Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD MEETING

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

10.30am – c.1pm WEDNESDAY 24TH FEBRUARY 2016

THE ACADEMIC CENTRE, MAIDSTONE HOSPITAL

A G E N D A – PART 1

Ref.	Item	Lead presenter	Attachment
2-1	To receive apologies for absence	Chairman	Verbal
2-2	To declare interests relevant to agenda items	Chairman	Verbal
2-3	Minutes of the Part 1 meeting of 27th January 2016	Chairman	1
2-4	To note progress with previous actions	Chairman	2
2-5	Safety moment	Director of Finance	Verbal
2-6	Chairman's report	Chairman	Verbal
2-7	Chief Executive's report	Chief Executive	3
2-8	A patient's experiences of the Trust's services[1]	Chief Nurse[2]	Verbal
2-9	Review of the Board Assurance Framework, 2015/16	Trust Secretary	4
2-10	Integrated Performance Report for January 2016 ▪ 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 Dir. of Infect. Prevention and Control Director of Finance Chief Operating Officer Dir. of W'force and Communications	5
	Quality items		
2-11	Progress with the Quality Improvement Plan	Chief Nurse	6
2-12	Planned & actual ward staffing for January 2016	Chief Nurse	7
2-13	Update on the extent of the use, within the Trust, of the clinical information in the 'Dr Foster' IT system	Medical Director	8
	Other matters		
2-14	Findings of the national staff survey 2015	Director of W'force and Comm's	9
	Planning and strategy		
2-15	Progress on the liaison with KCC re the development of a Vanguard scheme (to address DTOCs: Update	Deputy Chief Executive	10
2-16	Update on the development of the Sustainability and Transformation Plan (STP) for Kent and Medway	Deputy Chief Executive	11
	Assurance and policy		
2-17	Compliance oversight self-certification	Trust Secretary	12
2-18	Ratification of Standing Orders (ann. review)	Trust Secretary	13
	Reports from Board sub-committees (and the Trust Management Executive)		
2-19	Quality Committee, 01/02/16	Committee Chairman	14
2-20	Trust Management Executive, 17/02/16 (incl. ToR)	Committee Chairman	15
2-21	Finance Committee, 22/02/16 (incl. approval of the Business Case re the transfer of Crow. Birthing Centre & High Weald Comm. Midwifery; & the Trust's revised application for a "Single Currency Interim Revenue Support Facility")	Committee Chairman	16 (to follow), 17 & 18
2-22	Charitable Funds Committee, 22/02/16	Committee Chairman	Verbal
2-23	Audit and Governance Committee, 22/02/16	Committee Chairman	Verbal
2-24	**To consider any other business**		
2-25	**To receive any questions from members of the public**		
2-26	To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted	Chairman	Verbal
	Date of next meeting: 23rd March 2016, 10.30am, Education Centre, Tunbridge Wells Hospital		

Anthony Jones, Chairman

[1] 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

[2] A patient will also be in attendance for this item

Maidstone and Tunbridge Wells NHS
NHS Trust

MINUTES OF THE MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST BOARD MEETING (PART 1) HELD ON WEDNESDAY 27TH JANUARY 2016, 10.30 A.M. AT MAIDSTONE HOSPITAL

FOR APPROVAL

Present:	Anthony Jones	Chairman of the Trust Board (apart from part of item 1-11: refer to the minutes for details)	(AJ)
	Avey Bhatia	Chief Nurse	(AB)
	Sylvia Denton	Non-Executive Director	(SD)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Angela Gallagher	Chief Operating Officer	(AG)
	Alex King	Non-Executive Director	(AK)
	Steve Orpin	Director of Finance	(SO)
	Kevin Tallett	Non-Executive Director	(KT)
	Steve Tinton	Non-Executive Director	(ST)
In attendance:	Richard Hayden	Deputy Director Workforce	(RH)
	Jim Lusby	Deputy Chief Executive	(JL)
	Sara Mumford	Director of Infection Prevention and Control	(SM)
	Graham Russell	Deputy Medical Director	(GR)
	Kirsty Craven	Clinical Nurse Specialist, Stoma Care (for item 1-9)	(KC)
	Judy Mallett	Clinical Nurse Specialist, Stoma Care (for item 1-9)	(JM)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	Hannah Alland	Digital Communications Officer	(HA)
	Gemma Craig	Lead Cancer Nurse	(GC)
	Kelly Cushman	Matron Trauma & Orthopaedics	(KCu)
	David Gazet	Reporter, Kent Messenger (from item 1-5, until item 1-19)	(DG)

At the start of the meeting, AJ paid tribute to Phil Edbrooke-Childs, the Managing Director of the Kent and Medway Health Informatics Service (KMHIS) who died in a car accident on 04/01/16.

AJ also explained KC and JM would be attending, for item 1-9, to give a presentation on Stoma Care. AJ added that the Nurses had made it to the national finals of the Colostomy Association's "Purple Iris" Award (which they subsequently won).

1-1 To receive apologies for absence

Apologies were received from Glenn Douglas (GD), Chief Executive; and Paul Sigston (PS), Medical Director, though it was noted that GR was attending in place of PS.

It was also noted that Paul Bentley (PB), Director of Workforce and Communications would not be in attendance, but RH was attending in place of PB.

1-2 To declare interests relevant to agenda items

There were no declarations of interest.

1-3 Minutes of the Part 1 meeting of 25th November 2015

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

1-4 To note progress with previous actions

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

- **Item 10-8iii ("Provide Trust Board Members with details of the local healthcare economy schemes being financed via the Better Care Fund").** SO reported that a response was still awaited, but he was meeting with the Director of Finance from West Kent Clinical

Commissioning Group (CCG) on 28/01/16. SO added that the CCG had a specific duty to share and agree how the Better Care Fund would be spent.

AJ asked whether the CCG's duty was to agree the outcomes of the Better Care Fund schemes with Trusts. SO confirmed this was the case. AK asked that SO provide him with a list of the dates of the requests he had made to the CCG. SO agreed to the request.

Action: Provide Alex King with details of the dates of the requests that had been made to West Kent Clinical Commissioning Group for the details of the local healthcare economy schemes being financed via the Better Care Fund (Director of Finance, January 2016 onwards)

- **Item 11-10iv ("Arrange for the "% Stillbirths Rate" in the Trust Performance Dashboard for October 2015 to not be rated as "Green").** AB reported that she had checked the situation with the Head of Performance and Information and the Head of Midwifery, and both had confirmed that the indicator should be rated as 'green'. The action was therefore 'closed.

11-5 Safety moment

AK highlighted that on the two occasions he had been a patient at the Trust, at both Maidstone Hospital and Tunbridge Wells Hospitals, he had experienced a situation in that early arrival was required in order to obtain a car parking space. AK suggested that two actions be undertaken: that the Trust establish a group, consisting of enthusiastic managers, to tackle the current car parking problems; and that patients be better informed of the car parking situation, within the communication they are sent by the Trust. AK continued that the solutions proposed by the aforementioned group should be submitted to the Executive Team, and then to the Trust Board.

AK continued that although the issue was only tentatively connected to safety, addressing it was in the interests of the whole Board. AJ confirmed that he believed the issue raised was related to safety, given the parking-related behaviour of some drivers. AJ added that he perceived the situation had worsened, and asked AG to comment. AG pointed out that the shortage of car parking spaces had been recognised, but 100 more spaces had just been opened on the Maidstone Hospital (MH) site, near the Nursery, and efforts had been made to communicate this. AG continued that parking at Tunbridge Wells Hospital (TWH) was recognised as a key problem, and the Estates Department had reviewed capacity and demand, but the problem had not been solved. AG added that there was a plan, within the Trust's capital programme, to create a further deck of car parking at the TWH site, but this was dependent on the availability of capital, and may also require further planning permission. AG did however point out that the Trust did however have 50 spaces available (to staff) at the adjacent Mercure Hotel.

AJ asked whether the Trust was awaiting a decision on further planning permission. AG confirmed that a further 89 spaces had been subject to an application, but a decision had not yet been made. AK remarked that "Grasscrete" could be used, as this did not require planning permission. AJ acknowledged the suggestion, and added that any other suggestions were welcome. JL agreed that further action could be taken to expedite the aforementioned planning decision.

AJ acknowledged that the issue was a fundamental problem, and there was a need to ensure that the roads within the hospitals remained clear. AJ queried whether it was possible to secure supplementary parking spaces at the Mercure Hotel or Notcutts Garden Centre, and offer staff who parked there a reduced rate of parking. AG replied that Notcutts had not been able to offer any spaces since their new Garden Centre opened, but reiterated that the Trust still had 50 spaces at the Mercure Hotel, which were poorly used.

GR then remarked that the prohibition of parking on double red lined areas at the hospitals was not being enforced. AG agreed to ensure that the Security team enforced the prohibition.

Action: Ensure that the Security team enforced the prohibition of parking on double red lined areas at the Trust's hospital sites (Chief Operating Officer, January 2016 onwards)

AG also agreed to consider the establishment of the group proposed by AK.

Action: Consider the proposal made at the Trust Board on 27/01/16 to establish a group of enthusiastic managers, to aim to tackle the problems relating to parking at the Trust's hospital sites (Chief Operating Officer, January 2016 onwards)

1-6 Chairman's report

AJ reported that the Trust remained under pressure, and added that although there had been some recent reports in the media regarding the Trust being asked to take over the A&E at Medway NHS Foundation Trust (MFT), such reports were not entirely accurate, although discussions were continuing.

AJ also noted that the Corporate Manslaughter trial was continuing, but the Trust was unable to comment, as the trial was sub judice.

1-7 Chief Executive's report

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

- The capacity pressure faced by the Trust continued to be significant, and thanks should be given to staff for their response. The most significant driver of the Trust's ability to manage patient flow remained the ability to discharge patients
- The Trust was not alone in facing capacity pressures, but the level of Delayed Transfers of Care (DTOCs) experienced by the Trust was higher than at most other local Trusts
- There had been discussions with Swale CCG in relation to MFT, as had been reported in the media, but any significant change in activity would be subject to the usual rules and regulations regarding formal consultation. Therefore, no significant shift in service provision was expected
- Trust Board Members visited the new John Day Ward after the Part 1 meeting in November 2015, and the Ward was now fully open. JL noted there had been positive feedback, and appealed for Board Members to visit again.
- A new Consultant Neurologist had been appointed, from the Netherlands
- Christine Richards had been recognised as the Society of Radiographers' "Radiographer of the Year"

[Post-meeting note: It has since been clarified that Christine Richards was actually awarded the "South East Radiographer of the Year" award from the Society of Radiographers]

AJ proposed that a letter of thanks be sent to Ms Richards, from the Trust Board. This was agreed.

Action: Arrange for a letter of thanks to be sent from the Trust Board to Christine Richards, in recognition of her "South East Radiographer of the Year" award from the Society of Radiographers (Trust Secretary / Chairman of the Trust Board, January 2016 onwards)

ST asked whether a press release had been issued regarding Ms Richards' award. HA confirmed that a release had not been issued, but this would be done in due course. AB noted that a local MP was attending the Trust on Friday 29/01/16, to congratulate Ms Richards on her award.

KT then referred to the aforementioned visit to John Day Ward, and asked whether an update could be provided on the research trial taking place on the Ward that involved the consumption of beetroot juice. AJ replied that he understood the trial was being run by Guy's and St Thomas' NHS Foundation Trust, and the results would not be available for some time.

1-8 Integrated Performance Report for December 2015

JL referred to the circulated report and highlighted that he had been impressed by the level of clinician engagement in tackling the 62-day Cancer waiting time target.

Safe / Effectiveness / Caring and Safe / Effectiveness (incl. HSMR)

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

- The charts on page 5 of 13 showed an increasing trend for patient falls and Pressure Ulcers, but focus had been applied, including, for the former, a review at a recent Quality Committee 'deep dive'. This focus had resulted in a recent reduction.
- Pressure Ulcers had increased, but effort was again being applied

AJ asked for the reasons for the increase. AB replied that it was likely to be related to the increased frailty of patients who were subject to a DTOC. AJ challenged this, given that such patients did not require acute care. AB explained that such patients were often frail, and still required thorough Nursing support.

AJ reiterated the point that had been made previously SD and by AB's predecessor, that Pressure Ulcers were a key indicator of the quality of Nursing care. AB confirmed she also regarded this indicator as important, but emphasised the importance of maintaining focus.

AB then continued, and highlighted the following points:
- There had been two Never Events since the previous Trust Board. One involved the administration of Fresh Frozen Plasma to a baby, and one involved a retained specimen bag following surgery. Both would be reviewed at the next SI panel, on 05/02/16
- Complaints response performance had been sustained

ST then referred to the "Stroke:% to Stroke Unit <4hrs" target (page 4 of 13), and asked whether the trend was still improving. AG replied that the Stroke improvement plan was based on the key indicators, and performance reflected the aforementioned issues regarding flow and capacity. AG continued that Stroke patients were a key part of the hospital site reviews that took place several times each day. AG added that the national performance against that indicator was circa 55% to 60%. ST asked when the Trust expected to achieve 55%. AG replied that this was linked to the plans to increase capacity, as Stroke patients would be prioritised, along with other specialty specific patients. ST commended the achievement to date, despite the fact that the Trust was under considerable pressure. SDu noted that the 'main' Quality Committee continued to receive an update on Stroke performance at each meeting, and the overall improvement in performance had been acknowledged.

AJ expressed his disappointment at the forecast for the "Stroke:% assessed by Cons <24hrs" indicator (page 4 of 13), which had been set at 85%, and appealed for common sense to be applied when preparing the Performance Dashboard, as this level of performance would obviously not be achieved. The point was acknowledged.

Safe (infection control)

SM then referred to the report and highlighted that infection control performance was currently satisfactory, and there had been no further cases of MRSA bacteraemia.

AJ commended this achievement, given the aforementioned pressures being faced by the Trust.

SM then continued, and highlighted the following points:
- Action was being taken to encourage clinicians to exercise prudence in the prescribing of Tazocin, and communications had been issued
- The Trust had the second lowest rate of Clostridium difficile in Kent and Medway

Well-Led (finance)

SO then referred to the circulated report and highlighted the following points:
- The year to date deficit was £18.8m, which was £7.1m adverse to plan
- December had been a better month in terms of activity (including non-elective), but to offset this, there had been a need to open capacity to deal with the flow of patients. This situation had continued into January, and had adversely affected the ability to treat patients and receive the income association with such treatment
- Agency staffing expenditure had reduced below the level for the same point in 2014/15. Temporary staffing had however been required to deploy to escalation capacity
- Discretionary spend controls had been implemented, to restrict such spending for the remainder of 2015/16. However, the rest of the year would still be difficult and challenging

ST noted that there had been a long discussion at the Finance Committee on 25/01/16, and commented that there was a fundamental mismatch in activity, finances and workforce data. ST elaborated that there had been a change in patient case mix, but activity levels were not

fundamentally different to 2014/15, and there had been increases in staffing levels, which was not fully understood. ST continued that JL had agreed to undertake a detailed review of staffing, to understand the relationship between activity and workforce levels, and establish whether the staffing levels, managerial levels and support staffing levels were appropriate. ST added that with the nature of the tariff, the Trust was likely to continue to be in a difficult place financially.

AJ highlighted that no precondition had been set on the aforementioned review, which could conclude that the Trust needed more staff, but it was important to justify any increased expenditure. SO noted that the final report of Lord Carter's review of productivity in NHS hospitals was due to be published within the next two weeks, and this was likely to have a focus on staffing, and the efficiency and effectiveness of staff deployment.

SD then remarked that it would be beneficial to understand the cost of DTOCs, in relation to the staff the Trust had to deploy to escalation areas. AJ anticipated that it would be difficult to isolate such costs. AG agreed, but stated that the impact on bed days and the loss of income was known.

JL reported that the Executive Team had had a detailed discussion earlier that week, and highlighted that it was important to regard all of the pressures faced by the Trust as a whole. The point was acknowledged.

Effectiveness / Responsiveness (incl. DTOCs)

AG referred to the circulated report and highlighted that the key risk was performance on the A&E 4-hour waiting time target (where improvements had been made, but performance had been affected by DTOCs). AG continued that the Winter and Operational Resilience Plan had enabled many risks to be mitigated, but those that had emerged related to levels of Nursing and Medical vacancies.

SD pointed out that DTOCs were rising. AG replied that DTOCs were at 6% at the end of December, and a reduction was usually expected in January, before an increase in February. AG added that the Integrated Discharge Team had had a major positive impact, but the DTOCs related to Social Services remained high.

SD emphasised that improving the DTOC situation would have a significant impact on patient experience and cost. AG concurred. JL referred to his earlier comment, and added that the links between many of the indicators should be acknowledged, in that patients who were ready to be discharged were often frail and therefore at higher risk of, for example, falls. JL continued that the Trust had almost double the standard level of DTOCs set by the Care Quality Commission (CQC), although the responsibility for enforcing this standard was not clear.

ST commended that the Trust's performance should be regarded with pride, given the significant pressures faced. JL agreed, but added that there should also be consistent in-house challenge.

AJ then asked for an update on the opening of the new Ward at TWH. AG stated that there was no confirmed time at present, but the Ward was expected to be open near the end of February.

Well-led (workforce)

RH then referred to the circulated report and highlighted the following points:
- The Nursing recruitment pipeline continued to be healthy over the coming months
- The trust had committed to provide Trauma training, which would assist with recruitment efforts

Presentation from a Clinical Directorate

1-9 Stoma Care Nurses at Maidstone Hospital

AJ welcomed KC and JM to the meeting. KC and JM then gave a presentation which highlighted the following points:
- The Stoma service was based at MH, and covered Monday to Friday, 8am to 5pm
- The service also provided Nurse-Led Clinics, Community visits (to Maidstone and the surrounding area, Nursing Homes, Hospice and Community Hospitals, and HM Prison).

- Cross-site cover was provided at TWH, in terms of A/L and sickness absence
- Referral was via the Colorectal Multidisciplinary Team Meeting, and via other inter-professional teams including: Urology, Gynae Oncology, Paediatrics, and Inflammatory bowel disease
- Patients were also referred from regional centres, and there were community referrals i.e. GPs, District Nurses, Hospices, Nursing and Residential Homes. Self-referral was also possible
- "Stoma" originated from the Greek word meaning "opening". In medical terms this was described as an artificial Surgical opening, formed by mobilising the bowel out onto the abdominal surface
- There were three main types of Stoma: colostomy, ileostomy and urostomy (sometimes known as ileal conduit)
- For pre-operative care, early referral was essential. Community visits were offered, if appropriate. Otherwise, patients were seen in clinic or pre-admission clinic
- The intended Surgery, Stoma practicalities, body image and sexuality issues were discussed at the pre-operative stage, and a patient visit was offered. Patients were then sited for Stoma when they were admitted to hospital
- For post-operative care, there was daily Stoma care teaching. Patients were normally discharged once they or their carer were able to look after the Stoma independently
- In terms of the involvement of other teams/agencies, home visits were arranged within 1 week of discharge. There were also normally follow-up visits. There was also clinic follow-up, and ongoing support
- The aims of care were to: provide information, education and ongoing support; to promote rehabilitation; and to adapt and resume a normal lifestyle
- Families and carers were involved in discussing the implications and outcomes of Surgery, and future treatment. Emotional and psychological support was also offered.
- Workload could be unpredictable, and required flexibility. The administration of the service was also sometimes problematic.

KC and JM then demonstrated the Colostomy Association's "Purple Iris" Award they had received.

KT asked whether there was any way of improving administration, for example, via the use of IT; and also asked whether the service could benefit from adopting a "Stop, Start, Simplify" approach. KC replied that additional staffing hours within the administrative team would be beneficial, and noted that a Business Case was intended to increase the service cross-site. JM added that an additional PC was also being arranged.

AJ thanked JM and KC for attending, and asked them to keep up their good work.

Quality items

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

AB referred to the circulated report and highlighted that the report was intended to 'close' the review undertaken by Marion Smith Consulting Limited. AB added that much of the content had already been discussed by the Board.

Questions or comments were invited. AJ commented that the report was easy to read.

KT opined that would have liked the response to recommendation 1 to contain more than just a commitment to review the Quality Strategy "later in 2016". AB acknowledged the point, but highlighted that work on the Quality Strategy would be linked to the work JL was undertaking on the wider clinical strategy.

KT then referred to recommendation 3, and queried whether the response adequately matched the recommendation. AB confirmed that the intention was to promote the attendance of non-medical staff at Clinical Governance meetings, and gave assurance that the action in place was adequate. KT acknowledged AB's comments.

SDu stated she welcomed the report, but cautioned that the test would be in the outcome of the changes planned, and noted that the level of assurance to be provided to the 'main' Quality

Committee would change under the new Committee system. AJ replied that he understood there was a clear responsibility on the Executive Team to report any quality issues to the Quality Committee, and for the Quality Committee to hold the Executive Team to account. AB agreed, noted that the first 'main' Quality Committee under the new system would take place in March, and added that although this was a work in process, she recognised it was her responsibility to ensure that the Quality Committee received the assurance it needed to enable it provide onward assurance to the Board.

1-11 Quality and Patient Safety Report

AB referred to the circulated report and highlighted that the Trust would be adopting a new Serious Incident (SI) process from January 2016, which aimed to introduce more objectivity.

AJ asked whether the spread of learning was adequately catered for under the SI process. AB replied that communication, such as that within the "Governance Gazette", was important, although there was a further need to increase efforts to close the associated action plans. AB added that the new Patient Safety Committee would apply focus to the closure of action plans arising from previous SIs. AJ asked for assurance that there would be evidence that learning from SIs had occurred across Directorates. AB gave assurance that such learning was in place, but acknowledged that this was an ongoing area of work.

[At this point, AJ left the meeting, and KT presided]

GR then remarked that there was poor attendance at recent Root Cause Analysis (RCA) training that had occurred, and asked whether there was likely to be dearth of trained RCA investigators. AB replied that the training referred to by GR was only the first day of such training, and other dates had been scheduled. AB added that the new investigation model focused on investigation by two persons, one of which was required to be trained.

SM stated that she agreed with AJ's comments regarding the feedback provided to Directorates, as the information provided in Directorate reporting to the Quality Committee was of insufficient detail to enable detailed learning. SM proposed that it would be more effective to share messages via the issue of a detailed monthly report. AB welcomed the suggestion, and stated that the new Patient Safety Committee could issue such reports, but emphasised that Directorates needed to take responsibility for disseminating learning.

KT suggested that 'learning portals' used in Universities could perhaps illustrate approaches that the Trust could apply. The suggestion was acknowledged.

[AJ then returned to the meeting]

SD pointed out that that there had been examples of changes in practice that had occurred following SIs. AB agreed, but noted that this was not the case for all SIs, although the Trust was not alone in this, as this was often a feature in CQC inspection reports.

1-12 Progress with the Quality Improvement Plan

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

- Most actions were now rated 'blue', and many of those rated 'green' would soon be 'blue'
- There was one 'red' rated action, which related to the challenges in discharging patients from ICU, as a result of inpatient capacity constraints. In December, 11 patients at the TWH site had to be moved out of hours. However, this had been undertaken in a managed way

ST referred to the latter point, and stated that if decisions were made on clinical grounds, and had been documented, such action was the best for the Trust's patients. AJ concurred.

SDu queried whether this meant that 11 patients had therefore been moved out of hours from other areas. SDu added that the 'main' Quality Committee had previously received reports on all patients who had been moved out of hours, and suggested that such information needed to be reported. AG replied that the majority of patients that were moved from ICU were informed of the move earlier the same day, and such patients were then swapped with those on the Wards who

required admission to ICU. AG added that the patients needing ICU admission were mapped and moved as soon as a bed was available. AB acknowledged that despite the explanations given, the current situation was not good enough.

SDu then asked how many patients were moved out of hours across the Trust i.e. not just ICU. AG stated that she did not have such details readily available, but confirmed that there would have been a number of such moves, although efforts were made to minimise these. SDu asked that consideration be made to producing such information on a regular basis. AG agreed to consider how such information could be reported to the Trust Board on a regular basis.

Action: Consider how the number of 'out of hours' patient transfers could be reported to the Trust Board on a regular basis (Chief Operating Officer, January 2016 onwards)

KT then remarked that it was pleasing to see the progress that had been made with the Quality Improvement Plan, notwithstanding the latter issue, but asked what learning had occurred, in general, with regards to any future inspection by the CQC. AB answered that the actions would continue to be reinforced, and a new framework for in-house monitoring against the CQC's requirements had been introduced. AB added that the focus would be on assessing how new clinical guidance had been considered by the Directorates, to mirror the challenge that the CQC would apply in their inspections. JL added that the goal would be to actively embrace future CQC inspections. KT commended the plans.

KR asked whether reports on the Quality Improvement Plan should continue to be received at the Board. AB confirmed that one further report would probably be all that was required.

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

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

- The overall ratings were 'green' apart from Wards 10 and 12 at TWH, and these Wards had been the area of recent focus
- It was difficult to gauge whether quality of care had been adversely affected on these Wards, as although Ward 12 had seen an increase in falls, other Wards had seen similar increases, even though they were rated 'green' for their staffing
- The influx of new overseas recruits would however assist the situation
- The report did not include escalation or A&E, but A&E would be included in future reports

1-14 Board members' hospital visits

KR referred to the circulated report and highlighted that in addition to Mercer Ward, AB had also visited Whatman Ward, Ward 20, Ward 30, Ward 31, and the ICUs and Catheter Laboratories at both hospitals in December and January.

AJ appealed for those making visits to record these with KR. AB also highlighted that if any issues identified on the visits required follow-up, these should be made known to the Executive Team. AJ added that this principle should be applied to visits in which Trust Board Members attended with relatives who were receiving care.

Planning and strategy

1-15 To approve the transfer of Crowborough Birthing Centre and High Weald Comm. Midwifery Services

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

- The report contained the outcome of the due diligence that had been undertaken
- The governance process had commenced
- Twenty staff were eligible to be 'TUPE' transferred to the Trust, and this process would last 30 days
- A Business Case would outline any cost implications and the income that may arise from the additional activity at TWH

AJ confirmed that the Trust Board was supportive of the principle of the transfer, but it was important to acknowledge that further due diligence work was required. AG agreed.

SDu asked for further comment regarding the statement in the report that "Although there is a considerable staffing deficit which will need to be addressed, operationally, the current level was considered safe" (page 5 of 18). SDu also queried the expected ratio of midwives:women. AB confirmed that the expected ratio was 1:28. AG then confirmed that the staffing levels for current levels of activity were sufficient, but the aspiration for the Centre to have additional births would require additional staffing, subject to a Business Case. AG added that the increase related to the women who did not use the Birthing Centre at present, but who may choose to do so in the future.

ST stated that he was not convinced of the need for increased staffing, noting that there needed to be a balance, given the Trust's financial position. AJ clarified that safety would not be compromised, and ST agreed. AB added that the Trust applied the standards from "Birthrate Plus". AG noted that the aforementioned Business Case would explore the need for additional staffing in more detail, in the context of the expected demand. SDu cautioned against aiming to provide a 'Rolls Royce' level of service. AG acknowledged the point, but explained that the current environment at Crowborough Birthing Centre was unlikely to attractive new mothers. JL clarified that the key aspect was to ensure that staffing levels were set correctly.

ST clarified that none of the issues related to the incomplete due diligence should however prevent the transfer from taking place.

AJ asked when the situation regarding the tariff would be clear. AG replied that discussions were continuing. AJ asked how the continuation of a block contract would affect the service. JL suggested this be discussed further in the Part 2 meeting to be held later that day.

The Trust Board approved the transfer of Crowborough Birthing Centre and High Weald Community Midwifery Services, subject to the completion of the due diligence not revealing any significant concerns.

Assurance and policy

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

The circulated report was noted.

1-17 Approval of compliance oversight self-certification

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

- As the Trust Board did not meet in December 2015, to consider the self-certification for month 8, the certification submitted to the NHS Trust Development Authority for month 8 mirrored that for month 7 (i.e. the certification approved by the Board in November 2015). This approach had been agreed with AJ and GD
- There were no changes in compliance status proposed from that approved in November 2015

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

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

KR referred to the circulated report and highlighted that the proposed changes were self-explanatory, and had been reviewed and supported by the Audit and Governance Committee and Trust Management Executive.

The Gifts, Hospitality, Sponsorship and Interests Policy and Procedure was ratified as circulated.

1-19 Ratification of Reservation of Powers and Scheme of Delegation (annual review)

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

- The document was the second of a suite of three documents, which also included the Standing Financial Instructions and Standing Orders
- The proposed changes were self-explanatory, and were shown as 'tracked' in the document

- The correct name of the Remuneration Committee (the Remuneration and Appointments Committee) needed to be reflected in the document

KT referred to section 3.16, and the authority regarding the "Re-designation of existing posts as authorised car user" and "Requests for authorised mobile phone user status" (page 25 of 36), and queried whether the level of authority was correct. It was agreed to ratify the level of authority as circulated, but to arrange for the Workforce Committee to review the Trust's current list of authorised car and mobile phone users.

Action: Arrange for the Workforce Committee to review the current list of authorised car and mobile phone users at the Trust (Director of Workforce and Communications / Chairman of Workforce Committee, January 2016 onwards)

SM then referred to section 3.25 (page 27 of 36), and noted that the reference to the "Governance and Risk Committee" should be replaced by a reference to the "Trust Clinical Governance Committee". KR agreed to make the amendment.

KT noted that all of the references to the Director of Strategy and Workforce should be replaced with Director of Workforce and Communications. KR agreed to make the amendment.

KT then again referred to section 3.16, and queried whether the "Authority to employ bank/agency staff" (page 22 of 36) was correct. It was agreed that this heading should be split, to reflect the different levels of authority in place for authorising a) Bank and b) Agency staff.

It was also agreed that the document should reflect the different arrangements for authorising such staff during normal working hours and out of hours.

The Reservation of Powers and Scheme of Delegation was ratified subject to the changes being made.

Action: Revise the Reservation of Powers and Scheme of Delegation to reflect the amendments made at the Trust Board on 27/01/16 (Trust Secretary, January 2016 onwards)

[Post meeting note: It has also been noted that the document makes several references to "Divisions" (which should be replaced with "Directorates"), and the "Responsibility for ensuring complaints relating to a Directorate are investigated thoroughly" should be held jointly between the Chief Operating Officer and Chief Nurse]

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

1-20 Patient Experience Committee, 07/12/15

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

- The plans for the new translation service had been discussed, and it was agreed that AB would give a report to the meeting in March 2016
- The cessation of the 'red tray' mealtime support at MH had also been discussed, and AB also agreed to provide a report to March 2016 meeting
- The issues raised by the Junior Doctor who attended would also be responded to via a report at the March 2016 meeting

1-21 Trust Management Executive, 09/12/15 & 20/01/16

JL referred to the circulated report and invited questions or comments.

KT noted that there was an IT update scheduled to be reported to the Finance Committee in March, and asked that this include issues pertaining to the 'Sunrise' Electronic Patient Record solution. KR agreed to request that the Director of Health Informatics included this in the report to the Finance Committee.

Action: Arrange for the Director of Health Informatics to include issues pertaining to the 'Sunrise' Electronic Patient Record solution within the "update on IT strategy and related matters" report to be submitted to the Finance Committee in March 2016 (Trust Secretary, January 2016 onwards)

1-22 Quality Committee, 10/12/15, 06/01/16, and 11/01/16 (incl. SIs & approval of revised Terms of Reference)

SDu referred to the circulated report and highlighted the following points:
- The report contained an error regarding the date for the 'main' meeting, which had been held on 06/01/16
- The 'deep dive' into patient falls had involved staff from Brighton and Sussex University Hospitals NHS Trust
- The usual Stroke report was appended, and performance continued to be very good, with improvements made
- Attendance issues had arisen, but these had now been addressed
- Revised Terms of Reference had been submitted, for approval

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

The Committee's decisions from the meetings held on 10/12/15 and 11/01/16, as detailed in the report, were duly ratified.

1-23 Finance Committee, 12/01/16 & 25/01/16 (including approval of: the OBC for additional Radiotherapy LinAc bunker capacity at TW Hospital; and the Trust's application for a "Single Currency Interim Revenue Support Facility")

ST referred to the circulated report (Attachment 18) and highlighted that the major issues covered at the meeting on 25/01/16 had already been discussed earlier in meeting, or were scheduled to be discussed in the Part 2 Board meeting to be held later that day.

AJ noted that following a discussion at the Finance Committee on 25/01/16, the review of the Outline Business Case (OBC) for additional Radiotherapy Linear Accelerator (LinAc) bunker capacity at TWH had been deferred to the Finance Committee and Trust Board meetings in February 2016.

SO then referred to Attachment 20 and highlighted the following points:
- The Trust Board had approved the Trust's application for an Interim Revolving Working Capital Facility (IRWCF) in October 2015
- The new Single Currency Interim Revenue Support Facility contained a lower level of interest than the IRWCF. Other differences were listed on the first page of Attachment 18
- The offer in the Agreement had been made with the full knowledge of the NHS Trust Development Authority and Department of Health

ST added the application had been discussed in detail, and supported, at the Finance Committee on 25/01/16.

The application for a Single Currency Interim Revenue Support Facility was approved as circulated. Specifically, the Trust Board resolved that:
- The terms of, and the transactions contemplated by, the Finance Documents to which Maidstone and Tunbridge Wells NHS Trust is a party (i.e. the "Single Currency Interim Revenue Support Facility Agreement") be approved
- The Finance Documents to which Maidstone and Tunbridge Wells NHS Trust is a party (i.e. the "Single Currency Interim Revenue Support Facility Agreement") be executed
- The Director of Finance be authorised, on behalf of the Trust Board, to execute the Finance Documents to which Maidstone and Tunbridge Wells NHS Trust is a party (i.e. the "Single Currency Interim Revenue Support Facility Agreement")
- The Director of Finance and the Deputy Directors of Finance be authorised, on behalf of the Trust Board, 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 Maidstone and Tunbridge Wells NHS Trust is a party (i.e. the "Single Currency Interim Revenue Support Facility Agreement").
- The Direct Debit form (which forms part of the documents referred to in the point above) be signed by two signatories from the current Authorised Signatory panel held by the Department

of Health Cash funding team (i.e. the Trust's Chief Executive, Director of Finance, Deputy Directors of Finance, Head of Financial Services, and the Head of Financial Systems).

- Maidstone and Tunbridge Wells NHS Trust undertook to comply with the Additional Terms and Conditions listed within the "Single Currency Interim Revenue Support Facility Agreement"
- The amendment to the minimum cash balance (as listed in the letter from the Department of Health to the Trust) be approved

1-24 To consider any other business

There was no other business.

1-25 To receive any questions from members of the public

There were no questions.

1-26 To approve the motion that in pursuance of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public now be excluded from the meeting by reason of the confidential nature of the business to be transacted

The motion was approved.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – February 2016

2-4 Log of outstanding actions from previous meetings — Chairman

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress [1]
10-8iii (Oct 15)	Provide Trust Board Members with details of the local healthcare economy schemes being financed via the Better Care Fund	Director of Finance	October 2015 onwards	Requests have been made to West Kent Clinical Commissioning Group, but a response is still awaited
1-12 (Jan 16)	Consider how the number of 'out of hours' patient transfers could be reported to the Trust Board on a regular basis	Chief Operating Officer	January 2016 onwards	The data collection is being developed, via the Head of Performance and Information, but is not yet ready to be reported
1-19i (Jan 16)	Arrange for the Workforce Committee to review the current list of authorised car and mobile phone users at the Trust	Director of Workforce and Communications / Chairman of Workforce Committee	January 2016 onwards	The item is being scheduled for an appropriate meeting of the Workforce Committee
1-19ii (Jan 16)	Revise the Reservation of Powers and Scheme of Delegation to reflect the amendments made at the Trust Board on 27/01/16	Trust Secretary	January 2016 onwards	The amendments will be made in March 2016

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
11-9 (Nov 15)	Ensure, at the point of the next review, that the ratings on the Board Assurance Framework accurately reflect the sentiment that a 'green' rating could legitimately be applied where the Trust was doing all it could to achieve the objective (and there was confidence that this action would lead to the objective being met)	Trust Secretary	February 2016	The request has been incorporated as part of the latest review of the Board Assurance Framework, in February 2016
11-10i (Nov 15)	Provide an update to the Trust Board, in February 2016, on the latest situation as to the extent	Medical Director	February 2016	An agenda item has been added to the forward programme, for February

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

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
	of the use, within the Trust, of the clinical information within the 'Dr Foster' IT system			2016
1-4 (Jan 16)	Provide Alex King with details of the dates of the requests that had been made to West Kent Clinical Commissioning Group for the details of the local healthcare economy schemes being financed via the Better Care Fund	Director of Finance	February 2016	The requested dates were provided
1-5i (Jan 16)	Ensure that the Security team enforced the prohibition of parking on double red lined areas at the Trust's hospital sites	Chief Operating Officer	February 2016	The Security Team were instructed to enforce the prohibition, and have been doing so
1-5ii (Jan 16)	Consider the proposal made at the Trust Board on 27/01/16 to establish a group of enthusiastic managers, to aim to tackle the problems relating to parking at the Trust's hospital sites	Chief Operating Officer	February 2016	The proposal has been considered, and a group will be established, to be Chaired by the Director of Estates and Facilities
1-7 (Jan 16)	Arrange for a letter of thanks to be sent from the Trust Board to Christine Richards, in recognition of her "South East Radiographer of the Year" award from the Society of Radiographers	Trust Secretary / Chairman of the Trust Board	January 2016	A letter was sent on 28/01/16 (and copied to all Trust Board members). The letter also included congratulations for the award as "South East Radiography Team of the Year" (Christine Richards is the manager of the Department)
1-21 (Jan 16)	Arrange for the Director of Health Informatics to include issues pertaining to the 'Sunrise' Electronic Patient Record solution within the "update on IT strategy and related matters" report to be submitted to the Finance Committee in March 2016	Trust Secretary	January 2016	A request was made to include the requested information in the report to the Finance Committee, and the Director of Health Informatics confirmed this would be done

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
9-8i (Sep 15)	Ensure the Trust Board receives the outcome of the planned review of Medical rotas being led by the Medical Director	Trust Secretary / Medical Director	September 2015 onwards (but then extended to March 2016)	The Medical Director notified the Trust Board on 25/11/15 that he would be unable to provide the requested information until March 2016

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting - February 2016

2-6	Chief Executive's update	Chief Executive

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

1. Since our last Board meeting I have continued to work with colleagues to promote a patient safe culture that supports staff learning from patient experience. I have been open and transparent with our staff around areas of care where change is required and encouraged colleagues to think about how they can share best practice where we have made changes to the benefit of our patients.

   I have also emphasised to our Clinical Directors the important role they play in helping empower our staff to question standards of patient care if they feel something isn't right or could be done differently in a better way.

   I have helped share learning with staff, through my weekly written Update on medication changes following a Serious Incident to aid wider understanding and prevention through better clinical practice.

   Our organisation has also been open and inclusive about the need to continue to learn from patient falls. We have implemented further best practice from actual patient experience and shared learning with staff to support good clinical governance.

   Work continues to reduce our falls rate, which includes training, observations and risk assessments. We are also conducting a three-month pilot research project that will incorporate best practice from other NHS Trusts around changing the culture of falls and falls prevention.

2. Our Trust has been found not guilty of Corporate Manslaughter at Inner London Crown Court, after Mr Justice Coulson ruled that there was no case to answer in the trial relating to the maternal death of Frances Cappuccini. We have again extended our deepest sympathies to Mrs Cappuccini's family. Mr Justice Coulson's ruling is available to read on our website. Dr Errol Cornish was also found not guilty of Gross Negligence Manslaughter.

3. We are continuing to experience very high demand for emergency care involving patients with serious illnesses that require longer courses of treatment and recuperation in hospital. This is having an adverse effect on our ability to carry out planned procedures. Regrettably we have had to cancel and reschedule previously agreed appointments to help maintain safe emergency care. We would again like to apologise to any of our patients who have had appointments cancelled. We are working hard with our partners to help reduce hospital admissions and length of stay through improved community-based care.

4. We have now received full agreement for the management of Crowborough Birthing Centre to be transferred to the Trust, from 1st April. The transfer will mean a more seamless maternity service for women in the High Weald area, and follows feedback to the Better Beginnings consultation in 2014 when local people said they would support the transfer of the service to MTW.

5. We will soon be launching ground-breaking new technology to treat lung cancer patients with the support of local cancer charity, the Peggy Wood Foundation. Electromagnetic Navigation Bronchoscopy (ENB) uses GPS-like technology to create a three-dimensional virtual roadmap of the lungs. This map then helps specialist doctors guide a set of catheters through the lungs' most complex airways. It is a minimally invasive procedure that allows the doctor to diagnose and prepare to treat cancerous lesions using a single procedure.

6. There are many examples of ways in which our staff go beyond the call of duty to help others less fortunate than themselves. I would like to praise two of our nurses who have recently helped an international charity provide measles vaccinations for refugees in Calais.

7. I would like to pay tribute to one of the Trust's most proactive and prolific fundraisers, 31-year-old Hayley Martin from Maidstone, who sadly lost her battle with cancer and passed away in January. Hayley was a tireless fundraiser for the Trust & will be sadly missed by all those who knew her, in particular the team on Charles Dickens Ward. Her efforts saw the establishment of Hayley's Room (a room on the ward which was refurbished & upgraded) thanks to fundraising by Hayley and Freddie's Friends, the support group which she helped to establish. It was Hayley's wish that a charity be created to provide Kent Oncology Centre patients with access to funding to cover the cost of experiences and treats. Keli Tomlin, Charles Dickens Ward Manager, is helping to create this charity, alongside Hayley's family and friends.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Information and assurance

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – February 2016

2-9 Board Assurance Framework (BAF) 2015/16 Trust Secretary

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 management of the BAF
The BAF is managed by the Trust Secretary, who liaises with each "Responsible Director" to ensure that the document is updated throughout the year.

Link with the Risk Register
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 of questions posed
At the November 2015 Board meeting, there was some debate as to whether the questions that required a RAG rating were the correct questions to ask. It was also agreed to Ensure, at the point of the next review, that the ratings on the BAF accurately reflected the sentiment that a 'green' rating could legitimately be applied where the Trust was doing all it could to achieve the objective (and there was confidence that this action would lead to the objective being met). The questions posed in the BAF have therefore been reviewed with the Chief Executive, and the first question has been changed from "Are the actions that have been taken sufficient to achieve the objective at year-end?" to "Are all of the actions that had been planned for this point been taken?".

Review by the Trust Board
This is the fourth time during 2015/16 that the Board has seen the populated BAF. The content has been updated from the BAF reviewed at the Board in November. 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

Review by the Audit and Governance Committee and Trust Management Executive (TME)

- The BAF that was received at the November Trust Board was scheduled to be reviewed at the Audit and Governance Committee in February 2016, but as the date of the Committee was moved from 04/02/16 to 22/02/16, the enclosed version was submitted for review instead.
- The BAF that was received at the November Trust Board was reviewed at the TME on 20/01/16. The enclosed BAF was reviewed at the TME on 17/02/16

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 17/02/16
- Finance Committee, 22/02/16 (objective 4.a only)
- Audit and Governance Committee, 22/02/16

Reason for receipt at 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

Board Assurance Framework 2015/16

What is the key risk? [2] *Main risk*

1 "Quality i.e. failure to provide care and treatment within the upper quartile (as recognised by patients, staff & the CQC); & the need to improve the standard of the Trust's clinical governance arrangements"

What does the Trust want to achieve? *Objective*

1.a To provide care & treatment within the upper quartile (as recognised by patients, staff and the CQC)

1.b To improve the standard of the Trust's clinical governance arrangements

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

1. A failure to recognise the improvement required following the CQC inspection in October 2014
2. A failure to adequately monitor care and treatment, and to challenge poor performance
3. A failure to implement the actions within the QIP
4. A failure to identify exactly what changes are needed in relation to clinical governance & culture
5. A failure to respond to current (and future) capacity pressures, resulting in increased potential for poor care and patient experience

What actions have been taken in response? *Controls*

a. A Quality Improvement Plan (QIP) has been developed and significant progress has been made

b. The Trust's processes for monitoring care and treatment have been strengthened recently (in relation to the processes deployed by the Trust Board, Quality Committee (including the 'deep dive' meetings) & Patient Experience Committee)

c. An in-house 'assurance review', to further test compliance, was undertaken on 06/07/15

d. Plans to increase inpatient capacity and improve patient flow are being implemented (which will have a positive impact on the ability to provide quality care and patient experience)

e. An external "Good Governance and Culture" review has been completed. The final report & response was discussed at the Trust Board on 30/09/15, the Board 'away day' on 20/11/15, & the final response was received at the Trust Board on 27/01/16

f. In-house monitoring against the CQC standards has been developed (which includes a mixture of 'assurance reviews', desk-top reviews etc.). This aims to mirror the challenges the CQC will pose at a future inspection, and involves external stakeholders (CCG and Healthwatch Kent)

g. A revised Clinical Governance Committee structure has been agreed, and implemented

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

July 2015[3]			Sep. 2015[3]			Nov. 2015[3]			Feb. 2016		
Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No
☐	☐	☒	☐	☒	☐	☐	☒	☐	☒	☐	☐

If "Unsure" or "No", please explain[4]

1. N/A

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

1. QIP progress reports (to the TME and Trust Board)
2. Performance report to TME and Trust Board
3. Internal Audit "CQC Compliance Review"
4. CQC report re Maid. Hospital water quality testing
5. The agenda, minutes & reports to the Clinical Gov. Cttee, TME, Quality Cttee, Patient Exp. Cttee & Board (which includes a range of information on quality, incl. surveys, SIs, complaints, mortality etc.)

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

If "No", what other data is needed?

1. The data exists but there is a need for improved triangulation of all the data available from various sources

Responsible Director/s	**Committee/s responsible for oversight**
Chief Nurse / Medical Director	Quality Committee / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2015/16?[5]

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
☐	☒	☐	☐	☒	☐	☐	☒	☐	☒	☒	☐

Explanation of any "Amber" or "Red" rating:

1. The "amber" rating reflects the fact that "upper quartile" performance has not been demonstrated as a whole (1a), and the fact that the CQC's view will not be known in detail until a further inspection is undertaken
2. The "green" rating the improvements that have been made to the clinical governance arrangements (1b)

[2] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future
[3] The question asked for July, Sep & Nov was "Are the actions that have been taken sufficient to achieve the objective at year-end?"
[4] The question asked for July, Sep & Nov was "If "Unsure" or "No", what other actions are planned?"
[5] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2015/16

What is the key risk? [6] *Main risk*

2 Capacity i.e. the need to increase inpatient capacity to cope with rising non-elective demand

What does the Trust want to achieve? *Objective*

2.a To increase inpatient capacity to cope with rising non-elective demand

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

1. Failure to improve the flow of patients, by reducing Length of Stay (LOS) and reducing the number of Delayed Transfers of Care (DTOC)
2. Failure to recruit to the Trust's workforce establishments

What actions have been taken in response? *Controls*

a. Plans to open a 38-bedded ward at Tunbridge Wells Hospital (TWH) are being implemented, and the 'go live' date is now 14/03/16
b. An internal Capacity and Flow improvement Plan has been developed, and has become part of the operational resilience plans
c. Winter & operational resilience plans are in place
d. A fortnightly recruitment and retention group (Chaired by the Chief Nurse / Director of Workforce and Communications) is overseeing progress against recruitment plans

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

July 2015[7]			Sep. 2015[7]			Nov. 2015[7]			Feb. 2016		
Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No
☐	☒	☐	☐	☒	☐	☐	☒	☐	☒	☒	☐

If "Unsure" or "No", please explain[8]

The Trust has undertaken its planned actions, but a System-wide action plan has been under-developed, and the Executive Team have agreed that the Trust needs to therefore take a system leadership role on this issue (led by the Deputy Chief Executive)

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

1. There will be monthly reporting of progress to the Trust Management Executive
2. The Outline/Full Business Case (OBC/FBC) for the new ward at Tunbridge Wells Hospital (reviewed at Finance Committee / Board)
3. Updates are reported to the Trust Board (including LOS / DTOC)

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

Responsible Director/s	**Committee/s responsible for oversight**
Chief Operating Officer	Trust Management Executive / Trust Board

How confident is the Responsible Director that the objective will be achieved by the end of 2015/16?[9]

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
☐	☒	☐	☐	☒	☐	☐	☒	☐	☒	☒	☐

Explanation of any "Amber" or "Red" rating:

1. The new Ward at Tunbridge Wells Hospital will be open by the year-end (albeit later than planned), but this will not make a difference to the capacity in the system in 2015/16

[6] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future
[7] The question asked for July, Sep & Nov was "Are the actions that have been taken sufficient to achieve the objective at year-end?"
[8] The question asked for July, Sep & Nov was "If "Unsure" or "No", what other actions are planned?"
[9] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2015/16

What is the key risk? [10] *Main risk*

3 Staffing i.e. the need to reduce reliance on temporary staff and have the appropriate skill-mix

What does the Trust want to achieve? *Objective*

3.a Reduce the reliance on temporary staff

3.b To ensure the appropriate skill-mix of staff across the Trust

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

1. Failure to recruit to clinical vacancies
2. Failure to reduce / remove the agreed number of escalation beds within the Trust
3. Failure to reduce Length of Stay
4. Failure to utilise the existing workforce effectively
5. Lack of regular reviews of clinical skill mix

What actions have been taken in response? *Controls*

a. Trust Recruitment Plan – increased activity
b. Nurse Recruitment and Retention Group
c. Development of TWH New Ward Business Case
d. Increased recruitment staffing resource
e. NTDA Sponsored staffing toolkit
f. Nursing, Medical and Back Office CIP
g. Bi-annual Chief Nurse Staffing Assurance Report
h. Workforce Strategy 2015-20
i. New Ways of Working task and finish group

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

July 2015[11]			Sep. 2015[11]			Nov. 2015[11]			Feb. 2016		
Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No
☐	☒	☐	☐	☒	☐	☐	☒	☐	☒	☐	☐

If "Unsure" or "No", please explain[12]

1. N/A
2.

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

1. Trust Board reports and minutes
2. Workforce Committee reports and minutes
3. Trust Management Executive reports and minutes

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

Responsible Director/s
Director of Workforce and Communications

Committee/s responsible for oversight
Workforce Committee

How confident is the Responsible Director that the objective will be achieved by the end of 2015/16?[13]

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
☐	☐	☒	☐	☐	☒	☐	☒	☐	☐	☒	☐

Explanation of any "Amber" or "Red" rating:

1. The national shortage of qualified Nursing staff; Home Office visa restrictions / government drive to reduce immigration; and system-wide failure to reduce increasing demand on acute services constrain the Trust's ability to eradicate the risk in 2015/16

[10] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future
[11] The question asked for July, Sep & Nov was "Are the actions that have been taken sufficient to achieve the objective at year-end?"
[12] The question asked for July, Sep & Nov was "If "Unsure" or "No", what other actions are planned?"
[13] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2015/16

4 Finances i.e. the need to deliver the financial plan for 2015/16

What does the Trust want to achieve? *Objective*

4.a To deliver the financial plan for 2015/16

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

1. Failing to deliver the required income levels across all contracts
2. Failure to contain costs within the budgets allocated
3. Failure to deliver the CIP programme in full
4. Not receiving full payment for patient activity undertaken
5. Impact of increased emergency activity through the winter period
6. Failure to mitigate reliance on temporary staffing (and Agency staffing in particular)
7. The continuing high level of Delayed Transfers of Care (DTOCs) (which is linked to 1. and 2. above)

What actions have been taken in response? *Controls*

a. Assess the risks on the range of forecast outturn scenarios, identify & agree actions to mitigate risks
b. Review of Acute & Emerg. Directorate Nurse rotas
c. Escalate CQC , 7 day working, safer staffing funding requests with CCG
d. Close gap on CIP outturn delivery
e. Secure working capital facility for required liquidity per cash flow plans
f. Actions are in place to limit the Trust's use of non-Framework staffing Agencies
g. An Integrated Recovery Plan has been developed and submitted to the TDA

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

July 2015[15]			Sep. 2015[15]			Nov. 2015[15]			Feb. 2016		
Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No
☐	☒	☐	☐	☒	☐	☐	☐	☒	☒	☐	☐

If "Unsure" or "No", please explain[16]

N.B. Although a 'Green' rating has been applied, as all actions are being delivered, continuous scrutiny is being applied, to improve the position. Technical adjustments, to improve the position, are also being explored

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

1. Reporting of year to date financial performance
2. Agenda, reports and minutes of the Finance Committee, TME and Trust Board
3. The winter and operational resilience plan (reviewed by the Trust Board in May and July 2015)
4. External audit of accounts ('Value for Money' conclusion)
5. Internal audit reviews: "Financial Accounting and Non Pay" (Reasonable Assurance); "Budgetary Control" (Reasonable Assurance) "Payroll" (scheduled for Q3)
6. Review of the Integrated Recovery Plan at Finance Committee (January 2016)

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
2. N/A

Responsible Director/s	**Committee/s responsible for oversight**
Director of Finance	Finance Committee / Trust Management Executive

How confident is the Responsible Director that the objective will be achieved by the end of 2015/16?[17]

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
☐	☒	☐	☐	☒	☐	☐	☐	☒	☐	☐	☒

Explanation of any "Amber" or "Red" rating:

1. The financial position remains behind plan at the end of Quarter 3. The Trust is forecasting not to achieve its financial plan, despite the introduction of an Integrated Recovery Plan
2. The trend on temporary staffing was being partially offset by increased income, in Quarter 1. This has not continued through Quarters 2 and 3

[14] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future
[15] The question asked for July, Sep & Nov was "Are the actions that have been taken sufficient to achieve the objective at year-end?"
[16] The question asked for July, Sep & Nov was "If "Unsure" or "No", what other actions are planned?"
[17] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2015/16

What is the key risk? [18] *Main risk*

5 Culture i.e. the need to enhance and sustain a high-performing culture

What does the Trust want to achieve? *Objective*

5.a To enhance and sustain a high-performing culture

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

1. Dependence on temporary staffing
2. Staff non-alignment to Trust vision and values
3. Reputational damage from Corporate Manslaughter prosecution
4. Inconsistent and disjointed leadership
5. Staff morale resulting from national changes to terms and conditions of employment
6. Loss of key staff and lack of succession planning

What actions have been taken in response? *Controls*

a. Workforce Strategy 2015-2020
b. Development of integrated leadership development programmes
c. Introduction of Living our Values programme
d. Increased staff engagement activity
e. Independent review of Good Governance & Culture
f. Trust Recruitment Plan – increased activity
g. Improved recognition – monthly awards

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

July 2015[19]			Sep. 2015[19]			Nov. 2015[19]			Feb. 2016		
Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No
☒	☐	☐	☒	☐	☐	☐	☒	☐	☐	☐	☒

If "Unsure" or "No", please explain[20]

1. Integrated Leadership Development Programmes have not been commissioned due to funding requirements.
2. Whilst there has been some increase in staff engagement activity, it has not been to the level required. Dedicated capacity will be required

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

1. Trust Board reports and minutes
2. Workforce Committee reports and minutes
3. The Workforce Risk Register
4. Trust Management Executive reports and minutes
5. National Staff and Patient Surveys
6. Friends and Family Test (FFT) Scores

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

If "No", what other data is needed?

