONE

SCHEDULE 8: ADDITIONAL TERMS AND CONDITIONS

1. Surplus/Deficit and Capital Limits

- 1.1. The Lender has set a Surplus/Deficit Limit and/or a Capital Limit for the Borrower in consultation with the relevant Supervisory Body.
- 1.2. The Borrower understands and accepts these Limits in the recognition that any net expenditure in excess of the relevant Limit(s) cannot be funded by the Lender based upon the assumptions made by the Lender at the date of this Agreement.
- 1.3. The Borrower undertakes not to put forward any Utilisation Requests on this or any other Facility with the Lender that would result in Limits being exceeded by the Borrower without the explicit agreement of the Lender.
- 1.4. In the event that a utilisation is likely to lead to a Limit being exceeded, the Borrower shall inform the Lender two calendar months before any such utilisation may be submitted.
- 1.5. The Borrower will make no assumptions in any financial planning in relation to any financial support from the Lender beyond financing previously agreed to support the relevant Limit(s).
- 1.6. Limits may be adjusted by the Lender from time to time in consultation with the relevant Supervisory Body.
- 1.7. Performance against Limits will be monitored by the relevant Supervisory Body.

2. Nursing agency expenditure:

- 2.1. The Borrower undertakes to comply with nursing agency spending rules as set out in the letter of 1 September 2015 from David Bennett and Robert Alexander to NHS Foundation Trust and Trust Chief Executives as may be updated from time to time. In particular, the Borrower undertakes to:
 - 2.1.1. Procure all nursing agency staff through approved frameworks unless such action is otherwise authorised by the relevant Supervisory Body.
 - 2.1.2. Implement an annual maximum limit for agency nursing expenditure as a percentage of the total nursing staff budget as set out in the letter of 01 September 2015 or as otherwise notified by the relevant Supervisory Body.
 - 2.1.3. Implement any additional controls as may be required by the relevant Supervisory Body in relation to the planned introduction of price caps.
- 2.2. The Borrower additionally undertakes to Implement the NHS Employers Five High Impact Actions

3. Professional Services Consultancy Spend

- 3.1. The Borrower will not enter into any contract for the procurement of professional consultancy services with a value in excess of £50,000 without the prior approval of the relevant Supervisory Body. The value of multiple contracts issued in respect similar Terms of Reference will be aggregated, as though a single contract had been issued, in respect of the application of this clause.

4. VSM Pay Costs

- 4.1. Where the borrower is authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the views of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500.
- 4.2. Where the borrower is not authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the approval of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500.
- 4.3. The Borrower undertakes to implement the requirements in respect of the treatment of "off - payroll" workers included in the letter from David Nicholson to Chairs and Chief Executives of 20th August 2012, or any subsequent guidance issued by the Lender.
- 4.4. The Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England to all newly appointed VSMs except where existing statutory terms take precedence. In addition the Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England for existing VSMs where Section 16 is referenced in their contracts of employment.

5. Estate Costs

- 5.1. The Borrower undertakes to examine the overall running costs of Estates and Facilities against a benchmark group of similar NHS Trusts within 3 months from the date of this Agreement. Where higher than average costs are identified, and there is no valid reason for this, the Borrower will put in place an action plan to reduce these costs to match the agreed benchmark level. DH will need to satisfy itself that the benchmark is reasonable and plan is deliverable.

6. Surplus Land

- 6.1. The Borrower shall ensure that it has in place an up to date estates strategy covering a period at least 3 years from the date of this Agreement. The estates strategy should be informed by discussions with commissioners about clinical service requirements and consider options for rationalising the estate and releasing surplus land.
- 6.2. The report required in clause 6.1 shall identify surplus land and potentially surplus land to be released during the period from the date of this Agreement date to 31 March 2020.
- 6.3. The Borrower shall provide the Lender with a copy of its estate strategy within 6 weeks of the date of this Agreement or at a date otherwise agreed with the Lender. The Lender will need satisfy itself that the strategy is complete and deliverable for this condition to be satisfied.