1. The development of an MTW culture barometer is required

Responsible Director/s	**Committee/s responsible for oversight**
Director of Workforce and Communications	Workforce Committee

How confident is the Responsible Director that the objective will be achieved by the end of 2015/16?[21]

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
☐	☒	☐	☐	☒	☐	☐	☒	☐	☐	☒	☐

Explanation of any "Amber" or "Red" rating:

1. Culture change takes 5 to 10 years to materialise. The Trust has an ambitious Workforce Strategy and supporting implementation plan which will drive improvements in the culture over the next five years – dependent upon resources being made available

[18] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future
[19] The question asked for July, Sep & Nov was "Are the actions that have been taken sufficient to achieve the objective at year-end?"
[20] The question asked for July, Sep & Nov was "If "Unsure" or "No", what other actions are planned?"
[21] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2015/16

What is the key risk? [22] *Main risk*

6 Strategy i.e. the need for an updated cohesive strategy to deal with the instability and uncertainty in the wider health economy

What does the Trust want to achieve? *Objective*

6.a To develop a cohesive strategy to deal with the instability and uncertainty in the wider health economy

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

1. Competing priorities and operational pressures
2. Failure to broker agreed models and ways forward
3. Policy decisions, e.g. aspects of financing
4. External factors and instability in other organisations

What actions have been taken in response? *Controls*

a. Clear Board commitment and ownership
b. Active and continuing process of engagement
c. Close and transparent joint working with national organisations
d. Active scenario planning and engagement

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

July 2015[23]			Sep. 2015[23]			Nov. 2015[23]			Feb. 2016		
Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No
☐	☒	☐	☐	☒	☐	☐	☒	☐	☒	☐	☐

If "Unsure" or "No", please explain[24]

1. N/A
2. N/A

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

1. Regular updates and briefings to the Trust Board (and Trust Management Executive). In Jan. 2016, the Board received an Outline Structure for a Trust Clinical Strategy
2. Interaction with regulators and other national organisations, including formal feedback
3. Agreement of clear strategic direction, supported by partners

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
2. N/A

Responsible Director/s
Deputy Chief Executive

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 2015/16?[25]

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
☐	☒	☐	☐	☒	☐	☐	☒	☐	☐	☒	☐

Explanation of any "Amber" or "Red" rating:

1. The greatest risks lie in factors beyond the Trust's direct control – continuing external engagement and influencing will be crucial
2. The "NHS Shared Planning Guidance 2016/17 – 2020/21" requires a "place-based" five year Sustainability and Transformation Plan (STP) to be produced by the end of June 2016. The geographic scope (the "transformation footprint") of the STP involving the Trust has been confirmed to be Kent and Medway.

[22] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future
[23] The question asked for July, Sep & Nov was "Are the actions that have been taken sufficient to achieve the objective at year-end?"
[24] The question asked for July, Sep & Nov was "If "Unsure" or "No", what other actions are planned?"
[25] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Board Assurance Framework 2015/16

What is the key risk? [26] *Main risk*

7 Senior workforce i.e. the need to ensure effective succession planning for key critical posts, to ensure the continual development of the Trust and its services

What does the Trust want to achieve? *Objective*

7.a To ensure there is effective succession planning for key critical posts

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

1. National Terms and Conditions of employment
2. Business needs - i.e. the ability to release staff for development opportunities
3. Individual aspirations to take-up critical roles
4. Insufficient talent for key critical roles
5. Reduction in training resources

What actions have been taken in response? *Controls*

a. Workforce Strategy 2015-20
b. Executive Team Succession Planning Meeting
c. Annual appraisal and Personal Development Plans
d. Review of 2014/15 earnings for key roles
e. Scoping of the implementation of local senior manager pay (SMP)

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

July 2015[27]			Sep. 2015[27]			Nov. 2015[27]			Feb. 2016		
Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No	Yes	Unsure	No
☒	☐	☐	☒	☐	☐	☐	☒	☐	☐	☐	☒

If "Unsure" or "No", please explain[28]

1. Executive team succession planning has not taken place this year
2. The scoping of local management pay is not complete

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

1. Workforce Committee reports and minutes
2. Trust Board reports and minutes
3. Remuneration and Appointments Committee reports and minutes

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

Responsible Director/s	**Committee/s responsible for oversight**
Director of Workforce and Communications	Workforce Committee

How confident is the Responsible Director that the objective will be achieved by the end of 2015/16?[29]

July 2015			Sep. 2015			Nov. 2015			Feb. 2016		
☐	☒	☐	☐	☒	☐	☐	☒	☐	☐	☐	☒

Explanation of any "Amber" or "Red" rating:

1. The Trust will have in place a succession plan for critical roles within the organisation. However issues with supply (attraction and existing organisational talent) and development time will mean that the full implementation and assurance against each critical role will take time to deliver

[26] A "key risk" is something that could fundamentally affect the way in which the Trust exists or provides services in the future
[27] The question asked for July, Sep & Nov was "Are the actions that have been taken sufficient to achieve the objective at year-end?"
[28] The question asked for July, Sep & Nov was "If "Unsure" or "No", what other actions are planned?"
[29] "G": No reason to doubt that the objective won't be achieved; "R": Serious doubts exist regarding achievement

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – February 2016

2-10 Integrated Performance Report for January 2016	**Chief Executive / Executive Team**

The enclosed report includes:

- The 'story of the month' for January, which includes the latest position on Delayed Transfers of Care (DTOCs)
- The Trust performance dashboard
- Integrated performance charts
- Financial performance overview
- Finance 'pack'

Which Committees have reviewed the information prior to Board submission?

- Executive Team, 16/02/16
- Trust Management Executive, 17/02/16

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

Discussion and scrutiny

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

'Story of the month' for January 2016

1. Introduction

Board members have been regularly advised of the continuing challenges and failure to deliver the national standards for A&E and Cancer Waiting times. We have agreed recovery plans and trajectories for both these areas, with an expectation that we will deliver 95% at the end of Quarter 1 for A&E and be compliant with all cancer standards in the same time frame. Further work will occur with the A&E trajectory once the operational date for the new ward is confirmed

Although we are compliant with the aggregate target for RTT incomplete pathways the recent and prolonged problem with reduced elective activity has meant that the number of patients waiting longer than 18 weeks has increased substantially in the last 12 months. The key specialties are T&O, gynaecology, ENT and neurology. The Trust is currently revising the specialty level trajectories and we are expecting to be compliant at specialty level, with the exception of T&O by September 2016, but remain compliant at aggregate level throughout.

The key contributing factor to the underperformance on the A&E standard, underperformance on elective activity, prolonged use of escalation areas and continued high usage of temporary staffing is the increased length of stay for non-elective admissions. Therefore improving length of stay remains the main focus of our operational improvement plan for the next year.

2. Key headlines

a. A&E Performance

A&E attendances for January were 7.6% above our predicted levels and overall A&E activity has remained above plan all year. Typically in January we would expect to see around 320 attendances per day but in January 2016 the attendance was at 370 per day. This increase in demand had an adverse impact on our 4 hour performance which dropped to 80.4% for the month and is 88.6% year to date. There are no obvious patterns of patient presentations in terms of disease or age profile among our A&E attendances. Both A&E departments continue to maintain good performance against the 15 minute to assessment and 60 minute to treatment standards which demonstrate effective processes are in place at the front door.

b. Length of Stay and Delayed Transfers of Care (DTOCs)

The non-elective length of stay is at 7.7 days in January and total occupied bed days increased to a high level of 740 in January – the range between June and December was 650 – 670. The DTOC level reduced slightly in January as per the expected seasonal variation, 5.1% in the month and is currently at 6.3% YTD. The improvement plan is aimed at achieving a LOS improvement of 1.1 days on NEL admissions, achieved through a combination of increased ambulatory pathways, focus on early discharges and further developing the work of the integrated discharge team.

Count of Hospital ID	Column Labels																							
Row Labels	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Grand Total
A : Awaiting Assessment	8	6	2	3	5	7	3	2		11	17	17	15	6	15	21	15	17	15	10	5	7	207
B : Awaiting Public Funding		2		2	7	7	6	1		1	3	2	2		1	1	4	8	7	3	1		58
C : Awaiting Further Non-Acute NHS Care	18	38	40	46	31	33	30	25	19	21	18	28	32	34	39	48	33	30	20	6	3	8	600
Di : Awaiting Residential Home	2	2		9	4		1	6	10	5	3	6	18	1	11	27	28	26	22	16	21	15	233
Dii : Awaiting Nursing Home	3	3	2	9	2	20	13	16	8	17	12	30	40	21	38	90	57	52	56	40	73	53	655
E : Awaiting Care Package	2	11	9	6	8	8	13	26	15	11	18	10	7	7	20	16	27	17	32	26	43	28	360
F : Awaiting Community Adoptions	7	8	3	6	7	2	7	8	6	9	1	8	1	11	2	1		1	13	9	8	14	132
G : Patient of Family Choice	36	39	44	36	59	32	46	47	36	39	47	60	60	44	44	45	16	43	26	22	31	12	864
H : Disputes						1							2	1			1	3	1	1		1	11
I : Housing		2	6	2				2		2		1	3	4	3	1		1	13	12	9	3	64
Grand Total	76	111	106	119	123	110	119	133	94	116	119	162	180	129	173	250	181	198	205	145	194	141	3184
Trust delayed transfers of care	3.2%	3.6%	4.3%	3.8%	5.2%	4.4%	3.9%	5.2%	3.6%	3.3%	4.3%	6.0%	5.5%	4.8%	6.8%	7.9%	7.1%	7.9%	6.6%	5.7%	6.0%	5.1%	

c. Cancer 62 day & 104 day standards

The December performance for the 62 day FDT is 78%, with 27 breaches of the standard reported. 17 of the breaches were MTW only, 8.5 from other Trusts and 1.5 from MTW to other Trusts.

9.5 [13 patients] of the 27 breaches were treated beyond 104 days and 6 of those patients were MTW and 7 from elsewhere.

The full RCA of the breaches is currently underway in accordance with the new policy and on first review all the breaches are patients with complex pathways, needing treatment for other illness prior to cancer treatment, or have been transferred between different MDTs.

The performance for MTW only patients has improved slightly to 81.3%.

3. Patient Safety and Quality

January has seen the lowest rate of falls since March 2015 and remains a downward trend since September 2015. Although in December we saw a downward trend in hospital acquired pressure ulcers this has gone up slightly for January. We are monitoring this very carefully and all ward managers are focussed with their teams to ensure all preventative actions are being taken. On the 1st February we also reported a grade 4 hospital acquired pressure ulcer and although an internal investigation has commenced we have requested external review by a tissue viability nurse from another Trust.

There have been no cases of Clostridium difficile infection for December or January.

There has been a slight drop for complaints responded to within target but we are confident that the position will improve in February.

During this exceptionally busy month, although the Friends and Family Test (FFT) response rates have dropped a little (in particular in A&E) % positive score remain in line with or above the national average.

4. Workforce

During the month the Trust continued its recruitment performance and now employs 5,119 whole time equivalent substantive staff, as with the previous months this is an increase of 60 WTE compared with December 2015. This is the highest number of substantive staff employed by the Trust since reporting to the Board became the norm and represents a net increase of over 160 WTE against the same month last year. The month sees a net increase (25 WTE) in the numbers of substantive registered nurses and an increase of 7 WTE clinical support workers. Over the next few months the 'pipeline' of recruitment for registered nurses should enable the continued reduction in nurse vacancies with expected monthly net increases. However, despite the recruitment success the dependence upon temporary staff remained higher than planned and further work is ongoing to ensure, in line with the TDA requirements, we reduce our dependence upon expensive agency and interim workers. A task and finish group has been established to focus on medical recruitment, and has a defined plan of work.

Sickness absence in the month was 3.7%, representing a significant improvement on the same period last year and on the last month. and whilst not all areas of the Trust are consistently achieving the required levels of appraisal and statutory and mandatory training actions are in place to do so within the year.

TRUST PERFORMANCE DASHBOARD **Position as at:** **31 January 2016**

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

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

Delivering or Exceeding Target	
Underachieving Target	
Failing Target	

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

******A&E 4hr Wait is Quarter to date, Forecast is for Quarter 4 only

	Safe	Latest Month		Year to Date		YTD Variance			Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	Plan	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
'1-01	*Rate C-Diff (Hospital only)	4.60	0.0	13.0	8.6	11.6	-4.4	-3.0	11.5	8.8	
'1-02	Number of cases C.Difficile (Hospital)	1	0	25	17	23	-8	-6	27	21	
'1-03	Number of cases MRSA (Hospital)	0	0	1	1	0	0	1	0	1	
'1-04	Elective MRSA Screening	99.0%	99.0%	99.0%	99.0%	98.0%		1.0%	98.0%	99.0%	
'1-05	% Non-Elective MRSA Screening	97.0%	98.0%	97.0%	98.0%	95.0%		3.0%	95.0%	98.0%	
'1-06	**Rate of Hospital Pressure Ulcers	2.9	3.3	2.3	2.7	3.0	0.3	-0.4	*3.0*	2.6	3.0
'1-07	***Rate of Total Patient Falls	6.4	6.1	6.2	6.7	6.2	0.5	0.5	*6.2*	6.7	
'1-08	***Rate of Total Patient Falls Maidstone	4.4	6.1	5.0	6.1	-	1.1			6.1	
'1-09	***Rate of Total Patient Falls TWells	8.0	6.1	7.0	7.0	-	-0.0			7.0	
'1-10	Falls - SIs in month		4		41		41				
'1-11	Number of Never Events	1	0	2	2	0	0	2	*0*	2	
'1-12	Total No of SIs Open with MTW	19	37				18				
'1-13	Number of New SIs in month	10	11	92	89	100	-3	-11			
'1-14	**Serious Incidents rate	0.46	0.51	0.48	0.45	0.058	-0.03	0.39	*0.0584 - 0.6978*	0.45	*0.0584 - 0.6978*
'1-15	Rate of Patient Safety Incidents - harmful	1.09	0.86	1.07	1.19	1.23	0.12	-0.04	*0 - 1.23*	1.19	*0 - 1.23*
'1-16	Number of CAS Alerts Overdue	0	1			0	1	1	*0*		
'1-17	VTE Risk Assessment	95.8%	95.5%	95.6%	95.4%	95.0%	-0.2%	0.4%	95.0%	95.4%	95.0%
'1-18	Safety Thermometer % of Harm Free Care	97.3%	97.1%	96.5%	96.8%	95.0%	0.3%	1.8%	95.0%		93.4%
'1-19	Safety Thermometer % of New Harms	1.70%	2.35%	2.62%	2.42%		-0.20%	-0.58%	*3.00%*	2.42%	
'1-20	C-Section Rate (non-elective)	14.8%	14.9%	15.1%	12.9%		-2.22%	-2.14%	*15.0%*	12.9%	

	Effectiveness	Latest Month		Year to Date		YTD Variance			Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	Plan	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
2-01	Hospital-level Mortality Indicator (SHMI)******	Prev Yr: Oct 13 to Sept 14		103.4	102.6		-1.4	2.0	*Lower confidence limit to be <100*		100.0
2-02	Standardised Mortality (Relative Risk)	Prev Yr: Oct 13 to Sept 14		106.9	104.0		-2.9	4.0			100.0
2-03	Crude Mortality	1.1%	1.3%	1.1%	1.2%		0.0%				
2-04	****Readmissions <30 days: Emergency	12.0%	11.1%	11.7%	11.2%	13.6%	-0.4%	-2.4%	*13.6%*	11.2%	14.1%
2-05	****Readmissions <30 days: All	11.1%	10.5%	10.9%	10.4%	14.7%	-0.5%	-4.3%	*14.7%*	10.4%	14.7%
2-06	Average LOS Elective	3.4	3.2	3.2	3.2	3.2	0.0	0.0	*3.2*	3.2	
2-07	Average LOS Non-Elective	7.4	7.7	6.8	7.3	6.5	0.5	0.8	*6.5*	7.3	
2-08	New:FU Ratio	1.64	1.52	1.54	1.36		0.18	-0.16	*1.52*	1.52	
2-09	Day Case Rates	86.6%	86.8%	83.7%	84.2%		0.5%	4.2%	80.0%	84.2%	82.2%
2-10	Primary Referrals	8,409	8,244	84,437	87,008	85692	3.0%	1.5%	94,755	104,577	
2-11	Cons to Cons Referrals	3,378	2,926	34,216	34,496	32935	0.8%	4.7%	39,585	41,462	
2-12	First OP Activity	11,636	11,031	120,148	116,441	114419	-3.1%	1.8%	137,569	140,173	
2-13	Subsequent OP Activity	22,328	21,666	216,343	217,523	217089	0.5%	0.2%	260,989	260,448	
2-14	Elective IP Activity	483	456	6,355	6,426	6646	1.1%	-3.3%	7,988	7,939	
2-15	Elective DC Activity	2,918	2,955	31,106	32,490	32079	4.4%	1.3%	38,556	39,275	
2-16	Non-Elective Activity	3,838	3,606	39,585	37,669	40373	-4.8%	-6.7%	48,289	45,335	
2-17	A&E Attendances (Inc Clinics. Calendar Mth)	9,821	11,632	110,035	114,789	113640	4.3%	1.0%	135,922	137,293	
2-18	Oncology Fractions	5,809	5,460	58,720	57,376	59997	-2.3%	-4.4%	71,761	69,095	
2-19	No of Births (Mothers Delivered)	493	470	4,780	4,807	4757	0.6%	1.1%	5,708	5,768	
2-20	% Mothers initiating breastfeeding	79.9%	73.2%	81.6%	77.9%	78.0%	-3.7%	-0.1%	78.0%	78.0%	
2-21	% Stillbirths Rate	0.4%	0.21%	0.29%	0.41%	0.5%	*0.1%*	*-0.1%*	*0.47%*	0.41%	0.47%

	Caring	Latest Month		Year to Date		YTD Variance			Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	Plan	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
3-01	Single Sex Accommodation Breaches	33	6	68	6	0	-62	6	0	6	
3-02	*****Rate of New Complaints	2.21	1.29	4.00	2.08	1.32	-1.91305	0.77	*1.318-3.92*	2.08	
3-03	% complaints responded to within target	71.1%	68.6%	71.1%	74.2%	75.0%	3.2%	-0.8%	75.0%	75.0%	
3-04	****Staff Friends & Family (FFT) % rec care	New	82.2%	New	82.9%		New	7.9%	75.0%	75.0%	79.2%
3-05	*****IP Friends & Family (FFT) % Positive	New	96.1%	New	96.4%		New	1.4%	95.0%	95.0%	95.7%
3-06	A&E Friends & Family (FFT) % Positive	New	86.4%	New	88.8%		New	1.8%	87.0%	87.0%	86.9%
3-07	Maternity Combined FFT % Positive	90.5%	97.2%	90.7%	95.1%		4.5%	0.1%	95.0%	95.0%	95.5%
3-08	OP Friends & Family (FFT) % Positive	New	80.9%	New	79.9%		New			79.9%	

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

	Responsiveness	Latest Month		Year/Quarter to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
4-01	******Emergency A&E 4hr Wait	83.5%	80.4%	92.6%	80.4%	-12.2%	-14.6%	95.0%	83.4%	90.1%
4-02	Emergency A&E >12hr to Admission	0	1	2	1	-1	1	*0*	1	
4-03	Ambulance Handover Delays >30mins	New	No data	New	No data				No data	
4-04	Ambulance Handover Delays >60mins	New	No data	New	No data				No data	
4-05	18 week RTT - admitted patients	93.5%	91.5%	91.7%	90.3%	-1.4%	0.3%	90%	90.3%	
4-06	18 week RTT - non admitted patients	98.1%	95.7%	96.8%	97.6%	0.8%	2.6%	95%	97.6%	
4-07	18 week RTT - Incomplete Pathways	95.5%	93.6%	95.5%	93.6%	-1.9%	1.6%	92%	93.6%	
4-08	18 week RTT - Specialties not achieved	4	10	19	60	41	60	*0*	60	
4-09	18 week RTT - 52wk Waiters	1	0	0	5	5	5	*0*	5	
4-10	18 week RTT - Backlog 18wk Waiters	568	943	568	943				943	
4-11	% Diagnostics Tests WTimes <6wks	99.9%	99.7%	100.0%	99.7%	-0.3%	0.7%	99.0%	99.0%	
4-12	*Cancer WTimes - Indicators achieved	8	4	8	5	-3	-4	9	9	
4-13	*Cancer two week wait	95.9%	88.7%	96.5%	90.6%	-5.8%	-2.4%	93.0%	93.0%	
4-14	*Cancer two week wait-Breast Symptoms	90.3%	87.1%	94.8%	89.3%	-5.5%	-3.7%	93.0%	93.0%	
4-15	*Cancer 31 day wait - First Treatment	98.2%	96.3%	98.5%	96.6%	-1.9%	0.6%	96.0%	96.6%	
4-16	*Cancer 62 day wait - First Definitive	84.5%	78.0%	84.2%	76.2%	-8.0%	-8.8%	85.0%	85.0%	
4-17	*Cancer 62 day wait - First Definitive - MTW	93.6%	83.5%	90.5%	81.3%	-9.2%		85.0%		
4-18	*Cancer 104 Day wait Accountable	New	9.5	New	61.0	New	61.0	-	61.0	
4-19	Delayed Transfers of Care	3.3%	5.1%	4.0%	6.3%	2.3%	2.8%	3.5%	5.0%	
4-20	% TIA with high risk treated <24hrs	62.5%	66.7%	74.5%	69.8%	-4.7%	9.8%	60%	69.8%	
4-21	% spending 90% time on Stroke Ward	82.9%	65.9%	83.3%	81.7%	-1.7%	1.7%	80%	81.7%	
4-22	Stroke:% to Stroke Unit <4hrs	27.3%	33.3%	38.8%	48.9%	10.1%	-6.1%	55.0%	48.9%	
4-23	Stroke: % scanned <1hr of arrival	51.8%	57.1%	43.1%	55.3%	12.2%	12.3%	43.0%	55.3%	
4-24	Stroke:% assessed by Cons <24hrs	67.9%	55.1%	73.2%	69.5%	-3.7%	-15.5%	85.0%	69.5%	
4-25	Urgent Ops Cancelled for 2nd time	0	0	0	0	0	0	*0*	0	
4-26	Patients not treated <28 days of cancellation	0	6	0	6	6	6	*0*	6	

CWT run one mth behind, YTD is Quarter to date, Forecast is for Quarter 4* * Serious Incidents Rate is per 1,000 Occupied Beddays*

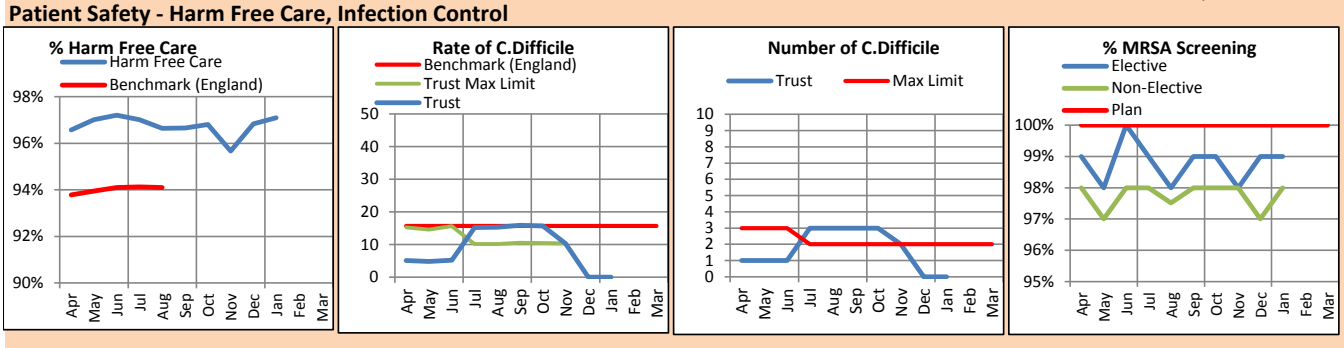
**** Contracted not worked includes Maternity /Long Term Sick* ***** Staff FFT is Quarterly therefore data is latest Quarter*

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

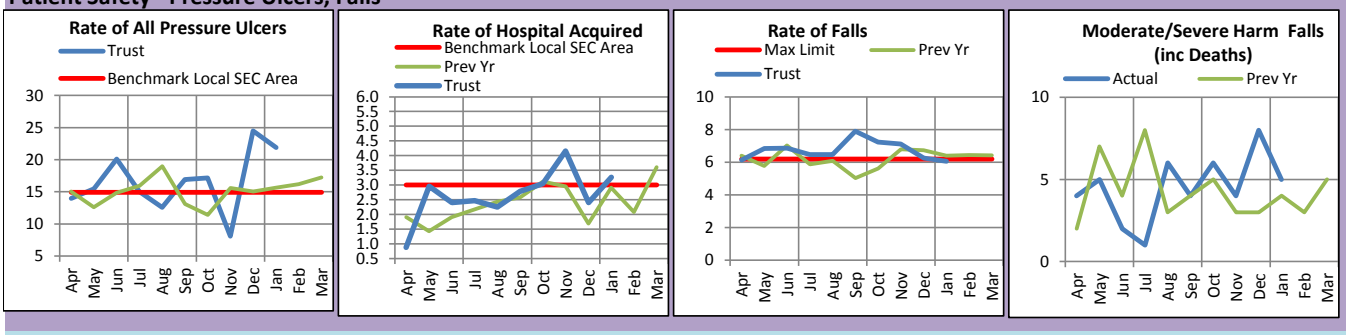
	Well-Led	Latest Month		Year to Date		YTD Variance		Year End		Bench Mark
		Prev Yr	Curr Yr	Prev Yr	Curr Yr	From Prev Yr	From Plan	Plan/ *Limit*	Forecast	
5-01	Income	34,582	32,238	330,201	331,537	0.4%	1.2%	400,587	399,790	
5-02	EBITDA	3,460	(365)	28,304	6,099	-78.5%	-65.7%	23,671	10,218	
5-03	Surplus (Deficit) against B/E Duty	646	(3,173)	(854)	(21,970)			(12,132)	(23,515)	
5-04	CIP Savings	2,384	1,557	19,889	17,527	-11.9%	-2.5%	21,496	20,752	
5-05	Cash Balance	9,126	4,117	9,126	4,117	-54.9%	35%	2,127	1,000	
5-06	Capital Expenditure	1,315	1,264	4,991	9,897	98.3%	-35.8%	*18,963*	14,823	
5-07	Establishment (Budget WTE)	5,493.3	5,702.0	5,493.3	5,702.0	3.8%	0.0%			
5-08	Contracted WTE	4,941.9	5,109.4	4,941.9	5,109.4	3.4%	-5.6%			
5-09	***Contracted not worked WTE	(94.9)	(96.2)	0.0	(96.2)					
5-10	Locum Staff (WTE)	31.7	70.5	31.7	70.5	122.6%				
5-11	Bank Staff (WTE)	274.9	321.3	274.9	321.3	16.9%				
5-12	Agency Staff (WTE)	193.8	248.7	193.8	248.7	28.3%				
5-13	Overtime (WTE)	64.4	53.7	64.4	53.7	-16.7%				
5-14	Worked Staff WTE	5,401.3	5,703.1	5,401.3	5,703.1	5.6%	0.0%			
5-15	Vacancies WTE	551.4	592.6	551.4	592.6	7.5%				
5-16	Vacancy %	10.0%	10.4%	10.0%	10.4%	3.5%				
5-17	Nurse Agency Spend	(587)	(827)	(4,440)	(8,389)	88.9%				
5-18	Medical Locum & Agency Spend	(998)	(1,211)	(8,325)	(10,358)	24.4%				
5-19	Temp costs & overtime as % of total pay bill									
5-20	Staff Turnover Rate	9.1%	10.3%		10.0%	1.3%	-0.2%	*10.5%*	10.0%	8.4%
5-21	Sickness Absence	5.2%	3.7%		3.9%	-1.4%	0.4%	*3.3%*	3.3%	3.7%
5-22	Statutory and Mandatory Training	83.6%	90.3%		90.3%	6.7%	5.3%	85.0%	85.0%	
5-23	Appraisal Completeness	74.3%	81.0%		81.0%	6.6%	-9.0%	90.0%	81.0%	
5-24	Overall Safe staffing fill rate	101.3%	104.1%	100.9%	101.6%	2.9%		93.5%	101.6%	
5-25	****Staff FFT % recommended work	New	56.9%	New	57.7%		-1.1%	58.0%	57.7%	62.9%
5-26	***Staff Friends & Family -Number Responses	New	253	New	253					
5-27	*****IP Resp Rate Recmd to Friends & Family	New	24.6%	New	26.1%		-3.9%	30.0%	26.1%	25.1%
5-28	A&E Resp Rate Recmd to Friends & Family	New	8.6%	New	13.7%		-6.3%	20.0%	13.7%	13.1%
5-29	Mat Resp Rate Recmd to Friends & Family	14.2%	28.9%	19.0%	20.9%	2.0%	5.9%	15.0%	20.9%	23.4%

INTEGRATED PERFORMANCE REPORT ANALYSIS - PATIENT SAFETY & QUALITY

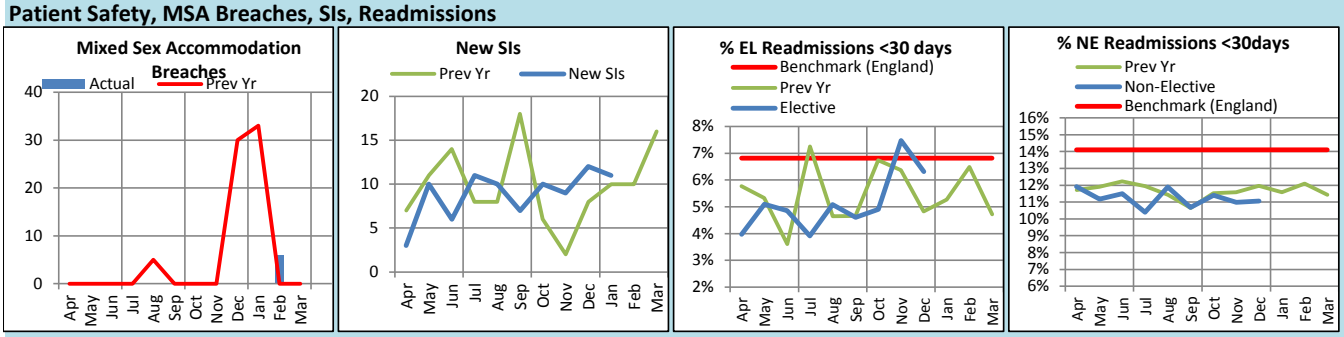
Patient Safety - Harm Free Care, Infection Control



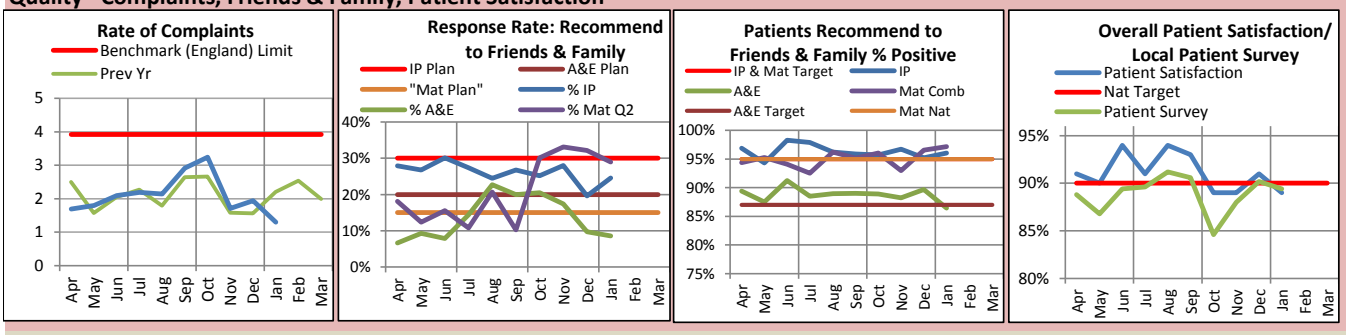
Patient Safety - Pressure Ulcers, Falls



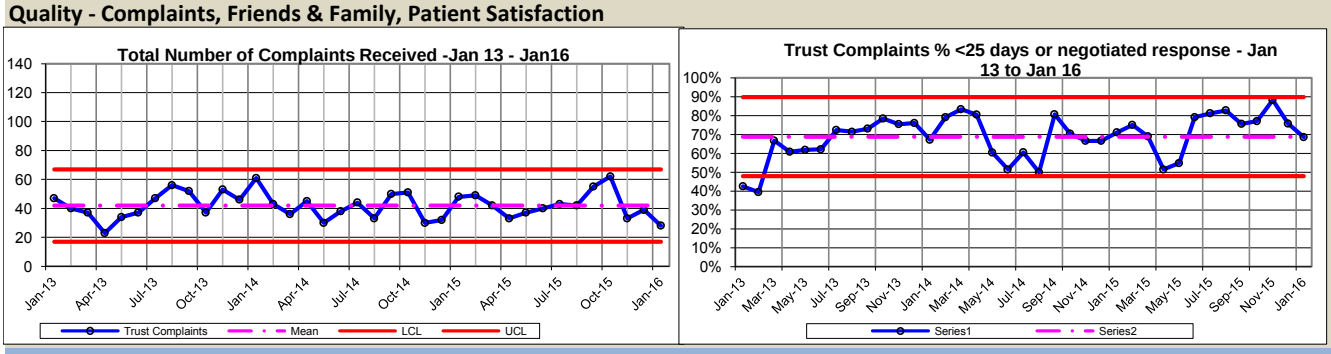
Patient Safety, MSA Breaches, SIs, Readmissions



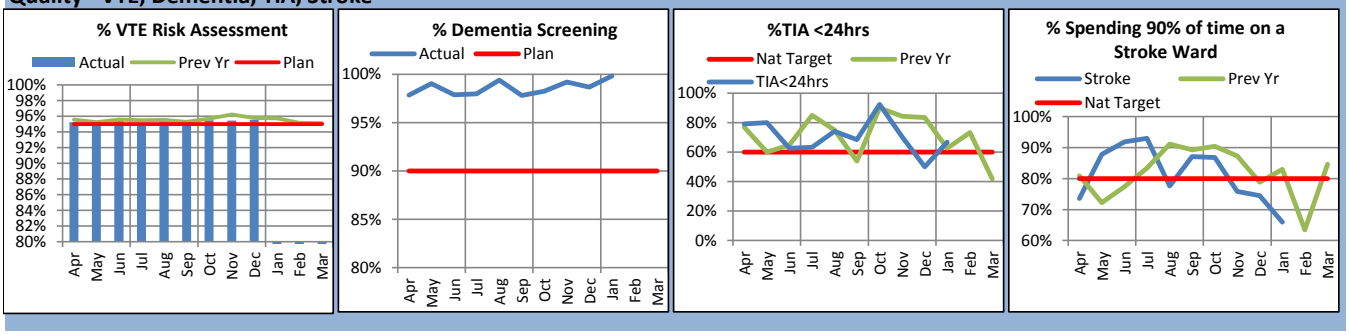
Quality - Complaints, Friends & Family, Patient Satisfaction



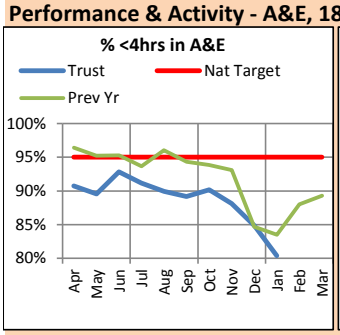
Quality - Complaints, Friends & Family, Patient Satisfaction

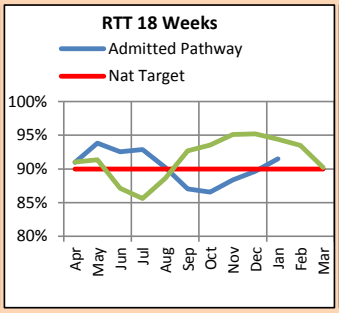


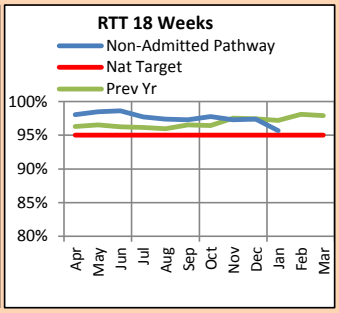
Quality - VTE, Dementia, TIA, Stroke

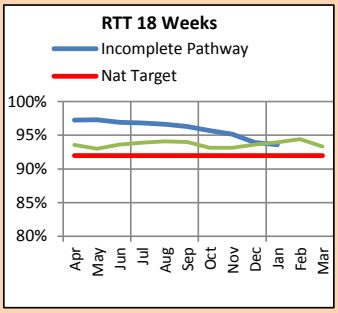


Performance & Activity - A&E, 18 Weeks

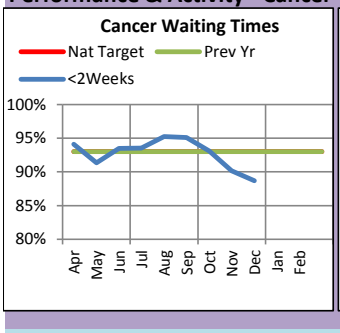


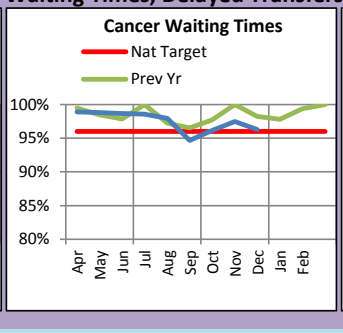


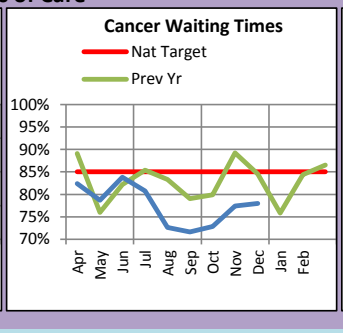


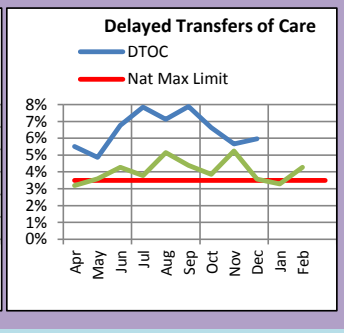


Performance & Activity - Cancer Waiting Times, Delayed Transfers of Care

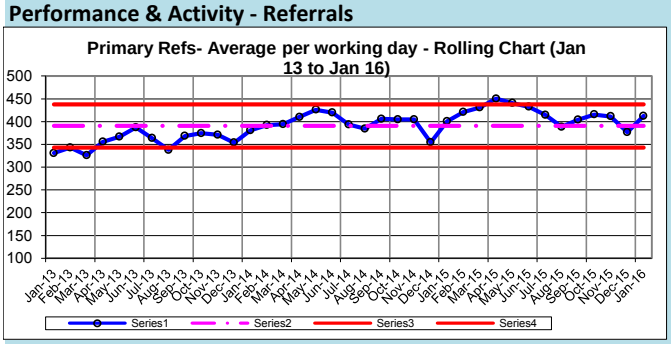


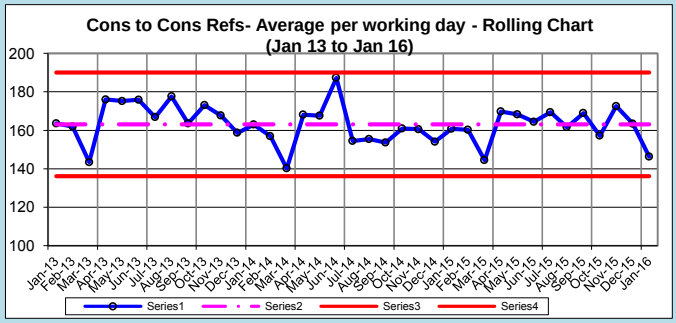




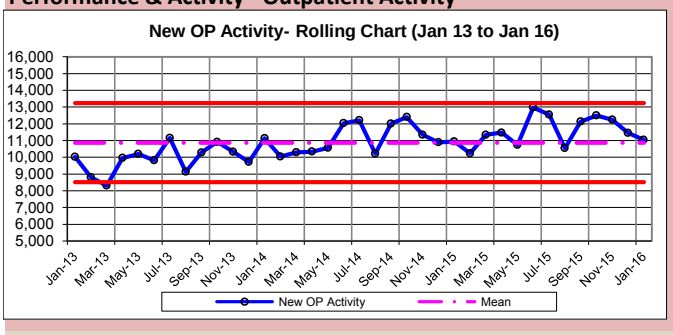


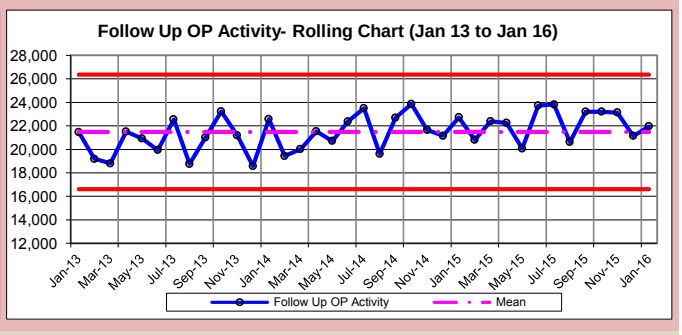
Performance & Activity - Referrals



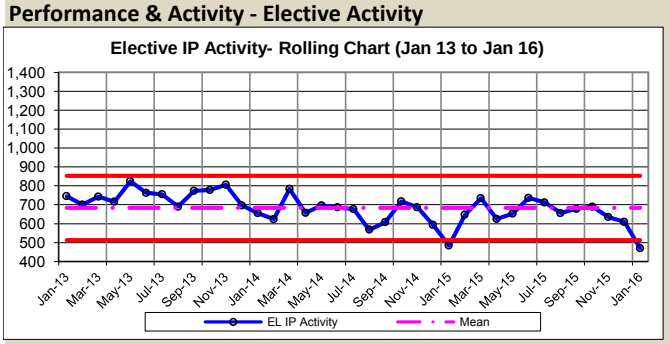


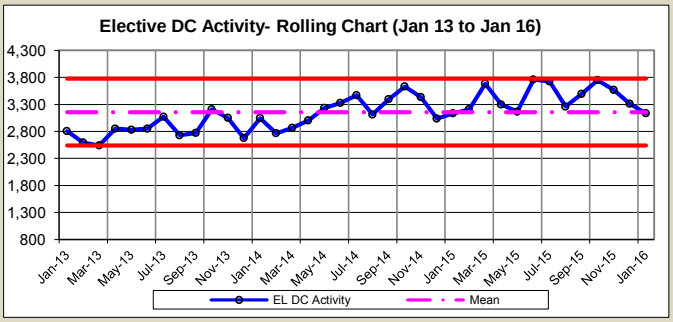
Performance & Activity - Outpatient Activity



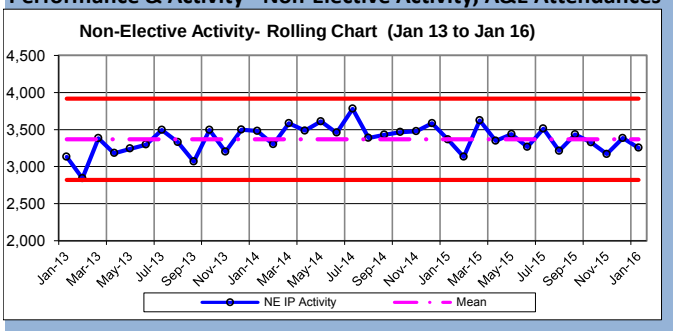


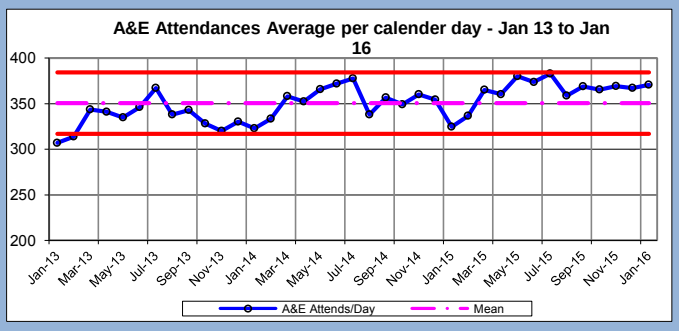
Performance & Activity - Elective Activity



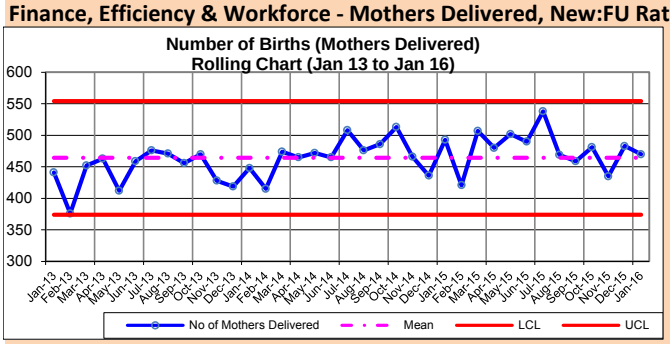


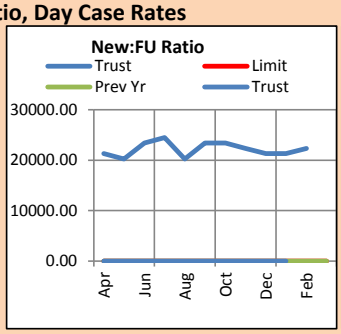
Performance & Activity - Non-Elective Activity, A&E Attendances

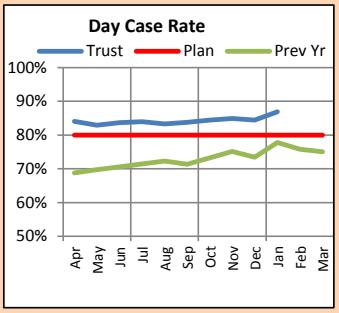




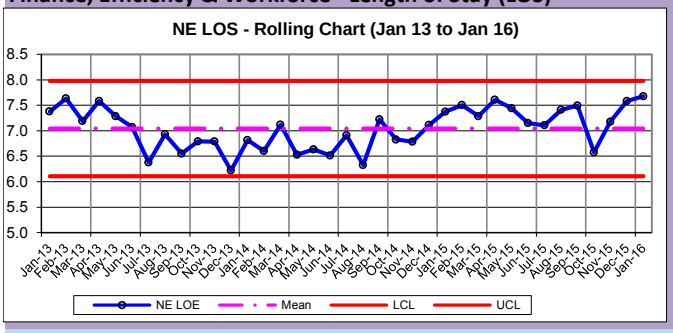
Finance, Efficiency & Workforce - Mothers Delivered, New:FU Ratio, Day Case Rates

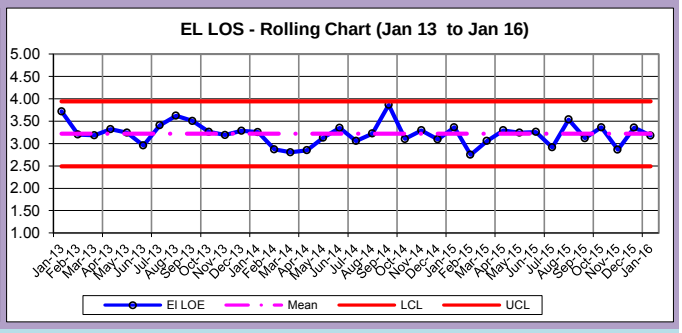




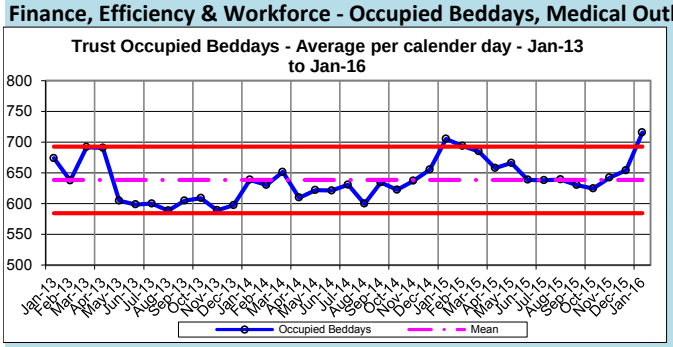


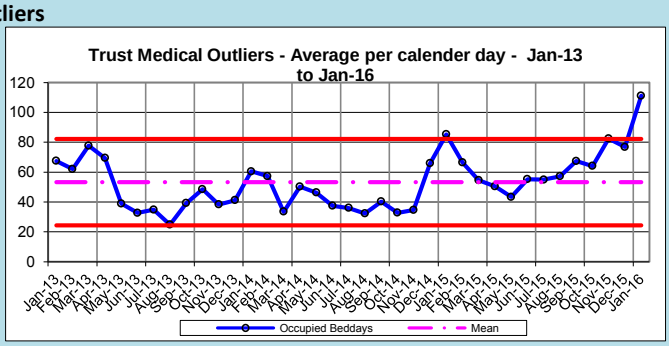
Finance, Efficiency & Workforce - Length of Stay (LOS)



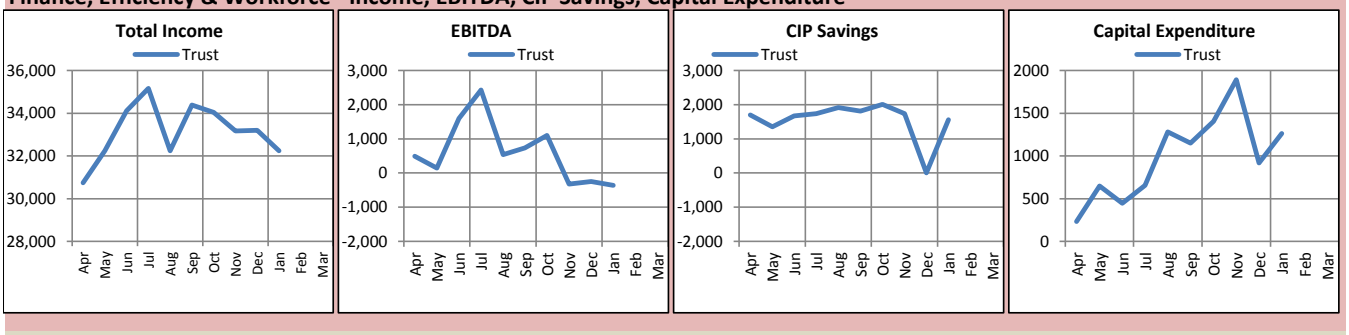


Finance, Efficiency & Workforce - Occupied Beddays, Medical Outliers

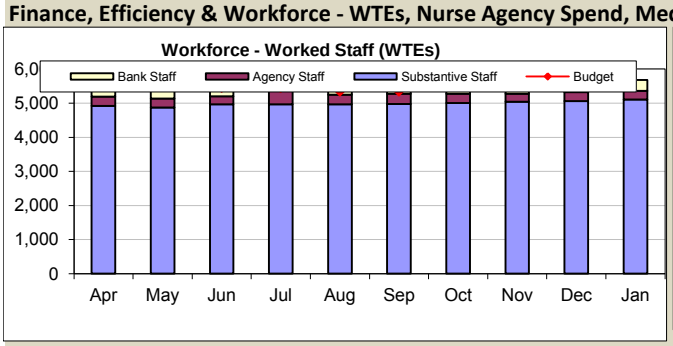


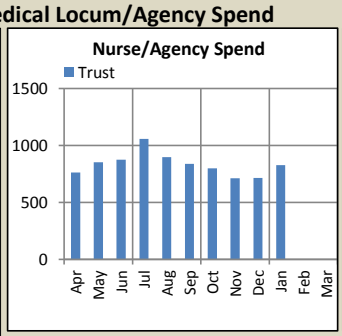


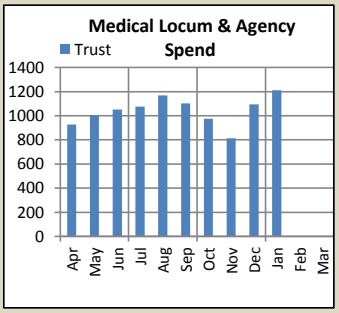
Finance, Efficiency & Workforce - Income, EBITDA, CIP Savings, Capital Expenditure



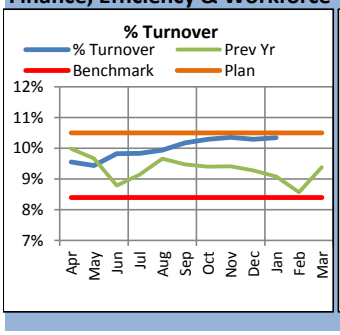
Finance, Efficiency & Workforce - WTEs, Nurse Agency Spend, Medical Locum/Agency Spend

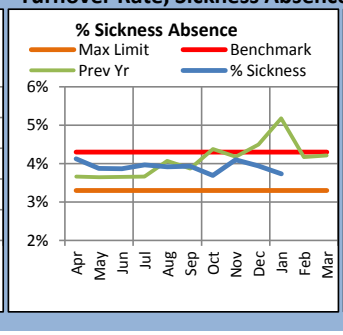


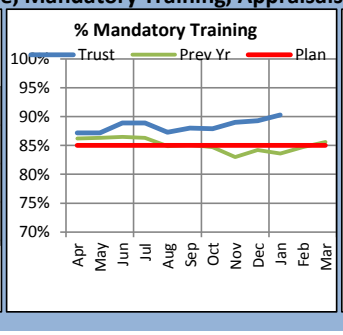


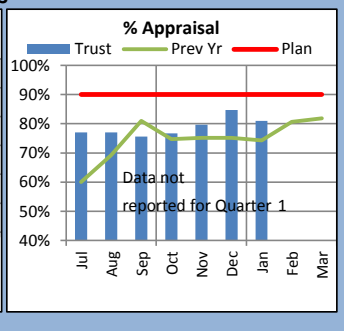


Finance, Efficiency & Workforce - Turnover Rate, Sickness Absence, Mandatory Training, Appraisals









Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST BOARD – FEBRUARY 2016

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

Summary / Key points

- The Trust had an adverse variance against plan at the end of January 2016 of £9.88m, an increase of £2.77m in the month.
- The Trust's net deficit to date (including technical adjustments) is £21.97m against the planned deficit of £12.09m. In the month the Trust operated at a deficit of £3.17m against a plan of £0.4m deficit for January.
- There remain a number of significant risks to the Trust's year end position. The risks are:
  - The Trust's ability to deliver its elective workload to planned levels and the recent trend of lower levels of SLA income performance coupled with high occupied bed days, lengths of stay and delayed transfers of care;
  - The impact of staffing costs over plan, including delivery of the plans in place to reduce agency reliance and recruit substantive posts;
  - The CCG's ability to provide the finance requested and included in the Trust's forecast to support escalation capacity, winter pressure plans, CQC action plan investments (e.g. in critical care outreach) & A&E paediatric doctors;
  - Slippage on the delivery of a number of Directorate and Strategic plans intended to increase market share relating to East Sussex and Medway non elective workload, E Sussex maternity developments, areas of Best Practice Tariff and other income related CIPs. High levels of income in early months of the year previously mitigated this slippage.
- In January the Trust operated with an EBITDA deficit of £0.37m which was £2.85m adverse to plan.
- The Trust held £4.1m of cash at the end of January, a decrease of £0.3m from the end of December.

Reason for circulation to the Trust Board

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

Briefing paper – Trust Board

M10 Financial Performance overview

1. Overview of the Financial Position at M10 2015/16

1.1. This written summary provides an overview of the financial position at M10 of 2015/16. It should be read alongside the finance pack, which has also been circulated to Trust Board members.

1.2. Under the TDA Accountability Framework the Trust is flagged as Red due to its reported financial position at month 10. The Finance pack shows for month 10 the Trust moved out adversely by £2.77m against its in-month deficit plan of £0.4m resulting in a year to date deficit of £21.97m against a planned deficit of £12.09m. This is an adverse year to date variance of £9.88m. These figures include the full utilisation of reserves available for the first ten months of 2015/16.

Income

1.3. Total income for the year to date is £331.54m against a budget of £327.54m. Income for the month is £32.24m compared to the £33.27m plan for the month.

1.4. The income headlines are outlined below:

- Total income is £4.0m favourable to plan year to date.
- All applicable contractual deductions and penalties have been included and a provision has been made for challenges.
- A&E attendance activity remains higher than in the corresponding period of last year.
- The A&E Conversion rate has increased to 26.73% in month 10 compared to the 26.51% experienced in month 9.
- Re-chargeable on High cost drugs and devices are favourable in the month by £0.6m, and year to date £5.5m but these are pass through costs charged back to CCGs so there is a corresponding over-spend in the non-pay budgets.

1.5. There was a reduction in Elective inpatient and day case activity compared to last month's level (£2.6m in month 10 compared to £4.6m in month 9) with a year to date (YTD) under performance of £3.0m, including dependency on outsourced activity.

1.6. The £2m reduction from last month's level is due to a combination of the high level of elective cancellations (£1.1m) and an adjustment for a CCG challenges.

1.7. The £1.1m impact from the high level of Elective cancellations was due to bed unavailability (418 in January vs 1208 YTD-all cancellations), while the reportable cancellations increased from 0.7% in December to 1% in January. The impact of cancellations was most visible in T&O.

1.8. The £0.9m CCG challenge was mitigated by the release of an equivalent amount of provision to remove the bottom line impact.

1.9. In month 10 A&E attendances remained relatively flat compared to the last 5 months' level and the conversion rate increased from 26.51% to 26.73%. To date A&E attendances are slightly above planned income levels (£68k) but this is higher than last year's level of income by 13.6%.

1.10. The Trust continues to experience an increase in the acuity of patients presenting in A&E which is further typified by the increase in conversion rates and ultimately LOS when such patients are admitted. Overall, the level of occupied bed days remains high and has increased further in month 10 resulting in increased usage of escalation capacity to manage flows in A&E.

1.11. Even though NEL admissions have reduced by 5.1% YTD (compared the corresponding period of last financial year), the richer and more acute case-mix has resulted in longer lengths of stay and an increase in the occupied bed days (OBD). During the same comparator period between years (April to January) delayed transfers of care (DTOCs) have increased to their highest ever levels (January comparison year on year 5.1% to 3.3%, some previous months have been over 7%). The increase in OBDs has generated a 5% increase in income from excess bed days which are only paid beyond the relevant HRG "trim point". NEL admissions are lower than planned in the month albeit slightly, mitigated by the increase in partially completed spells which are yet to be included in the position (Estimated at c£0.3m).

1.12. From April 2015 to January 2016, the Trust reported a total of 166,928 non elective occupied bed days compared to the 160,709 bed days used in the corresponding period of last year, representing a 3.9% increase. Our high bed utilisation rate coupled with our inability to discharge patients quicker is increasing the level of OBDs. Between month 9 and month 10 the daily bed occupancy rate has increased by 10 beds per day resulting in a total bed utilisation of 19,400 in January (19,097 in corresponding period of last financial year) compared to the 17,321 bed days utilised in December.

1.13. The increase in acuity (evidenced by an increased level of income per spell) and length of stay is reducing the throughput in non-elective activity, which is further reflected in an increase in medical outliers (which is currently at its highest ever level - 30% up on last year's level) and is adversely affecting bed capacity available for elective activity hence the high level of elective cancellations currently being experienced. This high bed occupancy and LOS levels is forcing the Trust to increasingly rely on escalation capacity, resulting in the designation of Foster Clark as an escalation ward and Whatman ward remaining open in January and its bed capacity increasing from 14 to 28 during the course of the month.

1.14. Outpatient activity (excluding diagnostics) is £4.6m in month 10 compared to £4.7m in the previous month. Year on year, the income from outpatient activity is 2.87% higher the corresponding period of the previous financial year but is still lower than planned levels (£0.5m YTD).

1.15. Readmissions, A&E waits, RTT and other contractual penalties (relating only to incomplete pathways) increased from a YTD level of £2.9m in December to a YTD level of £3.5m in January. The Readmissions, RTT and A&E penalties are calculated from Month 10 data whilst the other contractual penalties (e.g. First to Follow up OP ratios, Data quality queries) are estimates.

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

1.17. Non recurrent transitional support of £3.01m year to date for Cancer received from NHS England to reduce the impact of the cancer tariff in 2015-16 has been included in the position.

Outsourcing

1.18. The value of income related to outsourced activity reduced to £0.19m in January from £0.30m in December with a year to date total of £2.55m. For outsourced activity the Trust pays costs that remove any contribution that it would earn from undertaking the activity in-house. Over 80% of the income for outsourced activity for the year to date relates to orthopaedic cases where there may be potential to undertake this work internally by increasing actual or productive in house capacity.

Expenditure

1.19. Operating costs are £15.7m adverse for the year to date against a planned budget of £309.8m, including available reserves. Pay was over plan by £1.25m in January generating a year to date adverse variance of £10.04m.

1.20. Non pay (including reserves) overspent by £0.6m in January and is £5.6m overspent year to date.

1.21. Substantive staffing is underspent for the year to date by £1.2m made up of underspending on medical posts (£1.04m), scientific posts (£0.39m) and nursing posts (£0.33m). In the month substantive pay costs overspent by £0.14m.

1.22. The year to date major overspends on agency usage are in Nursing (£5.6m), Medical agency (£2.06m), Scientific/Therapeutic agency (£1.05) and Admin & Clerical (£1.06m). Nurse agency spend has risen from last month's level of spend (£716k) by £110k and reflects the increased numbers of escalated beds required to cope with the non-elective patient activity. Total agency costs are down on last month's levels by £138k overall (£1,565k compared to £1,427k). Total bank costs (including medical locums) are over planned levels by £0.45m in the month which gives a year to date overspend of £1.05m. The bulk of the adverse movement was on medical locums (£0.4m) which are currently £1.23m overspent to date.

1.23. The trajectory submitted to the TDA set out a reduction in agency costs from September (for trained nursing) of £0.5m through to the end of March with an overall reduction, including additional permanent staffing, of £0.3m. In January the qualified agency nursing increased to £827k from £715k in December and was largely linked to the increase in escalated beds. This was £286k greater than the January trajectory target which was set at £520k. The trajectory submitted to the TDA assumed that the total qualified agency nursing spend would be 8.8% by January but the Trust performance is actually 4.2% worse at 13.8%. Escalation pressures have contributed to the Trust not meeting the planned trajectory reduction.

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

- Drugs and medical gases £5.89m adverse (offset in the position by the over performance in HCD income to date of £5.13m)
- Clinical Supplies is £2.4m adverse to plan – this includes cardiology devices (e.g. ICDs) that are charged back to the CCGs. The spend levels from last month have reduced by £196k which will in part be due to the reduced elective activity levels.
- Purchase of Healthcare from non NHS is adverse to plan by £2.8m reflecting outsourced usage to date. This is largely offset by the corresponding activity based income, though this provides no net contribution to the Trust financial position.

1.25. The main areas of under-spending in non-pay are in "other non-pay costs" which is underspent by £4.8m to date including released reserves.

1.26. Premises is £0.38m underspent to date which includes underspending on power and energy of £0.40m to date which has improved by £0.36m in the month following confirmation of a reduction in tariff which has been backdated to 1st April 2015.

1.27. EBITDA is a £6.1m surplus year to date and is now adverse to plan by £11.7m.

1.28. The financing costs including those related to the PFI and deprecation total £28.9m year to date which is underspent against the plan by £1.7m. The plan was agreed prior to the finalisation of the revaluation in year-end accounts, which reduced planned levels of deprecation. In addition, the in-year capital plan reprioritisation and "capping" to provide funding for the new TWH ward development has slowed down originally planned spend,

and diverted it from shorter life, higher depreciating assets such as medical and IT equipment into build assets.

Forecast Outturn & Risks on delivery

1.29. The performance in month against the revised forecast trajectory was slightly worse than expected by £132k which has led to a £47k favourable position over the last two months.

Balance Sheet & Capital

1.30. Cash balances of £4.1m were held at the end of January (£4.4m at the end of December). The Trust has been in discussions with the TDA and they have agreed with the DH that a further £4.7m be added to the working capital loan in respect of the capital repayment element of the PFI unitary payment. Therefore the total value of the facility is now £16.9m of which the Trust has so far received £6.5m. A further £4m is forecast for drawdown in February with the remaining balance to be drawn in March.

1.31. Total debtors are £42.6m, £7m higher than the reported December figure. Debt over 90 days has increased by £1.8m to £10.9m at the end of January. Debtors in excess of a £1m are;

- WKCCG £8.4m
- NHS England £3.8m
- EK Hospitals FT £2.3m
- Medway FT £1.2m

90 day invoiced debt for private patients is currently £0.2m (£2.4m in total for all invoiced debt) with other non NHS invoiced debt over 90 days old totalling £0.2m (£0.8m in total).

1.32. Total creditors are £63.2m. Included within creditors is £18.4m deferred income of which £8.4m relates to 5 SLA advances and a further £4m from WK CCG. Against the 95% target for payments made within 30 days the Trust achieved in value 81.8% in January for Trade creditors (81.3% in March 2015) and 81.5% in January for NHS creditors (66.6% in March 2015).

1.33. The pressure on the Trust's outturn position means that it will be necessary for the Trust to manage its cash through tight controls over its working capital. The Trust has also agreed a reduction in the closing cash balance held at year end from £2.1m to £1m with the TDA in order to release further cash to support creditor payments.

1.34. Capital expenditure to month 10, including donated assets, was £9.9m which is an under-spend of £5.5m against the Trust's original plan of £15.4m for the same period. The forecast net outturn of c.£15m is £5.0m lower than the original plan, which is mainly accounted for by the agreement to reduce its loan request by £3m, and the decision not to proceed at this stage with the disposal of the Hillcroft residence (£0.9m, matched by reduction in spend). The Trust is anticipating spend in the last two months of the year that will bring it up to its forecast outturn as the new ward is completed and ICT and equipment is delivered.

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

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

2. CIP Delivery

2.1. The month 10 position shows a total CIP delivery (including full year effects) of £17.5m against the target that was included in the TDA plan of £18.0m, so under-performing by £0.5m to date.

2.2. The schemes identified are forecast to deliver £20.7m by year end which is £0.1m more than the forecast reported at month 9 due to reduced assumptions about PPU income, and leaves £0.9m of schemes that the Trust is working to identify.

2.3. Against the year to date total CIP expectation of £18.0m, under performance on Length of Stay (£0.95m), Theatre Productivity (£0.33m), Back office (£0.26m), PPU (£0.20m), Drugs (£0.20m) and Medical Efficiency (£0.22m) are in part offset by overachievement in Nursing and STT Efficiency (£0.86m), Procurement efficiencies (£0.68m) and Contract Management (£0.20m).

3. Conclusion

3.1. January elective performance was much lower than planned for this year, including outsourced activity, especially in orthopaedics, where the Trust does not earn a margin. Outpatient activity is higher than last year, but is also behind the plan for this year, and there are issues in ensuring outpatient clinic capacity is fully utilised while referral rates rise and waiting lists are growing.

3.2. Non elective activity is lower than last year but total numbers of occupied bed days have increased, along with delayed transfers of care. Income per spell has increased, indicating higher complexity. The increase in acuity and length of stay is reducing the throughput in non-elective activity, which is further reflected in an increase in medical outliers and is adversely affecting bed capacity available for elective activity.

3.3. Staffing costs remain a key area of continued focus as part of the Integrated Recovery Plan and normal day to day control. Overall agency costs in month down on last month's levels by £138k but nurse agency increased in month primarily due to escalation pressures. Pay costs remain the most significant area of pressure on the Trusts' budgets, and is currently not being covered off by income at or above planned levels.

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

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

3.5. The Trust Board are requested note this report.

Maidstone and Tunbridge Wells NHS Trust

Finance Pack

M10 - January 2015

January 2015

Maidstone and Tunbridge Wells NHS Trust

Contents

Key Performance Indicators as at Month 10 2015/16

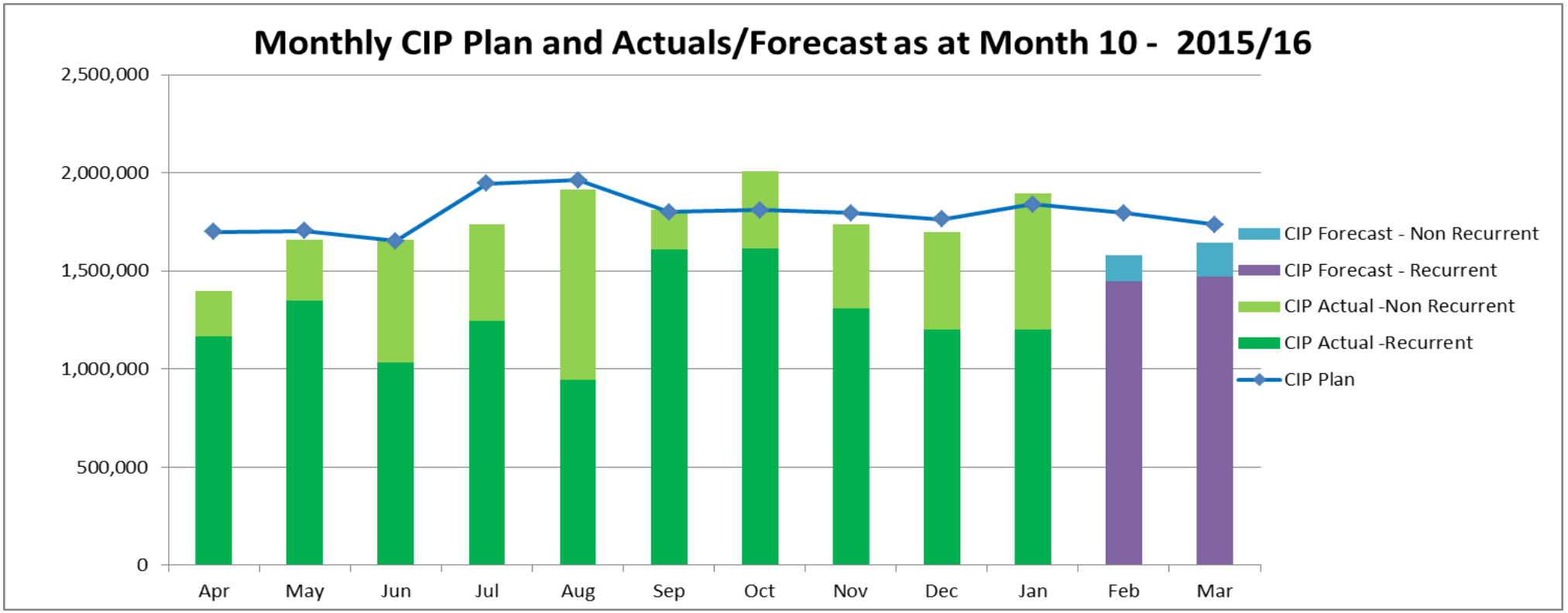
(A) TDA Accountability Framework and
(B) Monitor Continuity of Service Metrics

Maidstone and Tunbridge Wells NHS Trust

Key Metrics (A) Accountability Framework	Current Month Metrics: Plan (mc 01) £000s	Actual / Forecast (mc 02) £000s	Variance (mc 03) £000s	RAG Rating (mc 04)
NHS Financial Performance				
1a) Forecast Outturn, Compared to Plan	(12,132)	(23,515)	(11,383)	RED
1b) Year to Date, Actual compared to Plan	(12,084)	(21,971)	(9,887)	RED
Financial Efficiency				
2a) Actual Efficiency recurring/non-recurring compared to plan - Year to date actual compared to plan				RED
- Total Efficiencies for Year to Date compared to Plan	14,654	14,343	(311)	
- Recurrent Efficiencies for Year to Date compared to Plan	14,654	9,450	(5,204)	
2b) Actual Efficiency recurring/non-recurring compared to plan - Forecast compared to plan				RED
- Total Efficiencies for Forecast Outturn compared to Plan	18,146	17,528	(618)	
- Recurrent Efficiencies for Forecast Outturn compared to Plan	18,146	12,185	(5,961)	
Cash and Capital				
4) Forecast Year End Charge to Capital Resource Limit	14,823	14,823	0	GREEN
5) Permanent PDC accessed for liquidity purposes		6,500		RED
Trust Overall RAG Rating				RED
(B) Financial Sustainability Risk Ratings from M6 (Continuity of Services Risk Ratings for M3 to M5)				
Year to Date Rating	2.00	1.00	(1.00)	RED
Forecast Outturn Rating	2.00	1.00	(1.00)	RED

RAG STATUS		
Red	Amber	Green
A deficit position or 20% worse than plan	A position between 5% - 20% worse than plan	Within 5% or better than plan
20% worse than plan	A position between 10% - 20% worse than plan	Within 10% or better than plan
if either total or recurrent efficiencies are 20% worse than plan	if either total or recurrent efficiencies are between 0% and 20% of plan	If both total and recurrent efficiencies are equal to or better than plan
if either total or recurrent efficiencies are 20% worse than plan	if either total or recurrent efficiencies are between 0% and 20% of plan	If both total and recurrent efficiencies are equal to or better than plan
either greater than plan or 20% lower than plan	between 10% - 20% lower than plan	Within 10% of plan
PDC accessed	Not applicable	PDC not accessed
If forecast deficit position or if three or more RED in other metrics	If one or two RED or three AMBER	No RED and less than two AMBER
If score is 2.5 or lower	Not applicable	Score of over 2.5
If score is 2.5 or lower	Not applicable	Score of over 2.5

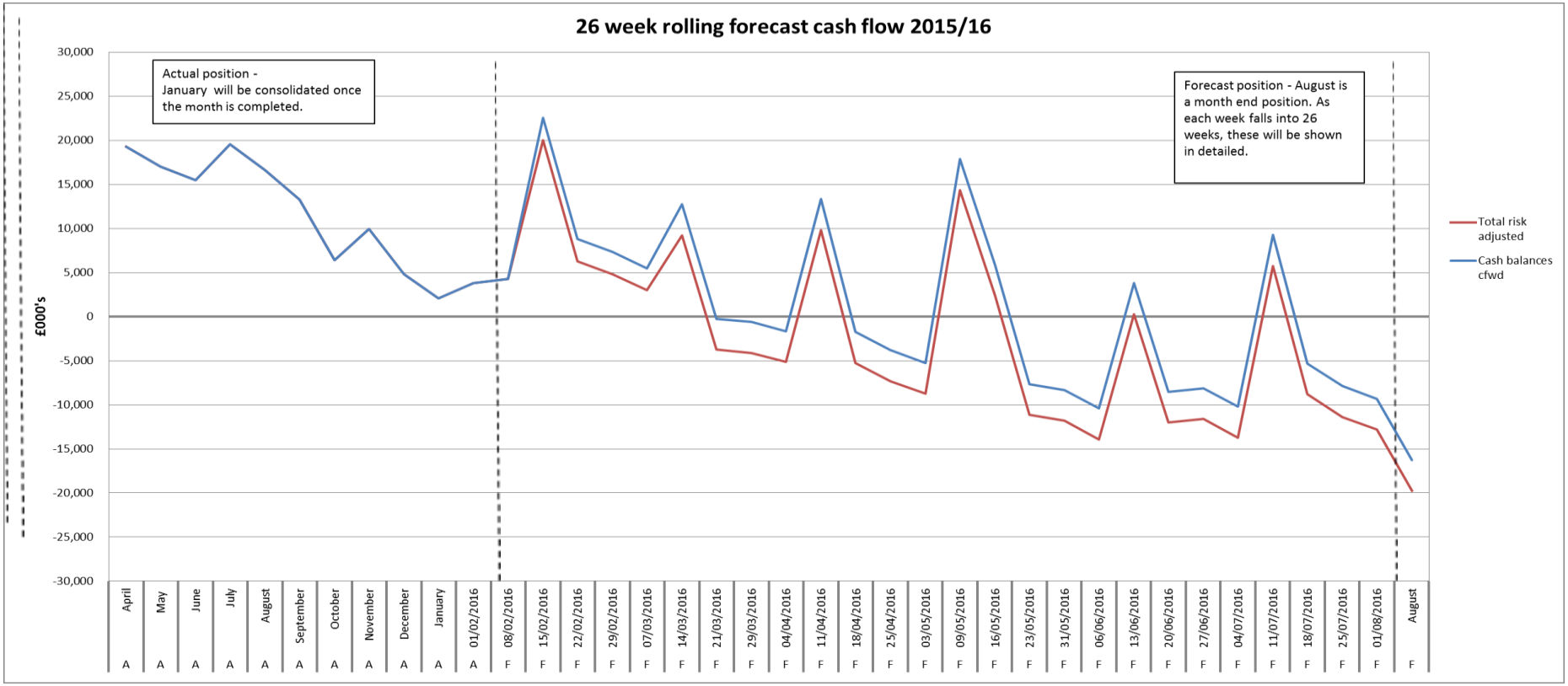
Maidstone and Tunbridge Wells NHS Trust



Recurrent v Non Recurrent	YTD	FOT
Recurrent Analysis	£000s	£000s
Recurrent	12,622	15,582
Non Recurrent	4,865	5,171
TOTAL	**17,527**	**20,752**

Maidstone and Tunbridge Wells NHS Trust

26 Week graphical presentation of forecast cash balances up to w/c 25th July 2016, actuals at 5th February 2016



Week commencing	A April	A May	A June	A July	A August	A September	A October	A November	A December	A January	A 01/02/2016	F 08/02/2016	F 15/02/2016	F 22/02/2016	F 29/02/2016	F 07/03/2016	F 14/03/2016	F 21/03/2016	F 29/03/2016
Cash balances cfwd	**19,276**	**17,036**	**15,452**	**19,552**	**16,586**	**13,306**	**6,434**	**9,970**	**4,838**	**2,094**	**3,829**	**4,263**	**22,557**	**8,788**	**7,350**	**5,512**	**12,727**	**-245**	**-605**
Debtors carry forward into 15/16	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15/16 o/performance	0	0	0	0	0	0	0	0	0	0	0	0	2,000	2,000	2,000	2,000	3,000	3,000	3,000
External Financing - Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
External Financing - capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Asset Sales	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NHD Support	0	0	0	0	0	0	0	0	0	0	0	0	505	505	505	505	505	505	505
Total risk adjusted	**19,276**	**17,036**	**15,452**	**19,552**	**16,586**	**13,306**	**6,434**	**9,970**	**4,838**	**2,094**	**3,829**	**4,263**	**20,052**	**6,283**	**4,845**	**3,007**	**9,222**	**-3,750**	**-4,110**

Week commencing	F 04/04/2016	F 11/04/2016	F 18/04/2016	F 25/04/2016	F 03/05/2016	F 09/05/2016	F 16/05/2016	F 23/05/2016	F 31/05/2016	F 06/06/2016	F 13/06/2016	F 20/06/2016	F 27/06/2016	F 04/07/2016	F 11/07/2016	F 18/07/2016	F 25/07/2016	F 01/08/2016	F August
Cash balances cfwd	**-1,648**	**13,332**	**-1,734**	**-3,817**	**-5,250**	**17,860**	**5,883**	**-7,637**	**-8,323**	**-10,406**	**3,780**	**-8,517**	**-8,125**	**-10,208**	**9,272**	**-5,320**	**-7,878**	**-9,311**	**-16,261**
Debtors carry forward in 15/16	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15/16 o/performance	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000	3,000
External Financing - Revenue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
External Financing - capital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Asset Sales	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NHD Support	505	505	505	505	505	505	505	505	505	505	505	505	505	505	505	505	505	505	505
Total risk adjusted	**-5,153**	**9,827**	**-5,239**	**-7,322**	**-8,755**	**14,355**	**2,378**	**-11,142**	**-11,828**	**-13,911**	**275**	**-12,022**	**-11,630**	**-13,713**	**5,767**	**-8,825**	**-11,383**	**-12,816**	**-19,766**

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – February 2016

2-11 CQC Quality Improvement Plan Chief Nurse

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

Which Committees have reviewed the information prior to Board submission?
- Trust Management Executive, 17/02/16

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

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

CQC Quality Improvement Plan

Assurance Report February 2016

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

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

Overview of progress to date

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

Compliance actions – Critical care

There are continued challenges with out of hours transfers from ITU. During January 10 patients, all at TWH were transferred out of hours for clinical need. This compares with 11 in December, 3 in November, 4 in October, 5 in September, 1 in August and 8 in July all TWH. All mitigation is in place and each case is reviewed and discussed at the operational site meetings. The opening of the new 38 bed ward in will ease capacity challenges and thus improve our ability to further reduce any discharges out of hours from ITU.

The Standard Operating procedure for managing critically ill patients requiring ITU, when ITU capacity is full (for example, in recovery ward) is now in place and operational.

Compliance actions – Paediatric PEWS

A standardised paediatric PEWS system and escalation protocol has now been implemented in all relevant areas in the Trust. Staff training has been completed and a spot check audit shows 100% compliance with the use of paediatric PEWS using Nervecentre.

Compliance Action – Incident reporting

Considerable work has been undertaken to improve the incident reporting process, making it clearer and easier for staff to report incidents. An education / update program on Governance, Quality and Patient Safety including incident reporting and learning lessons from incidents has been developed with a Trust-Wide roll out plan. There has been a month on month increase in numbers of in cidents being reported.

Status of plan

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

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

The table below provides a summary of any issues arising.

KEY to progress rating (RAGB rating)

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

	Operational lead	Progress rating	Issues / Comments
Enforcement Notice – Water testing	Jeanette Rooke, Director of Estate & Facilities		Enforcement notice lifted. Completed compliance action
CA 1 - Paediatric Early Warning Scoring (PEWS) system	Jackie Tyler, Matron Children Services		Completed compliance action
CA 2 – ICU weekend cover	Daniel Gaughan General Manager, Critical Care		Completed compliance action
CA 3 – ICU consultant within 30mins	Daniel Gaughan General Manager, Critical Care		
CA 4 – ICU delayed admissions	Jacqui Slingsby Matron, Critical Care Directorate		Completed compliance action.
CA 5 – ICU delayed discharges	Jacqui Slingsby Matron, Critical Care Directorate		
CA 6 – ICU overnight discharges	Jacqui Slingsby Matron, Critical Care Directorate		During December 11 patients, all at TWH were transferred out of hours for clinical reasons (none routine). This compares with 3 in November, 4 in October, 5 in September, 1 in August and 8 in July all TWH. ***Red over 5, Amber 5 or less. Green less than 3.***
CA 7 – Critical Care Outreach 24/7 service provision	Siobhan Callanan Associate Director of Nursing		Completed compliance action

	Operational lead	Progress rating	Issues / Comments
CA 8 – ICU washing facilities	Jacqui Slingsby Matron, Critical Care Directorate		Completed compliance action
CA 9 – Cultural/linguistic needs	Richard Hayden Deputy Director of Workforce		Substantive Equality and Diversity Lead post for MTW due to be advertised shortly with intended start date April 2016.
CA 10 – CDU Privacy and dignity	Lynn Gray Associate Director of Nursing		Completed compliance action
CA 11 – Medical records	Wilson Bolsover Deputy Medical Director		Completed compliance action
CA 12 – Security staff	John Sinclair Head of Quality, Safety, Fire and Security		Completed compliance action
CA 13 – Incident reporting	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		Completed compliance action
CA 14 – Joint management of children with surgery	Hamudi Kisat / Jonathan Appleby Clinical Directors		Audit undertaken awaiting results and presentation at clinical governance meetings
CA 15 – Children's Clinical governance	Karen Woods Risk and Governance Manager, Children and Women's Services		Completed compliance action
CA 16 – Incident reporting + lessons learnt	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		Completed compliance action
CA 17 – Corporate clinical governance	Jenny Davidson Associate Director of Governance, Patient Safety and Quality		Completed compliance action
CA 18 – Topical anaesthetics	Jackie Tyler, Matron Children Services		Completed compliance action

Enforcement Notice

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

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

Compliance action 1				CA1
Issue: *The PEWS system had not been validated and was not supported by a robust escalation protocol that was fit for purpose and was not standardised across the children's' directorate*				
Lead: *Hamudi Kisat, Clinical Director*		**Operational Lead:** *Jackie Tyler, Matron*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. PEWS chart reviewed in line with tertiary referral centres (Nottingham) or PEWS from National Institute for Innovation (used in other Trusts)	New PEWS charts now in use in all paediatric areas and old charts removed	1. Validated PEWS in place. 2. Revised escalation protocol in place 3. Staff competent and consistent in using PEWS and escalation. 4. 3 monthly audit of compliance 5. Evidence of communication via meetings	30/6/15 Fully implemented 1/9/15 only audit outstanding	
2. Escalation protocol reviewed alongside the PEWS chart review	Escalation protocol approved and added to back of new PEWs charts in use			
3. Once agreed, PEWS chart and escalation protocol implemented across Children's services directorate via teaching sessions, ward level meetings, A&E and Children's services Clinical Governance meeting	Training of new starters implemented Ongoing training of staff Audits underway to provide evidence of implementation: PEWs audit Inpatients completed 25th September PEWs audit Ambulatory completed 28th September PEWS audit ED completed Nov PEWs audit to be submitted via trust audit team			
PHASE 2 Electronic solution (Nervecentre) for PEWS and escalation implemented (brought forward within existing IT plan). NB excludes paediatric A&E	All medical and nursing training completed for nerve centre. Ongoing training for new staff organised as part of induction package Spot check audit shows 100% compliance with use of PEWS on Nervecentre	6. Compliance audit from Nervecenter	31/12/15 Actions completed. Audit due for completion end January 2016	
Action Plan running to time: YES				
Evidence submitted to support update (list): New PEWS Chart, audit results				
Assurance statement :				
PEWs chart in place and training implemented across all relevant departments. Nerve centre now in place across unit – to revert to paper PEWs if nerve centre fails				
Areas of concern for escalation:				
None				

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

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

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

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

Compliance action 6				CA6
Issue: *Contrary to the core standards of the Intensive Care Society: Overnight discharges take place from the ICU.*				
Lead: *Greg Lawton, Clinical Director*		**Operational Lead:** *Jacqui Slingsby, Matron & Lynn Gray, ADN emergency services*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. All ward fit patients to be identified to the site team at the earliest opportunity but by 1500 at the latest each day.	All patients deemed ward fit or likely to be fit are named at site meetings and entered on capacity handover form to the site team, together with any special requirements i.e. Side room needed, specialist ward etc. Displayed in site team on communications board	1. Incident (DATIX) report to be raised on all post 2000hrs transfers. Review and identification of where lessons can be learnt and improvements made	1/3/15	
2. Transfer plans to be agreed and completed by 2000 hrs at the latest. No patients to be routinely transferred from ITU after 2000.	Core standards state: *'Discharge from Critical Care should occur between 07:00hrs and 21:59hrs' (2.12)* During January 10 patients, all at TWH were transferred out of hours for clinical need. This compares with 11 in December, 3 in November, 4 in October, 5 in September, 1 in August and 8 in July all TWH. Incident reports were raised each time. Patients though deemed fit prior to these times were not able to be moved to a ward due to bed capacity issues. Trust operational plan in place to open an additional ward at TWH in Feb 2016 with the aim to ease patient flow across the trust.		1/3/15 (for robust patient identification and tracking New date (for new ward) 31/3/16	
Action Plan running to time: Yes (revised date)				
Evidence submitted to support update (list):				
Assurance statement :				
Areas of concern for escalation:				
Continuing issues with patient flow across the trust impacting on ICU patient discharges.				

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

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

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

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

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

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

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

Compliance action 14				CA14
Issue: *The clinical governance strategy within children's services did not ensure engagement and involvement with the surgical directorate*				
Lead: *Hamudi Kisat, Clinical Director & Jonathan Appleby, Clinical Director*		**Operational Lead:** *Hamudi Kisat, Clinical Director & Jonathan Appleby, Clinical Director*		
Actions	**Monthly summary update on progress**	**Evidence required**	**Action completion date**	**Rating**
1. Meeting between senior clinicians and managers Children's services directorate and Surgical directorates to establish clear roles and responsibilities of the care of children on the paediatric ward	Clinical Director attended surgical CG meeting to present papers	1. Minutes of joint meeting 2. Standard Operating Procedure 3. Audit of practice 4. MTW Clinical Governance Strategy 5. Agenda, Minutes and attendance records from CG meetings	1/5/15	
2. Standard Operating Procedure for care of children on surgical pathway on paediatric wards	SOP completed and circulated to staff		1/6/15 New date: 1/9/15	
3. Implementation of the SOP into routine daily practice	Patients admitted to Inpatient Ward now shared care between Paediatrics and Speciality Teams The audit has been undertaken, just awaiting results and presentation at paediatrics and surgical clinical governance meetings		1/8/15 Audit results expected March 2016	
4. Trust to develop a consistent approach to Clinical Governance through MTW Clinical Governance Strategy developed in collaboration with internal and external stakeholders	New Governance framework developed and agreed with implementation commenced December 2015		1/9/15 New date: 1/12/15	
Action Plan running to time: **Yes**				
Evidence submitted to support update (list): SOP				
Assurance statement :				
Areas of concern for escalation:				
None				

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

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

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

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – February 2016

2-12 Planned and actual ward staffing for Jan 2016 Chief Nurse

The enclosed report shows the planned v actual nursing staffing as uploaded to UNIFY for the month of January 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.

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. Notable in this respect are John Day, Chaucer and Ward 20.

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

Escalation also accounts for the significant overfill for Mercer Ward. Mercer Ward extended into a bay on Whatman Ward (neighbouring ward), with nursing provision and leadership provided by the Mercer team. There was a stepped increase in the use of escalation beds culminating in establishing Whatman Ward as a stand-alone escalation ward towards the end of the month.

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.

Maternity services have had challenges with CSW fill rates; however, their recruitment plans are now starting to impact and this is seen in a general increase in overall fill rates. Ante-natal remains below the 90% threshold, this was a managed approach to ensure areas such as Post-Natal had safe and appropriate cover as this area represents a higher risk for general care if support staff are not available.

A number of wards have had a shift in RN: CSW ratios, notably Wards 10, 12 and 30. In these areas this was a considered action based on professional judgement, available skill mix and patient acuity and dependency.

Accident & Emergency (A&E) Departments have been included this month. Demonstrating overall good fill rates against planned staffing levels. As expected Tunbridge Wells A&E had an increased RN fill rate, particularly at night.

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

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Assurance

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

Jan'16		Day		Night		Nurse Sensitive Indicators						Financial review		
Hospital Site name	Ward name	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives	Average fill rate - care staff (%)	FFT Response Rate	FFT Score - % Positive	Falls	PU - ward acquired	Overall RAG Status	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Acute Stroke	91.6%	93.5%	98.4%	129.0%	36.8%	100.0%	0	0		Specials required on 7 nights	107,867	131,820	(23,953)
MAIDSTONE	Romney	95.7%	98.9%	96.8%	106.5%			2	0			66,973	81,390	(14,417)
MAIDSTONE	Cornwallis	94.4%	117.7%	100.0%	100.0%	47.3%	93.2%	4	1		Increase in CSW requirements during the morning to meet changed dependency needs.	93,343	52,665	40,678
MAIDSTONE	Coronary Care Unit (CCU)	78.5%	N/A	103.3%	N/A	81.0%	88.2%	0	0		CCU is co-located on Culpepper. Cross cover was provided by Culpepper to ensure safe care delivery.	104,039	106,363	(2,324)
MAIDSTONE	Culpepper	96.8%	98.4%	100.0%	103.2%	31.6%	83.3%	2	1					
MAIDSTONE	John Day	97.7%	135.5%	99.5%	162.9%	10.7%	100.0%	9	2		5 patients during the month needing 1:1 care/supervision. Plus tracheostomy patient needing enhanced supervision throughout the month.	105,534	153,240	(47,706)
MAIDSTONE	Intensive Treatment Unit (ITU)	90.7%	N/A	97.2%	N/A	No patients discharged to home		0	0			162,340	163,039	(699)
MAIDSTONE	Pye Oliver	89.0%	109.7%	99.2%	129.0%	15.0%	77.8%	5	0		8 patients needing enhanced supervision/special at night.	95,665	108,928	(13,263)
MAIDSTONE	Chaucer	98.7%	122.6%	98.7%	133.3%	14.6%	100.0%	4	2		24/7 special required through the month.	79,298	154,097	(74,799)
MAIDSTONE	Lord North	102.0%	90.6%	98.9%	100.0%	100.0%	100.0%	1	0			97,051	101,604	(4,553)
MAIDSTONE	Mercer	125.6%	118.3%	139.8%	135.5%	5.9%	100.0%	8	1		Escalated into Whatman Ward. Stepped increase during the month prior to setting Whatman up as 'stand alone' escalation ward.	91,166	137,929	(46,763)
MAIDSTONE	Edith Cavel (MOU)	110.8%	111.3%	98.4%	167.7%	0.0%	0.0%	2	0		14 nights of special/enhanced supervision required.	134,418	63,803	70,615
MAIDSTONE	Urgent Medical Ambulatory Unit (UMAU)	95.1%	96.1%	134.4%	183.9%	9.5%	97.0%	3	1		Trolley bays escalated to beds overnight.	119,337	147,743	(28,406)
TWH	Acute Stroke	98.9%	98.4%	98.9%	100.0%	5.4%	100.0%	3	0			76,565	73,078	3,487
TWH	Coronary Care Unit (CCU)	98.9%	100.0%	100.0%	N/A	53.8%	92.9%	5	0			57,300	60,026	(2,726)
TWH	Gynaecology	108.2%	100.0%	100.0%	100.0%	21.4%	100.0%	0	0			66,261	58,193	8,068
TWH	Intensive Treatment Unit (ITU)	108.5%	100.0%	115.7%	N/A	No patients discharged to home		0	0		Additional bed open, and increased dependency (i.e. increased number of L3 patients).	185,377	181,464	3,913
TWH	Medical Assessment Unit	110.8%	107.3%	132.8%	103.2%	16.6%	96.0%	7	0		AAU beds fully escalated.	151,252	208,633	(57,381)
TWH	SAU	118.3%	206.5%	164.5%	371.0%			1	0		Escalated beds. Cross cover support to Theatre recovery in month.	65,750	138,235	(72,485)
TWH	Ward 32	95.2%	96.8%	96.8%	100.0%	3.3%	100.0%	3	0			119,912	126,748	(6,836)
TWH	Ward 10	89.8%	124.2%	101.6%	150.0%	8.8%	100.0%	1	1		Specials required throughout month for enhanced supervision. Considered approach to run with lower RN fill rate during the day, as recruitment plans start to impact.	124,165	122,416	1,749
TWH	Ward 11	99.1%	109.7%	87.9%	112.9%	13.5%	100.0%	3	0		Shift in RN:CSW ratio acceptable based on clinical need and dependency.	125,584	115,332	10,252
TWH	Ward 12	95.7%	117.2%	87.9%	116.1%	19.6%	100.0%	7	0		Low fill rate due, in part, to vacancy and sickness. RN:CSW ratio variation a consider approach as recruitment plans start to impact.	108,139	123,876	(15,737)
TWH	Ward 20	90.4%	90.3%	102.4%	119.4%	5.9%	100.0%	3	2		Specials required on 5 nights for 1:1 supervision.	122,805	133,363	(10,558)
TWH	Ward 21	99.0%	100.0%	104.0%	95.7%	8.9%	100.0%	12	1			119,912	133,720	(13,808)
TWH	Ward 22	91.9%	119.4%	100.0%	97.8%	70.6%	83.3%	10	0		RN:CSW ratio variation a considered approach to ensure provision of care.	93,043	110,337	(17,294)
TWH	Ward 30	92.3%	107.8%	96.8%	154.8%	0.0%	0.0%	11	2		Additional CSW requirements for increased dependency (increased number of medical patients)	121,746	119,549	2,197
TWH	Ward 31	88.7%	89.7%	94.4%	96.8%	3.1%	100.0%	1	1		Accepted risk to ensure cover maintained at night, as support available during the day from Trauma Coordinators et al.	136,057	123,455	12,602
TCH	Stroke Rehab	91.4%	108.1%	95.2%	112.9%	55.6%	100.0%	2	0		RN:CSW ratio variation a considered approach to ensure provision of care.	57,413	54,653	2,760
TWH	Ante-Natal	98.4%	80.6%	103.2%	90.3%	28.9%	97.2%	0	0		CSW fill rate in Ante-natal had minimal impact. Overall position improving as CSW recruitment pipeline is starting to impact.	590,514	628,802	(38,288)
TWH	Delivery Suite	98.6%	95.2%	99.3%	95.2%			0	0					
TWH	Post-Natal	99.3%	95.7%	95.2%	96.8%			0	0					
TWH	Gynae Triage	101.6%	103.2%	100.0%	103.2%			0	0			11,354	10,535	819
TWH	Hedgehog	93.5%	80.4%	96.8%	193.5%	14.8%	95.6%	0	0		Increased demand for CSW at night as Woodland fully escalated.	181,193	181,059	134
TWH	Birth Centre	100.0%	96.8%	100.0%	96.8%			0	0			65,393	65,347	46
TWH	Neonatal Unit	98.0%	96.8%	98.1%	135.5%			0	0		Additional support staff utilised for the night, to manage cohort nursing.	153,643	153,260	383
TWH	MSSU	131.9%	75.0%	122.9%	N/A	0.0%	0.0%	0	0		RN:CSW ratio variation due to increase demand on service to meet elective surgical demands.	55,535	45,605	9,930
TWH	Peel	88.1%	154.8%	97.8%	100.0%	0.0%	0.0%	0	0		Sickness over 7 days, and 5 specials required for patient in side room. RN:CSW variation a considered action.	80,269	74,659	5,610
TWH	SSSU	125.0%	125.0%	N/A	N/A	0.0%	0.0%	0	0		Escalated, with cross cover to theatres.	36,096	18,076	18,020
MAIDSTONE	A&E	96.8%	85.5%	100.0%	96.8%	8.6%	86.4%	3	0			161,634	217,178	(55,544)
TWH	A&E	103.7%	103.7%	111.3%	100.0%			4	0		Additional RN cover at night to provide to overnight waits.	252,724	283,809	(31,085)
											Total Established Wards	**4,576,667**	**4,964,030**	**(387,363)**
											Additional Capacity beds	39,045	88,554	-49,509
											Other associated nursing costs	2,421,946	2,600,236	-178,290
											Total	7,037,658	7,652,820	-615,162

RAG Key

Underfill

Over fill

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting - February 2016

2-13	Update on the extent of the use, within the Trust, of the clinical information in the 'Dr Foster' IT system	Medical Director

At the Trust Board meeting in November 2015, it was agreed that the Medical Director would provide an update to the Trust Board, in February 2016, on the latest situation as to the extent of the use, within the Trust, of the clinical information within the 'Dr Foster' IT system.

Dr Foster is able to provide high level information regarding outcomes (for mortality, readmissions and length of stay), but the use of this data has been limited by the difficulties encountered when drilling down into direct patient records. Up until the autumn of last year, it was possible to obtain the clinical details of patients who were included in an "alert" and allow an audit of that patient group to identify learning that could improve the patient journey.

An example of this was a high readmission rate for patients who had undergone tonsillectomy. The underlying issues here were pain relief that was not commensurate with patient's expectations, hence causing patients to represent at hospital – rather than the more worrying concern that there may have been a high incidence of complications such as infection, or more worryingly bleeding.

Following the Dr Foster report to the Quality Committee 'deep dive' meeting, a number of groups of patients were highlighted where there was a higher than expected mortality. Unfortunately, our informatics team have been unable to trace the patient details for these groups, hindering our ability to analyse whether this is a coding issue, or one of clinical care. This issue is now in the past, but is stopping us reviewing such cases beyond last summer.

Moving forward, it is important to stress that the clinicians will always be hesitant to accept some of this data unless they have access to the direct patient details in order that they can drill down and interrogate the data themselves. We are working with Dr Foster and will work with our new informatics team to ensure that this is put in place.

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

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Discussion 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 – February 2016

2-14 Findings from national staff survey 2015 Director of Workforce & Communications

The enclosed report provides full details of the Trust's performance on the national staff survey 2015.

The report is however embargoed until they are published nationally on 23rd February 2016. Trust Board members are therefore asked not to share the findings until published.

Which Committees have reviewed the information prior to Board submission?
- Trust Management Executive, 17/02/16

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

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – February 2016

2-15	**Development of a Vanguard scheme to address Delayed Transfers of Care**	**Deputy Chief Executive**

The enclosed report sets out a proposal to establish:

- A whole system project to address issues around flow and specifically relating to discharge in the short term, drawing on the learning from external reviews and analysis.
- A time-limited piece of work to establish the scale and nature of the shortfall in capacity that exists within the health and social care system in West Kent and to initiate a process to address it.
- Establish a chief officer level System Leadership Group to oversee this work and drive greater alignment of objectives and efforts.

Subject to Board endorsement this proposal will be taken formally to partner organisations.

Which Committees have reviewed the information prior to Board submission?

- N/A

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

Discussion and decision

[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

Development of Proposals for New Ways of System Working

1. Context

In common with many parts of the care system West Kent is facing considerable pressures. Demand for urgent care continues to increase and the system is fragmented. Priorities and incentives are not aligned and success is not always measured consistently. Each part of the system faces its own challenges and sustainable solutions will be dependent on the health and social care system's ability to find new and more effective ways of working together.

While all parts of the system are under real pressure it is inevitable that the collective and visible impact will be manifested in our acute hospitals. This can and does take the form of long waits in A&E, cancelled operations, loss of income, increased costs and an inability to discharge patients when they are clearly ready to leave hospital. This last point is particularly significant. A large proportion of our patients are elderly and a bed in a busy acute hospital is an entirely inappropriate setting for a frail older person who does not need to be there.