7. Procure21

- 7.1. The Borrower will use the P21+ Procurement Framework for all publicly funded capital works, unless otherwise agreed with the relevant Supervisory Body.
- 7.2. Where the Borrower proposes to use an alternative procurement route, the Borrower will submit a business case to the relevant Supervisory Body for approval demonstrating that an alternative procurement route offers better Value for Money than the P21+ Procurement Framework.

8. Finance and Accounting and Payroll

8.1. The Borrower undertakes to commission NHS Shared Business Services to complete a baseline assessment of the Borrower's finance and accounting and payroll services to assess the benefit of the use, or increased use, of an outsourced service provider. The Borrower will provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement.

8.2. Where the assessment by NHS Shared Business Services supports the case for the use, or increased use, of an outsourced service provider, the Borrower will undertake an appropriate market testing exercise or use existing Government Framework Agreements to procure an outsourced service provider within a timescale to be agreed with the Lender.

9. Bank Staffing

9.1. The Borrower will undertake an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency to assess the benefit of the use, or increased use of an Outsourced Staff Bank provider. The Borrower commits to provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement.

9.2. Where an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency supports the case for the use of Outsourced Staff Bank provider, the Borrower will undertake an appropriate market testing exercise or use an existing Government Framework Agreement to procure an Outsourced Staff Bank provider within a timescale to be agreed with the Lender.

10. Procurement

10.1. The Borrower shall provide third party non-pay spend to the lender in a format specified by the Lender, within 6 months of the date of this Agreement, and at least annually thereafter, on the request of the Lender,

10.2. The Borrower shall test the savings opportunities of increasing usage of the NHS Supply Chain and future editions and/or replacements of the NHS Catalogue within 6 months of the date of this Agreement and at least annually thereafter, on the request of the Lender,

10.3. Any savings identified through the process set out in 10.2 will be pursued by the Borrower. Any identified savings which the Borrower does not intend to pursue must be notified to the Lender along with the reasons for not doing so.

10.4. The Borrower will provide the Lender with current copies of its medical capital equipment asset register, medical equipment maintenance schedule, and capital medical equipment procurement plans within 6 months of the date of this Agreement, and at least annually thereafter on the request of the Lender.

11. Crown Commercial Services ("CCS")

11.1. The Borrower undertakes to test the scope of savings opportunities from CCS within 6 months of the date of this Agreement, subject to appropriate CCS resources being available to support this undertaking. Any savings identified as part of this process which the Borrower does not intend to pursue must be notified to the Lender with the reasons for not doing so.

11.2. The Borrower additionally undertakes to provide details of its relevant requirements in support of all future collaborative procurements including e-auctions.

12. EEA and non-EEA Patient Costs Reporting

- 12.1. The Borrower undertakes to:
 - 12.1.1. Become a member of the EEA portal and actively report EHIC and S2 patient activity on the portal
 - 12.1.2. Provide an overview of the patient identification, billing and costs recovery systems in place with any planned improvements (for EEA and non-EEA patients)
 - 12.1.3. Participate and collaborate with local/national commissioners in the development of the new ""risk sharing"" model for non-EEA chargeable patients.

13. On request of the Lender, the Borrower agrees to provide timely information and enable appropriate access to parties acting on behalf of the Lender for the purposes of appropriate tracking and reporting of progress delivering the conditions set out within this Schedule.

SIGNATORIES

Borrower

For and on behalf of MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

By:



Name:

STEPHEN ORPIN

Position:

DOF

Address:

Maidstone Hospital
Hermitage Land
Maidstone
Kent
ME16 9QQ

Email:

Stephen Orpin

Attention:

stephen.orpin@nhs.net

Lender

The Secretary of State for Health

By:



Name:

Scott Marley

Address:

Department of Health,
2nd Floor
Quarry House,
Quarry Hill,
Leeds, LS2 7UE

Email:

dbloanscentralinbox@dh.gsi.gov.uk