With this in mind it is proposed that Maidstone andTunbridge Wells NHS Trust (MTW) initiates a piece of whole system work designed to challenge and improve our current ways of working together. This will not be dissimilar to initiatives developed in some of the Vanguard sites identified nationally. We need to transform the way we work together as a system and this paper proposes three strands of work:

- An initial project focusing specifically on improving flow and specifically discharge, with a focus on improving performance during the next three to six months and then sustaining it.
- A time-limited process to assess the nature and size of the shortfall in capacity in West Kent and to develop a process to bridge that gap.
- The establishment of a System Leadership Group to oversee both pieces of work and to identify and implement new ways of working.

If taken forward with pace this work can support the development of business plans for 2016/17 and our local five year Sustainability and Transformation Plan

2. Improving Flow/Discharge

The suggestion is that the initial scope of this work is kept tight to ensure focus but that the level of ambition for where it might take us needs to be high. To be fully successful the following organisations would need to be involved:

- Kent Community Healthcare NHS Foundation Trust
- Kent County Council
- Kent & Medway Partnership NHS & Social Care Trust
- Maidstone & Tunbridge Wells NHS Trust
- West Kent Clinical Commissioning Group

The greatest single challenge facing us as a system is flow and this should be the focus of the initial project, most likely with the number of patients who are Medically Ready for Discharge or who are agreed by all to be Delayed Transfers of Care as a reasonable measure of impact and success.
The project would be structured as follows:
Stage One – Scoping and development of a single project plan.

Stage Two – Diagnostic and establishment of baseline, drawing heavily on external reviews that are either imminent or due to take place shortly (ECIP analysis and NHS England review).
Stage Three – Identification of sharp actions with the quantification of the anticipated impact and clear ownership. Measures of success will need to be clear and captured in a single plan.

The initial project, therefore, will be short and focused on driving improvements on an agreed and shared group of operational objectives. It would be overseen by a Project Board with Executive level input from each of the partner organisations. As part of the opening stage the agreement of a clear set of principles and values would be crucial in guiding the way we work together and these can be revisited and refined as progress is made.

This initial project will be focused on driving real improvements in the effectiveness of our services and ultimately on patient experience and value for money. This is explicitly designed to avoid the trap of focusing from the outset on bureaucratic processes and the development of tortuous governance

3. Addressing the Capacity Gap

The project described in 2 above is explicitly focused on delivering improved performance in the short term (i.e. three to six months). In the longer term there is a collective view in West Kent that there is a capacity imbalance, with a need for access to more non-acute inpatient beds or places. Financing is clearly the single biggest barrier to the commissioning of new capacity but a number of additional routes remain open. These could include the development of straightforward contractual relationships with other providers or the use of alternative vehicles for partnership.

A joint piece of work is now needed to determine the size and nature of the capacity gap in West Kent and to agree a single plan and process for addressing it during the course of 2016/17. It is proposed that this is given a deliberately limited timeline within which to conclude of no more than six weeks, by which stage a formal process should have been agreed and initiated.

It is proposed that both the project on discharge and the development of a process to address the capacity gap would sit under the umbrella of a new form of joined up system governance.

4. New Ways of System Working

The alignment of objectives and leadership arrangements is crucial. As indicated earlier this proposal does not advocate the introduction of complex governance. It does, however, recognise the need to create a mechanism through which system leaders can come together and provide oversight and challenge. It is suggested that this could take the form of a Chief Officer level System Leadership Group, meeting monthly and with explicit objectives around partnership working, the alignment of delivery objectives and systems and ever greater integration of systems and services. The initial areas of focus described in 2 and 3 above would be overseen by the System Leadership Group, though this would not compromise or cut across the sovereignty of organisational Boards.

5. Next Steps

Subject to Board endorsement MTW will write to its partner organisations, setting out its proposal that the project on discharges is initiated urgently. This work would be overseen by a new System Leadership Group as would a parallel process to assess the capacity gap that exists within West Kent and develop a process to address it.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – February 2016

2-16	**Update on the development of the Sustainability and Transformation Plan (STP) for Kent and Medway**	**Deputy Chief Executive**

In addition to setting a requirement for NHS Trusts and Foundation Trusts to produce one year Operational Plans for 2016/17, *Delivering the Forward View: NHS Planning Guidance 2016/17 - 2020/21* calls for five year Sustainability and Transformation Plans (STPs). These will be:

- Place-based, with planning footprints to be agreed with NHS England and NHS Improvement
- Set out plans for the local implementation of the *Five Year Forward View*

Expectations of providers are further clarified in *Implementing the Forward View.* Both documents are enclosed.

The local planning footprint has been confirmed as Kent and Medway.

The Board will be fully briefed on the STP as it emerges. The deadline for submission is the end of June 2016. It will be important to ensure that MTW's Strategy is fully aligned with commissioning intentions and approved by the Board in April as this will provide crucial context to the STP.

Which Committees have reviewed the information prior to Board submission?
- Trust Management Executive (a verbal update was given on 17/02/16)

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

Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

December 2015

Delivering the Forward View: NHS planning guidance

2016/17 – 2020/21

Version number: 2

First published: 22 December 2015

Prepared by: NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), Public Health England (PHE).

This document is for: Commissioners, NHS trusts and NHS foundation trusts.

Publications Gateway Reference: 04437

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England*
- NHS Improvement (Monitor and the NHS Trust Development Authority)
- Health Education England (HEE)
- The National Institute for Health and Care Excellence (NICE)
- Public Health England (PHE)
- Care Quality Commission (CQC)

*The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Introduction

1. The Spending Review provided the NHS in England with a credible basis on which to accomplish three interdependent and essential tasks: first, to implement the Five Year Forward View; second, to restore and maintain financial balance; and third, to deliver core access and quality standards for patients.

2. It included an £8.4 billion real terms increase by 2020/21, front-loaded. With these resources, we now need to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap.

3. In this document, authored by the six national NHS bodies, we set out a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules. We reflect the settlement reached with the Government through its new Mandate to NHS England (annex 2). For the first time, the Mandate is not solely for the commissioning system, but sets objectives for the NHS as a whole.

4. We are requiring the NHS to produce two separate but connected plans:

   - a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
   - a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

5. The scale of what we need to do in future depends on how well we end the current year. The 2016/17 financial challenge for each trust will be contingent upon its end-of-year financial outturn, and the winter period calls for a relentless focus on maintaining standards in emergency care. It is also the case that local NHS systems will only become sustainable if they accelerate their work on prevention and care redesign. We don't have the luxury of waiting until perfect plans are completed. So we ask local systems, early in the New Year, to go faster on transformation in a few priority areas, as a way of building momentum.

Local health system Sustainability and Transformation Plans

6. We are asking every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View. STPs will cover the period between October 2016[1] and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016. We are asking the NHS to spend the next six months delivering core access, quality and financial standards while planning properly for the next five years.

Place-based planning

7. Planning by individual institutions will increasingly be supplemented with planning by place for local populations. For many years now, the NHS has emphasised an organisational separation and autonomy that doesn't make sense to staff or the patients and communities they serve.

8. System leadership is needed. Producing a STP is not just about writing a document, nor is it a job that can be outsourced or delegated. Instead it involves five things: (i) local leaders coming together as a team; (ii) developing a shared vision with the local community, which also involves local government as appropriate; (iii) programming a coherent set of activities to make it happen; (iv) execution against plan; and (v) learning and adapting. Where collaborative and capable leadership can't be found, NHS England and NHS Improvement[2] will need to help secure remedies through more joined-up and effective system oversight.

9. Success also depends on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards.

10. As a truly place-based plan, the STPs must cover all areas of CCG and NHS England commissioned activity including: (i) specialised services, where the planning will be led from the 10 collaborative commissioning hubs; and (ii) primary medical care, and do so from a local CCG perspective, irrespective of delegation arrangements. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

[1] For the period October 2016 – March 2017, the STP should set out what actions are planned but it does not need to revisit the activity and financial assumptions in the 2016/17 Operational Plan.

[2] NHS Improvement will be the combined provider body, bringing together Monitor and the NHS Trust Development Authority (TDA).

Access to future transformation funding

11. For the first time, the local NHS planning process will have significant central money attached. The STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.

12. The Spending Review provided additional dedicated funding streams for transformational change, building up over the next five years. This protected funding is for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health. Many of these streams of transformation funding form part of the new wider national Sustainability and Transformation Fund (STF). For 2016/17 only, to enable timely allocation, the limited available additional transformation funding will continue to be run through separate processes.

13. The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards. The process will be iterative. We will consider:

    (i) the quality of plans, particularly the scale of ambition and track record of progress already made. The best plans will have a clear and powerful vision. They will create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new care models; and finance. They will systematically borrow good practice from other geographies, and adopt national frameworks;

    (ii) the reach and quality of the local process, including community, voluntary sector and local authority engagement;

    (iii) the strength and unity of local system leadership and partnerships, with clear governance structures to deliver them; and

    (iv) how confident we are that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities.

Content of STPs

14. The strategic planning process is intended to be developmental and supportive as well as hard-edged. We set out in annex 1 of this document a list of 'national challenges' to help local systems set out their ambitions for their populations. This list of questions includes the objectives set in the Mandate. Do not over-interpret the list as a narrow template for what constitutes a good local plan: the most important initial task is to create a clear overall vision and plan for your area.

15. Local health systems now need to develop their own system wide local financial sustainability plan as part of their STP. Spanning providers and commissioners, these plans will set out the mixture of demand moderation, allocative efficiency, provider productivity, and income generation required for the NHS locally to balance its books.

Agreeing 'transformation footprints'

16. The STP will be the umbrella plan, holding underneath it a number of different specific delivery plans, some of which will necessarily be on different geographical footprints. For example, planning for urgent and emergency care will range across multiple levels: a locality focus for enhanced primary care right through to major trauma centres.

17. The first critical task is for local health and care systems to consider their transformation footprint – the geographic scope of their STP. They must make proposals to us by Friday 29 January 2016, for national agreement. Local authorities should be engaged with these proposals. Taken together, all the transformation footprints must form a complete national map. The scale of the planning task may point to larger rather than smaller footprints.

18. Transformation footprints should be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required, and how it best fits with other footprints such as local digital roadmaps and learning disability units of planning. In future years we will be open to simplifying some of these arrangements. Where geographies are already involved in the Success Regime, or devolution bids, we would expect these to determine the transformation footprint. Although it is important to get this right, there is no single right answer. The footprints may well adapt over time. We want people to focus their energies on the content of plans rather than have lengthy debates about boundaries.

19. We will issue further brief guidance on the STP process in January. This will set out the timetable and early phasing of national products and engagement events that are intended to make it much easier to answer the challenges we have posed, and include how local areas can best involve their local communities in creating their STPs, building on the 'six principles' created to support the delivery of the Five Year Forward View. By spring 2016, we intend to develop and make available roadmaps for national transformation initiatives.

20. We would welcome any early reactions, by Friday 29 January 2016, as to what additional material you would find most helpful in developing your STP. Please email england.fiveyearview@nhs.net, with the subject title 'STP feedback'. We would also like to work with a few local systems to develop exemplar, fast-tracked plans, and would welcome expressions of interest to the above inbox.

National 'must dos' for 2016/17

21. Whilst developing long-term plans for 2020/21, the NHS has a clear set of plans and priorities for 2016/17 that reflect the Mandate to the NHS and the next steps on Forward View implementation.

22. Some of our most important jobs for 2016/17 involve partial roll-out rather than full national coverage. Our ambition is that by March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week, and 20 percent of the population will have enhanced access to primary care. There are three distinct challenges under the banner of seven day services:

(i) reducing excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends. During 16/17, a quarter of the country must be offering four of the ten standards, rising to half of the country by 2018 and complete coverage by 2020;

(ii) improving access to out of hours care by achieving better integration and redesign of 111, minor injuries units, urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital; and

(iii) improving access to primary care at weekends and evenings where patients need it by increasing the capacity and resilience of primary care over the next few years.

23. Where relevant, local systems need to reflect this in their 2016/17 Operational Plans, and all areas will need to set out their ambitions for seven day services as part of their STPs.

The nine 'must dos' for 2016/17 for every local system:

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.

2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.

3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.

4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.

6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.

8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

24. We expect the development of new care models will feature prominently within STPs. In addition to existing approaches, in 2016/17 we are interested in trialing two new specific approaches with local volunteers:
    - secondary mental health providers managing care budgets for tertiary mental health services; and
    - the reinvention of the acute medical model in small district general hospitals.

Organisations interested in working with us on either of these approaches should let us know by 29 January 2016 by emailing england.fiveyearview@nhs.net

Operational Plans for 2016/17

25. An early task for local system leaders is to run a shared and open-book operational planning process for 2016/17. This will cover activity, capacity, finance and 2016/17 deliverables from the emerging STP. By April 2016, commissioner and provider plans for 2016/17 will need to be agreed by NHS England and NHS Improvement, based on local contracts that must be signed by March 2016.

26. The detailed requirements for commissioner and provider plans are set out in the technical guidance that will accompany this document. All plans will need to demonstrate:

- how they intend to reconcile finance with activity (and where a deficit exists, set out clear plans to return to balance);
- their planned contribution to the efficiency savings;
- their plans to deliver the key must-dos;
- how quality and safety will be maintained and improved for patients;
- how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan; and
- how they link with and support with local emerging STPs.

The 2016/17 Operational Plan should be regarded as year one of the five year STP, and we expect significant progress on transformation through the 2016/17 Operational Plan.

27. Building credible plans for 2016/17 will rely on a clear understanding of demand and capacity, alignment between commissioners and providers, and the skills to plan effectively. A support programme is being developed jointly by national partners to help local health economies in preparing robust activity plans for 2016/17 and beyond.

Allocations

28. NHS England's allocations to commissioners are intended to achieve:

- greater equity of access through pace of change, both for CCG allocations and on a place-based basis;
- closer alignment with population need through improved allocation formulae including a new inequalities adjustment for specialised care, more sensitive adjustments for CCGs and primary care, and a new sparsity adjustment for remote areas; and
- faster progress with our strategic goals through higher funding growth for GP services and mental health, and the introduction of the Sustainability and Transformation Fund.

29. In line with our strategic priorities, overall primary medical care spend will rise by 4-5 percent each year. Specialised services funding will rise by 7 percent in 2016/17, with growth of at least 4.5 percent in each subsequent year. The relatively high level of funding reflects forecast pressures from new NICE legally mandated drugs and treatments.

30. To support long-term planning, NHS England has set firm three year allocations for CCGs, followed by two indicative years. For 2016/17, CCG allocations will rise by an average of 3.4 percent, and we will make good on our commitment that no CCG will be more than 5 percent below its target funding level. To provide CCGs with a total place-based understanding of all commissioned spend, alongside allocations for CCG commissioned activities, we will also publish allocations for primary care and specialized commissioned activity.

    NHS England will in principle support any proposals from groups of CCGs, particularly in areas working towards devolution who wish to implement a more accelerated cross-area pace-of-change policy by mutual agreement.

31. Mirroring the conditionality of providers accessing the Sustainability and Transformation Fund, the real terms element of growth in CCG allocations for 2017/18 onwards will be contingent upon the development and sign off of a robust STP during 2016/17.

Returning the NHS provider sector to balance

32. During 2016/17 the NHS trust and foundation trust sector will, in aggregate, be required to return to financial balance. £1.8 billion of income from the 2016/17 Sustainability and Transformation Fund will replace direct Department of Health (DH) funding. The distribution of this funding will be calculated on a trust by trust basis by NHS Improvement and then agreed with NHS England.

33. NHS England and NHS Improvement are working together to ensure greater alignment between commissioner and provider financial levers. Providers who are eligible for sustainability and transformation funding in 2016/17 will not face a double jeopardy scenario whereby they incur penalties as well as losing access to funding; a single penalty will be imposed.

34. Quarterly release of these Sustainability Funds to trusts and foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation. The three conditions attached to the transitional NHS provider fund have to be hard-edged. Where trusts default on the conditions access to the fund will be denied and sanctions will be applied.

35. Deficit reduction in providers will require a forensic examination of every pound spent on delivering healthcare and embedding a culture of relentless cost containment. Trusts need to focus on cost reduction not income growth; there needs to be far greater consistency between trusts' financial plans and their workforce plans in 2016/17. Workforce productivity will therefore be a particular priority as just a 1 percent improvement represents £400 million of savings. All providers will be expected to evidence the effective use of e-rostering for nurses, midwives, Health Care Assistants (HCAs) and other clinicians to make sure the right staff are in the right place at the right time to ensure patients get the right hours of care and minimum time is wasted on bureaucracy. This approach will enable providers to reduce their reliance on agency staffing whilst compliance with the agency staffing rules will also reduce the rates paid. In addition, providers will need to adopt tightly controlled procurement practices with compliance incentives and sanctions to drive down price and unwarranted variation. For example, all providers will be expected to report and share data on what they are paying for the top 100 most common non-pay items, and be required to only pay the best price available for the NHS.

36. Capital investments proposed by providers should be consistent with their clinical strategy and clearly demonstrate the delivery of safe, productive services with a business case that describes affordability and value for money. Given the constrained level of capital resource available from 2016/17, there will be very limited levels of financing available and the repayment of existing and new borrowing related to capital investment will need to be funded from within the trust's own internally generated capital resource in all but the most exceptionally pre-agreed cases. Trusts will need to procure capital assets more efficiently, consider alternative methods of securing assets such as managed equipment services, maximize disposals and extend asset lives. In January, the DH will be issuing some revisions to how the PDC dividend will be calculated and a number of other changes to the capital financing regime.

Efficiency assumptions and business rules

37. The consultation on the tariff will propose a 2 percent efficiency deflator and 3.1 percent inflation uplift for 2016/17 (the latter reflecting a step change in pension-related costs). This reflects Monitor and NHS England's assessment of cost inflation including the effect of pension changes. To support system stability, we plan to remain on HRG4 for a further year and there will also be no changes to specialist top- ups in 2016/17; the specialised service risk share is also being suspended for 2016/17. We will work with stakeholders to better understand the impact of the move to HRG4+ and other related changes in 2017/18. For planning purposes, an indicative price list is being made available on the Monitor website. The consultation on the tariff will also include the timetable for implementing new payment approaches for mental health.

38. As notified in Commissioning Intentions 2016/2017 for Prescribed Specialised Services, NHS England is developing a single national purchasing and supply chain arrangement for specialised commissioning high cost tariff excluded devices with effect from April 2016. Transition plans will be put in place prior to this date with each provider to transition from local to national procurement arrangements.

39. The 2 percent efficiency requirement is predicated upon the provider system meeting a forecast deficit of £1.8 billion at the end of 2015/16. Any further deterioration of this position will require the relevant providers to deliver higher efficiency levels to achieve the control totals to be set by NHS Improvement.

40. For 2016/17 the business rules for commissioners will remain similar to those for last year. Commissioners (excluding public health and specialised commissioning) will be required to deliver a cumulative reserve (surplus) of 1 percent. At the very least, commissioners who are unable to meet the cumulative reserve (surplus) requirement must deliver an in-year break-even position. Commissioners with a cumulative deficit will be expected to apply their increase in allocation to improving their bottom line position, other than the amount necessary to fund nationally recognised new policy requirements. Drawdown will be available to commissioners in line with the process for the previous financial year. CCGs should plan to drawdown all cumulative surpluses in excess of 1 percent over the next three years, enabling drawdown to become a more fluid mechanism for managing financial pressures across the year-end boundary.

41. Commissioners are required to plan to spend 1 percent of their allocations non-recurrently, consistent with previous years. In order to provide funds to insulate the health economy from financial risks, the 1 percent non-recurrent expenditure should be uncommitted at the start of the year, to enable progressive release in agreement with NHS England as evidence emerges of risks not arising or being effectively mitigated through other means. Commissioners will also be required to hold an additional contingency of 0.5 percent, again consistent with previous years.

42. CCGs and councils will need to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) in 2016/17. The plan should build on the 2015/16 BCF plan, taking account of what has worked well in meeting the objectives of the fund, and what has not. CCGs will be advised of the minimum amount that they are required to pool as part of the notification of their wider allocation. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care; further guidance on the BCF will be forthcoming in the New Year.

43. Commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase. Where CCGs collaborate with specialised commissioning to improve service efficiency, they will be eligible for a share of the benefits.

44. NHS England and NHS Improvement continue to be open to new approaches to contracting and business rules, as part of these agreements. For example, we are willing to explore applying a single financial control total across local commissioners and providers with a few local systems.

Measuring progress

45. We will measure progress through a new CCG Assessment Framework. NHS England will consult on this in January 2016, and it will be aligned with this planning guidance. The framework is referred in the Mandate as a CCG scorecard. It is our new version of the CCG assurance framework, and it will apply from 2016/17. Its relevance reaches beyond CCGs, because it's about how local health and care systems and communities can assess their own progress.

Timetable

Timetable	Date
Publish planning guidance	22 December 2015
Publish 2016/17 indicative prices	By 22 December 2015
Issue commissioner allocations, and technical annexes to planning guidance	Early January 2016
Launch consultation on standard contract, announce CQUIN and Quality Premium	January 2016
Issue further process guidance on STPs	January 2016
Localities to submit proposals for STP footprints and volunteers for mental health and small DGHs trials	By 29 January 2016
First submission of full draft 16/17 Operational Plans	8 February 2016
National Tariff S118 consultation	January/February 2016
Publish National Tariff	March 2016
Boards of providers and commissioners approve budgets and final plans	By 31 March 2016
National deadline for signing of contracts	31 March 2016
Submission of final 16/17 Operational Plans, aligned with contracts	11 April 2016
Submission of full STPs	End June 2016
Assessment and Review of STPs	End July 2016

Please note that we will announce the timetable for consultation and issuing of the standard contract separately. A more detailed timetable and milestones is included in the technical guidance that will accompany this document.

Annex 1: Indicative 'national challenges' for STPs

STPs are about the holistic pursuit of the triple aim – better health, transformed quality of care delivery, and sustainable finances. They also need to set out how local systems will play their part in delivering the Mandate (annex 2).

We will publish further guidance early in 2016 to help areas construct the strongest possible process and plan.

We will also make available aids (e.g. exemplar plans) and some hands-on support for areas as they develop their plans.

The questions below give an early sense of what you will need to address to gain sign-off and attract additional national investment.

We are asking local systems first to focus on creating an overall local vision, and the three overarching questions – rather than attempting to answer all of the specifics right from the start. We will be developing a process to offer feedback on these first, prior to development of the first draft of the detailed plans.

A. How will you close the health and wellbeing gap?

This section should include your plans for a 'radical upgrade' in prevention, patient activation, choice and control, and community engagement.

Questions your plan should answer:

1. How will you assess and address your most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local government?

    - How rapidly could you achieve full local implementation of the national Diabetes Prevention Programme? Why should Public Health England (PHE) and NHS England prioritise your geographical area (e.g. with national funding to support the programme)?

    - What action will you take to address obesity, including childhood obesity?

    - How will you achieve a step-change in patient activation and self-care? How will this help you moderate demand and achieve financial balance? How will you embed the six principles of engagement and involvement of local patients, carers, and communities developed to help deliver the Five Year Forward View?

2. How will you make real the aspiration to design person-centred coordinated care, including plans to ensure patients have access to named, responsible consultants?

3. How will a major expansion of integrated personal health budgets and implementation of choice – particularly in maternity, end-of-life and elective care – be an integral part of your programme to hand power to patients?

4. How are NHS and other employers in your area going to improve the health of their own workforce – for example by participating in the national roll out the Healthy NHS programme?

B. How will you drive transformation to close the care and quality gap?

This section should include plans for new care model development, improving against clinical priorities, and rollout of digital healthcare.

Questions your plan should answer:

1 What is your plan for sustainable general practice and wider primary care? How will you improve primary care infrastructure, supported in part through access to national primary care transformation funding?

2. How rapidly can you implement enhanced access to primary care in evenings and weekends and using technology? Why should NHS England prioritise your area for additional funding?

3. What are your plans to adopt new models of out-of-hospital care, e.g Multi-specialty Community Providers (MCPs) or Primary and Acute Care Systems (PACS)? Why should NHS England prioritise your area for transformation funding? And when are you planning to adopt forthcoming best practice from the enhanced health in care homes vanguards?

4. How will you adopt new models of acute care collaboration (accountable clinical networks, specialty franchises, and Foundation Groups)? How will you work with organisations outside your area and learn from best practice from abroad, other sectors and industry?

5. What is your plan for transforming urgent and emergency care in your area? How will you simplify the current confusing array of entry points? What's your agreed recovery plan to achieve and maintain A&E and ambulance access standards?

6. What's your plan to maintain the elective care referral to treatment standard? Are you buying sufficient activity, tackling unwarranted variation in demand, proactively offering patient choice of alternatives, and increasing provider productivity?

7. How will you deliver a transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?

8. How will you improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health?

9. What steps will your local area take to improve dementia services?

10. As part of the Transforming Care programme, how will your area ensure that people with learning disabilities are, wherever possible, supported at home rather than in hospital? How far are you closing out-moded inpatient beds and reinvesting in continuing learning disability support

11. How fast are you aspiring to improve the quality of care and safety in your organisations as judged by the Care Quality Commission (CQC)? What is your trajectory for no NHS trust and no GP practice to have an overall inadequate rating from the Care Quality Commission (CQC)?

12. What are you doing to embed an open, learning and safety culture locally that is ambitious enough? What steps are you taking to improving reporting, investigations and supporting patients, their families and carers, as well as staff who have been involved in an incident?

13. What plans do you have in place to reduce antimicrobial resistance and ensure responsible prescribing of antibiotics in all care settings? How are you supporting prescribers to enable them issue the right drugs responsibly? At the same time, how rapidly will you achieve full implementation of good practice in reducing avoidable mortality from sepsis?

14. How will you achieve by 2020 the full-roll out of seven day services for the four priority clinical standards?

15. How will you implement the forthcoming national maternity review, including progress towards new national ambitions for improving safety and increased personalisation and choice?

16. How will you put your Children and Young People Mental Health Plan into practice?

17. How quickly will you implement your local digital roadmap, taking the steps needed to deliver a fully interoperable health and care system by 2020 that is paper-free at the point of care? How will you make sure that every patient has access to digital health records that they can share with their families, carers and clinical teams? How will you increase your online offer to patients beyond repeat prescriptions and GP appointments?

18. What is your plan to develop, retrain and retain a workforce with the right skills, values and behaviours in sufficient numbers and in the right locations to deliver your vision for transformed care? How will you build the multidisciplinary teams to underpin new models of care? How ambitious are your plans to implement new workforce roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice?

19. What is your plan to improve commissioning? How rapidly will the CCGs in your system move to place-based commissioning? If you are a devolution area, how will implementation delivery real improvements for patients?

20. How will your system be at the forefront of science, research and innovation? How are you implementing combinatorial innovation, learning from the forthcoming test bed programme? How will services changes over the next five years embrace breakthroughs in genomics, precision medicine and diagnostics?

C. How will you close the finance and efficiency gap?

This section should describe how you will achieve financial balance across your local health system and improve the efficiency of NHS services.

Questions your plan should answer:

1. How will you deliver the necessary per annum efficiency across the total NHS funding base in your local area by 2020/21?

2. What is your comprehensive and credible plan to moderate demand growth? What are the respective contributions in your local system of: (i) tackling unwarranted variation in care utilisation, e.g. through RightCare; (ii) patient activation and self-care; (iii) new models of care; and (iv) urgent and emergency care reform implementation?

3. How will you reduce costs (as opposed to growing income) and how will you get the most out of your existing workforce? What savings will you make from financial controls on agency, whilst ensuring appropriate staffing levels? What are your plans for improving workforce productivity, e.g. through e-rostering of nurses and HCAs? How are you planning to reduce cost through better purchasing and medicines management? What efficiency improvements are you planning to make across primary care and specialised care delivery?

4. What capital investments do you plan to unlock additional efficiency? How will they be affordable and how will they be financed?

5. What actions will you take as a system to utilise NHS estate better, disposing of unneeded assets or monetising those that could create longer-term income streams? How does this local system estates plan support the plans you're taking to redesign care models in your area?

Annex 2: The Government's mandate to NHS England 2016/17

The table below shows NHS England's objectives with an overall measurable goal for this Parliament and clear priority deliverables for 2016-17. The majority of these goals will be achieved in partnership with the Department of Health (DH), NHS Improvement and other health bodies such as Public Health England (PHE), Health Education England (HEE) and the Care Quality Commission (CQC). It also sets out requirements for NHS England to comply with in paragraph 6.2.

Read the full Mandate to NHS England

1. Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.	
1.1 CCG performance	**Overall 2020 goals:** • Consistent improvement in performance of CCGs against new CCG assessment framework.
	2016-17 deliverables: • By June, publish results of the CCG assessment framework for 2015-16, which provides CCGs with an aggregated Ofsted style assessment of performance and allows them to benchmark against other CCGs and informs whether NHS England intervention is needed. • Ensure new Ofsted-style CCG framework for 2016-17 includes health economy metrics to measure progress on priorities set out in the mandate and the NHS planning guidance including overall Ofsted-style assessment for each of cancer, dementia, maternity, mental health, learning disabilities and diabetes, as well as metrics on efficiency, core performance, technology and prevention. • By the end of Q1 of 2016-17, publish the first overall assessment for each of the six clinical areas above.

2. To help create the safest, highest quality health and care service.	
2.1 Avoidable deaths and seven-day services	**Overall 2020 goals:** • Roll out of seven-day services in hospital to 100 percent of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards), so that patients receive the same standards of care, seven days a week. • Achieve a significant reduction in avoidable deaths, with all trusts to have seen measurable reduction from their baseline on the basis of annual measurements. • Support NHS Improvement to significantly increase the number of trusts rated outstanding or good, including significantly reducing the length of time trusts remain in special measures. • Measurable progress towards reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries that are caused during or soon after birth by 50 percent by 2030 with a measurable reduction by 2020. • Support the NHS to be the world's largest learning organisation with a new culture of learning from clinical mistakes, including improving the number of staff who feel their organisation acts on concerns raised by clinical staff or patients. • Measurable improvement in antimicrobial prescribing and resistance rates.
	2016-17 deliverables: • Publish avoidable deaths per trust annually and support NHS Improvement to help trusts to implement programme to improve from March 2016 baseline. • Rollout of four clinical priority standards in all relevant specialties to 25 percent of population. • Implement agreed recommendations of the National Maternity Review in relation to safety, and support progress on delivering Sign up to Safety. • Support the Government's goal to establish global and UK baseline and ambition for antimicrobial prescribing and resistance rates.

2.2 Patient experience	**Overall 2020 goals**: • Maintain and increase the number of people recommending services in the Friends and Family Test (FFT) (currently 88-96 percent), and ensure its effectiveness, alongside other sources of feedback to improve services. • 50-100,000 people to have a personal health budget or integrated personal budget (up from current estimate of 4,000). • Significantly improve patient choice, including in maternity, end-of-life care and for people with long-term conditions, including ensuring an increase in the number of people able to die in the place of their choice, including at home.
	2016-17 deliverables: • Produce a plan with specific milestones for improving patient choice by 2020, particularly in maternity, end-of-life care (including to ensure more people are able to achieve their preferred place of care and death), and personal health budgets. • Building on the FFT, develop proposals about how feedback, particularly in maternity services, could be enhanced to drive improvements to services at clinical and ward levels.
2.3 Cancer	**Overall 2020 goals:** • Deliver recommendations of the Independent Cancer Taskforce, including: o significantly improving one-year survival to achieve 75 percent by 2020 for all cancers combined (up from 69 percent currently); and o patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.
	2016-17 deliverables: • Achieve 62-day cancer waiting time standard. • Support NHS Improvement to achieve measurable progress towards the national diagnostic standard of patients waiting no more than six weeks from referral to test. • Agree trajectory for increases in diagnostic capacity required to 2020 and achieve it for year one. • Invest £340 million in providing cancer treatments not routinely provided on the NHS through the Cancer Drugs Fund, and ensure effective transition to the agreed operating model to improve its effectiveness within its existing budget.

3. To balance the NHS budget and improve efficiency and productivity	
3.1 Balancing the NHS budget	**Overall 2020 goals**: • With NHS Improvement, ensure the NHS balances its budget in each financial year. • With the Department of Health and NHS Improvement, achieve year on year improvements in NHS efficiency and productivity (2-3 percent each year), including from reducing growth in activity and maximising cost recovery.
	2016-17 deliverables: • With NHS Improvement ensure the NHS balances its budget, with commissioners and providers living within their budgets, and support NHS Improvement in: o securing £1.3 billion of efficiency savings through implementing Lord Carter's recommendations and collaborating with local authorities on Continuing Healthcare spending; o delivering year one of trust deficit reduction plans and ensuring a balanced financial position across the trust sector, supported by effective deployment of the Sustainability and Transformation Fund; and o reducing spend on agency staff by at least £0.8 billion on a path to further reductions over the Parliament. • Roll-out of second cohort of RightCare methodology to a further 60 CCGs. • Measurable improvement in primary care productivity, including through supporting community pharmacy reform. • Work with CCGs to support Government's goal to increase NHS cost recovery up to £500 million by 2017-18 from overseas patients. • Ensure CCGs' local estates strategies support the overall goal of releasing £2 billion and land for 26,000 homes by 2020.

4. To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.	
4.1 Obesity and diabetes	**Overall 2020 goals:** • Measurable reduction in child obesity as part of the Government's childhood obesity strategy. • 100,000 people supported to reduce their risk of diabetes through the Diabetes Prevention Programme. • Measurable reduction in variation in management and care for people with diabetes.
	2016-17 deliverables: • Contribute to the agreed child obesity implementation plan, including wider action to achieve year on year improvement trajectory for the percentage of children who are overweight or obese. • 10,000 people referred to the Diabetes Prevention Programme.
4.2 Dementia	**Overall 2020 goals:** • Measurable improvement on all areas of Prime Minister's challenge on dementia 2020, including: o maintain a diagnosis rate of at least two thirds; o increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral; and o improve quality of post-diagnosis treatment and support for people with dementia and their carers.
	2016-17 deliverables: • Maintain a minimum of two thirds diagnosis rates for people with dementia. • Work with National Institute for Health Research on location of Dementia Institute. • Agree an affordable implementation plan for the Prime Minister's challenge on dementia 2020, including to improve the quality of post-diagnosis treatment and support.

5. To maintain and improve performance against core standards	
5.1 A&E, ambulances and Referral to Treatment (RTT)	**Overall 2020 goals:** • 95 percent of people attending A&E seen within four hours; Urgent and Emergency Care Networks rolled out to 100 percent of the population. • 75 percent of Category A ambulance calls responded to within 8 minutes. • At least 92% of patients on incomplete non-emergency pathways to have been waiting no more than 18 weeks from referral; no-one waits more than 52 weeks.
	2016-17 deliverables: • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for A&E. • Implement Urgent and Emergency Care Networks in 20 percent of the country designated as transformation areas, including clear steps towards a single point of contact. • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for ambulance responses; complete Red 2 pilots and decide on full roll-out. • With NHS Improvement, meet the 18-week referral-to-treatment standard, including implementing patient choice in line with the NHS Constitution; and reduce unwarranted variation between CCG referral rates to better manage demand.
6. To improve out-of-hospital care.	
6.1 New models of care and general practice	**Overall 2020 goals:** • 100 percent of population has access to weekend/evening routine GP appointments. • Measurable reduction in age standardised emergency admission rates and emergency inpatient bed-day rates; more significant reductions through the New Care Model programme covering at least 50 percent of population. • Significant measurable progress in health and social care integration, urgent and emergency care (including ensuring a single point of contact), and electronic health record sharing, in areas covered by the New Care Model programme. • 5,000 extra doctors in general practice.

	2016-17 deliverables: • New models of care covering the 20 percent of the population designated as being in a transformation area to: o provide access to enhanced GP services, including evening and weekend access and same-day GP appointments for all over 75s who need them; and o make progress on integration of health and social care, integrated urgent and emergency care, and electronic record sharing. • Publish practice-level metrics on quality of and access to GP services and, with the Health and Social Care Information Centre, provide GPs with benchmarking information for named patient lists. • Develop new voluntary contract for GPs (Multidisciplinary Community Provider contract) ready for implementation in 2017-18.
6.2 Health and social care integration	**Overall 2020 goals:** • Achieve better integration of health and social care in every area of the country, with significant improvements in performance against integration metrics within the new CCG assessment framework. Areas will graduate from the Better Care Fund programme management once they can demonstrate they have moved beyond its requirements, meeting the government's key criteria for devolution. • Ensure the NHS plays its part in significantly reducing delayed transfers of care, including through developing and applying new incentives.
	2016-17 deliverables: • Implement the Better Care Fund (BCF) in line with the BCF Policy Framework for 2016-17. • Every area to have an agreed plan by March 2017 for better integrating health and social care. • Working with partners, achieve accelerated implementation of health and social care integration in the 20 percent of the country designated as transformation areas, by sharing electronic health records and making measurable progress towards integrated assessment and provision. • Work with the Department of Health, other national partners and local areas to agree and support implementation of local devolution deals. • Agree a system-wide plan for reducing delayed transfers of care with overall goal and trajectory for improvement, and with local government and NHS partners implement year one of this plan.

	2016-17 requirements: • NHS England is required to: o ring-fence £3.519 billion within its allocation to CCGs to establish the Better Care Fund, to be used for the purposes of integrated care; o consult the Department of Health and the Department for Communities and Local Government before approving spending plans drawn up by each local area; and o consult the Department of Health and the Department for Communities and Local Government before exercising its powers in relation to failure to meet specified conditions attached to the Better Care Fund as set out in the BCF Policy Framework.
6.3 Mental health, learning disabilities and autism	**Overall 2020 goal:** • To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce). • Access and waiting time standards for mental health services embedded, including: o 50 percent of people experiencing first episode of psychosis to access treatment within two weeks; and o 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks.
	2016-17 deliverables: • 50 percent of people experiencing first episode of psychosis to access treatment within two weeks. • 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks. • Increase in people with learning disabilities/autism being cared for by community not inpatient services, including implementing the 2016-17 actions for Transforming Care. • Agree and implement a plan to improve crisis care for all ages, including investing in places of safety. • Oversee the implementation of locally led transformation plans for children and young people's mental health, which improve prevention and early intervention activity, and be on track to deliver national coverage of the children and young people's Improving Access to Psychological Therapies (IAPT) programme by 2018. • Implement agreed actions from the Mental Health Taskforce.

7. To support research, innovation and growth.	
7.1 Research and growth	**Overall 2020 goals:** • Support the Department of Health and the Health Research Authority in their ambition to improve the UK's international ranking for health research. • Implement research proposals and initiatives in the NHS England research plan. • Measurable improvement in NHS uptake of affordable and cost-effective new innovations. • To assure and monitor NHS Genomic Medicine Centre performance to deliver the 100,000 genomes commitment.
	2016-17 deliverables: • Implement the agreed recommendations of the Accelerated Access Review including developing ambition and trajectory on NHS uptake of affordable and cost-effective new innovations.
7.2 Technology	**Overall 2020 goals:** • Support delivery of the National Information Board Framework 'Personalised Health and Care 2020' including local digital roadmaps, leading to measurable improvement on the new digital maturity index and achievement of an NHS which is paper-free at the point of care. • 95 percent of GP patients to be offered e-consultation and other digital services; and 95 percent of tests to be digitally transferred between organisations.
	2016-17 deliverables: • Minimum of 10 percent of patients actively accessing primary care services online or through apps, and set trajectory and plan for achieving a significant increase by 2020. • Ensure high quality appointment booking app with access to full medical record and agreed data sharing opt-out available from April 2016. • Robust data security standards in place and being enforced for patient confidential data. • Make progress in delivering new consent-based data services to enable effective data sharing for commissioning and other purposes for the benefit of health and care. • Significant increase in patient access to and use of the electronic health record.

7.3 Health and work	**Overall 2020 goal:** • Contribute to reducing the disability employment gap. • Contribute to the Government's goal of increasing the use of Fit for Work.
	2016-17 deliverables: • Continue to deliver and evaluate NHS England's plan to improve the health and wellbeing of the NHS workforce. • Work with Government to develop proposals to expand and trial promising interventions to support people with long-term health conditions and disabilities back into employment.

NHS Improvement

IMPLEMENTING THE *FORWARD VIEW*:
Supporting providers to deliver
SUMMARY

February 2016

Implementing the *Forward View*

Supporting providers to deliver

SUMMARY

Version number: 1

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Prepared by: NHS Improvement in collaboration with a range of provider leaders, NHS Providers, NHS Confederation, NHS Clinical Commissioners, NHS Partners and the Local Government Association.

This document is for: Boards, senior leaders and clinicians, and interested staff in NHS trusts and NHS foundation trusts as well as their commissioners.

This document is designed for NHS provider organisations. It is part of a series of roadmaps that draw on messages from the NHS Planning Guidance and set out the key priorities for specific audiences that are responsible for delivering high quality health and care this year and beyond. Each roadmap draws on a shared vision for the health and care sector as set out in the Five Year Forward View (5YFV) – about the challenges ahead and the choices we face about the kind of health and care service we want and need in 2020. This is not just about stabilising services for today, but about driving the necessary scale of transformation required to meet the needs of future patients in a sustainable way and to help close the three gaps identified in the 5YFV: health and wellbeing; care and quality; and finance and efficiency.

The solutions to today's problems lie in a radical upgrade of prevention and new models of service delivery. This means working differently, and collaboratively, on identifying solutions and sharing problems, at both national and local levels and with wider stakeholders, such as local government, individuals and community partners. This will be increasingly important as we move further towards place-based planning, commissioning and delivery of preventative, person-centred and co-ordinated care in which individuals are increasingly empowered to take responsibility for their own care where relevant, thereby reducing pressure on existing services. Success will require us all to think beyond our statutory and organisational borders to meet the needs of the people we serve. Further strengthening of collective system leadership at both national and local levels is essential to ensure that we succeed.

1 Introduction

All providers of NHS services have been under increasing pressure in recent years, most acutely from slowing growth in the NHS budget, but also from rising expectations, an ageing population and an expanding range of treatments and therapies. Managing this increase in demand during a period of limited funding growth was the key challenge identified in the NHS Five Year Forward View (5YFV).

In response to the 5YFV, the government has pledged an additional £8.4 billion of real-term investment in the NHS by 2020, heavily weighted to the earlier years of the spending period. This gives NHS providers a window in which to invest in lasting improvements in the quality and efficiency of care, so they can sustain higher standards as funding growth slows later in the period.

Implementing the Forward View*: supporting providers to deliver*, summarised below, describes for provider boards and leadership teams the task they face, how to build the capability they need to achieve it, and what NHS Improvement and other arm's length bodies will do to support them.

2 The provider task to 2020

The challenge facing providers to 2020 is to deliver patient care of outstanding quality, regain NHS Constitution access standards, return to financial balance and eliminate unwarranted variation across all these areas, while at the same time making the transformation needed to ensure long-term sustainability.

Getting the 'quality, access, finance' triangle right while transforming care adds up to an ambitious and stretching task. Provider boards will need clear strategies for achieving it, using their local Sustainability and Transformation Planning process to plan elements needing action across local health systems. Providers will also need to develop a new partnership with patients and their families.

Quality: The vision for 2020 is that the vast majority of NHS providers will have an 'Outstanding' or 'Good' CQC rating and no trusts will be in special measures. At the same time, all providers will have made the improvements specified by national taskforces in the priority areas of cancer, mental health, maternity, dementia, and urgent and emergency care. They will also have made significant progress in eliminating unwarranted variation in clinical performance. Patient safety will have consistently improved and all providers will be delivering seven-day services in line with the priority clinical standards.

Access: The vision is that by 2020 all NHS providers will be delivering the agreed NHS Constitution access standards for urgent and emergency care, elective care and cancer care, and be meeting the new access standards for mental health services. Providers' recovery plans will include measures such as better demand and capacity planning, better use of better quality data, better operational management

within providers and across local systems, and improved referral management, responding to patient choice.

Finance: The vision for 2020 is that all NHS providers will have balanced their books and released significant efficiency savings, maximising value for patients and improving the quality of care. Fortunately, quality and efficiency are two sides of the same coin in healthcare. To start with, providers need to achieve the best possible outturn position in 2015/16 and develop a plan for 2016/17 based on agreed control totals. Providers are expected to become less reliant on temporary staff by sticking to recent guidance on agency staff controls. Acute trusts will need to plan to achieve the savings of up to 10% of their expenditure identified in Lord Carter's recent report. All providers may need to take action to release the value in surplus NHS estate: for example, by co-locating primary and secondary care where possible.

Transformation for sustainability: The vision for 2020 is of providers joining up with other organisations to transform services in ways that best meet the needs of their local population. Providers will drive a shift of emphasis in NHS financial, regulatory and performance management processes from individual organisation performance to the performance of whole local health and care systems, recognising that the success of individual organisations remains important. NHS Improvement and NHS England will support this shift by increasingly engaging jointly with local health and care economies, encouraging joint planning and collaboration across boundaries. All local health and care systems will need clear plans to move to new care models – such as the five the sector is currently testing – and to reconfigure services where required. Providers will play a big part in developing these plans, and a more prominent role in prevention, early intervention and improving life expectancy.

3 Building capability for the task

Providers do not yet have enough capability to achieve the task to 2020, summarised above. Provider boards will need to increase their capability by investing in workforce and leadership, and in technology, innovation and research.

Workforce and leadership: A highly skilled, motivated and healthy workforce, deployed in the right place and at the right time, will continue to be the driving force behind high quality, innovative, patient-centred care. Providers will need to equip staff to deliver even greater value and the shape of the workforce will change.

So provider boards will need to devote significantly more time and focus to strategic workforce issues. First, providers will need to recruit, develop and retain the right workforce for the future. Far more care will be delivered closer to home, by multiprofessional teams with more generalist skills, able to operate between different care settings and with more specialist colleagues. Staffing levels will be appropriate to the needs of patients and care models, and providers will be using tools such as e-rostering and caring hours per patient day to ensure their services are both safe and efficient.

Providers will also need to improve their performance on equality and diversity, so NHS organisations have leadership teams that more closely resemble the communities they serve. They should make sure the workforce plans they submit to Health Education England match staff projections in local Sustainability and Transformation Plans, so the supply of suitably trained staff is more likely to meet future patient needs.

Providers will need to help staff increase their productivity, especially by developing managers and leaders, including clinical leaders. Their NHS culture will recognise and value the role and importance of provider leadership and management. In line with growing evidence of a strong correlation between organisational performance and staff engagement, providers will foster a culture in which staff feel valued and engaged, where bullying and harassment are not tolerated, and staff health and wellbeing are paramount. This goes hand in hand with creating the culture of learning and improvement that underpins achieving the task to 2020.

To support these developments, NHS Improvement is working with arm’s length bodies and other expert organisations on several workforce measures, including a national strategy for leadership development and improvement. This will also cover talent management in the NHS, from graduate to board level.

Investing in technology, innovation and research: The vision for 2020 is of providers fully exploiting the benefits of technology to interface between different parts of the health and care system and to enable efficient, patient-centred ways of working. Clinicians and patients will benefit from improved information, less paper and rapid access to services facilitated by new technology.

Provider boards will therefore consider technology investments to support, for example, basing staff and asset management on real-time supply and demand information to improve patient flows, or enable complete and up-to-date records to accompany patients around the health and care system. Providers should engage in and lead on the development of digital roadmaps by local health economies, as well as broader strategic planning for innovation. NHS Improvement and NHS England plan jointly to appoint a chief information and technology officer to support local joint working.

Advances in the use of data and technology are also critical to research and innovation. Providers need to support high quality research and innovation and its rapid translation into clinical practice, so patients and the population benefit from leading-edge, cost-effective care. Academic health science centres and networks lead on diffusing such innovations. Provider boards should therefore clearly define their role in science, education and training, and research and innovation, including how they will work with their local academic health science network.

4 Support from NHS Improvement

NHS Improvement's first and most important purpose is to support providers to deliver their task to 2020, summarised above. To support providers we will:

Develop a new oversight model. In the short term, the scale of financial and operational challenges faced by many providers will necessitate more involvement than we intend long term. But we recognise the limitations of such an approach. Our ambition is to develop an oversight model where we support first, building deep and lasting relationships with providers, and working alongside them to help them to improve, and only intervene when we have to.

Develop the right relationships. In our relationships with providers and local health and care systems we will put patients' interests first, respect and empower provider boards and hold them to account against a single, clear definition of success. We will give leaders space to innovate and take well-managed risks. Our practical, evidence-based support will recognise and share good practice to drive continuous improvement. We will strive to eliminate unnecessary data reporting requirements and lighten other regulatory burdens.

With our national system partners, we aim to create an environment for provider and system success through national policy, pricing and other levers. We will collaborate instinctively and naturally with NHS England and CQC at national, regional and local levels, so we all speak with one voice to the service.

Create a single definition of success. We will align with CQC and NHS England to create a single, simple definition of success for providers. It will cover quality, finance and use of resources, operational performance, leadership and strategic change.

Allow autonomy for good performers. Providers that meet the definition of success will earn greater autonomy, while those that do not will receive more intensive support from NHS Improvement in line with the scale of the challenges they face. Providers facing the biggest challenges – including foundation trusts in breach of their licence, NHS trusts in similar circumstances and providers in special measures – will receive more directive support.

Support providers in adopting evidence-based improvement approaches. To help providers address unwarranted variations in quality, access and efficiency, NHS Improvement will support all trusts in developing the capability to apply evidence-based improvement approaches. The kind of approaches we want to test and develop going forward include the Sign up to Safety campaign, the Emergency Care Improvement Programme, the Virginia Mason Institute's work with five NHS trusts, and the NHS Leadership Academy's leadership development programmes.

Much of the expertise needed to address the challenges set out in this document already exists in the system. We will work collaboratively across the sector to support improvement and to broker support between providers. We will also share our analysis and insights, enabling more systematic sharing and adoption of best practice among providers.

We will continue to provide dedicated support and development for providers in, or at risk of being in, special measures. This includes expanding senior leadership capacity and buddying with high-performing providers at home and abroad, in health and other sectors. We will support acute providers in implementing the recommendations of the Carter Review and work with non-acute providers to apply similar methodologies and tools.

At the same time, NHS Improvement will embed the principle of continuous improvement in the way we work. We will monitor and evaluate the effectiveness of our support, and will refine our methods in line with evidence of what works, including the feedback we get from providers.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – February 2016

2-17	**Oversight Self-Certification, Month 10, 2015/16**	**Trust Secretary**

As Board members are aware, up until now, the Trust Board has been required to undertake a monthly self-assessment against the questions contained in two self-certification documents under the NHS Trust Development Authority (TDA) oversight process:

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

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

However, on 09/02/16, the TDA emailed Trusts to state that "Since the Self Certification process has not been updated in accordance with the Accountability Framework and is no longer in line with Monitor reporting requirements, we have decided to stop this collection with immediate effect until further notice. The web form has now been closed. Thanks to all who have taken the time to submit the collection all these months. We will keep you informed as and when new reporting requirements evolve.". Clarification was sought that this meant that the Trust was therefore no longer required to self-certify at all, and the TDA confirmed that this was correct.

Given this, and the recent "Stop, Start, Simplify" approach that has been discussed at the Finance Committee and Trust Board, it is proposed that the Self-Certification exercise cease after the February Board meeting. The Board is therefore asked to consider this proposal.

However, for completeness, and to enable formal closure, the self-assessment has been updated i.e. the evidence has been refreshed and updated from that reviewed at the January 2016 Board meeting. Additions are highlighted, whilst deletions are shown as ~~struckthrough~~. There are no changes in compliance status proposed from that agreed by the Trust Board in January 2016. For completeness, the report also includes details of all License Conditions, including those for which the Trust is exempt (i.e. G1, G2, G3, G9, CoS1 to CoS7, and FT1 to FT4).

Which Committees have reviewed the information prior to Board submission?

- N/A

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

The Board is asked to:

1. Review the evidence presented to support the self-assessment and the "Latest assessment – Compliant?" status (and amend if required)
2. To consider the proposal that the Self-Certification exercise cease after the February Board meeting

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

Oversight Self Certification – NHS Provider Licence Conditions

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

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

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

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

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

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

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

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

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

Oversight Self Certification – Board Statements

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

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

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

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

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

Statement	Evidence of Trust compliance	Latest assessment – Compliant?
	committees, provides a report to the Board following each meeting which is presented by the Committee Chairman (a NED). The Board is fully engaged with the development of the IBP and the Clinical Strategy that underpins it.	
For governance, that: 9. an Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	The Annual Governance Statement 2014/15 was approved by the Trust Board in May 2015.	Yes
For governance, that: 10. the Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward	The Trust Board monitors compliance with existing targets, and actions to address any issues, at each meeting, primarily via the integrated performance report.	Yes
For governance, that: 11. the trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit	The Trust achieved IG toolkit level 2 for 2014/15 against all Requirements. The submission was approved by the Trust Board in March 2015	Yes
For governance, that: 12. the board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.	A Trust Board Code of Conduct is in place which confirms the requirement to comply with the Nolan principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership. A register of Directors' interests is maintained and Board members are invited to declare any interests relevant to the agenda at the beginning of each Board meeting, and each Board sub-committee. The Register of Directors' Interests was refreshed in March/April 2015, and features within the Annual Report for 2014/15, which the Trust Board approved in May 2015. The Trust's revised "Gifts, Hospitality, Sponsorship and Interests Policy and Procedure" (which strengthens the Trust's processes for monitoring interests) has been submitted to the TME for approval, and was ratified by ~~has been submitted to~~ the Trust Board~~, for ratification,~~ in January 2016.	Yes

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board Meeting – February 2016

2-18 Ratification of revised Standing Orders — Trust Secretary

The Trust's Standing Orders (SOs) are overdue their routine review, but have now been reviewed, and a number of changes are proposed.

A pre-consultation version was submitted to the Audit and Governance Committee in August 2015. The document was then issued for formal consultation in September (which closed in October).

All of the proposed changes are 'tracked' in the enclosed document. No significant changes to existing practice are proposed, but the key changes in the document relate to the following:

- Expansion and strengthening of the 'definitions' section (to cover the fact that Boards now have 'Members' that don't have voting powers etc.)
- Removal of the detailed descriptions of the Board's sub-committees. A cross-reference is instead made to the Terms of Reference, which are now routinely reviewed annually
- Removal of much of the detail regarding interests and standards of business conduct, to be replaced by cross reference to the Trust's Gifts, hospitality, sponsorship and interests policy and procedure (which was ratified by the Trust Board in January 2016)
- Inclusion of the 'fit and proper persons' procedures that the Board agreed in December 2014
- Changes to reflect the alteration of status of the Kent & Medway Health Informatics Service (KMHIS) from a formally "hosted" service to a Trust Directorate, and the consequential absorption of its governance within the normal Trust arrangements
- Refining of the arrangements for use of the Trust's Seal (including the introduction of a formal request process), and inclusion of a requirement that uses of the Trust's Seal are reported to the Finance Committee
- General tidying up / housekeeping

The Audit and Governance Committee "approved" the Standing Orders on 04/11/15, and the Trust Board is now asked to "ratify" the document.

The Standing Orders are the third of three related documents – the Standing Financial Instructions (SFIs) were ratified by the Board in November 2015, whilst the Ratification of Reservation of Powers and Scheme of Delegation were ratified in January 2016.

Which Committees have reviewed the information prior to Board submission?

- Audit and Governance Committee, 06/08/15 & 04/11/15
- Finance Committee, 20/11/14

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

Ratification

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

Maidstone and Tunbridge Wells NHS
NHS Trust

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:	~~Head of Financial Services~~Trust Secretary
Contact details:	kevinrowan@nhs.net, 01622 228 698
Other contributors:	Consultation list contributors (Appendix Two)
Document lead:	Director of Finance ~~Contact Details: 01622 226422~~
Supersedes:	Standing Orders (~~with effect from July 2012~~v4.3)
Reviewed by:	Audit and Governance Committee, 6th August 2015
Approved by:	Audit and Governance Committee, 4th November 2015
Ratified by:	Trust Board, 17th February 2016
Review date:	February 2017

With effect from February 2016

Document history

Requirement for document: ~~*(Why is this document necessary?)*~~	• Code of Conduct / Code of Accountability in the NHS (NHS Appointments Commission / Department of Health) • ~~Trust (Functions) Directions 2000 issued by the Secretary of State~~
Cross References / Associated Documents: *(List all best practice documents supporting this document)*	• National Health Service and Community Care Act 1990 • National Health Service Act 2006 • Freedom of Information Act 2000~~.~~ • Code of Conduct for NHS Managers (Department of Health 2002) • Data Protection Act 1998 • Health and Social Care Act 2012 • ~~Standards of Business Conduct for NHS Staff, Code of Conduct and Trust Board Code of Conduct~~Gifts, hospitality, sponsorship and interests policy and procedure [RWF-XXX-XXX] • Nolan Standards of Public Life • ~~Staff~~ Disciplinary ~~and Appeals~~ Policy and Procedure~~s~~ ~~adopted by the Trust~~ [RWF-OPPPCS-NC-WF10] • Bribery Act 2010 • Standing Financial Instructions [RWF-OPPCS-NC-TM22] • Reservation of Powers and Scheme of Delegation [RWF-OPPCS-NC-TM21] • Anti Fraud, Bribery and Corruption Policy and Procedure [RWF-OPPPCS-NC-WF48] • ~~Response Plan~~ • Code of Practice on openness in the NHS (Department of Health) • International Financial Reporting Standards • ~~NHS Capital Investment Manual~~ • ~~NHS TDA~~ Capital Rregime and Investment Bbusiness Cc~~a~~se Aapprovals Gguidance for NHS Trusts (NHS Trust Development Authority) • The ~~TDA~~ Accountability Framework for NHS Trust Boards (NHS Trust Development Authority) • Code of Conduct / Code of Accountability in the NHS (NHS Appointments Commission / Department of Health) • The National Health Service Trusts (Membership and Procedure) Regulations 1990 (and subsequent amendments) • Managing Public Money (HM Treasury) • Model Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions, Department of Health (2006) • 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)

	• The Healthy NHS Board 2013 (NHS Leadership Academy) • NHS Trust Chair Role and behaviours & Framework (NHS Trust Development Authority) • NHS Trust NED Role and behaviours & Framework Jan 15 (NHS Trust Development Authority) • Removing or suspending from office – chairs and non-executive directors of NHS trusts and NHS charity trustees (NHS Trust Development Authority) • Terms of Reference for the Trust Board and its sub-committees • The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 • The Public Bodies (Admission to Meetings Act) 1960 • Practice Guide 8: Execution of Deeds (Land Registry)

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
~~4~~5.0~~4~~	Revised, to incorporate the following changes: ▪ 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 match those in the Gifts, hospitality, sponsorship and interests policy and procedure	~~March~~ November 2015

Maidstone and Tunbridge Wells NHS
NHS Trust

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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 ~~to the Board~~).

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" ~~(May 2012)~~. For this Trust it shall be the Chief Executive.

"ADO / ADNS" means Associate Director of Operations (ADO) or Associate Director for Nursing Services (ADNS)

"Associate Non-Executive Director~~Member~~" means a person appointed to ~~perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.~~ 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.

~~**"Board"** means the Chairman, officer and non-officer members of the Trust collectively as a body.~~

~~"~~"**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", "Budget Manager" or "Cost Centre Manager" means the Ddirector 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 ~~(or Trust)~~**"" 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. A Committee can be a "Parent Committee" or a "Sub-Committee" (see below)

""**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 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~~ Non-Executive Director of the Board as the context permits. ~~Member in relation to the Board does not include its Chairman.~~ 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" 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 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.

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

"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 ~~and Administration Arrangements~~ Regulations""** ~~———~~means The National Health Service Trusts ~~NHS~~ (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.

""**"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 ~~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 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 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

""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~~, is the Trust's designated risk management committee, and reports to the Trust Board~~.

""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 ~~by the Board~~ to take on the ~~Chairman's~~ 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 Act 1977 (NHS Act 1977), the~~ National Health Service and Community Care Act 1990 ~~(NHS and CC Act 1990) as amended by the Health Authorities Act 1995 and the Health Act 1999~~, National Health Service Act 2006 and Health and Social Care Act 2012. ~~The Trust is required to meet the regulatory requirements laid down in the Health and Social Care Act 2009~~.

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 ~~28A~~ 7 of the National Health Service Act 2006~~NHS Act 1977, as amended by the Health Act 1999~~, 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 ~~setting out~~ 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 Eexecutives (a Sscheme of Ddelegation). The Ccode also requires the establishment of Aaudit and Rremuneration Ccommittees with formally agreed Tterms of Rreference. The Codes of Conduct makes various requirements concerning possible conflicts of interest of Board Mmembers.

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 ~~to the Board~~ and Scheme of Delegation ~~of Powers~~). ~~(See Section 1.8 and Appendix 2 of the Corporate Governance Framework Manual.)~~ Thatis document has effect as if incorporated into the Standing Orders~~.~~ ~~Delegated Powers are covered in a separate document entitled 'Reservation of Powers and Scheme of Delegation' and have effect as if incorporated into the Standing Orders~~ and Standing Financial Instructions (all 3 documents comprise the "Standing Orders Set").

~~1.4 Integrated Governance~~

~~Trust Boards are now encouraged to move away from silo governance and develop integrated governance that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. Guidance from the Department of Health on the move toward and implementation of integrated governance has been issued and will be incorporated in the Trust's Governance Strategy (see Integrated Governance Handbook 2006). The Trust has an agreed Integrated governance model which will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.~~

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 and Administration Arrangements Rregulations, 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 Appointments function);

2.1.2 Up to 5 non-officer Non- -Executive Directors (appointed by the TDA Appointments function);

2.1.3 Up to 5 officer Executive Directors members with voting rights (but not exceeding the number of Nnon-Executive Directorsofficer members). For this Trust this currently includes:

- ~~the Chief Executive;~~
- 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~~ the Finance Director of Finance;
- the Medical Director (who must be a medical practitioner[1]) ;
- ~~the Chief Nurse~~
  ~~The Chief Operating Officer~~

The Trust shall have not more than 11 and not less than 8 Voting Board Mmembers (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 Trust will determine (currently the Director of Workforce and Communications and Deputy Chief Executive).

2.1.5 Other non-voting positions as the Trust will determine (currently the Director of Infection Prevention and Control).

2.1.46 The Trust may confer on senior 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, nor a member of the Executive Team. ~~Such additional Directors will not have the voting rights of statutory directors.~~

[1] As per The National Health Service Trusts(Membership and Procedure) Regulations 1990

2.1.~~5~~7 The Trust may appoint Associate ~~Non~~ 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 ~~Appointment of the Chairman and Non Executive of the Trust -~~ 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 ~~and Administration Arrangements~~ 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 ~~of the Chairman and Non Executive Directors~~, 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 ~~and Administration Arrangements and Administration~~ 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~~one of their numbers, who is not also an Executive Director,~~ to be Vice-Chairman, for such period, not exceeding the remainder of his term as a Non-Executive Director ~~of the Trust~~, 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 ~~and Administration Arrangements~~ 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 ~~Patient and Public Involvement Forum~~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 organis~~z~~ation 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 ~~Directors~~

The Trust Board will function as a corporate decision-making body, Executive and Non-Executive Directors ~~Officer and Non-Officer Non Executive~~ 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 ~~Members~~ 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 ~~Finance~~ Director of Finance

The ~~Finance~~ 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 ~~Members~~ 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~~of~~ or when C~~c~~hairing 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 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"~~Schedule of Matters Reserved to the Board~~' 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~~Directors~~

2.10.1 The Chairman will ensure that the designation of Lead roles or appointments of Trust Board M~~m~~embers 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 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 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 days before a meeting may be included on the agenda at the discretion of the Chairman.

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 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, ~~save in~~ unless there are extenuating circumstances~~emergency~~.

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 R~~r~~escind a R~~r~~esolution', a member of the Board wishing to move a motion shall send a written or electronic transmission notice to the Trust Secretary ~~Chief Executive~~ 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 days before the meeting. ~~-~~The ~~Chief Executive~~ 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 ~~I~~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~~member who is also an Officer Member of the Trust and one member who is not~~) 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 M~~m~~embers 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 M~~m~~embers present so request, the voting on any question may be recorded so as to show how each M~~m~~ember present voted or did not vote (except when conducted by paper ballot).

3.12.4 If a Voting Board M~~m~~ember so requests, their vote shall be recorded by name.

3.12.5 In no circumstances may an absent Voting Board M~~m~~ember 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 ~~Officer Member~~ during a period of incapacity or temporarily to fill a vacancy for an Executive Director with voting rights ~~vacancy~~ shall be entitled to exercise the voting rights of that Executive Director~~e Officer Member~~.

3.12.7 A manager attending the Trust Board meeting to represent an Executive Director with voting rights ~~Officer Member~~ during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director~~Officer Member~~. 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 M~~m~~embers ~~of the Board~~ are present (including at least one Executive Director ~~member who is an Officer Member of the Trust~~ and one Non-Executive Director~~member who is not~~) 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 ~~members of the~~ 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 Mmembers are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive DirectorsOfficer members 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 Directors present 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.

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 l960

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 l960.

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 ~~'In Confidence' or minutes headed 'Items Taken in Private'~~"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 ~~or~~/ 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 Tterms of Rreference 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 Tterms of Rreference 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 Tterms of Rreference 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 ~~committees,~~ sub-committees~~, and joint committees~~ constituted by the Board are listed below.

~~Committees will meet at least quarterly.~~ 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. ~~Exact frequencies are set out in individual committee terms of reference which are available from the Trust Management office and from the Trust Website~~ The final version of each sub-committee's Terms of Reference will be held by the Trust Secretary.

▪ ~~4.8.1~~ Audit and Governance Committee

~~In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, and the Higgs report (2003), an Audit Committee has been established and constituted to provide the Trust Board with an independent and objective review on its processes for financial management, governance, risk and compliance with laws, guidance, and regulations governing the NHS. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis.~~

~~The Board has agreed that the quorum will be two non executive directors. The Chairman of the Trust Board can not be a member of the Audit Committee.~~

~~The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. The duties of the Committee can be categorised as follows:~~

- Government, Risk Management and Internal Control: to review the establishment and maintenance of an effective processes of integrated governance, assurance, risk management, and the associated internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.
- Internal Audit: to ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal audit Standards and provides appropriate independent assurance to the audit Committee, Chief Executive and Board.
- External Audit: to review the work and findings of the External Auditor and consider the implications and management's responses to their work.
- Other Assurance Functions:
  - to 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. These will include reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (e.g. Care quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)
  - to review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Trust Management Executive Committee which is the Trust's designated risk management committee responsible for ensuring the effective applications of assurance and risk management structures, systems and processes.

Representatives of the following organisations attend Audit Committee meetings

- Internal Auditors (South Coast Audit)
- Local Counter fraud
- External Auditors (Grant Thornton)

4.8.2 Remuneration and Appointments Committee

In line with the requirements of the NHS Codes of Conduct and Accountability, and the Higgs report, a Remuneration Committee has been established and constituted.

The Remuneration Committee is comprised of the Trust Chair and all other Non-Executive Director's, with the Chief Executive and the Director of Strategy and Workforce in attendance as appropriate.

Quoracy requires Remuneration Committee Chair plus two Non executive Directors.

Key responsibilities are:

- Make recommendation to Board with respect of the appointment of Executive Directors and other staff appointed on Trust contracts (i.e. Staff not employed under national terms and conditions of service);
- Make such recommendation to the Board on the remuneration, allowances and terms of service of Executive Directors and other staff appointed on Trust contracts;
- Monitor and evaluate the performance of Executive Directors and other staff appointed on Trust contracts;
- Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate. For all Trust staff any non-contractual severance payment or payment of a novel or unusual nature must be first reviewed and agreed by the Committee. If the Committee is unable to meet then authority will be delegated to the Chairman and Chief Executive jointly to formally agree. Any such payment must then be reviewed at the next Remuneration Committee.
- Review other significant employment terms changes, e.g. "Agenda for change", consultant contract, for approval by the Board.

▪ 4.8.3 Charitable Funds Committee

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non charitable funds, the Trust Board has established a Charitable Funds Committee to ensure that the Trust's charitable funds are managed efficiently and effectively in accordance with the directions of the Charity Commission and the wishes of donors.

A Non Executive Director will be appointed as Chair of the Committee and another Non Executive Director appointed as Deputy Chair. Other Non Executive Directors may attend, and fully participate in, meetings of the Committee. In addition the Finance Director, the Chief Executive Officer, and other Executive Directors may attend as members of the committee.

The provisions of this Standing Order must be read in conjunction with Standing Order 2.8 and Standing Financial Instructions 29.

The Committee acts on behalf of the Corporate Trustee and will:

Develop an annual plan
Approve policies and procedures
Approve and monitor fundraising and investment strategies and campaigns
Seek assurances that all income is secured and that expenditure is within the purpose of the funds (where stated) and is used to best effect given the priorities and values of the Trust

~~Ensure compliance of all statutory legislation Charity regulations and seek assurance on compliance~~
~~Ensure there is adequate provision for the independent monitoring of investment activity~~
~~Receive all relevant internal and external audit reports, and ensure compliance with recommendations~~
~~Agree approval and authorisation limits for expenditure from charitable funds~~
~~Consider applications for support~~

- **Finance Committee**

~~The Trust Board has established a Finance Committee to provide the Trust Board with assurance on the effectiveness of financial performance/ management and informatics in the Trust.~~

~~A Non-Executive Director will be appointed as Chair of the Committee and another Non-Executive Director appointed as Deputy Chair. Other Non-Executive Directors may attend, and fully participate in, meetings of the Committee. In addition the Chief Executive Officer, the Finance Director and other Executive Directors may attend meeting as members of the Committee.~~

~~The Committee has the following areas of responsibility:~~

- ~~Financial Management: review of financial plans and strategies, the budgetary control framework, financial performance against plan and the key financial performance indicators~~
- ~~Treasury Management: approve treasury management policies and plans, external funding arrangements within delegated authority, benchmarks for measuring performance and review investment and borrowing policy and performance against the relevant benchmarks. Also to ensure proper safeguards are in place for security of the Trust's funds and review the cash flow and balance sheet of the Trust~~
- ~~Capital Expenditure: review the Trust's capital programme ensuring its alignment to strategic priorities and to review major or contentious business cases for capital and service development~~
- ~~Financial Governance, Reporting, Systems and Function: review and assess arrangements for financial governance, agree financial policies, monitor financial reporting to Trust Board meets the requirements of the Board and individual members, review the effectiveness of financial systems, assess the capacity and effectiveness of the finance function and ensure development plans are in place to meet the current and future requirements of the Trust including the requirements of Foundation Trust status. Also to assess the organisational awareness and adherence to financial management disciplines and controls and promote congruence between quality patient care and the achievement of financial objectives.~~
- ~~Review strategies and plans and ensure they are consistent with the Trust's overall vision and strategic goals~~

- ~~Review plans and proposals for major development and investment and advise the Board on its alignment to the Trust's overall vision and strategy as well as the financial implications and risks of the proposals~~

- ~~Assure itself on (i) the identification of principal risks associated with the financial performance and financial management of the Trust, and information technology, (ii) the effective management of those risks and (iii) the escalation to the Board of matters of significance. Also to ensure that the Board Assurance Framework record of these risks and actions is comprehensive and up to date.~~

▪ Quality ~~and Safety~~ Committee

~~The Quality and Safety Committee is constituted to oversee the quality of care and patient service.~~

~~A Non-Executive Director will be appointed as Chair of the Committee and another Non-Executive Director appointed as Deputy Chair.~~

~~Other Non-Executive Directors may attend, and fully participate in, meetings of the Committee. In addition the Chief Nurse, the Chief Operating Officer, the Medical Director, the Director of Infection Prevention and Control, the Head of Quality and Governance, the Risk and Compliance Manager and Divisional Directors or designated deputies (ADO or ADNS) are members of the committee.~~

~~The Committee will:~~

~~provide assurance to the Trust Board that risks to achieving excellence in the quality of care and clinical operation of are being effectively understood, managed and mitigated~~
~~identify significant risks relating to Quality and Safety that the Trust Board needs to consider in detail.~~
~~ensure that the Trust Risk Management Strategy and Policy is implemented consistently across the Trust. Approve, review and monitor the implementation of other relevant clinical and patient service policies and procedures. As a committee of the Board the committee will also ratify policies and procedures approved by it's sub-committees.~~
~~monitor and ensure the effectiveness of quality systems at a Corporate and Directorate level in order to evaluate their impact and consequences.~~
~~identify significant risk to clinical services that requires the development of business cases and/or processes by the Trust Management Executive, and/or sub-committees.~~
~~ensure quality and patient safety issues are appropriately recorded on the Trust Risk Register and Assurance Framework and appropriately mitigate and manage such risks and issues.~~
~~ensure that Directorates identify and are managing their own quality and patient service risk issues effectively.~~

~~receive reports about patient experience through complaints, claims and incidents made against the Trust in order to be assured of the Trusts good reputation and standing.~~
~~receive reports to monitor against action plans arising from Serious Untoward Incidents, complaints and claims to share learning and to ensure that actions have been completed.~~
~~receive progress reports on compliance with the NHSLA Risk Management standards.~~
~~receive, review and comment on reports from the Standards, Health and Safety, Infection Control, Information Communication and Technology and Safeguarding Committees.~~
~~ensure the Trust and its officers are working in partnership with external agencies (Clinical Commissioning Groups, Trust Development Authority, Department of Health and so on) for the effective management of risk across the health economy.~~
~~The following sub-committees report to the Quality and Safety Committee through their respective chairs or representatives:~~

- ~~Health and Safety Committee~~
- ~~Standards Committee~~
- ~~CLIP Group~~
- ~~Safeguarding Adults Committee~~
- ~~Safeguarding Children Committee.~~
- ~~Infection Prevention and Control Committee (The IPCC is also a sub-committee of the Board and some issues will be reported directly to the Board)~~

▪ Workforce Committee

~~The Workforce Committee is constituted by the Trust Board to oversee workforce development, planning and performance. The Committee will work to assure the Board that the Trust has the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce that is supporting business success.~~

~~A Non-Executive Director will be appointed as Chair of the Committee and another Non-Executive Director appointed as Deputy Chair. Other Non-Executive Directors may attend, and fully participate in, meetings of the Committee. In addition the Director of Strategy and Workforce, the Chief Executive Officer, the Finance Director the Chief Operating Officer, The Medical Director and the Chief Nurse are members of the committee. Other Executive Directors may attend as members.~~

~~The Committees monitors and advises on:~~

- ~~Workforce planning and development, including alignment with business planning and development~~
- ~~Equality and diversity in the workforce~~

- Employee relations trends and issues, e.g. discipline, grievance, bullying/harassment, sickness absence, disputes;
- Occupational health and wellbeing in the workforce
- External developments, best practice and industry trends in employment practice;
- The performance management system;
- Staff recruitment, retention and satisfaction;
- Terms and conditions of employment, including reward;
- Organisation development, organisational change management and leadership development in the Trust;
- Training and development activity in the Trust including prioritisation;

▪ Patient Experience Committee

The Committee is established to provide to the Board of Directors with assurance, and encourage development, related to the quality and safety of patient services and the patient experience.

In addition to Non Executive Directors and Executive Directors, this Committee is attended by senior matrons and senior nurses, the Head of Quality and Governance, external community groups and special interest groups.

The Committee meets quarterly and the objectives of the committee are:

- To positively promote patient and public partnership by valuing the contribution of each Committee Member and organisation represented .
- To provide the perspective of patients and the public and to present the patients' and public's perception of services within the Trust at Trust Committees.
- To liaise with Patient Information and Letter Groups (PILG) regarding key patient information concerns and to support and influence the development of patient information within the Trust.
- To review, discuss, and influence Trust Policies as they develop and change.
- To develop a group of individuals of diverse backgrounds from whom the Trust can seek input in respect to service or policy change.
- To work in partnership with the Trust in determining priorities for patient surveys and local patient feedback methods.
- To consider and review the findings of national surveys and to oversee the improvements against the in-patient survey action plan.
- To provide an arena for public and patient representatives on the Committee to meet members of the Trust Board and other officers.
- To contribute to an annual report to the Trust Board on the development and implementation of the Trust's Patient and Public Partnership strategy.

- ~~Assure itself on (i) the identification of principal risks associated with the experience of patients, (ii) the effective management of those risks and (iii) the escalation to the Board or Quality and Safety Committee of matters of significance. Also to ensure that the Board Assurance Framework record of these risks and actions is comprehensive and up to date.~~

▪ **Foundation Trust Committee**

~~The Foundation Trust Committee is a task and finish group established to oversee the Trust's preparations to submit a successful application to become a NHS Foundation Trust. The Trust Board Chairman chairs this committee and membership comprises all Board members. The Committee meets as required during the year.~~

~~The Committee develops, monitors and advises the Board on:~~

- ~~Board governance and assurance~~
- ~~Quality governance~~
- ~~Board development~~
- ~~Membership development~~
- ~~The Monitor and TDA Oversight process~~

~~4.8.4 Trust Management Executive (TME)~~

~~The TME is the senior management committee within the Trust and reports to the Trust Board. The purpose of the TME is to oversee and direct:~~

- ~~the effective operational management of the Trust including achievement of statutory duties, standards, targets and other obligations,~~
- ~~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 as the designated integrated risk management committee of the Trust~~

~~The Committee comprises Executive Directors and Clinical Directors and other officer of the Trust, or external experts, may be invited to attend the meeting by the Chair. The TME is chaired by the Chief executive, or his designated deputy.~~

~~4.8.5~~4.8.4 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.

~~4.8.6~~4.8.5 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.

~~4.8.7~~4.8.6 Confidential Proceedings

A D~~d~~irector 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 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, 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~~non-officer members~~. 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 ~~t~~Terms of R~~r~~eference 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~~prepare~~ a Scheme of Delegation is prepared ~~identifying his/her proposals~~ 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 ~~Finance~~ 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 ~~Finance~~ Director of Finance shall be accountable to the Chief Executive for operational matters.

~~5.5 Delegation to HIS~~

~~5.5.1 Delegation to the Kent and Medway Health Informatics Service – The Board recognises that the role of the Trust as host authority for the Kent and Medway Health Informatics Service (HIS) is to provide a legal framework in which the HIS can operate for the benefit of its Partner organisations. As such, the Board also recognises that day to day responsibility for managing the operations of the HIS should rest with the Management Board of the HIS, supervised by the HIS Partnership Board. Therefore, in so far as the HIS operates within the legal framework provided by the Trust, the Board delegates its powers over the authorisation and control of the day to day functions of the HIS to the HIS Management Board.~~

~~5.5.2 References to the Board and the Chief Executive in these Standing Orders, the 'Standing Financial Instructions' and the 'Reservation of Powers to the Board and Delegation of Powers' shall, in the context of the HIS, be read as referring to the HIS Management Board and the HIS Director, respectively. However, in SO 8.4 'Signature of documents',~~ references to the Chief Executive and Board shall continue to refer to the Trust's Chief Executive and Board. In addition, any agreement or other document which is required to be executed as a deed must be approved and properly executed in the name of the Trust in accordance with section 12 of these Standing Orders.

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" ~~"Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers~~ 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 ~~and approve~~ 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 ~~approve~~ 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 ~~Policy statements~~documents ~~that will each have effect as if incorporated in these Standing Orders~~:

- Standing Financial Instructions (SFIs) [RWF-OPPCS-NC-TM22]
- Reservation of Powers and Scheme of Delegation [RWF-OPPCS-NC-TM21]
- ~~Standards of Business Conduct and Conflicts of Interest Policy~~
- Gifts, hospitality, sponsorship and interests policy and procedure [RWF-XXX-XXX]
- Board of Directors Code of Conduct
- Disciplinary Policy and ~~Appeals~~ Procedures ~~adopted by the Trust both of which shall have effect as if incorporated in these Standing Orders.~~ [RWF-OPPPCS-NC-WF10]
- ~~Trust Procurement Policies~~

6.3 Review of Standing Orders

Standing O~~o~~rders shall be ~~regularly~~ reviewed annually~~by the Trust~~. 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 ~~Finance~~ 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 ~~Updated copies~~ shall be made available to all staff, via the Trust intranet~~, to staff designated by the Chief Executive~~.

7. Duties and obligations ~~of Board Members/Directors and Senior Managers~~ 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 ~~and Senior Managers~~ to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members ~~and Senior Managers~~ should declare such interests, as and when they arise, to the Trust Secretary. Any Board members ~~or senior Managers~~ appointed subsequently should do so on appointment, and as and when they arise (to the Trust Secretary).

II) ~~In relation to the duties and obligations outlined in section 7 'senior manager' is defined as an officer holding a senior managerial or senior clinical role with management responsibility~~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).

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 ~~charity or voluntary~~ organisation in the field of health and social care (i.e. separate to any position held at the Trust);

e) Any connection with an organisation that could be viewed as a direct competitor to the Trust in the field of health and social care

f) Any connection with a voluntary or other organisation contracting for NHS services (this would include being a minority shareholder in such organisations);

g) Research funding/grants that may be received by an individual or their department;

h) Interests in pooled funds that are under separate management.

i) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.

j) Appointment to a public office which may result in the individual's association with the Trust being made public. This could include, for example, election to a Parish Council.

k) Political affiliation which may result in the individual's association with the Trust being made public

(ii) Any ~~member of the~~ 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, ~~the Board member~~ 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 M~~m~~embers have any doubt about the relevance of an interest, this should be discussed with the Chairman of the Trust Board or with the Trust~~'s Company~~ 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

~~At the time~~ Trust Board M~~m~~embers'~~'~~ interests in the agenda item/s of particular Board meetings should be~~are~~ declared at the start of the relevant meeting, ~~they~~ and should be recorded in the ~~Trust Board~~ minutes.

~~Any changes in interests should be declared at the next Trust Board meeting following the change occurring and recorded in the minutes of that meeting.~~

7.1.5 Publication of declared interests in Annual Report

Trust Board Mmembers'' declared interests directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's Aannual Rreport. The interests to be published will be those declared at the end of the relevant financial year.information should be kept up to date for inclusion in succeeding annual reports.

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 Mmember concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (sSee overlap with SO 7.3)

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 or Committee Mmembers. 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 by both executive and non-executive Trust Board members.

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 ~~member of the~~ 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.

(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 ~~member of the~~ 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 ~~("the Regulations")~~, 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;

(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~~Standards of Business Conduct and Conflicts of Interest Policy and~~ , the national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff' (see Appendix Six~~annex B~~) , ~~-~~and the Bribery Act 2010.

A ~~Trust~~ Board of Directors Code of Conduct has been established to promote the highest possible standards of conduct and ~~behavior~~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 ~~in Contracts~~

i) ~~Any officer or employee of the Trust 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 SO 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust's Company Secretary as soon as practicable~~. The arrangements relating to interests of Trust Officers are covered via

the Gifts, Hospitality, Sponsorship and Interests Policy and Procedure [RWF-XXX]

ii) ~~An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust~~.

iii) ~~The Trust requires interests, employment or relationships declared, to be entered in a register of interests of staff.~~

7.4.3 Canvassing of and Recommendations by Trust Board Members in Relation to Appointments

i) Canvassing of ~~members of the~~ 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) ~~Members of the~~ 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 ~~and officer~~ of the Trust Board shall disclose to the Trust Secretary ~~Board~~ 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 ~~Chief Executive~~ to report to the Trust Board any such disclosure made.

iii) On appointment, ~~members~~ (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.

~~v) In order to protect the interests of both members of staff and the Trust, a confidential register is to be maintained by the Chief Executive or such senior officer as he may designate, listing all employees who have any pecuniary activities outside of their employment with the Trust, including such activities as other employment, directorships, consultant work, etc. It shall be the duty of all staff falling within these and similar categories to declare such activities and they will also be entitled to see what information is recorded against their name. The list may be limited to Board and Executive Management Team members and to those Senior Managers and other staff who occupy positions where they are able to influence the awarding of contracts.~~

7.5 Acceptance of gifts by staff ~~and link to Standards of Business Conduct and Bribery Act 2010 (See Trust Code of Conduct Policy and SO Annex B and overlap with SFI 12.2.6(d) and 21)~~

7.5.1 The ~~Finance~~ 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"~~'Code of Conduct policy' on acceptance of gifts and other benefits in kind by staff~~. This policy ~~is deemed to be an integral part of these Standing Orders and the Standing Financial Instructions and~~ 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.

~~**7.5.2** The guidance also refers to and permits small gifts and rewards to employees that may be given voluntarily where, within the course of their employment, have produced innovative work of significant benefit to the Trust and NHS as a whole.~~

~~**7.5.3** Employees are responsible for settling any income tax liability with the Inland Revenue that may result.~~

8. Custody of Seal, Sealing of documents and signature of documents

8.1 Custody of Seal

The common Sseal of the Trust shall be kept by the Trust Secretary ~~Chief Executive or a nominated Manager by him/her~~ 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 ~~Where~~ it is necessary for the ~~that a~~ document to ~~shall~~ be S~~s~~ealed, the S~~s~~eal shall be affixed in the presence of the Trust Secretary, and one member of the Executive Team~~two Senior Managers duly authorised by the Chief Executive, and not also from the originating department~~, and shall be attested by them. The member of the Executive Team should not be from the department from which the document arises. ~~Documents required to be signed under Seal shall be signed by the Chief Executive, or in his/her absence, the Deputy Chief Executive~~

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 ~~Chief Executive~~ shall keep a register in which he/she, ~~or another manager of the Authority authorised by him/her,~~ shall enter a record of the S~~s~~ealing 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~~Director~~.

8.4.2 The Chief Executive, ~~Finance~~ Director of Finance or other ~~Officer~~ member of the Executive Team shall be authorised, by resolution of the Trust Board, to sign on behalf of the Trust~~authority~~ any agreement or other document (not required to be executed as a D~~d~~eed, 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~~approved by the Trust Board or any committee or sub-committee of the Trust to which the Trust Board has delegated appropriate authority~~. 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 D~~d~~eed, 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 ~~Document Lead or~~ Author will send this ~~policy/procedural~~ document to the Clinical Governance Assistant who will publish it on the Trust intranet.

1.2 All staff will have access to a copy of the policy and procedure through the Trust's intranet site. ~~–~~A monthly table of Trust publications will be produced by the Clinical Governance Assistant; this will be published on the Bulletin Board (Trust intranet) under "Trust Publications", and a notification email circulated Trust wide by the COMMS team.

1.3 On receipt of the Trust wide Bulletin Board notification all managers should ensure that their staff members are aware of the new publications.

2.0 Review

The 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]

Maidstone and Tunbridge Wells NHS
NHS Trust

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 October 2015

Name: Name: *List key staff appropriate for the document under consultation. Select from the following:*	**Date sent**	**Date reply received**	**Modification suggested? Y/N**	**Modification made? Y/N**
Local Counter Fraud Specialist	10/09/15			
Chief Internal Auditor	10/09/15	13/10/15	Y	Y
Director of Finance	10/07/15			
Deputy Director of Finance	10/07/15			
Executive and other Directors	10/09/15			
Non-Executive Directors	10/09/15			
Risk Manager	10/09/15	22/09/15	Y	Y
Head of Information Governance	10/09/15			
Human Resources Business Partner	10/09/15			
Head of Finance Systems	10/09/15			
Head of SLA and Income	10/09/15			
Head of Financial Management	10/09/15			
Head of Procurement	10/09/15			
Financial Services Manager	10/09/15			
Financial Accountant	10/09/15			
Technical Team Leader	10/09/15			
Debt Management Team Leader	10/09/15			
Payables Team Leader	10/09/15			
Associate Directors	10/09/15			
HIS Managing Director				
Head of R&D – CLRN				
Head of Quality and Governance				
EME Services Manager				
Capital Planning Manager				
Local Security Management Specialist				
Staff side Representative	10/09/15			
Audit and Governance Committee	06/08/15	06/08/15	N	N
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

Maidstone and Tunbridge Wells NHS
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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 Orders
What are the aims of the policy or practice?	Financial Governance document
Identify the data and research used to assist the analysis and assessment	
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no).** **If yes give details.**
Males or Females	No
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak english as a first language	Yes (May have difficulty in understanding document, support / interpretation can be provided by the Trust Secretary on request)
People who have a physical disability	Yes (Sight impaired may have difficulty in reading document, a braille version can be provided on request)
People who have a mental disability	Yes (May have difficulty in understanding document, support can be provided by the Trust Secretary on request)
Women who are pregnant or on maternity leave	No
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	N/A
When will you monitor and review your EqIA?	At the same time as the Standing Orders document (annually)
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix Three~~3~~ of the Standing Orders documents on the Trust

~~Annex A~~

~~STANDING ORDERS - MONETARY VALUES~~

~~Para. 7.3.1 (iv)c Register of Interests for the Board and Committee members~~

~~A declaration in the Trusts Register of Interests should be made if Board members and senior managers relevant interests exceed £5,000 in nominal value or one per cent of the total issued share~~

~~Para 6.2 PROCEDURES REQUIRED WITHIN STANDING ORDERS~~

- ~~Standards of Business Conduct and Conflicts of Interest Policy~~
- ~~Disciplinary and Appeals Procedures~~
- ~~Trust Procurement Policies~~

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.

Maidstone and Tunbridge Wells NHS
NHS Trust

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 activity[2] 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 activities[2]

(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 Date:
Job title

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.

APPENDIX SIX
~~**Annex B**~~

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.

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

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 dear 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.

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – February 2016

2-19	**Summary report from the Quality Committee meeting, 01/02/16**	**Committee Chairman (Non-Exec. Director)**

The Quality Committee has met once since the last Trust Board meeting, on 01/02/16. The meeting was a 'deep dive', and covered 2 issues, as follows:

The Trust Lead Cancer Clinician attended, along with members of the Clinical Audit team, to give a report on the **findings from the National Clinical Audits relating to Cancer**

- The Committee was told that there were currently 5 national Cancer Clinical Audits in place (Bowel cancer audit, Head and neck cancer audit, National lung cancer audit, Oesophago-gastric (stomach) cancer audit, and National prostate cancer audit), each of which had evolved and developed independently, but then been brought under the umbrella of the Healthcare Quality Improvement Partnership (HQIP).
- Data was collected from Trusts and Cancer Centres throughout the UK, but the Audits were retrospective, and therefore the data that was reported was for 2 to 3 years before. For the Trust, the relevant data was collected via the "Infoflex" IT system, but the data primarily originated via the Multidisciplinary Team (MDT) meetings
- The national Clinical Audits were included in the Trust's rolling audit programme, and therefore an action plan was expected to be developed and acted upon. The Trust was included in some of the reports (which were publicly available) by name.
- The Trust's results on the Bowel Cancer Audit were generally very good - There was an extremely low 90-day mortality, and no 'red flags'. However, Length of Stay was worse than average, but the Committee heard that this finding had been discussed at the recent Cancer Summit, and further work was planned.
- The Trust was not specifically named in the latest (2015) Head and Neck Cancer Audit, but the Trust's performance was included within the findings for the "South East Cancer Network". The Network's performance was better than average except for recording performance status; comorbidity and pre-treatment staging; and the presence of a Clinical Nurse Specialist at diagnosis. It was however not clear whether this latter finding related to the situation at the Trust, or at the other Trusts in the Network. The published 1-year mortality for Head and Neck Cancer for the Network was higher (24.6%) than the national average (21.6%), and although the need to know the Trust's specific performance, was acknowledged as important, it was emphasised that establishing this was not straightforward.
- For the national Lung Cancer Audit, the Trust achieved all targets except for the percentage of patients being treated with Chemotherapy
- The national Oesophago-gastric Cancer Audit also presented its findings for Networks rather than specific Trusts (although there was Trust-specific data for case ascertainment and data completeness), and the Network's 90-day mortality rate was higher than average. However, since the Audit, the service had been relocated to London
- The national Prostate Cancer Audit showed that the results for the Network (Medway, which was the host for the west Kent Urology MDT meeting) were better than average
- The Committee then discussed the analytical resources available in the Cancer Directorate, and it was agreed that the Trust Lead Cancer Clinician would arrange for the Cancer Board to consider the establishment of a partnership with a local University, to enable a 'data scientist' role to be introduced at the Trust (to assist in data analysis)
- It was also agreed that the Trust Lead Cancer Clinician would provide members of the meeting with details of the Trust's performance on the National Head and Neck Cancer Audit (on condition that the organisers of the audit were able to provide Trust-specific data)

The Patient Safety Manager then attended for a **review of compliance with the statutory Duty of Candour** (the item had originated from a discussion at the Audit and Governance Committee)

- The Committee heard that although a Duty of Candour was not a new concept, a statutory duty was introduced as Regulation 20 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014. The Duty was also part of the NHS Standard Contract, and a requirements of the various clinical professions

- The Duty focused on the whole process of communication with patients and their families, although there were some specific process requirements in the Regulation, namely to provide a series of notifications and apologies (in person initially, then followed up in writing, within 10 working days of the incident being reported to local systems), and also provide the outcome or results of any further enquiries and investigations in writing. The Chief Nurse made the point that it would be reasonable to expect these steps to be undertaken for all Serious Incidents (SIs), but compliance was more challenging for "moderate" harm incidents
- The Committee then heard that some staff were resistant to the Trust's practice of issuing an apology at the outset of an incident (i.e. before the full details where known), but the point was made that such apologies were not an admission of liability. The importance of language was therefore emphasised, as was the need to avoid over-apologising to patients.
- Elements of good practice were however reported as being in place (as was illustrated by the communication in relation to the Trust's most recent Never Event)
- The Committee discussed the definitions relating to the Statutory Duty, namely those of "moderate" and "minor" harm, and the need to use judgement was acknowledged
- Audits of "moderate" harm had not been undertaken, but 2 audits had been undertaken for SIs, in July and December 2015. These showed that the percentage compliance with "apology offered in person" had reduced, from 80% to 75% (but it was noted that 100% compliance was not achievable, as for some SIs, such as Child Protection cases, it would be inappropriate to offer an apology in person). For the "Initial duty of candour letter sent" aspect, there had also been no improvement between the two audits (68% to 65%), but this was expected this to improve to nearer 100% in future. The performance for the "second duty of candour letter sent" had however improved markedly, from 4% in July to 32% in December, and it was heard that some patients and relatives wished to be informed of the outcome differently, and some had declined the offer of receiving written notification
- It was reported that there had been a recent increase in staffing within the central Patient Safety team (1.8 WTE), which would enable the Team to be more involved in the SI process from the outset, and provide greater support for Directorates.
- In summary, it was acknowledged that the subject was still an area of work in progress, rather than an area of full compliance. However, there was evidence to suggest that the Trust's performance was similar to other Trusts
- The Committee concluded that the Chief Nurse and Patient Safety Manager had demonstrated that a process was in place, but the Chair of the Committee expressed regret that such a process was required, in the face of the underlying principle behind the introduction of the Duty of Candour.
- The Chair of the Audit and Governance Committee was present at the meeting, and confirmed he had been assured by the information presented
- The Committee then confirmed its intentions to review the following **items at future 'deep dive' meetings:** "Critical Care" (April 2016) and "Paediatric care (with a focus on the non-elective pathway for children at both hospital sites)" (June 2016)

Which Committees have reviewed the information prior to Board submission?

- N/A

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

- Information and assurance

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

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – February 2016

2-21 Summary of the Trust Management Executive (TME) meeting, 17/02 Chief Executive

The TME has met once since the last Board meeting. The key items covered were as follows:

- In the **safety moment**, the Chief Executive highlighted the importance of promoting a culture in which all staff felt empowered to raise concerns, particularly in relation to patient deterioration.
- **Revised Terms of Reference** were approved. The revisions had been made to reflect the recent changes to the Committee structure (and in particular, to reflect the fact that the TME would now be the 'parent' committee for several of the former sub-committees of the Quality C'ttee, including the Clinical Governance C'ttee). The revised Terms of Reference are enclosed, for information.
- The key issues highlighted via the **reports from the Clinical Directors** were as follows:
  - Problems that had arisen with regards to Disclosure and Barring Scheme (DBS) checks of staff in Children's services had now been resolved, but it was agreed that the TME should receive a formal report on the process in place, and compliance with that process
  - As has been the case for several meetings, staffing issues were again were a theme for several Directorates, in relation to recruitment to specific posts and/or the continued usage of temporary staff. For one particular issue, the Chief Operating Officer reported that she continued to work with the Clinical Director for Trauma & Orthopaedics on ways to manage the continuing problems with their Junior Doctor rota
  - It was confirmed that the Trust had submitted a response to the tendering of Histopathology services in Medway (the outcome is due to be announced on 10/03/16)
  - A Quality Assurance visit of Maternity screening services was scheduled for June, but the Clinical Director gave assurance that she had no obvious concerns in advance of the visit
  - It was reported that the Trust had been unsuccessful in its bid to operate Sexual Health services in the Medway area (but the experience had been beneficial in terms of the preparation of future tender submissions)
  - It was noted that another circular had been issued by the Department of Health regarding the impact on consumables of the manufacturing process problems being experienced by Baxter Healthcare UK. The Cancer and Haematology Directorate have introduced temporary mitigations until the situation is resolved (which was likely to be May 2016)
- The latest **performance, for month 10**, 2015/16 was reported, which included the latest **financial performance**. The former included an update on the opening of the **new Ward at Tunbridge Wells Hospital**, and it was agreed that some time should be set aside at the TME meeting on 16/03/16 to discuss the configuration of capacity, following the opening of the Ward
- The latest position regarding **infection prevention and control** was reported, which included notification that the Trust's rate of hospital-attributable Clostridium difficile was the second lowest in the South East.
- The findings of the **national staff survey 2015** were reported, as was the latest update on progress in implementing **the Quality Improvement Plan** developed in response to the findings from the Care Quality Commission's (CQC) inspection
- The Director of Finance gave an update on **business planning, 2016/17**, which included the submissions that had been made to the NHS Trust Development Authority in February 2016
- The Deputy Chief Executive gave an update on the **development of the Sustainability and Transformation Plan** for Kent & Medway
- The **business cases** that had been recently-approved by the Investment Appraisal Group and/or Executive Team were noted, and the **Business Case for the transfer of Crowborough Birthing Centre & High Weald Community Midwifery Services** was reviewed, and supported
- Two **replacement Obstetrics and Gynaecology Consultants posts** were approved
- The latest **Board Assurance Framework** and **Risk Register** was reviewed, and it was agreed to submit a report to a future TME meeting to enable a review of red-rated risks
- Updates were received on the work of the **TME's existing sub-committees** (Capital meetings; Procurement Strategy Committee; Health & Safety Committee, Clinical Operations and Delivery Committee; Policy Ratification Committee; and Informatics Steering Group). Following the report

of the latter Group, it was agreed that a report should be submitted to a future TME meeting on the output of the prioritisation to be undertaken regarding the Trust's proposed future IT projects

- The Committee discussed the Annual Report from **Senior Information Risk Owner (SIRO)** (a role which is fulfilled by the Chief Nurse)
- A Patient Administration System **(PAS) transition strategy document** was reviewed, which related to implementation of the replacement PAS scheduled for later in 2016. The significance and scale of the undertaking was emphasised, but it was noted that this would be the Chief Operating Officer's third PAS implementation. The meeting also received a report formally closing the project in which the **Maternity IT system** was replaced
- Finally, it was noted that the CQC would be undertaking a further round of **inspections of Cancer Centres**, so the Trust would therefore be inspected at some future point

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

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

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

Maidstone and Tunbridge Wells NHS
NHS Trust

TRUST 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. 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)
- 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

2.2. 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 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 3 Clinical Directors.

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 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 Trust 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 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 TrustPerformance 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.
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 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, 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.

7.26 Review Business Cases, prior to review by the Finance Committee and 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 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)

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – February 2016

2-21	**Business Case re the transfer of Crowborough Birthing Centre & High Weald Community Midwifery**	**Chief Operating Officer**

At its meeting on 25/01/16, the Finance Committee received a report describing the due diligence that had been undertaken regarding the proposed transfer of Crowborough Birthing Centre & High Weald Community Midwifery Services. The due diligence outlined the investment that would be required. The Finance Committee duly supported the financial aspects of the transfer, subject to completion of the due diligence (particularly on maintenance, estate and staffing costs). It was however clarified that none of these issues were fundamental to the transfer going ahead.

The transfer was then formally approved by the Trust Board (subject to the completion of the due diligence not revealing any significant concerns), on 27/01/16.

The enclosed Business Case outlines the investment referred to in the due diligence. The Case was unable to be reviewed by the Investment Appraisal Group, as it was not finalised in time.

As the value involved requires the approval of the Trust Board (under the Trust's Standing Financial Instructions), the Trust Management Executive (TME) was asked to support the Case, and such support was duly given, on 17/02/16. The Finance Committee was also asked to provide its support, at its meeting on 22/02/16. The outcome of the Finance Committee's review will be reported to the Board as part of the summary report of the meeting (Attachment 16).

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive, 17/02/16
- Finance Committee, 22/02/16

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

Approval

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

Maidstone and Tunbridge Wells NHS Trust

Business Case

Transfer of Crowborough Birthing Centre and High Weald Community Midwifery Services

Issue date	17th February 2016
Department	Obstetrics
Directorate	Women's & Sexual Health
Author	Steve Williams
Clinical lead	Jenny Cleary
Executive Sponsor	Angela Gallagher
ID reference	

Approved by	Name	Signature	Date
General Manager			
Finance manager			
Clinical Director			
Executive sponsor			
Supported by	**Name**	**Signature**	**Date**
Director Estates & Facilities			
Director of Informatics			
HR Business Partner			
Approved by	**Name**	**Minute**	**Date**
Directorate Board			
Investment Appraisal Group			
Trust Management Executive			
Finance Committee			
Trust Board			

Contents

1. The Business Case Summary

Strategic context
The Crowborough Birthing Centre is a midwife-led service current run by East Sussex Healthcare NHS Trust who indicated in January that it was prepared to transfer the birthing centre and community midwifery service to MTW. Midwife-led care for low risk women has been shown to improve a range of clinical outcomes, reduce the amount of intervention in labour and increase satisfaction with care. In addition to being clinically effective, Midwifery led birthing centres are more cost-effective than consultant led birthing centres for standard deliveries because the national tariff for a delivery is the same regardless of location. The proposed service is consistent with Trust objectives in particular: • To become a truly patient and customer centred organisation • To deliver services that are viable and sustainable • To operate at high levels of quality and efficiency to generate long-term financial sustainability
Objectives of the investment and the problems with the status quo
This business case is concerned with the transfer of the existing service and staff and investment to ensure parity with MTW staffing levels. The objective therefore is to create an environment and culture in which the number of babies being delivered out of hospital can increase. Despite being a well-regarded service, the number of deliveries in a midwife led unit as a proportion of all births in the Crowborough catchment area is low. This creates unnecessary pressure on beds at TWH and is not cost-effective. By assuming responsibility for the Crowborough Birthing Centre and the High Weald community midwifery team, MTW will be able to actively promote the virtue of the midwifery led service and link in with NHS property services to improve the environment and ultimately patient experience.
The main benefits expected from the investment
There are numerous benefits associated with this investment including: • Provides women with a real choice of either a home birth, birthing centre or obstetric unit. • Improves financial contribution from maternity services. • Presents opportunity to shift deliveries of low risk pregnancies from TWH to the Crowborough Birthing Centre which is a more efficient approach. • Aligns community midwifery with MTW consultant led unit in High Weald. • Congruence with emergent clinical strategy.
The main risks associated with the investment

The key risks associated with this investment are as follows:

- Adoption of 3-part national tariff – The costing model assumes the 3-part national tariff for Antenatal, Delivery and Postnatal care will be adopted. A finance schedule provided by ESHT indicates a lower than expected income stream, a part of which was paid as part of a block contract.

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

- Increase in demand - Births at CBC may increase due to reduction in perceived risk of closure as a result of MTW taking over the management of the centre.

Available options

Option A - Do nothing. The Maternity services in the High Weald will remain as they are now, with the Crowborough Birthing Centre and Community Midwifery team managed by East Sussex Healthcare Trust.

Option B – Assume Responsibility for Crowborough Birthing Centre and Community Midwifery team. TUPE transfer the CBC and Community Midwifery team from 1st April 2016

Option C - Community Midwifery only. ESHT retains responsibility for Crowborough Birthing Centre and MTW assumes responsibility for the Crowborough Community Midwifery team only.

Option D – Refurbish First. ESHT retains responsibility for Crowborough Birthing Centre and the Community Midwifery team until the birthing centre has been refurbished.

The preferred option

Option B – Assume responsibility for Crowborough Birthing Centre and High Weald community midwifery service.

Funding, affordability	Revenue	£605,640
	Capital	(£90,837)

Management arrangements

The project to mobilise the transfer of services will be clinically driven via a Clinical Reference Group (CRG) chaired by the Head of Midwifery for MTW with a wide-ranging membership to oversee the due diligence and supported by a number of work streams to ensure a safe transfer by the 1st April 2016. The CRG reports to the Clinical Steering Group which has the following membership:

- Chair - COO, Angela Gallagher
- Clinical Reference Group Chair – HoM & CD for Womens & Sexual health Services, Jenny Cleary
- ESHT representative – Michelle Small, Business Manager / Jenny Crowe, HoM
- HR Lead – Richard Hayden
- Estates Lead - Jeanette Rooke
- IT Lead - Donna Jarrett
- Consultant Obstetrician – Shazia Nazir
- GP Representative - TBC
- Business / contracting /strategic Lead – Steve Williams
- Programme Manager – Steve Jones
- Project Manager – Susan Powley

The Strategic Case

2.1 Context

Strategic Case

Demonstrates that the case fits with current strategies and there is a strong case for change.

Opportunity

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

On 12th January, the East Sussex Hospitals Trust Board confirmed that it was prepared to transfer the Crowborough Birthing centre and Community Midwifery service to MTW.

This business case is concerned with the transfer of the existing service and staff and investment to ensure parity with MTW staffing levels. In due course, a further business case will be presented concerned with the refurbishment and reconfiguration of Crowborough Birthing Centre necessary to generate additional demand.

NICE Guidance

Midwife-led care for low risk women has been shown to improve a range of clinical outcomes, reduce the amount of intervention in labour and increase satisfaction with care. It is becoming an increasingly popular choice for women in the UK; with around 12,000 women (2%) each year having their baby in a 'free standing' midwife led unit (Birth Centre) and a further 12,000 having their baby at home. The National Institute for Clinical Excellence (NICE) recently published an updated version of the guideline Intrapartum care: Care of healthy women and their babies during birth (NICE, December 2014). In this guideline NICE recommends that all women with an uncomplicated pregnancy should be given the option of giving birth in a midwifery led unit (Birth Centre) as well as at home or in hospital, citing evidence from the Birth Place in England study (2011). This land mark study (which studied a total of 64,000 women), found that, for low risk women, birth is as safe for babies in a Birth Centre as it is in hospital, with the added benefit of reduced intervention for the mother, including lower rates of caesarean, instrumental birth and episiotomy.

Financial Incentive

In addition to being clinically effective, Midwifery led birthing centres are more cost-effective than consultant led birthing centres for standard deliveries because the national tariff for a delivery is the same regardless of location.

Links with Strategic Aims

This business case is consistent with the following strategic objectives of the Trust:

To become a truly patient and customer centred organisation - *"It's about really understanding the needs of our patients, caring for them in the right environment and getting the best outcomes for them".* Women have stated that "Proximity/location" is the overwhelming driver of choice to help them decide

where to have their baby. Local support for the unit is indicated by Chantal Wilson, Chairman, Friends of Crowborough Hospital, who said:

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

To deliver services that are viable and sustainable - *"We can do this by making MTW the first name that comes to mind when patients choose their care, no matter where they live or if it is highly specialised or routine treatment".* When the A21 dualling is completed, access times to TWH from North Kent and South East London Boroughs will improve which in turn is expected to increase demand. By increasing the proportion of patients seen at Crowborough, capacity will be made available at Pembury to accommodate the expected increase in demand.

To operate at high levels of quality and efficiency to generate long-term financial sustainability - "Making the very best use of our budgets to continue to provide the very best care for every patient we see". Midwifery led birthing centres are a cost-effective way of providing maternity care and the financial modelling within this business case has identified a positive contribution.

2.2 Case for change - business needs *Strategic Case*

The objective/s of the proposed investment

The objectives are as follows:

- Increase the proportion of women in the Crowborough catchment area who, in line with NICE guidance, choose to have their baby outside of a consultant led delivery unit.
- Increase the resilience to fluctuations in demand for delivery beds at TWH.
- Increase the contribution associated with the provision of maternity services.
- Increase the potential to develop more effective services (subject to future business case approval) in line with HOSC recommendations

The current situation

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

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

The Crowborough Birthing Centre (CBC) is a midwife-led service and has six beds, is open 24 hours a day and is run by a dedicated team of experienced midwives. The Centre offers complete ante-natal care, screening tests, parent education classes, as well as the option of having a home birth or birth centre birth. MTW accepts all emergency transfers from the Birth Centre as it is the nearest acute hospital.

Table 1 shows the number of deliveries in total and at MTW for the practices within the Crowborough catchment area. In 2014/15, there were 1,991 deliveries from the Crowborough catchment area of which

only 127 (6%) gave birth at CBC. In comparison, activity at Maidstone Birthing Centre (plus Homebirths) has grown and accounts for 15% of the births from the population in the Maidstone catchment area.

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

The national tariff for the maternity pathway provides a payment for both the delivery and non-delivery phase which for standard patients is as follows:

- Delivery Phase £1,795
- Antenatal Phase £1,161
- Postnatal Phase £ 274

Where women in the High Weald area choose to have their baby at TWH, MTW only receives the delivery phase payment.

The problems with the current situation

Birth numbers at Crowborough Birthing Centre have been in decline and account for only 6% of the activity in the Crowborough catchment area. In contrast, the Maidstone Birthing Centre accounts for 15% of the deliveries from the Maidstone catchment area. Furthermore, it is noticeable that MTW undertakes 97% of the deliveries from the West Kent CCG practices located in the CBC catchment area at Pembury Hospital.

The high proportion of women choosing Pembury Hospital over Crowborough Birthing Centre creates avoidable pressure on the existing bed stock at TWH Because the tariff for standard deliveries is the same regardless of where the delivery took place, this is not the most cost-effective use of acute beds.

Whilst the decline in numbers and negative impact this has is evident, it is necessary to understand the route cause behind the decline in numbers.

- MTW Community Midwives covering the Tunbridge Wells are less inclined to promote the virtue of a service provided by a different organisation.
- Evidence from MTW whereby women are choosing TWH at Pembury due to en-suite single room option where the partner can stay over.

2.3 Case for change - benefits *Strategic Case*

The investment generates a number of benefits including:

- **Increased income**. Financial analysis suggests that income expectation of £1,581k for the non-delivery phase and £263k for the delivery phase.
- **Increased contribution**. The expected costs of delivering this service are £1,238k which should generate a contribution of £605k.
- **Improved synergy with MTW.** An improved working relationship between MTW and CBC teams which will promote the use of CBC.
- **Reduce bed pressures.** By promoting the use of CBC, bed pressures at TWH should reduce.
- **Potential to increase cost effectiveness**. A reduction in the proportion of uncomplicated pregnancies at TWH will improve cost effectiveness.
- **Increased Job Satisfaction**. Job satisfaction is expected to improve due to increased confidence in the availability of services offered and continuity of care.
- **Better local services**. Local woman can deliver in their local unit, consistent with the objectives of the NHS 5 year forward view.

2.4 Case for change – risks *Strategic Case*

It is important to recognise that there are 2 phases to this programme. The first phase is to assume responsibility for Crowborough Birthing Centre and the High Weald Community Midwifery Team, and the second phase relates to changes required to increase activity. This business case is concerned with phase 1 – assuming responsibility for Crowborough.

The risks associated with this proposal include:

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

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

2.5 Constraints *Strategic Case*

Timelines

The target date for commencing the service is 1st April 2016 although it is recognised that this go-live date will only proceed if the service is ready and safe to do so.

Resource availability

Meeting the target go-live date is resource intensive in a number of areas and requires the following:

- Dedicated project manager. To support the project throughout the mobilisation period.
- Operational management. To specify service requirements (Equipment and IT) and amend/implement changes to the operational policies.
- IT Support. Equipment needs to be purchased and staff trained on how to use it. This is a considerable concern given the uncertainty surrounding the HIS.
- HR. Staff need to be consulted as part of the TUPE transfer.

2.6 Dependencies *Strategic Case*

Commencing the service by 1st April 2016 is dependent upon the following:

- Business Case agreement at TME in order to fund the individual components

- IT
    - Evaluation of IT required
    - Transfer or purchase new equipment
    - Training in use of IT
    - KMHIS resources

- Equipment
    - Fit for purpose evaluation of existing equipment retained by CBC or offered by ESHT
    - Evaluation of equipment required
    - Transfer or purchase new equipment

- Operational
    - Safeguarding and Escalation operational policies must be updated including
    - Clarification of provision from support services
    - Training including MTW staff familiarisation
    - Agreement of rotas

- HR
    - Due diligence
    - TUPE process completed

- Finance
    - Clarify SLA assumptions with commissioners

- Estate
    - Confirm role of NHS Property Services Ltd regarding hard and soft FM.
    - SLA agreement with NHS Property Services

- Procurement
    - Securing the requisite equipment in time for go-live.

2.7 Statements of support from stakeholders *Strategic Case*

In a joint statement on 10 November 2015, HWLH CCG, ESHT and MTW announced they had reached agreement in principle to move the management of maternity services provided within the High Weald area, including those at CBC, to MTW; to help provide a more seamless maternity service for women in that area.

3. The Economic Case

3.1 The long list of options

Economic Case

Options are assessed against the following Objectives and Critical Success Factors:

I. Increase the proportion of women in the Crowborough catchment area who, in line with NICE guidance, choose to have their baby outside of a consultant led delivery unit.
II. Increase the resilience to fluctuations in demand for delivery beds at TWH.
III. Increase the contribution associated with the provision of maternity services.
IV. Increase the potential to develop more effective services (subject to future business case approval) in line with HOSC recommendations
V. Achievable
VI. Affordable
VII. Strategic fit

Option	Objective				CSF			Outcome
	I	II	III	IV	V	VI	VII	
Scope								
Do Nothing	×	×	×	×	✓	✓	?	*Carry forward*
Crowborough Birthing Centre & High Weald Community Midwifery team	✓	✓	✓	✓	✓	✓	✓	*Preferred*
Community Midwifery team only	✓	✓	✓	✓	×	✓	✓	*Carry forward*
Crowborough Birthing Centre only	✓	✓	×	?	×	×	?	*Discount*
Delivery Method								
Existing MTW to undertake all new activity in High Weald	✓	✓	✓	✓	×	✓	✓	*Discount*
Subcontracted ESHT staff to undertake activity	×	×	✓	×	✓	✓	×	*Discount*
TUPE ESHT staff into MTW & recruit to vacancies	✓	✓	✓	✓	✓	✓	✓	*Preferred*
Implementation Method								
Assume responsibility from 1st April, refurbish Autumn 16	✓✓	✓	✓✓	✓	✓	✓	✓	*Preferred*
Assume responsibility from 1st April, refurbish in Spring 16	✓✓	✓	✓✓	✓	×	✓	✓	*Discount*
Refurbish CBC then assume responsibility post refurbishment	✓✓	✓	✓	✓	×	✓	✓	*Carry forward*
Assume responsibility once vacancies recruited to – Summer 16. Refurb Winter 16.	✓	✓	✓	✓	×	✓	✓	*Discount*
Funding								
MTW Capital & Revenue	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	×	✓	*Discount*
NHS Propco Capital & MTW Revenue	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	✓	✓	*Carry Forward*
NHS Propco & CHLOF Capital & MTW Revenue	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	✓✓	✓	*Preferred*

The shortlist carried forward is as follows:

Option A – Do nothing

Do Nothing.

Option B (Preferred) – CBC & Community Midwifery

TUPE transfer the staff working in the Crowborough Birthing Centre & Community Midwifery Team from 1st April 2016 and assume responsibility for the whole midwifery service in the High weald.

Option C (More Ambitious) – Community Midwifery only

As the Community Midwifery service is the profit making part of the service, the Birthing Centre remains the responsibility of East Sussex Healthcare Trust with MTW assuming responsibility for the Crowborough Community Midwifery team.

Option D (Less Ambitious) – Refurbish first

Seek capital funding from NHS Property Services and Crowborough Hospital League of Friends to modernise the birthing centre before assuming responsibility for the staff and service.

3.2 The short list of options

Economic Case

Option A - Do nothing

- *Description*: Maternity services in the High Weald remain as they are now, with the Crowborough Birthing Centre and Community Midwifery team managed by East Sussex Healthcare Trust.

- *SWOT*:

Strengths	**Weaknesses**
• Managerial capacity.	• Does not secure improved contribution for maternity services. • Does not address bed pressures at TWH. • Will not increase the proportion of women choosing to have their baby outside of a consultant led birthing unit.
Opportunities	**Threats**
• Encourage Tunbridge Wells women to utilise Maidstone Birthing Centre.	• Service could be taken over by competitor Trust. • Loss of credibility with HWLH CCG regarding future services.

- *Discounted or Possible*: Discount. This solution fails to address the issue of women with uncomplicated pregnancies choosing TWH. This option does not encourage the most cost-effective use of resources and fails to improve the contribution to overheads.

Option B (Preferred) – CBC & Community Midwifery

Description: TUPE transfer the staff working in the Crowborough Birthing Centre & Community Midwifery Team from 1st April 2016 and assume responsibility for the whole midwifery service in the High weald. Modernisation of Crowborough Birthing centre to be sought subsequently using

capital funding from NHS Property Services and Crowborough Hospital League of Friends from Autumn 16.

- *SWOT*:

Strengths	Weaknesses
• Increased contribution to overheads. • Greater continuity with a single provider for the whole pathway.	• Existing midwifery staffing levels in High weald. • Lack of control over CBC estate.
Opportunities	**Threats**
• Increase the proportion of uncomplicated pregnancies being delivered away from TWH. • Potential access to capital through NHS Property Services	• Dependency on IT solutions. • Dependency on NHS Property Services for access to capital.

- *Discounted or Possible:* Preferred.

Option C (More Ambitious) – Community Midwifery only

- *Description:* the Birthing Centre remains the responsibility of East Sussex Healthcare Trust with MTW assuming responsibility for the Crowborough Community Midwifery team.

- *SWOT*:

Strengths	Weaknesses
• Increased contribution to overheads. • No estate issues to be addressed.	• Fragment existing team which is currently integrated. • Lack of influence regarding modernisation of the birthing centre.
Opportunities	**Threats**
• Increase the proportion of uncomplicated pregnancies being delivered away from TWH.	• Service could be taken over by competitor Trust. • Loss of credibility with HWLH CCG regarding future services. • Acceptability to ESHT who will retain responsibility for the loss making Birthing Centre.

- *Discounted or Possible:* Discount – ESHT and the CCG are unlikely to support this proposal and the approach will fragment the existing team.

Option D (Less Ambitious) – Refurbish first

- *Description:* Crowborough Seek capital funding from NHS Property Services and Crowborough Hospital League of Friends to modernise the birthing centre before assuming responsibility for the staff and service.
- *SWOT:*

Strengths	Weaknesses

• Increased contribution to overheads. • CBC is modernised before increase in numbers makes temporary closure more difficult to accommodate.	• Increase in contribution will be delayed. • Lack of influence regarding modernisation of the birthing centre.
Opportunities • Increase the proportion of uncomplicated pregnancies being delivered away from TWH.	**Threats** • Newly refurbished unit may attract competitor interest. • Loss of credibility with HWLH CCG regarding future services. • Acceptability to ESHT who will retain responsibility for the service until the refurbishment is complete.

- *Discounted or Possible:* Discount – ESHT and the CCG are unlikely to support this proposal which would compromise the ability to secure the funds for the modernisation programme.

3.3 Option appraisal

Economic Case

Option Appraisal. Why the preferred option optimises value for money (VFM)

	Note	Option A	Option B	Option C	Option D
		Do Nothing	**CBC & Com Midwifery**	**Com MidW Only**	**Refurb first**
Capital					
Estates & Facilities*		£0	£0	£0	£0
ICT	Appendix A1	£0	-£43,039	-£5,810	-£43,039
Equipment**	Appendix A2	£0	-£73,330	-£11,686	-£73,330
Capital – Sub-total		**£0**	**-£90,837**	**-£17,496**	**-£90,837**
Revenue					
Income	Appendix A3	£0	£1,843,242	£1,580,727	£1,843,242
Pay	Appendix A4	£0	-£1,008,190	-£504,095	-£1,008,190
Non-pay	Appendix A5	£0	-£229,412	-£114,706	-£229,412
Revenue – Sub-total		**£0**	**£605,640**	**£961,926**	**£605,640**
Cost of risk***		£0	-£244,634	-£1,264,582	£921,607
Total cost		**£**	**£361,006**	**-£302,656**	**-£315,995**
Benefits (non-financial) score	Appendix B	15	80	50	70
Risk (non- financial) score	Appendix B	56	40	71	33

* **Estates & Facilities Capital** - Crowborough Birthing Centre was transferred from ESHT to NHS Property Services in November 15. Estates & Facilities costs will be funded as part of lease with NHS Property Services. Day to day maintenance of buildings are undertaken in accordance with landlord obligations.

** **Equipment –** As a functioning unit, the Crowborough Birthing Centre has a wide range of equipment purchased by either East Sussex Hospitals NHS Trust or the Crowborough Hospital League of Friends. For the purpose of this business case, and in the interests of prudence, it has been assumed that all the equipment will be replaced. However ESHT have agreed that MTW can purchase their equipment and the items purchased by the League of Friends (c£10k) will remain at Crowborough. The capital outlay within this business case is therefore overstated and will be refreshed as part of the fit-for-purpose review of the equipment currently being undertaken.

*** **Cost of risk assumptions –**

- **Option B -** 20% probability of the High Weald Lewes & Havens CCG not adopting the 3-part national tariff for maternity services. Impact is a net reduction in income of £1,223,170. Risk value calculated as 0.2 x £1,223,170 = £244,634

- **Option C –** 80% probability of East Sussex Hospitals Trust and/or the High Weald Lewes & Havens CCG refusing to the transfer of just the Community Services. Impact is a net reduction in revenue from £1,580,727. Risk value calculated as 0.8 x £1,580,727 = £1,264,582

- **Option D** – 50% probability of East Sussex Hospitals Trust and/or the High Weald Lewes & Havens CCG refusing to the transfer of just the Community Services. Impact is a net reduction in revenue from £1,843,242. Risk value calculated as 0.8 x £1,843,214 = £921,607

3.4 The preferred option *Economic Case*

The preferred option is Option B: Assume Responsibility for Crowborough Birthing Centre and Community Midwifery team. The reasons for this preference are as follows:

- Provides women with a real alternative to consultant led birthing centres.
- Improves financial contribution from maternity services.
- Presents opportunity to shift deliveries of uncomplicated pregnancies from TWH to the Crowborough Birthing Centre which is a more efficient approach.
- Aligns community midwifery with consultant led unit in High Weald.
- Congruent with emergent clinical strategy.
- Has wide stakeholder support.

Services and/or assets required

- **Building** - Crowborough Birthing Centre was transferred from ESHT to NHS Property Services in November 15. Form 1st April, MTW will become their tenant. The Birthing Centre will therefore not be listed on the MTW asset register.

- **Equipment** – As a functioning unit, the Crowborough Birthing Centre already has a wide range of equipment purchased by either East Sussex Hospitals NHS Trust or the Crowborough Hospital League of Friends. ESHT have agreed that MTW can purchase their equipment and the items purchased by the League of Friends will remain at Crowborough. The equipment is currently being reviewed by the Operations department and EME to assess its fitness for purpose. After this review it will become clear what new equipment is required. For the purpose of this business case, and in the interests of prudence, it has been assumed that all the equipment will be replaced.

- ***IT –*** There will be a requirement to replace or add to the existing IT equipment at CBC. An initial review has identified that staff following MTW processes will be required to enter more records electronically than at present which will necessitate additional computer access, for example in consulting rooms used for antenatal appointments. The capital requirements have been incorporated within the business case.

Activity and service level agreement (SLA) implications

HWLH CCG have been notified that the 3-part NHS tariff will apply and IT/training needs have been identified which will support the activity data capture.

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

Workforce impact

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

Estates impact

Crowborough Birthing Centre is in need of modernisation – but is essentially safe. The Birthing Centre will be owned by NHS Property Services who will be MTW's landlords responsible for providing hard and soft FM. As a tenant, MTW cannot access its own capital to fund developments in Crowborough Birthing Centre. Capital spend undertaken by NHS Property Services falls into two categories:

- Landlord spend - defined as day to day maintenance of buildings in accordance with landlord obligations.

- Customer spend - defined as that which is required to fund strategic works such as major refurbishments, change of use, re-modelling of floor layouts, and new builds requested by customers.

The Estates & Facilities management team have visited CBC as part of the due diligence process and identified a few issues which needed to be addressed including the removal of a sink from the cleaning/electrical room and fixing 2 fire door alarms. These issues have been taken to NHS Property Services who have since raised work orders with Sussex Community Trust (the hard FM contractor) to address. A draft lease been agreed providing Hard & Soft FM

Impact on other directorates

Because TWH is considered the local obstetric unit to the population from the High weald, the impact on other directorates is not considered to be material.

4. The Financial Case

4.1 Sources of organisational funding *Financial case*

Capital

This scheme is a key Trust priority. The directorate is looking for central funding from the trust to cover the initial capital cost pressure, recognising that the trust will be assessing the existing equipment being made available by ESHT and the Crowborough Hospital League of Friends.

Longer term, MTW will be working with NHS property services and High weald Lewes Havens CCG to access "customer-spend" capital held by NHS property services. This resource is available to fund strategic works such as major refurbishments, change of use, re-modelling of floor layouts, and new builds requested by customers. In addition, the Crowborough Hospital League of Friends have offered to match fund any capital developments up to £130k.

Revenue

The revenue costs are covered by the income generated under the 3-part national tariff.

4.2 Costs and affordability *Financial case*

The following assumptions have been made in calculating the costs associated with this business case:

- **Activity** - Circa 800 births per annum from the High Weald practice population.
- **Complexity** - The complexity profile (standard, intermediate, intensive) of women in High weald is the same as West Kent currently served by MTW
- **PbR** - CCG adoption of the 3-part national tariff
- **CBC Deliveries** - The number of deliveries at CBC does not increase. This would necessitate an additional midwife working nights whereas the current caseload does not justify increased staff.
- **National caseload guidelines** - The recommended caseload per midwife remains 120.
- **Uplift** - 22% uplift has been incorporated to cover annual, sickness and maternity leave.
- **Management Time** - Management time of 0.4 WTE Band 7 is required to support the transition and replace the management support previously provided by ESHT.
- **Midwifery Supervision** - The Nursing & Midwifery Council stipulate that all midwives are required to have a supervisor allocated to them and recommend a caseload of 15 midwives per supervisor. An additional 0.1 WTE Band 7 is therefore required to provide the requisite supervision time. As 2 of the members of the Crowborough team are supervisors, this will also help MTWs supervision team to reach this target.
- **Sonography** - 0.4 WTE Band 7 Sonography provision is required to ensure patients have access to the requisite tests. Nationally, there is a shortage of sonographers so as part of the workforce plan, community midwives are being trained to provide this service. This will help ensure tests are carried out in the community.
- **Specialist Support** – Additional 1 WTE Band 7 is required to provide the specialist services as follow:
    - Safeguarding,
    - Infant Feeding,
    - Screening

5. The Commercial Case

5.1 Procurement route

Commercial case

Following the agreement from our own board in January, the East Sussex Healthcare NHS Trust Board agreed on the 11th February 2016 to the transfer of the management of maternity services in the High weald area, including Crowborough Birthing Centre to MTW.

6. The Management Case

6.1 Programme structure *Management case*

Appendix C illustrates the governance structure with regard to the delivery of this project. The project to mobilise the transfer of services will be clinically driven via a Clinical Reference Group chaired by the Head of Midwifery for MTW with a wide-ranging membership to oversee the due diligence and supported by a number of work streams to ensure a safe transfer by the 1st April 2016. The CRG will report to and exec led Steering Group chaired by the Chief Operating Officer.

6.2 Project management arrangements *Management case*

Steering Group – Roles & Responsibilities

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

- To drive the project forward and deliver the objectives and benefits of the Project as identified in the business case. Ensure the project is delivered on time and within budget
- Test that Project objectives are appropriately defined and owned consistently throughout the delivery structure and that those objectives remain aligned to the Trust's strategic objectives;
- To direct, develop, agree, monitor and maintain a clear plan of action and delivery via the Clinical Reference group, reporting into it:
    - Agree the governance structure, terms of reference and membership
    - Ensure that required resources are committed to the project
    - Ensure the project remains within any constraints
    - Approve project documentation, including the Project Mandate, Deployment Plan Document, Risks and Issues Log and End Project Report
    - Agree the project plan, time frames and potential constraints. Ensure that the Project is monitored, timetables are managed and that obstacles are removed that may delay its delivery
    - Ensure that Risks and Issues are managed appropriately identify mitigating actions, with all significant red risks being identified to the TME
    - Ensure that a full Quality Impact Assessment has been undertaken and supported by all parties prior to implementation.
- Establish the Clinical Reference Group, set up and oversee the work of the relevant working groups as required to deliver the project within the agreed time-scale
- Ensure that the needs of stakeholders are appropriately represented throughout the delivery structure
- Receive and consider progress reports from the Clinical Reference Group and act, when required, upon its recommendations
- Make recommendations to TME on the information needed by them, to provide the necessary assurances that the Project will deliver as planned

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

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

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

Clinical Reference Group – Roles & Responsibilities

The key roles and responsibilities of the CRG in respect of governance are:-

- To deliver the objectives of the Project as identified above and the benefits as identified in the business case
- Ensure the project is delivered on time and within budget
- Agree CRG terms of reference and membership
- Establish the Clinical Reference Group and any working groups as required to enable progression of the project
- To develop, agree, monitor and maintain a clear project plan covering all aspects of the project and within agreed time frames and potential constraints
- Ensure that the Project is monitored, timetables are managed and that obstacles are removed that may delay its delivery
- Develop project documentation, including, Deployment Plan, Risks and Issues log, Progress Reports and End Project Report
- Ensure that Risks and Issues are managed appropriately, identifying mitigating actions, with all significant risks being identified to the Steering group
- Undertake a full Quality Impact Assessment and ensure it is supported by all parties prior to implementation
- Ensure that the Clinical Reference Group has representation from all stakeholders to allow a comprehensive understanding of how the clinical service is to be delivered
- Develop progress reports against the comprehensive project plan and submit them into the steering group via the Chair of the CRG.
- Make recommendations to the steering group on the information needed by them to provide the necessary assurances that the Project will deliver as planned

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

6.3 Quality Impact Assessment (QIA) *Management case*

Clinical Effectiveness
Have clinicians been involved in the service redesign? If yes, list who.
Yes. Jenny Cleary: Head of Midwifery and Interim Director for Women's & Sexual Health Services. Consultants and Midwives in High weald.
Has any appropriate evidence been used in the redesign? (e.g. NICE guidance)
Yes: Nice guidance (CG190 Dec. 14). According to NICE, the evidence from the Birthplace study now shows midwife-led units to be safer than hospital for women having a straightforward (low risk) pregnancy. Its updated guidance also confirms that home birth is equally as safe as a midwife-led unit and traditional labour ward for the babies of low risk pregnant women who have already had at least 1 child previously.
Are relevant Clinical Outcome Measures already being monitored by the Directorate? If yes, list. If no, specify additional outcome measures where appropriate.
Yes: Full set of outcome measures as required by the TDA and reported on Trust Performance dashboard including: • Infant health and inequalities; breastfeeding (CQC definition - in hosp beds) • C-Section rate

• Stillbirths Rate (%) • Data Quality on Ethnic Groups • Mothers Delivered by site (Home/CBC/Hospital)
Are there any risks to clinical effectiveness? If yes, list
Yes: Current staffing levels inability to cover unexpected leave which results in potential closure of the birthing centre. The service relies heavily on bank staff.
Have the risks been mitigated?
Yes: Business case includes additional staffing to ensure parity with MTW staffing ratio. Operational policies have been reviewed to provide increased cover if required during periods of high clinical activity.
Have the risks been added to the departmental risk register and a review date set?
No: This is not a risk until the business case has been approved.
Are there any benefits to clinical effectiveness? If yes, list
Yes: According to NICE (CG190 December 14), the evidence now shows midwife-led units to be safer than hospital for women having a straightforward (low risk) pregnancy.
Patient Safety

Has the impact of the change been considered in relation to:	
Infection Prevention and Control?	Y
Safeguarding vulnerable adults/ children?	Y
Current quality indicators?	Y
Quality Account priorities?	N
CQUINS?	Y

Are there any risks to patient safety? If yes, list
There are no perceived risks to patient safety. The birthing unit serves the population of the High Weald in which many women regard MTW as their local obstetric unit. MTW already accept all emergency transfers from the Birth Centre as it is the nearest acute hospital with robust transfer policies and processes in place.
Have the risks been mitigated?
Operational policies are in the process of being updated including the escalation policy and safeguarding.
Have the risks been added to the departmental risk register and a review date set?
No: This is not a risk until the business case has been approved.
Are there any benefits to patient safety? If yes, list
Yes: According to NICE (CG190 December 14), the evidence now shows midwife-led units to be safer than hospital for women having a straightforward (low risk) pregnancy.
Patient experience
Has the impact of the redesign on patients/ carers/ members of the public been assessed? If no, identify why not.

Yes: Ongoing dialogue with Crowborough league of friends and an engagement event in Crowborough to seek views on how we can develop and improve the maternity services offered to women in the area. The session centred on a game called "Whose Shoes" which, through discussion of a wide range of topics and scenarios, helps participants explore key local issues and identify opportunities for development and change. A wide range of topics were discussed, including understanding stillbirth, valuing staff, improving communication, developing community services, use of medical terminology continuity of care, building relationships, self-preparation and different cultural groups.
Has the impact of the change been considered in relation to: • Promoting self-care for people with long-term conditions? • Tackling health inequalities?
No:
Does the redesign lead to improvements in the care pathway? If yes, identify
Yes: The closer relationship with Crowborough Birthing Centre should lead to more women choosing to have their baby outside of Hospital. With the service rated as "Excellent" in the friends and family test and NICE guidance indicating that midwife-led units are safer than hospital for straightforward (low-risk) pregnancy, this will improve the patient experience.
Are there any risks to the patient experience? If yes, list
Yes: Crowborough is a well-regarded service, rated as "Excellent" in the friends & family test. However, the number of deliveries as a percentage of births in the Crowborough catchment area is low with women currently choosing the single room with en-suite facilities at the Tunbridge Wells Hospital at Pembury.
Have the risks been mitigated?
Yes: Women who choose not to have their baby in the Midwife led birthing centre are likely to have their baby in Tunbridge Wells Hospital. Longer term, the objective will to refurbish Crowborough Birthing centre to encourage more women to have their baby in a Midwife led unit.
Have the risks been added to the departmental risk register and a review date set?
No.
Are there any benefits to the patient experience? If yes, list
Yes: The Patient experience of birthing centres is excellent with both Crowborough and Maidstone rated as "Excellent" in the friends & family test. The strategy for the unit is to increase birthing numbers.
Equality & Diversity
Has the impact of redesign been subject to an Equality Impact Assessment?
Yes.
Are any of the 9 protected characteristics likely to be negatively impacted? (If so, please attach the Equality Impact Assessment)
No.

Has any negative impact been added to the departmental risk register and a review date set?					
No.					
Service					
What is the overall impact on service quality? – please tick one box					
Improves quality	✓	Maintains quality		Reduces quality	
Clinical lead comments					

6.4 Outline project plan and timetable *Management case*

Key phases of the project plan are as follows:

1	**Set up clinical reference group and steering group**	**25th Dec**
2	Undertake a **due diligence assessment for** MTW to take on the birthing unit at Crowborough hospital, along with the associated community maternity service.	**27th Jan**
3	Develop the necessary **business case** to identify all necessary costs including project cost, to enable appropriate budgets to be set.	**22nd Feb**
4	**Develop all policies and procedures** to be in place for the new unit covering all clinical, administrative, hard and soft FM services.	**25th Mar**
5	**All staff affected have been TUPE'd across to MTW in a timely way**	**25th Mar**
6	Ensure that all **MTW IT systems are in place and fully operational to** capture and monitor activity and help with clinical decision making.	**25th Mar**
7	**Equipment has been purchased**, tested, staff trained and operationally ready	**25th Mar**
8	All patients are fully aware of the new service and there is **excellent local communication** concerning access and service delivery for patients, local GPs and all other affected clinicians	**19th Feb**
9	The **physical environment is appropriate to meet the needs of the patients and staff.**	**25th Mar**
10	ALL necessary **Service Level Agreements are in place covering the maternity service** along with agreed contract activity levels and KPI's	**18th Mar**
11	**Confirm soft FM service commissioning plan and set up for birthing unit**	**25th Mar**
12	**Risk mitigation**	**18th Mar**
13	**Monitoring and Audit**	**18th Mar**

The overall project plan is in appendix D.

6.5 Training arrangements *Management case*

On-going training and development is crucial to the success of this service. Training has been scheduled within the project plan in the following areas:

- Training Assessment by Clinical Skills Facilitator

- Training and orientation of staff on new policies and procedures
- Training of all staff (incl. community midwifery staff) on the use of PAS and data systems
- Familiarisation training of MTW staff of the Crowborough Birthing Centre
- Training of staff on any new equipment purchased

6.6 Business assurance and benefits realisation arrangements *Management case*

The benefits identified within the Outline Business Case (OBC) and set out below will be monitored throughout the development of the scheme, via project evaluation reviews (PER) and post implementation reviews (PIR), to maximise the opportunities for them to be realised.

6.7 Risk management and contingency plans *Management case*

The project uses a standard MTW risk matrix scoring to develop a project risk register. The risk register can be found in appendix E

6.8 Arrangements for post project evaluation *Management case*

Post Project Evaluation (PPE) will be undertaken to improve future project briefing, project management, and implementation for future projects. It will also be used to measure the performance of the completed facility against the benefits identified within this Business Case.

Version history

Version	Issue date	Brief Summary of Change	Owner's Name

Pre- submission checklist

Item	Complete
Completed fully signed business case template	Yes/no
Revenue breakdown completed	Yes/no
Capital breakdown completed	Yes/no
Supporting statements from stakeholders attached	Yes/no
Quality impact assessment completed	Yes/no
Commissioner support agreed	Yes/no
Appendices attached	Yes/no

Maidstone and Tunbridge Wells Hospitals

Crowborough Birthing Centre Business Case
Finance - Summary

	Note	Option A	Option B	Option C	Option D
		Do Nothing	**CBC & Com Midwifery**	**Com MidW only**	**Refurb**
Capital					
Estates & Facilities*		£0	£0	£0	£0
ICT	Appendix A1	£0	-£43,039	-£5,810	-£43,039
Equipment	Appendix A2	£0	-£73,330	-£11,686	-£73,330
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Total cost		**£0**	**£361,006**	**-£302,656**	**-£315,995**
Benefits (non-financial) score	Appendix B	15	80	50	70
Risk (non- financial) score	Appendix B	56	40	71	33

* - There are no E&F capital requirements

Crowborough Birthing Centre Business Case
Capital - ICT

Capital Purchases	Units	Unit Cost £	Total Cost £	Total Cost £	Total Cost £
PC/Phones					
Phones 7945	2	£278	£556		
Phones 7921	4	£160	£641		
Phones 7925	5	£370	£1,850		
Phone multicharger	1	£232	£232		
ATA190	1	£116	£116		
Red phone	1	£180	£180		
Wristband printers	1	£440	£440		
PC	5	£951	£4,755		
				£8,771	
Nursing Obs					
Ipad + cases	10	£197	£1,968		
NerveCentre	10	£759	£7,590		
				£9,558	
Build					
Phones	12	£188	£2,250		
PCs	5	£675	£3,375		
				£5,625	
Community Mid-Mobile					
Surface tablet / keypad / pen	10	£550	£5,500		
Case	10	£31	£309.50		
				£5,810	
Infrastructure Network					
Patch Panels	1	£75	£75		
Racking	1	£1,000	£1,000		
Switches	1	£6,000	£6,000		
Cables Cat5	10	£20	£200		
Access Points & Wireless	1	£4,500	£4,500		
UPS & PDU	1	£1,500	£1,500		
				£13,275	
Total Cost (Incl. VAT)					**£43,039**

Supported by:

	Name	Signature	Date
ICT Project Manager	K Rowe		
Director of ICT	DM Jarrett		

Maidstone and Tunbridge Wells Hospitals

Crowborough Birthing Centre Business Case
Capital - Equipment

	Units	Unit Cost £	Total Cost £	Total Cost £	Total Cost £
Operational					
Delivery Room - Corner Bath					
Bed	1	£684	£684		
TV	1	£552	£552		
Towel Rack	1	£30	£30		
Chairs x 2	2	£240	£480		
Bean Bag	1	£296	£296		
Bedside Cabinet	1	£96	£96		
Stool	1	£191	£191		
trolley	1	£433	£433		
Sonicaid	1	£408	£408		
Sphyg	1	£72	£72		
Howes Mirror	1	£30	£30		
Oscillating fan	1	£360	£360		
Bins	1	£127	£127		
				£3,759.30	
Delivery Room - Fixed Pool					
Bradbury couch	1	£684	£684		
TV	1	£552	£552		
Towel Rack	1	£30	£30		
Chairs x 2	2	£240	£480		
bean Bag	1	£296	£296		
Bedside cabinet	1	£96	£96		
Stool	1	£191	£191		
Trolley	1	£433	£433		
Sonicaid	1	£408	£408		
Sphyg	1	£72	£72		
Howes Mirror	1	£30	£30		
Oscillating fan	1	£360	£360		
Bins	1	£127	£127		
				£3,759.30	
Lobby area outside delivery rooms					
Resuscitaire	1	£10,680	£10,680		
CD Cupboard	1	£700	£700		
Baby Scales	1	£406	£406		
Mobile drawer storage unit	1	£360	£360		
Drug fridge	1	£299	£299		
Entonox trolleys	4	£84	£336		
Defib	1	£360	£360		
				£13,140.00	
Sluice					
Built in cupboard & drawer unit	1	£360	£360		
Bins	3	£127	£382		
Linen skip	1	£71	£71		
Scales for blood estimation	1	£144	£144		
				£956.40	
Kitchen (small)					
Fridge (domestic)	1	£180	£180		
Steriliser	4	£18	£72		

Maidstone and Tunbridge Wells Hospitals

Crowborough Birthing Centre Business Case
Capital - Equipment

	Units	Unit Cost £	Total Cost £	Total Cost £	Total Cost £
Medulla pump	1	£720	£720		
Kettle	1	£38	£38		
				£1,010.35	
Corridor area					
Cot	1	£114	£114		
Wheelchair	1	£210	£210		
Noticeboard	1	£54	£54		
				£378.00	
3 bedded postnatal room					
Beds	3	£338	£1,015		
Bedside cupboard	3	£96	£288		
NCT Cost	3	£114	£342		
TV	1	£552	£552		
Armchair	1	£240	£240		
Small chairs	5	£108	£540		
Small table	1	£146	£146		
Bin	1	£127	£127		
Noticeboard	1	£54	£54		
				£3,304.80	
Single bedroom					
Bed	1	£338	£338		
Large armchair	1	£420	£420		
Bedside cabinet	1	£96	£96		
Small chair	1	£108	£108		
Cot	1	£114	£114		
TV	1	£552	£552		
				£1,628.40	
Office / Staff Room					
Corner desk	1	£413	£413		
Arm chair	2	£94	£187		
Desk chair	1	£94	£94		
Unit with small drawers for leaflets	1	£110	£110		
Freestanding lamp unit	1	£180	£180		
CD player	1	£216	£216		
Hair drier	1	£24	£24		
Bin	1	£127	£127		
				£1,351.20	
Dining Room					
Large Table	1	£480	£480		
Chairs	6	£108	£648		
Small table	1	£146	£146		
Clock	1	£36	£36		
				£1,310.40	
Kitchen					
Microwave	1	£101	£101		
Fridge	1	£300	£300		
CD Player	1	£216	£216		
Taoster	1	£38	£38		

Maidstone and Tunbridge Wells Hospitals

Crowborough Birthing Centre Business Case
Capital - Equipment

	Units	Unit Cost £	Total Cost £	Total Cost £	Total Cost £
Cutlery	1	£30	£30		
Crockery	1	£60	£60		
Paper roll holder	1	£36	£36		
				£781.38	
Main Office					
Desk	1	£206	£206		
Desk chair	3	£94	£281		
Noticeboards	5	£48	£240		
Free standing drawer unit	1	£186	£186		
CD Player	1	£216	£216		
Floor fan	1	£360	£360		
TENS	4	£36	£144		
Ophthalmoscope	1	£215	£215		
Ophthalmoscope batteries	1	£4	£4		
Ophthalmoscope bulb	1	£60	£60		
Bin	2	£127	£254		
				£2,165.96	
Corridor to Antenatal area					
Wardrobe style cupboards	2	£300	£600		
Water dispenser	1	£96	£96		
Chairs	7	£108	£756		
Toys	1	£120	£120		
				£1,572.00	
Antenatal consulting room					
Couch	1	£452	£452		
Book case	1	£240	£240		
Desk	1	£206	£206		
Desk Chair	1	£94	£94		
Chairs	2	£94	£187		
Trolley	1	£433	£433		
Sonicaid	2	£408	£816		
				£2,428.50	
Community Midwifery Office					
Desks	4	£206	£826		
Desk chairs	4	£94	£374		
2-drawer filing cabinet	1	£110	£110		
Clock	1	£36	£36		
Bin	1	£127	£127		
				£1,473.60	
Outside Seminar Room					
Wardrobe style cubboards	2	£300	£600		
leaflet display	1	£157	£157		
				£756.62	
Seminar Room					
Large round table	1	£168	£168		
2 oblong tables	1	£336	£336		
Staff lockers	24	£23	£540		
Small coffee table	1	£146	£146		

Maidstone and Tunbridge Wells Hospitals

Crowborough Birthing Centre Business Case
Capital - Equipment

		Units	Unit Cost £	Total Cost £	Total Cost £	Total Cost £
	TV/DVD	1	£552	£552		
	Suturing couch	1	£10,200	£10,200		
	Car seats	2	£156	£312		
	Chairs	22	£60	£1,320		
	Desk chairs	2	£206	£413		
	Fans	1	£720	£720		
	Flipchart	1	£120	£120		
	Freezer	1	£300	£300		
	Mugs / tea making facilities	1	£24	£24		
	4-drawer Filing cabinet	1	£110	£110		
					£15,261.60	
Other						
	Paed stethoscope	1	£12	£12		
	Stethoscope x 8	1	£48	£48		
	Pinnards stethoscopes x 4	1	£28	£28		
	Suturing spotlight	1	£474	£474		
	pool thermometers	1	£11	£11		
	Laerdale suction unit	1	£828	£828		
	laminator	1	£78	£78		
	Shredder	1	£70	£70		
	Drip stand	1	£119	£119		
	baby changing station	2	£138	£276		
	Defibrillator	1	£2,384	£2,384		
	Scales - sit on	1	£631	£631		
	Thermometer tympanic	2	£132	£264		
	Drug fridge	1	£299	£299		
	Baby bath	1	£25	£25		
	Patient lifting net	1	£192	£192		
	Resus bag	1	£49	£49		
	Radio controlled clock	3	£60	£180		
	Torches x3, batteries x6	1	£36	£36		
	Step stool	1	£45	£45		
	Radio controlled clock	2	£60	£121		
	9l plastic box x 12	1	£29	£29		
	35l plastic box	1	£71	£71		
	Neonatal thermometer	1	£132	£132		
	Infusion pump	1	£1,680	£1,680		
					£8,079.74	
Community Midwifery Equipment						
	Stehoscope	10	£12	£120		
	Sphyg	10	£46	£456		
	Sonicaid	10	£408	£4,080		
	Baby scales	10	£406	£4,056		
	Digital thermometer	10	£12	£120		
	Tympanic thermometer	10	£132	£1,320		
	Torch	10	£6	£60		
					£10,212.00	
	Total Cost (Incl. VAT)					**£73,330**

Maidstone and Tunbridge Wells Hospitals

Crowborough Birthing Centre Business Case
Capital - Equipment

	Units	Unit Cost £	Total Cost £	Total Cost £	Total Cost £

Supported by:

	Name	Signature	Date
Consultant Midwife	S Gregson		
Head of Community Midwifery	A Mendes		
Finance Manager	D Shelton		

Maidstone and Tunbridge Wells Hospitals

Crowborough Birthing Centre Business Case
Revenue - Income

Income - Non-Delivery Phase

			Standard	Intermediate	Intensive	Total
Tariff						
	Antental		£1,161	£1,857	£3,091	
	Postnatal		£274	£312	£839	
MTW Split						
	Antenatal	No.	3,800	1,863	588	6,250
		%	61%	30%	9%	
	Postnatal	No.	3,463	2,210	128	5,800
		%	60%	38%	2%	
Crowborough						
	Antenatal	No.	525	258	81	864
		£	£610,045	£478,250	£251,104	£1,339,399
	Postnatal	No.	479	306	18	802
		£	£131,190	£95,335	£14,803	£241,328
Total Income - Non-delivery Phase						***£1,580,727***

Income - Delivery Phase

Tariff			
	Without complications & co-morbidities		£1,795
	No. Deliveries - CBC	127	
	No. Deliveries - Home	19	
	Total No. deliveries		146
Total Income - Delivery Phase			***£262,515***
GRAND TOTAL			***£1,843,242***

Supported by:	**Name**	**Signature**	**Date**
Head of Contracting & SLAs	E Ejiofor		
Finance Manager	D Shelton		

Maidstone and Tunbridge Wells NHS Trust

Ward Establishment Costing

Cost Centre	
Ward	Crowborough BC
Number of Beds	

Ward Shifts

						Current Shift Pattern (Enter No People on Shift)																				
						Mon			Tues			Wed			Thur			Fri			Sat			Sun			Total		
Start	UnPaid Break	Finish	Paid Hours	Leave Cover	Shift	RN	Band 4	CSW	RN	Band 4	CSW	RN	Band 4	CSW	RN	Band 4	CSW	RN	Band 4	CSW	RN	Band 4	CSW	RN	Band 4	CSW	RN	Band 4	CSW
07:00	00:30	15:00	07:30	22%	Early shift:																					0	0	0
07:00	01:00	20:00	12:00	22%	Long-day shift:	2		1	2		1	2		1	2		1	2		1	2		1	2		1	14	0	7
13:30	00:30	20:00	06:00	22%	Late shift:																					0	0	0
09:00	00:30	17:00	07:30	22%	Community shift	3			3			3			3			2			1			1			16	0	0
19:30	01:00	07:30	11:00	22%	Night shift:	2		1	2		1	2		1	2		1	2		1	2		1	2		1	14	0	7
																										0	0	0
					Hours =	68.5	0.0	23.0	68.5	0.0	23.0	68.5	0.0	23.0	68.5	0.0	23.0	61.0	0.0	23.0	53.5	0.0	23.0	53.5	0.0	23.0	442.00	0.00	161.00
					W.T.E. (includes leave cover) =	2.23	0.00	0.75	2.23	0.00	0.75	2.23	0.00	0.75	2.23	0.00	0.75	1.98	0.00	0.75	1.74	0.00	0.75	1.74	0.00	0.75	14.38	0.00	5.24
					Ratio (%) =	75%	0%	25%	75%	0%	25%	75%	0%	25%	75%	0%	25%	73%	0%	27%	70%	0%	30%	70%	0%	30%			

Other Ward Shifts

						Current Shift Pattern (Enter No People on Shift)																				
						Mon			Tues			Wed			Thur			Fri			Sat			Sun			Total		
Start	UnPaid Break	Finish	Paid Hours	Leave Cover	Shift	RN	Band 4	CSW	RN	Band 4	CSW	RN	Band 4	CSW	RN	Band 4	CSW	RN	Band 4	CSW	RN	Band 4	CSW	RN	Band 4	CSW	RN	Band 4	CSW
09:00	01:00	17:30	07:30	0%	Specialist	1			1			1			1			1									5	0	0
09:00	01:00	17:30	07:30	22%	Sonographer	1			1																		2	0	0
09:00	01:00	17:30	07:30	15%	Ward Clerk																						0	0	0
09:00	01:00	17:30	07:30	0%	Management Time	1			1																		2	0	0
09:00		12:45	03:45	0%	Supervisory							1															1	0	0
			00:00																								0	0	0
					Hours =	22.5	0.0	0.0	22.5	0.0	0.0	11.3	0.0	0.0	7.5	0.0	0.0	7.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	71.25	0	0
					W.T.E. (includes leave cover) =	0.64	0.00	0.00	0.64	0.00	0.00	0.30	0.00	0.00	0.20	0.00	0.00	0.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			
					Ratio (%) =	100%	0%	0%	100%	0%	0%	100%	0%	0%	100%	0%	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%			
					TOTAL WTE	2.87	0.00	0.75	2.87	0.00	0.75	2.53	0.00	0.75	2.43	0.00	0.75	2.18	0.00	0.75	1.74	0.00	0.75	1.74	0.00	0.75	16.37	0.00	5.24

Total Staffing WTE and Cost per Annum £

Band	%	W.T.E.	Ratio	Cost per WTE £	TOTAL COST PER ANNUM £
8c	0%		76%	90,967	**0**
8b	0%			77,288	**0**
8a	0%			64,406	**0**
7	23%	**3.79**		59,407	**225,153**
6	77%	**12.58**		50,384	**633,837**
5	0%	**0.00**		40,502	**0**
4	0%		24%	25,071	**0**
3	0%			28,772	**0**
2	100%	**5.24**		28,485	**149,200**
	Total:	**21.61**			**1,008,190**

Maidstone and Tunbridge Wells Hospitals

Crowborough Birthing Centre Business Case
Revenue - Non-Pay

		Notes	Units	Unit Cost £	£	£	£
ICT							
	Capital Charges						
	Depreciation	Appendix A5i				£14,346	
	PDC	Appendix A5i				£1,255	
	Capital Charges sub-total						**£15,601**
	PC/Phones						
	Red phone		1	£89	£89		
	MFP		1	£794	£794		
	PC		5	£140	£700		
	PC/Phones sub-total					**£1,583**	
	Nursing Obs						
	Airwatch		10	£69	£690		
	NerveCentre		15	£119	£1,789		
	Nursing Obs sub-total					**£2,479**	
	Community Midwife						
	SIM card - data		10	£156	£1,559		
	VPN Soft Token		10	£93	£930		
	Nursing Obs sub-total					**£2,489**	
	Infrastructure Network						
	Switches				£6,750		
						£6,750	
	Total ICT Non-Pay						**£13,301**
E&F							
	Lease & Service Charge						
	Rent - CBC					£57,650	
	Rent - Other Clinics					£5,000	
	Service Charge (Rates, Utilities and Hard FM)					£34,000	
	Soft FM (Cleaning etc..)					£10,982	
							£107,632
Operational							
	Capital Charges						
	Depreciation	Appendix A5ii				£10,476	
	PDC	Appendix A5ii				£2,383	
	Capital Charges sub-total						**£12,859**
	Other Non-Pay						
	Consumables					£45,018	
	EME					£10,000	
	Pathology					£15,000	
	Other					£10,000	
							£80,018
Non-Pay Sub-Total							**£229,412**

Supported by:

	Name	Signature	Date
ICT Project Manager	K Rowe		
E&FM Project Manager	M Stronghill		
Consultant Midwife	S Gregson		
Hd of Community Midwifery	A Mendes		
Finance Manager	D Shelton		

Maidstone and Tunbridge Wells Hospitals

Crowborough Birthing Centre Business Case
Revenue Non-Pay (Capital Charges - ICT)

ICT - Capital Charges	Units	Unit Cost £	Total Cost £	UEL	Depreciation Charge	PDC
PC/Phones						
Phones 7945	2	£278	£556	3	£185.33	£16.22
Phones 7921	4	£160	£641	3	£213.71	£18.70
Phones 7925	5	£370	£1,850	3	£616.73	£53.96
Phone multicharger	1	£232	£232	3	£77.42	£6.77
ATA190	1	£116	£116	3	£38.76	£3.39
Red phone	1	£180	£180	3	£60.00	£5.25
Wristband printers	1	£440	£440	3	£146.72	£12.84
PC	5	£951	£4,755	3	£1,585.00	£138.69
Nursing Obs						
Ipad + cases	10	£197	£1,968	3	£656.00	£57.40
NerveCentre	10	£759	£7,590	3	£2,530.00	£221.38
Build						
Phones	12	£188	£2,250	3	£750.00	£65.63
PCs	5	£675	£3,375	3	£1,125.00	£98.44
Community Mid-Mobile						
Surface tablet / keypad / pen	10	£550	£5,500	3	£1,833.33	£160.42
Case	10	£31	£309.50	3	£103.17	£9.03
Infrastructure Network						
Patch Panels	1	£75	£75	3	£25.00	£2.19
Racking	1	£1,000	£1,000	3	£333.33	£29.17
Switches	1	£6,000	£6,000	3	£2,000.00	£175.00
Cables Cat5	10	£20	£200	3	£66.67	£5.83
Access Points & Wireless	1	£4,500	£4,500	3	£1,500.00	£131.25
UPS & PDU	1	£1,500	£1,500	3	£500.00	£43.75
Total			**£43,039**		**£14,346**	**£1,255**

Supported by:	**Name**	**Signature**	**Date**
ICT Project Manager	K Rowe		
Finance Manager	D Shelton		

Maidstone and Tunbridge Wells Hospitals

Crowborough Birthing Centre Business Case
Revenue Non-Pay (Capital Charges - Operations)

Equipment - Capital Charges	Units	Unit Cost £	Total Cost £	UEL	Depreciation Charge	PDC
Delivery Room - Corner Bath						
Bed	1	£684	£684	7	£97.71	£22.23
TV	1	£552	£552	7	£78.86	£17.94
Towel Rack	1	£30	£30	7	£4.29	£0.98
Chairs x 2	2	£240	£480	7	£68.57	£15.60
Bean Bag	1	£296	£296	7	£42.34	£9.63
Bedside Cabinet	1	£96	£96	7	£13.71	£3.12
Stool	1	£191	£191	7	£27.26	£6.20
trolley	1	£433	£433	7	£61.84	£14.07
Sonicaid	1	£408	£408	7	£58.29	£13.26
Sphyg	1	£72	£72	7	£10.29	£2.34
Howes Mirror	1	£30	£30	7	£4.29	£0.98
Oscillating fan	1	£360	£360	7	£51.43	£11.70
Bins	1	£127	£127	7	£18.17	£4.13
Delivery Room - Fixed Pool						
Bradbury couch	1	£684	£684	7	£97.71	£22.23
TV	1	£552	£552	7	£78.86	£17.94
Towel Rack	1	£30	£30	7	£4.29	£0.98
Chairs x 2	2	£240	£480	7	£68.57	£15.60
bean Bag	1	£296	£296	7	£42.34	£9.63
Bedside cabinet	1	£96	£96	7	£13.71	£3.12
Stool	1	£191	£191	7	£27.26	£6.20
Trolley	1	£433	£433	7	£61.84	£14.07
Sonicaid	1	£408	£408	7	£58.29	£13.26
Sphyg	1	£72	£72	7	£10.29	£2.34
Howes Mirror	1	£30	£30	7	£4.29	£0.98
Oscillating fan	1	£360	£360	7	£51.43	£11.70
Bins	1	£127	£127	7	£18.17	£4.13
Lobby area outside delivery rooms						
Resuscitaire	1	£10,680	£10,680	7	£1,525.71	£347.10
CD Cupboard	1	£700	£700	7	£99.94	£22.74
Baby Scales	1	£406	£406	7	£57.94	£13.18
Mobile drawer storage unit	1	£360	£360	7	£51.43	£11.70
Drug fridge	1	£299	£299	7	£42.69	£9.71
Entonox trolleys	4	£84	£336	7	£48.00	£10.92
Defib	1	£360	£360	7	£51.43	£11.70
Sluice						
Built in cupboard & drawer unit	1	£360	£360	7	£51.43	£11.70
Bins	3	£127	£382	7	£54.51	£12.40
Linen skip	1	£71	£71	7	£10.11	£2.30
Scales for blood estimation	1	£144	£144	7	£20.57	£4.68
Kitchen (small)						
Fridge (domestic)	1	£180	£180	7	£25.71	£5.85
Steriliser	4	£18	£72	7	£10.28	£2.34
Medulla pump	1	£720	£720	7	£102.86	£23.40
Kettle	1	£38	£38	7	£5.49	£1.25
Corridor area						
Cot	1	£114	£114	7	£16.29	£3.71
Wheelchair	1	£210	£210	7	£30.00	£6.83
Noticeboard	1	£54	£54	7	£7.71	£1.76
3 bedded postnatal room						
Beds	3	£338	£1,015	7	£145.03	£32.99

Maidstone and Tunbridge Wells Hospitals

Crowborough Birthing Centre Business Case
Revenue Non-Pay (Capital Charges - Operations)

Equipment - Capital Charges	Units	Unit Cost £	Total Cost £	UEL	Depreciation Charge	PDC
Bedside cupboard	3	£96	£288	7	£41.14	£9.36
NCT Cost	3	£114	£342	7	£48.86	£11.12
TV	1	£552	£552	7	£78.86	£17.94
Armchair	1	£240	£240	7	£34.29	£7.80
Small chairs	5	£108	£540	7	£77.14	£17.55
Small table	1	£146	£146	7	£20.91	£4.76
Bin	1	£127	£127	7	£18.17	£4.13
Noticeboard	1	£54	£54	7	£7.71	£1.76
Single bedroom						
Bed	1	£338	£338	7	£48.34	£11.00
Large armchair	1	£420	£420	7	£60.00	£13.65
Bedside cabinet	1	£96	£96	7	£13.71	£3.12
Small chair	1	£108	£108	7	£15.43	£3.51
Cot	1	£114	£114	7	£16.29	£3.71
TV	1	£552	£552	7	£78.86	£17.94
Office / Staff Room						
Corner desk	1	£413	£413	7	£58.97	£13.42
Arm chair	2	£94	£187	7	£26.74	£6.08
Desk chair	1	£94	£94	7	£13.37	£3.04
Unit with small drawers for leaflets	1	£110	£110	7	£15.77	£3.59
Freestanding lamp unit	1	£180	£180	7	£25.71	£5.85
CD player	1	£216	£216	7	£30.86	£7.02
Hair drier	1	£24	£24	7	£3.43	£0.78
Bin	1	£127	£127	7	£18.17	£4.13
Dining Room						
Large Table	1	£480	£480	7	£68.57	£15.60
Chairs	6	£108	£648	7	£92.57	£21.06
Small table	1	£146	£146	7	£20.91	£4.76
Clock	1	£36	£36	7	£5.14	£1.17
Kitchen						
Microwave	1	£101	£101	7	£14.40	£3.28
Fridge	1	£300	£300	7	£42.86	£9.75
CD Player	1	£216	£216	7	£30.86	£7.02
Taoster	1	£38	£38	7	£5.49	£1.25
Cutlery	1	£30	£30	7	£4.29	£0.98
Crockery	1	£60	£60	7	£8.57	£1.95
Paper roll holder	1	£36	£36	7	£5.17	£1.18
Main Office						
Desk	1	£206	£206	7	£29.49	£6.71
Desk chair	3	£94	£281	7	£40.11	£9.13
Noticeboards	5	£48	£240	7	£34.29	£7.80
Free standing drawer unit	1	£186	£186	7	£26.57	£6.05
CD Player	1	£216	£216	7	£30.86	£7.02
Floor fan	1	£360	£360	7	£51.43	£11.70
TENS	4	£36	£144	7	£20.57	£4.68
Ophthalmoscope	1	£215	£215	7	£30.69	£6.98
Ophthalmoscope batteries	1	£4	£4	7	£0.51	£0.12
Ophthalmoscope bulb	1	£60	£60	7	£8.57	£1.95
Bin	2	£127	£254	7	£36.34	£8.27
Corridor to Antenatal area						
Wardrobe style cupboards	2	£300	£600	7	£85.71	£19.50
Water dispenser	1	£96	£96	7	£13.71	£3.12
Chairs	7	£108	£756	7	£108.00	£24.57

Maidstone and Tunbridge Wells Hospitals

Crowborough Birthing Centre Business Case
Revenue Non-Pay (Capital Charges - Operations)

Equipment - Capital Charges	Units	Unit Cost £	Total Cost £	UEL	Depreciation Charge	PDC
Toys	1	£120	£120	7	£17.14	£3.90
Antenatal consulting room						
Couch	1	£452	£452	7	£64.63	£14.70
Book case	1	£240	£240	7	£34.29	£7.80
Desk	1	£206	£206	7	£29.49	£6.71
Desk Chair	1	£94	£94	7	£13.37	£3.04
Chairs	2	£94	£187	7	£26.74	£6.08
Trolley	1	£433	£433	7	£61.84	£14.07
Sonicaid	2	£408	£816	7	£116.57	£26.52
Community Midwifery Office						
Desks	4	£206	£826	7	£117.94	£26.83
Desk chairs	4	£94	£374	7	£53.49	£12.17
2-drawer filing cabinet	1	£110	£110	7	£15.77	£3.59
Clock	1	£36	£36	7	£5.14	£1.17
Bin	1	£127	£127	7	£18.17	£4.13
Outside Seminar Room						
Wardrobe style cubboards	2	£300	£600	7	£85.71	£19.50
leaflet display	1	£157	£157	7	£22.37	£5.09
Seminar Room						
Large round table	1	£168	£168	7	£24.00	£5.46
2 oblong tables	1	£336	£336	7	£48.00	£10.92
Staff lockers	24	£23	£540	7	£77.14	£17.55
Small coffee table	1	£146	£146	7	£20.91	£4.76
TV/DVD	1	£552	£552	7	£78.86	£17.94
Suturing couch	1	£10,200	£10,200	7	£1,457.14	£331.50
Car seats	2	£156	£312	7	£44.57	£10.14
Chairs	22	£60	£1,320	7	£188.57	£42.90
Desk chairs	2	£206	£413	7	£58.97	£13.42
Fans	1	£720	£720	7	£102.86	£23.40
Flipchart	1	£120	£120	7	£17.14	£3.90
Freezer	1	£300	£300	7	£42.86	£9.75
Mugs / tea making facilities	1	£24	£24	7	£3.43	£0.78
4-drawer Filing cabinet	1	£110	£110	7	£15.77	£3.59
Other						
Paed stethoscope	1	£12	£12	7	£1.71	£0.39
Stethoscope x 8	1	£48	£48	7	£6.84	£1.56
Pinnards stethoscopes x 4	1	£28	£28	7	£3.94	£0.90
Suturing spotlight	1	£474	£474	7	£67.65	£15.39
pool thermometers	1	£11	£11	7	£1.60	£0.37
Laerdale suction unit	1	£828	£828	7	£118.29	£26.91
laminator	1	£78	£78	7	£11.18	£2.54
Shredder	1	£70	£70	7	£9.94	£2.26
Drip stand	1	£119	£119	7	£17.06	£3.88
baby changing station	2	£138	£276	7	£39.43	£8.97
Defibrillator	1	£2,384	£2,384	7	£340.53	£77.47
Scales - sit on	1	£631	£631	7	£90.14	£20.51
Thermometer tympanic	2	£132	£264	7	£37.71	£8.58
Drug fridge	1	£299	£299	7	£42.69	£9.71
Baby bath	1	£25	£25	7	£3.60	£0.82
Patient lifting net	1	£192	£192	7	£27.43	£6.24
Resus bag	1	£49	£49	7	£6.94	£1.58
Radio controlled clock	3	£60	£180	7	£25.69	£5.84
Torches x3, batteries x6	1	£36	£36	7	£5.14	£1.17

Maidstone and Tunbridge Wells Hospitals

Crowborough Birthing Centre Business Case
Revenue Non-Pay (Capital Charges - Operations)

Equipment - Capital Charges	Units	Unit Cost £	Total Cost £	UEL	Depreciation Charge	PDC
Step stool	1	£45	£45	7	£6.43	£1.46
Radio controlled clock	2	£60	£121	7	£17.26	£3.93
9l plastic box x 12	1	£29	£29	7	£4.11	£0.94
35l plastic box	1	£71	£71	7	£10.08	£2.29
Neonatal thermometer	1	£132	£132	7	£18.86	£4.29
Infusion pump	1	£1,680	£1,680	7	£240.00	£54.60
Community Midwifery Equipment						
Stehoscope	10	£12	£120	7	£17.14	£3.90
Sphyg	10	£46	£456	7	£65.14	£14.82
Sonicaid	10	£408	£4,080	7	£582.86	£132.60
Baby scales	10	£406	£4,056	7	£579.43	£131.82
Digital thermometer	10	£12	£120	7	£17.14	£3.90
Tympanic thermometer	10	£132	£1,320	7	£188.57	£42.90
Torch	10	£6	£60	7	£8.57	£1.95
Total			**£73,330**		**£10,476**	**£2,383**

Supported by:	**Name**	**Signature**	**Date**
Consultant Midwife	S Gregson		
Head of Community Midwifery	A Mendes		
Finance Manager	D Shelton		

Crowborough Birthing Centre Business Case
Non-Financial Score

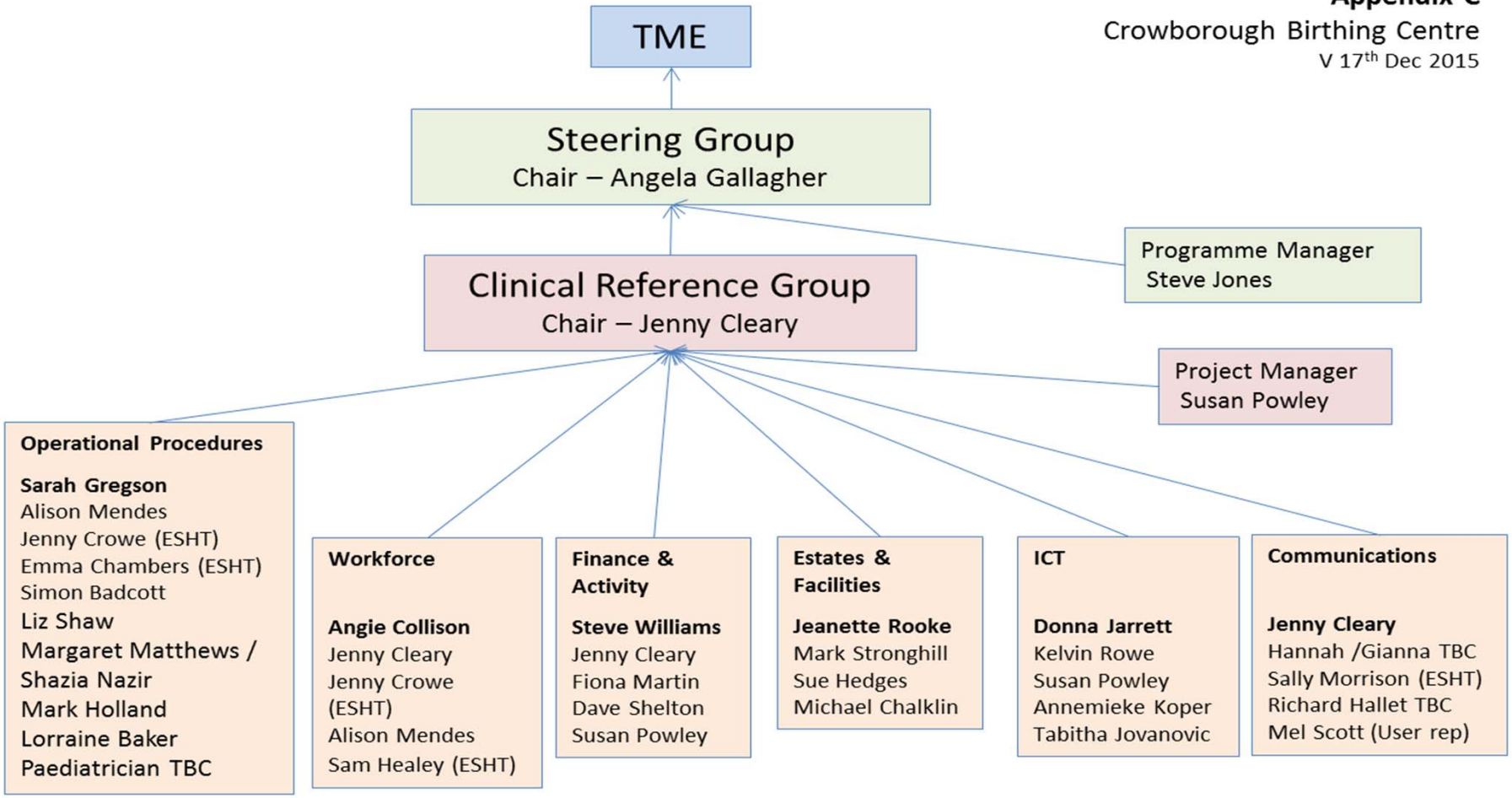
Benefits (Non-Financial)

		Option A		Option B		Option C		Option D	
		Do nothing		CBC & Comm Midwifery team		Community Midwifery only		Refurb first	
Objectives	**Weighting**	**Score (0-5)**	**Weighted Score**	**Score (0-5)**	**Weighted Score**	**Score (0-5)**	**Weighted Score**	**Score (0-5)**	**Weighted Score**
Increase Choice	50%	0	0%	4	40%	2	20%	3	30%
Resilience	25%	1	5%	4	20%	3	15%	5	25%
Local Access	25%	2	10%	4	20%	3	15%	3	15%
Total	100%		15%		80%		50%		70%

Risks

		Option A		Option B		Option C		Option D	
		Do nothing		CBC & Comm		Community Midwifery		Refurb first	
Objectives	**Weighting**	**Score (0-5)**	**Weighted Score**	**Score (0-5)**	**Weighted Score**	**Score (0-5)**	**Weighted Score**	**Score (0-5)**	**Weighted Score**
Commissioner credibility	15%	5	15%	0	0%	5	15%	4	12%
Staffing Pressures	25%	3	15%	2	10%	4	20%	1	5%
Operational risk - policies	20%	0	0%	3	12%	3	12%	1	4%
Operational risk - beds	30%	4	24%	2	12%	3	18%	1	6%
Managerial capacity	10%	1	2%	3	6%	3	6%	3	6%
Total	100%		56%		40%		71%		33%

Appendix C
Crowborough Birthing Centre
V 17th Dec 2015



Crowborough Birthing Centre Business Case

Maidstone and Tunbridge Wells Hospitals

Project Plan: Crowborough Birthing Centre																								
Project Plan Version 28 Jan 2016		2015			2016			week completing Friday date																
		Dec			Jan					Feb				March				April						Lead Name
	Action	11	18	25	1	8	15	22	29	5	12	19	26	4	11	18	25	1	8	15	22	29		
1	**Set up clinical reference group and steering group**																							Steve Jones
	Dedicated steering group meeting to review recommendation from project group as to stop go readiness															TBC								
2	Undertake a **due diligence assessment** for MTW to take on the birthing unit at Crowborough hospital, along with the associated community maternity service.																							Steve Williams
3	Develop the necessary **business case** to identify all necessary costs including project cost, to enable appropriate budgets to be set.																							Steve Williams
	Develop the Due Diligence assessment into a businesses case to include benefits, full costs of service including project costs , income , along with any capital cost for estates and equipment.																							
	Submit the BC to IAG and TME											17												Steve Williams
	Secure finance budget codes											19												Dave Shelton
	submit BC to finance committee												22											
	Secure agreement to allocate expenditure on the project prior to the B case completion																							Jenny Cleary
4	**Develop all policies and procedures** to be in place for the new unit covering all clinical, administrative, hard and soft FM services .																							Sarah Gregson
	Develop draft policies and procedures (Including access to other services on Crowborough site) NB Other Clinical Issues to be included within the policies and procedures: Privacy & Dignity/Patient Experience Issues Philosophy of care - to be agreed by all staff Patient Information																							
	Obtain feedback from all key staff group including infection control																							
	Consultation with clinical reference group											17												
	Obtain formal approval from W&C Directorate											19												
	Trust wide consultation for any non maternity policies and submission to TME & Clinical Operations Group																							
	Publish on Q-Pulse																							
	Enable CSF to visit CBC for training assessment																							
	Confirm screening processes at CBC for QA assessment																							
	Train and orientate staff on new polices and procedures																							
	Staffing arrangements after go live and as activity increases																							
5	**All staff affected have been TUPE'd across to MTW in a timely way**																							Angie Collinson
	Identify midwifery service model and staffing establishment for new environment																							
	Identify affected staff by name																							
	Develop JD for posts																							
	Undertake due process of consultation/ discussion, sharing management structures																							
	Confirm appointment arrangements - start date and contracts																							
	Finalise staff allocation and undertake recruitment of any shortfall in staffing																							
	Develop staff rosters for service start dates																							

Crowborough Birthing Centre Business Case

Maidstone and Tunbridge Wells Hospitals

	Project Plan: Crowborough Birthing Centre																						
	Project Plan Version 28 Jan 2016	2015			2016			week completing Friday date															
		Dec			Jan					Feb				March				April					Lead Name
	Action	11	18	25	1	8	15	22	29	5	12	19	26	4	11	18	25	1	8	15	22	29	
6	Ensure that all **MTW IT systems are in place and fully operational** to capture and monitor activity and help with clinical decision making.																						Donna Jarrett
	Undertake assessment of infrastructure																						
	Inform PAS/Information/Coding/Finance etc. for data bases																						
	Secure IT delivery plan																						
	Purchase and install any IT equipment needed																						
	Set up IT & Telephone equipment																						
	Train all staff (inc community midwifery staff) on new MTW midwifery/ PAS and data systems																						
	Go live with new system																						
7	**Equipment has been purchased**, tested, staff trained and operationally ready																						Sarah Gregson
	Identify equipment being left and equipment needing to be purchased																						
	Place orders and confirm any support from League of Friends																						
	Undertake testing and commissioning of equipment																						
8	All patients are fully aware of the new service and there is **excellent local communication** concerning access and service delivery for patients, local GPs and all other affected clinicians																						Jenny Cleary
	Develop and implement stakeholder engagement and communication plan																						
	Contact all key stakeholders & keep updated: Medical staff/Therapies																						
	Radiology																						
	Procurement																						
	GPs/Community Services																						
	League of Friends																						
	Develop and send regular progress reports to the steering group and TME																						
9	The **physical environment is appropriate to meet the needs of the patients and staff.**																						Jeanette Rooke
	Secure the users wishes, needs and wants - in a priority listing																						
	Secure a time line for small works once Business case agreed and funding available																						
	Develop and agree access time table to undertake necessary works																						
	Complete and commission area																						
10	ALL necessary **Service Level Agreements are in place covering the maternity service** along with agreed contract activity levels and KPI's																						Steve Williams
	Ensure that there are formal SLA agreements in place from go live date, with providers of services which MTW are not able to support																						
11	**Confirm soft FM service commissioning plan and set up for birthing unit**																						Jeanette Rooke
	Set up commissioning planning meeting with key stakeholders																						
	Set up domestic services																						
	Set up changes in catering services																						
	Set up any other changes in support services																						
	Deep clean																						
	Set up furniture on ward																						
	Set up ward stocks/kit																						
	Safety Checks																						

Appendix D

Crowborough Birthing Centre Business Case

Maidstone and Tunbridge Wells Hospitals

Project Plan: Crowborough Birthing Centre																								
Project Plan Version 28 Jan 2016		2015			2016			week completing Friday date																
		Dec			**Jan**					**Feb**				**March**				**April**						**Lead Name**
	Action	**11**	**18**	**25**	**1**	**8**	**15**	**22**	**29**	**5**	**12**	**19**	**26**	**4**	**11**	**18**	**25**	**1**	**8**	**15**	**22**	**29**		
12	**Risk mitigation**																							Susan Powley
	1.Identify exact nature of risk - develop risk log																							
	2. Identify plans/timeline to mitigate risk																							
	3. Implement plans																							
13	**Monitoring and Audit**																							Jenny Cleary
	1. Agree KPIs																							
	2. Set up system with Information Team																							
		KEY																						
	Overdue																							
	under development																							
	On track or completed																							
	planned completion date																							

Crowborough Birthing Centre Business Case

Maidstone and Tunbridge Wells Hospitals

Risk Log: Crowborough Birthing Centre							V 28.1.16	
ID NO.	RISK DESCRIPTION	RISK SCORE likelihood X impact	RAG RATING	MITIGATING ACTIONS	RESIDUAL RISK SCORE likelihood x impact (same)	RESIDUAL RAG RATING	PROGRESS REPORT	LEAD
1	**Business case time line risk:** Risk to being able to develop a comprehensive BC Business case for approval from all relevant committees, in order to secure approval to proceed, in sufficient time to allow opening in line with planned April 1st deadline	3x3 Possible x Mod	Amber	Agenda items on committees set to receive BC and Due Diligence reports	2x3 Unlikely x Mod	Green	26 Jan -Confirm arrangements for PbR with CCG	Steve Williams
2	**Achieving go live date:** The indicative time line of achieving the 1st April 2016 needs to be fully assessed as at present we do not know all the facts to confirm this date.	3x3 Possible x Mod	Amber	Project plan developed - identifies early assessment of key areas in order to ascertain risk to go live date	2x3 Unlikely x Mod	Green		Susan Powley
3	**Staffing** : Need for quick and timely TUPE process , in order to identify numbers of staff moving to MTW and therefore any vacancies which will then need to be recruited to., in order to allow safe running of the unit . The unit cannot open without appropriate staff.	4x4 Likely x Sig	Red	TUPE process and formal consultation with ESHT staff planned once MTW board formal approval to proceed planned for end for January. Informal discussion with staff to ascertain possible staffing shortfall to proceed.	4x4 Likely x Sig	Red	12 Jan - Improved understanding of staff employed by ESHT. Awaiting consultation to begin through ESHT to confirm exact numbers of staff being TUPED. 28 Jan -Escalated to HR Director at ESHT	A Collinson
4	**Operational Risk**: of securing MTW operational pathways and models of care within the Crowborough unit and community service.	3x3 Possible x Mod	Amber	Sharing proposed care pathways and operational ways of working, early with clinical stakeholder , so that good understanding can be achieved along with necessary training. Contact made with SECAM to confirm emergency transfer arrangements	2x3 Unlikely x Mod	Green		Sarah Gregson

Crowborough Birthing Centre Business Case

Maidstone and Tunbridge Wells Hospitals

Risk Log: Crowborough Birthing Centre							V 28.1.16	
ID NO.	RISK DESCRIPTION	RISK SCORE likelihood X impact	RAG RATING	MITIGATING ACTIONS	RESIDUAL RISK SCORE likelihood x impact (same)	RESIDUAL RAG RATING	PROGRESS REPORT	LEAD
5	**IT, telephones infrastructure** and capacity will not meet the needs of the MTW systems in terms of software and hardware	3x3 Possible x Mod	Amber	Early assessment of IT/ telephone infrastructure needed - Any cost to be identified in business case Clear plan for software role out to birthing unit and community staff to be identified	3x4 Possible x Sig	Amber	12 Jan- KMHIS engaged , assessment underway , understanding of IT equipment being developed covering both birthing unit and community midwives	D Jarrett
6	**IT support** will not be available to achieve the desired time line due to KMHIS closure and staffing situation	3x4 Possible x Sig	Red	Ensure early identification of KMHIS requirements and identify staff to be allocated to project	3x3 Possible x Mod	Amber	26 Jan - Assurance from D Jarrett that this project will be prioritised	D Jarrett
7	**Equipment Risk** : If key pieces of equipment are owned and removed by ESHT, then MTW will need to identify cost within the business case and purchase this equipment in a timely way, in order that it is tested and ready for us from planned opening date.	3x4 Possible x Sig	Red	Ensure that all equipment is identified in a timely way so that purchase order can be place considering their lead in and delivery times once the business case has been agreed and revenue budget agreed. Include provision of medical gases	2x3 Unlikely x Mod	Green	12 Jan - Inventory of equipment being identified and who ones it eg ESHT or League of Friends 26 Jan - J Crowe informed MTW of ESHT's intention not to remove equipment from CBC.	Sarah Gregson
8	**Insufficient communication and stakeholder engagement and understanding** as to project objectives	3x3 Possible x Mod	Amber	Develop a comprehensive communication and stakeholder engagement plan which clearly identifies the project objectives and regularly communicates the up to date position of project To ensure that there is opportunity for feedback from the users and affected staff groups	3x3 Possible x Mod	Amber	12 Jan - Once both boards give formal agreement and confirmation of start date which is dependent staffing then greater communication can take place	J Cleary

Crowborough Birthing Centre Business Case

Maidstone and Tunbridge Wells Hospitals

Risk Log: Crowborough Birthing Centre							V 28.1.16	
ID NO.	RISK DESCRIPTION	RISK SCORE likelihood X impact	RAG RATING	MITIGATING ACTIONS	RESIDUAL RISK SCORE likelihood x impact (same)	RESIDUAL RAG RATING	PROGRESS REPORT	LEAD
9	**Management availability** for timely decision making within the W&C directorate	3x3 Possible x Mod	Amber	Project governance structure involves a range of senior managers to ensure that recommendations can still be developed and decisions made in a timely way	2x3 Unlikely x Mod	Green	12 Jan -no impact as yet 26 Jan -Agenda item on relevant forums	J Cleary
10	**Unable to predict staff intentions** re transferring to MTW, staying at ESHT or leaving for alternative employment	3x4 Possible x Sig	Red	Consider potential requirements within existing workforce planning. Ensure MTW recruitment processes continue to fill existing vacancies. Risk assess the impact of levels of staff not transferring to MTW	3x3 Possible x Mod	Amber	26 Jan -awaiting confirmation of numbers involved following consultation	A Collison

Maidstone and Tunbridge Wells NHS
NHS Trust

Trust Board meeting – February 2016

2-21	**Revised application for a "Single Currency Interim Revenue Support Facility"**	**Chairman of Finance Committee / Director of Finance**

On 27th January 2016, the Trust Board approved the recommendations of the Finance Committee (25/01/2016) to agree the Trust's application to convert its "Single Currency Interim Revolving Working Capital Support Facility" (IRWCF) of £12.132m to an alternative financial vehicle i.e. a "Single Currency Interim Revenue Support Facility", as proposed by the DH. The paper to the January Trust Board set out the differences between the products, and in particular the more favourable terms of the Support Facility (1.5% interest rate against 3.5%).

In approving the recommendation the Trust Board made the necessary resolution (set out in Schedule 1 to the Agreement) to include the requirements:

(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"
(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"

Subsequent to the Board meeting and prior to the loan documentation being sent by the NHS Trust Development Authority (TDA) to the Department of Health (DH) for completion, the Trust attended a TDA Cash and Capital group and was made aware of an emerging concept of "equivalent value" that had been recently applied to loan facility agreements in other Trusts. This related to the TDA obtaining agreement from the DH that Trusts with a PFI arrangement might vary their working capital limit to include the capital element of the Unitary Payment disbursements in the financial year. This was taken up by the Trust with the TDA Head of Capital and Cash and agreement was obtained from the DH to increase the Trust's loan from the £12.132m limit by the value of the PFI capital repayment which for 2015/16 is £4.776m.

The DH has therefore drawn up replacement documentation of a Single Currency Interim Revenue Support loan of £16.908m. The Trust needs therefore to repeat the process undertaken at the January Trust Board to make the appropriate resolution and authorisations, and to sign a new Direct Debit (DD) Mandate.

The "Additional Terms and Conditions" referred to in Resolution (D) above are again contained in Schedule 8 of the enclosed Agreement.

The Agreement must be signed in blue ink by the officer named in part (B) of the resolution

The Trust requested the DH to reduce the minimum cash balance held to £1m, from the £2.1m suggested by the DH in the original financing documentation. This has now been approved and the enclosed Agreement reflects this reduced minimum balance.

On 22/02/16, the Finance Committee was asked to review the enclosed Agreement and agree to recommend that the Trust Board (on 24/02/16):

- Approves the resolution above
- Authorises the Director of Finance to execute the Finance Documents on its behalf
- Authorises, on its behalf, the Director of Finance and Deputy Directors of Finance to sign and/or despatch all documents and notices and to be signed and/or despatched by it under or in connection with the Finance Documents
- Authorise the signing of the Direct Debit Mandate by two signatories from the current

Authorised Signatory panel held by the DH Cash funding team (i.e. the Chief Executive, Director of Finance, Deputy Directors of Finance, Head of Financial Services, and the Head of Financial Systems)
- Confirm the undertaking to comply with the Additional Terms and Conditions (as listed in Schedule 8)
- Approves the amendment to the minimum cash balance

The outcome of the Finance Committee's review will be reported within the summary from the meeting (Attachment 16)

Which Committees have reviewed the information prior to Board submission?
- Finance Committee, 22/02/16

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
- To approve the resolution above
- To authorise the Director of Finance to execute the Finance Documents on behalf of the Trust Board
- To authorise, on its behalf, the Director of Finance and Deputy Directors of Finance to sign and/or despatch all documents and notices and to be signed and/or despatched by it under or in connection with the Finance Documents
- To authorise the signing of the Direct Debit Mandate by two signatories from the current Authorised Signatory panel held by the DH Cash funding team (i.e. the Chief Executive, Director of Finance, Deputy Directors of Finance, Head of Financial Services, and the Head of Financial Systems)
- To confirm the undertaking to comply with the Additional Terms and Conditions (as listed in Schedule 8)

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

DATED 2016

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST
(as Borrower)

and

THE SECRETARY OF STATE FOR HEALTH
(as Lender)

£16,908,000

SINGLE CURRENCY INTERIM REVENUE SUPPORT

FACILITY AGREEMENT

REF NO: DHPF/ISWBL/RWF/2015-12-16/A

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THIS AGREEMENT is dated 2016 and made between:

(1) **MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST** of**, Maidstone Hospital, Hermitage Land, Maidstone, Kent, ME16 9QQ** (the **"Borrower" which expression shall include any successors in title or permitted transferees or assignees**); and

(2) **THE SECRETARY OF STATE FOR HEALTH** as lender (the **"Lender" which expression shall include any successors in title or permitted transferees or assignees**).

IT IS AGREED as follows:

1. DEFINITIONS AND INTERPRETATION

1.1 Definitions

In this Agreement:

"Account" means the Borrower's account held with the Government Banking Service.

"Act" means the National Health Service Act 2006 as amended from time to time.

"Additional Terms and Conditions" means the terms and conditions set out in Schedule 8.

"Agreed Purpose" means working capital expenditure for use only if it has insufficient working capital available as set out under the Terms of this Agreement, to maintain the provision of the Borrower's services in its capacity as an NHS Body. For the purposes of this agreement, working capital expenditure shall include repayment of outstanding loans under any working capital facility provided by the Lender to the Borrower.

"Authorisation" means an authorisation, consent, approval, resolution, licence, exemption, filing, notarisation or registration.

"Available Facility" means the Facility Amount less:

(A) all outstanding Loans; and

(B) in relation to any proposed Utilisation, the amount of any Loan that is due to be made on or before the proposed Utilisation Date.

"Availability Period" means two years from and including the date of this Agreement. The Availability Period may be extended, at the Borrower's option, subject to no outstanding Event of Default. Any extension can be for a period of up to twelve months, subject to the Availability Period expiring no later than the Final Repayment Date.

"Business Day" means a day (other than a Saturday or Sunday) on which banks are open for general banking business in London.

"Capital Limit" means the overall maximum net inflow/outflow from investing activities incurred by the Borrower as set by the Lender for any relevant financial year

"Cash Balance" means the Borrower's available cash balances, whether held within the Government Banking Service or otherwise, on the Utilisation Date to the Monday preceding the 18th day of the following Month.

"Cashflow Forecast" means the Borrower's current rolling 13 week cashflow forecast in a form to be agreed with the Lender from time to time (and as prepared on behalf of the Borrower's Board). The forecast must include all utilisations and proposed utilisations under any agreement with the Lender for the relevant period.

"Compliance Framework" means the relevant Supervisory Body's frameworks and/or any replacement to such frameworks for monitoring and assessing NHS Bodies and their compliance with any consents, permissions and approvals.

"Dangerous Substance" means any natural or artificial substance (whether in a solid or liquid form or in the form of a gas or vapour and whether alone or in combination with any such other substance) capable of causing harm to the Environment or damaging the Environment or public health or welfare including any noxious, hazardous, toxic, dangerous, special or controlled waste or other polluting substance or matter.

"Default" means an Event of Default or any event or circumstance specified in Clause 18 (*Events of Default*) which would (with the expiry of a grace period, the giving of notice, the making of any determination under the Finance Documents or any combination of any of the foregoing) be an Event of Default.

"Default Rate" means the official bank rate (also called the Bank of England base rate or BOEBR) plus 300 basis points per annum.

"Deficit Limit" means the Surplus/Deficit outturn for the Borrower set by the Lender for any relevant financial year before impairments and transfers.

"Environment" means the natural and man-made environment and all or any of the following media namely air (including air within buildings and air within other natural or man-made structures above or below ground), water (including water under or within land or in drains or sewers and inland waters), land and any living organisms (including humans) or systems supported by those media.

"Environmental Claim" means any claim alleging liability whether civil or criminal and whether actual or potential arising out of or resulting from the presence at on or under property owned or occupied by the Borrower or presence in or escape or release into the environment of any Dangerous Substance from any such property or in circumstances attributable to the operation of the Borrower's activities or any breach of any applicable Environmental Law or any applicable Environmental Licence.

"Environmental Law" means all statutes, instruments, regulations, orders and ordinances (including European Union legislation, regulations, directives, decisions and judgements applicable to the United Kingdom) being in force from time to time and directly enforceable in the United Kingdom relating to pollution, prevention thereof or protection of human health or the conditions of the Environment or the use, disposal, generation, storage, transportation, treatment, dumping, release, deposit, burial, emission or disposal of any Dangerous Substance.

"Environmental Licence" shall mean any permit, licence, authorisation, consent or other approval required by any Environmental Law or the Planning (Hazardous Substances) Act 1990.

"Event of Default" means any event or circumstance specified as such in Clause 18 (*Events of Default*).

"Facility" means the Interim Support facility made available under this Agreement as described in Clause 2 (*The Facility*).

"Facility Amount" means £16,908,000 at the date of this Agreement and thereafter that amount to the extent not cancelled, reduced or transferred by the Lender or the Borrower (as may be amended by the Lender from time to time).

"Final Repayment Date" means 18/02/2019.

"Finance Documents" means:

(A) this Agreement; and

(B) any other document designated as such by the Lender and the Borrower.

"Financial Indebtedness" means any indebtedness for or in respect of:

(A) moneys borrowed;

(B) any amount raised by acceptance under any acceptance credit facility;

(C) any amount raised pursuant to any note purchase facility or the issue of bonds, notes, debentures, loan stock or any similar instrument;

(D) the amount of any liability in respect of any lease or hire purchase contract which would, in accordance with any applicable Audit Code for NHS Bodies, any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies, be treated as a finance or capital lease;

(E) receivables sold or discounted (other than any receivables to the extent they are sold on a non-recourse basis);

(F) any amount raised under any other transaction (including any forward sale or purchase agreement) having the commercial effect of a borrowing;

(G) any derivative transaction entered into in connection with protection against or benefit from fluctuation in any rate or price (and, when calculating the value of any derivative transaction, only the marked to market value shall be taken into account);

(H) any counter-indemnity obligation in respect of a guarantee, indemnity, bond, standby or documentary letter of credit or any other instrument issued by a bank or financial institution; and

(I) the amount of any liability in respect of any guarantee or indemnity for any of the items referred to in paragraphs (A) to (H) above.

“Government Banking Service” means the body established in April 2008 being the banking shared service provider to government and the wider public sector incorporating the Office of HM Paymaster General (OPG).

"Interest Payment Date" means the last day of an Interest Period.

"Interest Period" means, in relation to a Loan, the period determined in accordance with Clause 9 (*Interest Periods*) and, in relation to an Unpaid Sum, each period determined in accordance with Clause 8.3 *(Default interest).*

"**Interest Rate**" means 1.5% per annum.

"Licence" means the licence issued by Monitor to any person who provides a health care service for the purposes of the NHS.

"Limits" means the Deficit Limit and/or the Capital Limit where set out in the Finance Document

"Loan" means a loan made or to be made under the Facility or the principal amount outstanding for the time being of that loan.

"Material Adverse Effect" means a material adverse effect on:

(A) the business or financial condition of the Borrower;

(B) the ability of the Borrower to perform any of its material obligations under any Finance Document;

(C) the validity or enforceability of any Finance Document; or

(D) any right or remedy of the Lender in respect of a Finance Document.

"Minimum Cash Balance" means £1,000,000;

"**Monitor**" means the sector regulator for health care services in England or any successor body to that organisation

"Month" means a period starting on one day in a calendar month and ending on the numerically corresponding day in the next calendar month, except that:

(A) (subject to paragraph (C) below) if the numerically corresponding day is not a Business Day, that period shall end on the next Business Day in that calendar month in which that period is to end if there is one, or if there is not, on the immediately preceding Business Day;

(B) if there is no numerically corresponding day in the calendar month in which that period is to end, that period shall end on the last Business Day in that calendar month; and

(C) if a period begins on the last Business Day of a calendar month, that period shall end on the last Business Day in the calendar month in which that period is to end,

provided that the above rules will only apply to the last Month of any period.

"NHS Body" means either an NHS Trust or an NHS Foundation Trust , or any successor body to that organisation**.**

"NHS Trust Development Authority" means the body responsible for monitoring the performance of NHS Trusts and providing assurance of clinical quality, governance and risk in NHS Trusts, or any successor body to that organisation;

"Original Financial Statements" means a certified copy of the audited financial statements of the Borrower for the financial year ended 31st March 2015.

"Participating Member State" means any member state of the European Communities that adopts or has adopted the euro as its lawful currency in accordance with legislation of the European Community relating to Economic and Monetary Union.

"Party" means a party to this Agreement.

"Permitted Security" means:

(A) normal title retention arrangements arising in favour of suppliers of goods acquired by the Borrower in the ordinary course of its business or arising under conditional sale or hiring agreements in respect of goods acquired by the Borrower in the ordinary course of its business;

(B) liens arising by way of operation of law in the ordinary course of business so long as the amounts in respect of which such liens arise are not overdue for payment;

(C) any existing Security listed in Schedule 7;

(D) any Security created or outstanding with the prior written consent of the Lender; and

(E) any other Security securing in aggregate not more than £150,000 at any time.

"Relevant Consents" means any authorisation, consent, approval, resolution, licence, exemption, filing, notarisation or registration of whatsoever nature necessary or appropriate to be obtained for the purpose of entering into and performing the Borrower's obligations under the Finance Documents.

"Relevant Percentage" means in respect of each Repayment Date, the percentage figure set opposite such Repayment Date in the Repayment Schedule.

"Repayment Dates" means the repayment dates set out in the Schedule 6 (Repayment Schedule).

"Repayment Instalment" means each instalment for the repayment of the Loan referred to in Clause 6.2.

"Repayment Schedule" means the repayment schedule set out in Schedule 6 (*Repayment Schedule*).

"Repeating Representations" means each of the representations set out in Clause 14 (*Representations*) other than those under Clauses 14.9, 14.10, 14.12.2 and 14.16.2.

"Security" means a mortgage, charge, pledge, lien or other security interest securing any obligation of any person or any other agreement or arrangement having a similar effect.

"Supervisory Body" means either the NHS Trust Development Authority and/or Monitor.

"Tax" means any tax, levy, impost, duty or other charge or withholding of a similar nature (including any penalty or interest payable in connection with any failure to pay or any delay in paying any of the same).

"Tax Deduction" means a deduction or withholding for or on account of Tax from a payment under a Finance Document.

"Test Date" means the Utilisation Date and each Interest Payment Date.

"Unpaid Sum" means any sum due and payable but unpaid by the Borrower under the Finance Documents.

"Utilisation" means a utilisation of the Facility.

"Utilisation Date" means the date of a Utilisation, on which a drawing is to be made under the Facility, such date to be the Monday preceding the 18th day of any month.

"Utilisation Request" means a notice substantially in the form set out in Schedule 2 (*Utilisation Request*).

"VAT" means value added tax as provided for in the Value Added Tax Act 1994 and other tax of a similar nature, whether imposed in the UK or elsewhere.

1.2 **Construction**

1.2.1 Unless a contrary indication appears, any reference in any Finance Document to:

(A) the **"Lender"**, the **"Borrower"** the **"Supervisory Body"** or any **"Party"** shall be construed so as to include its successors in title, permitted assigns and permitted transferees;

(B) **"assets"** includes present and future properties, revenues and rights of every description;

(C) a **"Finance Document"** or any other agreement or instrument is a reference to that Finance Document or other agreement or instrument as amended or novated;

(D) **"indebtedness"** shall be construed so as to include any obligation (whether incurred as principal or as surety) for the payment or repayment of money, whether present or future, actual or contingent;

(E) a **"person"** includes any person, firm, company, corporation, government, state or agency of a state or any association, trust or partnership (whether or not having separate legal personality) or two or more of the foregoing;

(F) a **"regulation"** includes any regulation, rule, official directive, request or guideline (whether or not having the force of law) of any governmental, intergovernmental or supranational body, agency, department or regulatory, self-regulatory or other authority or organisation;

(G) **"repay"** (or any derivative form thereof) shall, subject to any contrary indication, be construed to include **"prepay"** (or, as the case may be, the corresponding derivative form thereof);

(H) a provision of law is a reference to that provision as amended or re-enacted;

(I) a time of day is a reference to London time; and

(J) the word **"including"** is without limitation.

1.2.2 Section, Clause and Schedule headings are for ease of reference only.

1.2.3 Unless a contrary indication appears, a term used in any other Finance Document or in any notice given under or in connection with any Finance Document has the same meaning in that Finance Document or notice as in this Agreement.

1.2.4 A Default (other than an Event of Default) is **"continuing"** if it has not been remedied or waived and an Event of Default is **"continuing"** if it has not been waived or remedied to the satisfaction of the Lender.

1.3 **Third party rights**

1.3.1 Except as provided in a Finance Document, the terms of a Finance Document may be enforced only by a party to it and the operation of the Contracts (Rights of Third Parties) Act 1999 is excluded.

1.3.2 Notwithstanding any provision of any Finance Document, the Parties to a Finance Document do not require the consent of any third party to rescind or vary any Finance Document at any time.

2. THE FACILITY

2.1 Subject to the terms of this Agreement, the Lender makes available to the Borrower a sterling interim support facility in an aggregate amount equal to the Facility Amount.

2.2 The Facility shall be utilised by the Borrower for the purposes of and/or in connection with its functions as an NHS Body.

3. PURPOSE

3.1 Purpose

The Borrower shall apply all Loans towards financing or refinancing the Agreed Purpose.

3.2 Pending application

Without prejudice to Clause 3.1 *(Purpose)*, pending application of the proceeds of any Loan towards financing or refinancing the Agreed Purpose, the Borrower must deposit such proceeds in the Account.

3.3 Monitoring

The Lender is not bound to monitor or verify the application of any amount borrowed pursuant to this Agreement.

4. CONDITIONS OF UTILISATION

4.1 Initial conditions precedent

The Borrower may not deliver the first Utilisation Request unless the Lender has received all of the documents and other evidence listed in Schedule 1 (*Conditions precedent*) in form and substance satisfactory to the Lender or to the extent it has not received the same, it has waived receipt of the same. The Lender shall notify the Borrower promptly upon being so satisfied.

4.2 Further conditions precedent

The Lender will only be obliged to comply with a Utilisation Request if on the date of the Utilisation Request and on the proposed Utilisation Date:

4.2.1 No Event of Default might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware;

4.2.2 the Repeating Representations to be made by the Borrower with reference to the facts and circumstances then subsisting are true in all material respects; and,

4.2.3 the Borrower has provided to the Lender its most recent 13 week cash flow forecast, together with any other information that may from time to time be required.

5. UTILISATION

5.1 Utilisation

5.1.1 The Borrower may take Loans from time to time hereunder, subject to receipt by the Lender from the Borrower, of a Utilisation Request in accordance with this Agreement and an appropriate Cashflow Forecast.

5.1.2 The Utilisation Request must be for an amount not greater than the amount specified under Clause 5.4.2

5.1.3 Where agreed by the Lender, the proceeds of a Utilisation may be used to repay outstanding loans under any working capital facility between the Lender and the Borrower provided that:

(A) Such agreement is granted by the Lender;

(B) any request is included in the Cashflow Forecast; and

(C) that such repayment is received by the Lender on the same working day as the Utilisation.

5.2 **Delivery of a Utilisation Request**

The Borrower may utilise the Facility by delivery to the Lender of a duly completed Utilisation Request not later than 11.00 a.m. five Business Days before the proposed Utilisation Date unless otherwise agreed.

5.2.1 The Borrower may only issue one Utilisation Request per Month unless otherwise agreed.

5.3 **Completion of a Utilisation Request**

The Utilisation Request is irrevocable and will not be regarded as having been duly completed unless:

(A) the proposed Utilisation Date is a Business Day within the Availability Period; and

(B) the currency and amount of the Utilisation comply with Clause 5.4 (*Currency and amount*).

5.4 **Currency and amount**

5.4.1 The currency specified in the Utilisation Request must be sterling.

5.4.2 The amount of each proposed Loan must be an amount which is not more than the amount required to maintain a Cash Balance equivalent to the Minimum Cash Balance for a period from the Utilisation Date to the Monday preceding the 18th day of the following Month

5.4.3 The amount of each proposed Loan must be an amount which is not more than the Available Facility and which is a minimum of £150,000 or, if less, the Available Facility.

5.5 **Payment to the Account**

The Lender shall pay each Loan:

5.5.1 by way of credit to the Account and so that, unless and until the Lender shall notify the Borrower to the contrary, the Lender hereby consents to the withdrawal by the Borrower from the Account of any amount equal to the relevant Loan provided that any sums so withdrawn are applied by the Borrower for the purposes for which the relevant Loan was made;

5.5.2 if the Lender so agrees or requires, on behalf of the Borrower directly to the person to whom the relevant payment is due as specified in the relevant Utilisation Request; or

5.5.3 in such other manner as shall be agreed between the Lender and the Borrower.

6. PAYMENTS AND REPAYMENT

6.1 Payments

6.1.1 The Borrower shall make all payments payable under the Finance Documents without any Tax Deductions, unless a Tax Deduction is required by law.

6.1.2 The Borrower shall promptly upon becoming aware that it must make a Tax Deduction (or that there is any change in the rate or the basis of a Tax Deduction) notify the Lender accordingly.

6.1.3 If a Tax Deduction is required by law to be made by the Borrower, the amount of the payment due from the Borrower shall be increased to an amount which (after making any Tax Deduction) leaves an amount equal to the payment which would have been due if no Tax Deduction had been required.

6.1.4 If the Borrower is required to make a Tax Deduction, the Borrower shall make that Tax Deduction and any payment required in connection with that Tax Deduction within the time allowed and in the minimum amount required by law.

6.1.5 Within thirty days of making either a Tax Deduction or any payment required in connection with that Tax Deduction, the Borrower shall deliver to the Lender evidence reasonably satisfactory to the Lender that the Tax Deduction has been made or (as applicable) any appropriate payment paid to the relevant taxing authority.

6.2 Repayment

The Borrower shall repay the aggregate value of all outstanding Loans drawn under the Facility in full on or before the last day of the current Availability Period as set out in Schedule 6 *(Repayment Schedule)*.

6.3 Reborrowing

The Borrower may not reborrow any part of the Facility which is repaid or prepaid.

7. PREPAYMENT AND CANCELLATION

7.1 Illegality

If it becomes unlawful in any applicable jurisdiction for the Lender to perform any of its obligations as contemplated by this Agreement or to fund or maintain all or any part of the Loans:

7.1.1 the Lender shall promptly notify the Borrower upon becoming aware of that event;

7.1.2 upon the Lender notifying the Borrower, the Available Facility will be immediately cancelled; and

7.1.3 the Borrower shall repay such Loans on the last day of the Interest Period for Loans occurring after the Lender has notified the Borrower or, if earlier, the date specified by the Lender in the notice delivered to the Borrower (being no earlier than the last day of any applicable grace period permitted by law).

7.2 Voluntary cancellation

The Borrower may, if it gives the Lender not less than seven days' (or such shorter period as the Lender may agree) and not more than fourteen days' prior notice, cancel the whole or any part (being a minimum amount of £100,000) of the Facility Amount.

7.3 **Voluntary prepayment of Loans**

The Borrower may, if it gives the Lender not less than seven days' (or such shorter period as the Lender may agree) and not more than thirty days' prior notice, prepay the whole or any part of any Loan (but, if in part, being an amount that reduces the amount of the Loan by a minimum amount of £250,000).

7.4 **Restrictions**

7.4.1 Any notice of cancellation or prepayment given by any Party under this Clause 7 shall be irrevocable and, unless a contrary indication appears in this Agreement, shall specify the date or dates upon which the relevant cancellation or prepayment is to be made and the amount of that cancellation or prepayment.

7.4.2 Any prepayment under this Agreement shall be made together with accrued interest on the amount prepaid without premium or penalty and applied against the outstanding Repayment Instalments in inverse order of maturity.

7.4.3 The Borrower shall not repay or prepay all or any part of the Loan or cancel all or any part of the Available Facility except at the times and in the manner expressly provided for in this Agreement.

7.4.4 No amount of the Available Facility cancelled under this Agreement may be subsequently reinstated.

7.5 **Automatic Cancellation**

At the end of the Availability Period the undrawn part of the Available Facility will be cancelled.

8. INTEREST

8.1 **Calculation of interest**

The rate of interest on each Loan for each Interest Period is the Interest Rate.

8.2 **Payment of interest**

The Borrower shall pay accrued interest on each Loan on the last day of each Interest Period.

8.3 **Default interest**

8.3.1 If the Borrower fails to pay any amount payable by it under a Finance Document on its due date, interest shall accrue on Unpaid Sums from the due date up to the date of actual payment (both before and after judgment) at the Default Rate. Any interest accruing under this Clause 8.3 shall be immediately payable by the Borrower on demand by the Lender.

8.3.2 Default interest (if unpaid) arising on an overdue amount will be compounded with the overdue amount at the end of each Interest Period applicable to that overdue amount but will remain immediately due and payable.

9. INTEREST PERIODS

9.1 **Interest Payment Dates**

The Interest Period for each Loan shall be six Months, provided that any Interest Period which begins during another Interest Period shall end at the same time as that other Interest Period (and, where two or more such Interest Periods expire on the same day, the Loans to which those Interest Periods relate shall thereafter constitute and be referred to as one Loan).

9.2 **Shortening Interest Periods**

If an Interest Period would otherwise overrun the relevant Repayment Date, it shall be shortened so that it ends on the relevant Repayment Date.

9.2A **Payment Start Date**

Each Interest Period for a Loan shall start on the Utilisation Date or (if already made) on the last day of its preceding Interest Period.

9.3 **Non-Business Days**

If an Interest Period would otherwise end on a day which is not a Business Day, that Interest Period will instead end on the next Business Day in that calendar month (if there is one) or the preceding Business Day (if there is not).

9.4 **Consolidation of Loans**

If two or more Interest Periods end on the same date, those Loans will be consolidated into and be treated as a single Loan on the last day of the Interest Period.

10. PREPAYMENT AMOUNT

10.1.1 If all or any part of the Loans are subject to a voluntary prepayment pursuant to Clause 7.3 (*Voluntary prepayment of Loans*), the Borrower shall pay to the Lender on the relevant prepayment date the Prepayment Amount in respect of the same.

10.1.2 For as long as the Secretary of State for Health remains the Lender, the Lender will consider waiving the Prepayment Amount in cases where the Borrower can demonstrate to the Lender's satisfaction that the voluntary prepayment results from the Borrower's proper use of genuine surplus funds resulting from a sale of assets or trading activities.

11. INDEMNITIES

11.1 **Currency indemnity**

11.1.1 If any sum due from the Borrower under the Finance Documents (a **"Sum"**), or any order, judgment or award given or made in relation to a Sum, has to be converted from the currency (the **"First Currency"**) in which that Sum is payable into another currency (the **"Second Currency"**) for the purpose of:

(A) making or filing a claim or proof against the Borrower;

(B) obtaining or enforcing an order, judgment or award in relation to any litigation or arbitration proceedings,

the Borrower shall as an independent obligation, within five Business Days of demand, indemnify the Lender against any cost, loss or liability arising out of or as a result of the conversion including any discrepancy between (A) the rate of exchange used to convert that Sum from the First Currency into the Second Currency and (B) the rate or rates of exchange available to that person at the time of its receipt of that Sum.

11.1.2 The Borrower waives any right it may have in any jurisdiction to pay any amount under the Finance Documents in a currency or currency unit other than that in which it is expressed to be payable.

11.2 **Other indemnities**

The Borrower shall, within five Business Days of demand, indemnify the Lender against any cost, loss or liability incurred by the Lender as a result of:

11.2.1 the occurrence of any Event of Default;

11.2.2 a failure by the Borrower to pay any amount due under a Finance Document on its due date;

11.2.3 funding, or making arrangements to fund, all or any part of the Loans requested by the Borrower in a Utilisation Request but not made by reason of the operation of any one or more of the provisions of this Agreement (other than by reason of default or negligence by the Lender alone); or

11.2.4 the Loans (or part of the Loans) not being prepaid in accordance with a notice of prepayment given by the Borrower.

11.3 **Indemnity to the Lender**

The Borrower shall promptly indemnify the Lender against any cost, loss or liability incurred by the Lender (acting reasonably) as a result of:

11.3.1 investigating any event which it reasonably believes is a Default; or

11.3.2 acting or relying on any notice, request or instruction which it reasonably believes to be genuine, correct and appropriately authorised.

11.4 **Environmental indemnity**

The Borrower shall promptly indemnify the Lender within five Business Days of demand in respect of any judgments, liabilities, claims, fees, costs and expenses (including fees and disbursements of any legal, environmental consultants or other professional advisers) suffered or incurred by the Lender as a consequence of the breach of or any liability imposed under any Environmental Law with respect to the Borrower or its property (including the occupation or use of such property).

12. MITIGATION BY THE LENDER

12.1 **Mitigation**

12.1.1 The Lender shall, in consultation with the Borrower, take all reasonable steps to mitigate any circumstances which arise and which would result in any amount becoming payable under or pursuant to, or cancelled pursuant to Clause 7.1 (Illegality) including transferring its rights and obligations under the Finance Documents to another entity owned or supported by the Lender.

12.1.2 Clause 12.1.1 does not in any way limit the obligations of the Borrower under the Finance Documents.

12.2 **Limitation of liability**

12.2.1 The Borrower shall indemnify the Lender for all costs and expenses reasonably incurred by the Lender as a result of steps taken by it under Clause 12.1 (Mitigation).

12.2.2 The Lender is not obliged to take any steps under Clause 12.1 (Mitigation) if, in its opinion (acting reasonably), to do so might be prejudicial to it.

13. COSTS AND EXPENSES

13.1 **Enforcement costs**

The Borrower shall, within three Business Days of demand, pay to the Lender the amount of all costs and expenses (including legal fees) incurred by the Lender in connection with the enforcement of, or the preservation of any rights under, any Finance Document.

14. REPRESENTATIONS

The Borrower makes the representations and warranties set out in this Clause 14 to the Lender on the date of this Agreement.

14.1 **Status**

14.1.1 It is an NHS Body in accordance with the provisions of the Act.

14.1.2 It has the power to own its assets and carry on its business as it is being conducted.

14.2 **Binding obligations**

The obligations expressed to be assumed by it in each Finance Document are legal, valid, binding and enforceable obligations.

14.3 **Non-conflict with other obligations**

The entry into and performance by it of, and the transactions contemplated by, the Finance Documents to which it is party do not and will not conflict with:

14.3.1 any law or regulation applicable to it;

14.3.2 its constitutional documents; or

14.3.3 any agreement or instrument binding upon it or any of its assets.

14.4 **Power and authority**

It has the power to enter into, exercise its rights under, perform and deliver, and has taken all necessary action to authorise its entry into, performance and delivery of, the Finance Documents to which it is a party and the transactions contemplated by those Finance Documents.

14.5 **Validity and admissibility in evidence**

All Authorisations required:

14.5.1 to enable it lawfully to enter into, exercise its rights and comply with its obligations in the Finance Documents to which it is a party; and

14.5.2 to make the Finance Documents to which it is a party admissible in evidence in its jurisdiction of incorporation,

have been obtained or effected and are in full force and effect.

14.6 **Relevant Consents**

14.6.1 All Relevant Consents which it is necessary or appropriate for the Borrower to hold have been obtained and effected and are in full force and effect.

14.6.2 There exists no reason known to it, having made all reasonable enquiries, why any Relevant Consent might be withdrawn, suspended, cancelled, varied, surrendered or revoked.

14.6.3 All Relevant Consents and other consents, permissions and approvals have been or are being complied with.

14.7 **Governing law and enforcement**

14.7.1 The choice of English law as the governing law of the Finance Documents will be recognised and enforced by the courts of England and Wales.

14.7.2 Any judgment obtained in England in relation to a Finance Document will be recognised and enforced by the courts of England and Wales.

14.8 **Deduction of Tax**

It is not required to make any deduction for or on account of Tax from any payment it may make under any Finance Document.

14.9 **No filing or stamp taxes**

It is not necessary that the Finance Documents be filed, recorded or enrolled with any court or other authority in any jurisdiction or that any stamp, registration or similar tax be paid on or in relation to the Finance Documents or the transactions contemplated by the Finance Documents.

14.10 **No default**

14.10.1 No Event of Default might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware.

14.10.2 No other event which constitutes a default under any other agreement or instrument which is binding on it or to which its assets are subject which might have a Material Adverse Effect might reasonably be expected to result from the making of an Utilisation other than those of which the Lender and Borrower are aware.

14.11 **No misleading information**

14.11.1 All factual information provided by or on behalf of the Borrower in connection with the Borrower or any Finance Document was true and accurate in all material respects as at the date it was provided or as at the date (if any) at which it is stated.

14.11.2 Any financial projections provided to the Lender by or on behalf of the Borrower have been prepared on the basis of recent historical information and on the basis of reasonable assumptions.

14.11.3 Nothing has occurred or been omitted and no information has been given or withheld that results in the information referred to in Clause 14.12.1 being untrue or misleading in any material respect.

14.12 **Financial statements**

14.12.1 Its financial statements most recently delivered to the Lender (being on the date of this Agreement, the Original Financial Statements) were prepared in accordance with any applicable Audit Code for NHS Bodies, any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies and/or any other guidance with which NHS Bodies are (or in the case of the Original Financial Statements were) required to comply.

14.12.2 Its financial statements most recently delivered to the Lender (being on the date of this Agreement, the Original Financial Statements) fairly represent its financial condition and operations during the relevant financial year.

14.12.3 There has been no material adverse change in the business or financial condition of the Borrower since the date to which its financial statements most recently delivered to the Lender were made up.

14.13 **Ranking**

Its payment obligations under the Finance Documents rank at least pari passu with the claims of all its other unsecured and unsubordinated creditors, except for obligations mandatorily preferred by law.

14.14 **No proceedings pending or threatened**

No litigation, arbitration or administrative proceedings of or before any court, arbitral body or agency which, if adversely determined, might reasonably be expected to have a Material Adverse Effect have (to the best of its knowledge and belief) been started or threatened against it.

14.15 **Environmental Matters**

14.15.1 It is and has been in full compliance with all applicable Environmental Laws and there are, to the best of its knowledge and belief after reasonable enquiry, no circumstances that may prevent or interfere with such full compliance in the future, in each case to the extent necessary to avoid a Material Adverse Effect and the Borrower has not other than in the ordinary course of its activities placed or allowed to be placed on any part of its property any Dangerous Substance and where such Dangerous Substance has been so placed, it is kept, stored, handled, treated and transported safely and prudently so as not to pose a risk of harm to the Environment.

14.15.2 It is and has been, in compliance in all material respects with the terms of all Environmental Licences necessary for the ownership and operation of its activities as presently owned and operated and as presently proposed to be owned and operated.

14.15.3 It is not aware, having made reasonable enquiries, of any Environmental Claim.

14.16 **Repetition**

The Repeating Representations are deemed to be made by the Borrower by reference to the facts and circumstances then existing on the date of each Utilisation Request and on the first day of each Interest Period.

15. INFORMATION UNDERTAKINGS

The undertakings in this Clause 15 remain in force from the date of this Agreement for so long as any amount is outstanding under the Finance Documents or any part of the Facility is available for utilisation.

15.1 **Financial statements**

The Borrower shall supply to the Lender its audited financial statements for each financial year and its financial statements for each financial half year (including any monitoring returns sent to the appropriate Supervisory Body), in each case when such statements are provided to the appropriate Supervisory Body.

15.2 **Requirements as to financial statements**

15.2.1 Each set of financial statements delivered by the Borrower pursuant to Clause 15.1 (Financial statements) shall be certified by a director of the Borrower, acting on the instructions of the board of directors of the Borrower, as fairly representing its

financial condition as at the date as at which those financial statements were drawn up.

15.2.2 The Borrower shall procure that each set of financial statements delivered pursuant to Clause 15.1 (Financial statements) is prepared in accordance with any applicable Audit Code for NHS Bodies and any applicable Manual for Accounts for NHS Bodies and Annual Report Guidance for NHS Bodies or in the case of the Original Financial Statements in accordance with such guidelines with which NHS Bodies are required to comply.

15.3 **Information: miscellaneous**

The Borrower shall supply to the Lender:

15.3.1 copies or details of all material communications between the Borrower and the relevant Supervisory Body, including all relevant official notices received by the Borrower promptly after the same are made or received and, upon the Lender's request, any other relevant documents, information and returns sent by it to the appropriate Supervisory Body;

15.3.2 copies or details of all material communications between the Borrower and its members or its creditors (or in each case any class thereof), including all official notices received by the Borrower promptly after the same are made or received and upon the Lender's request any and all other documents dispatched by it to its members or its creditors (or in each case any class thereof), promptly after they are sent to such members or creditors;

15.3.3 details of any breaches by the Borrower of the Compliance Framework;

15.3.4 details of any breaches by the Borrower of the Licence or the terms of their Licence;

15.3.5 details of any other financial assistance or guarantee requested or received from the Secretary of State for Health other than in the ordinary course of business promptly after the same are requested or received;

15.3.6 upon the Lender's request, information regarding the application of the proceeds of the Facility;

15.3.7 promptly upon becoming aware of them, the details of any litigation, arbitration and/or administrative proceedings which are current, threatened or pending against the Borrower which would reasonably be expected to have a Material Adverse Effect;

15.3.8 promptly, such further information regarding the financial condition, business and operations of the Borrower as the Lender may reasonably request to the extent the same are relevant to the Borrower's obligations under this Agreement or otherwise significant in the assessment of the Borrower's financial performance and further to the extent that the disclosure of information will not cause the Borrower to be in breach of any obligation of confidence owed to any third party or any relevant data protection legislation; and

15.3.9 any change in the status of the Borrower after the date of this Agreement

15.4 **Notification of default**

15.4.1 The Borrower shall notify the Lender of any Default (and the steps being taken to remedy it) promptly upon becoming aware of its occurrence.

15.4.2 Promptly upon a request by the Lender, the Borrower shall supply a certificate signed by two of its directors (acting on the instructions of the board of directors of the

Borrower) on its behalf certifying that no Default is continuing (or if a Default is continuing, specifying the Default and the steps, if any, being taken to remedy it).

15.5 **Other information**

The Borrower shall promptly upon request by the Lender supply, or procure the supply of, such documentation and other evidence as is reasonably requested by the Lender (for itself or on behalf of a prospective transferee) in order for the Lender (or such prospective transferee) to carry out and be satisfied with the results of all necessary money laundering and identification checks in relation to any person that it is required to carry out pursuant to the transactions contemplated by the Finance Documents.

16. GENERAL UNDERTAKINGS

The undertakings in this Clause 16 remain in force from the date of this Agreement for so long as any amount is outstanding under the Finance Documents or any part of the Facility is available for utilisation.

16.1 **Authorisations**

The Borrower shall promptly:

16.1.1 obtain, comply with and do all that is necessary to maintain in full force and effect; and

16.1.2 supply certified copies to the Lender of any Authorisation required under any law or regulation of its jurisdiction of incorporation to enable it to perform its obligations under the Finance Documents and to ensure the legality, validity, enforceability or admissibility in evidence in England of any Finance Document.

16.2 **Compliance with laws**

The Borrower shall comply in all respects with all laws to which it may be subject, if failure so to comply would materially impair its ability to perform its obligations under the Finance Documents and shall exercise its powers and perform its functions in accordance with its constitutional documents.

16.3 **Negative pledge**

16.3.1 The Borrower shall not without the prior written consent of the Lender (such consent not to be unreasonably withheld or delayed) create or permit to subsist any Security over any of its assets save for any Permitted Security.

16.3.2 The Borrower shall not:

(A) sell, transfer or otherwise dispose of any of its assets on terms whereby they are or may be leased to or re-acquired by it;

(B) sell, transfer or otherwise dispose of any of its receivables on recourse terms;

(C) enter into any arrangement under which money or the benefit of a bank or other account may be applied, set-off or made subject to a combination of accounts; or

(D) enter into any other preferential arrangement having a similar effect,

in circumstances where the arrangement or transaction is entered into primarily as a method of raising Financial Indebtedness or of financing the acquisition of an asset.

16.4 **Disposals**

16.4.1 The Borrower shall not in a single transaction or a series of transactions (whether related or not) and whether voluntary or involuntary sell, lease, transfer or otherwise dispose of any material asset without the prior written consent of the Lender.

16.4.2 Clause 16.4.1 does not apply to:

(A) any sale, lease, transfer or other disposal where the higher of the market value or consideration receivable does not (in aggregate) in any financial year exceed 10% of the total net assets of the Borrower as at the end of the most recent financial year end for which audited financial statements have been published.

(B) any sale, lease, transfer or other disposal expressly identified in Schedule 8..

16.5 **Merger**

Without prejudice to Clause 16.4 (disposals) the Borrower shall not, without the prior written consent of the Lender, enter into nor apply to the relevant Supervisory Body (including pursuant to Section 56 of the Act) to enter into any amalgamation, demerger, merger or corporate reconstruction.

16.6 **Guarantees**

The Borrower will not, without the prior written consent of the Lender, give or permit to exist any guarantee or indemnity by it of any obligation of any person, nor permit or suffer any person to give any security for or guarantee or indemnity of any of its obligations except for guarantees and indemnities:

16.6.1 made in the ordinary course of the Borrower's business as an NHS Body ; and

16.6.2 which when aggregated with any loans, credit or financial accommodation made pursuant to Clause 16.7 (*Loans*) do not exceed £1,000,000 (or its equivalent in any other currency or currencies) in aggregate in any financial year.

16.7 **Loans**

The Borrower will not make any investment in nor make any loan or provide any other form of credit or financial accommodation to, any person except for investments, loans, credit or financial accommodation:

16.7.1 made in the ordinary course of the Borrower's business as an NHS Body ;

16.7.2 made in accordance with any investment policy or guidance issued by the relevant Supervisory Body; and

16.7.3 which when aggregated with any guarantees or indemnities given or existing under Clause 16.6 (*Guarantees*) do not exceed £1,000,000 (or its equivalent in any other currency or currencies) in aggregate in any financial year.

16.8 **Consents**

The Borrower must ensure that all Relevant Consents and all statutory requirements, as are necessary to enable it to perform its obligations under the Finance Documents to which it is a party, are duly obtained and maintained in full force and effect or, as the case may be, complied with.

16.9 **Activities**

The Borrower will not engage in any activities other than activities which enable it to carry on its principal purpose better, if to do so may, in the Lender's opinion, have a Material Adverse Effect.

16.10 **Environmental**

The Borrower shall:

16.10.1 obtain, maintain and comply in all material respects with all necessary Environmental Licences in relation to its activities and its property and comply with all Environmental Laws to the extent necessary to avoid a Material Adverse Effect;

16.10.2 promptly upon becoming aware notify the Lender of:

(A) any Environmental Claim current or to its knowledge threatened;

(B) any circumstances likely to result in an Environmental Claim; or

(C) any suspension, revocation or notification of any Environmental Licence;

16.10.3 indemnify the Lender against any loss or liability which:

(A) the Lender incurs as a result of any actual or alleged breach of any Environmental Law by any person; and

(B) which would not have arisen if a Finance Document had not been entered into; and

16.10.4 take all reasonable steps to ensure that all occupiers of the Borrower's property carry on their activities on the property in a prudent manner and keep them secure so as not to cause or knowingly permit material harm or damage to the Environment (including nuisance or pollution) or the significant risk thereof.

16.11 **Constitution**

The Borrower will not amend or seek to amend the terms of its authorisation as an NHS Body or the terms of its constitution without the prior written consent of the Lender, in each case if to do so would be reasonably likely to have a Material Adverse Effect.

16.12 **The relevant Supervisory Body**

The Borrower will comply promptly with all directions and notices received from the relevant Supervisory Body to the extent failure to do so might have a Material Adverse Effect and will, upon the Lender's request, provide reasonable evidence that it has so complied.

16.13 **Additional Terms and Conditions**

The Borrower will comply promptly with the Additional Terms and Conditions.

17. COMPLIANCE FRAMEWORK

17.1 **Compliance**

The Borrower shall ensure at all times that it complies with its Licence and/or any other terms and conditions set by the Relevant Supervisory Body.

17.2 **Advance Notification**

Without prejudice to the Borrower's obligations under Clause 17.1 (*Compliance*), if the Borrower becomes aware at any time after the date of signing of the Agreement that it is or is

likely to breach any of the terms referred to in Clause 17.1 and/or a material failure under the requirements of the Compliance Framework is likely, it shall immediately notify the Lender of the details of the impending breach.

18. EVENTS OF DEFAULT

Each of the events or circumstances set out in this Clause 18 is an Event of Default.

18.1 Non-payment

The Borrower does not pay on the due date any amount payable pursuant to a Finance Document at the place at and in the currency in which it is expressed to be payable unless:

18.1.1 its failure to pay is caused by administrative or technical error; and

18.1.2 payment is made within two Business Days of its due date.

18.2 Compliance Framework and Negative Pledge

Any requirement of Clause 17 (*COMPLIANCE FRAMEWORK*) or Clause 16.3 (*Negative Pledge*) is not satisfied.

18.3 Other obligations

18.3.1 The Borrower does not comply with any term of:

(A) Clause 15.5 (*Notification of default*); or

(B) Clause 16 (*General Undertakings*).

18.3.2 The Borrower does not comply with any term of any Finance Document (other than those referred to in Clause 18.1 (*Non-payment*), Clause 18.2 (*Compliance Framework and Negative Pledge*) and Clause 18.3.1(*Other obligations*) unless the failure to comply is capable of remedy and is remedied within ten Business Days of the earlier of the Lender giving notice or the Borrower becoming aware of the failure to comply.

18.4 Misrepresentation

Any representation or statement made or deemed to be made by the Borrower in any Finance Document or any other document delivered by or on behalf of the Borrower under or in connection with any Finance Document is or proves to have been incorrect or misleading in any material respect when made or deemed to be made.

18.5 Cross default

18.5.1 Any Financial Indebtedness of the Borrower is not paid when due nor within any originally applicable grace period.

18.5.2 Any Financial Indebtedness of the Borrower is declared to be or otherwise becomes due and payable prior to its specified maturity as a result of an event of default (however described).

18.5.3 Any commitment for any Financial Indebtedness of the Borrower is cancelled or suspended by a creditor of the Borrower as a result of an event of default (however described).

18.5.4 Any creditor of the Borrower becomes entitled to declare any Financial Indebtedness of the Borrower due and payable prior to its specified maturity as a result of an event of default (however described).

18.5.5 No Event of Default will occur under this Clause 18.5 if the aggregate amount of Financial Indebtedness or commitment for Financial Indebtedness falling within Clauses 18.5.1 to 18.5.4 is less than £250,000 (or its equivalent in any other currency or currencies).

except that for as long as the Secretary of State for Health remains the Lender, the provisions of Clause 18.5 relate to Financial Indebtedness owed to any party but do not apply to amounts owed to other NHS bodies in the normal course of business where a claim has arisen which is being disputed in good faith or where the Borrower has a valid and contractual right of setoff.

18.6 **Insolvency**

18.6.1 The Borrower is unable or admits inability to pay its debts as they fall due, suspends making payments on any of its debts or, by reason of actual or anticipated financial difficulties, commences negotiations with one or more of its creditors with a view to rescheduling any of its indebtedness.

18.6.2 A moratorium is declared in respect of any indebtedness of the Borrower.

18.7 **Insolvency proceedings**

Any corporate action, legal proceedings or other procedure or step is taken:

18.7.1 in relation to a composition, assignment or arrangement with any creditor of the Borrower; or

18.7.2 in relation to the appointment of a liquidator, receiver, administrator, administrative receiver, compulsory manager or other similar officer in respect of the Borrower or any of its assets; or

18.7.3 in relation to the enforcement of any Security over any assets of the Borrower,

or any analogous action, proceedings, procedure or step is taken in any jurisdiction.

18.8 **Appointment of a Trust Special Administrator**

An order, made as required under The Act for the appointment of a Trust Special Administrator.

18.9 **Creditors' process**

Any expropriation, attachment, sequestration, distress or execution affects any asset or assets of the Borrower having an aggregate value of £250,000 and is not discharged within ten Business Days.

18.10 **Repudiation**

The Borrower or any other party to a Finance Document repudiates any of the Finance Documents or does or causes to be done any act or thing evidencing an intention to repudiate any Finance Document.

18.11 **Cessation of Business**

Other than with the prior written approval of the Lender, the Borrower ceases, or threatens to cease, to carry on all or a substantial part of its business or operations.

18.12 **Unlawfulness**

It is or becomes unlawful for the Borrower or any other party to a Finance Document to perform any of its obligations under any Finance Document.

18.13 **Material adverse change**

Any event or circumstance or series of events or circumstances occurs which, in the reasonable opinion of the Lender, has or is reasonably likely to have a Material Adverse Effect.

18.14 **Additional Terms and Conditions**

In the reasonable opinion of the Lender, the Borrower fails to make reasonable efforts to comply with the Additional Terms and Conditions.

18.15 **Acceleration**

On and at any time after the occurrence of an Event of Default which is continuing the Lender may by notice to the Borrower:

18.15.1 cancel the Facility whereupon it shall immediately be cancelled; and/or

18.15.2 declare that all or part of the Loans, together with accrued interest, and all other amounts accrued or outstanding under the Finance Documents be immediately due and payable, whereupon they shall become immediately due and payable; and/or

18.15.3 declare that all or part of the Loans be payable on demand, whereupon they shall immediately become payable on demand by the Lender.

19. ASSIGNMENTS AND TRANSFERS

19.1 **Assignments and transfers by the Lender**

Subject to this Clause 19, the Lender may:

19.1.1 assign any of its rights; or

19.1.2 transfer by novation any of its rights and obligations,

to another entity owned or supported by the Lender or to a bank or a financial institution or to a trust, fund or other entity which is regularly engaged in or established for the purpose of making, purchasing or investing in loans, securities or other financial assets (the **"New Lender"**).

19.2 **Conditions of assignment or transfer**

19.2.1 The consent of the Borrower is required for an assignment or transfer by the Lender, unless:

(A) the assignment or transfer is to an entity owned or supported by the Lender; or

(B) a Default is continuing.

19.2.2 The consent of the Borrower to an assignment or transfer must not be unreasonably withheld or delayed. The Borrower will be deemed to have given its consent twenty Business Days after the Lender has requested it unless consent is expressly refused (and reasons for such refusal are given) by the Borrower within that time.

provided that nothing in this Clause shall restrict the rights of the Secretary of State for Health to effect a statutory transfer.

19.3 **Disclosure of information**

The Lender may disclose to any person:

19.3.1 to (or through) whom the Lender assigns or transfers (or may potentially assign or transfer) all or any of its rights and obligations under the Finance Documents;

19.3.2 with (or through) whom the Lender enters into (or may potentially enter into) any transaction under which payments are to be made by reference to, any Finance Document or the Borrower;

19.3.3 to whom, and to the extent that, information is required to be disclosed by any applicable law or regulation;

19.3.4 which are investors or potential investors in any of its rights and obligations under the Finance Documents and only to the extent required in relation to such rights and obligations;

19.3.5 which is a governmental, banking, taxation or other regulatory authority and only to the extent information is required to be disclosed to such authority,

any information about the Borrower and/or the Finance Documents as the Lender shall consider appropriate if, in relation to Clauses 19.3.1, 19.3.2 and 19.3.4 the person to whom the information is to be given has agreed to keep such information confidential on terms of this Clause 19.3 provided always that the Lender shall comply with any relevant data protection legislation.

19.4 **Assignment and transfer by the Borrower**

The Borrower may not assign any of its rights or transfer any of its rights or obligations under the Finance Documents.

20. ROLE OF THE LENDER

20.1 **Rights and discretions of the Lender**

20.1.1 The Lender may rely on:

(A) any representation, notice or document believed by it to be genuine, correct and appropriately authorised; and

(B) any statement made by a director, authorised signatory or authorised employee of any person regarding any matters which may reasonably be assumed to be within his knowledge or within his power to verify.

20.1.2 The Lender may engage, pay for and rely on the advice or services of any lawyers, accountants, surveyors or other experts.

20.1.3 The Lender may act in relation to the Finance Documents through its personnel and agents.

20.1.4 Notwithstanding any other provision of any Finance Document to the contrary, the Lender is not obliged to do or omit to do anything if it would or might in its reasonable opinion constitute a breach of any law or a breach of a fiduciary duty or duty of confidentiality.

20.2 **Exclusion of liability**

20.2.1 Without limiting Clause 20.2.2, the Lender will not be liable for any omission or any act taken by it under or in connection with any Finance Document, unless directly caused by its gross negligence or wilful misconduct.

20.2.2 The Borrower may not take any proceedings against any officer, employee or agent of the Lender in respect of any claim it might have against the Lender or in respect of any act or omission of any kind by that officer, employee or agent in relation to any Finance Document and any officer, employee or agent of the Lender may rely on this Clause. Any third party referred to in this Clause 20.2.2 may enjoy the benefit of or enforce the terms of this Clause in accordance with the provisions of the Contracts (Rights of Third Parties) Act 1999.

20.2.3 The Lender will not be liable for any delay (or any related consequences) in crediting an account with an amount required under the Finance Documents to be paid by the Lender if the Lender has taken all necessary steps as soon as reasonably practicable to comply with the regulations or operating procedures of any recognised clearing or settlement system used by the Lender for that purpose.

20.2.4 The Lender shall not be liable:

(A) for any failure by the Borrower to give notice to any third party or to register, file or record (or any defect in such registration, filing or recording) any Finance Document; or

(B) for any failure by the Borrower to obtain any licence, consent or other authority required in connection with any of the Finance Documents; or

(C) For any other omission or action taken by it in connection with any Finance Document unless directly caused by its gross negligence or wilful misconduct.

21. PAYMENT MECHANICS

21.1 **Payments**

21.1.1 The Borrower shall receive notification 10 working days prior to each payment required under a Finance Document, the Borrower shall make the same available to the Lender (unless a contrary indication appears in a Finance Document) for value on the due date at the time and in such funds specified by the Lender as being customary at the time for settlement of transactions in the relevant currency in the place of payment.

21.1.2 Payment shall be collected through Direct Debit from a Borrower's account with the Government Banking Service.

21.2 **Distributions to the Borrower**

The Lender may (with the consent of the Borrower or in accordance with Clause 22 (*Set-off*)) apply any amount received by it for the Borrower in or towards payment (on the date and in the currency and funds of receipt) of any amount due from the Borrower under the Finance Documents or in or towards purchase of any amount of any currency to be so applied.

21.3 **Partial payments**

If the Lender receives a payment that is insufficient to discharge all the amounts then due and payable by the Borrower under the Finance Documents, the Lender shall apply that payment towards the obligations of the Borrower in such order and in such manner as the Lender may at its discretion decide.

21.4 **No set-off**

All payments to be made by the Borrower under the Finance Documents shall be calculated and be made without (and free and clear of any deduction for) set-off or counterclaim.

21.5 **Business Days**

21.5.1 Any payment which is due to be made on a day that is not a Business Day shall be made on the next Business Day in the same calendar month (if there is one) or the preceding Business Day (if there is not).

21.5.2 During any extension of the due date for payment of any principal or Unpaid Sum under this Agreement, interest is payable on the principal or Unpaid Sum at the rate payable on the original due date.

21.6 **Currency of account**

21.6.1 Subject to Clauses 21.6.2 to 21.6.5, sterling is the currency of account and payment for any sum due from the Borrower under any Finance Document.

21.6.2 A repayment of the Loan or Unpaid Sum or a part of the Loan or Unpaid Sum shall be made in the currency in which the Loan or Unpaid Sum is denominated on its due date.

21.6.3 Each payment of interest shall be made in the currency in which the sum in respect of which the interest is payable was denominated when that interest accrued.

21.6.4 Each payment in respect of costs, expenses or Taxes shall be made in the currency in which the costs, expenses or Taxes are incurred.

21.6.5 Any amount expressed to be payable in a currency other than sterling shall be paid in that other currency.

21.7 **Change of currency**

21.7.1 Unless otherwise prohibited by law, if more than one currency or currency unit are at the same time recognised by the central bank of any country as the lawful currency of that country, then:

(A) any reference in the Finance Documents to, and any obligations arising under the Finance Documents in, the currency of that country shall be translated into, or paid in, the currency or currency unit of that country designated by the Lender (after consultation with the Borrower); and

(B) any translation from one currency or currency unit to another shall be at the official rate of exchange recognised by the central bank for the conversion of that currency or currency unit into the other, rounded up or down by the Lender (acting reasonably).

21.7.2 If a change in any currency of a country occurs, this Agreement will, to the extent the Lender (acting reasonably and after consultation with the Borrower) specifies to be necessary, be amended to comply with any generally accepted conventions and market practice in the London interbank market and otherwise to reflect the change in currency.

22. SET-OFF

The Lender may set off any matured obligation due from the Borrower under the Finance Documents against any matured obligation owed by the Lender to the Borrower, regardless of

the place of payment, booking branch or currency of either obligation. If the obligations are in different currencies, the Lender may convert either obligation at a market rate of exchange in its usual course of business for the purpose of the set-off.

23. NOTICES

23.1 Communications in writing

Any communication to be made under or in connection with the Finance Documents shall be made in writing and, unless otherwise stated, may be given in person, by post, fax or by electronic communication.

23.2 Addresses

The address and fax number (and the department or officer, if any, for whose attention the communication is to be made) of each Party for any communication or document to be made or delivered under or in connection with the Finance Documents is:

23.2.1 in the case of the Borrower, that identified with its name below; and

23.2.2 in the case of the Lender, that identified with its name below,

or any substitute address, email address, fax number or department or officer as the Borrower may notify to the Lender by not less than five Business Days' written notice.

23.3 Delivery

23.3.1 Any communication or document made or delivered by one person to another under or in connection with the Finance Documents will only be effective:

(A) if by way of fax, when received in legible form; or

(B) if by way of letter, when it has been left at the relevant address or five Business Days after being deposited in the post postage prepaid in an envelope addressed to it at that address,

and, if a particular department or officer is specified as part of its address details provided under Clause 23.2 (*Addresses*), if addressed to that department or officer.

23.3.2 Any communication or document to be made or delivered to the Lender will be effective only when actually received by the Lender and then only if it is expressly marked for the attention of the department or officer identified with the Lender's signature below (or any substitute department or officer as the Lender shall specify for this purpose).

23.4 Electronic communication

23.4.1 Any communication to be made between the Borrower and the Lender under or in connection with this Agreement and any other Finance Document may be made by electronic mail or other electronic means, if the Borrower and the Lender:

(A) agree that, unless and until notified to the contrary, this is to be an accepted form of communication;

(B) notify each other in writing of their electronic mail address and/or any other information required to enable the sending and receipt of information by that means; and

(C) notify each other of any change to their address or any other such information supplied by them.

23.4.2 Any electronic communication made between the Borrower and the Lender will be effective only when actually received in readable form and only if it is addressed in such a manner as the Borrower and the Lender, as the case may be, specify for this purpose.

24. CALCULATIONS AND CERTIFICATES

24.1 Accounts

In any litigation or arbitration proceedings arising out of or in connection with a Finance Document, the entries made in the accounts maintained by the Lender are *prima facie* evidence of the matters to which they relate.

24.2 Certificates and Determinations

Any certification or determination by the Lender of a rate or amount under any Finance Document is, in the absence of manifest error, conclusive evidence of the matters to which it relates.

24.3 Day count convention

Any interest, commission or fee accruing under a Finance Document will accrue from day to day and is calculated on the basis of the actual number of days elapsed and a year of 365 days or, in any case where the practice in the London interbank market differs, in accordance with that market practice.

25. PARTIAL INVALIDITY

If, at any time, any provision of the Finance Documents is or becomes illegal, invalid or unenforceable in any respect under any law of any jurisdiction, neither the legality, validity or enforceability of the remaining provisions nor the legality, validity or enforceability of such provision under the law of any other jurisdiction will in any way be affected or impaired.

26. REMEDIES AND WAIVERS

No failure to exercise, nor any delay in exercising, on the part of the Lender, any right or remedy under the Finance Documents shall operate as a waiver, nor shall any single or partial exercise of any right or remedy prevent any further or other exercise or the exercise of any other right or remedy. The rights and remedies provided in this Agreement are cumulative and not exclusive of any rights or remedies provided by law.

27. AMENDMENTS AND WAIVERS

Any term of the Finance Documents may only be amended or waived in writing.

28. COUNTERPARTS

Each Finance Document may be executed in any number of counterparts, and this has the same effect as if the signatures on the counterparts were on a single copy of the Finance Document.

29. GOVERNING LAW

This Agreement shall be governed by and construed in accordance with English law.

30. DISPUTE RESOLUTION

The Parties agree that all disputes arising out of or in connection with this Agreement will be settled in accordance with the terms of Schedule 5.

This Agreement has been entered into on the date stated at the beginning of this Agreement.

SCHEDULE 1: CONDITIONS PRECEDENT

1. Authorisations

1.1 A copy of a resolution of the board of directors of the Borrower:

(A) approving the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;

(B) authorising a specified person or persons to execute the Finance Documents to which it is a party on its behalf; and

(C) authorising a specified person or persons, on its behalf, to sign and/or despatch all documents and notices (including, if relevant, any Utilisation Request and) to be signed and/or despatched by it under or in connection with the Finance Documents to which it is a party.

(D) Confirming the Borrower's undertaking to comply with the Additional Terms and Conditions

1.2 A certificate of an authorised signatory of the Borrower certifying that each copy document relating to it specified in this Schedule 1 and provided to the Lender is correct, complete and in full force and effect as at a date no earlier than the date of this Agreement.

2. Financial Information

Updated financial statements of the Borrower unless otherwise available.

3. Finance Documents

3.1 This Agreement (original).

3.2 The original or certified copy (as the Lender shall require) of any Finance Document not listed above.

4. General

4.1 A copy of any other Authorisation or other document, opinion or assurance which the Lender considers to be necessary or desirable in connection with the entry into and performance of the transactions contemplated by any Finance Document or for the validity and enforceability of any Finance Document.

4.2 Evidence that the fees, costs and expenses then due from the Borrower pursuant to Clause 13 (*Costs and expenses*) have been paid or will be paid by the first Utilisation Date.

SCHEDULE 2: UTILISATION REQUEST

From:[ ]

To: The Secretary of State for Health

Dated:

Dear Sirs

[ ] – £
dated [ ] (the "Agreement")

1. We refer to the Agreement. This is a Utilisation Request. Terms defined in the Agreement have the same meaning in this Utilisation Request unless given a different meaning in this Utilisation Request.

2. We wish to borrow a Loan on the following terms:

Proposed Utilisation Date:	[ ] (or, if that is not a Business Day, the next Business Day)
Amount:	[ ] or, if less, the Available Facility
Payment Instructions:	[*Relevant account to be specified here*]

3. We confirm that each condition specified in Clause 4.2 (Further conditions precedent) is satisfied on the date of this Utilisation Request.

4. We represent and warrant that the Loan will be applied solely towards working capital requirements of the Borrower in its requirement as an NHS Trust/NHS Foundation Trust.

5. This Utilisation Request is irrevocable.

Yours faithfully

……
authorised signatory for and on behalf of the Board of Directors
[ ]

SCHEDULE 3: NOT USED

SCHEDULE 4: ANTICIPATED DRAWDOWN SCHEDULE

£000	Q1	Q2	Q3	Q4	TOTAL
2015-16	0	0	0	16,908	**16,908**
TOTAL					**16,908**

SCHEDULE 5: DISPUTE RESOLUTION

1. NEGOTIATION

If any claim, dispute or difference of whatsoever nature arising out of or in connection with this Agreement ("**Dispute(s)**") arises, the Parties will attempt in good faith to settle it by negotiation. Each Party will nominate at least one management representative ("**Authorised Representative**") who shall attend and participate in the negotiation with authority to negotiate a solution on behalf of the Party so represented.

2. MEDIATION

It shall be a condition precedent to the commencement of reference to arbitration that the Parties have sought to have the dispute resolved amicably by mediation as provided by this paragraph 2.

2.1 Initiation of Mediation Proceeding

(A) If the Parties are unable to settle the Dispute(s) by negotiation in accordance with paragraph 1 within 15 days, either Party may by written notice upon the other initiate mediation under this paragraph 2. The notice initiating mediation shall describe generally the nature of the Dispute.

(B) Each Party's Authorised Representative nominated in accordance with paragraph 1 shall attend and participate in the mediation with authority to negotiate a settlement on behalf of the Party so represented.

2.2 Appointment of Mediator

(A) The Parties shall appoint, by agreement, a neutral third person to act as a mediator (the "Mediator") to assist them in resolving the Dispute. If the Parties are unable to agree on the identity of the Mediator within 10 days after notice initiating mediation either party may request the Centre for Effective Dispute Resolution ("CEDR Solve") to appoint a Mediator.

(B) The Parties will agree the terms of appointment of the Mediator and such appointment shall be subject to the Parties entering into a formal written agreement with the Mediator regulating all the terms and conditions including payment of fees in respect of the appointment. If the Parties are unable to agree the terms of appointment of the Mediator within 10 days after notice initiating mediation either Party may request CEDR Solve to decide the terms of appointment of the Mediator

(C) If the appointed Mediator is or becomes unable or unwilling to act, either Party may within 10 days of the Mediator being or becoming unable or unwilling to act follow the process at paragraph 2.3 to appoint a replacement Mediator and paragraph 2.4 to settle the terms of the appointment of the replacement Mediator.

2.3 Determination of Procedure

The Parties shall, with the assistance of the Mediator, seek to agree the mediation procedure. In default of such agreement, the Mediator shall act in accordance with CEDR Solve's Model Mediation Procedure and Agreement. The Parties shall within 10 days of the appointment of the Mediator, meet (or talk to) the Mediator in order to agree a programme for the exchange of any relevant information and the structure to be adopted for the mediation.

2.4 **Without Prejudice/Confidentiality**

All rights of the Parties in respect of the Dispute(s) are and shall remain fully reserved and the entire mediation including all documents produced or to which reference is made, discussions and oral presentations shall be strictly confidential to the Parties and shall be conducted on the same basis as "without prejudice" negotiations, privileged, inadmissible, not subject to disclosure in any other proceedings whatever and shall not constitute any waiver of privilege whether between the Parties or between either of them and a third party. Nothing in this paragraph 2.4 shall make any document privileged, inadmissible or not subject to disclosure which would have been discloseable in any reference to arbitration commenced pursuant to paragraph 3.

2.5 **Resolution of Dispute**

If any settlement agreement is reached with the assistance of the Mediator which resolves the Dispute, such agreement shall be set out in a written settlement agreement and executed by both parties' Authorised Representatives and shall not be legally binding unless and until both parties have observed and complied with the requirements of this paragraph 2.5. Once the settlement agreement is legally binding, it may be enforced by either party taking action in the High Court.

2.6 **Failure to Resolve Dispute**

In the event that the Dispute(s) has not been resolved to the satisfaction of either Party within 30 days after the appointment of the Mediator either party may refer the Dispute to arbitration in accordance with paragraph 3.

2.7 **Costs**

Unless the Parties otherwise agree, the fees and expenses of the Mediator and all other costs of the mediation shall be borne equally by the Parties and each Party shall bear their own respective costs incurred in the mediation regardless of the outcome of the mediation.

3. **ARBITRATION**

3.1 If the Parties are unable to settle the Dispute(s) by mediation in accordance with paragraph 2 within 30 days, the Dispute(s) shall be referred to and finally determined by arbitration before an Arbitral Tribunal composed of a single Arbitrator.

3.2 Any reference of a Dispute to arbitration shall be determined in accordance with the provisions of the Arbitration Act 1996 and in accordance with such arbitration rules as the Parties may agree within 20 days after notice initiating arbitration or, in default of agreement, in accordance with the Rules of the London Court of International Arbitration which Rules are deemed to be incorporated by reference into this clause.

3.3 London shall be the seat of the arbitration.

3.4 Reference of a Dispute to arbitration shall be commenced by notice in writing from one Party to the other Party served in accordance with the provisions of Clause 23 (Notices).

3.5 The Arbitral Tribunal shall be appointed as follows.

(A) Within 14 days of receipt of any notice referring a Dispute to arbitration the Parties shall agree the identity of the person to act as Arbitrator. In default of agreement or in the event the person so identified is unable or unwilling to act, either party shall be

entitled to request the President for the time being of the Chartered Institute of Arbitrators to appoint an Arbitrator for the Dispute and the parties shall accept the person so appointed.

(B) If the Arbitrator becomes unwilling or unable to act, the procedure for the appointment of a replacement Arbitrator shall be in accordance with the provisions of paragraph 3.5(A).

3.6 The language of the arbitration shall be English.

SCHEDULE 6: REPAYMENT SCHEDULE

Repayment Date	Relevant Percentage
18th February 2019	100%

SCHEDULE 7: PERMITTED SECURITY – EXISTING SECURITY

NONE

SCHEDULE 8: ADDITIONAL TERMS AND CONDITIONS

1. Surplus/Deficit and Capital Limits

1.1. The Lender has set a Surplus/Deficit Limit and/or a Capital Limit for the Borrower in consultation with the relevant Supervisory Body. These Limits reflect the aggregate of Voted Funds available to the Lender at the date of this Agreement.

1.2. The Borrower understands and accepts these Limits in the recognition that any net expenditure in excess of the relevant Limit(s) cannot be funded by the Lender based upon the assumptions made by the Lender at the date of this Agreement.

1.3. The Borrower undertakes not to put forward any Utilisation Requests on this or any other Facility with the Lender that would result in Limits being exceeded by the Borrower without the explicit agreement of the Lender.

1.4. In the event that a utilisation is likely to lead to a Limit being exceeded, the Borrower shall inform the Lender two calendar months before any such utilisation may be submitted.

1.5. The Borrower will make no assumptions in any financial planning in relation to any financial support from the Lender beyond financing previously agreed to support the relevant Limit(s).

1.6. Limits may be adjusted by the Lender from time to time in consultation with the relevant Supervisory Body.

1.7. Performance against Limits will be monitored by the relevant Supervisory Body.

1.8. For the avoidance of doubt, as at the date of this Agreement and for the financial year to which this agreement relates, the Surplus/Deficit Limit is (£12,132,000) and the Capital Limit is not applicable.

2. Nursing agency expenditure:

2.1. The Borrower undertakes to comply with nursing agency spending rules as set out in the letter of 1 September 2015 from David Bennett and Robert Alexander to NHS Foundation Trust and Trust Chief Executives as may be updated from time to time. In particular, the Borrower undertakes to:

2.1.1. Procure all nursing agency staff through approved frameworks unless such action is otherwise authorised by the relevant Supervisory Body.
2.1.2. Implement an annual maximum limit for agency nursing expenditure as a percentage of the total nursing staff budget as set out in the letter of 01 September 2015 or as otherwise notified by the relevant Supervisory Body.
2.1.3. Implement any additional controls as may be required by the relevant Supervisory Body in relation to the planned introduction of price caps.

2.2. The Borrower additionally undertakes to Implement the NHS Employers Five High Impact Actions

3. Professional Services Consultancy Spend

3.1. The Borrower will not enter into any contract for the procurement of professional consultancy services with a value in excess of £50,000 without the prior approval of the relevant Supervisory Body. The value of multiple contracts issued in respect similar Terms of Reference will be aggregated, as though a single contract had been issued, in respect of the application of this clause.

4. VSM Pay Costs

4.1. Where the borrower is authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the views of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500.

4.2. Where the borrower is not authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the approval of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500.

4.3. The Borrower undertakes to implement the requirements in respect of the treatment of "off - payroll" workers included in the letter from David Nicholson to Chairs and Chief Executives of 20th August 2012, or any subsequent guidance issued by the Lender.

4.4. The Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England to all newly appointed VSMs except where existing statutory terms take precedence. In addition the Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England for existing VSMs where Section 16 is referenced in their contracts of employment.

5. Estate Costs

5.1. The Borrower undertakes to examine the overall running costs of Estates and Facilities against a benchmark group of similar NHS Trusts within 3 months from the date of this Agreement. Where higher than average costs are identified, and there is no valid reason for this, the Borrower will put in place an action plan to reduce these costs to match the agreed benchmark level. DH will need to satisfy itself that the benchmark is reasonable and plan is deliverable.

6. Surplus Land

6.1. The Borrower shall ensure that it has in place an up to date estates strategy covering a period at least 3 years from the date of this Agreement. The estates strategy should be informed by discussions with commissioners about clinical service requirements and consider options for rationalising the estate and releasing surplus land.

6.2. The report required in clause 6.1 shall identify surplus land and potentially surplus land to be released during the period from the date of this Agreement date to 31 March 2020.

6.3. The Borrower shall provide the Lender with a copy of its estate strategy within 6 weeks of the date of this Agreement or at a date otherwise agreed with the Lender. The Lender will need satisfy itself that the strategy is complete and deliverable for this condition to be satisfied.

7. Procure21

7.1. The Borrower will use the P21+ Procurement Framework for all publicly funded capital works, unless otherwise agreed with the relevant Supervisory Body.

7.2. Where the Borrower proposes to use an alternative procurement route, the Borrower will submit a business case to the relevant Supervisory Body for approval demonstrating that an alternative procurement route offers better Value for Money than the P21+ Procurement Framework.

8. Finance and Accounting and Payroll

8.1. The Borrower undertakes to commission NHS Shared Business Services to complete a baseline assessment of the Borrower's finance and accounting and payroll services to assess the benefit of the use, or increased use, of an outsourced service provider. The Borrower will provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement.

8.2. Where the assessment by NHS Shared Business Services supports the case for the use, or increased use, of an outsourced service provider, the Borrower will undertake an appropriate market testing exercise or use existing Government Framework Agreements to procure an outsourced service provider within a timescale to be agreed with the Lender.

9. Bank Staffing

9.1. The Borrower will undertake an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency to assess the benefit of the use, or increased use of an Outsourced Staff Bank provider. The Borrower commits to provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement.

9.2. Where an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency supports the case for the use of Outsourced Staff Bank provider, the Borrower will undertake an appropriate market testing exercise or use an existing Government Framework Agreement to procure an Outsourced Staff Bank provider within a timescale to be agreed with the Lender.

10. Procurement

10.1. The Borrower shall provide third party non-pay spend to the lender in a format specified by the Lender, within 6 months of the date of this Agreement, and at least annually thereafter, on the request of the Lender,

10.2. The Borrower shall test the savings opportunities of increasing usage of the NHS Supply Chain and future editions and/or replacements of the NHS Catalogue within 6 months of the date of this Agreement and at least annually thereafter, on the request of the Lender,

10.3. Any savings identified through the process set out in 10.2 will be pursued by the Borrower. Any identified savings which the Borrower does not intend to pursue must be notified to the Lender along with the reasons for not doing so.

10.4. The Borrower will provide the Lender with current copies of its medical capital equipment asset register, medical equipment maintenance schedule, and capital medical equipment procurement plans within 6 months of the date of this Agreement, and at least annually thereafter on the request of the Lender.

11. Crown Commercial Services (“CCS”)

11.1. The Borrower undertakes to test the scope of savings opportunities from CCS within 6 months of the date of this Agreement, subject to appropriate CCS resources being available to support this undertaking. Any savings identified as part of this process which the Borrower does not intend to pursue must be notified to the Lender with the reasons for not doing so.

11.2. The Borrower additionally undertakes to provide details of its relevant requirements in support of all future collaborative procurements including e-auctions.

12. EEA and non-EEA Patient Costs Reporting

12.1. The Borrower undertakes to:

12.1.1. Become a member of the EEA portal and actively report EHIC and S2 patient activity on the portal

12.1.2. Provide an overview of the patient identification, billing and costs recovery systems in place with any planned improvements (for EEA and non-EEA patients)

12.1.3. Participate and collaborate with local/national commissioners in the development of the new ""risk sharing"" model for non-EEA chargeable patients.

13. On request of the Lender, the Borrower agrees to provide timely information and enable appropriate access to parties acting on behalf of the Lender for the purposes of appropriate tracking and reporting of progress delivering the conditions set out within this Schedule.

SIGNATORIES

Borrower

For and on behalf of MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

By:

Name:

Position:

Address: Maidstone Hospital
Hermitage Land
Maidstone
Kent
ME16 9QQ

Email: stephen.orpin@nhs.net

Attention: Stephen Orpin

Lender

The Secretary of State for Health

By:

Name:

Address: Department of Health,
4th Floor,
Skipton House,
80 London Road,
London SE1 6LH

Email: dhloanscentralinbox@dh.gsi.gov.uk